

Towards structuring community-based integrated care systems in Japan: Research and Practice

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ABSTRACT

How and where to provide end-of-life care to older people in Japan is bound to become a national issue of great concern.

By 2025, Japanese national and local governments will be entrusted with the responsibility of setting up community-based integrated care systems (CICs) designed to allow older citizens who need care to stay in their own community and lead dignified, independent lives. However, in spite of the many efforts made to rationalize and improve the performance and quality of the CICs, only a limited degree of success has so far been achieved. This paper reviews researches and practices, including the author's experiences, related to structuring community-based integrated care systems in Japan. I also propose a conceptual model of dissemination of community-based interprofessional education, which is made up of the following bodies: medical school, regional CICS, local CICS. The author defines the relationship between medical schools and communities as education and research "E&R". In the future, more in-depth empirical, qualitative, and quantitative assessments of the authenticity of the model will be needed.

Key words: community-based integrated care system, interprofessional education, care manager, case conference

1. Introduction

Japan's population ages 65 and above increased from 5.7 % in 1960 to 26.7 % in 2015.⁽¹⁾ This number is still on the rise and is expected to reach 30% in 2025, when the first baby boomers turn 75 and above.⁽²⁾ Older people often experience a gradual deterioration of clinical condition associated with complex physical, mental and social problems.⁽³⁾ The complexity of diseases that develop in old age and the limited care settings available make it difficult for older people and their families to cope.⁽³⁾ It has become urgent to find a way to handle the mounting financial and social burdens of a rapidly aging society; how and where to provide end-of-life care to older people in Japan is bound to become a national issue of great concern.⁽⁴⁾

By 2025, Japanese national and local governments will be entrusted with the responsibility of setting up community-based integrated care systems (CICSs) designed to allow older citizen who need care to stay in their own community and lead dignified, independent lives.^(5,6) Although the system is a new concept for the provision of care services for older people in Japan, it has been difficult to create a feasible scheme of CICS that guarantees quality long-term care in all industrialized nations.^(7,8,9) The ineffectiveness stems from a lack of coherence among the various approaches employed and their underlying theories.⁽¹⁰⁾ Japan's CICS is defined as "a community-based system designed to secure suitable living arrangements and appropriate social care such as daily life support services as well as long-term and medical care, in order to ensure the health, safety and peace of mind of older people in their everyday life."⁽⁷⁾ "The ideal size of each community is also

defined as an approximate range of 30-minute walk, which represents a junior high school district or a sphere of daily life in Japan.⁽⁶⁾ This is mostly because older people dying at home require the provision of 24-hour expert support.⁽⁶⁾ "Community-based" here is shifting from a hospital-based to community-based mindset, and "integrated" here is providing healthcare, long-term care, preventive long-term care, housing, and livelihood support in an integrated manner in collaboration with private sectors, volunteers and so on.⁽⁶⁾ The system is expected to increase cost efficiency and improve the quality of life of older people living in the communities.⁽¹¹⁾

To promote the provision of comprehensive medical and long-term care in the community, the Japanese government implemented an array of laws, such as the Act for Securing Comprehensive Medical and Long-term Care in the Community passed in June 2014.⁽¹¹⁾ Although these types of governmental initiatives are aimed at providing integrated care systems with the collaboration of professionals and organizations, the concept of integration itself is viewed differently among regions.⁽⁷⁾

Therefore, the Japanese government emphasizes independent, community-based strategies based on the specific characteristics of each region.⁽⁶⁾ This approach is essential partly because there are huge differences in the aging speed as well as in the availability of social resources between urban and rural areas. To understand the barriers, challenges, and best practices of integrating care, the Ministry of health, labor and welfare, dedicates a section of its website to promoting community-based integrated care systems and publicizing the system nationwide.⁽⁶⁾

However, in spite of the many efforts made to rationalize and improve the performance and quality of the CICSs, only a limited degree of success has so far been achieved. The various health care and social care bodies responsible for care provision in Japan have been described as fragmented and poorly coordinated, as reported by a number of recent studies.⁽¹²⁾ As a result, successfully sharing expertise on the implementation of CICSs nationwide still represents a challenge.

This paper reviews researches and practices, including the author's experiences, related to structuring CICSs in Japan.

