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Editorial

Concrete Steps Toward Academic Medicine in Long Term Care

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Over the past 5 years, many articles have been published about the role of nursing home (NH) physician specialists in the quality of medical care in long term care settings.[1–12] Recently, Katz and Pfeil[7] argued in the *Journal* that there is a necessity to increase the credibility of NH physicians. One of the initiatives of the board of directors of the American Medical Directors Association (AMDA) was to develop a core set of competencies for physicians working in NHs. Katz and Pfeil[7] state that there is also a need for NH leadership and that physicians who are embedded in the organizational culture of the homes are more likely to find success in leadership and therefore can have great impact on quality of care. Finally, Katz and Pfeil[7] call for more research to demonstrate the link between physician competency and quality of care.

That research can improve quality of care is also argued by Rolland and de Souto Barreto.[13] They state that research can improve ongoing training of NH staff, encourage new strategies of care, including medication and nonpharmacological interventions, enhance daily practice, and can help to change negative cultural and societal representations of NHs and their workers.[13] However, improving research in NHs poses many challenges for academics, as there is neither a research culture nor an adequate infrastructure to perform high-quality research.

Although some of the articles have pointed at the Dutch situation, most of the authors insufficiently recognize the achievements and the developments of the Dutch long term care sector and that the Netherlands already has provided some answers to the challenges raised before. We point at 2 concrete initiatives: (1) the establishment of a NH physician specialty with a 3-year training program, and (2) the establishment of academic networks of NHs providing an infrastructure for teaching, research, and best practices.

NH Physician Specialist

Working in NHs makes unique demands on (1) problem-oriented working methods; (2) medical knowledge of chronic diseases and the presentation of illness in frail elderly; (3) communication skills, multidisciplinary cooperation, and organization; and (4) the competency to deal with complex medical-ethical dilemmas. Against this background, the new specialist elderly care physician (ECP) has arisen in the Netherlands.[11] The ECP combines the competencies of a general practitioner (GP) with those of a geriatrician. So the Netherlands has moved beyond the concept of the NH physician specialist as is described by Katz et al.[4] Over the past 20 years, unique problem-oriented working methods have been developed.[14–17] Moreover, Dutch nursing homes employ their own multidisciplinary teams, consisting of an ECP and many other professionals. The fact that ECPs are responsible for the multidisciplinary care plan of each resident improves commitment and leadership of ECPs.

The Training Program

The first and only specialist training program for NH physicians in the world started in 1989.[15,16] The current 3-year training program consists of 4 days of practical training and a 1-day-a-week theoretical course at the university. The program is based on competencies according to the Canadian Medical Education Directions for Specialists (CANMEDS) framework. The entrustable professional activities are categorized into 6 themes: acute care, chronic somatic care, rehabilitation, palliative care, institutional psychogeriatric/mental health care, and community psychogeriatric/mental health care.

After 1 year in a teaching NH, trainees work 6 months in 1 or 2 of the following hospital wards: geriatrics, internal medicine, neurology, surgery, or orthopedics. Furthermore, trainees work 6 to 12 months with psychogeriatric patients (mainly dementia) or patients with mental health problems who live at home. Institutions for Mental Health Care offer this latter part, sometimes in combination with NHs, with a day care facility or outpatient services. Finally, there is a 3-month internship of choice; for example, in a rehabilitation hospital, a hospice, or in a GP practice. Another possibility is to carry out a research project. Trainees can combine 2 learning periods and create individual, tailor-made learning trajectories.

A problem-oriented theoretical course of minimal 40 days a year supports the learning process in practice. Most of the theoretical course is offered at the university. About 10% is offered in the regions of the teaching nursing homes, with a focus on topics, such as the regional organization of care or disease-management programs for patients with stroke, dementia, or Parkinson disease. Another 10% consists of national teaching days for all trainees with lectures given by national experts.

