

Efforts of Medical Associations to Support Home Medical Care Services: Case of the Nagasaki City Medical Association*¹

JMAJ 58(1·2): 53-55, 2015

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Introduction

Through the Nagasaki Home Care Dr. Net (hereinafter referred to as “Dr. Net”) and OPTIM Project, the number of cases of patients being transferred from hospital to home care and the rate of patients dying at home in Nagasaki City have both increased, and regional medical collaboration is acknowledged to have made a huge step forward.

Nagasaki Home Care Dr. Net (“Dr. Net”)

Establishment and structure

In order for general clinics with outpatient facilities to undertake home care services, it is essential that the burden be reduced through mutual collaboration. The Dr. Net was launched in 2003 as an organization for promoting clinic-clinic collaboration. The network was created based on the idea of preventing patients from giving up on home care because no physician is available to oversee their care in cities where the number of clinics is large but the ratio of patients dying at home is low. In the case that a physician for home care cannot be found for a hospitalized patient who wishes to be cared for at home, the secretariat acts as a contact/liaison, introducing chief and sub-chief physicians to the hospital and patient. In concrete terms, coordinators located in 5 districts within Nagasaki City notify network members via mailing list regard-

ing information about the patient’s condition and the area where they are living—with all due care being given to the handling of personal information—and the both physicians are decided according to a “show of hands.”

The chief physician newly provides the sub-chief physician with the patient’s treatment information; the role of the sub-chief physician is to provide support should the need arise, and he/she does not carry out everyday home visits or visiting care. Since the sub-chief physician acts as back-up for the chief physician, the sense of burden for him/her is smaller and he/she is not inconvenienced. In addition to enabling 24-hour responses, the both physicians can also cover each other with their different areas of specialization. A questionnaire survey found that, although sub-chief physicians actually carried out home visits rarely, the existence of them gave the chief physician a sense of security.

Dr. Net was launched in 2003 with 13 physicians, and acquired a corporate status as specified nonprofit corporation in 2008, and then became an approved specified nonprofit corporation in 2010. Currently the network has more than 170 participating physicians, and it also doubles as a Nagasaki City Medical Association committee on home care.

Performance

As of December 2011, Dr. Net has been requested by hospitals to introduce a chief physician for

*¹ This article is a revised English version of a paper originally published in the Journal of the Japan Medical Association (Vol.142, No.7, 2013, pages 1552-1553).

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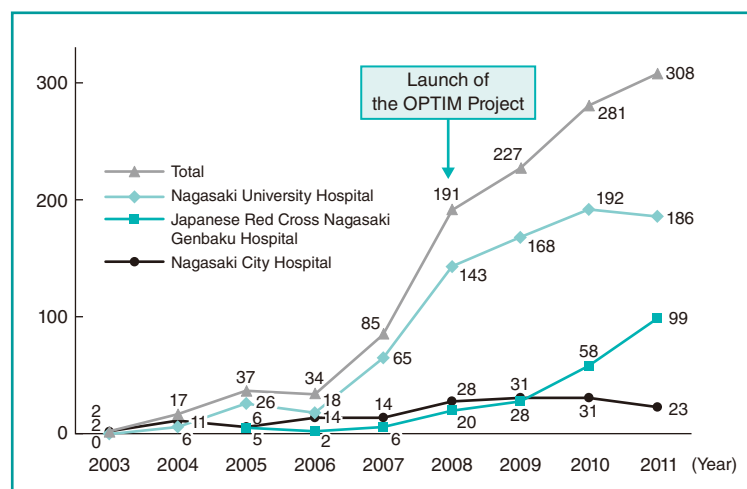


Fig. 1 Number of patients who began receiving visiting care after being discharged from a designated cancer care hospital in Nagasaki City (2003-2011)

home care in 549 cases.

The time required to decide on the chief and sub-chief physicians is 0.72 days on average, with 87% of the cases in 48 hours. Of the 435 cases that were possible to follow-up, the patient was deceased in 358 cases, and of these 185 patients had died at home (52% of all cases).

OPTIM Project

A regional project for spreading palliative care (Outreach Palliative care Trial of Integrated regional Model: “OPTIM Project”) was conducted over three years beginning in April 2008. The project comprised before-and-after research on regional intervention in four regions throughout Japan: Tsuruoka, Kashiwa, Hamamatsu, and Nagasaki. The research target was cancer patients; the main evaluation items were quality of care, number of time the patients used specialized palliative care services, and home death ratios. In each region, combined intervention was carried out based on four pillars: (1) Improvement of palliative care knowledge and skills; (2) Provision of appropriate information to cancer patients and their families; (3) Promotion of comprehensive coordination and collaboration regarding palliative care within the region (establishment of regional counseling offices, introduction of post-hospital discharge support/

liaison programs, regional multi-profession collaboration conferences); and (4) Provision of medical examinations and care by palliative care specialists.

Based on the results of a survey conducted after the intervention, medical welfare workers’ sense of difficulty regarding regional cooperation, support provided by specialists, and inter-profession communication were resolved by experiencing the value of the network and acquiring knowledge regarding palliative care. Comprehensive regional palliative care programs under the OPTIM project made it possible to construct regional networks—despite the fact that this did not accompany organizational changes in systems and structures—and not only increased medical welfare workers’ knowledge and reduced their sense of difficulty regarding palliative care, but also enabled patients to live where they desired, many of them at home. These results indicate that it is possible to indirectly improve the quality evaluation of palliative care by patients and their families and patients’ quality of life as well. Centered on the “Nagasaki Cancer Consultation and Support Center” established at the association, the Nagasaki City Medical Association had been carrying out palliative care education for city residents and health care professionals; functioning as a comprehensive counseling window and liaising/

coordinating between related organizations; providing support for patients discharged early from hospital; and promoting regional cooperation. Furthermore, nurses and clinic physicians involved in the project attended Designated Cancer Care Hospital conferences on palliative care and high-risk (considering not only cancer, but also other medical cases in which risk screening in hospital indicated problems for the patient to be transferred to home care), working with hospital staff to think of how to achieve smooth transitions to home care, and these efforts led to many cases of post-hospital discharge support.

Following the conclusion of the OPTIM Project, Nagasaki City established the *Nagasaki-shi Hokatsu Kea Machinnaka Launji* (“Nagasaki City Comprehensive Care Center-of-Town Lounge”) in April 2011 as a comprehensive counseling window providing a “healthcare support function”—which had been provided by the Nagasaki Cancer Consultation and Support Center—as well as a “comprehensive support function” for counseling regarding nursing and welfare to enable patients and their families to select a place for treatment with peace of mind. Operation of this facility has been delegated to the Nagasaki City Medical Association, and results are gradually being achieved.

Impact on Community Healthcare

The number of patients receiving visiting care after being discharged from Designated Cancer

Care Hospitals in Nagasaki has been increasing rapidly since 2008 (**Fig. 1**). Furthermore, the home death rate for Nagasaki City was 7.3% in 2005—the lowest in Nagasaki Prefecture—but by 2010 this figure has increased to 10.5%—propelling the city into 4th Place. Dr. Net and the OPTIM Project are believed to have played major roles in these changes. Dr. Net style clinic-clinic collaboration can also be applied in other cities where there is a sufficient number of clinics.

Conclusion

If face-to-face relationships such as Dr. Net and the OPTIM Project (promoting collaboration) are built up and education, edification, and support from specialists are incorporated, it is possible to construct a regional network that needs not accompany structural changes. In such cases, network-building is thought to be even more effective when carried out under medical association leadership. Expectations are held for the application of such networks for not only palliative care but also diabetes, CKD, and other medical conditions.

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