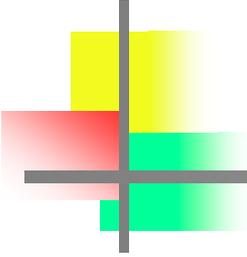


Community-based Integrated Care System in Japan



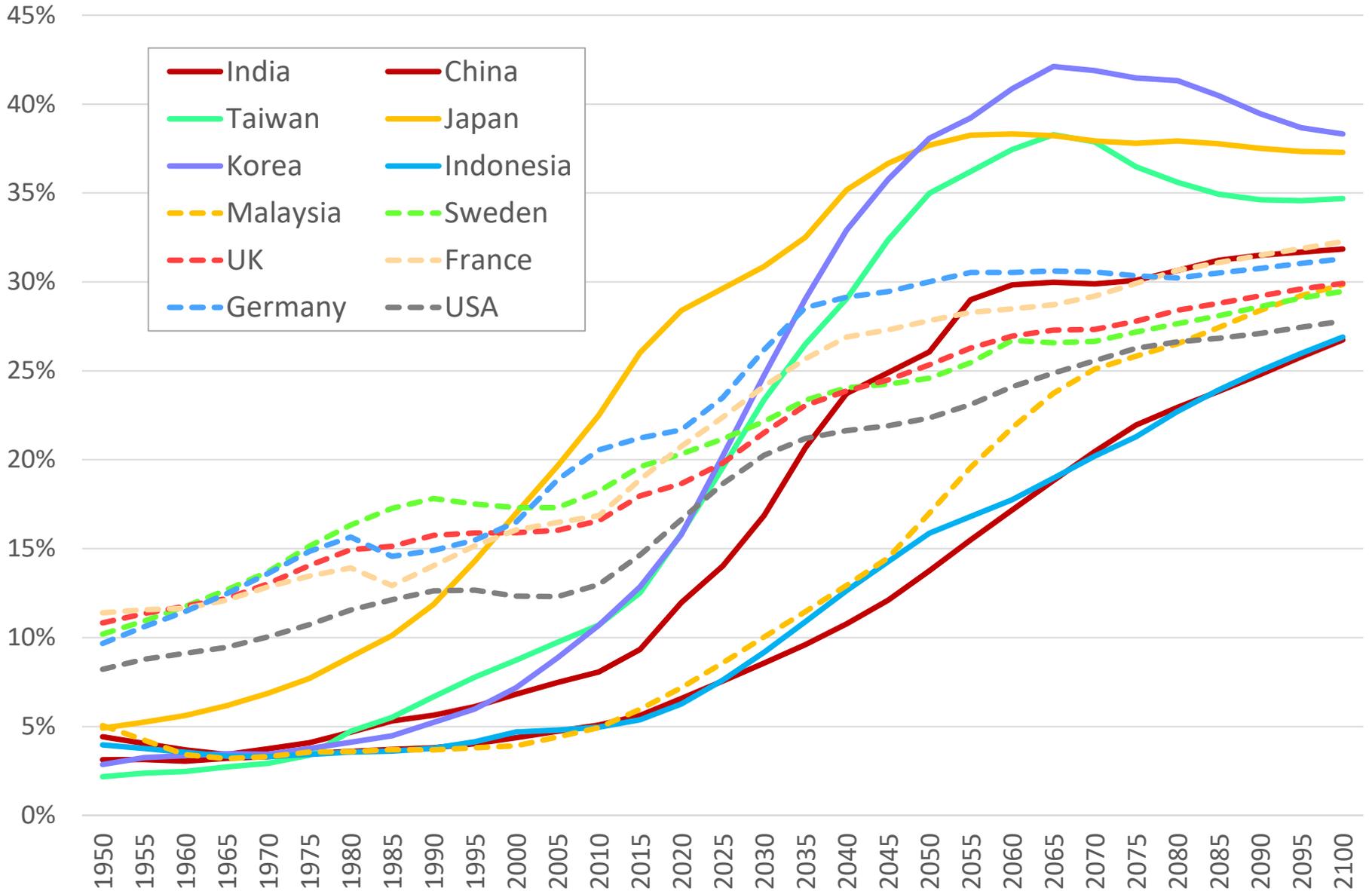
Hiroataka Onishi MD, MHPE, PhD

Dept of Medical Education for Int'l Cooperation

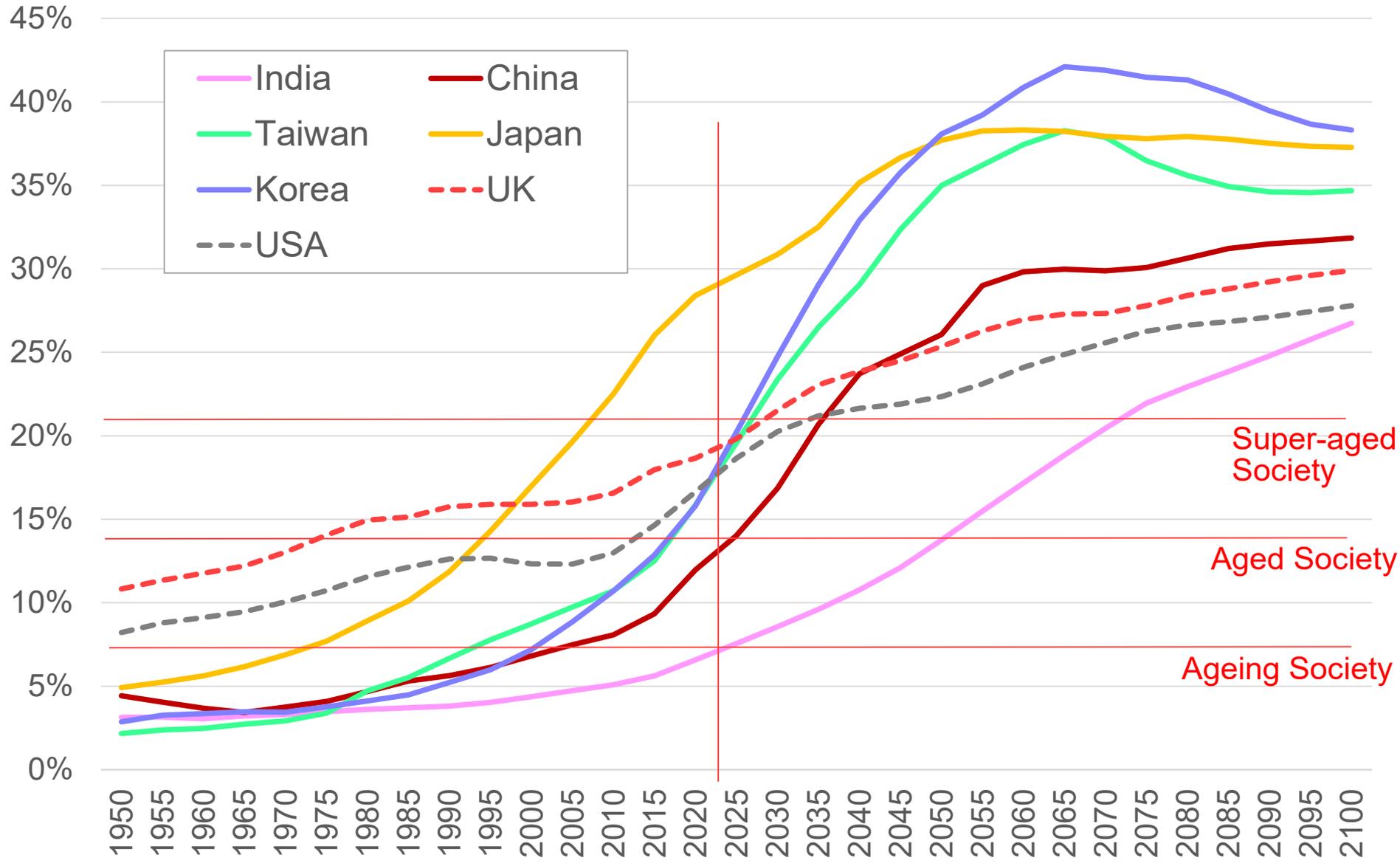
Int'l Research Center for Medical Education

