Review

Asian Pacific Journal of Disease Management 2010; **4**(1), 13-17

Onomichi Medical Association (OMA) Method on Dementia Care Management Programs

Hisashi Katayama[1, 2], Shinya Matsuda[3]

[1]*Onomichi Medical Association*

[2]*Faculty of Medicine, Okayama University*

[3]*Department of Preventive Medicine and Community Health, School of Medicine, University of Occupational and Environmental Health, Japan*

Abstract

According to the estimation of Ministry of Health, Labour and Welfare, there will be 3.8 million of dementia elderly in Japan in 2045. It is an urgent task to prepare enough volume of quality community services for the dementia persons. It is also important to organize the flexible system which makes it possible for the dementia cases to use institutional and community services according to their condition. This requires a good care management system. Based on their quality care management system, the Onomichi Medical Association (OMA) has developed a fine-tuned care management system for dementia persons, so called the OMA method on dementia care management programs. In this article, the authors would like to explain the overview of this system.

Key words: Onomichi Medical Association, dementia, care management, family doctor, Dementia Balance Check Sheet

❖Introduction

The Japanese Ministry of Health, Labour and Welfare (MHLW) estimates that there will be 3.8 million of dementia elderly in 2045, twice more than in 2005[1]. As the dementia elderly require more resources of medical and social care services, it is an important problem for the government how to establish a new social system for them.

According to the results of our research on factors associated with aggravation of dependency level among the frail elderly, dementia was detected as one of the significant risk factors[2]. Furthermore, our research suggested that quality care management could prevent aggravation of dependency level. Quality assessment of care plan for dementia person is now one of the hot research topics in Japan.

Traditionally, the dementia persons have been treated in institutional services, such as psychiatric wards and nursing home. But the rapid increase of dementia persons makes it impossible to treat all of them in such institutions. We have to prepare good quality community services for the dementia persons. Without enough volume of community services for the dementia persons, it is not possible to practice the good quality care management. It is also important to organize the flexible system which makes it possible for the dementia cases to use institutional and community services according to their condition. This requires a good care management system. Based on their quality care management system, the Onomichi Medical Association (OMA) has developed a fine-tuned care management system for dementia persons, so called the OMA method on dementia care management programs. In this article, the authors would like to explain the overview of this system.

Received: September 16, 2011
Accepted: November 9, 2011
Correspondence: H. Katayama, Katayama Clinic, Kurihara-machi 8513-1, Onomichi, Hiroshima 722-0022, Japan
e-mail: miles02katakata@celery.ocn.ne.jp

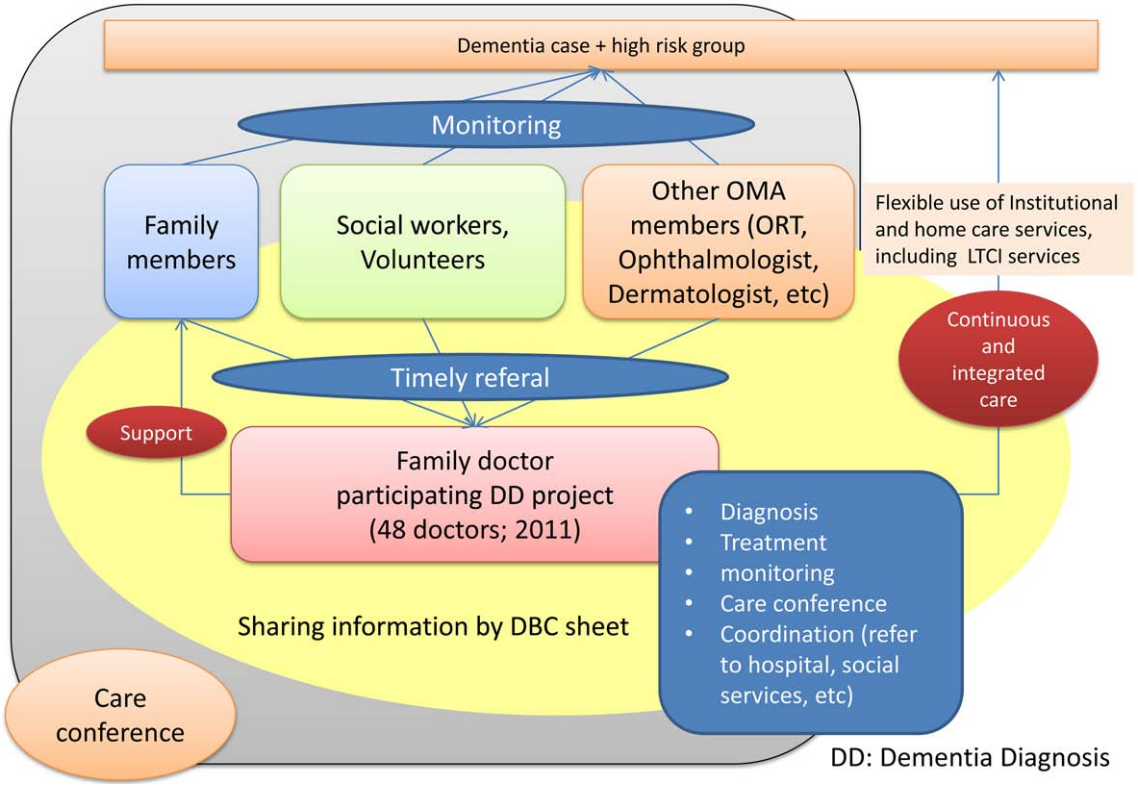

Figure 1 OMA method on dementia care management programs.

