A t the request of a coalition of physi-
cians and other health care profes-
sionals who care for vulnerable North
Dakotans residing in skilled nursing
facilities (SNFs), the North Dakota De-
partment of Health (DOH) has added a
list of SNF medical directors to its web-
site (https://www.health.nd.gov/
regulation-licensure/health-facilities/
north-dakota-skilled-nursing-facilities).

The publication of this list was a suc-
cessful effort of the North and South
Dakota chapter of AMDA – The Society
for Post-Acute and Long-Term Care
Medicine (known as the North Central
Society for Post-Acute and Long-Term
Care or NCSPALTC) and the other
group members, including the North
Dakota Medical Association (NDMA),
the North Dakota Long Term Care
Association (NDLTCA), and Donald
Jurich, DO, chair of geriatrics at the
University of North Dakota School
of Medicine and Health Sciences and
program director for Dakota Geriatrics
(https://www.dakotageriatrics.org/).

As the physician who assembled this
collection, I hope that sharing my experi-
ences may assist other state chapters in
similar advocacy efforts.

**Regional Realities and Pandemic-Inspired Advocacy**

Growing up in a small town in the
fourth least populous state in the coun-
try, I learned that all North Dakota
politics are truly local. My mother served
two terms in the state legislature, and my
family has known the chairs of the state
Legislative Assembly Health Services
Committee for years. The mayor of
Fargo was chief resident on the surgical
service when I was a medical student,
and I also knew the governor and had
cared for his brother’s family as a young
family physician.

After retiring from my family and geri-
atriatric medicine practice in 2020, I volun-
teered to the governor’s office and was
appointed to the North Dakota DOH
physician advisory committee, which
advised the DOH during the pandemic.
I also joined the NCSPALTC COVID-
19 state task force work group and state-
based policy and advocacy subcommi-

The words of the Society’s 2021
Medical Director of the Year, Dr. Leslie
Eber, come to mind: “I got my CMD,
and that was a game changer,” she said
in *Caring for the Ages* (2021;22[3]:3). “I

In the fall of 2021, I submitted a policy
proposal to the NDMA forum calling for
a state SNF medical director
registry and for medical director CME.
The NDMA approved our proposal, and
its executive director, Courtney Koebele,
JD, presented the policy to the state
health officer, Nizar Wehbi, MD, and
requested the registry. By developing
this state program, North Dakota has
enabled efficient communication to
improve care in future public health
emergencies and to increase transparency
for residents and their families.

The Society continues to advocate for
public listings of medical directors to the
Centers for Medicare & Medicaid
Services — a resolution passed by the
House of Delegates last year. Alex
Bardakh, MPP, CAE, the Society’s
director of public policy and advocacy,
had confirmed that North Dakota is the
first state to accomplish the goal of
a public medical director registry. “Some,
like New York, may be attempting to
collect the information, but it’s unclear
exactly where that information is,” Mr.
Bardakh said. “California via their new
law is set to do this, but we don’t have
details yet.”

**Continued Efforts: CME Curriculum for Medical Directors**

Dr. Jurich and I are also develop-
ing a voluntary CME curriculum for
North Dakota medical directors
utilizing Project ECHO (Extension for
Community Healthcare Outcomes). He
is currently heading a regional consor-
tium in a 12-week educational program
for SNF medical directors and staff.
Known as the Great Plains Mountain
Geriatric Workforce Enhancement
Program (GWEP), the consortium
encompasses Health Resources and
Services Administration (HRSA) Region
8 (UT, WY, MT, ID, CO, ND, and
SD). The programs are archived at
Dakotageriatrics.org.

As a faculty member for the program,
I am proud and excited to be able to
advocate for vulnerable North Dakotans,
even in retirement. In North Dakota,
we only have about eight CMDs (as of
2021) — five of whom were my class-
mates — which means we really want
to mentor and inspire young physicians
in rural areas to become involved in
long-term care medicine.

The Coalition’s 2021
Medical Director of the Year, Dr. Leslie
Eber, come to mind: “I got my CMD,
and that was a game changer,” she said
in *Caring for the Ages* (2021;22[3]:3). “I

**Parkinson’s Disease & Psychosis in the**
**Post-Acute and Long-Term Care Setting**

Parkinson’s disease is a progressive,
neurodegenerative movement disorder. As the
population ages, so does the increase in its
prevalence. This pocket guide is intended to
provide guidance on the management and
treatment of the disease for clinicians in the
post-acute and long-term care settings.

https://paltc.org/product-type/cpg-pocket-guides
In 1976 when I completed my residency in internal medicine, I knew for certain what I wanted to do. And I proceeded in my youthful and admittedly naïve way to accomplish my dream.

I left the hallowed halls of medical academia where I had trained for seven years — primarily on the sickest of the sick in those days, always looking for the “zebra” diagnosis, no matter how loud the hoofbeats of “horses” pounded in my ears. I had never been inside a nursing home during all those years of training. I could float a Swan Ganz catheter into the heart, but I hadn’t a clue how to treat a pressure ulcer.

I was 26 years old, and I knew nothing of the “business” side of medicine. I had no doctors in my extended family and had no connections in San Antonio, let alone the entire state of Texas, the place that was to become my home for the next 50 years. I leased a small space, filled it with used medical and office equipment, bought a few cheap waiting room chairs, and hung out my shingle.

And no one called.

I did internal medicine consultations in my hospital’s emergency department whenever slots were available, went around to visit the offices of other physicians in the area, and gave out my business cards. It was a start at least, though a pitiful one.

One day an older doc rang me up, told me he was retiring, and asked if I would take over his 40 nursing home patients. In those times, I wasn’t seeing that many patients in a month. So, of course, I said yes. In July 1976, I stepped into a long-term care (LTC) facility for the first time.

