

Onomichi Medical Association (OMA) Method on Long-term Care Management Programs

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Abstract

The care of frail elderly requires multidisciplinary approach. It has long been a important problem how to systematize the quality care management for integrated care. The Onomichi Medical Association regards the care conference as a core of quality services and establishes a very sophisticated care management system that is based on the family physician led conference system, so called “the OMA method on long-term care management programs”. Thus the percentage of having CC is more than 95%. In this paper, the authors would like to explain an overview of this excellent system.

Key words: Onomichi Medical Association, Care conference, Care management, Integrated care, Networking

❖ Introduction

In 2000, the Japanese government has introduced the Long Term Care Insurance scheme in order to systematize ADL (Activities of Daily Living) care for the frail aged¹⁾. Usually a frail aged has various kinds of health, ADL and social needs. Thus such a person requires an integrated care system. In policies concerning integrated care for the disabled elderly, care management has become an important topic for consideration. Standardized care, continuity of care, flexibility of care, and finely tuned co-ordination between the different kinds of care providers are central parts of care management in order to realize an integrated care for the disabled aged and to enable them to continue to live independently in their own homes for as long as possible²⁾. This is the most important reason that the Japanese LTCI scheme has formalized the care management process.

In the Japanese LTCI system, it is required for care managers to organize a care conference (CC) in order to discuss the content of services in respecting the needs and wants of users and their family members. However, this CC is not fully utilized mainly because of busy working condition and difficulty for care managers to establish a good relationship with family doctors of clients. In fact the percentage of having CC is less than 50% for most of the cases.

In the case of Onomichi Medical Association (OMA), they regard the care conference as a core of quality services and establish a very sophisticated care management system that is based on the family physician led conference system, so called “the OMA method on long-term care management programs”. Thus the percentage of having CC is more than 95%. In this paper, we would like to explain an overview of this excellent system.

❖ OMA method on long-term care management programs

Figure 1 shows the OMA method on long-term care management programs. Before discharging from

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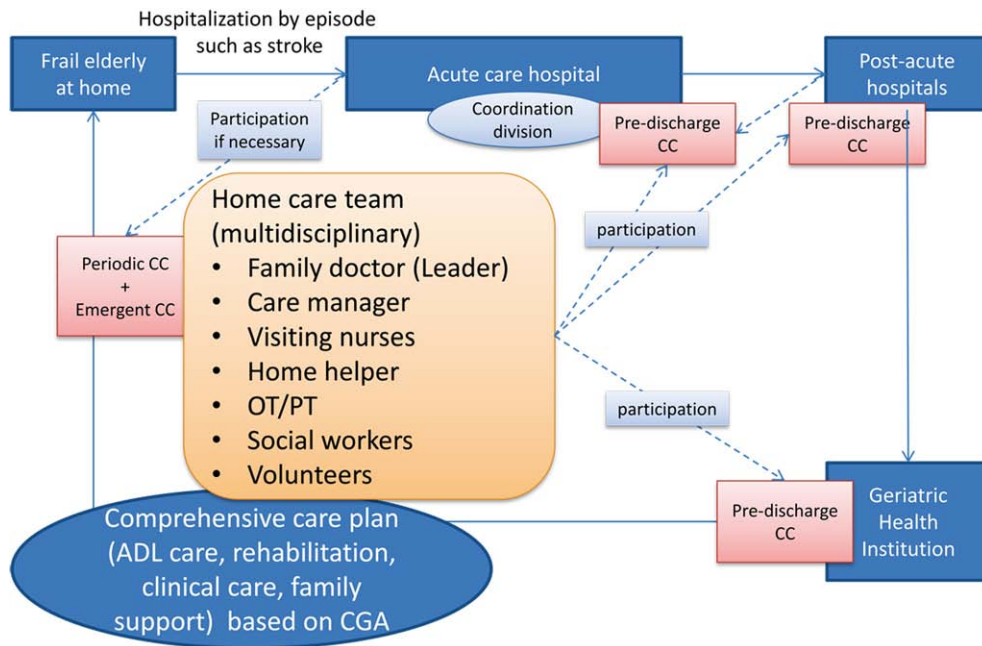


Figure 1 OMA method on long-term care management programs.



