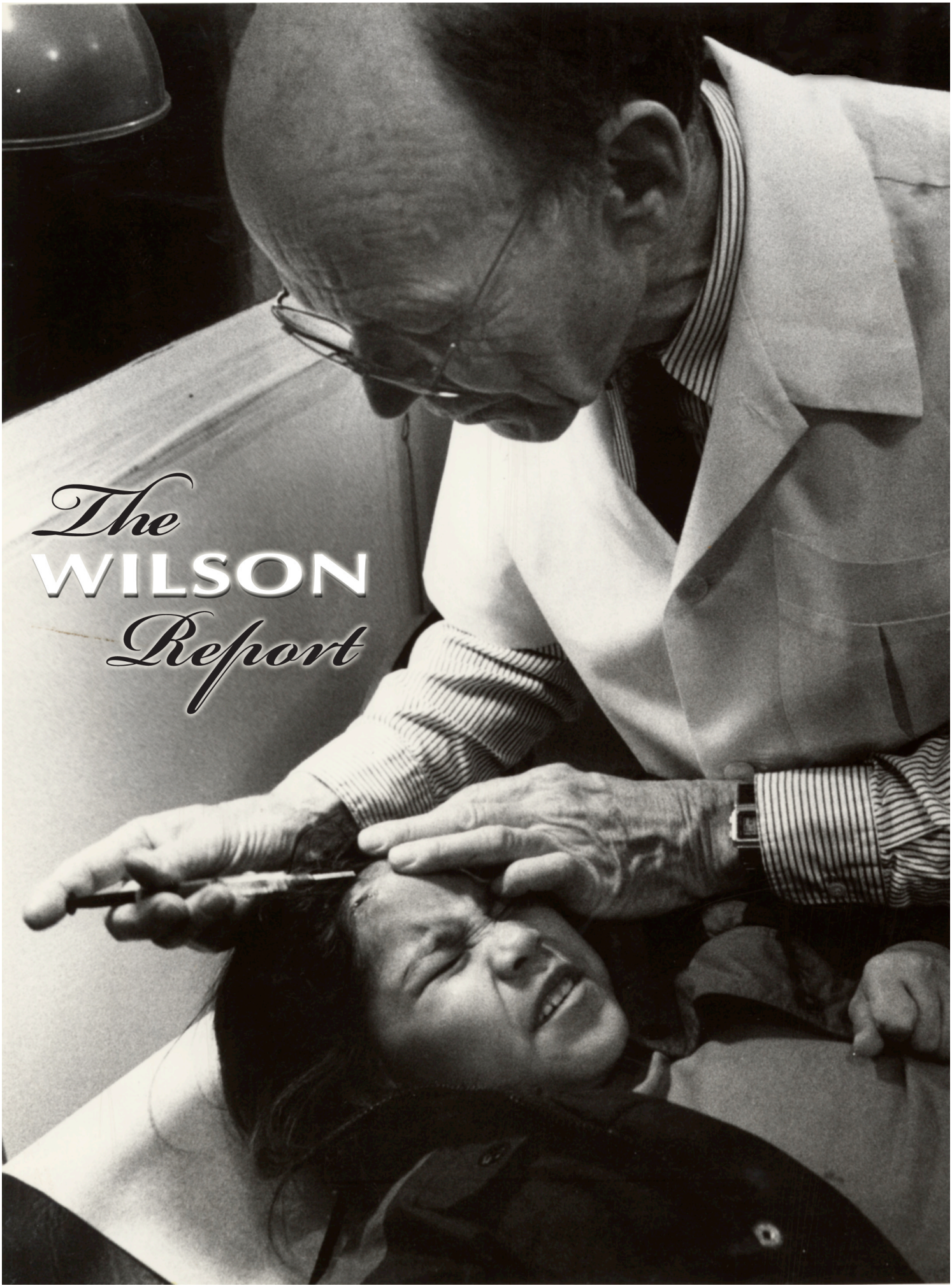
The
WILSON
Report

The WILSON Report

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About the publishers

The Wilson Health Planning Collaborative was created in 2006 to improve the health care system in the eight counties serviced by Northwest Venture Communities Inc. These counties are: 1) Ward; 2) McHenry; 3) Bottineau; 4) Renville; 5) Mountrail; 6) McLean; 7) Burke; and 8) Pierce. This planning area includes all of the Mandan, Hidatsa, Arikara Nation. During the planning period, McKenzie, Dunn and Mercer counties also joined.

Health service providers, faith-based leaders, government employees, rural developers and others gathered to talk to one another about ways to reduce disparities and increase the years of healthy life in this 11-county region.

The Collaborative was co-chaired by Ed Hall of Parshall and Bill Patrie from Bismarck. It also received technical support from Souris Basin Planning Council, Northwest Venture Communities Inc. and Northcountry Cooperative Foundation and Common Enterprise Development Corporation.

After almost three years of meetings and member growth, the group incorporated as the Wilson Health Planning Cooperative in April 2009. It is named after Herbert Wilson, a physician who practiced for 43 years at Elbowoods and New Town. Now 87, Wilson was a member of the Collaborative since the beginning and is now one of the new Cooperative's board members.

The Cooperative will design an integrated health care system for the 11 counties and all of the Mandan Hidatsa and Arikara Nation.

The Cooperative's board approved a three-year budget and work plan during its organizational meeting in April 2009. Officers elected are Fred Larson of Bismarck, chairman; Ed Hall of Parshall, vice chairman; the Rev. Marilyn Levine of New Town, secretary; and Shelly Weppler of Minot, treasurer. Larson works for the North Dakota Department of Health. Hall is a retired engineer and an enrolled member of the Three Affiliated Tribes. Levine serves United Church of Christ parishes in New Town and Parshall and Weppler is the executive director St. Joseph's Community Health Foundation.

Other directors elected to the Wilson Health Planning Cooperative board are Stella Berquist, CEO of Minne-Tohe Clinic, New Town; Dan Kelly, administrator of McKenzie County Healthcare System, Watford City; Terri Lang, project coordinator of UND Center for Rural Health, Minot; Randy Schwan, vice president of Trinity Health, Minot; Delores White, Garrison; and Dr. Herbert Wilson, Bismarck.

For more information or to join the Wilson Health Planning Cooperative, contact Chairman Fred Larson at 701-226-9616 or fredl@btinet.net.

About the printer

Arrow Graphics is an on-campus printing and publishing shop at United Tribes Technical College (UTTC), Bismarck, N.D. The college is operated by five North Dakota tribes: Three Affiliated Tribes of Fort Berthold, the Spirit Lake Dakotah Tribe, the Sisseton-Wahpeton Sioux Tribe, the Standing Rock Sioux Tribe, and the Turtle Mountain Band of Chippewa.

For almost 40 years, UTTC has served more than 10,000 American Indian students from more than 75 federally-recognized Indian tribes across the nation. In addition to American Indians, the college welcomes and serves students of all backgrounds.

UTTC is a regionally accredited institution and the first tribal college in the nation authorized to offer full online degree program. The college is a 1994 Tribal Land Grant Institution.

Cover photo

Dr. Herbert Wilson works on a young patient at his clinic in New Town in 1995. Photo by Minot Daily News.

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Introduction: Wilson Health Planning Cooperative

The Wilson Health Planning Cooperative is a non-profit cooperative association dedicated to creating a strategy to end health disparities and to promote longer, healthier lives for all residents in an 11-county region of North Dakota.

Members of the Cooperative believe planning for a health care system should be done in an inclusive, collaborative manner, with everyone interested in the health of the region participating.

Dr. Herbert Wilson and family prepare to leave for North Dakota in their 1946 Hudson.

Dr. Herbert Wilson

The Wilson Health Planning Cooperative is named after Dr. Herbert Joslin Wilson, who practiced medicine at the Elbowoods Clinic before this town was flooded in the 1950s. Wilson then practiced in New Town and other communities in the region. He dedicated himself to the health and welfare of both Native Americans and non-Native Americans for 43 years before he retired in 1995. He then dedicated six more years at the 20 40 Health Clinic at Selfridge.

Wilson was born in the small town of Bethel, Vt., in 1921. As a child he moved about the South as his family looked for a healthy climate for his invalid father, a World War 1 veteran. Wilson got his high school education from New Hampshire's Philips Exeter Academy, which earned him a ticket to Harvard College. While at Harvard, his education was interrupted by three years of service in the Army Air Force, where he flew 31 missions over German-occupied Europe in B-24s. His service was a life-changing one, as when he returned to Harvard he decided to study to become a physician.

Wilson earned his medical doctorate degree from Tufts University School of Medicine. While there he joined the Public Health Service, which required that he give back two years as a practicing physician. He performed his internship and one year of his assignment at a Tampa, Fla., outpatient clinic before being assigned to one year at Elbowoods.

"One of the highlights of my life was the day I arrived in Elbowoods in my Hudson—1946 Hudson, a wife, four kids and a cat named Massachusetts. And two people on one horse came riding up and I said, 'Ah, my first people to come help me unload.' No, it was my first patients. The guy had a sliver in his finger," Wilson recalls with a laugh.

During his years in England, Wilson met an English member of the Women's Auxiliary Air Force and he and Lillian were married in January 1945. The Bismarck couple has six children, 14 grandchildren and six great-grandchildren.

The group's beginnings

The Collaborative started to take shape in 2002, when Northwest Venture Communities Inc. received a grant from the Northwest Area Foundation to reduce poverty. One of the platforms of this poverty-reduction plan was health

care. At that time it was widely recognized that poverty led to poor health and poor health often led to poverty. So important was heath care that a stand-alone collaborative was created in the fall of 2006 in the home of Ed Hall, an enrolled member of the Three Affiliated Tribes.

Since 2002, there has been discussion about a new health care facility currently being built at New Town on the Fort Berthold Reservation. It was Hall's vision to see an integrated health facility where Native Americans, non-Native Americans, Veterans and anyone else could get treated. Others liked this idea so much it quickly broadened to include the entire health care system. Collaborative members realized the current health care system is highly segregated by payer source and this segregation creates inefficiencies.

From the fall of 2006 through 2008, the Wilson Health Planning Collaborative raised money and recruited individuals, organizations and three more counties to join the effort. It grew to cover an 11-county region in northwest and north central North Dakota as well as the Fort Berthold Indian Reservation. The 11 counties are Bottineau, Burke, Dunn, McHenry, McKenzie, McLean, Mercer, Mountrail, Pierce, Renville and Ward. *(See Graph 1 on this page.)*

GRAPH 1: THE 11-COUNTY REGION

The Collaborative also expanded from only a handful of individuals interested in health care to more than 40 individuals representing health care facilities, government agencies, community organizations, churches and many others.

Becoming a cooperative

The Collaborative filed articles of organization with the North Dakota Secretary of State's office and formally became a cooperative—the Wilson Health Planning Cooperative—in April 2009. This non-stock, membership cooperative is open to any organization, company, corporation, cooperative or individual interested in its health care work and activities. Its main purpose is to plan a high-quality integrated universal health care system that will provide a single-source payer. Membership is open to all. *(See Appendix A and B for the Wilson Health Planning Cooperative's articles or organization and bylaws.)*

Members include the Souris Basin Planning Council, the Three Affiliated Tribes, Northwest Venture Communities Inc., Common Enterprise Development Corporation, the Community Health Care Association of the Dakotas, the North Dakota Department of Health, the U.S. Department of Agriculture-Rural Development, Coal Country Community Health Centers, Northern Plains Conference of the United Church of Christ, the Bismarck/Mandan United Church

By 2008, the Wilson Health Planning Collaborative had expanded to more than 40 members. Some of those attending the Collaborative's Jan. 17, 2008, meeting at New Town take time to pose for a photo.

of Christ, St. Joseph's Community Health Foundation, and numerous health care providers and individuals. These organizations and individuals represent many different segments of the population of the region that have unique perspectives on the health care system.

Examining the current system

In early 2008, the Wilson Health Planning Collaborative applied for and received a Rural Health Network Development Planning Grant from the Health Resources and Services Administration to assess the state of the health care system in the 11-county region. In conducting its work, the Collaborative did three things:

1. *Literature research:* The Collaborative analyzed the health statistics to get an understanding of the health status of the residents of the 11-county region.
2. *Health care facility site visits:* Collaborative members toured many health care facilities in the 11-county region to assess the health services available in the 11-county region.
3. *Public meetings:* The Collaborative organized and led 10 public meetings to learn what the residents of the 11-county region think an ideal health care system should look like.

The first section of this document examines the results of the literature research on the health status of the residents of the 11-county region. It describes why the Wilson Health Planning Cooperative has chosen to get involved in planning the health care system.

Bill Patrie, a co-chair of the Wilson Health Planning Collaborative, explains Appreciative Inquiry (AI) during the public meeting at Velva. AI is the art of asking positive questions to get positive answers.

The second section discusses the theoretical background for and the research methodology used for the health facility site visits and the public meetings. Bill Patrie and Ed Hall, co-chairs of the Collaborative, participated in an Appreciative Inquiry research training workshop at Case Western Reserve University in May 2008. Appreciative Inquiry is an alternative research methodology to traditional research methodologies. Appreciative Inquiry encourages positive change by focusing on "what is right," rather than "what is wrong."

The third section of the article presents the results of the health care facility tours and the 10 public meetings. It describes the "positive core," or the health care assets of the 11-county region. It also explains what has led to success in the past so we can apply those lessons to the future. This is called the "Discovery Phase" in Appreciative Inquiry.

The fourth section is a synthesis of the data gathered at the public meetings on the ideal health care system. Residents were asked to imagine they had fallen asleep for four years. They awaken to find the health care system is exactly the way they always wanted it to be. They then describe what they see. This is called the "Dream Phase" in Appreciative Inquiry.

The final section discusses the future activities for the Wilson Health Planning Cooperative. Despite all the hard work members have put in to date, there is still much more that must be done to create the health care system of our dreams.

The collaborative nature of this work is vital to the process of designing a new health care system. For too long, the health care system has been primarily viewed from an economic model perspective. While this is an important perspective, it is not the only one. Other perspectives must be included in the planning process to create a health care system that serves everyone. Although there may be many different models of health care in the Cooperative, all members share the same dream: A health care system that increases years of healthy life and eliminates disparities.

Chapter I: Health Status

"In order to change we must be sick and tired of being sick and tired." – Unknown author

One of work elements of the Wilson Health Planning Collaborative was to examine the health status of the residents of the 11-county region. It is important to keep in mind that there are many healthy people in the region and there is much that is right with available health care. Therefore, we focused on the positive aspects of the health care system by using Appreciative Inquiry to build upon the assets that already exist. This doesn't mean we ignored the unmet needs, challenges and obstacles in our health care system. It just means we did not and will not focus all of our energy and time on finding the problems and root causes of these problems.

This section discusses the current health status of the 11-county region so we better understand the realities of the present.

Community members share their visions of the future health care system during the public meeting held at White Shield. Following this meeting, some of those attending formed the White Shield Health Care Committee.

Anyone living in the 11-county region knows there is a need for better health care. Perhaps most people don't know the statistics, but almost everyone has at least one unfavorable experience with the health care system they could share. During the 10 public meetings, we heard some tragic stories of failure in the health care system.

What made these stories most tragic was not that people suffered, but that most of the suffering could have been prevented. The stories of people unable to pay for medical treatment, of losing toes or feet to diabetes, of strong individuals who are unable to cope with the psychological stress of having cancer, of suicides, of not being able to afford medications, were devastating.

Payment system is broken

One of the most discussed issues with health care was payment for services. On a national level, medical care is growing more and more expensive. In 2004, people in the United States spent $1.9 trillion on health care—an increase of 7.9 percent since 2003. This accounts for nearly 15 percent of our country's gross domestic product, the highest percent of any other major industrialized country. Even though the United States spends more than any other country, it does not have the healthiest population.

From a patient's perspective, costs of health care are sky-rocketing. Many people cannot afford to go to the doctor or cannot afford their medications. Their co-pays, deductibles and insurance rates are going up. According to the National Coalition on Health Care:

> *"The average employee contribution to company-provided health insurance has increased more than 143 percent since 2000. Average out-of-pocket costs for deductibles, co-payments for medications, and co-insurance for physician and hospital visits rose 115 percent during the same period."*

The cost of insurance for employers is rising as well:

> *"In 2007, employer health insurance premiums increased by 6.1 percent—two times the rate of inflation. The annual premium for an employer health plan covering a family of four averaged nearly $12,100. The annual premium for single coverage averaged over $4,400."*

The Wilson Health Planning Cooperative serves a region that includes 115,192 residents. This includes 11 counties and the Fort Berthold Indian Reservation. Of this number, 17,808, or 16.2 percent, suffer from a disability and 11.2 percent live in poverty. *(See Appendix C for population statistics.)*

So, with these kinds of health care cost increases, even some of those with health insurance must make the difficult choice between meals and medical treatment. Those without health insurance are at an even greater disadvantage.

First District Health Unit at Minot uses marbles in glass jars to portray the leading causes of death.

Uninsured number could explode

Approximately 12.5 percent of all people living in the 11-county region have no health insurance. This affects the health of those individuals, but it has broader effects as well. When a health facility renders care and the patient is unable to pay, it puts economic pressure on the facility. The facility must raise its rates on people who can pay (or will pay even if they can't afford to).

If the trend in the rest of the country's economy makes its way into North Dakota, this uninsured number could explode, making health care impossible to deliver. Likewise, the threat of losing health insurance can also affect mental health. *(See Appendix D for the uninsured numbers by county.)*

Worries grow for providers

Judging by statements at the site visits at health facilities and at the community meetings, one of the biggest problems for providers is getting paid for the services they provide. Health care providers are constantly worrying about how they are going to pay their bills. Many health facilities are forced to cut services that fail to pay their way. *(See Appendix E for a list of the health care providers in the 11-county area.)*

Another pressure that affects both the health providers and patients is the difficulty of recruiting medical professionals in these 11 counties. For health providers, it is difficult to maintain medical staff because of the costs involved. Doctors want to be paid more to live in rural areas. Many health professionals want to be in or near a big city. For patients it is critical to have qualified doctors and nurses close to home. The 11-county region is vastly rural and many people must drive long distances to get care from

Mountrail County Health Center Administrator Mitch Leupp, left, shows Collaborative members the hospital's emergency room at Stanley. Located on the campus with the hospital is a clinic, nursing home, independent living apartments and an aquatic center. This integrated health care system is also looking at adding assisted living services. "When the boomer balloon hits, we'll need more skilled nursing home beds," Leupp says.

qualified medical professionals. *(See Appendix F for the land area in the 11 counties.)*
During the 10 public meetings, a doctor interviewed a man about his ideal health care system:

> *"He wants fast response—that is, qualified people to take care of him in a one-stop place. You don't have to be sent on from here to there and everywhere."*

This one statement represents well what we heard at the public meetings. This speaker said he wanted qualified health professionals. He also stated he didn't want to be sent from one place to another to get care. For many people, distance is a major barrier to getting quality primary health care. The average population density in the 11-county region is six people per square mile. When the primary health physician sends a patient to a specialist, the driving only increases and becomes even more of a barrier to adequate care. Most of the Cooperative's region has been declared a Primary Care Health Professional Shortage Area by the Health Resources and Services Administration (HRSA). *(See Appendix G for these shortage areas.)*

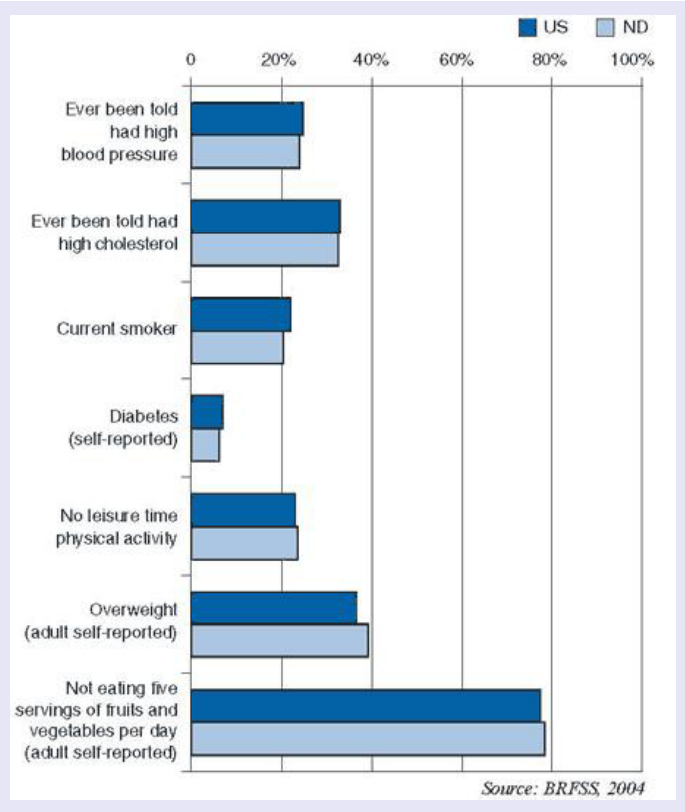
Heart disease kills many

In addition to the economic issues of the health care system, there are a number of health-specific problems facing the people of the 11-county region. The No. 1 cause of death in North Dakota and the 11-county region is heart disease. *(See Appendix H for the leading causes of death.)*

More than 27 percent of all deaths from 2001 to 2005 in North Dakota were due to heart disease.

The same is true for the 11-county region. While the statistics don't tell us the reason why heart disease kills so many people, it certainly gives us some clues. The biggest contributing factors to heart disease are high blood pressure, high cholesterol, physical inactivity, tobacco use and being obese or overweight. In 2003, 24 percent of adults had high blood pressure and 33 percent of adults had high cholesterol. By eating right and exercising, these numbers could be lowered drastically. It will take more than doctors to overcome this problem.

GRAPH 2: ND/US ILLNESSES



Diabetes taking a toll

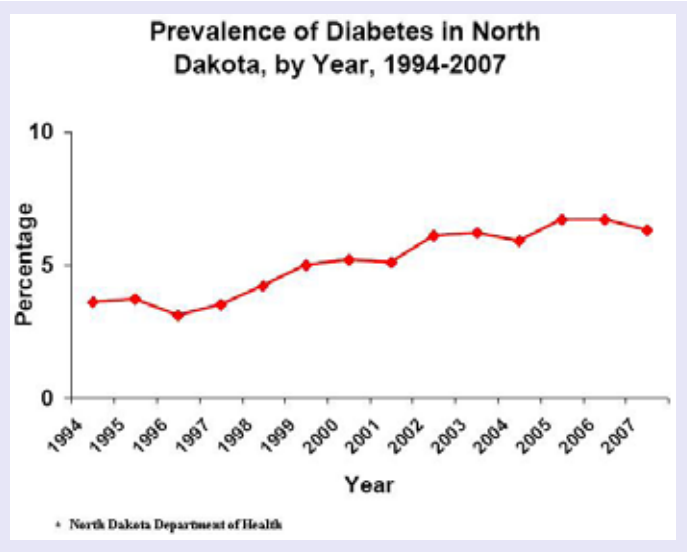
Diabetes was another health issue, closely linked with heart disease, that we heard discussed during the community meetings. The estimated statewide prevalence of diabetes in North Dakota is 6.1 percent of all adults. This prevalence rate has steadily increased in North Dakota since 1994. *(See Graph 2 on this page.)*

In the 11-county region, it is conservatively estimated that 7.4 percent of the adult population has diabetes. Native Americans are twice as likely to develop diabetes, meaning about 16.5 percent of Native Americans age 20 and older are diagnosed with diabetes. The prevalence of Type 2 diabetes, formerly called adult-onset diabetes, is increasing in children in North Dakota. The Type 2 diabetes rate has increased from 2.8 per 1,000 children in 2003 to 4.5 per 1,000 in 2007. One man, during his vision of the future of health care for diabetes, described some of the complications associated with this disease as follows:

"Until you go into these households and you see the foot is bleeding because they've just got their toes chopped off…that is reality. Or else someone taking insulin and the kids' involvement with that. Or the other illnesses that they get from it where they're not feeling well…vision (loss) and all that kind of stuff. So I guess that's where I see this stuff working in 2012."

Diabetes is an important health issue. It is the sixth leading cause of death in North Dakota, representing 4 percent of all deaths and is a contributing factor in an additional 7 percent of all deaths.

GRAPH 3: PREVALENCE OF DIABETES



People with diabetes are also two to four times more likely to develop heart disease, which is the No. 1 cause of death in North Dakota and two to four times more likely to have a stroke. Obesity is the biggest risk factor for Type 2 diabetes. For Native Americans age 18 and over, nearly 16 percent are diagnosed with diabetes and are more than twice as likely to have diabetes as whites of similar age. Nearly 8 percent of the population in the 11-county region is Native American.

Associate Press writer Blake Nicholson quotes David Hanekom: "Really, it's a societal issue," he said. "It's not something the medical community can deal with. The medical community deals with the complications and effects." Instead of treating the cause of diabetes, doctors can only treat the effects. Treating the symptoms is important, but tackling the cause is more important in the long-run.

At one of the community meetings, a woman echoed this sentiment in her vision for the ideal future health care system as it pertains to diabetes:

"I'm not a diabetic but my husband is. My family has a lot of diabetes, so I thank the Lord that I'm not diabetic, because I did a lot of exercise when I was younger and I'm still very active. So, if our people could be that way in 2012—a lot more active rather than a TV and a remote control and driving a vehicle—that would be the vision to see here with the health care."

The Kidney Dialysis Unit at the Minne-Tohe Clinic in New Town is open four days a week. It features 10 stations and two isolation rooms. The average stay for a dialysis patient is 3 ½ hours. "Twelve years is the longest a patient has been on dialysis," says Stella Berquist, the CEO of the Minne-Tohe Clinic.

Physical activity a must

As the above statement illustrates, this and many other health issues that affect the people of North Dakota and the 11-county region are not simply health care issues that can be dealt with solely by medical professionals. In fact, she doesn't even mention doctors in her vision. She talks about being active when she was younger and being currently active. These are personal and social choices, such as not sitting so much, but walking more, that doctors cannot make for patients. Physicians also cannot control what adults or children eat and how much exercise they get. These health problems need to be dealt with by individuals, families, community organizations and health care providers working together. This is one of the reasons the public was invited to participate in the process; community organizations must be an integral part of the new health care system.

Alcohol, drugs claiming many

It is especially true that community support is necessary for treatment when it comes to alcohol and drug abuse. One individual put it this way:

> *"I was visiting with her and these ladies back here. And I said, 'If I was going to sleep and I woke up in 2012, what I would like to see is that all the addictions here are gone.' There are a lot of addictions here, and that's a lot of our problems. And I said, 'What if they weren't here?'"*

A total of 8.9 percent of North Dakota adults binge drink compared to 14.4 percent for the U.S. average. From 2001 to 2005, a total of 530 persons died in 475 crashes, and 248 (46.8 percent) of these deaths were a result of alcohol. In addition to the problem of vehicle accident deaths due to alcohol, there are the liver diseases associated with alcoholism. From 1999 through 2003, North Dakota had an average of 66 chronic liver deaths per year. The age-adjusted death rate for liver disease increased from nine to 12 deaths per 100,000 people in North Dakota, while it has remained stable in the United States as a whole.

Members of the Wilson Health Planning Collaborative visit Circle of Life during their tour of the Three Affiliated Tribes health services during July 2008. Circle of Life, located in New Town, offers substance abuse treatment.

Once again, doctors can't convince people not to drink excessively or not to drink and drive. This is a much broader problem that must involve the whole community. It has been argued that boredom is one of the leading factors to alcohol and drug abuse, especially on reservations.

GRAPH 4: ALCOHOL USE

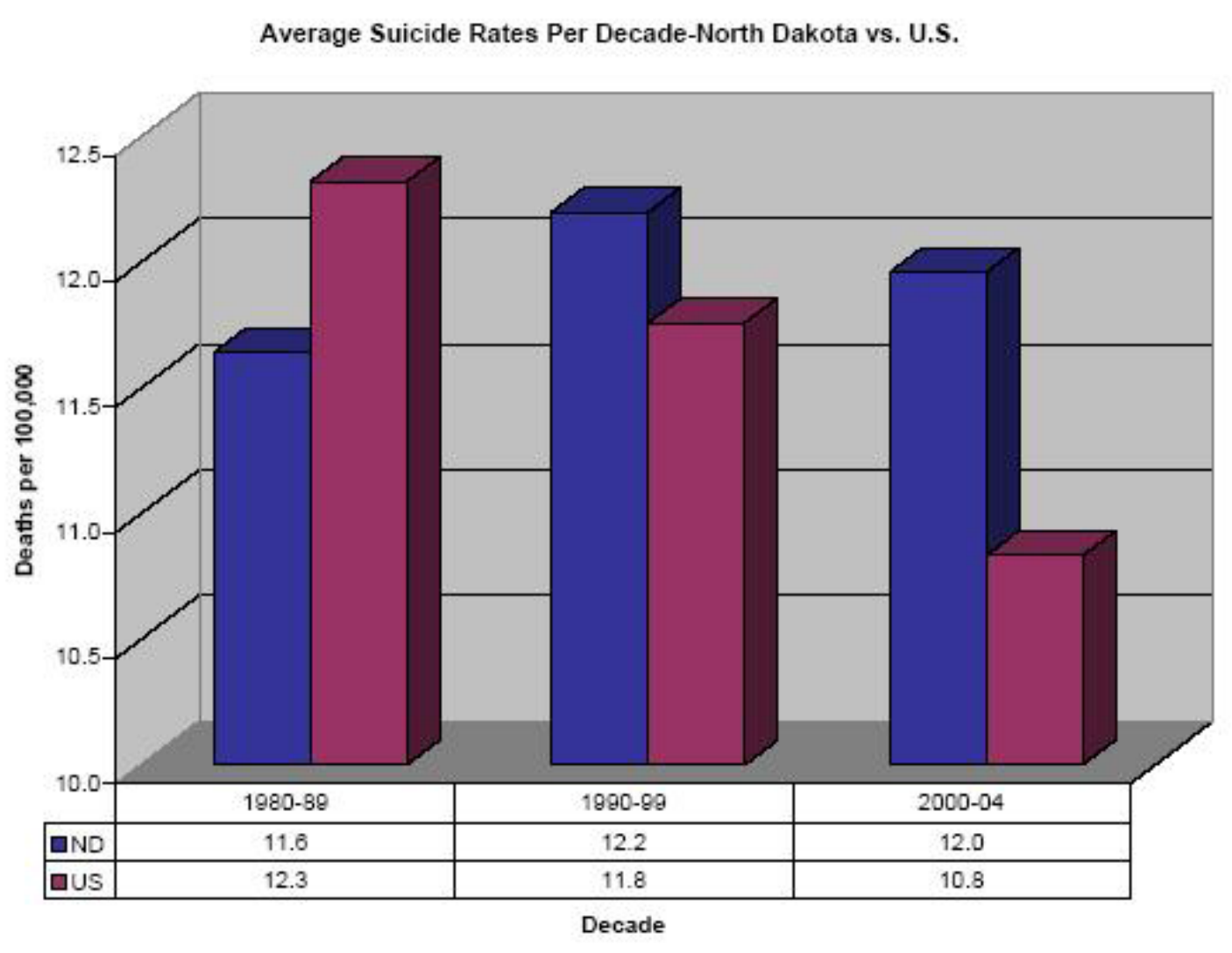
Percent of Recent, Heavy, and Binge Alcohol Use Among Adults Ages 18+, by Gender, Age, and Income, North Dakota and United States, 2005

	Recent		Heavy		Binge	
	ND	US	ND	US	ND	US
Overall	59.6	56.2	5.0	4.9	18.9	14.4
Gender						
Male	67.6	63.5	6.5	5.6	27.7	22.0
Female	51.6	49.0	3.5	4.0	10.2	7.4
Age						
18-24	62.4	56.4	10.3	7.4	34.0	26.1
25-34	68.1	62.6	9.7	5.3	30.4	21.4
35-44	67.1	61.3	3.6	5.1	20.7	16.1
45-54	63.9	59.1	4.4	4.7	16.3	11.9
55-64	59.3	53.3	4.5	4.2	12.0	7.8
65+	39.3	39.5	1.3	2.9	2.5	3.0
Income (thousand)						
<$15	46.1	36.7	7.9	4.2	19.1	12.3
$15-24	47.7	45.1	5.4	4.5	15.5	14.0
$25-34	58.4	50.3	5.3	4.7	24.6	14.0
$35-49	66.4	57.9	5.1	5.4	19.0	15.2
$50+	70.0	68.3	4.7	5.4	19.8	16.4

Boredom is something that can be dealt with by communities and community groups. There are groups already working on this in the 11-county region. During one of the community meetings, a Vietnam veteran described his involvement in establishing a "drop-in" center, where people can drop in and eat popcorn and play pool and do other fun things that don't involve the use of alcohol. Church groups often deal with alcohol-related issues as well. Alternatives to alcohol and drug use is not only critically important to prevention, but also critically important to drug and alcohol addiction recovery. Once again, communication and coordination between these organizations and health care facilities could substantially benefit the health of our communities.

There are also links between alcohol use and suicide and homicide. Nearly 20 percent of suicides and 30 percent of homicides involve alcohol use. Suicide is the 11th leading cause of death in the 11-county region. Once again, Native Americans have the highest suicide rate at 27.99 per 100,000 compared to whites at 17.54. "In some tribal areas of North Dakota, the rate was five times higher than that of the white population."

GRAPH 5: SUICIDE RATE



Dwell on the strengths

It is important to recognize the difficulties that face us; however, it does no good to dwell on the negativities. More important are the strengths of the health care system and of the communities of the 11-county region.

By working together and sharing our strengths, we will be able to fashion the best health care system ever known: One that gives everyone in the region the care they need, when they need it, regardless of income, age, race or any other distinction. The people of the 11-county region are the most important asset for the actualization of this new health care system.

Chapter II: Theory and Methodology

"No problem can be solved from the same level of consciousness that created it. We must learn to see the world anew."

– Albert Einstein

Medicine in this country is primarily reactionary. Patients' symptoms are treated, while the causes of the symptoms are largely left untreated. This state of affairs is the fault of no one in particular. It is just the way the health care system has developed. We treat individual health as a problem to be solved. Likewise, we treat the health care system as a whole as a problem to be solved. However, it is precisely this line of thinking that has led to the development of the reactionary and thus inadequate health care system of today.

There is a fundamental epistemological difference between the traditional scientific research method and the method the Wilson Health Planning Cooperative uses. The very basic traditional scientific epistemology asserts that there is an objective reality that exists outside of peoples' minds. This objective reality can be observed and measured. The researcher tries to stay objective and influence this reality as little as possible. The task of a researcher is to simply describe reality and to determine cause and effect. It is thought that once a cause has been determined, it is possible to make the necessary changes to foster positive change.

This is a research and change methodology that David Cooperrider calls the deficit theory of change. He quotes a Gallop Poll, saying that most organizations interested in change implicitly follow the rule: "Let's fix what's wrong and let the strengths take care of themselves."

Using the deficit theory of change, most researchers fail to take Einstein's advice. Instead, they ask the same questions again and again. They tend to ask negative questions and focus on the negative aspects of the health care system with the intention to fix these negatives. They normally use a four-step plan:

1. Identify the problem.
2. Conduct a root cause analysis.
3. Brainstorm solutions.
4. Develop action plans.

Wilson Health Planning Collaborative members tour the Garrison Memorial Hospital Nursing Facility. The 28-bed skilled nursing facility is located on the third floor of the hospital building. Being a wholly-owned subsidiary of St. Alexius Medical Center is beneficial to the Garrison health care facilities, says Dean Mattern, administrator. "We struggle with the cost of technology, which is moving so rapidly," says Mattern. "Small hospitals have a tough time keeping up. Software is very expensive to continue to upgrade and support it. One advantage is we have a significant benefit from St. A's."

They basically treat the research as problems to fix. If this process was capable of "fixing" the health care problems, it would seem likely to have done so by now. According to Cooperrider and Diana Whitney, authors of "*Appreciative Inquiry: A Positive Revolution in Change,"* this process is not only incapable of fixing the problems, but also contributes to the problems under question.

One of the unintended results of the deficit theory methodology is fragmentation. When a researcher attempts to find the root causes of a problem, blame is usually fixed on some individual or group of individuals. This often pits one group against another and fosters resentment. This can create splinter groups within an organization or community. This hinders, rather than promotes, positive change. A unified health care system where people are working together to provide high-quality care is a key element of the ideal health care system as will be shown in later sections.

Another consequence is that it creates a negative framework that becomes a self-fulfilling prophesy. Researchers who ask questions about problems will inevitably find problems. When people are asked about problems they think about problems. When people are constantly thinking about the problems of the health care system, many times they lose hope that it can be any better. The more a researcher asks questions about the problems and causes of the problems, the more people think about the problems and they behave in ways that create more problems. It's a never-ending cycle that is difficult, if not impossible, to get free of.

Finally, this process discourages participation. People get burned out quickly when they are constantly focusing on problems and the causes of these problems. They feel like they don't have a voice and they begin to rely on "experts" who plan their research behind closed doors and get only a narrow understanding of the actual life of an organization or community.

Ed Hall, one of the Collaborative's co-chairs, explains at the public meeting at Rugby that Appreciative Inquiry is the art of asking positive questions to get positive input. It focuses on "what's right," rather than "what's wrong."

Appreciative Inquiry focuses on strengths

The epistemology of the Wilson Health Planning Cooperative is different. Instead of an objective reality, independent of human thought and motivations, this epistemology considers reality to be socially created. It is constantly changing and the reality can be very different when looking from a different vantage point. The reality of the health care system for someone with good health insurance is very different than the reality of the health care system for someone without health insurance, just as it is different from a health care facility. Research is seen as a transformative activity according to this epistemology, so it should attempt to be as positive as possible.

As Einstein recommended, we must look at the health care system from a different perspective. It should not be thought of as a problem to be fixed. The Wilson Health Planning Cooperative is taking a different approach with Appreciative Inquiry. Instead of focusing our questions about the problems of health care, and then trying to fix them, the Cooperative has focused its questions on the strengths of the health care system and the communities of the 11-county region. *(See Appendix I for the PowerPoint presentation on Appreciative Inquiry used at the public meetings.)*

The fundamental assumption of Appreciative Inquiry is that the way we talk influences the way we think. Likewise, the way we think influences our actions. This has long been demonstrated in the social sciences. It is called the "self-fulfilling prophesy." For example, when individuals tell themselves they are poor at mathematics, they become poor at mathematics. If individuals would tell themselves they are good at mathematics, they would eventually start to believe this and would thus become better at mathematics.

'Stories stick like glue'

Another assumption is that stories are valuable for fostering change and as research data. People are much more inclined to remember stories of success than they are to remember theory-based rationales. People remember stories because they are personal and meaningful. "Stories stick like glue," says Bill Patrie, a co-chair of the Cooperative.

"What we focus on becomes reality," Patrie told citizens attending the 10 public meetings. This is precisely why—when researchers focus on the negative aspects of the health care system—they continually find more things wrong with it. It becomes a self-fulfilling prophesy. Likewise, when we focus on the positive aspects of the health care system, we will discover more positive aspects. This will lead not only to more discoveries of positive things, but also to the development of positive change.

During the 10 public meetings, Patrie often quoted Peter Drucker, widely considered to be the father of "modern management." Drucker, who died in 2005, said, "The task of leadership is to create an alignment of strengths, making our weaknesses irrelevant." This report attempts to do the same—to illuminate the strengths of the communities in the 11-county region in the hopes that, by doing so, our weaknesses *do* become irrelevant.

Collaborative member Dallas Knudson, left, and a community member interview each other on a personal highlight during one of the public meetings. They, and others, then shared these success stories with the larger group.

It is our belief that by examining and sharing our community strengths, we will be able to realize the positive changes in our health care system that we desperately need. The process will not be without its frustrations, but the frustrations will be greatly outweighed by the benefits of a health care system where everyone gets the care they need, when they need it, regardless of their age, race, income or any other characteristic. There are currently many obstacles in the way, but together, as a famous song states, "We Shall Overcome."

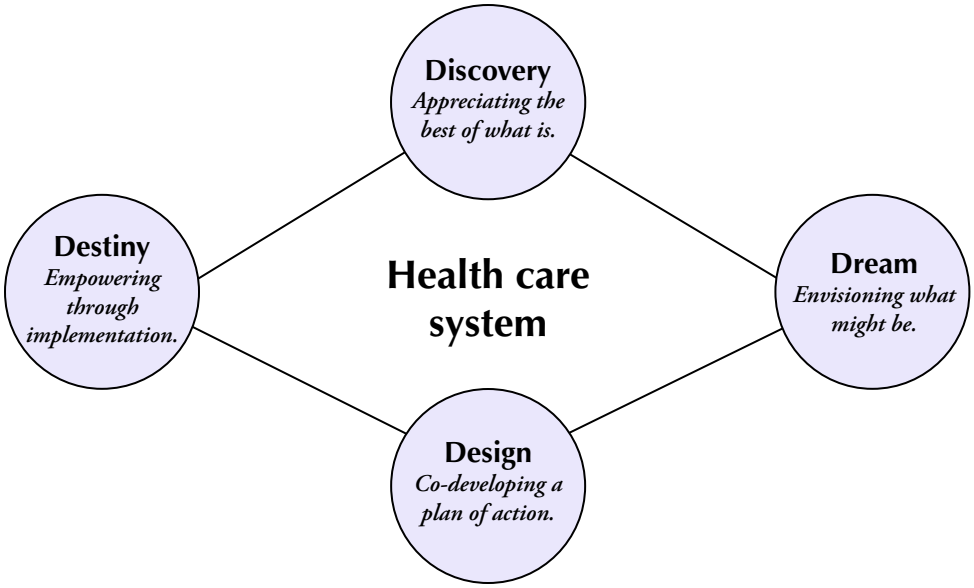
Chapter III: Discovery Phase

"No pessimist ever discovered the secret of the stars or sailed an uncharted land, or opened a new doorway for the human spirit."

