

Magnolia Curry

Nurse Case Manager I

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STRENGTHS



Clinical assessment

Structured assessments connected symptoms, function, medications, and social needs with clear care plan priorities.



Transition planning

Discharge work linked patients, caregivers, facilities, and providers. Follow up became easier for everyone involved.



Barrier resolution

Provider and claims issues received steady follow up. Partners knew when concerns needed escalation.



Member education

Teach back made medication instructions and warning signs clearer. Patients could explain next steps with confidence.



Team coordination

Medical Directors, Physician Advisors, and operational partners received concise updates that supported timely decisions.

SKILLS

Care management

Clinical assessment Chronic care

Care planning

Telephonic case management

Discharge planning Authorizations

Referrals Benefit navigation

Resource coordination

Medical Director collaboration

Physician Advisor collaboration

Claims coordination

Member education

Clinical documentation

SUMMARY

Registered Nurse Case Manager with eight years of clinical nursing and care management experience supporting adults with complex and **chronic health needs** across inpatient, discharge, and health plan settings. Holds a **current unrestricted RN license** with multi state privilege and **Certified Case Manager** credentials. Provides comprehensive clinical assessment, individualized care planning, telephonic case management, utilization aware referrals, authorization support, discharge planning, member education, and coordination of medical, behavioral, and community resources. Partners with Medical Directors, Physician Advisors, hospitals, providers, claims teams, and community organizations to address barriers and improve continuity across the **care continuum**. Applies sound clinical judgment, clear documentation, and consistent follow up while adapting interventions as member conditions, goals, benefits, and service access change.

EXPERIENCE

RN Case Manager

Blue Ridge Member Care 📅 February 2022 to Present 📍 Richmond, VA

Leads virtual care management for members with complex and chronic conditions across health plan services. Owns clinical assessment, individualized planning, authorization support, provider coordination, physician consultation, discharge outreach, and outcome monitoring. Uses benefit knowledge and documented follow up to address barriers, support safe transitions, and revise interventions as member needs change.

- Manage virtual caseloads through nursing assessment, benefit review, and individualized member goals.
- Complete telephonic assessments covering clinical status, medications, function, social barriers, and service access.
- Coordinate **authorizations, referrals**, specialty care, home services, and community resources for member goals.
- Review complex treatment decisions with **Medical Directors** and **Physician Advisors** during clinical escalation.
- Support hospital to home transitions through discharge outreach, medication review, and **provider coordination**.
- Resolve provider, claims, and service barriers through documented escalation and revised care plans.

Clinical Case Manager, RN

Atlantic Care Coordination Group 📅 June 2020 to January 2022 📍 Norfolk, VA

Delivered telephonic and facility based case management for members transitioning among acute care, rehabilitation, home health, and outpatient services. Built post discharge plans, facilitated benefit based referrals, monitored outcomes, investigated service concerns, and maintained documentation that connected nursing, physician, utilization, claims, and provider teams.

- Provided telephonic and facility based case management across acute, rehabilitation, home, and outpatient settings.
- Built post discharge plans from records and interviews, confirming medications, transportation, equipment, and caregivers.
- Facilitated **referrals** and service **authorizations** while explaining benefit requirements to members and providers.
- Monitored care plan progress through outreach and provider updates, changing interventions when conditions shifted.
- Partnered with utilization, claims, and provider teams to investigate **service issues** and clarify next steps.
- Maintained concise **clinical documentation** supporting continuity among nursing, physician, and operational partners.

Registered Nurse, Care Transitions

James River Medical Center 📅 August 2018 to May 2020 📍 Richmond, VA

LANGUAGES

English Native

Spanish Intermediate

MY CAREER

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MONTHS

Coordinated hospital **care transitions** for adult medical patients with chronic and complex conditions. Connected bedside assessment, discharge readiness, patient education, medication review, durable medical equipment, caregiver support, and community services into practical transition plans that supported safe movement into post acute and outpatient care.

- Coordinated discharge readiness for adult medical patients with chronic and complex conditions.
- Assessed education, medication, follow up, mobility, caregiver, and community support needs before discharge.
- Worked with physicians, pharmacy, therapy, social work, and case managers on transition services.
- Used teach back education to reinforce warning signs, medication instructions, and follow up expectations.
- Tracked pending services and durable medical equipment before discharge, limiting avoidable coordination delays.
- Documented transition needs and nursing observations for post acute and outpatient handoffs.

Staff Registered Nurse, Medical Surgical

Piedmont Regional Hospital 📅 October 2017 to July 2018 📍 Charlottesville, VA

Provided direct medical surgical nursing for adults with acute and chronic conditions. Performed focused assessment, monitored treatment response, coordinated interdisciplinary care, delivered individualized education, and identified social barriers affecting discharge readiness. This role established a strong clinical foundation for later transition and case management work.

- Delivered direct nursing care for adults with diabetes, heart failure, pulmonary disease, and infections.
- Performed focused assessments and reported clinically significant treatment changes to physicians and care teams.
- Coordinated daily care with pharmacy, therapy, dietary, social work, and case management.
- Educated patients on medications, symptom monitoring, follow up care, and self management.
- Identified practical discharge barriers and referred concerns to case management and support services.
- Built clinical prioritization, documentation, transition, and multidisciplinary communication skills.

PROJECTS

Telephonic Chronic Care Coordination 📅 2024

Created a structured outreach approach for complex and chronic members, linking assessment findings with goals, referrals, follow up, and care plan changes across remote workflows.

Hospital to Home Transition Support 📅 2021

Coordinated discharge details across facilities, patients, caregivers, and outpatient providers, keeping medication review, equipment, appointments, and service access visible after discharge.

LEADERSHIP & AWARDS

- Certified Case Manager credential earned in 2021, reflecting commitment to coordinated care and member centered planning.
- Recognized by interdisciplinary partners for clear clinical documentation and dependable follow up during complex transitions.
- Provided informal peer leadership through practical guidance on discharge coordination, referrals, and service barrier resolution.

EDUCATION

Bachelor of Science in Nursing

Virginia Commonwealth University 🎓 GPA: 4.0 📅 2017 📍 Richmond, VA

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

CERTIFICATIONS

- Certified Case Manager 📅 2021
- Registered Nurse, Virginia Current License 📅 2026

- Nurse Licensure Compact Multi State Privilege 📅 2026

TECHNICAL SKILLS

- **Clinical Nursing:** Registered nursing, Medical surgical care, Chronic condition management
- **Case Management:** Case management, Care coordination, Care continuum planning
- **Clinical Assessment:** Nursing assessment, Risk prioritization, Functional assessment
- **Care Planning:** Individualized care plans, Goal setting, Intervention revision
- **Discharge Planning:** Hospital discharge planning, Care transitions, Post acute coordination
- **Utilization Review:** Utilization awareness, Benefit structures, Treatment planning
- **Authorization Services:** Service authorizations, Referrals, Extra contractual arrangements
- **Provider Relations:** Provider coordination, Service issue resolution, Reimbursement negotiation
- **Claims Operations:** Claims coordination, Claims issue review, Benefit navigation
- **Virtual Care:** Telephonic care management, Remote workflows, Virtual member outreach
- **Clinical Documentation:** Clinical records, Care plan documentation, Follow up documentation
- **Member Support:** Member education, Barrier resolution, Resource coordination

PROFESSIONAL AFFILIATIONS

- Virginia Nurses Association, professional nursing connection and continuing practice engagement.
- Commission for Case Manager Certification, professional case management community and credential maintenance.

ADDITIONAL INFORMATION

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

REFERENCES

AVAILABLE ON REQUEST