gpTRAC
Great Plains Telehealth
Resource & Assistance Center

Chronic Care Management Toolkit

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Toolkit Overview

This toolkit was created to assist organizations in understanding and implementing a chronic care management program through an active care coordination approach. This approach has become increasingly popular for a wide range of conditions, including both medical conditions and behavioral health (known as Collaborative Care Management in the behavioral health context).

As the focus of healthcare changes from a "sick" care model to a population health model, primary care practices have new opportunities to improve patient health outside traditional individual outpatient appointments.

In recent years, Medicare and other payers have increasingly covered Chronic Care and Collaborative Care Management codes. These codes provide significant workforce and technology flexibilities, but they can also be challenging to implement. It is our hope that this toolkit will be useful to plan and implement Chronic Care Management (CCM) and Collaborative Care Management (CoCM) programs in a variety of settings.

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Overview of Care Management

MEDICARE AND MEDICAID SERVICES CHRONIC CARE MANAGEMENT PROGRAM

The Medicare Chronic Care Management program began in 2015. At its inception, the Center for Medicare and Medicaid Services (CMS) estimated that approximately 68% of all Medicare beneficiaries would qualify for CCM services. In the fall of 2016, after almost two-years of CCM reimbursement, only about 500,000 beneficiaries had received any CCM services. Changes to the CCM regulations that took effect January 1, 2017 strengthened CMS's commitment to CCM in the primary care setting. These changes were designed to impact more beneficiaries and extend Care Management to Rural Health Clinics and Federally Qualified Health Centers. In 2020 and 2021, CMS continued to make regulatory changes to expand opportunities for reimbursement in a variety of Care Management (CM) services for practices, as these services continue to show positive outcomes for the almost three million beneficiaries who have received them.

As outlined in the CMS Chronic Care Management Fact Sheet, there are several required elements to have a reimbursable CCM program. A foundational requirement is the use of an electronic medical record. Additional requirements include:

- The patient must be an established patient of the primary care provider and the provider must initiate the service by informing the patient of their chronic conditions and risk factors.
- Patients must have two or more chronic conditions.
- The patient must agree to the service. Obtaining ***consent*** can be accomplished verbally or in writing.
- A ***care plan*** must be developed in conjunction with the patient.
- The practice should make available an electronic form of communication that can be used with the patient, care givers, and ***community resources***.
- The practice must ***track time*** spent with or on behalf of the patient in coordinating care.

THE CARE COORDINATION APPROACH

The Agency for Healthcare Research and Quality (AHRQ) defines ***care coordination*** as "…deliberately organizing patient care activities and sharing information among all of the participants concerned with a patient's care to achieve safer and more effective care" (2018). Utilizing appropriate ***communication***, through both a patient-centered and a team-based approach, is at the center of effective care coordination, with care coordination focusing on the total health care needs of the patient.

Although an evolving care delivery model, key elements of any effective care coordination program include good communication between the health care team members, good communication between the health care team and the patient, easy and timely patient access to a range of health care services and providers, active patient engagement with their plan of care, and smooth transitions between providers and services. A patient's comprehensive ***care plan*** is developed by the care coordinator, following the steps of the nursing process. The care plan serves as a working guide in support of the patient's ***health promotion*** goals. All members of the healthcare team should possess

cultural competence and be aware of the cultural differences and health beliefs of their patient population.

As the care coordination delivery model continues to evolve, the inclusion of age friendly care is an emerging element. ***Age-Friendly Health Systems*** is an initiative of the Institute for Healthcare Improvement (IHI) and the John A. Hartford Foundation, in partnership with the American Hospital Association (AHA) and the Catholic Health Association of the United States (CHA). A framework for age-friendly health systems, known as the 4Ms , "entails reliably providing a set of four evidence-based elements of high-quality care, known as the '4Ms,' to all older adults in your system: What Matters, Medication, Mentation, and Mobility" (IHI, 2021). The 4Ms framework is not a program, but rather a shift in care.

THE IMPORTANCE OF TEAM-BASED CARE

A ***team-based care approach*** is a key component of any successful chronic care management program. The team consists of everyone involved with the patient's care, including the care coordinator, provider, clinical staff, family members, other care givers, community members, and the patient themselves. The team can also include, indirectly, those specialists, such as a cardiologist or psychiatrist, who may address specific needs of the patient.