Graduate School of Medicine, The University of Tokyo

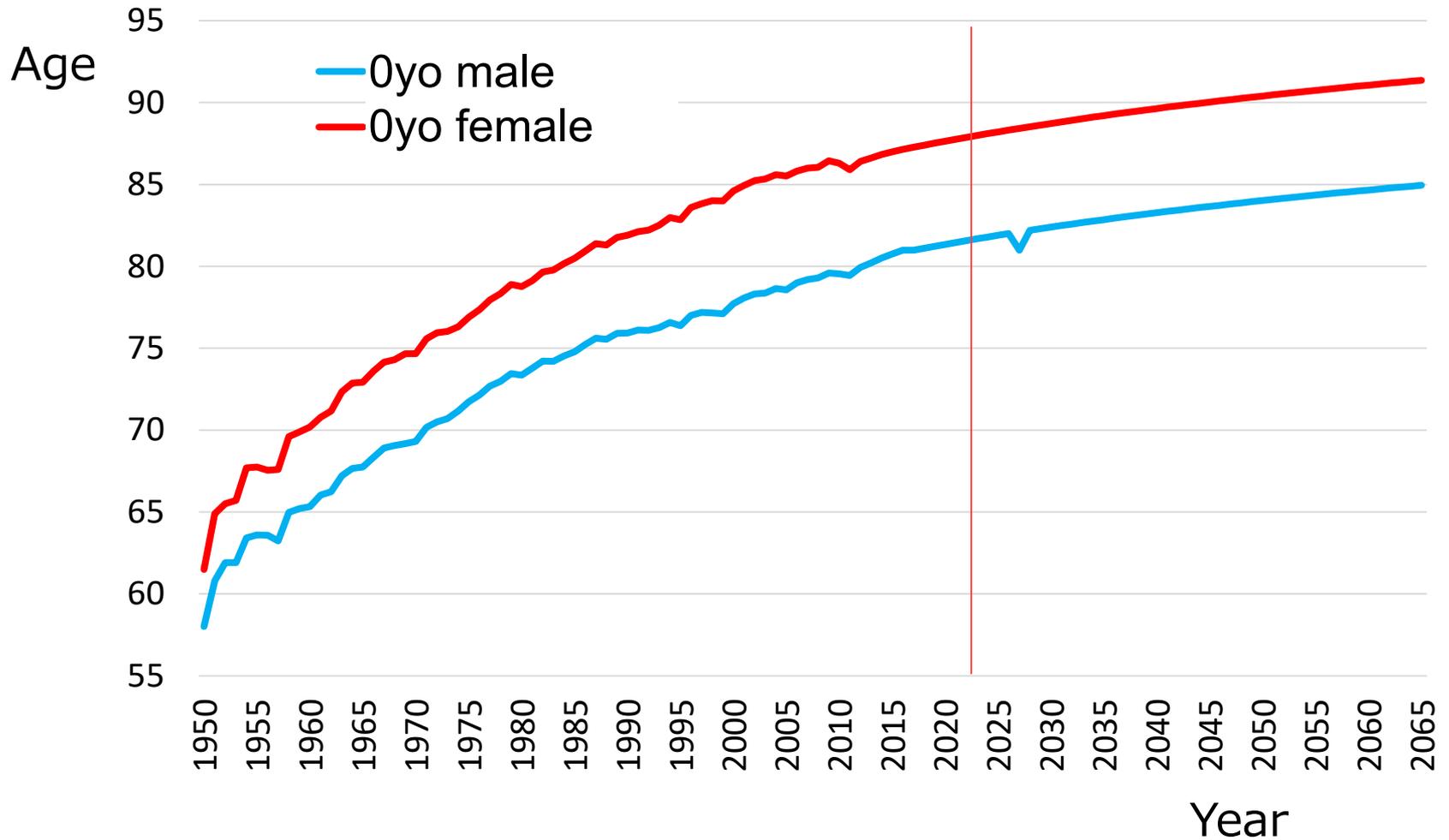
% Population Over 65 in Trend



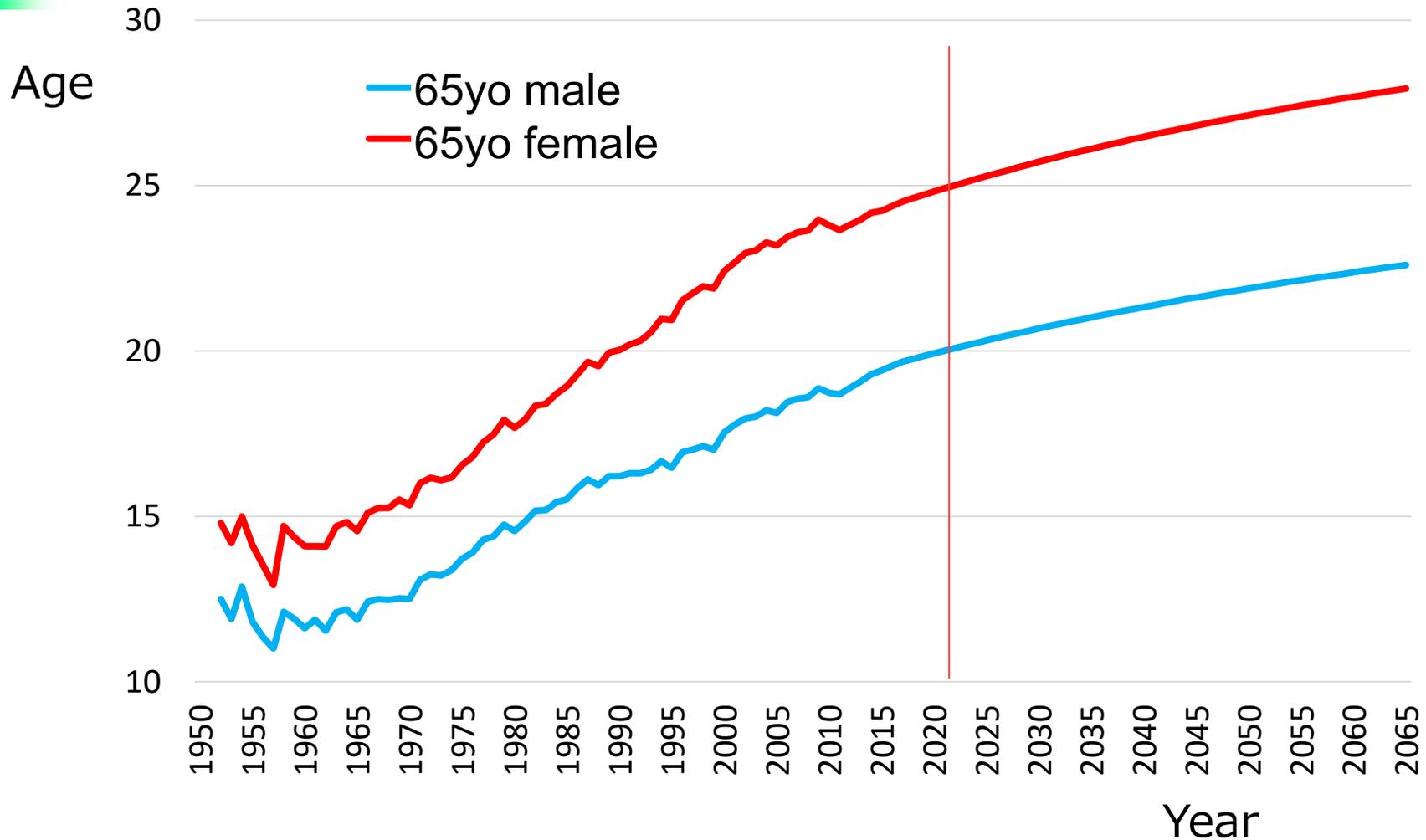
% Population Over 65 in Trend



Life Expectancy and Prediction in Japan

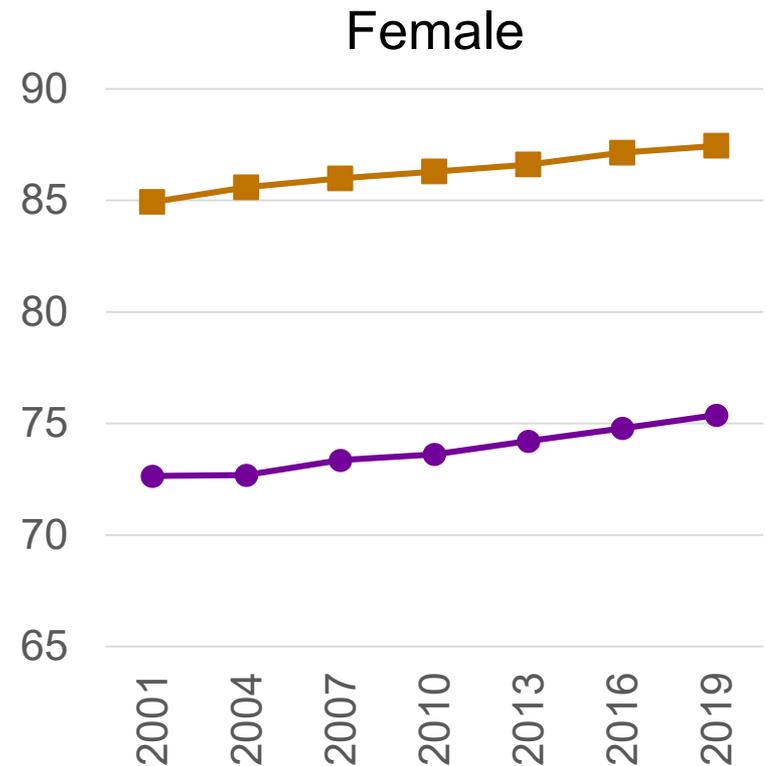
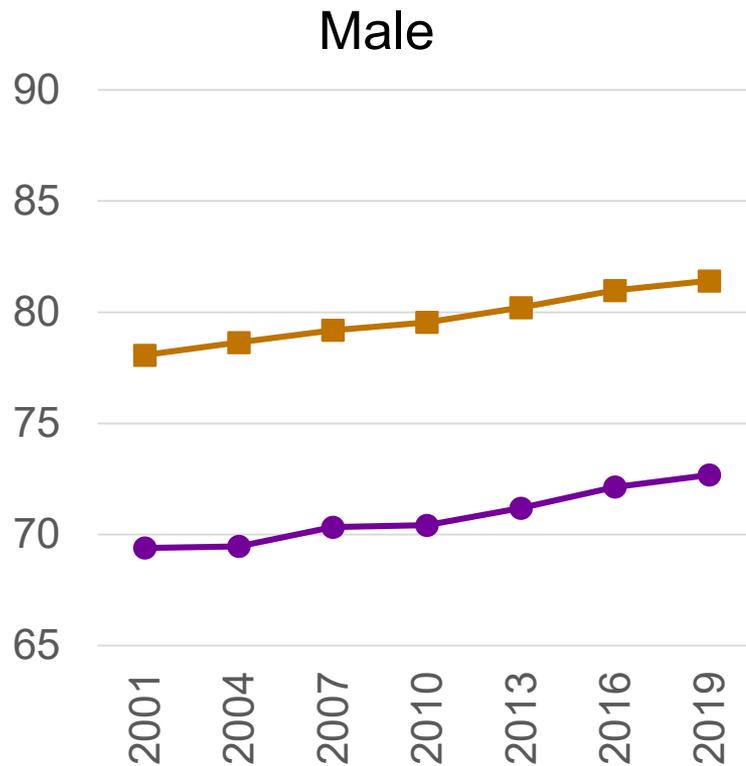


