

# Parniece Marone

Care Manager

✉ [parniece.marone@gmail.com](mailto:parniece.marone@gmail.com)

☎ (512) 248-6413

📍 3417 College Ave, Detroit, MI 48201

## EDUCATION

### Associate's Degree in Health Care Administration at Grand Rapids Community College, MI

Sep 2013 - May 2017

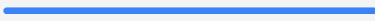
Some skills I've learned are management and organization, communication, critical thinking and problem solving.

## LINKS

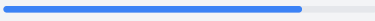
[linkedin.com/in/parniecemarone](https://www.linkedin.com/in/parniecemarone)

## SKILLS

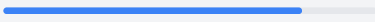
Communication



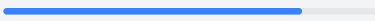
Interpersonal skills



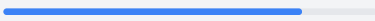
Organizational skills



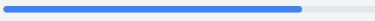
Time management



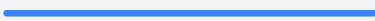
Documentation



Case management software

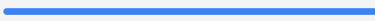


Ability to work with a multidisciplinary team

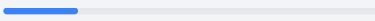


## LANGUAGES

English



Japanese



## PROFILE

I am a highly experienced Care Manager with over 5 years experience in the industry. I have worked extensively with clients of all ages and backgrounds, and have successfully managed care teams of up to 15 members. My key strengths include my excellent communication skills, ability to build strong relationships with clients and families, and my proven track record in delivering high quality care. I am passionate about making a difference in the lives of those I support, and am committed to providing the best possible care for each individual client.

## EMPLOYMENT HISTORY

### Care Manager at Aetna, MI

May 2022 - Present

- Negotiated health insurance for low-income families and individuals.
- Assisted in the development of a care plan for patients with chronic diseases.
- Monitored patient progress and advocated for necessary resources.
- Coordinated services between medical, social, and behavioral health providers.
- Acted as a liaison between patients and their families.

### Assistant Care Manager at Blue Cross Blue Shield of Michigan, MI

Sep 2017 - Mar 2022

- Successfully implemented new care management program that resulted in a decrease of patient hospital readmissions by 20%.
- Successfully advocated for resources for at risk populations which led to an increase in access to services by 15%.
- Worked collaboratively with community partners to develop and implement wraparound services for high-risk patients which resulted in a decrease in emergency department visits by 30%.
- Utilized data analytics to identify gaps in care and created action plans resulting in improved health outcomes for 85% of patients.
- Conducted home visits for newly diagnosed or high-risk patients which led to increased medication adherence by 25%.

## CERTIFICATES

### Certified Care Manager (CCM)

Sep 2020

### Certified Geriatric Care Manager (CGCM)

Jul 2019

## MEMBERSHIPS

American Association of Care Management

National Association of Professional Geriatric Care Managers