As a model of care that serves as a collaborative effort among multiple providers of care and across settings of care, the team-based approach works toward shared goals that reflect the patient's priorities, needs, and values. Through a team-based lens, all members involved with the patient's care clearly communicate with one another to ensure care is patient-centered, appropriate, value-based, and of high quality. This ***patient-centered care*** practice supports shared decision making by assisting the patient with identifying those ***health promotion*** goals that are important to them.

SUPPORTING POPULATION HEALTH THROUGH CHRONIC CARE MANAGEMENT

Care coordination improves population health through the population health management and coordination of multiple providers and complex services for patients with chronic disease. Using a ***patient-centered***, ***team-based care approach***, care coordination seeks to effectively utilize resources from the community and healthcare system to deliver services that are in alignment with patient and family needs and preferences.

The Institute for Healthcare Improvement (2021) defines ***population health*** as, "The health outcomes of a group of individuals, including the distribution of such outcomes within the group." The Pathways to Population Health: An Invitation to Health Care Change Agents (2017) includes the ***Portfolios of Population Health Framework*** that supports healthcare organizations in their efforts to improve population health.

The United States healthcare system continues to be plagued with inconsistent quality, high costs, and inequitable outcome. Care coordination models are being recognized as a way to improve healthcare delivery and meet the goals of the Triple Aim (AONE, 2015). As the number of Medicare patients continues to increase, care coordination brings a multi-disciplinary team-based approach to meet the chronic care needs of this population.

Program Details & Requirements

REIMBURSEMENT

Since its inception, Chronic Care Management (CCM) was designed to be reimbursed under Medicare Part B. As a Part B service, all rules around Part B apply, including patient responsibility for deductibles and copays as outlined in the patient ***consent*** documentation. Over time, other insurance carriers, including some state Medicaid programs, began covering CCM. Each state and each plan are unique and must be researched specifically. These state policies are summarized at the ***qpTRAC state policy pages***.

Billing Requirements

Chronic Care Management and Complex CCM are billed by calendar month. In any given month, the provider's practice may bill for either CCM *or* Complex CCM depending on the amount of time spent and tracked. Billing for a patient may be done at the end of each calendar month when the following criteria are met:

- The patient is established with the provider and the provider has referred the patient or agreed to enroll the patient in the program
- There is documentation of at least two chronic conditions
- There is documentation of the patient's signed or verbal ***consent***
- There is a patient centered ***care plan*** developed with the patient
- At least 20 minutes of ***time has been tracked*** in care coordination activities completed with or on behalf of the patient during the calendar month

Additional ***CCM billing*** may be captured when more time is spent, or when a medical decision is made that requires additional follow-up. This is only allowed when the *total* time tracked is *at least* 60 minutes in a calendar month.

The complete list of CCM codes and requirements are as follows:

CCM ("Regular" CCM)

- 99490 may be billed once per month for the first 20 minutes of CCM
- 99439 may be billed a maximum of twice per month for each additional 20 minutes of CCM (beyond the initial 20 minutes)

Complex CCM

- 99487 may be billed once per month for the first 60 minutes of CCM
- 99489 may be billed for each additional 30 minutes of CCM (beyond the initial 60 minutes)

Chronic Care Management codes and Complex CCM codes may not both be billed in the same month for any one patient.

Rural Health Clinics (RHC) and Federally Qualified Health Centers (FQHC) may provide care management services for Medicare patients. Although the same rules apply, RHCs and FQHCs do not bill Medicare using the CPT codes above, but rather with the HCPCS code G0511. This code covers both "Regular" CCM and Complex CCM

Workforce and productivity estimates

Although there are no minimum professional requirements specified in the regulation, it is important to ensure that the care coordinator has the

qualifications necessary to complete the tasks required to perform care coordination.

Based upon the time commitment to recruit patients, interaction with community resources, and proactively managing patients each month, it is estimated that one full-time care coordinator can manage approximately 200-250 patients. This ***staffing estimate*** is based on providing patients with a combination of monthly CCM services, Complex CCM services (as needed), Annual Wellness Visits, and Advance Care Planning.

