Long-term Care Insurance in Japan: How physicians are involved in providing rehabilitation for the elderly

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Abstract

For many years, ease of falling and fatigability are considered part of the aging process. However, it was recently revealed that with some training to increase musculoskeletal functions the elderly can improve in muscle strength. Accordingly, the national long-term care insurance in Japan, which takes effect after the day limit for rehabilitation expires under the national medical insurance, also emphasizes the principle of putting rehabilitation first. Under the national long-term care insurance in Japan, there are 2 types of rehabilitation services available: patients may either live at home or stay in a facility or hospital. The former type includes in-hospital/in-facility day care rehabilitation and home-visit rehabilitation, as well as individual rehabilitation programs available during short-stays at medical long-term care institutions and long-term care health facilities (also called "rehabilitation camp") that meet the insurance policy. On the other hand, the latter includes rehabilitation programs at medial long-term care institutions and long-term care health facilities. These rehabilitations covered by the long-term care insurance include not only physical rehabilitation but also address cognitive impairment, which is the major feature of the long-term care insurance. People who wish to apply for these rehabilitation services require prescriptions (or written instructions) by physicians in advance.

Key words Long-term care insurance, Rehabilitation, Day care rehabilitation, Home-visit rehabilitation, Elderly, In-hospital long-term care beds

Introduction

For many years, ease of falling and fatigability are simply considered part of the ageing process. However, clinical studies conducted in the early 1990's at nursing homes in the United States revealed that elderly people who received training to increase musculoskeletal functions can improve in muscle strength as well as the level of activity of daily living (ADL).[1,2] Since then, the methodology of geriatric rehabilitation has been actively discussed globally, and World Health Organization (WHO) announced the period of 10 years from 2000 as the "Bone and Joint Decade" and also proposed the "Move for Health" initiative since 2002. Fortunately in Japan, physicians play a major role in the long-term care insurance system. By increasing the number of physicians who share the "rehabilitation mind," I believe we physicians can improve the effectiveness of rehabilitation.

Roles of Rehabilitation Under the Long-term Care Insurance System

The long-term care insurance system in Japan is a national insurance policy for long-term care, but in principle it assumes putting rehabilitation first. In 2004, Elderly Rehabilitation Research Center pointed out certain problems with the rehabilitation services of the time, including: 1) sometimes a long-term rehabilitation program

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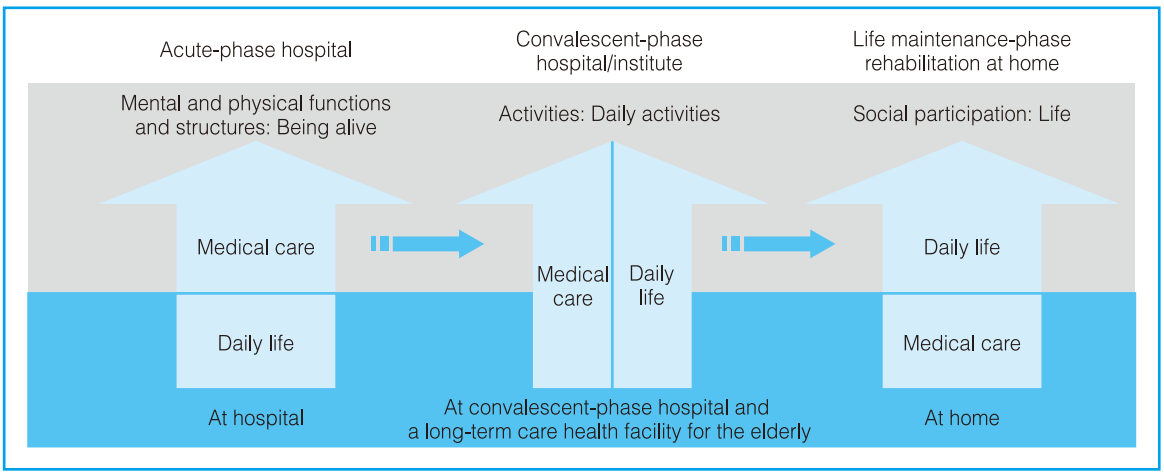

