Application of the Concept of "Dignity of Risk" – Jane's Story

A genuine person-centered approach is a key priority for effective disability competent care coordination. Care Coordinators help people with disabilities and chronic health conditions manage risk, within the context of what is important to them and what is important for them.

Jane's Story

Jane[1] is a 38 year old female with right sided hemiplegia (a very mild weakness affecting both upper and lower extremities) that has been attributed to a stroke experienced in 2004. She is newly diagnosed with Type 2 diabetes; and additionally hypertension, chronic pain, and significant longstanding mental health issues related to major depression. Jane is independent with Activities of Daily Living (ADLs), but, due to mobility limitations, requires assistance with housekeeping and laundry. She receives homemaking services through county waiver long-term care services. Jane has a very limited informal support network. She has a boyfriend who does not live with her, and she is at risk of social isolation.

Jane appeared to have a limited awareness and understanding of her diabetes. She was struggling to follow the diabetic treatment plan that included monitoring of blood glucose 4 times per day, significant diet changes and daily oral medication to control her blood glucose levels. She was not checking her blood glucose, and very concerned about giving up things that give her pleasure, such as soda pop and sweets. She did not want to add another medication to her already large volume of medications.

Below is a summary of what the assessment team took away from their first meeting with John, and how they approached developing a plan for their work with him.

Understanding the Story

- 38 year old woman with mild right sided hemiplegia attributed to a stroke in 2004
- Has hypertension, chronic pain and mental health issues related to long standing major depression
- Independent with Activities of Daily Living (ADL) but, due to mobility limitations, requires assistance with housekeeping and laundry
- She has a boyfriend who does not live with her
- Has a very limited informal support network, and is at risk of isolation
- Health History includes:

[1] *Jane's story was written by Kathy Thurston, MS, PHN, Director of Health Coordination at AXIS Healthcare, a disability-competent care coordination organization in Minnesota. Some facts have been modified to protect the participant's privacy.*

- ❖ Her doctor recently told her she had Type II Diabetes
- ❖ Given a diabetic treatment plan that included monitoring of blood glucose 4x/day, significant diet changes and daily oral medication to control her blood glucose levels

Understanding What is Important to Her

- She did not believe she had Diabetes, and didn't want to add any more medications to her currently extensive list of medications
- Life is hard for her as it is, and she didn't want to give up the few things that give her pleasure – specifically sweets and soda pop
- She was not willing to go to any group education sessions to learn about diabetes and diet

Developing a Plan

1. Framing her key risks
2. Identifying ideal short and long-term goals
3. Developing a strategy for approaching Jane to discuss her plan of care
4. Ideas for supporting Jane to achieve her goals

Care Coordination Intervention & Outcome:

The care coordinator worked with Jane and her primary care provider to establish one to two changes she thought she could make. She thought she could check her blood glucose three times / week and reduce some simple sugars in her diet. The care coordinator set up a plan with Jane to check in with her via phone calls every week while she was working on these goals. The care coordinator also arranged for skilled nursing visits for diabetic education in her home because standard diabetic teaching in a group setting was not effective for Jane.

Over a two-month period, Jane was successful with checking her blood glucose 80% of the time; she also reduced her consumption of soda pop and sweets. Following these successes, she subsequently agreed to try taking the prescribed medication. Her routine diabetic blood work has improved and she readily admits that she has "Diabetes that is well controlled."

Through the support of care coordination, Jane became more engaged in her own care, and is taking concrete steps to keep herself healthier. She is focused on learning more about diabetes and wants to find an exercise program that will work for her. Her goal is to improve to the point where she no longer needs to take medication to control her diabetes.