

American Indian and Alaska Native Oral Health Access Summit



Summary Report

November 12-14, 2007
Hyatt Regency Tamaya
Santa Ana Pueblo, New Mexico

“What are we going to do, both individually and collectively, to improve access to dental treatment and prevention strategies that address the oral health of American Indian and Alaska Native people?”



American Dental Association
www.ada.org

February 1, 2008

Dear Summit Participants and Other Interested Parties:

On behalf of the American Dental Association (ADA), we were honored to host the first American Indian/Alaska Native Oral Health Access Summit, November 12-14, 2007 in Santa Ana Pueblo, New Mexico. The following report provides a summary of the Summit and copies of the notes gathered during the event.

The Summit was an excellent opportunity for key stakeholders to gather to discuss the many factors that impact the oral health of American Indian and Alaska Native (AI/AN) people. The ADA leaders and others who attended the Summit learned a great deal about the daily obstacles to dental care faced by these populations and the providers who serve them.

We thank the Summit participants who took a leap of faith and openly shared their experiences, perspectives and ideas about the oral health of American Indian and Alaska Native people. Their willingness to reveal their attitudes and expertise helped others better understand the oral health needs of AI/AN communities and possible responses to address these challenges.

The Summit was effectively facilitated by Howard Ross, founder and chief learning officer of Cook Ross, Inc., using the "Future Search" model. Mr. Ross led participants through a series of small and large group activities to solicit information about knowledge, attitudes and practices related to the past, present and future oral health of AI/AN people. The Summit focused on answering the question, **"What are we going to do, both individually and collectively, to improve access to dental treatment and prevention strategies that address the oral health of American Indian and Alaska Native people?"** These exercises were supplemented by presentations by Dr. Nancy Reifel and L.D. "Dee" Robertson, M.D., who provided additional information about the history of health care for AI/AN populations and the burden of oral disease among Native American children.

The Summit resulted in the formation of seven action teams to address the multiple facets related to the oral health of AI/AN communities. Each Summit participant volunteered to serve on one action team, and one leader from each group was identified to participate on the coordinating AI/AN Strategic Work Group.

The ADA agreed to communicate the Summit process, content and outcomes to the dental profession and use additional ADA mechanisms to "tell the story" of oral health disparities in Indian Country. The Association will convene the AI/AN Strategic Work Group and assist its members to coordinate their action teams. The ADA will also provide progress reports on the work of each action team and develop and distribute a written consensus report that describes the work of the Summit participants.

Thank you, again, to the diverse Summit participants who passionately demonstrated their commitment to the oral health and oral health care of American Indian and Alaska Native people. We were enlightened and inspired by what community members and professionals shared with us.

Sincerely,

Mark J. Feldman, D.M.D.
President

Lindsey A. Robinson, D.D.S.
Chair, Council on Access,
Prevention and Interprofessional Relations

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Agenda

Monday, November 12

Registration

Traditional Blessing

E. J. Lujan, Santa Ana Pueblo
William Clark, Navajo, flutist

Welcome and Meeting Overview

Dr. Mark Feldman, President, American Dental Association
Dr. Lindsey Robinson, Chair, Council on Access, Prevention and Interprofessional Relations
Howard Ross, Founder and Chief Learning Officer, Cook-Ross, Inc.

Presentation

“Oral Health and Health of American Indians and Alaska Natives: A Historical Perspective,”
Dr. Nancy Reifel, Assistant Researcher, UCLA School of Dentistry

Future Search

Focus on the Past: Highlights & Milestones

Goal: Appreciate our history, trends we have experienced and what the past means to us.

ADA Hosted Reception

Tuesday, November 13

Traditional Blessing

Jimmie Cimarron, San Felipe Pueblo

Future Search

Focus on the Present: Current Trends

Goal: Understand the forces having an impact on oral health access for American Indian/Alaska Native people now.

Presentation

“Early Childhood Caries and Dental Disease Burden,”
L. D. “Dee” Robertson, M.D., M.P.H., Consultant in Pediatrics and Health Research

Future Search

Focus on the Future

Goal: Imagine an ideal future for American Indian/Alaska Native oral health access.

Future Search

Common Ground for the Future

Goal: Discover our common future and direction.

ADA Hosted Dinner

Wednesday, November 14

Traditional Blessing

Jimmie Cimarron, San Felipe Pueblo

Future Search

Common Ground for the Future

Goal: Discover our common future and direction.

Adjourn

Introduction

The American Indian/Alaska Native Oral Health Access Summit (“Summit”) was convened by the American Dental Association (ADA) and its Council on Access, Prevention and Interprofessional Relations (CAPIR), November 12-14, 2007 at the Hyatt Regency Tamaya on the Reservation of the Santa Ana Pueblo of New Mexico. This report provides a summary of the planning, implementation and outcomes of the Summit, as well as “raw” chart notes from the facilitated activities.

The Summit involved more than 100 participants, representing public and private interests, from local communities, state dental societies, specialty organizations, the U.S. Public Health Service, philanthropy and the ADA. This is a summary report of the Summit. It includes findings and recommendations, along with text of the many flip-charted conversations held by participants so that the reader will have a better understanding of the thought process that led to the participants’ recommendations.

In May 2006, CAPIR proposed the Summit. The Council’s goals for the Summit included:

1. identifying and discussing innovative approaches to address oral health disparities and access for AI/AN people, including best practices and the role of allied dental professionals;
2. developing a multidisciplinary approach to oral health promotion and prevention;
3. analyzing available and needed resources to address oral health issues in Indian country;
4. discussing mechanisms to increase recruitment and retention of oral health professionals at Indian Health Service/Tribal/Urban clinics;
5. describing ways to promote “pipeline” programs to get Native and other students interested in pursuing oral health professions and serving AI/AN people;
6. emphasizing the need for public-private and patient-provider partnerships to improve oral health;
7. increasing “spirit of collaboration” by viewing all parties as valued partners;
8. creating a common vision for long-term success and identify next steps.

In June 2006, CAPIR requested, and the ADA Board approved, to implement the Summit. CAPIR staff continued informal conversations with external organizational representatives to discuss plans for the Summit. The general consensus was the Summit was a good idea, but it should be postponed until 2007 due to competing scheduling priorities and the pending lawsuit against the Alaska Native Tribal Health Consortium (ANTHC) and individual dental health aide therapists by the American Dental Association and Alaska Dental Society. The consulted organizations believed delaying the Summit might allow for additional planning time and the possibility of the *ADA v. ANTHC* lawsuit to be resolved. Regardless, several Native dental and Tribal organizations agreed to assist in Summit planning if the event was held in 2007.

