

# Rosalie Salas

## Care Manager, Registered Nurse

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### STRENGTHS

- ♥️ **Person Centered Assessment**  
Starts with member priorities, then connects clinical findings and daily barriers with practical next steps.
- 👥 **Care Plan Coordination**  
Brings caregivers, specialists, and providers into one clear plan. Colleagues valued calm follow through.
- 📖 **Member Education**  
Uses plain language and teach back. Members often left conversations clearer about instructions and choices.
- ⚠️ **Barrier Resolution**  
Looks beyond symptoms to housing, transportation, and access gaps, then helps move referrals forward.
- ♥️ **Clinical Documentation**  
Keeps records useful and complete. Strong notes gave partners a reliable view of progress and changing needs.

### SKILLS

Care management   Care planning

Member assessment

Physical health needs

Social determinants

Care coordination

Provider collaboration

Specialist referrals

Community resources

Telephonic outreach

Digital outreach

Member education

Care gap resolution

### SUMMARY

Registered Nurse Care Manager with four years of experience supporting members with complex physical health needs through person centered assessment, individualized care planning, education, referral coordination, and access to healthcare and community resources. Holds a **Bachelor of Science in Nursing** and an **unrestricted Michigan RN license**. Provides thoughtful telephonic and digital outreach, monitors changes in condition, addresses **social determinants of health**, and revises service plans with members, caregivers, providers, and specialists. Maintains accurate documentation under state, federal, and **third party payer requirements** while identifying care gaps and access barriers. Brings sound clinical judgment, member advocacy, organized remote work practices, and cost conscious coordination that support continuity, quality, informed decisions, and better achievable outcomes.

### EXPERIENCE

#### RN Care Manager

Lakeshore Community Health Network 📅 July 2024 - Present 📍 Grand Rapids, MI

Supports members with complex **physical health needs** through individualized assessment, service planning, clinical monitoring, education, outreach, referral coordination, and compliant documentation. Partners with caregivers, providers, specialists, and community resources while offering quality improvement feedback for remote care operations.

- Built individualized care plans from member priorities, **access barriers**, and **social determinants of health**.
- Used telephonic outreach to identify changing conditions, **care gaps**, and follow up barriers.
- Coordinated providers, specialists, caregivers, and **community resources** across referral transitions.
- Revised service plans with members and clinicians after changing health needs or priorities.
- Taught **disease processes**, care options, benefits, and warning signs through teach back.
- Maintained payer compliant records while surfacing recurring access issues for quality improvement.

#### Registered Nurse, Care Coordination

Great Lakes Integrated Care 📅 October 2022 - June 2024 📍 Lansing, MI

Coordinated care for adults with chronic and complex physical conditions by reviewing clinical information, identifying unmet needs, connecting members with services, and monitoring progress. Supported communication among members, caregivers, primary care teams, specialists, and payer resources while maintaining privacy and regulatory standards.

- Reviewed clinical information and member priorities to identify unmet care needs.
- Connected members with **specialists**, housing, transportation, and **independent living** resources.
- Tracked referrals and treatment plans through scheduled outreach and timely reassessment.
- Clarified next steps among members, **caregivers**, primary care teams, and specialists.
- Adapted chronic disease education for **health literacy**, readiness, and caregiver involvement.
- Documented assessments, referrals, updates, and outcomes under payer and **regulatory requirements**.

### PROJECTS

#### Community Resource Access Initiative 📅 2024

Mapped housing, transportation, independent living, and healthcare resources for care coordination workflows. Clear resource guidance helped staff connect members with appropriate services sooner.

#### Remote Care Plan Review Process 📅 2023

Created a structured review approach for outreach findings, referral progress, changing conditions, and service plan updates. Consistent follow through supported continuity across care relationships.

Regulatory compliance

Payer documentation

## LANGUAGES

English Native

Spanish Intermediate

## MY CAREER



● RN Care Manager at Lakeshore Community Health Network (2.2 Years)

● Registered Nurse, Care Coordination at Great Lakes Integrated Care (1.7 Years)

## LEADERSHIP & AWARDS

- Recognized by clinical peers for dependable coordination across members, caregivers, providers, and specialists.
- Selected for quality improvement feedback after identifying recurring barriers affecting referral follow through.
- Commended for clear member education that supported informed decisions and caregiver confidence.

## EDUCATION

### Bachelor's Degree in Nursing

Grand Valley State University 🎓 GPA: 0 📅 2022 📍 Allendale, MI

**Coursework:** Community health nursing, Medical surgical nursing, Health assessment, Care coordination

## CERTIFICATIONS

- Michigan Registered Nurse License 📅 2022
- Bachelor of Science in Nursing 📅 2022

## TECHNICAL SKILLS

- **Care Management:** Complex care management, Individualized care plans, Service plans
- **Clinical Assessment:** Member assessment, Physical health assessment, Clinical monitoring
- **Care Coordination:** Provider coordination, Specialist coordination, Caregiver coordination
- **Member Outreach:** Telephonic outreach, Digital outreach, Home visits
- **Health Education:** Disease process education, Member education, Caregiver education
- **Resource Navigation:** Community resources, Housing resources, Independent living resources
- **Referral Management:** Specialist referrals, Referral follow through, Timely referrals
- **Healthcare Benefits:** Healthcare benefits, Benefit education, Payer resources
- **Documentation Standards:** State requirements, Federal requirements, Third party payer requirements
- **Quality Improvement:** Care gap resolution, Service delivery feedback, Cost effective outcomes
- **Clinical Communication:** Provider instructions, Care options, Warning signs
- **Remote Work Systems:** Remote care management, Digital channels, Care management records

## PROFESSIONAL AFFILIATIONS

- Member of the American Nurses Association, supporting continued nursing practice growth.
- Member of the Michigan Nurses Association, connecting clinical practice with statewide nursing standards.

## ADDITIONAL INFORMATION

**Work Status** : Authorized to work in United States. No sponsorship required.

## REFERENCES

AVAILABLE ON REQUEST