

# CARE MANAGEMENT: EXPLAINED

# Agenda

What is Care Management

Care Management vs Case Management

Benefits & Outcomes

Identifying Supports



# Golden Oak

## CARE MANAGEMENT

### Carly Kyle, Certified Care Manager

I own Golden Oak Elder Care Management and founded Golden Oak Cares, a non-profit, we do Care Management for folks in the Greater Treasure Valley. Before starting Golden Oak, I worked in post-acute and acute care services- Case Management in Home Care, Social Services in Skilled Nursing Facilities, and in at St Luke's for a few years in Case Management.



# Care Management

As defined by the Life Care Management Handbook, Life Care Management (LCM), or Aging Life Care Management (ALCA) “is defined as a field of practice, utilizing educated and experienced professionals specializing in assessment and care planning, connecting to vital services and resources, coordinating care through collaboration, managing care and providing professional oversight and helping resolve issues to achieve optimal health regardless of age or ability.”

Care Managers typically use a team approach, working closely with other professionals with specialized knowledge and expertise within their network.

When professionals effectively understand each other's roles, we can work together to provide the best person-centered care.

# Aging Life Care Association (ALCA)



# National Academy for Certified Care Managers (NACCM)



## **Health and Disability:**

- Attend doctor appointments and facilitate communication between doctor, client, and family. These professionals help determine types of services – such as home health and hospice – that are right for a client and assist in engaging and monitoring those services.

## **Financial:**

- Provide information on Federal and state entitlements, connecting families to local programs when appropriate. They also help clients and families with insurance concerns, claims, and applications.

## **Housing:**

- Help families and clients evaluate and select appropriate level of housing or residential options.

## **Families:**

- Help families adjust, cope and problem-solve around long-distance and in-home caregiving, addressing care concerns, internal conflicts and differences of opinion about long-term care planning.

## **Local Resources:**

- Know the specifics of the local resources in their communities and know how services are accessed.

### **Advocacy:**

- Strong and effective advocates for clients and their families, promoting the client's wishes with health care and other providers, ensuring that client's needs are being adequately addressed.

### **Legal:**

- Refer to legal experts, like elder law attorneys, estate planners, and Powers of Attorney. Some Aging Life Care Professionals provide expert opinion for courts in determining level of care and establishing client needs.

### **Crisis Intervention:**

- Offer crisis intervention when it is needed, helping clients navigate through emergency departments and hospitalizations, rehabilitation stays, and ensuring that adequate care is available to the client. For families that live at a distance, this can be a much-needed 24/7 emergency contact.

Local, cost-effective resources are identified and engaged as needed.

A care plan tailored for each individual's circumstances is prepared after a comprehensive assessment. The plan may be modified, in consultation with client and family, as circumstances change.