Fig. 1 Approaches to rehabilitation between medical insurance and long-term care insurance

When a patient who has developed acute disease is admitted to a hospital, the patient is often forced to forego visitors under the righteous cause of providing treatment and is severed from his/her familiar life. The rehabilitation provided there focuses on medical aspects to prevent disuse syndrome such as maintaining a range of motions. At convalescent-phase hospital and a long-term care health facility for the elderly, which exists halfway between hospital and home, the target is to have the patient return home and conduct rehabilitation for daily life functions of his/her living environment. Once the patient returns home, he/she is now a resident at home despite the inability he/she may suffer from the sequelae. Thus, people involved in medical care and rehabilitation of the patient must fulfill the role of supporting his/her domestic life behind the scenes so that the patient can fulfill his/her life goals.

with no evident results is continued, 2) the system that links medicine to long-term care is not functioning, and 3) rehabilitation at home is insufficient. Accordingly, Ministry of Health, Labour and Welfare of Japan (MHLW) established a limit to the total number of days eligible for rehabilitation services in the medical fee schedule based on the disease. MHLW is also facilitating the transition from medical insurance rehabilitation to long-term care insurance rehabilitation, and preparing the framework for a home rehabilitation system as well.

In rehabilitation services covered by medical insurance, they aim to improve the physical functions and ADL as swiftly as possible during the acute and convalescent phases, by sustaining or increasing mental and physical functions and taking advantage of remaining abilities effectively to maintain or improve the independent everyday life functions of an individual. When rehabilitation is not likely to improve the condition of the patient (meaning the patient truly needs long-term care), then the focus of his/her care plan will have to be placed on long-term care insurance services. However, if rehabilitation is likely to take an effect (temporarily in need of long-term care), it is advised to prioritize rehabilitation services (—the principle of putting rehabilitation first).

Those who receive long-term care often suffer both chronic disorder and life function impairments. Therefore, it is no exaggeration to say that the physician's involvement plays a critical role in the effective management of rehabilitation services.[3,4]

What is expected from a primary physician

Examine the patient's status in daily life

Elderly people can easily develop ADL disorders in eating, excretion, or bathing from a simple illness, immediately requiring social resources such as home care to support daily living. The supporting long term care staff are asked to play the role of a stage hand, helping the patient from behind the scenes (**Fig. 1**).

Ability to predict rehabilitation prognosis is questioned

Elderly people have various diseases and rehabilitation impeding factors in a complex and wide-ranging manner, so the exact problems in ADL need to be clarified. The ability to analyze movements can aid in adjusting the level of care

Fig. 2 Home care staff meeting

At the Hatano Rehabilitation Group (Hiroshima, Japan) facilities, a home care staff meeting is held every other Thursday from 13:30 to 15:00. The care manager in charge, who serves as the coordinator, collects information from the branches, set goals, and adjusts the rehabilitation services accordingly. This meeting is not like a top-down meeting that is commonly seen in acute care hospitals, in which a physician acts as the leader. Physicians participate in the meeting as a member of the same team, just as other staff of different professions do, and provide advice on cautions and contraindication regarding rehabilitation, nursing care, and long-term care.

and in making a prognosis to a certain degree, allowing the provision of precise rehabilitation instructions toward an independent and carefree life. Rather than starting from the negative perspective of looking at the disorders at issue, approaching the subject with a positive perspective that considers the remaining functions and potential abilities increases the effect of rehabilitation. Accumulating both the knowledge and experiences through real life situations nurtures a physician.