❖OMA method on dementia care management programs

The OMA started the early diagnosis of dementia (DD) project in 2003. Based on the common perspective that dementia is an important pathology that must be treated by family doctors, we have started the program. In order to distribute appropriate knowledge and skills, the OMA organized a series of seminars for diagnosis and care.

Figure 1 shows the OMA method on dementia care management program (OMA-DCM). This system is constructed based on the OMA method on long-term care management programs. The most important point is that the system uses a standardized battery for early detection of dementia (Clock Drawing Test: CDT)[3] and a standardized dementia evaluation sheet, so called DBC sheet (Dementia Balance Check sheet). Figure 2 shows the CDT. At the first consultation, a suspected patient is required to respond several questions on season, years and date. And then the patient is required to draw a clock indicating 10:10, for example. This test was introduced into Japan by Dr. Kono and has been examined on its validity for the Japanese

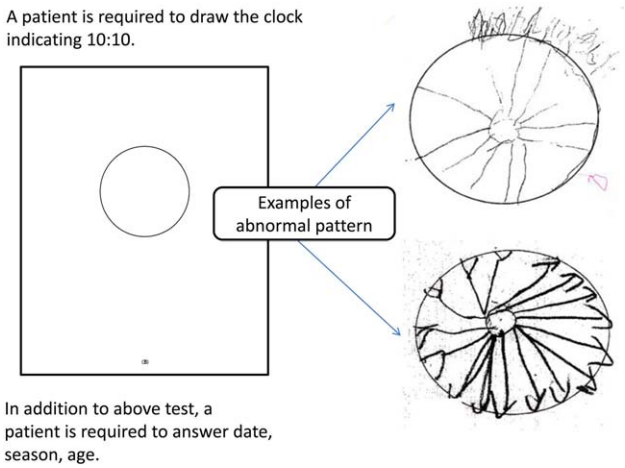

Figure 2 CDT and an example of dementia case.

patients[4]. In order to apply this method to our daily clinical activity, we have examined all the patients more than 65 yrs old using CDT in order to detect dementia cases. Based on the results of more than 500 cases examined, we have developed the manual of early detection of dementia cases[5]. Using this manual, most of the family doctors in Onomichi offer an integrated dementia care in collaboration with other

Table 1 Dementia Balance Check Sheet

Patient Name:
Date:

Prescribed drugs
1
2
3
4
5

A Positive symptoms	No	Slightly	Moderate	Severe
1 Irritation, Angor, Loud voice, Violence	0	1	2	3
2 Resistance to ADL care	0	1	2	3
3 Wish to go back home, Intention to go out	0	1	2	3
4 Insomnia	0	1	2	3
5 Wandering (all day long, day time, night)	0	1	2	3
6 Egocentric behavior, Frequent nurse call	0	1	2	3
7 Impatience	0	1	2	3
8 Delusion, Hallusinosis, Pathological soliloquy	0	1	2	3
9 Nervous	0	1	2	3
10 Stealing, Pica, Binge eating	0	1	2	3
11 Others	0	1	2	3
B. Negative symptoms				
1 Appetite loss	0	1	2	3
2 Vitalty loss	0	1	2	3
3 Somnolent, Unusual nap, Decreasing conversation, Mask-like face expression	0	1	2	3
4 Depression	0	1	2	3
5 Apathy	0	1	2	3
6 Others				
C. Body trunk balance				
1 Impaired trunk balance	0	1	2	3
2 Easy to falling	0	1	2	3
3 Festination	0	1	2	3
4 Swallowing disturbances	0	1	2	3
5 Tremor, Lunge walk (Parkinson's Disease like)	0	1	2	3
6 Others	0	1	2	3

Subtotal Score of A =
Subtotal Score of B =
Subtotal Score of C
Total Score =

Evaluation

health professionals and patient's family.

For the detected dementia case, his/her family doctor, care managers, care staffs, and family members in charge of patient's care are required to monitor the patient by DBC (Dementia Balance Check) sheet (Table 1). Using DBC sheet, the family member can notice any changes in symptoms of the patient and then to consult the family doctor in appropriate timing. As other care programs, care conference (CC) is the center of system. Periodically related persons gather at the family doctor's clinic for CC (Figure 3). It is important that a dementia person is also requested to participate in CC. This would contribute to prevent a sense of alienation of the case and then to maintain stability of symptom and caring environment.

