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The Role of Home-Based Care Managers in Japan: A study using home-based care management work hours and subjective evaluations

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Abstract

Surveys were conducted to study the role and function of care managers (CMs) in Japan's long-term care insurance system by examining work hours and subjective evaluations. Between October and December 2011, we used a self-report time study method with 745 CMs in 308 home-based care management agencies and received responses from 373 people in 153 businesses (50.1% response rate). By performing cluster analysis based on the values of necessity, burden, and achievement in the subjective evaluations of the CMs' duties, we were able to classify 16 duties into two groups; cluster 1 included conclusion of contracts, in-service/seminars, staff supervision, patients' rights advocacy, complaint resolution, direct/nursing care activities, quality improvement activities and facility administration-related activities, and cluster 2 included pre-admission consultations, assessment, care planning activities, team management, consultation, cooperation with the community, indirect care activities, and other. Cluster 2 had a greater rate of occurrence than cluster 1, and more time was spent on these duties. In addition, necessity was higher in cluster 2 than in cluster 1, although burden and achievement were lower. The duties in cluster 2 are consistent with the role of CMs required under the long-term care insurance system. Eleven years of practice have passed since the birth of care management along with the long-term care insurance system; CMs are recognizing the necessity of these duties as realities confronting them become apparent, and the CMs' role has been clarified.

The duty with the highest necessity and achievement was patients' rights advocacy. Complaint resolution had the highest burden. In terms of the CMs' role, the possibility of further proactive involvement in patients' rights advocacy and improving the ability to cope with complaint resolution could lead to a reduced burden on CMs.

Key words: care managers, working hours, necessity, burden, achievement

I. Introduction

According to the Annual Report on the Aging Society: 2014[1] problems of an aging society is expected to progress rapidly not only in developed regions such as Europe, North America, Japan, Australia, and New Zealand but also in developing regions such as Africa, Asia (outside of Japan), Central and South America, Melanesia, Micronesia, and Polynesia, making it a worldwide issue. Even among aging societies in developed regions, aging in Japan has progressed at a rate unseen elsewhere in the world. It is predicted that, in the future, aging will come in successive waves even in Asian countries, and in Korea in particular, aging is expected to progress at a rate to surpass Japan. Japan's knowledge of aging can be shared with other Asian countries that face a rapidly aging society in the future.

Included in this knowledge is Japan's long-term care insurance (LTCI), which served as a reference when Korea introduced insurance similar service. In Japan's LTCI, care managers (CMs) possess the skills and expertise to help individuals requiring care to sustain independent daily living and provides care suited to patients' physical and mental conditions.

Care management is a new job that was introduced to Japan in 2000 with the establishment of the long-term care insurance system. Most CMs are employed by nursing facilities or home-based care management (HBCM) agencies and fulfill different roles in these contexts. At nursing facilities, they create care plans to outline the nursing actions undertaken by the nursing staff (institutional care management), while at HBCM agencies, they act as liaison coordinators with government and several care services providers and provide support to provide in-home nursing services to those requiring nursing care (HBCM). In either case, they have an important role in Japan's LTCI. In 2025, however, the large population of "baby boomers" will be 75 or older, and in Japan, where the number of care

recipients is expected to increase, HBCM by CMs will take on even greater importance. Their role will become particularly important as more older adults live alone and it becomes more difficult for family caregivers to support older adult family members due to changes in family structures and the advancement of women in the workplace following economic growth.

Despite research in recent years has focused on the work/duties of HBCM, there are very few studies investigating necessity, satisfaction, and burden in the work of CMs. Therefore, this study focuses on HBCM and quantitatively visualizes and quantifies the various care management activities taking place at HBCM agencies. This study also aims to investigate CMs' function and role by looking at time spent by CMs on each care management activity and subjective evaluations of necessity, burden, and achievement.

II. Methods

The survey targeted 487 CMs from 141 HBCM agencies throughout the country, which agreed in advance to participate. In accordance with the population ratio, 248 CMs from 167 HBCM agencies were randomly selected across different prefectures from nursing care information published through the Welfare and Medical Service Network System (308 agencies and 745 CMS in total). From these, we received responses from 373 CMS at 153 agencies (50.1% response rate).