Life Expectancy at 65 yo and Prediction in Japan

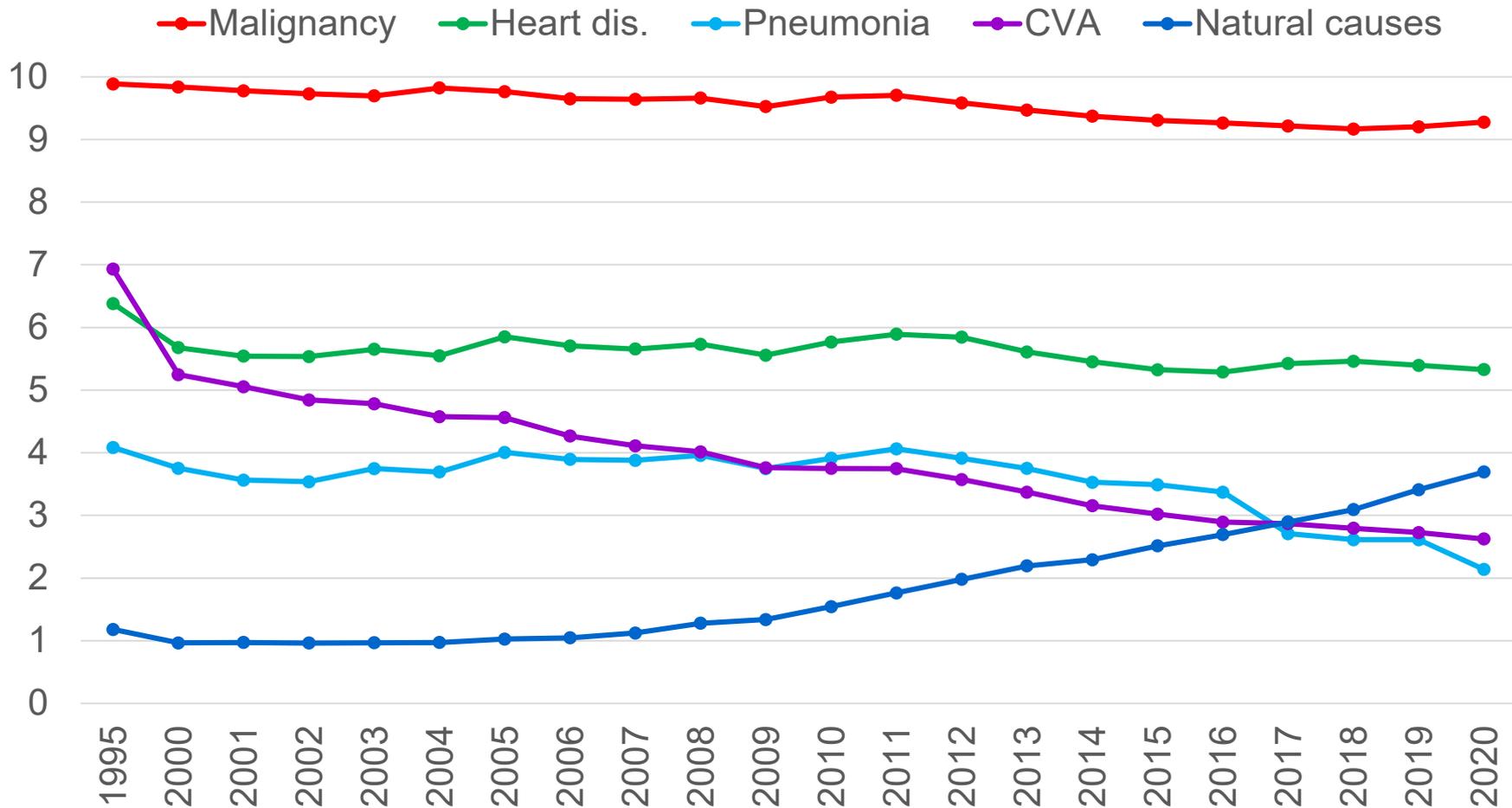


Trend of Healthy Life Expectancy in Japan

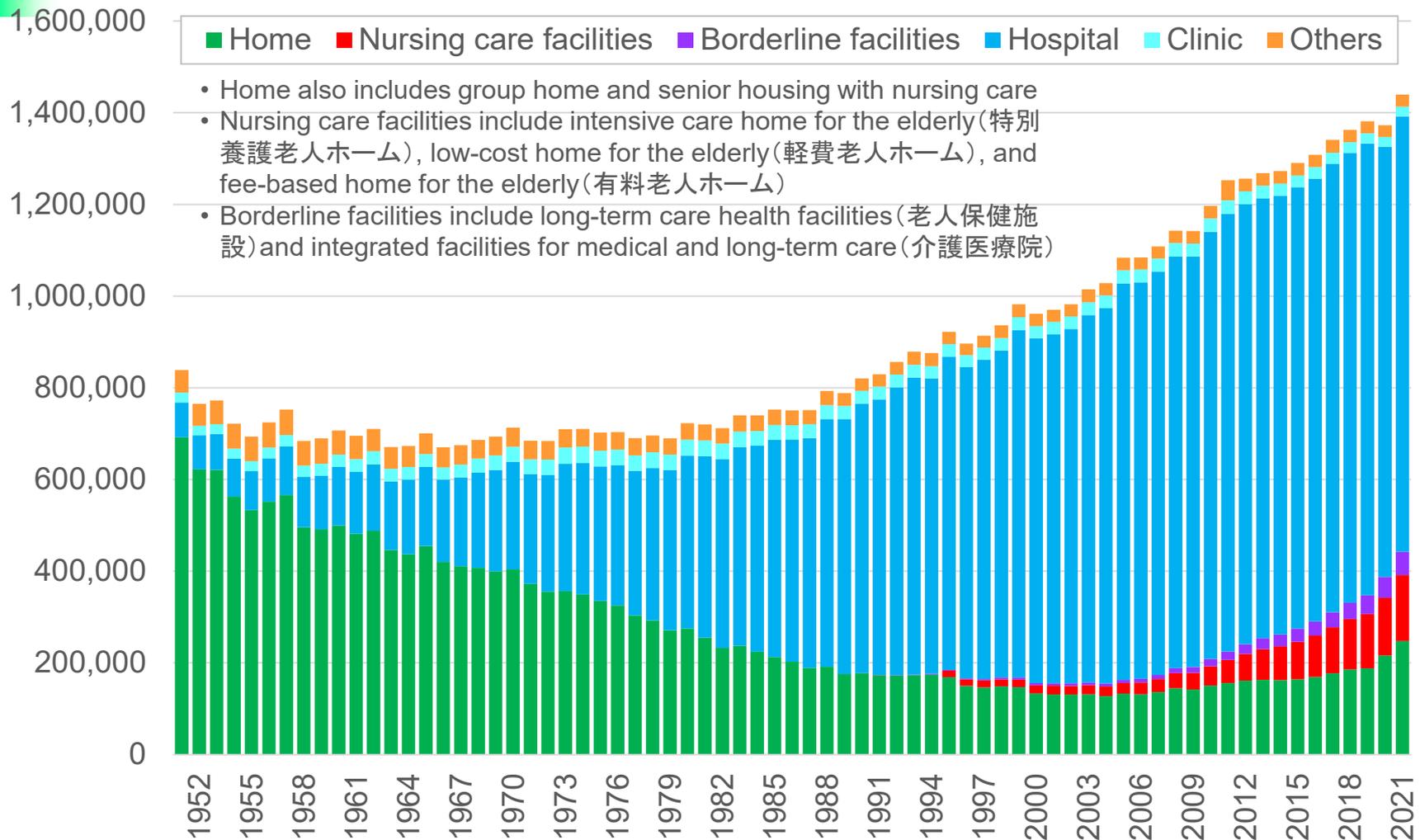
■ Life Expectancy ● Healthy Life Expectancy