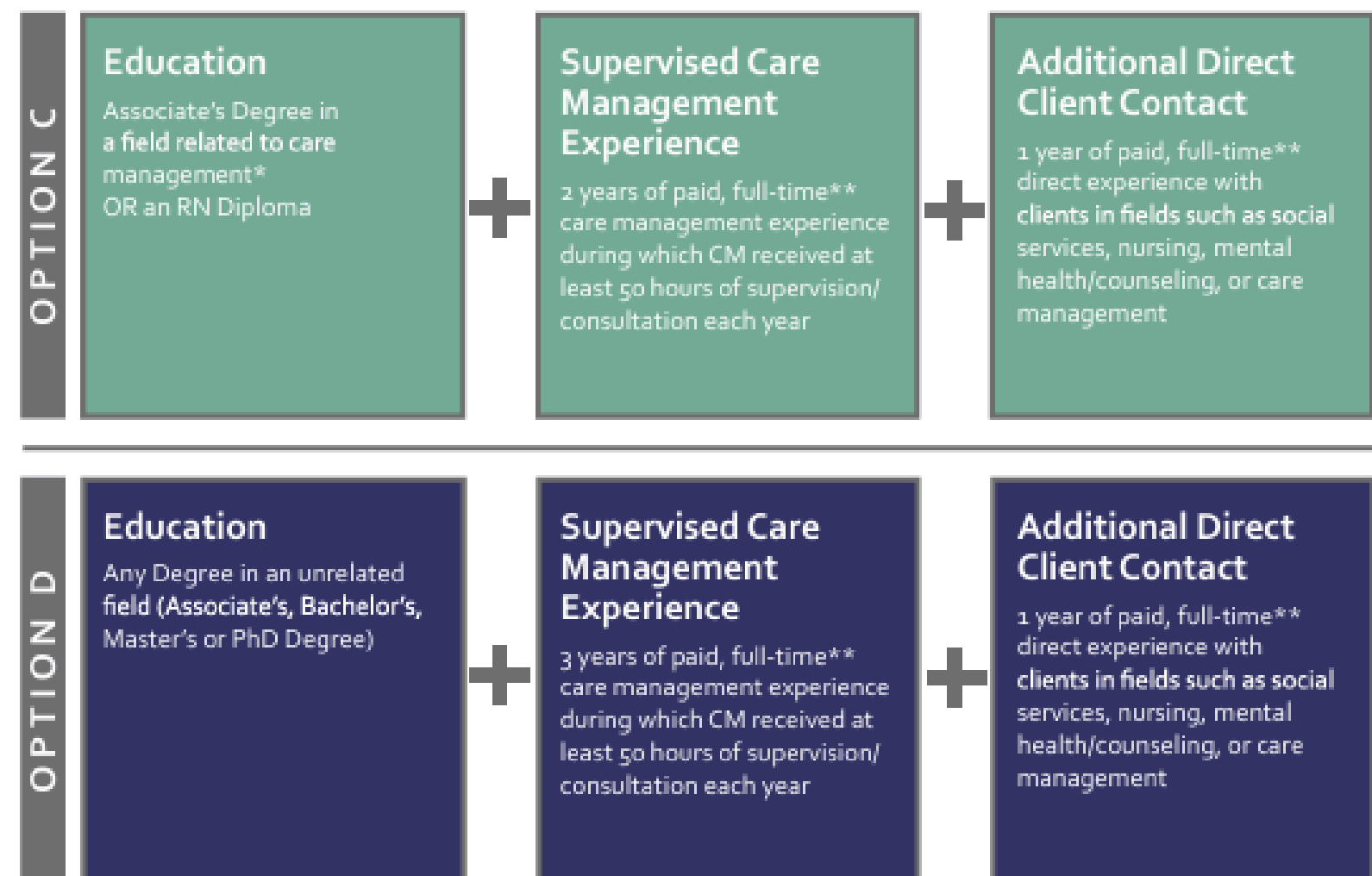
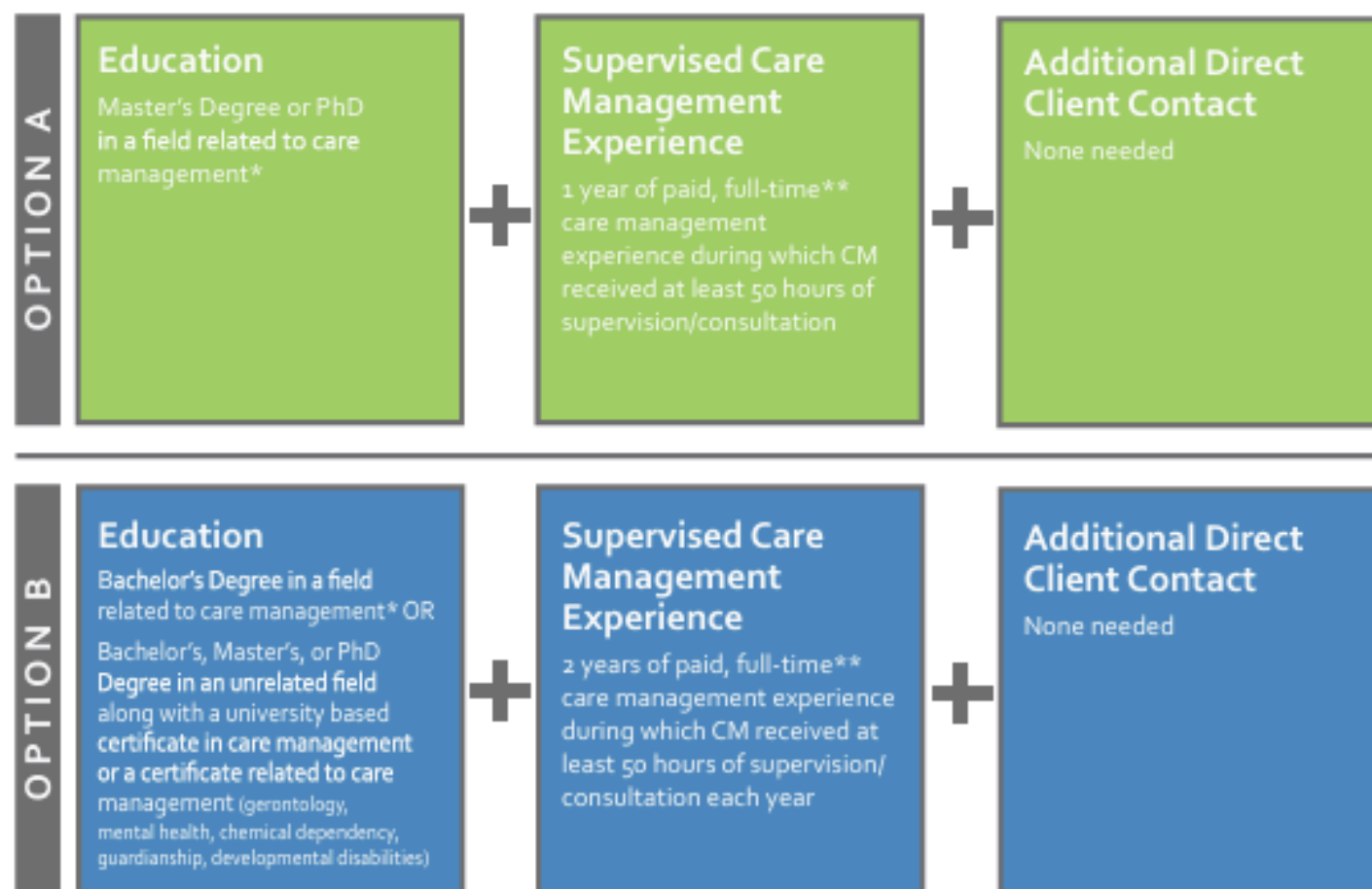
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## Eligibility Requirements

Candidates must meet ONE of the following eligibility options at the time of the application deadline.



