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Home Care Cooperatives Revenue Growth And Diversification

A guide to help home care cooperatives better understand and assess revenue growth to support long term sustainability. This guide provides a discussion and review of four promising revenue diversification opportunities home care cooperatives could pursue to support long term growth.

About The Organizations

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Introduction

In 1985 the first home care cooperative, Cooperative Home Care Associates, based in the Bronx, New York, was born. Now 34 years later, there are twelve home care cooperatives in different stages of development, operating in eight states across the country, with numerous new cooperatives under development. Like all successful businesses, home care cooperatives must regularly adapt to grow and thrive. In a rapidly changing industry, strong home care agencies must continually assess their place in the market, adapt their business model, and capitalize on new market opportunities. While there are numerous factors that contribute to the development and maintenance of strong and agile businesses, regular investment in revenue growth and diversification is one critical piece of the pie.

For obvious reasons revenue growth can be good for business by allowing businesses to make investments in systems improvements, workforce benefits, business expansion or other needs. For home care cooperatives, more revenue for the business can also means more profit for its members. Revenue diversification on the other hand, reduces dependence on any one line of business, reducing vulnerability and risk to regulatory and market changes associated with that line of business. In combination, a diversified revenue stream that supports revenue growth, should result in a financially strong and resilient business. Of course, developing, launching and managing new lines of business is challenging and can create operational burdens that have the opposite impact--reducing organization efficiency and service quality. Despite these challenges, the benefits are substantial, and most businesses will eventually choose to pursue revenue diversification at some point.

This guide was developed to help home care cooperatives understand revenue growth and diversification, assist home care cooperative leadership in making informed, strategic decisions about growth and diversification options, and to outline specific paths that home care cooperatives in different stages of their growth and development can pursue.

In this guide you will find:

- An in-depth explanation of revenue growth and diversification
- A review of home care industry trends that impact service and customer diversification
- A framework for assessing revenue growth and diversification options
- A summary of four fruitful expansion options available to home care co-ops today

For readers who want to explore individual revenue growth and diversification options in greater depth, individual reports on each of the four most viable market expansion options accompany this guide.

- Referral Partnerships: Expanding Personal Care Services to New Customers
- Care Management: Growing Revenue Through Value-Added Support Services
- Specialized Care: Growing revenue through specialized care services: A focus on dementia care
- Home Health Care: Moving up the Continuum of Care

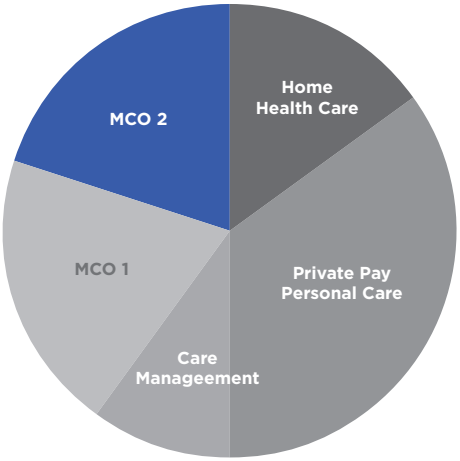
These reports take an in-depth look at market demand, payers, operational needs, financial feasibility, and barriers to entry for each revenue growth and diversification opportunity.

What is Revenue Diversification?

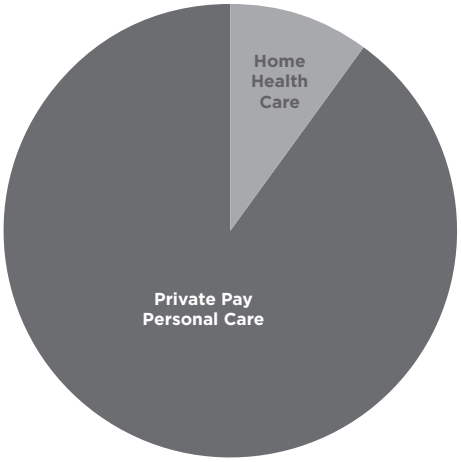
Revenue diversification is when a business decides to sell a new service to current customers, the same product to different customers, or some combination of both. Expansion to new customers or the introduction of new products to existing customers creates new revenue streams. New revenue streams that are successful result in revenue growth.

Managing new lines of business is not without challenges however. If not done properly, diversifying can create operational burdens that reduce organization efficiency and product quality. Despite these challenges, the benefits are substantial, allowing companies to enter new markets while simultaneously reducing their dependence on any one line of business in the case of policy change or emergency.

Diversified Revenue



Concentrated Revenue



Why Should Home Care Cooperatives Diversify?

The home care cooperative community encompasses a wide variety of businesses from small start-ups to large established agencies, and from agencies that only serve private pay clients to those that primarily serve the public pay market. Despite these differences, all co-ops must be able to adapt to rapid changes in the market, including government regulations, client preferences, technology advancements and more. For small start-up cooperatives, focusing on one service, ensuring high-quality delivery, and gaining market share is essential to entering the market and building a strong business. As organizations mature and have more access to resources, it is wise to expand into new markets, products, and/or services to continue to grow and remain agile and relevant in the market.

Not only does revenue diversification enable a company to access larger markets and new customers, it also reduces the risk that poor performance in any one service or product line could topple the entire business. In home care a singular focus on one revenue stream comes with the additional risk that changes in public policy or customer preference can deal a fatal blow to the business.

Risks of Revenue Concentration	
Policy Risk	**Payor Risk**
Reimbursement rates get reduced	A primary referral partner such as a Managed Care Organization (MCO) goes out of business or prefers a different agency
Overall home care funding reduced	Home Care Client switches to a competitor
Policy changes direct service to other providers	MCO or other primary referral partner creates their own in-house home care division
	Payor decides to no longer utilize home care services

For home care business with more diversified revenue streams policy and payor risks still represent real and important business challenges, but their severity is lessened.

For example, take two home care agencies each with $1 million in annual revenue. Agency 1 has two customers each representing 50% of total revenue. Agency 2 has 20 customers each representing 5% of revenue. If Agency 1 loses one customer, the business immediately loses $500,000 in revenue and will likely be at risk of shutting down. Agency 2 could lose 5 times as many customers as Agency 1, yet would lose only $250,000 in revenue, half the loss experienced by Agency 1. This is, of course, a simplified model, yet it shows how agencies with more diversified revenue streams are more resilient to changes in the industry. Thus, the most important question for organizations considering revenue growth and diversification to ask is not should we diversify our revenue or focus on current products/services, but when, what, and how should we diversify? In other words, when in the growth of the business is it right to diversify? What products or services best match the organization's operational and management capacity? And how can this new service expansion be implemented?

Cooperative Home Care of Boston: A Cautionary Tale

As part of an effort to replicate the success of Cooperative Home Care Associates in the Bronx, Cooperative Home Care of Boston (CHCB) was launched in 1994 to provide quality home care jobs and quality home care services to Boston's seniors and people with disabilities. CHCB initially had success in the public pay market and was a profitable business with 70 employees by 1997. CHCB revenue, though, was heavily concentrated in the publicly funded home care market. In 1997, welfare reform led to significant cuts in Medicare and Medicaid funding for home care forcing 26 home care agencies in Massachusetts to close including CHCB. Overall, 30 percent of Medicare home care businesses closed due to policy changes in the late 90's.

A retrospective written by PHI, one of the organizations instrumental in launching CHCB, on the closure of CHCB found that the cooperative did attempt to diversify its service offerings and payor mix as a response to the Medicare reforms. Unfortunately, this reactive attempt to rapidly diversify services following policy reform created significant operational challenges for the cooperative. The increase in back-office complexity led to increased operational expenses and directed management time away from more strategic work. Had CHCB anticipated change and proactively planned, the organization would have been better insulated against the negative impacts of regulatory change.

For CHCB revenue diversification was not a panacea. The organization could not rapidly build the back-office system needed to handle a more complex business. Clearly, revenue diversification is not effective as an emergency response to a sudden change in the market. Organizational and financial capacity must be built over time so the business can support new revenue streams prior to a crisis. Once that capacity is built, though, the business will be more capable of weathering a crisis.

Industry Context

When considering market expansion and revenue diversification, it is important to consider the industry context in which a cooperative operates. In a regulated industry such as home care, it is also important to keep track of policy changes, both at the state and federal levels. Major industry trends that will continue to change the industry include:

Consolidation: Over the last few years there has been significant merger activity including the merger of two of the largest home care companies, LHC and Almost Family. Other large home care agencies are pursuing growth through acquisitions of small- to medium-sized agencies. For the larger agencies, the focus of their expansion is to offer services across the continuum of care from personal care to home health care and hospice, and to other specialized in-home services.

Franchise Growth: The industry has seen aggressive growth of home care franchises in nearly every major geographic market. Franchises are becoming more sophisticated and are beginning to look at acquisitions of small-and medium-sized agencies as a growth strategy. Franchises typically operate in the private-pay market and have been gaining increased market share in that space.

Venture Backed Technology: In 2016 alone, venture capital firms invested $60 million into developing technology platforms with the hope of disrupting the home care industry. Home care, however, is an industry based upon strong relationships between agencies, clients, and caregivers. While technology platforms can facilitate these relationships, they cannot replace them. This fundamental reality of the industry has ultimately forced successful venture backed home care companies to work with on the ground partners and agencies. Technology innovations continue however and will inevitably impact the industry in important ways.

Policy Changes: The emphasis on home-based care is growing across all publicly funded long-term care programs. In the upcoming months and years, Medicare Advantage will expand public payments for home care outside of Medicaid, but the exact impact of these changes is uncertain. As home-based programs expand, so does regulation and oversight. At the state level, moratoriums on new home care agencies have been imposed in several states to try to control unwieldy growth of new agencies.

Takeaways: As the home care industry moves towards consolidation, mergers, and internal organizational growth, it will be imperative for smaller home care agencies, including co-ops, to grow and expand service offerings to remain competitive. Diversification of revenue sources will grow in importance as policy changes create risk for agencies that earn revenue from only one or two sources.

How & When Should Home Care Cooperatives Diversify?

As a cooperative grows and changes over time, different revenue growth and diversification opportunities will be more or less viable, and it is important to begin exploration of options with a clear understanding of where the cooperative agency sits within the broader industry context. Today, most new home care cooperatives start as small private pay companies. With fewer regulatory and licensing barriers to entry and often significantly higher rates, this is the most logical point in which to enter the home care market. Once fully operational and financially sustainable, small, private pay cooperatives can consider expansion into diversification opportunities that require simple operational changes and have few regulatory barriers. As a cooperative grows however, it can consider more complex diversification options as the organization will have the operational and financial capacity needed to add more complex services. As cooperatives expand into public pay markets, additional opportunities for diversification become feasible. While expanding into the public pay market is an important diversification strategy, it is not discussed in this guide.

For cooperatives already operating in the public pay market, regardless of scale, diversification is perhaps even more important. The home care regulatory market is rapidly changing, and as demonstrated by the Cooperative Home Care of Boston case suggests, for agencies concentrated in public pay programs, a single change can result in agency closure. Diversifying earlier rather than later will better protect the agency against regulatory changes. Of course, agency size, maturity, location, internal capacity and other internal and external factors must be considered carefully.

When assessing revenue growth and diversification strategies, the key question a cooperative must ask are;

1. Do we want to pursue this strategy?
2. Will this strategy help us be financially sustainable?
3. Are the market conditions right for this to be a feasible strategy?

What follows is a framework to determine how such an assessment should be made.