2. Practice and Research

2.1. Practices in interprofessional collaboration and education

Community-based integrated care providers are required to acquire fundamental knowledge about health care and welfare, communicate and collaborate with other professionals, and integrate home care services. In addition, care managers are also required to acquire the skills needed to communicate effectively and efficiently with other medical professionals.⁽¹³⁾ For example, care managers play a key role in community-based integrated care under the public insurance system, helping individual older clients, families and other caregivers adjust and cope with the challenges of aging or disability by: conducting care-planning assessments to identify needs, problems and eligibility for assistance; screening, coordinating and monitoring home care services; providing client and family education and advocacy; and offering counseling and support.^(13,14) However, care managers are often unable to communicate

efficiently with medical professionals because they lack the skills and terminology to effectively convey their messages.⁽¹⁵⁾

The hierarchy of the medical community is also a hindrance to professional and interprofessional communication. We previously conducted a qualitative study of the emotional and psychological profile of home helpers which revealed that home helpers often feel discriminated against and treated poorly by their clients and their families in comparison with medical professionals.⁽¹⁶⁾ A previous study also suggests that care managers often feel anxious when they are in the presence of physicians or nurses because they lack the necessary interprofessional communication skills.^(13,15)

A previous WHO report has indicated that interprofessional education (IPE) could lead to enhanced interprofessional communication and collaboration in community settings.⁽¹⁷⁾ In Japan, the "Dementia Café" is a widely-recognized coffee lounge where care managers, non-profit organizations, and specially trained citizens come together to freely exchange on health-related issues.⁽¹⁸⁾ The café, which is generally managed by volunteers, aims at better serving the needs of older people with dementia and their family caregivers. The Japanese government has come to recognize the importance of creating spaces where older people with dementia and their families and professionals can meet casually to gather information and advice. Abe et al. developed an original Café system named the "Care Café" based on the World Café method.⁽¹⁹⁾ The Cafés are scheduled meetings or discussions held between healthcare and welfare service providers such as physicians, nurses, care

managers, social workers to discuss health-related topics. Another popular initiative in Japan is the “Medical Café” where citizens have the opportunity to meet with medical professionals (i.e. physicians, nurses and pharmacists) to formulate inquiries on various health-related issues and obtain advice on medical treatment in a coffee lounge setting. The café was originally designed for care managers and other non-medical professionals needing to consult with medical professionals and to deepen their medical knowledge; topics covered include diseases, dementia care, end-of-life issues, logical thinking, and psycho-therapeutic program for anger prevention and control.^(13,20)

Although medical associations and community support service centers led by local governments have set up a number of educational initiatives aimed at improving interprofessional communication, these bodies lack the funds, the skilled staff, and the expertise to provide a well-organized scheme. Therefore, disseminating facilitation and management education programs in the communities has become increasingly important recently. Care professionals including care managers are expected to hold multidisciplinary case conferences (MCCs) and facilitate group discussions partly due to the fact that physicians and nurses do not have enough time and experience to educate care managers during clinical practice.⁽²¹⁾ Facilitation training is an ideal training program to promote the activities of chief care managers.⁽²²⁾ The program focuses on facilitation skills training as a key element to enhance peer education among care managers in the community. Peer education, which is based on the premise that “teaching is learning”, is an effective and efficient

method to learn. The author developed a nationwide facilitation training program for care managers designed to enhance their end-of-life care knowledge and facilitation skills.⁽²²⁾

Medical schools also play an important role in the successful implementation of CICSs. Some medical schools collaborate with local governments to create good practices of CICSs, as reports have indicated.^(21,23) These institutions have expertise in education and community management, and provide educational and support services to surrounding local governments or communities in order to build up distinctive CICSs.

2.2. Researches in interprofessional collaborative practice

Very few studies have scientifically confirmed the effect of IPE on community practices. Abe et al. and Hirakawa et al., using the same questionnaire form, assessed the impact of their MCCs on participant satisfaction, knowledge improvement of health care services and providers, as well as community integration.⁽²⁴⁾ In the palliative cancer care field, large-scale interventional studies have been conducted. From 2008 to 2010, collaborative researches on the quality and dissemination of palliative cancer care were conducted in 4 cities nationwide.⁽²⁵⁾ Based on preliminary studies aimed at people in the community and medical staff, they developed a number of interventional strategies including leaflets, DVDs, and educational workshop programs, and assessed the effects of the intervention on the quality of community-based integrated care.

3. Conceptual model of dissemination of community-based IPE

Some literatures dismissed the concept of CICS for being ideal but unrealistic, referring to it as a myth.⁽²³⁾ Implementing quality CICSs requires comprehensive and multidisciplinary collaboration in the areas of medicine, care and welfare, as well as solid practical expertise. In addition, the

implementation of a sound CICS across Japan still represents a challenge due to a lack of facilitators, insufficient funds and the hierarchical organization of the medical community. Drawing from the results of previous studies and our experience, we have come to realize the need to develop a model of dissemination of community-based IPE in order to promote interprofessional collaborative practice nationwide.