As shown in Table 1, 83.1% of the participants were female. The average age was 41.59 ± 9.58, with the largest group (32.2%) in their 50s. Total experience in health, medicine, and welfare fields was 174.31 ± 78.99 months, and 87.1% were full-time employees. For basic qualifications held as prerequisites, over half (54.7%) worked as nurses' assistants, such as home-helpers and certified care-workers, followed by social welfare professionals such as social workers (27.6%) and nursing professionals such as nurses and public health nurses (12.9%). For job title, general employees were

the most common at 58.2% followed by managers at 22.5% and supervisors at 8.6%. For highest education, technical college was most common at 28.2%, followed by four-year college at 25.2%, high school at 24.4%, and two-year college at 20.4%. The average number of assigned clients was 30.23 ± 11.12.

In the period from October 2011 to December 2011, participants could choose any two consecutive workdays at their discretion to participate in the survey. The survey request forms, survey guidelines, manual, anonymous self-report questionnaire, and return envelope were sent to the participants' workplaces.

We used a self-report time study method to investigate work contents and total time spent on work. Participants were asked how many minutes of every hour they spent on which duties and self-recorded the work contents and work time (minutes). We requested descriptions of work contents with as much detail as possible. Additionally, the participants referred to the manual's Residential Social Work Code[2] (Table 2) and entered the code that matched their recorded work contents. For necessity, burden, and achievement, the participants used a 5-point rating scale (1. none, 2. low, 3. moderate, 4. high, 5. very high) to evaluate each of the recorded duties on the questionnaire.

We used statistical analysis software (IBM SPSS Statistics ver. 21) for data analysis. For ethical considerations, an explanation of the survey contents was given in the request document, and questionnaire responses received directly from the participants were considered to constitute consent. On the questionnaire, consideration was given to avoid having individuals enter identifying information. During the data creation process, questionnaire contents were identified, digitized, and calculated/tallied, and adequate consideration was given so that facilities and individuals would not be identified.

Table 1. Respondents' attributes

Characteristics		Number(Percent)
Sex		
	Male	59(15.8)
	Female	310(83.1)
	Unknown	4(1.1)
Age		
	20-29 years	5(1.3)
	30-39 years	100(26.8)
	40-49 years	110(29.5)
	50-59 years	120(32.2)
	60-69 years	22(5.9)
	70-79 years	1(0.3)
	Unknown	15(4.0)
Total experience in health, medicine, and welfare		
	5-9 years	76(20.4)
	10-14 years	131(35.1)
	15-19 years	87(23.3)
	20-24 years	31(8.3)
	25-29 years	14(3.8)
	30 years and over	15(4.0)
	Unknown	19(5.1)
Employment status		
	Full-time	325(87.1)
	Part-time	42(11.3)
	Unknown	6(1.6)
Basic qualifications		
	Nurse's assistant	204(54.7)
	Nurse	48(12.9)
	Social services	103(27.6)
	Other	13(3.5)
	Unknown	5(1.3)
Job title		
	Management	84(22.5)
	Supervisor	32(8.6)
	Deputy chief, etc.	9(2.4)
	General employee	217(58.2)
	Other	16(4.3)
	Unknown	15(4.0)
Education		
	Junior high school	2(0.5)
	High school	91(24.4)
	Technical college	105(28.2)
	Two-year college	76(20.4)
	Four-year college	94(25.2)
	Unknown	5(1.3)
Average number of assigned clients		30.23±11.12

Table 2. Residential Social Work Code

Broad classification	Detailed classification
Pre-admission consultations	Conducting pre-admission consultations
	Conclusion of contracts, understanding wants and needs related to (entering) contracts
	Understanding the wants and needs of client
	Handling the wants and needs of clients
	Explaining to clients what cannot be handled/dealt with
	Other
Conclusion of contracts	Signing off on the conclusion of contracts
	Sharing methods related to the conclusion of contracts with related staff
	Providing information about and explaining important matters for the conclusion of contracts
	Other
Assessment	Assessment to understand clients' overall lifestyles
	Task analysis based on assessment
	Finding needs based on assessment
	Discharging planning assessment/evaluation
	Creation of assessment-related documents
	Other
Care planning activities	Creation of individual care plans in line with clients' physical/mental/social status
	Reflecting the clients' and families' desires in the care plans
	Creation of individual care plans from the viewpoint of middle- and long-term goals
	Creation of care plans with the aim of a return home
	Creation of care plans that take into account the client's potential
	Consent in writing regarding the care plan contents
	Monitoring
	Other
Team management	Participating in care conferences
	Planning and managing care conferences
	Planning staff meetings
	Managing staff meetings
	Planning and managing committees such as Business Improvement Study
	Coordinating and liaising with each job within the organization
	Other
In-service/ seminars	Planning trainings within the organization
	Implementing trainings within the organization
	Evaluating trainings within the organization
	Planning trainings outside the organization
	Implementing trainings outside the organization
	Evaluating trainings outside the organization
	Other
Staff supervision	Providing staff supervision
	Receiving staff supervision
	Management of duties through supervision
	Educating through supervision
	Self-awareness through supervision
	Other
Patients' rights advocacy	Activities related to patients' rights advocacy
	Reviewing the opinions and concerns of clients and family members, and feedback
	Protection of patients' rights and privacy
	Use of adult guardianship, community welfare, and patients' rights advocacy services
	Liaising/coordinating with guardians and agents/representatives (including family)
	Other
Complaint resolution	Receiving requests and complaints from clients and their families
	Managing requests/complaints and feedback
	Coordinating with third-party committees