Figure 2 Pre-discharge CC at the acute care hospital. Case: 78 yr old Male, Recurrent brain hemorrhage, conscious loss, prostate cancer.

the acute care hospital, the pre-discharge care conference (CC) is organized. The participants of CC are physicians, nurses, PTs/OTs/STs and other health professionals of the hospital, those of recipient organizations (i.e., post-acute care hospitals, LTCI facilities), care manager, family doctor in charge of the patient, patient and his/her family members (Figure 2). It is important to know that the family doctor is requested to participate at the CC in the OMA method. After CC, the family doctor frequently visits the hos-

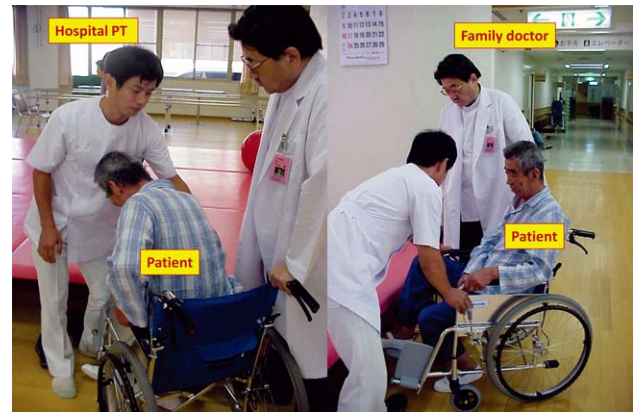


Figure 3 Rehabilitation care at the post-acute hospital. The family doctor frequently visits the hospital for the functional evaluation before discharge.

pital for the functional evaluation before discharge (Figure 3). This activity is very important to establish the reliance between family doctor and patient. Before returning to the community (patient's home, assisted living, etc), the CC is to be held at the family physician's clinic (Figure 4). The participants are same as the pre-discharge CC.

In order to manage CC efficiently, there are several rules. At first, a standardized assessment sheet (Comprehensive Geriatric Assessment; CGA) is used. The OMA has long been using the MDC-RAPs since

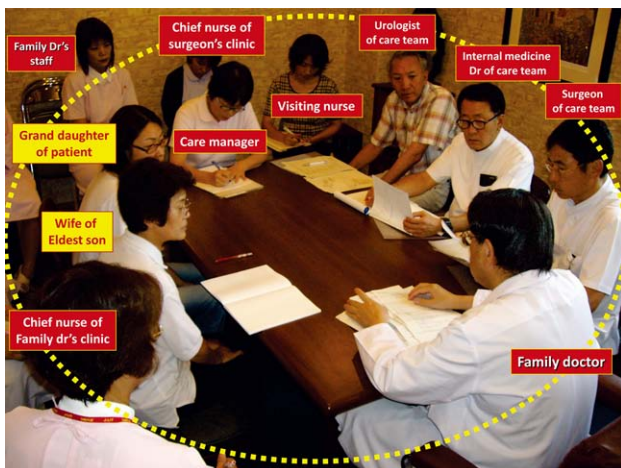


Figure 4 Periodic CC at the Family doctor's office.

1996. Based on this experience, we have developed the OMA version of CGA and use it for all clients. Secondary, the duration of CC must be about 15 to 20 min for each case. Each participant must prepare his/her own summary of the case before attending CC.