– Helen Keller

Although there are problems with the current health care system, as the previous section illustrates, the Wilson Health Planning Cooperative will not focus on the negative. Rather, the co-op is dedicated to Appreciative Inquiry as a transformative approach to studying the health care system. This approach focuses on asking positive questions. The 11-county region has a unique opportunity to create an integrated health care system.

Appreciative Inquiry consists of a "4D" cycle: Discovery, Dream, Design and Destiny.



During the Discovery Phase, we ask questions to appreciate the best of what currently exists. In this phase, we discover the "positive core." According to Cooperrider, the positive core is a "diverse set of assets, strengths and resources."

During the Discovery Phase, Collaborative members visited 10 communities in the 11-county region to ask individuals to tell stories about individual and group triumphs. We recorded those hundreds of stories both in writing and on audio tape. *(See Appendix J for transcripts from the 10 meetings.)*

Appreciative Inquiry is more than just telling and listening to positive stories, however. We wanted to understand not only the "assets, strengths and resources" of the communities, but also the reasons why people succeeded in the past so we can use these lessons and apply them in the future.

From the 10 public meetings, we discovered the 11-county region has an extraordinary "positive core" consisting of talented individuals, active community organizations and dedicated health providers. We also discovered why people in the region are successful in their endeavors. They have positive attitudes, cooperate with others, persevere despite obstacles and experience a little good luck.

Those attending the 10 public meetings held throughout the 11-county area during 2008 were asked to break into teams of two to interview each other on three issues. These two participants talk to each other about a high point experience in their lives.

Individuals and organizations

An important element of the positive core of the 11-county region is the talented residents. Regardless of the community in which we held our public meetings, individuals told stories of remarkable achievements. Many of these individuals worked very hard, sometimes for little or no pay, for the benefit of the whole community.

"Well, I think volunteers are fantastic. I got involved quite a bit with the Head Start Program. It covered nine counties and one of the things we had was the Foster Grandparent Program. And pretty much what we got around here is a lot of grandparents, but they were so great to help out, non-paid and they might have raised 12, 15 kids of their own.

But here they were out volunteering to help young mothers get along. I know one mother asked how to make bread and rolls. And one grandma did so. She had raised 12 kids herself, and here she is teaching this young gal to bake. Now, I think this Foster Grandparent Program was one of the most successful things that Head Start put out because it covered nine counties.

I know one time we ran a van trip to Grand Forks and I told this one boy that we had a new rule this time: There'd be no talking on the bus. And I tell you, there was silence for about 30 seconds. And that took care of the no talking. But anyway, I certainly enjoyed the Volunteer Grandparent Program and I think we're working with seniors here now and I think that shows a lot. They worked their life, and they're willing to help the next generation come along."

The last sentence in this story conveys an important theme: selflessness. It is a theme of using one's strengths to help others, and it came up again and again. A couple of local doctors told stories about using their strengths for the benefit of others. One doctor described his motivation for practicing medicine in rural North Dakota this way:

"Actually, I went through the war and went through the GI bill to become a doctor. In a way, that was money that paid for my medical education. But following that, I went back into the public health service because I was interested in public health. And I thought that in medicine you should be a servant—in a way—to everyone. And public health seemed to offer the most; preventive medicine and the like.

Then my assignment to go to Elbowoods—unfortunately, that was not my top choice, it was my fifth choice. It should have been my first. But when I got to Elbowoods, I was only obligated to spend a year—or two years rather. But I went on and on and it became a lifetime. And so I was motivated. I certainly didn't get paid very much as doctors do, but I mean just because of the people—the Indian people, the Fort Berthold people—I came to like so well and could see their suffering, well... from so many things."

Collaborative member and namesake Dr. Herb Wilson, left, and another public meeting attendee take time out of their interviews for a quick photo.

Another doctor told the story why he practiced in rural North Dakota:

Participants share stories of perseverance and triumph during one of the 10 public meetings held in 2008 throughout the 11-county area served by the Wilson Health Planning Cooperative.

"My father was a struggling clerk in a big import/export company. But he decided that he would borrow money, if he had to, to send me to medical school. And, of course, that was the incentive for me to do well. I went up, did everything. Graduated in '54. Did my post-graduate surgery training in India and in England. And then I came over to the States in 1967... until I retired in the year 2002. People ask me, 'Do you miss medicine?' I say, 'No, but I miss the people. The patients, the nursing staff, the lab technicians, the pharmacists, these are the people I miss.' People ask, 'Why don't you like medicine?' I say, 'Because medicine as it is being practiced in this country today has so many drawbacks. I keep hearing these politicians talking about health care. Unfortunately, it's all determined in terms of dollars and cents.'"

"When I went to medical school, I went to a medical school called the Christian Medical College and Hospital in Belmore, South India. It was founded by an American missionary lady from Kansas, Ida Scudder. Her parents were missionaries in India. At the age of 16 she came to visit her folks and while she was there a young man came up and said, 'I want you to come and help deliver my wife who is in labor.' Ida said, 'I'm just a high school student. I could have my dad come and do it.' The main replied, 'No. We are not allowed to have men deliver babies. I need a woman.' So he went away. Later that day, the same thing happened. Another young man came begging for her to come and deliver the baby. And she said the same thing. And strangely enough a third time it happened. Anyway, she found out the next day that all three women died in childbirth. That is when she decided to become a physician.

"Ida came back to America, went to Cornell University, did her training, came back to India, and started a medical service—strictly a women's clinic. Over the years she started to get other missionaries, surgeons, doctors from all over the world came to work with her. She started a dispensary. She started a small cottage hospital. And she gradually got to the point where she started a medical school for women, until the year 1947, when they decided to allow some men students into the school. In '49 I was the third batch of men students in our class. There were 14 guys and 21 women.

"Now Ida Scudder lived to the age of almost 100, and she had a tremendous effect on me. I remember one day when I was standing outside by the door waiting for the school bus to take us up to the college. And she said to me, 'How are you?' I said, 'Fine. You know, it was a beautiful night last night with the moon and the millions of stars.' And she said, 'You know, that might have been beautiful but those stars and planets are cold, impersonal places. I prefer the mass of humanity that's on this earth.' And that was something that influenced me.

"Anyway, to cut a long story short... I went on, finished my medical training in India, in Belmore, went to England, did my post-graduate training, and was all set to go back. I even spent a year in LA—Las Angeles—doing urology. And finally I went back; we were going to go back somewhere. And then I saw an ad here in the paper asking for a surgeon in Mohall, North Dakota. That's how I came here in 1967. And I kept going until the year 2002. Most of my classmates had retired and they asked, 'What's going on, what are you doing?" And I said, 'Well, I'm providing health care in a small town of under a thousand people with the help of medical staff.' Many years I was a solo physician here. Occasionally we had one or two come in, spend a year or two and then they were gone. And all I can say is, it's been fulfilling."

An interesting aspect of this concept of using your strengths to help others is that it is contagious. This amazing woman, who used her strength to help others, inspired this particular doctor to do the same. It motivated him to provide health care to rural people in North Dakota, not because he could make a lot of money, but because the people needed a good doctor and surgeon.

A participant shares a story of a positive team experience during one of the 10 public meetings.

We also recorded many wonderful stories of group triumphs. When a group of people think positively, cooperate with one another, and never give up, they can achieve any goal they set for themselves. Another thing that happens when people are positive, cooperative and dedicated is that it has an incredible energy that affects others and spreads. The following stories illustrate this quite well. One participant told a story of a whole community coming together:

"In my small hometown was a mentally handicapped man with a very small shack of a home. He used to pick up pop cans off the ground to make his money. And one day, this little shack of his burned down. Instead of letting him be homeless, the community came together and raised money, donated materials and labor and we built him a new house. It wasn't a fancy house, but it was better than the house that burned down. The community really came together and all had a common goal and achieved that goal. It couldn't have been done if the whole community hadn't come together."

Another participant shared how she and others touched the lives of children:

> *"As a special education teacher, we would work in teams with these special children. All needed to work together—the child, parents, teacher and support staff. All would need to know each others' strengths to make a difference in children's lives. There was a real sense of team accomplishment when these children graduated from high school."*

Making a difference in the lives of families resulted in another participant's story:

> *"Last year during spring semester I took a class on health law/gerontology. At the end of the semester we worked with the sociology class to set up a goal to develop the idea of drafting and notarizing health care directives. Two classes met weekly outside of class and drafted more than 600 free health care directives. Heath care directives allow you to talk things over with your loved ones. It was very rewarding. It made people aware of health care. It allowed me to apply the knowledge I had learned so far. This project will be a tradition from now on. Creating health care directives is a lifetime gift for families."*

Collaborative member and report author Pierce Stepp, right, laughs at a participant's humorous story during one of the public meetings.

Health care facilities

One thing we were impressed by again and again is the dedication of the health care providers to the well-being of the people in the 11-county area. Each facility has its challenges, primarily financial and staffing. However, these facilities are some of the greatest health care resources in the 11 counties for a coordinated health care system.

Since May 2008, members of the Wilson Health Planning Collaborative toured the health facilities of many communities in the 11 counties. *(See Appendix B for a list of health facilities in the 11-county region.)*

These facilities are an integral part of the positive core of the 11-county region.

The health care system as it functions today is not the result of a lack genuine concern; it is a result of artificial boundaries that prevent communication and coordination. That we were allowed to tour each of these facilities is evidence of the concern of health providers for the well-being of the communities they serve. It was the critical first step in building the foundation of bridges that allow for cooperation of health facilities.

The following are descriptions of just some of the health facilities that members of the Wilson Health Planning Collaborative toured during 2008. These organizations are a sampling of the tools available for the health care system of the future. They are what author David Cooperrider calls the "positive core."

Collaborative members Pierce Stepp, left, Bill Patrie, center and Dr. Herbert Wilson arrive at the Knife River Care Center at Beulah for a tour of the facility.

- **Knife River Care Center, Beulah:** We visited the Knife River Care Center (KRCC) on Sept. 2, 2008. The KRCC is a new care facility for the elderly, although it does not explicitly say it is such. The center has just recently moved from its old location to a new state-of-the-art building that overlooks the rolling plains north of Beulah. KRCC's goal is to:

"Provide the best home for our present and future residents and to safeguard and preserve the dignity of the residents and their families. Excellence is our standard, and we will make every effort to always provide the tools and support the staff needs to do their jobs. We will persist on being better tomorrow and every day thereafter. Leading the way to a new culture change, we will work boldly to become a world-class organization."

The center was first called the Beulah Community Nursing Home when it incorporated in 1962. At that time, it provided 22 beds of skilled care to the elderly. The demand for more beds resulted in the 1981 union of the Beulah Community Nursing Home and the Rev. Jochim Memorial Home, a basic care facility. This new 90-bed facility was the first one to have basic, intermediate and skilled care in the same facility. The name was changed in 1996 to the Knife River Care Center because it was more fitting of the geographical area served. It also bespeaks the philosophy of elder care as well.

According to leaders of the new care center, the goal was to de-institutionalize the facility. They use what they called the "social model." The language used by staff, combined with architectural design, is how this social model is facilitated. The goal is that the language used will influence the way residents, families and staff members view the facility and themselves as part of the facility.

Those involved say they really wanted to get away from the idea that this is a nursing home. Instead, they call it a care center, which has fewer stigmas attached to it. Studies show that most people do not like the idea of going to a nursing home, but living in a care center is more acceptable.

The elderly who live in the Beulah facility are not "patients," but are "residents." This distinction is important psychologically to those living there. If they are treated like patients, they will think of themselves as patients and, it is thought, they will get sick more often. If they are treated like community members, they will have a sense of belonging, leading to happier and healthier lives.

The facility is divided into three named neighborhoods that contain two households each. The residents chose the names of their communities. Each neighborhood is painted a different color so it is harder to get lost and easier to maintain a sense of direction. Each neighborhood has a supervisor, who has the responsibilities of a head nurse. However, there are no traditional nurses' stations as these were deemed too "institutional." There is a chapel that has a big stained glass religious scene with lights behind it that was donated by a local church.

The coffee bar near the entrance to the facility helps cement the feel of a "community." Residents and guests can sit at the coffee bar like they would a coffee shop in their former communities. Each neighborhood has a family dining room that can be reserved. Each neighborhood also has a day room that has a computer with the Internet, a big screen TV, Nintendo Wii video game console and a bird aviary. All resident rooms are private except for six double rooms, where married couples sometimes stay. Resident rooms are all painted a sunny yellow and have a large accessible bathroom. There are also neighborhood kitchens where residents can help themselves to the contents of the refrigerator and can even cook if they are hungry for something other than what is being served.

In each neighborhood there are two dining rooms that hold up to 15 residents. Residents are allowed and encouraged to go to other neighborhoods for dinner so they can visit with friends and "neighbors." Also, there is a bathing suite in each neighborhood. These state-of-the-art baths make it possible for residents who would otherwise not be able to take a bath to do so. Since some residents would rather take showers, 16 resident rooms have showers. Finally, there is what is called a serenity suite. This quiet, cozy room with a single bed, a couch and several chairs is where residents can spend their last days.

Bill Patrie, Wilson Health Care Collaborative co-chair, looks at the coffee bar at Beulah's new Knife River Care Center. This 86-bed facility employs about 145 for the all skilled care that is offered there. The goal of the seven-member board is to attach an assisted living facility unto the west side of the care center. Fred Stern, board chair, says local residents and businesses donated nearly $2 million for the center that was completed in January 2008.

The Beulah facility also has a wing, Whispering Winds, dedicated to residents with special needs such as Alzheimer's disease. There are two sides of this wing with 12 residents on each side. Windows are limited to reduce Sundowner's Syndrome, which is confusion, anxiety and hallucination that can increase toward the end of the day, most often at sunset. Besides the locked main doors and lack of windows, the rest of the wing mirrors that of the other neighborhoods. There is a day room and a shared kitchen. There is also a cat named Little Red residents can spend time with.

If more intense care is needed, residents travel to a hospital that is only 15 miles away. This means emergency care is quick when needed. There is an exam room in every neighborhood and a physician visits once a month. In the basement, residents can do physical and speech therapy. There are also two social workers on staff. There is a medication room in each neighborhood. A nurse administers the necessary medications from this room or in residents' rooms. The health records of the residents are also kept here. These records are still primarily paper records, but by 2014 all records will be electronic.

Electronic records will benefit nurses who already use personal digital assistants (PDAs). These handheld computers contain residents' pictures, allergies and special notes. The PDAs can also locate residents through a global

positioning system that is incorporated in the small badges that everyone, including residents, wear. If a resident needs help, he or she can push a button on the badge and nurses will know exactly where that resident is. Instead of flashing lights and buzzers going off in the hallways, the message goes straight to the nurses' PDAs. This cuts down on the noise and commotion for both visitors and residents.

The Knife River Care Center is community owned and is governed by a seven-member board.

Members are elected from the region by the membership. The center gets 35 to 40 percent of its revenue from private payers. This is shifting toward more money from Medicare and Medicaid. It also gets a lot of support from the community. Local businesses and individuals donated more than $2 million, in addition to the art and other decorations that are part of the facility. There are minor staff shortages in all areas of the facility for some of the approximately 160 positions. In addition to staff shortages, the center sometimes has financial difficulties because it is an up-front service and sometimes it takes a long time to get reimbursed for these services.

■ **Hill Top Home of Comfort, Killdeer:** Collaborative members visited the Hill Top Home of Comfort (HTHC) on Sept. 3, 2008. As you walk into the Hill Top Home of Comfort you are greeted by the presence of beautiful landscaping that features colorful flowers and a little picturesque pond. When you enter the facility, a nurses' station forms a small island in the middle of vast, open room. Walking around to the left there are locked bathrooms, the keys to which are with the nurses in the nurses' station. Continuing to the left there is a sitting room that contains chairs, a TV, a bird aviary, fireplace and an activity section. Residents can get their hair cut at the barber shop on site. There is also a chapel that contains a donated altar. Just one of the many remodels to this building are recently-installed hardwood floors.

Health care employees at the Knife River Care Center at Beulah explain and show how the PDAs work to track residents and employees.

The residents have access to outside gardens, which are raised to wheelchair height so interested residents can work in the soil. Residents also like using the Nintendo Wii game system to have bowling tournaments and play other games.

The common room at the Hill Top Home of Comfort at Killdeer is roomy and bright, and features a fireplace and aviary.

Hill Top Home of Comfort is a community-owned non-profit organization governed by a board of directors. Until 2000, HTHC was an 80-bed skilled nursing facility. Because there is a 90 percent occupancy rule, meaning it must maintain 90 percent occupancy, the facility needed to reduce the bed count to 50 in 2000.

The services HTHC provides are IV therapy, in- and out-patient physical and occupational therapy, tube feedings, speech language pathology and home health. In 1999 therapy services contracted out because of staff shortages.

Home health services include skilled nursing, medication set-up, bathing assistance, therapy and more. The home health

services are unique in the region because they are not losing money. In fact, these services are making money that helps other sections of the home. A physician visits every 60 days.

For a long time, there were no laundry facilities on site. The soiled linens had to be transported to a different part of town to be cleaned and then transported back. Because this was costly and time-consuming, HTHC built an inventory and laundry room, which operates about 3½ days a week.

Although the facility used to have psychological services, it cut that because of budget and staff shortages. The nearest hospital is in Dickinson, which has experienced financial struggles. Many people bypass it and go to Bismarck, even though it is further away.

Ambulance service is available in the Killdeer area, thanks to mostly volunteer help and one paid certified medical technician.

The biggest challenge Hill Top Home of Comfort faces has to do with government regulations that tie the hands of health providers. These regulations mandate a high level of health care but then don't allow the providers to do so. Another problem is the increasing costs of health care. It currently costs $5,700 a month per resident to stay at the facility. Another problem is that it is difficult to maintain staff. Staffing shortages in all areas forces current employees to work extra shifts. This is hard on employees and also costs more money, as HTHC is forced to pay overtime rates. There are about 120 staff members including on-call staff.

Although the facility has problems that are common to many rural health facilities, there is much going well. Contrary to popular assumptions, not all residents remain at the facility until they die. Nearly 25 percent of residents use this facility for a short time before returning home. Also, the home health service is working with budget surpluses. Home health is a service that many at the community meetings expressed an affinity for. This service can be used as a working example for other would-be home health agencies.

Beautiful landscaping greets residents and guests at the North Central Good Samaritan Center at Mohall. The center averages 90 employees "We also serve the community with outpatient physical therapy and occupational therapy," says Kelly Vig, administrator.

■ **North Central Good Samaritan Center, Mohall:** We visited this facility on Sept. 4, 2008.

The North Central Good Samaritan Center in Mohall is one branch of the Evangelical Lutheran Good Samaritan Society. The Evangelical Lutheran Good Samaritan Society started in 1922 in Arthur, N.D., when a little boy with polio could not get the care he needed for lack of money. A couple of pastors decided to ask their congregations to donate 2 cents each so that this boy could go to St. Louis and get the care he needed. They raised enough money to do so and had $2,000 left over. They used this money to start the first Good Samaritan Christian Home for disabled children and others. As with all Good Samaritan homes, the nursing home in Mohall operates with the motto, "In Christ's love, everyone is someone."

The original building in Mohall was built in 1977 and was remodeled in 1981. The facility features a garage that enables residents to get into vans without ever going outside—important during frigid northern North Dakota winters. Between 1993 and 1995 a new wing, which has larger resident rooms, was added. And, most recently, windows in all 20 of the residents' rooms in the original part of the building were replaced with energy-efficient ones.

The facility now has four wings and currently 57 residents is considered "full." This facility is a skilled nursing facility, but they also have in and out-patient therapy, hospice care and Alzheimer's care. There are a couple of special rooms for bathing residents. One bath is an older model and the new one is called the Apollo. The home has also ordered a new bariatric tub to bath residents who weigh 450 pounds or more.

Kelly Vig, the administrator of the Mohall Good Samaritan Center, shows the Collaborative group one of the facility's bathing tubs. "It's about 30 years old," says Vig, who joined the Mohall center in 1979.

Although this facility has more of a traditional nursing home feel than some of the others we visited, they do some very interesting things here that are anything but traditional. For example, residents are encouraged to help plant and weed the gardens. The bounty paid off with a first-time farmer's market right on the plaza of the facility. This growing project will help get the community involved and offer residents outside exercise. In the hobby room there is a laptop residents can use for e-mailing Web searches. Also, according to the home's December 2008 newsletter, they just put into effect hand-helds and a new electronic records system that will help reduce the staff time spent on paperwork, resulting in more time with residents.

About 90 employees work at the nursing home in Mohall. They have many nurses, a nutritionist, social worker and a doctor who visits every other week. The nursing home is just across the driveway from Trinity Clinic. Someday they would like to connect the two buildings with a tunnel so residents can go to the doctor's office without ever going outside. There is a beauty shop.

The biggest strength of the Good Samaritan Center is the community support. The community donates money and individuals volunteer. The new windows were purchased with money donated by the community. The staff has attempted to integrate the home into the community by hosting the farmer's markets where residents can sell their own produce and buy produce from local farmers. Once again, it is communication with the community that allows the nursing home to really help the residents and their families.

Just think what could happen when it isn't just the community of Mohall, a 900-person community that supports and is supported by "Good Sam" as it is lovingly called. If the entire 11-county region becomes that community of support, there is really no limit to what the home can do for the residents.

■ **First District Health Unit, Minot:** We visited this facility on Aug. 5, 2008**.** The First District Health Unit is a public health agency, responsible for community health. Community health includes, but is not limited to, environment, direct health service, education, prevention and collaboration. In addition to a public health facility, it is also an emergency operations center. This aspect of the facility was built between 2003 and 2004. Public health scares like the terrorist attacks of 9/11, the train derailment in 2002, and the anthrax scares overwhelmed the facility, but now it is better equipped to handle such public health scares.

This organization was founded in 1893 under the name of the Minot City Health Department. This organization agreed to join with Ward County in 1942 and changed its name to Ward-Minot Health Unit. Since then, the North Dakota Legislature passed a bill that allowed multiple counties to combine their resources to create a common health department. This organization grew until it encompassed the entire seven-county region. First District Health Unit was established in 1945, becoming the first multi-county health district in North Dakota. There are now 63 employees across the seven counties served by the First District Health Unit.

Lisa Clute, the executive administrator of the First District Health Unit, explains some of the services to members of the Collaborative.

This organization serves seven counties: Bottineau, Burke, McLean, McHenry, Sheridan, Ward and Renville. The environmental health division covers the entire seven-county area, making sure the water is safe to drink, sewage is disposed of properly and safely and restaurants meet sanitary standards.

The First District Health Unit's new emergency operations center facility contains a library of emergency books and literature. It also contains phones that are in direct link to other emergency organizations and first responders. Hidden in the ceiling, these phones are out of the way unless a disaster strikes. This will better enable the coordination of rescue and public safety officials to deal with these problems quickly and efficiently.

The older part of the facility contains a water testing lab, where seven environmental health staff work. The large room features a black lab table in the middle, a refrigerator in the back and half-full test tubes of yellowish water along the left-hand wall. Further down the hallway, there is a sexually transmitted disease testing room, where tests such as HIV/AIDS are conducted. There is also a place here that parents can rent car seats for their children for $10 to $15 and get the training necessary to use it properly. This service helps ensure that area children are as safe as possible while riding in vehicles. This Health Unit also holds breast-feeding classes, tobacco education and injury prevention classes.

First District Health Unit is governed by the North Dakota Board of Health, comprised of a board member from each county appointed by the county government. While each county has at least one board member, Ward County has three. The board holds quarterly meetings, which are open to the public. First District Health Unit gets most of its money from county, state and the federal government. Approximately 20 percent of its money comes from consumer fees, such as food licenses. Staff salaries account for about 73 percent of the Health Unit's expenditures, while 11 percent is spent annually on supplies.

Like most rural health organizations, First District Health Unit struggles with economic issues. It costs about $1,500 to immunize a child and there are no government program to help pay for them. People without health insurance can't afford to pay for immunizations and people with health insurance are seeing their deductibles sky-rocketing, making them unaffordable.

Despite these rising costs, people still need their immunizations for school, work and travel. If they can't pay, it comes out of the First District Health Unit budget. Because of this and other costs, the facility can no longer afford to travel more than 45 miles from Minot. Therefore, they have been forced to cut home health visits to many rural areas. Rural people are already more likely to die of heart attacks than their urban counterparts. These cuts will only make the disparity even greater.
Despite budget worries, First District Health Unit is a nice modern facility that is an incredible asset to the area. First District's clinics in each of the seven counties are an excellent resource for the Wilson Health Planning Cooperative. First District is also willing to get involved; as its board and employees are genuinely concerned about the health and welfare of the people they serve.

Elements of success

During our public meetings, we were told many powerful stories about individual and team successes. In most of these stories there were at least one of three elements they attributed success to, either explicitly or implicitly. The first element of success is maintaining a positive attitude. The next element of success is cooperation or teamwork.

Dr. Herbert Wilson, right, looks over his first patient record book while visiting the Three Affiliated Tribes' Mandaree Field Clinic during the summer of 2008. Holding the book from the early 1950s is Arlene Muzzy, the clinic's licensed practical nurse.

The last element of success is never giving up despite obstacles. All three of these elements contributed to success in the following stories. When these elements are combined, the probability of success is dramatically increased.

■ **Being positive:** Although many people have never heard of AI, they still use the primary element of AI: focusing on the positive. When we focus on the positive aspects of a team, organization, community, institution, or system, we discover what works well and we can build on those things. This leads to the change that we seek. A woman from New Town talked about instilling a positive attitude into her family as her personal triumph. Her interviewer described her statements:

> *"I interviewed this nice lady. And she was saying that kind of her personal triumph is kind of as being the head of her family. How she's encouraged family members to be the best that they can be and going to school and that sort of thing. She says that it starts in the home. To have this positive outlook on life starts in the home. And she's proud that she was able to put that into her kids and also now her grandchildren's lives even from the home."*

Here's an example of positivity leading to success:

Dr. Herb Wilson shares a story during the public meeting at Beulah.

> *"I'll tell one about my son—when he was a sophomore. He played a lot of soccer, and he went to Bismarck High School; and there was not any chance he was gonna make varsity. But he didn't make the JV either. Bismarck, in soccer, they don't cut anybody. They just keep adding teams, so he was on the third team as a high school student.*
>
> *He played a lot of traveling soccer. But the third team—they played a JV tournament and they wound up playing their arch-rival, Century. But it was Century's JV team, a much better team. And the JV team had players on there that couldn't play varsity because of discipline problems, but they were good…really big and strong and fast. And this third-level JV team had a number of exchange students on it who weren't really good and it had a number of other players who just needed some place to play. And he [the coach] played them all.*
>
> *Now this was a championship game, and so this coach is playing everyone, going through his rotation. And my son's team beat this team and won the championship. They played out of their minds. You know, they did stuff they weren't capable of doing most of the time. But I asked him, 'What did the coach tell you at half-time?' At half-time it was tied and it ended in a tie, and the Bismarck team won it in overtime.*
>
> *He said, 'It's not the skill that will determine who will win." That was good, you know. Because they clearly didn't have as much skill. But he said, 'Who wants it the worst, or who wants it the best?' And as coaches, that's what you tell your kids. And these kids believed this guy and they thought they could win. And they did.*

It was just beautiful and when that senior class graduated and they were all playing varsity and they had the senior banquet, they asked me to read a poem about that game their sophomore year. It meant more to them than all the games they won after that as varsity players. That game is the one they remembered."

The coach told his team they could win. This was internalized by the players and because they believed it to be true, they performed better than they ever had before. This is an excellent example of the self-fulfilling prophesy. If you tell yourself you can win—and you believe it—it will come true.

One important result of maintaining a positive attitude, working together and working through obstacles is that it spreads like wildfire. People love to be involved with positive projects. They get energized by others' positivity and it just grows. This is one of the reasons that organizations can reach even lofty goals. People get excited about a project and more people get involved and they take ownership of the goals. It is a snowball effect that once it starts to roll, it is almost impossible to stop:

"Her story was about the time when the bridge was first dedicated and there was a group of people who were in charge of making sure that this all happened for the TV cameras, etc. So there were real experts on that board who were planning everything. They sort of assigned her the veterans. And they assigned her the veterans' auxiliary ladies.

So what she did was, she called each one of them all over the reservation. Pretty soon other ones from off the reservation were calling her saying, 'Can we do it? Can we come up, too?' Before she knew it—and she didn't really do it with them—they took her lead and they spread it all out. So it was like starting with her and then spreading out over the whole reservation.

A community member shares a personal high point, while another public meeting participant listens.

On that day, when they dedicated that bridge, the whole place was full of veterans in their whole eagle feather regalia. And all the little ladies having such great fun and it was just a massive demonstration of people working together with one person kind of leading the way and saying, 'Why don't we do this?' Then they were all coming together and doing it. So she was really awed that they did that."

All this woman did was have a positive attitude and make a few phone calls. Pretty soon the project moved beyond her and took on a life of its own. The success of this project was better than anyone would have imagined it could be.

■ **Cooperation:** Obviously, for a group or organization to achieve any goal, cooperation is necessary. We can learn lessons from past successes regardless of how different our current organization and goals are from the successes in the past.

"This goes back to my college days. My actual degree is not in medicine, but is in theater. Yes, quite the change! But I was directing a play for my senior class project to graduate from college with my degree. And we were doing a play, ironically enough, called 'Oh God!' And, yeah, it's not the movie... it's a Woody Allen thing. We had protests about that even, so we won't go there.

But the thing is—the whole point is, of course, in a theater troop you do have—everything is teamwork. From the actors, to the lights…everything. And the night that we went on, there were people sitting outside the

auditorium waiting for the next show—my show. And I was saying, 'Go ahead. Go in.' And they said, 'No. That one is so rotten. The next show is really really good!'

And it was. Our show really brought the house down. And of course the director, you know of course I had some guidance, but again it was the actors and everything else that came together to pull it off. And it was—if I say so myself—one of the best shows they had up there in a long time. That was a long time ago, too, so I mean...

Collaborative member Fred Larson, right, takes time out from interviewing Jocelyn Turner for a quick photo.

But again, it was just a real proud experience you know to see the dedication that everybody put into that. And it was a large cast show and any one of them, they were key parts, and if they blew one spot it affected the whole show. It was like dominoes. All of it had to go if one part wasn't there. You know, you had egg on your face. But that went over very well and it was a proud moment for me."

Another individual told a story of cooperation leading to success:

"Unfortunately, one time the dam was built here in Garrison and the doctor here was swimming….had to swim from Elbowoods to New Town. But anyway, with the help of the New Town people there, they helped him build his clinic and, you know, started his practice there. He's been there for... how many years? 43? 43 years. So they helped him a lot there."

The following story also talks about the positive influence of cooperation:

"The story I'd like to share is that in Jan. 26 of this year is when we moved residents from our old facility to this facility... But I think what made it most memorable was, we were always concerned about having enough help to move all the equipment and all the residents in a single nine-hour day. And it was just amazing how much support we had from the local community.

The number of people that showed up with horse trailers and other trailers. As a matter of fact, we had to turn many of them away because we didn't have any room to park them all anymore. But, instead of finishing in eight or nine hours, I believe we completed the move in about five hours. But to see that level of support, and in a way it just seemed like a sanctioning of all your effort to get to that point. So, thank you."

This is a testament to the power of cooperation to achieve a goal. In this case, the community was so helpful and cooperative they actually surpassed their expectations.
Cooperation is a crucial element of success. Just like the parts of a bicycle, if one part of a team or community doesn't work properly, the whole thing breaks down very quickly. Every part must work properly, in accordance with the other parts for an organization or a community to successfully achieve a goal.

■ **Perseverance:** Any time an individual or a group attempts something important, there will inevitably be speed bumps and road blocks. Some people will try to prevent the individual or group from succeeding for any number of reasons. If an individual or group runs into one of these obstacles and gives up, success is not possible. If they are so dedicated to a specific goal that they never give up, they cannot fail. The same woman whose personal triumph was instilling a positive world view to her family also talked about the importance of perseverance:

Community members share stories of cooperation during a 2008 public meeting.

"And there's a really good quote if you don't mind me reading what you said... You said, 'When you hit a rock, you don't just stand there and say I'm never gonna get around it.' You have to say….. you have to stand back and say…..'How do I get around this rock or this mountain?' Because there is always a way around it."

Here is an example of perseverance leading to success:

"I interviewed this lady. And she had a really great story. She says she's the youngest of 11 children and two of her older brothers both got bachelor's degrees. So they inspired her to go and continue her education and so she went on... and later in life went on to seek her bachelor's degree and then also received her master's degree from the University of Mary. She was the first one in her family to get her master's degree.

> *Of course she felt very joyful, very hopeful, and proud of that. But also, she's very proud of the fact of the example that she set for her children and for her grandchildren. She said it even carried on to, not only to her family that are still here, but also those that have passed on. And she just felt really good about that.*
>
> *She also told me that her native name is Ambitious Woman and I think that is a very good name. Obviously, you have to be pretty ambitious to go on and to take that on especially for a lot of us that when we first go to high school, or maybe we go to college and get that BA and we think, "Well, that's great." But for her to go back later in life and take that on and do that, that's a great thing so... that's her story."*

As we get older there are many obstacles to getting an advanced degree. It takes incredible perseverance to successfully complete a higher degree, especially at an older age.

A woman with a public speaking phobia also told a similar story of perseverance:

> *"The other thing I can think of, is that last fall, I'd been putting off a speech class for years, like for five years I've been putting off speech. It was the only general I still had left to take. So I did take it last fall. And as it turned out I wanted to do it, not online, but in front of people. I get real nervous in front of people. So I did. I went to class. Well, I was the only 50 year old in the class. Everyone else was under 23 except for the instructor, but they accepted me and I had fun with them. Their tattoos and their earrings and you know it was a lot of fun. And I made it through class and got an A so I felt pretty good."*

Perseverance and cooperation are both present in the following story:

> *"For this project, for the Health Care Collaborative, we needed some funding to help us with our work. And so we heard about this grant through HRSA, Health Resources Services Administration, and there was some funding for a collaborative planning effort throughout the country.*
>
> *So we talked about it in one of the meetings and everyone, you know, really discouraged us. They're like, "You know, that's a lot of*

Community members listen as a participant at one of the 10 public meetings shares a story.

work and you never get it the first year. And so you'd just be wasting your time. But go ahead and do it if you want." You know, so it was really discouraging but he and I really teamed up well. We plodded forward and we had some research help from a few other folks from the collaborative. Boy, we put in a lot of hours in it, and it felt good to get it done. And it felt even better to get awarded on the first try, so we were pretty proud of that effort."

■ **Good luck:** In addition to all these elements of success, a little good luck never hurts. Now some people call it luck, some people call it fate, some call it destiny, some call it fortune, some call it karma. Regardless of what it is called, this seems to be an aspect of these stories. Few people at the meetings discussed luck or any of these things explicitly. But just think for a moment. What are the odds that so many dedicated individuals and organizations happened to come together and get involved in this process?

Chapter IV: Dream Phase

"*Health is a state of complete physical, mental and social well-being, not merely an absence of disease or infirmity.*"

– World Health Organization, 1948

As we discovered the "positive core" of the 11-county region, we also dreamed of what the health system should be. During our community meetings, we asked people to describe their vision of the ideal health care system.

"Pretend you've fallen asleep for four years," Patrie told the group at many of the public meetings. "It's now 2012 and you've just awakened. You look around and you see the health care system is operating just the way you've always wanted and dreamed about. What does that ideal system look like?

Patrie encouraged the audience to not hold back—to dream big. "There will be naysayers," Patrie said. "Some may be threatened by the prospect of a population taking responsibility for their own health care. Some may call this dream Utopian and unrealistic. Some may argue that we should take small incremental steps of reform."

Collaborative members tour the Trinity Health Care Center in Minot. The facility features 292 rooms and wide open spaces that the public can use for community events. There are about 450 part-time and full-time employees in this modern facility that resembles an upscale hotel.

However, without a goal—without a shared dream of the future—we will never get what we want. If a target is off in the distance, and you aim a bow directly at the target, the arrow will inevitably fall short. To hit the target, we must aim high.

This is the same as the health care system. We must aim very high if we are to get what we want out of the health care system.

And the participants of the 10 public meetings did aim high. Through a process of interviewing a partner or speaking for themselves, they dream of a health care system that is or has:

1. Available to all
2. Local
3. Abundant providers
4. Diverse
5. Affordable
6. High quality
7. Family medicine
8. Efficient
9. Preventive care
10. Home health care and hospice
11. Medical research
12. Dental care
13. Passionate providers
14. Independent
15. Cooperative

Collaborative members tour the Mandaree Field Clinic during July 2008. A nurse practitioner staffs the clinic three to four days a week. The clinic sees 12 to 15 patients a day. The Three Affiliated Tribes also has field clinics at Parshall and Twin Buttes and White Shield.

Available to all

We dream of an integrated health care system; of a health care system where everyone will receive quality health care when they need it, regardless of race, ethnicity, age, income, veteran status or sexual orientation. No group of people is so different that they should be treated differently by health professionals. We all look the same on the inside; we all have a heart beating in our breast and lungs to give us breath. One individual put it this way:

"I guess I look at a system in four years that is color-blind. It doesn't see if a patient is Native American or white or Mexican or whatever, and treats everyone the same regardless of how the bills are paid."

Another individual had a similar view:

> *"When it comes to working with Native Americans (and the Bureau of Indian Health), the big change in systems between the non-Native American health care systems and the Native American health systems is just really hard to work through...*
>
> *So that would really be a great thing, if we could make that more doable. Get rid of the…..have it all be one system so that you can care for everyone uniformly and the bills and the costs all take care of themselves in the background somehow."*

An individual at the Mandaree community meeting told us about the doctor's idea of an integrated health care system:

> *"Man! You got a long list here. But basically it boils down to if he wakes up in 2012, he would like no inequality—black, brown, red, orange, purple, green, you name the color, everything's the same. The same procedures for everybody also. So if you go in there, they do the same thing on you regardless so everybody gets the same care. Equal funding regardless. If you're rich, if you're poor, you go in there and everything is under one umbrella."*

We dream that when anyone is sick or injured, they will be treated quickly by qualified health care professionals. This includes primary care, emergency care, mental/emotional care, dental care, hospice care, home health care, vision and hearing, all medications and preventive care. In short, we dream of a holistic health care system where the whole person is treated.

> *"What I envision: Walking into a new facility where everything is laid out, mental health, you know, and all of that. Being able to just get up and go up North up the street here to get some care in the middle of the night. Instead of like, you get sick... well, we gotta go up to Stanley. I mean, hey, I really don't feel like riding all the way to Stanley or Minot. And the thing that I'd like to see is walking into a building like this…like he says we have all this equipment for the people. I'd like to walk into a facility where I can get care for whatever ails me."*

A sign on the bulletin board inside the Mandaree Field Clinic reminds patients that it will take 7 days to get their prescriptions refilled. The prescriptions are filled at New Town and then delivered to the clinic.

Local

In addition to being all-encompassing, the previous dream includes the idea of travel. The 11-county region is very large and not heavily populated. There are only about six people per square mile in this region. *(See Appendix F.)*

As such, travel to and from health care facilities can be very time consuming and costly, especially during the winter or at night. In light of this fact, we dream that travel to and from health care facilities will be taken care of and will be kept to a minimum. One woman summed up her dream well:

> *"She would like to probably see a good facility here that we can go to as individual people. Right now she said that she sends her kids to Bismarck, because it's better care. But in the future we know some day we're gonna have a better facility here and I hope it's on... you know, like, close to home here in Mandaree. And each of our little segments has one, so we won't have to worry about traveling off very far, or waiting for an ambulance to come get us. It'll just be done right here."*

Dan Kelly, right, CEO of McKenzie County Healthcare Systems, conducts a tour of the health care facilities at Watford City that consists of the McKenzie County Memorial Hospital, McKenzie County Clinic, Good Shepherd Home Nursing Home, Horizon Assisted Living and Healthy Hearts Wellness Center. Kelly says his three main challenges are: 1) Reimbursement payment; 2) dwindling population; and 3) an aging population. "The main problem we all face is we just don't have the revenue," Kelly says. "It's the driver of all ills."