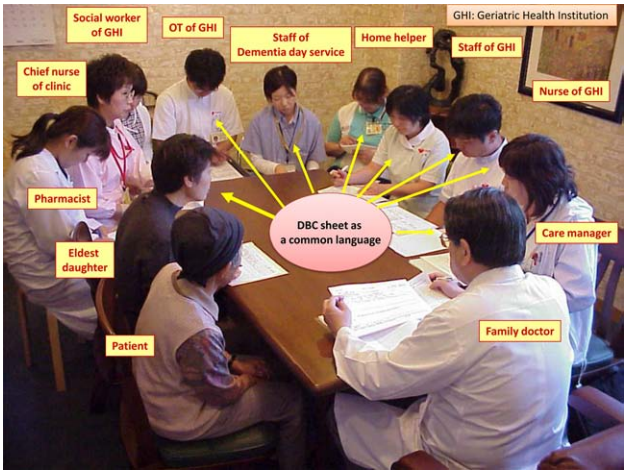

Figure 3 Care conference of a dementia case held at the Family Doctor's clinic.

One of the most important characteristics of OMA-DCM is that a family doctor plays a pivotal role for dementia care, including early detection of mild cognitive impairment (MCI), care management, treatment, and following-up. In order to make it possible, the OMA has organized a series of seminars on dementia for OMA members, care managers, other health professionals and citizens. For example, in order to master the diagnostic skill using CDT, the OMA invited Dr. Kono (Specialist of CDT) to give a series of lectures for the OMA members. It is obligation for the DD program participant doctor to attend the continuous training course at least four times per year.

For the case of diagnosed dementia case, existence of positive and negative behavioral problems are cautiously examined. This is very useful for choice of pharmaceuticals. For example, Tiapride hydrochloride or Quetiapine fumarate might be used for positive symptom cases and Donepezil hydrochloride or Nicergoline used for negative symptom cases. The detection of Dementia with Lewy Bodies is always paid special attention, because it usually needs modification of treatment. As a good clinical control of dementia symptom is a basis of home based dementia care, the OMA has organized seminars on the up-to-date pharmaceutical treatment of dementia. In order to construct reliance among the OMA members (especially between hospital based specialists and clinic based family doctors), it is very important to have this kind of systematic continuous learning system. We regard that this is one of the most important role of local medical association.

❖Conclusion

Today many communities are suffering from the problem how to care the increasing number of dementia cases. The methodology of care management of dementia case is one of the hottest issues among the related professionals. According to the authors' opinion, the introduction of LTCI has some responsibility for today's confusion of dementia care. It seems that LTCI scheme intends to de-medicalize the dementia care. However, dementia cases need an appropriate treatment and clinical monitoring. It is quite often that family doctor knows some symbolic life episodes of the dementia clients through his long relationship with the patient and daily communication as a neighbor. These episodes are very useful to organize a care program for the dementia patients. This point of view is similar to that of "The Center Method to Support Persons with Dementia Commentary & Sheet Pack Care Management" developed by Dementia care research and training center[6]. This kind of episode related information is often difficult to be grasped by the occasional assessment by LTCI scheme. Thus the community based dementia care should be organized based on the primary care model that family doctors play a pivotal role.

We do not say that the family doctors should dominate over other care professionals. We only say that a family doctor must play a pivotal role of care network as one of the most important "entrance" for care of the frail aged. Before becoming "dependent", most of the frail elderly have long been cared for their chronic diseases (i.e., hypertension, diabetes, etc) at the family doctor's office. This means that a family doctor has a responsibility to notice the dementia related symptoms as early as possible and then must take a role of multifunctional coordinator. The family with dementia cases often faces to various difficulties. The problems are not only clinical but also socio-economic and emotional. To keep a clinically stable situation is a basis of "normal" family life. The family doctor in charge of dementia care must pay enough attention for environmental coordination both for patients and their family. This kind of activities must be organized systematically. The local medical association is expected to play this important role of systematization of dementia care for the coming aged society.

❖References

1) Ministry of Health, Labour and Welfare: Estimation of number of future dementia cases, http://www.mhlw.go.jp/shingi/2009/07/dl/s0709-7b_0005.pdf. (access 24 August 2011).
2) Matsuda S, Fujino Y, Kubo T: Analysis of factors associated with changes in dependency level among the slightly frail elderly using the LTCI services in Japan. APJDM 3, 39–45 (2009).
3) Brodaty H, Moore CM: The Clock Drawing Test for dementia of the Alzheimer's type: a comparison of three scoring methods in a memory disorder clinic. Int J Geriatr Psychiatry 12, 619–627 (1997).
4) Kono K, Yamamoto R, Iguchi A, et al.: New scoring

method of the Clock Drawing Test for dementia patients and its validity. Ageing and Diseases 7, 1875–1885 (1994).
5) Onomichi Medical Association: OMA manual for early detection of dementia case. http://www.onomichi-med.or.jp/oioi/24-1.pdf. (access 24 August 2011).
6) Dementia care research and training center: The Center Method to Support Persons with Dementia. Commentary & Sheet Pack Care Management, Tokyo: Chuohoki Publishing (2007).