A Framework for Assessing Revenue Diversification Options

As a cooperative considers the viability of potential revenue growth and diversification options, there are five key questions that must be asked of each strategy:

❶ Demand	Is there a significant need for this service?
❷ Payers	Do clients or institutions have the ability and willingness to pay for the service?
❸ Capabilities	Does the cooperative have the expertise, operational ability, and staff capacity to launch this type of service?
❹ Financial Feasibility	Is this a financially feasible strategy for the home care cooperative?
❺ Barriers to Entry	Are there obstacles, beyond operational and financial feasibility, standing in the way of pursuing such an opportunity?

The first two questions—demand and payers—focus on whether there is a critical mass of clients in the market. In the home care space, differentiating between users of a service (e.g. home care clients) and payers for the service (e.g. Medicaid) is necessary in order to determine whether a strategy is viable. Recent and continuing changes to health care and long-term care reform could mean that not every state will have the same streams of funding (e.g. private insurance, Medicare Advantage Plans, Medicaid) to pay for the delivery of home care. To find a viable market, a cooperative must both identify significant demand for the service and payers for the service. Markets are not static however. Regular assessment of the market and assessment of

new or changing opportunities is advisable for all healthy businesses. By staying abreast of industry and market news and trends a home care co-op will be better prepared to identify growing market demand for a service.

Once a market opportunity is identified, questions three and four—capabilities and financial feasibility—define whether a revenue expansion strategy is feasible for a cooperative to pursue. The purpose of question three is to determine if there is a fit between a growth or diversification strategy and a home care cooperative's current operating capacity. For example, while a new revenue stream may show great promise for a large public pay cooperative, it may prove very difficult, if not impossible, for a small private pay cooperative to pursue due to given limited internal capacity. Similarly, for a large co-op with a focus on public pay, staff may not have the knowledge or systems in place to effectively reach or serve private pay clients. Therefore, an opportunity must match a co-op's size and operational capacity, or adequate resources to develop and increase operational capacity must be available to warrant examination of a new opportunity.

The fourth question addresses whether starting a new business line would be financially feasible. A thorough assessment of a revenue growth and diversification strategy will at minimum outline the costs of starting a new business line, the ongoing expenses of operating that service, and the number of new client hours needed to make that service financially feasible at a break-even rate. Finally, the fifth question asks what other non-operational and non-financial barriers might stand in the way of launching such an endeavor, including potential opportunity costs—the loss of benefits from one opportunity as a result of choosing another opportunity. For example, an agency that launches its own home health business line could lose referrals from partner home health agencies. It is always important for leadership to take a holistic view when conducting an opportunity analysis and preemptively consider all potential risks, challenges, and opportunity costs.

In summary, when considering an opportunity to expand service offerings, a cooperative's leadership should ask:

- Have we maximized delivery of our current services within our current customer market?
- Is there significant demand for the new service?
- Is there a population or payer that can pay for it?
- Are we capable of providing the service?
- Does this service make financial sense?
- What are the risks and opportunity costs inherent in pursuing the strategy?

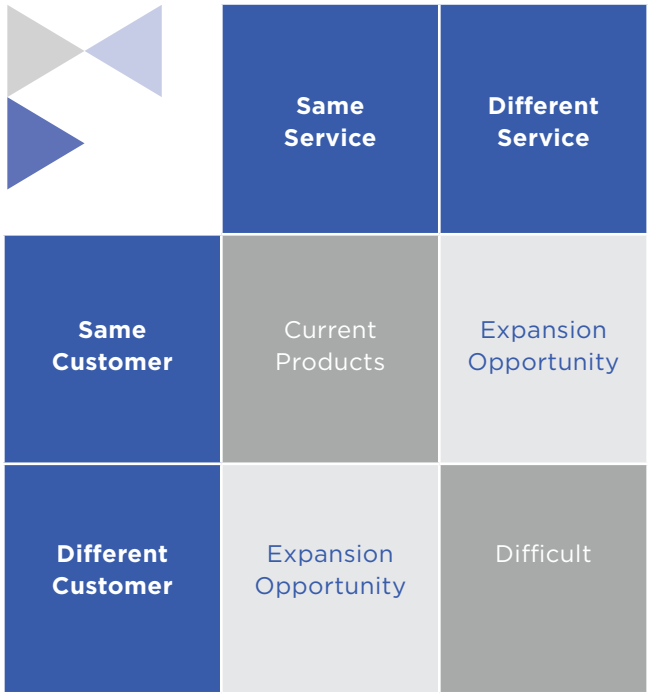
Given that the home care industry is rapidly evolving and subject to substantial shifts in national policy and market driven changes, the best options for revenue growth and diversification may look different in five to ten years, but the process of assessing new opportunities will remain the same.

Primary Pathways to Diversification

When considering potential revenue growth and diversification options, there are three primary categories of opportunities that a company can pursue:

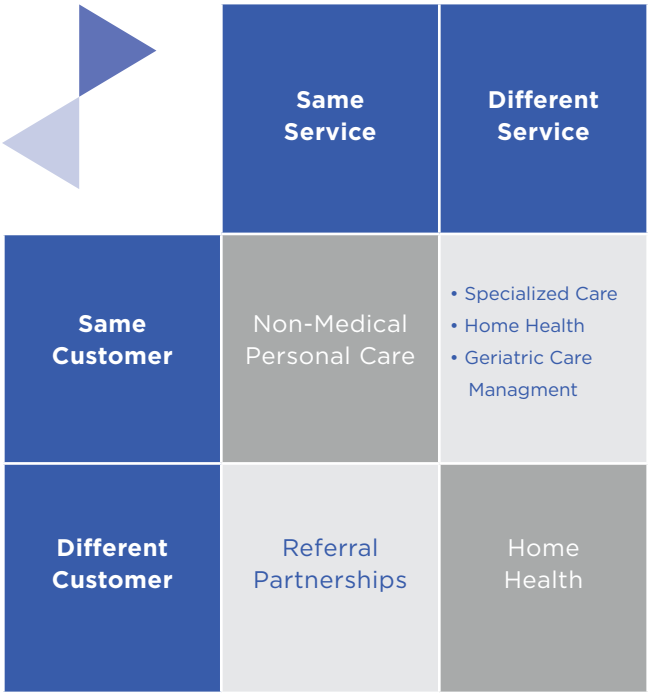
1. Offer the same service to a new customer group
2. Offer a new service to the same customer group
3. Offer a new service to a new customer group

In order of ease of implementation, offering the same service to a new customer group will be the easiest, followed by offering a different service to the same customer group. Efforts to provide a new service to a new group of customers will be the most difficult, especially for smaller organizations that have limited capital or management time available to launch a new business line and market that line to a new group of customers.



Summary of Primary Market Expansion Options

Utilizing the above framework, the ICA Group identified four primary strategies for revenue growth and diversification that show the most potential in terms of Demand, Payers, Capabilities, Financial Feasibility, and Barriers to Entry for existing home care cooperatives. These strategies are Referral Partnerships with a focus on hospice and assisted living facilities, Specialized Care with a focus on dementia care, Geriatric Care Management, and Home Health. In total, the ICA Group analyzed fourteen potential growth and diversification options. Several additional strategies are worthy of consideration depending on an agency's size or location, but were not found to be broadly applicable. These include respite care, Dual Eligibles and Home Services (see full report for analysis of all 14 options). The four selected primary options encompass different approaches to either provide the same service to new clients or increase the number of services offered to current clients.



The table below presents a summarized analysis of the four primary market expansion strategies. More in depth analysis of each strategy can be found in individual reports dedicated to each expansion strategy.

	Referral Partnerships	Geriatric Care Management (GCM)	Specialized Care - Dementia	Home Health
Opportunity	**Primary:** Small and large private pay co-ops and public pay co-ops for expansion of public pay or growth into private pay	**Primary:** Small and large private pay co-ops **Secondary:** Public pay co-ops for growth into private pay	**Primary:** Small and large private pay co-ops **Secondary:** Public pay co-ops pursuing a pay for success model	Large public pay cooperatives
Demand	Increasing demand for home care Untapped potential for referral partnerships with Hospice and ALFs	Minimum of 400,000 potential clients, with growing awareness of GCM services	33% of all home care clients have dementia	$90 billion in revenue today, estimated growth to $170 billion by 2026
Payers	Primarily a private pay opportunity	Private pay opportunity	Private pay opportunity	Public pay through Medicaid & Medicare reimbursement
Operational Capabilities	• Already a core service • Plays into cooperative advantage • Key need is strong marketing materials and partnership development capabilities	• Need a Geriatric Care Management Specialist • Expanded marketing and admin support for scheduling and billing	• Already serving many of these clients • Caregivers will need additional training in specialized services • Expanded marketing of services	• Nurse supervision and Home Health Aides needed • State licensing
Financial Feasibility	• Low cost with few barriers to entry • Opportunity to grow private or public pay revenue streams	• Low cost with few barriers to entry • Opportunity to grow private pay revenue streams	• Low cost with few barriers to entry • Opportunity to grow private pay revenue streams	Feasible only for the largest cooperatives that are already operating in the public pay space.
Barriers to Entry	• No regulatory or other barriers to entry	• Attracting and hiring qualified GCM staff and covering upfront employment costs before new client revenue	• Limited barriers to entry with only a few states requiring additional training for dementia care	• Complex licensing • High upfront costs • Stiff competition particularly by large players

Ranked from most to least feasible, the four primary opportunities are:

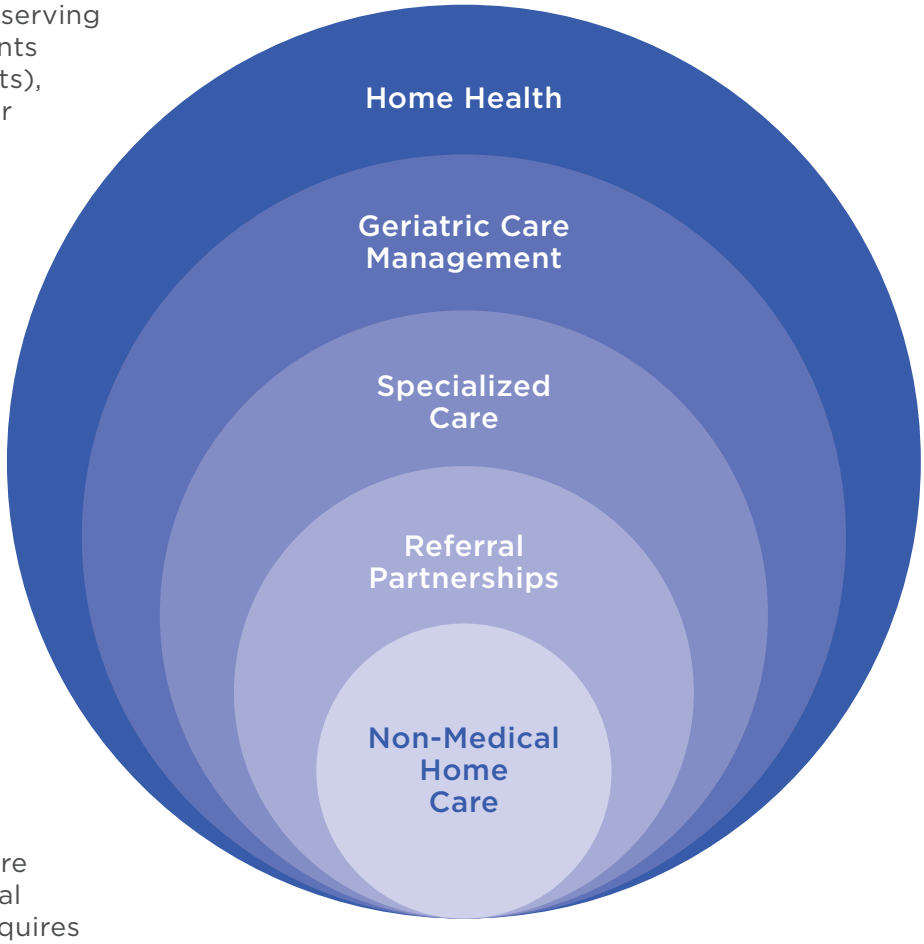
1. **Referral Partnerships** are the most feasible opportunity for home care cooperatives to grow their revenue. While many cooperatives already utilize referral partnerships, as is true in the broader home care sector, this is an underutilized market expansion strategy. It is crucial that all cooperatives invest staff time and money in developing and growing referral partnerships.

