



**2026 ANNUAL
CONFERENCE & EXPO**
Celebrating 60 Years
Then. Now. Next.

Referral Shift: Strategic Positioning into Value-Based Care
Casey Rausin, RN, CCM

April 29, 2026

2026 Annual Conference & Expo © 2026 California Association for Health Services at Home

1

Casey Rausin, RN, CCM
*VP Strategic Partnerships, Home Care Sales
Founder 3C Strategies
Casey@HomeCareSales.com*



2026 Annual Conference & Expo © 2026 California Association for Health Services at Home

2

The \$265 Billion Shift Home

- Up to \$265 billion worth of care services for Medicare beneficiaries could shift to the home by 2025*.
- The opportunity lies in aligning Home Health with the goals of value-based care.

2026 Annual Conference & Expo

3

The Disconnected Continuum

- Patients don't fail the system -- the system fails to connect around the patient.
- Fragmented communication across hospitals, SNFs, home health, and private duty leads to gaps in care.
- **The gap is not just at discharge. The gap is during the episode too.**
- Your skilled clinician visits two to three times a week. The other four or five days? That patient is on their own. No reinforcement of the plan of care. No one watching for early signs of decline. No one making sure medications are taken correctly.
- That gap is where readmissions are born.

 2026 Annual Conference & Expo

4



5

The Opportunity Gap

Home-based care is central to value-based models.

“When you focus on outcomes, you get value-based care without waiting for payer permission.”

 2026 Annual Conference & Expo

6

Coordinated Home-Based Care: The Readmission Prevention Strategy

- In a hospital-to-home pilot for CHF patients, coordinated home-based care participants had a 12.5% readmission rate versus 14.5% in control groups.
- What drove that result? Daily in-home presence reinforcing the clinical plan of care between skilled visits.
- For Medicare home health agencies, this is your model.
- Private duty support during your skilled episode means a caregiver is in that home on the days your clinician is not. Medication adherence. Diet compliance. Early symptom recognition. Fall prevention.
- Your outcomes are protected. Your star rating reflects it.

2026 Annual Conference & Expo

7

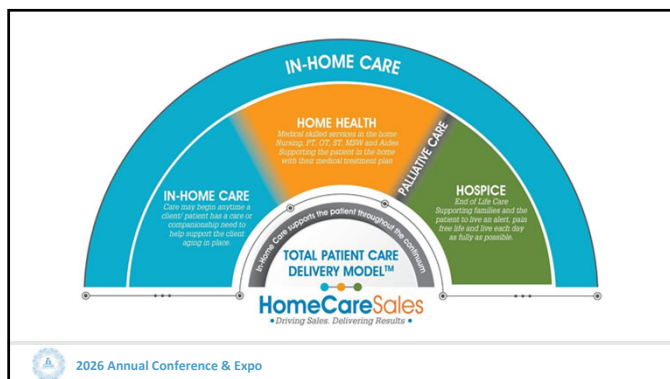
Home-Based Support Saves the System Money

- Community-based support reduces hospital utilization and costs.
- HCBS use reduced hospital utilization and spending among disabled elders.
- Systematic reviews show home-based care is cost-effective versus inpatient care.



2026 Annual Conference & Expo

8



2026 Annual Conference & Expo

9

Your Unique Position in the Continuum

Hospital → Home SNF/ Clinic → Home Home Health → Home Hospice → Home

2026 Annual Conference & Expo

10

Home Health = Value-Based Care

Every skilled visit contributes to the same goals value-based models reward:

- Reduced readmissions
- Lower costs
- Higher satisfaction

2026 Annual Conference & Expo

11

Reframing Private Duty's Role

Myth: 'We provide skilled visits.'