❖ Historical factors for successful care management system in OMA method

The introduction of LTCI in 2000 had a policy objective to expand the volume of ADL care mainly depending on non-medical sectors and private sectors. Another main objective of LTCI is the de-medicalization and de-institutionalization of care for the frail aged. In 2000, 604,000 aged were institutionalized, and 1,236,000 aged received home-based ADL care services on monthly basis³⁾. On monetary base, these figures correspond to 1940 billion yen (19.4 billion USD; 100 yen=1 USD) to institutional care and 996 billion yen (10.0 billion USD) to home-based care in each month. Eight years later, in 2009, the monthly average number of aged persons who received institutional care and home-based care increased up to 827,000 and 2,730,000, respectively. On monetary base, these figures correspond to 3,160 billion yen (31.6 billion USD; 100 yen=1 USD) to institutional care and 3,316 billion yen (33.2 billion USD) to home-based care.

It is sure that the volume of ADL care services (especially that of home care services) has been expanded by LTCI scheme. However, increasing the number of care providers (mainly private organizations) has caused the fragmentation of service network and resulted in difficulty to harmonize and to integrate



Figure 5 Geriatric Health Institution (GHI) "Yasuragi-no Ie".

the services. Furthermore, de-medicalization of care for the frail aged is disturbing the realization of integrated care. This situation is very problematic for dementia cases and palliative cases who require medical and ADL care at the same time.

In the case of OMA, there has long been the culture of family doctor. Most of the OMA member's clinics are located at the just next door of their residence. They have a clear will to care their clients for 24h/24h and to provide an integrated care. This attitude has naturally resulted in the organization of committee for integrated care for the frail aged in early 1990s when the ageing of Onomichi city attracted attention of the OMA members.

In order to realize an integrated care for the aged, the OMA constructed a visiting nurse station in 1995, a medical nursing home (Geriatric Health Institution; GHI) so called "Yasuragi-no Ie (Residence for comfort in English; Figure 5)" and home care support center "Yasuragi" (comfort in English) in 1997. For users of this institution, they have been conducting comprehensive geriatric assessment using MDS-RAPs. It is very important to know that MDS-RAPs is not only an assessment tool but also a tool for education of care professionals. The use of MDS-RAPs functioned as common language among the professionals and thus created a common culture of integrated care. In this way the OMA has trained many health professionals who can appropriately respond to multidisciplinary needs of the frail aged.

Based on this experience, the OMA established the home helper station that provides 24h/24h services in 1998, the care management center in 1998. It is important to know that all these programs were realized before the introduction of LTCI scheme. The OMA took these actions in order to respond to the needs of community, not to prepare for the introduc-

tion of LTCI scheme. In order to create a really working system, it is very important to cherish a culture of “trust” between health care professionals and citizens. The health professionals must take actions to respond to the needs of inhabitants even though such activities are not covered by official insurance schemes. For example, the OMA members have participated to the pre-discharge CC without any financial support (no reimbursement is set for such activities under the public health insurance scheme before 2008^{Note1}). We participate in it because we regard it indispensable to function as a family doctor. This sense of advocacy must be one of the most important historical characteristics of OMA members.

❖ Geriatric Health Institution as a buffer of long term care

Before introduction of LTCI, care at GHI was financed by medical insurance scheme. The original function of GHI is a half-way institution between in-hospital care and home based care. Clinically GHI is expected to provide chronic phase of rehabilitation care. However, after the introduction of LTCI, GHI has become under the LTCI scheme. This causes several problems; at first GHI is becoming nursing home like institution, that is, users tend to stay at GHI up to the end of their life. Secondary, as LTCI does not appropriately cover the pharmaceutical cost in GHI, it has become difficult to properly treat the aged. Especially this is problematic for dementia cases who require expensive drugs such as donepezil hydrochloride.

In the case of OMA method, we do not change the characteristics of OMA owned GHI under the LTCI scheme, even though this management style sometimes causes financial demerits. That is, the “Yasuragi-no Ie” is still functioning as a half-way institution where the users can receive enough rehabilitation (Figure 6) and necessary medical care including dementia drugs such as donepezil hydrochloride. The institute provides respite care such as short stay services and day services, and care management services. Furthermore under the OMA method, GHI is used as a training institution for care workers. For example, the freshman nurses and home helpers receive their OJT (On the

Note 1: According to the positive results of OMA activities for integration of care, this kind of activity becomes one of the services for reimbursement of public health insurance scheme after 2008.