In July 2006, CAPIR solicited “letters of interest” from consultants to assist in the planning and implementation of the Summit. From a pool of seven candidate organizations, CAPIR (in consultation with Council on Government Affairs staff) chose Cook Ross, Inc. For over 20 years, Cook Ross has provided a broad range of organizational consulting skills to a wide diversity of national and international clients. It has specialized in the areas of diversity and cultural competency and how these issues impact the health care delivery system. Its clients have included large and small health care systems, managed care providers, state and local health departments and national health care organizations. Cook Ross served as the facilitator of the Summit, guiding participants through a series of guided discussions and exercises designed to reach consensus on key objectives.

In December 2006, a planning meeting was held at the ADA Washington Office. Invited participants included representatives from the Indian Health Service (IHS); national, regional and local Native health care organizations; the Society of American Indian Dentists and Tribal Nations. Participants discussed the benefits and obstacles of convening the Summit and identified key stakeholder groups to be included in the event. In January 2007, another planning meeting was held. At this meeting, the participants began to identify actual individuals and/or organizations to invite to the Summit and established the recommended goals for the Summit. Planning conference calls and electronic communications continued during 2007.

The Summit was originally proposed to occur at the ADA Headquarters Building. After discussions with the planning group and other stakeholders, it was decided a “neutral” environment would help promote more open and honest dialogue among participants. Several potential sites were investigated. Ultimately, CAPIR chose to host the Summit at the Hyatt Regency Tamaya which is located on the Santa Ana Pueblo Reservation 30 miles north of Albuquerque, New Mexico.

Methods

Participants from a variety of stakeholder groups gathered to consider the following question.

“What are we going to do, both individually and collectively, to improve access to dental treatment and prevention strategies that address the oral health of American Indian and Alaskan Native people?”

The Summit used a unique planning method known as Future Search to create an environment in which to:

- understand past efforts to improve oral health of AI/AN people and the current reality of these efforts
- look at the whole picture before making decisions about its parts
- allow a wide range of voices to be heard
- focus on the future toward which all are willing to commit

The following characteristics distinguish Future Search conferences from other participatory strategy meetings.

1. The **WHOLE SYSTEM** participates—a cross-section of as many interested parties as practical. That means more diversity and less hierarchy than is usual in a working meeting, and a chance for each person to be heard and to learn other ways of looking at the task at hand.
2. Future scenarios are put into **HISTORICAL** and **GLOBAL** perspective. That means thinking globally before acting locally. This feature enhances shared understanding and greater commitment to act. It also increases range of potential actions.
3. People **SELF-MANAGE** their work, and use **DIALOGUE**—not “problem-solving” as the main tool. That means helping each other do the tasks and taking responsibility for our perceptions and actions.
4. **COMMON GROUND**, rather than “conflict management,” is the frame of reference. That means honoring differences rather than having to reconcile them.

Stakeholder Groups

Originally, the Summit planning group identified twelve stakeholder groups. Based on participant registration, the number of stakeholder groups was reduced to the following eight groups (Appendix 1). The participants began the Summit in these stakeholder groups and remained in these groups for the first portion of the conference.

1. Indian Health Service Area Dental Officers and Headquarters Personnel
2. State Dental Societies
3. Local Tribal Health Programs
4. American Dental Association
5. Indian Health Service Dental/Clinical/Preventive Support Programs and Other Local Programs
6. Specialty and Special Interest Oral Health and General Health Care Organizations
7. Regional Health Boards and Philanthropic Organizations
8. Dental Education

Additional organizational representatives attended the Summit as observers.

Outcomes

At the conclusion of the Summit, all participants agreed to work on activities related to the following seven AI/AN oral health focus areas. Each Summit participant volunteered to participate in a group. A team leader was assigned by each group, and they are indicated below.

1. creating a new paradigm for improving the dental workforce (Dr. Alyssa York, dental director, Inter-Tribal Council of Arizona)
2. developing collaborative strategies for lobbying, funding, policy making, etc. (Mr. Joe Finkbonner, executive director, Northwest Portland Area Indian Health Board; Roxanne Spruce Bly, Coordinator, Native Health Care Council)
3. designing research and implementing “best practices” for the prevention of oral disease, including early childhood caries (Dr. Patrick Blahut, assistant branch chief, Indian Health Service Division of Oral Health)
4. fostering broader community involvement to identify oral health issues and their solutions (Mr. Kenneth Nicholson, health systems specialist, Billings Area Indian Health Service)
5. advocating for a fully funded IHS/Tribal/Urban (ITU) dental program (Mr. Paul Sherry, chief executive officer, Alaska Native Tribal Health Consortium)
6. building trust among the partners/communities of interest (Ms. Jean Connor, president, American Dental Hygienists Association)
7. encouraging meaningful tribal empowerment in oral health policy making (Dr. Nancy Reifel, assistant researcher, UCLA School of Dentistry)

Group members preliminarily discussed some of the key issues related to each focus area. Their work will continue and become more focused in the future. Based on available financial and other resources, the ADA agreed to support ongoing efforts by:

1. establishing a listserv group e-mail for all interested Summit participants as a mechanism to share progress, concerns, etc.
2. communicating Summit process, content and outcomes to the dental profession, using ADA electronic communication tools, ADA News and other available resources.
3. finding ways within ADA venues to “tell the story” of oral health disparities in Indian country
4. convening a strategy group, consisting of a leader from each action team, and sponsoring/organizing that group as needed (This group will coordinate the work of the action teams, identify needed resources, etc.)
5. providing progress reports on the work of each action team
6. developing and distributing the written consensus report that captures the work of the Summit participants

Appendix 1

Stakeholder Group Members

1. Indian Health Service Area Dental Officers and Headquarters Personnel

Dr. Mitch Bernstein
Dr. Patrick Blahut
Dr. George Chiarchiaro
Dr. Woody Crow
Dr. Robert Good
Dr. Dan Huber
Dr. Tim Lozon
Dr. Ron Nagel
Dr. Steve Riggio
Dr. Kirk Ritchie
Dr. Sidney Temlock
Dr. Richard Troyer

