RN, MSN, CCM, CCP

Skilled care management leader with 20+ years of healthcare experience in both direct care and administrative roles. Background includes developing complex care management programs, supervising case managers, and ensuring programs meet clinical, regulatory and financial goals. Passion for advocating for clients, educating providers and promoting positive health and financial outcomes. Known for a forward-thinking, energetic, and team-building approach.

Passion for balancing care and cost to deliver superior patient care in a way that benefits consumers, providers and payers. Excel in building trusting relationships with patients, providers, and staff. Create Quality Improvement plans that significantly improve program effectiveness and set achievable patient and program goals.

Complex Care Program Management | Program Design and Implementation |Operations Management |Data Analysis Staff Management |Team Building and Leadership | Training and Development | Relationship Building
Nursing Education |Case Management | Utilization Management | Milliman Care Guidelines|Interqual
Clinical Consultation | Discharge Planning|Transition of Care Planning | Disease Management | Patient Advocacy Patient Assessment | Quality Improvement| Motivational Interviewing|Trauma-Informed Care|
Project and Program Management|Excel|Triple Aim|Triage|Hospice|Epic|Netsmart

PROFESSIONAL EXPERIENCE

HOSPICE OF

Clinical Nurse Program Manager, RN

Responsible for leading day-to-day operations of the Transitions and Palliative Care team/program which consists of nurses, social workers, student interns and a Medical Doctor. Provide oversight, management and optimization of clinical processes and activities to effectively meet customer service, patient satisfaction and care standards. Deliver medical information and triage of symptoms on an individual and departmental level. Ensure and develop standards of care and practice. Support and develop effective team dynamics. Communicate information and make recommendations to improve and promote quality and efficiency. Provide education and collaboration with community partners.

- **OPERATIONS MANAGEMENT:** Develop standard work and procedures to ensure high-quality, consistent, cost-effective care and operations. Provide supervision and constructive feedback to the interdisciplinary team Facilitate clear communication and bi-weekly team meetings with a focus on ongoing process improvement, staff morale and patient care coordination. Evaluate productivity data and coach for improvement and develop processes and procedures to ensure understanding and follow through of best practices.
- **PROBLEM SOLVING:** Daily problem-solving on an individual and organizational level. Function as Administrator on Call. Minimize conflict and maximize support between individuals, teams and departments.
- **TEAM LEADERSHIP:** Interviewing, onboarding and evaluations. Ongoing coaching, performance improvement plans and disciplinary action as needed. Daily supervision of staff and yearly evaluations and goal-setting. Data analysis and productivity reports and follow-up.
- **QUALITY IMPROVEMENT**: Audit clinical documentation and provide appropriate training and plans of correction. Monitor and respond to Unusual Occurrence reports, family surveys and complaints. Research hospice staffing models and provide recommendations to Senior Leadership.
- **COMPLIANCE**: Ensure compliance with all job-related State/Federal laws; ensures all HIPAA Privacy and Security regulations, Medicare Conditions of Participation, and all other regulatory/compliance requirements are understood and followed.

ALLIANCE FOR HEALTH

Care Management Practice Educator|Senior Case Manager, RN

Drive process and practice improvement as a change agent. Revamp assessment process to ensure a member-centered approach. Research innovative, evidence-based best practices and provide ongoing Trauma-Informed and Motivational Interviewing approach mentoring. Educate healthcare providers and patients. Facilitate a multidisciplinary approach to care. Encourage chronic disease management and patient empowerment.

- **CARE COORDINATION:** Develop cost-effective, individualized plans of care and perform clinical assessments. Provide education to physicians, pharmacists, nurses, social workers, care coordinators and other community staff.
- **PROBLEM SOLVING:** Recognize barriers to adherence and develop solutions, adjusting plans as needed and agreed upon by patient. Recognize barriers to clinic and plan success and drive changes for quality improvement.
- **PATIENT ADVOCACY:** Advocate for patient empowerment and understanding of plan of care and disease process. Reinstill a sense of hope for the patient who may have lost their way.
- **QUALITY IMPROVEMENT**: Participate in Quality Improvement activities, evaluate effectiveness of interventions and promote quality-driven, cost-effective, achievable goals for key patients and providers. Encourage Integrated Care Management approach to address clinical, behavioral and social determinants of health.

SOURCEWISE

Director of Healthcare Innovation

Led innovation initiatives, which involved identifying emerging trends, sponsoring innovation challenges, and engaging in discussions that provoked thinking, pushed boundaries, and moved core work toward the future.

- **CARE COORDINATION:** Developed a care management program and chronic disease management product with a focus on transitions of care.
- **RELATIONSHIP BUILDING:** Developed strategic partnerships to enhance care delivery and the consumer experience, and managed those partnerships to drive innovative outcomes.