Become actively involved when completing the primary physician's written opinion form

When rehabilitation services under the long-term care insurance are expected to benefit a patient, then, the physician should enter the needs of in-hospital/in-facility day care rehabilitation (including those provided at care facilities) and/or home-visit rehabilitation in the space provided by stating the necessary services (the space for the medical management needs) in the primary physician's written opinion form. The physician should ask to be informed of the assessment result on the degree of care required, and make sure to check that the patient's care plan includes the rehabilitation services specified in the form. We physicians need to bear in mind that completing the written opinion form alone does not complete our work.

Participate in a home care staff meeting

The staff members in charge of rehabilitation services hold meetings to prepare care plans that allow the people in need of assistance to continue with their independent and dignified lives. Patients as well as their family members are encouraged to join these meetings as it gives the staff a chance to hear about their difficulties in everyday life and their goals in life. Participating in the planning of their own care plans and rehabilitation programs also has the effect of increasing their motivation. People in the at-home long-term care business ask for detailed medical information when they provide services. Physicians provide information, such as medical issues to be noted in everyday life, the need for rehabilitation service, and risk, contraindication, and prognosis of rehabilitation involved with providing rehabilitation. In my hospital, we hold a home care staff meeting on a bi-weekly basis (**Fig. 2**).

Rehabilitation Services Provided Under the Long-term Care Insurance System

Under the long-term care insurance system, a patient can receive rehabilitation services either at home or in a hospital or care facility.

In-hospital/in-facility day care rehabilitation (so called "day care rehabilitation")

The current systems are not fully prepared to smoothly transfer the patients from the medical insurance system to the long-term care insurance system when they require maintenance-phase rehabilitation. So, even when a patient exceeds the day limit eligibility for rehabilitation service provided under the medical insurance policy (180 days for cerebrovascular and other related diseases, 150 days for musculoskeletal rehabilitation), the patient can continue to receive rehabilitation for up to 13 units*2 for the first month and 7 units for the second month. In addition, the short-time day care rehabilitation service (1 to 2 hours) was emphasized in order to smoothly transfer the patients receiving in-hospital outpatient rehabilitation under the medical insurance to the rehabilitation services covered by the long-

*2 One unit means 20 minutes' rehabilitation service.

term care insurance. This was because the data show that the medical outpatient rehabilitation service users stay about 1 to 2 hours at a medical facility. Also, MHLW provisionally considers those medical institutions that offer rehabilitation services for cerebrovascular and other diseases and for musculoskeletal functions under the medical insurance coverage as running the outpatient rehabilitation business to prevent long-term care (—the so called "quasi-designation" by MHLW). In fact, the outpatient rehabilitation offered at care facilities is the service that represents the smooth transition from the medical insurance to the long-term care insurance.

People in need of daily life assistance first often use in-hospital or in-facility day care services rather than home-visit services. That is because the idea of having complete strangers inside their own home makes them uncomfortable. However, it is difficult to obtain information about the status of care they receive at home when they only use day care services. In order to obtain such information, the transportation staff who provide rides to and from a care facility or hospital need to read the facial expressions and greetings of the care givers at home and interpret their attitudes as they send off or welcome the person in need of care. Therefore, the staff members in charge of transportation must be perceptive enough to evaluate a lot from the little they see. If the transportation staff can enter inside the place of residence, it allows the observation of family relationships, living environment status, and sanitary condition of the rooms—the kind of information not available from just observing externally. Based on all that information, rehabilitation plans and care plans are prepared.

Because the day care rehabilitation is offered at medical institutions and facilities, their employers include not only physicians and nurses but also rehabilitation specialists, offering many functions to patients. The purposes of day care rehabilitation include: 1) medical management, 2) evaluation by rehabilitation specialists, 3) basic and practical movement training, 4) instrumental ADL training, 5) increasing stamina, 6) promotion of the acceptance of one's own disability (regaining the lost confidence), 7) advice on welfare equipment and appliances and their adjustment, 8) consultation for treatment, rehabilitation, and care (living environment at home, financial issues, etc.), 9) preventing social withdrawal and promoting social exchange and participation, and 10) palliative care. It is unfortunate that the difference between such day care rehabilitation and the day service, which any corporate body can provide, is still being questioned.