The university medical centers of Amsterdam, Nijmegen, and Leiden offer the training program. Since 2009, they have cooperated in a national foundation, called SOON (Samenwerkende Opleidingen

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tot specialist Ouderengeneeskunde Nederland; www.soon.nl). Trainees are employed by an organization financed by the Ministry of Health. The specialist training program can be followed full-time (36 hours per week) or part-time. The registration committee of the Royal Dutch Medical Association authorizes all institutions and supervisors involved in the training program. Supervisors who guide trainees in practice are contracted to participate at least 8 days per year in a national training program provided by SOON.

Academic Networks

Dutch Elderly Care Medicine has a long academic tradition. The first professor in NH medicine in the world, Prof. dr. J. Michels, was appointed in Nijmegen in 1980. To date, 4 ECPs have a chair in Elderly Care Medicine, and there are 3 emeriti. The universities of Nijmegen, Leiden, Amsterdam, and Maastricht have established academic networks and the University of Groningen is setting up such a network.

Basically, the network is a close cooperation between NH organizations and a university medical center. The goals of the networks are (1) the development of an infrastructure for teaching in medical school and the postgraduate specialist training program, (2) the development of an infrastructure for research projects in long term care, and (3) the development of best-practices in long term care.

Teaching

One of the strengths of the close collaboration between the university and NHs is that parts of the curriculum of medical school take place in NHs. The Radboud University Nijmegen Medical Centre, for instance, offers students a year 1 nursing attachment and a year 5 mandatory internship, both in NHs.[18,19] Our own research revealed that NHs and hospitals were found to be equally suitable for the enhancement of students' early professional development.[20] Students reported similar educational experiences and learning activities in both these institutions. However, students in NHs more frequently referred to their own relationships with patients.[21] A recent focus group study with 4 groups of elderly care residents from the first or third year of the specialist training program and 1 group of family medicine residents during their long term care internship revealed that the main challenge in the NH as a learning environment is "dealing with less," which, according to the residents in this study, often leads to "learning more."[22] These findings offer evidence that medical students can adequately develop desired competencies within so-called "teaching" or "academic" NHs.

Research

The academic networks provide an excellent infrastructure to perform multicenter research projects. Projects are presented in a steering committee that consists of the chairs of the local, multidisciplinary, academic network committees. Every NH organization decides whether or not to participate in a particular study. Over the past years in Nijmegen, studies on several issues like neuropsychiatric symptoms in patients with dementia,[23,24] geriatric rehabilitation,[25] patient safety,[26] people with young-onset dementia,[27] patients with Locked-in syndrome,[28] and depression[29] have been carried out. Especially the study on depression is an example of an interdisciplinary intervention, as Nazir et al[30] pointed out in their recently published review. In the accompanying editorial, Resnick[31] points at the barriers for successful implementation of quality improvement projects. We experienced this also in our Act in case of Depression (AiD) study.[32] With the exception of the first screening step (nursing staff members using a short observer-based depression scale), AiD components were not performed fully by NH staff as prescribed in the AiD protocol.[32] However, we can learn much from these findings and it can stimulate researchers to improve implementation strategies, for instance, by increasing leadership of managers or staff members.

Best Practices

The ultimate goal of the academic networks is to develop best practices with best evidence-based care with measurable high quality of care and high quality of life of the residents. Developing best-practices is facilitated by the fact that Dutch NHs have a long tradition of grouping patients in units with specialized care covering, for instance, (young-onset) dementia, Huntington and Korsakow disease, geriatric rehabilitation, palliative care, and patients with mental-physical multimorbidity. Multiprofessional and multicomponent care programs like the AiD-program or the "Grip on challenging behavior" program are examples of such initiatives that are currently under study to determine their (cost-) effectiveness.[33]

In Conclusion

The Netherlands has developed a roadmap toward academic medicine in long term care. Key elements are a significant contribution in the medical curriculum, a specialty with a 3-year specialist training program, and academic networks that provide an infrastructure for teaching, research, and best practices. Maybe this can inspire other countries that deal with the same challenges to set these steps too.

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