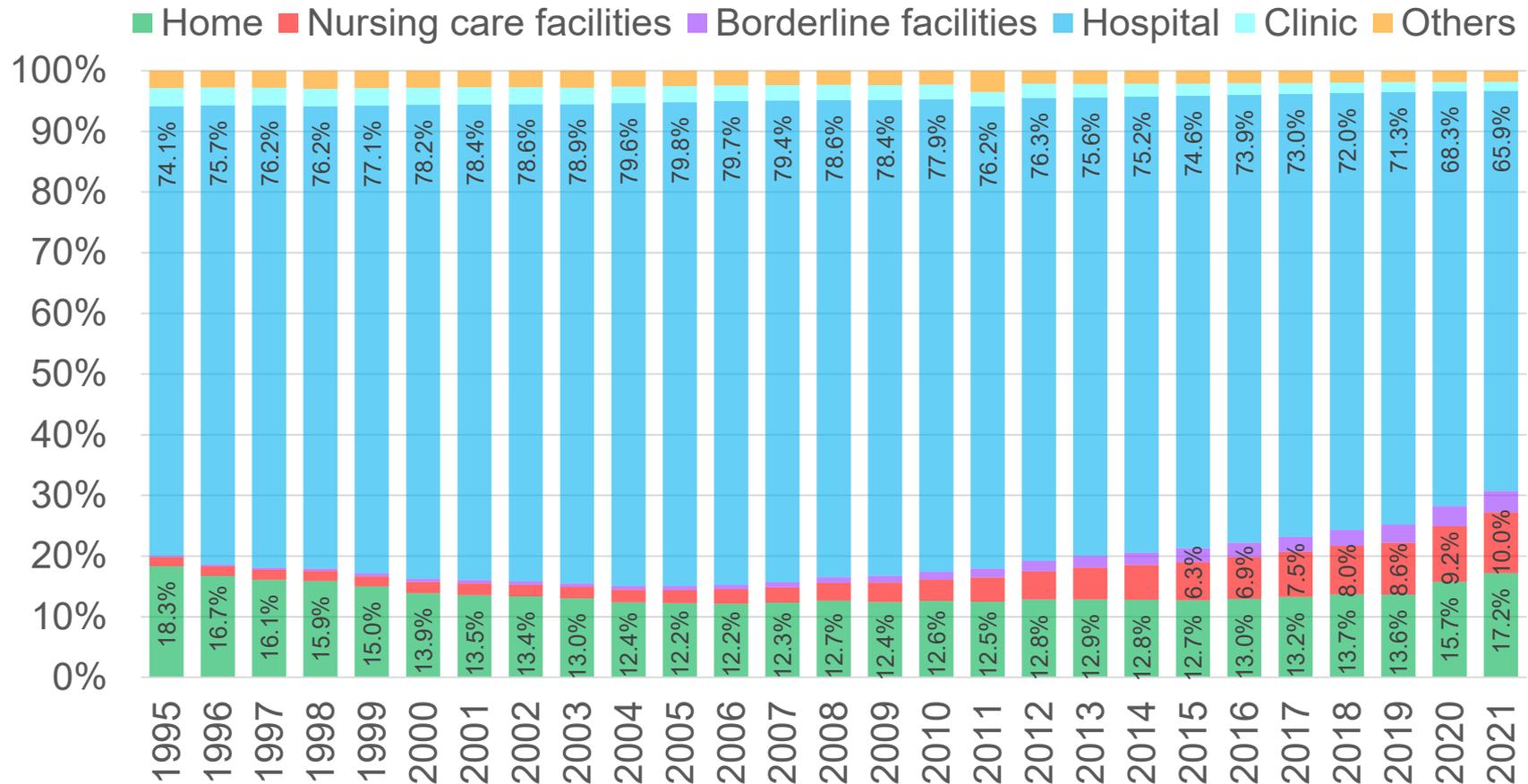
Reasons of Death for 10³ Senior People



Trend of Numbers and Sites of Deaths in Japan

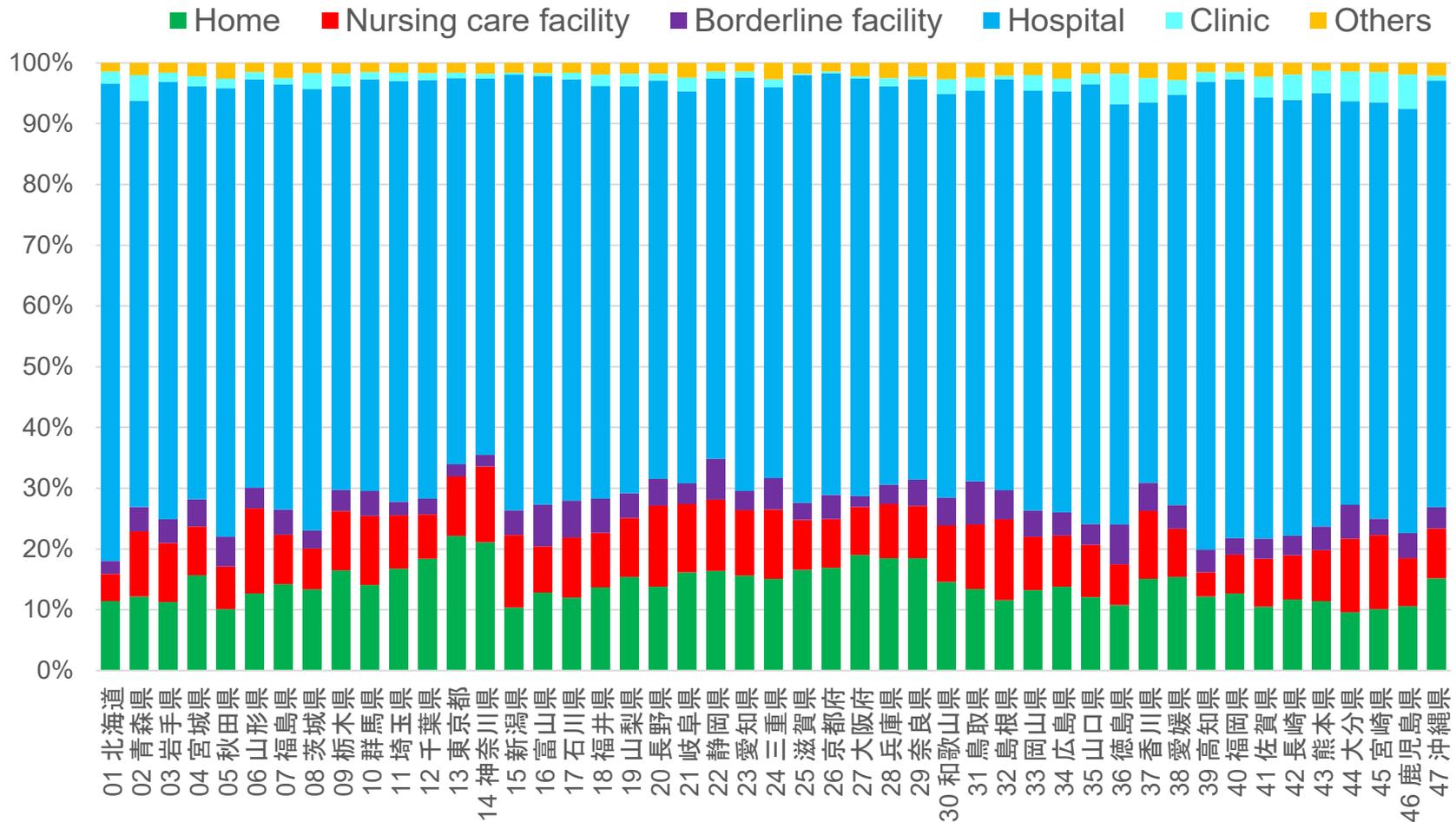


Trend of % and Sites of Deaths in Japan



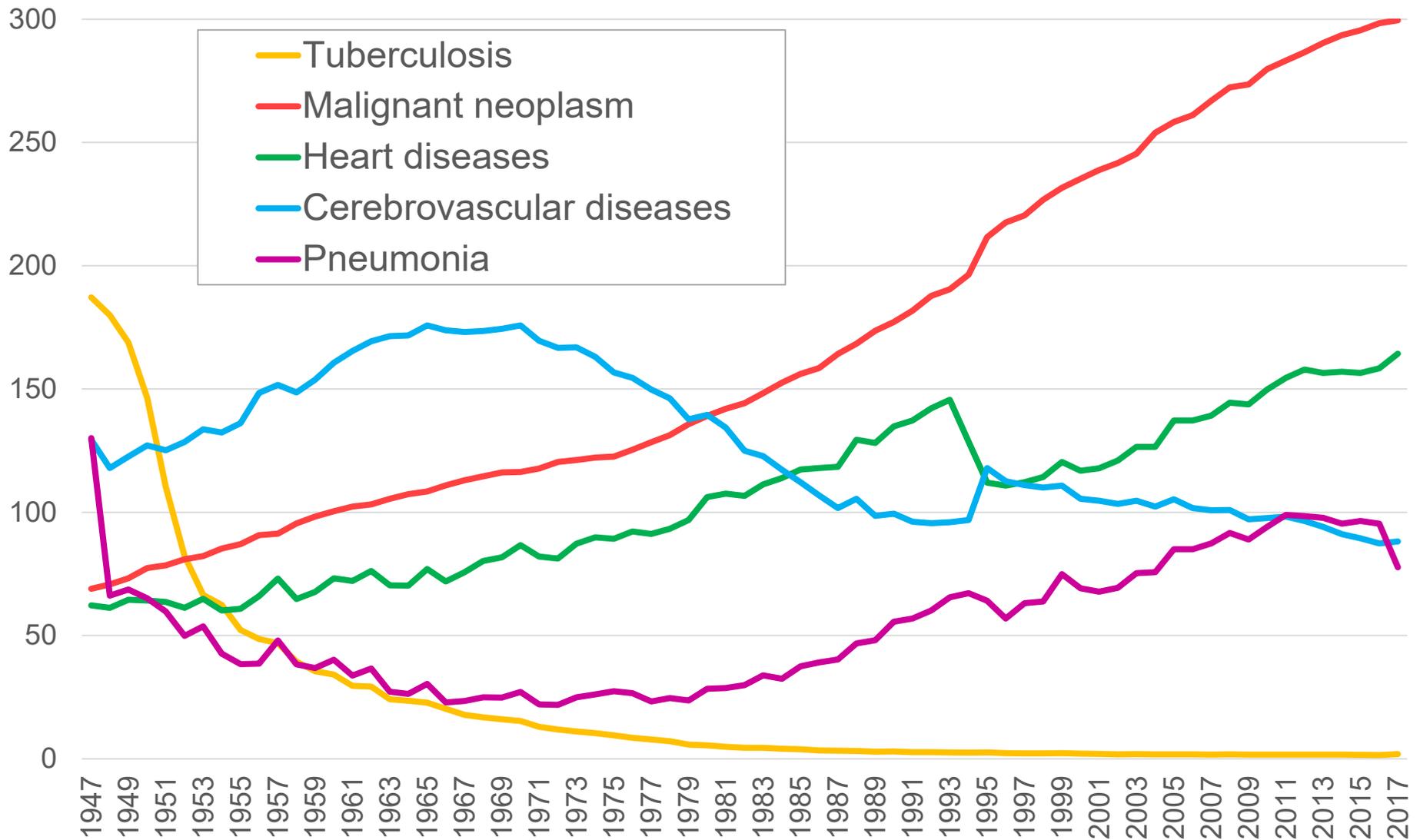
Sites of Death in 2020

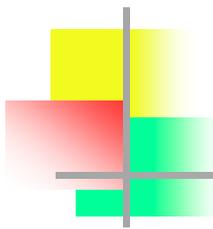
Prefectural Differences



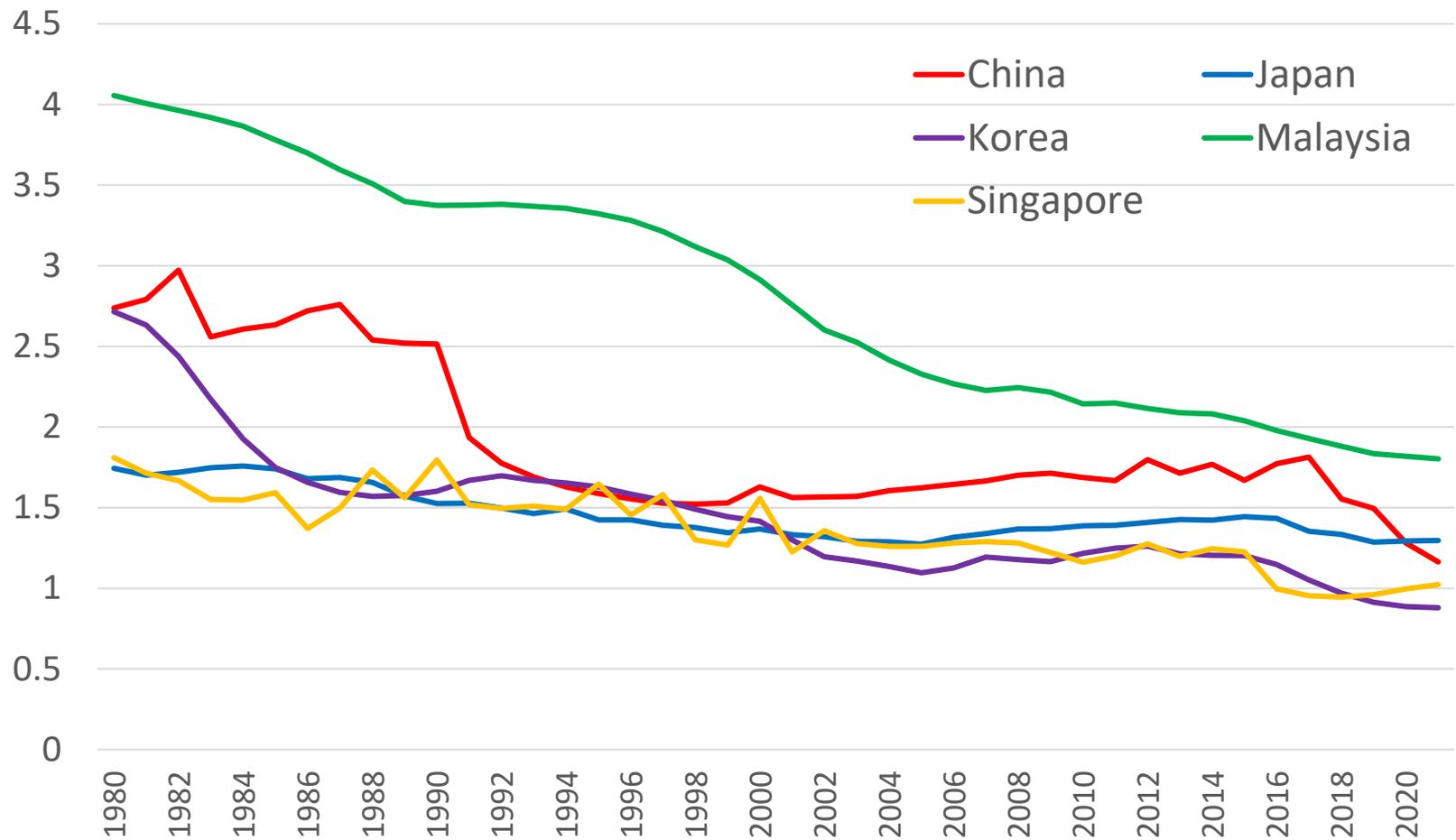
Disease structure

Trends in death rates for leading causes of death

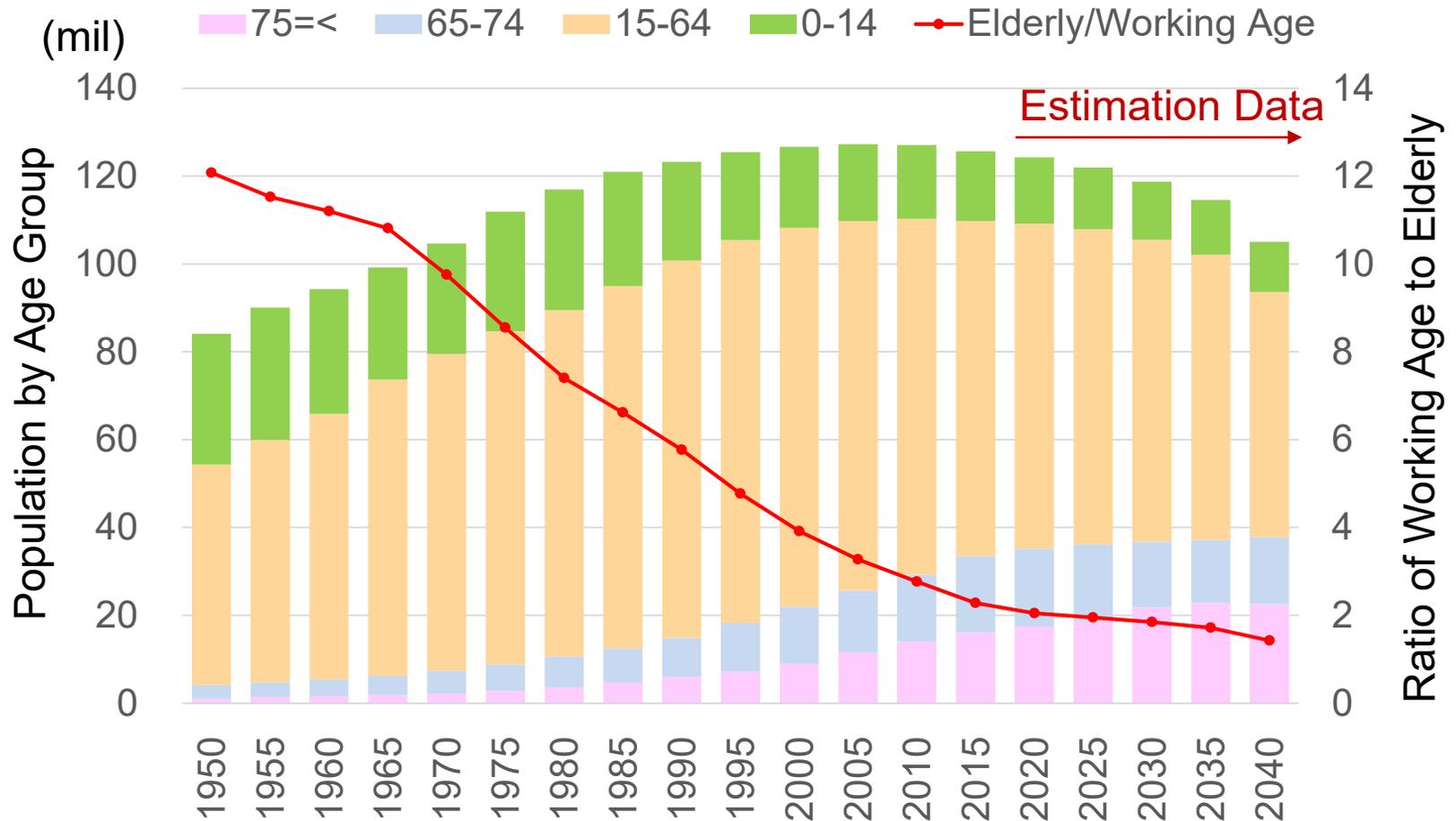




