Community Liaison Path for Stroke Rehabilitation in the Southern North-Tama, Tokyo

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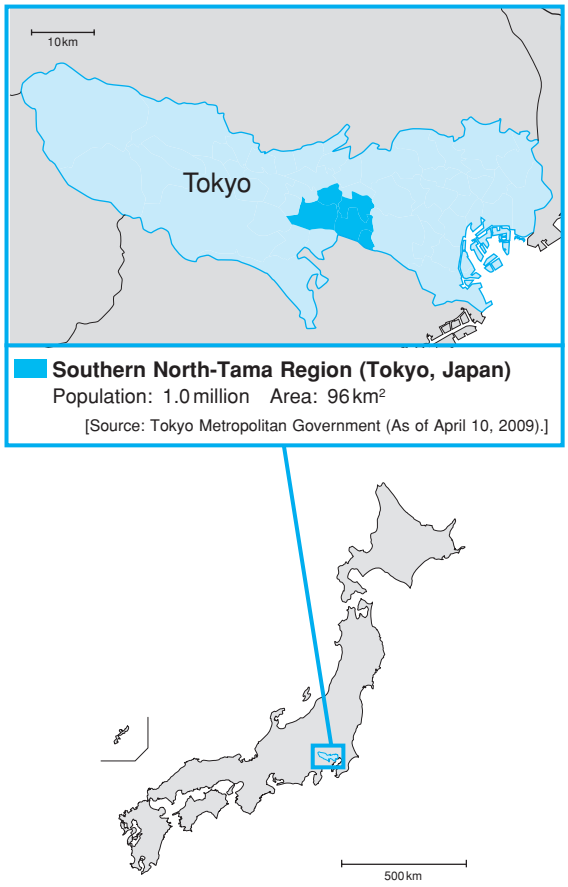
Abstract

The "Southern North-Tama Stroke Network Study Group" has been leading the efforts to enrich rehabilitation programs in the community liaison system for stroke for the southern North-Tama region (secondary medical district in Tokyo), as the most important task for the region based on a questionnaire survey. First, maintenance rehabilitation programs at long-term care facilities for the elderly were expanded and improved, and the establishment of convalescent rehabilitation wards has been promoted. In addition, the formation of community liaison path gave an opportunity to establish a self-contained liaison system from acute to convalescent, maintenance, and in-home care, in cooperation with municipal medical associations, administration, and public health centers in the region. For acute care facilities to fully satisfy their role, opinions of various facilities and professions that are beyond the framework of medical facilities should be condensed and reflected in a community liaison system, as well as planning rehabilitation programs with the consistent goal of achieving self-reliance in the convalescent stage and enriching patient support in the maintenance stage.

Key words Community liaison, Stroke rehabilitation



Introduction

Since 2000, efforts have been made to establish a self-contained liaison system in a suburb of Tokyo called the Musashino-Mitaka area. Through promotions of cooperation among nearby hospitals and facilities as well as municipal medical associations and local administrative agencies, a community liaison path for stoke in the southern North-Tama region was created in April 2008.

Although terms like *community healthcare* and *healthcare cooperation* are frequently used to refer to cooperation between medical institutions only, in the case of stroke care, the cooperation between medical institutions and non-medical parties, such as licensed care managers, long-term care facilities for the elderly, and local administrative agencies, is also imperative (**Fig. 1**) since the patients must live with residual disabilities for a long time.

