



**2026 ANNUAL
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Celebrating 60 Years
Then. Now. Next.

**Referral Shift: Strategic Positioning
into Value-Based Care**
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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 private duty home care with the goals of value-based care.

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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.

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The Opportunity Gap

Home-based care is central to value-based models—non-medical care is often overlooked.

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

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Non-Medical Home Care: Proven Partner in Reducing Readmissions

- In a hospital-to-home pilot for CHF patients, non-medical home care participants had 12.5% readmissions vs. 14.5% in control groups.
- Families received consistent caregiver visits focused on adherence, communication, and home stability.

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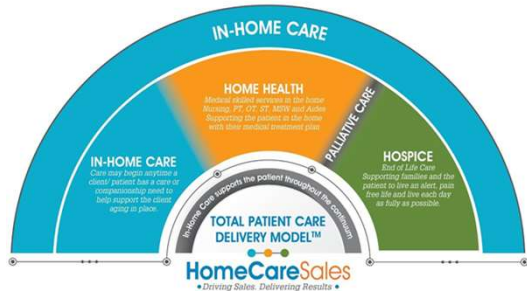
Home-Based Support Saves the System Money

- Community-based, non-medical 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.



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Your Unique Position in the Continuum

You're not just IN the continuum - you ARE the continuum

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

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Private Duty = Value-Based Care

Every hour of non-medical care contributes to the same goals value-based models reward:

- Reduced readmissions
- Lower costs
- Higher satisfaction

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Reframing Private Duty's Role

Myth: 'We're just sitters.'

Truth: 'We're stabilizers of care transitions.'

Non-medical home care ensures continuity when clinical services end.

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Language Shift: From Features to Outcomes

			
DON'T SAY: "We provide companionship"	DO SAY: "We help prevent costly readmissions"	DON'T SAY: "We help with daily activities"	DO SAY: "We help ensure medication adherence and early intervention"

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Case Study: Aligning Private Duty with Hospital



- Challenge: High readmission rates after discharge on a subset of patients
- Solution: Coordinated non-medical support 4 hrs a day for 30 days paid for by the hospital
- Result: Increased patient stability, decreased readmission rates to single digits and stronger referral relationships.

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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

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Case Study: Aligning Private Duty with CCRC



- Challenge: HC lost market share at a CCRC. CCRC: decrease in occupancy
- Solution: Coordinated non-medical support in weekly meeting
- Result: HC increased market share by 30% and CCRC reported 90% occupancy with less move outs

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Case Study: Aligning Private Duty with SNF with Rehab



- 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

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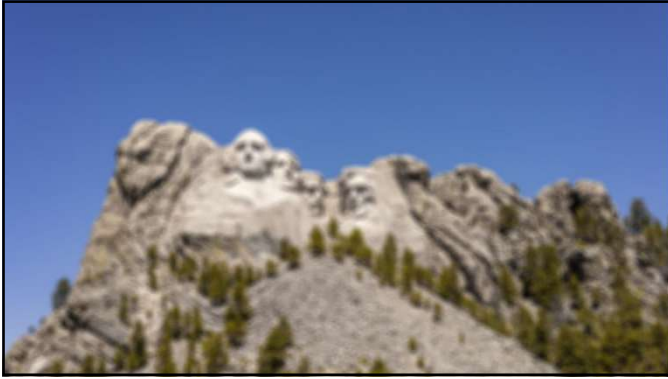
Referral Continuum Framework

Three Levels of Referral Growth:

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

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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?



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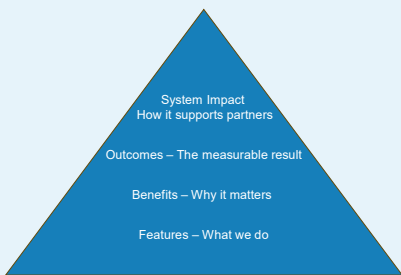
From Features to Frameworks

- **Feature:** 'We provide medication reminders.'
- **Outcome:** 'We reduce medication errors post-discharge.'

Shift your message from what you do to what difference it makes.

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Value Messaging Pyramid



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From Transactional to Total Patient Care

- Private duty home care is not waiting for payer permission—it's defining value-based care from the ground up.

When compassion meets data, we create partnerships that last.

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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.

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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

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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?




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

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Thank You!

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