

NURS-FPX4065 Assessment 2 Preliminary Care Coordination Plan

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NURS-FPX4065: Patient-Centered Care Coordination

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Month, Year

Preliminary Care Coordination Plan

Care coordination is essential to delivering safe, effective, patient-centered care, particularly for individuals managing chronic conditions. By coordinating the efforts of multiple providers and connecting patients to resources, care coordination improves outcomes and enhances the patient experience. This paper presents a preliminary care coordination plan for a patient population affected by type 2 diabetes, identifying health concerns, establishing goals, and connecting patients to community resources to support coordinated care.

Health Concern and Population

The selected health concern is type 2 diabetes, a chronic condition requiring ongoing management and coordination across multiple providers and settings. Diabetes management involves medication, lifestyle modification, monitoring, and the prevention of complications, all of which benefit from coordinated care. The complexity of diabetes management makes it an appropriate focus for a care coordination plan.

The population includes adults with type 2 diabetes who face challenges in managing their condition, including medication adherence, lifestyle modification, and access to care. These patients often struggle with the demands of managing a complex chronic condition and may benefit significantly from coordinated support. Focusing on this population allows the plan to address common challenges and to improve outcomes for a substantial group of patients.

Effective care coordination for this population can improve glycemic control, prevent complications, and enhance quality of life, making it a valuable focus for a care coordination plan. By coordinating care and supporting self-management, the plan aims to help patients

manage their diabetes more effectively and to reduce their risk of complications. These benefits underscore the value of care coordination for patients with type 2 diabetes.

Analysis of the Health Concern

Managing type 2 diabetes requires addressing multiple, interrelated needs. Patients must manage medications, monitor blood glucose, modify their diet and physical activity, and attend regular appointments with various providers. The complexity of these demands can be overwhelming, particularly for patients who face additional barriers to care. Care coordination helps patients navigate these demands and manage their condition effectively.

Barriers such as limited health literacy, financial constraints, and fragmented care can impede effective management. Patients with limited health literacy may struggle to understand their condition and treatment, while financial constraints may limit their access to medications, healthy food, and care. Fragmented care, in which providers do not communicate or coordinate effectively, can result in gaps and inconsistencies in treatment.

A coordinated approach that integrates medical care, education, and community support is essential to helping patients manage their condition effectively. By addressing the physical, psychosocial, and economic dimensions of diabetes, care coordination provides comprehensive support that addresses the full range of patients' needs (Powers et al., 2020). This holistic, coordinated approach is central to the care coordination plan.

Goals and Interventions

The care coordination plan establishes several goals. The first goal is improved glycemic control through medication management and regular monitoring, which reduces the risk of

complications. The second is enhanced self-management through patient education on diet, exercise, and blood glucose monitoring, empowering patients to manage their condition. The third is improved access to care through coordination among providers and connection to community resources.

Interventions include structured diabetes education, medication reconciliation, coordinated scheduling of appointments, and referral to community resources such as nutrition programs and support groups. These interventions address the various dimensions of diabetes management and provide comprehensive support for patients. Each intervention is designed to advance the plan's goals and to improve patients' ability to manage their condition.

These interventions are designed to be patient-centered, addressing each individual's specific needs and circumstances. By tailoring interventions to the individual patient, the plan ensures that care is relevant and effective. This patient-centered approach respects patients' autonomy and supports their engagement in their care, which is essential to effective diabetes management.

Community Resources

Connecting patients to community resources strengthens care coordination. Relevant resources include diabetes self-management education programs, community health centers, nutritional assistance programs, and local support groups. These resources provide ongoing education, support, and access to care that complement clinical services and address the broader needs of patients.

These resources provide ongoing education, support, and access to care that complement clinical services. By connecting patients to community resources, the plan extends support

beyond the clinical setting and addresses the social determinants that affect diabetes management. Community resources can help patients access healthy food, engage in physical activity, and receive ongoing support for self-management.

By linking patients to these resources, the care coordination plan extends support beyond the clinical setting and addresses the broader determinants of health that affect diabetes management. This connection to community resources is an essential component of comprehensive care coordination. It ensures that patients receive the full range of support they need to manage their condition and to improve their health.

Conclusion

This preliminary care coordination plan for patients with type 2 diabetes identifies key health concerns, establishes patient-centered goals, and connects patients to community resources. By coordinating medical care, education, and community support, the plan aims to improve glycemic control, enhance self-management, and prevent complications. The plan addresses the multiple, interrelated needs of patients with diabetes through a comprehensive, coordinated approach.

Effective care coordination, grounded in a comprehensive understanding of patient needs, is essential to improving outcomes for individuals with chronic conditions. By providing coordinated, patient-centered support, the plan helps patients manage their diabetes more effectively and improves their quality of life. This preliminary plan provides a foundation for ongoing care coordination that can be refined and expanded to meet the evolving needs of patients. As the plan is implemented and evaluated, it can be adjusted to reflect what works best for each patient, ensuring that care coordination remains responsive and effective over time.

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