



Reagan Collier

Outpatient Case Manager, Outpatient Case Management

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SUMMARY

Registered Nurse and **outpatient case manager** with nine years of clinical experience across hospital nursing, **care coordination**, **discharge planning**, **utilization review**, and post acute transition support. Guides patients and caregivers through home and post acute transitions with clear education, referral coordination, follow up planning, and self management coaching. Applies clinical judgment, analytical thinking, and independent prioritization when complex barriers emerge. Coordinates physicians, hospital teams, caregivers, post acute providers, and community resources while protecting confidential information. Uses Epic for record review, referral tracking, contact documentation, and timely communication. Certified Case Manager with a patient centered approach that supports safer transitions, stronger physician communication, and practical continuity across care settings.

EXPERIENCE

Outpatient RN Case Manager

Gulf Pines Medical Network 📅 April 2023 - Present 📍 Tallahassee, FL

Leads outpatient transition support for recently discharged adults, coordinating clinical review, **patient education**, referrals, follow up, documentation, and escalation of complex barriers.

- Reviewed clinical needs, medications, and follow up plans before prioritizing outreach for discharged adults.
- Used teach back education to clarify **self management**, warning signs, and physician follow up needs.
- Coordinated primary care, specialist, home health, rehabilitation, equipment, and community resource **referrals**.
- Used **Epic** for hospitalization review, contact documentation, referral tracking, and clinically relevant team updates.
- Applied **utilization review** knowledge to identify transition risks and escalate complex barriers for timely resolution.
- Defined realistic care goals during high stress conversations while maintaining confidential, objective documentation.

RN Care Coordinator

Capital Coast Health Partners 📅 January 2021 - March 2023 📍 Tallahassee, FL

Coordinated complex **discharge planning** across home, rehabilitation, skilled nursing, and home health settings while resolving access barriers and strengthening inpatient to outpatient handoffs.

- Coordinated discharge plans for medically complex patients moving home, rehabilitation, skilled nursing, or home health.
- Reviewed clinical records and utilization information to route time sensitive questions and unresolved needs.
- Prepared patients and caregivers with appointment, instruction, resource, and clinician communication education.
- Maintained referral status and transition documentation in Epic for clearer inpatient to outpatient handoffs.
- Resolved coverage, scheduling, and service access barriers through structured patient and provider follow up.
- Prioritized changing caseloads independently while protecting confidential information and escalating clinical concerns.

Registered Nurse

Magnolia Regional Hospital 📅 June 2019 - December 2020 📍 Thomasville, GA

Provided adult medical surgical nursing while building strong assessment, prioritization, discharge education, documentation, safety, and interdisciplinary communication skills.

STRENGTHS



Transition Guidance

Turned complex discharge instructions into practical next steps, helping caregivers feel prepared during home transitions.



Clinical Prioritization

Reviewed competing risks during busy caseloads and focused outreach first on patients facing urgent barriers.



Patient Education

Used teach back during difficult conversations, and patients often left with clearer confidence about follow up.



Resource Coordination

Connected patients with providers and community services, creating smoother handoffs when access problems surfaced.



Confidential Communication

Kept sensitive updates objective and timely across teams, earning trust during high stress coordination work.

SKILLS

Care coordination

Case management

Discharge planning

Utilization review

Clinical assessment

Patient education

Care transitions

Post acute care

Critical thinking

[Resource referrals](#)

[Epic documentation](#)

[Physician communication](#)

[Caregiver support](#) [Confidentiality](#)

[Analytical thinking](#)

LANGUAGES

English Native

Spanish Intermediate

MY CAREER



● Outpatient RN Case Manager at Gulf Pines Medical Network (3.5 Years)

● RN Care Coordinator at Capital Coast Health Partners (2.2 Years)

● Registered Nurse at Magnolia Regional Hospital (1.5 Years)

● Registered Nurse at Red Hills Community Hospital (2 Years)

- Delivered medical surgical nursing care while strengthening assessment, prioritization, education, and safety practices.
- Identified mobility, medication, caregiver, transportation, and follow up risks during **discharge planning**.
- Educated patients and families on diagnoses, medications, recovery expectations, and warning signs.
- Documented assessments, interventions, education, and care plan updates in Epic for downstream teams.
- Managed competing priorities during high acuity periods and escalated changes in condition promptly.
- Followed **confidentiality**, infection prevention, safe handling, and OSHA aligned practices across assignments.

Registered Nurse

Red Hills Community Hospital 📅 May 2017 - May 2019 📍 Tallahassee, FL

Delivered bedside nursing for adult patients, developing **clinical judgment**, care planning, medication administration, discharge preparation, communication, and electronic documentation capabilities.

- Provided bedside nursing for adult patients while building clinical judgment and care planning skills.
- Organized shift priorities from assessments, physician orders, and changing patient needs.
- Prepared patients and caregivers with medication, appointment, activity, and warning sign education.
- Communicated status changes and unresolved needs to physicians and interdisciplinary team members.
- Maintained complete electronic documentation supporting continuity across shifts and clinical disciplines.
- Applied safe body mechanics, infection prevention, and confidentiality standards during busy assignments.

PROJECTS

Post Acute Transition Pathway 📅 2025

Created a structured transition pathway for outreach, referral tracking, patient education, physician communication, and escalation of unresolved post acute needs.

Caregiver Self Management Guide 📅 2024

Developed practical education content supporting medication follow up, warning sign recognition, resource access, and confident caregiver communication after discharge.

LEADERSHIP & AWARDS

- Certified Case Manager credential earned in 2024, recognizing applied expertise across transitions and care coordination.
- Recognized by care teams for dependable follow through during complex discharge and post acute coordination.
- Trusted by patients and caregivers for calm education during stressful transition conversations.

EDUCATION

Bachelor's Degree in Nursing

Florida State University 🎓 GPA: 4.0 📅 2017 📍 Tallahassee, FL

Coursework: Clinical assessment, care coordination, patient education, health assessment

CERTIFICATIONS

- Certified Case Manager 📅 2024
- Basic Life Support 📅 2026
- Registered Nurse, Florida 📅 2017

TECHNICAL SKILLS

- **Electronic Health Records:** Epic, clinical documentation, patient records
- **Case Management:** Outpatient case management, transition planning, follow up
- **Utilization Review:** Clinical review, resource review, service authorization
- **Discharge Planning:** Home planning, rehabilitation planning, skilled nursing planning
- **Referral Coordination:** Primary care referrals, specialist referrals, community referrals
- **Patient Education:** Teach back, medication education, warning sign education
- **Care Transitions:** Post acute transitions, home health, durable medical equipment
- **Clinical Nursing:** Medical surgical nursing, clinical assessment, care planning
- **Communication Systems:** Physician communication, interdisciplinary communication, caregiver communication
- **Safety Standards:** OSHA guidelines, safe body mechanics, infection prevention
- **Documentation Practices:** Confidential documentation, contact notes, care plan updates
- **Resource Navigation:** Community resources, rehabilitation services, skilled nursing services

PROFESSIONAL AFFILIATIONS

- Case Management Society of America, professional interest in coordinated transitions and patient centered outcomes.
- American Nurses Association, commitment to ethical nursing practice, education, and clinical communication.

ADDITIONAL INFORMATION

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

REFERENCES

AVAILABLE ON REQUEST