2. State Dental Societies

Dr. Anita Elliott
Dr. Pete Higgins
Dr. Mary Jennings
Dr. Krista Jones
Dr. David Keim
Paul Knecht
Dr. David Moore
Dr. Roger Newman
Dr. Lana Schlecht
Dr. Brian Scott

3. Local Tribal Health Programs

Kathy Clark
Kenneth Nicholson
Sara DeCoteau
Stuart Holmes
Steven Howlett
Colleen Lampson
Jean Othole
Paul Sherry
Roxane Spruce Bly

4. American Dental Association

Dr. Donald Cadle
Dr. John Findley
Dr. Lewis Lampiris
Mary Logan
Dr. John Luther
William Prentice
Judy Sherman
Dr. Charles Smith
Dr. Keith Suchy
Dr. Ronald Tankersley

5. Indian Health Service Dental/Clinical/Preventive Support Programs and Other Local Programs

Dr. Edwin Allgair
Joyce Biberica
Dr. Richard Champany
Valerie Davidson
Travis Fisher
Dr. J. Dale Goad
Marty Jones
Suzanne Marks
Terri Riggs
Bob Smith
Dr. Alyssa York

6. Specialty and Special Interest Oral Health and General Health Care Organizations

Dr. Ruth Bol
Jean Connor
Dr. Steven Holve
Cheryl Parker
Dr. M. Dean Perkins
Dr. Howard Pollick
Dr. Nancy Reifel
Dr. Steven Reitan
Dr. Lawrence Robertson
Dr. Steven Steed
Dr. Robert Weyant

7. Regional Indian Health Boards and Philanthropic Organizations

Rob Allen
Robert Birdwell
Susan Dahl
Joe Finkbonner
Lori Grange
Diane Kaplan
Maira Leiberman
Carrie Mikkonen
Alida Montiel
Rick Neimeyer
Dolores Roybal

8. Dental Education

Dr. Jack Bresch
Dr. W. David Brunson
Dr. Richard Buchanan
Dr. Patrick Ferrillo
Dr. Bill Plummer
Dr. Paula O'Neill
Dr. Martha Somerman
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Appendix 2

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Appendix 3 Presentation Slides


“Oral Health and Health of American Indians and Alaska Natives: A Historical Perspective,”
Dr. Nancy Reifel, Assistant Researcher, UCLA School of Dentistry

	1803	Indian Health in War Department
Johnson v. McIntosh	1823	
	1824	BIA within War Department
Cherokee Nation v. Georgia	1831	
Worcester v. Georgia	1832	
	1849	Smallpox vaccinations
End of Treaty Era	1870	
Boarding Schools established	1878	
Dawes Act	1880	
Mayo clinic accepted interns	1897	
Flexner report	1910	
Flu epidemic	1919	
	1921	Snyder Act
Indian Citizenship Act	1924	
	1928	Meriam Report
New Deal	1930s	
Indian Reservation Act	1934	
Hill-Burton Act	1946	
	1955	Transfer Act
	1957	Indian Health Facilities Act
	1959	Indian Sanitation Facilities & Services
Civil Rights Act	1964	
	1968	Ca Rural Indian Health Board
	1975	Indian Self-Determination Act
	1976	Indian Health Care Improvement Act

Appendix 4 Presentation Slides

“Early Childhood Caries and Dental Disease Burden,”

L. D. “Dee” Robertson, M.D., M.P.H., Consultant in Pediatrics and Health Research



Early Childhood Caries in Indian Country

by
L. D. Robertson, MD, MPH

with
Sara DeCoteau, BS
Stuart Holmes, DDS
Steve Holve, MD
Cheryl Wilson, MS
John Zimmer, DDS


1



ECC in Indian Country Panel

1. Sara DeCoteau, BS: Health Programs Coordinator, Sisseton-Wahpeton Oyate, Sisseton, South Dakota
2. Stuart Holmes, DDS: Dental Director, Whiteriver IHS, Whiteriver, Arizona; and Chair, IHS National Oral Health Council
3. Steve Holve, MD: Director of Pediatrics, Tuba City Regional Health Care Corporation, Tuba City, Arizona; and Chief Clinician in Pediatrics for IHS
4. Cheryl Wilson, MS: Director, IHS Head Start Program
5. John Zimmer, DDS: Aberdeen Area IHS Pediatric Dental Consultant


2



Quote for the Day

- “We were astounded to learn that about 95 percent of 4-year-olds in this American Indian population have carious teeth.
- In addition to the need to implement proven prevention and restorative techniques...
- additional research is needed to help develop new modalities to prevent and remedy oral health disease among Indian children.”

3



Health Disparity for Early Childhood Caries in Indian Children

- The rate of ECC in Head Start children in many Indian communities is 80% or higher (IHS, 2001) compared to 19% for white children (NHANES III)
- In some Indian communities 25–50 percent of children require restorations for ECC in the operating room under general anesthesia. (personal communication, IHS pediatric dentists)
- This may represent the largest health disparity in the U.S. today.

4




2nd Quote for the Day

“The long-range goal is for all Sisseton-Wahpeton children beginning kindergarten in the year 2013 to be free of tooth decay.”

Tribal Council Resolution No. SWO-07-080,
July 11, 2007,
Sisseton-Wahpeton Oyate of the Lake Traverse Reservation
northeast South Dakota




5



There Are Many Ways to Get This Wrong...

- THE solution to ECC is more access to dental services
- THE solution to ECC is community water system fluoridation.
- THE solution to ECC is more sealants applied earlier.
- THE solution to ECC is fluoride varnish applied at Head Start.
- THE solution to ECC is better oral hygiene for young children by their parents.
- THE solution to ECC is better oral health education for parents on correct use of the baby bottle.
- THE solution to ECC is more breast-feeding.
- THE solution to ECC is applying an antimicrobial to the mother’s teeth when the child’s teeth first erupt.
- THE solution to ECC is applying an antimicrobial to the child’s teeth through the first three years.


6



To Get This Right We Need...

1. Better tools
- +
2. Better strategies
- +
3. A sustained, multifaceted, multi-organizational campaign


7



Back to the Basics

- Caries results from the combination of three conditions:
 - Susceptible teeth
 - A carbohydrate substrate
 - Cariogenic bacteria (Streptococcus mutans and related species)

8



United States Surgeon General
Press release

"a tooth cavity is a late manifestation of a bacterial infection."