	Other
Consultation	Responsibilities for financial, social, and psychological consultations
	Informing the availability of consultation
	Support for clients' self-determination
	Coordinating with interdisciplinary team members
	Coordinating with agencies outside the organization (and/or community)
	Privacy considerations
	Other
Direct/nursing care activities	Providing nursing and medical services
	Assistance in choosing palliative/terminal care providers and making decisions about health care
	Providing direct care based on care plans
	Assistance with eating
	Assistance with toileting
	Assistance with bathing, personal hygiene, and dressing
	Assistance with transfer to and from a wheelchair/bed, position change
	Providing direct care in response to behavioral problems
	Other
Quality improvement activities	Social support (including daily living, interpersonal relationships, and social skills training)
	Independent living support (assisting with laundry, cleaning, and organization)
	Efforts toward eliminating seclusion and restraint
	Encouraging participation in individual and group activities
	Assistance for enjoying luxury goods, reading newspapers/magazines, and communication with persons inside and outside the organization
	Providing assistance for the self-financial management
	Providing preventative care services (functional training, assistive device)
	Providing assistance with outings & medical visits
	Other
Facility administration-related activities	Informing the organization's philosophy and policies to the staff
	Informing the organization's philosophy and policies to the clients and their families
	Providing facility information through a variety of media
	Disclosure of all records pertaining to the client, such as clinical records, upon the request of clients and their family
	Developing a system for the occupational health and safety of staff
	Facility and equipment maintenance
	Developing disaster/emergency plan
	Administrative decision-making duties
	Other
Community cooperation	Coordinating with healthcare and welfare organizations and groups in the community
	Finding and developing social (informal) resources in the community
	Efforts to strengthen cooperation with the community
	Responding to the needs of local residents
	Renting facility space and equipment to the public
	Acceptance and cultivation of trainees
	Acceptance and cultivation of volunteers
	Acceptance and cultivation of welfare education (elementary and middle school students)
	Other
Indirect care activities	Creation of records and documents related to clients
	Creation of records and documents related to environment maintenance and cleaning
	Management of client funds
	Management of clients' belongings (including item purchasing)
	Activities/paperwork related to LTCI eligibility assessment
	Activities/paperwork related to LTCI billing
	Work assignment of staff members
	Arranging/providing transportation
	Other
Other	Activities related to clients
	Activities related to staff members
	Meal/ bathroom breaks
	Other

III. Results

1. Accumulated Work Time and Work Contents

Calculation of the average accumulated work time (minutes) in one day showed that the most time was spent on indirect care activities (174.78 ± 86.77 minutes). Care planning activities were second with 108.01 ± 74.21 minutes followed by consultation with 34.50 ± 40.65 minutes (Figure 1, Table 3).

Within the broad classification, the detailed classification reveals more specific work and actions. Among indirect care activities, the longest time was spent on "activities/paperwork related to LTCI eligibility assessment" followed by "creation of records and documents related to clients." Among care planning activities, the longest time was spent on "creation of individual care plans in line with clients' physical, mental, emotional and social health status" followed by "monitoring." Within consultation, the longest time was spent on "support for clients' self-determination" followed by "responsibilities for financial, social, and psychological consultations."

