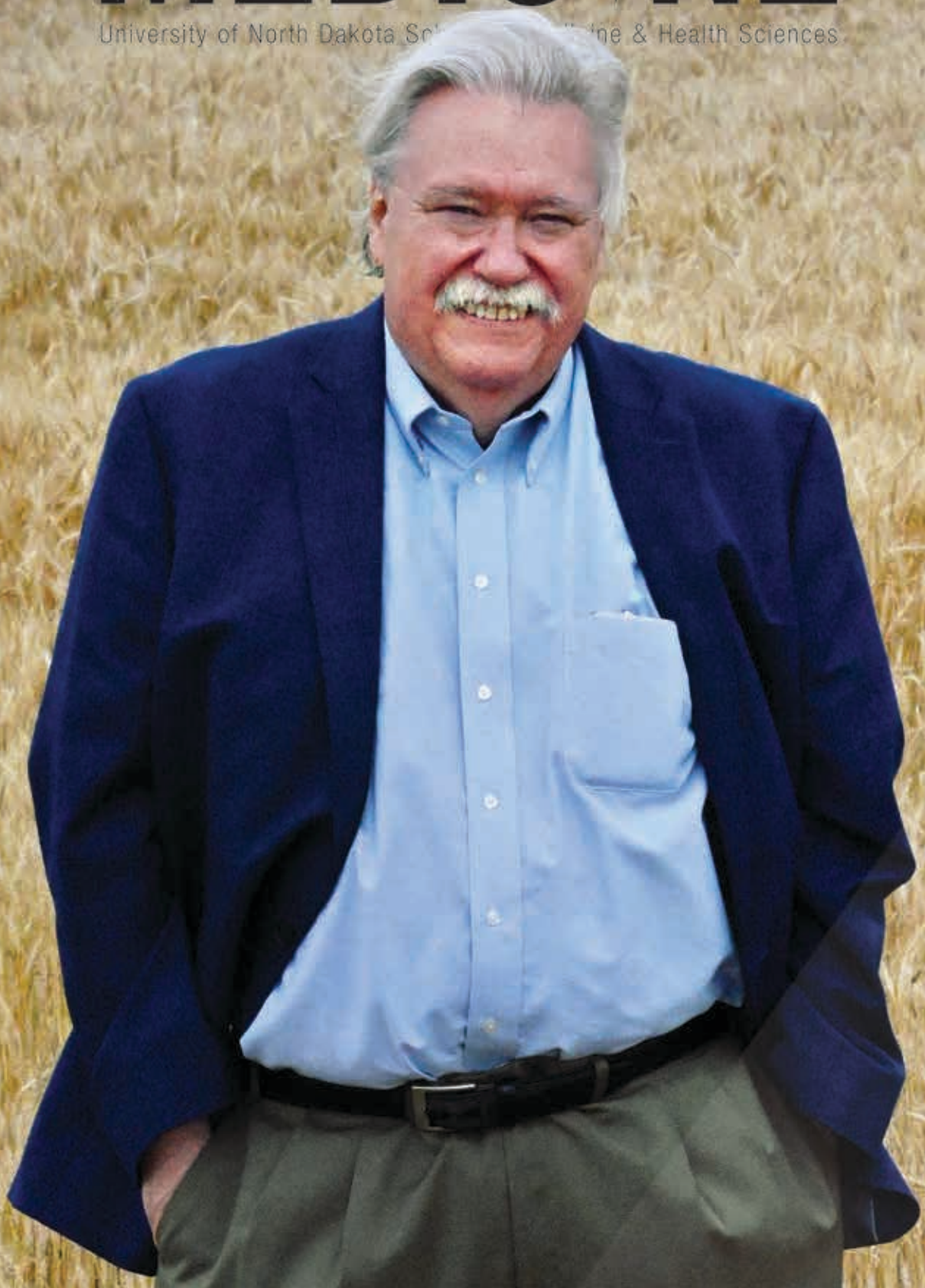
NORTH DAKOTA MEDICINE

University of North Dakota Sch[illegible]ine & Health Sciences



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Alumni Honors

Thursday, September 26 | Alerus Center

Congratulations to
UND School of Medicine & Health Sciences graduate

DR. MONICA MAYER, '95

on being honored with the 2024 Sioux Award for
Distinguished Achievement & Leadership!

ESTEEMED ALUMNI

Dr. Mayer is among nine University of North Dakota alumni being recognized for their achievements at the Alumni Honors Banquet. Scan the code to learn more.

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UND ALUMNI ASSOCIATION FOUNDATION
LEADERS IN ACTION

UNIVERSITY OF NORTH DAKOTA SCHOOL OF MEDICINE & HEALTH SCIENCES

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ON THE COVER: Acting director of the UND Center for Rural Health, Brad Gibbens, basks in the glow of North Dakota wheat. Gibbens is retiring later this year after 40 years at the Center.

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NORTH DAKOTA MEDICINE

University of North Dakota School of Medicine & Health Sciences

FEATURE STORIES

DEPARTMENTS

UND School of Medicine & Health Sciences
University of North Dakota

LEARNING, DISCOVERY, AND SERVICE

With the arrival of a new cohort of students and the return of current students for the start of the fall semester, there is a lot of activity at the School. The start of the school year also signals the reality of my transition out of my administrative roles as UND's vice president for health affairs and dean of the UND School of Medicine and Health Sciences this fall. The search process for my replacement is in full swing, and we anticipate that UND President Andy Armacost will be naming the new dean soon. I am now in my sixteenth year as dean and I'm ninth on the medical school dean seniority list (out of 158 medical schools). Four of us in the top nine slots have indicated that we'll be stepping down soon, so I have plenty of company!

I expect a very smooth transition of leadership as the SMHS is in good shape from many perspectives, but perhaps most importantly from a financial point of view. We are fortunate to have a solid financial position for three important reasons. First, due to the outstanding efforts of our faculty and staff, we run a tight financial ship. One important measure of this is the cost to attend our medical student program, where we are at the 9th percentile compared with other medical schools, meaning that 91% of other schools in the country are costlier to attend than UND (at least for students who hail from North Dakota, as do the majority of our students). To be fair, another important reason – beyond good management – is that we don't employ a large cadre of clinicians to both deliver care and teach our students. Rather, we employ a small cohort of employed physicians and we rely on a large cadre of volunteer physicians who typically work for one of the hospital systems in the state. Furthermore, the state of North Dakota has provided exceptionally strong financial support over the years; during the past decade, many other medical schools saw a decrease in state support while we saw an increase. Finally, our faculty and staff have been extremely productive in generating revenue from other sources – typically the federal government through scientific research grants that usually emanate from the National Institutes of Health. The investigators at the school have been exceptionally successful, especially over the past decade; the amount of funding they've attracted to the School has doubled in that time. And funding so far this calendar year is already in the range of $22 million!

Of particular note in this regard is the recent announcement of funding of almost $11 million for a five-year grant submitted by Dr. Gary Schwartz, professor and chair of our Department of Population Health, to expand our efforts in clinical and translational research and hopefully accelerate the development of new treatments and preventive strategies for various diseases. The grant is called TRANSCEND, for Translational Science Engaging North Dakota. The end result of the grant will be a shortening of the time between discovering something in the laboratory and actually using that discovery to help a patient in need in the clinical or hospital setting.

Our educational efforts have been similarly successful. Over the past few years our faculty and staff, working with our students, have made innumerable improvements in our educational programs. One major change in our medical student program, for example, has been a major revamping of the curriculum to achieve four important goals, all of which were brought to us by our medical students: 1) Earlier medical student inpatient and ambulatory patient clinical experiences; 2) Earlier and an increased number of elective experiences for medical student exploration of interests and potential career pathways; 3) Intentional horizontal and vertical curricular integration of basic biomedical and clinical sciences; 4) Preparation for and completion of USMLE Step 1 during the clinical phase of the curriculum.

The final component of our mission – in addition to education and discovery/research – is the service we provide to the people of North Dakota. By far the biggest service that we provide is through our healthcare workforce productivity, where *your* UND School of Medicine and Health Sciences provides a substantial portion of the healthcare providers in your community. We educate roughly half of the healthcare workforce in the state in those areas where the school has programs, specifically medical doctor, physical and occupational therapist, medical laboratory scientist, athletic

trainer, and physician assistant. And in the vitally important field of family medicine, nearly 80% of the family physicians in the state went through our medical doctor program and/or graduated from one of the four in-state family medicine residency programs.

The expectation that we fulfill those three foundational missions – education, discovery, and service to the people of North Dakota and the region – is embedded in the language of the North Dakota Century Code, the laws of the state that have been passed by our legislature and signed by the governor. We are the only institution of higher learning in the state that has its purpose specifically and clearly defined by state law (see NDCC Chapter 15-52-01).

Those three missions also are essential components of the UND LEADS Strategic Plan, where the L is for learning (education), the D is for discovery (research and scholarship), and the S is for service. Also integral to how we function as an institution of higher learning is E for equity (inclusiveness) and A for affinity (community).

Thus, I believe that the school is very well positioned for the future, especially in view of the outstanding blueprint we have for going forward through the LEADS strategic plan. I anticipate a smooth transfer of leadership from me to the next vice president and dean, much like the smooth transition we had in 2020 when I was interim president of UND until Andy Armacost took the reins. I'm really looking forward to watching the continued growth and success of the UND SMHS, albeit from the sidelines.

Joshua Wynne, MD, MBA, MPH
Vice President for Health Affairs, UND
Dean, School of Medicine & Health Sciences

First-year INMED students make skirts and moccasins for Indigenous infants during INMED's CLIMB and 'Honoring the Seventh Generation' programs in June 2024.

JUST KEEP CLIMBING

The Indians Into Medicine CLIMB program builds community and acclimates new students to the rigors of medical education.

Choosing her words carefully, Kendra Roland, a fourth-year medical student at the UND School of Medicine & Health Sciences (SMHS), sought to convey the significance of the sewing project she was helping manage with first-year Indigenous medical students.

"We're here for anything. Just being there . . . providing support."

She was referencing her portion – "Honoring the Seventh Generation: A Student Doctor Approach to Leadership and Respect for Indigenous Cultures" – of this year's 10-day Career and Life Instruction for Matriculation Building (CLIMB) program within the School's Indians Into Medicine (INMED) program.

Designed to help new medical students acclimate to the rigors and culture of medical school and develop a sense of community prior to the start of classes, CLIMB connects veteran students like Roland with students still learning the ropes at North Dakota's only medical school.

Even more, it connects medical students at all levels with the local Indigenous community, students in INMED's Summer Institute (or SI, a five-week, on-campus academic enrichment session for Indigenous students entering grades 7-12 who are exploring careers in healthcare), and INMED's Med Prep program, a summer program for American Indian college upperclassmen and graduates who are preparing to take or retake the Medical College Admissions Test and apply to medical school.

In this case, Roland, with the help of a grant from the Alpha Omega Alpha (AOA) medical honor society designated for health equity projects and "underserved communities," had found a new way to embed community service into the CLIMB program.

CLIMB

"The purpose of the program is to help get students better prepared for medical school academically, yes, but probably more importantly to create a social network support system," said Yvette LaPierre, an academic advisor for INMED who manages the CLIMB program. "Getting to know each other, getting to know the faculty and staff, and getting to know the community. This matters because INMED students tend to come from across the country and have less of an immediate support system here in Grand Forks."

As LaPierre put it, educational activities embedded within CLIMB include an introduction to the medical curriculum,

a tour of the School's library resources and research facilities, and sessions on financial literacy, study and test-taking strategies, personal wellness strategies, and field trips and social events around the community and region.

The latter was on tap this past July at Roland's session at the new INMED space in the SMHS building in Grand Forks.