There are 3 different types of day care rehabilitation services based on the total number of visits per month on average. In the day care rehabilitation at a large-scale operation, people often imagine scenes of group care as resembling that of a shepherd giving orders to move a flock of sheep. On the other hand, a small-scale operation implies meeting individual needs and providing individualized care. At a Class II facility with over 900 cumulative uses each month, the fee schedule stipulated by MHLW for the long-term care is cheaper than that of a Class I operation with 751 to 900 users. Similarly, the fee schedule for a Class I facility is cheaper than that of the regular-sized operation with 750 or less users. This is because larger scale operation is more beneficial in terms of management efficiency.

Let me introduce my own experience of running a short-time day care rehabilitation service as an incorporated body. The benefits that users listed include: 1) provides the means of transportation, 2) allows the user to make good use of a day, 3) physically and mentally less strenuous, 4) only need to associate with certain individuals, and not have to engage in group activities, 5) still allows the users to receive service such as respite care services etc. On the other hand, some users have complained that the short-time service is not flexible, saying that it is only available during certain hours of the day and the length of stay is fixed. My staff have mentioned that there are people who do not want to start the regular day care rehabilitation since it takes up too much time, but the short-time day care rehabilitation service allows those people to start from the experience of the short-time stay and then switch to the regular type. For a corporate body, providing this short-time service requires more staff members and restricts the capacity of users because the time is limited. After 3 months of being released from a hospital or facility, over 13 units per month are not allowed to provide rehabilitation service. In order to effectively provide rehabilitation, possible options include encouraging multidisciplinary collaboration among vari-

ous professions, increasing the staff and providing more hours available for the service so that users can chose more freely, increasing the total number of use per user, and continuing with the respite care service immediately after completing the short-time rehabilitation.

Before the fee schedule for the long-term care was revised in FY 2009, only those living in the long-term care health facilities for the elderly who suffer mild cases of dementia were eligible for short-term intensive rehabilitation for dementia (so-called "dementia rehabilitation"). But after the revision, those who use day care rehabilitation service also became eligible, and the eligibility was also expanded to include moderate and severe dementia.

Home-visit rehabilitation

Achieving wonderful results in a hospital ward or a care facility in the convalescent-phase rehabilitation is like doing well in the pre-season games in professional baseball. The success in the pre-season games serves as the reference point, but it is the outcome of the pennant race that determines the players' lives. For a person in need of assistance, it is probably more important to have a good result in the rehabilitation at home (home-visit rehabilitation), where he/she feels more comfortable, than in the convalescent-phase hospital ward, since a good result from the home-visit rehabilitation allows the patients to maintain their own domestic life. The home-visit rehabilitation service provided by hospitals, clinics, and long-term care health facilities for the elderly has become more accessible, thanks to the "quasi-designation" by MHLW. However, it is still quite underutilized.

In-hospital rehabilitation has the benefit of having good risk management systems due to having physicians and other professions, and can be provided safely. However, the rehabilitation at home for a senior with any kind of risk means imposing a burden on the patient, and the patient is constantly surrounded by danger, often putting up a lone fight. Thus, the physician must write up rehabilitation risk management and contraindication in detail in the instruction sheet. Fortunately, MHLW announcement clearly states that the rehabilitation professionals are allowed to perform expectoration suction from April 2010, enabling them to promptly prevent an accident.

Of all the rehabilitation services offered under the long-term care insurance, the home-visit rehabilitation is used the least. There are some possible reasons for this. A patient often experiences reduced ADL and daily life functions due to a change in the environment when released from a hospital or care facility and moving back home, but the role and significance of the home-visit rehabilitation to address such issues are not well recognized. In addition, few rehabilitation businesses offer the home-visit service. It should be noted that the patients with the terminal phase of malignant tumor or other illness stipulated by the minister of MHLW receive their insurance benefit under the medical insurance, not the long-term care insurance.

