Planning Care Coordination

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WHAT IS END OF LIFE CARE

- End of life care can be described as the time of death or breathing stops and the heart stops beating. End of life care is acceptance by patient and families that life is near. The goals at this time is to provide preference and quality of life.

END OF LIFE CARE

- IT’S A DIFFICULT TIME AND DIFFICULT SITUATION…..BUT ITS REALITY, WHEN THERE IS BIRTH, THERE WILL BE DEATH

- FAMILIES, FRIENDS, SOCIAL WORKERS, NURSES AND COMMUNITY SUPPORT IS IMPORTANT.

CARE COORDINATION PLAN FOR END OF LIFE…/

Step 1: Discussion as end of life near – honest and open communication with patient and family members

Step 2: Assessment and care planning – Identifying areas of preference and wishes.

Step 3: Coordination of Care – Explaining symptom of relief

CARE COORDINATION PLAN FOR END OF LIFE

- Step 4: Delivery of care – Delivery of quality and safe care.
- Step 5: Care in the last days of life – care in the last days of life.
- Step 6 : Care after death-Care after death.

VISION OF INTERAGENCY COORDINATED CARE…/

- Implement team approach
- Know your population and risk factors
- Building relationship
- Know your patients/individualized care
- Holistic care

VISION OF INTERAGENCY COORDINATED CARE

- Interagency communication and collaboration
- Effective Public Health System
- Multidisciplinary team collaboration and information sharing within interagency.
- Collaborative team effort with families, patient involvement and providers.
- Nurses involvement with care managers coordinated care
- Quality improvement initiatives with stakeholders

END OF LIFE CARE COODINATION

- Everyone is seen as an individual
- Everyone gets fair and equal care
- Providing comfort and preferences
- Coordinated care
- Multidisciplinary team prepared to care
- Community and population prepared to help

GROUPS AND ORGANIZATIONS PARTICIPATION IN CARE

- Accountable Care Organizations (ACO)
- Community
- Families and friends
- Providers, healthcare professionals
- Nurses
- Multidisciplinary team
- Managed care team
- Medicare, Medicaid

GROUPS AND ORGANIZATIONS PARTICIPATION IN CARE

- National Hospice and Care Organization
- Community Groups e.g. spiritual groups, supportive to the patient.
- Multi-disciplinary team members to coordinate timely care.
- Family members to provide feedback for patient preference if unable to talk.
- Chapel - preference

RESOURCE NEEDS OF POPULATION

- Hospitals
- Transportation
- Churches
- Library
- Schools
- Play ground
- Community leaders

RESOURCE NEEDS OF POPULATION

- Consideration and best practice from hospice to other care settings as preference
- Palliative care
- Resources available to enable patient to die with dignity.
- Nurses
- Care coordinators
- Case managers
- Working as multi-professional team
- Ongoing assessment of medication and patient care

PROJECT MILESTONES AND OUTCOME MEASURES…

- Connecting with patients
- Develop strategies to address health needs
- Address needs such as education, poverty and exposure to negative health conditions
- Providing health education and outreach workers to assist in needs
- Evaluate quality of life

PROJECT MILESTONES AND OUTCOME MEASURES

- Early establishment of care plan and diagnosis for the dying is crucial.
- Daily family meetings with multidisciplinary team members and care team
- Policies and practices to advance patient centered care
- Access to coordinated care by quality and skilled staff.
- Honest conversations with healthcare staff will give peace of mind to family members.
- Care coordinator should be the first point of contact to assesses and coordinate care in a timely manner.

WHY HEALTHCARE OUTCOMES IS IMPORTANT

- To improve patient care and experience
- Improving the health of the population
- Reducing per captia cost in healthcare services
- Reduce staff burn out

PRESENTING PROJECT PLAN END OF LIFE CARE…/

- Care coordination is the organizing of patient care with more than one person addressing multiple healthcare needs. There are many challenges and barriers that affect patient quality of care such as cultural barriers, little or no money to pay for healthcare needs, no follow up care, transition form one healthcare facility to another (Razmaria, 2016).
- As care coordinator, I am seeking to improve safe and quality care, care coordination within the population through our quality improvement initiatives. Our team will complete an assessment of the population identify the risk factors and as a team will determine a safe improvement measure. With this analysis of the population we hope to improve and increase the coordination of care between the many entities within our population.