Roland and a handful of her colleagues, including first-year INMED students, were hard at work cutting ribbon, backstitching calico, and punching leather, all in an effort to make ribbon skirts and moccasins for Indigenous infants in the North Dakota. Made possible through an AOA Medical Student Service Leadership Project Grant, the project "takes an Indigenous-led approach to leadership and mentorship of younger students through cultural connectivity," said Roland.

Gesturing to the first-year medical students, Roland said that the idea is to build bonds – and trust – not only among Indigenous students from different Tribes, but between future health providers and their future patients.

"Our students – the mentees – write down their name, where they're from, and write a short message to the mom and their baby as a way of addressing health equity and disparities – to give light to our native babies being born," Roland added. "We all bond through crafting and then distribute the final products to families across the state."

The "skirts and moccs" program accomplishes this by providing Indigenous infants and their parents with health information and support, and encouraging mothers in particular to pursue prenatal health for unborn babies, well-child visits for their newborns, and maternal health for themselves.

The medical students then engage the younger SI students, who are also on campus in July, hoping to water the seeds that INMED has already planted.

"The whole premise is honoring the seventh generation," Roland explained. "Seven generations meaning: everything we do now should be considered in light of those who came before us and for those who will come after. We're trying to start [Indigenous] students young and mentor them from a young age, showing them they can be successful and giving them support on their future endeavors."

Evolving program

Having originated several years ago in the SMHS Office of Student Affairs & Admissions, CLIMB took off in recent years, said LaPierre, when she and her INMED colleague Kathleen Fredericks – who coordinates INMED's Med Prep program – found a way of embedding the program within INMED.

This move, along with feedback from previous CLIMBers, allows LaPierre to modify CLIMB to better meet the needs of each unique student cohort. Whereas one cohort could use more help in biochemistry, for example, another might want more exposure to histology content in advance of medical school.

"Once CLIMB got through year or two, I developed a debrief for students, asking them to identify what went well, what they learned during CLIMB that helped them in their first year, or what they wish they would have learned," LaPierre continued. "Those conversations led to some changes, like adding the introduction to histology and immunology courses. Everyone struggles with immunology, but it seems like a lot of INMED students are coming in without much histology knowledge."

The "debrief" in question is a pre- and post-test that LaPierre gives CLIMBers to assess how the program is helping them make the transition to medical school in North Dakota.

"Comparing pre-and post-tests, students generally come into CLIMB much more worried and apprehensive. But they come out of it feeling more confident, understanding better what's going to be expected of them as students and what's going to happen."

Exploring infant and maternal health

Beyond community building, though, said Roland, is the fact that combining the extra biomedical education with social activities also teaches new students about the social determinants of health, especially those that affect Indigenous communities.

"Infant mortality, access to prenatal care, all of the postnatal things that we need – these are huge in the Indigenous community," Roland said.

So it is that an activity like assembling clothing for Indigenous infants helps animate the training that students both will have already received and will be absorbing over the next several months and years.

LaPierre agreed, noting that the extra practice the cohort gets in the School's small group-based patient-centered learning (PCL) model brings all of this – science content, social determinants, community-building – together, helping retain Indigenous students.

"Introducing students to PCL is one of the things that most helps them feel confident when they start medical school," she concluded, "because they understand how the process works. They've already practiced this bit and can hit the ground running."

By Brian James Schill

'WE ARE PART OF NORTH DAKOTA'

On the cusp of stepping down from his role as dean of the School of Medicine & Health Sciences, Dr. Joshua Wynne spoke with North Dakota Medicine *about the School's accomplishments during his watch and recent changes in both clinical practice and medical education.*

Good morning, Dr. Wynne. Getting right to the point, you will be stepping down as Dean of the School of Medicine & Health Sciences sometime within the next few months – but you will stay on as faculty here. So, what advice might you offer to the new dean before she or he takes the reins?

Well, I guess one of the things that I would say, to paraphrase John F. Kennedy, is especially when you're dealing with the North Dakota Legislative Assembly is not go to the legislature and tell the legislature what it can do for the School, but to continue the tradition that we've introduced over the past 15 years of going to the legislature and asking the legislature what we can do for the state of North Dakota and its people. I would say that's the single most important viewpoint that I think the new dean should continue – asking what we can do for the state rather than what the state can do for us.

Many of us know little about your actual biography or your history. Is there a condensed version of Josh Wynne – where you're from and how you got interested in medicine and cardiology?

Sure. I'm originally from the East Coast. I was born in New York City and raised on Long Island. Then I went to college at Boston University, but it was an interesting program. It was a combined BA/MD program. So I got both of my degrees in six years. As a matter of fact, because of the order that they had the ceremonies, I actually received my MD degree before my BA degree. After I got my MD degree, I did a residency at the Brigham and Women's Hospital of Harvard Medical School. At the time, it was called the Peter Bent Brigham Hospital. Then it

> "We've assembled a phenomenal array of leaders and we've encouraged the various units to really maximize their productivity and the cooperative idea of working with each other for the good of North Dakota."

became the Brigham and Women's Hospital when I was there, and people may know it more recently as Mass General Brigham. In any event, I did my internal medicine and cardiology training there and I stayed on the faculty at Harvard, and ran the Non-invasive Cardiac Laboratory at the Brigham. Following that, I went on to be Chief of Cardiology at Wayne State University in Detroit, Michigan. And then, 20 years ago, Susan and I came out here. For the past 16 years I've been vice president for health affairs and dean.

You've been practicing medicine for many years, of course. What are the most notable changes you've seen in the clinic?
One of the big ones, of course, is the electronic health record. The other day, we had some computer outages, and people were going back to paper charts. Well, that's what I grew up with! A second huge change, particularly in cardiology, is the number of procedures that we can do that either couldn't have been done before or were done only via surgery. Now, of course, everyone is aware of stents, but we also can close holes in the heart. And we can do similar things like that less invasively. A third important thing is in pharmaceuticals. We now have dozens of pharmaceutical agents that really have changed the landscape for cardiology. I'll give you an example. Not long ago, the mortality rate for heart attacks approached about 33%. Today, it's about 5%. So that gives you the order of magnitude of what's changed. And from an insurance standpoint, like it or not, so called Obamacare resulted in more people in this country getting health insurance than at any time in history. I'm not going to get into the political debate about it, but what's important as far as the average citizen is concerned is that they're more likely than not to be covered by insurance. Why is health insurance so important? Well, it isn't like you won't get any care if you don't have health insurance, but it sure makes it easier, and you have a wider array of choices. I would say that's a good thing.

How about medical education? You've been here since 2004 and serving as Dean since 2009-10. What are some of the major changes you've seen in medical education in that time?
One of the nice things, and actually one of the things that attracted me to the University of North Dakota, is that even before I got here, this school was initiating a major change in medical education. It started around the time of the Red River flood in 1997. And that was just coincidental, but one of the things that this school really emphasized was so-called patient-centered learning or PCL. There are a couple of components to this. Number one, the students learn in small groups, typically seven or eight students. Number two, the students teach each other so the students would be given a patient history and then they collectively have to answer a number of questions about that patient, and learn from that.

The third thing that was really unique, compared with the way I was educated, is that students get to experience an actual patient encounter very early in medical school. As an example, I have been doing the so-called wrap up, where we discuss with the students and the actual patient, whose case history they've been studying all week. Well, I recently did a case with a patient who has done this for sixteen consecutive years. He was nine years old when the when he first had his problem – a bone infection – and he's been kind enough to come back to UND even though now he's a grown man and lives elsewhere. He comes back each year to participate in this session with students. Let me emphasize that this occurs in students' second week of medical school. That's a huge change in medical education compared with what I experienced as a medical student; I didn't interact with an actual patient until my third year! We've made some additional changes in response to student requests. We now divide classes not into your typical 1-2-3-4 years of school, but we have phases. Phase one is pre-clinical. Phase two is the clerkship, where students are actually out in the community learning from doctors and their patients. And then phase three is to prepare the students for residency. So we are exposing students to clinical scenarios even earlier in their education.

"We now have reduced the shortage by providing the state with almost 80% of the family medicine practitioners in North Dakota."

Looking forward, then, what do you see as the horizon of medical education?

One of the big things coming – well, it's already here – is artificial intelligence. I see AI having three major impacts. Yes, in the educational sphere, but also in the clinical sphere when we take care of patients. Certain health systems are already using AI in that regard. And it's been used to help with research. There's an aphorism that is a little cynical, but it's humorous as well. It goes as follows: when we educate medical students, we know that 50% of what we teach them is going to turn out to be wrong, as we learn more things in the future. The trouble is, we don't know which 50%. So, one of the things that has really impressed me is how rapidly medical knowledge changes, and that makes it difficult for patients because I tell them one thing on one day, and then a year later, I say, "Oh, we've learned some more, and we're actually going to change what I told you a year ago." AI will accelerate that process of both gathering new information but also helping us convey it to patients in a way where they can assimilate it and they will not be as surprised or frustrated when changes occur. But that's one of the big challenges – how do we, as physicians, stay up-to-date, but also how do we convey new knowledge to patients? AI is going to be a game changer. I'll give you an example. Mayo Clinic has taken electrocardiograms – the recordings that we make of heartbeats – and they've analyzed millions of them. And what they can now do is insert your electrocardiogram into the scanner, take a look at it, and the AI software can make a prediction not just about things like the likelihood of heart attack, but other things like if patients might have problems with their heart valves. I have no idea what the AI software is seeing in that electrocardiogram to give a reliable prediction like that. But I'll take all the help I can get, and I think that help will then translate into even better and faster patient care.

Our School is one of thirty-some "community-based" schools in the U.S., meaning we don't own or operate our own attached hospital. Is it getting easier or more difficult to be a community-based medical school and why?

I think we are uniquely positioned in North Dakota to be a community-based medical school because we are the only medical school in the state. That means we can be the connector of the various healthcare systems and therefore impartial in terms of whose "market" this is and so forth. I hate that stuff – let's come together for the good of the community, which is all of North Dakota. Community-based medical schools in most other states have an additional challenge because there are other medical schools and medical schools that are often affiliated with hospital systems. So then you get into a pick-and-choose with one system against the other. That's not what we have here. What we have here is a cooperative venture, where the single medical school asks all of the healthcare systems in the state to help us educate

medical students, and other types of health students as well. But specifically for medical students, we are impartial. Also, we need all of the hospital systems to be involved in education, because we've expanded our class size and we are right at the limit of what the various hospital systems can accommodate from a teaching standpoint. As far as educating students, there's a finite number of students that providers can accommodate. And we're fortunate that we have students at every hospital system. That's not what we see in many other states, so we are very unique. If we were not a community-based school and we had our own hospital, we would then be competing with local hospitals in the state. That doesn't lead to a nice outcome. So being a community-based school in this state has really worked out well. I'll tell you what the key requirements are, though, for that arrangement to occur. First, most medical schools rely on their clinical practices for a substantial portion of their operating revenues. It may well be in the range, on average, of around 40%. That's a lot of money. We do not have that sort of practice plan. Our clinical income is under 10%. So how do we make up the difference in our revenues? The answer is the state of North Dakota. We have among the highest percentages of revenue coming from the state legislature of any medical school in the country. Over one-third of our operating revenue comes from the people of North Dakota through taxes going into appropriated funding as well as via the mill levy. If we didn't have that support from the state, the only way we could balance our budget would be to expand our own clinical practice, which immediately would put us at odds with the local hospitals. So we are fortunate to be in a state where the commitment from the legislature is so high.