Truth: 'We are the clinical anchor of the care continuum from hospital discharge to independent living at home'

2026 Annual Conference & Expo

12


Language Shift: From Features to Outcomes

<p>DON'T SAY: "We provide PT in the home"</p>	<p>DO SAY: "We help reduce fall risks"</p>	<p>DON'T SAY: "Provide Medication set up"</p>	<p>DO SAY: "We help ensure medication adherence and early intervention"</p>

2026 Annual Conference & Expo

13

Case Study: Aligning with Hospital



- Challenge: High readmission rates after discharge on a subset of patients
- Solution: Coordinated home health & non-medical support 4 hrs a day for 30 days
- Result: Readmission rates dropped to single digits, referral relationships locked in and the hospital funded the non-medical support because it was cheaper than a readmission.

2026 Annual Conference & Expo

14

Case Study: Aligning Private Duty with Home Health



- Challenge: Not fully compliant patients and decreased outcomes
- Solution: Coordinated non-medical support at SOC
- Result: Increased patient compliance and increased oasis scores. Resulting in a 4.5 star rating from 3 stars

2026 Annual Conference & Expo

15

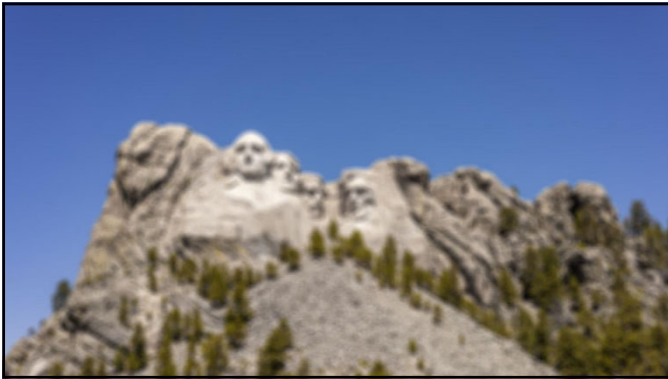
Referral Continuum Framework

Three Levels of Referral Growth:

- 1. Home Based Partners – Home Health, Hospice, HME, Home Care
- 2. Direct Clinical Partners – Hospitals, SNF, Clinics
- 3. Community Ecosystem – ALFs, CCRC's, IIs, Senior Housing

 2026 Annual Conference & Expo

16



17



18

Executive Reflection

- Write down two organizations in your market who should understand your value—but don't yet.
- **Consider:** What outcome language would resonate with them?



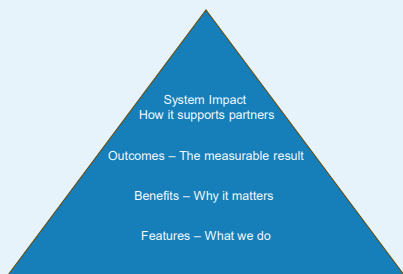
19

From Features to Frameworks

- **Feature:** 'We provide medication reminders.'
 - **Outcome:** 'We reduce medication errors post-discharge.'
- Shift your message from what you do to what difference it makes.*

20

Value Messaging Pyramid



21

From Transactional to Total Patient Care

Medicare home health agencies are not transactional visit providers.
You are outcome engineers.

When you walk into a hospital or a physician's office with outcomes data, a coordination model, and a communication protocol you are not selling a service. You are solving a problem they are being measured on and paid on.
Value-based care is not a future state for home health. It is happening right now. Claim your position.

When compassion meets data, we create partnerships that last.



22

The Future of Collaboration

Hospitals, Home Health, Hospice, Private
Duty, and Families
all working in one coordinated ecosystem.

When we coordinate, everyone wins: patient, provider, payer, and partner.



23

Member Agency Growth Case Study

\$500M+
Annual Revenue

10-15% Annual Growth
Substained over 3 years, even in tight labor markets.

2x Faster Growth
For agencies with professional partnerships, care managers and liaisons.

Higher Margins + More Clients
Agencies with hybrid care managers/liaisons report stronger client acquisition and longer length of service.



24

Vision-Driven Call to Action

- You have the power to reshape the continuum.
- **Ask yourself:** Who needs to know the value you bring—and how will they hear it from you this week?



25

Outcomes are the bridge:
where care management meets home care,
value-based care is happening now for us—
without waiting for payer permission.

26

Thank You!

27