[Oral Health in America, 2000](#)


9

Plaque Samples Were Analyzed for Northwest Tribal Head Start Children

Streptococcus mutans counts in children by c

10

Not all *S. mutans* are alike...



- Some clonal types are more virulent (more aggressively cause ECC)

11

List of FDA-approved Antimicrobials for Prevention of Caries

12

Funded Research on the Largest Health Disparity in the U.S.

- Year 2004: Using 10% Chlorhexidine Varnish to Prevent Early Childhood Caries (funding from MCHB/HRSA; PI — L. D. Robertson) A Phase III RCT in four tribal communities.
- Year 2005: Using CBPR to Improve the Oral Health of Northern Plains Indian Children (funding from NCMHD/NIH; PI — L. D. Robertson) Three tribal pilot study sites in South Dakota (including Sisseton, SD) using a multimodal intervention.

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3rd Quote for the Day

- "Everything that we have done for the last 20 years has not worked to control ECC in our community.
- Participating in this chlorhexidine varnish ECC-prevention study gives us some hope that things may be better in the future."

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In Conclusion...

- "What are we going to do, both individually and collectively, to improve the oral health of AI/AN people?"
- We need to find better strategies to implement prevention techniques.
- Additional research is needed to develop new tools and modalities to prevent and remedy oral health disease among Indian children."
- ECC is a multifaceted disease, and we need a multifaceted approach to control it.

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Appendix 5

Summit Notes

IMPORTANT NOTE: These are “raw” notes taken from the flipcharts of the various segments of the Summit. Some of these notes may be difficult to understand, because there were no explanatory or contextual statements provided. The purpose of the notes is to preserve and share the raw data with Summit participants, ADA leadership and other interested parties. Follow-up reports will be shared as next steps are developed.

Day 1

Presentation

“Oral Health and Health of American Indians and Alaska Natives: A Historical Perspective,”
Dr. Nancy Reifel, Assistant Researcher, UCLA School of Dentistry

Introductory Exercise

All participants were asked to make a list of things that define who they are and then find someone else in the room who shared one of the items on that list. Each two-some was then instructed to find another twosome who shared something in common, continuing on until groups of eight are formed. They then introduce themselves each other and share any concerns or resistance they might have coming into this meeting.

Focus on the Past: Highlights & Milestones

Participants created a shared time line that captured their experience and recollections of their personal histories; the history of Native American and Alaskan Native health issues; and the societal issues that were going on over a period of the past 150 years. The goal of the exercise is to develop an appreciation of the history, trends, and common experiences that people in the group have experienced and to gain knowledge from the past. The findings included:

Trends – 1875 and before

ADA / IHS

- Founding of ADA
- “Unethical Research”
- Supreme Court Decisions
- Maryland+Temple Dental Schools
- NYU – Harvard

Societal

- Pre-traditional cultures
- Manifest Destiny
- Westward Expansion
- Reservations

Personal

- Trail of tears
- Grandparents taught at boarding school

Trends – 1940 to 1980

ADA / IHS

- Tribal Self-Governance
- Transfer Act/IHS (1955)
- Indian Health Care Improvement Act
- Expanded Dental Auxiliaries
- Hill Burton Act
- NIH (1948)
- Funding changes in IHS

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Trends – 1940 to 1970 (continued)

Societal

- WWII
- Baby Boomers (1946)
- GI Bill
- Health Benefits
 - NHS-UK
 - Employer financed – U.S.
- Societal Revolutions
 - TV
 - Rock-n-Roll / Beatles
 - Political Assassinations
 - Man on the moon
 - Civil rights
 - Vietnam
- Medicaid/Medicare (1964)
- Building up to war(s)
 - Global impact + Domestic
 - Land acquisition & expansion, including effects on Native American Tribes
- Greater societal recognition of previously disenfranchised groups
 - Women’s right to vote
 - Native Americans citizenship
- U.S. population expansion – westward migration
- Expansion of federal govt/policy
 - Including re: American Indians
 - Negative/restrictive
 - Boarding Schools
 - Dawes Act
- Urbanization/factory expansion/technology
- Medical discoveries – beginning of medical system as we know it
 - 1st dental hygienist
 - 1st DHAT in New Zeal
 - 1st auxiliaries
- Widespread poverty (not limited to traditionally impoverished)
- Economic development in West (particularly) and impact on environment: health – mining

Personal

- Born
- Events leading to interest in undeserved
- Graduate/attend dental school
- Marriage
- Children
- Military Service
- Began Career
- Family Illness/Death
- Experienced Oral Disease

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Trends – 1971 to 1990

IHS / ADA

- School-based sealant programs
- General focus on prevention
- Boarding school tx shift to demand care
- Shift from IHS direct to tribal operated care begins
- Exponential growth of Indian population
- More IHS provider manpower LRP Vietnam
- EFDA

Societal

- HIV/AIDS
- Universal precautions
- Auxiliary support improve
- Vietnam war ends

Personal

- High school
- College
- Dental school
- Masters in public health
- Marriages/divorces
- Children born
- Job development
- Practices
- Educational
- IHS
- First careers get started
- Career moves/personal moves
- Personal tragedies
- Activity in organized dentistry

Trends – 1991 to Present

Societal

- turmoil – societal
 - 9-11
 - Iraq 1 and 2
 - Challenger
 - Berlin wall
- Growing understanding of need for oral health at National level Vs. decentralization of solutions – States
- Some ↑ ed autonomy at DHAid and CHAP
- (Alternative Models) American Indians
- New Treatment Modalities
 - Chemotherapies
 - Medical model
 - Medical mid levels expand
- Information technology
- Federal Budget cuts
- Less government better
- Dental P.H. infrastructure begins to disappear

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Day 2

Focus on the Present: Current Trends

Working in their stakeholder groups, participants worked to identify trends that they observed that were having an impact on oral health access for American Indian/Alaska Native people now, and also looked at places where they felt they were proud of their stakeholder group accomplishments, and others where they felt that they regretted things that were done, or not done.

