NURS FPX 4050 Assignment 4 Final Care Coordination Plan Paper

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Final care coordination plan on a 65 y/o Hispanic female patient with a recent stroke. HX of hypertension, high cholesterol, heart failure, non-compliant with medications.

Assessment 4 Instructions: Final Care Coordination Plan

For this assessment, you will evaluate the preliminary care coordination plan you developed in Assessment 1 using best practices found in the literature.

NOTE: You are required to complete this assessment after Assessment 1 is successfully completed.

Care coordination is the process of providing a smooth and seamless transition of care as part of the health continuum. Nurses must be aware of community resources, ethical considerations, policy issues, cultural norms, safety, and the physiological needs of patients. Nurses play a key role in providing the necessary knowledge and communication to ensure seamless transitions of care.

They draw upon evidence-based practices to promote health and disease prevention to create a safe environment conducive to improving and maintaining the health of individuals, families, or aggregates within a community. When provided with a plan and the resources to achieve and maintain optimal health, patients benefit from a safe environment conducive to healing and a better quality of life.

This assessment provides an opportunity to research the literature and apply evidence to support what communication, teaching, and learning best practices are needed for a hypothetical patient with a selected health care problem.

Demonstration Of Proficiency

By successfully completing this assessment, you will demonstrate your proficiency in the course competencies through the following assessment scoring guide criteria:

Competency 1: Adapt care based on patient-centered and person-focused

- Design patient-centered health interventions and timelines for a selected health care

Competency 2: Collaborate with patients and family to achieve desired

- Describe priorities that a care coordinator would establish when discussing the plan with a patient and family member, making changes based upon evidence-based practice.

Competency 3: Create a satisfying patient

- Use the literature on evaluation as a guide to compare learning session content with best practices, including how to align teaching sessions to the Healthy People 2020

- Competency 4: Defend decisions based on the code of ethics for
  - Consider ethical decisions in designing patient-centered health

Competency 5: Explain how health care policies affect patient-centered

- Identify relevant health policy implications for the coordination and continuum of

Competency 6: Apply professional, scholarly communication strategies to lead patient-centered

- Apply APA formatting to in-text citations and references, exhibiting nearly flawless adherence to APA
- Organize content so ideas flow logically with smooth transitions; contains few errors in grammar/punctuation, word choice, and

Preparation

In this assessment, you will evaluate the preliminary care coordination plan you developed in Assessment 1 using best practices found in the literature.

To prepare for your assessment, you will research the literature on your selected health care problem. You will describe the priorities that a care coordinator would establish when discussing the plan with a patient and family members. You will identify changes to the plan based upon EBP and discuss how the plan includes elements of Healthy People 2020.

Instructions

Note: You are required to complete Assessment 1 before this assessment. For this assessment:

- Build on the preliminary plan, developed in Assessment 1, to complete a comprehensive care coordination

Document Format and Length

Build on the preliminary plan document you created in Assessment 1. Your final plan should be a scholarly APA formatted paper, 5–7 pages in length, not including title page and reference list.

Supporting Evidence

Support your care coordination plan with peer-reviewed articles, course study resources, and Healthy People 2020 resources. Cite at least three credible sources.

Grading Requirements

The requirements, outlined below, correspond to the grading criteria in the Final Care Coordination Plan Scoring Guide, so be sure to address each point. Read the performance-level descriptions for each criterion to see how your work will be assessed.

- Design patient-centered health interventions and timelines for a selected health care

        - Address three health care
        - Design an intervention for each health
        - Identify three community resources for each health
- Consider ethical decisions in designing patient-centered health interventions.
- Consider the practical effects of specific
- Include the ethical questions that generate uncertainty about the decisions you have
- Identify relevant health policy implications for the coordination and continuum of
    - Cite specific health policy provisions.
- Describe priorities that a care coordinator would establish when discussing the plan with a patient and family member, making changes based upon evidence-based practice.
- Clearly explain the need for changes to the
- Use the literature on evaluation as a guide to compare learning session content with best practices, including how to align teaching sessions to the Healthy People 2020 document.
- Use the literature on evaluation as guide to compare learning session content with best
- Align teaching sessions to the Healthy People 2020
- Apply APA formatting to in-text citations and references, exhibiting nearly flawless adherence to APA format.
- Organize content so ideas flow logically with smooth transitions; contains few errors in grammar/punctuation, word choice, and

Additional Requirements

Before submitting your assessment, proofread your final care coordination plan to minimize errors that could distract readers and make it more difficult for them to focus on the substance of your plan.