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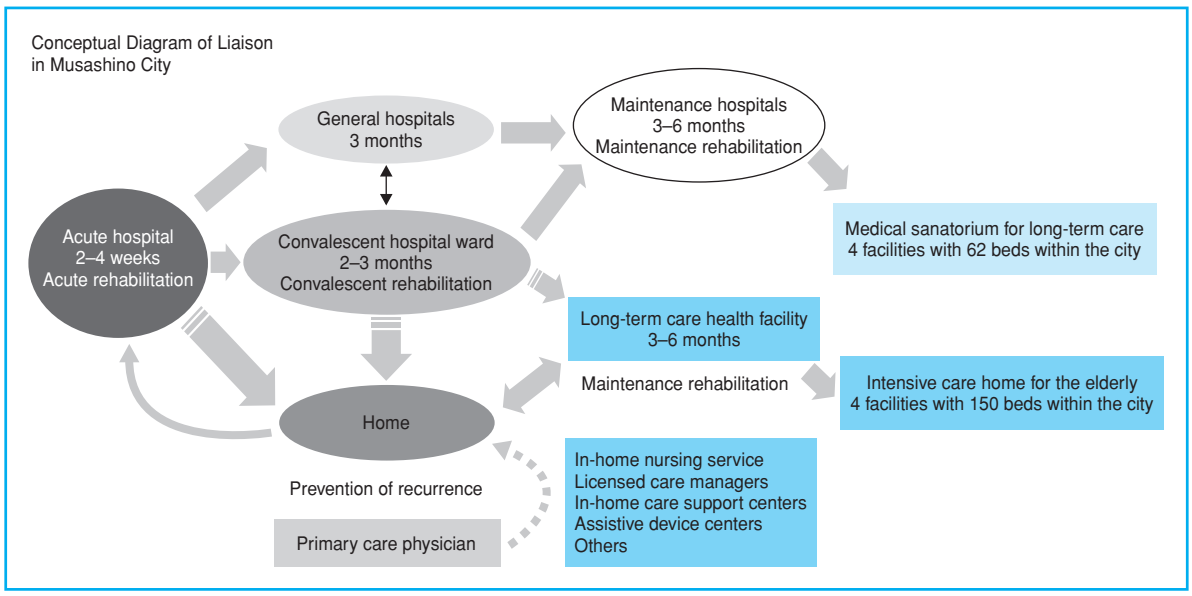

Fig. 1 Conceptual Diagram of Community Liaison in Musashino City, Tokyo (as of May 2006)

Table 1 The course of expansion and improvement of stroke rehabilitation services in the southern North-Tama region

2001	Establishment of Stroke Network Study Group
2003	Designations of regional rehabilitation support centers
2005	Opening of a maintenance rehabilitation facility: Mitaka Chuo Rehabilitation Care (newly opened)
2006	Opening of a convalescent rehabilitation ward: Musashino Yohwakai Hospital
2007	Opening of Musashino Red Cross Hospital Stroke Care Unit (SCU): 4 physical therapists and 2 occupational therapists assigned exclusively to SCU Upgrading and expansion of maintenance rehabilitation facility: renovation and staff expansion of House Green Park

Creating a Self-contained Community System for Stroke Care

The neurosurgery, neurology, and rehabilitation departments of four hospitals with emergency care units within the secondary medical district of the southern North-Tama took the central role in establishing the "Southern North-Tama Stroke Network Study Group" in 2001, which initiated activities to support rehabilitation programs at the local community level since 2003 based on the survey results on the current status of stroke cases. As the head of Department of Rehabilitation Medicine of Musashino Red Cross Hospital, I believed it was imperative to tie up with suitable hospitals and facilities in the same medical district in order for Musashino Red Cross Hospital to specialize in acute stroke care. With support of others who shared the same concept (see Acknowledgement), alliances were sought with hospitals specialized in convalescent care and long-term care facilities specialized in maintenance care.

The first alliance formed was with two long-term care facilities with reinforced rehabilitation services, one in each city of Musashino and Mitaka. Subsequently since 2006, new convalescent rehabilitation hospitals were gradually constructed in the medical district. In order to construct a liaison system encompassing the entire region, collaborative ties were also formed with local administrative agencies, municipal medical associations, long-term care insurance services, and public health centers in the region. In 2006, a Stroke

Table 2 Occupation-based Subcommittees (at the July 2007 meeting)

1) Hospital physicians 2) Nurses 3) Rehabilitation medical staffs 4) In-home care, municipal medical associations, and administrative agencies 5) MSW (medical social workers)	• Leader: President, Mitaka Medical Association • Subcommittee Members: (1) Directors in charge of in-home healthcare from local municipal medical associations (2) Physicians mainly involved in in-home healthcare (3) In-home nursing service (4) In-home care support centers (5) Administrative agencies in charge of welfare-related services
September–December (meetings twice a month): Discussions on styles and operations January–March: Trial operations	

Center was established at Kyorin University Hospital, and an SCU (stroke care unit) specializing in the intensive stroke treatment opened at Musashino Red Cross Hospital in 2007. Since the SCU at Musashino became operational after the establishment of convalescent-to-maintenance liaison system, Musashino Red Cross Hospital was also able to reduce the duration of hospitalization for stroke patients and secure sufficient number of hospital beds for emergency cases (**Table 1**).