Findings included:

We Are Proud

1. To provide the clinical care we do with limited resources
2. of the success of the expanded functions program
3. of our success in providing clinic and school based sealants
4. Native American focus (AA Ped) (ADHA)
5. Periodontitis – Diabetes link
 - Support DHA
 - Investment in dental unit to expand tech
 - Enlarging by using 3rd party
 - Adding mobile unit
 - Tribe capable to admin fed programs
 - Cohesion among off-rez leading to effective advocacy
 - DO's hanging tough
 - Built new operations in ½ out clinics ½ tribal >90
 - Dental Health Aid program therapist
 - Increased capacity
 - Dental therapist program
 - Community ownership
 - Workforce work we have done
 1. New CDHC and DPA models
 2. IHS residencies
 3. Loan repayment
 - Advocacy for every one to get safe effective oral health
 - We are in a place where we are more comfortable bringing people together like at this event
 - Students are willing to serve the underserved and are in the communities (structural and mind set)
 - Moving to holistic admissions
 - Faculty commitment
 - Changing the model – thinking outside the box
 - Tribal orgs: implement dental support centers
 - Dental sealant program
 - Tribes beginning to identify oral health as a major issue
 - Our communities strength
 1. Tribal
 2. IHS
 3. Direct
 - Passion for what we do
 - Appreciation to see changes is possible
 - Community champions
 - Tribes identify need for change in language to IHCIA legislation to address oral health
 - Problem resolution attempts

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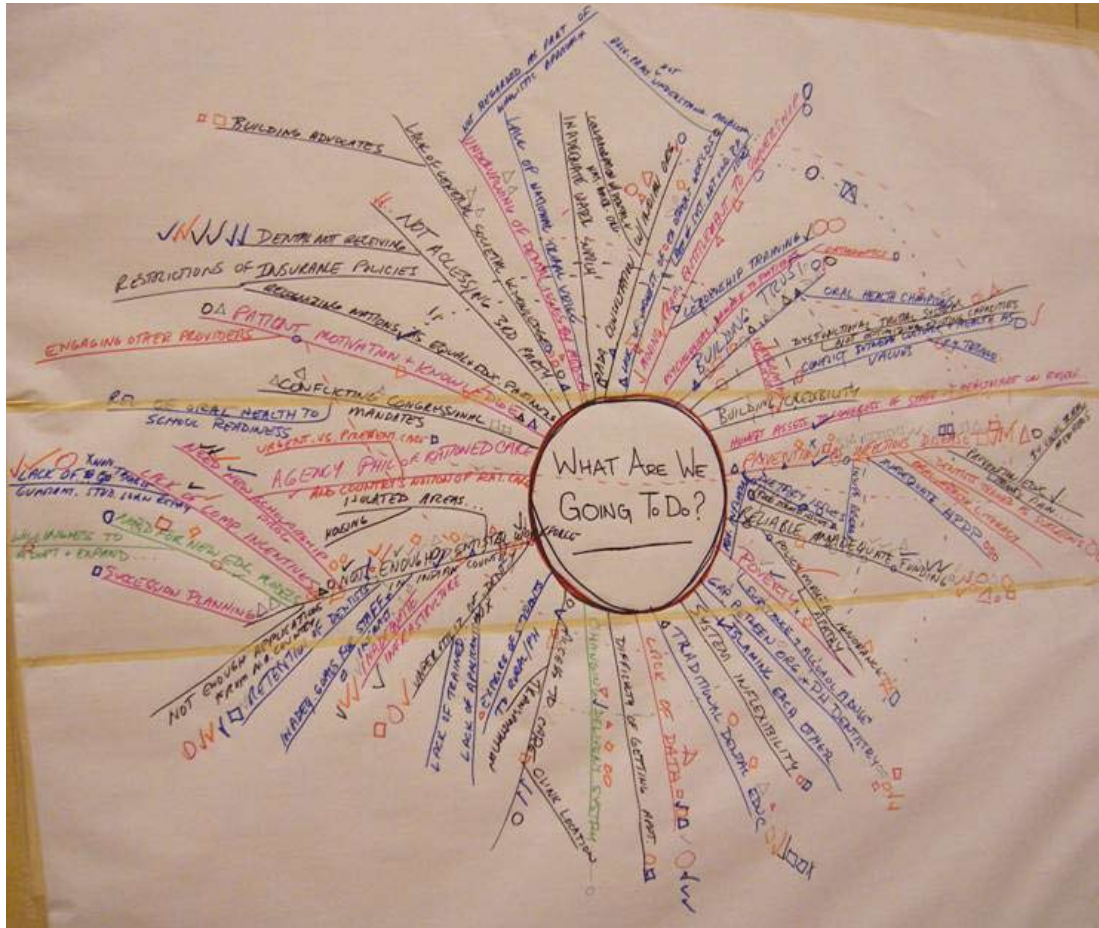
We Regret

- Not having the desired impact on the level of oral disease
- Not being able to provide higher levels of care
- Not being more successful at community based prevention programs
- Lifestyle/healthy choices
- Expansion didn't take place across all sectors
- Didn't accept challenges fully haven't recognized self-governance opportunities
- Didn't expand DA's as we did dentists
- “Fed Mask” v. doing it our way
- Off-reservation advocacy alienated tribal leaders – political fall out
- Community mobilization advocacy
- Dietary-Tribes haven't dealt aggressively with healthy choices/lifestyle issues
- Not enough health Ed.
- That we didn't try to find pragmatic solutions early enough
- That we didn't see the need for closer collaboration with all other stakeholders (Tribes, Public Health Community....)
- Education (understanding & Acceptance) of membership started too late and progressed too slowly – the political problems of an organization and difficulty of agreement with 72% of approx. 180,000 people.
- Lack of collaboration
- Huge Disconnect
- Native Americans – needs trust
- IHS – needs programs – needs \$\$\$
- State Dental Association and component – needs to involve private practice
- Policy and prevention need to advocate together
- “We're not going to drill and fill through this problem”
- Increase in educational costs
- Ethical lapses
- Not enough Researchers
- Not enough Students
- Not enough Practitioners/faculty
- Isolated from the rest of healthcare groups and removal of allied health from many dental schools
- Did not establish good relationships with IHS and Native Americans
- Apathy/ignorance from private sector to solve problem
 - Did not educate membership
- Lack of activity in political process.
- EFDA backslide
- Not yet being successful in amending IHCIA legislation to expand DHAT
- Haven't accomplished O.H.
- Didn't recog/opt for DA's to do more earlier
- Loss of School FL – rinse
- Lack of Data
- We didn't showcase the good stuff

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Identifying the Current State: Mind Mapping

The conference participants then came together in a large group and collectively created a mind map (photograph below) that captured their collective sense of the current issues that impacted the ability to provide dental care to Native American and Native Alaskan peoples. After putting all of the information on the mind map the participants went back into their stakeholder groups for one last time to identify trends in the current state.