Since the revision of FY 2009, the medical fee schedule encourages home-visit rehabilitation offered by "visiting nurse stations" (incorporated business operated by certified nurses and acknowledged by prefectural governments) under the category of Class 7 home-visit nursing, so home-visit rehabilitation in the form of Class 7 home nursing is rapidly increasing. Also, the managers of visiting nurse stations, which had to be either certified nurses or public health nurses, now include rehabilitation staff as well. Accordingly, the Japanese society for the promotion of home-visit rehabilitation (operated by Japan Physical Therapy Association, Japan Association of Occupational Therapists, and Japanese Association of Speech-Language-Hearing Therapists) is starting to hold seminars for home-visit rehabilitation managers to raise manager-class staff. In addition, the Japanese society for the home-visit rehabilitation study holds 12 home-visit rehabilitation seminars annually in various parts of Japan, trying to raise more home-rehabilitation staff. These three PT, OT, and ST associations have continuously submitted a petition concerning the establishment of home-visit rehabilitation stations, and it is currently under review.[5,6]

Long-term care health facilities for the elderly

There are about 3,500 long-term care health facilities for the elderly, whose objectives include the residents live independently according to their own abilities and are able to return home. Accordingly, those facilities are equipped to: 1) provide comprehensive care service, 2) provide rehabilitation service, 3) promote the residents to return home, 4) support their life at home after

being discharged, and 5) have strong bonds with the local communities. The multi-function long-term care health facilities are allowed to claim extra points on the medical fee schedule if a resident receives terminal care. But still, long-term care health facilities for the elderly are intended to return the residents' home and support their life at home, and therefore, the rehabilitation function of those facilities is expected to produce results. In that sense, long-term care health facilities are different from special nursing homes for the elderly. Since MHLW encourages reducing the number of days for hospital stays, the rehabilitation service offered at long-term care health facilities for the elderly now includes rehabilitation similar to a convalescent stage, but it mainly consists of rehabilitation programs for everyday life activities to promote the return home.

Incidentally, of the people admitted to the long-term care health facility for the elderly in my corporation in FY 2009, 58% moved in from their home, 32% were from medical institutions, and 9% were from other facilities (including other long-term care health facilities). As for the people who left, 54% went home, 30% moved to medical institutions (mostly through emergency transportation via ambulance), 12% went to other facilities, and 4% were others. These figures show that the rehabilitation service provided by long-term care health facilities for the elderly is fulfilling its role of promoting the return home. Recently, however, the conditions of the newly admitted people are becoming more severe with multiple disabilities, and the increase in dementia is producing more people who cannot easily return home. As a result, the average age of the residents is quickly rising to about 93 years old. Even under such situation, many long-term care health facilities are particular about fulfilling the original role of serving as an intermediary facility between a hospital and the return home.

As discharge and the return home becomes possible for a resident, rehabilitation specialists become more actively involved. Before leaving a long-term care health facility, the status of the domiciliary side receiving the resident needs to be evaluated, and the resident must be prepared accordingly. Releasing the resident without this process is like throwing a person needing care into the roaring waves of the Bering Sea from the tranquil beaches of the Aegean. Through pre-discharge visits, factors such as the living environment including welfare equipment/appliances, the ability to provide care including informal services, and the environment near home need to be evaluated, while considering how to support the independent life of the person requiring care and how to reduce the burden on the care givers. After making pre-discharge visits, a staff meeting consisting of a care manager, primary physician, and the staff from a home care business should be arranged to prepare the domiciliary side.

During the early phase after leaving a long-term care facility, the home-visiting rehabilitation from the facility should be reflected in the care plan to maintain everyday life. Long-term care facilities include many staff of various professions in the field of medicine and long-term care. I am hoping that long-term care health facilities will have a greater role to fulfill as the basis of the "comprehensive community care system," which has been proposed by MHLW as the goal to be materialized in Year 2025.