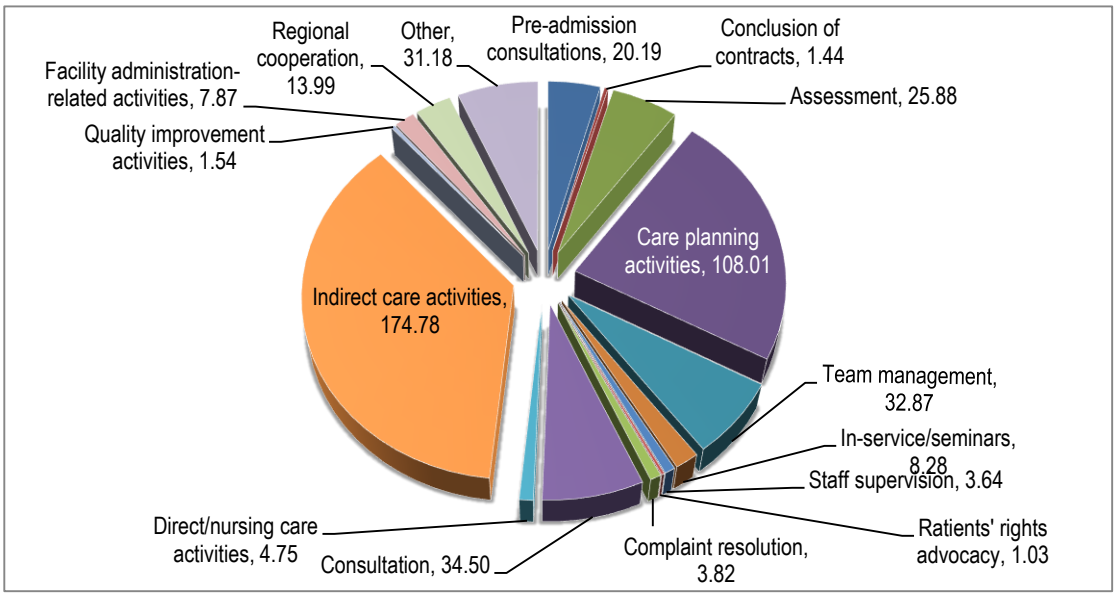

Figure 1. 1 Day's Average Accumulated Work Time (minutes)

Table 3. 1 Day's Average Accumulated Work Time (mean ± SD)

Broad classification	Accumulated work time mean ± SD
Pre-admission consultations	20.19±34.78
Conclusion of contracts	1.44±6.40
Assessment	25.88±35.15
Care planning activities	108.01±74.21
Team management	32.87±34.54
In-service/seminars	8.28±24.84
Staff supervision	3.64±14.30
Patients' rights advocacy	1.03±6.10
Complaint resolution	3.82±15.23
Consultation	34.50±40.65
Direct/nursing care activities	4.75±21.64
Indirect care activities	174.78±86.77
Quality improvement activities	1.54±8.68
Facility administration-related	7.87±29.14
Community cooperation	13.99±23.37
Other	31.18±48.22

2. Necessity, Burden, Achievement, and Work Contents

In order to understand the characteristics of care management work, we attempted to classify the 16 work contents. Based on the values of necessity, burden, and achievement, we performed cluster analysis using Ward's method and found two clusters for potential interpretation. The dendrogram is shown in Figure 2, and the work contents included in each cluster are shown in Figure 3.

Analysis was also performed to investigate the presence or absence of differences in necessity, burden, and achievement between the two clusters. A Mann-Whitney U test was performed for necessity and burden that Levene's test did not assume equality of variances (Table 4). Results showed a significant difference between cluster 1 and cluster 2 in necessity (U = 7183513, p < .001) and burden (U = 6628543, p < .001). Equality of variances was assumed for achievement, and one-way

analysis of variance was performed. Between the two clusters, a significant main effect was found in achievement, $F(1,16604) = 6.63$, $MSe = 1.385$, $p < .05$ (Table 5). For cluster 1, necessity was low, and burden and achievement were high; for cluster 2, necessity was high, and burden and achievement were low.