2. **Specialized Care** services are an important method for cooperatives to differentiate themselves in the market. As many, if not all, cooperatives are already serving specialized customer segments (such as dementia care clients), differentiation through better training and marketing is feasible and will be advantageous.

3. **Geriatric Care Management** services are another method of providing more value to new and existing customers. This service requires hiring a Geriatric Care Manager. While barriers to entry are low, it is not as feasible as specialized care or referral partnerships given the upfront costs of employing a GCM and marketing a new service.

4. **Home Health** is the next stage in the continuum of care up from non-medical personal care. Adding home health requires new state licensing and more expensive medical staff required for supervision. This is the next logical step for large cooperatives.

At this complex, challenging, and fast-moving time in the home care industry, home care cooperatives provide a unique and promising opportunity to transform the home care industry. Caregiving jobs should be quality jobs; jobs worth owning. To do this, co-ops need to be on the leading edge of the home care industry. With this guide, we hope home care cooperatives can develop new revenue streams, grow their business, and bring about more quality caregiving jobs. We hope these reports will give your co-op the information needed to not just survive, but to thrive in the years ahead.



Referral Partnerships

Expanding Personal Care Services to New Customer Segments

Opportunity Snapshot	
Opportunity	• To expand personal care services to a new customer segment. • Strategy for small or large private pay co-ops or public pay co-ops looking to grow client hours and grow company revenue.
Demand	• Strong and growing national demand for home-based personal care services. • National move towards partnerships that establish “continuums of care”, one-stop-shop, “wrap around services” etc. • Desire among businesses in the continuum of care for reliable service partners to ease their own workload.
Payers	• Private Pay, Long Term Care Insurance, Public Pay
Operational Capabilities	• **Staffing Needs:** Additional staff capacity (whether new or existing staff) for outreach and building “win-win” partnerships. Additional caregiving staff as needed to reliably fulfill additional client hours originating from referral partners. • **Marketing Needs:** Ability to market to existing clients and referral partners. Development of materials to market services to referral partners. Ongoing relationship building and networking. Online presence and Search Engine Optimization.
Financial Feasibility	• **Revenue:** Standard private pay and public pay rates. • **Costs:** Comparable to general client acquisition costs (national median is $540 per client) for relationship establishment. Ongoing costs for relationship maintenance, however this should be lower.
Barriers to Entry	• No regulatory or other barriers to entry.

Summary of Primary Market Expansion Options

Within the personal care industry there are three primary avenues to new client acquisition: ❶ direct to client marketing, ❷ client referrals, and ❸ referrals from partner organizations[1]. This guide provides and in-depth look at referrals from partner organizations, an important strategy for client growth within the home care cooperative sector. With lower turnover and

Top 3 Reasons Why Consumeres Choose a Home Care Provider

1	Recomended by Family & Friends (Client Referrals)
2	Reputation of Company
3	Partner Referals (SNFs, ALFs, & Hospice)

[1] Home Care Pulse 2018 Benchmarking Survey

longer caregiver tenure, better quality training and higher quality care, home care cooperatives have a marketing advantage that can and should be leveraged to secure and maintain strong partnerships with referral partners.

Within the home care industry there are numerous possible targets for referral partnership development including hospital discharge nurses, physicians, skilled nursing facilities, home health agencies, Area Agencies on Aging and more. The best targets for partnership development will vary based on internal factors such as an agency's location, core competencies, and business growth needs (for example the need to grow private pay versus public pay client hours), as well as external factors such as area competition, the presence and needs of specific partner types, partner services and service gaps and client needs. This guide explores referral partnerships through the lens of hospice care agencies and Assisted Living Facilities (ALFs), both because hospice care agencies and ALF's are strong potential referral targets for home care cooperatives, and because they are useful generally as illustrative examples. Interestingly, an increasing number of hospice care recipients reside in ALF's, presenting a dual outreach and marketing opportunity for home care cooperatives to explore. However, as stated above, each cooperative should consider the best opportunities for referral partnership development within the context of their own internal and external environment

Demand

Demand for home care services is at an all-time high and is rapidly increasing. By 2030, seniors aged 65 and over will represent 20% of the U.S population (an estimated 71.5 million people) and over 19 million seniors are estimated to need home care services to age at home. For home care cooperative agencies looking to grow private or public pay personal care, referral partnerships represent a strong business growth opportunity. For referring partners, having reliable, high quality home care partners to service the needs of their clients is often central to their own success.

Hospice agencies and assisted living facilities typically provide limited direct personal care under standard care plans. As such both hospice and assisted living facility clients often rely heavily on outside providers to meet their complete care needs. The following sections explore this demand within hospice care and assisted living facilities specifically.

Hospice

Hospice care is end of life care that provides holistic and individualized care to patients facing a life-limiting illness or injury, and support to the families and other individuals who support them. Hospice care is nearly 100% covered under Medicare (through the Medicare Hospice Benefit), Medicaid, many private insurance plans, HMOs and MCOs. Personal care is a vital component of both home-based hospice care and facility-based hospice care, but cost coverage for personal care is very limited under hospice care plans, with Medicare, Medicaid, and most insurance plans typically covering only one hour of non-medical personal care services per day. Establishing hospice care as a line of business inside of a home care agency is difficult. There is, however, a strong and untapped opportunity for cooperative home care agencies to partner with existing hospice agencies to offer personal care aide services to individuals and families that need more support for activities of daily living, companionship, or other personal care needs in addition to their hospice care.

Data from 2017 suggests that there are 4,400 hospice care agencies in operation across the nation, with two-thirds representing for-profit agencies[2]. Despite the recent trend towards consolidation and acquisition of hospice care providers (primarily by large home health care companies), the majority of hospice care agencies remain small, serving 50 clients or fewer per day. The largest agencies, which represent less than 10% of agencies in the market, serve 500 or more clients per day[3]. Currently, only 6% of home care agencies rate hospices as one of their top two revenue generating referral sources (representing 15% of their annual revenue). It is therefore likely that significant additional opportunity exists to develop referral partnerships with hospice care agencies, particularly among smaller, independent agencies.

[2] Baxter, Amy. July 4, 2018. 2017 Hospice and Home Health Medicare Utilization Trends. Accessed Online: https://homehealthcarenews.com/2018/06/2017-hospice-and-home-health-medicare-utilization-trends/

[3] Facts and Figures: Hospice Care in America (2017) National Hospice and Palliative Care Organization. Accessed Online: https://www.nhpco.org/sites/default/files/public/Statistics_Research/2017_Facts_Figures.pdf

Hospice Care Recipient Profile	
Age	64% of Medicare hospice patients are 80 or older
Percentage of Hospice Care by Location[4]	• Home: 55% • Nursing Facility or SNF: 25% • Assisted Living Facility: 13% • 64% growth in hospice beneficiaries residing in ALF's between 2010-2016
Length of Service	• Average 71 days • Median 24 days • 54% enrolled for less than 30 days

Assisted Living Facility Resident Profile	
Age	53% of ALF residents are 85 or older
Gender	70% female
Median Length of Residency	22 months
Residents with Chronic Conditions	• Cardiovascular Disease: 46% • Alzheimer's or Dementia: >40% • Depression: 23% • Diabetes: 17%

Assisted Living Facilities

According to the National Center for Assisted Living (NCAL), there are currently over 30,200 assisted living communities in the U.S—56 percent chain affiliated, and 44 percent independently owned—serving more than 835,000 seniors. While the lack of federal regulations and standards on assisted living means wide variation in service provision and costs between states and facilities, a study by the Centers for Disease Control found that on average, residents of ALF's receive approximately twelve minutes of nursing care and two hours of personal care per day as part of their assisted living services package[5]. Many ALF residents, however, need additional care.

Large home care companies including Honor and CareLinx have been capitalizing on this need, seeing strong potential in growing partnerships with Assisted Living Providers[6]. That said, just under 9%% of home care agencies rated Assisted Living Facilities as one of their top two revenue generating referral sources (representing 22% annual revenue) in 2017, demonstrating significant untapped potential for referral partnership development. For large national assisted living chains, partnerships with large national home care companies will likely be most attractive, but smaller independent assisted living facilities may be more open to partnering with other local or independent providers. In all cases, referral partners will be keen to partner with agencies that are responsive and provide reliable, consistent, and high-quality care.

Payers

Growing referral partnerships is a key strategy for growing both public and private pay revenue. The focus is on increasing client hours, while ideally reducing client acquisition costs. Both hospice and assisted living facilities are presented here as an opportunity to grow private pay dollars, by addressing the service gap left by hospice and ALF programs. While hospice care and Assisted Living Facility care plans do provide some cost coverage for personal care services, this care is very limited. Additional personal care support must be covered by out-of-pocket, private pay dollars.

[4] Chiedi, Joanne, M. July 2018. Vulnerabilities in the Medicare Hospice Program Affect Quality Care and Program Integrity: An OIG Portfolio. U.S Department of Health and Human Services, Office of Inspector General. Accessed online: https://oig.hhs.gov/oei/reports/oei-02-16-00570.asp

[5] Rome, Vincent and Harris-Kojetin, Lauren. National Health Statistics Reports: Variation in Residential Care Community Nurse and Aide Staffing Levels: United States, 2014 https://www.cdc.gov/nchs/data/nhsr/nhsr091.pdf

[6] Mullaney, Tim, July, 23, 2017. Honor Sees Senior Living Partnerships as Route to New Markets https://homehealthcarenews.com/2017/07/honor-sees-senior-living-partnerships-as-route-to-new-markets/

Operational Capabilities

Staffing Needs

The core staffing needs necessary to support referral partnership development are:

1. Outreach Staff: Knowledgeable, passionate, and articulate cooperative representatives to do outreach and partnership development
2. Office Staff: Sufficient office staff to respond to partner requests in a timely manner and coordinate caregiving schedules.
3. Caregiving staff: Adequate caregiving staff to meet the needs of referred clients. Depending on the type of referral partners being targeted, caregivers with specialized training or experience in relevant areas would likely be helpful in securing referral business. If relevant expertise does not already exist among a cooperative's caregiving staff investing in relevant training or hiring for specific skills may be advised.

Marketing Needs

Expanding home-based personal care supports for referral partners is a relationship-based marketing strategy. As such, key marketing needs are staff with strong outreach and relationship building abilities and strong marketing materials including handouts/ brochures and an attractive agency website. Both the outreach manager and marketing materials should highlight why a home care cooperative is a better partner than another traditional home care agency. Outreach should also be regular and recurring. Once a referral relationship is established, agencies should not assume that referrals will continue to flow without regular check-ins and reminders.

Potential Cooperative Differentiators:

- Strong agency communication and accountability
- Lower turnover rates
- Greater consistency of caregivers
- Better trained caregivers
- Better caregiver supports to manage daily work challenges
- Agency reliability
- Caregiver flexibility
- Experience with specific client pools (hospice, dementia, etc.)

Financial Feasibility

Costs

Because referral partnership development is effectively a marketing strategy, costs are likely comparable to client acquisition costs generally. Client acquisition costs would include the cost to the business to effectively outreach, network, communicate and establish new referral partnerships. Client acquisition costs (for all client acquisition methods) vary regionally and are estimated at a high of $675 per client in the Northeast Region to a low of $405 per client in the Great Lakes Region, with the national median at $540 per client (based on 2017 data)[7]. Given the nature of referral partnership development, the upfront costs of establishing a strong partnership will be higher, but the longer-term costs of maintaining that relationship and acquiring new clients should be lower.