Total Fertility Rate



Generational Population and Ratio of Elderly People



Previous Family Style

- 3 generations
- Working man and housewife
- Child-raising and elderly care is also included in housekeeping?



Current Family Style

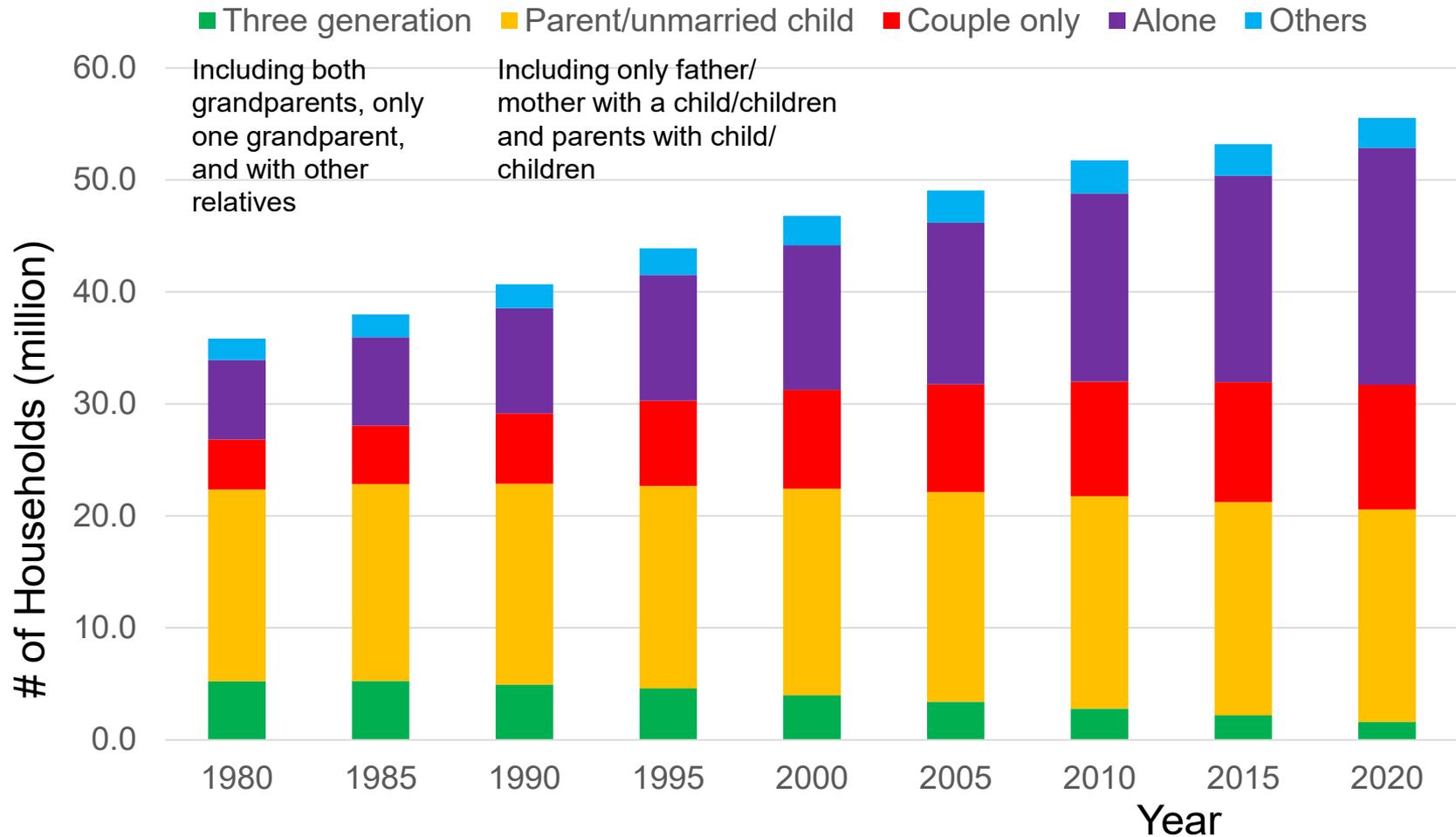
- Nuclear family
- Double income
- Shared housework
- Small house



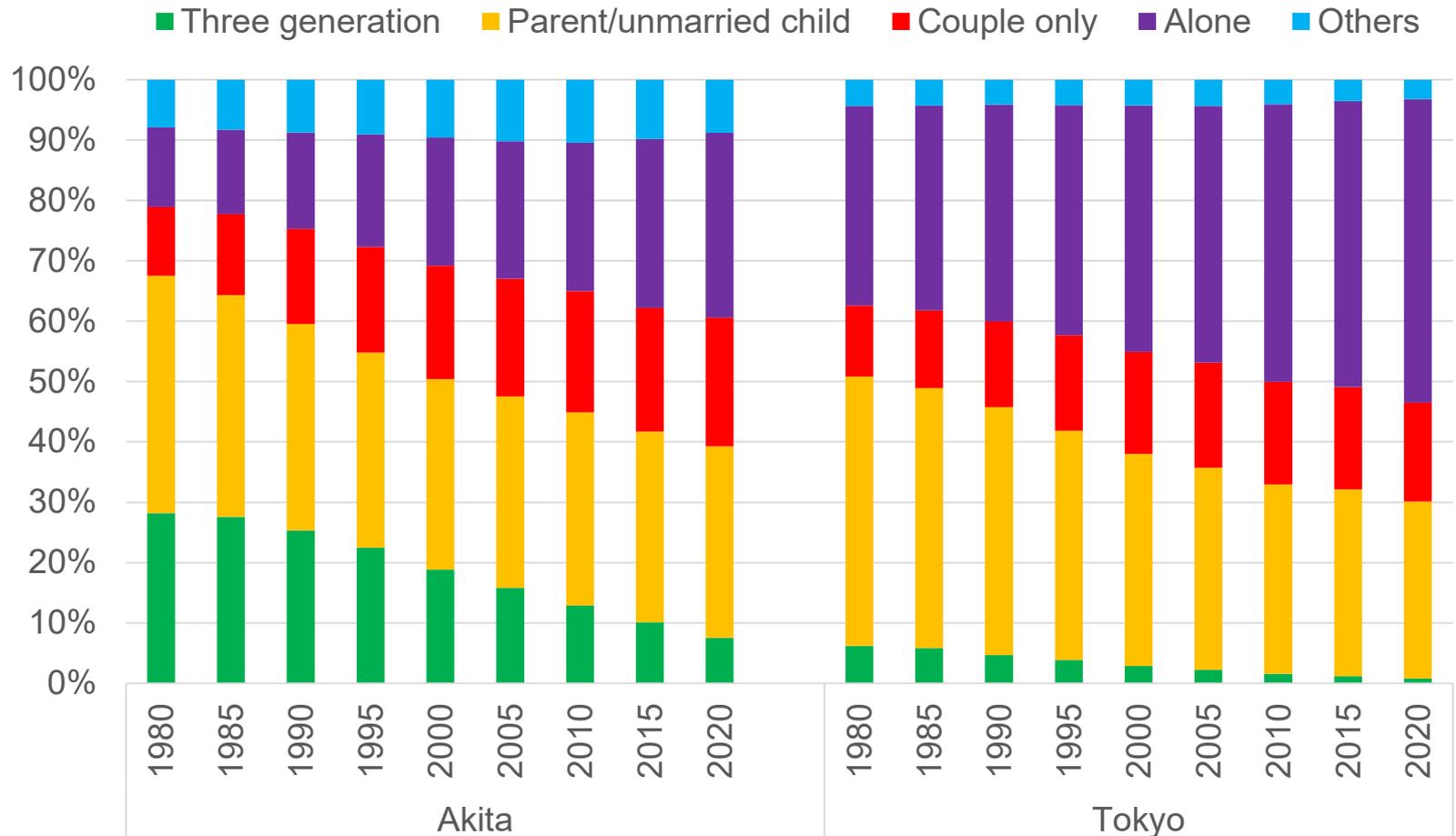
- Discord between mother-in-law & daughter-in-law
- Separation of households

→ Nostalgia won't work...