Abundant providers

We dream that there are plenty of quality health care providers available in the region; that each family will have a family physician, whose responsibility will be the health of that family. Physicians will be able to spend time with patients and get to know them on a personal basis as well. They will have no worries about seeing a certain number of patients per day. This will allow them to really listen to a patient and focus on a patient's well-being.

> *"Four years, if we're successful and achieve everything needs to be achieved, then we will have a lot of health care workers here because they have come from all over to be part of this kind of system where they're allowed to work and to do what they love to do and they've been trained to do. And they can do that in an environment where they are not always cutting corners or pinching pennies so that the organization can pay its light bill.*
>
> *Hospitals and clinics and the whole health care system, including home care, will be free to do what they do best without worrying about the gas bill—that it can't go more than 45 miles out of town because it isn't reimbursed and we can't lose that much money on that kind of service, kind of thing. We just do what we know what to do. We know how to do it best and we're passionate about it and we're allowed to do it without being handcuffed and dependent on some archaic formula and system of regulation that make no sense anymore. Where it's actually fun to be part of the management team of a great team instead of a nightmare and one of constant worry and stress. That would be fun."*

A pharmacist put it this way:

> *"In my health care system I would have lots of caregivers who looked after very basic things. I guess today we call them nursing assistants or nurses' aides or things like that. People get worried about things. People get frightened about things. And they don't necessarily need to have a doctor or a nurse who can listen to them. They just need someone compassionate who can sit and listen and maybe do a few little things for them. And then, if necessary, relay some of their concerns on to a health care person. But there would be plenty of people to just take care of people. And that would be how I would see the whole system.*

In this view, there is not only an abundance of certified health care providers, but also an abundance of community organization that can help each other with their problems.

Another individual also discussed the importance of an abundance of health care providers:

> *"There is a need right now. If our practitioner wants to take a vacation, we aren't able to find anybody that time off, so our clinic has to be closed during that time. So in my ideal world there wouldn't be a shortage of (practitioners), there would be enough to cover that and people. You could have your clinics in the small towns to keep your small towns more alive and people would be able to take vacation and there would be people to fill in..."*

The lab at St. Andrew's Health Center at Bottineau is used by the 25-bed acute care hospital, clinic and senior housing. Jodie Atkinson, CEO, says the health center has about 70 full-time employees, making is about the third largest employer in Bottineau. "We've seen an increase in the utilization of our facilities," Atkinson says. "The clinic has reported three to five new patients a day."

Diverse

A high-quality health care system would be diverse. It would include family health, mental health, dental health, home health/hospice, holistic health, spiritual health, emergency health and preventive health care. Our bodies are not made up of discreet parts that can be cared for independently. When one aspect of an individual is sick, the whole person is sick. This rural health care meeting participant captured it well:

"I said to the doctor a little while ago, 'Will it go holistic [natural] medicine?' We've had doctors here that came to do family medicine among us, but went holistic. And I don't know what they're doing presently, but it would be interesting to know that."

(Question in background: Would you like it to be?)

> *"I would... So, holistic medicine we…..there's tribes in the United States here for sure. Years ago when we went to New York, the Six Nations people have been doing holistic medicine all along in New York at Onondaga...*
>
> *But I do know they use their medicine people there and here we've more or less lost—almost lost—ours…..our holistic medicine here. South Dakota's not doing too bad. They have a number of medicine people over there. We have all those plants out there that people used to use... and they stayed healthy for many years."*

A doctor said this about his dream of the health care system:

> *"Well, there's a movement now called Food is Medicine. Has anyone heard of that? And it's trying to have…. people have gardens and they grow their own food and go back to the old ways where they…..and thinking of trying to avoid diabetes and all. There's another thing though that I was thinking of and that is people should be more concerned with, well, preventive medicine actually.*
>
> *And go back and find out what their ancestors' cause of death and sickness were. So many are inherited, so to speak. There is a great possibility to wake up in 2012 and find that people are being treated in their own areas, they have the same doctor all their lives or the family does have the same sort of relationship. That would be good medicine."*

The same doctor also talked about a different side of health:

> *"Now, I was saying some of these things the other night in White Shield and suddenly I realized that the priest that I had known for many years was in the audience also. And then I regretted I hadn't brought out anything spiritual, the spiritual nature of life and all and I think we could develop that."*

Health care, like food, water and shelter is an absolute necessity of life. The dream health care system would ensure that all people had equal access to quality care.

Affordable

We dream of an affordable health care system, where all health services are paid for in a timely manner, and patients have no worries about how they are going to pay for these services. According to the Network for Regional Health Improvement, we need to shift our focus from the quantity of care to the quality of care, which would lower costs for everyone. This is part of our dream. Patients will never have to decide between paying for a meal or paying for their medications. They will never forgo any treatment because of the costs.

> *"The biggest thing that jumped out at me was medications, because that has to be one of the biggest needs that we see at the clinic. Medications are so unaffordable. So my dream would be that everybody would have access to affordable medications for a nominal fee, because I think people take a little bit of ownership from it when they are able to contribute to something. So I think some people would like to say "free meds" but I think when you are able to contribute a little bit on your own it makes you feel proud, too, that you were a part of that. So that would be my biggest dream is that meds are more accessible to everybody."*

Likewise, health care providers will never worry if they are going to get paid for their services. They can focus on providing the highest quality health care possible. Health facilities would be free to make decisions based on the well-being of their patients. All medications and procedures would be available for patients for there would be no lack of money.

The children's exam room at the Washburn Family Clinic is bright and colorful with bandanas serving as curtains and stuffed animals lining the top of supply cupboards.

> *"My dream would be that reimbursement would be covered for all services in the health care system. That we would have more providers available. That more of our young people—or whatever age, it doesn't matter—would go into the medical field and become providers. We have a lack of physicians that are available in North Dakota especially, but throughout the whole United States."*

An affordable health care system would allow all people to receive the health services they need and would allow health facilities to focus on providing the best health care possible. It would take unnecessary pressure off of health care institutions and off of individual families. This is an important aspect of the dream health care system.

High quality

We dream of a health care system of the highest quality. People want to have the best care available to them. A high-quality health care system is one in which people, organizations and communities work together to ensure the health of the members of their communities. It is one that focuses on preventive care, contains more money and effort for medical research, includes home health care and hospice, uses efficient technologies, and has an abundance of well-trained, passionate providers who are not constrained by monetary issues.

Family medicine

Family medicine is also an important aspect of a high-quality health care system. Family doctors are more inclined to understand a family's medical history to better advise about, diagnose and treat illnesses that occur. A doctor mentioned family medicine in an interview with a community member at a public meeting.

> *"He'd also like to see where you're seen by one doctor and one doctor only. 'Cuz that one doctor, if he could be qualified enough, he'd know all your records and he'd be able to treat you as an individual."*

Efficient

We dream of an efficient health care system, where there is little or no waste. When doctors repeat tests, it bogs down the entire system. Doctors waste their time and energy and their patients' time and energy when they perform the same tests as the last doctor. Inefficiency is also a contributing factor to costs, so it is imperative that waste be eliminated.

Dean Mattern, CEO of the Garrison and Washburn family clinics, shares a laugh with fellow Collaborative members Terri Lang, center, and Shelly Weppler, right, during the tour of the Washburn Family Clinic.

One man stated he would also like waste eliminated. He has been a doctor and he's seen a lot of waste from various insurances, paperwork and duplication of all kinds of tests. In this regard, technology could really help:

"One of the things that we've listened to since we've been involved in this committee is the new technologies that are gonna be available. They're talking about you going to a clinic and your information all goes into a computer that's linked to every clinic in the country.

So if you go to Bismarck and you go to a doctor's office, he goes to a computer and he can find out all about you. You don't have to take your records or call anybody else. It's all there for him so he can treat you better.

> *We also had an interesting visit with the University, North Dakota State University Medical School. They're working on a lot of new technology where, like for home visits, a CHR could come out and strap you into a vest or whatever and that would electronically go back to a doctor who can diagnose you and prescribe many things that could save you from going to the clinic. And in rural country that's gonna be real useful.*
>
> *The point is, that here on the reservation, I guess our job is to see that we are designing a new health care system now. Let's make sure we're involved in that. Let's don't design something that was 10 years old. Let's require them and get involved and see that we're state of the art in this type of equipment."*

An efficient health care system will save patients and providers time, energy and money and will lead to better overall health. A community member describes a doctor's view of efficiency:

> *"He would like to see one equipment center, where you go in and you get your MRIs, your radiology tests, everything, so you don't go from one place to another, because that just involves more waste…..with more doctors, nurses and paperwork."*

Preventive care

Preventive care is an important aspect of health care that is largely ignored today. We shouldn't wait to get sick before we worry about our health. There are things that can be done proactively to ensure a healthy life. Regular physical examinations, diet coaching, exercise programs and other programs will help create a healthy environment for residents.

> *"Just to comment on that, in 1989, I had an opportunity to go to Japan. I looked around at that community and I thought, 'My goodness,' everybody just seemed physically fit. They walk and ride bikes and they eat healthy. I lost 8 pounds while I was there, and I wasn't there very long! I couldn't find a McDonald's.*
>
> *But the place really struck me as, 'How much of our health is culturally induced?' You know, my folks, my dad lived to be 90 and he worked hard every day, had a modest diet, and my grandmother lived to be 99. They had that balance of exercise in everything they did. They worked every day.*
>
> *And now it's cultural. It's a great comment. Imagine how fun it would be, too. One writer I read talked about how silly it was to work all night so you had enough money to go to a health spa and work out. What if your job actually had healthy activities in it, so that you didn't have to go to the health spa?"*

Another individual told a story about prevention and healthy living:

> *"We just came back from France. We spent about five weeks over there. We never saw an obese person. But they eat so different than we do. They use only olive oil. And he's on a diet now, which is fruits and vegetables. But I don't know about France and how they get their eating habits and so forth because I'm not from there.*
>
> *But I do think that if we could find a way to really promote prevention in our diets and our behavior that would be a beginning to avoid all the problems. I really do."*

A college student also thought preventive care was important:

> *"I think that what I would hope for is for a greater emphasis on the long-term portion of health care. By that, I mean everywhere we're talking about 'going green' and being a sustained nation that will prosper for another 200 to 300 years. And I think that in keeping with that spirit we need to work a lot on the preventive aspect of public health.*
>
> *I would like to see a greater emphasis place on a healthy North Dakota and get us out of the bad statistics for obesity and heart disease and these problems that are gonna spiral out of control if we don't do something soon. It's just gonna cost us more if we don't. Not only would I like to see everything that you guys have all said, but I….also working on maybe 50 years down the road and how this generation is gonna be at that point."*

Home health care/hospice

People don't want to spend a lot of time in the hospital or nursing home if it is not necessary. Some individuals could live at home with just a little help now and then. If they could get care in the comfort of their own homes, they would feel much healthier—both physically and mentally—than if they had to spend that time in the hospital or nursing home. One individual put it this way:

> *"I have only met one elderly person that said, 'I wanna go to the nursing home.' 99.9 percent of the people want to stay in their own homes. I'll use a gentleman from Antler, North Dakota, that….I mean, Antler has nothing. There are no grocery stores, no restaurants, and the idea was to move him either into Minot or to West Hope.*

And he said, 'I was born in this house, and I wanna live in this house and will die in this house.' And that should be all our options. We should have that option. So if I can wake up in 2012 and see home- and community-based services funded to the level that they need, that would be my dream."

A woman with multiple sclerosis put it this way:

"As somebody in my shoes I would love to see home health care. I don't look forward to going to a nursing home or anywhere else. I want to stay home, but I'm gonna need help... And I keep fightin', but I need help. And I'm gonna need help. 'Cuz this [multiple sclerosis] is a progressive disease and it's not going to go away. And when I heard that, it was like a death sentence had just been written out. You know there's no cure. Life is gonna change whether you want it to or not. So find me some help. Some home health care is necessary. Not right yet, but pretty darn soon. Unfortunately, we're getting closer all the time."

Wilson Health Planning Collaborative members arrive at the Hill Top Home of Comfort in Killdeer for a tour and public meeting. From left are Dr. Herbert Wilson, Bill Patrie, Pierce Stepp and Fred Larson.

Medical research

The doctors we talked to during our health facility tours and our public meetings overwhelmingly indicated that more money for medical research was an important part of their dream health care system. One doctor who was interviewed "*would also like to see the research funding increased on all types of cancers and whatnot, just across the board. More research funding."*

There were several patients that shared this view as well. An elderly gentleman at a public meeting told of a future without cancer:

"I'd like to really see a cure for cancer. I'm involved in that. I had prostate cancer a few years ago. I got treatment. I got that fixed up. But my son... all of a sudden at 54 years old. That's why I'd really like to see this cancer being beat. I guess in... oh, I don't know, about 60... I'm 70 some years old now. Anyway I heard my dad talk about cancer. He said, "Krebse." How do you say cancer in German? Well anyway, I'd like to see that taken care of. That they find a cure for it."

A woman talked about the necessity of research as it applied to her diagnosis with multiple sclerosis:

I'd like for them to find a cure for MS nationwide. There are a lot of people that have it. There are a lot of us who would like to not have it. It's nothing you ask for. They don't know what causes it, how you get it, and there's no cure. And I don't like that idea. That's why my husband said, 'You're just too damned stubborn and you won't ever listen.' And I said, 'Well, honey, what am I supposed to do? Sit down and say help me I have MS? And sit and do nothing?' He said, 'No, you're not ever gonna do that.' And I said, 'You're right I'm not gonna ever do that.'"

Dental care

Quality care must include dental care as well. Many people who currently have health insurance do not have dental coverage. Ideally, everyone would have dental coverage as well. Our teeth are just as important as our eyes, ears, nose, throat or any other body part. Diseases of the mouth can spread to other parts of the body, just as other diseases can spread to the mouth. One individual explained it nicely:

"Well, if I was sleeping for 20 years and wake up, I wished we'd have a good dental plan. Not just for health, but for dental, too. You can have good nutritious foods but you have to be able to chew it."

Passionate providers

Another important aspect of a high-quality health care system is the presence of passionate health care providers. This was mentioned by both health professionals and by non-health professionals alike. Health providers would ideally go into the health field because of a passion to help people stay healthy and not only because it paid the bills.

> *"I hope—and if I would wake up and see that all caregivers are well prepared to make those decisions and if it's in the home, which I'm all for that—the home- and community-based services and being able to go out into the community and provide what people need. They [health providers] know what they can do without a policy or procedure telling them that they should do it. So it's a matter of the heart.*
>
> *It's that hedgehog concept of having that passion. You can't motivate people so having a health care system that isn't so bogged down should be self-motivating. If you don't have to check this and do that and take a percentage of what you're doing well and do it as a quality assurance measure, you're doing it because you wanna do it. So all health care providers want to be providing health care. So that would be my ideal 2012—it would be to have it not a money-making venture, but a passion to provide the care."*

Independent

We dream of a health care system in which the control is in the hands of locals. We know what the health care needs are in our area more than any outsider does. We should not be dependent on outsiders for our health care, either monetarily or executively. We want to have a self-sufficient health care system. During a public meeting, a doctor put it this way:

Some of the members of the Wilson Health Planning Collaborative pose for a photo after touring the Garrison Memorial Hospital in late July 2008.

> *"I have an idea that should work; it all depends on implementation. We're dependent on national organizations and federal big government to implement programs in individual states. Each state should be held responsible for starting and maintaining health care. City councils, other groups and state government could raise money and be involved.*
>
> *Right now our health care is being designed by people in D.C. with no windows. Our congressional reps are good, but if this is done at the state level, local governments of each community could come up with a system that is acceptable to all. No political parties involved. We're Americans and we need to think as a group."*

Another health professional put it this way:

> *"I don't know about 2012, but in this position….I'm very new at this…..and so in the future what we're trying our goals right now which if they take til 12 or to 20 is to make that transition to more autonomy on the caregiver's part so they are able to make those decisions on their own without a policy of procedure. I mean, of course, those are things that have been around forever and they may shackle us and keep us in a negative direction at times."*

Cooperative

We dream of a cooperative health care system where people, organizations and communities work with one another to better serve the health needs of the region. The health care system would be community-owned and operated, would foster a wider and deeper sense of community and would involve all stakeholders.

A young man discussed the importance of community involvement in the ideal health care system:

> *"I guess for me, I'm coming from the opposite direction, as a patient. What I would like to see in four years is everyone has a certain amount of say in the kind of services that are offered and are available. They have an equal say in how the money they pay at the doctor's office, [for] insurance coverage and in taxes is being used by health facilities. People are the 'bosses. And I definitely think there should be more conversation and more dialog between doctors and patients, so that both groups get what they want and what they need."*

Communication is extremely important for communities to effectively provide health care for its members. Patients and doctors especially need to communicate clearly with one another.

Ed Hall, left, Wilson Health Planning Collaborative co-chair, interviews a community member during a public meeting.

This communication is also incredibly important for health care organizations to effectively provide quality care to the community. They, too, must share the cultural tools and resources they have, which makes each facility stronger and better able to provide the care they are so eager to provide. Each facility struggles on its own, but by working together they can flourish. One man told the following story about a project he was involved with that dealt with communication between health facilities:

> *"I'm gonna focus on a little piece of work I've done the past year, year and a half... It's a team-building exercise was really the way I view it. It's an IT project involving 10 rural hospitals that satellite on Trinity. Among other accomplishments, the 10 hospitals did actually all contribute cash to the establishment of a non-profit corporation of the…..the acronym that they're going by is NOWAIT, which has obvious implications as far as the IT system is concerned. There was a commitment made along the way—I believe Trinity is on the Turner System—and all of these satellite facilities would be on Dairyland.*
>
> *And the commitment was made to create the bridge, or create the cross-walk, that would allow the systems to talk to each other on an instantaneous basis... The positive parts of this team-building activity were really quite important. It provides evidence to the fact that we've overcome the old basketball rivalries between the communities that are participating together. Those kinds of things have been very real—as recently as maybe only 10 years ago—and would have really blocked any possibility of these communities cooperating together to the extent that they have."*

That these facilities are already trying to communicate to share ideas and strategies is a very encouraging prospect. This sharing of documents would cut down on a lot of extra paperwork and extra lab tests, etc. This, in turn, saves money both for the health facilities and for patients. It also enhances the ability of health facilities to provide the best care available. The Wilson Health Planning Cooperative will be the shuttle that weaves the disparate medical and social threads into a single, integrated health care tapestry.

> *"When I wake up in 2012 I'm going to be retired. And, let's see, I probably will be 65 also. I have a dream of less paperwork. I have a dream of a universal health record so that we would use the same form in every clinic*

and every hospital in the whole country. That the information would be able to be shared. That lab reports could be shared. That x-rays could be shared. There would be less duplication. Figure out a way. We're heading in that direction on prescriptions and renewing them so that I don't refill a prescription then somebody else refills the prescription and somebody else changes the dose and the patients get confused and the doctor gets confused. So we need some kind of a common universal health record."

We currently tend to think of our communities as independent groups that must fend for themselves against other communities that are competing for scarce resources. It fosters an "us vs. them" mentality that does not promote a cooperative health care system.

Alice Grinsteinner, an administrative assistant at the Knife River Care Center at Killdeer, talks about the tub and shower room at the facility.

During our public meetings, several people brought up competitiveness and lack of communication as obstacles to a better health care system. One man described it like this:

"Right now we live in a community, I think, that does a very good job of where we're at and from where we've came... from '53 to present as New Town works together as a community. But I hate the thing that we're in segments.

Why are we from Four Bears? Why are we from Northeast Segment? Why are we from North Segment? To me, as we set up boundaries and we compete against each other, I think one of the things about the Collaborative is to see that we're working together and we're getting rid of the competitiveness.

I know we're all brought up to compete...but that's where we are brought up as youth and younger. So that's one of the barriers we need to break down in our communities, is to quit competing against each other. If we all had the same medical health facilities, the same walking paths. We have the same kind of economy out there. That's what I would envision..."

Although the previous health care meeting participant is talking primarily of the Fort Berthold Reservation, his statement can be extended to include the entire 11-county region. A woman from the same community explains how this lack of communication between community members can directly affect someone's health:

"The one thing that I would really like to see—and he said as far as support—is finding that support for addiction and grief. The one thing that I really longed for recently was a support group for cancer patients. I was diagnosed in February or in March. When I was diagnosed, I lost my oldest brother before I was supposed to start treatment.

Dealing with both those things I saw…..I looked for something that would support me. But as far as a support group, I would like to see that in our community; and for the grief. Because, like he says, we console them and we have to move on. But, you know, dealing with this illness, you know, was hard for me because of my loss. Because of what my brother meant to me as a leader and a mentor, and almost like a father because, you know, our parents have been gone for years."

Amazingly, the collective dream is harmonious despite the diversity of perspectives, which makes it a thing of great beauty. This collective dream is an important reference point for all subsequent planning. We must always keep this dream in mind and not stray from it. When a group of people share common dream and genuinely pursue this dream, it will become reality.

Conclusion

"*Words create worlds.*" – *David Cooperrider*

The Wilson Health Planning Collaborative has been busy since its inception. The strengths of the organization are being discovered. As more people and organizations join the new cooperative, they will be adding their expertise to the positive core of the group. They will be adding new perspectives to the dream health care system.

The first two phases, discover and dream, are not finished. There are always more strengths to discover and more dreams to incorporate into the collective dream. We must reach out to as many individuals and organizations in the 11-county region as we can. Their strengths and dreams are necessary for the creation of the best health care system in the world.

In addition to continuing to discover and dream, it is time to move on to the next step in the "4-D" cycle. The Wilson Health Planning Cooperative must now begin to design this new dream health care system, using the strengths we have discovered.

Design

In other models of social change, the design of a system or of programs is usually done behind closed doors by "experts." In these other models, it is thought that the residents' ideas and perspectives are unnecessary. The Wilson Health Planning Cooperative disagrees. Members of the communities know what they want and need better than so-called experts in Washington or other faraway places. The knowledge and skills exist in the communities to design the dream health care system and deliver it. *(See Appendix K for the cooperative's three-year work plan and budget.)*

Dr. Herbert Wilson, 87, visits the chapel area during the health care tour and meeting at the Hilltop Home of Comfort at Killdeer.

When designing this dream health care system, it should be a process that takes every perspective into account. This is what will make this new health care system the best in the world. The health care system will be designed and implemented by the people who are affected by it the most. This is an exciting time. Never before has such a group been assembled to create a new vision of a health care system.

Destiny

The final phase of Appreciative Inquiry is the "Destiny Phase." This means that we put into practice what we have discovered, dreamed and designed. The term "destiny" is extremely powerful because it creates a feeling of expectancy.

Words do have the power to influence both our thoughts and our attitudes. As Bill Patrie mentioned in many of the public meetings, a basketball player shooting a free throw that continually thinks about missing it, will likely miss. The same basketball player focusing on making the free throw is more likely to make the basket. In this way, our positive focus will become our reality.

If we talk about the successful implementation of our design as our destiny, we begin to think it is our destiny. Our collective dream health care system, when help deep in our hearts and shared publicly, will become reality.

When Michelangelo was asked how he created the Statue of David, he replied that he just started carving away the stone and David appeared. Like Michelangelo, all we have to do is chip away the unnecessary—the unwanted—and there will appear the dream health care system. It already exists; we just need to uncover it.

Articles of Organization
for
Wilson Health Planning Cooperative

ARTICLE I
NAME
The name of this cooperative association is Wilson Health Planning Cooperative (the "Cooperative").

ARTICLE II
PURPOSE
The Cooperative is organized for the purpose of planning a high-quality integrated universal health care system that will provide a single-source payor for the Fort Berthold Indian Reservation as well as the following eleven North Dakota counties: Bottineau, Burke, Dunn, McHenry, McKenzie, McLean, Mercer, Mountrail, Pierce, Renville, and Ward, as well as for any lawful purpose for which cooperatives may be organized under North Dakota law.

ARTICLE III
DURATION
The period of duration of the Cooperative shall be Perpetual.

ARTICLE IV
REGISTERED AGENT AND REGISTERED OFFICE
The address of the registered office of this Cooperative is:
106 Second St. N.W.
Parshall, ND 58770
and its registered agent at that address is Ed Hall.

ARTICLE V
MEMBERSHIP
This Cooperative is a non-stock, membership cooperative which shall have one or more classes of members that shall have the rights as prescribed in the Bylaws of the Cooperative. Eligibility for membership in the Cooperative and the rights, benefits and obligations of members shall be specified in the Bylaws. The membership of the Cooperative shall consist of any organization, company, corporation, cooperative or individual interested in the work and activities of the Cooperative.

ARTICLE VI
DIRECTORS
A. The government of the Cooperative shall be vested in a board of directors as prescribed in the Bylaws.
B. The initial members of the board of directors shall be as provided in Exhibit A. The initial board of directors shall serve for a period of six months (or until their successors are elected and qualified), at which time a permanent board of directors shall be elected by the members.
C. Vacancies in the board of directors may be filled by the remaining members of the board. The person or persons so appointed shall hold office only until the next annual meeting of the Members and until their successors have been elected and qualified.

ARTICLE VII
LIQUIDATION AND DISSOLUTION

If the Cooperative dissolves in accordance with applicable law, its assets shall be liquidated and the proceeds shall be used to pay certain items and distributed in the following sequence:

(a) Cost of dissolution;
(b) The liabilities of the Cooperative according to their respective priorities;
(c) The payment, to the individuals or entities to whom it is issued or allocated, of the stated value of any form of equity that is issued or allocated on the books of the Cooperative to reflect a distribution of equity based on patronage; and
(d) Any remainder, including reserves, to be distributed to any non-profit organization committed to universal health care planning.

ARTICLE VIII
INCORPORATORS

The Incorporators for the Cooperative are:

Name and Address	Signature
Ed Hall 106 Second St. N.W. Parshall, ND 58770	_____
Fred Larson North Dakota Department of Health 600 E. Boulevard, Dept. 301 Bismarck, ND 58505	_____
Marilyn Levine 305 Sixth St. N. New Town, ND 58763	_____
Mitch Monson Northwest Venture Communities Inc. P.O. Box 2024 Minot, ND 58702	_____
Delores White 1728 32nd St. N.W. Garrison, ND 58540 701-743-4149	_____
Dr. Herbert Wilson 1244 W. Coulee Road Bismarck, ND 58501	_____

Date: February _____, 2009

EXHIBIT A

Wilson Health Planning Cooperative
Interim Board of Directors

Stella Berquist
Ed Hall
Dan Kelly
Teri Lang
Fred Larson
Marilyn Levine
Randy Schwan
Shelley Weppler
Delores White
Dr. Herbert Wilson

Bylaws of Wilson Health Planning Cooperative

ARTICLE I — NAME AND PURPOSE

Section 1 — Name: The name of the organization shall be the Wilson Health Planning Cooperative**.** It shall be a non-profit cooperative association incorporated under the laws of the State of North Dakota.

Section 2 — Purpose: The Wilson Health Planning Cooperative will dedicate its work to the design and implementation of a new health care system. It is organized for charitable, scientific and education purposes.

The purpose of this cooperative is:

The cooperative is organized for the purpose of planning a high-quality integrated universal health care system that will provide a single-source payer for the Fort Berthold Indian Reservation as well as the following 11 North Dakota counties: Bottineau, Burke, Dunn, McHenry, McKenzie, McLean, Mercer, Mountrail Pierce, Renville and Ward, as well as for any lawful purpose for which cooperatives may be organized under North Dakota law.

The Wilson Health Planning Cooperative intends to: 1) Support and conduct non-partisan research, education and informational activities to increase public awareness of health disparity issues and health needs; 2) improve the health of the residents in the communities and rural areas in its service area; and 3) provide health-related education.

ARTICLE II — MEMBERSHIP

Section 1 — Eligibility for membership: Application for voting membership shall be open to any individual residing within the State of North Dakota who supports the purpose statement in Article I, Section 2. Membership is granted after completion and receipt of a membership application and annual dues. All memberships shall be granted upon a majority vote of the board.

Section 2 — Annual dues: The amount required for annual dues shall be determined by the board unless changed by a majority vote of the members at an annual meeting of the full membership. Continued membership is contingent upon being up-to-date on membership dues.

Section 3 — Rights of members: Each member shall be eligible to appoint one voting representative to cast the member's vote in association elections.

Section 4 — Resignation and termination: Any member may resign by filing a written resignation with the secretary. Resignation shall not relieve a member of unpaid dues, or other charges previously accrued. A member can have their membership terminated by a majority vote of the membership.

Section 5 — Non-voting membership: The board shall have the authority to establish and define non-voting categories of membership.

ARTICLE III — MEETINGS OF MEMBERS

Section 1 — Regular meetings: Regular meetings of the members shall be held at least quarterly, at a time and place designated by the chair.

Section 2 — Annual meetings: An annual meeting of the members shall take place in October, the specific date, time and location of which will be designated by the chair. At the annual meeting the members shall elect directors and officers, receive reports on the activities
of the association, and determine the direction of the association for the coming year.

Section 3 — Special meetings: Special meetings may be called by the chair, the Executive Committee, or a simple majority of the board of directors. A petition signed by 5 percent of voting members may also call a special meeting.

Section 4 — Notice of meetings: Printed notice of each meeting shall be given to each voting member, by mail, not less than two weeks prior to the meeting.

Section 5 — Quorum: The members present at any properly announced meeting shall constitute a quorum.

Section 6 — Voting: All issues to be voted on shall be decided by a simple majority of those present at the meeting in which the vote takes place.

Section 7 — Parliamentary procedure: All meetings of the Wilson Health Planning Cooperative will be governed by "Robert's Rules."

ARTICLE IV — BOARD OF DIRECTORS

Section 1 — Board role, size, and compensation: The board is responsible for overall policy and direction of the cooperative association, and delegates responsibility of day-to-day operations to the staff and committees. The board shall have up to 13, but not fewer than 7 members. The board receives no compensation other than reasonable expenses.

Section 2 — Terms: All board members shall serve two-year terms, but are eligible for re-election for up to five consecutive terms.

Section 3 — Meetings and notice: The board shall meet at least quarterly, at an agreed upon time and place. An official board meeting requires that each board member have written notice at least two weeks in advance.

Section 4 — Board elections: New directors and current directors shall be elected or re-elected by the voting representatives of members at the annual meeting. Directors will be elected by a simple majority of members present at the annual meeting.

Section 5 — Election procedures: A Board Development Committee shall be responsible for nominating a slate of prospective board members representing the cooperative's diverse constituency. In addition, any member can nominate a candidate to the slate of nominees. All members will be eligible to send one representative to vote for each candidate, for up to 10 available positions each year.

Section 6 — Quorum: A quorum must be attended by at least 40 percent of board members for business transactions to take place and motions to pass.

Section 7 — Officers and Duties: There shall be four officers of the board, consisting of a chair, vice chair, secretary and treasurer. Their duties are as follows:

The chair shall convene regularly scheduled board meetings, shall preside or arrange for other members of the executive committee to preside at each meeting in the following order: Vice chair, secretary and treasurer.

The vice chair shall chair committees on special subjects as designated by the board.

The secretary shall be responsible for keeping records of board actions, including overseeing the taking of minutes at all board meetings, sending out meeting announcements, distributing copies of minutes and the agenda to each board member, and assuring that corporate records are maintained.

The treasurer shall make a report at each board meeting. The treasurer shall chair the Finance Committee, assist in the preparation of the budget, help develop fundraising plans and make financial information available to board members and the public.

The presiding officer of meetings shall vote only in the case of a tie.

Section 8 — Vacancies: When a vacancy on the board exists mid-term, the secretary must receive nominations for new members from present board members two weeks in advance of a board meeting. These nominations shall be sent out to board members with the regular board meeting announcement, to be voted upon at the next board meeting. These vacancies will be filled only to the end of the particular board member's term.

Section 9 — Resignation, termination, and absences: Resignation from the board must be in writing and received by the secretary. A board member shall be terminated from the board due to excess absences, more than three unexcused absences from board meetings in a year. A board member may be removed for other reasons by a three-fourths vote of the remaining directors.

Section 11 — Special meetings: Special meetings of the board shall be called upon the request of the chair, or one-third of the board. Notices of special meetings shall be sent out by the secretary to each board member at least two weeks in advance.

ARTICLE V — COMMITTEES

Section 1 — Committee formation: The board may create committees as needed, such as fundraising, housing, public relations, data collection, etc. The board chair appoints all committee chairs.

Section 2 — Executive Committee: The four officers serve as the members of the Executive Committee. Except for the power to amend the Articles of Organization and bylaws, the Executive Committee shall have all the powers and authority of the board of directors in the intervals between meetings of the board of directors, and is subject to the direction and control of the full board.

Section 3 — Finance Committee: The treasurer is the chair of the Finance Committee, which includes three other board members. The Finance Committee is responsible for developing and reviewing fiscal procedures, fundraising plans, and the annual budget with staff and other board members. The board must approve the budget and all expenditures must be within budget. Any major change in the budget must be approved by the board or the Executive Committee. The fiscal year shall be the calendar year. Annual reports are required to be submitted to the board showing income, expenditures, and pending income. The financial records of the organization are public information and shall be made available to the membership, board members, and the public.

ARTICLE VI — DIRECTOR AND STAFF

Section 1 — Executive Director: The executive director is hired by the board. The executive director has day-to-day responsibilities for the organization, including carrying out the organization's goals and policies. The executive director will attend all board meetings, report on the progress of the organization, answer questions of the board members and carry out the duties described in the job description. The board can designate other duties as necessary.

ARTICLE VII — AMENDMENTS

Section 1 — Amendments: These bylaws may be amended when necessary by two-thirds majority of the board of directors. Proposed amendments must be submitted to the secretary to be sent out with regular board announcements.

CERTIFICATION

These bylaws were approved at a meeting of the board of directors by a two-thirds majority vote on April 17, 2009.

_____ _____

Secretary Date

Appendix C

Region	Population	65+*	Native American*	Disability		Poverty†
				#	%	
USA	281,421,906	12.4%	1.0%	49,746,248	17.7%	12.7%
North Dakota	642,200	14.6%	5.4%	97,817	15.2%	10.8%
11 County Region	115,192	18.9%	7.6%	17,808	16.2%	11.2%
Bottineau County	7,149	20.9%	2.2%	1,222	17.1%	11.0%
Burke County	2,242	23.7%	0.3%	344	15.3%	10.2%
Dunn County	3,600	16.8%	13.1%	544	15.1%	11.5%
McHenry County	5,987	20.6%	0.5%	1,181	19.7%	12.8%
McKenzie County	5,737	15.3%	22.0%	843	14.7%	13.7%
McLean County	9,311	20.5%	6.9%	1,688	18.1%	11.3%
Mercer County	8,644	14.7%	2.7%	1,357	15.7%	7.4%
Mountrail County	6,442	16.3%	31.2%	1,083	16.8%	14.2%
Pierce County	4,675	24.4%	1.1%	780	16.7%	11.4%
Renville County	2,610	21.5%	0.9%	395	15.1%	9.4%
Ward County	58,795	13.4%	2.3%	8,371	14.2%	10.7%

Data from 2000 census.

* Estimates for 2006.

† Percent below the poverty line in 2004.

APPENDIX D

ALL AGES, 2000

State and County	Number Insured	Number Uninsured	90% Confidence Interval (±)	Percent Uninsured	90% Confidence Interval (±)
United States	239,713,822	39,803,537	492,720	14.2	0.2
North Dakota	563,246	60,222	4,890	9.7	1
11 County Region	99,913	12,178	2,424	12.5	2.35
Bottineau County	6,068	710	145	10.5	2.1
Burke County	1,939	283	52	12.7	2.3
Dunn County	3,047	519	109	14.5	3.1
McHenry County	4,997	842	158	14.4	2.7
McKenzie County	4,833	878	140	15.4	2.5
McLean County	7,982	1,135	196	12.5	2.1
Mercer County	7,846	709	198	8.3	2.3
Mountrail County	5,420	1,121	150	17.1	2.3
Pierce County	4,011	560	102	12.3	2.2
Renville County	2,247	270	57	10.7	2.2
Ward County	51,523	5,151	1,117	9.1	2

UNDER 18, 2000

State and County	Number Insured	Number Uninsured	90% Confidence Interval (±)	Percent Uninsured	90% Confidence Interval (±)
United States	63,696,617	8,617,432	244,607	11.9	0.3
North Dakota	134,620	10,643	1,365	7.3	1
11 County Region	24,673	2,241	738	10.98	3.04
Bottineau County	1,276	132	41	9.4	2.9
Burke County	353	54	12	13.2	2.8
Dunn County	778	104	36	11.8	4.1
McHenry County	1,093	172	47	13.6	3.7
McKenzie County	1,371	193	51	12.3	3.2
McLean County	1,717	216	54	11.2	2.8
Mercer County	2,040	168	64	7.6	2.9
Mountrail County	1,471	241	47	14.1	2.7
Pierce County	865	114	30	11.6	3
Renville County	465	54	16	10.4	2.9
Ward County	13,244	793	340	5.6	2.4

US Census Bureau 2000.

Appendix E

Counties	Cities	County Seat	Healthcare Facilities	Bed Capacity	Toured	Public Meeting
Burke	Bowbells	*	Bowbells Clinic - RHC			
	Lignite		Lignite Clinic - RHC			
	Powers Lake		Tioga-Powers Lake Clinic - RHC			
Mountrail	Stanley	*	Mountrail County Rural Health Ctr. - RHC		*	
			Mountrail Bethel Home - LTC	57		
			Mountrail County Medical Center - CAH	11		
	New Town		Minne-Tohe Clinic - 638		*	*
			Trinity Clinic			
			Good Samaritan - BC	16		
	Parshall		Trinity Clinic			
			Rock View Good Samaritan - LTC	42		
McKenzie	Watford City	*	McKenzie County Healthcare System Clinic - RHC		*	
			McKenzie County Healthcare System LTC - LTC	47	*	
			McKenzie County Healthcare System Basic Care - BC	9		
			McKenzie County Healthcare Systems Hospital - CAH	24		
	Mandaree		Mandaree Clinic - 638		*	*
Dunn	Manning	*				
	Killdeer		Killdeer Medical Clinic - RHC			*
			Hilltop Home of Comfort - LTC	50	*	
	Twin Buttes		*			
Mercer	Beulah		Coal Country Community Health Center - CHC		*	*
			Sakakawea Beulah Clinic - RHC			
			Knife River Care Center - LTC	85	*	
			Senior Suites at Sakakawea - BC	34		
			Sakakawea Medical Center - CAH	25		
	Stanton	*				
	Hazen		Sakakawea Hazen Clinic - RHC			
McLean	Washburn	*	Washburn Family Clinic - RHC		*	
			Washburn Clinic			
	Underwood		Underwood Clinic		*	
			Medcenter One Prairieview - LTC	68		
	Garrison		Garrison Family Clinic - RHC		*	
			Garrison Memorial Nursing Facility - LTC	28	*	
			Benedictine Living Center - LTC	63		
			Garrison Memorial Hospital - CAH	22		
	Turtle Lake		Northland Health Partners - CHC			
			Community Memorial Hospital - CAH	25		
	Wilton		Redwood Village - BC	16		
	White Shield		White Shield Clinic - 638			*
McHenry	Velva		Trinity Clinic		*	*
			Souris Valley Care Center - LTC	50		
	Towner	*	Johnson Clinic PC - RHC			
			Sandhills Community Health Center - CHC			
Pierce	Rugby	*	Johnson Clinic			*
			Heart of America Nursing Facility	80		
			Harold S. Haaland Home - BC	68		
			Heart of America Medical Center - CAH	25		
Bottineau	Westhope		Westhope Home - LTC	25		
	Bottineau	*	St Andrew's Bottineau Clinic - RHC		*	*
			Good Samaritan Bottineau - LTC	81		
			St Andrew's Health Center - CAH	25	*	
Renville	Mohall	*	Mohall Clinic			*
			Good Samaritan - LTC	61	*	
Ward	Minot	*	Trinity Medical Center Clinics		*	*
			UND Family Practice Ctr. Clinic			
			Manor Care of Minot - LTC	106		
			Trinity Homes - LTC	292	*	
			Edgewood Vista - BC	53		
			Emerald Court - BC	28		
			Trinity Hospitals - PPS	416	*	
	Kenmare		Trinity Community Clinic - RHC			
			Kenmare Community Nursing Facility - LTC	12		
			Baptist Home - BC	60		
			Kenmare Community Hospital - CAH	25		

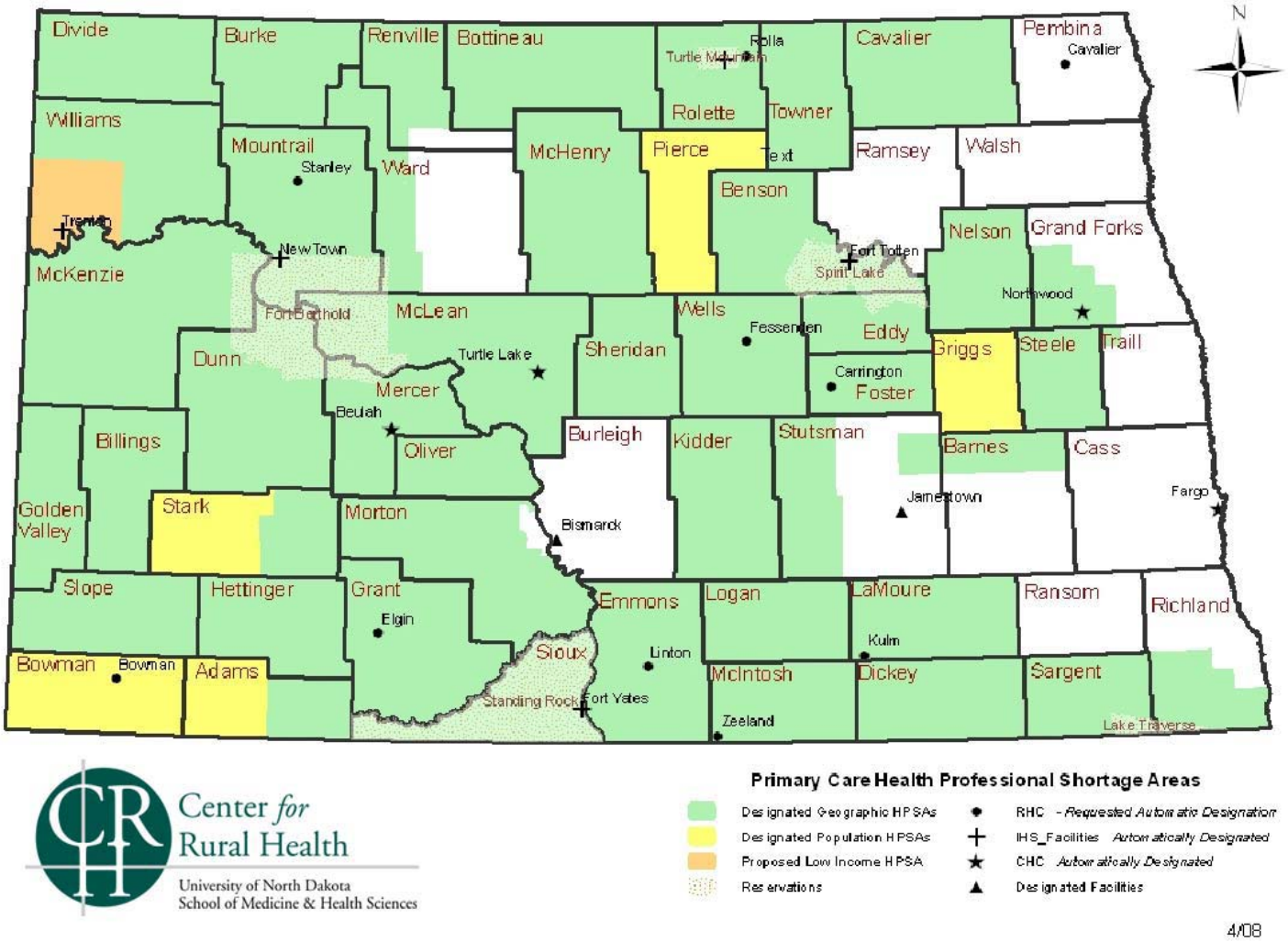
RHC	Rural Health Clinic
LTC	Skilled Long-term Care Nursing Facility
BC	Basic Care Facility
638	Tribally Operated Healthcare Facility under Title 638
CAH	Critical Access Hospital
PPS	Acute Care Hospital under Prospective Pricing System

Appendix F

Region	Land Area (Square Miles)	People per Square Mile
USA	3,537,438.4	79.6
North Dakota	68,975.9	9.3
11 County Region	18,282.7	6.0
Bottineau County	1,668.6	4.3
Burke County	1,103.5	2.0
Dunn County	2,009.6	1.8
McHenry County	1,874.1	3.2
McKenzie County	2,742.0	2.1
McLean County	2,110.0	4.4
Mercer County	1,045.5	8.3
Mountrail County	1,823.9	3.6
Pierce County	1,017.8	4.6
Renville County	874.8	3.0
Ward County	2,012.9	29.2

US Census Bureau 2000.