On that note, when you're at M.D. Commencement or giving a public address, you often refer to this institution as "your" – meaning the audience's – School of Medicine and Health Sciences. Why do you emphasize that collective ownership?
There are a couple of reasons for it. The first one we just touched on, which is that we get much more financial support from the state than most medical schools in the U.S. That's coming from the people of North Dakota. The second reason is that we are very much focused on growing healthcare providers for the local community. Of all the institutions of higher learning in the state, we're the only one where our purpose, as defined by the state, is actually in the Century Code – in the laws of the state of North Dakota. North Dakota expects us to produce healthcare providers for the state. The third reason is because we do think of ourselves as part of a community. We are part of North Dakota. Our focus is on North Dakota. Our students are mainly from North Dakota. So, it really is the people of North Dakota who we answer to. What I've tried to do, when we go to the legislature and request appropriations to support our functions, is change the paradigm for the School. As I suggested at the beginning, in years past, the dean would go to the legislature and basically tell the legislature what the school needed to operate. I turned that upside down. I went to the legislature and asked the legislature what they wanted from the School. The legislature represents the people of North Dakota, and therefore it is the legislature's School. That's why I like to emphasize that we are the UND School of Medicine and Health Sciences, and we are your school.

Which of the School's recent accomplishments make you feel the most proud?
One of the things at the top of the list is our strong emphasis on taking a team approach to problems. We've assembled a phenomenal array of leaders and we've encouraged the various units to really maximize their productivity and the cooperative idea of working with each other for the good of North Dakota. So I'm pleased that we have a strong ethic of working together. Additionally, the increase in the number of healthcare providers that we've retained in the state, particularly in rural areas, is noteworthy. Overall, the School of Medicine and Health Sciences and our associated residency programs have produced about half of all the health providers in the state. Consider the area of family medicine, where there used to be a dire shortage of practitioners. We now have reduced the shortage by providing the state with almost 80% of the family medicine practitioners in North Dakota. We're very proud of that accomplishment. And one of the things related to that is our success in lowering student debt. Using medical students as an example, compared with other medical schools we've gone from way above the national average in the debt an average medical student holds at the end of their time in school to well below the national average. Those two things are related. The fact that we're retaining more doctors in-state is related to the fact that their debt load is lower at the end of medical school. That's because the average medical student who graduates doesn't now feel the compunction to go to an urban area to potentially generate more income in order to pay off their loans. Their loans are already at a lower level here than they'd be at other schools. Thus, we've removed an obstacle for graduates who want to stay here and practice here.

Interview conducted and edited by Brian James Schill

FOLLOW THE RURAL MED ROAD

A trio of UND graduates finds that the road 'home' runs through Dickinson, N.D.

In the far western North Dakota community of Dickinson, three graduates of the University of North Dakota (UND) School of Medicine & Health Sciences (SMHS) have found their purpose and passion in rural practice. In their short time in the field, they've learned firsthand the unique challenges of rural healthcare, such as their patients' need to navigate long travel distances to access specialty care.

But through it all, they're realizing they are right at home in rural.

Samantha (Dusek) Kiedrowski (M.D. 2016), Nolan Kleinjan (M.D. 2018), and Mat Gerving (M.D. 2020) are newly minted physicians in Dickinson, all claiming between one and four years of practice experience. Kiedrowski and Kleinjan work for CHI St. Alexius, one of North Dakota's 37 Critical Access Hospitals. Gerving is two miles down the road at Sanford East Dickinson Clinic.

> **"I can bring the next level of care into a clinical setting and help patients..."**
>
> **MAT GERVING, M.D.**

Each physician participated in rural immersion programs during medical school, which paved the way for them to enroll in the RuralMed program, a state-sponsored tuition reimbursement program awarded to SMHS graduates in return for five years of rural practice in North Dakota. The RuralMed program may be what brought the trio to Dickinson, but the ability to make a major impact on rural patients' lives is what keeps them there.

New faces in the medical field

Kleinjan is an internal medicine physician finishing his third year at CHI St. Alexius. When he first started, Kleinjan had trouble finding his place and discovered slowly how he could fill the needs of his facility and community.

Starting his practice solely in the clinic, Kleinjan pushed himself to expand his role for the good of his patients. He added hospital and stress test lab work to his schedule. He also started participating in physician committees, like infectious disease prevention and quality committees. Later, he added the role of director of the cardiac rehab division, as well as interim chief hospitalist, to his list of credentials.

Organizations outside of Kleinjan's workplace took notice of his involvement and he now serves on the Western Area Health Education Center (AHEC) board to help steer efforts surrounding clinical rotation support and healthcare leadership development for students.

"It was hard to expand my role without feeling that I was stretched too thin, but looking back now, I believe I am a more complete physician due to pushing those boundaries," Kleinjan said.

Kiedrowski started her career at CHI St. Alexius in Dickinson in November 2020, after completing family medicine residency followed by a family medicine obstetrics fellowship at Altru Health System in Grand Forks. Going from trainee to physician proved to be a tough adjustment – at least at first.

"It has been difficult to establish independence in decision making," Kiedrowski said. "I didn't realize I relied so heavily on my 'safety net' of attending physicians and preceptors."

As she nears the end of her fourth year of practice, though, Kiedrowski has gained confidence as a physician and has quickly become a leader in her facility. She takes part in physician-led recruitment efforts and serves as a co-director

for the Rural Opportunities in Medical Education (ROME) program in her community. Additionally, she is assistant medical director for Connect Medical Clinic, a clinic that supports sexual health and reproductive healthcare in the Dickinson area.

Gerving is the youngest of the three physicians and is just a year into his practice at Sanford East Dickinson Clinic. According to Gerving, his first year as a rural internal medicine physician has been more daunting than he anticipated.

“Almost every day, I encounter new and complex patients or pathologies that require extensive evaluation for treatment,” he said.

Regardless of the challenges, Gerving is confident that he is in the right place, and for the right reasons.

“As an internal medicine physician, I can bring the next level of care into a clinical setting and help patients who, due to their illness, feel lost in the medical system,” he said. In return, his patients are grateful for the care he can provide. “The most rewarding aspect is when patients express their gratitude, even through the most difficult times, and look to me for guidance.”

Rural reality

Rural medicine offers a unique opportunity for a simultaneously rewarding and challenging environment. One of the main challenges rural physicians face head-on is the distance required for patients to access specialty care.

Gerving’s career choice was heavily influenced by his rural upbringing, and by his ROME experience with Dr. Josh Ranum from West River Health Services in Hettinger, N.D. While a career in rural health has been in his sights since before medical school, the reality of rural healthcare has been surprising to him.

"My perspective on rural care has changed significantly since starting practice," he said. "In residency, I was in a larger system where specialists and escalation of care was easy to obtain. Now, I must take care of patients who need additional help but either distance, time, or availability get in the way, requiring me to help them however I can locally until that next step can be taken."

Much like Gerving, Kiedrowski's perspective about rural health has flipped since starting her practice. What she once thought might be a common day-to-day practice is quite varied and challenging.

"Entering residency, I envisioned rural medicine as a sort of 'bread and butter' practice filled with commonly encountered diagnoses," she said. "But it's the exact opposite."

Like Gerving, Kiedrowski noted how referral and travel challenges for her patients complicate her work, adding that these limitations encourage rural physicians to leave no stone unturned when it comes to finding viable solutions for their patients.

"We are asked to stretch our medical brains quite a bit more since we don't have access to specialty referral right at our fingertips," she said. "I've learned to never be surprised in medicine anymore. Even here in rural North Dakota, there are rare cases all the time."

Kleinjan says that by choosing to practice in a rural community, he can relieve some of the travel challenges that patients may otherwise face.

"I feel patients are more satisfied with their medical care when they have a local physician treating their medical conditions. I feel this is magnified when working in a rural community," he said. "Patients are grateful they can have excellent medical care and not have to travel to larger referral facilities."

Full circle moments

Although each physician is still in the early days of their careers, they've come to realize that rural is where they want to be, and they are wasting no time sharing their passion with the next generation.

Gerving lends his time each year to incoming medical students during Primary Care Week at the UND SMHS in Grand Forks. During the week-long event focused on promoting the different pathways of primary care, Gerving participates in panels to share insights about the impact internal medicine physicians can have in rural communities, as well as tips and advice for what students can do in medical school to prepare for residency.

Kleinjan has made it part of his practice to teach both physician assistant students and medical students, including those in the ROME program. "I believe that it's my responsibility – and it's my joy – to teach medical students due to the excellent experience I had as a ROME student," Kleinjan said. He wants students to understand the broad scope of practice a rural setting can provide: "I believe rural medicine gives physicians the ability to influence and change a facility at a much greater level than at a larger center."

> **"Patients are grateful they can have excellent medical care and not have to travel to larger referral facilities."**
>
> **NOLAN KLEINJAN, M.D.**

During medical school, Kiedrowski took part in a now-discontinued program called the Don Breen Externship through the North Dakota Academy of Family Physicians. And although she didn't participate in ROME while a student, she serves as the co-director for her ROME site and wants to "pay forward" the excellent experience she had from former teachers.

"I attribute my decision to pursue a career in rural medicine largely to one of my preceptors in my rural rotation," she said. "It's fun for me to pay it forward now as a preceptor myself. The students keep me on my toes. They are always asking great questions that keep my own love of learning alive."

By Stacy Kusler

BRIDGING THE GENERATION GAP

Two current UND occupational therapy students learn how their moms also graduated from UND's OT program together three decades ago.

Current OT students Sydney Johnson (left) and Olivia Dobrinz and their mothers Darla Johnson (far right) and Lia Dobrinz

It's amazing what a Christmas card can do.

Visiting her parents at her childhood home in Mapleton, N.D., over the holiday break last year, third-year occupational therapy student Olivia Dobrinz was looking through the greeting cards that her mother Lia had posted on the farmhouse's front foyer.

Then Olivia froze.

"I was like, 'What's my friend Sydney doing in this card?'" Olivia recalled with a laugh, turning to smile at her mother. "I said, 'Mom, I take classes with her.'"

"I said, 'Oh, that's Darla Johnson's daughter Sydney,'" Lia replied. "Darla and I trained together at UND. So I asked 'Is Sydney in OT too?'"

Sure enough, Sydney Johnson was – and is – an occupational therapy doctorate (OTD) student alongside Olivia at the UND School of Medicine & Health Sciences in Grand Forks. And, yes, the two students' mothers – Darla Johnson and Lia Dobrinz – were also OT classmates at UND in the 1990s.

Small world

After a few excited – and amazed – texts and emails, the four current and future OTs had figured it out: Despite starting in physical therapy, Olivia had switched her major to OT in her first year at UND. Soon thereafter she learned that she was on the same floor of the same residence hall as Sydney – whom Olivia had started noticing in her pre-OT classes. And both trainees had, as Sydney put it, spent their childhoods "learning about OT" from their moms.

Small world, indeed.

"We would go to my mom's office work parties and play in the sensory gym at her facility," remembered Sydney, who is in the middle of a pediatric outpatient fieldwork placement at the Altru Health System Performance Center in Grand Forks. "So I decided to go to UND. Olivia was actually roommates with someone I knew from high school, so we all became friends."

Years earlier, Elk River, Minn., native Darla had met Fargo-Moorhead native and former pre-med student Lia at UND around 1989. Back then, UND's Department of Occupational Therapy, which celebrates its 70th anniversary in 2024, offered "just" a Bachelor of Science degree in OT, which both Lia and Darla took home in 1993. (UND replaced its BSOT degree with a Master of Occupational Therapy degree in 2000 and the MOT with an OTD degree in 2019.)

After graduation, Darla ended up back in south-central Minnesota and Lia ended up back on the North Dakota side of the Red River Valley. Both are still practicing in the profession: at Sanford Health in Fargo and Mercy Hospital in Coon Rapids, Minn., respectively.

