How a hospice agency can build a more deliberate relationship plan

Research a hospice market, prepare useful professional outreach and review recorded referrals, while keeping market patterns apart from confirmed ones.

Hospice agencies

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

Which relationships should a hospice team work on?

A hospice team should work on the relationships that fit its service area and have a clear next step, not only the familiar ones. An agency reviewing its marketing plan needs to decide how the team divides attention among physician practices, hospitals, nursing homes, and other care organizations. Some accounts may receive regular visits because they are familiar. Others may be researched repeatedly without a clear next step. A useful plan connects the service area with the purpose of each professional relationship.

Understand the territory before choosing the conversation

The team selects the hospice research view and reviews available county measures, including older-adult population context, hospice utilization, provider presence, and hospitals serving the area. County measures help describe the market. They do not identify individual patients or establish that a particular organization should send referrals.

The manager also checks provider and facility profiles, locations, and the source periods behind the figures. Comparing information from different reporting periods without noticing the dates could create a misleading impression of change. Where detail is unavailable, the team keeps that uncertainty visible rather than filling the gap with an assumption.

Who refers patients to a hospice?

CareMetric Intel ranks five kinds of hospice referral source for the counties on the plan: hospitals, physicians, nursing homes caring for long-stay residents, personal care and assisted living homes, and home health agencies whose patients are declining. The New referral sources page marks the ones already on the agency's book.

Physicians are ranked by the hospice care plan oversight they billed to Medicare (code G0182). Medicare requires a hospice physician and, if the patient has one, the attending physician to certify that the patient is terminally ill, with a life expectancy of six months or less. Care plan oversight shows which physicians already follow hospice patients closely; it does not show which hospice they chose.

Which CMS hospice measures can a referral source see?

Care Compare publishes two hospice measures a referral source is likely to check. The CAHPS Hospice Survey asks family caregivers about the care, and CMS turns the answers into a star rating from one to five. The Hospice Care Index combines ten indicators from Medicare claims into one score.

CareMetric Intel shows both on the agency's own card and in its outcomes packet, with the reporting period. A rating CMS did not publish, often because a small agency had too few completed surveys, is shown as not published rather than as zero.

Does Medicare Advantage change the hospice numbers?

Medicare Advantage changes hospice figures less than it changes other settings. Original Medicare pays for hospice care even when the patient is enrolled in a Medicare Advantage plan. Hospice utilization figures therefore include those patients, while home health and physician fee-for-service figures for the same county do not. Keep that difference in mind when a hospice measure and a home health measure sit side by side.

Prepare outreach around an explicit purpose

The manager and marketers select a manageable group of accounts and agree on a professional objective for each conversation. One visit might introduce the agency's service area; another might follow up on a requested business discussion. Existing account history helps the team prepare without treating every visit as a first introduction.

Account ownership, call planning, visit activity, and scheduled follow-ups provide continuity.

After the conversation, the marketer records what was discussed and the appropriate next action. Free-text notes remain about business relationships and contain no patient names, diagnoses, or other identifying clinical information.

Review the relationship and the recorded results together

In a team review, the manager can ask whether planned conversations happened, whether requested follow-up was completed, and whether recorded referral activity has changed. Referral and admission facts come from agency records or supported CSV imports, not from interpreting a market data score as a confirmed referral.

If the organization admin imports a referral report, reviewing the mapping and preview helps the team understand what it is adding. Saved layouts support file-based work with common reports; they do not imply a live vendor integration. The manager should also check whether missing records explain an apparent gap before drawing conclusions about an account.

Source quality after admission adds another view where stays are loaded. It shows, by referral source, how long patients stayed and how often care ended in a live discharge or a revocation. A source is rated only after 10 or more of its stays have ended, so a small source shows no rate rather than a misleading one.

What the team could gain

A more consistent approach could make preparation and handoffs easier, reduce repeated research, and keep useful follow-up from being lost between visits. The approach could also help leadership direct attention more deliberately. Those are potential operational benefits; the workflow does not establish a referral increase, a savings amount, or a clinical outcome.

Questions to bring to the trial

Test the workflow with relationships your agency is authorized to manage and information appropriate for a marketing workspace.

- Does the research view provide useful context for the counties you serve?
- Can a marketer prepare a relevant conversation from the account history?
- Are follow-ups assigned and visible to the right people?
- Can leadership review recorded results without confusing them with opportunity signals?

Sources and further reading

CareMetric Intel data sources and use
https://caremetricintel.com/data-use

CAHPS Hospice Survey
https://www.hospicecahpssurvey.org/

CMS Hospice Quality Reporting Program
https://www.cms.gov/medicare/quality/hospice

Medicare.gov: hospice care coverage
https://www.medicare.gov/coverage/hospice-care

Hospice care regulations (42 CFR part 418), eCFR
https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-B/part-418