

# CHCA Project ECHO Integrated Seniors Care

All Teach, All Learn

Bridging the Knowledge Gap in Home and Primary Health Care



## Assessing Frailty in Medically Complex Older Adults: Integrated Approaches to Care Across Home, Community, and Primary Care Settings

### Case Study: Mr. André

Age: 85

**Background:** Mr. André is a widowed gentleman who completed high school and is retired, having worked for more than 35 years as a maintenance supervisor at a local manufacturing plant. He lives on a fixed income through the Canadian Pension Plan (CP), Old Age Security (OAS), and a modest workplace pension. While financially stable, he has limited flexibility for private services, home modifications, or transportation costs. He is Francophone. His two adult children live several hours away and provide emotional support, help in placing online grocery orders for delivery, assistance with paperwork and are involved in his overall health care matters and service coordination by phone, but are not involved in his day-to-day care. He has a small social network, including one close friend in his building and occasional participation in a local seniors' centre, which he attends less frequently due to fatigue and mobility limitations. Mr. André is rostered to a family physician at a primary care clinic. Until about 12–18 months ago, Mr. André managed his own shopping, light housekeeping, and medications independently, pacing himself around symptoms. He receives home and community care services for personal care and meal support. Transportation to appointments is challenging, particularly during winter, and he has declined some referrals due to travel demands.

**Location:** Small city in central-western Manitoba (population <75,000 residents).

**Living Situation:** Lives alone in a one-bedroom rental apartment in an older low-rise building with elevator access. The apartment has narrow hallways and a standard bathtub without grab bars. Snow and ice in winter limit outdoor mobility and access to services.

#### Medical History & Functional Status (Multimorbidity):

- Chronic obstructive pulmonary disease (mild-moderate)
- Atrial fibrillation (rate controlled)
- Chronic kidney disease (Stage 3)
- Chronic low back pain related to a previous injury and osteoarthritis
- Hearing impairment
- 2 reported falls in the past year
- Unintentional weight loss of 15lbs/6.58kg in past year
- ADLs: Independent with basic self-care, slower and needs rest
- IADLs: Requires help with meals, transportation, and appointment coordination

#### Mental & Emotional Wellbeing:

- Mr. André's increased fear of falling has caused him to limit his activities leading to social isolation, and an increase in loneliness
- He has expressed sadness and loss of confidence in his mobility and threats to his independence
- His shrinking social interaction has affected his social network whom he has relied on for emotional support and connection

#### Current Challenges & Concerns:

- Home care providers report a gradual decline in Mr. André's endurance, increased shortness of breath with exertion
- Mr. André describes occasional dizziness when standing
- Chronic pain limits Mr. André's mobility
- Mr. André did not seek emergency or medical care following either fall and minimized their significance, stating he "just lost his balance"
- Home care staff have noted increased caution with walking and reduced activity since these events
- **He remains clear that staying in his own home is his priority, even if it involves accepting some risk**



Project ECHO Integrated Seniors Care (ISC) is a transformative initiative to enhance primary and home care providers' skills, knowledge, and attitudes to deliver integrated, patient-centered care for seniors with complex chronic conditions. Project ECHO ISC offers collaborative, expert-led presentations and case-based learning to bridge these gaps.