EDITORIAL

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The health and well-being of Alzheimer's patients requires an integration of services centered on the patient

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“Especially for individuals with diminished abilities to express their needs, it is important to go beyond the good intentions of professionals by establishing concrete mechanisms to support them...”

Mr José, an immigrant, is 80 years old. This story began shortly after he was widowed. We first met him during an emergency hospitalization in the geriatric department of a large university hospital. He was admitted for deterioration of his general status, with recent declared falls. Since the death of his wife, his entourage consists only of his son, with whom he has a strained relationship. Based on his medical work-up, he is probably suffering from moderately severe Alzheimer's disease and the falls were explained by the association of possible neuropathy of the lower limbs, combined with deformed feet and osteoarthritis in several sites. He also had diabetes that was easily controlled. He expressed sadness, deemed normal during this period of mourning. After time in an intensive rehabilitation department, Mr José was discharged from the hospital and returned home. To compensate for his cognitive impairment, his son was appointed as his legal guardian, despite him being poorly attentive to his father's

needs. Over the next few months, Mr José was consulted at the hospital emergency department 48 times for minor complaints that did not warrant hospitalization. His personal hygiene was regularly noted as poor. When the emergency department social worker changed, a doctor, who considered Mr José's home environment unsafe, requested an application for emergency social housing. It is noted in his medical chart that Mr José's apartment is dilapidated and dirty. The social worker asked a colleague in the housing department about emergency social housing for Mr José and was told that Mr José had been directed toward this service several weeks earlier but had never come and no one knew why. The hospital social worker responsible for the return to home finally took charge of the file and visited Mr José's home to see for herself and to make her own decisions. Mr José was absent (she later learned that he was in the emergency department). She met a worried neighbor, as Mr José was no longer eating. For

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“The integration of care services will probably improve the outcomes of patients with Alzheimer’s disease and related pathologies, but should not be limited to those entities.”

some time, the neighbor had voluntarily been carrying out errands for Mr José. He told the social worker that another social worker from the city had come. After making several calls, the hospital social worker contacted her city colleague. Apparently, Mr José is on a waiting list for temporary housing. The city social worker, not knowing that a legal guardian had been appointed, had started a new judicial procedure for guardianship. Financial aid for a home assistant was also requested, but required a visit by a third social worker. As Mr José was absent when that individual came (he was again at the emergency department), the file was set aside. Given the complexity of the situation, the hospital social worker contacted the mobile geriatric team. A new memory work-up confirmed Mr José suffered from dementia with a superposed depressive syndrome. A high nutritional risk was also brought to light. Mr José was oriented toward a health center close to his home to start medical follow-up. A visiting nurse would come to his home every morning to administer treatments, and monitor his diabetes and blood pressure. The financial aid request was awarded several weeks later, but setting up home assistance was slow because Mr José was often absent and does not have a primary care physician (he was subsequently unable to contact the health center). Now, prescriptions need to be renewed, which poses a problem, especially because his health insurance card seems to have been lost. On top of this, his guardian forgot to pay for meals on wheels, which led to the suspension of the service. Finally, Mr José was again subject to emergency hospitalization and was sent, against his will, to a long-term care facility, which led to rapid deterioration of his health and well-being.

Unfortunately, Mr José’s situation is not uncommon, even if it is particularly complex. This complexity results from the interaction of cognitive, psychological, health, social and environmental dimensions. It is important to emphasize that Mr José is far from being abandoned by the system. Indeed, he has benefited from numerous resources but the outcome has been inconclusive for him and society. Are the professionals at fault? Taken individually, no; each individual correctly fulfilled his/her assigned task. So, why is this case summary so problematic? Could the outcome of this care pathway have been different?

Mr José’s situation highlights the fragmentation of service, notably the rupture between

social and health services [101]. Despite the sustained assistance during medical emergencies, the hospital considers that he does not have the pathologies requiring hospitalization. First-line medical care is barely present and social services are disorganized. Geriatric resources overcame that once but their follow-up was interrupted, notably because no one maintained the fragile relationship with an individual whose psychosocial conditions (e.g., isolation, low literacy and impaired ability to make choices) necessitated responses ‘closer to home’. The numerous social workers, one after another, truly tried to improve Mr José’s social situation but only minimally took charge of his healthcare needs, probably thinking that they were the hospital’s responsibility. In the end, the system deployed major resources for a merely modest outcome.

France, like many other countries, has long been aware of the fragmentation of its system [1,2]. Responses to this problem devised to date were based on the concept of ‘coordination’ rather than integration. Although the mechanisms of coordination and integration are indeed linked, the two aspects differ fundamentally [101]. The coordination of Mr José’s case is illustrated by the creation of social worker teams at the hospital for the return home and a mobile geriatric team. This first mode of organization attempts to oil the gears of the existing organizational and professional complexity, whereas integration aims to eliminate this complexity by a profound reorganization of the system, *a priori* without sparing any of those working parts. Although coordination can theoretically provide partial short-term solutions for complex situations, it is insufficient in cases such as Mr José’s.

Individuals in complex situations expose the real dysfunctions of a fragmented system based conceptually on a service-driven approach, rather than a patient-orientated strategy. However, the principal of an integrated social and medical intervention centered on the patient is recognized as a core marker of the quality of the services [3]. Especially for individuals with diminished abilities to express their needs, it is important to go beyond the good intentions of professionals by establishing concrete mechanisms to support them, such as shared information systems, common tools, standardized evaluations and service planning. Do these tools suffice to achieve integration? No [101]. They need a professional, most often called a case manager, whose primary function is to evaluate, plan and

coordinate the services required by the individual, regardless of where this individual is in the network [102]. To do so, the case manager must be officially dedicated to coordinating these tasks in such a way as to be freed of other tasks associated with their previous social worker role. Does case management achieve integration of the services? Again, no [4]. It must be closely integrated with the tools previously mentioned. In addition, the case manager constitutes the professional who assigned the mission of receiving the life project for the elderly individual and representing it throughout the network. Indeed, it is by systematically taking this life project into consideration that the personal and systemic actions can achieve the desired enhancement of the individual's autonomy.

The integration of care services will probably improve the outcomes of patients with Alzheimer's disease and related pathologies [4], but should not be limited to those entities. Although it is true that they frequently affect the elderly, aging is fundamentally characterized by multiple illnesses. It is counterproductive to generate new fragmentation, this time among diseases [5]. In the case of Mr José, it would be absurd to have a case manager for his Alzheimer's disease and another for his diabetes and its complications.

In an integrated system, the hospital would be the automatic link with the primary care system. Social services would not be comprised of multiple professionals with different prerogatives. Above all, case managers could hear Mr José's preferences and be the spokesperson for the entire care network. Beyond its possible gains in efficacy, notably in terms of coherent interventions, the integration of services can be a sustained approach to concretely embody patient-centered care [4,101,102]. Indeed, for several years, it has been proposed to young health and social professionals as a basis for their professional practices. It is a good idea but, like all promising concepts, it must be fully incorporated into a well-founded organization of services.

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