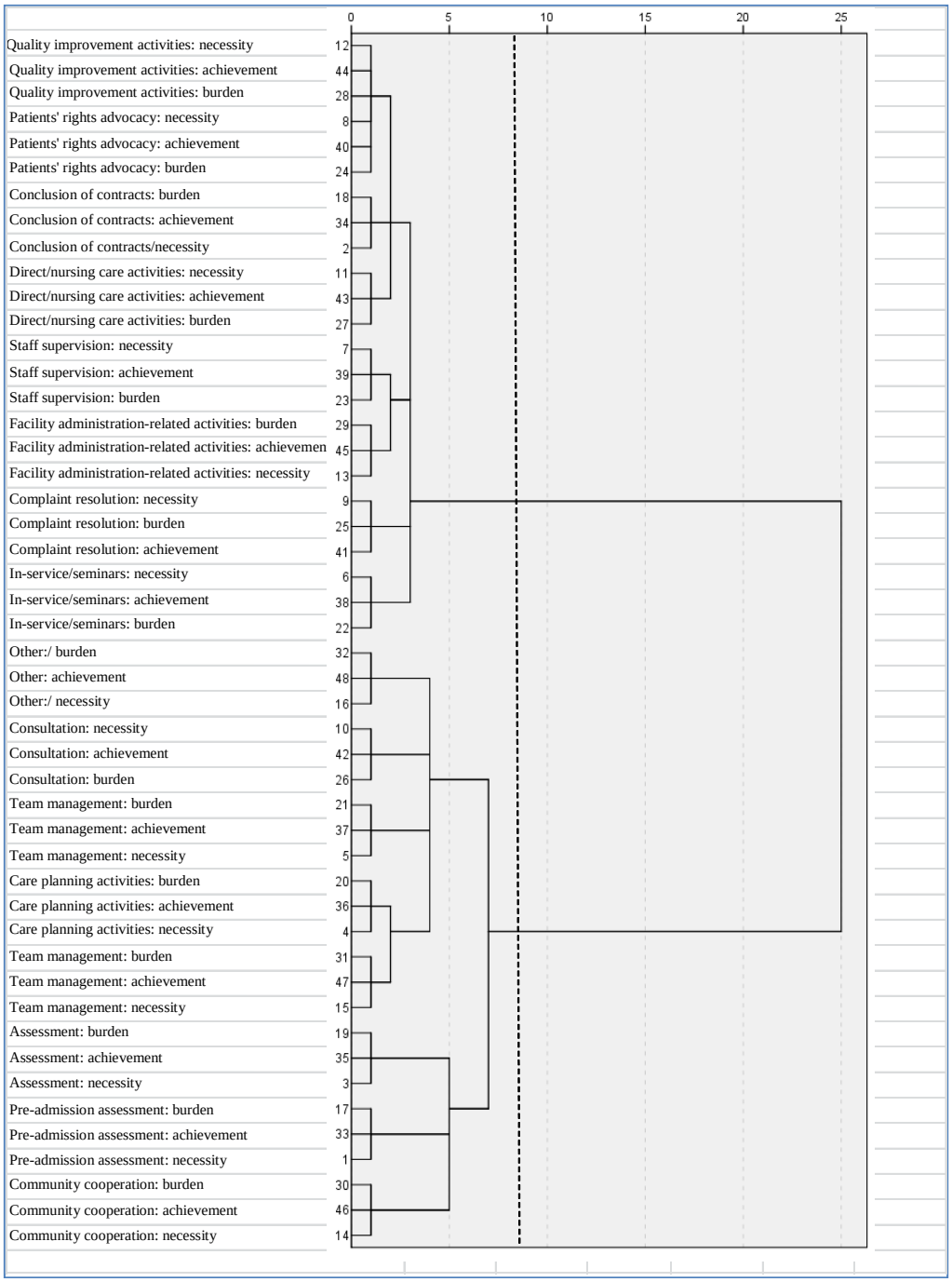

Figure 2. Dendrogram of Broad Work Classifications Based on Quality of Work

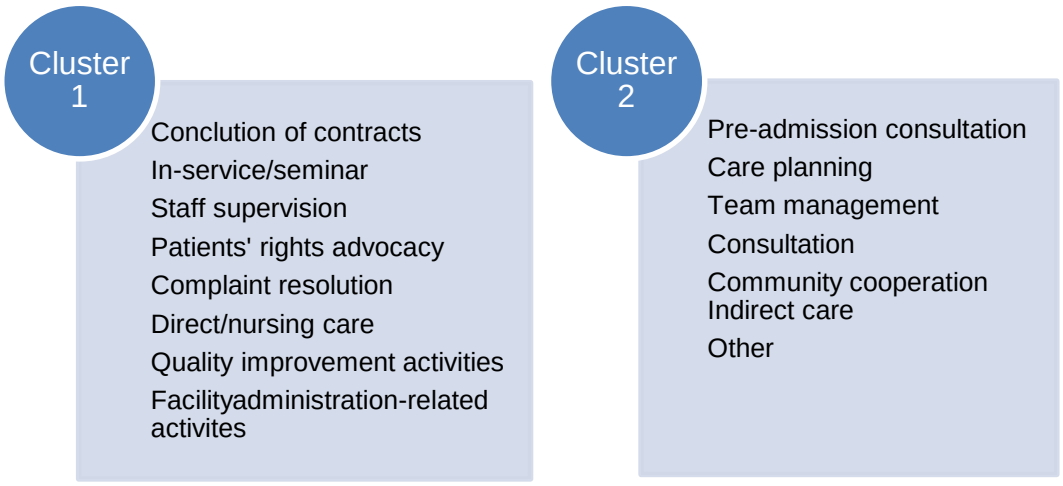

Figure 3. Broad work classification included in each cluster

3. Necessity, Burden, and Achievement for Each Work Content Area and Accumulated Work Time

Necessity, burden, and achievement for each of the 16 work content areas and the average accumulated work time in one day are shown in Table 6. The accumulated work time classified in cluster 1 tended to be shorter than that classified in cluster 2, and frequency of this work was also less than for that classified in cluster 2.

Table 4. Test Results for Necessity and Burden Differences Between Clusters

	Cluster 1		Cluster 2		Mann-Whitney U	Asymptotic significance probability (both sides)
	mean ± SD	median	mean ± SD	median		
Necessity	4.10 ± 1.12	5.00	4.23 ± 1.10	5.00	7183513.000	.000*
Burden	3.38 ± 1.15	3.00	3.08 ± 1.15	3.00	6628543.000	.000*
Achievement	3.42 ± 1.08	3.00	3.33 ± 1.18	3.00	—	—

***p* < .05

Table 5. Analysis of Variance Table for Achievement

Fluctuation Causes	Sum of Squares	Degree of Freedom	Mean Square	F-value	Significance Probability
Cluster	9.183	1	9.183	6.632	.010*
Error	22990.482	16604	1.385		
Overall	22999.665	16605			

*p < .05

Table 6. Necessity, Burden, Achievement for Each Broad Classification and Accumulated Work Time (minutes)

Broad Classification		Necessity	Burden	Achievement	Accumulated work time mean ± SD