Sample Final Care Coordination Plan

Final Care Coordination Plan

Jane Doe is a 77 year old, African American, female, who is a recent widower and has no children, was admitted to the hospital due to complaints of shortness of breath, chest pain, and fatigue. She was diagnosed with Congestive Heart Failure (CHF) during this admission and we are creating a care coordination plan for Jane Doe to control signs and symptoms of CHF and prevent further admissions to the hospital.

Three Health Care Issues

- **CHF**

The interprofessional team, this includes physicians, nurses, specialists, case management, the patient, and family if available, to create a care plan to improve signs and symptoms of CHF that is individualized. Jane Doe will be educated on CHF, follow-ups, medication adherence, low-sodium diet and fluid restrictions, and maintain weight by self- management as these elements are known to improve patient outcomes. Self-management is an intervention that puts the patient in control. The patient is required to have CHF knowledge, meaning they understand the disease and signs of symptoms, how to eat a low sodium diet, fluid restrictions, and be able to recognize fluid overload and when to seek additional health care (Zakrisson, A., Arne, M., Hasselgren, M., Lisspers, K., Ställberg, B., & Theander, K, 2019). To make behavioral changes, support groups are a key element in success. Support groups allow patients to see that they are not alone and can be persuaded by trustworthy people to see and accept positive changes. There are many community resources available. There are many online support groups and information such as, https://www.heartfailurematters.org, but for the older population it may be difficult to use technology. The American Heart Association also offers support groups online and in person for patients and caregivers.

They also have print out educational pamphlets available such as care sheets for Self-check management and about the disease itself.

2. Physical Activity And Nutrition

Poor physical activity and nutrition is linked to increased risk of CHF. Several reviews have found that sedentary behavior consistently increases the risk of both non-fatal and fatal cardiovascular diseases and CHF in the general adult population. As patients are educated on an exercise program following a cardiovascular event, preventative care works too. CHF patients should partake in an exercise program to improve quality of life (Tan, M. K. H., Wong, J. K. L., Bakrania, K., Abdullahi, Y., Harling, L., Casula, R., . . . Jarral, O. A, 2019). Nutrition is also linked to heart conditions. African American culture tends to eat a “southern diet.” These are foods that include fruits and vegetables but are prepared in an unhealthy fashion. This diet is high in added fats, sugars, and sodium, with prominent use of high-fat meats for main dishes and the use of deep frying and other cooking techniques that add excess calories and sodium (Mercedes R. Carnethon, Jia Pu, George Howard, Michelle A. Albert, Cheryl A.M. Anderson, Alain G. Bertoni, Mahasin S. Mujahid, Latha Palaniappan, Herman A. TaylorJr, Monte Willis, and Clyde W. Yancy, 2020). Jane Doe must be educated on how to prepare the foods she likes in a healthier fashion. Jane Doe can meet with a Dietician to obtain the resources to learn how to cook foods she likes. She is an elderly woman and may need help obtaining groceries and preparing meals. Transportation, affordability of food, and physical activity has to be examined. There are community resources to help with physical activity and nutrition. Occupational or physical therapists can be prescribed to help improve physical activity. Home care can help with activities of daily living such as grocery shopping, cooking, and cleaning. And there are organizations such as meals on wheels that will bring healthy meals to the patient’s home.

3. Access To Health Care

According to the American Heart Association, an estimated 7.3 million Americans with cardiovascular disease (CVD) are currently uninsured. As a result, they are far less likely to receive appropriate and timely medical care and often suffer worse medical

outcomes, including higher mortality rates (AHA, 2018). Efforts are being made to extend health care coverage to all Americans; so that patients have a continuum of care and better outcomes. The Affordable Care Act has expanded on rural and urban populations. The patient also needs to be able to go to appointments. If transportation is an issue, there are community resources such as senior citizens transportation. There are bus services available to transport senior citizens to places they need to go. If Jane Doe lives in a rural community transportation can be more of a barrier. Telemedicine is on the rise. This is where patients can grant access to health services through telephone or video conferencing. This will help with follow up visits and continued monitoring with Jane Doe's health care team.