A Consistent Rehabilitation Conceptual Design

Ideally, a rehabilitation program based on a uniform principle should be implemented continuously from the acute care at hospital to the in-home care. In the southern North-Tama, we were able to establish convalescent rehabilitation wards and long-term care facilities in cooperation with healthcare corporations that agreed with this conceptual design. Outpatients training in the maintenance stage as well as intensive training programs during short-term stays are particularly effective, which we were able to implement at long-term care facilities. Considering the importance of educating and securing physical therapists (PTs) and occupational therapists (OTs) who are responsible for implementing those training, we actively sought cooperation from vocational schools since 2006.

A "liaison" system must not be a one-way relegation of duties. We believed it was imperative to teach a collaborative approach to participants and prepare the environment that cultivates a desire for learning among young staff. As a system in which participants learns from practical experience, Department of Rehabilitation Medicine of Musashino Red Cross Hospital provides practical training programs as well as weekly joint workshops and case study meetings for full-time rehabilitation staff working at the collaborating hospitals and long-term care facilities. There are three hospitals and two long-term care facilities in collaboration, with over 80 registered rehabilitation staff in 2009. In the Musashino's programs, participants learn to face patients and their families while maintaining the principle of supporting their independence without forgetting to work on the self-mobility of patients at any occasions.

Creation of a Community Liaison Pathway

In 2007, Southern North-Tama Stroke Network Study Group held an Occupation-based Subcommittees meeting, which main issue was the support for patients living at home after being discharged from convalescent hospitals (**Table 2**). In this meeting, participants agreed that it was urgent to create the "In-home Care Support Path," with the Subcommittees of Home-care, Medical Associations, and Administrative Agencies being the leading force.

After approximately six months of deliberations, an information sheet to be used when patients are discharged from hospital (*Community Liaison Path: Form No. 3*) and a feedback sheet to provide information approximately six months after the discharge (*Community Liaison Path: Form No. 4*) were completed. **Tables 3 and 4** briefly show the purposes and operations of these plans. Furthermore, sections for explana-

Table 3 Purposes of the "In-home Care Support Path" (tentative name) (*Community Liaison Path: Form No. 3*)

- Information exchange in order to build good interrelationships between various institutions and professions
- Information sharing in order to connect hospital care and in-home care
- Hospital staff keeping in touch with in-home care supporters frequently
- Shift from medically oriented treatment plans to in-home care oriented plans
- Information exchange for advancing the patient to the next treatment stage without persistently maintaining treatment policies of the acute stage

Table 4 The operation of the "In-home Care Support Path" (tentative name) (*Community Liaison Path: Form No. 3*)

• Time	During consultation when a patient is discharged from a hospital to home
• Place	At a convalescent hospital when considering a discharge
• Occasions	When hospital staff is discussing in-home care services with a patient and the family members
• For	Patient and the family members, physicians, nurses, rehabilitation staff, member physicians of municipal medical associations, licensed care managers, etc.