Revenue Projections

Prior to beginning CCM, a practice should evaluate the potential revenue to be gained based upon the practice's demographics. Evaluating the Medicare population is a good place to start as Medicare provides reimbursement for CCM. Some electronic medical record systems can provide the number of unique Medicare patients in a practice, while others provide a percentage of Medicare patients out of the total panel size. Once the total number of Medicare patients is determined, applying the factor of 68% (the estimated percentage of Medicare patients with two or more chronic conditions) to the number of Medicare patients will provide an estimate of those patients in the practice that will likely qualify for the program.

The CCM program is designed to be ongoing. Once a patient is enrolled in the program it is assumed they will receive the service each month. There will be some months when they may require more coordination activities than others. The ***expected projections*** for enrollment along with the assumptions used to project revenue can be estimated using the companion calculator spreadsheet available with this document.

OTHER REQUIREMENTS

Consent

Prior to beginning any time tracking for Chronic Care Management (CCM), consent must be obtained from the patient. This agreement ensures that the patient is engaged in the process and understands that this service may only be provided by one primary care provider. The consent, or agreement, can be obtained verbally or in writing. Regardless of which method is used, it must be documented in the medical record. A popular method is to use a consent form that outlines all required elements that must be discussed with the patient. If the consent is being obtained with the patient in person, the patient should sign the consent/agreement and be given a copy. If the consent is being obtained over the phone, verbal consent should be noted on the form and the form sent to the patient, either through a secure electronic communication, such as the portal, or through the mail.

The consent should include the following elements:

- The patient must be informed that this service may only be provided and billed by one provider for any given month.
- The patient must be given information on how to access their care team at any time 24 hours per day, 7 days per week. This requirement can be accomplished through the use of a welcome letter that outlines the name of the care coordinator, their phone number, voicemail information, office hours, and instructions for after-hours service access (which could be an Ask-A-Nurse line or hospital help line within the organization).
- The patient should be informed that every attempt will be made to set a regular follow-up, routine appointment with their designated primary care provider and that

assistance will be given to ensure scheduling of all recommended preventative services, medication reconciliation, and oversight of symptom management.

- The patient must understand that they are an integral part of their health care team and, as such, they will need to work with a care coordinator to create a ***care plan*** that is specific to them and congruent with their choices and values. The patient must receive a copy of the care plan.
- The patient must be informed that care management services are subject to the usual deductible and coinsurance applied to provider services.
- The patient must be informed that they may revoke consent at any time and the services will end on the last day of that calendar month.
- The patient will agree to allow the care team to share information electronically with other treating providers, consultants, relevant specialists, and home and community-based resources, as part of the care coordination involved in care management services.

Care Plan

Patient engagement in any Chronic Care Management (CCM) program must include a patient-centered care plan that supports the patient's personal health goals, as identified by a physical, mental, cognitive, psychosocial, functional, and environmental (re)assessment. Any comprehensive assessment must be done from the patient perspective, with the care coordinator supporting and guiding the patient toward healthy decisions. The care plan must be regularly reviewed by the care coordinator and patient, and updated as needed.

A discussion of patient-determined goals should be part of every clinical encounter, and the care plan revised as needed. Changes to the care plan can be driven by lack of goal attainment and/or lack of improvement in symptoms. Motivational interviewing is a goal-oriented, client-centered counseling style for eliciting behavior change by helping clients to explore and resolve ambivalence. It recognizes and accepts the fact that patients who need to make changes are at different levels of readiness to change their behavior. In a non-judgmental, non-confrontational environment, motivational interviewing attempts to increase the patient's awareness of the potential problems caused, consequences experienced, and risks faced due to the behavior in question.

Time Tracking

Chronic Care Management (CCM) is reimbursed by calendar month under a time tracking model. CCM is NOT encounter based. All activities performed either with the patient, or on behalf of the patient, should be tracked and counted toward the monthly total. These activities occur outside of any billable patient encounter and are considered non-face-to-face activities. Therefore, time may not be tracked during a billable encounter such as an office visit, when a patient is admitted to the hospital, or when the patient is receiving another billable service. Billing may occur for a face-to-face encounter with a provider *OR* time may be tracked as part of CCM services, BUT NOT BOTH. Billing and time tracking may *not* be done for the same time period. Examples of time tracking activities could include:

- Patient communication, such as phone calls, correspondence, or electronic communications

- Communication with the care team regarding reports/results and treatment plan management
- Referral management
- Care plan updates
- Medication reconciliation and adjustment
- Assistance with community resource access and/or other health care resources
- Communication with community resources and/or other health care resources

The minimum amount of time required to bill for CCM is 20 minutes during a calendar month. This is a cumulative total for the month and will determine the codes to be billed. Over the course of the month, all time should be tracked, and any medical decisions that are made outside of a provider appointment should be recorded. In addition to ***billing for CCM***, there is an opportunity to bill for Complex CCM with 60 minutes of care coordination *and* the documentation of a complex medical decision.