The Trend of Number of Households with Each Family Structure

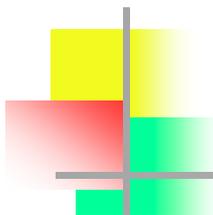


The Trend of % of Households in Akita and Tokyo



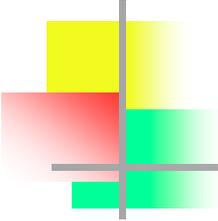
Development of welfare policies for the elderly

	Major topics	Aging	Major policies
60s	Beginning of welfare policies for the elderly	5.7% (1960)	1963 Act on Social Welfare Services for the Elderly <ul style="list-style-type: none"> ➤ Intensive care homes for the elderly created ➤ Legislation on home helpers for the elderly
70s	Expansion of healthcare expenditures for the elderly	7.1% (1970)	1973 Free healthcare for the elderly
80s	“Social hospitalization” and “bedridden elderly people” as social problems	9.1% (1980)	1982 Health and Medical Services Act for the Aged <ul style="list-style-type: none"> ➤ Adoption of the payment of co-payments for elderly healthcare, etc. 1989 Gold Plan (10-year strategy for the promotion of health and welfare for the elderly) <ul style="list-style-type: none"> ➤ Promotion of the urgent preparation of facilities and in-home welfare services
90s	Promotion of the Gold Plan	12.0% (1990)	1994 New Gold Plan (new 10-year strategy for the promotion of health and welfare for the elderly) <ul style="list-style-type: none"> ➤ Improvement of in-home long-term care
	Preparation for adoption of the Long-Term Care Insurance System	14.5% (1995)	1997 Long-Term Care Insurance Act
00s	Introduction of the Long-Term Care Insurance System	17.3% (2000)	2000 Long-Term Care Insurance System



Need for a New Health System for 2025 and 2040

- Mutual support in senior generation
 - Development of a new community with social capital
 - Integration of health/medical care with everyday life
- ➔ Community-based integrated care system (CBICS)



Long-term Care Insurance (LTCI)

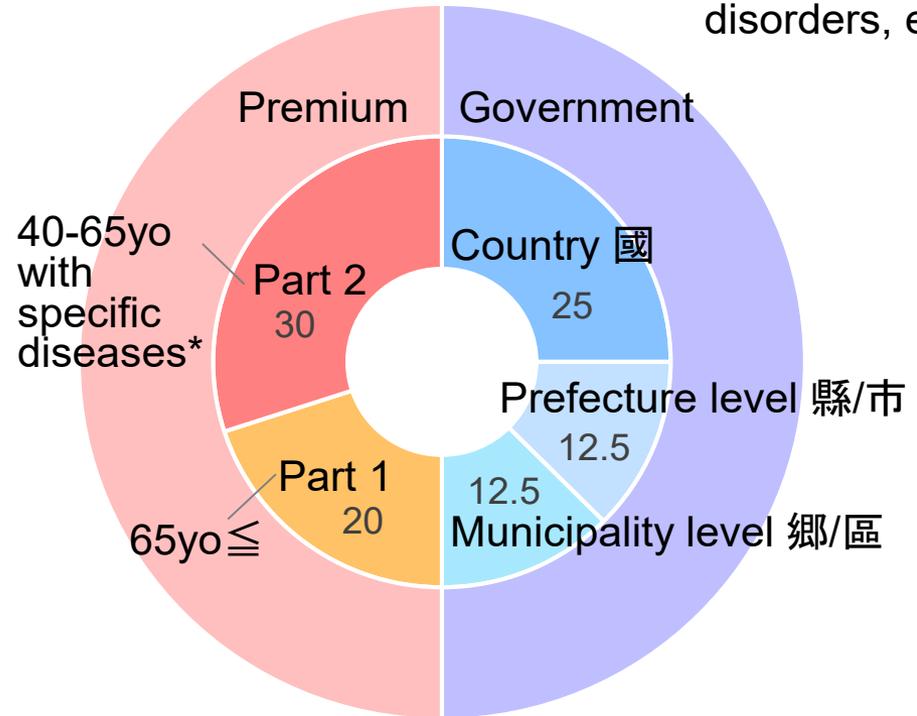
- Separation of elderly care from medical service
 - Pressure to decline length of hospital stay
- Socialization of elderly care
 - Reduce daughter-in-law's burden to care parents-in-law
 - More daughters-in-law started to work
- Introduced market mechanism
 - Private institutions allowed to provide services
 - Rich seniors can buy services with their own expenses

Structure of LTCI

*terminal cancer, neurological disorders, etc.



10-30% of the LTC cost



The rest of the LTC cost is reimbursed from LTCI

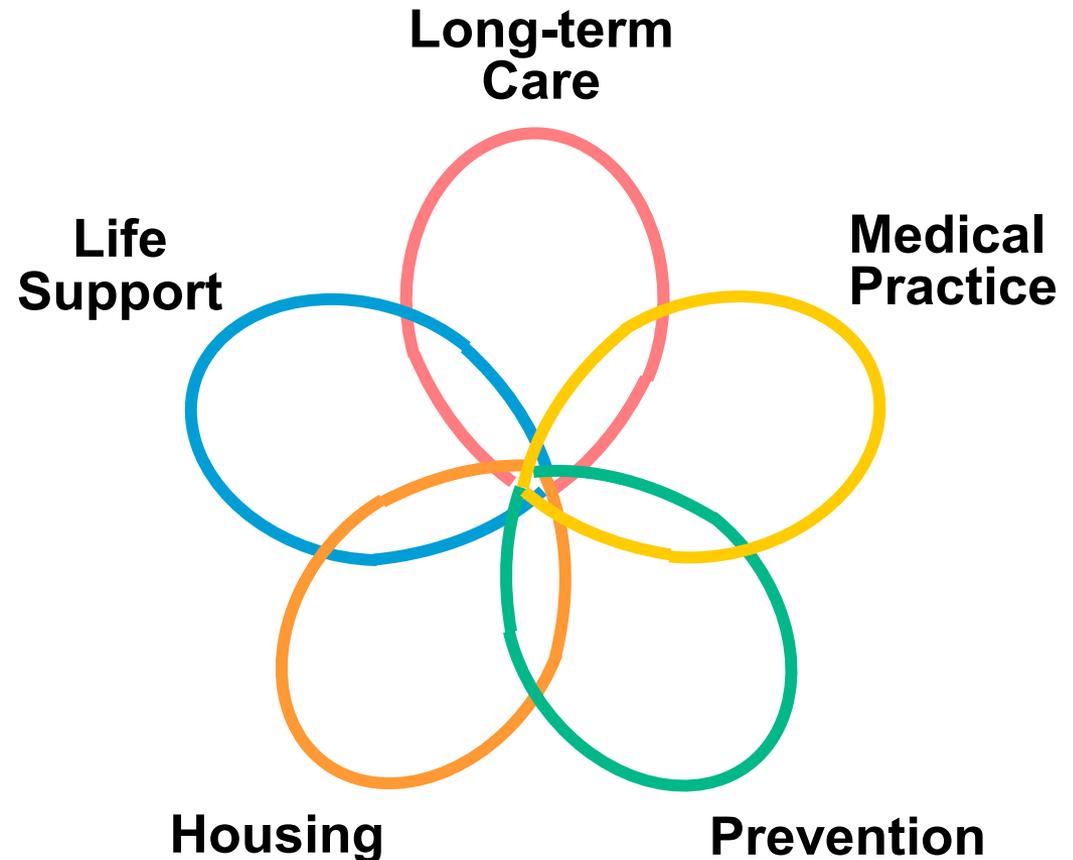


- **Benefit package**
 - Home-based care: care worker visit, nurse visit...
 - Facility-based care: nursing home, adult daycare (rehabilitation included)
 - 10% co-payment is applicable with upper limit, depending on nursing care level
- **Accreditation**
 - Standards for facilities
 - Guideline for human resources

Level	Service Fee Upper Limit
Support 1	50,320 JPY
Support 2	105,310 JPY
LT care 1	167,650 JPY
LT care 2	197,050 JPY
LT care 3	270,480 JPY
LT care 4	309,380 JPY
LT care 5	362,170 JPY

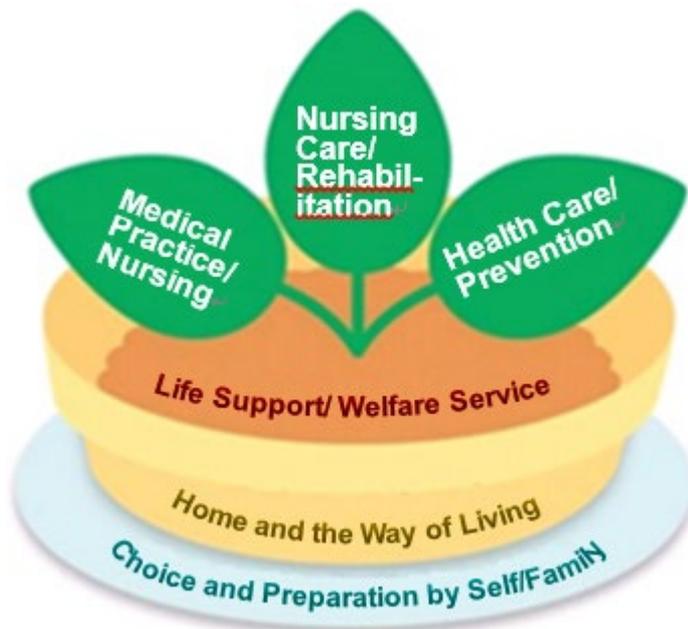
Model for CBCIS Flower by Five Rings (2008)

- For everyday living area equivalent to junior high school
- Professionals can arrive users at home in 30 mins



