Kenyetta Ellis-Williams

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Objective: Dedicated Nursing Professional with 16+ years of delivering evidence-based nursing practice with a holistic approach to stabilize disease trajectories. Focused on optimizing patient care outcomes with strong interdepartmental communication and patient education.

Work Experience

RN Case Manager

The Coordinating Center
August 2021 to Present

Provide face-to-face and telephonic Care Management services to assigned members.
Monitor utilization of healthcare services, treatment of member's complex conditions and social determinants of health to help reduce unnecessary emergency room visits and avoidable hospitalizations. Develop and implement an individualized plan of care using our integrated care team approach comprised of primary care providers, transitional care managers, social workers, registered dieticians, pharmacists, behavioral health clinicians, and outreach workers, based on comprehensive assessments from each respective discipline, the social determinants of health and barriers to care member is experiencing. Facilitate and manage the integrated care team meetings, soliciting feedback, modifying goals and interventions, and reporting out member progress. Escalate quality of care issues requiring medical director intervention including collegial level discussions with facility physicians, medical directors, family meetings and care givers. Navigate managed care coverage, access to benefits and procures DME and other healthcare treatment.

Care Transition Coordinator / UMMC

Visiting Nurses Association of Maryland
June 2014 to May 2021

Clinical liaison between health care providers to ensure continuity of care for patients transitioning from a facility to a home care environment. Build and maintain professional relationships with key referral sources in the medical community. Perform Utilization Review along with gathering claims data for secondary insurance, assessment, planning, implementation, evaluation, and documentation of nursing care for patients, interdisciplinary team collaboration, recognizes emergency situations and demonstrates effective actions, case chart reviews, determines appropriateness of care per evidence-based care guidelines, ensures appropriate utilization of resources, interdisciplinary discharge plan development, facilitates and coordinates community resources and consults. Data abstraction, chart auditing, EMR used. Scheduling onsite visit with provider's offices. Visit the patient onsite to review and assess the patient's clinical needs along with gathering clinical information from the patient and the physician. Collaborate with the patient care team to aid in obtaining information from referral sources and handling stressful situations and deadlines by effectively communicate with all members of the clinical staff.

Visiting Nurse

Heartland Hospice/ PRN

August 2007 to December 2019

Provided care, and comfort to the terminally ill and their families. Liaison visits to prospective patients as well as for providing palliative nursing visits that augment and support the care provided overseen by an RN/Case Manager.
Assisted in all admission-related services and renders professional care in accordance with the physician/ provider treatment plan and the nursing process of assessment, diagnosis, planning, implementation and evaluation.

LPN/ Home Visiting Nurse

Amedisys Home Health
September 2009 to May 2013

Evaluate and treat patients using the most current technology and practices. Aid the physician and registered nurse in performing specialized procedures. Assist patients in learning appropriate self-care techniques. Help achieve and maintain continuity of patient care by assisting in planning and exchanging information with appropriate staff.

Charge Nurse/Staff Nurse-PRN

North Oaks Retirement Community
May 2006 to November 2011

Worked in conjunction with the DON/Unit Manager, provided a range of services, including skilled nursing care, assisted living, post-acute medical and rehabilitation care, hospice care. Delivered evidence-based patient-centered care plan development and coordination, managed care complex case management, acute care and telephonic triage, data abstraction, specimen collection, patient education and advocacy, disease management, wound and ostomy care, injections, IV
Infusions, interdisciplinary team collaboration, interdisciplinary discharge plan development, facilitates and coordinates community resources and consults, determines appropriateness of care per evidence-based care guidelines and utilization benchmarks, case chart reviews, quality improvement, nursing care and within scope of practice coordinates care delivery, ensured that patient’s needs are met in accordance with professional standards of practice through physician orders, center policies and procedures, and federal, state and local guidelines.

Assisted Living Nurse

Crystal Homes
November 2000 to December 2005

Manage patient care with specific knowledge and experience in bedside nursing, symptom management. Demonstrated management ability with an interdisciplinary team and other health care providers. Provided chart audits. Excellent skills in communication both verbal and written, interpersonal relations, and documentation organization developed and maintained rapport with the client and families.

Medical Claims Examiner/CSR

Carefirst BC/BS
November 1998 to August 2003

Used knowledge of products and the contractual provisions that govern administration to provide customer service to policyholders through telephone/written inquiries. Demonstrates the flexibility to process and service various types of products for a variety of customer bases according to the established quality, productivity and performance standards. Maintained current case inventory using the system and routing forms through the appropriate case handling and claims adjustments if required.

Skills

- Nursing
- Vital Signs
- EMR Systems
- Triage
- Hospice Care
- Case Management

Certifications and Licenses

LPN

RN

BLS Certification