An additional cost consideration worth considering is length of service. For example, based on available length of service data, agencies can only safely assume revenue from hospice care patients for a period of 30 days. As such, it is important for agencies to consider the costs associated with onboarding new hospice clients and the need to more regularly fill caregiver schedules. In contrast, the median length of stay in an Assisted Living Facility is 22 months[8], so client turnover will be less of a concern with this partner type. Referral Partners will service different client pools with

[7] Home Care Pulse 2018 Benchmarking Survey

[8] National Center for Assisted Living (NCAL), Fast Facts & Figures https://www.ahcancal.org/ncal/facts/Pages/Communities.aspx

different service needs. Cooperative's should carefully consider their needs and capacity before beginning a new referral partnership.

Revenue

Additional revenue will be commensurate with an agency's standard private pay or public pay rates and the additional client hours secured. Agency's should establish and track against specific goals to drive and measure the success of specific referral partnership targets.

Barriers to Entry

There are no regulatory barriers to pursuing a referral partnership opportunity or to providing personal care services to referral partners. Of course, an agency must adhere to the general rules and regulations governing the delivery of personal care services in their state.

Implementation & Entry Points

An agency interested in pursuing referral-partnerships as a growth strategy should follow these key steps:

1. Confirm that your agency has adequate staff capacity to respond to referrals, both in terms of office staff and caregivers to service clients[9].
2. Survey your market area to determine potential partners. Prioritize the list based on partnership fit and identify specific contacts for outreach.
3. Research and develop a strong marketing pitch and associated materials that speak to both the referral partners and the clients that your partners would refer.
4. If your agency is not already engaged in partnership outreach and development, identify appropriate staff to conduct this work. Strong communication skills and responsiveness are critical to partnership success.
5. If serving a specialized population base determine whether existing knowledge and experience exists on staff or whether additional training is needed.
6. Begin outreach. Check-in with partners to remind them you have capacity to help and to keep your agency top of mind.

Key Determinants of Success:

- Capacity to develop strong partnerships
- Staff capacity (both administrators and caregivers) to quickly respond to referrals
- Specialized caregiver training and experience
- Commitment to long-term partnerships

Risks & Challenges

Relative to other client growth strategies, there are very few risks and challenges to expanding through referral partnerships. Hospice support specifically warrants special consideration given the high rate of client turnover and the emotional distress that may follow. Ensuring caregivers have appropriate support systems in place to manage grief is an important factor to consider and may prevent caregiver turnover.

[9] In a recent article published in Home Care News, Assisted Living Providers highlighted two key attributes of successful home care partners: 1) strong communication and responsiveness, and 2) specialized training for caregivers, particularly in dementia care (an interesting tie in to the dementia care strategy discussed elsewhere in this diversification strategies report).

Geriatric Care Management

Growing Revenue Through Value-Added Support Services

Opportunity Snapshot	
Opportunity	• To provide a new value-added service to the same customer segment to grow agency revenue. • Strategy for small or large private pay co-ops or public pay co-ops looking to expand private pay business.
Demand	• Primary population utilizing geriatric care management services is elderly individuals aged 81-90 and their families. Estimated client pool of 400,000. • Continued growth of demand likely as population ages, ability of families to coordinate and manage care continues to decline, and awareness of care management grows.
Payers	• Private pay opportunity[10].
Operational Capabilities	• **Staffing Needs:** -Knowledgeable Care Management staff--certified Geriatric Care Management (GCM) Specialist or staff with relevant field experience. -Added administrative capacity to support scheduling and client billing. -If promoting internally, additional caregiving staff to cover lost field capacity. • **Marketing Needs:** -Ability to market to existing clients and referral partners. -Marketing materials to support sale of services. -Online presence and Search Engine Optimization.
Financial Feasibility	• **Revenue:** Average hourly rate of $175 per hour in 2017, paid out of pocket. • **Costs:** Primary cost is Care Management personnel. Client acquisition costs range from $86-193 per client.
Barriers to Entry	• No regulatory barriers to entry. • If hiring a certified Geriatric Care Manager (GCM), primary barriers will be attracting and hiring qualified GCM staff and covering upfront employment costs before new client revenue accrues.

[10] Public pay case management requires significant scale to be financially sustainable and is therefore excluded from this guide.

Introduction

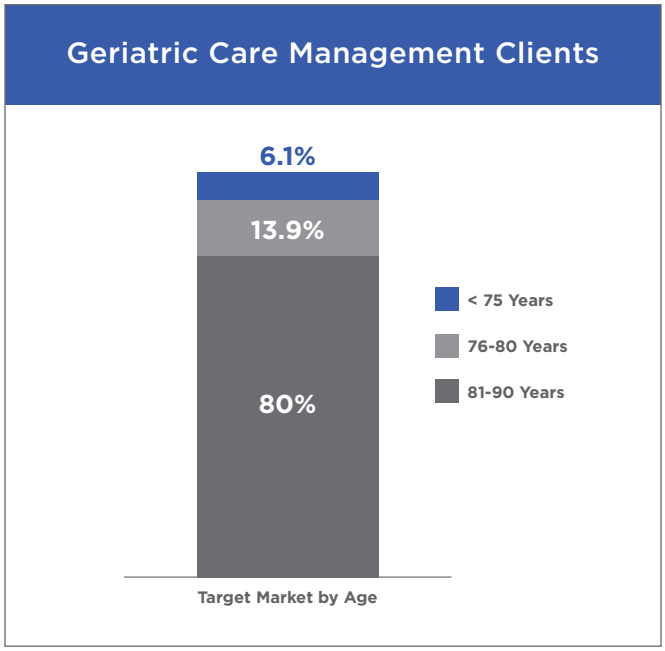
Geriatric care management is a growing sub-specialty within the field of case management focused on assisting elderly[11] populations and their families. Geriatric care managers assess client needs, develop and coordinate care plans, monitor and regularly evaluate care quality and client outcomes, and advocate for services and supports on behalf of clients.

In addition to supporting clients in need of care, geriatric care managers are becoming increasingly important to client families with limited capacity and/or geographic barriers to caring for aging family members. A recent study conducted by the Aging Life Care Association found that 73% of "Responsible Parties"—individuals that authorize and pay for services--that engaged a GCM, did so because the family "lives far away"[12]. As America's population ages, and the number of family caregivers available to manage family members care decreases, demand for GCM services is expected to increase.

Demand

By 2030, seniors aged 65 and over, will represent 20% of the U.S population (an estimated 71.5 million people) and over 19 million seniors are estimated to need home care services to age at home. While specific data on the demand for private pay geriatric care management services is not available, we can presume that the market is represented by a subset of the out-of-pocket home-based personal care population. If we assume 25% of private pay home care clients will need GCM services, the potential pool of clients would be 400,000 at the low end. While this is a relatively small market, the market is growing, and for agencies that are successful at launching and running a practice, profit margins are high.

The primary population utilizing GCM services is elderly individuals aged 81-90 and their families, representing nearly 80% of clients. Of the remaining GCM client population, 13.9% of clients range in age from 76-80. Finally, 93.3% of GCM clients are Caucasian[13], though this could change over time.



Payers

Rates for private pay care management, are high and steadily increasing. As such, geriatric care management has been identified by the ICA Group as an opportunity for home care cooperatives to diversify and grow private pay revenue. Some long-term care insurance plans will cover the cost of an initial care plan, but rarely cover ongoing services. While care management (or case management as it is more commonly known in the public pay arena) is a common service covered by public pay dollars, reimbursement rates are extremely low. Due to these low rates, agencies operating in the public pay case management space must operate at a very large scale to be financially sustainable or must offset the cost of care management services with other higher cost services.

[11] Despite their title, Geriatric Care Managers can and do also assist other client groups including the disabled.

[12] Horne, Mary Anne. Journal of Aging Life Care, How Responsible Parties Value Aging Life Care Professionals' Services. Volume 27, Special Issue, March 2017.

[13] Home Care Pulse, 2014 Care Management Benchmarking Study.

Operational Capabilities

Staffing Needs

On average, agencies earning less than $200,000 from GCM services employ one (1) dedicated care manager and one part-time (.5) administrative staffer. In the case of a cooperative home care agency, administrators would already be in place, but the capacity of the administrative staff to take on new care management associated tasks including scheduling and billing would need to be assessed. For GCM agencies earning between $200,000-$499,999 in annual revenues, no additional administrative capacity is needed, however agencies of this size typically employ three (3) care managers. For providers earning $500,000 and above on GCM services, significant additional capacity is typically added including managerial level staffing.[14]

Annual Care Management Revenue	Care Management Staff Needed	Administrative Staff Capacity Needed
>$200,000	1	.5
$200,001-$499,999	3	.5
$500,000+	6.5	2

Starting hourly wages for geriatric care managers range from approximately $17 to $110, with the median hourly wage at $35. Similarly, annual salaries range from approximately $21,000 to $90,000 with a median salary of $48,000. Educational attainment and certifications, regional and rural versus urban variations, and agency size, are the primary factors driving differences in hourly wages and annual salaries. Many large agencies also offer monthly bonuses for client acquisition.[15]

Geriatric Care Manager Job Profile *For certified GCM Professionals	
Median Wage	• $35 per hour or $48,000 per year
Benefits	• Paid Vacation • Sick Leave • Health Coverage
Other	• Performance Bonuses
Qualifications	• Trained Social Worker or Nurse • Advanced Degree • Professional Certification

Most care managers are paid on an hourly basis (51.3%), and most receive benefits including paid vacation (86.2%), sick leave (69.2%), and major health coverage (63.1%). Being able to provide benefits to care managers may present a barrier to home care cooperatives looking to hire outside certified and experienced geriatric care managers.[16]

There are currently no federal or state requirements for training or certification of GCMs. Training and certification are however, important indicators of quality, and well-trained care managers have higher client acquisition rates, provide better quality service, and demonstrate better client outcomes. Over 80% of GCMs are trained social workers or Registered Nurses and a majority hold advanced degrees (64.5% Masters' and 23.5% 4-year degree) as well as an industry certification[17]. Like the home care workforce, the GCM workforce is predominantly female and predominantly older with the median age for a GCM at 57 years old[18], presenting an

[14] Home Care Pulse, 2014 Care Management Benchmarking Study

[15] Home Care Pulse, 2014 Care Management Benchmarking Study

[16] Home Care Pulse, 2014 Care Management Benchmarking Study

[17] There are currently four certifications broadly recognized by the field: 1) Care Manager Certified (CMC)—administered by the National Academy of Certified Care Managers (NACCM), 2) Certified Case Manager (CCM)—administered by the National Commission for Certifying Agencies (NCCA), the accrediting body of the Institute for Credentialing Excellence (ICE), 3) Certified Advanced Social Work Case Manager (C-ASWCM), and/or 4) Certified Social Work Case Manager (C-SWCM)—credited by the National Association of Social Workers

[18] Home Care Pulse, 2014 Care Management Benchmarking Study

opportunity for younger career professionals to enter the market. Unlike the home care workforce, however, the GCM workforce is predominantly Caucasian.

All GCM certifications require prior completion of an advanced degree (Associates, Bachelors, Masters', or PhD in a related field), supervised care management experience, and in some cases, direct client contact. As such, for those wishing to employ a certified GCM, it may be very difficult for a cooperative to promote from within existing membership. That said, there many are agencies and individuals without formal credentials, but substantial knowledge and experience supporting seniors and their families with resource identification and care coordination, operating in the field. Unsurprisingly, professional care management associations do not look favorably upon uncredentialled individuals operating in the field. Launching a practice utilizing staff that are not credentialed could be a risk to the agency's reputation and should be considered carefully. Accurate marketing of services that are reflective of the care managers' capabilities and knowledge set is one way to ensure quality and customer satisfaction.