"I'd grown up with a friend who had a spinal cord injury, and it was neat to see how independent he was and lived a completely normal life," Lia said of her decision to explore OT as a college student. "I kind of found my niche in that area, I guess – growing up with this friend. I wouldn't have known that he was paralyzed from the waist down. He worked every day, drove, did everything independently. It was a cool, inspirational thing, and I was able to see how impactful OT could be in a lot of ways for a lot of people."

Then and now

That impact has only grown since the 1990s. As Darla explained, the expansion of OT across the therapeutic spectrum this century means that she and her colleagues are a much larger piece of the patient care puzzle than they were when UND's OT program was founded in 1954.

Of this there is no better example than autism diagnoses.

"One of the big changes in the field and probably in our culture is the change with autism diagnosis," said Darla. "We had very minimal training in the 1990s – just a brief touch on sensory integration. For my very first job, I saw one person with a diagnosis of autism. Right now, autism accounts for 80% of the kids who walk through the door in our clinic."

Sitting alongside her mother, Sydney nodded, explaining how central autism training is to the current OTD curriculum.

"Yeah, classroom and fieldwork," Sydney added. "I learned a lot of those sensory things with autism early. And I'm assuming that even in your fieldwork training you didn't have that."

OT alums Darla Johnson (left) and Lia Dobrinz at the UND School of Medicine & Health Sciences.

Also missing from her educational experience a quarter century ago was feeding intervention, Darla continued.

"There's often a comorbidity of autism and feeding difficulties," she said. "Feeding aversion and picky eating with limited diets. I see many of those kids, and also see kids with feeding difficulties who were born prematurely and have a G-tube placement. I see them when they're around two years old, and we work on getting them to eat orally. Those kids born prematurely didn't survive at 25 weeks in 1994. That's a huge change."

What has also likely changed since Lia and Darla graduated, said Olivia, is the amount of research and evidence-based intervention training ongoing in OT programs, UND's included.

"There was more of a psychiatric component at that time at UND," added Lia. "That's a very important component of what we do, but I appreciate that it's gotten away from that a bit, allowing you to explore other avenues to get in more neuro-physical disability training as well."

These changes in OT education – which follow changes in both research and clinical practice, noted both Darla and Lia – have meant a greater acceptance of the profession today, relative to 70 years ago.

"It's a more respected profession," quipped Lia. "There's a lot more collaboration and working with the other providers to have the best outcome in the rehab setting – the team approach. That's what we're realizing as health systems, and even with insurance companies. The new norm is helping keep our clients as independent as we can. We were at the cutting edge of that as OTs. That concept has exploded and really shined a positive light on our profession. It's very collaborative now, and I appreciate that."

Resisting the parental instinct

This shift in the culture of health systems, never mind society at large, means Lia and Darla both had to deal with challenges that their daughters could hardly image today. That's exactly why it's sometimes difficult for the moms to step back and let their daughters learn the profession their own way.

But not too difficult.

"It's not really that hard," shrugged Sydney of having an OT mom while she's in an OT training program. "We talk about what assessments we like. I ask her if they use certain assessments at her clinic and then if there were some that she'd never heard about. But I had minimal education on feeding interventions coming into my fieldwork, so I was able to ask my mom a lot of different questions about different interventions and what to look for and different things to do."

"Sydney does a good job of saying 'Okay, Mom, I got it. I'm learning all of this in school,'" acknowledged Darla, who along with Lia keeps up with advances in OT through continuing education programs. "She does a good job of setting boundaries."

Lia agreed, adding that having a daughter in OT now helps her learn more of what's current in the profession.

"It's a fine line, because you want to allow them the opportunity to experience this themselves and grow and learn from it, and not just constantly be whispering in their ear," admitted Lia, who works with UND OT students at Sanford and has lectured at UND to discuss occupational therapy and driving rehabilitation. "It's been exciting for me as a mom to watch that happen. I try to not offer feedback unless she reaches out for it, and I'm learning from her as well, because the field is constantly evolving."

Next gen

Because the profession continues to evolve, both daughters expect to specialize in fields different from those of their mothers. Sydney hopes to end up in pediatric therapy in the nature-based setting (the focus of her senior capstone project), or perhaps pursue travel OT.

"I would like to experience new things, places, settings and then probably end up somewhere around Minnesota," she said. "Or maybe even practice in a rural setting. Wyoming or Montana would be cool."

And instead of focusing on driving interventions for adults like her mom, Olivia expects to explore orthopedics or pediatrics in an urban setting, to "see where that takes me."

For their part, both Lia and Darla are still satisfied with the training they received at UND, and the current state of UND's OT program, which they get to absorb – 30 years after their own graduation – through their children.

"It's been fun to see the UND program I love grow, especially now that it's included in the med school and that interprofessional paradigm," Lia mused. "Back when Darla and I went to school, we were in the old Hyslop building, above the pool. Everyone in class would be like, 'Why does my head hurt?' It was the chlorine. So, it's been neat to see the wonderful environment there now, and the beautiful facility. It's awesome."

"We used to hang out together both in and outside of the classroom," added Darla of her and Lia's UND experience. "We spent Halloweens together and did the dress-up thing with the department. It was fun. And I'm glad to hear that hasn't changed."

Or if it has changed seventy years into its run, the moms imply, UND's Department of Occupational Therapy has only gotten better with age.

By Brian James Schill

ENHANCING THE GERIATRIC WORKFORCE

UND's Department of Geriatrics receives $5 million from the U.S. Health Resources and Services Administration to support 'age-friendly' health systems and communities.

"Look – North and South Dakota are ranked numbers four and five on the list of states for the percentage of Alzheimer's incidence," stressed Dr. Don Jurivich, chair of the UND School of Medicine & Health Sciences Department of Geriatrics. "We're still not doing enough early detection and need to move the needle on that. And we've not been able to put a dent in the reduction of injury from falls. All of this remains a problem for older adults' morbidity and mortality."

In other words, tackling the chronic health challenges facing older adults in the Dakotas hasn't been easy for Jurivich and his Dakota Geriatrics crew.

Fortunately, addressing such thorny challenges effectively just got much easier.

Jurivich received word recently that the UND-led Dakota Geriatrics group was the recipient of a second $5 million Geriatrics Workforce Enhancement Program (GWEP) grant from the federal Health Resources and Services Administration (HRSA). The new grant will be used to expand existing geriatrics programs in the Dakotas and educate better the geriatric healthcare workforce, particularly within the states' Tribal, Tribal Organization, Underserved, and Rural – or TTOUR – constituencies.

What that means, said Dr. Gunjan Manocha, UND assistant professor of geriatrics and associate program director for Dakota Geriatrics, is that Dakota Geriatrics retains the capacity to redouble its development of more and better "age-friendly and dementia-friendly care for older adults in integrated geriatrics and primary care health systems."

GWEP redux

Looking to reduce avoidable hospital admissions, among other goals, Jurivich said the grant will help providers across the region better prevent conditions that remain preventable.

"Falls and frailty are often preventable," he said. "Cognitive decline may be slowed or prevented, but you have to start early. Once the cat is out of the bag with cognitive decline, it becomes a battle to suppress or slow the degeneration process."

Referencing the programs Dakota Geriatrics has already developed, Manocha noted that HRSA awarded UND its initial GWEP grant in 2019. That original $3.75 million award was used to advance geriatrics education and healthcare system transformation in the Dakotas, which, although boasting a population with a relatively low median age also claim half of the top ten U.S. counties with populations age 85 and over, according to one 2023 U.S. Census Bureau report.

"We've added 'multi-complexity' to our geriatric 4Ms," Manocha said, explaining the expansion of her group's initial focus on medication, mentation, mobility, and "what matters" in older adults. "With multi-complexity as part of the mix now, we can bring technology to rural and Tribal areas. That will strengthen chronic disease management."

Partnering with the SMHS on the original GWEP were the North Dakota State Division on Aging Services and Health Promotion, UND Center for Rural Health, Good Samaritan Society, Alzheimer's Association, Memory Café, North Dakota State University, and South Dakota State University. Joining this list of partners in 2024 are the University of South Dakota, Indian Health Service (IHS), and Spirit Lake Nation, among other organizations.

"Spirit Lake has partnered with their elders and we'll be helping them create health promotion programs as part of those activities," said Jurivich. "These will be almost monthly events that provide socialization, support cultural identity, and just augment general living skills for Indigenous Elders. A few months ago, we hosted model car drag racing to encourage socialization, mobility, and team building amongst the elders, and I was impressed that the women smoked the men in the race."

'Tremendous pressure'

"The new GWEP is a lot more ambitious," continued Manocha. "We're trying to cover all entities, but will focus primarily on clinical programming and long-term care."

And as Jurivich put it, such expanded programming for rural and underserved areas couldn't have come at a better time. Rural long-term care facilities – many

of which have closed since COVID-19 hit rural and tribal areas hard – are under "tremendous pressure" to remain solvent as their resources dwindle, he said.

"North and South Dakota are 60% rural, geographically speaking, so the vast majority of the population here is not receiving the same support as more urban areas," he explained. "There has been a lot of turnover, and we have staff shortages across the board. So, we're hoping to be a catalyst that brings new trainees into areas that have not traditionally been seen as venues for provider training. We want to infuse educational resources into these areas, with the dual effort of bringing faculty expertise that can help sustain the interest of the physicians or nurses or therapists in these regions."

"We'll really be emphasizing interprofessional training," quipped Manocha, adding that the Dakota Geriatrics GWEP grant runs through 2029.

To that end, said Jurivich, the grant proposal identified a series of "milestones" it hopes to meet, including achieving a higher percentage of dementia detection for older adults and a higher percentage of seniors assessed for fall risk, relative to current figures. The program has also identified reducing the percentage of older adults on unnecessary medications as a goal.

"And then, just a lot of promoting preventive medicine," Jurivich concluded. "Having a mobility plan for older adults, knowing what matters most to them, and making sure that the healthcare plan from providers is aligned to the patient's wishes and not somebody else's agenda, whether it be a family member or provider who says 'you must do this.' We always have to align what's important for the patient and not impose medical authority when that may not be in patients' best interest."

By Brian James Schill

THE GERIATRIC "5MS"

Geriatrics providers focus on five key areas, known as the Geriatric 5Ms, that not only providers but anyone caring for older adults – and seniors themselves – should consider when developing a health plan.

Mind

- Maintaining mental activity
- Helping manage dementia
- Helping treat and prevent delirium (an abrupt, rapid change in mental function that goes well beyond the typical forgetfulness of aging)
- Working to evaluate and treat depression (a mood disorder that can interfere with all aspects of your daily life)

Mobility

- Maintaining the ability to walk and/or maintain balance
- Preventing falls and other types of common movement injuries

Medications

- Reducing polypharmacy (the medical term for taking several medications)
- De-prescribing (the opportunity to stop unnecessary medications)
- Prescribing treatments exactly for an older person's needs
- Helping build awareness of harmful medication effects

Multi-Complexity

- Helping older adults manage a variety of health conditions
- Assessing living conditions when they are impacted by age, health conditions, and social concerns

What Matters Most

- Coordinating advance care planning
- Helping manage goals of care
- Making sure that a person's own wishes, goals, and care preferences are reflected in treatment plans

THE MORE THINGS CHANGE, THE MORE THEY STAY THE SAME

Brad Gibbens reflects on nearly 40 years at UND's Center for Rural Health.

On a fall day in 1985, Brad Gibbens began working at the Center for Rural Health (CRH) on the campus of the University of North Dakota (UND). A recent graduate with a master's degree in public administration from UND, he was looking for his passion – or at least something that interested him.

Gibbens took a job at the North Dakota Office of Rural Health (which eventually became the Center for Rural Health) at UND, planning to get professional experience until he found the passion he was searching for.

Thirty-nine years later, Gibbens is ready to retire from the same office. Although he didn't know it in 1985, it turns out his passion was always rural health in North Dakota.

