Person-Centered Planning with Rural Senior Citizens in Maine: Case Presentations From Piscataquis Thriving in Place Project

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Meet Chris

Meeting attendees – **Chris** (person meeting is for), **Evan** (46 year old nephew), **Dee-Ann** (38 year old niece), **CJ** (Chris’s dog), **Janet**, meeting facilitator. (Evan & Dee-Ann participated via Skype), Chris’s primary care provider (Dawn) convinced Chris to have the meeting and Dawn provided input for the meeting through email.

Who is she?

◊ 72-year-old woman
◊ Born in 1943
◊ Sister, Aunt, retired teacher
◊ Lived in same home (trailer) for 25 + years
◊ Born in small town in PA
◊ Graduate degree from Ohio State University
◊ 7th Grade English teacher
◊ Moved to Maine in 1982
◊ Retired from teaching 2002, age 59
◊ Self -described loner – likes to make crafts for town library sales
◊ Niece & nephew concerned about Chris living alone, especially as she grows older
◊ Knee replacements in both knees
◊ Has mixed-breed dog, CJ, who lives with her.
◊ Type 2 diabetes
◊ Rotator cuff surgery on both shoulders (2014).
◊ Balance & slip and fall danger
◊ Fell on icy walkway and broke left wrist in 2008

What is needed? Concerns?

Safety – Family worries about Chris being isolated, especially as she ages. Her primary care provider (PCP) is concerned about Chris falling and needing help. The PCP also concerned about management of Chris’s diabetes.

Priorities:

Better monitoring of diabetes.
Strength and flexibility exercises to lessen risk of falling & broken bones.
Assistance with icy walk and steps in the wintertime.
### Chris’ Action Plan

<table>
<thead>
<tr>
<th>What</th>
<th>Who</th>
<th>When</th>
<th>Resources</th>
<th>Done or Not</th>
</tr>
</thead>
<tbody>
<tr>
<td>Monitor blood sugar 3x daily &amp; get new meter with larger numbers.</td>
<td>Chris, with assistance from PCP office</td>
<td>By July make appointment to get new meter and trained in use.</td>
<td>Large number glucose meter &amp; test strips</td>
<td>Appt. set July 2</td>
</tr>
<tr>
<td>Balance assessment</td>
<td>Chris to have balance assessment – PCP office will make referral</td>
<td>By middle of July – they are scheduled 2x a month</td>
<td>None needed</td>
<td>Scheduled for 7/21</td>
</tr>
<tr>
<td>Sign up &amp; meet program manager Area Agency on Aging for help with snow removal</td>
<td>Niece Dee-Ann will call &amp; set this up</td>
<td>Dee-Ann visiting in October &amp; will schedule for then.</td>
<td>Phone number &amp; contact person</td>
<td>Dee-Ann will call by August</td>
</tr>
</tbody>
</table>

The Action Plan, (above) is being developed to help address the priorities that were listed on the prior page. Through time other priorities may also be added. It is often wise to begin with 1-2 so that they may be addressed and the individual and planning group experience success.