Figure 6 Rehabilitation services at day service center of GHI. Family doctor frequently visits the GHI day service center in order to evaluate patient's ADL level.

Job Training) of the dementia care under the instruction of doctors and senior nurses working there. In this way, the “Yasuragi-no Ie” contributes to smoothen the return from acute care hospitals to patient's home, and to keep the patients at home as long as possible. Considering the importance of function of GHI as a buffer between medical and LTCI schemes, it might be reasonable to change the responsibility of GHI care from LTCI to medical insurances. Anyway, it seems a very important point to utilize the buffer function of GHI for the better long term care management of the frail aged.

❖ Conclusion

According to the governmental report, only 20% of citizens wish to stay at their own residences as long as possible, if they might have some handicaps⁴). Main reasons of this low percentage would be that they do not want give trouble for their family and that they are afraid of pain and other safety related events. In fact, it is very difficult to keep the severe frail elderly at their home for most of the communities. Why could the OMA realize it? This is a question that we have received from various persons such as policy makers, health professionals and researchers. There is no miracle prescription for it. The most important thing is that the health professionals made up their mind to have responsibility for their community. This naturally requires for health professionals to create a network for collaboration. The OMA members routinely visit patients home in order to provide rehabili-

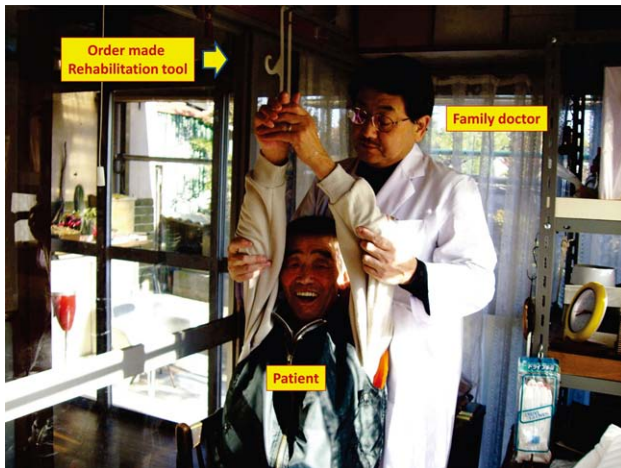


Figure 7 Rehabilitation care at patient's home.

The family doctor tries to activate patient's voluntary effort for rehabilitation.



Figure 8 Home visit by family doctor for rehabilitation services at patient's residence.

At the moment of home visit, the family doctor check the ADL level of patient with in their daily life. If necessary, he orders the environmental coordination to care manager, such as reform of housing.

tation care (Figure 7) and to know any problems that the patients have in their daily life. Sometimes, we walk around with patient in order to know the environmental problems that patients have (Figure 8). This kind of activity is very important to maintain the QOL of patient at home. The continuous rehabilitation care with the clear goal setting, facilitates the patient's voluntary effort and increases patient's self-esteem. The family doctor's support is essential to keep patient's will for improvement. In fact, it is not rare that this



Figure 9 Functional improvement by rehabilitation care at patient's home.

The continuous rehabilitation care with the clear goal setting, facilitates the patient's voluntary effort and increases patient's self esteem. This ameliorate the patient's QOL. The family doctor's support is essential to keep patient's will for improvement.

continuous rehabilitation care improves the functional independency of patients (Figure 9).

Of course the leadership is also important. Considering the multidisciplinary problems that the frail aged has, it will be desirable for local medical organization to take a role of leadership. We do not know if it is possible to generalize the OMA methods. Because the network system must be organized reflecting the characteristics of each community. Facing to the coming highly aged society, we need to organize a new community movement. The OMA could be such a model.

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