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CONFERENCE ABSTRACT

Progress of Japan's community-based integrated care system for disaster response

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Introduction: The community-based integrated care system was introduced as a nationwide public service in Japan approximately ten years ago. The system has been focused mainly on cooperation between health care and social services. Combined services have been implemented in some "integrated care centers" to reach more areas of the population; not only the elderly, but also abused or neglected children; people with disabilities; and those with poor living standards. The centers became hubs connecting vulnerable citizens, and had a new role in community-based disaster responses.

Many municipalities in Asia-Pacific countries must prepare for and respond to natural disasters such as earthquakes and typhoons. It is critical that we plan for the evacuation and security of those who need assistance, by working with neighborhood associations; community social workers; nursing homes; welfare offices; and in-home care services; among others.

Methods: The survey was conducted by questionnaire, targeting all 2,013 community-based integrated care centers in Japan, with the approval of the Ethics Committee at Tohoku University. Participants were asked questions about the current status of disaster preparedness and response; and what problems need to be addressed in the future.

Results: There were responses from 1,101 community-based integrated care centers. The response rate was 54%. Eighty percent of the centers had a manual for disaster response. Only 10% had a Business Continuity Plan (BCP). One third had mobile phone and social networking site (SNS) plans for communication between staff members, and 22% had criteria for using the centers in cases of emergency. Approximately 30% of centers had no stockpiling. However, 21% had more stockpiling than they needed. Very few centers were collaborating with local medical institutions. More than half did not know about the community map indicating residents who need support in an emergency; although many had a medical and social care resource map. Staff at nearly 80% of the centers had never received training. The privacy protection law prohibited the team from obtaining precise information about the people who need the most support during disasters.

Discussion: There were significant differences in disaster preparedness plans among the centers. Plans varied depending on the priorities of each center's administration. Additionally, support services can be different depending on the type of disaster; i.e., an earthquake rather than a tsunami.

In particular, plans are needed for those requiring electricity to power respirators or at-home oxygen machines; and to operate electric vehicles. It is vital to collect data on vulnerable residents while

respecting privacy protection laws. It is also crucial that local organizations work together to create a map of each community's health and social care services.

Conclusion: This study shows the current status of community-based integrated care systems, and the problems that must be addressed in the future.

Limitation: The low response rate may be due to the fact that many centers are not currently considering disaster preparedness.

Suggestions for future research: Based on the current system for disaster response, it is necessary to add a community-based, integrated BCP to risk-management plans.