Pre-admission assessment**	mean	4.42	3.22	3.51	20.19±34.78
	n	826	826	826	
	SD	0.87	1.03	0.93	
Conclusion of contracts*	mean	4.48	3.19	3.44	1.44±6.4
	n	52	52	52	
	SD	0.8	0.97	0.98	
Assessment**	mean	4.51	3.55	3.56	25.88±35.15
	n	760	760	760	
	SD	0.83	1	0.92	
Care planning activities**	mean	4.58	3.34	3.71	108.01±74.21
	n	3070	3070	3070	
	SD	0.74	0.96	0.93	
Team management**	mean	4.41	3.22	3.62	32.87±34.54
	n	1086	1086	1086	
	SD	0.85	1.12	0.99	
In-service/seminars*	mean	4.3	3.35	3.66	8.28±24.84
	n	165	165	165	
	SD	0.93	0.92	0.94	
Staff supervision*	mean	4.47	3.28	3.67	3.64±14.3
	n	132	132	132	
	SD	0.74	1.06	0.9	
Patients' rights advocacy*	mean	4.63	3.59	4	1.03±6.1
	n	41	41	41	
	SD	0.54	1.2	0.87	
Complaint resolution*	mean	4.43	3.73	3.29	3.82±15.23
	n	158	158	158	
	SD	0.91	1.06	1.1	
Consultation**	mean	4.46	3.19	3.61	34.5±40.65
	n	1627	1627	1627	
	SD	0.79	1.02	0.99	
Direct/nursing care activities*	mean	3.94	3.69	3.47	4.75±21.64
	n	132	132	132	
	SD	1.26	1	1.14	
Quality improvement activities*	mean	3.82	3.1	3.43	1.54±8.68
	n	51	51	51	
	SD	1.01	1.08	0.96	
Facility administration-related activities*	mean	3.55	3.14	3.11	7.87±29.14
	n	262	262	262	
	SD	1.33	1.39	1.18	
Community cooperation**	mean	4.27	3.06	3.37	13.99±23.37
	n	580	580	580	
	SD	0.96	1.04	1.02	
Indirect care activities**	mean	4	2.9	3.02	174.78±86.77
	n	6333	6333	6333	
	SD	1.29	1.25	1.33	
Other**	mean	3.85	2.73	3.01	31.18±48.22
	n	1331	1331	1331	
	SD	1.27	1.18	1.21	