I didn’t realize it then, but I was fortunate to have landed in that particular nursing home, at that particular time in my life, and in that particular era of medical practice. The facility had been owned and operated by the same family for decades. The staff — the director of nursing, registered nurses, licensed practical nurses, and many of the nursing assistants — had worked there for many years, and they were fully invested in the care they provided. They were happy in their work, covered for one another, and learned from one another. At their request, I gave many in-service presentations on topics they wanted to learn more about. In truth, working with the staff and preparing these talks is where I first began to learn about how to practice LTC medicine, not to mention enlightened geriatrics.

In my early years so much was changing. The Karen Quinlan (1975) and Nancy Cruzan (1989) court cases, which together established legal precedent for advance care planning, allowed the staff and me the opportunity to rethink end-of-life care together. This was a long and complicated process, fraught — as it still is — with philosophical and religious resonance, which continues to require open and honest discussion. But at least the process was finally initiated in those years, as was the very thorny topic of conjugal visits by spouses. (See my essay “Sex and the Septuagenarian ... and Beyond” in Caring for the Ages 2015;16[10]:16.) It took a long time, deep in the heart of Texas, to begin to change hearts and minds about this issue.

I soon realized that the patients I had inherited were overmedicated. This was years before the day when credentialed medical directors were mandated to lead the medical staff at LTC facilities, but I took it upon myself to talk about and educate anyone who would listen regarding more appropriate prescribing practices — something that not many doctors were talking about back then.

We were rewarded: many of our patients “woke up” as I reduced their medication burden. I know this wasn’t as dramatic as Oliver Sacks described in his 1973 memoir Awakenings (the movie didn’t come out until 1990), but, still, what we witnessed with our less-is-more approach to LTC medicine was, for us, an awakening in its own right.

Meanwhile, my work in LTC helped build my practice. Because I took the time to get to know my patients and their families as I made my rounds, many family members became my patients as well and then referred others. The opportunity to build a practice of interconnected families and friends was the most satisfying experience of my lifetime in medicine. It involved, on my part, a huge commitment of time and energy; I answered all my own nighttime phone calls and rarely took a weekend off or a vacation away, especially during those early years.

In the early 1990s, the first hospital-based skilled nursing unit (SNU) in the city opened in my hospital. Because of the Omnibus Budget Reconciliation Act of 1987 (OBRA 87), my hospital was mandated to have a medical director for this facility, and they asked me to take this job. I might have been flattened, but at that time I was the only nonacademic physician in San Antonio who openly admitted to practicing geriatric medicine and had the credentials to do so.

The hospital administration was only checking a box in hiring me. The pay was terrible for the half day per week that I spent on the SNU, leading the team conference, and being on-call for problems 24/7. But I got to work with a great staff of professionals, including nurses, nursing assistants, social workers, therapists, dieticians, and pharmacists. I learned what depth real teamwork can bring to caring for patients, as well as for their families.

The attending physicians, though always invited to these team conferences, rarely came. To most of them the SNU was just a place to send a patient they hadn’t figured out what to do with or a destination when a family refused to take a parent or grandparent back home.

And yet over the years that I was the SNU medical director, I still vividly remember how often our team saved the day: with an overmedicated patient, or a missed diagnosis, or a helpful referral to physical therapy, or prognostic truth-telling about someone’s dementia and the need for more supervised care, or the complicated untangling of family relationship knots to get everyone on the same page.

These were the many small triumphs that happened week by week, unnoticed and largely unappreciated by the business types running the hospital. Indeed, after 10 years my hospital closed its SNU because Medicare had changed its reimbursement scheme and it behooved the bottom-liners to convert the SNU back to acute hospital beds. I was told about the change only a few weeks before it happened — a fait accompli, and an afterthought at that. No one asked me if I felt that the care for older adults at our hospital might suffer once the SNU closed. For the record, I told the CEO that it would do just that.

Alongside the clinical successes the SNU team and I had during those years, the other bright spot for me was joining the American Medical Director’s Association (AMDA) — long before its evolution into AMDA — The Society for Post-Acute and Long-Term Care Medicine. At that time there were fewer than 300 doctors in the United States who had done the work to receive the Certified Medical Director (CMD) credential. I got to meet — and learn from — many of the early founders of the Society: the men and women dedicated to LTC patients, who forged a vibrant discipline out of what was decidedly a backwater of American medicine. I’ve now watched with pride as so many of these professionals have continued to advance our field: they’ve infused it with scientific rigor and powerfully advocated for our patients at all levels of government.

It’s been quite a journey. But we are now at an inflection point. The tragedy that has unfolded during and after the COVID-19 pandemic has necessitated a reckoning with both the strengths and weaknesses of America’s predominant model of LTC for our older adult citizens. Dedicated facility medical directors are one of the strengths of our current system of LTC — albeit an underrecognized and largely unappreciated one by citizens, government bureaucrats, and payors.

California is the first state — but will not be the last — to mandate the CMD credential for LTC facility medical directors. It is now up to the Society — and to each of us — to continue to educate and advocate as we press our case for well-deserved recognition and essential funding for the work in which we are all engaged: the critical mission of elevating the care of our growing aged population.

LTC medicine in America is in crisis. It is time to admit this fact and then come together as a nation and do something about it. The talent to devise the strategies and build the alternative models already exists in the world. Government needs to do more than pay lip service to the problem.

Dr. Winakur practiced medicine for 36 years and is an adjunct faculty member in Geriatrics at UTHealth—San Antonio. His book, “Memory Lessons: A Doctor’s Story” chronicles the journey he took with his father and Alzheimer’s disease.