Long-term care medical facilities for the elderly

The long-term care medical treatment facilities are to be abolished in March 31, 2012, and long-term care medical facilities for the elderly are expected to fulfill their role. The national government has offered various incentives to make this transition as smooth as possible, but the transition is not progressing as much as it was initially hoped. These new types of facilities for the elderly are allowed to provide not only short intensive rehabilitation but also oral care maintenance and eating and swallowing therapy. In the clinic with inpatient beds under my corporation, there is a renovation plan to convert 15 long-term care medical facilities and 4 beds for general patients with public financial aid of 10 million yen (125,000 USD).*3 My clinic with inpatient beds is now specialized in medical rehabilitation and each inpatient is allowed to have 6 units rehabilitation per day. But most rehabilitation service will be greatly restricted to not exceed limited units per month once it is converted to a long-term care medical facility for the elderly. After the

*3 Yen/US dollar exchange rate: 1 US$≒80 yen.

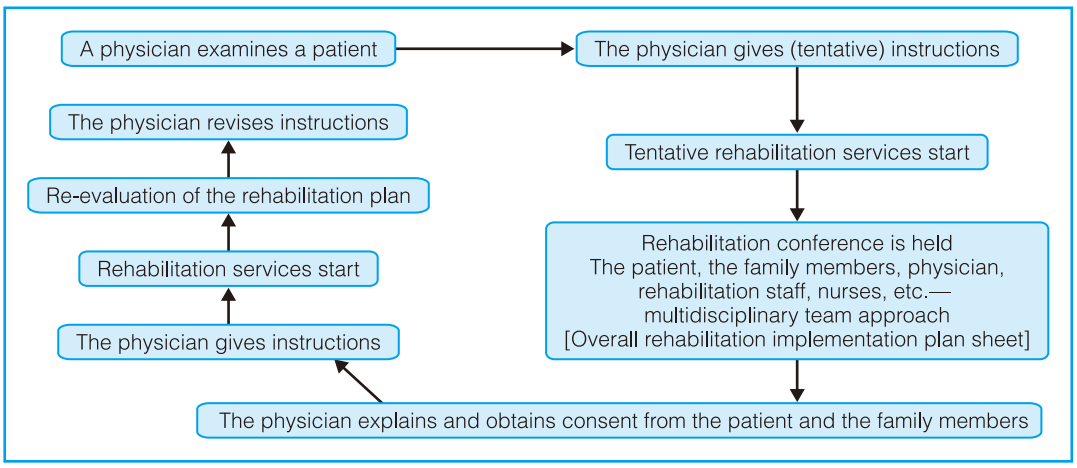

Fig. 3 The process of rehabilitation management
This diagram shows the series of steps involved in rehabilitation management. Rehabilitation becomes more effective when this process is repeated.

conversion, I am determined to further increase my effort to enable the residents to return home through rehabilitation.

Long-term care medical treatment facilities

The service time that can be added for providing short intensive rehabilitation (20 minutes each time) during the first 3 months of the hospital admission were increased, but because the patients using the medical treatment beds are long-stay patients, this newly available, well rewarded short intensive rehabilitation scheme cannot apply to almost all of them. If the medical treatment beds become actively involved in promoting the return home like long-term care health facilities, the current medical fee system will allow the medical treatment beds to fully provide sufficient rehabilitation service, providing benefits to both the residents and the facility owners.

Rehabilitation during the short-stay program for medical treatment and care

Long-term care health facilities, long-term care medical facilities, and clinics with inpatient beds can offer the short-stay program for medical treatment and care (typically called "short-stay"). It has long been pointed out that the patients using the short-stay program rapidly decrease in their ADL that they maintained at home. So, individual rehabilitation service was made available during the short-stay after the revision of FY 2009. People requiring assistance at home can take advantage of this system when their ADL decreases, by using this short-stay program for the purpose of rehabilitation and achieve recovery to continue their life at home (—the so-called "rehabilitation camp").

