

NURS-FPX4005 Assessment 4 Stakeholder Presentation

Student Name

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NURS-FPX4005: Nursing Leadership: Focusing on People, Processes, and Organizations

Professor Name

Month, Year

Stakeholder Presentation: Interdisciplinary Plan

Securing stakeholder support is essential to implementing organizational change in healthcare. This paper presents the content and supporting narrative for a stakeholder presentation proposing an interdisciplinary plan to address delays in implementing an integrated diabetes education program at a regional health center. The presentation is designed to secure stakeholder support by articulating the organizational issue, proposing an evidence-based interdisciplinary solution, and outlining the resources, implementation steps, and anticipated outcomes associated with the plan.

Organizational Issue

The health center faces significant delays in establishing a structured diabetes education program. Fragmented care coordination and inconsistent communication among healthcare teams prevent real-time collaboration, leading to suboptimal diabetes management and reduced patient adherence to self-management strategies. These delays negatively affect clinical outcomes and patient satisfaction, underscoring the need for a coordinated interdisciplinary response.

Addressing this issue is essential because effective diabetes management depends on timely, consistent patient education and coordinated care across disciplines. Patients with diabetes require ongoing support to manage their medications, monitor their blood glucose, modify their lifestyles, and prevent complications. When the education program is delayed or fragmented, patients do not receive the support they need, and their outcomes suffer. Improving the program will enhance patient self-management, reduce complications, and lower long-term costs.

The issue also has implications for the health center as an organization. Poorly managed diabetes leads to costly complications and hospitalizations, which affect both patients and the organization's financial performance. By addressing the delays and improving the diabetes education program, the health center can improve outcomes, reduce costs, and enhance its reputation for quality care.

Proposed Interdisciplinary Plan

The proposed plan establishes a formal interprofessional collaboration network that brings together nurses, physicians, dietitians, pharmacists, and diabetes educators. The plan standardizes communication through shared protocols and regular interdisciplinary meetings, ensuring that all team members contribute to and align on patient education and care coordination. By formalizing collaboration, the plan addresses the fragmentation that has hindered the diabetes education program.

Evidence supports this approach. Interprofessional collaboration optimizes healthcare delivery through improved communication, teamwork, and collaborative decision-making, which in turn improves patient outcomes (Labrague & de los Santos, 2021). When healthcare professionals from different disciplines work together effectively, they can provide more comprehensive, coordinated care that addresses the multifaceted needs of patients with diabetes.

Transformational leadership will guide the initiative, fostering engagement and a shared vision among team members. By articulating a compelling vision for improved diabetes care and empowering team members to contribute, leaders can build the commitment and collaboration necessary for the plan's success. The combination of structured collaboration and effective leadership provides a strong foundation for addressing the organizational issue.

Resources and Implementation

Implementing the plan requires modest investment in staff training, coordination time, and educational materials. Existing personnel will be organized into a structured interdisciplinary team, minimizing the need for additional hires. The plan includes a timeline for rollout, designated roles and responsibilities, and metrics for evaluating progress. This pragmatic approach makes the plan feasible within the health center's existing resources.

The implementation process will proceed in phases. The first phase involves establishing the interdisciplinary team, defining roles, and developing shared protocols. The second phase involves training staff and launching the enhanced education program. The third phase focuses on monitoring, evaluation, and refinement. This phased approach allows the team to build momentum, address challenges as they arise, and ensure that the plan is implemented effectively.

Key performance indicators will include patient adherence rates, glycemic control measures, patient satisfaction scores, and team communication effectiveness. Regular evaluation will allow the team to assess progress, identify areas for improvement, and demonstrate the value of the plan to stakeholders. By tracking these metrics, the team can ensure that the plan delivers measurable benefits.

Anticipated Outcomes and Stakeholder Benefits

The interdisciplinary plan is expected to improve communication, enhance patient education, and optimize diabetes care coordination, ultimately improving patient outcomes. Patients will benefit from more consistent, coordinated education and support, which will help them manage their diabetes more effectively and reduce their risk of complications. Improved

self-management and glycemic control will enhance patients' quality of life and reduce their need for costly interventions.

Staff will benefit from clearer communication and collaborative workflows, which reduce frustration and improve job satisfaction. When team members work together effectively and understand their roles, they experience less stress and greater fulfillment in their work. The organization will benefit from improved outcomes, higher patient satisfaction, and reduced costs associated with poorly managed diabetes.

The plan also positions the health center to succeed under value-based care models, which reward improved outcomes and efficient, coordinated care. As reimbursement increasingly depends on quality metrics and patient outcomes, an effective diabetes education program becomes not only a clinical asset but a financial one. This alignment between quality and financial performance further strengthens the case for the plan.

By framing the plan in terms of these benefits, stakeholders can readily appreciate the value of investing in interdisciplinary collaboration to resolve the current delays. The plan offers a compelling combination of improved patient outcomes, enhanced staff satisfaction, and organizational benefits, making a strong case for stakeholder support. Securing that support is the essential next step toward implementation.

Conclusion

This stakeholder presentation proposes a clear, evidence-based interdisciplinary plan to resolve delays in the diabetes education program. By establishing a structured interprofessional collaboration network guided by transformational leadership, the organization can improve communication, patient education, and care coordination.

The anticipated improvements in patient outcomes, satisfaction, and cost-efficiency make a compelling case for stakeholder support. The plan is feasible, evidence-based, and aligned with the organization's mission to provide high-quality care. By securing stakeholder support and implementing the plan, the health center can address the current delays and establish a model of coordinated, effective diabetes care that benefits patients, staff, and the organization alike. The success of this initiative can also serve as a template for addressing other care coordination challenges, demonstrating the broad value of structured interdisciplinary collaboration across the organization.

References

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