Appendix G



Center for Rural Health
University of North Dakota
School of Medicine & Health Sciences

Appendix H

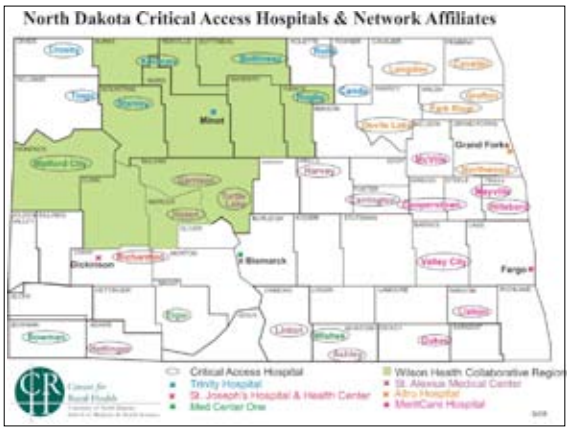
Leading Causes of Death	USA 2001-2005		North Dakota 2001-2005		11 County Region 2001-2005*	
	Number	Percent	Number	Percent	Number	Percent
All Causes	12,153,732	100.00%	29,375	100.00%	5,703	100.00%
Heart Disease	3,386,755	27.87%	7,937	27.02%	1,570	27.53%
Cancer	2,781,141	22.88%	6,585	22.42%	1,233	21.62%
Stroke	777,552	6.40%	2,295	7.81%	438	7.68%
Chronic Lower Respiratory Disease	627,131	5.16%	1,477	5.03%	350	6.14%
Accidents	547,377	4.50%	1,327	4.52%	257	4.51%
Diabetes	367,097	3.02%	1,034	3.52%	242	4.24%
Influenza/pneumonia	315,543	2.60%	833	2.84%	132	2.31%
Alzheimer's	313,739	2.58%	1,431	4.87%	220	3.86%
Nephritis	209,288	1.72%	285	0.97%	X	X
Septicemia	167,681	1.38%	195	0.66%	X	X
Suicide	158,837	1.31%	416	1.42%	47	0.82%
Chronic liver disease/cirrhosis	136,338	1.12%	329	1.12%	49	0.86%
Hypertension	109,429	0.90%	317	1.08%	51	0.89%
Homicide	91,159	0.75%	43	0.15%	X	X
Parkinson's Disease	89,033	0.73%	275	0.94%	X	X
Atherosclerosis	X	X	151	0.51%	29	0.51%
All other causes	2,075,632	17.08%	4,488	15.28%	1,085	19.03%

Data from CDC: http://webappa.cdc.gov/cgi-bin/broker.exe.
*Data from North Dakota Department of Health

WILSON HEALTH PLANNING COLLABORATIVE

Using Appreciative Inquiry as a methodology
to end disparities and increase years of healthy life

Based on the book *"Appreciative Inquiry"* by Cooperrider, Sorensen, Whitney and Yaeger and the 2008 workshop by Ronald E. Fry at the Weatherhead School of Management/ Case Western Reserve University attended by Ed Hall and Bill Patrie, co-chairs of the Collaborative



Our purpose

The Collaborative will assist the residents of 11 North Dakota counties and the Mandan, Hidatsa and Arikara Nation in designing the healthcare system they want.

1. Higher quality goals and strategies
2. Faster decision-making
3. Collectively imaging our highest hopes and greatest possibilities to stimulate:
   - Co-construction of the ideal future, and
   - Launch self-directed change and innovation

Peter Drucker

"The task of leadership is to create an alignment of strengths, making our weaknesses irrelevant."

How we talk influences how we think

- The deficit theory of change is pervasive
- Most schools, companies, families and organizations function on an unwritten rule:

  "Let's fix what's wrong and let the strengths take care of themselves." – Gallop Poll

Deficit Theory of Change
(and Cultural Consequences of Deficit Discourse)

- Identify problem
- Conduct root cause analysis
- Brainstorm solutions
- Develop action plans

Metaphor: Organizations are problems to be solved!

"The signal accomplishment of the Industrial Age was the notion of continuous improvement. It remains the secular religion of most managers…has reached the point of diminishing returns in incremental improvement programs." – Gary Hamel, Leading the Revolution

Consequences of Deficit Discourse

- Fragmentation
- Few new images of possibility…self-fulfilling frames/questions
- Exhaustion & visionless voice
- "The experts must know"…dependence and hierarchy
- Spirals in deficit vocabularies
- Breakdown in relations/closed door meetings/decrease in public space/cycle of despair

Basic belief

- What we focus on becomes reality
- Reality is created in the moment; there are multiple realities
- In any situation, some thing(s) work(s)
- People are more able to journey into the unknown if they can carry forward parts of the past (known)

2 key questions

1. What in this context has already made the development of an integrated health system possible?

1. What possibilities exist, latent or explicit, for the Wilson Health Planning Collaborative organizing a more effective and improved healthcare system?

Question 1: High point experience

- Please recall a recent moment or day that stands out as a "high point" for you; a peak experience in your life that left you feeling fulfilled, joyful, hopeful and proud that you had been a part of something meaningful

- Please tell a story about that peak moment

Question 2: High point experience of positive change

- Recall a time in your recent work experience where you were involved in a positive change—a time that stands out because you remember feeling proud, fulfilled and a necessary part of some collective effort that exceeded everyone's expectation—it was an exceptionally successful change effort!
- Please tell a story about that positive change experience
- Reflecting on your story:
  - What made it so memorable to you?
  - What did you do to help make it a success?
  - What did others do to help?
  - How did the organization help the change occur?

Question 3: Ideal future image

- Imagine you have just awoken from a long, deep sleep. It is 2012! You go to work to find that, as if a miracle has occurred, everything is as you always wished it could be. Everywhere you look, people are succeeding in their jobs and goals; there is an excitement around the workplace; people embrace change and learning new skills; the Wilson Collaborative is being benchmarked for the remarkable transformation since 2008…What do you see? What are you doing? What has changed most since 2008?
- Based on these images, what are one or two specific things to change today in order to move toward your ideal in 2012?

Beginning appreciative conversations

- A interviews B for 15 minutes
- B interviews A for 15 minutes
- "Mine for the Gold" in each story—Curiosity of the young child—brief notes

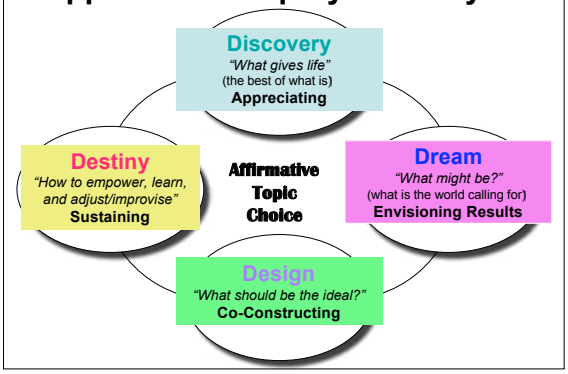
The power of positive stories

(an underutilized tool for the leader)

Stories stick like glue:

- Make information easier to remember… "whole brain"
- Build identities and fosters relationships
- Medium for conveying values and visions
- Create space for human hope; suspend notions of why things cannot happen

Appreciative Inquiry "4D" Cycle



What would you call it?

- Achievements, strategic opportunities, cooperative moments, technical assets, innovations, elevated thoughts, community assets, positive emotions, community wisdom, core competencies, visions of possibility, vital traditions, values, social capital, embedded knowledge, financial assets

The *"Positive Core"*

- Complete organizational wealth…..*"well-being"*
- An incredible energy
- Source of continuity (hedgehog)
  - Economic driver
  - Passionate
  - Best in the world

Whole organizational connection to the "positive core"

- **Elevates:** Elicits positive emotions of hope, inspiration, confidence, joy; rise in intelligence, expands the language of life (internal dialogue); increase in appreciative interchange and mutually elevating relationships; heightens creativity, ignites decision making, increase collective capacity
- **Undoes negative impacts:** Releases, makes irrelevant, finishes the residual of negative past
- **Protects:** Increase health, resilience, accumulation of power—like an increase in immune system functioning

Appreciative Inquiry is a shift

- *"No problem can be solved from the same level of consciousness that created it. We must learn to see the world anew."*
- *"There are only two ways to live your life. One is as though nothing is a miracle. The other is as though everything is a miracle."* – Albert Einstein

It begins with positive topic choice

- Human systems move in the direction of what we deeply and persistently ask questions about
- Transformational topics are possible in any situation and will generate more positive change—every time.
- What ever we study, GROWS!
- The skill of framing and re-framing: M. Seligman

Aug. 11, 2008
Rural Health Care Public Meeting
Minot Public Library,
Minot, N.D.

Call to order

Bill Patrie, co-chair of the Wilson Health Planning Collaborative, called the first rural health care public meeting to order at 6:30 p.m. He welcomed those attending and gave a brief history of the Collaborative. He said the Collaborative is assisting the residents of 11 North Dakota counties and MHA Nation to design the health care system they want.

"This is huge," Patrie said. "We're not going through the existing system. We're designing the system. We won't look to someone else to do it. We're uniquely situated to do it."

Patrie explained that the Collaborative effort is named after Dr. Herb Wilson, a physician in New Town for 43 years. Now 86, Wilson was also a B-24 pilot in World War II. Wilson, a member of the Collaborative, has long worried, "Why is it that I have to treat Native Americans and whites in separate buildings?"

"It is often said that Native Americans and non-Native Americans live in parallel worlds that don't intersect," Patrie said. "Well, they intersect with Wilson. He is the bridge between the two cultures."

Attending

Those attending included Megan Kaiser, a Minnesota State University-Moorhead student; Mike Horan, director of radiology at Trinity's cancer care center; and Deb Nelson, health information management at Trinity.

Collaborative members attending were Susan Davis, Fred Larson, Mitch Monson, Bill Patrie and Randy Schwan.

Appreciative Inquiry

The appreciative Inquiry (AI) approach was developed as a business theory. It helps "unstick" situations where things seem to get stuck. Health care has gotten stuck and doesn't seem to know how to get unstuck.

One of the ways to get it unstuck is to talk to one another. "It's how we talk to each other than influences how we think," Patrie said.

AI has been shown to create higher quality goals and strategies; faster decision-making; and imaging highest hopes and greatest possibilities.

"The idea is empowerment," Patrie said. "When people ask positive questions, people respond with positive thoughts."

When kids come home with three A's and one D on their report card, what do parents focus on? The D. Studies show the overwhelming focus in households is on "what's wrong" rather than "what's right."

There is no national plan for health care. The old adage that "the experts must know" doesn't hold true in health care. The answer is not necessarily "outside" the room.

AI's basic belief is: What we focus on becomes reality. In health care many things work and we must focus on what works—not on what doesn't. Through AI, you begin to change the dialogue of what you hope to become.

We have positive images of our own pasts. We will work to anchor the future with something from the past as we discover the ideal imagined future. All visions of the future are utopia. Why not?

"We have some enormously gifted people in the Collaborative," Patrie said. "We want to anchor these skills to the future."

If it's a common desired future, it will start to draw people in—we'll focus on not what they're mad about, but what they really want. We will do this by using stories. Why use stories rather than data? Because stories "stick like glue." Stories have power.

Appreciate Inquiry 4-D cycle

Patrie explained that appreciative inquiry has four basic cycles: Discovery, dream, design and destiny (or implementation). More about each one includes:

- *Discovery:* Setting the values. Sharing positive stories. Fundamentals of creating the vision.
- *Dream:* What might be. Most people don't feel they deserve a positive future so they won't talk about it. This is even more prevalent among the low-income and Native American populations. Or, people might try to look witty and wise and not really say what they feel but what they think sounds good.
- *Design:* Structural changes that are needed to get what we want. The design needs to be done with the participants. You don't dismiss the public after you've heard from them; you involve them in the design.
- *Destiny:* Launching the design. Implementation.

"Human hope," Patrie said, "is literally a brain chemical. It causes you to put together building blocks to reach success. Hope is as important as water to people. We will anchor hope with the people in the communities we visit." People need to be encouraged to tell positive stories.

"Words create worlds," said Patrie. "And words create action. If you ask people what they want the future to look like, it will transform them—and you." We ask questions we care deeply about: "How can we help design the best health care system in the world?" People who expect the miraculous, see it.

The positive core: Your creative self generates incredible energy. What is the core of what we're going to do?

1. *Economic driver:* Is it economically viable? We need to remain solvent in the health care industry.
2. *Passionate:* Do we really care about it?
3. *Competent:* Can we be good at it? Is it doable?

There are ways to create a positive future and overcome a negative past. Look at South Africa as an example. They ended Apartheid without a shooting war.

What you focus on and study grows. An example of this is General Electric, which had a high incidence of sexual harassment in the early 1980s. They studied the sexual harassment problem and guess what? It grew. Instead, they needed to ask, "What is the behavior you're in favor of?" The two sexes working together harmoniously. This was occurring, but they needed more of it.

According to Patrie, we need to imagine a health care system that doesn't fight itself. It's like a well-trained swimmer. We need to learn in the healthcare system, "I got your back." We need to see it as "our collective system."

North Dakota currently has a budget surplus of $1.2 billion. We need to use some of this money to create sustainable healthcare systems in North Dakota. How do we go from a needs based to an opportunity based health care system with our Legislature? It's a paradigm shift.

Question 1: High point experience

- You said you don't have to do a recent one, but I'll tell you about a recent one. Just this last weekend, on Saturday, I and two of my children and my daughter and my youngest son and my daughter's boyfriend went on a canoe trip. We went on a canoe trip down the Yellowstone River from between Sydney and Fairview, Montana. It was just a day trip, but it was one of those times when you think back about that. You created a memory, you know. It's probably something that your kids are going to remember all their life. At least I'll remember it certainly. And so that was really fun. There were a lot of high points and a lot of fun times. There were some lower points, like 'Geeze, are we ever gonna get there?' when we got near the end. But it was very fun. It created a memory with my kids. Unfortunately, my oldest son was unable to go with us, but that's just a positive thing. It was something I accomplished, because I hadn't done that in 25 years. So, even as old and out of shape as I am I was able to do it, so that's my story.

- I'll tell the same story I did a week ago when we were doing this exercise. Towing my grandkids around behind the boat as they were learning to water ski. And each of the kids achieved something new, some new milestone, like getting outside the wake and getting back in without falling….or managing to ski without the cheater bar. They each had a pretty neat story to tell, to take home. One thing I didn't talk about before was my grandson's—my younger grandson's—achievement on the inner tube. He actually—when we hit some big wakes—he actually did a back flip—a full flip—landed face-down on the inner tube and bounced off into the lake. And, of course, I do a 180, figuring I've killed my grandson. And he comes out of the water just like that. That was one of the happiest moments of his young life because he'd managed to survive that thing without a scratch.

- OK. I'm going to go back a little further. This was really a proud moment for me. I was a single mom for quite a few years. I had gotten divorced in 1982 and moved up to Mandan from South Dakota with my two boys who were then 8 and 4. We lived in an apartment for quite a while, struggling to make ends meet on a single salary. But in 1989, I decided it was time—my kids were 16 and 12 and it was time for me to see if I could buy us a house before they got too much older. A lot of people told me I was crazy and couldn't do it. Who was gonna keep up the house? Mow the lawn? And I said, "Well, I'm going to." So I was able to finance it. I bought a little house in Mandan for the three of us. It really was one of my proudest accomplishments. My boys and I had a lot of fun years in that house and we'll all look back on it with just wonderful memories. So, that was one for me.

- A personal experience that brought me great joy and feelings of accomplishment would probably have to be my high school graduation. I'm quite young. I haven't really done a lot yet. So, on that day I graduated from a small school. I'm from East Grand Forks originally. And you're all probably well aware of the enormous flood that took place there. After the flood, our school, which is private, considered not reopening—you know, just throwing in the towel and everything. But it did reopen. And every single student that was in my class in 1997 graduated from Sacred Heart—which was the school—on that day. I was elected by my classmates to be the speaker at the commencement ceremony. I decided to highlight that and how special it was that everybody that went through the flood also managed to get through middle school and high school, which was kinda hard. And it was a really, really good day. The sun was shining and everybody was really happy, and we just got to highlight a lot of the good memories we had—both in the old school and the new, improved school. So it was nice to reflect on that.

- I've been blessed with a lot of positive things in my life. But what I will share will be: Last year, when I was out in Glacier National Park we went to the very top of the highest mountain out there. And things that scare me are always things that I need to do. And so, all by myself, I walked out on the path. And those of you who have been there, you walk out on the path and you're OK for a while, and then the path gets less and less and pretty soon there's just a cable. And so the group before me was quite a ways down. I couldn't see them as when you go around the mountain you don't see anybody. There was nobody behind me. It was just me. So I inched my way,

hanging onto the cable and then I had this moment of stopping. And there was thousands and thousands of feet below me….and birds. And that's all there was. And I was proud that I was able to stand there and I had my life in my hands I decided to walk back. But it was a defining moment.

- The story I'm going to tell about is developing the cancer care center back in 1998 and 1999. We had a vision of developing a cancer care center, but really no other thoughts other than that. The CEO—still currently there—called me to his office one day and said the board of directors had decided that we were going to develop our own cancer center and wanted me to start developing a plan for that, and developing a team and building that and getting that in place. And so, it took about two years to do. We had some consultants involved and things like that. But opened the center in May of 1999, with the idea that we were gonna treat probably 10 radiation patients a day and maybe 10 to 12 medical oncology patients. That center has flourished along with the acquisition of the St. Joseph's Hospital and consolidation of some of that care there. We treat probably around 25 to 35 radiation therapy patients a day. And maybe around 60 medical oncology patients a day, so... It made me very proud to be a part of that process.

- Where do I begin? My defining moment of affirmation and pride was probably…..in my prior life—before health care—I was in law enforcement. And as a police officer in the city of Williston Police Department—I was there about 13 years or so—and had the honor of being selected by peers as police officer of the year midway through that career. That was a very proud moment for me. I hadn't done anything special…more than just going to work and just trying to work hard every day, doing the right things that I could to make a good impact on the city, to do the badge honor. And that happened a couple more times in my career there and once at the state level. It was just affirmation that the values that I—growing up with, and the people that I hung out with and the things that we tried to do—were all on the right track. And so it was just a very affirming and rewarding moment. So then it went downhill. No. Strike that from the record.

- I was trying to think of which story to tell. One experience I had that was—it probably fits in the teamwork stories well—I served as the interim CEO for Northern Plains Premium Beef. We were trying to organize a beef cooperative in three provinces and five U.S. states. We had a board of directors who came from all of those places. They had to fly to get together. We raised a million and a half dollars just to put that campaign on. We were trying to….our minimum was 250,000 head of cattle. That represented $25 million of equity that we were trying to raise. We were not successful in raising that amount of money. We raised about half of that money and gave it all back. But in the process of doing that, we had an external public relations campaign and a media campaign. We wanted to tell our story to the greater world. I hired a young journalist who is now a state senator. He was working for me and we went through this campaign strategy of how do we get the news about Northern Plains Premium Beef to the world? On March 26, 1997, we were the front-page story in the *Wall Street Journal.* My cousins from Indiana called me up and said, "Is that you?" You know, 'cuz we'd failed to reach the goal... But to make the front page…. But anyway, that was a high point for me to make the Journal. Maybe one other time that I remember feeling really special. I went to school in Indiana, at a private college, Anderson, Indiana. I traveled with a lobbyist for the private colleges of Indiana, which included Notre Dame. So we were having a political meeting trying to get language in the Indiana law that was favorable to private colleges….there's a lot of them. The lobbyist I was working with organized this meeting at Notre Dame. The president of Notre Dame, Father Theodore Hesburgh, asked me to say grace for the meal. I was proud to say grace for a meal in a Catholic church—a pretty well known one. I was really honored to do that. That was another really high point.

Question 2: Positive team experience

- This second question will come a little easier for me. Last year in the spring semester I was involved, or I took a class, it was a health law class with an emphasis on the gerontological side of health care. At the beginning of the semester we did a lot of studying on lots of facts and data and kind of the boring stuff that comes along. And toward the end of the semester we worked very closely with a sociology class that was from the gerontology department. And we set a goal to develop the idea that drafting and notarizing health care directives was a good idea for people that were middle-aged and were not in a retirement home already. Drafting a health care directive is not fun, nobody ever wants to do it. You have to really dig down deep in your soul and talk about things with your loved ones. That is hard to do. Well, that's very difficult. It's also very rewarding if you understand and look past all the morbidity of it. The two classes met weekly for about a month—outside of class. We decided that we wanted to inform people on the campus—faculty and staff—about the other side of drafting a health care directive. We thought that the campaign would be kind of a bust. It was a lot of work to do in a short amount of time. But by the end of the semester, between 60 students we had drafted over 300 health care directives. It was a lot of work, but it was a wonderful idea and the whole campus was really excited about it. And I think it will be a tradition from now on for those two classes to do. So it was probably one of my favorite things I did at college so far.

Question: The directives….you helped other people draft their health care directives?

Yep. We learned the structure of it.

Question: Now were they in college? Or in nursing homes?

It was a combination of that. We started out with just the faculty. Our professor sent out the e-mail and we had a lot of feedback from that. And, you know, people kept asking, "Oh, can you do one for my husband?" "Can you do one for my daughter?" And we all did our own. A couple roommates here and there also. Once we spread the message, everybody was like, "Oh yeah, I'll do that." It was free. You didn't need to go to an attorney. Our health law teacher, she took it under her belt to review every single directive. And you know, I think that some other classes. People are even calling for wills and more stuff than just the health care directive. But it really got the message out there that it is important to do. And that, you know, it's way better than letting it get all complicated. And we used the example of Terri Schiavo a lot and...

Question: How did that change you? We're talking about transformational change. What was the effect of *people doing that on those folks?*

Well, as far as changing myself... it really made me feel good about all the time I put into studying health care and how it is portrayed by the general public, and people that aren't necessarily—the word isn't knowledgeable—but just lots of people just don't understand that even though health care issues seem very complex and very morbid, it can be very enlightening and very…..it can make you feel good about looking into those issues and seeing how they affect your own life. So, for me, it was good to apply all the knowledge I had learned thus far and really do something positive. And as far as the effect on the people that I worked with, I think that they were obviously glad they did it. And knew that they were, in essence, creating a once-in-a-lifetime gift for their family. But I think that they also felt like once they had gone through all the presentations and worked with the students that they had a vocabulary and a little more—they were a little savvier in terms of talking with their doctors and talking and paying attention to the news and the different legislative changes that take place. When you're gonna do something with health care, you don't do one little aspect of it. You need to understand, generally, the whole picture and how everything falls into place. Especially when it comes to finances and that's part of the health care directive. So, people felt good about the education they got from it, I believe. I think that they could pass that on to other people. It was just a really positive experience all the way around.

- Let me try. I'm not sure I remember all the questions you asked other than being part of a team that did something positive. As you know, Trinity now has an electronic health record. My profession is health information management. So I'm a medical record person from 30 years. And so I was part of the team. Not the leader, but a part just like 40 other people, of trying to work through the transformation of documenting on paper to utilizing this electronic health care record. It was about a two-year project. There were, again, lots of people involved and the first thing that a person learns is this is not my project. I've had other projects in the past that have been mine, or mine and another person's. But this was not mine. And so I think we all learned 'cuz we were all, you know—all the different clinical areas, all the other paper-pushing people like myself—we had to learn how to get along and how to negotiate. All of those kind of things. But it did get done. It got accomplished. We converted on a particular day and it actually went very well. All of the time that was put in was well worth it. It wasn't perfect, but that's OK. We knew how to work through the imperfections. The patients were winners. They liked the system. Our physicians generally liked the system. The caregivers liked the system. I mean it's been a very real positive piece. So it's fun to be a part of that.

- I'll go back a few years to attending graduate school at the University of Minnesota, there in Minneapolis. My young family of three kids and my wife and I. I had come from a background of law enforcement and into business school later in life than most of my classmates. OK, all of my classmates. Of 90, I was the only one married with children. It was a two-year program and I was pretty well intimidated going in and overwhelmed by it all. But I kind of knew what I wanted to do. Or at least what direction I wanted to go. But I wasn't sure that I'd be successful in that. So, the second year of our study—about half the class was international students and half were native to this country and English speaking and so on—but the other half were very international and weren't very adept at the English language or culture. So it was really an interesting melting pot of all different languages and peoples. I was on a team of four people for our senior project. In lieu of a thesis, we conducted a senior field project. We consulted with a local firm in the Minneapolis/St. Paul area. We were selected to help a large natural gas company with a project that they faced in the gas deregulation. I didn't know squat, and still don't know squat about energy and the deregulation issues that might come about for a company like this. It was a very regulated monopoly about to enter a very competitive environment in the delivery of natural gas. And so we were tasked with helping the company through that…. interviewing large numbers of its commercial clients like hospitals and schools and factories. So I found myself in the CEOs' offices and board rooms talking about how utilities played a role in their operation and what kinds of services and values they get out of their electrical or gas companies—which is not something that most people normally think about. So it was interesting from that perspective and I think it served as a capstone for me and my team that we could apply what we were learning. And even though you don't know anything about an industry going in, you can apply the studies that you've been together on and apply the principles that you've read about and studied in cases and so on and still solve an issue for people who do that kind of thing for a living. So we were hired by this natural gas company, conducted this field study, did a lengthy set of interviews, and studied the industry at length, and ended up having to present our findings to the executive team and members of the board, suggesting some strategies that they could employ to remain competitive in that industry. It was during that presentation that I….that it finally struck me that, you know, I get this stuff. Serving as a consultant in that role, at that time, with that project, it was very rewarding for the whole team that when we completed the project the company did adopt a set of our recommendations as part of their strategic plan. It was just very rewarding that what we did was….had value….not only from a learning perspective from us, but from…for helping this large utility company in Minnesota—or in the tri-state region—to survive.

- I'm gonna piggy-back on her story a little bit about the electronic health record at Trinity. My part of that is the imaging services aspect in bringing radiography that used to be on X-ray film into the electronic age. I think we probably had around 40 people on the team just for the imaging part of that at different points with the development of the process and testing and all those sorts of things. But what it involved was both hospitals here in Minot and about six different clinics in town, getting digital imaging equipment so we would go from

exposing a piece of film in an X-ray cassette to radiation to actually exposing a charged plate in that cassette and then reading it into a digital reader that would convert it into computer lingo and send it in to the PAC system to be distributed to all of our providers. At present we have about 140 providers in the Trinity health system that all of their images are online and no matter where they're at in their clinic they can access all the images for about three years back. And the reports—the x-ray reports—along with those. And we're now continuing on with that to expand it to the Critical Access Hospitals throughout central and western and northwestern North Dakota. So that they will have that same capability and we'll be able to share our X-ray films and reports with all of them and vice-versa in the next couple of years. So, it's been very rewarding.

- Well, talking about working with a team, I'll go back to another life, too. At one time, I was a project manager for a call center. And we had a corporate client that was Chuck E. Cheese Pizza. We were tasked with creating a birthday hotline for their company. They had 165 corporate stores and they wanted to bring them together so that they had a central reservation line. 'Cuz if you've ever been to a Chuck E. Cheese Pizza, you'll know that 90% of their business is birthdays and with little kids. So they wanted a hotline where people could call in to-whether it was to Plano, Texas, or Pekipsa, New York, and make a birthday reservation for their child's birthday. So, we…..I…. led a team of local folks, plus working with their corporate headquarters, working with their store managers. And we had to do it…had to create this process and network and we also had to take in the fact that we needed both English and Spanish speaking people….and created that network. I remember the day when we got all 165 stores online and they were working. It was quite a sense of accomplishment that we had been able to do something like that. I still to this day—the director of operations for Chuck E. Cheese gave me a portrait—and I can't remember the famous……the artist who does the different paintings like Muhammad Ali. I think it's Niemen? And they gave me a portrait of Chuck E. Cheese painted by him; and that said thanks for your help with that and creating this hotline. And so that was quite a sense of accomplishment.

- I'm gonna focus on a little piece of work I've done the past year, year and a half. It's a team-building exercise was really the way I view it. It's an IT project involving 10 rural hospitals that satellite on Trinity. Among other accomplishments, the 10 hospitals did actually all contribute cash to the establishment of a non-profit corporation of the….the acronym that they're going by is NOWAIT, which has obvious implications as far as the IT system is concerned. Among the accomplishments, I think that we'll have some residual value. The overall design of a system that can digitize the operations and can move each of those facilities forward to the point where they are capable of producing an electronic medical record that is universally transmittable. There was a commitment made along the way…I believe Trinity is on the Turner System...and all of these satellite facilities would be on Dairyland. And the commitment was made to create the bridge, or create the cross-walk that would allow the systems to talk to each other on an instantaneous basis. Assuming that Trinity was gonna be able to talk to the rest of the world, this would solve the small facilities' issue in terms of inter-interoperability and so on. Part of the project was to seek a federal grant under the new Farm Bill. That would have provided about $10 million in resources to accomplish all of this. The language was actually written into the House version of the bill. And there was a segment of the Senate version that would have—with very minor modification—provided the funding that was necessary to underwrite this project. Succumbing, however, to the magic that is called a conference committee in Washington, D.C., the language that appeared in both versions of the bill disappeared in the compromise that emerged from the conference committee. We think, primarily because it was necessary to make it veto-proof in order to get it online. But the positive parts of this team-building activity were really quite important. It provides evidence to the fact that we've overcome the old basketball rivalries between the communities that are participating together. Those kinds of things have been very real—as recently as maybe only 10 years ago—and would have really blocked any possibility of these communities cooperating together to the extent that they have.

- I was raised by a single mom who raised 10 of us by herself. The old adage always was, 'If you want something done, do it yourself.' So, I'm sort of a little bit of an individualist. But not too long ago, my colleague and my husband were involved in something that was very rewarding to me. In the building we work in, in Mandan—it's

the old Lewis and Clark Hotel building on Main Street—we happened to meet a young Mexican family who had been kind of enticed to come to Mandan to work for Cloverdale. They were struggling to make ends meet. They have three small children and were living in a one-bedroom, tiny efficiency apartment in that low-income apartment building. No beds, no table. The kids were sleeping on the floor wherever they could find room. We found out a lot of times they were low on food and we'd take them to the grocery store and get them some things. It's really hard to understand how that situation can happen in today's world, but there's still a lot of families out there where kids don't have enough to eat. But the biggest problem was they needed some more adequate housing. So we spent some time and they got qualified for housing and my colleague was looking and we were keeping our eyes out and we finally found them the top floor of a rental home with three bedrooms. So the girl—the oldest was a girl who's 11—and the boys, 10, and the little boy, 6, could have her own room and the boys could share a room and the parents could have a room. It's got a nice little yard. It was just really a fulfilling experience. My husband and I chased all over town to rummage sales and want ads in the paper and we found a kitchen table and a davenport and chairs. And one lady even gave us a computer for the kids. It was just…just made me feel really good…the generosity of people when we told them we were shopping for this….looking for this needy family. People were just like, "Ah, take it. You know, they can use it more than we need the $50." We had the house all furnished for them. The only thing we hadn't found was beds for the boys. But we did find them a mattress. On a night shortly before the family moved in we all sat in the living room and I think we were all pretty proud of our accomplishment. There were dishes in the cupboards; food in the pantry. I didn't get a chance to see the look on their faces when they moved in, but it made me feel real good that we had gotten that accomplished.

- One of the…probably the greatest team accomplishment I had was fairly recently. I was a moderator for the United Church of Christ in Bismarck. It's a congregation of about 400 people. It's not very large. Our pastor, who is a graduate of Princeton—got a Ph.D. from Princeton—but he's originally from Streeter…a country kid. He's 6'5" and just a brilliant, really wonderful guy. But he got it in his mind that we needed to expand the church; we needed to grow the church. Everybody was doing that. All kinds of other churches were expanding and... I was a moderator. I've helped raise lots of money, and I thought, 'Well, how hard can this be?' Man it... (Laughter) It got real scary. We needed about $1 million total: debt and equity. And when we looked at what we could service, from the giving at that level, was that we needed to raise over $600,000 in donations in order to cash flow. Otherwise we couldn't make payments with our congregation at that level. And all the promoters are saying, 'Oh, the church will grow, you know, it'll be there.' But we were very conservative. We said, 'No we're not gonna do that. If we don't get to 600,000, we're not building.' So we started down that trail and we got the formulas from the national church on how to do this. They recommended hiring a person to lead the process. I was on the interview committee and there was a retired physician who went to our church and I was gonna call on him. He died the day I was…had an appointment to see him. So there our big giver was gone, you know. Oh man, that didn't work. We had several other untimely deaths of people that had money. And, man, this is not gonna happen. We had bogged down. We were still $200,000 short of what we needed to be, and we had to order the steel. This was in 2003- it was near [Hurricane] Katrina…it was during the time of Katrina, and steel prices were just going…shot through the roof. So, we either accepted the contractor's bid for steel or he couldn't hold it. And we were $200,000 short... I didn't know what to do. The congregation was divided on that our minister just…was really nervous. He didn't want to break the congregation, but we couldn't stop. So, we negotiated a short-term loan. I called a special meeting with two people in the congregation. One was a retired high school administrator; the other was a Realtor. We met at a restaurant with our pastor and the head of the fund-raising. We said, 'How do we get this 200,000?' I don't remember how exactly we came up with the plan. And we got it all. We were in there on….I think Christmas Eve 2004. Now we look back at that and it's just so smooth. But it was just an example of teamwork staying positive. One of the persons—he'd gotten Alzheimer's—and was no longer able to make a decision. I went to the guardian services that were working with him and they said, 'We can't do this.' I went to his wife. They were almost in a divorce situation. She paid off the last…the loan…about two months ago on her own. That was really heartwarming to see that. So, that was being part of a team that just…it faced reality, but it stayed relaxed. We had enough resources on that team that we could count on each other.

Question 3: Ideal future image for health care

- I think I've lived well. I would really like to die well. I'd like to spend my last years of my life doing stuff I'd really like to do. I'd like to see the Wilson Collaborative be successful in this region so that all the health care that I need as I age is here, including hospice. My brother-in-law is a hospice chaplain. I really appreciate that guy. And like your experience, I'm beginning to see this phase not be feared but to be planned for and to be thought about. And it's integrated in the health care system and it's not morbid at all. This is the end…everyone who's ever lived has died. Except this generation. So, we're not gonna be any different. I thought of the lessons I'm learning from the Doc. My goodness, that guy teaches you how to live. And I'd love…and I don't wanna die in 2012, I'd like to make more than that. But in 2012 I'd like to see an integrated health system, plans for life-long health in this region. Integrated—Native Americans, whites—fully active, still using the name Wilson. And maybe somewhere in those days they'll remember Fred and me and a few other people. And, yeah, they helped design that system—that integrated health care system that's life-long, all the way to the grave. That would make me very happy. I can see myself living in a nice house, maybe with some chickens and a few things like that. And people could come visit me, provide the care I need in my house. That would be my idea of the Wilson Health Planning Collaborative's accomplishments.

- Well, it's 2012 and I've retired two years ago. Medicare is still functioning. I've got a pretty good health care plan. I'm still meeting with the Wilson Collaborative on occasion. We've seen a huge surplus of money that was accumulated in the state of North Dakota spent wisely in a number of areas. One of them being health care. We no longer have any small rural hospitals that appear on the threshold of failure. They are all operating with a bottom-line that is in the black. And we have managed to create a hospice system that is functional statewide. We have networked that system together so that it can function statewide. We've developed a means of providing home care on an appropriate level to both aged and disabled people and people that have been discharged from hospitals. We no longer call it home health or home and community based care—it's just home care. It provides services to people as they're needed. That's sort of my vision for the future.

- Well, if it's four years from now. My youngest son's a sophomore at college. So that means my two oldest are all the way graduated from college. And there's available and affordable health care for everyone in our region. Our local hospitals and clinics and nursing homes won't be under constant threat of trying to find qualified staff. They won't be scrambling to find physicians and RNs and CNAs. But the most important thing is, that if someone is in need of help and quality health care it'll be there for them and it will be affordable and available to everyone.

- Four years, if we're successful and achieve everything needs to be achieved, then we will have a lot of health care workers here because they have come from all over to be part of this kind of system where they're allowed to work and to do what they love to do and they've been trained to do. And they can do that in an environment where they are not always cutting corners or pinching pennies so that the organization can pay its light bill. Hospitals and clinics and the whole health care system, including home care, will be free to do what they do best without worrying about the gas bill. That it can't go more than 45 miles out of town because it isn't reimbursed and we can't lose that much money on that kind of service, kind of thing. We just do what we know what to do. We know how to do it best and we're passionate about it and we're allowed to do it without being handcuffed and dependent on some archaic formula and system of regulation that make no sense anymore. Where it's actually fun to be part of the management team of a great team instead of a nightmare and one of constant worry and stress. That would be fun.

- I guess I agree with his statements in regard to being able to practice medicine and be a part of medicine in a less cost restrained way. I think when you look across the whole northwest, north central and northwest North Dakota the group of health care facilities all really have the passion for doing it right. It's the cost-effectiveness and the ability to pay the bills with the current reimbursement issues that are in place that really hand tie you… hog tie you. In addition, when it comes to working with Native Americans, the big change in systems between the non-Native American health care systems and the Native American health systems is just really hard to work through and actually make it autonomous. So that would really be a great thing if we could make that more doable. Get rid of the…have it all be one system so that you can care for everyone uniformly and the bills and the costs all take care of themselves in the background somehow.