From recruiter to acting director

Gibbens, who grew up on a durum farm outside of Cando, N.D., was hired to work in health manpower, now known as health workforce. Before he knew it, he'd been conscripted as a physician recruiter.

"I like to joke I was the world's worst recruiter," laughs Gibbens, who is set to retire this year. "I never recruited a physician and I was never likely to do so. Fortunately, in the recruitment process, we were doing placement reports associated with the community, describing the community environment and context. They discovered I was a good writer, so I started working on Community Health Needs Assessments (CHNAs) and other reports."

About two years later, says Gibbens, his team secured its first Rural Health Research Center grant: "With my background in policy, I became the health policy analyst. In 1991, Dr. Jack Geller, our director, made me an associate director and I became a faculty member. I also assumed the role as the State Office of Rural Health (SORH) director."

Gibbens fully admits today that he had no intention of building a career in rural health. He just "got lucky" he says, and "kept finding things that were fun to do and important" to him.

"Opportunity was given to me and I took advantage of it," Gibbens muses. "That's advice I give younger staff: to take advantage of every opportunity, learn from it, and overtime it will add to your skill set and your value to an employer."

As he prepares for retirement at the end of the year, Gibbens has spent time thinking about the past four decades and what that has meant for rural health, in and out of North Dakota, and at CRH. During that time he has served as: physician recruiter, health policy analyst, SORH director, North Dakota Medicare Rural Hospital Flexibility (Flex) Program director, editor of the CRH newsletter *Focus on Health*, CRH associate director, CRH deputy director, and for the past four-plus years as the CRH acting director.

This is the fourth time in almost 40 years that Gibbens has been the Center's acting or interim director.

"I think I am now a semi-professional acting director," says Gibbens, who served in leadership roles not only with the National Rural Health Association, the National Organization of State Offices of Rural Health, and the North Dakota Rural Health Association, but on numerous state and UND committees. "It seems to be one of my skill sets, and I have always enjoyed it."

Acting Director of the Center for Rural Health, Brad Gibbens, through the years.

The origins of rural health

CRH has been known under several names: the North Dakota Office of Rural Health, the Center for Rural Health Service, Policy, and Research, and finally the Center for Rural Health. The division was officially created in 1980. The Center's first director and graduate of SMHS, Dr. Kevin Fickenscher, traveled across the state to find out what rural communities needed and wanted. The answer: More physicians and assessments to know what communities need from their local hospital. Equipped with staff to do the physician recruitment and health assessments, a new era in rural health was born.

"The Center for Rural Health really began by helping communities address healthcare workforce and understanding community health needs," Gibbens says. "Forty-four years later, we are still doing work focused on those two areas, but we have expanded to meet the needs of the state. We also try to help with strategic planning for health facilities, facilitating community dialogues, and identifying financial resources to better serve community needs such as grants, offering grant writing workshops, and providing training and education."

Gibbens points out that while CRH still has a strong focus on rural North Dakota, it has diversified over the years.

"I am proud that we now have staff and programs addressing rural behavioral and mental health, aging, Indigenous health, human service needs, brain injury, and other significant rural needs," he continues. "And we have a national footprint with six national programs addressing Native American aging, information dissemination, and research dissemination."

Gibbens gave credit for the original idea of a rural health office to Dr. Robert Eelkema, former chair of the Department of Community Medicine at the SMHS. In the 1970s, Eelkema wrote the original grants for the Area Health Education Center, Indians Into Medicine (INMED), and the physician assistant program (then known as MEDEX), all while helping guide SMHS in its transition to becoming a four-year M.D. program.

"Dr. Eelkema had a vision recognizing that North Dakota was a rural state," Gibbens shares. "Bob saw that a medical school in a rural state needed some form of organizational rural health presence. Dr. Fickenscher added his vision, which in many ways was an orientation to listening to communities and employing a form of public sector entrepreneurship, which I am proud we still follow."

Following Fickenscher, says Gibbens, each subsequent CRH director – Jack Geller, Mary Wakefield, and Gary Hart – added their own touch to CRH. And according to Gibbens, by focusing on rural health and having a dedicated office for it, CRH played a "significant role in shaping what we consider the organizational structure of rural health nationally."

"Our primary federal funder, the Federal Office of Rural Health Policy, used North Dakota as a model when the federal State Office of Rural Health program was created in 1991," he says. "Before that, around 1987, the work we were doing on rural health research guided the development of the Rural Health Research program. There were only four other states that had state rural health offices in 1980."

Eventually, the Health Resources and Services Administration and the Federal Office of Rural Health Policy developed the

1985 profile photo of Brad Gibbens.

SORH program, ensuring every state had an office focused on rural health. CRH is the official SORH for North Dakota. The designation helps CRH partner with state medical, hospital, and nursing associations, work with rural economic development groups, and work with the USDA, the North Dakota Department of Commerce, and North Dakota Health and Human Services.

"Our being the SORH is a great connector for CRH and SMHS," explains Gibbens. "It allows us to work with so many important stakeholders and partners, and has given us the opportunity to apply for other federal grants that are tied to a SORH."

Structure of rural care

One of the opportunities that arose from being the SORH was when CRH received funding from the Centers for Disease Control and Prevention (CDC) to improve health equity. The CDC Health Equity funding first flowed to the North Dakota Department of Health and Human Services.

According to Gibbens, CRH used its CDC funding to address a range of rural and tribal health issues, including physical plant planning and assessment for Critical Access Hospitals (CAHs) to be better prepared for future pandemics, addressing community health workforce, understanding the impact of COVID on Tribal nations, and finding additional resources to help Tribes address behavioral health education and a dedicated effort on restructuring the rural health and payment systems.

The system restructuring means a new payment structure for CAHs. This systemic change involves more than rural hospitals and medical providers, though. Over the past 50 years, the federal government has tried to find a reimbursement structure that works for all hospitals.

Unfortunately, urban and rural hospitals operate differently.

"Rural providers have always faced headwinds with health workforce, and inadequate payment or payment not well aligned for what they do," Gibbens says. "These are twin issues that have challenged providers and policymakers. The goal has always been to increase access while simultaneously trying to control and lower costs."

To that end, Gibbens adds that a new model, "value-based" care, modifies how healthcare is provided and how it is paid.

"CRH has played a significant role in exploring the type of structure for rural called value-based care, where providers are paid on showing positive health outcomes, instead of a straight fee for service," says Gibbens of the model strongly supported by the Centers for Medicare and Medicaid Services (CMS). "We've seen that develop quickly in North Dakota. We used the grant to develop a relationship with an organization with expertise in both rural health and value-based care, called Rural Health Value, to conduct education, training, and one-on-one assistance to CAHs in our state."

And so far, so good.

"We had Rural Health Value conduct a number of educational sessions with CAHs and providers to understand the nuts and bolts of value-based care and set up direct technical assistance with five CAHs," Gibbens notes. "Together they ran financial scenarios looking at what happens in 5-10 years if things stay the same, what happens if they are part of an accountable care organization (ACO), and what happens if they are part of another model. The analysis found when CAHs are part of an ACO, there was a positive impact."

As Gibbens puts it, a group of 23 CAHs in North Dakota formed their own hospital network, the Rough Rider High Value Network. The group entered into an agreement with an ACO. As a result, North Dakota has 65% of its CAHs in a value-based care structure.

Economics drive viability

Healthcare is often the economic driver in a rural community. Often a local hospital is one of the top two employers. And if that healthcare system also has a clinic and a nursing home, then the system itself becomes the largest employer.

This structure, Gibbens says, results in significant economic impact on the community.

"It makes a difference to the schools, the local tax base, the number of people who can shop locally, and attend church," he says. "A strong rural health system helps to maintain community viability, and a strong community contributes to the viability of the health system. It all intertwines. Living in a rural community means taking care of your friends, neighbors, and families. The level of intimacy in rural communities is greater than in urban."

The economic and population demographics of rural North Dakota are not the same as those of larger cities. Where rural areas tend to be more dependent on one or two primary

economic sectors (such as agriculture and/or energy), urban communities have a more diverse economy. And while urban populations tend to experience steady growth, much of rural North Dakota has experienced population declines over the past 40 or 50 years. Even so, some rural areas have seen acute population spikes due to the expansion of the energy sector. Rural areas also tend to be older and less diverse culturally.

"My background in public administration, and generally a strong core in political science and organizational theory also includes sociology," says Gibbens. "The people who taught me rural health tended to be sociologists, and even rural sociologists, and that has always guided my thinking. That means we pay attention to how broader environmental factors – such as economics and population – influence not only community development but also rural health development."

Or, as Gibbens quips, "the old joke is that if you've been to one rural community, you've been to one rural community. The same holds true for Tribal communities. If you stereotype rural or Tribal, you miss the uniqueness of each."

Looking for challenges

Challenges exist for all rural communities, but so do opportunities for growth.

"What we have done in our 44 years is constantly try to think of what more we can do," concludes Gibbens. "We don't provide services like medical care, but we try to help the people who do provide health services do their job better."

Because CRH operates on soft funding, only 10% of its budget comes from state appropriations, explains Gibbens. The other 90% the CRH pursues through state and federal grant opportunities.

"We have a culture of entrepreneurship, a culture of really wanting to try to address problems," Gibbens says. "Our staff loves to help people and to make a difference. Honestly, our staff like problems. They seem to thrive on working toward solutions that improve the lives of rural people."

Many of the grant funded projects have received state, regional, and national attention for the work they are doing in rural health. CRH has set up networks for CAHs and Rural Health Clinics, providing guidance, training, and leadership over changing regulations and policies. The North Dakota Brain Injury Network, for example, has become nationally known for education and resources for survivors of brain injuries and those caring for them. Likewise, the North Dakota Qualified Service Provider Hub offers assistance and resources for individual and agency in-home care providers. Two national centers – the National Resource Center on Native American Aging and the Resource Center on Native Aging and Disability – focus on Native American aging and disability. Finally, the Rural Health Information Hub is a clearinghouse on rural health issues, and the Rural Health Research Gateway provides access to research publications focused on rural health.

"It amazes me that an office that started with one person, a director, now has about 70 staff and faculty, 30 or more separate funding sources, and national programs," Gibbens admits. "We are frequently cited as a national leader, and, yes, we have influenced much of the work found elsewhere in rural health. However, always understand rural health is a two-way street and CRH has greatly benefited from other states."

The future of rural health

As he imagines what the next 40 years will bring to rural health, Gibbens explains that CRH exists to help improve and maintain the health status of people who live in these communities. One important development is learning and working with concepts like population health, health equity, and social determinants of health.

"All of those factors flow into value-based care, which is a process that can deal with improved population health," he says. "Health equity is aspirational. It will take many years of hard work to ensure all people, regardless of who they are or where they live, have the same right to good health status."

Gibbens never intended to dedicate a lifetime to rural health, or spend his career as a champion for improving rural communities through healthcare. In fact, he considered leaving UND and North Dakota a time or two.

But once he found his passion, he never looked back.

"I've had a career where I have been able to help the people I grew up with," he smiles. "I get a genuine thrill when I am able to get into the car and drive out to a rural community and do something with the people there. I've had opportunities to do other things, but it always came back to: I am a farm boy from rural North Dakota, so I decided to stay here."

By Jena Pierce

FINDING JOY IN NORTH DAKOTA

Judy Bruce on the new scholarship endowment she established to honor her late husband and former Medical Laboratory Science chair Wayne Bruce.

"Just a side note – this is a love story."

So began the former UND School of Medicine & Health Sciences (SMHS) faculty Judy Bruce as she launched into the story behind the new Dr. Albert Wayne and Julie Ann Bruce Endowment.

Widow of the late Wayne Bruce, the longtime chair of the School's Department of Medical Laboratory Science, Judy established the endowment recently with the UND Alumni Association & Foundation to support the Department Wayne helped build.