Team-Based Care

A chronic care management (CCM) program is designed to improve ***population health*** outcomes through improved patient behavior. To support this patient-centered and population based approach, the Centers for Medicare and Medicaid Services requires a team-based care model. With this model, the care coordinator is the key patient contact and the focal point for any patient care activities between the various team members, including the patient. The National Academy of Medicine (2021) described team-based health care as having the following principles:

1. Shared Goals: "The team—including the patient and, where appropriate, family members or other support persons—works to establish shared goals that reflect patient and family priorities, and that can be clearly articulated, understood, and supported by all team members."
2. Clear Roles: "There are clear expectations for each team member's functions, responsibilities, and accountabilities, which optimize the team's efficiency and often make it possible for the team to take advantage of division of labor, thereby accomplishing more than the sum of its parts."
3. Mutual Trust: "Team members earn each other's trust, creating strong norms of reciprocity and greater opportunities for shared achievement."
4. Effective Communication: "The team prioritizes and continuously refines its communication skills. It has consistent channels for candid and complete communication, which are accessed and used by all team members across all settings."
5. Measurable Processes and Outcomes: "The team agrees on and implements reliable and timely feedback on successes and failures in both the functioning of the team and achievement of the team's goals. These are used to track and improve performance immediately and over time."

Taking these five principles into account, the CCM care coordinator must always be mindful of clarity around shared goals, a clear understanding of everyone's role and scope of practice, mutual trust among the team and most importantly – effective and constant communication – both orally and in writing.

Qualifications for the Care Coordinator

The care coordinator is responsible for maintaining and managing the care coordination program. This includes recruiting and maintaining patients enrolled in care management services, ensuring completion of the Annual Wellness Visit, following up on all elements of

the preventative plan of care, and discussing advance care planning with patients. These responsibilities are completed through the provision of disease management/care management, care coordination/health promotion, education/training and motivational support to patients, referral sources, and community outreach. The care manager supports quality outcomes and the quality of life of the CCM patient through all transitions of care, coordination of care across the health continuum, and encouragement of healthy lifestyle choices to reduce the long term negative effects of chronic illness.

To fulfill the responsibilities of this role, the care coordinator should possess a minimum of language, mathematical, and reasoning skills, with the following abilities:

- Ability to read, analyze, and interpret common scientific and technical journals, financial reports, and legal documents. Ability to respond to common inquiries or complaints from customers, regulatory agencies, or members of the business community. Ability to write policies and procedures that conform to prescribed style and format. Ability to effectively present information to top management, public groups, and/or boards of directors.
- Ability to add, subtract, multiply, and divide in all units of measure, using whole numbers, common fractions, and decimals. Ability to compute rate, ratio, and percent and is knowledgeable in metric, apothecary and household measurements and can convert from one system to another.
- Ability to solve practical problems, to include a variety of concrete variables in situations where only limited standardization exists. Ability to interpret a variety of instructions furnished in written, oral, diagram, or schedule form. Ability to modify care based on the developmental and/or functional age of the patient as well as that of the patient's cultural background.
- Ability to act as a patient advocate. Ability to interact with patients, families, visitors, and co-workers. Ability to interact assertively and tactfully when dealing with conflict and in group solving activities. Ability to demonstrate a professional, open-minded approach in identifying and resolving problems/conflicts. Ability to develop creative solutions outside of the health care setting. Ability to develop relationships with community resources. Ability to appropriately manage time and work in flexible environments. Ability to work autonomously and meet demanding deadlines.

Typically, registered nurses are a good fit for the role of care coordinators. According to the American Nurses Association's Nursing Scope and Standards of Practice (4th ed.) (2021), a registered nurse has the qualifications to coordinate care. Standard 5A – Coordination of Care, outlines the competencies that a registered nurse should have to perform this function:

> "The registered nurse:
>
> - ❖ Collaborates with the healthcare consumer and the interprofessional team to help manage health care based on mutually agreed-upon outcomes.
> - ❖ Organizes the components of the plan with input from the healthcare consumer and other stakeholders.
> - ❖ Manages the healthcare consumer's care to reach mutually agreed-upon outcomes.