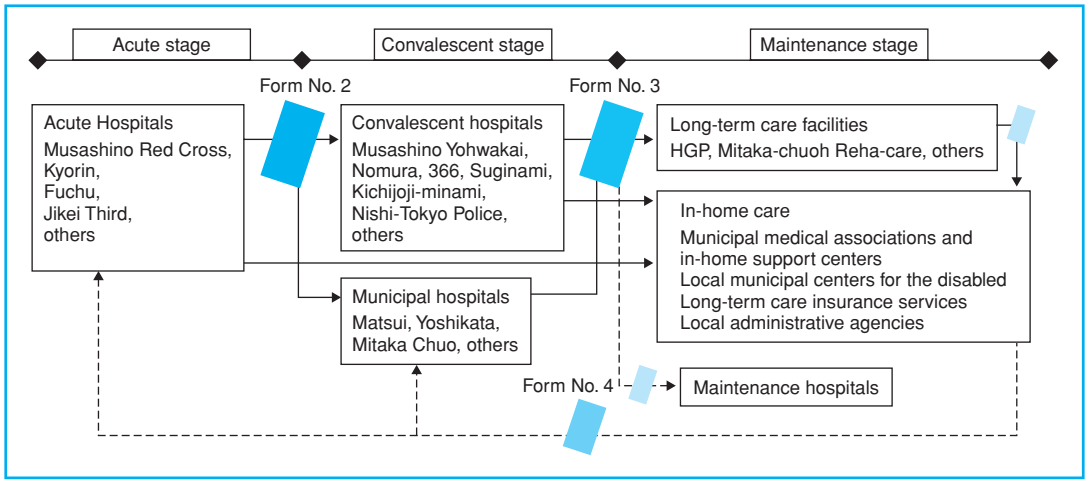

Fig. 2 The flow of the community liaison path in the southern North-Tama region (as of May 2008)

tions to patients and their families and their consent were added to the acute-to-convalescent liaison path (see *Community Liaison Path: Form No. 2*) that had been operated experimentally since 2006. Also, an overview of the critical pathway from the acute stage to in-home care was created (see *Community Liaison Path: Form No. 1*) and implemented in May 2008 as a self-contained community liaison path for the region (**Fig. 2**). For the details of the documents mentioned above (*Forms* 1 through 4), please refer to: *http://www.musashino.jrc.or.jp/renkei/path-nou.html* (in Japanese).

Characteristics of the Community Liaison Path of the Southern North-Tama Region

Most hospitals already have in-hospital paths in place. Because such paths vary among hospitals and facilities, concentrated efforts were made to put together the necessary information in the community liaison path. Priority was placed on information that accepting hospitals require, options were provided for items that need to be shared among multiple professions, and separate information sheets were prepared for items that

are useful for only certain occupations. The *Paths* #2, 3, and 4 are forms to provide explanations to patients and their families and obtain their consent. On each occasion of explanations, a physician is to specify what should be carried out and anything that must not be performed.

Requiring a receiving facility to follow treatment plans that proceed with certain temporal axis is merely arrogance on the part of a sending facility. Attempts for quality management and standardization themselves can impede collaboration and hinder willingness to join hands and work together. "Relegation" of duties that consist of unilateral information provision and cooperation is nothing more than "imposition." Requests that demand changes to the existing treatment system are not welcomed. Additionally, in creating a community liaison path that consider as far as in-home care, local administrative agencies and municipal medical associations need to work together as a team from the very beginning of a community liaison system.

The Necessity to Expand and Improve Community Liaison

In cases where rehabilitation is implemented during the acute stage, it is often possible to continue maintenance training for functional abilities during in-home care with relatively little difficulty. When convalescent rehabilitation brings a possibility for a patient to be able to live at home under the care of family members with the added assistance of public care services, it is important to establish an extended system where a patient can receive the training for home living at a convalescent hospital even if the patient's condition is serious. Rehabilitation time may not be as long as the hospital wards specialized in convalescent rehabilitation, but it is more desirable if patients could overcome the deterioration from complications and continue in-home care. In the future, more hospitals that have no rehabilitation wards are expected to join the liaison as collaborating hospitals to treat patients who do not qualify for rehabilitation.

Acknowledgements

In developing this community liaison system for the southern North-Tama region, I believe the advice by the late Dr. Shozo Miyake, former Director of Musashino Red Cross Hospital, has motivated many collaborators to join this project, which encouraged promoting collaboration in a "spirit of altruism." Additionally, I feel that the liaison system was only realized because of the tremendous understanding of the late Dr. Takaaki Kobayashi, former Director of the Musashino Yohwakai Hospital, in the field of rehabilitation medicine in convalescent and maintenance stages. I am also deeply grateful for the cooperation of the physicians, nurses, and rehabilitation staff of Musashino Red Cross Hospital, as well as many nurses and rehabilitation staff of collaborating hospitals and facilities, member physicians of each municipal medical associations involved, and local administrative agencies.

References

1. Primary Care Physician Handbook 2009. Tokyo: Tokyo Medical Association; 2009. p. 293–297. (in Japanese)