From her home in Florida, Judy smiled as she recalled the story of how a long love affair resulted in a gift to what has become one of the largest and most innovative medical laboratory science programs in the nation.

"We always intended to leave something to the University of North Dakota," said Judy, an Illinois native who went to college in Wisconsin. "It comes from wanting to give back to the MLS program at UND, particularly because Wayne spent so many years there and was so foundational in its development. I remember, while working there, we were always looking for money, either to repair equipment or travel to a seminar or something."

Hopefully, Judy said, her and Wayne's gift will help alleviate some of the burden current faculty and staff feel as they manage the Department in the future.

Love story

Named for Wayne and his daughter, who also works in healthcare in North Dakota, the endowment is unrestricted, Judy continued, meaning the Department is free to use it for "priority needs," whatever those needs might be.

> **"I have great, heartfelt feelings for North Dakota. So we're giving back."**
>
> **JUDY BRUCE**

"I'm not from North Dakota originally, but my joy came from North Dakota," Judy says. "I have great, heartfelt feelings for North Dakota. So we're giving back."

North Dakota is, after all, where she spent some of her happiest years.

Having met Wayne at an American Society for Medical Technology meeting in 1989, Judy, who was at the meeting representing America's Rust Belt states relative to Wayne's upper-Midwest group, was intrigued by the former farm kid Wayne's presentation on a new distance learning program in North Dakota.

"He received a grant from the U.S. Department of Agriculture to develop distance learning at UND," she explained. "It was a big grant and he was looking for someone to coordinate it. I thought, 'This sounds like an interesting job.' So, I applied for it and was working in North Dakota by 1989."

That job eventually led to a relationship, said Judy, that would last more than 30 years.

After managing the distance program for a time, Judy hopped over the Red River to serve as an associate dean at Northland Community & Technical College in East Grand Forks, Minn. She returned to UND in 1999, retiring in 2007 to follow Bruce up to Thunder Bay, Ontario, where he had taken the role of Associate Dean of Continuing Health Professional Education at the Northern Ontario School of Medicine.

Before Ontario, though Wayne helped "save" UND's MLS program, say current and former SMHS faculty.

"Dr. Bruce had some great ideas," noted longtime MLS faculty Mary Coleman of the former department chair. "He saved our program."

Judy Bruce (left) with former chair of the UND Department of Medical Laboratory Science Wayne Bruce.

As health providers and hospitals started to develop their own medical laboratories and train their own technologists in-house in the 1980s, UND's training program saw a drop in enrollments.

So Wayne and his team needed to get creative.

The distance learning grant was just one of Wayne's many ideas to boost enrollments at UND. Other ideas included the initiation of a postgraduate training partnership with Mayo Clinic and the forming of a Western College Alliance for Medical Laboratory Science (WCAMLS), which brought students from twelve midwestern colleges and universities to UND for training in MLS.

Each of these programs expanded the department's scope, opening up avenues for students from across the region to become UND MLS students, even if they still lived in Rochester, Minn., Billings, Mont., or La Crosse, Wis.

Giving back

"So he developed all that, and you get the sense of him always wanting to provide for his state," Judy continued. "That's the real thing about his vision: he was always trying to give back."

All of this, concluded Judy, is what drew her to Wayne: the generosity of his mind.

"He found creative ways to generate dollars – he was very good at that," she smiled. "There's a saying that creative minds are never very neat. And he had a creative mind. That's part of his legacy for UND. He didn't let things get in his way. He was very dedicated."

Admitting her bias, Judy said she found Wayne, who passed in 2023, to be so smart and so creative that she couldn't help wanting to be near him.

"I found a quote from a letter Wayne wrote about his career in lab science," Judy explained, pulling out a paper note. "He wrote, 'I have an infectious passion for educational technology and the utilization of multiple modes of delivery.' This pretty much sums up the distance learning programs he created with a supportive team of professionals in UND MLS."

And she's hoping the Dr. Albert Wayne and Julie Ann Bruce Endowment will continue to help today's supportive team of MLS professionals for many years to come.

By Brian James Schill

For more information on how to establish an endowment for the UND School of Medicine & Health Sciences, contact Jeff Dodson at **jeffd@UNDfoundation.org**

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ALTRUISM, LOCALISM, PRAGMATISM

Second-year physical therapy student Karlie Wardner looks to bring her skills to rural North Dakota soon.

Karlie Wardner is a pragmatist. And maybe a bit of a homebody.

And that's okay, admits the second-year Doctor of Physical Therapy (DPT) student from Grafton, N.D.

"My main focus is geriatrics," says Wardner, making the most of her summer study break at home in Grafton. "But in a rural community, you have to serve all populations. So, really, I'll be seeing everyone in this area."

As Wardner suggests, this focus on geriatrics and rural healthcare – but a commitment to serving community needs broadly – is as much a matter of mathematics as it is simple pragmatism. Yes, nearly 22% of North Dakotans are age 60 or older. But that leaves 78% of a largely underserved population that is not in the "older adult" category.

> "I love getting to know the patient. I really saw the impact that a physical therapist can make on someone's life."
>
> KARLIE WARDNER

Rural therapy

All of this is why Wardner is learning how to treat both older adults and younger clients – and looking to stay in North Dakota to practice after she graduates.

"I recently completed the LSVT BIG certification, which is for individuals with Parkinson's disease who are typically part of the geriatric population," Wardner continues. "At the clinical rotation I did last summer, most of the individuals that I saw who were in the geriatric population had total joint replacements, low back pain, or Parkinson's Disease. So that's what I've seen, and it's all very common in this area."

Also common in the area, though, is a shortage of not only physical therapists but most other health providers.

This fact makes it harder for providers who choose to practice in North Dakota – or any rural area – to justify specializing in a certain type of problem or patient. They will, after all, be seeing it all.

North Dakota winters notwithstanding, part of the local provider recruitment struggle, adds the chair of UND's Department of Physical Therapy Cindy Flom-Meland, is the region's geography.

"Recruiting and retaining physical therapists in rural North Dakota can be challenging due to location, the potential for isolation, and, depending on the size of the clinic, limited professional support onsite," Flom-Meland says, referencing a recent American Physical Therapy Association survey that reports a 10% average PT vacancy rate among practices of all types. "A multifaceted approach that addresses financial, professional, and personal factors is needed to aid in recruitment and retention."

Many area clinics understand this well, Flom-Meland adds, and work hard to implement targeted strategies for young

Karlie Wardner (right) with Department of Physical Therapy faculty Steve Halcrow at Karlie's 'Entrance into the Profession' ceremony in 2023.

therapists like Wardner in an effort to foster a supportive professional environment.

"This way we can ensure that our rural communities continue to receive the essential physical therapy services they need."

Relationship building

Serving such needs is exactly what Wardner has in mind.

Introduced to physical therapy after working her way through a number of sports injuries, Wardner explains that she found herself drawn to geriatric care generally not long after taking her first job in high school.

"My first job was working at a nursing home, and I worked there throughout high school and college," she explains. "I feel like there's so much to learn from older adults, from their stories, their experiences. I just really enjoy that population."

Part of that enjoyment, Wardner says, comes from getting to know clients well. In fact, the prolonged interface with clients is part of what attracted her to PT over other health professions.

"I love getting to know the patient," she smiles. "I really saw the impact that a physical therapist can make on someone's life. They see their patients multiple times a week, for 45 minutes at a time. I just like that aspect where you really get to know the patients and you can have a direct impact on their life."

It is this relationship-building that, Wardner says, helps clients trust her when she's both asking them to do difficult physical acts and referring them to other health providers – which Wardner estimates constitutes a significant portion of the therapist's role.

"Obviously we can't provide direct psychological support, but we can talk to them and ask questions," says Wardner, referencing patients' needs for nutrition and dietetic services, billing assistance, and even psychological assessment. "If you don't get to know your patients, you're probably not going to find out what their ongoing needs are. Then you may not be able to get them to another professional who can help."

'Mental toughness'

After all, helping clients recover from injuries, illnesses, and accidents is often as much of a mental challenge as a physical one, concludes the outgoing co-president of UND's Physical Therapy Club.

"The rehabilitation side of therapy is about getting stronger physically, but so much of it is building up mental toughness," she says, noting how a lot of patients aren't prepared for the emotional difficulties of therapy. "I experienced it myself, so I help clients understand that you have to go over those mental hurdles as much as anything. I feel like that's something I can help future patients with well."

Fortunately, for both Wardner and her future patients, the aforementioned small-town geography and cold weather questions are the very "hurdles" that help build mental toughness in so many North Dakotans.

"Coming from a small town has instilled the value in me to develop strong relationships with my peers," Wardner concludes. "I appreciate the small class sizes in UND's PT program because I have been able to bond with my classmates quite well – we go through all the ups and downs together. Because of this, I have been able to develop great friendships over the past two years. And I hope to help others face their challenges with courage as my physical therapist taught me."

By Brian James Schill

UND School of Medicine & Health Sciences receives $11 million NIH grant to help it 'transcend' in clinical and translational research

"This really is a game-changer," said Dr. Gary Schwartz, professor in the University of North Dakota School of Medicine & Health Sciences (SMHS) Department of Population Health. "As the project's name suggests, it's going to help move our state to the next level for clinical and translational research."

Schwartz was speaking of the Translational Science Engaging North Dakota project, or TRANSCEND.

Awarded to the SMHS and its partners in July by the National Institutes of Health (NIH) via the U.S. Department of Health and Human Services, TRANSCEND will allow area researchers to dive deeper into the study of multiple health conditions prevalent in North Dakota, including colorectal cancer, neurodegenerative diseases like Alzheimer's and Parkinson's, and a variety of mental and behavioral health challenges.

At $2.1 million per year, the five-year, nearly $11 million grant is one of the largest research awards the School has ever seen.

The award is an NIH Clinical & Translational Research Development (CTR-D) award, meaning the goal of researchers working within TRANSCEND is to bolster clinical and translational (C&T) research projects that go beyond "basic science" to develop strategies and therapeutics that can be applied by health providers in hospitals and clinics to a variety of patients directly.

"We're looking to elevate the profile of C&T research throughout North Dakota universities and clinics," added Schwartz, who served as point person on the large grant application. "We think of this as streamlining the road to successful clinical and translational research, in part by removing roadblocks and by offering 'roadside assistance' to researchers."

Such streamlining – practical research training and assistance for investigators – should produce tangible, positive impacts on the health of North Dakotans, Schwartz said.

To that end, part of the point of TRANSCEND is to help researchers get better at what they do by connecting them to potential research partners in the area, offering professional development and training opportunities, including pilot grant opportunities, and allowing them to test novel, patient-focused research innovations.

"There is a significant need for enhanced didactics and mentorship in the areas of clinical and translational research across our region," noted Dr. Paul Carson, professor in the North Dakota State University Department of Public Health. "I believe that these deficits will be meaningfully addressed by the services that would be provided by the TRANSCEND research core."

Part of the challenge in producing such research in North Dakota is that the state's only school of medicine and health sciences is "community-based," as the Association of American Medical Colleges (AAMC) puts it. That is, the school doesn't own or operate its own hospital. Consequently, university-based researchers in North Dakota face special challenges in conducting patient-focused research.

TRANSCEND should help address that challenge by connecting researchers at UND and NDSU with health systems like Sanford Health. Likewise, other partners, including the Community Health Association of the Dakotas (CHAD), have joined the team, meaning several community clinics will be working with TRANSCEND researchers on multiple projects, giving researchers better access to patient health data.

"TRANSCEND innovates in many ways, including helping investigators 're-enter' the grant process, adding other non-clinical faculty, like those in the UND School of Engineering & Mines, to the mix, and providing financial incentives for submitting grant applications to agencies like the NIH," said Schwartz. "Our Community Engagement and Outreach group is highly experienced in working with minority communities and our Community Physician at Large (CoPal) program will send a physician researcher out into the community to align TRANSCEND with community priorities."