A “mind map” created by Summit participants to illustrate ideas about ways to address oral health for Ai/AN people.

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Trends

- Funding
- Staffing
- Infrastructure

What we are doing

- Funding
 - Billing 3rd parties
 - Utilizing existing funds efficiently
- Staffing
 - Extensive recruiting activates
 - Providing loan repayment
 - Offer LTT opportunities
 - Training for expanded functions
 - Offer scholarships to AI/AN dental students
- Infrastructure
 - Modular dental units
 - Utilizing existing facilities
 - Providing oral HP/DP

What we would like to do

- Funding
 - Have dental 3rd part revenues dedicated to providing dental services
 - Receive increased appropriation
 - Provide higher levels of care
- Staffing
 - Guarantee non-taxable loan repayment
 - Offer more LTT opportunities
 - Develop future dental program leaders
 - Offer scholarships
 - Offer competitive salaries
- Infrastructure
 - Increase access (ops, clinics, etc.)
 - Expand HP/DP programs
 - Offer more housing
 - Provide adequate bio med support

How trends are related to impacting consumers:

- Need for retention focus by identifying what motivators are (e.g. modern facilities, good housing, good school systems, socio-economic conditions).
- Overpopulation on reservation as people move back from cities
- Access is limited by geographical distinctness
- Access to pediatric dentist is 4 hours away
- Dental providers do not feel as if they belong in their communities

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What Mind Map Means-trends impacting consumers

- Lack of education and information and policy issues
- Lack of understanding of tribal health environment, health professionals do not understand Tribal Government policies, priorities lack of good political administrative, cultural and social orientation to working in I-T-U systems and communications
- Are becoming more selective in hiring health professional to ensure they will be a “fit:
- Barriers to providing student exposure to Indian communities include lack of housing Need to partner with universities for externship placement opportunities
- Facilities are old, need upgrading and additional capacities – which requires more resources Inadequate space, size, and staff impacts access to care
- Importance of partnership with schools and other organizations
- Comprehensive report is needed on oral health status in Indian Country
- Where is the oral Health Advocacy group composed of Tribal Gov’t leadership (NIHB work group?)

List of things (examples) Consumer stakeholders are or want to do

- Optimizing third party revenue generation
- Long term strategic planning at Tribal level Including economics, social, workforce development
- Education and advocacy (SIPI Dental Clinic)
- Urban Indian Center pursuing non-IHS funding
- Upgrade facilities in Alaska to include dental operations in small community clinics
- Telemedicine for dental care
- Training dental therapists (mid-levels) Hire native people and train them for 2 years to be Dental Health Aides
- Trying to offer better compensation package to dentists to attract them (title 30)
- Advertising for dentists in hunting and fishing magazines in addition to professional magazines
- Find family, spouse and friends in the community for single providers
- Increased ops from 5 → 16
- Dentists 1 → 6
- Participation in Pediatric Dental carries research project
- New health care facility

Trends on Mind Map that Impact Us

- Listening to one another: we have been pretty good about listening to private practicing dentists & not so good at listening to anyone else (& at times difficult to reconcile the listening to everyone)
- We have to overcome our fear of true collaboration that starts with a blank piece of paper --- & trust that working together we will all be able to support what emerges from the collaboration
- We need to build an understanding of one another’s world.
- We need to overcome our fear of the entitlement programs moving toward tribal ownership because of our fear of losing control.
- At the same time, we need to work together to help maintain and honor the economic model that has made the dental profession (private practice) successful.

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What we are doing currently

- Learning to collaborate
- Learning to listen
- This symposium
- Development of 2 new workforce models for auxiliaries: CDHC & OPA
- Funding of ↑ pilots
- Comm. Water fluoridation advocacy
- Advocacy for SCHIP funding
- Advocacy for inclusion of oral health education for new moms in SCHIP
- Advocacy for public oral health
- Oral Health literacy initiative
- Institute for diversity in leadership
- Scholarships for college students attending SMDEP (getting more N.A. into dental schools)
- Pipeline project
- Introduced advocacy for meth mouth legislation
- Introduced advocacy for essential oral health legislation
- Advocacy for loan repayment
- Site visits to learn about public health dentist needs
- Improving ada.org oral health info.

What to do more of

- Listening
- Collaboration
- Learning more about non-traditional settings to provide care
- 09 Access Summit

ADOC

- Free clinics
- Mobile clinics
- Give Kids A Smile
- Charitable giving
- Community fluoride programs

Which trends affect us

- Workforce needs
- Change in health care delivery
- Students education/public health
- Allied healthcare education
- Research outcome assessment
- Dentists trained as surgeon
- Redo whole education model
- Not enough AI/AN students
- Advocating for loan repayment
- Lack of understanding each others world

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Workforce

- admissions practices
- scholarship recruitment
- SMDEP
- K-12 pipeline
- Addressing and changing school cultures

Change in health care delivery

- Community based experiences
- Projection of workforce needs
- Beginning community collaborations

Education models

- CCI – focus on curriculum change

Research

- Prevention models
- CA Endowment
- NIDCR
- RWJF
- Prevention models
- Funding disparities research
- MACY*S
- Kellogg

Need to:

- More with scholarships
- Admissions practices
- Curricular reform
- Outcomes research on these
 - Models of delivery
 - Models of education
- Be more receptive to change
- Better communication with stake holders collaborators
- Better prevention of students faculty, staff
- Integrate better with other professions

Additional Trends

- Advocating for additional funding for prevention treatment, research and education
- development of a broad based coalition focused on AI/AN oral health
- HPDP
- Educating dental professional on AI/AN disparities and workforce implementations
- IHS scholarships for 30 dds’s per year
- fund through congressional appropriations and then use best dental business practices
- Caries should be viewed by ALL as an infectious disease!
- workforce – define community appropriate midlevel providers with national standards – utilize community outreach liaisons
- collaborate with tribes ADA components educators researchers and the private sector

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Presentation

“Early Childhood Caries and Dental Disease Burden”