PRESENTING PROJECT PLAN END OF LIFE CARE…/

- The challenge continues with many health problems with limited resources to resolve and address them such as poor care planning, failure to recognize people are dying, lack of communication with providers, no insurance or money to pay for health services. I will be addressing end of life care coordination within the United States population. End of life is a sensitive and delicate situation for many of us and we are never prepared to accept but it is reality when there is birth their must be death. Community based care coordination is one way we as a population can assist patient and family centered care in achieving effective and efficient health outcomes. Our care coordination team will follow step by step guide to end of life care.

PROJECT PLAN TO ADMINISTRATIVE DECISION

- Effective communication and collaboration with care givers and healthcare professionals.
- Advance Directives – following patients preferences.
- Health/Medicare Coverage – Gaps in care.
- Continuous patient monitoring and assessment to ensure patient quality of care.
- Daily briefing with healthcare providers and sharing of patient information in care.
- Involvement of leadership within the organization
- Supportive workforce – care should be given with compassion, trust and confidence.
- Eliminating unfairness and inequalities

FOLLOW THE COORDINATION OF CARE FOR DYING

Step 1: Discussion as end of life near – honest and open communication with patient and family members

Step 2: Assessment and care planning – Identifying areas of preference and wishes.

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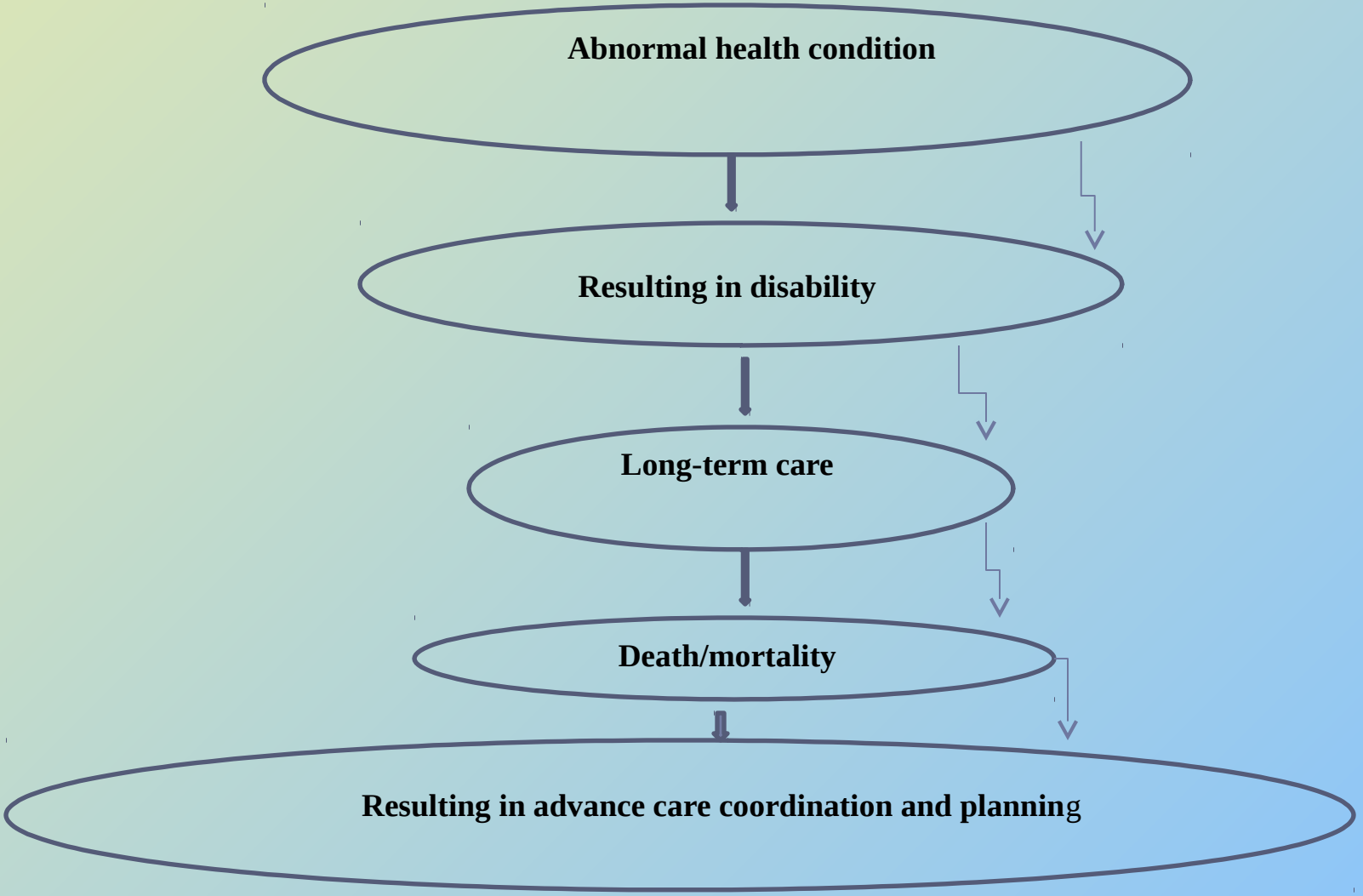
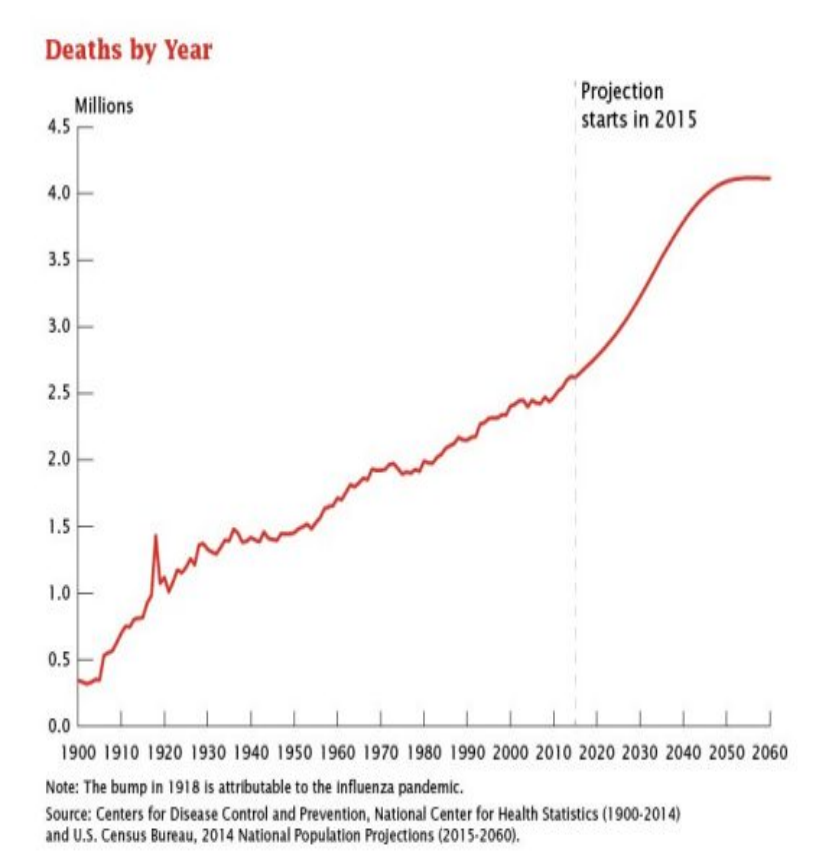
DYING CAN BE A LONGTERM CARE



PATIENT FACTS TO KNOW

- Management of symptom/s
- Patient preferences: place of comfort
- Carry out spiritual and religious beliefs/traditions

U.S PROJECTIONS 2015-2037



The aging population
Increase in death by 2037 by 3.6 million.