Flower Pot

2012 version



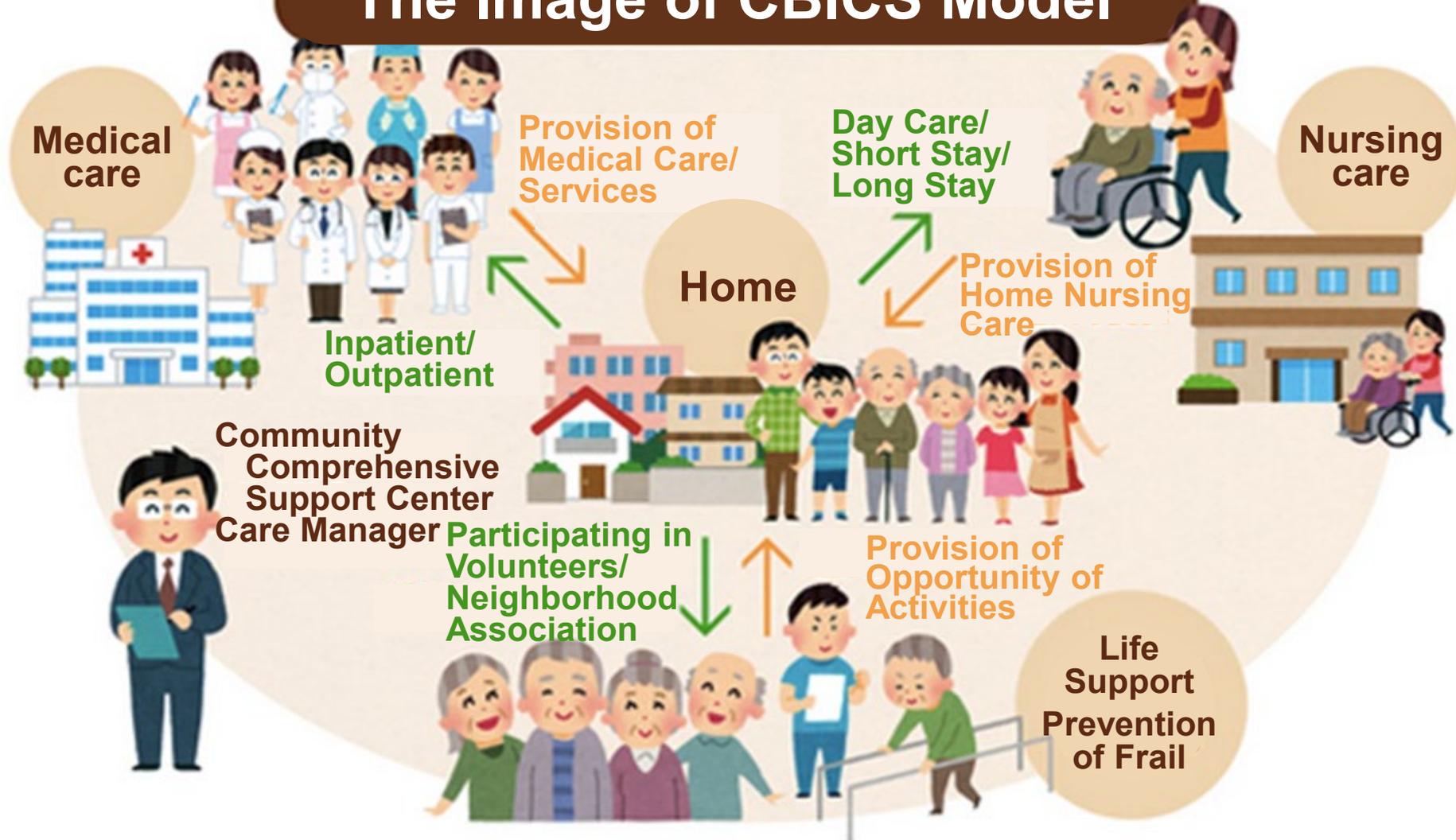
2015 version



- Nursing care prevention became a key phrase
- Self-choice is more emphasized

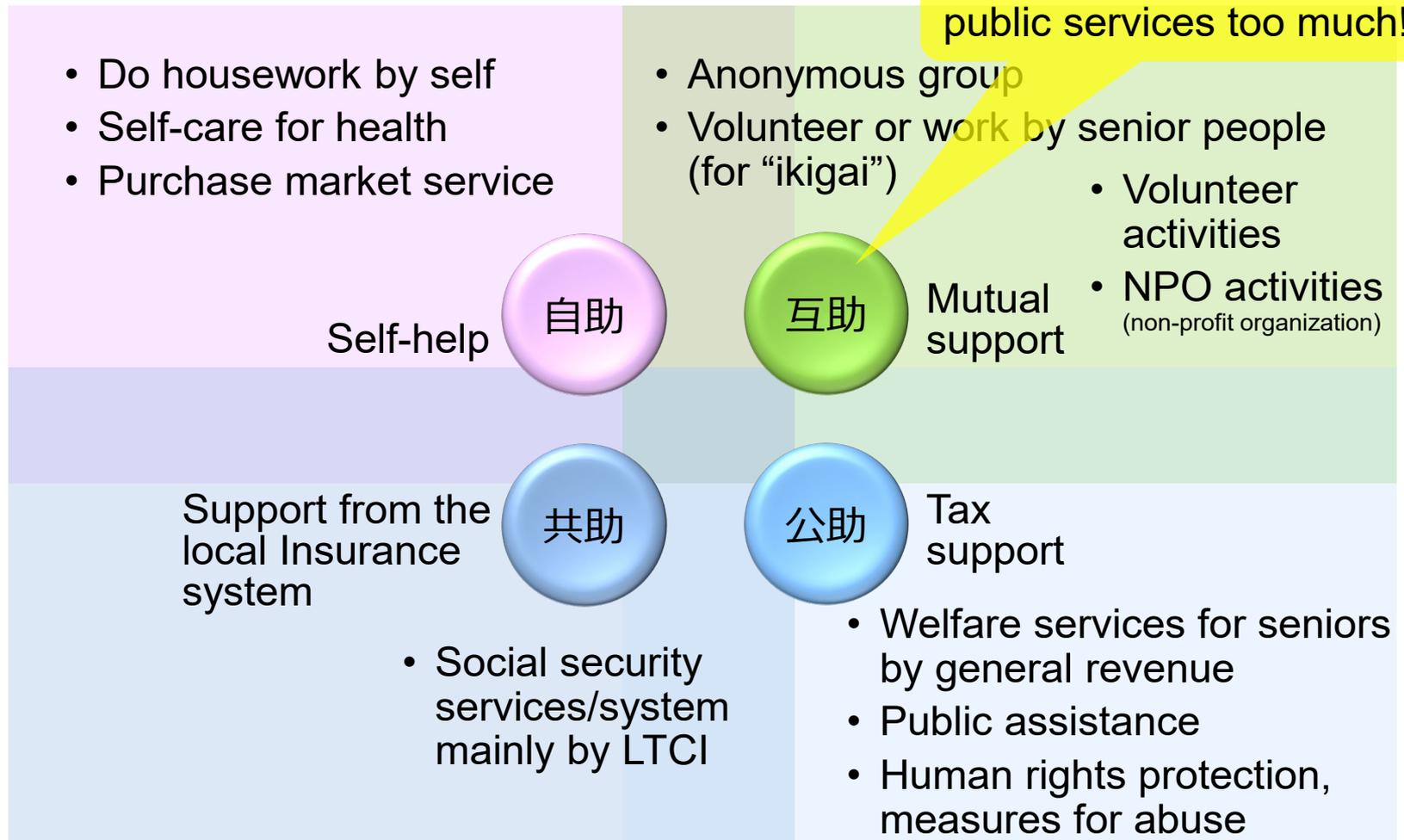
Whole Picture of CBICS Model

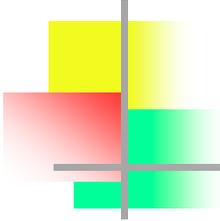
The Image of CBICS Model



Self-help, Mutual Support, LTCI and Tax Support

We should not depend on public services too much!





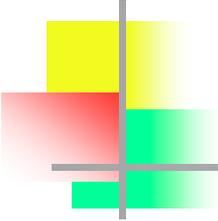
Key Professionals

- Home nurses
- Rehabilitation therapists: physical/ occupational/speech (PT, OT, ST)
- Care manager
- Home helper/Care worker

Home Nursing

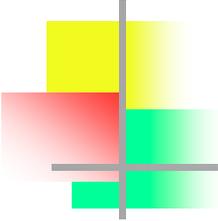


- Partly by health insurance, mainly by LTCI
- Observation of conditions, Patient guidance, Rehabilitation, Sanitization, Monitoring for drug therapy, Care for dementia/psychiatry problems, Nutritional/dietary care, Prevention/care for decubitus ulcer, Enema/Stool extraction, Airway aspiration, Management for bladder cath, Tubal feeding...
- Home nurses are more independent.



Home Nursing Station

- 46% is less than 5 members
- 24hr care is expected by users but it is hard for small station to apply for it
- Relatively healthy users tend to demand services from rehabilitation therapists
 - Some station has rehabilitation therapists for at-home rehabilitation



PT, OT, ST

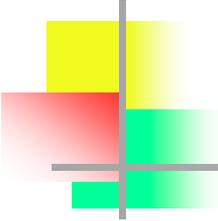
- Services by physical/ Occupational/Speech therapists are partly covered by health insurance but mostly by long-term care insurance
- Both assessment and therapy can be offered through the observation of life at home.



Care Manager (CM)

- Before LTCI is implemented, users are freely able to select long-term care services within the limit.
- However, it was difficult for users to select and order care services.
- Many helpers were upgraded to care manager.
- Some health professionals took certificate of CM but they do not work as CM because of lower income level.





Home helper/Care worker

- Settings
 - Home: Home helper
 - Facility: Care worker
- Nursing care
 - Physical nursing care – transfer, bathing, toileting
 - Life support – cleaning, food preparation, shopping
 - Recreation – exercise, games
- Issues
 - Low salary, physical labor, affective labor, harassment, foreign workers...