His team's vision, concluded Schwartz, is that TRANSCEND transforms the academic culture in North Dakota by training future C&T leaders and contributing to the medical school's long-term goal of improving health in North Dakota.

"We need to develop clinical and translational research that is relevant to a wide range of medical illnesses and health related problems experienced by people in our region," added Dr. Stephen Wonderlich, vice president for research and chief of behavioral health research at Sanford Health in Fargo. "TRANSCEND provides resources, support, and opportunities for clinicians and scientists to work together to conduct these relevant and meaningful studies. It is a remarkable opportunity."

UND researchers awarded nearly $500,000 from U.S. Department of Housing and Urban Development for radon projects

"Because the threat is not visible, it's not something that people readily appreciate and act upon," said Gary Schwartz, professor and chair of the UND School of Medicine & Health Sciences (SMHS) Department of Population Health.

He was speaking of radon gas, the colorless and odorless radioactive gas present in many homes in North Dakota: "We often say it's like trying to convince your 10 year-old to save for retirement."

In other words, although the evidence is clear that radon causes not only lung cancer but likely contributes to other illnesses such as stroke, the delay in radon's effects means that convincing homeowners to act on mitigating their exposure today is a challenge.

Looking for support in researching ways of convincing people to take radon more seriously, Schwartz and a team of researchers at UND applied for a grant from the U.S. Department of Housing and Urban Development (HUD).

In May, the team received confirmation that they were awarded $486,377 for their project – one among 57 grants HUD announced "that will help transform communities."

According to the U.S. Environmental Protection Agency, every county in North Dakota is considered Zone 1 for radon levels, placing the state in the top 25% of states for radon prevalence. Many studies place North Dakota first in the U.S. for the level of residential radon to which homeowners are exposed.

Even so, radon's literal invisibility complicates researchers' efforts to educate the public on its effects.

Assuming a homeowner opts to act on radon, those in warmer climates can seek out low-cost radon mitigation by simply ventilating their homes better year-round (although this isn't a long-term or perfect solution). Such strategies are harder in North Dakota, where opening windows is impractical for much of the year and home mitigation systems can be costly.

All of this can make convincing homeowners to follow through on testing for radon a challenge, said Schwartz.

To that end, added Soojung Kim, associate professor and chair of UND's Department of Communication, the researchers will use the grant to engage North Dakotans directly on identifying factors that will help them take action on radon.

"Our overall goal is understanding the last step of this whole behavioral chain," said Kim. "Homeowners order the test kit, but it's often sitting on their counter, unused. How can we get them to act?"

This effort is the latest in a series of projects that the team, which includes Marilyn Klug, professor in the Department of Population Health, has initiated on radon communication strategies. More than six years ago, the research team developed an app for smartphones that informs users about radon. The group subsequently compared the app to traditional communication methods for both approaches' ability to "unlock" homeowners' behaviors around radon.

"Originally, I would have thought that getting people to test their homes for radon would be a one-step thing – it'd be like a padlock where we just need to find the key," said Schwartz. "What we learned from our clinical trials is that it's more like a combination lock. You have to turn 17 notches to the left, 31 to the right, and four to the left again to get the lock to make the tumblers work."

After years of research, said Schwartz, the team is finally close to cracking that combination.

"We've gotten to the point where we are very good at teaching people about radon," he added. "And we've tested whether or not the app is better than brochures – and it's way better. It teaches users more about radon and stimulates their interest in testing for radon such that they're three times more likely to order a test kit on their phone."

Given how the researchers have already demonstrated that they can change peoples' thinking about radon, the next step is motivating and changing behavior.

That's the goal of the HUD grant.

"As the only medical school in the state, and with radon such an important public health issue here, we hope to use this grant both to better change radon testing behaviors and involve community members who are actually affected by radon exposure," said Kim. "We look at this as a service to the state that also contributes to our research mission."

Calling a radon test a "cancer test for your home," Schwartz noted how UND has become a national leader on radon research – not only in terms of epidemiology and education but communication.

"We have collaborated on several papers, including one in the journal *Neurology*, showing that radon also may cause stroke," Schwartz said. "And that's very, very big. Yes, 21,000 people die each year from radon-induced lung cancer. But there are more than 795,000 strokes every year. So, if we can reduce that number even modestly, you can see what the return on health would be from reducing exposure to radon."

New projects funded by the grant are likely to kick-off around September, concluded Schwartz, who is also working on radon education thorough the SMHS Radon Outreach And Research (ROAR) project.

"Radon is a national problem, but since we have more of it here than most states, it's really a North Dakota problem. So, it's an opportunity for UND to exert national leadership in this area. Who better to do it than us?"

Medical Doctor Class of 2028 begins studies at School of Medicine & Health Sciences

"The first week of medical school has me reflecting humbly on how fortunate I am to finally begin medical education," admitted Grand Forks, N.D., native Madeline Comeau. "Working through our first patient case was a great start for developing those clinical skills we'll need as physicians."

A Grand Forks, N.D., native, Comeau is one of nearly 80 first-year medical students, members of the Doctor of Medicine Class of 2028, who began their journey to become physicians in July 2024 at the UND School of Medicine & Health Sciences (SMHS).

Unlike her cohorts, Comeau already has something of an inside track on the next four years.

"I just finished watching Kole complete his medical education at UND and was impressed with the early clinical exposure, patient-centered learning, and simulation training he received," continued the two-time UND grad of her husband Dr. Kole Hermanson, who completed his M.D. program at UND last May. "Kole and I want to continue to practice medicine in North Dakota when we're done with our training so UND was a natural fit for me."

The first week for medical students is dedicated to orientation, including an introduction to UND's nationally recognized, four-year, patient-centered learning curriculum where biomedical and clinical sciences are taught in the context of an interdisciplinary educational setting. Special emphasis is placed on students' new roles and expectations of them as health professionals.

Orientation week concluded with a White Coat Ceremony, wherein students recited the Oath of Hippocrates and received their first white coats, which have been donated by the North Dakota Medical Association.

"I was incredibly excited to begin medical school in North Dakota, and it feels wonderful to finally be close to family and loved ones again," added Fargo, N.D., native Marcela Hanson. "The first week has been fantastic! The faculty and other students have been so welcoming and helpful and really have solidified and reassured my decision to attend UND."

Although she remains "open to any specialty," Hanson has spent the past four years as a nurse in Wisconsin, focusing on cardiac care and labor and delivery. As such, she is especially interested in the practice of obstetrics and gynecology.

"I chose UND SMHS because of the outstanding reputation it has, as well as the tight knit community that is so prevalent here," she said. "I knew I would get a strong foundational medical education along with having an immense amount of support. I also wanted to give back to the North Dakota community that raised me."

Ranging in age from 20 to 31 years, and with an average age of 24, the vast majority of this year's entering students are from North Dakota and Minnesota. The cohort comes to UND's medical school with experience in an array of fields, including art history, biochemistry, biology, chemical engineering, chemistry, community nutrition, international studies, kinesiology, mathematics, physics, psychology, public health, and theatre arts.

Some of these first-year students already hold advanced degrees, including graduate degrees in athletic training, biomedical science, healthcare administration, microbiology, physiology, and public health.

Founded in 1905, the UND School of Medicine & Health Sciences is North Dakota's only medical college and the most comprehensive collection of health sciences programs in the state, graduating more than 300 physicians, physician assistants, physical and occupational therapists, medical lab scientists, athletic trainers, and public and Indigenous health professionals annually.

"Coming from a small town in Montana, UND felt like a great fit for me given the community-based experience and rural opportunities offered here," concluded Glendive, Mont., native Ase Ackerman, who is thinking of specializing in either family medicine or sports medicine. "I was excited to start school here at UND. We were provided a large amount of information preparing us for the challenges ahead, but it's been great and I feel well prepared to begin my medical education."

The UND M.D. Class of 2028 is as follows:

- Ase Ackerman, Glendive, Mont.
- Grace Blair, Andover, Minn.
- Abigail Boehmer, Negaunee, Mich.
- Nicholas Brown, Bismarck, N.D.
- Janine Bury, Elk River, Minn.
- Autumn Charette, Grand Forks, N.D.
- Hunter Colby, Fargo, N.D.
- Madeline Comeau, Grand Forks, N.D.
- J Delorme, Belcourt, N.D.
- Kwyn Demmert, Kingston, Wash.
- Ally Feland, Antler, N.D.
- Benjamin Fischer, Raleigh, N.C.
- Anna Fleming, Sauk Rapids, Minn.
- Rylie Fode, Bismarck, N.D.
- Ryan Froom, Crystal, Minn.
- Nishita Gaba, Fargo, N.D.
- Kemal Hajric, West Fargo, N.D.
- Michael Hall, Kindred, N.D.
- Evan Halvorson, Lawton, N.D.
- Marcela Hanson, Fargo, N.D.
- Jackson Haug, West Fargo, N.D.
- Nathaniel Hensel, Fargo, N.D.
- Htet Hnin, Minot, N.D.
- Emma Hoover, Pelican Rapids, Minn.
- Jackson Hopfauf, Bismarck, N.D.
- Vaneka Hoskie, Albuquerque, N.M.
- Alexander Iverson, Moorhead, Minn.
- Lillian Johnson, Duluth, Minn.
- Olivia Johnson, Fargo, N.D.
- Paloma Johnson, Fargo, N.D.
- Teya Keeling, Minot, N.D.
- Noah Keller, Minot, N.D.
- Jason Kells, Lino Lakes, Minn.
- Camille Klindworth, Beulah, N.D.
- Brooke Kohler, Bismarck, N.D.
- Hannah Krier, Fargo, N.D.
- Gabrielle Krzyske, Brownstone, Mich.
- Taylor Lange, Waconia, Minn.
- Evan Lattimer, Alexandria, Minn.
- Hannah Laumb, Grand Forks, N.D.
- Becker Lindner, Spooner, Wis.
- Emily Lygre, St. Cloud. Minn.
- Brenden Lyons, Carlisle, Penn.
- Jason Martin, Rochester, Minn.
- Aurora Martinez, Snohomish, Wash.
- Brooke Miller, Starbuck, Minn.
- Annika Mogck, Fargo, N.D.
- Patrick Mullon, Rochester, Minn.
- Olivia Murdoff, Bismarck, N.D.
- Brady Nygaard, Mayville, N.D.
- Sophia Oen, Grand Forks, N.D.
- Mia Olsen, Scottsdale, Ariz.
- Jack Ommen, Rochester, Minn.
- Lauren Ostlie, Fargo, N.D.
- Jaksen Perrin, Bismarck, N.D.
- Paige Priest, Irving, N.Y.
- Joshlyn Resek, Murray, Utah
- Camryn Schall, Grand Forks, N.D.
- Cecelia Schmelzle, St. Louis Park, Minn.
- Corey Schneider, Mankato, Minn.
- Evan Sczepanski, Grand Forks, N.D.
- Claire Sell, Oakes, N.D.
- Sarah Seyfried, Buxton, N.D.
- Samantha Sheldon, Fargo, N.D.
- Kaitlyn Smith, Staples, Minn.
- Andrew Stayman, Grand Forks, N.D.
- Alexander Upton, Woodbury, Minn.
- Charisse Vetsch, Grand Forks, N.D.
- Faith Weibye, Horace, N.D.
- Kaylee Weigel, Alexandria, Minn.
- Carter West, Eagan, Minn.
- Jacob Wieland, Rice, Minn.
- Jaxton Wiest, Mandan, N.D.
- Madelyn Wilaby, Hankinson, N.D.
- Mya Winjum, Fargo, N.D.
- Jack Wolsky, Minot, N.D.