Furthermore, the special short-stay program for medical treatment and care (typically called "1-day short-stay") is also available only from long-term care health facilities. People requiring intensive care, such as the patients with terminal cancer or Parkinson's disease, are eligible for this service. This service is useful when such people are starting to live at home again after being discharged from hospital because it is difficult to tend to all the necessary care at home all at once for such people. The fee schedule is determined based on the hours of use, and the users can also receive individual rehabilitation. The function of this 1-day program is similar to that of day care rehabilitation, but the facilities can claim the added fee for providing transportation since it is a short-stay program.[7]

Various Additional Points Available on the Fee Schedule for Providing Rehabilitation Services

Additional fee for providing rehabilitation management (Fig. 3)

The aim is to clearly establish the short-term and long-term goals while considering the goals of

the patient, explain them to the patient, obtain the consent of the patient, and ask to sign on the rehabilitation implementation plan sheet. This plan sheet is to be shared by all staff members, and the physician will issue a new prescription based on this plan. The effectiveness of rehabilitation will be regularly evaluated, and if the rehabilitation plan is found to be ineffective it will be suspended or another meeting will be held to resolve the issue.

This series of the "plan-do-see" process is rehabilitation management, and a service provider can claim additional 2,300 yen (29 USD) per month on a monthly basis, only when the patient participates in the in-hospital/in-facility day care rehabilitation 4 days or more per month.

Additional fee for providing short-term intensive rehabilitation

After being discharged from a medical institution or facility where nursing and long-term care are available around the clock, the patient will go back home. Home was once a familiar environment, but now it is like entering a new living environment no matter how well the conditions are prepared. As a consequence, the patient often experiences reduced ADL. Therefore, the patient should undergo intensive rehabilitation from the beginning and prevent the lowering of the ADL and daily life functions. The first 3 months after being discharged from a facility or becoming eligible for long-term care insurance rehabilitation services provide high (fee) payment. However, rehabilitation that exceeds 3 months is considered sluggish and ineffective, providing only low payment. The first month especially provides high payment, reflecting the principle of "rehabilitation first." Physicians should also carry out this idea of the "rehabilitation first" principle when completing the primary physician's written opinion form or participating in home care staff meetings in order to enable the patients requiring assistance to become independent and continue with their life at home without anxiety.

Additional fee for providing short-term intensive rehabilitation for dementia

The methods for early detection of dementia include Revised Hasegawa Dementia Scale (HDS-R) and Mini-Mental State Examination (MMSE). After a definitive diagnosis of dementia is given, dementia rehabilitation can be prescribed only by psychiatrists, neurologists, and other physicians with proper training. Organizations such as Japan Association of Geriatric Health Services Facilities or Japan Association of Rehabilitation Hospital and Institution provide training sessions for this purpose.

A service provider may offer both dementia rehabilitation and short-term intensive rehabilitation and claim for additional fee for both services at the same time. The purposes of dementia rehabilitation include improving ADL, securing emotional stability, and controlling the progress of cognitive impairment. Toba[8–10] recommends taking an individualized approach after the patient's problems in everyday life have been clearly identified. A 20-minute rehabilitation provided by a PT, OT, ST, or physician is eligible for additional units under the long-term care fee. As the rehabilitation methods for dementia, Toba[8–10] proposes therapies such as exercise therapy, learning therapy, memory training, reality orientation training, and reminiscence therapy, as well as training care providers at home to cope with dementia patients' abnormal behaviors.

Conclusion

In order to prevent the state of requiring long-term care or the worsening of such state, promoting and propagating the WHO's "Move for Health" initiative is important. However, one's mind must be motivated first to move one's body. Rehabilitation is not to be provided passively; it is to come from one's willingness to rehabilitate. A target-oriented approach supporting the desires of the elderly in their lives is effective. All who are involved in providing care to the elderly—including physicians—must share the same understanding and support the lives of the elderly so that they can continue to live in the community respectfully and in their own way. All involved parties should follow through the principle of "rehabilitation first" as they start assistance.

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