Marketing Needs

A strong marketing plan will ensure direct outreach to clients and client families, referral partners, and the community, and investment in online marketing. As is true of personal care services, referrals from existing and past clients and referral partners are the strongest and best source of new business. Home care and home health agencies that also offer GCM services often market their services as complimentary and often as an additional value-add to a suite of services including specialized care, respite care, and more[19].

In today's digital world, online searches are a critical marketing channel for all home care and related services, and investments in website updates to promote GCM services would be necessary. There is currently no central source for identifying home care agencies offering GCM services[20], and online searches for GCM services return few and scattered results. As such, having a strong online presence could significantly increase client sales. Home care cooperatives wishing to build their business from online searches will need to invest in website modifications and search engine optimization (SEO) to see strong results.

Financial Feasibility

Costs

Like home care generally, the primary cost in GCM is personnel, with (certified) care manager wages accounting for 51.6% of direct expenses on average and all personnel related expenses (care manager benefits, payroll taxes, etc.) accounting for 57.25% of expenses on average. As would be expected, direct expenses are higher for smaller agencies than for larger agencies. In contrast, indirect expenses including marketing, rent, and software are lower for smaller agencies. It is worth noting that a cooperative home care agency that adds GCM services will have lower overhead than a standalone GCM practice as rent, software, and other costs will already be paid for by the cooperative. Client acquisition costs range from $86-193 per client, with smaller providers spending less to acquire new clients than larger providers.[21]

Revenue

GCM services are typically billed at an hourly rate, with rates ranging from a low of $75 per hour to a high of $250 per hour depending on experience, geography, and other factors. Available data shows that rates are on the rise with an average rate of $175 per hour in 2017[22]. Many GCMs also offer flat rate fee options for initial assessment and development of a care plan. According to the 2014 Care Management Benchmarking Study, the median rate for initial care management consultation in 2013 was $350 per hour. Some long-term insurance plans will cover the one-time cost of a care assessment or care plan development.

[19] Examples of agencies offering GCM along with home care, home health and other support services include: Best of Care, Angels of Mercy Macon, Elder Care Home Care

[20] Associations representing the GCM field including the Aging Life Care Association and National Academy of Certified Care Managers (NACCM) do not list agencies (home care or otherwise) offering GCM services, rather they list certified member practitioners.

[21] Home Care Pulse, 2014 Care Management Benchmarking Study.

[22] Average rates in 2000 were $74 per hour and in 2013 $110 per hour

Assessing the Competition

5 quick tips to help you assess demand and competition in your area.

- Google Search a variety of related terms to identify competitors to see who might be providing services in your area. For example: "Geriatric Care Management New York City" and "Senior Care Coordination Dane County"
- Reach out to senior care service providers including Area Agencies on Aging to inquire about GCM service providers and the frequency of requests for services from their stakeholders.
- Search online databases consolidating senior service provider listings.
- Contact your state Department of Health or other regulatory body.
- Reach out to geriatric doctors, church clergy and other community members with frequent interaction with seniors to explore need among their constituents.

A single full-time GCM services an average of 17 clients per month[23] at roughly two billable hours per client per week[24]. On average, agencies receive 56 inquiries per year and 21 of those inquiries become active clients, meaning the median close rate is 48%[25]. According to a 2002 study by AARP, 45% of client contracts lasted one year or less, 21% of client contracts lasted between one and two years, and the remaining 33% for longer[26]. Taking length of service, fee differentials, client acquisition costs, and other factors into account, client average lifetime values range from a low of $2,000 for small providers to a high of $8,297 for large providers[27]. We estimate that a home care cooperative would need to have ten ongoing GCM clients to cover additional expenses from launching a Geriatric Care Management service line.

Barriers to Entry

There are currently no federal or state regulations covering the Geriatric Care Management sector. Primary barriers to entry are the cost of hiring a trained professional (if desired) and marketing GCM services to potential clientele. Notably, these expenses would need to be incurred prior to earning revenue from providing GCM services. Therefore, the cooperative would need to be financially stable and must fund the new program out of home care revenues or through a loan or line of credit. As a private pay business, potential clients in a cooperative agency's area must have the ability to pay for services. Understanding the appropriate rate to charge for services to both ensure affordability for potential clients and financial sustainability and profitability for the home care agency will be critical.

Implementation & Entry Points

The critical steps for an agency interested in pursuing Geriatric Care Management as a growth strategy are:

1. Research local competition and confirm unmet demand in agency's service area.
2. Attract and hire a qualified Geriatric Care Manager or identify existing staff with adequate skills and experience to succeed in the position.
3. Develop a strong outreach and marketing plan and accompanying materials.
4. Outreach to clients and referral partners, develop an online presence and invest in Search Engine Optimization.
5. Quickly secure clients and develop a strong client pipeline.

For home care agencies, offering Geriatric Care Management in-house creates an internal client referral feedback loop that can be leveraged. Prospective clients (individuals

[23]Stone, Reinhard, Machemer, and Rudin. November 2002. AARP, Geriatric Care Managers: A Profile of an Emerging Profession.

[24]Home Care Pulse, 2014 Care Management Benchmarking Study

[25]Home Care Pulse, 2014 Care Management Benchmarking Study

[26]Stone, Reinhard, Machemer, and Rudin. November 2002. AARP, Geriatric Care Managers: A Profile of an Emerging Profession

[27]Home Care Pulse, 2014 Care Management Benchmarking Study

or their families) who inquire about home care services but are not ready to commit, or need assistance in assessing options before committing, can be referred to the agency's internal GCM for support. While a client (or client's family) may determine that they are not ready for home care services, they may need some level of assistance, such as developing a care plan. The agency can charge a fee for care plan development, while also keeping the potential client notified of potential future home care services. In cases where family members are geographically separated, clients may elect for both home care services and GCM services as an added support.

Risks & Challenges

While launching a GCM service presents fewer risks and challenges than other diversification strategies, as with any new business venture risks and challenges are still present. Primary business risks and challenges include:

- Upfront cost of hiring a GCM before client load can cover costs (if hiring externally or increasing pay)
- Potential that client acquisition will be slower than anticipated
- Client demand is not sufficient to cover GCM staffing costs or too much competition
- Difficulty hiring a trained/certified GCM that may be used to receiving benefits (if not offered at the agency)

Additionally, as GCMs frequently work with client families, many of whom live out of state, it is important to remain focused on what is best for the client, rather than convenient for the client family. This has become a criticism of the GCM field, and a good GCM will be adept at managing both what is best for the client and what is desired by the client's family.

Appendix: Break-Even Estimate

At a conservative rate of $100 per hour assuming two client hours per week, at a median salary of $60,000 plus benefits, an agency would only need to acquire and service 14 clients per year (accounting for client turnover) to break even. While studies have shown that client acquisition is typically slow in year one, most agencies are able to build a base of clients and a reputation to continue to grow the GCM business by year two. As such, acquisition of 14 clients in year one does not seem unreasonable for an agency motivated to introduce a GCM service. Experienced GCMs will likely come to the agency with experience growing referral partnerships, and agencies can be careful to hire practitioners with this experience to assist with initial program growth.

Estimated Revenues and Expenses of GCM	
Revenue	
Clients per Month	17
Weekly Billable Hours	2
Yearly Hours	1,768
Hourly Rate	$100
Weekly Revenue	3,400
Monthly	14,722
Yearly	$176,664
Additional Expenses	
Median Salary	60,000
Payroll & Benefits (30%)	18,000
Marketing	3,698
Admin Time (.5 FTE)	18,720
Total Expenses	$100,418
Net Income	$76,247
Yearly Break-even	
Hours Needed	1,004
Clients Needed	9.7
Clients Needed + Client Turnover	14.0
Inquiries Needed	37.3

Growing revenue through specialized care services: A focus on dementia care

Opportunity Snapshot	
Opportunity	• The primary opportunity for specialized care appears to be for private pay home care cooperatives. • A secondary opportunity exists for public pay home care cooperatives that are working to grow their private pay services and revenue and/or are pursuing pay for success models. • While there are numerous types of specialized care, dementia care stands out as the largest and most universal opportunity for home care cooperatives.
Demand	• The potential pool of dementia care clients is estimated to be 33% of all home care clients and it will continue to grow over the next decade.
Payers	• Dementia care services are paid through both public payers (as personal care services) and private payers, but the primary market opportunity will be through marketing to private pay clients.
Operational Capabilities	• **Staffing Needs:** Caregivers trained and certified in dementia care (or other specialized care fields). Administrative staff time for marketing specialized services. • **Marketing Needs:** Ability to market to existing clients and referral partners. Online marketing of specialized service capabilities and SEO.
Financial Feasibility	• **Costs:** Specialized caregiver training in dementia care as needed and additional marketing investments to promote and sell specialized services. • **Revenue:** If a cooperative can acquire two to four more clients per year, it will begin to earn additional profit with this strategy.
Barriers to Entry	• Limited barriers to entry with only a few states requiring additional training for dementia care.

Introduction

Specialized home care services are typically provided by specially trained caregivers for populations including individuals with dementia, autism, and chronic diseases. Many home care businesses already serve these populations. For example, one in three home care agency clients have been diagnosed with some form of dementia. There is potential for agencies that provide specialized training for their caregivers to better serve these populations leading to an advantage in the marketplace.

The ICA Group's research has identified dementia care as the best opportunity in specialized care for home care cooperatives to pursue. This does not preclude strategies in other specialized care markets, but these markets are either quite small (pediatric)

or involve a shift towards home health care (chronic disease) that may be too expensive for many cooperatives. A dementia care strategy, on the other hand, is relatively inexpensive to launch, targets a large and growing market, and builds on skills and experience already developed within the home care cooperative community. As such, home-based dementia care has been identified by the ICA Group as an opportunity for home care cooperatives to diversify and grow revenue.

Demand

The term dementia is used to describe a group of symptoms that are associated with several diseases including Alzheimer's, Lew Body, and Parkinson's[28]. Dementia is already a common condition among the nation's elderly, with 33% of home care agency clients diagnosed with some form of dementia nationally. As the population ages, the number of people living with some form of dementia is expected to grow. As preferences for aging at home also grows, the demand for home focused dementia care will also continue to increase.

Market for Dementia Care	
Populations	• 2017: 5.3 million 2025: 7.1 million
Spending	• $259 billion per year • $186 billion from public payers
Individual Cost	• $341,840 per individual with dementia
Out-of-pocket spending	• 70% of dementia care costs are out-of-pocket • $61,522 over five years

Given this large and growing base of clients, there is significant market opportunity to improve care for current clients and to bring in new clients through the marketing and provision of specialized dementia care services. Outside of clients already working with home care agencies, it is estimated that friends and family members provide 18.4 billion hours of unpaid caregiving hours each year for loved ones with dementia.[29] Providing relief and support for these family caregivers is another opportunity to bring new clients into a home care business, with the potential for hours to grow as conditions worsen or family capacity changes.

Payers

There are two payers through which a home care agency may choose to bring on new dementia care clients: public sources such as Medicaid or private pay sources. Currently, public programs supporting home care clients do not differentiate and pay service premiums for dementia care clients under their purview. As such, the primary benefit to marketing and offering specialized dementia care services to public payers (such as Managed Care Organizations) is the potential for increased referrals. On the other hand, given the large and growing number of families caring for loved ones with dementia, it seems that private pay sources – either out-of-pocket or through long-term care insurance – could be a strong market. Further, families seeking support services for their loved ones suffering from dementia will in many cases prefer (and in some cases pay a premium for) caregivers experienced and trained in dementia care.