# Case Management

According to CMSA, Case management is a collaborative process of assessment, planning facilitation, care coordination, evaluation, and advocacy for options and services to meet an individual's and family's comprehensive health needs through communication and available resources to promote patient safety, quality of care, and cost effective outcomes. The professional case manager executes the process based on their scope of practice using critical thinking and evidenced-based knowledge.

Case managers work at many places such as hospitals, health insurance companies, medical or mental health offices, outpatient clinics, doctor's offices, home care, rehabilitation facilities, or almost anywhere you receive care.

Typically tied to a health system, insurance company, clinic, etc.

Acute Case Management, Post-Acute Case Management and mobile/ community based case management.

# Care Management vs. Case Management: Key Differences

## Care Management vs. Case Management: Key Differences

| Differentiating Aspects | Care Management                                                                                     | Case Management                                                      |
|-------------------------|-----------------------------------------------------------------------------------------------------|----------------------------------------------------------------------|
| Patient Focus           | Chronic conditions requiring ongoing support (diabetes, heart disease, multiple chronic conditions) | Acute episodes and transitions (surgery, discharge, hospitalization) |
| Primary Goal            | Prevent crisis through proactive monitoring                                                         | Navigate crisis through intensive coordination                       |
| Timeline                | Months to years with the same patients                                                              | Days to weeks per episode                                            |
| Key Activities          | Medication adherence monitoring, care plan adjustments, addressing social determinants              | Discharge planning, insurance authorization, facility placement      |
| Success Metrics         | Reduced hospitalizations over time, improved chronic disease control                                | Smooth transitions, prevented readmissions, timely authorizations    |

# Care Management Benefits?

- Holistic, proactive & person-centered care
  - Addresses medical, social, emotional, and practical needs
- Expert coordination across systems
  - Connects healthcare providers, services, and community resources
  - Ensures continuity and reduces gaps in care
- Advocacy and guidance for patients & families
  - Promotes client preferences and supports decision-making
  - Provides education and caregiver coaching
- Improved quality of life & reduced stress
  - Reduces caregiver burden and improves well-being
  - 93% of clients report benefits outweigh costs
- Prevention of crises and unnecessary hospital use
  - Proactive planning, monitoring, and intervention
  - Helps avoid hospitalizations and care breakdowns

# Hospitalizations/ Readmissions

**15–20% of Medicare patients are readmitted within 30 days**

**Costs: \$12–17 billion annually**

## **Functional Decline & Loss of Independence**

- Up to 30% of older adults develop new disability in activities of daily living (ADLs) during hospitalization
- 1 in 3 hospitalized seniors experience functional decline
- Functional decline is linked to:
  - Higher readmission rates
  - Institutionalization (nursing home placement)
  - Increased mortality
- About 64% are discharged with worse function than baseline
- Delirium occurs in up to 30–40% of hospitalized older adults and increases mortality risk

# Impact of Care Management

Reduces readmissions by 5–15%

Early follow-up care lowers risk by ~21%

Transitional care programs significantly improve outcomes, up to 50% in some models/ research.

These stats come from CMS data summaries, AHRQ/HCUP analyses, and peer-reviewed research, not opinion — they are widely accepted in healthcare research today

# Care Management in Action

Ongoing Care Management always starts with a Comprehensive Assessment. At Golden Oak, we look at the following areas:

- Cognition, Depression, Social Isolation Risk
- Sleep, Pain & Nutrition
- ADL, IADL & Fall Risk
- Medical History, Medications & Provider List
- Routines, Goals & Preferences
- Environment and Advance Planning

Once we complete the Assessment, we compile client goals, area of risk and identified gaps into a Plan of Care (POC). We review the POC with our client and once approved, we get started on managing everything outlined in the POC. We review the POC every 90 days or sooner.

# How to know if someone would benefit?

Care Management is an extra layer of formal support for seniors and their families. People that could use more support usually have one or more of the following:

- Diminished support system locally (or family has a hard time managing)
- Poor health insight
- Hard time keep track of details (missed appointments, etc)
- Changing health needs
- Recently has had acute and/or post-acute services (recent hospitalizations or re-hospitalizations or SNF visit)
- Additional touch points/ more support on understanding health needs
- Worried about Aging in Place
- Concerns over safety
- Concerns once Home Health ends

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Questions?