- You are all very wise and I will just say ditto to yours. I have no original thoughts on this.

- This is a very interesting question. Something that comes to mind for me is a little bit more abstract I think. In looking at the condition of the current health care system, not only in North Dakota, but also on the national level, I think that what I would hope for is for a greater emphasis on the long-term portion of health care. By that I mean everywhere we're talking about "going green" and being a sustained nation that will prosper for another 200 to 300 years. And I think that in keeping with that spirit, we need to work a lot on the preventive aspect of public health. I would like to see a greater emphasis place on a healthy North Dakota and get us out of the bad statistics for obesity and heart disease and these problems that are gonna spiral out of control if we don't do something soon. It's just gonna cost us more if we don't. Not only would I like to see everything that you guys have all said but I…also working on maybe 50 years down the road and how this generation is gonna be at that point.

- I guess I look at a system in four years that is color-blind. It doesn't see if a patient is Native American or white or Mexican or whatever and treats everyone the same regardless of how the bills are paid. The hospitals are…the bed numbers in the hospitals are going down; they're not needed. As she said, there's more preventive care. Long-term hospitalizations aren't needed. Also, the elderly are allowed to die with dignity, mostly in their homes. With good care and pain medications, no real long-term life-saving measures, just a graceful, natural death. And I think that's about it.

Summary

Regardless of race, our blood types are the same. We're all the same. Veterans, Native Americans, whites—we're all human begins. We all deserve the same level of health care. The kids in school now know this. We have the ability in this room tonight and we'll find ways to do this. To make sure health care is 1) affordable; 2) deliverable; and 3) enjoyable.

We want to carry the stories forward. We will see elements emerge. We'll see solid themes after nine additional meetings. We will turn health care on its head—from negative to positive.

Aug. 18, 2008
Rural Health Care Public Meeting
Velva Senior Citizens Center
Velva, N.D.

Call to order
Bill Patrie, co-chair of the Wilson Health Planning Collaborative, called the second of 10 rural health care public meetings to order at 6:30 p.m. He explained that this project grew out of a project—Northwest Venture Communities Inc.—that worked to reduce poverty. Health care was one of the initiatives and is linked to poverty. Health and prosperity are tied together.

"If you're poor, you're likely to get ill," Patrie said. "And if you're ill, you likely to get poor."

He told the group that there is a pronounced difference in longevity between Native American and Whites. He reported that Native Americans in the area live to be 66 years old, while this number is 77 years for whites.

Attending
Those in attendance included Mary Grossman, Janyce Feist, Roger Howe, Hazel Gackle, Rudy Mickelson and Jocelyn Turner (Dr. Herb Wilson's daughter, who is from Nederland, Colo.)

Collaborative members attending were Susan Davis, Fred Larson, Mitch Monson, Bill Patrie, Randy Schwan and Dr. Herb Wilson.

Wilson reported that he doctored on the reservation for 43 years and kept one statistic: The age people died and the cause of death. He said it was amazing the discrepancies of how and why people died.

Appreciative inquiry
Patrie reported that appreciative inquiry (AI), a business strategy, is being applied to this project. In its simplest form, it's "asking positive questions."

Three Affiliated Tribes is going to get funding for a new health care facility. Congress and the U.S. Army Corps of Engineers are defining health care as a problem to solved, but it's not a problem to be solved. There is no hope or joy in our voices when we start focusing on deficits and problems.

Why AI? Communities are smart if they start thinking together. Regions are smart if they start thinking together. AI identifies the "positive core." We want to undo the negative arguments.

We've stumbled onto the right people at the right time and at the right place. Tonight, we'll come up with:
- Short-term plan
- Long-term design

Question 1: High point experience

- Delivering turkeys during the holidays. Had lots of problems, including car breaking down. But I looked up and saw the sparkling snow. Stopped me in my steps. I was held in a spell. It was a spiritual experience. The turkeys got delivered.

- Last year in December, I made a commitment to compete in the Fargo marathon. Soon after, I had trouble with my knee. I had to work on my knee, which took away from marathon training. My friend and I had committed to doing the marathon as a team, even though I wasn't a marathoner. I ran and finished the 26.2 miles.

- I interviewed a very fine man. He is a native of this area all his life and his high point experience that he can recall right at the moment was when he graduated from high school, as he graduated. Afterward he started to work on his dad's farm, his parents' farm. He loves the earth. He loves working with cattle and whatever: dairy farm and so forth. And I think that was a good experience.

- I interviewed my partner here. He was a cop in Williston for 15 years and he got police officer of the year—not once—but three times. He got voted police officer of the year before going back to school and doing this.

- My partner is a native of the area. He grew up here and I think his personal experience is probably similar to a lot of others. He says probably his highlight is when he was converted to the Catholic faith. He said that was really the highlight of his life.

- I interviewed someone's lovely daughter, Jocelyn, and she spoke of a very challenging experience that she took on, which was climbing Longs Peak in Colorado. That's a 14,000-foot high peak. And, first of all, it's probably the hardest thing she's ever done, physically. And she thought often throughout the climb that she wasn't gonna make it; that she'd have to turn around and turn back. But she also noted that it fulfilled all these requirements that are listed on the slide feeling fulfilled, feeling joyful, hopeful and proud that she'd done something meaningful. But it also serves as a real high point in her life and a peak experience.

- I interviewed my partner and his high point was going to the lake recently with his son and grandchildren, and seeing how joyful it was for those grandkids to learn to water ski as his kids had. And, oh yeah, the joy of teaching young his grandchildren how to water ski and to have fun at the lake. In spite of being thrown from the boat, you know they still...you know, pumped their fists and to see the joy and to see the young people learn something that you taught your own children. That was a highpoint of his life.

Question 2: Positive team experience

- I'll start this one off. Jocelyn's part of a team. She works in pre-op and recovery in the surgery unit. One of the things that research and data indicates is that there'll be better surgical outcomes if the surgery patients are kept warm during surgery. They instituted the use of "Bear Huggers," which are warm air circulating blankets to keep the patients warm. The other key element that they also identified was that timely administration of antibiotics is important to good outcomes and to accelerate the recoveries. The entire process requires lots of checking at various points and a lot of teamwork from pre-op through recovery, involving all the people that contact the patient to ensure that temperature is maintained, etc. It's a total team effort and they have had very good results as a result of the teamwork that they managed to put in place.

- Well, continuing on about here. We all get older and time to retire or semi-retire. That's happened to my partner and he came to live in this town and was surprised at how well, how easily, he fit in with the group; people living in town. They're friendly and so forth. And then came along to the senior citizens, worked with the center here. And though it has some negative points, he didn't want to dwell on those. I guess he's treasurer and a spark-plug here. Right?

- Yeah, I think I can tell my partner's story is very similar. You know, he retired and moved to town and has been working with the community here. And I think one of the things…you know, we talked about the core, the core group. That's the core of your community that's positive. He feels that there's a lot of good positive core work here in this community. He works at taking care of the cemetery, you know. They have a beautiful cemetery. You can look at the community; it's nice. Of course you've had more rain than we've had, but you have a real pretty community. That's your core people in the city that are keeping it that way. The yards are trimmed and that's nice. The other thing is working with the senior center, here, delivering meals, you know. He gets enjoyment out of that. But, that's been positive in the community.

- I heard a story of how a community is brought together, and everybody comes together to support the education and the kids in the community. And in this case, my partner kind of organized and led Dollars for Scholars Program, which offers graduating seniors a chance to further their education with a benefit, financial boost from the community. And she talked about how the team all came together to organize these events and fund-raise. Really, it wasn't so much an exercise in fund-raising as much as it was just watching community support build over time. It's one of the things that makes a community like this thrive: The community spirit led by volunteers who give of themselves and take satisfaction in that.

Question 3: Ideal future image for health care

- I'll get older and need medical care so… My partner told me a little bit about his experience with a pain in the chest and how no one could find out what it was. So they eventually sent him to a psychologist. But he's sure it is a muscle sprain, but nobody would listen to him on that. But that brought up a thought about the over-utilization of medical care; especially technology. How the MRI and all these things have to be used, even though the diagnosis is something very simple. Similarly about all the pills we gotta take. You say you are taking ten different kinds? Usually that's about the number we hear people taking, and some of them are fighting with one another. Anyway, the ideal image, or maybe I'm putting my own words in here, my own thoughts of 2012 would be where some of the abuses of medical care are eliminated and it would become less expensive. The bill for medical care would be less expensive for everyone and everyone can participate in the new future of better health for everybody.

- One of the things we were talking about was prevention. You know, good eating habits, exercising and avoiding hazardous behavior, which we feel people will be doing more of in the future. I think that the prevention part is probably going to help us a lot.

- Just to comment on that: In 1989 I had an opportunity to go to Japan. I looked around at that community and I thought, 'My goodness,' everybody just seemed physically fit. They walk and ride bikes and they eat healthy. I lost 8 pounds while I was there, and I wasn't there very long! I couldn't find a McDonald's. But the place really struck me as... how much of our health is culturally induced. You know, my folks—my dad—lived to be 90 and he worked hard every day and had a modest diet and my grandmother lived to be 99. They had that balance of exercise in everything they did. They worked every day. And now... it's cultural. It's a great comment. Imagine how fun it would be, too. One writer I read talked about how silly it was to work all night so you had enough money to go to a health spa and work out. What if your job actually had healthy activities in it so that you didn't have to go to the health spa?

- I think to promote this thought, which is so important, and prevention. We just came back from France. We spent about five weeks over there. We never saw an obese person. But they eat so different than we do. They use only olive oil. And he's on a diet now, which is fruits and vegetables. But I don't know about France and how they get their eating habits and so forth because I'm not from there. But I do think that if we could find a way to really promote prevention in our diets and our behavior that would be a beginning to avoid all the problems, I really do.

- Yeah. When I was in Barcelona, I noticed that they don't even have king-sized meals. They were more limited because they didn't have several double quarter-pounders, bacon... I don't know…whatever that thing is called.

- My uncle lived to be 108. They canned their own food. They even canned chicken. Would cut off all the fat. They ate lots of vegetables they grew. Fertilizations was natural—manure—and not all these chemicals used today.

- The natural food industry is growing in leaps and bounds across this country. The Wedge in Minneapolis is doing $600,000 a week in sales. Annual sales are more than $30 million. I counted more than 60 bikes outside the store.

- In 2012 there are community gardens. We are going back to the "old ways" of raising and eating healthy foods.

- CSAs are catching on around the country. That's something we could do. Local foods can be sold through local schools, hospitals and other places. The market is the key.

- Aging in good health without having to be institutionalized and maintaining your independence. Keeping your independence will lead to good health.

- People are keeping active.

- Aging in place. My dad passed away at 87. He kept working until a couple of days before he died. Keeping active is wonderful.

- In-home construction; look to the future. Do some of these things before you need them. In senior cooperative housing in Minnesota and Iowa, services are brought to you as you need them.

- In 2012, health care workers are in such supply in North Dakota that we can keep health care centers, such as in Velva, open. We have bright, young people working. There is a spirit of service—giving back to the state that trained them. We are not only training doctors for the rest of the world. Our community is alive and thriving with workers.

- We've kept what we have. The public is working to keep the nice facility we have.

- Young people are becoming aware of how food is grown. There is fresh grown food.

- I miss the smell of the fresh plowed earth in the spring. I would like to see my own kids understand this and would like to see a return to this. Country Natural Beef sells to the Wedge Co-op. They raise cattle and keep ownership all the way to the store. Provide people with the "story" of how the beef is raised.

- My granddad died in 1933. He told his mom that man would destroy the earth.

Summary

By October 2008, Patrie reported, the Wilson Health Planning Collaborative will have a short-range plan on something we can do something about: A "right now" strategy.

Then, by the end of 2008, we will have a broader strategy for the whole region.

Aug. 19, 2008
Rural Health Care Public Meeting
Bottineau Technology Center
Bottineau, N.D.

Call to order
Fred Larson and Ed Hall led the PowerPoint presentation on the Wilson Health Planning Collaborative and appreciative inquiry.

Attending
In attendance was one community member—Joan Mortensen, manager of the St. Andrew's Bottineau Clinic.

Collaborative members attending were Susan Davis, Ed Hall and Fred Larson. Bill Patrie also attended for a short time.

Discussion
The group discussed health care disparities. They questioned how to motivate and educate people to take care of themselves. According to Mortensen, only 31 people signed up for the new colonoscopy service. The goal was 300. She said the services may need to be taken to the people. Locations may include churches, schools, Ladies Aid meetings—wherever people are gathering.

Hall added that if people help design their own health care system they may be more apt to participate in it.

Reservation needs
Hall reported that Indian Health Services runs on a shoestring and they're broke most of the time. He said residents have learned to accept; to take what they can get. However, he stressed that IHS needs to do a customer survey in the area.

Hall reported that the former hospital that was located at Elbowoods was underfunded and was in poor condition. Then, when it was flooded for Garrison Dam, the U.S. government promised a new facility. That was 58 years ago. He said $20 million has been appropriated for a new health care facility at New Town, but the needs have not been examined. The real needs in the community need to be discovered, he added.

According to Hall, Indian Health Services uses existing data, which does not include a lot of people. Because of this lack of new research, IHS is eliminating a lot of services in the proposed new facility because this data might not be in the system. An example is mental health care, which Hall says there is a drastic shortage of on the reservation.

Question 3: Ideal future image for health care

- By 2012, we'll have trained and an adequate amount of mental health care providers.
- We need oil tax money back to invest in health care. There will be earmark dollars for health care.
- There is a Health Care Trust Fund.
- Insurance covers screenings. There is more preventative coverage. There are healthier citizens because they can get pap smears and other preventive tests.
- Insurance companies are agreeing to do colonoscopies before you have bright red bleeding.
- An immunization program is back in place. The federal government has pulled the plug on one of the best programs in the last 150 years.
- There are no more disparities. Government has gotten out of health care.
- There are more doctors and equal and fair reimbursements.
- There is no more Medicare Advantage Program.
- There is needed home health care and hospice.
- Another thing I envision is an electronic records system—"No Wait."

Summary/other info

Other discussion included the following:

- The Perspective Pricing System (PPS) is not used as intended.
- Mortensen said good things are happening at Bottineau and the CT scanner is one of them. She added that Jodi Atkinson (the administrator of St. Andrew's Hospital in Bottineau) is also one of them.
- Mortensen reported there is no telemedicine at Bottineau, but it is not needed. Providers provide on-site services and if there is an emergency they send the patients on. The MRI truck comes to the Bottineau facility every other week.
- A video teleconferencing system is in place. All hospital in the state have the BT1 system and all are connected together.
- Ten hospitals are working on a joint storage and access program to decrease costs and reduce duplication in testing (such as X-rays).
- SecuriIt costs $5 a month for IT help.
- Harvey has a co-op health system and the students get credit in school through this program.
- Privatization of health care is not working well.
- North Dakota has gas taxes, cigarette taxes and alcohol taxes. Why don't those taxes go to health care?

Aug. 20, 2008
Rural Health Care Public Meeting
Senior Citizens Center
Rugby, N.D.

Call to order

Fred Larson opened the meeting at 6:30 p.m. at the Rugby Senior Citizens Center. Larson and Ed Hall led the PowerPoint presentation on the Wilson Health Planning Collaborative and appreciative inquiry.

Ed Hall told the group that appreciative inquiry is a way to look at the positives rather than the negatives. Too many, he said, look at the negatives—what's wrong. Hall sees a lot of accomplishments. He remembers when Elbowoods was flooded during the building of Garrison Dam. He remembers when Dr. Herb Wilson came to serve the area. Hall was a young man waiting to go into the Armed Services in 1950. "We need to carry good ideas with us in whatever we do."

Hall told the group that positive stories take the good feeling with you. We want to do the same with health care. He said their have been cuts in home health care—especially around the Minot area. What is the state—that has surplus money—going to do about it? Is health care one of the things the state will use it on? There is a dream for health care; why not use some of it on this?

Ed Hall told the group that poverty and health are related. "If you're poor, you may have poor health. If you're in poor health, you may become poor," he said.

Attending

In attendance were 13 community members. They included Mary Armstrong, Richard Bickler, Myrna Johnson, Mary Jelsing, Warner Knudson, Dr. Seiler, Lisa Thorpe and Frank Wolf.

Collaborative members attending were Susan Davis, Ed Hall, Dallas Knudson, Fred Larson and Mitch Monson.

Question 1: High point experience

- My partner's most recent moment or day experience is basically on a daily basis with her family. Being able to sit and visit with them. And their daughter is going to be taking off to college soon. The pride in being Mom and Dad and having their family get together evenings and always talk about their days or upcoming events, etc. There aren't very many families that have that camaraderie and she is feeling that that is the high point.

- My partner recently had a sister-in-law who suffered from ALS. She lived in California, and they were in a tough spot for some health care and she went out there and helped take care of her sister-in-law and did a really good job of it. I know her brother really appreciated having her there. It was a very fulfilling experience for her to help out her brother in his time of need.

- This doctor was awarded in church... What month was this again? In the past year, right? Little over a year ago. He was called up front and was awarded the Silver Beaver Award from our pastor from the Boy Scouts.

- My partner related a story of when her daughter was in college, sending her Erma Bombeck's story about the world's meanest mom. The point being that even if kids perceive the meanest mom, it's all done with love. Ultimately, everybody benefited from that. She recalled that story.

- Well, this caught me off guard. I thought I was gonna talk about myself instead of about my partner. But I think he can talk about a similar thing. We both kind of focused on our families. I know he and his wife were just with their whole family on a trip in Arizona. He thought that was definitely a recent high point of their lives. It left him fulfilled, joyful and proud that they were the parents of that great big family reunion and she is saying, yes, too?

- I guess my partner had the same thing. They were together down in the Black Hills, South Dakota. They had a wonderful time. What else did you do down there? Enjoyed the family. Well, that's the main thing there, get together with the family and enjoy 'em.

- Well, my partner here, was one of Rugby's businessmen for years with the grocery store business. He got out of the Service, and that was a big moment to come home. And then he stepped right into the family business and continued it. So, you know, these small towns and everything are very fortunate to have a business continue and not many outsiders will come in and buy a business to take over. So he continued with the business that way. Good for the community.

- I recently had heart surgery and I was impressed with all the help I received when I had this problem. They helped me recover, and I never knew we had these programs, so I think people should get acquainted with that.

- Well, my partner talked about his 80th birthday, which he just had here at the Senior Center. And he said he had two grandsons who were not here? Two grandsons that were not here. One is over in Iraq.

- Well... my recovery was pretty good. I had a heart attack July the 7th and I've done real good on the recovering.

- Like the other woman, I was caught off guard. I'm gonna talk about myself and I'll let my partner talk about herself. I'm retired and I just can't volunteer like I used to. I used to enjoy it. Kids left home and my husband and I did a lot of work on the farm. My husband said, "I don't know why you want to go out and work for anybody else." But I came to the hospital here. Had my CNA and volunteered. I just wouldn't give up anything that I ever learned at the hospital. And I wish I could have volunteered a whole lot more, but I just can't do it anymore.

- Well, I enjoyed my years as a 4-H leader. I was a leader for nine years. My sons, all four of them, were in 4-H. There were the community kids that were with them and we had a great time showing the calves and whatever projects they had. Also, another high point in my life is when I became a certified medical transcriptionist at the Good Samaritan Hospital. I typed for the doctor here, a lot of other ones. And I really enjoyed that, because I learned something new every day—especially when the students would come in. They would harass me and give me a bad time. But I had a good time doing it.

- I interviewed this fine lady. And she just had a milestone just very recently; she just had her 80th birthday. She's moved here from Bottineau and she has... and on her 80th birthday she had a host of friends from many different communities: Bottineau, Minot, Tuttle and different places where her relatives all came to help her and enjoy her 80th birthday. The one thing that she did mention as a high point of her experience was that she told me that her mother had been married three times. They had a home life that was not always stable. There were 14 children in the home. And the mother was not always caring for the children. So she took that responsibility and she was the one that made sure that the kids got to school on time and that the help was needed. And so her, the high point for her was now when the brothers and sisters have come back and thanked her for all the caring years she gave to the family to keep the family together.

- I did really good and the thing that impressed me the best is that I worked at the Good Samaritan Hospital in Bottineau for 20 years and now I'm retired and I'm tired.

- Well, mine is the same as my husband because we had a family reunion this summer around the Grand Canyon. And I tell you, when you see all these children and grandchildren and the greats, you gotta be thankful.

- I just wanted to tell you what was a high point in my experience. There were four of us children in our family, and we decided to give my parents a round-trip ticket to Norway because they wanted to study genealogy. My father was a country minister and the highest wage he ever received was $2,800. So what we did was we all chipped in and bought them tickets and enough money so they could stay in Norway for a few weeks, so they were able to track this down. By that time, I looked at my bank account and you know what? I didn't have enough money for a round-trip ticket. So, I just told my friends and colleagues (I was teaching in Wisconsin) "You know what? I'm gonna go to Norway. I'm resigning my job. And when I get to Norway, there'll be a job waiting for me." You know the first day I was there, I opened up the paper and there it was. I stayed four years.

Question 2: Positive team experience

- The group experience at work would be in 2004 when we converted from our paper appointments, etc., to computerized appointments. We have several people who have been with us for many years and their conversion from paper to computer was absolutely awesome. The group worked together. It's teamwork and it's still fun. We're still learning lots about what we can do with the new computer system. I know the doctor probably doesn't agree totally, but it's been rewarding, needless to say. To see everyone on board and basically enjoying it and learning constantly has been a challenge.

- Mine's the same as hers, because we were working on the same project. Like she said, we had a lot of employees there who had no computer experience at all. And we had a huge learning curve. And they all mastered it and are doing quite well. And now we're just learning some of the extra things that we can do now that everybody is comfortable at the computer. So, there are still challenges, but we're getting there.

- I guess working here at the Senior Center has been probably the most fulfilling thing in the job line that I've ever done. I've gotten to meet many wonderful people that I would have never have been with before and they've all been like moms and dads to me. We've worked together to make a lot of changes here in this room through fund-raisers. You can just see the results if you were here every day. There's the new carpet, and there's just different things that we tried to update. So everything here is just a joy for me.

- I chose specifically not to talk about a work experience, but an experience in a group relationship that was very positive for me and it has to do with my relationship with the Lutheran Disaster Response in a program called "Rise up and Build," which was organized in response to Hurricane Katrina. I've been to Mississippi and Louisiana three times. The first time I went down was as a physician, and the other times I went down as a laborer. It was a very good group to work for, very well-organized. We accomplished a lot of things for the people of that area. This group has stayed organized although we've lost some of our workers. Obviously, it was meaningful to the people down there and very meaningful to me. I was telling this woman that I... a recent conclusion the first time I was down there that the rest of my life, as long as I am physically able, I'm going to spend at least one week, if not more, volunteering for some place. I have actually worked in North Dakota, too, related to this. I just wish that I had more time to take off whenever I wished.

- With my work experience, I think just writing grants to subsidize our program from a small amount to quite large amounts over the years has definitely created a positive change for our programs. Allowed us to expand. We cannot charge for any of our services, so we depend totally on donations. With medication costs, balancing the seniors account. They choose to pay for medications and sometimes don't have anything left over for our services. People that work with me, definitely the board—I have a great granting board—I think one of the most intelligent ones in the state. And I really mean that from my heart. Professional people that come at any time when we set a meeting and don't fall asleep, set goals, and timelines for me to follow, and then I try to do my part. Together, I think we've been very effective in allowing us to expand into the three-county area and offering multiple nutrition programs.

- Well, I guess if I went back so many years ago…I used to be in the Boy Scouts, and we had a bunch of kids we'd take out there. I guess I worked with the Boy Scouts about five years or so. It's a lot of fond memories. And lots, oh gosh, it'd take a long time to explain it, to talk about all of what was done. I think another great thing that I think a lot of is I volunteer a lot in the hospital. We go out there and even read the newspaper or take them to the church services, or bingo, or whatever it is. And it's nice to work with this other group of volunteers. And, you know what? It's the greatest thing in the world to have them "thank yous" and they say, "Thank you" and "Thank you to these people." They're long-term, in tough shape, some of 'em. And it's nice to hear 'em say, "Thank you." And I'll always appreciate it.

- Well, I think volunteers are fantastic. I got involved quite a bit with the Head Start Program. And one of the things we had was the Foster Grandparent Program. And pretty much what we got around here is a lot of grandparents, but they were so great to help out as they were non-paid, and they might have raised 12, 15 kids of their own. But here they were out volunteering to help young mothers get along. I know one mother asked how to make bread and rolls. And one grandma did so. She had raised 12 kids herself, and here she is teaching this young gal to bake. Now, I think this Foster Grandparent Program was one of the most successful things that Head Start put out because it covered nine counties. I know one time we ran a van trip to Grand Forks and I told this one boy that we had a new rule this time: There'd be no talking on the bus. And I tell you, there was silence for about 30 seconds. And that took care of the no talking. But, anyway, I certainly enjoyed the volunteer grandparent program and I think we're working with seniors here now and I think that shows a lot. They worked their life, and they're willing to help the next generation come along.

- I have a daily chore. I usually play pinochle. And if you want to get acquainted with people, you sure find out about them when you start to play cards. I also enjoy it very much.

- Well, I'm going to go to the volunteering again. We do that quite a bit and I think that some of these residents can be the greatest and you can learn something from them every day. You can see their smile on their face. Like I said, there are a lot of "thank yous." And they're just great.

- Well, I had so many experiments... experiences. I visited four foreign countries. Korea was the first one, and then Japan, then I took a trip to Russia and Finland. And I got some experiences from them countries.

- It's an experience when you've been on a farm for over 50 years and then you move to town. And, we're in an apartment. I'll be my 13th year; my husband passed away several years ago. We've got the greatest group [at the apartment complex]. We have our birthday parties and just last Friday we had a picnic. So people, don't worry if you ever have to get into an apartment. It's great. And senior citizens...I just love to come up here and visit with people and have my dinner here. I just love senior citizens.

- Well, I'm gonna talk about a work experience. This gentleman mentioned that I was the director of a Head Start program for nine counties. I happened to be one of five Early Childhood educators in the state, and at the time none of our colleges offered any courses in early childhood. It was elementary education if you were a teacher, but there was not early childhood. Then the federal government came in and said these people have to have some college—they have to have some course in training. So the problem was, I had some wonderful young staff members. They did a fantastic job of doing home visiting; going into the homes, sharing things, information, and working with the mother and the child individually. But the problem was most of these were farm women who could not go to summer school at a college, even though we offered to pay all their expenses. So, doing some problem-solving, listening to what they had to say, my premise to them was, "You know, don't wait until you need education to start taking courses. Prepare before hand. Start taking courses because you never know in life whether you're going to be alone raising your family, or if you going to be a family that can still stay on the farm or the ranch." As a result of listening, I found that some of them said, "You know what? We'll take the course if you can bring it to Rugby." And so I had to come up with another plan. So what I did was, I talked to Mayville State University, which was the only one at the time that offered early childhood classes, and they only offered one or two. They said they would be very happy to incorporate our staff. But I had some options there that I wanted. One that I wanted is we would pay the expenses of the teacher to complete it and also pay for the credit, the college credit. But I wanted to select the instructor. The reason for that was, in a school like Mayville where you may have one or two in the department, you don't get a broad view. So, I knew there were many early childhood educators around the state that had master's degrees, were competent to be college instructors and they had specialized in certain fields. So this is exactly what we did. We set it up, I wrote out a plan in writing, the president of Mayville State College approved it and we set up this college instruction. And you know what makes me excited today? It's the number of young mothers, the young staff, that got a two-year degree. And there's one who just finished her four-year degree after working many, many years toward getting her college credit.

Question 3: Ideal future image for health care

- I'll give you a unique start here. I'll tell you what my dream is. The North Dakota Legislature found a use for some of its $2+ billion surplus. They created a viable Health Care Trust Fund. And from that trust fund, they're underwriting all of the deficits that have been created by the reduction in the federal Medicare payment program that resulted in the loss of home health care to most of rural North Dakota. We now have statewide rural home health subsidized out of that health care trust fund and everyone who needs home health care is receiving it. We're also merging into that system the program that has been called home and community based care. So we're merging both the social model and the medical model of home care. People are receiving the services that they need in their homes when they need them so that they can remain independent and healthy for as long as possible in their own homes.

- My dream would be that reimbursement would be covered for all services in the health care system. That we would have more providers available. That more of our young people—or whatever age it doesn't matter—would go into the medical field and become providers. We have a lack of physicians who are available in North Dakota especially, but throughout the whole United States. The other thing is that there would be some help for medication for our patients. There's a few other things, but I'm gonna let other people go on.

- The biggest thing that jumped out at me was medications, because that has to be one of the biggest needs that we see at the clinic since medications are so unaffordable. So my dream would be that everybody would have access to affordable medications for a nominal fee because I think people take a little bit of ownership from it when they are able to contribute to something. So I think some people would like to say, "Free meds," but I think when you are able to contribute a little bit on your own it makes you feel proud, too. That you were a part of that. So that would be my biggest dream is that meds are more accessible to everybody.

- Well, I don't know too much about health care, and I'm just getting to the age of Medicare, and I hope there will be less paperwork.

- When I wake up in 2012 I'm going to be retired. And, let's see... I probably will be 65 also. I have a dream of less paperwork. I have a dream of a universal health record so that we would use the same form in every clinic and every hospital in the whole country. That the information would be able to be shared. That lab reports could be shared. That X-rays could be shared. There would be less duplication. Figure out a way... we're heading in that direction on prescriptions and renewing them so that I don't refill a prescription, then somebody else refills the prescription and somebody else changes the dose and the patients get confused and the doctor gets confused. So we need some kind of a common universal health record. The other area, obviously, is that I'm on the front edge of the Baby Boomers. And while we're all thinking we're gonna be old and healthy, we're not. We're all gonna get old, and we're all gonna have chronic health problems. As a country, we have to figure out how we're gonna address that. I think, unfortunately, it may require some soul searching on what's gonna be covered and what's not gonna be covered. Because at the rate we're going, we're gonna be broke.

- I've worked for the aging services programs for 27 years. And home and community based services has always been our targeted goal every year. I'm glad there aren't any legislators in here because the legislators have a tendency to fund nursing homes over and above what we feel they should be. That allows less and less money out in the community to keep people in their own homes. I have only met one elderly person who said, "I wanna go to the nursing home." 99.9 percent of the people want to stay in their own homes. I'll use a gentleman from Antler, North Dakota, as an example. Antler has nothing. There are no grocery stores, no restaurants, and the idea was to move him either into Minot or to West Hope. And he said, "I was born in this house, and I wanna live in this house and will die in this house." And that should be all our options. We should have that option. And we don't have that option if we don't have enough money out there to keep them in their homes. I would gladly testify at any time that nutrition has got to be the most important factor in keeping people in their homes. They may not have the cleanest house, but they have to eat. We just don't ever see increases in that area. So if I can wake up in 2012 and see home and community based services funded to the level that they need, that would be my dream.

- I guess everything's been said that I was ever thinking about. I guess what I'd like to see in 2012, if I wake up, is I'd like to see the rates as far as long-term care come down. This is terrible. These people go in there and they cost them $5,000 to $6,000 a month. It's terrible. There's nobody left after a few years that is not on Medicaid. They have to or they'd starve to death, you know. I'd like to really see a cure for cancer. I'm involved in that. I had prostate cancer a few years ago. I got treatment. I got that fixed up. But, my son... all of a sudden at 54 years old. That's why I'd really like to see this cancer being beat. I guess in... oh, I don't know... about 60. I'm 70 some years old now. Anyway I heard my dad talk about cancer. He said, "Creitze." How do you say cancer in German? Well anyway, I'd like to see that taken care of. That they find a cure for it.

- Well, that cancer idea is good. I have it right now myself, so I am for that. What I would dream would be that this silly war to be done with so that we can quit sucking all the funds out of all these other programs for the war. If we didn't have the war, we could be using a lot more of these funds on health care and things along that line. This gentleman and I also belong to the National Silver Haired Congress. And if there are any individuals here who have a pet idea that they'd like us to pass along nationally, and we can confer with people from all other states, please do so. We'll accept any ideas.

- Well, I guess I'm spoiled like everybody else. I'm taking about 10 different pills. If somebody could figure out how I could throw away about half of them, I'd sure appreciate it.

- Well, if I was sleeping for 20 years and wake up, I wished we'd have a good dental plan. Not just for health, but for dental, too. You can have good nutritious foods, but you have to be able to chew it. And, of course, affordable health care and medications.

- Well, it seems like that 2012 is a little ways off yet. So I don't know what's gonna come along with the election after this, and what's gonna be new.

- I don't know what to say either. We kinda think a few years back with the computer and this and that, and everything is coming to us so fast. I just can't believe that there's anything newer that can happen to us right now. And like 2012, well, like so many say, we just have to be glad we're gonna wake up and be able to move around at our age.

- Well, when I wake up in 2012, I hope there's peace on earth and we get ourselves back to God.

- Well, I'd just like to reiterate some things that have been in the Rugby paper the last month. And one is the need for a dialysis department at Rugby. And the reason for that even in 2012. We've had friends that have had to drive to Bismarck and they had really a lot of mileage to drive to do it for three times a week. And I'm sure there's a lot of people in this area still going to Minot who could actually have that service. And I was a little disappointed; maybe some of those people should have been here tonight.

- Yeah, I'm not gonna complain because all I ever take is one prescription and I pay for that and I'm still here.

Summary/other info

Fred Larson reported that one of the things we've found is there is a complete vacuum in home health care. A $2+ billion surplus for a population of 600,000 can go a long way to cure some health care issues. We need both short-term and long-term goals.

Aug. 25, 2008
Rural Health Care Public Meeting
Water Chief Hall
Mandaree, N.D.

Call to order/input

Bill Patrie opened the meeting at 6:45 p.m. at the Water Chief Hall at Mandaree. He told the group that the purpose of the meeting is to talk about what's right—not about what's wrong.

"We're going to talk about the things that work well tonight," he said. "If we talk about what's wrong, we'll become miserable." Patrie told the group that people get tired about talking about what's wrong. They get exhausted. "Those of you who learned how to shoot baskets in this facility know you learned hot to make a basket and then did it again," he said. "It's no use to focus on and learn how to miss a basket."

Patrie reported that stories are being used for the 10 public meetings because the themes that will emerge become the building blocks for the design and launch stages. Positive stories that we'll build our planning on. We hope to create a system that gives you energy back.

Katherine Young Bear, president of the Mandaree Segment, told the group that there is a need to have qualified doctors in each community. She said it is hard to get into the clinics. "Asking folks what they want is a good thing. I hope you'll take that information and do something with it," Young Bear said.

Dr. Herb Wilson, who practiced in the New Town area for 43 years, also addressed the group. He said that during all of those years, he thought Native American and non-Native Americans should have the same medical services—the same opportunities. "There are still disparities—an inequality—in the health care that Native American receive," Wilson said. "There's no reason for it. It shouldn't be that way at all."

Wilson said he kept records of the ages people died at. Half were from the Fort Berthold communities and half were from non-Fort Berthold communities such as Plaza. The average age at death for Indian males was 49. And, the average age of death in 1995 (the last year he kept records) was 48. "It went down," Wilson said. "I wasn't very proud of that." He added the major cause of death for Native Americans was auto accidents. For non-Natives the main causes of death were heart disease and old age.

"I've been away for 13 years, but there's still a lot of auto accidents," Wilson said.

Attendance

Community members attending the meeting included Walter Deville, Arnold Strahs, Wendell White, Paul White Owl Jr., Rosie White Owl, Lyle Wind and Katherine Young Bear.

Collaborative members attending were Susan Davis, Ed Hall, Phyllis Howard, Fred Larson, Mitch Monson and Bill Patrie.

Question 1: High point experience

- I interviewed this fine gentleman. A high point for him individually was after he got out of the Army he became a police officer and also was very active for veterans. One of the things that he was able to do was to make a "drop-in center." Where, you know, kids could come and adults and anyone could just drop in and have fun. You know, make popcorn and stuff like that. And he did this—he helped do this with no federal money. They got all their money elsewhere. So that was a really positive thing that he did individually.

- I interviewed this guy. The high point of his career was when he hooked up with you guys with your health collaborative—and hoping that he's gonna get something done. The other one was he earned his Eagle Scout badge, which is the highest honor for a Boy Scout. Now he's a full-fledged vegetarian after failing two times, so he's what you call a "vegan."

- I interviewed this man, and we had a nice visit. We talked about a lot of things; we didn't leave much time for the questions, but I did get an answer for number one. One of his high points was he recently wrote and was successful at securing a $140,000 grant for the Brownfield Environmental Division. He just received it and heard about it last week. So it was really fulfilling for him. He had just started the position and when he was told he had one week to complete the grant application. And I thought I had it bad. So, I won't be complaining any more when we have a couple weeks. So he did it in one week. Although it was an individual highlight, it was also a good team highlight as he had a couple people who really stepped up and helped him. It really felt good to get it done and being successful at it, too.

- I got to interview the good doctor here. One of his nice experience, a personal one, was he was flying B-24s in the service in World War II, doing bombing missions over Europe. His most memorable mission was his 31st mission. It was his last one. He was glad to quit.

- Ok, I'll say something about you. This is a nice young man, and he's went all over the country but his most memorable time of all the places he's been, and all the places he's worked, his most memorable time was coming home to the reservation. Right? Good.

Question 2: Positive team experience

- This is a group situation. When things worked well. Remember when it's positive everything has to work well. When he was thrown from a horse and broke a couple of ribs and had a broken collar-bone. But, CHRs were there. They took him to Watford City and he got fixed right up in Watford City. In other words, something worked well in the health system then.

- Unfortunately, one time the dam was built here in Garrison and the doctor here was swimming. Had to swim from Elbowoods to New Town. But anyway, with the help of the New Town people there, they helped him build his clinic and, you know, started his practice there. He's been there for... how many years? 43? 43 years. So they helped him a lot there.

- This guy on his team accomplishments, he was real proud of his soccer team. He was a member of a soccer team and they won second place. They were playing against older kids. Most of his players were 10, 11 years old against 14-year-olds. Anther one was when he won first place…his band won first place in the Battle of the Bands in Illinois. And there were 500 bands!

- This gentleman was on a basketball team. He's been playing basketball... he played basketball from 1973 to 1999. This one particular instance he and his team were playing against the State Highway Patrol. His team only had four people and the other team had five, but they ended up winning because of the three-pointers that they were making, and apparently the other team wasn't making them, so that was one of them. A couple more... oh, and also, the name of his team, they were made up of Vietnam vets and they were called the University of Southeast Asia School of Warfare. I thought that was fitting. And one of the other things...they were able to raise funds for cross-country uniforms and also for, I guess, kinda like an alcohol-free post prom. So that the kids would have an alternative to drinking and different things like that. This was at the New Town High School. So, those were some team moments that were high points.

- The highpoint of her experience has been when her daughter…well, her daughter's gonna graduate from the University of North Dakota with a four-year degree in nursing. And it's been a real proud moment for her because when she was young wanted to be a nurse. And so her daughter fulfilled her dream of becoming a nurse. So she's going to have a special event for her daughter here when she graduates in October. But it's real interesting because when I was in my former job with the tribal colleges, her daughter was one of the students who were selected from the Fort Berthold Community College to go to NASA to be an intern for one summer. So that was an interesting thing that we had a chance to talk about.

- Hers was when she got to be a great-grandmother. She was very proud. She has a grandson and she's very proud of him. He's healthy; and she's had a lot to do with telling her granddaughter which doctor to go to and how to take care of the baby and she had a lot of influence in that and is a very proud grandmother and great-grandmother.

- The high point experience of a positive change that she talked about was when she went to some job training, which was real interesting for her. [This] was blood borne pathogens, and she really enjoyed that training and she felt that was a real positive change for her and her work experience. It didn't really involve a team effort, but it was just something that she did for herself and her work.

- Hers was being the director of the Health Department... Health Disparities of North Dakota Department of Health. She was excited about that and proud of going there and she's doing a good job.

Question 3: Ideal future image for health care

- When interviewing this guy, he said he would like to see a health care system where health care was available without worrying about who's going to pay for it. And the doctors are up-front with you about your health condition.

- Likewise, this gentleman thinks that is…what he would like is to be seen when you need to be seen. To have no worries about how he's gonna get to the doctor and also no worries about how he was going to pay for it.

- We kinda talked about this. She said that she has used the hospital and the doctors in Dickinson because there's better doctors and better health care. The access isn't as close to home, but it gives her family a lot better health care. And she said that she would like to see a better health system and that one doesn't have to travel long distances to get to a health facility.

- She would like to probably see a good facility here that we can go to as individual people. Right now she said that she sends her kids to Bismarck, because it's better care. But, in the future, we know some day we're gonna have a better facility here and I hope it's close to home here in Mandaree. And I hope each of our little segments has one, so we won't have to worry about traveling off very far or waiting for an ambulance to come get us. It'll just be done right here.