Health Policy Provisions

The Affordable Care Act, also known as OBAMACARE, is an act signed into law in 2010, which allowed persons to have an increase in access to health care, lowered costs, and incentivized care coordination to decrease gaps in care (ACA, n.d). This expanded Medicaid program to cover all adults in the poverty level. What this means is that more people have been granted easier access to health services. It allows for people to be able to seek care and afford treatments available to improve health outcomes.

According to the US Department of Health and Human Resources, Health Insurance Portability and Accountability Act (HIPAA) establishes national standards that protect individuals' medical records and other personal health information. The Rule requires appropriate safeguards to protect the privacy of personal health information, and sets limits and conditions on the uses and disclosures that may be made of such information without patient authorization. The Rule also gives patients' rights over their health information, including rights to examine and obtain a copy of their health records, and to request corrections (HHS.gov, 2020). This allows the patient to be involved and in control of where and with whom their health information is being shared. Paving the way for efficient care coordination.

Healthy People 2020

According to Healthy People 2020, it is important to recognize the impact that social determinants have on health outcomes of specific populations. Over the past two decades Healthy People has been focusing on health disparities and how to eliminate them while providing equity of healthcare and improving the health of all groups. In order to accomplish this goal, Healthy People have been performing ongoing studies; which examine American influential factors of availability and access to healthcare. These include: high-quality education, nutritious food, decent and safe housing, affordable and reliable public transportation, culturally sensitive health care providers, health insurance coverage, and clean water and non-polluted air (Healthy People, 2020). Healthy People 2020 promotes preventative measures to improve people's lives. For example, the Community Preventive Services Task Force is working to reduce costs for patient medications, improving patient-provider interaction and patient knowledge, such as team-based care with medication counseling, and patient behavioral and nutritional counseling (Healthy People, 2020). Costs for services can be reduced by eliminating out of pocket expenses such as copayments or deductibles.

Ethical Decisions

As the interprofessional healthcare team, the care coordination plan must address the needs and wants of Jane Doe and the ethical responsibilities of care. What the health care team thinks may be right for the patient may not line up with what the patient believes or wants. The patient has the right to refuse medications or treatments. It is the health care team's job to inform and educate the patient on all aspects of their disease and treatments. It is important to act in best practice to ensure safety and cause no harm to the patient. As the care plan is implemented it is also important to make sure that the wishes and goals of the patient are being met. Everyone comes from different backgrounds and morals or beliefs but in health care, the healthcare team must respect the patient's beliefs and values in order to have a successful care plan. In a study data was collected and implied that when allocating services, healthcare professionals need to find a balance between responsibility and accountability in their role as care-manager

to reduce conflicting interests and ethical dilemmas (Tønnessen, S., Ursin, G., & Brinchmann, B. S,2017).

Priorities Of Care Coordination

The priorities of planning care coordination are as follows. The nurse and physician must have open communication and speak with the patient and family to obtain insight on their values, beliefs, and wants. The patient and families knowledge of the disease process must be evaluated and reinforced. Then from there, coordinating services and other disciplines can be implemented. Health care is ongoing; even after discharge from hospitals or other facilities such as rehabilitation centers or nursing homes. Continued evaluation of the patient is essential to improve patient outcomes; through follow-ups and implementing the proper interventions to reach patient specific goals. For Jane Doe, her home needs to be accessed. It is the healthcare team's job to figure out how she will obtain the right nutrition, exercise, transportation, medications, weight-management, and resources. Along with being able to afford care and lifestyle.

References

1. American Heart Association (AHA). (2018). Access to Care. Retrieved from https://www.heart.org/en/get-involved/advocate/federal-priorities/access-to-care
2. Healthcare.gov. Affordable Health Care Act. N.d. Retrieved from https://www.healthcare.gov/glossary/affordable-care-act/
3. Healthy People 2020. (2020). Healthypeople.gov. Retrieved from https://www.healthypeople.gov/2020/about/foundation-health-measures/Disparities#5