Using market data to choose your next county

Compare demand, service capacity and source coverage across counties, then turn a short list of counties into a field plan you can test in one quarter.

Healthcare organization owners, growth leaders and field managers

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Educational workflow with demonstration screenshots. Example records are not customer outcomes or evidence of production data coverage. Market data supports research, not a guarantee of referrals.

Which county can your team actually serve?

A county is workable only when your service line, travel radius, staffing and accepted payers all reach it. Start with those four facts and record the date and the person who confirmed capacity. A high research score cannot make up for unavailable staff or an unworkable drive. Then set the question before comparing counties: where could the team support more relationships during the next quarter?

Write the constraints down before looking at any figures. A home health agency might limit the search to counties within a 45-minute drive of a location with open nursing capacity. A personal care home might limit it to the towns its residents' families already come from. A written constraint keeps the shortlist honest when a large county farther away looks attractive.

Use the Site finder to build a shortlist

Use the Site finder to compare demand, population growth, community need and supply context. Open the County view for each candidate and retain its county FIPS identifier. Check older-adult demographics, relevant facilities and Medicare activity. Compare the same care setting and source period where possible; a missing value is not zero.

Keep the shortlist to three to five counties. More than five spreads the account research too thin to finish in a quarter. Fewer than three leaves nothing to compare when one county turns out to have thin source coverage.

- Write down each source period and load date.

- Distinguish providers located in the county from providers serving county residents.

- Keep population estimates separate from estimates of clinical eligibility.

What is the difference between providers located in a county and providers serving it?

Providers located in a county have their address there; providers serving a county treat patients who live there, wherever the provider is based. The two counts can differ widely. A rural county might have three home health agencies based in it and twenty agencies serving its residents from neighboring counties.

CareMetric Intel ranks home health and hospice agencies among every agency serving the county when the state's ZIP code service areas are loaded. Each agency's published Medicare patient total is split across the ZIP codes it serves, so a rank reads "#3 of 20 serving" rather than "#2 of 3 located". Nursing homes are counted where they stand, and hospitals by the county residents' own inpatient cases.

Which patients do the Medicare figures leave out?

Most Medicare provider figures count Traditional Medicare (fee-for-service) patients only, so they leave out people enrolled in Medicare Advantage plans. Home health and physician fee-for-service measures do not represent Medicare Advantage activity. In a county where half of the Medicare beneficiaries are in Medicare Advantage, those figures describe roughly half of them. Check each county's Medicare Advantage share before comparing two counties on fee-for-service volume.

Hospice is the exception. Original Medicare pays for hospice care even for people enrolled in a Medicare Advantage plan, so hospice figures cover both groups. Read the definition for each dataset rather than applying one payer exclusion everywhere.

CMS also withholds small counts to protect patient privacy. In the physician files, a clinician's count for a billing code is listed only when it is above 10 patients, so a 0 in CareMetric Intel means "not listed", not "no patients". A small county can therefore look emptier than it is.

A recently imported file may describe an older reporting period. Suppressed and missing values remain unavailable. Custom report exports include observed and missing source-record counts; an observed subtotal does not become a complete county total merely because it appears in a spreadsheet.

Research accounts before planning outreach

Open relevant hospitals, agencies and clinicians. Review CMS quality measures, historical utilization and source dates. Physician certification counts and post-discharge spending by setting are research signals, not proof of current referrals. For hospital conversations, use an outcomes packet to present the available agency evidence and TEAM context with its stated reporting period.

Add suitable accounts to a lead list and record why each belongs. Keep account identity, owner and service line clear. Search lead lists by name or description to find earlier work before creating a duplicate list.

Example: comparing two neighboring counties

The figures in this example are made up to show the method; they describe no real county. A home health agency is choosing between County A and County B, both within its drive time. County A has 14,000 residents aged 65 or older and 22 agencies serving it. County B has 9,000 residents aged 65 or older and 6 agencies serving it.

County B looks less crowded, but the comparison is not finished. County B's Medicare Advantage share is higher, so its fee-for-service figures understate its market by more. Most of County B's residents are hospitalized across the county line, at a hospital the team has never called on. County A has more competition, but its two largest hospitals already know the agency.

The useful output is not a winner but a test. Which ten accounts in each county would the team call on first, and what would it need to learn from them in 90 days? A test of that size fits one quarter, and its result is recorded in the book rather than inferred from the market data.

Turn the shortlist into a testable field plan

Assign a small set of accounts, schedule visits and review the pre-visit card. Download the day's schedule in Visit log before entering a low-signal area. Queued visits are pending until the server confirms them; review conflicts after reconnecting. A spoken debrief can help prepare a note when the device and plan support it.

Track completed activity, referral response time and reconciled logged admissions over an agreed period. Compare like periods and note staffing or payer changes. Those observations can inform the next county decision; they do not prove that outreach caused an admission.

Sources and further reading

CareMetric Intel data sources and permitted use

https://caremetricintel.com/data-use

CMS Medicare physician and other practitioners data

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

U.S. Census American Community Survey

https://www.census.gov/programs-surveys/acs

CMS Medicare Advantage state and county penetration

https://www.cms.gov/data-research/statistics-trends-and-reports/medicare-advantagepart-d-contract-and-enrollment-data/ma-state/county-penetration

Medicare.gov: hospice care coverage

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