* cluster 1
**cluster 2

IV. Discussion

This study focused quantitatively and qualitatively on HBCM, which is expected to diversify and become increasingly complex by 2025. We conducted a survey to clarify the function and role of CMs in the long-term care insurance system and were able to visualize subjective evaluations and total time spent on the 16 care management duties in HBCM agencies. Since this time-study was conducted for only 2 consecutive days, the time and pattern of activities may not be applicable to the other days of the week. However, this study gives useful information about how CMs of HBCM agencies spend their time and what role they play.

1. Indirect Care Activities, the Longest Accumulated Work Time

Indirect care activities occupied the greatest amount of work time in a single day (one third or more) among all CMs' duties. These indirect care activities are not classified as care management duties, but they include client-related duties that occur incidentally with care management duties (Table 2). Among these, the greatest amount of work time was spent on "LTCI eligibility assessment" followed by "creation of records and documents related to clients." Although Baba's[3] classification of work contents in her 2007 survey of care management work volume differed from that used in this study, she also found that the greatest percentage of work contents aligned with the creation, organization, and sending of records and documents and eligibility assessment, which is consistent with this study's findings. The CMs' role in maintaining client-related records and handling LTCI eligibility assessment has an extremely important position within the LTCI system. While, in principle, the government implements LTCI eligibility assessments, it is not uncommon for the implementation to be entrusted to HBCM agencies. CMs are sometimes, but not always, responsible for patients in need of care. It is

mandatory for insured persons to take the eligibility assessment in order to receive long-term care insurance services. Since insured persons may not be eligible for services or may be eligible for a limited number and amount of services depending on the results of the eligibility assessment, a considerable amount of time and energy is spent not only on performing eligibility assessments but also on developing questionnaires to use as materials during the assessment. Client-related records are indispensable for records of accumulated care and communication with clients, family, and related organizations. These are also documents providing reasons for the purchase of assistive device and home modifications. While CMs are naturally expected to create documents related to duties central to care management, such as assessment, creation of care plans, and monitoring, they are also asked to create numerous other client-related documents and records.

In this survey, indirect care activities was classified into cluster 2, and necessity was high for these, while burden and achievement were low. This suggests that, while these are not duties central to care management, they are being carried out with the understanding that they are necessary duties for CMs. In addition, since burden and achievement were not high, it is difficult to deem these duties as accompanied by a great sense of burden or achievement.

2. Care Management Duties as a Required Role

In the Long-Term Care Insurance Act, CMs are defined as individuals who possess specialized knowledge and skills necessary to help people needing care lead independent daily lives, provide consult for those in need of care, and organize communication between the government and service providers so that those needing care can access/utilize the appropriate services for their mental and physical conditions[4]. Within HBCM, CMs are expected to effectively combine services that meet the needs of those requiring care and their families and to provide support so they can utilize services as

well as act as team coordinators to support the daily lives of those in need of care and their families[5].

After indirect care activities, the duties taking up the next longest work time in a single day were "care planning activities," "consultation," "team management," "other", and "assessment." With the exception of "other," these occupied about 42% of work time and are major roles required of CMs. These duties were classified in cluster 2 and tended to have high necessity but low burden and achievement compared to cluster 1. These results confirm the expected role of CMs within the Long-Term Care Insurance Act from aspects of both work volume and recognition of necessity.

In a literature review of research papers during the two years since the start of the long-term care insurance system, Sakou et al.[6] indicate that the role and expertise of CMs is unclear. Kimura et al.[7] explain that there is a difference in the care management process depending on whether the understanding of a role is clear or unclear. Additionally, in interview with care providers, Yuhara et al.[8] found disappointment among care providers stemming from the fact that understanding of CMs' roles and scope of work was vague. Despite having qualifications positioned within the Long-Term Care Insurance Act and having a legally specified role, CMs' own lack of recognition of their role may impact care management. Furthermore, care providers' and the general public's lack of understanding regarding CMs' role potentially influences their relationship with CMs. Therefore, it is important that CMs practice while recognizing their professional roles to establish social status. The results from this study support that CMs are practicing care management with an explicit understanding of their role and may provide an evaluation of CMs.