Nancy L. Balvin, age 86, of Huron and Sioux Falls, S.D., passed away on Thursday, April 25, 2024. Nancy Lou Balvin was born on June 4, 1937, in Sauk Centre, Minn., to parents Charles and Ruth (Hutchinson) Balvin. As a young child, Nancy moved to a farm near Wolsey where Nancy and her siblings grew up. She graduated from Wolsey High School in 1955. Nancy knew she always wanted to become a nurse. She enrolled in the St. John's Hospital nursing program, where she graduated with her registered nurse degree. She then attended South Dakota State University to get her baccalaureate degree as a nurse practitioner (NP). Nancy received her NP license in 1958 and was the first NP in South Dakota. Nancy was working as an NP at the hospital when she heard about a nurse practitioner/physician assistant program being offered through the University of North Dakota. Nancy enrolled in the first PA class at UND. She graduated in October of 1975, took her required boards for NP and PA, and became the first NP in South Dakota and the first female provider in Huron. Nancy practiced at Tschetter & Hohm Clinic and then with Dr. Mark Belyea. She practiced for more than 41 years and retired in 2017 at the age of 80. She is survived by her siblings, Doug (Marlas) Balvin of Huron and Virginia "Ginny" Gravelle of Sioux Falls; her nieces and nephews, Kristi Perrin, Dale Balvin, Roger Gravelle, Jr., Roxane Ensz, and Robin Gravelle; and several great-nieces and nephews. She was preceded in death by her parents and her brother-in-law, Roger Gravelle.

Dr. Samir I. Farah, 85, of Minot, N.D., passed away peacefully on May 20, 2024, in Maple Grove, Minn. Samir embraced a life filled with tight-knit family bonds and a deep-rooted passion for medicine. He was a devoted husband, father, grandfather, and friend. He was a humble servant to his patients in northwestern North Dakota and dedicated teacher to students and residents at the University of North Dakota (UND) School of Medicine & Health Sciences. Samir is survived by his wife, Hanzada; daughters, Ronda (Kellen) and Rina; grandchildren, Lilah and Gavin; brothers, Said and Sameh; sister, Asmat; and other relatives. Samir was born on September 25, 1938, in Alexandria, Egypt, to Ensaf Ali El-Sayed and Ibrahim Farah Nagi. Samir grew up by the Mediterranean Sea, which he adored. He loved playing soccer, but academics were the center of his life. He graduated ninth out of all high school graduates in Egypt and immediately enrolled at Alexandria University Faculty of Medicine, where he earned his medical degree. In 1972, driven by his dedication to healing and helping others, he immigrated to the United States to complete his internship at Ascension Columbia St. Mary's Milwaukee Hospital, a residency at Detroit Medical Center and Wayne State University School of Medicine, and fellowship in endocrinology at Wayne State University. He was also a fellow of the prestigious American Association of Clinical Endocrinology. In 1977, he was recruited by St. Joseph's Hospital to Minot, N.D., and opened his private practice in the Trinity Health professional building. He practiced at Trinity Hospital, St. Joseph's Hospital, and Trinity Nursing Home. He married his wife Hanzada in 1982. Over the next four decades, as he grew his family, Samir diligently cared for patients in Minot and the surrounding area. Early in his career, he served as a clinical professor at the UND School of Medicine & Health Sciences and received the Dean's Special Recognition Award for Outstanding Volunteer Faculty at UND. He later became the director of Internal Medicine and vice chairman of the Department of Internal Medicine for UND's Northwest Campus.

Tom Milroy Johnson, M.D., passed away Friday, May 10, 2024, at the age of eighty-nine. An internist, he was recruited to Michigan State University in 1968 by the College of Human Medicine's founding Dean Andrew Hunt and was an inaugural faculty member of the Department of Internal Medicine. Dr. Johnson was part of the original two-year curriculum, the four-year curriculum that started the year he arrived, and "focal problems," the forerunner of problem-based learning that is now ubiquitous in medical education. He was charged with setting up clinical campuses in Flint, Saginaw, Grand Rapids, Alma, and other Michigan communities, and became the founding community assistant dean of Grand Rapids. In 1977, Dr. Johnson left MSU to be dean at the UND School of Medicine & Health Sciences for 11 years. At UND, Johnson was instrumental in helping convert the formerly two-year Bachelor of Science in Medicine degree into a four-year M.D. program. "Tom took a school that had been created on paper and he actually made it work," said Dr. Dennis Lutz, chair of the School's Department of Obstetrics & Gynecology, in John Vennes's and Patrick McGuire's history of the UND medical school *North Dakota, Heal Thyself* (2005). "What Tom Clifford was to UND, Tom Johnson was to the medical school. He knew what he needed to do. He knew what had to be done. He was the right person for the medical school at the time expansion occurred. He was always friendly, always available if you had a question. He got the school up and running." Founding director of the UND Center for Rural Health, Dr. Kevin Fickenscher, agreed, explaining how Johnson "was central towards getting the four-year program off the ground and the instigator for creating the Office of Rural Health, the predecessor of the Center for Rural Health." Following his successes at UND, Johnson returned to the College of Human Medicine in Michigan in 1988 and became associate dean for community and clinical affairs, retiring in 1998. Johnson received his medical degree from Northwestern University and completed

his residency at the University of Michigan before serving two years in the Air Force, stationed at F.E. Warren base in Wyoming. Upon returning to Michigan he completed a fellowship at the University of Michigan. Subsequent to his retirement, Johnson, who attended a one-room school as a child, became active in the Michigan One Room Schoolhouse Association and was chair of the organization for a number of years. Tom was a restorian, having restored three old homes, a one room school, and many antique cares. In many ways, health education and healthcare in North Dakota would not be what they are today without Johnson's leadership.

Mark Eldon Manteuffel, M.D., was called home to the Lord on June 19, 2024, just days before his 64th birthday. Mark was born in Spokane, Wash., on June 24, 1960, to Eldon and Mary Manteuffel. He graduated from West Valley High School in 1979. He went on to earn a Bachelor of Science degree in 1983, followed by his Doctor of Medicine degree in 1987 from Oral Roberts University, Tulsa, Okla. He completed a transitional internship at Deaconess Hospital in Spokane and a family medicine residency at the University of North Dakota. Mark's medical career included service as a commissioned officer and flight surgeon in the United States Air Force Medical Corps — he is one of very few people who got the opportunity to ride in a B2. He served as an emergency physician at Logan Regional Hospital in Logan, Utah, for two years and then cared for the northern Idaho community as an emergency physician at Kootenai Health for 26 years. He retired from the emergency department in 2022 but continued practicing medicine at Lakeland Immediate Care in Rathdrum. He is survived by his loving wife of 33 years, Michelle Manteuffel; his son, Matthew Manteuffel; daughter Aubrey Harper; and precious grandson Rhett Harper. He is also survived by his parents, Eldon and Mary Manteuffel of Spokane; his sisters, Kay (Steve) May and Lori (Larry) Gibson; as well as nieces, nephews, and great-nieces.

Cheryl Ann (Hamness) Stauffenecker, M.S., Nursing, '00, was born on April 12, 1954, in Greenbush, Minn., and left this earth on June 14, 2024. Cheryl married her high school sweetheart, Lonnie Stauffenecker, on Sept. 23, 1972, and the pair made their home in Warren, Minn. While raising her family, Cheryl attended the University of North Dakota, graduating with honors from the College of Nursing. She was a labor and delivery nurse at Altru Health System for 21 years. In that time, she completed her master's degree in nursing and fulfilled her passion for educating the next generation of nurses as a Nurse Educator at UND. Her teaching led to an instrumental position at the UND School of Medicine & Health Sciences Simulation Center as a simulation education coordinator. Our beloved wife, mom, and Nana will be missed by her loving husband of 51 years, Lonnie, and her kids, Tina (Todd) Larsen, Tracy (Jason) Turner, and Scott (Keely) Stauffenecker. She is preceded in death by her parents, Arnold and Eunice Hamness, her brother Greg, and sister Joyce.

'00s

Thomas Wyatt, M.D. '00, was recently appointed Chair of the Department of Emergency Medicine at Hennepin Healthcare in Minneapolis, Minn.

"Training the best residents in the world, recruiting diverse world-class faculty, conducting research, and promoting innovations that advance the specialty of emergency medicine are just a few of the departmental goals we'll continue thanks to the standards of excellence set by this team," said Wyatt. "Mentorships and programs play essential roles in preparing future medical professionals – and I also realize the significance of being an example to other American Indians and American Indian youth who might want to pursue a similar career path."

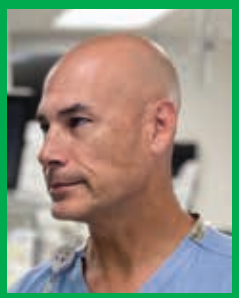
Dr. Wyatt is one of the first Tribally enrolled American Indians (Shawnee/Quapaw) to lead an academic emergency department in the United States – and the first to chair an emergency department in Minnesota.

'90s

Monica Mayer, M.D. '95, is being honored by the UND Alumni Association & Foundation at UND Homecoming 2024 for "distinguished achievement and leadership." Dr. Mayer was the first female physician to serve on a Tribal Council in the United States. See this magazine's inside front cover for more information.

'80s

William McKinnon, M.D. '83, has joined the Dakota Regional Medical Center in Cooperstown, N.D., as Medical Director. McKinnon will also be seeing patients.



Thomas Wyatt, M.D.

William McKinnon, M.D.

PARTING SHOTS

Did you attend an event related to the UND SMHS? Share it with your colleagues. UND SMHS alumni, faculty, staff, students, friends, and family are welcome to send a high resolution photo to kristen.peterson@UND.edu for possible inclusion in the next *North Dakota Medicine*.

SMHS graduate Dr. Jonathan Haug speaks to the M.D. Class of 2028 at the class's White Coat Ceremony in July 2024.

The School of Medicine & Health Sciences building in Grand Forks took on new exterior signage in August 2024.

Occupational Therapy student Paige Earnest (left) with 1972 OT grad and UND supporter Maggie Hjalmarson Lesher at the Department of Occupational Therapy Adopt-an-OT event in August.

First-year Doctor of Physical Therapy student Kameron Selvig shows off her new PT gear bag, donated by supporters of UND's Adopt-a-PT program in August.

Trista Olson (left) and Anna Jackson talk healthcare education with providers from across North Dakota at the annual Dakota Conference on Rural and Public Health, held in Grand Forks last June.

Department of Physician Assistant Studies students Jordan Saxerud (left) and Grace Grani practice splinting with assistant professor Russ Kauffman (standing).

Dr. Ken Ruit (left) offers a token of appreciation to Dr. Jon Allen, who in June 2024 retired from his long role as director of the SMHS Simulation Center.

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EVENTS

Friday, Sept. 27

Continuing Education Symposium
8:30–11:30 a.m.
Topic: Rise of the Machines: A.I. in healthcare education and clinical practice
School of Medicine & Health Sciences
Room W206 and Zoom

Reunion & Banquet (1944-2014) | 5 p.m.
Ely's Ivy | 22 S 3rd St, Grand Forks, ND
5 p.m. social, 6 p.m. dinner, and program at 7 p.m.

Saturday, Sept. 28

Homecoming Parade | 9 a.m.
University Ave

Football game vs. Murray State
Alerus Center, 1200 S 42nd St

JOIN US
UND HOMECOMING

Sept. 23–28, 2024

We're celebrating milestone grads
(if your graduation year ends in a 4 or a 9),
75 years of Medical Laboratory Science and
70 years of Occupational Therapy at UND!

For updates, check:
med.UND.edu/events/homecoming

UND School of Medicine & Health Sciences
University of North Dakota