Operational Capabilities

Staffing Needs

Most existing home care cooperatives already take care of clients with dementia and some caregivers will have considerable practical

[28]Alzheimer's Disease and Dementia. (2019). Alzheimer's and Dementia. [online] Available at: https://www.alz.org/alzheimer_s_dementia [Accessed 3 Sep. 2019].

[29]Alzheimer's Disease and Dementia. (2019). Facts and Figures. [online] Available at: https://www.alz.org/alzheimers-dementia/facts-figures [Accessed 3 Jan. 2019].

experience providing dementia care. Despite this experience, for a co-op to deliver the highest quality care to its clients with dementia and market this advantage effectively, the cooperative needs to clearly demonstrate that all, or a subset of caregivers are officially trained in treating clients with dementia. Certifications or other official and reportable forms of training will significantly strengthen that advantage. There are numerous reputable training resources from national Alzheimer's Association to community colleges and online training sites that cooperatives can leverage for caregiver training.

When it comes to treating dementia or other chronic diseases, retaining a customer is just as important as acquiring a customer. The progression of dementia can take up to 10 years through many distinct stages and care needs. A cooperative must be able to provide quality home care across most stages of dementia from initial support up until the client needs facility-based care. This creates a long-term relationship between client and caregiver leading to better quality care and more satisfied clients and caregivers. Ultimately, these relationships drive business success by reducing expenses on sales, marketing, and client and caregiver retention.

Marketing Needs

While it is always the goal of a home care cooperative to provide the best care possible, a cooperative must also leverage its high-quality care to bring in new clients[30]. A home care cooperative interested in pursuing a specialized dementia care growth strategy will need to increase marketing spending to attract new clients. This should include at minimum, an update to the agency's website describing and highlighting its dementia care service and a corresponding investment in search engine optimization, an update to other marketing and sales materials including printed brochures and print advertisements, and a planned effort to reach out to current and past clients and referral partners to highlight the agency's capabilities.

Financial Feasibility

Revenue

Home care agencies typically do not charge more for clients with dementia[31], but could charge more if expanded services are offered. Given this constraint, acquiring new clients with dementia is necessary to diversify revenue sources. In other words, this is primarily a marketing and volume strategy and not a margin strategy.

Costs

To implement this strategy, a home care business must 1) develop a clear competitive advantage in caring for clients with dementia, and 2) be able to communicate that advantage to the marketplace. A home care cooperative looking to pursue this strategy must invest in additional training for caregivers and additional marketing of services.

Training Expenses: In order to estimate the additional cost of specialized care, The ICA Group looked at the CARES training program, which is designed to prepare caregivers for the Alzheimer's Association's Essential ALZ exam. This program is a dementia care training program and is not limited to Alzheimer's care. This training program provides comprehensive training forthe exam using an online platform. To access the complete catalog of CARES training programs it cost $2,500 per year[32] for a single site with an unlimited number of user licenses. This analysis also factors in the cost of paying

Specialized Care Costs	
Training Program	• $2,500 (High Estimate)
Training Time	• $480/caregiver
Additional Marketing	• $2,500 initial and $1,200 ongoing

[30]Bildandco.com. (2019). 4 Ways to Market Memory Care on Your Website - Bild & Company. [online] Available at: https://www.bildandco.com/2017/02/21/4-ways-to-market-memory-care-on-your-website/ [Accessed 3 Sep. 2018].

[31] Alzheimer's Disease and Dementia. (2019). In-home Care. [online] Available at: https://www.alz.org/help-support/caregiving/care-options/in-home-care [Accessed 8 Aug. 2018].

[32]Hcinteractive.com. (2018). Pricing at a Glance | HealthCare Interactive. [online] Available at: http://www.hcinteractive.com/pricing [Accessed 16 Aug. 2019].

caregivers for the time spent completing the training. The full CARES program takes 32 hours to complete. Assuming a $15 per hour[33] fully loaded cost, it costs about $480 per caregiver to complete the training. This estimate is conservative and likely represents the higher end of training expenses.

Marketing Expenses: According to the 2018 home care pulse survey, the median cost of acquiring a new home care client is $590. The cooperative will likely also have additional expenses to add a new dementia focused page to its website, engage new referral partners or re-engage existing referral partners on dementia care, and to develop other new marketing materials such as fliers and online advertisements that the co-op deems necessary. It is safe to estimate that the cooperative will need to spend an additional $2,500 in year one and an ongoing additional expense of $1,200 per year.

State	Training Requirements
Illinois	24 hours of initial training and 12 hours per year ongoing
Massachusetts	Aides provided through HCBA waivers must be certified as a Home Health Aide or CAN and have additional training from the Alzheimer's Association of MA
Rhode Island	20 hours initial training and 5 hours of practical experience
Minnesota Missouri Delaware Florida	No hourly requirements. Training is needed on 4 or 5 of 7 requirements specified in each individual state's laws
Arkansas Colorado Connecticut Washington New York West Virginia	Other

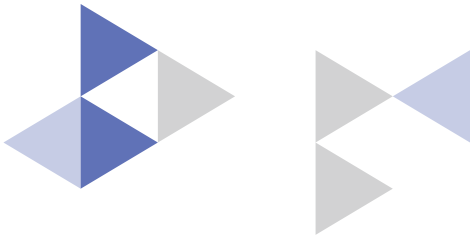
Barriers to Entry

Presently there are no additional licensing requirements for home care agencies taking on clients with dementia. Only 13 states have additional requirements for caregivers working with clients with dementia. As outlined in the financial feasibility section, there are some additional expenses needed to develop a quality dementia care program. While these costs are relatively low, a cooperative with limited credit or cash on hand may have difficulty launching such a program as operational needs will be more pressing. A cooperative could mitigate these barriers by only training a smaller subset of caregivers in dementia care. In general, this strategy is a low-cost method of diversifying revenue streams with few structural barriers to entering the market.

Implementation & Entry Points

Successfully pursing a dementia care strategy hinges on execution and differentiation. To bring in new customers a cooperative must have a marketing strategy that differentiates them from local competitors. This is clearly a competitive space, and a "build it and they will come" strategy will not be effective in bringing in new customers. To effectively enter this market a home care cooperative needs to:

1. Provide high quality training in dementia care to some or all its caregivers.
2. Have messaging and branding that stands out and differentiates the co-op from the competition. Pairing specialized training and care marketing with strong marketing about the cooperative difference (emphasizing lower turnover, a greater consistency of care, more committed caregivers, and better-quality care), could provide a competitive edge.



[33] Rate will vary by geographic location.

Risks & Challenges

- Competition: Dementia care is a competitive market, and most major home care franchises and agencies have some marketing materials focused on dementia care.
- Quality and Training: Quality dementia care is not the result of a one-time investment, but rather an ongoing commitment to recruiting, training, and retaining the best caregivers and ensuring caregivers serving dementia care clients receive ongoing and updated training. If a cooperative fails to provide high quality dementia care services, the organization could have a damaged reputation and lose clients.
- Marketing: If clients do not know about a cooperative's dementia care expertise and services, a cooperative will not be able to effectively execute this strategy. A long-term commitment to marketing to clients, families, and referral partners is needed to be heard in a crowded marketplace.

Additional Specialized Care Opportunities

	Chronic Disease	Pediatric Care	Autism Care
Demand	• 75% of all health care spending • 90% of Americans over 65 have a chronic condition	• 500,000 children need home care • $6.7 billion in pediatric home care spending	• $236 billion in yearly spending on autism care • $50,000- $90,000 in yearly spending for individuals with autism
Operational Feasibility	• Home health care services are needed • Relationships with large health systems for referrals is beneficial	• Specialized training is needed	• Specialized training is needed • Substantially different population than current home care co-op clientele
Opportunity	• For large certified home health cooperatives	• Feasible in local markets, but not broadly	• Respite care

Appendix: Break Even Estimate

For a client acquisition and volume strategy to be viable, we need to know how many additional clients are needed to cover the new marketing and training expenses. The 2018 Home Care Pulse survey found that the median rate for a private duty agency was $23 per hour. Assuming a gross margin of 35%, each new billable client hour contributes $8.05 to cover overhead expenses. Using these assumptions and the cost estimates developed, we can determine how many new client hours are needed for this strategy to break even and start generating new income for a cooperative.

Using a hypothetical cooperative with 25 full-time caregivers on staff and a yearly caregiving staff turnover of 30%, the year one expense for training for all 25 caregivers is $14,500 and $6,500 each year thereafter. These expenses would be lower for a cooperative that chooses to train only a portion of their caregivers, say those that are members and have over one year of experience with the cooperative.

In this scenario, for the cooperative to break even in the first year it would need to add just over 2,000 more caregiving hours. In the following years the cooperative would need just under 1,000 additional caregiving hours. The cooperative could also recoup its costs over a longer time frame and add 1,340 hours per year over three years to break-even.

Clients with dementia have a range of care needs based on their family situation and the progression of their dementia. This can be as little as a few hours per week for respite care to 24/7 care in the later stages of the disease. Because of this complexity, it is difficult to estimate exactly how many new clients are needed for a dementia care strategy to be financially feasible. As can be seen in the above chart, if the typical dementia care client needs 10 hours per week, the cooperative will need to add four new clients in year one to break-even. If the typical new client needs 40 hours per week the cooperative will only need to bring on one additional client for financial feasibility. These estimates will, of course, vary based on the size and location of a home care cooperative, but those factors do not change the overall conclusions.

Based on this analysis, a focus on dementia care as a strategy for increasing revenue is financially feasible. Additional new costs are not significant, and a cooperative would only need the strategy to bring on a handful of new clients to cover expenses and start bringing in new income. For a cooperative working in the private pay market, emphasizing dementia care can be a financially viable strategy.

	Year 1	Year 2	Year 3
Gross Margin	$8.05	$8.05	$8.05
Expenses			
Training License	2,500	2,500	2,500
Caregiving Time	12,000	4,000	4,000
Marketing	2,500	1,200	1,200
Total New Costs	$17,000	$7,700	$7,700
Additional Clients Hours	2,112	957	957
40 hours/week	1.0	0.5	0.5
20 Hours/Week	2.0	0.9	0.9
10 Hours/Week	4.1	1.8	1.8

Home Health Care

Moving up the Continuum of Care

Opportunity Snapshot	
Opportunity	• The primary opportunity to expand into home health lies with large public pay cooperatives that have efficient hiring practices, strong referral sources, and efficient back-office and administrative practices. • Providing both personal care and home health services for a client is a significant benefit for both home care agencies and clients. Agencies increase client values and clients are able to work with one trusted agency for their diverse care needs.
Demand	• $90 billion in industry revenue, growth to $170 billion expected by 2026 • 4.5 million clients
Payers	• Primarily public pay opportunity through Medicaid and Medicare. • Smaller but not insignificant private pay market (estimated at $8 billion).
Operational Capabilities	• **Staffing Needs:** Nurse supervision and certified Home Health Aides are needed. • **Marketing Needs:** Ability to market to existing clients and referral partners. Online presence and SEO, updated marketing materials. • **Other:** Experience and success providing personal care services to a public pay market.
Financial Feasibility	• **Costs:** Additional personnel costs for nurse supervision and home heath staff. Licensing costs both initial and for ongoing compliance. • **Revenue:** $5-$6 per hour higher than non-medical home care.
Barriers to Entry	• Complex licensing and ongoing maintenance of licenses and certifications. • Upfront costs of licensing and hiring before new home health revenue generated. • Stiff competition in the home health space, particularly by large players.