- What I'd like to see, if I fell asleep for four years, is for the Mayo Clinic to be... this new health care facility to be a branch of the Mayo Clinic. Where all the facilities are provided for our people. We won't have to go nowhere. And the flip side of it is, we don't have to worry about paying for it either. It's already there. It's one of the treaty rights that was given to us. It is one of our rights that has never been provided adequately. That's what I would dream. That's what I would like to see.

- I fear all these are pretty much all going to be the same. He wants fast response…that is, qualified people to take care of him in a one-stop place. You don't have to be sent on from here to there and everywhere.

- Man! You got a long list here. But basically it boils down to if he wakes up in 2012, he would like no inequality. Black, brown, red, orange, purple, green, you name the color, everything's the same. The same procedures for everybody also. So if you go in there, they do the same thing on you regardless so everybody gets the same care. Equal funding regardless. If you're rich, if you're poor, you go in there and everything is under one umbrella. He would also like waste eliminated. Evidently he has been a doctor and he's seen a lot of waste from various insurances, paperwork and duplication of all kinds of tests. He'd also like to see where you're seen by one doctor and one doctor only. 'Cuz that one doctor, if he could be qualified enough, he'd know all your records and he'd be able to treat you as an individual. He would like to see one equipment center, where you go in and you get your MRIs, your radiology tests, everything, so you don't go from one place to another, 'cuz that just involves more waste—with more doctors, nurses, paperwork. And he would also like to see the research funding increased on all types of cancers and whatnot. Just across the board…more research funding.

- If I wake up four years from now, I'm gonna be a lot older than I am today. One of the things that I'm really interested in is being able to receive services in my home. At this point in time, except for a little 45-mile radius island around Trinity Medical Center, there's no home health care from Devils Lake all the way to Montana. That's a result of some funding decisions on the federal level that have been unfortunate in terms of the result. But we need home and community based care, a social model care that is a good replacement for "nursing homes." We need home health, a medical model that is a good replacement for hospital days. These services should be readily available and they should be reimbursed appropriately. And then I'll also jump in on one of Doc's favorite themes and that is preventive care. Preventive care needs to be readily available and should be available at home—in terms of dealing with chronic diseases and various other things that can help to stabilize and maintain your life.

- One of the things that we've listened to since we've been involved in this committee, is the new technologies that are gonna be available. They're talking about you going to a clinic and your information all goes into a computer that's linked to every clinic in the country. So if you go to Bismarck and you go to a doctor's office, he goes to a computer and he can find out all about you. You don't have to take your records or call anybody else. It's all there for him so he can treat you better. We also had an interesting visit with the University of North Dakota Medical School. They're working on a lot of new technology where, like for home visits, a CHR could come out and strap you into a vest or whatever and that would electronically go back to a doctor who can diagnose you and prescribe many things that could save you from going to the clinic. And in rural country that's gonna be real useful. The point is, that here on the reservation, I guess our job is to see that we are designing a new health care system now. Let's make sure we're involved in that. Let's don't design something that is 10 years old. Let's require them and get involved and see that we're state-of-the-art in these types of equipment.

- One of the things that I'd like to see, that I got from the idea from Doc, is that in 2012 there would be a lot of kids going into the practice of medicine from here. And that it becomes a growth industry—the medical industry becomes a growth industry and people start coming here to get treatment. I thought of the same thing about the Mayo Clinic. Why not become the Mayo Clinic of the plains? We've got doctors who have grown up here. We've got young people who are bright, and could go to school. And why don't we turn it into a growth industry, economically, where people come to this area to receive treatment rather than having to go other places to get treatment? And that turns things around for us and it creates many new well-paying jobs and encourages people to come and encourages people to stay. And the other thing I'd like to see is I'd like to see that idea of in-home health care to the point where you go all the way to hospice, so that I could age in my own home. When I got to the point where I would normally have to go to a nursing home, I could get that care in my home. That just sounds really nice to me. I look forward to that.

- You know, what we do need is dental. We need a lot of... we need more dentists in every community because we... I for one, I know I need a lot of dental work. The older you get it seems like we need that. But when females have children, it really knocks the heck out of your teeth, too, you know. So they need that, too. As women, I speak for the women. We do need a lot of calcium to build up our bones. And osteoporosis sets in on us and all that kind of stuff. And so we need preventive measures in that area. My mother passed away here just recently and, you know, I took care of her until she passed away. She really lacked a lot of health care. I wanted people to come in and help me out, too, because when you're taking care of an elder and you're alone taking care of an elder, it's really difficult. It's kinda like taking care of a newborn baby all over again. That's really hard on one individual. So if there was something put into place with our tribe where this person could come and take a break now and again, that would help, too. I come from a big family but we still... there's a lot of us that don't pay attention to our elders so we need to be doing more for our elders. Whatever we can come together and provide for our elders. I think we need to do that because I don't want to see people being weighted down and that kind of a thing. Because it does take a toll on an individual when you're taking care of an aging parent. Another thing I'd like to see is MRIs. That's a really important topic that we need on this reservation. We send our people out and a lot of times they might have a blood clot some place and we don't find it until that person passes away and it could have easily been prevented with an MRI available in our clinic or in our new facility that's coming up. But we need our people—our young people. We have a lot of young people that are going to college and getting educated. They need to be educated in this medical field. So there needs to be more grants and make it more available for them. I've gone to school for so long, probably most of my life. But, you know, it's really... education every year goes up, especially in the medical field and legal field. Your fees are continually rising, so we need to help in that respect, too. But we need our own people educated in that area, in those areas. Especially in health and legal. I'd like to see more of our people become lawyers and doctors—medical doctors. But dentists, too. I really think we need more dentists. We need a facility, we need doctors, we need trained people, we need hospice, and we need it on this reservation. But we need to be open with this new facility and the tribe going with the 638 process. We need to make sure that our people aren't left out. These satellite offices need to have more availability of things coming into our community. I hear White Shield has a dentist and even has the dental chairs and everything in there. But Mandaree needs that. Twin Buttes needs that. All of our segments need those things. So there's just so many things that we need for our people. I always have a problem with being anemic. We need to have things done in that area, too. A lot of our people need to have blood transfusions and those kinds of things. So, you name it, we need it as far as medical goes. That's what I have to say. But as far as the facility, the up-and-coming facility, I'd like to see that our people get to have more input on it. More of all the community members. Every enrolled member need to have their input into that facility. This Minne-Tohe clinic that was built up here, our people didn't have input into that. Now this is gonna be a big facility I understand so we all need to have our input into that. And it's good that you've come down to the communities and I'm glad that you're taking notes and taking our ideas because this is important. This is our health. You can have everything in the world, but if you don't have health, you're nothing. So, thank you.

Summary/other info

Bill Patrie told the group, "We now have federal control over health care. What about community-based health care? Can a community design a system that it owns and controls? There are models like that. Who knows better than those receiving the services?"

Bill reported that the Wilson Health Planning Collaborative plans to submit an application to HRSA for an outreach grant. This three-year grant is to provide a health care service that is not currently being provided.

By 2012, when it's time to implement the full system, the Collaborative will go back to HRSA to apply for a larger grant. The Collaborative will come up with a strategic plan by March 2009.

The group discussed research. The Gates Foundation is one funding source. Could do some extensive research and have the community involved. Students at colleges could help with the research by providing a lot of the raw data that is needed.

Aug. 26, 2008
Rural Health Care Public Meeting
Northern Lights Cafeteria
New Town, N.D.

Call to order

Scott Eagle, a community chairman for 12 years, opened the meeting at 6:30 p.m. at the Northern Lights Community Wellness Center at New Town. He welcomed those attending and said "health care issues are always on the uprise." He added that there has been a war on diabetes, but that war is being lost.

"We need to start health education at a younger age," Eagle said. "Those affected with diabetes are getting younger and younger." He also said the population is getting to be more rural. "The rural areas we live in are so vast. What about those who live out in the country?" he asked.

Eagle told the group that that in 1991 he was severely burned. Going through this tragedy and getting rehabilitated was a hardship. He lived four miles out of town. He also needed to go back to work soon after the accident because he had a family to support.

Eagle said relationships need to be formed to provide and define good health care.

Dr. Herb Wilson also addressed the group. He held up the first medical record book he kept at Elbowoods. He said back then there was no diabetes. He said something must have happened in the years to follow that caused it.

Wilson told the group that the Wilson Health Planning Collaborative wants to stay upbeat and positive—thinking of things that work, rather than what doesn't work. Results, he said, don't happen overnight, but we can dream about them. "If we dream about it, it can come true," he said.

Care Aubol, New Town mayor, also welcomed those at the meeting. He said he remembers talking to "Doc" Wilson when he first came to this area. Aubol said at that time diabetes was an unknown illness.

Attending

A total of 27 people attended this meeting. Community members participating included Sarah Dea, Val Eide, Gloria Fast Dog, Alfreda Good Bird, Susan Hall, Cedar Heart, Dakota Heart, Juanita Helphry, Marilyn Hudson, Jerry Nagel, Marvin Pretends Eagle, Pearl Ross and Glenda Rush.

Collaborative members attending included Susan Davis, Ed Hall, Phyllis Howard, Fred Larson, Marilyn Levine, Mitch Monson, Bill Patrie, Pierce Stepp and Dr. Herb Wilson.

Overview

Ed Hall, co-chair of the Wilson Health Planning Collaborative, addressed the group. He said that one way to stem out-migration is to have good health care. "It will get folks to stay," he said.

He reported that Trinity Health at Minot used to provide home health care within a 90-mile radius of Minot. However, the hospital recently had to cut back to only a 45-mile radius.

Hall also stressed that the Bakken Formation should be tapped to help pay for quality and accessible health care. "When we started this work four years ago, this oil thing wasn't here," he said. "Now we're sitting on top of the Bakken Formation." He said a lot of cigarette and liquor taxes were paid by area residents, but not much was returned for health care. Hall said he doesn't want the same thing to happen with the Bakken Formation.

Question 1: High point experience

- I interviewed this lady. And she had a really great story. She says she's the youngest of 11 children and two of her older brothers both got bachelor's degrees. So they inspired her to go and continue her education and so she went on... and later in life went on to seek her bachelor's degree and then also received her master's degree from the University of Mary. She was the first one in her family to get her master's degree. Of course, she felt very joyful, very hopeful and proud of that. But also she's very proud of the fact of the example that she set for her children and for her grandchildren. She said it even carried on to—not only to her family that are still here—but also those that have passed on. And she just felt really good about that. She also told me that her native name is "Ambitious Woman" and I think that is a very good name. Obviously, you have to be pretty ambitious to go on and to take that on. For a lot of us when we first go to high school or maybe we go to college and get that BA we think, "Well, that's great." But for her to go back later in life and take that on and do that, that's a great thing. So...that's her story.

- I interviewed this young woman and her brother. And she got a big smile on her face when I asked her about her high point. She had one right away. It's pretty exciting. She recently won first place in the state finals with her science project. Yay! It was in Bismarck. She had one here locally first. She got first place and she was competing with kids all the way up to fifth grade, so that was out of all the grade-schoolers. She was in fourth grade at the time, so she beat out all the fifth graders. She did her project on Big Foot. She proved that he really existed. So she did a lot of research and so, "Good job!" And then another one that she wanted to share 'cuz it was pretty exciting was at the end of July she and her family—and some nephews and cousins it sounds like—they went to The Dells in Wisconsin. The roller coasters sure put a twinkle in her eye when she mentioned that. So it was a very high point, literally.

  Her brother's high point has been his job, in general. It's been very fulfilling. He's the director of food and lodging at the casino. He basically started out on the front line and the last 13 years he's worked his way up to where he's at now. So he's done a remarkable job. He's really proud of that place and proud of what he's accomplished. He's glad to go to work every day, and glad he can work. He supervises about 60 folks out there in those two departments and he takes a lot of pride in his work.

- I interviewed this nice lady. And she was saying that her personal triumph is kind of as being the head of her family—how she's encouraged family members to be the best that they can be and going to school and that sort of thing. She says that it starts in the home; to have this positive outlook on life starts in the home. And she's proud that she was able to put that into her kids and also now her grandchildren's lives. I think... was it your grandson that is just starting kindergarten? Oh, her great-grandson is starting kindergarten. So that's really good. And there's a really good quote if you don't mind me reading what you said. You said, "When you hit a rock, you don't just stand there and say, I'm never gonna get around it. You have to say... you have to stand back and say, How do I get around this rock or this mountain? Because there is always a way around it." You just have to think in terms of how do you get around it and not how do I just stay here? So I thought that was really good.

- I interviewed her. One of the high points in her life was when she graduated with a nursing degree. Her degree was as an LPN. And she did this with four small children and she was a single mother. When she graduated that was just the high point of her life.

- I interviewed her. The highlight of her life is when she became a great-grandmother in February of 2008; the way she felt because she was so young a great-grandmother. That was a high point—that she felt so relieved and joyful and had a feeling of hope because her family was able to keep carrying on and that it was a little boy.

- Hi, I interviewed her. And she told me the story of the time when her son had finished college and had gotten a job and going to work every day. And after a month or so, he told her... asked her a question. He said, "What can I take with me? I'm gonna move out." So then he went up to the bedroom and started asking, "Can I take this? Can I take that? She said, "Sure. It's your stuff, you can take it." So she was feeling kinda bad because it sorta sounded like he just wanted to leave her there and abandon her. So she asked him, which was very brave of her, "Is that what you're doing? Are you just leaving me?" His answer was, "Mom. Don't you realize that the reason I can go out and be who I really am is because you were such a great mom?" And I thought that was so good.

- I interviewed the pastor here. She's new to the area here and this past week we were introduced to her son when he came to visit her. While he was here, she said he's still developing his Christian relationship with God. But he did a lot of things. He was working with a Father, he was singing in the church and different things like that. He gave the... he participated in giving the church money and things like that. She said, "Gee, you don't have to do all of that." And he said, "Well, I wanna support you and I want to show my support for you because I love you." So she was very proud of that—that he was becoming an individual who was showing his support and showing his love for her.

- Because she is a childhood friend, I didn't ask her a lot of personal questions. We just reminisced about learning how to inhale in the seventh grade. So that's a good health quote. But it was very, very interesting to realize that her highlight—that popped right into her mind and stayed there—was childbirth. When you look at the question that talks about if it was fulfilling, yes it was of course. It was joyful, yes it was. It was hopeful—the hope that she has for her children as she helps them grow up. And the pride. So, all of that is there in her experience of childbirth.

- She was a career person, so hers is related to her work. It is the creation of the Racism Resource for the United Church of Christ that has been used by churches all over the United States.

- I interviewed this man. He is actually an employee of the Rock View Good Samaritan Center and I haven't seen much of him lately because last spring he went to the hospital for one issue and ended up having open-heart surgery, which was unexpected. So his highlight was that he came through the surgery and that he's worked very hard to regain his strength and continues to do that. So... that's a good accomplishment.

- Well, I just got a mouthful! I don't know if I could interview her. Well, anyhow, I didn't really interview her. We reminisced... we were co-workers. We worked together for a number of years so that's what we talked about. We talked about teamwork. We looked at some of the things that in addition to getting a lot work done, you know, in the office, we looked at some of the highlights. That would have been some of the things we got together and planned, particularly going-away parties. Or if somebody retired and so forth. So we called to mind some of them. In particular, we had maintenance men dancing and a road crew singing. And just a number of things where through planning and through involving everyone, we would have the whole entire agency involved in it and it would be a real highlight and a lot of fun. I think that one that came to mind is when we had a bunch of guys singing 40 hours a week and they even made their own guitars and fashioned them out of the junk they found laying around the maintenance yard. You wanna add anything to that?

Well, the thing was that even with all the fun that we had, there was a lot of work that got done. And I said, even to this day, a lot of people come back and they ask... you know, the ones that we helped or assisted... they ask, "Do you remember 'cuz this is what I need." And we've had to reflect back on those at the time and where we were at and are able to help. I've gotten quite a few of them because I was the secretary for the superintendent. She was the administrative officers. So when he wasn't there she was my boss. And she is still my relative in the other way. But we really worked good as a team. Everybody had a good time. But then the BIA was down-sizing, but the work got done.

- I interviewed her, but I had a little trouble interviewing you because I was thinking so much of the past. Her parents had a little story... Can I tell that story about them? You know how women sort of relate to doctors? Well her father thought that her mother was a little too close with me. Actually, he went after me with a knife! But anyway, we're friends now. Their daughter here is a very amazing person. One of the things that she had recently—the moment that stands out—was sort of an out-of-body experience. And I think she can describe it a little bit better than I can, about seeing a boat. Here, you tell about it.

- We live in different spaces and the world around us moves ahead of us, past us, under us and around us all the time. That we are here. So, this one time I was standing up, and it happened about a month and half ago, and I was telling my daughter about it. I said to her, "Did anything happen to you like that?" "Oh, yeah, it did," she said. So she told me her story. But my story to her was that I was standing up somewhere. Like a flash, I was in another space. It was bright. I was at the end of the water, at this end of the water. There was water all around. Beautiful. And the colors were real bright. The water was real still and there was a ship there at the far side straight across from me. It was bright blue. In front of the ship was sparks, like spirit sparks going. And then I was back in reality again. So I was thinking, "What was that I wonder... You know, how come that happened just now?" Because I was standing up. Sometimes it happens to me when I'm sitting down or laying down. Before I gave it another thought, I was back in the same place. Same colors; the water was still. Bright colors of green and blue with the water; real beautiful colors, and the ship was gone. So, I believe that in the world we live in we need to go forward and do things and believe in miracles. Really. Every day.

- I talked to the doctor here, and he's writing his memoirs. He was trying to think of a theme that went along with his stories. Many stories, I suppose, that he has of when he lived here and worked here and did all his medical work with all the families that are here on the reservation. He needed something to hold all these stories together. The one that he remembers best is his mother. She would always talk to him whenever he would ask her questions. She would answer him. He didn't finish after that so... you'll have to ask him what else.

  We got interrupted because of the end of the time. But anyway, the thing is that my mother would always do what I wished. Maybe I was a spoiled child. Probably was. But anyway, I was an only child and attribute my inquisitiveness, my wanting to be with people and interact, to my very earliest years. Before I was 1 year old... or between 1 or 2 or 3... As I say, Mother would always answer and encourage me to be inquisitive. All right, who's next?

- I got to interview her. Her topic was about the... when she moved here from Texas and that's been four years ago. She knew very few people. She tried to find jobs around. It was tough to find jobs. She took spot jobs. The thing that she did in four years was watching and learning from people. A few months ago, she was hired on by the MHA Times. With that she has learned things from the cultural history around the area and the people. As far as one of her positive things…as far as feedback from people now in the community, they come up to her and tell her that they enjoy her stories that she writes and her columns are very positive. That makes her feel part of the community now. So, that's a high point.

- Actually, I'm a writer and not a talker. I don't like this. But the whole thing with the columns that I started in the paper…"Hands around the rez." The idea behind that is that I write about the people here, different individuals. Everybody has a story and everybody has good in them. The column is to remind everyone in the community and the individuals that I'm writing about, about the good in them. There's so much good here. It's to celebrate that. I'll interview you. I'll interview…I'll talk to everybody on this reservation if they'll talk to me. OK, I interviewed him, and the highlight for him was going to Minot State. He was in the NIA Conference. He was a defensive tackle and his team won the All-Conference Award. That meant a lot to him. It made a difference in his life, because for one thing, he was off the res. He was among other people, so he had to grow socially. He had to fit in. He met a lot of people. He found that people have feelings just like him…people from other countries, other states, other communities. So he wasn't so different after all. It's frightening to go away for the first time like that, to a strange place. In order to receive the award, it took dedication. It was a very big accomplishment. He had to have respect for his teammates, respect for the higher powers, respect for the coach that taught him and gave him confidence. The coaches taught him to take on diversity. And that has taught him to set his life goals. That has taught him to take on projects with vigor. And so that experience has made a difference in his life.

- Can I just sneak one in about the doctor? I knew the doctor's mother, when she'd come to visit and stay at the house with him, you know. There were summers where they took my mother and went to Boston where his mother used to stay in Boston. So then my mother flew out there or sometimes she... The first trip she took, they'd go to Regina first and then go down to Boston. So she said they went down, you know. And she said, "You know what happened? When we went on a train, we got by one of the lakes. I don't know what or where they had to go across... Lake Superior or something. You know, we got so far...you know, on the buildup on that train tracks. That train started on fire, or that wheel or something, and they were way out on that lake." She said, "Oh, I was so scared." But she said, "That Mrs. W didn't even care or anything." She said, "Did you know, I was like a hobo. I walked…we had to walk on that train track and go to the end of that lake," And she always tells about that, "but when we got to Boston, oh! I got to meet a lot of the English ladies. And, oh! You know, they just wear such nice clothes... they're them rich people. And so I had to act like that, too," she said. "And then in the afternoon," she said, "they'd have their tea parties. So me, an Indian... oh! I'd try to kind of have fingers out like this (holds fingers out while pretending to put a tea cup to her mouth) when I drank my tea in a glass cup... and hold that little plate. Or hold that little plate under my cup," she said. "And, oh! I'd just be handling that and try to act like them," she said. That's a little story I remember about the doctor's mother. But she was treated so good out there. And they invited her to them schools, and she talked to the children about being an Indian, you know. They asked her a lot of questions. But she sure enjoyed them summers, going out there with the doctor's mother.

- Well, we started out with an interview and then we changed... my story was pretty corny. The only thing that I could think of was…counting my days to go home. But hearing the stories here I thought of another one that may be more interesting. That was a day of reckoning, I guess. That's when I decided to quit farming. I farmed in Twin Buttes. Farmed a couple of thousand of acres over there. One spring I was putting in a crop, and there was no rain. And that's back in the strip-cropping days: farmed half and summer-fallowed half. I'd have to stop to see where I was going. I farmed alone. I got home that night exactly at 10 o'clock. My wife had the meal on the coffee table so I could eat and watch the news and the weather—the Chicago Board of Trades and all that stuff. The bathtub was already filled up to go get in. And so I ate and here I was watching those guys and they were fighting over my spring crop and I hadn't even seeded it yet. The Chicago Board of Trades, they were buying futures on spring wheat. I knew I was on the wrong side of the street on that deal. So I went in; got in the tub. I was laying there soaking. Took my bath. I got out and my back end kinda hurt here. My wife has a big mirror on the door to look at her hem, you know, in the bathroom. So I went over there, and I turned around and I looked at myself in the back. My back end looked like a baboon! From that farming, you know. And I looked down at my hands and I counted. I had 45 calluses on each hand. I looked closer and I could see a green stain... where that money went…sliding across there. So that was a proud moment at that time to let it go. But I really loved it before I seen that guy at the Chicago Board of Trades.

So I leave and I go to Montana and I make friends with people. There was a guy that made a lot of money managing property for other people. One of his clients was a guy with a $250 million cash financial statement. He used to hire this guy to do things for him. He went out to Montana, bought a ranch with 10,000 acres on it 'cuz he said, "I wear cowboy boots, and I'd like to get some manure on 'em. That whole Polson country in the Mission Mountains is just beautiful...go buy me a ranch so I can get me some manure on these boots." So my friend did and he bought it. And guess who that guy is? Retired at 35—the chairman of the Chicago Board of Trades.

- One of my high points in life was in 1968, when I met this fella's grandmother. And she was 100 years old, I think at that time, and was getting ready to go on the poor people's march in Washington D.C. Is that right? I think he was the last full-speaking Mandan Indian on the reservation. Full-blooded. But, my, a high point for me will come next Tuesday when—after seven or eight years of negotiations and working with the Tribe and the city—will sign the Water Supply Agreement with Sen. Dorgan at the event center at the casino. It's taken a long time and it's one of those problems that you start working on and it takes some patience and you have to have patience with the process. So that is coming up Tuesday at 12:15 p.m. at the event center. You're all invited, but bring your own cookies and coffee!

Question 2: Positive team experience

- When I came here this evening, I hadn't seen this building... not very much. What a wonderful thing that's here! So this is perhaps the story I would start with on teamwork. This woman tells me that they were meeting in the North Segment Hall and were chilly, and I can remember being so chilly there myself. They said, "Do we have to keep on putting up with this?" Eventually, this is what the result was (looking up and pointing around at the walls of the new building). So there was a positive thinking.

- Teamwork and positive thinking and getting started to do it. I remember the day that we were there in the evening. Him and the other guys were there and we said, "Why don't we just start it?" That was great teamwork and they started right away. Before I knew it the building was here. The doctor was talking about change and when it came about was when they formed the town here of New Town. It had to do with relocation to begin with. People were moving different places and everything was moving around here. There was teamwork and talks with different people that laid out the plan for the streets and the place here in New Town... where the buildings were gonna be and this and that. He remembers the names of the men.

- Well, my term with the Public Health Service was up. And so I could go anywhere I wanted to, and Tioga was really wooing me. My wife and I went up there. Anyway, we decided on New Town. Actually, it was so exciting—all the people moving around and all that. I tell you, a lot has been written about the dam and how it made everybody leave and how bad it was and all that. But we tried in those days to look on the positive side to make people feel at least a little better about it. Anyway, there were all sorts of possibilities. Thinking back now we did try to use some appreciative inquiry but we would never know what those words would mean in those days. But we tried to foster that. I think we did for some—to some extent. Does anybody know Dan Pfaff? Remember him? Yeah. And how he would go around and talking about time, work and savings? And that's how the Indian people would have to learn that and learn live out in the general population. So that was teamwork we had then.

- I had an interesting one here with her. She was part of the North American Indigenous Games in 2006. Her title was "Chef de Mission." Is that what it was? She said she got a lot of harassing about that. But anyway, she helped organize that and she said when they first asked her to do that she was very hesitant and thought, you know, she was kinda scared to do it. But then she realized that she had a great board and a great team behind her to help her with that. So they all worked together. They had to. Of course, there were tryouts for all the athletes

and the young folks. They had a lot of things they had to do. But she said it was….she had a real sense of accomplishment of what they had done when it was held in Denver. When they came into the stadium there at Mile High—or INVESCO Field I think it's called now—so when they stepped into that stadium as team North Dakota and they had their own chant and had their banners and they had their flags, and how proud they were that all the work they had to put into that. They had to have athlete tryouts. They had to order uniforms. They had to get parent permission. They had to work with coaches, and it was just a huge undertaking. And the sense of accomplishment that she had that they were able to work together and pull that off. So that was really fulfilling for her.

- I was really impressed with his story because it deals at a national level. He helped Chuck E. Cheese with a hotline—a call line? A birthday reservation hotline. And they had 470 stores. And he felt fulfilled that the team he had accomplished this and when they got that last store on the call line. To me, that's a big thing because we think of our kids and we think a lot of our children and what we want to do is see them happy, you know. And they're happy…make their hearts happy. When you have a birthday party at some place like that, you know, it gives you a good feeling. So to me, that's a big accomplishment at a national level. That takes a lot of work and he had a lot of good people that helped him and they eventually took it on themselves. If it wasn't for him and that team developing that birthday reservation call line, Chuck E Cheese wouldn't have that going today, so... I was really impressed because this is a big nation, you know. A bunch of little kids, too…

  We have heard that story before and it is exciting and it sure put a smile on her (a child's) face. And what I want to ask him is for the next meeting, could you bring that picture of Chuck E. Cheese you got as your present—as your award? When he left, they gave him a big picture of Chuck E. Cheese.

- I interviewed him. One of his highlights for a team experience was—is and still is—being on the North Segment Board. There are five board members and they really work well together to do a lot of fund-raisers. They do Christmas community events and dinners. And then what they do is buy presents for all the children and the elders and they give them out. That's really special. Seeing the joy in the gift-recipients has been a very rewarding to him. And so it's been quite an accomplishment.

  And then I'm gonna share the one she said. Her grade school is just near the nursing home and—I think this is really special and they must have a real special teacher—their teacher encourages them for class projects and things to go over to the nursing home to visit with the residents. They go over there and they visit and they sing Christmas songs and go over for different events. They'll even go into the rooms and tell the patients stories and they draw pictures for them and take them over. Talk about a good example of teamwork when a class works together to help a whole other segment of people. Good job!

- I interviewed again the pastor here. And the experience that she had was when she first began teaching. She was hired as a music coach or a music teacher. So she had these young men and they were in a jazz band. So she went in there and she would do her little teaching and then she would stand back and let them have….do what they needed to do. After they had done that, they went to a studio and they did a CD…or something with five songs? And she said the tape and the recording was just awesome and fantastic and she had to step back and just see what a wonderful job they had done. She was just awed by them and the positive change that developed in her was that she understood that teaching is making enough room to let the students be who they really are and let them fill the space, as the student has so much to offer. So that was her story.

- I'll follow it up with hers, which was very like that. And also very much like the national story, only it was the national of the Three Tribes kind of story. Her story was about the time when the bridge was first dedicated, and there was a group of people who were in charge of making sure that this all happened for the TV cameras, etc. So there were real experts on that board who were planning everything. They sort of assigned her the veterans. And they assigned her the veterans' auxiliary ladies. So what she did was, she called each one of them all over

the reservation. Pretty soon other ones from off the reservation were calling her saying, "Can we do it? Can we come up, too?" Before she knew it, and she didn't really do it with them, they took her lead and they spread it all out. So it was like starting with her and then spreading out over the whole reservation. On that day, when they dedicated that bridge, the whole place was full of veterans in their whole eagle feather regalia. And all the little ladies having such great fun and it was just a massive demonstration of people working together with one person kind of leading the way and saying, "Why don't we do this?" Then they all were coming together and doing it. So she was really awed that they did that.

- The other guy had to leave, so I guess I gotta do my own. I guess as far as a positive high point, I was on a committee and working with the Tourism Department and planning out the museum here. But being there when they inducted the Sakakawea statue in the Rotunda Room in Washington, D.C. The building and putting up tepees and doing the parading and as far as representing...and being able to do that. Seeing Sakakawea in the Capitol Building was just to me as a tribal member—as far as a representative of the Three Tribes and of North Dakota—that was very positive. The whole experience went well and I do believe that's where Pomeroy mighta got bucked off... no he got that one out here across the river. But he did get to ride in that parade. I guess just the whole positive aspect of working with all the senators and the people from the state of North Dakota and with the Tribe and community members and elders. And I guess that's probably one of the more positive highlights, but there's all kinds of them that I could say... but that was very humbling.

- I interviewed her. She talked about how her work experience where it made a change was when she went to work for the Department of Health. She was working with the Tribal colleges or some colleges down in Bismarck. She thought about retiring. But she got a job interview and she took a change in careers. She works with health disparities, and that's special group populations. Now they're focusing on Native Americans and her new work environment is…I think she's the only Native American in her department. But in the work environment is a very accepting atmosphere and she has a good feeling when she goes to work in this job—that she's taking and dealing with health disparities, that there is a need out there in that field and that she's the right person that met that need.

- I interviewed her. Her experience was helping Head Start teachers. They completed a task, which was kind of a large task, of getting photos and getting those photos printed in a home-made picture and poem book, "My Little Hands." She was able to get a camera and a printer and a photographer on a very short notice. It was all made as a gift for moms; for the mothers at Head Start. So that was a very fulfilling time for her. It was kind of like a team effort. But it was done on very short notice with very little money.

- Ok, I interviewed her again. This story of a group triumph involves the Arikara language. Whenever she was a little girl, her Dad spoke it a lot in the home and her Mom would often answer in English. So she was around the language a lot and understands it fine whenever someone speaks it to her. But for a long time, she had a really hard time to speak the language. So, apparently, there was an Estonian teacher, I'm sorry I forgot his name... that is in town now. He speaks fluent Arikara. And so there's a group of people who are going to these classes, sessions, and learning how to speak the language. And of course, they have to work together and with the teacher to do that. One of the things that she does to really help the learning process is, you know, she has to encourage the others and so I think that's really important. And she didn't mention this, but I thought that it was really interesting, too, that there's so much intercultural information going on there. It's an integrated classroom with an Estonian teacher and Native Americans working together to really preserve and to keep alive the Arikara language. I think that's really great.

  One thing, I think most of you know the Estonian teacher. When I first came in the room here, I looked at Pierce here and it startled me. I thought, "He looks like [the Estonian teacher.]" He does. He's from Estonia across, you know. And he looks like him; blue eyes, blond and everything. And now, I thought, maybe this guy can talk the Arikara language. You know, it's really something and like he said in the home my dad spoke Arikara

and my mother would talk that, but she'd answer him in English. So I think that kinda really confused my mind because all these years I just couldn't get going, you know. I wanted to talk, but I could say words and maybe a little phrases. But then he really helped us to, you know, start talking this language here. And I'm way better at it, especially in the morning when I wake up. I can just lay there and start telling a story by myself. And I could just go down the line, you know. And remember a lot of things. And I said, "You know, us older Arikaras need to start talking to the children. That's how we can get this all together here. We both gotta talk." Some might not think it's necessary, but I see it as something we all need to talk and learn. Because what are you talking about when you say "our culture" and things like that? We as parents gotta help them children so then they understand. And in school, they have them languages that's being taught. And then when they get home, well, who's gonna talk to them? You gotta—as parents or grandparents or whoever is around—talk that language so we can keep this going. And so in future years they can say, "Well, I set money aside for Indians, you know, their health and like that." So we can be counted, you know. Because I see our culture and everything is kinda going down and people are not interested. They think, "Oh, that's not gonna do us any good." But it is when it comes to that Congress setting money aside and like that. So we gotta be Indians, and not lose it.

Question 3: Ideal future image for health care

- I said to the doctor a little while ago, "Will it go holistic medicine?" We've had doctors here that came to do family medicine among us, but went holistic. And I don't know what they're doing presently, but it would be interesting to know that. I would like it to be. I was telling him that in our family—our immediate family—we have no diabetes. Except my brother was in Vietnam and he was under Agent Orange and when he came back, he became diabetic. And he said, "Well, did he pass away from it?" And I said, "He had colitis." I looked to see if it had anything about diabetes on it, on his death certificate and it had nothing. So, for holistic medicine we…there's tribes in the United States here for sure... Years ago when we went to New York, we found that the Six Nations people have been doing holistic medicine all along in New York at Onondaga. They don't tell the state; they're sovereign people so they don't tell the state who dies on the reservation. They don't report it. And they don't tell the state who is born there. So that kinda makes you wonder, you know. What's happening with holistic medicine there. But I do know they use their medicine people there and here we've more or less lost ours—our holistic medicine here. South Dakota's not doing too bad. They have a number of medicine people over there. I remember years ago in California…we had a conference in San Francisco. Our little school in California was able to motivate a lot of people to come and do different things and we had a conference on holistic medicine. There must have been about 15 medicine people that came from South Dakota and were on the panel over in California. Locally there, they have women that use holistic medicine there from their tribes in California, and they still do it to this day. Things go full circle sometimes and I believe that it will go in that direction. We have all those plants out there that people used to use... and they stayed healthy for many years. So, I don't know what happened in our family. We still don't have diabetes yet in our family.

- Well, there's a movement now called Food as Medicine—has anyone heard of that—and it's trying to have… people have gardens and they grow their own food and go back to the old ways and thinking of trying to avoid diabetes and all. There's another thing, though, that I was thinking of and that is people should be more concerned with, well, preventive medicine actually. And go back and find out what their ancestors' cause of death and sickness were. So many are inherited, so to speak. There is a great possibility to wake up in 2012 and finding that people are being treated in their own areas. They have the same doctor all their lives or the family does have the same sort of relationship. That would be good medicine.

- That's curious to like that to see what it would be like in four years. I mean, we've been working on this hospital for a few years here. If that's too big of a step for us we need to start smaller, you know, like make better clinics or something. Improve the dialysis place over there. Get more rooms or something. More rooms for our people not to go off the reservation or go elsewhere and get their help right here. There's not enough there for them and I'd just like to see the smaller steps right now. And just to get it accomplished 'cuz I think about it myself and

I'm diabetic for eight years now. I don't wanna travel or go anywhere else to go get help. I just wanna have it here right at home. So my vision is just small…just to start off small with expanding what we have, if that helps out or whatever. Add branches on or whatever. But if the hospital's not really gonna happen, let's just improve it that route then. That's what I wanna see in at least four years here.

- I was visiting with her and these ladies back here. And I said, "If I was gonna sleep and I woke up in 2012, what I would like to see is that all the addictions here are gone. There are a lot of addictions here, and that's a lot of our problems." And I said, "What if they weren't here? What if there's a lot of exercise programs? Diabetes wouldn't be here. 'Cuz a long time ago, we had to carry our water, we had to haul the wood; we went long ways to get the stuff that we needed. And we had the wild game there that we ate." And I'm from that generation where I grew up in a log house and I had to do a lot of work. I'm not a diabetic and my husband is. He had the comforts of life but he went to Vietnam and he has that Agent Orange stuff. I'm not a diabetic but my husband is. My family has a lot of diabetes, so I thank the Lord that I'm not diabetic, because I did a lot of exercise when I was younger and I'm still very active. So, if our people could be that way in 2012—a lot more active rather than a TV and a remote control and driving a vehicle—that would be vision to see here with the health care.

- That's some of the visions I have of this place (the facility in which the meeting was taking place) here, as far as... I gotta say that I've learned in the years that we opened this place, us as Native Americans are very conservative and as they get older they're more conservative. And I'm gonna talk about them…and excuse me as far as my elders... that they don't like to work out in front of people. They don't like to walk in front of people. I would vision someday as to be able to see them at 6:30 in the morning here walking the halls and getting exercise or on a treadmill watching the news at a very slow speed, so that they walk up to a mile, half a mile or a quarter mile. And where do we start? And I guess that's really one of the visions there and how do you break them barriers down? Because you need to respect our grandpas, grandmas, uncles. And to me it's very puzzling to get that there.

  My mother had broken her collarbone and I was trying to say we have therapy poles in here. And there is no way I woulda got her into those poles to try. You know what I'm saying? Stretch it out a little bit and all that kind of stuff. But I guess there's where how do we break them barriers? How do we get that so that people are comfortable enough doing that in front of others? But there's that cultural difference there that they don't…they just don't do that. A lot of it is attributed back to the Garrison Diversion. They hate water. They hate swimming. And, I mean, and that's kind of some of the stuff that I've learned as far as working with the people in the community. I guess that's the vision that I see. I'd love to see people saying, "Oh man, look at these tennis shoes I just got because I just walked 20 miles in three months." Or, "This is the suit that I've earned." And then not knowing that they're healthier. And not saying, "Oh look, they just chopped three of my toes off because I didn't do anything, or I didn't know what to do."

  So I guess really that's the thing there as far as the visionary thing. And I guess the thing that I would say is the image that I'm seeing in New Town; the statistics are one in three households. Until you go into these households and you see the foot is bleeding because they've just got their toes chopped off…that is reality. Or else someone taking insulin and the kids' involvement with that. Or the other illnesses that they get from it where they're not feeling well...vision (loss) and all that kind of stuff. So I guess that's where I see this stuff working in 2012. It's hard for me to fathom that in four years because of where we came and we didn't accomplish that in eight years. But I guess we gotta start somewhere and we always gotta continue to work on that and I guess the thing that I would like to say is no boundaries.

  Right now we live in a community, I think, that does a very good job of where we're at and from where we've came. From '53 to present as New Town, working together as a community, but I hate the things that we're in segments. Why are we from Four Bears? Why are we from Northeast Segment? Why are we from North Segment? To me, as we set up boundaries, we compete against each other. I think one of the things about the

collaborative is to see that we're working together and we're getting rid of the competitiveness. I know we're all brought up to compete against Parshall. You never lose to Parshall. That's just a given, man. Go to Stanley. But that's where we are brought up as youth and younger so that's one of the barriers we need to break down in our communities is to quit competing against each other. If we all had the same medical health facilities, the same walking paths; we have the same kind of economy out there. That's what I would envision, but in reality it isn't there. And I think one of the things that we need to work on as far as looking at that is that we go through—and I look at what happened and I couldn't even fathom and I've talked to elders and got to interview a lot of them—is the Garrison Diversion. There's the story of the tragedy that happened there. But now as far as present day how much does that affect us now with the tragedies that are happening around us today and how many people that we are losing from cancer, from auto accidents, from alcoholism, from diabetes? We all know each other around the whole reservation as far as the Three Affiliated Tribes.

How do we deal with grief? It puzzles me each day because we go through a tragedy and how much does that cause us illness? And we don't even know it because of the stresses that are from depression and what does it lead to? Alcoholism, which leads to more prescription pills, which lead on to more chemical dependency. We do not deal with it. We deal with it in our own way, you know, that stuff. Boy, if someone just lost a loved one here how would we react to him? You know, we'd probably turn the other way because we don't know how to try to help them out. We can console them and all that stuff, but what programs do we have set in place to help better our mind. And if our mind is strong I think there is where our bodies will be at. But nobody wants to show that grief. So I guess that's just something that in the future that, if that was gone, I think we would be healthier. I think that health would…I think that would be there. 'Cuz how do we deal with stress and so forth there?

