How a home health agency can focus its outreach

Connect county research, account priorities, field activity, and recorded referrals to give a home health marketing team a clearer reason for each visit.

Home health agencies

Published October 21, 2026 · Updated November 26, 2026

A practical example workflow for evaluating CareMetric Intel. Benefits described are potential benefits, not measured customer results.

Why does a busy home health team need a shared focus?

A shared focus lets a home health manager explain why particular accounts receive attention and which follow-ups remain unfinished. A regional agency may have established relationships across neighboring counties and still lack that focus. Each person can describe a busy week, but a busy week is not the same as a deliberate one. A more deliberate plan can start before assigning additional visits.

Start with the market and the agency's own records

The manager begins with the home health research view. Available county demographics, Medicare utilization context, provider supply, and hospitals serving the area help frame the territory. Provider profiles and practice locations help identify accounts worth investigating. Source periods matter: a published utilization measure describes its reporting period, not today's referral activity.

The agency's marketing book supplies a different kind of evidence: the relationships, visits, and referral facts the team has actually recorded. Opportunity signals help generate questions; they do not establish that a physician has referred to this agency.

Which physicians certify home health in your county?

CMS's Medicare Physician & Other Practitioners file shows which clinicians billed for certifying home health care (code G0180) and recertifying it (G0179), and for how many Traditional Medicare patients. CareMetric Intel ranks a county's clinicians by those certifications. Medicare requires a physician or allowed practitioner to certify that a patient needs home health care, so the count points to the clinicians whose patients start home health.

The certification file has limits worth knowing. CMS lists a clinician's count for a code only when it is above 10 patients, so a 0 means "not listed", not "none". A patient counted in two care settings is counted twice. The figures cover Traditional Medicare only and describe a past year, not this month's referrals.

Physician share puts the agency's book beside that figure: admissions recorded from a physician over 12 months, divided by the physician's published certifications, shown in bands. The share is an estimate and says so. A share over 100% can happen when the agency's admissions include Medicare Advantage patients or cover a different year than the published one.

How do you count the agencies serving a county?

Count every agency that serves the county's residents, not only the agencies based there. When the state's ZIP code service areas are loaded, CareMetric Intel splits each agency's published Medicare patient total across the ZIP codes it serves. A county with three agencies based in it but twenty serving it then reads "#3 of 20 serving", not "#2 of 3".

Agencies with equal totals share a rank, and an agency whose total CMS withheld is listed but not ranked. The same figures appear on the agency's own My organization card and in its market report, so a manager never has to explain two different ranks.

Turn research into an account plan

The manager reviews a focused list of physician practices and facilities within the service area. For each account, the team agrees on a reason for outreach: an existing relationship requiring follow-up, a relevant practice to research, or an area where current account coverage appears thin. Account ownership makes responsibility visible.

Account tiers make visit frequency explicit. An agency can mark accounts A, B or C and set how many visits a month each tier gets; Build my month then places those visits on weekdays under a daily limit. Every completed visit or call records its purpose, such as relationship, education or referral follow-up, so a review can see what the time was spent on.

Before leaving the office, marketers prepare call sheets or account briefs and organize their visits. After a conversation, they record the activity and the next appropriate action. Notes describe professional relationships and business follow-up, without patient names, diagnoses, or other patient information.

Which CMS scores will a referral source look at?

Discharge planners can see an agency's Care Compare star ratings, and since 2023 Medicare-certified agencies have been measured under the expanded Home Health Value-Based Purchasing Model. CareMetric Intel puts the agency's published scores in its outcomes packet beside its referral response time and current availability. A score CMS did not publish is shown as not published, never as zero.

Bring recorded results into the manager's review

At the next review, the manager compares logged visits and overdue follow-ups with recorded referrals and admissions. If the agency imports a supported CSV report, the organization admin checks the column mapping and preview before saving. A saved EMR report layout is a file-import aid, not a live connection to the EMR.

Response time is part of the review too. CareMetric Intel measures the hours from a referral's receipt to the first response, only for referrals logged with a time, so a file import without times is left out rather than counted as instant.

The conversation stays specific: Was an account contacted for the agreed reason? Is the next step assigned? Do recorded source trends suggest that the relationship deserves a closer look? An increase in visits alone does not demonstrate that outreach caused additional admissions.

Where practical value could come from

A shared workflow could reduce repeated account research, duplicated visits, and the time spent reconstructing follow-up history. The workflow also gives a manager a clearer basis for coaching. The agency would need to observe its own use of the tools and its own results to judge the time or financial benefit.

What to evaluate during a trial

Use a small, relevant portion of your service area to test whether the workflow supports the way your team works.

- Can the team explain why each target belongs on its list?

- Are ownership and next actions clear after a visit?

- Can managers distinguish market signals from recorded referral facts?

- Does the selected plan include the territory, seats, and home health CRM workflow the agency needs?

Sources and further reading

CareMetric Intel data sources and use

https://caremetricintel.com/data-use

CMS Medicare Physician & Other Practitioners, by provider and service

https://data.cms.gov/provider-summary-by-type-of-service/medicare-physician-other-practitioners/medicare-physician-other-practitioners-by-provider-and-service

CMS Expanded Home Health Value-Based Purchasing Model

https://www.cms.gov/priorities/innovation/innovation-models/expanded-home-health-value-based-purchasing-model

Requirements for home health services (42 CFR 424.22), eCFR

https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-B/part-424/subpart-B/section-424.22

Medicare.gov: home health services coverage

https://www.medicare.gov/coverage/home-health-services