ECHO ISC CASE STUDY

Applying the Comprehensive Geriatric Assessment in Integrated, Team-Based Care

Client: Mrs. Lillian Chen **Age:** 76 years **Location:** Markham, Ontario - Central Region, Ontario Health atHome

Background and Living Situation

- Widowed; lives alone in a one-storey bungalow and wants to remain at home.
- Retired teacher who values privacy, routine, and independence.
- Daughter lives 20 minutes away and helps with groceries, rides, check-ins, and monitoring; son lives out of province.
- Daughter is increasingly strained and feels guilty raising safety concerns.
- Receives nursing for diabetes and personal support twice weekly, but care coordination is unclear.
- Has withdrawn from a local seniors program and has no clear emergency plan if she falls or becomes confused.

Medical History and Functional Status

- Mild-to-moderate vascular dementia, type 2 diabetes, hypertension, osteoarthritis, urinary incontinence, and chronic kidney disease.
- Two falls in six months; one caused a minor wrist fracture.
- Increasing difficulty with medications, meals, shopping, transportation, and appointments.
- Needs more help with bathing and cueing for dressing; toilets and transfers independently.
- Knee pain limits gait, stamina, stairs, and community outings.
- Mild weight loss, poor appetite, expired food, and inconsistent walker use suggest declining resilience and safety.

Current Concerns

- More forgetful; missed medications and primary care visits over the past three months.
- Episodes of confusion and distress; calls her daughter feeling "mixed up" and tired.
- Rising blood sugars and late refills suggest unsafe medication and chronic disease management.
- Home safety concerns include bruising, throw rugs, and difficulty using the microwave.
- More withdrawn, poor hygiene, and evening anxiety raise concerns about mood, self-care, and loneliness.
- Occasional suspiciousness suggests worsening cognitive symptoms and distress.

Caregiver and Team Perspective

- Daughter questions whether home remains safe but is unsure how to raise more support or alternate housing.
- Family physician is concerned about missed visits, declining self-management, and the need for a broader review.
- Home care nurse notes weight loss, variable glucose control, bruising, and inconsistent walker use.
- Personal support worker notes reduced hygiene, withdrawal, and difficulty using household appliances.
- Pharmacist has flagged late refills and possible medication confusion.
- Family repeats the same information to multiple providers; no one is clearly coordinating the plan.

Challenge

- How can the team support independence without overlooking gradual decline - and how might each discipline's assumptions shape decisions about risk, capacity, caregiver strain, and quality of life?
- Beyond the obvious safety risks, what does the team need to assess, prioritize, and share to build a truly person-centred plan that supports living well at home?