3. CMs' Subjective Evaluations of Care Management Duties

From CMs' subjective evaluations, we were able to understand the characteristics/features of care management duties based on their relation to necessity, burden, and achievement. Median and average

values showed that an average tendency for a high degree of necessity was felt in both cluster 1 and cluster 2, and a medium level of burden and achievement was felt. With regard to the 16 duties, CMs generally felt a high degree of necessity and moderate burden and achievement.

In addition, we were able to classify the 16 duties into two groups. The duties classified in cluster 1 were: 1) conclusion of contracts, 2) in-service/seminars, 3) staff supervision, 4) patients' rights advocacy, 5) complaint resolution, 6) direct/nursing care activities, 7) quality improvement activities, and 8) facility administration-related activities. Cluster 1 duties occurred less frequently than cluster 2 duties, and less time was spent on them. Necessity was also lower in cluster 1 than in cluster 2, although burden and achievement were higher than cluster 2.

If we consider cluster 2 to be the main roles required of CMs, then we can say the duties in cluster 1 are those that support care management implementation.

4. Highest Necessity and Achievement - Patients' Rights Advocacy - and Highest Burden - Complaint Resolution

Looking at necessity, burden, and achievement within each of the 16 duties, we found necessity and achievement to be highest in patients' rights advocacy. A reason for this may be that, while care management is often not work that sees immediate physical and psychosocial changes in care service recipients, it is easy to see the results of their interventions for patients' rights advocacy, such as their dealings with abuse and adult guardianship. Therefore, evaluations of necessity and achievement were high.

According to 2012 survey results on older adult abuse,[9] there were 15,202 confirmed cases of abuse in Japan by caregivers such as family members, relatives, and live-in nurses/aides; 23,843 cases were reported to local authorities/municipalities. Of the people reporting these cases, 32% were CMs. The

top two factors for occurrence of abuse were “abusers’ disabilities or disease” and “abusers’ nursing-care fatigue and stress.” “Financial hardships in the home (financial problems)” was the next factor mentioned. “Unstable mental states of the abusers” was also seen as a factor for occurrence in 3.3% of the cases. As women’s social advancement progressed along with high economic growth, changes in family structure and societal/social roles appeared. The recession also had an effect. Kasuga[10] confirms that, since the era when the daughter-in-law shouldered the responsibility of nursing care, the number of cases of single children living with and caring for their parents is rising. Furthermore, the number of cases of mental and psychological problems and problems such as multiple debts among the generation of children now caring for older adults is also on the rise, making efforts to prevent abuse a crucial issue for the future. CMs, who go into homes and provide monitoring and consultation for care service recipients and their families, are well positioned to notice when older adults’ rights are being violated, and it is expected that they will be actively involved in patients’ rights advocacy in the future.

Burden, however, was found to be highest in complaint resolution. There are considered to be at least two types of complaints: those about the CMs themselves and those about service providers. In either case, they are stressful for the person hearing the complaints and are sometimes difficult to resolve. CMs’ evaluation of burden in complaint resolution is thought to be high for this reason. However, this cannot be taken lightly, as responses to care service recipients’ complaints are associated with improvement of their quality of life and the quality of care provided to them. In the future, it will be important to lower the burden associated with complaint resolution and be able to appropriately handle complaints from care service recipients.

V. Summary

The self-report time study was conducted to investigate work time and subjective features of the role of CMs in Japan's long-term care insurance system. Among the 16 work duties, the main roles required of CMs—care planning activities, consultation, team management, and assessment—occupied more than two-fifths of work time. We were also able to classify the CMs' 16 work duties into two groups. Conclusion of contracts, in-service/seminars, staff supervision, patients' rights advocacy, and others were included in cluster 1, and pre-admission consultations, assessment, care planning activities, and others were included in cluster 2. Cluster 2 duties appeared more frequently, and more time was spent on them compared to those in cluster 1. Moreover, necessity was higher in cluster 2 than in cluster 1, although burden and achievement were lower. The duties in cluster 2 conformed to the role of CMs as required by the long-term care insurance system. In sum, 13 years of practice has passed since the birth of the care management along with the long-term care insurance system, and CMs have come to recognize the necessity of this work. The realities facing their work have come to light, and it is thought that their role has become clarified.

In addition, the duty with the highest necessity and achievement was patients' rights advocacy. The duty with the highest burden was complaint resolution. In terms of the CMs' role, further active involvement in patients' rights advocacy and improving the ability to cope with complaint resolution could lead to a reduced burden on CMs.

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