- What I envision is walking into a new facility where everything is laid out—mental health, you know, and all of that. Being able to just get up and go up north up the street here to get some care in the middle of the night. Instead of like, you get sick... well, we gotta go up to Stanley. I mean, hey, I really don't feel like riding all the way to Stanley or Minot. And the thing that I'd like to see is walking into a building like this—like he says we have all this equipment for the people. I'd like to walk into a facility where I can get care for whatever ails me. The one thing that I would really like to see—and he said as far as support—is finding that support for addiction and grief. The one thing that I really longed for recently was a support group for cancer patients. I was diagnosed in February or in March. When I was diagnosed, I lost my oldest brother before I was supposed to start treatment. Dealing with both those things I saw…I looked for something that would support me. There's a lot of us that have this illness. What exercises can we do as a cancer patient? You gotta stay out of the sun, you can't be in the cold, you can't touch door knobs, or you're gonna get sick. I mean, there's so many things that go with cancer. But as far as a support group, I would like to see that in our community…and for the grief. Because, like he says, we console them and we have to move on. But, you know, dealing with this illness was hard for me because of my loss. Because of what my brother meant to me as a leader and a mentor, and almost like a father because, you know, our parents have been gone for years. I see a lot of good things. This building is a good thing. A new facility is…I can just picture it, you know. A brand-new facility with beds—emergency, you know. Examining rooms. Things to do with mental health. Support groups. Everything that ties in for all age groups. And I also think we need to think of the technology part. I know this meeting here is to get our input because you guys don't know what we need. We know what we need for our people and for our children and our grandchildren. We do have to take that…when I got sick I was gonna tough it out. That's how we think. We tough it out! Us guys we have to be strong as an Indian and our men and our mothers and grandmothers, we have to be strong. We can't get sick sometimes, even though we don't feel good. We still have to carry on the duties that fall on us because of our role as mother, grandmother, sister. It's that…having to get up and then drive to Minot. Thankfully, we do have something that is close by us in Stanley and Watford and Minot, but it would be so great for us to have that something here so we could just drive two to three blocks instead of driving 20 miles or 60 miles or 30 miles. And just having that whole thing in one place to help all generations. That's what I see when I woke up in 2012 was a new facility where everything is laid in place. There's no learning as you go. Because of these four years we have to plan that and get this input and think about the future because technology—I always

picture pretty soon we'll be like the Jetsons sitting on a conveyor belt going through, you know, technology and just showing you what's all wrong with you. And so then like those pills... you pour water and it turns into a meal, you know. That's what I'd like to see. That's what I see is a whole new facility with everything laid out, planned to meet our needs—our physical needs, our emotional needs, our mental needs. And we have the people here that can make it happen.

- I guess when I wake up…I'm kind of taking a step back here, and I really like her ideal. And I like the things here that were said, but what I see here is hoping to have a cohesive relationship with the surrounding communities that do have a hospital. That is in Watford City or in Stanley. Because I've had a son that's had to go over to Watford City for a broken collarbone, or sliced his finger open. Then, from IHS I get a letter that my son wasn't dying so they're not going to pay for it. So I pay for it. Getting insurance for our people. I pay for my son's insurance. I went and got him insurance 'cuz I work for the casino here and now that he's not in school anymore I bought him insurance. Now I got a grandbaby and she's gonna be on that insurance, too, but I'm paying that. And I thank God that I have the opportunity with what I'm doing to be able to do that for him. Also, I look at our communities and we've had heart attacks…we've got people that have died in their homes. We have car accidents out in Twin Buttes…out in Mandaree. Why can't we have triage centers out there where they can get to them people right now? Or get that vehicle out to where the accident is so that person can be stabilized before they move them? That's what I see when I wake up.

- In this last issue of Inc. they do the 500 fastest growth companies. The number one in there at 13,000% growth in three years is a health delivery system that focuses on Medicare and Medicaid and they overlap. Going out there and looking at what we have available and making it work. We sit here with five different Blue Cross and Blue Shield insurances, just for the tribal when there should only be one. Only one. When you have one policy you can negotiate the terms. You can actually do away with Blue Cross and Blue Shield, 'cuz they're just the middle-man. They're not an insurance company. You can deal directly with the insurance company and get your rates. We have VA that we can't even get together with. VA wants to come here to meet with tribal officials to share services and do things together and they can't even do that. 'Cuz of the same situation you brought up, you have to worry about having to pay for it yourself 'cuz I get help through the Indian Health Service 'cuz I'm a Native American here. I'm retired. So you have to make a value judgment. I mean, you can't get ahold of anybody here on the weekend or after 5 to deal with emergencies, so you're on your own. You know, you're the doctor. So I'm hurting pretty bad and I get a grandson who's 14 years old to drive with me to Minot, 'cuz I'm in a lot of pain. In case I don't make it, he can drive on. I can teach him how to drive up on the hill there. So we get there, go to emergency and they give me a pain pill. That gets me back home, and they misdiagnose. That's a regional hospital. That's regional up there, that's ER. They still can't do it. All that time it wasn't because of the health food that I was eating, it was because I had a gallbladder problem. They couldn't diagnose it. You don't want to end up in a hospital here where…that's what happened to Standing Rock. They built a brand-new 28-bed hospital. All they could do was deliver babies. Back in the days when they were doing tonsillectomies they had to go send them to Bismarck to do a tonsillectomy. So then you have the cost of running two hospitals. Standing Rock and Fort Yates has to run it; has to pay the overhead for a hospital. And they're paying contributing costs up in Bismarck. You've gotta really seek this out. In four years now I think that it's all there, but it takes this kind of discussion. All of our two bits thrown in. You know, I'd rather be at home with my wife. My wife is sickly. So I have an interest here. I'm the guy that goes over there and waits for the prescriptions and sees the long line and all that stuff. I wanna make it better. If I don't work with the Tribe, 'cuz I'm kinda radical out there, I'll write editorials and I'll make changes there. I see a lot of things that can help—that I think I can throw in my whole two cents, you know. But I will tell you a story. It's kinda interesting. It's got a…it's a true experience.

  I left here in '77 as a CEO of my tribe one year. I was in Pierre, South Dakota. And I was flying from Pierre to Boise, Idaho. I was putting a construction company together. The plane was full. It originated in Rochester, then Pierre, then Denver, then terminated in Boise. And the plane was full and I alongside of a guy about 10 in the morning. He was kind of 50ish and we got to talking. And here he was a surgeon, who had a practice

in Boise, Idaho. He flew two times a week to Rochester, to Mayo Clinic, to perform surgery. One of the best surgeons in the world. His practice was over there. We got to visiting and he said, "You know, I'd like to hear from you what you think. I have a reservation—I help Indians in my private practice. I have a clinic in Boise. They got the Fort Hall Indian Reservation there and Indians live in town. They don't have nothing. And I have a successful practice; health facilities, so I just help them. But I'd like to be able to help them more. See what I can put together with resources and I met with the federal agencies that deal with Indians and I haven't got nowhere. I just went up against a wall." So he said, "I wanna ask you: what do you see for the resolve to Indian care?" And I said, "I can only speak for Fort Berthold here because I was their CEO, born and raised there. And we have a dam in the middle and it's about 300 and some miles around. I got relatives across the river I haven't seen since it flooded. And 85% of our hospital care is emergency. In Twin Buttes, where I'm from, the hospital is 50 miles away. So you really can't bring them over here to a central hospital at 125 miles, 'cuz 85% is emergency. So again, you end up paying the cost of two hospitals. So we have those problems. So what I would do…is I need somebody that has a lot of experience. He or she has already been there. They didn't go into medicine because they wanted to make a lot of money. Because you can be a real estate agent and make more money than a doctor if you're hungry enough—ambitious with realty. They went into it because they're humanitarians. So I would…we own property across the river here that's been designated as the most scenic spot in all of North Dakota as identified by the old (tape ends)…

- A lot of tribes in New Mexico have helicopter service—medic copters. The rez needs a helicopter.

- No more diabetes. A walking path. Also, working on preserving language and culture.

- My vision is no matter what or any insurance, it doesn't matter. You get service. Every person has the opportunity to be put back together again. Everyone can get fixed up the same. It cost me a quarter of a million to be put back together when I was burned. IHS paid $2,000.

- Our own designed health insurance so it fits our needs. Politics is taken out of health care. Ambulance service in all communities with EMTS and first responders. No waiting for ambulances.

Summary/other info

Bill Patrie told the group that the take-away from this meeting is that human systems move in the direction of what we deeply care about. "What's right with us?" needs to be focused on. Patrie said an example is Scott Eagle's story about being severely burned and being treated immediately with no questions by Dr. Wilson.

Mutual insurance is well-understood and something we can do.

High energy going through town. Can we get oil companies involved in this? They have workers who need immediate care if something happens.

Health-care plans are: 1) Integrated system; 2) common payer; and 3) universal records.

Aug. 27, 2008
Rural Health Care Public Meeting
Raymond Family Community Center
White Shield, N.D.

Call to order

Dewey Hosie called the meeting to order at 6:30 p.m. He introduced those attending, including Dr. Herb Wilson, Ed Hall and Bill Patrie.

"It's good to be back after 13 years," Wilson said. He added that the three public meetings this week at Mandaree, New Town and now White Shield have been like "home week." He said when practicing medicine on the reservation he didn't have much time to do research. However, he did keep track of the death causes and the age of the dead. "For Indian people, it was appalling," he said. He said that Indian people died much earlier on average than white people of the area. He also said that the life expectancy for Indian people went down over the period in which he was doctor here. He says he is not proud of that statistic and he hopes that he didn't contribute to it.

Ed Hall told the group that "this is our one chance to get something that we want." He told attendees to think and dream about what they want for health care.

Bill Patrie told the group: "If you folks link up, you can design the health care system you want."

Attending

In attendance were about 34 community members. They included Madonna Azure, Alice Everett, Diane Fox, Rev. Wayne Fox, Yvonne Fox, Everett Hosie, Karilee Lieberman, Marti Stevenson, Delores White, Dolores Wilkinson and Delilah Yellow Bird.

Collaborative members attending were Bill Davis, Susan Davis, Phyllis Howard, Fred Larson, Bill Patrie, Pierce Stepp and Dr. Herb Wilson.

Question 1: High point experience

- My CNA work at the Garrison nursing center has been a highpoint in my life. It's my 20th year there and I really enjoy taking care of "neighbors" there. The highlight of my life is taking care of others.

- My great grandson was born on my birthday—June 2. His name is Coby James Everett Hosie. I am just so proud.

- I've had many highpoints in my life; it's hard to pick just one. Getting married. The birth of child and grandchildren. I achieved my black belt in karate.

- I played on champion basketball team in high school in South Dakota. I was the outstanding athlete in South Dakota. I achieved time to retire and spend time with my family. I stayed at my job and reached my goals.

- I spent many years in seminary to achieve my degree. They Need and use me in community ceremonies. Getting ordained as a priest in Episcopal diocese. Being there for my kids' events.

- During the San Haven closing, 400 jobs needed to be replaced. How could I do this? I thought of Bill Davis. The San Haven Redevelopment Committee resulted in more than 400 new jobs in place in the Dunseith area.

- At an event at the Waldorf-Astoria Hotel in New York City, my mother was selected as one of the finalists for Mother of the Year. J.C. Penney was the speaker.

- I was a health nurse in IHS for 25 years. As a contractor with the North Dakota Department of Health, I went on two-year public health assessment all over North Dakota. Through these assessments, we almost had a Native American on the Health Planning Board. Through this work, we got the seatbelt law passed.

- I was part of NVCI and the part with poverty was very rewarding. It's why I'm a part of this tonight.

- Graduating from college and teaching the Arikara Nation language from grade school through high school. I got my calling at a later age, but accomplished going back to college. I helped a lot of people with learning the language so it's not lost.

- I received the Outstanding Disabled Citizen Award in 1996 from Gov. John Hoeven. I know of the adversities folks go through, but still make it. It makes us stronger people.

- I play three sports as a junior in high school—cross country, basketball and track. My goal is to make it to state this year. A high point was also winning the science fair and then traveling to Albuquerque. I placed first two years in a row in Albuquerque.

- The day I got my master's degree in special education. I was a teacher's aide for a while, then got my degree to be a teacher. I retired from teaching and now each children of the community about Arikara culture. This gives me a feeling of being fulfilled. Another high point in my life is when my kidneys failed, my son was able to donate a kidney. Ten years later, it is still working.

- I played on a soccer team and we make it to state. We were able to compete and do our very best, even though we didn't win.

- Two of my children made commitments to the U.S. Marine Corps. Both retired with honors in 2002 after 22 and 25 years. I was able to be present. My own retirement after 25 to 30 years in education at the local community college, which has educated a lot of our tribal members. The one who gave me my first break is here and that is Phyllis Howard. She's like Miss Tribal College with her mentorship.

- My three boys were involved in hockey. We would travel in the winter. Then we finally won the state tournament in Jamestown.

- Knowing elders who lived in Elbowoods—their hard times and their health. They told us about it; we didn't have to read about it. They always had hope. You never felt poor, even though you were. We always felt hopeful.

- When my first baby was born at the Elbwoods hospital. I was 18 at the time and weighed 125 pounds. There were good doctors and the health care here was super.

- In 1942 when I was living in Cambridge, Mass. Best time was then I was on my way to go serve my country.

Question 2: Positive team experience

- In my small hometown was a mentally handicapped man with a very small shack of a home. He used to pick up pop cans off the ground to make his money. So, in a way, he was doing a good service for the town, keeping it clean of pop and beer cans. And one day, this little shack of his burned down. Instead of letting him be homeless, the community came together and raised money, donated materials and labor and we built him a new house. It wasn't a fancy house, but it was better than the house that burned down. The community really came together and all had a common goal and achieved that goal. It couldn't have been done if the whole community hadn't come together. I was really proud of myself and my community when we got that house built.

- As a special education teacher, we would work in teams with these special children. All need to work together—the child, parents, teacher and support staff. All would need to know each others' strengths to make a difference in childrens' lives. There was a real sense of team accomplishment when these children graduated from high school.

- In 1975, I was part of a girls' basketball team that went to state. It was the first year White Shield ever went to state. Coach Baker was the coach at the time. Our first game was with Hankinson. In the second half, the referee was about to give the ball to my sister, Cheryl, when out of the blue here comes a streaker with nothing on but red Converse tennis shoes. The girls were laying on the floor laughing. Even the referee couldn't keep his eyes off the streaker. The streaker made it all the way across the gym. It was a lot of fun. It's been 33 years since girls' basketball has made it back to state. It took discipline and teamwork. The coach was strict. If you were late, everyone ran. It was really a lot of fun, though. I scored an average of 45 points each game.

- The Lady Thorpes of Big Crow on the Pine Ridge Reservation were playing in Leeds, S.D. The crowd was doing the Tomahawk Chop to defame the players. The girl who was supposed to lead the team out there was so ashamed that she would not run out there. SuAnne, only a sophomore at the time, said, "Follow me." She led her team members out onto the basketball court with all those jeering fans. Instead of running around the outside of the court, we came around the center circle. She then took off her warm-up jersey and used it to start doing a shawl dance to all the people doing the Tomahawk Chop. There was complete silence. Then the crowd went nuts and clapped and cheered. The lesson about our culture and teamwork is that it isn't something to be ashamed of. It is something to be proud of, as long as it is "authentic." Teamwork is about unselfishness.

Question 3: Ideal future image for health care

- I hope I look the same in 2012. My dream would be no heart disease, no diabetes and no obesity. These are all behavior diseases that we can do something about but don't. I want a system where people, especially the elders, aren't afraid to exercise—to take care of themselves. Everyone takes responsibility for their own health care—it's not someone else's responsibility, such as the doctors, IHS or the tribes.

- I would like to see a facility in each segment and other areas that have health care facilities. And I'd like to see a facility for swimming and exercising... even a sauna. Our ancestors had sweats and it really helped. Diabetes is out. Prevention programs are in place to help. All are working together. We don't have to travel long distances as health care is in each town. The emphasis is not on dollars, but on health. We are taking care of people and not letting money get in the way—both for the young and the old. Also, we would all be working together to provide health care. And also, money is not an issue any more. That's what I would like to see.

- People are having long, healthy lives. We are responsible for our own health. Also, they are responsible for their childrens' health, including prenatal and babies. We are starting prevention at an early age, before things get to where they are now. People have started exercising. There are drug and alcohol prevention programs. We are looking at ourselves, our grandchildren and unborn grandchildren. Preventative measures are things that all are doing—not just the healthy ones. This wouldn't be done only by health care workers, everyone would be involved. We are looking at the schools, too. There is no fried food. People are learning at home and at school, too.

- Right now we have so few services, so I want more services—services such as CAT scans, mammograms and MRIs. And you no longer have to go to Bismarck or Minot. Tribal members, if they need specialized care, are remembered and are getting services. Access to health care is right at home for any enrolled member. You can see specialists as you need to. Parents are taught more how to take care of themselves and their children. Parents are teaching children more prevention. People are responsible for health care. The clinic is open every day. More than one day a week (Tuesdays).

- The knee and joint problems that were showing up more and more—even in young people—are gone.

- Everyone has one family physician over a long time. Electronic records can be accessed from anywhere. There is no eligibility—everyone has what they need. Addictions are gone. Something has been discovered that takes the place of a high without a substance. One of my highs was after bombing areas. I was really on a high. You can be high and happy without drugs and alcohol. There is no more smoking. There would be electronic records that would follow patients, so doctors could easily access patients' health records.

- There is clean air and honest, good water. The yellow haze over the community is gone. There are specialty clinics in the community and we have our own ambulance service.

Summary/other info

Ed Hall told the group that new technologies are becoming available, including electronic records that can be accessed anyplace. UND Medical School is working on new technology. The clinic in White Shield could get your information and transmit it to doctors and treat you there. This would save a lot of travel. Hall said the Siemens Corp. indicated it would have supplied the reservation with equipment on a pay-off basis.

"How are we going to change?" Hall asked the group. We can't do it under IHS. If we stay strictly IHS, we'll stay the same. There are confusion and money shortages. No treatment because of no funding.

Hall said we can't just provide health care with just Indian people. Need to open it up to everyone and provide equally.

Who's going to study what kind of system? Hall asked. If we're not going to do it, who will? "Since we signed our treaty, look what we've lost," Hall said. 12 million acres. It's going to continue until we get together to work together to design and get something going.

Hall said there are a lot of people on the Collaborative who can help plan and design but must by the people on the reservation who can help. "We had it once and we can get it again," Hall said.
He spent some time at Elbowoods and always got good care. Some of the nurses were our aunties, he said. It was a good place to go if you got sick.

"You can plan what you want in health care and present it to the right people in your community," Hall told the group. "White Shield can go ahead and develop a plan. The Collaborative will help you plan and design what you want."

Hall recommended the White Shield community form a health care committee and use the Collaborative for assistance.

It was briefly discussed that health education in early grades is a good idea—prevention at an early age.

Patrie reported that everyone is invited to become members of the Collaborative. He told the group that this is a demonstration project. Oct. 16 is the deadline for the next HRSA grant application. Then, by March 2009 will be a full-blown strategy that defines the health care system we'd like to see. Part of that strategy may be:

1. A single-payer card in the 11-county area that everyone has (some way of universal health care).
2. Service available locally to minimize travel. Plus services in homes—aging in place. Bring service to the people who need it.
3. An integrated system—for veterans, Native Americans and whites. Our blood is the same. We're all the same people.

Sept. 2, 2008
Rural Health Care Public Meeting
Knife River Care Center
Beulah, N.D.

Call to order/attendance

Bill Patrie called the meeting to order 6:30 p.m. in the chapel of the Knife River Care Center. Self-introductions were made.

In attendance were three community members and five Wilson Health Care Collaborative members. Community members were Mindy Goodman (finance director at Coal Country Community Health Center); Christie Obenauer (Sakakawea Medical Center board); and Fred Stern (president of the care center). The five Collaborative members attending were Dawn Berg, Susan Davis, Bill Patrie, Pierce Stepp and Dr. Herb Wilson.

Questions 1: High point personal experience

- VE Day 1945. I was in the Air Force in England. We just went wild. It was a culmination of three years of not knowing what was going to happen. Then suddenly we were free to go back home and start anew.

- I have three children and on the birth of those—especially the first one.

- I just graduated from college. I finished in three years. I'm now working toward my master's degree.

- March 9 was my last official day at Dakota Gasification. There was a going-away party for me. A couple of folks walked out and shook my hand and said, "You're a class act." I'm not used to that and it made me feel really good.

- One of the most important accomplishments in my life happened when I became vegan. Veganism is a lifestyle that includes a strict vegetarian diet, and an awareness of animal rights. I was in college at the time, but still lived at home, when I first tried to become vegan. I knew what I couldn't eat, but I really had no idea what I could eat. I stopped eating what I knew I shouldn't eat, but because I didn't know what I could eat I was hungry all the time. And over the course of one week, I lost about 10 pounds which, for someone my size, is pretty significant. So I abandoned my attempt at going vegan for a while. I did some research about what I could eat and I gradually substituted vegan foods for non-vegan foods in my diet. By the time I was finally vegan I was so proud. Not only did I have the conviction to be successful, but I also learned that I had to focus on the positive: what I could eat, and not the negative: what I couldn't eat, in order to make that personal change.

- My one story of personal accomplishment that it kinda…you shouldn't brag about it in public. But, when I went to high school I was OK popular. We were very poor. I was class officer and in FFA was chapter president so I was OK. I wasn't much of an athlete, but I was on some teams and stuff. There was a kid that got on the bus and their family… what do you say when you're mean to kids? So and so has such and such germs? We would

do this about this family. And my mother just couldn't stand that behavior from her kids. So she expected us to treat everybody nice and you can't say this about germs. There was one kid who was…when I was a senior he was a seventh grader I think, and he sat next to me on the bus and he smelled like the barn because he didn't change clothes. He'd come right from the barn and get on the bus. Sometimes we'd have to wait for him. People ridiculed him like something terrible. And I thought, "What the heck, he can sit with me." And so a senior and a seventh grader sat together and quite a few years later, probably 10 years later, I went to an all-school reunion. And this tall, decent looking guy came up to me and says, "Well, good to see ya!" And I could not think of who he was. I apologized to him that I couldn't remember his name and he told me his name and he said, "Do you remember? You sat next to me on the bus." And he was grateful. And I am still moved by that. That wasn't a very hard thing to do, but it was probably the nicest thing I did. Not that I didn't smell like the barn some days, too, ya know. But that was kind of a high point. And when I think back at the kind of person I'd like to be, I'd like to be like that more often.

Question 2: Positive team experience

- I was interviewed by Modern Health Care this past year about health care related things and they asked me about what we had done at our organization. And when I got on the board at the hospital, we were... most of our time was spent talking about how to keep the doors open and the financial difficulties we had from day to day. So it was the kind of board meetings you leave late and lose sleep over. And over the past few years, we've had an opportunity, for a number of reasons, but an opportunity to change that financial picture. And we made a pointed effort to focus on being about governance instead of about management and redefined our vision, mission and core values. It's made a huge difference in the way in which we even handle our board meetings now and so that was really about going through a process that's not all that different from what you're talking about [Appreciative Inquiry] at this point, talking about relating change to the personal level and then translating that to an organizational perspective. It's really worked for SMC. So that was a neat experience.

- When I worked with a group, going through this beautiful facility these last couple of hours has reminded me of starting the New Town nursing home. It was an early nursing home, and I understand this one first started in '52. Is that right? Well, we were a little later than that; maybe '59 or so. But there weren't many nursing homes around at the time. And it was a new concept. And also, we had the concept we were going to have a rehabilitation place. People would go in and get better, too. New Town didn't have a hospital. There was a doctor from McVille who came up and gave us some inspiration. And then we went ahead and I know the dollar has changed a lot but we got the whole thing built for $400,000. A beautiful place. The only one that had air conditioning at the time. But there was a group effort of the people in town in getting together, and I guess there are a lot of towns that do this, of course. Get together and build a place. But I was particularly involved and thought it was a wonderful thing. However, after a few years, the board got tired of trying to make ends meet, and they called in the Good Samaritan people to help with the administration and finally they sold it to the Good Samaritan people for $1. It really bothered me to have that happen and lose local control. But for a while it was very positive with the people in town having the board.

- One experience I remember with a team is this. I am from a very small school that had a hard time meeting the quotas to make teams; basketball teams, football teams. And after many years of struggling, we consolidated our school district. And that is a difficult thing for kids to do and mesh with different teams. There were six schools that meshed to make one team and we still didn't have enough players most days. But we learned how to build a team from scratch, where we didn't have the chemistry of knowing these kids forever or building the team and being successful and the work that everybody has to put into it.

- The story I'd like to share is that in Jan. 26 of this year we moved residents from our old to this facility. And one of the things that made it memorable was just that looking back at the years of planning, the years of fund-raising, the years of criticism, and to finally see it all come together. But I think what made it most memorable

was, we were always concerned about having enough help to move all the equipment and all the residents in a single nine-hour day. And it was just amazing how much support we had from the local community—the number of people that showed up with horse trailers and other trailers. As a matter of fact, we had to turn many of them away because we didn't have any room to park them all anymore. So instead of finishing in eight or nine hours, I believe we completed the move in about five hours. To see that level of support just seemed like a sanctioning of all our effort to get to that point. So thank you.

■ When I was 11, I was on a soccer team that played in an under-14 league. Our team only had two 13-year-olds, while the other teams had mostly 13-year-olds. So we were at a disadvantage and everyone said we wouldn't win a game; we'd be last place for sure. So we played the season with the goal of not being in last place. I think we actually won two games and we didn't get dead last place. We got second to last place. Since our goal was to not get last place, that was a real high point for our team.

■ A teamwork experience that I had goes back to the slide about a miracle. Doc and I attend the United Church of Christ in Bismarck. And we got it in our mind that we needed to expand the church. We needed to make it physically bigger, and the congregation had an image of itself of being very frugal. They bragged about it. We had the lowest per capita giving of any United Methodist church in North Dakota. Some of the rural churches were way, way higher than us. But that's the way we were, so as we started this process, I was the moderator and we developed these teams. And we were gonna call on people that…I was calling on a retired physician and me and another fellow were gonna call on him and he died on the day I was supposed to see him. And there I thought, "There goes our big gift!" And the estate just gave us a little bit of something but not like something he would have. We needed to raise…it was about a million dollar project, and we wanted to have a very modest amount of debt, and we thought we needed to raise $600,000 in donations before we'd start. And we didn't have it. Hurricane Katrina had just hit and the steel prices were just taking off. And the low bidder, who bid on the steel on our building, wouldn't hold his bid if we didn't accept it. He wouldn't let us extend it. So we did that kind of miraculous thing, and said, "OK." And I didn't know where the rest of that money was gonna come from. We did not have what we needed. Talk about sleeplessness! You know, I was very anxious about that and our pastor was worried. There's a Realtor and a retired person with a PhD in curriculum, and I called a meeting. It was the pastor and I and those two people and we sat down at a restaurant and said, "What do we got to do to close this gap?" We had some good ideas. We did them, closed the gap, built the church. It just worked out perfectly. And at the dedication, it was such a sweet thing. Not something you gloat about, or it wasn't that just one of us did that. The whole congregation stepped up and they changed that attitude about themselves. That teamwork has changed them; they got used to thinking of themselves in a different way. Since then, we started a mission in East Timor. The church has now got the idea that it's a giving place. And it was remarkable.

■ For this project, for the health care collaborative, we needed some funding to help us with our work. And so we heard about this grant through HRSA, Health Resources Services Administration, and there was some funding for collaborative planning efforts throughout the country. So we talked about it in one of the meetings and everyone, you know, really discouraged us. They're like, "You know, that's a lot of work and you never get it the first year. And so you'd just be wasting your time. But go ahead and do it if you want." So it was really discouraging but Bill and I really teamed up well. We plodded forward and we had some research help from a few other folks from the collaborative. Boy, we put in a lot of hours on it, and it felt good to get it done. And it felt even better to get awarded on the first try! So we were pretty proud of that effort.

Question 3: Ideal future image for health care

- Obviously, my perspective is from that of the hospital. Our biggest struggle at the moment is finding providers. And I could go into lots of stories about that, but finding people who want to come here not only to North Dakota, but to rural North Dakota and practice and stay is a big endeavor. We went to a meeting and Fred joined us. Fred's on the hospital board with me, too, so he gets to be both nursing home and hospital. We went to Dickinson for a board/trustee training not that long ago, and you may even know about that. The hospital in Bowman has facilitated this particular thing for a couple of years. Anyway, that was one of the big pieces that everyone is talking about. Mitch has been trying to get a provider for 30 months. And we have a few, but we don't have enough. And I know that Coal County can speak for that, too. So, if I could wake up in a few years and have an ideal health care picture, it would be one in which we have providers who are here and we have enough family practitioners and we have a successful OB program in the area and can keep all of those patients within our area that we can service and recognize that there's some things that in rural North Dakota we won't ever do. We're probably not ever going to have an orthopedist and that kind of thing but being able to develop relationships with the larger hospitals that would serve those specialty needs and have that be symbiotic. And perhaps even, in terms of providers, create a program somehow between all of us that starts kids who are interested in medicine earlier in their life. I don't know, we've brainstormed about this. But do we pay for their loans? Do we create some sort of program where they have a little bit of their residency here so they don't even leave the state? Imagine that. They just stay home, or they go somewhere and get a little training and then come back home. The people that are from here are the ones who are gonna want to stay. I think many people like me left for a long time and then eventually came back home and those are the people we want to be around here. And then to be able, I guess, to just make sure that we're, as you mentioned in an earlier slide, that we're playing on our strengths and mitigating our weaknesses and mitigating all of the political aspects of trying to have several organizations accomplishing what we are all trying to accomplish.

- I'm not originally from this area, but Don brought me into this area and we are from a small town. And small towns are important and they can offer a lot to people coming in. They offer them a little bit of a different cultural experience. And I think a lot of physicians aren't willing to come here because they don't think the money is here or anything else. So if we can find a way to bring in those providers...

- Specialists are coming in on a contractual basis to provide for needs and not forcing people to drive to Bismarck. We are capturing market and providing services they need such as mental health and others.

- I suppose in an ideal world we wouldn't need a facility [nursing home] like this. That would probably be a good start. But absent that, what I'd love to do is walk in here one morning and see that every resident is being cared for the way they should be. They are happy, their family members are happy, and all of the employees are having a cheerful time and are happy as well. Now, as how to get there, one of the problems we have is attracting enough people. We have some people that really care about providing health care services and service to the elderly or those in need. But a lot of the employees come because they just need a job. And many times these are people that are not that well-educated, and so at best view this as a stop-gap. So in the ideal world, in a facility such as this, I'd love to have staff and supervision that are able to motivate employees and have adequate funds to attract people that have a passion for providing service to our residents, instead of just being a means to an end, which is their own survival.

- From the physician's point of view, let's see if I can bring up the fact that four year is a short time to make all these changes. I'm particularly interested in preventive medicine of course. And the statistics on how the residents of this nursing home—why they have to be here—could be compiled and shown to point to a way of life that would make it so people don't get this way. Of course, there are a lot of things we know already about not smoking, not drinking, not taking risks and over-eating and so forth. But it seems to be that a lot more

could be done. I think every person should have his personal physician, the same one, his life-long or the family should have a family physician life-long. And of course the referral system could still go on. I think that there's a lot in medicine that's wasted: money with hocus-pocus medicine I call it—sort of believing in lab work and figures and all that rather than the personal. After all, our body takes care of itself most of the time and a lot of medicines I feel are unnecessary. You see, I'm an old-timer. So if I wake up in the four years, I would like to see more organization, although I'd like to see more dedicated people, too. Now, I was saying some of these things the other night in White Shield and suddenly I realized that the priest that I had known for many years was in the audience also. And then I regretted I hadn't brought out anything spiritual—the spiritual nature of life and all and I think we could develop that. If you can think of the religion evolving, that is getting a better kind of religion than we have now. That certainly wouldn't come in four years.

- I guess for me, I'm coming from the opposite direction, as a patient. What I would like to see in four years is that anyone who needs health care gets it—regardless of how much money they make or what the color of their skin is, anything like that. Everyone has a certain amount of say in the kind of services that are offered and are available. They have an equal say in how the money they pay at the doctor's office, insurance coverage, and in taxes is being used by health facilities. People are the "bosses." And I definitely think there should be more conversation and more dialog between doctors and patients, so that both groups get what they want and what they need.

- I think in an ideal health care setting in the future, I'd like to see more home health care. Especially as I grow older, I'd like to be able to stay in my own home and get services in the home, ideally, if I could... and just live out my life at home and even die there. Not that I have anything against nursing homes. This is a beautiful facility, and they serve a useful purpose, but if we can keep people in their homes for as long as possible and if that's good for them, then I think that's the way to go. Those that need more care can certainly get the institutionalized care but more aging-in-place service so that we can live our whole lives in the same home if we want to.

- I would like to see, as I get older and need more health care, I would like to be in a positive setting of where we're enjoying life, like the spiritual idea. We feel rich. I already do kinda feel rich. I was privileged to live in North Dakota. I grew up in a small town, had great parents and I've had a great career. I feel empowered by that. I feel wealthy that I've been given so much. Yet the folks around me are cynical. And some are mean-spirited and angry at others. And I don't understand that. I mean, my goodness, we do have it good here! So I want to live in a very positive community rather than that griping kind of community. Where I grew up—and I'm not blaming it on the Germans—but they had a very negative attitude about kids. I mean, they liked you and everything, but they just couldn't say it. It was not that way. I shouldn't pick on her, but my mother-in-law is just like that. And she thinks that she's not being honest if she isn't criticizing someone. I want to live in a community where there's a sense of belonging, of knowledgeable and intelligent people that you feel good about and you like them. And you know you're all gonna die some place and you do that gracefully. And I want the health care system to be open and accessible to folks.

- Something you said reminded me of a very cute little story about the difference between heaven and hell. I guess somebody got up there to St. Peter and wanted to know the difference and he showed them two rooms. Each room had a number of people that sat at a long banquet table opposite each other, two or three tables to a room. And he showed them heaven and further... now let's see if I can tell the story right. At any rate, the gong rang and they started eating. But they all had boards on their arms so they couldn't bend their elbows. The people in hell were trying to get their food and they couldn't. Of course, they couldn't bend their elbows. But the people that were in heaven were feeding each other across the table. Have you ever heard that story before? Well, I got the story out. Not very well, though.

- In health care right? Ok, I'll keep it clean then. For this area, how I would see health care or how I'd like to see health care is our local providers are working together much better than they are today. I think there is a lot of duplication of services, a lot of fragmentation of our health care system in this area. And,' you know, when you have separate organizations it's very difficult because everybody wants to win. Both sides want to win. Or how many are involved? Everyone wants to come up as a winner. Typically, it is revenue. I'm relatively new to this area. I've been here for four years, and it's not any different than any of the other places that I've worked, but I think this area could have a stellar health care community. You know, can I call it the mini-Mayo? Probably not. But I think we could be top-notch. I think we are shorting the communities in our service area. And I just think it's a shame. And if I could wake up in, what was it? 2012? In four years, if we could get it right, we could be rockin' and rollin' I think. But we are wasting our energies trying to cripple each other is what it feels like to me. And it's energy that could certainly be focused in a direction more positive. And bringing in additional services so we're not losing patients to the tertiary care centers. Because once you lose them for special needs—cardiac, dermatology, whatever it may be—you lose them for their primary health care, too. And these rural areas are certainly the ones suffering because of that, and it's so hard to get them back.

Summary/other input

Patrie told the group that Three Affiliated Tribes came to the Collaborative and asked for a letter of recommendation for its new health care facility at New Town. We voted to do this.
Ed Hall, Patrie said, had a dream about the new health care facility at New Town. It included a different location and beautiful homes for doctors.

We have created a positive emotion of success and camaraderie. We hope we can continue it.

Sept. 3, 2008
Rural Health Care Public Meeting
Hill Top Home of Comfort
Killdeer, N.D.

Call to order/attendance

Bill Patrie called the meeting to order 6:30 p.m. in the "living room" area of the Hill Top Home of Comfort. Self-introductions were made.

In attendance were nine community members and five Wilson Health Care Collaborative members. Community members included Chuck Andrist, Linda Kittleson, Patty Jo Hall, Todd Hall, Shirley Meyer and Linda Wallace (director of nursing). Home residents attending were Harold and Shawn. The five Collaborative members attending were Susan Davis, Fred Larson, Bill Patrie, Pierce Stepp and Dr. Herb Wilson.

Questions 1: High point experience

- We have one thing that we like to participate in, and that's rodeo. And we've watched all of our sons go through the steps of going through the rodeos and winning their awards. You know, from the little stick horse race and all of that. Well, we had one son who's 12 years old and he's in seventh grade and he was having a tough time with rodeo. He had kind of a bad experience with a horse, and so was trying to build that confidence up. So we kept working with him, and working with him, and finally we told him how to get more competitive and ride it competitively. We told him that the horse wouldn't hurt him. He had to work together as a team. So two weeks ago we took him to the Velva rodeo, the Velva youth rodeo, and all that hard work for him paid off. He was the Velva all-round cowboy for his age division and I think that was one of our proudest moments, when we finally saw him win the hardware. You know, all the other boys had won their hardware and he won his, too. So that was good.

- My best memory, I guess, is related to health care. It was the birth of my son, and at that time my wife had to have a C-section and at that time they did not allow the husband to come in. And I was the first one allowed to come in and assist in the delivery with the C-section in St. Joseph's Hospital here. Of course for those who are not doctors who have seen a little blue thing suddenly become a living, breathing creature, pink and crying. But seeing that moment of the miracle of life happen; that was quite an awesome experience. And I got to have that privilege twice in identical situations with two children.

- I was just thinking, "I've had so many of these..." The good Lord has been so good to me all my life that it's hard for me to choose the one. Bu for the sake of this group here, maybe I'll say the day I arrived in Elbowoods in my Hudson—1946 Hudson, four kids and a cat. And two people on one horse came riding up and I said, "Ah, my first people to come help me unload." No, it was my first patients. The guy had a sliver in his finger.

- Well, I'm going to use this as a positive experience. I felt really good about it. When both my mom and my sister were sick with cancer, and dying in the hospital—of course not at the same time—I was able to be there and be a part of their care-giving team, both at home and in the final days at the hospital. It's not a joyful experience,

but it's a very fulfilling experience that you know you've been there for somebody. You did what you could. You always wish you could have done more, but I don't think I'd ever want to take those experiences away as hard as it was to watch them die. I was very proud and feeling fulfilled that I was there with them at the end.

- I can't think about it too much. I guess my most recent highlight and most joyful and fulfilling experience is becoming a grandmother—finally. I just had my first grandchild in January; she was born on my daughter's birthday on January 15. So that was a very fulfilling event for me. So that's the most recent thing I can think of I guess.

- I guess one of my most recent moments is sitting in the Hilltop Home of Comfort with a man I really admire, Dr. Wilson here. He patched me up, mended my broken bones, relieved pain when I had it, and just sitting here with him... to have the possibility, and I guess this is hope here, to have the possibility to help people with their rural health needs and meet those needs. Whether they are in my role as a future representative at the state level or just as a common citizen just like I am right now, it's an inspirational moment for me.

- I guess I can play the grandma card, too. We have the opportunity as legislators to attend a lot of different functions and events, and if you aren't educated you just aren't trying. And one of those things was early childhood education. And the things you could do. We went to quite a few programs from presenters on how you can start educating a child at 1 month, 7 months, and all these different programs. And so I started using my little grandson as an experiment, to see if this really did work. I was kind of forbidden to do so by my son, but I said, "As long as I have to watch him, he's gonna be a little experiment." And so we were teaching him to sign. And it was amazing to me. One day as I was leaving he signed, "I love you." And I just melted. I thought I helped this little guy. He was 7 months old. He could just barely crawl, but he could sign. And once they can sign and tell you they're hungry, then they don't cry, you know? So it was an amazing experience.

Question 2: Positive team experience

- In a sense, all government work is teamwork. And I'm thinking particularly now of the relocation—leaving Elbowoods—because of the Garrison waters coming up. And how there were so many people that were trying to help ease that terrible burden, that terrible nightmare that the Fort Berthold people were going through to leave their homes, their ancestral area. And I worked with Bob Reese, probably nobody remembers these names. Bob Reese was an anthropologist from Chicago. And then Ben Rifle. Anybody heard of Ben Rifle? He was the superintendent. His father was German and his mother was from Cheyenne. She was an Indian from South Dakota somewhere. And we got together and we felt we were doing something. We knew that water was coming, but we tried to ease it as much as we could for the people. Eventually, they all got up to higher ground, but there were lots of tragedies involved, too. That was teamwork, as I say. Government work at its best, I thought.