- Engages healthcare consumers in self-care to achieve preferred goals for quality of life.
- Assists the healthcare consumer to identify options for care and navigate the healthcare system and its services.
- Communicates with the healthcare consumer, interprofessional team, and community-based resources to effect safe transitions in continuity of care.
- Advocates for the delivery of dignified and person-centered care by an interprofessional team.
- Documents the coordination of care." P. 97.

"In addition to the competencies of the registered nurse, the graduate-level prepared registered nurse:

- Provides leadership in the coordination of interprofessional health care for the delivery of integrated system-level healthcare consumer services to achieve safe, efficient. Timely, person-centered, and equitable care.
- Manages identified healthcare consumer panels or populations." P.97-98.

Communication

Effective communication between members of the health care team, patients, and their families is essential in the provision of safe and quality healthcare. Inadequate communication can lead to misunderstanding, compromised patient safety and poor outcomes. Communication comes in many forms, such as verbal, non-verbal, written (print), listening, and visual communication.

Direct communication between the health care team and the patient should also be adapted to address any additional barriers that may hinder the patient's understanding of their plan of care. Recognizing language barriers and patient health literacy limitations can provide the care coordinator, and other team members, with an understanding of how health beliefs and cultural practices influence the way advice is received. Health Literacy Improvement Tools can provide strategies to improve health literacy. The creation of a shame-free environment, encouraging questions, being specific and concrete, listening carefully, limiting and repeating content, speaking clearly and using plain language, the use visual aids and graphics, and the application of the teach-back method, as described in the Health Literacy Universal Precautions Toolkit, 2nd edition, provide support for those with limited health literacy.

Health Promotion

Supporting the patient's health promotion goals require a proactive approach. Such an approach should take into account the Triple Aim, a framework developed by the Institute for Healthcare Improvement (IHI), that describes a mode for optimizing health system performance. It includes the three dimensions of: (1) improving the patient experience of care; (2) improving the health of populations; and (3) reducing per capita cost of health care. ***Care coordination*** embraces these dimensions through the support of goal of improved patient outcomes to populations, while providing high-quality, high-value health care services. The Quadruple Aim expands upon the Triple Aim, with the additional dimension of improving the work life of health care providers.

Nola J. Pender's Health Promotion Model described health as a "positive dynamic state rather than simply the absence of disease," and focused on the areas of

"individual characteristics and experiences, behavior-specific cognitions and affect, and behavioral outcomes" (Nursing Theory, 2020). Care coordinators should support health promotion by recognizing social determinants, empowering communities, supporting public awareness, and actively engaging in health policy and legislative reform.

Cultural Competence

For the care coordinator, clear communication must not only be directed toward other health care team members and the patient. It should also be a part of those relationships the care coordinator has with others who play a role in the patient's care management, such as family members and caregivers, local community resources, and government agencies. Barriers to effective communication include lack of congruence of the message, distorted perceptions, distorted sources of information, defensive non-verbal posture and behavior, and the lack of cultural competence or awareness. Religion, culture, beliefs, and ethnic customs can impact how patients perceive and understand health concepts, and the health care team must be sensitive to different cultures and recognize that cultural differences can affect verbal and non-verbal communication. Such familiarity is important toward building trust with the patient.

Staffing Estimates

Once a patient has been enrolled in a Chronic Care Management (CCM) program, the goal is to provide proactive care coordination each month by interacting with, or on behalf of, the patient. There may be months that require more time than others. On average, the care coordinator will spend at least 20 minutes per patient per month.

The patient may need management that includes complex care coordination. Complex CCM patients will require at least 60 minutes of care coordination with close follow-up, along with provider involvement for medical decision-making. Although there is no specific standard, it is not unreasonable to assume that approximately 10% of the patient population will require Complex CCM in any given month. For some practice populations, this percentage may be higher.

Additionally, patients enrolled in the CCM program must have a process to ensure health promotion services and screenings are completed. The Annual Wellness Visit (AWV) should be the process to ensure preventive services are met. The AWV can be performed under a team-based approach and completed by the care coordinator, as can Advance Care Planning in conjunction with the AWV.