Introduction

Home health care encompasses a wide variety of in-home services ranging from a Home Health Aide reading vital signs to a Registered Nurse (RN) administering medication through a syringe, or even a physician providing significantly more intensive medical services. Home health care is usually less expensive, more convenient, and is just as effective as care provided in a hospital or skilled nursing facility. Home health services include therapy and skilled nursing, administration of medication, medical tests, monitoring of health status, and wound care. Home health agencies are regulated by state and federal laws. Since home health involves medical care, it is covered by Medicaid, Medicare, and private insurance. Home health agencies employ a number of certified professionals from Home Health Aides (HHA) to Certified Nursing Assistants (CNA) to Physical Therapists.

For both clients and caregivers, adding home health services to a non-medical agency provides noteworthy benefits. By offering non-medical personal care and home health care, a cooperative can provide services for the same client across a broader spectrum of the care continuum leading to increased customer value. This strategy requires a cooperative to be large enough to recruit, hire, train, and retain HHAs, CNAs and possibly RNs to meet the needs of clients. For the client, this allows them to work with the same agency and possibly the same caregiver for a longer period. This leads to stronger relationships and a lower administrative burden both for the agency and for the client. For an agency, a longer-term relationship increases the total revenue earned per client, reduces per client marketing expenses, and decreases the administrative time spent onboarding new clients. Additionally, in an industry beset with high turnover, providing career pathways can increase caregiver retention. This can reduce hiring expenses and retain valuable expertise within a cooperative.

Customer Segment Highlight: Dual Eligible Population	
Who?	Individuals who are covered by both Medicare and Medicaid: • Older adults • Younger adults living with disabilities
Size of Market	$9 million
Market Opportunity	• High cost: average individual spending of $135,343 per year • 57% of high cost dual eligibles live in the community
Cooperative Opportunity	• For large public pay cooperatives certified to provide home health services • Ongoing partnerships with local hospitals, health systems, and nursing homes

Demand

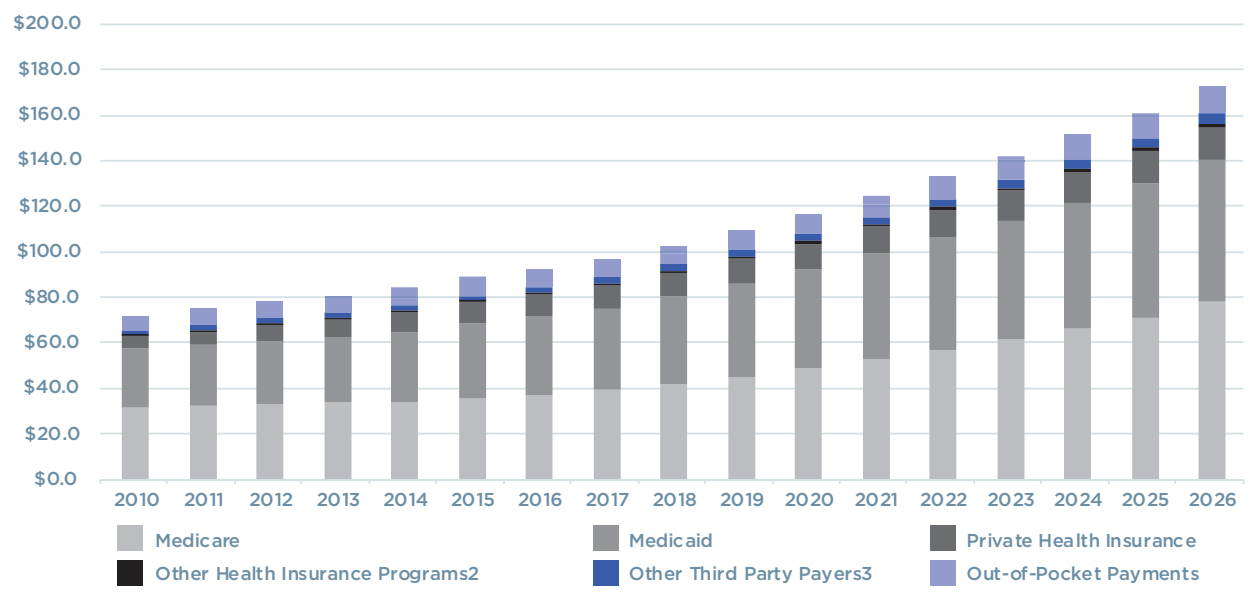
Home health is one of the nation's fastest growing health care sectors, with over 12,000 home health agencies serving approximately 4.5 million Medicare and Medicaid patients annually. This makes it a highly competitive industry with some big-name businesses dominating the market, namely Addus, LHC Group, and Amedysis. Generally, the trend in the home care space has been towards revenue diversification with both personal care and home health providers finding it profitable to expand their services to cover the broader continuum of care. Some home health-focused businesses like Amedisys have successfully added personal care services. Others like Almost Family struggled to keep up with rising wage rates for home care workers. The key takeaway is that while expanding services to cover the broader continuum of care is a logical business growth strategy, it does not guarantee success.

Payers

National Health Expenditure data gathered by CMS estimates that 2016 spending on home health care totaled $92.4 billion. 77% of home health care spending was from public payers with $37.4 billion from Medicare and $34 billion from Medicaid. Of the remaining spending, $9.6 billion was from private insurance, $8.1 billion was out-of-pocket (private pay), and the remaining $3.4 billion was from other third-party payers[34]. By 2026, CMS projects that home health care spending will increase to $172.6 billion and a rapid increase in Medicare spending as a large number of seniors continue to age into the program. The home health care market is projected to grow faster than all other health care services over the next ten years.

[34] RCms.gov. (2018). Projected - Centers for Medicare & Medicaid Services. [online] Available at: https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/NationalHealthAccountsProjected.html [Accessed 11 Aug. 2018].

Home Health Expenditure (2010-2016 actual; 2017- projected)



Operational Capability

The most viable opportunity for home care cooperatives to expand into the home health market will be through Medicaid payment for low level home health care delivered by HHAs and CNAs. Providing in-home care that must be directly performed by an RN is outside the core competency of home care cooperatives and would not be a viable strategy at this time. Home health care that can be delivered by an HHA and overseen by an on-staff RN, however, is a viable path to entry for home care cooperatives already operating in the public pay market. As such, experience providing non-medical personal care services in the Medicaid market is a critical operational capability that must be established and proven before expansion into home health care can be considered.

Staffing Needs

To meet licensing requirements and provide home health services, a cooperative agency will need to hire certified Home Health Aides and a supervising RN at minimum. CNAs can also be engaged for higher level care but are not necessary to launch a home health program. Like personal care, recruitment and retention of HHAs and CNAs is an ongoing challenge in the market. Shifting into the home health space from the personal care space may lead to additional challenges in recruiting and retaining a quality direct care workforce as there are more training requirements for HHAs and CNAs. A home health agency must either recruit from an already trained workforce or have access to enhanced training opportunities for their current workforce.

Marketing Needs

To drive new home health business, home care cooperatives need to focus on either expanding services to current clients, acquiring new customers through new referral sources, or both. At a minimum, administrative and sales staff would need to have both the ability and capacity to connect with new partners at medical facilities to inform them of the co-op's new service, and to reconnect with clients currently receiving non-medical care that could potentially benefit from home health care. Other key needs include website updates and revision and reprinting of updated marketing materials. This could be done in-house or by an outside professional depending on the capabilities and existing practices of administrative staff.

Financial Feasibility

Costs

Personnel

The primary cost of pursing a home heath diversification strategy is the cost of hiring home health personnel and state required supervision of that personnel. Home Health Aides (HHAs) earn about $1.00 per hour more than Personal Care Aides, and Certified Nursing Assistants (CNAs) earn $2.00 an hour more than Home Health Aides. These rates vary from state to state. The Bureau of Labor Statistics (BLS) survey provides state level rates that offer a more accurate estimate of local rates. Co-ops interested in pursuing a home health strategy should look at the BLS survey, and research the local competition. Based on the number of additional client hours that need to be covered, a cooperative would need to hire a minimum of five new caregivers (HHAs or CNAs). We estimate it would cost approximately $3,600 to hire new caregivers and about $1,200 per year afterwards to account for staff turnover. More detail on these calculations can be found in the break-even analysis in the Appendix.

Position	Per Hour Rate
PCA	$10.40
HHA	$11.46
CNA	$13.72

In addition to direct caregiver expenses, home health regulations require a supervisory nurse or physician for all medical home care[35]. This adds a significant overhead expense that must be considered before launching an expansion of services into home health care. The national average yearly salary for a Registered Nurse is about $70,000. Assuming the supervisory nurse also receives benefits, the additional overhead expense for a full-time RN position is about $90,000 per year. This is a conservative assumption, as a slower rollout of a home health program may start with a part-time supervisory nurse.

Licensing

Home health agencies need to be licensed in the state they are working in. This can be a time-intensive process that will delay the launch of a home health business line and will also require ongoing compliance. There is a licensing fee, but the cost of ongoing compliance will be the largest new expense. A California state report estimated that for the average home health agency in the state 3.5% of administrative time was dedicated to compliance activities.

Revenue

Home health care services are primarily paid through public payers such as Medicaid or Medicare. Nationally, reimbursement rates from public payers for Home Health Aide services are about $5-6 dollars per hour higher than they are for non-medical personal care services[36], resulting in higher gross margins (44% vs. 34%). Rates do vary from state to state and any individual home health revenue strategy should be modified to match a cooperative's local market reimbursement rates. Additionally, some state's reimbursement rates are calculated per visit and not by hour, meaning average hourly rates would be calculated based on the average length of a client visit. While out-of-pocket payments represent a much smaller portion of the home health care market and gross margins for private pay services are comparable to personal care, it would be wise for a cooperative to consider diversification of payers as well as services. This would allow cooperatives that are already accepting private pay clients for personal care to add additional services for that pool of clients.

Rates	Private	Public
Home Health	$24.50	$24.50
Personal Care	$23.50	$19.00

[35] Law Firm | Health Care Law Firm in the USA | Hall Render. (n.d.). CMS Finalizes New Conditions of Participation for Home Health: Part 3 | Hall Render. [online] Available at: https://www.hallrender.com/2017/01/26/cms-finalizes-new-conditions-participation-home-health-part-3/ [Accessed 5 Sep. 2018].

[36] O'Malley Watts, M., & Musumeci, M. (2018). Medicaid Home and Community-Based Services: Results From a 50-State Survey of Enrollment, Spending, and Program Policies [Ebook]. Kaiser Family Foundation. Retrieved from http://files.kff.org/attachment/Report-Medicaid-Home-and-Community-Based-Services

Barriers to Entry

While stronger margins can make the home health market look like an attractive prospect, entering the market is a complex process that takes significant time and has substantial up-front costs. Depending on the state, a home health agency must meet certain requirements to be licensed as a home health provider.

Home Health Aide Training Requirements	
Federal	• $10.40
State*	• No additional training requirements: 33 states • 75-120 hours: 17 states • 120+ hours: 6 states
*PHI has conducted a survey of all state Home Health Aide training requirements that can be found here.	

Home health agencies must also meet state and federal requirements for Home Health Aide training. If a cooperative's caregivers are not trained and certified as Home Health Aides, the cooperative will either need to hire new caregivers who do meet state training requirements or provide training for caregivers to become certified HHAs. Developing and implementing a training program in-house or investing in an outsourced training platform is not insignificant. Finally, as outlined in the financial feasibility analysis, the fixed costs of operating a home health agency are greater than the fixed costs associated with operating a non-medical personal care agency. More specifically, hiring a supervisory nurse adds significant ongoing personnel costs that would be burdensome for a smaller cooperative. This is also a cost that must be incurred prior to bringing on new home health services and receiving new revenue. Therefore, a cooperative that moves towards home health care must have cash reserves or access to a line of credit that can cover additional costs until new revenue can cover these costs.