Community-based Integrative Support Center

- Members

- Community health nurse
- Chief care manager
- Social worker

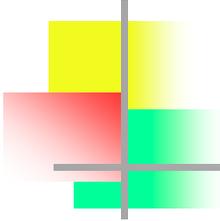
- Functions

- Construction of community network
 - Community care meeting: case/community study
- One-stop service counter for CBICS



- Functions (cont'd)
 - Advocacy for human rights
 - Elderly abuse
 - Adult guardianship: decision making by a third party
 - Support for care manager





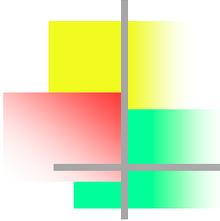
Long-term Care Facilities

- Home
 - Public
 - Care house
 - Private
 - Elderly housing with care services
 - Pay nursing home for healthy person
- Nursing care home
 - Public
 - Special nursing home
 - Geriatric Health Services facility
 - Group home (mainly for dementia persons)
 - Private
 - Pay nursing home

Difference in Facilities

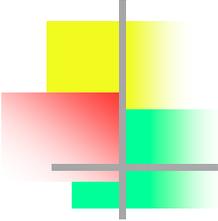


- “Home” is for more independent users, and “Nursing care ~” is for more dependent users
- Private ones are more expensive
 - Pay nursing home costs JPY150,000<
- Public ones are competitive but inexpensive
 - Some special nursing home has long list (e.g. 500)



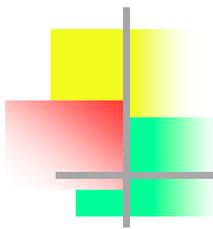
Interim Summary

- Dramatic changes in age groups is a catalyst to develop Japanese healthcare system.
- Professional members, insurance system, combination of home/facility/clinic/hospital care, etc. are the components for CBICS
- Preparing the mindset of nursing care users is the key to success of CBICS



How Should We Prepare Physicians for CBICS

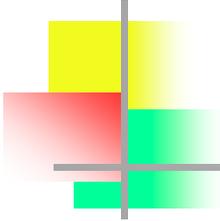
- Undergraduate (6 years)
- Initial postgraduate (2 years)
- Specialist ←————
 - General medicine (3 years) by JMSB (Japan Medical Specialty Board)
 - Family medicine (+1 year) by JPCA (Japan Primary Care Association)



History of General/Family Medicine Specialty Training

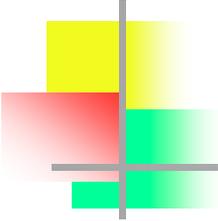
- 2006: Japan FM Academy started a program.
- 2010: Three societies of PC/FM/GM merged. Family medicine specialist program was continued.
- 2017: Japan Medical Specialty Board planned to start general medicine program (1 year delayed)
- 2020: Japan Primary Care Association launched a combined program of FM with GM

PC: primary care, FM: family medicine, GM: general medicine



Competencies for GM Specialist Program

1. Comprehensive integrated approach
 2. Ability to address common health problems
 3. Patient-centered medicine and care
 4. Interprofessional practice management
 5. Community-oriented approach
 6. Professional attitude to serve the public
 7. Ability to adapt to diverse practice settings
- FM specialist program also accepts these competencies but uses portfolio areas as more specific competencies.



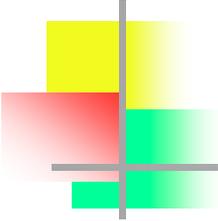
Typical Rotation

FM Specialist Exam

R4	FM Specialist Training 1 (in a clinic or a community hospital)		
	GM Specialist Exam		
R3	GM Specialist Training 2 (in GM/FM dept in a hospital) (also counted as FM Specialist Training 2)		
R2	Pediatrics	Emergency medicine	GM Specialist Training 1 (also counted as FM Specialist Training 1)
R1	Internal Medicine		

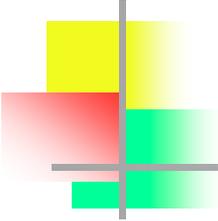
2-year mandatory initial training





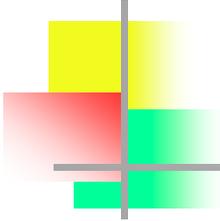
Workplace-based Assessment

- Checking of logbook – every mo
- 360-degree assessment – every 6mos
- Case-based discussion – every 3 mos
- Mini-CEX – every 6mos
- Video review – every 6 mos



Requirement for Completion

- Experience list must be filled 90%
- Record community activity
- Proof of academic activity
 - One paper/book chapter or three presentations
- Off-the-job training requirement
 - Clinical 36hr, Education 6hr, Research 6hr, Mgmt 6hr
- Submission of portfolio with 20 cases



What is Portfolio?

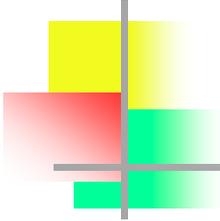
A learner experiences clinical practice.

He/She takes a record/log.

He/She accumulates the log and reorganizes it into the portfolio.

Portfolio conference is held for draft version of portfolio.

Learners finalize the portfolio for submission.

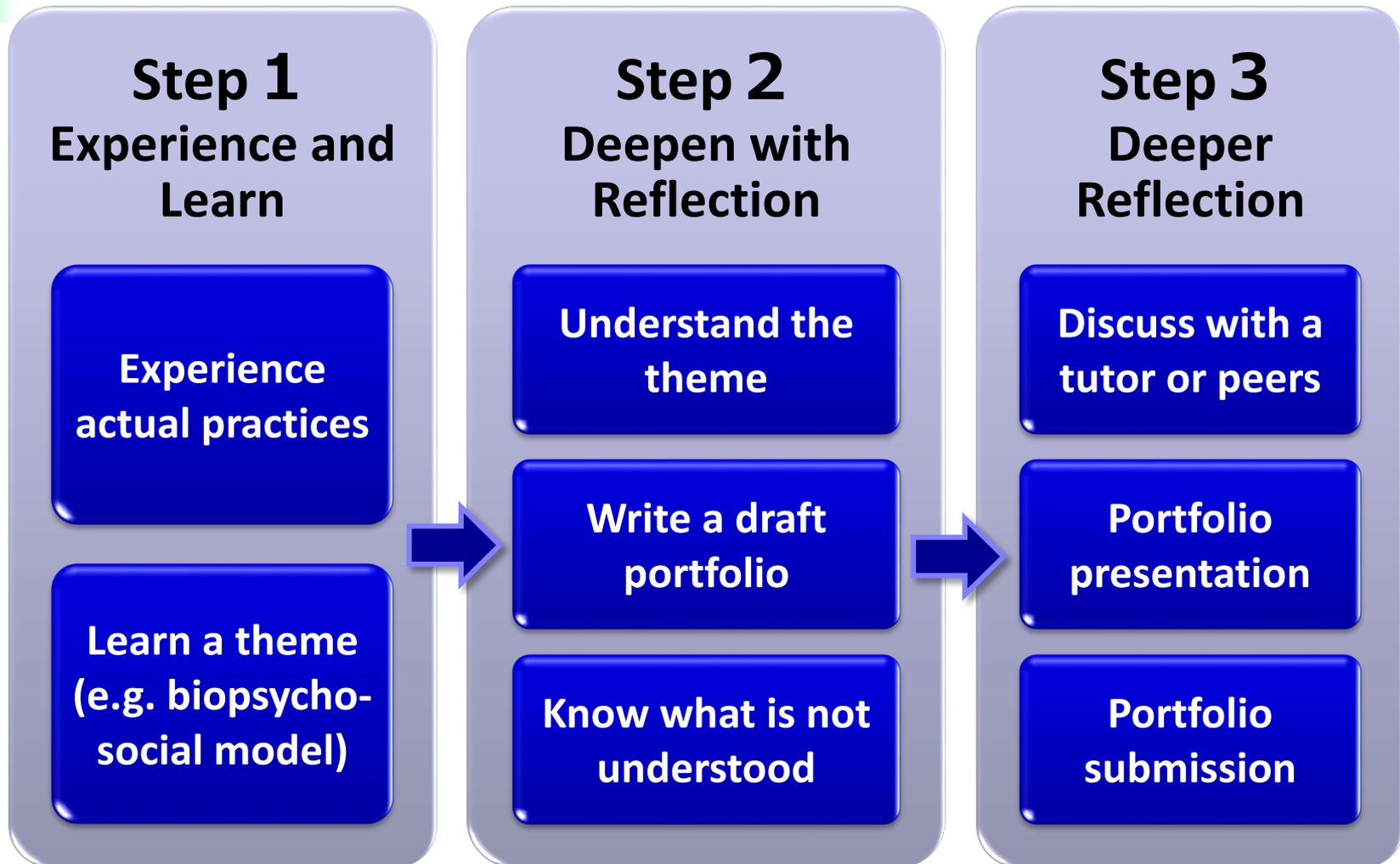


20 Areas for Portfolio

1. Undifferentiated health problems
2. Preventive medicine and health promotion
3. Chronic disease care
4. Multimorbidity
5. Care with continuity
6. Patient-centered care
7. Family-oriented care
8. Community-oriented approach
9. Disability and rehabilitation
10. Clinical education and teaching
11. practice of EBM
12. Transition of care
13. Systems-based practice
14. Mental health
15. Social determinants of health
16. Health care providers' own care
- 17a. Complex cases
- 17b. Integrated care
- 18a. Acting with high professionalism
- 18b. Ethically difficult decision cases
- 19a. Sexual health/gender sensitive care
- 19b. Adolescent care
- 20a. Palliative care
- 20b. End-of-life care

To sit in the board examination
all applicants must submit
detailed reports for all the areas

How to Deepen the Experiences



How To Learn Theoretical Framework

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基本研修ハンドブック

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基本研修ハンドブック

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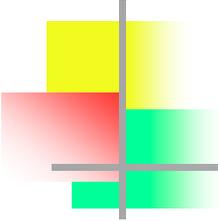


日本プライマリ・ケア連合学会
基本研修ハンドブック

改訂3版

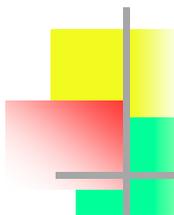
日本プライマリ・ケア連合学会 編





Board Examination

- Oral examination for portfolio
- Written examination
 - 200 MCQs
- Clinical skill assessment (OSCE)
 - 8 stations → 12 stations in 2025

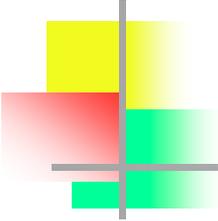


Reliability Coefficients

Assessment	4 Components	3 Components
CSA-ICE	0.64	0.75
CSA-CIS	0.54	
MCQ	0.69	0.69
Portfolio	0.88	0.88
Composite score	0.86	0.87

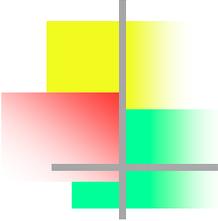
ICS: Integrated clinical encounter

CIS: Communication and interpersonal skills



Voices from Trainees

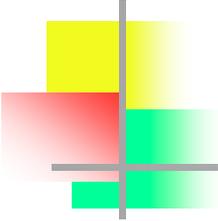
- To write portfolio is not easy
 - In the beginning, most residents don't know what to write because they have no basic understandings.
 - If they write a case, they slowly understand the principles/frameworks.
 - If they become confident in portfolio writing, many are satisfied with it.
- Some trainers are poor to teach portfolio writing
 - Such trainers don't know theoretical framework.
 - Their comments won't be helpful to revise the report.



Career After FM Specialists

- Clinical practice
 - Those in clinic or hospital are both 50%.
 - Their activities in CBICS are highly recognized.
- Academic institutions: university etc.
 - Working in education/research

The number of FM is not so expanded because FM specialist is not a certificate from Japan Medical Specialty Board



Wrap Up

- FM specialist program is targeted to actualize CBICS model.
- Competencies/experiences required to do CBICS and items of assessment have been specified in the program.
- Portfolio assessment is a key to enhance the teaching of CBICS.