The productivity of a full-time care coordinator managing 200-250 patients is outlined as follows:

> 225 patients x 20 min/month = 4500 min/60 = 75 hours x 12 months = 900 hours/year
>
> 25 patients x 60 min/month = 1500 min/60 = 25 hours x 12 months = 300 hours/year
>
> 250 Annual Wellness Visits x 1 hour each = 250 hours/year
>
> 250 Advance Care Planning x 1 hour each = 250 hours/year

Direct care coordination time totals 1700 hours per year. In addition to conducting direct care coordination with patients, care coordinators should recruit community resources by having an active, interactive presence in the community. Community interactions should be scheduled for at least four hours a week x 50 weeks for a total of 200 hours/year. One full-time equivalent is equal to 2080 hours/year, with 1900 hours out of 2080 hours used for care coordination (180 hours/year for vacation, holidays, and education time).

Care coordination is a team effort and the time spent by the care coordinator and other clinical staff can contribute to monthly cumulative time tracking. This time is trackable only when interacting with patients or working on their behalf outside of a scheduled appointment. As the CCM program grows, it is essential to have a workforce strategy in place to support growth. As the program grows, a registered nurse is often an ideal candidate to lead a care coordination program.

Not all members of the care coordination team must be registered nurses. For example, as the number of patients in the CCM program approaches 200, the overall level of needs of the patients should be evaluated. Some patients may be very ill and need the skills of a registered nurse. Others may be stable enough to only require follow-up care and reminders. Others may benefit from the occasional home visit to assist with medication management. Having a CCM program with a mix of RNs, LPNs/LVNs, medical assistants, community paramedics, and community health workers may provide a range of skill sets and service types that meet the needs of a particular patient population.

Estimated total patient panel sizes with various staffing plans are as follows:

Staffing	*Patients*	*Considerations for future staff mix*
1 – RN FTE	1-200	Based on patient needs
1 – RN FTE and 1 – LPN or MA FTE	200-350	Evaluate complex needs
2 – RN FTEs and 1 – LPN or MA FTE	350-550	Evaluate home care options
2 – RN FTEs, 1 MA FTE, 1 – Community Paramedic or Community Health Worker	550-700	Continue to evaluate patient needs

Community Resources

A successful care coordination program, including Chronic Care Management (CCM), should work closely with community resources. According to the Bipartisan Policy Center, only 10% of what makes us healthy is access to healthcare, whereas 70% is attributed to environment and healthy behaviors. Engaging community resources into the health of patients is critical. Every community has a wealth of resources. Some are formalized, such as senior centers, while others may be less structured such as church groups, service organizations, youth organizations, neighbors, and even local or distant family members. These resources can serve as the "eyes and ears" of the care coordinator to alert the coordinator of small variations in behavior that can serve as an early detection of issues and prevent emergency visits or even admissions when symptoms can be managed early. The use of HIPAA compliant electronic communications should be used to protect patient privacy when communicating with community resources.

Social Determinants of Health

Social determinants of health play a pivotal role in the physical and mental well-being of an individual. Such factors as education, working life conditions, housing, and food insecurity can influence health equity in a positive or negative way. Healthy People 2030 define the social determinants of health as, "…conditions in the environments in which people are born, live, learn, work, play, worship, and age that affect a wide range of health, functioning, and quality-of-life outcomes and risks." The United Nations' Sustainable Development Goals support prosperity amongst countries of all income levels, while addressing environmental concerns and climate change. They support equity improvement to meet the needs of disadvantaged populations

About the Authors

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Ms. Jones is the Director of Care Coordination and Lean Consulting for HealthTechS3. She currently implements care coordination programs focusing on the Medicare population and teaches concepts related to care coordination and team-based approaches to care nationally. Ms. Jones began her healthcare career in the US Navy over 35 years ago. She has worked in a variety of roles in clinical practice, education, administration, and consulting. In her leadership roles she has been responsible for the operational leadership for all clinical functions in the hospital, ambulatory care, and community settings. She has held a variety of leadership positions in the profession of nursing and was recently the Vice President of the American Nurses Association Board of Directors and the Co-Chair of the ANA-PAC Leadership Society. She currently holds a certification from the American Nurses Credentialing Center as a Nurse Executive Advanced, is a fellow of the American Nurses Advocacy Institute, and holds certifications in Lean for Healthcare and Advance Care Planning.

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