Implementation & Entry Points

Key Determinants of Success	
Licensing & Regulation	• Ability to successfully navigate the home health licensing process. • Ability to attract trained caregivers or train caregivers to meet state requirements.
Client Acquisition	• Capital cushion needed to cover additional expenses prior to acquisition of new clients.
Policy	• Organizational ability to anticipate and navigate upcoming policy changes including the expected shift towards value-based care and Patient-Driven Groupings Model (PDGM).

The key steps for an agency interested in pursuing home health care as a revenue growth strategy are:

1. For a private pay, personal care cooperative interested in home health care, the cooperative must first enter the public pay market as a personal care services provider before attempting to take on home health. The cooperative should maximize and fine-tune its public pay personal care service line before expanding into home health.
2. For a public pay cooperative that is already successfully operating in the public pay personal care space, the first step is for a cooperative to conduct a thorough feasibility assessment including a market assessment to confirm demand, research the home health licensing process, and confirm available working capital to cover both licensing and new personnel expenses including any needed training.
3. Assuming the feasibility assessment returns positive results, the cooperative must then begin the licensing and hiring process. The cooperative should also begin work on marketing materials and the development of a marketing and outreach plan, focusing on the identification of key referral partners, and outreach to existing and past clients who may benefit from home health services.

Risks & Challenges

There are several risks in pursuing expansion into home health care. First, if client acquisition is much slower than expected, this could cause the cooperative to increase costs without adding additional revenue. Second, if a cooperative cannot meet state and federal regulatory requirements, it could lose its home health license or close altogether. Third, in any highly regulated industry there will always be a risk that policy changes will cause significant changes to that market. CMS has recently proposed changes to the Prospective Payment System called the Patient-Driven Groupings Model (PDGM).[37] The trend is a long-term shift from the current payment system towards value-based care. All home health providers, especially those that are reimbursed through public payers, need to pay attention to and be prepared for upcoming changes in regulations and reimbursements. Finally, a risk that is not unique to home health, but must be noted, is that cooperative management will have to oversee two lines of business as opposed to one. Anytime an organization brings on a new business line there is a risk that focus on the new business line will lead to a loss in quality or revenue in the agency's core business. Any cooperative considering pursuit of a home health care diversification strategy will need to carefully weigh these risks against potential gains.

Appendix: Break-Even Estimate

Based on rate estimates and the typical pay differences between Personal Care Aides and Home Health Aides, public pay home health care services show higher gross margins than public pay personal care services (44% vs. 34%). Meanwhile, gross margins for private pay services are comparable between personal care and home health.

Assuming a larger home care cooperative is looking to expand into Home Health Aide services in the public pay market, ICA estimates that the cooperative will need to take on an additional 9,500 billable home health client hours to cover additional expenses from new supervision, licensing, and compliance. Given that client needs can vary significantly depending on the level of care needed, ICA also estimated the number of new clients needed based on different levels of care.

At an average of 20 hours per week per client, a cooperative would need to bring on an additional nine or ten ongoing clients to cover expenses generated from launching a home health business. Assuming there is some client turnover the cooperative will need to acquire more than ten clients per year.

Given that it will take time to acquire ten new clients, a cooperative must have the financial ability to fund the upfront expenses associated with launching a home health line of business. Assuming a linear growth rate of one new client per month, a cooperative would need approximately $45,000 to fund this strategy before enough clients have been acquired to fund ongoing expenses. While an agency can certainly reduce upfront costs by launching an HHA service with only a part-time supervisory nurse and fewer HHA staff, some additional working capital will be needed to fund a home health start-up strategy regardless of scale.

	Year 1	Year 2	Year 3
Gross Margin	$10.75	$10.75	$10.75
Expenses			
Supervision	70,000	70,000	70,000
Benefits & Fringe	21,000	21,000	21,000
Licensing	2,500	-	-
New Hires	3,640	1,092	1,092
Compliance	4,284	4,284	4,284
Total New Costs	$101,424	$96,376	$96,376
Additional Clients Hours	9,437	8,967	8,967
New Clients Needed			
At 40 hours/ client/week	4.5	4.3	4.3
At 20 hours/ client/week	9.1	8.6	8.6
At 10 hours/ client/week	18.1	17.2	17.2

[37] Holly, R. (2018). NEWS [Updated] CMS Proposes Home Health Groupings Model, $400 Million Medicare Payment Boost. Home Health Care News. Retrieved from https://homehealthcarenews.com/2018/07/cms-proposes-home-health-groupings-model-400-million-medicare-payment-boost/

Appendix:

Summary of Non-Selected Reviewed Diversification Opportunities

Introduction

The following nine reviewed diversification opportunities that were not selected for a full-scale analysis are presented here in the following order:

1. Feasible for the right home care cooperative
   a. Respite Care
   b. Dual Eligibles
2. Feasible but small opportunity
   a. Home services—Home Modifications and Domestic Work
   b. Community Health Worker
3. Unlikely given complexity/capital needed
   a. Financial Management Services (FMS)
   b. TeleMedicine/TeleHealth
   c. Durable Medical Equipment (DME)
4. Opportunity unknown/undetermined
   a. Opioid Recovery Support
   b. Home Dialysis

Many of these strategies may prove to be feasible and financially viable in the near term as regulations and funding change, such as Community Health Workers, and/or may become feasible in specific locations as programming takes shape, such as Opioid Recovery Supports. At this time however, these are not seen as broadly feasible, beneficial or likely for most cooperatives. It is worth noting that a handful of additional opportunities were assessed above and beyond those presented here but were quickly dismissed because they did not meet any core criteria.

	Summary	Demand	Opportunities	Challenges	Assessment
Respite Care	• Respite care offers a break for caregivers (typically family and friend caregivers) by providing temporary caregiving for a client.[38] Respite care can be offered for a few hours or a few days depending on the regular caregiver's needs.	• Un-met need in the market • High number of clients, but each client only needs a limited number of hours	• Same service as already provided • Access to new pool of clients • Good to fill caregiver hours	• Short hours • Unpredictable hours • Administratively complex • Difficult to staff • Requires a large number of clients to make the service regular enough to be worth it	• Feasible for larger home care cooperatives that can manage the administrative burden of respite care • Not a good source of primary clients/ hours, but a good option for filling caregiver schedules
Dual Eligbles	• Dual eligibles are individuals who are covered by both Medicare and Medicaid. Dual eligibles are a high cost population that needs both complex medical services and in-home long-term care supports and services.	• Large market of up to 9 million potential clients	• Dual eligibles have high needs and are funded by multiple public payers leading to higher reimbursement rate and more billable hours • 57% of dual eligibles live in the community and likely need some form of home care	• A co-op needs to be able to accept Medicare and Medicaid payments and be able to manage the regulations and admin that come with public pay • A co-op would need a partnership with larger health facilities to coordinate care	• Feasible for larger public pay cooperatives that can develop and maintain relationships with larger health systems
Home Services	• Home services encompasses domestic work above and beyond typical personal care supports, and home modifications defined as physical changes to the home that allow a senior or disabled person greater accessibility and independence based on their changing needs.	• Growing home modifications market • Domestic help market is a much smaller subset of the overall home care market	• Domestic work can be performed by personal care aides • Value added services to provide to existing clients (one stop shop)	• Many caregivers not interested in more intensive domestic work (such as cleaning), up charge is minimal • Home renovations are far outside the core competency of home care co-ops, and co-ops would need to work with vendors limiting income opportunity • Not a large enough market	• Feasible, but a small market

[38] Generally, this population includes children or adolescents who are developmentally disabled, and adults who are either frail, aging, disabled, and/or have chronic diseases.

	Summary	Demand	Opportunities	Challenges	Assessment
Community Health Worker	• Community health workers (CHW) are members of a community that usually share socio-economic, language, ethnicity, and life experiences with the community in which they work. They provide supportive health services including health education, outreach, care coordination, and medication adherence support.	• There is a significant need for CHW services • Limited funding sources and payers	• CHW's add value to the business when a co-op's clients need both facility based and home-based care • CHW's can work with vulnerable populations that home care co-ops frequently serve	• CHW programs rarely make the transition from pilot program to fully funded initiative • While a needed service in the overall health system, there is not enough public funding or private demand to make this a significant market opportunity	• Feasible, but a small market with little prospect for long term funding. There is growing interest in CHW's however, and numerous pilots and studies underway looking at cost savings derived from this model. This is an opportunity that should be watched for future potential.
Financial Management Services	• Providers of Financial Management Services (FMS) manage and direct the distribution of funds for participants in publicly funded home and community-based services programs. In home care, these services and funds go to support clients that hire family caregivers or independent providers.	• Large market of independent providers across a number of states	• Many states are moving towards this model	• Complex business that requires payroll processing, software development, and significant back office support • Organizational capabilities needed in terms of knowledge, capital, and technology are beyond what the majority of home care co-ops can manage.	• Highly complex and capital-intensive business, that requires significant scale and state contracts. At the moment, FMS services are out of the scope of home care co-ops current capabilities.
Telemedicine and/or Telehealth	• Telemedicine or Telehealth uses communications technologies, including video conferencing and text-based communications to deliver health care services remotely. It has now expanded across the spectrum of medical care and clients. More recently, telehealth models have been used to expand home and community-based services to more clients with barriers to accessing care in facilities.	• A growing market • Half of all state Medicaid programs provide reimbursements for telehealth	• A growing market • States and other funders are exploring new telehealth initiatives	• Evidence is mixed on efficacy of telehealth • Significant investment in technology is needed	• Unlikely given complexity/ capital needed

	Summary	Demand	Opportunities	Challenges	Assessment
Durable Medical Equipment	• Durable Medical Equipment (DME) is defined as any medically necessary equipment that can: • Withstand repeated use • Used for a medical reason • Not usually useful to someone who isn't sick or injured • Used in your home • Has an expected lifetime of at least 3 years[39]	• $42 billion market • Growing at 4% per year	• High profit margins • Growing industry • New service for existing clients	• Co-op would need to develop capacity to purchase and store equipment • Highly competitive market • Would need significant capital to launch this service • A lot of fraud in public pay DME space, significant Medicaid oversight	• Unlikely given complexity/ capital needed
Opioid Recovery	• Support for activities of daily living and emotional support for recovering opioid addicts. It is likely that home care aides are already actively providing support to recovering opioid addicts that have returned to their homes, however no public research on this topic has been done to date. There appears to be a potential opportunity for home care workers to become involved in this growing and important space.	• Undeveloped, but growing market • Opiate recovery care is a new field • Higher demand in rural areas • Difficult to fully assess demand as home-based	• Co-ops could be first entrants into the market • Opportunities to take part in pilot programs	• Unknown if there is consistent demand or payors • Co-ops would need to train caregivers on providing opiate care	• Opportunity unknown/ undetermined
Home Dialysis	• Home dialysis is hemodialysis done at home. While a greater proportion of dialysis patients still receive care in a facility-based setting, home-based dialysis is quickly growing in popularity. It is less disruptive to patients' lives, generally results in better patient outcomes, and it is also less expensive.	• 400,000 patients nationwide, but a much smaller population on home dialysis	• **Possible role for co-ops as a dialysis support service. Home care aides would not perform the dialysis but could support clients in self-administration. Typically, family members get trained in this role, but cannot always be available to provide the supports.**	• Specialized training for caregivers is needed • RN supervision is needed • Direct entry into the market would require capital intensive purchases of the equipment, and is not recommended for home care co-ops.	• Opportunity unknown/ undetermined

[39] Medicare.gov, Durable Medical Equipment (DME) Coverage, https://www.medicare.gov/coverage/durable-medical-equipment-dme-coverage

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TO BREAK BARRIERS TO SUCCESS

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