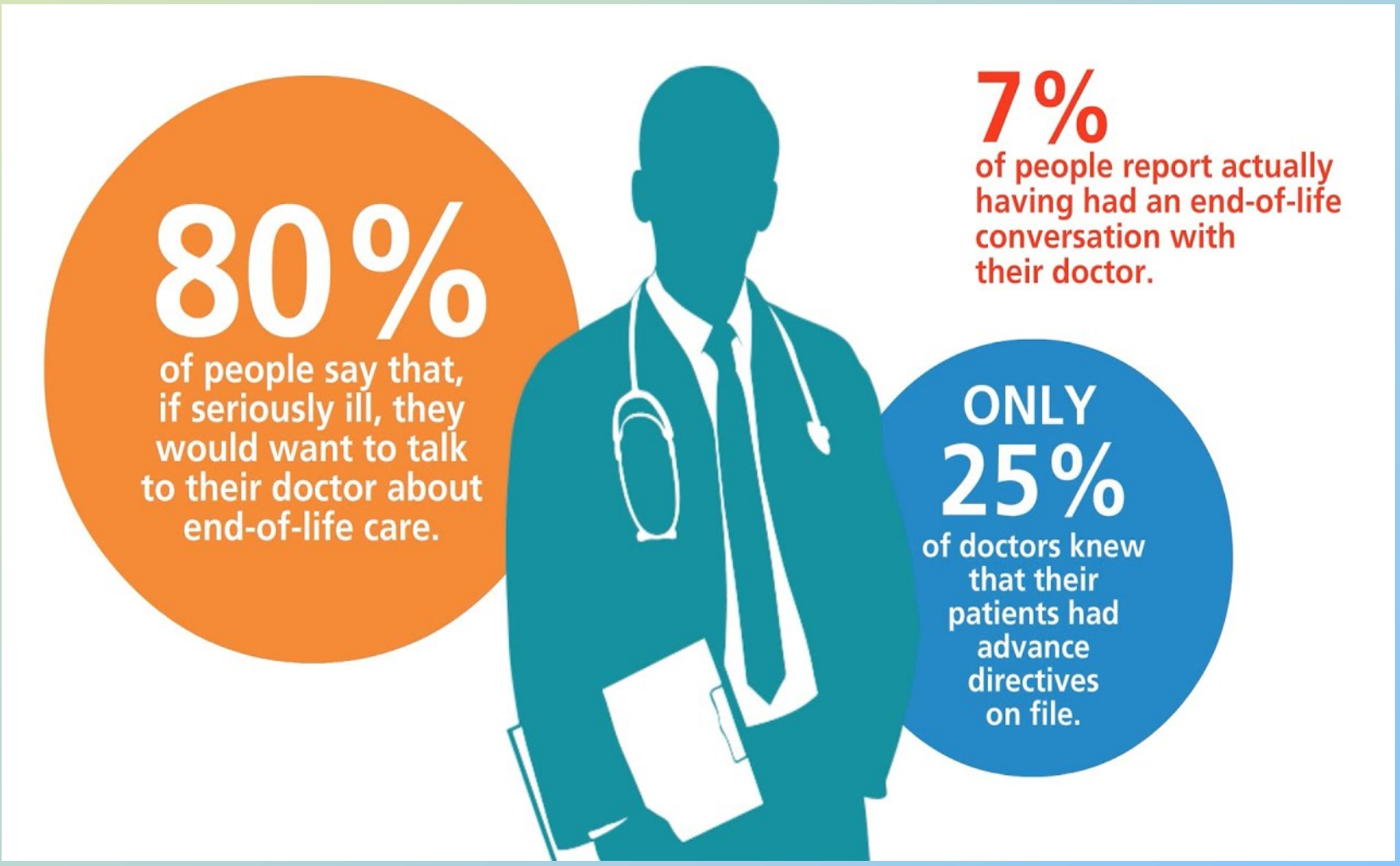
Cost: Approximately 20% of resources are spent during the final days of life.

With the increase in deaths hospitals and healthcare facilities will need approximately 15% more beds with additional staffing.

CONNECTING END OF LIFE

- Important to connect and respect end of life preferences:
- Spiritual
- Physical
- Management of health conditions
- Family support
- Bereavement support
- Natural environment

WHAT PEOPLE SAY . . .



Conclusion

- The need for a care plan is important in the end of life care so that we can meet the needs and preferences of our patients. Coordination of care can be recorded in the electronic health care system and can be shared with other providers within the network for caring. Care coordination will enable quality end of life care and will meet the patients ultimate and final goal as preference in advance directives.

Conclusion

- Death is certain but time of death is uncertain.
- Communication can become a challenge
- Early diagnosis and integration with provider can improve outcomes for patient, families and friends.

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