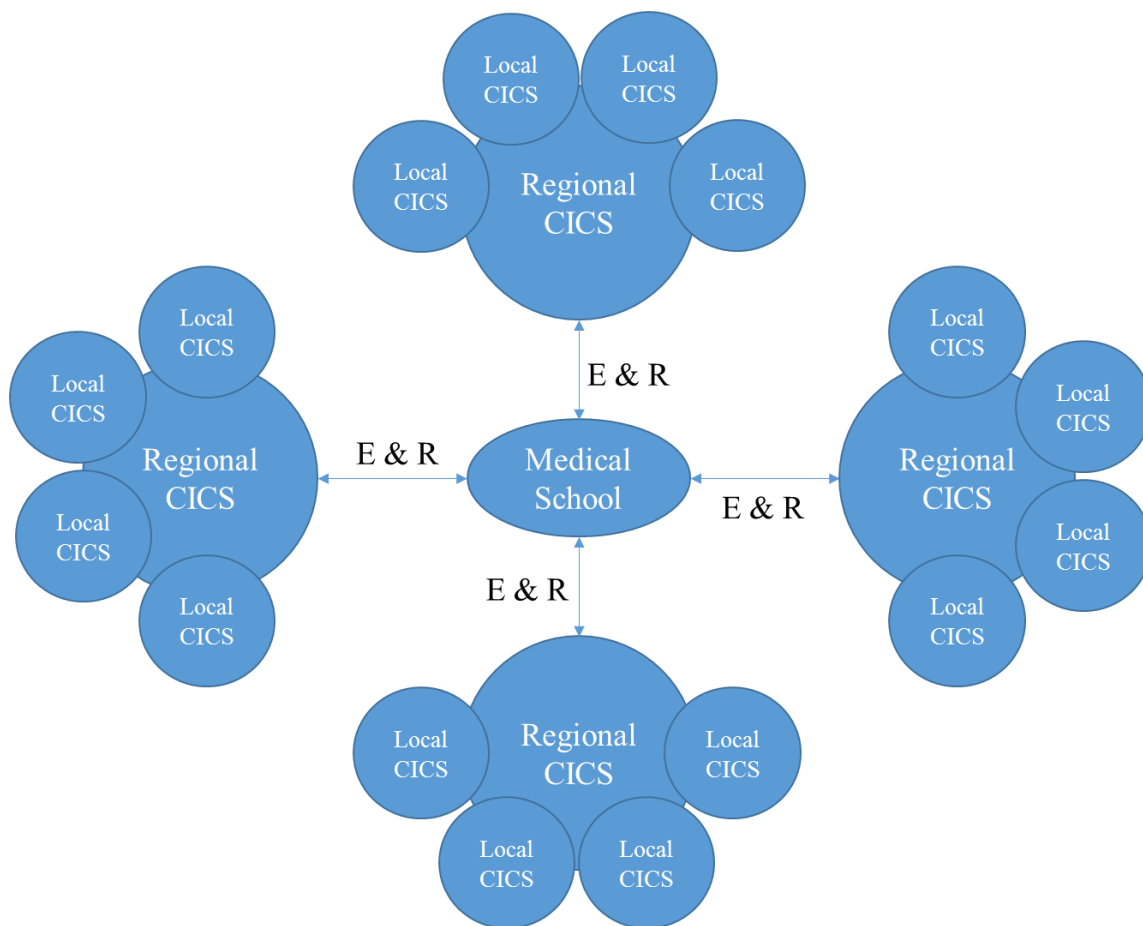


Figure 1. The model of dissemination of community-based interprofessional education and practice.

The author created a conceptual model based on the above-mentioned practices and researches (**Figure 1**). The model is made up of the following bodies: medical school,

regional CICS, local CICS. A regional CICS is defined as the inclusive multidisciplinary network managed by a regional center hospital or a medical association. A Local

CICS is rather small and exclusive multidisciplinary network managed by a local hospital or a clinic. The regional CICSs provide educational information and opportunities to affiliated local CICSs. The author defines the relationship between medical schools and communities as education and research “E&R”. Because medical schools have a lot of expertise on IPE, they are required to develop tailor-made IPE programs for individual regional communities. Meanwhile, since CICSs have not yet been thoroughly investigated, medical schools collect qualitative and quantitative data from individual regional communities in return for IPE provision. In each regional community, there are scattered local interprofessional networks in which a local hospital or clinic plays a leading role in the community-based integrated care system. Regional medical associations or center hospitals are responsible for bridging the gap

between these local community interprofessional networks.

In summary, the conceptual model revealed that it is important to structure community-based IPE systems with a focus on E&R as a function of medical school. The author concluded that, to understand the barriers, challenges, and best practices of integrating care and to promote CICSs nationwide, it is necessary to develop the strategies and methods to promote collaboration between medical schools and regional communities in the near future.

4. Conclusion

After reviewing the literature on Japanese CICSs, I propose a conceptual model of dissemination of community-based IPE. In the future, more in-depth empirical, qualitative, and quantitative assessments of the authenticity of the model will be needed.

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