- I'll tell one, about my son, Ben, when he was a sophomore. He played a lot of soccer, and he went to Bismarck High School, and there was not any chance he was gonna make varsity, but he didn't make the JV either. Bismarck, in soccer, they don't cut anybody. They just keep adding teams, so he was on the third team as a high school student. He played a lot of traveling soccer. But the third team played a JV tournament and they wound up playing their arch-rival, Century, but Century's JV team, a much better team. And the JV team had players on there that couldn't play varsity because of discipline problems, but they were good—really big and strong and fast. And Ben's coach taught Sunday school, or his mother taught Sunday school at the Presbyterian church. This kid was a good soccer player himself. He's out of college now and coaching this third-level JV team. And this third-level JV team had a number of exchange students on it that weren't really good and it had a number of other players that just needed some place to play. And he played them all. Now this was a championship game, and so this coach is playing…going through his rotation. And Ben's team beat this team and won the championship. They played out of their minds. You know, they did stuff they weren't capable of doing most of the time. But I asked Ben, "What did the coach tell you at half time?" At half time it was tied and it ended in

a tie, and the Bismarck team won it in over-time. He said, and it gets me emotional, "It's not the skill that will determine who will win." That was good, you know. Because they clearly didn't have as much skill. But he said, "That's not gonna... who wants it the worst, or who wants it the best." You know, and as coaches, that's what you tell your kids. And these kids believed this guy and they thought they could win and they did. It was just beautiful and when that senior class graduated and they were all playing varsity. And when they had the senior banquet they asked me to read a poem about that game their sophomore year. It meant more to them than all the games they won after that as varsity players. That game is the one they remembered.

- This goes back to my college days. My actual degree is not in medicine, but is in theater. Yes, quite the change! But I was directing a play for my senior class project to graduate from college with my degree. And we were doing a play, ironically enough, called "Oh God!" And, yeah, it's not the movie... it's a Woody Allen thing. We had protests about that even, so we won't go there. But the thing is, the whole point is, in a theater troop you do have... everything is teamwork. From the actors to the lights, I mean everything. And the night that we went on, there were people sitting outside the auditorium waiting for the next show, you know, my show. And I was saying, "Go ahead. Go in." And they said, "No. That one is so rotten. The next show is really really good!" And it was. Our show really brought the house down. And of course the director, you know, of course I had some guidance, but again it was the actors and everything else that came together to pull it off. And it was, if I say so myself, one of the best shows they had up there in a long time. That was a long time ago, too, so I mean... But again, it was just a real proud experience you know to see the dedication that everybody put into that. And it was a large cast show and any one of them, they were key parts, and if they blew one spot it affected the whole show. It was like dominoes; all of it had to go if one part wasn't there. You know, you had egg on your face. But that went over very well and it was a proud moment for me.

- I have several that I could talk about, but one that I really think made a point was when I worked for the Three Affiliated Tribes. I was the program manager and there was one entity that I always referred to as the stepchild that nobody wanted. It was one program I was looking at the amount of bills that they had because they had broken-down equipment, couldn't get anything done, and they were always broke down. It was the solid waste department and nobody wanted to work with it. And in 10 years time I had watched it continually go in a downward spiral. And so I went and talked to the chairman of the council and I said, "I have a lot of talent here. I know what I can do for this department." And I said, "You need some help here. Nobody else has stepped up to the plate. So if you give me the opportunity I'll go ahead and do that." So what I did was, I went around and networked with a lot of different entities from the federal level and the state level and the tribal level. And as a result of all of that, it took a long time, you know. It didn't happen over night. But as a result of everybody coming together and me working with everyone. And I always like to say I have the gift of gab. But I know when to use it and when to relay the story so that everyone can work together for the benefit of everybody. And so with the result of that, the Three Affiliated Tribes was a recipient of a million dollars for the first phase, but I had that money coming in in three different phases for their solid waste program. And I think one of the proudest days of my life was watching that whole staff when all those trucks came in from Fargo. They came in in a caravan and watching the workers and the look on their face I think I was proud.

- When I was still in high school, I was in a band and we entered a battle of the bands. It was a lot of fun because the place we were going wasn't our hometown. It was some other hometown. The local band there, we knew they were going to have a lot of their own friends and fans and stuff that were going to be there. So we figured, whether we win or lose, it will still be fun to play our music in front of new people. But we thought we probably wouldn't win because the fans voted for the winner and the local band's fans would vote for them, right? So we went anyway. We played. We played well, from what I remember. And we actually won! A lot of their fans must have voted for us, which felt really good. Of course, for a band to really work it's sort of similar to doing a play. Everyone has to be doing their part. Different parts, too. You can't, well I guess you could have a band with four drummers or something, but that wouldn't be as entertaining as our band was.

- I have one story about the health care system when it was really working well. I've got a grandson who's 8 years old now. And he's a hotdog hockey player and a pretty good football player. When he was born he was a gastroschisis baby, which means he was born with his intestines formed on the outside of the abdomen. Probably 20 years ago there would have been no chance at saving this baby at all. But there were a number of very dedicated people neonatal care specialists, a very talented surgeon, and some very dedicated parents and grandparents that stuck with this baby. The doctor, first of all, took a major chance in not doing a bowel section because the bowel had been severely constricted where it passed through the abdomen. There were just considering after six weeks in intensive care going in to do a bowel section, when one night he seemed to just be straining over something. My daughter-in-law checked his diaper and there was one little hard marble in there. And let me tell you, it's probably rare to crack open a magnum of champagne over a soiled diaper, but that did happen that night. And we've got a youngster that is just ten-tenths as far as outcome is concerned with gastroschisis. It's a very difficult beginning to life, but he's doing great, thanks to a lot of really great teamwork primarily between his parents and the medical system that took care of him.

Question 3: Ideal future image for health care

- Well, I can lead off on this one, because I've answered it about three or four times. Yes, from a physician's point of view it's got a lot to do with the records. It would be an electronic record and it would follow him wherever he goes, with his permission of course. So it can be accessed by anyone he goes to. That's coming in the future we hope. Also from the point of view of what we're trying to fathom out here in this collaborative is to make it equal, have people... I hate to use the communist phrase, "To everyone according to his needs, from everyone according to his abilities." To pay, so to speak. Everyone should have access to the same care, the same high care without worrying about costs. So those are the two main things of the way I want to see health care go when I wake up in four years. But I think it wouldn't come for about 12 years.

- I would say that I would dream about a health care system similar to what the doctor just mentioned. Where the people can go to the physician without fear that it would have an economic hardship on the family. And that they are treated with respect. I think there are times maybe… some of us here are nodding, but where you have gone to a physician and have left feeling worse than you did when you went in to see the physician. So I think that there is probably something that could be done there.

- I would like to see enough health care workers to take care of the patients in the system.

- North Dakotans are known for their work ethic. I'd like to see that North Dakota is not taking advantage of its hardworking workers. They are paid fair salaries.

- We do not have to call insurance companies to get an OK to get a procedure done.

What, aside from money, would bring people to rural North Dakota?

- Actually, I went through the war and went through the GI bill to become a doctor. In a way that was money that paid for my medical education. But following that, I back into the public health service because I was interested in public health. And I thought that in medicine you should be a servant in a way, to everyone and public health seemed to offer the most; preventive medicine and the like. Then my assignment to go to Elbowoods. Unfortunately, that was not my... it was my fifth choice. It should have been my first. But when I got to Elbowoods, I was only obligated to spend a year, or two years, rather. But I went on and on and it became a lifetime and so I was motivated. I certainly didn't get paid very much as doctors do. But just because of the people, the Indian people, the Fort Berthold people I came to like so well and could see their suffering, well... from so many things. It was from having to move and the emotional problems they had and all. And that's my answer.

Summary/other input

The group also discussed the opportunity to employ people in rural places. Bill Patrie said his mother came to North Dakota to work for $27 a week in North Dakota.

Employing people in health care creates really good jobs. Why not create a Mayo Clinic on the prairie? Import dollars and skilled workers. Identify who are the people who would love to be an RN, CNA or a doctor here. Participants said it meant a lot for them to have had a doctor like Dr. Wilson.

What other reasons would people have to move to rural North Dakota? For Wilson, it was the war and then the GI Bill that paid for his medical education. Also, public health services—that you should be a servant in a way.

There are lots of ways to create some programs to try something or get people to come back. Since 1956, North Dakota has exported 300,000 or more residents. What would it take to have them come back? We have a worker shortage in this state.

Transportation system needs in North Dakota was also briefly discussed. How can we accommodate a train system to fill up rural North Dakota with workers? The state has a $1.2 billion surplus. This is remarkable. What can we do with $1.2 billion? We have a worker shortage in this state.

If we took the 11 counties and the 115,000 residents in them and tried to serve them all with universal coverage, I bet we can. What would it cost if every graduate in this area could have a college education? It really isn't that huge an amount of money. It's not a money issue. There is lots of cash floating around.

We want to create a pilot health care program that's a model for the whole country—an integrated system. Would not have 50 million without health insurance—50 million filing bankruptcy because of health care emergencies. Preventive care in children needs to happen—start early in life.

There are new wells every day here in the Bakkens. Oil field workers and their spouses are coming, too. The area needs more housing.

Sept. 4, 2008
Rural Health Care Public Meeting
Good Samaritan Center
Mohall, N.D.

Call to order/attendance

Bill Patrie called the meeting to order 6:30 p.m. in the Solarium Room at the Good Samaritan Center. Self-introductions were made.

In attendance were six community members and five Wilson Health Care Collaborative members. Community members were Dr. Walter Gokavi (retired physician), Coleen Kinzley, Cindy McLain, Beth Schoenberg, Jack Southham (retired pharmacist) and Kelly Vig (Good Samaritan Center administrator). The five Collaborative members attending were Susan Davis, Ed Hall, Fred Larson, Bill Patrie and Pierce Stepp.

Patrie presented the PowerPoint on the Collaborative and Appreciative Inquiry. During the "positive core" discussion, he said Ed Hall has told him that Garrison Dam and the flooding on Indian lands prevents many from moving forward. Until we can find a way to lay down that hurt, we can't all move forward to a positive future. "We need some way to lay down the 'burden basket,'" he said.

Another example is focusing on terrorism by trying to stamp it out. "Doesn't that just make it grow?" Patrie asked. "Shouldn't we focus on human cooperation instead?"

Question 1: High point experience

- My son has autism. A joyful time was when he was able to move away from home. It'll be four years Oct. 1. But putting that in place to make that happen for him, because he has no functional language. So on the spectrum of autism he's really high and low. He has high skills in computers and that type of thing and low in communication and low in personal care. But to have him be successful away from home was a very high point. Well, that happens not just four years ago, but it happens every week. When something takes place, that is, we figure out was right what was happy for him. He really struggles, so if he struggling it's like, "OK, what happened?" The remote needs to be reprogrammed or the batteries are out on something. And he has his own apartment and has care services. He lives in Bismarck. It's very exciting that every week or every two weeks if there's a little bit of an event and he tries to explain something. Without functional language, it's pretty hard. You have to pick up on his tone of voice—pick up on what he's repeating. He's echolalic. Those sort of things… and when you figure that out that's a really joyful time in my life when that happens.

- I'm gonna have to work at this one because when I tell this story I get quite emotional so I'm not sure it [the microphone] will pick up very well. I'm gonna tell a story about a little friend of mine called Allen. He was a little boy who lived across the street from where my wife and I had the drugstore. His mother and father lived in an apartment above the business that they had. In the summertime particularly, Allen was a street kid. That was his playground. When he would get up in the morning, eat a little breakfast and get dressed he would head out on the street. He played in the street and alleys and played in all different places. He had a beautiful ability to

show up at the drugstore about 9:30 in the morning with the dirtiest face of any little boy I ever saw in my life. How he managed to do that I don't have any idea. He had great big beautiful brown eyes. And in the drugstore, the pharmacy, where we would fill prescriptions and where I worked, was on an elevated platform in the back of the store and there were two or three steps that came up the side to let you get into the back room of the store where the pharmacy was. And Allen would come up the steps in the morning and stand over off to one side but at the top of the steps and we'd talk about what was going on in his life what he'd been doing what he planned to do. And he'd sometimes ask me questions, what I'd been doing, and we'd have conversations about what was going on in our lives. Eventually Allen would either get ready to leave or sometimes I'd get busy and the phone would ring and I'd have to tell him, "You have to go. I'm gonna be busy." And he'd have to leave. He'd look at me with those big brown eyes and he'd say, "Well, have you got time for a hug?" And we'd give each other a great big hug. That went on for several years. One year just a few years just down the road before Allen was… I don't remember how old he was, but he wasn't even 12. He was out at his relative's farm out in the country and they were sledding and he was involved in an accident and was killed. Well, not at that moment but he had a serious head injury. And after about two to three weeks in the hospital his mom had to pull the plug on the respirator and Allen died... But I still miss those hugs! Because Allen has been a very special person in my life and he was just a neat little kid.

- I don't know where to begin. Let me go back to 1935. I was 5 years old. I'd gone to school and came home and there was a power outage. Mother was boiling some coffee on the primus stove—one of those things that you pumped up. Those of you older will remember that. And she'd made the coffee and she turned the valve off and left the room. I came into the room at that time and saw the flame dying down and thought, "Uh oh, this is going out, so I better pump it up." I was barely able to reach the top of the table. I pulled the handle—didn't hold the stove. Pulled the handle, pulled a whole lot of boiling coffee all over myself on the right-hand side. And, of course, I must have let out a shriek you could have heard 15 miles away. A lady who used to do the cooking for my mother came into the room and said, "Pull up the boy." And she picked me up and peeled all the skin off my side. I then went to a local hospital. The person who took care of me was my family doctor. Up in the pediatric ward, He'd go around and check on all the children. Although he did general practice, he was a pediatrician. And he would come by and change my dressing and talked to me. He'd ask me how I felt and so forth. And he said, "Well, you'll come along." And I was there for I don't know how long, several weeks. And then one day he stopped by and asked me, "What are you going to be when you grow up." And I said, "I'm going to be doctor just like you." I never saw a face beam like he did. The man ran a very successful practice. He used to treat our family for various conditions I mean we had some of chickenpox and the whole bit... scorpion stings and the whole bit. And then after a while he left the area. I went to school and then to college. I went to medical school and on the final day of examination, you had to go to the room where you had an oral examination. And there was the doctor sitting there. And other examiners kept asking questions about TB and stuff like that. At one stage I couldn't come up with the answer that the other examiner asked me. So my doctor just leaned back, took his pencil and tapped his head. The other examiner asked me what are the complications of pulmonary TB and what he was trying to get from me was cerebral TB complication of meningitis. Anyway, after the exam was over he said, "Come over here. Come behind the screen. Take your shirt off. I want to listen to your heart." Because as a child he had seen and treated me for rheumatic fever. "I wonder if you still have the after effects." He listened to my heart, and he said, "No, you don't." Because up until then I was restricted from any activities, sports and so forth. He says, "You can go and do what you want." I didn't see him again after that. The next thing I knew he died. And there was a funeral procession. There was as many as 35 to 40 thousand people followed his funeral pyre. So I just wanted to tell you that he was the guy that influenced me into becoming a physician. And I know my father called me Doc even at the age of 5.

  My father was a struggling clerk in a big import/export company. But he decided that he would borrow money if he had to send me to medical school. And, of course, that was the incentive for me to do well. I went up, did everything. Graduated in '54. Did my post-graduate surgery training in India and in England. And then I came over to the States in 1967 and practiced until I retired in the year 2002. People ask me, "Do you miss medicine?"

I said, "No, but I miss the people. The patients, the nursing staff, the lab technicians, the pharmacists, these are the people that I miss." "Why don't you like medicine?" they ask. I say, "Because medicine as it is being practiced in this country today has so many drawbacks. I keep hearing these politicians talking about health care. Unfortunately, it's all determined in terms of dollars and cents." When I went to medical school, I went to a medical school called the Christian medical college and hospital in Belmore, South India. It was founded by an American missionary lady from Kansas, Ida Scudder. Her parents were missionaries in India. At the age of 16 she came to visit her folks and while she was there a young man came up and said, "I want you to come and help deliver my wife who is in labor." Ida said, "I'm just a high school student. I could have my dad come and do it." The man said, "No. We are not allowed to have men deliver babies. I need a woman." So he went away. Later that day, the same thing happened. Another young man came begging for her to come and deliver the baby. And she said the same thing. And strangely enough a third time it happened. Anyway, she found out the next day that all three women died in childbirth. That is when she decided to become a physician. She came back to America, went to Cornell University, did her training and came back to India and started a medical service. Strictly a women's clinic. Over the years she started to get other missionary surgeons; doctors from all over the world came to work with her. She started a dispensary; she started a small cottage hospital. And she gradually got to the point where she started a medical school for women—until the year 1947 when they decided to allow some men students into the school. In '49 I was the third batch of men students in our class. There were 14 guys and 21 women. Now Ida Scudder lived to the age of almost 100. And she had a tremendous effect on me. I remember one day when I was standing outside by the door waiting for the school bus to take us up to the college. And she said to me, "How are you?" I said, "Fine." I said, "You know, it was a beautiful night last night with the moon and the millions of stars." And she said, "You know, that might have been beautiful but those stars and planets are cold, impersonal places. I prefer the mass of humanity that's on this earth." And that was something that influenced me. Anyway, to cut a long story short, I went on finished my medical training in India, in Belmore. I went to England and \ did my post graduate training. Was all set to go back. I even spent a year in Las Angeles, doing urology. And finally I went back, we were gonna go back somewhere. And then I saw an ad here in the paper asking for a surgeon in Mohall, North Dakota. That's how I came here in 1967. And I kept going until the year 2002. Most of my classmates had retired and they asked, "What's going on? What are you doing?" And I said, "Well, I'm providing health care in a small town of under a thousand people with the help of medical staff." Many years I was a solo physician here. Occasionally we had one or two come in, spend a year or two and then they were gone. And all I can say is, "It's been fulfilling."

When the hospital looked like it was going to close, I then proposed opening a nursing home. I took it to the community club and they all laughed and said, "Doc, where the heck are you going to get the money for this? Where are you going to get the nursing staff? Where are you going to get this that and the other?" And I said, "Look, you have to have faith in God and faith in yourselves if you want to achieve something that's the way to do it. You don't rely on government grants' you don't rely on all these politicians and all these things. You have to start and it will happen." Well, lo and behold, and I'm not claiming all credit for this because I had a tremendous committee, Jack was one of the members. And we went out and sold this idea to the community. And the next thing we knew there was a man traveling through town from Broken Bow, Nebraska, who found out that we were trying to start a nursing home. And he said, "Well, it'll be a little hard for you guys to find administrators and stuff like that. I know a Good Samaritan Society that'll come in and take over. They came here and said, "If you can come up with $300,000, we'll come up with the rest and we'll put up this nursing home." That was in 1976.

- I wanna tell a quick story about Dr. Gokavi. In the 50-plus years that I was a pharmacist, I had worked with quite a few doctors in different communities where I worked. But of all the doctors that I ever worked with or associated with, Dr. Gokavi was probably the smartest diagnostician or diagnosing doctor I ever knew. And one day, after we were both retired, we were visiting and I told him this, how I felt about him. And I said, "What is your talent? Why were you so really, really good at diagnosing things?" And he had a very simple answer. He said, "I listened."

- I'm glad that Dr. Gokavi came here to Mohall, North Dakota, because he delivered the first baby, which was my son. In 1968. We also have been good friends over the years. Our children grew up together and went to school together. And we did things my husband and I and Doc and Anne. We were very happy to be around them. We had a good time. I could tell a bad story on him though. I have never forgotten when my husband came home from a hunting trip one time. He said, "Dr. Gokavi just blew a hole in the floorboard of his car." I said "What?!" My husband answered, "He stuck a rifle in there that was still loaded and it shot a hole right through the floorboard." I said, "That's not the way you tell me you're supposed to hunt!" And he said, "No, it's not but he sure did do a number to that car!" They did have a lot of fun. They were good friends—had a lot of hunting experiences over the years. And Doc, you know, has been really good to me.

  I came down with multiple sclerosis in 1989. And then he sent me on down the road to somebody who was more experienced in that than he was. So I ended up at the University of Minnesota at St. Paul. They said that's what they thought I had, but come back in another year and find out for sure. I went through a CAT scan, MRI, spinal tap. They still couldn't find anything. My husband had a good time with that CAT scan. They were checking my brain. Well, they told him, "We couldn't find a thing." He said, "I could have told you that without the CAT scan!" He was one of those guys. A real sweetheart. I lost him 7 ½ years ago, unfortunately. That was not a fun time at all. That was one of my worst moments in my life 'cuz we were very happily married for 36 years. And he was a farmer who had to teach me how to be a farmer. I was originally from North Carolina. I was not raised on a farm. He taught me how to be a farmer though. I could run combine tractors, swath, pick up hay bales to a certain level—only the second level on the trailer. I could stack 'em in the barn as long as someone threw them up there. But I also raised sheep for 20 years. And I've worked all my life.

  I finally did retire. I hit the magic 65 and I thought, "OK, honey, I'm gonna retire now whether you're here to tell me that or not. I'm gonna quit while I'm ahead." And still I'm fighting this darn MS. It's not getting any better and I know it won't but I keep switchin'... I went to a new neurologist now in Grand Forks and I really do like the guy. He's young. He's originally from Devils Lake but we just happened to hit it off pretty good. And I went to a seminar in Minot, and I kinda like the guy. Now I've had other neurologists, but this one is one of the better ones, I think. So I'm still fightin' it. My husband always said I'm too damned stubborn to quit, which is true.

  I think the high point of my life was when I married that dag-gum farmer. We met at a party in Minot. I didn't like the man when I first met him. And it took a while. He was persistent enough and I finally changed my mind. I won't tell you why I changed my mind. It was something silly. But once I changed my mind that was it. And we were very happily married and we have two children and we now have six grandchildren. Our youngest grandson, my son's son, looks like his father. Finally. My children came out looking like I do, dark hair and brown eyes, you know. My husband was a blue-eyed blond. But, Levi, the youngest grandson is a towhead with blue eyes. Looks like grandpa. Or Papa, we're Papa and Nana. Anyway, I'm sure Papa is seeing that from heaven. We finally got one to look like him. It took another generation to do it, but our son had to do that, not me. But, no, I really have enjoyed living here in Mohall. We have a lot of wonderful people here. I've had a very good life here. And I don't know that I'd change a thing. I definitely wouldn't go back to North Carolina. I've got relatives there still, but I prefer it out here. I like the wide open spaces. I like my elbow room, you might say. I just wish I had the husband back, but that's not gonna happen. But I do talk to him and he listens. He's saving me a place on that cloud up there. I'm gonna join him some day, hopefully, if I'm a good girl.

- I think something that really got me going, I'm doing this, which I never would have done many years ago. I wouldn't get up and talk in front of people for anything. I joined Eastern Star and through that I learned you can get up in front of people. You can do things. And that was a good thing for me. And when this place opened, I was employed in the kitchen. So I was here for almost 15 years. When Good Sam opened, I was employed in the kitchen for 15 years. Yeah, it was about 15. I spent the first seven cooking and then I was manager for 7 ½ or so. So I found out I was capable of doing things if I just do it. So that's my thing.

- I don't have a great big story. So, the first thing that comes to mind is last weekend. I usually like to play things pretty cool— just, you know I'm not really an adventurist or anything. So when I was with my sister-in-law, who kinda takes the bull by the horn and goes, and she has her own jet ski and everything. So she talked me into going on the tube with two other women. And I gotta say, we did have a great time. And we laughed so hard and she almost couldn't drive anymore because she was laughing so hard. So we made her day and I guess we all got a couple more years of life out of that, all that laughter and the joy. The other thing I can think of is last fall. I've been putting off a speech class for years, like for five years I've been putting off speech. It was the only general I still had left to take. So I did take it last fall. And as it turned out I wanted to do it, not online, but in front of people. I get real nervous in front of people. So I did. I went to class. Well, I was the only 50-year-old in the class. Everyone else was under 23 except for the instructor, but they accepted me and I had fun with them…their tattoos and their earrings, and you know it was a lot of fun. And I made it through class and got an A so I felt pretty good.

- I've been an engineer in construction, road construction, and so forth. Every time you finish a project you look back and it's an accomplishment. After I retired, I moved home in 2000. I had an opportunity to work on a bridge at home, the new Four Bears Bridge. And I remember I just got home and Congress approved funding for it. And so they asked me to work as the liaison with the state to build that thing. And I remember the first time I went down and met with Francis Ziegler, who's now the state DOT director. He was the project manager on it, and he and I sat at a table and we didn't have any papers or anything there, and we started laying out the game plan. But anyway we went through the process and so forth, but it was quite a project to put together. And it was unique in its design and so forth. We got it designed we advertised for a design firm. And we had a firm, Kadrmas Lee and Jackson, and it was a local firm and they had a firm from Florida or an international firm really, they had a big staff of architects and planners and so forth. And I remember when we selected them and they got involved in the project and they looked at our plans for design, they got excited about it because they had built bridges and won a lot of awards before and they really liked the challenge. Anyway, when we decided to put our tribal culture into the bridge that's what they really enjoyed. But the culture that was put in there, well we have three tribes and there are 14 piers on the bridge. So we had a committee from each tribe to work to design each tribe's culture in there and they worked with that design team to do that. They attended meetings in Bismarck where everybody gets together and discusses things you had to design the concept first. We had a walkway with a railing and so forth, and they even got into commenting on the railing. I remember one lady there was there was always afraid that somebody was gonna fall over it. She wanted it covered you know. But it was quite an experience. But just to finish it and get it done. Those three committees are the ones that designed the medallions, if you have ever been across that bridge. They worked with the computer gal in Bismarck to design the medallions. But it got completed and that was a big accomplishment and I think everybody felt real good about it. But just working on a team and seeing everybody work together. How something can start from a bare table and go to a bridge like that you see a lot of teamwork a lot of people working and it's a good feeling to get it done.

Question 3: Ideal future image for health care

- I'm going to wake up in about 2020 because this will take some time. There are no longer any insurance companies involved in health care. We have a single-payer system that is paying for the services people need, and paying for those services to be delivered where they need them. The opportunity to stay as you age—and of course I'm very old by this time—the opportunity to stay in your home and be supported there as long as possible is being facilitated as you age. The health care system is being allowed to function at its best without the interference of the payers. And I think that this will go a long ways toward re-establishing the health care as it should be in this country.

- That was very interesting. Because I've worked with those insurance companies that you talk about and I fully understand that positive direction and that waking up in that area because sometimes our minds aren't turned in a positive direction. Those companies are directing and it really is the people giving the care that should be doing that and not what you can and cannot provide because of what's paid for and what isn't. I don't know about 2012, but in this position I'm very new at, so in the future what we're trying our goals right now which if they take 'til 12 or to 20 is to make that transition to more autonomy on the caregivers part so they are able to make those decisions on their own without a policy of procedure. I mean of course those are things that have been around forever and they may shackle us and keep us in a negative direction at times. But I hope and if I would wake up and see that all caregivers are well prepared to make those decisions and if it's in the home, which I'm all for, that the home and community based services and being able to go out into the community and provide what people need know what they can do without a policy or procedure telling them that they should do it. So it's a matter of the heart. It's that hedgehog concept of having that passion you can't motivate people so having a health care system that isn't so bogged down, should be self-motivating. If you don't have to check this and do that and take a percentage of what your doing well and do it as a quality assurance measure, you're doing it because you want to do it. So all health care providers want to be providing health care. So that would be my ideal 2012 would be to have it not a money-making venture, but a passion to provide the care.

- My ideal system would be quite similar to what we have already heard. My ideal system is not driven by finances. We would not have insurance companies controlling decisions. We would have enough people in the health care system providing health care to be able to adequately care for the needs of people that needed care. And be able to do it in a timely manner. And they are able to do it giving time to the people. They can listen like Dr. Gokavi did. My health care system would have physicians and nurse practitioners and physician assistants and all of those people doing that kind of work able to function with disease and care offensively and not defensively—they would not have to be ordering tests and expensive diagnostic things on a defensive basis, which in turn would help control the costs. So, therefore, I would not have lawyers involved in my health care system. They would not be there at all. And in my health care system I would have lots of caregivers who looked after very basic things. I guess today we call them nursing assistants or nurses aides or things like that. People get worried about things. People get frightened about things. And they don't necessarily need to have a doctor or a nurse who can listen to them. They just need someone compassionate who can sit and listen and maybe do a few little things for them. And then if necessary relay some of their concerns on to a health care person. But there would be plenty of people to just take care of people. And that would be how I would see the whole system. And, like I said, finances would not be driving it. The doctors would be able to spend plenty of time with patients because they want to and they could, rather than being allocated 10 or 15 minutes because that's all the amount of time Medicare or the insurance companies would allow. One other thing that I would have in my ideal health care world, everybody would be able to get the medication that they wanted and needed because it wouldn't be a concern about whether or not it was too expensive and they wouldn't have to go without something because they couldn't afford it.

- Home health care is something that should be able to be had. And in this area the stuff that is provided and where the home health care from Trinity is provided right now. There was an article in the paper again that they will go out only 45 miles from Minot. So that does away with anybody that doesn't live within that 45-mile area. But I think that is something that should be had because there are lots of people that could probably stay in their own homes if they had that care. It would be on a need basis; it wouldn't be on a "you're not old enough basis."

- Home health care with no boundaries. Not regulated.

- Everyone is able to get the medication they need and want and not because it's too expensive.

- As somebody in my shoes I would love to see home health care. I don't look forward to going to a nursing home or anywhere else. I want to stay home, but I'm gonna need help. And what I have to take every other day is very

expensive. I'd like to have lower cost or no cost at all plus I'd like for them to find a cure for MS nationwide. There are a lot of people that have it anymore. There are a lot of us who would like to not have it. It's nothing you ask for they don't know what causes it, how you get it, and there's no cure. And I don't like that idea. That's why my husband said, "You're just too damned stubborn and you won't ever listen." And I said, "Well, honey, what am I supposed to do? Sit down and say help me; I have MS? And sit and do nothing." He said, "No, you're not ever gonna do that." And I said, "You're right, I'm not gonna ever do that." And I keep fightin', but I need help. And I'm gonna need help. 'Cuz this is a progressive disease and it's not going to go away. And when I heard that, it was like a death sentence had just been written out. You know there's no cure. Life is gonna change whether you want it to or not. So find me some help. Some home health care is necessary. Not right yet, but pretty darn soon. Unfortunately, we're getting closer all the time.

- The one thing that I think about is being able to have a clinic in your small towns. Like you were talking about, that helps keep your small towns alive if you have health care people who are willing to move here. And that there is a need right now if our practitioner wants to take a vacation. We aren't able to find anybody that time off, so out clinic has to be closed during that time. So in my ideal world there wouldn't be a shortage of... there would be enough to cover that and people you could have your clinics in the small towns to keep your small towns more alive and people would be able to take vacation and there would be people to fill in. And I don't know if that would be a consortium where you would have a group of practitioners who would be willing to deal with rural health. Because it's not easy.

- I think if I woke up in 2012 I'd like to see a lot more of the new technologies applied all over. Like when we first started back in 2001 and we were looking at health care. Siemens Corp, which is one of the largest manufacturers of medical supplies, sent four people out here to look and see and they were willing at that time to work with us to provide the MRI, CAT scan and so forth. At that time we were looking at a clinic in New Town. And they would work out some way of paying for it on a use basis but that would give us that link to telemedicine. Right now, you know, when we get sick out there in the rural area we go to a doctor and then they call and get us an appointment at Minot or Bismarck and it might be three weeks or a month and you go and you travel that far to get your CAT scan or MRI and then you come back and you wait for the results and it's not too good. It would be nice if the doctor could say, "Go next door and get a CAT scan" or "go next door and get an MRI we'll come back and look at it. If we can't interpret it, we'll go to telemedicine and we'll get your results in a matter of days." But the thing of it is, you would probably use it a lot more, you would get better diagnostic services, and prevent a lot of illnesses. Or you probably won't prevent illness, but find cures. You can catch things in time so that you can cure them rather than wait until the last minute and they say you have cancer and you've got a week to live. You know, maybe you could catch it in time to treat it.

  But in addition to that, we went to the University of New Mexico medical school and they explained to us a lot of their research they've been doing on certain pieces of equipment. And the day is probably coming where in rural health care a rural nurse or somebody can come to your home and strap you into that machine and it'll tell the doctor all of your information and you don't have to drive that far in the wintertime and so forth. You know you can use it. And I heard you folks talking about the little pad, what'd you call it? All that technology is available. It should be made more accessible and all over so everybody can use it. Where you can have your information put into your palm here, and if you go to a doctor in Bismarck, he can go to a computer and look at all of your health records. That's all available now. It's just getting it out to you to use and that's what I would see in 2012; we should have all that technology out for everybody to use.

Summary/other input

Mohall is looking at regional home health.

Mohall had telemedicine at one time, but it went away.

What we invent here in the 11 counties will be parallel to the federal debate on health care. Somewhere they are going to touch.

Dr. Gokavi: I have an idea that should work; it all depends on implementation. We're dependant on national organizations and federal big government to implement programs in individual states. Each state should be held responsible for starting and maintaining health care. City councils, other groups and state government could raise money and be involved. Right now our health care is being designed by people in D.C. with no windows. Our congressional reps are good, but if this is done at the state level, local governments of each community could come up with a system that is acceptable to all. No political parties involved. We're Americans and we need to think as a group. Also, no religions or denominations, but as a group.

We need to design a system in North Dakota that would be unique. If folks in the state had a state-sponsored health care program that had the best coverage, we'd have lots of people wanting to move to North Dakota. If we leave it in the hands of our political party, they'll kill it. They'll fight over it.

For state and locally managed health care to work, we will need to have a good cadre of local leadership in each community. We need to inspire and encourage people to be leaders. We need training to help.

Maybe we could do the 11-county area as a pilot project? Get together a few people as a nucleus and then can expand.

The energy to change the health care system is already in the folks who want to change it. We just need to figure out ho to harness it. Let's not give up on this health care thing; it's got legs.

Dr. Gokavi recommended two final things: Be sure to put information down on paper. Also, produce a brochure in simple language that all can understand.

Wilson Health Planning Cooperative

BUDGET AND WORK PLAN COMMITTEE OUTLINE OF RECOMMENDATIONS

WORK ELEMENTS

Work tasks under this proposed work plan and budget will include:

- Design and execute media and external/internal communications plan.
- Organize and lead visit to Group Health Cooperative in Seattle, Wash.
- Organize and participate in appreciative inquiry training for staff and board.
- Lead fund raising, including preparation of grant requests and reporting.
- Manage budget and arrange for audit.
- Finalize Collaborative vision, design and carry out vision-sharing meetings.
- Design and execute member recruitment strategies.
- Serve as spokesperson for Collaborative.
- Staff board meetings.
- Design and staff membership meetings and annual meeting.
- Publish annual report.
- Facilitate health care system design using the Appreciative Inquiry process.
- Supervise staff.

WHAT PEOPLE WANT

The system design parameters were gathered from the citizens of the Cooperative's 11-county region. These counties are Bottineau, Burke, Dunn, McHenry, McKenzie, McLean, Mercer, Mountrail, Pierce, Renville and Ward, as well as the Fort Berthold Indian Reservation. The results include:

I. *Available to all*
   - A. Abundant providers
     - i. Local clinics
     - ii. Local doctors
   - B. Diverse
     - i. Dental health
     - ii. Mental health
     - iii. Family health
     - iv. Holistic health
     - v. Spiritual health
     - vi. Home health/hospice
   - C. Integrated
     - i. Accessible
     - ii. Affordable
   - D. Independent
     - i. Locally owned
     - ii. Cooperative

II. *High quality*
   - A. Passionate providers
   - B. Efficient
     - i. Technology
     - ii. Preventive care
   - C. Medical research

THE NARRATIVE

The result of the Appreciative Inquiry phases of discovery, dreaming, design and destiny has resulted in a clear picture of the type of health system people want. The residents of the region want an integrated health care system. The health care system is now segregated, resulting in the citizens of the region getting quite different levels of care. The level of care available to an individual is dependent on the payer class he or she belongs to. In many cases, people cannot choose their payer class. The type of care available for a veteran is different than the care available to active service personnel at the Minot Air Force Base. A person with BlueCross BlueShield of North Dakota full coverage health insurance has vastly superior care to a person in the uninsured class, which includes 12,178* people in the region. *(*Center for Disease Control 2005.)*

The current segregated system is illogical and inefficient. White residents of Mountrail County, until recently, could not receive care at the Minne-Tohe Clinic in New Town while it was run by Indian Health Service. Likewise, non-Indian health care providers who provide services to Native Americans could not get reimbursed from Indian Health Service if the assistance could have been provided at the Minne-Tohe Clinic. Veterans are bused from Mountrail County to Fargo for hospitalization. Reimbursements from Medicare, Medicaid and Blue Cross Blue Shield follow payer formulas that, in many cases, do not cover actual costs incurred by the provider. This system distorts actual demand signals from the consumers of services to the providers. The result is the provision of services based on what a payer group will pay for rather than services actually needed by the residents of the region to stay healthy.

The purposed work plan and budget is based on the premise that the 115,000 residents of this 11-county area can design and implement the kind of health care system they want. They will also responsibly design a revenue system to pay for it. The design parameters gathered from the public meetings clearly show the performance measures of the new system. When implemented, this system will eliminate health disparities and increase years of healthy life in the region. The Wilson Health Planning Cooperative has agreed that tweaking the current system may provide some short-term benefit, but will not yield the results people want. The Cooperative will dedicate its work to the design and implementation of a new health care system.

This work plan and budget calls for the expansion of the Wilson Cooperative into a grassroots organization that a broad cross section of residents can join. An affordable membership fee will be charged and members solicited. Individuals joining the Cooperative will have membership rights and responsibilities and will elect a permanent board of directors. The Cooperative will hire permanent staff to manage this network of members, formalize the vision of the organization and, using Appreciative Inquiry, design the desired system and the methodology for financing it. The work plan and budget presented here is for three years as the cooperative will likely be at work for at least that many years to accomplish its objectives.

MAJOR WORK ELEMENTS

■ *Leading a site visit to the Group Health Cooperative in Seattle, Wash., or other more appropriate models:* The Group Health Cooperative has been in existence since 1949 and could teach us about the potential benefits of a similar system in North Dakota.

■ *Board and staff training in Appreciative Inquiry methodology:* The co-chairs of the Wilson Collaborative have had one day of training at Case Western Reserve University in Cleveland, Ohio. This budget and work plan calls for a formal four-day training most likely at Minot State University with at least 23 participants. Not all of the participants need be Cooperative members. This training will be capable of certifying those participants who may wish to use this training in their professional careers. This training is expected to cost $1,000 per participant and this budget anticipates individual fund-raising strategies to pay for them. Only the cost of hosting the event is included in this budget.

- *Communicating the Cooperative message:* The Cooperative will use Appreciative Inquiry as a communication strategy as well. Understanding that words create worlds, the Cooperative will stay on message about the type of health care system desired by the people in the region and asking the positive questions as to how that system can be built and operated. This means communication with health care policy leaders in the Obama administration, such as U.S. Sen. Max Baucus of Montana; Kathleen Sebelius, the new secretary of U.S. Health and Human Services; the North Dakota congressional delegation; Gov. John Hoeven; and members of the North Dakota Legislature. It also means an intense grassroots campaign to get this message to the individuals and households in the region. Much like organizing a rural water cooperative, we need to ask people who would use the service, to design the system that will deliver it.

- *Fund raising, grant and contract management and reporting:* This budget assumes contributions from major foundations, local organizations and individual memberships. The executive director and the administrative assistant will have the principle responsibility for these tasks but will be joined by members and directors in raising the needed funds and communicating the Cooperative's message.

- *Organizing and guiding the ongoing health care system planning process:* The planning process will use Appreciative Inquiry as a methodology, asking for and receiving technical operational strategies from residents in the region. Reimbursement policy can be designed by providers, delivery systems can be designed by consumers, and revenue procurement strategies can be gained for regional residents expert in the subject. Appreciative Inquiry has demonstrated that the unfettered flow of good ideas will build solid strategies that work. Codifying and sharing those strategies with the citizens of the region, and enlisting their help in implementing them, is a key function of this Cooperative and its professional staff.

- *Acquiring, managing, analyzing and distributing data:* Funding for consultants is provided in this area in the budget. However, the understanding of the dollars currently being spent, the services being provided, the demographics, and the existing system and its history will be the responsibility of staff, directors and members. Insuring accurate numbers are used to reflect the current system of health care is a primary responsibility.

  Through the use of an econometric model developed and supported by consultants, the Cooperative will estimate the dollars needed to close the gap between what is being spent for all health care now and the cost requirement of the system when fully used under the Wilson Universal Care System.

Executive director and administrative assistant salaries	$100,000	$100,000	$100,000	$300,000
Executive director and administrative assistant benefits	33,000	33,000	33,000	99,000
Staff and board travel	18,000	18,000	18,000	54,000
Staff and board training (Appreciative Inquiry)	4,000	4,000	4,000	12,000
Printing and publications	4,000	4,000	4,000	12,000
Office equipment and supplies	2,500	2,500	2,500	7,500
Office space	3,000	3,000	3,000	9,000
Communications/phone/Internet/fax	3,640	3,640	3,640	10,920
Consultants (accounting, legal, tech and Web support)	20,860	20,860	20,860	62,580
Health economist (econometric modeling)	75,000	75,000	75,000	225,000
TOTALS	**$264,000**	**$264,000**	**$264,000**	**$792,000**