Supervisor, Case Management

Directed daily activities of case management staff to include complex care management, children's care management, long-term support services, long-term care, and utilization management.

- **CASE MANAGEMENT:** Redesigned and revamped the care planning process to improve outcomes.
- **OPERATIONS MANAGEMENT:** Streamlined operations to improve processes and minimize duplication of efforts.
- **TEAM LEADERSHIP:** Established case manager relationships and maintained a positive work environment.
- **UTILIZATION MANAGEMENT:** Decreased unnecessary utilization of emergency room and hospital services.

Care Manager

Worked with an interdisciplinary care team using a LEAN methodology to build and deliver a patient experience that was coordinated, high quality and understood. Built the program from the ground up. Triaged patients' issues and promoted self-care. Used data to drive interventions and track effectiveness. Utilized a Plan-Do-Study-Act (PDSA) method for program and process improvement. Participated in several Rapid Improvement Events with Chief-Level staff. Developed Standard Work based on the PDSA process which flushed out the most effective and efficient way to deliver care.

- **CARE COORDINATION:** Served on Steering Committee that developed an Ambulatory Intensive Care Program to empower patients to manage their health, as well as to reduce unnecessary emergency room and hospital admissions.
- **RELATIONSHIP BUILDING**: Built strong physician relationships, overcoming a reluctance to use case managers.
- **CARE IMPROVEMENT**: Successfully increased PCP visits following hospitalizations and ER visits. Participated in Integrated Case Management training provided by the Case Management Society of America. Drove program improvement by sharing evidence-based practices and providing continued mentorship to fellow team members.

Case Manager | Team Leader | Supervisor

Promoted from Case Manager to Team Leader and Supervisor due to top-quality patient care and leadership.

- **CASE MANAGEMENT:** Absorbed a greater caseload following major staff reductions to successfully manage a 160-member caseload. Collaborated with community providers, public health agencies, and social service organizations.
- **STAFF DEVELOPMENT:** Directed training efforts to enable other case managers to earn Certified Case Manager designation. Led HR functions including on-and off-boarding procedures and staff evaluations.
- **PROCESS IMPROVEMENTS:** Reduced time required for medical chart organization and caseload planning from 6 hours to 10 minutes by developing spreadsheet of patient specs and training staff on proper use.
- **RELATIONSHIP BUILDING:** Collaborated with staff members of skilled nursing facilities—including MDs and Directors of Nursing—to transform reputation from "outsiders" to true partners in care.
- **UTILIZATION MANAGEMENT:** Slashed hospital admission rates 50% while improving patient/doctor communication by directing pilot program that required nurses to make rounds with attending physicians. Specialized in the care of transplant patients.

Care Coordinator: Program Development and Management

Launched an integrated pilot program combining Medicare and Medicaid (Minnesota Senior Health Options) for 10 counties. Gained consensus from a multi-agency staff of 75 county-care managers that had initial reservations.

- **CARE COORDINATION:** Built care coordination program from the ground up for a 10-county region. Championed short- and long-term goal setting for assigned case type and closely monitored clinical and financial outcomes.
- **STAFF TRAINING:** Authored a training manual and curriculum for all case managers.

Public Health Nurse | Case Manager

Provided education and clinical support to community members ranging from new born babies to the elderly. Worked closely with all new mothers within the county to ensure positive outcomes.

- **CASE MANAGEMENT:** Long-term care assessments for clients and caretakers with a caseload of 60-80 clients.
- **PROGRAM MANAGEMENT:** Created a train-the-trainer program and educational materials for fall prevention.
- **RELATIONSHIP BUILDING:** Built key relationships with community agencies to provide complete care to caseload.

EDUCATION & CREDENTIALS

Master of Science in Nursing (MSN), Major in Case Management, GPA: 4.0 ▫ University of

Bachelor of Science in Nursing (BSN), GPA: 3.8 ▫ State University,

Licensure	Registered Nurse (RN): CA and MN, PHN MN, Licensed Practical Nurse (LPN)
Certifications	Certified Case Manager (CCM), Certified Chronic Care Professional, Certified Project and Program Manager (20 -UC Santa Cruz Extension
Training	Stanford "Living Well with Chronic Conditions," Motivational Interviewing, Integrated Case Management/Complexity Assessment Grid, LEAN Management, Leadership Workshops, "Healthcare Transformation Leadership Summit," UCSC Extension: Leadership and Communication, The Role of the Project Manager, Lean-Agile Project Management, Project Risk and Integration, Applied PM, Trauma-Informed Care
Memberships	Board of Directors for Sourewise, Case Management Society of America, Sigma Theta Tau National Honor Society of Nursing
Presentations	