L. D. “Dee” Robertson, M.D., M.P.H., Consultant in Pediatrics and Health Research

Focus on the Future

Working for the first time in mixed stakeholder groups, the participants worked to create a vision of the a future in 2012 in which there was a dramatic breakthrough in the quality of dental healthcare for Native American and Native Alaskan peoples. The presentations included the following:

Future Presentations

- Reimbursement for the underserved is at competitive rates!
- 75% of dentists are participating!
- Programs for mid-level providers are in place (dental hyg, Dental Assis. Other healthcare providers and community)
- Through the collaborative work of organized dentistry, public health, IHS and AI/AN the public and media have been informed and educated on this highly important issue.
- Curriculum has been enhanced to address issues related to cultural competencies. Prevention of diseases and commitment to the underserved
- Increased interest of our AI/AN youth in oral healthcare careers
- Amazing trust has been established between all the stake holders (org. Dent., PH+IHS, AI/AN)
- Through the combined efforts of the IHS, Tribal Leadership, ADA, ADEA, APHA, AAP, AAPD, USPHS, NNOHA..... Indian Oral Health Disparity Eliminated!
- The disparity in ECC prevalence between the U.S. general population and AI/AN population has been eliminated
- Effort began in 2007 when congress committed an additional 50 million dollars to eliminate the disparity and NIDCR grant to develop caries vaccine
- Key elements of the program include
 - Equitable reimbursement for dental services
 - Development of different delivery models appropriate for the communities they serve
 - Infant and peri-natal oral health care programs implemented
 - Regional/dental support centers established for training personnel
 - CLP receives FDA approval and patent
 - ADA works with commercial beverage companies to develop non-cariogenic beverage
 - Fully implemented electronic med/dent records
- Ongoing assessments developed to measure effectiveness and expansion
- Dental Health Aide therapists training and practice lawsuit –and- large numbers of vaccines in IHS dental programs /50%
- 60 native applicants for dental schools
- ADA develops CDHC workforce model
- Deamonte driver dies from complication of dental infection
- IHS funding is tighter while population grows
- Indian Healthcare Improvements Act Reauthorization bill stalls for 7 years
- Initiative to ban soda pop sales in health clinics
- First woman president
- Bush administration ends
- Iraq war ends
- Resurgence of Native Culture
- Head start initiates tooth brushing

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- Democrats control congress
Summary: changing political climate is impacting healthcare in Indian Country
Less dentists
Less CHS
- Local ownership of the problem
- dental research/bacteria
- private sector recognizes different approach to AI/AN
 - Tell the story (avoid stereo type)
 - Economic model is sustainable
 - Workforce prevention strategies
- Water and Varnish – FL, (e.g. “triple cocktail”)
- community division
- jobs/ economic development
 - Dental technician? (logistics concerns)
 - Pipeline for Dental Auxiliary (Allied Dental Personnel)
 - Scholarships
 - Commitments to practice at the reservation
 - Keep all health workers on the reservation to keep the numbers local

Triple Cocktail

- Local problems – local solutions
- workforce development
- tell the story
- combining different treatments and prevention

Funding

- At least doubled funding for IHS (inflation) and sustained support in congress for reasonable yearly increases
- higher level of reinvestments of clinic funds from 3rd parties back into dental
- Robust clinical translation research dollars for NA/AI dental issues – public/private sector partnerships

Prevention

- All children entering Head Start are caries free
- New mothers would have ready access to chlorahexidine or other medical treatment with strong demonstrable results
- Significant widespread outreach that successfully targets all families through diverse range of approaches – collaborative
- Dental health is a top priority for the public and policy makers – very heightened public awareness
- Commended collaboration to funding

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Workforce

- Full complement of dental providers including but not limited to dentists in the communities themselves
- Greater use of auxiliaries (agreement on innovative workforce models in Tribal communities to meet the need
 - BUT: significant debate re: DHATE v. other significant models
- Fill existing IHS vacancies
- Realigned case load = fewer patients per provider
- Both private practitioners and public health practitioners including tribal communities, have economically viable and adequately compensated careers

Dental Facilities

- Growth in dental facilities by at least twice the population growth

Collaboration

- Strong established and far more effective and efficient collaboration between all major stakeholders = a meaningful coalition with a shared agenda based on trust
- Dental health is a top priority for public and policy makers – heightened public awareness

Historical Perceptions 2008

- President of U.S. today aimed at funding research devoted to the cure of infectious diseases of oral health in Native American children
- Legislation is the result of years of effort & collaboration between various federal agencies, the organized dentistry, National Indian Organization.
- Studies began at the University of Kentucky to treat caries as the disease it is and its genetic basis. Researchers Dr. Ritchie headed up and identified an effective treatment.
- Funding was provided by a surplus of dollars after the end of the Iraq War and joint public/private funding partnership at the “New National Dental Research Center”
- It was because of the 2007 ADA conference that we were able to accomplish all of this.

Future Vision

- Eradicate ECC
- IHS dentist vaccines filled
- Mid-level providers developed and fully utilized
- Fully funded tribal/IHS dental program
 - IHS dental budget doubles
 - 3rd party reimbursement
 - Major research initiative
 - Facilities expansion
- Institutionalized collaboration
- Major oral disease prevention initiative

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Key Points

- Tribal ownership of dental issues
 - 638
 - Education
 - Community focus on problem
- Magic bullet – vaccine
- Access/workforce
 - More clinics
 - More staff
 - More mid-levels
 - Increased services
 - Change education model
- Prevention
 - Multidisciplinary
 - One on one
 - Community champions
- Continued collaboration

Common Topics

- Improvement of dental workforce through innovation
- Eradication of dental caries through research and development
- Increased funding through federal funding and 3rd party re-imbusement
- Fill blanks on Dee’s slides (research)

Key issues

- Dental Workforce
- Lack of Data
- Prevention of Infect. Disease
- Entitlement/ownership
- Lack of trust/understanding
- Workforce models that include mid-level providers
- Educational pipeline for AI/AN for health workforce
- Local solutions coming from local ownershi
- Collaborative-trust among all constituent groups
- Scientific breakthroughs
- Increased budget-resources
- Telling the story and creating buy in and understanding in dentistry

Out of these skits, the Summit participants created seven action teams to begin to work on, including:

- Creating a new paradigm for improving the dental workforce
- Developing collaborative strategies for lobbying, funding, policy making, etc.
- Designing research and implementing “best practices” for the prevention of oral disease, including early childhood caries
- Fostering broader community involvement to identify oral health issues and their solutions
- Advocating for a fully funded IHS/Tribal/Urban (ITU) dental program
- Building trust among the partners/communities of interest
- Encouraging meaningful tribal empowerment in oral health policy making

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Day 3

Common Ground for the Future

Participants signed up for each of the seven areas identified the day before and divided into mixed stakeholder groups to discuss the issues. After working in their small group on identifying the key elements to address in each area, the groups reported back to the larger group. Findings included:

- Needs assessment / recurring cost for base care
- Renew generation strategies
 - Facilities strategy?
 - IHS base appropriation %?
 - ↑ Dedicated use of IHS 3pr – IHS Dental program
 - ↑ MCD reimbursement
 - ↑ MCR reimbursement
 - ↑ Other (casino foundation etc)
 - (NIH/CDC) research initiatives
 - ECVC Initiatives

Dental Workforce Pyramid

- “Old School”
 - DDS
 - RDH
- “New School”
 - DDS
 - RDH
 - DHAT
 - DA+EFDA
 - Community Dental Champions
- Rethinking who we need to recruit
- Finding OH Champions
 - Head start Elementary Schedule
- Desired workforce model
- Stiffing model
- Thinking outside the box
 - LRP not the answer
 - Match.com model to ID providers to staff locations
 - Desire to recruit
 - Problems w/ \$
 - Providers who are there for the “right” reason
 - Social commitment to the community
 - Integrate tad healers

Knowledge of the culture & desire to be a part of the culture & community

- Champion the “good stuff” don’t get bogged down with the bad
- Identify the payers in the community who will the community listen to?
- Funding not flexible for multi-year programs (granting cycles inflexible and changing)
- Changing societal as for occupation paradigm
- More alternatives for allied professionals (instead of becoming DA + working for IHS for 30+ years they get bachelors and master degrees)
- Finding people who are a member of the community -or- becomes a member of the community

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Workforce Development

Midlevel Providers

- Clear and accurate assessment of need and better communication of that need
- Identify and disseminate summary of models on the table
- Come to a generally accepted definition of terms
- Explore & discuss existing and new/innovative models and important issues
 - Recruiting strategies
 - Certification/licensing
 - Supervision – including use of innovative technology
 - Education and training
 - Initial
 - Continuing
 - Career enhancement
 - Assessment of fit between models and needs
 - Funding – including third party reimbursements
 - Education and training of dentists who will work with mid levels
- Models should use best practices
- Look at midlevel models in other fields, such as medicine: learn what works, avoid what doesn't
- Outcomes and assessments

AN/AIs in Dental Education

- Concerted national efforts to raise awareness of opportunities and regional & local efforts to deliver participants into those programs
 - RWS=existing funding. But more is needed
 - Mentoring
 - Pre-dental advising by & for NAs

Emphasis on public Health Dentistry

- Currently almost 50 schools have affirmative with outreach/delivery programs, 18 funded by RW. More schools need to offer these
- Exploring connection between service learning and public health
 - Is the connection actually happening? Why or why not? How can it be improved?
- Creating innovative funding models for schools and IHS. (limited ability to bill and raise revenue for students in non-school clinics and for supervisors time.
- Changing paradigm in how we teach
- Curriculum development

Recruit and retain and expand

- Filling ALL existing positions
- True evaluation of need and ability resources to expand to meet that need
- Greater incentives on both recruitment and retentions
- For example: loan repayment (non-taxable)
- Funding Scholarships
- Salaries and benefits

Workforce

- midlevel providers
- AN/AIs in dental education
- emphasis on public health dentistry
- recruit, train and expand Indian health dental providers

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Collaborating Strategies

- Actions
- Groups
- Creating collaborative strategies for lobbying, funding, policy makers, etc (for oral health)
- Develop new coalition of all stakeholders at Summit plus others

Initial proposed

- Focus: eradicate the plague of ECC
- (would want group to agree on focus)

Also for focus – lobbying that our other Summit teams have as high priorities for advocacy (e.g. research)

Others to invite

- Engage area health boards (12 IHS areas) – get them to buy in & then they will get NIHB – NCAI
- CDC/USPHS/IHS
- AAPHD
- ASTDD
- Bureau of Indian Education
- ADA
- AAPD
- AAP (Pediatrics)
- AADR
- MSDA – Medical SCHIP Dental Assn.
- National Council on Urban Indian Health
- Tribal Health Directors
- Tribal Head Start
- State Dental Assns. (rep of ASCDE)
- DTA
- National Indian Gaming Association (6I6A)_Smile link – Bad image tobacco
- Sesame Workshop
- American Association of Indian Physicians (AAIP)

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Actions

- Identifying and inviting key stakeholders – Inclusion
- Convene invitees
- Develop short and long term goals
- Agree on 5 year focus (tentative: eradicate ECC)
- Develop lobbying strategies & success measures to achieve short and long term goals
- Setup communication structure and strategies for coalition
- Develop communication structure and strategies to tell the story about ECC, need, social justice (partner with community team to accomplish)
- Build bridges with local tribes through tribal networks in each of the 12 states

Broader Community Involvement in identifying health issues and their solutions

- Multi-disciplinary health procedures in oral health education
- State/local health departments involvement as a resource
- Develop working relationships amongst all the stake holders
 - 1:1
 - Oral health coalition – could be mini-health coalition
 - Assessment, policy, development, and assurances

Strategies

- ID local tribal health champions
 - Provide direction, guidance etc.
 - To the tribe
 - To the mini health coalition
 - Education: HP/DP info, where to go who to see, etc
- Community forums
- Tribal/state/IHS working groups (the Montana Model)
- NCAI, National Indian Health Board – subcommittee on oral health

Trust Building Partners

- Identify Partners – stakeholders (non-inclusive)
 - NASW
 - Head Start
 - W/C
 - ADA
 - ADHA
 - Dental Schools/ training programs
 - SAID
 - State Dental Soc.
 - NIHB
 - RIHB
 - IHS
 - Tribally operated programs
 - APHA
 - Specialty

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Trust Building Partners (continued)

- Identify Partners – stakeholders (inclusive)
 - Medical
 - Tribal Outreach
 - Other H.C. workers
- Blank slate (no preconceived outcomes)
- Open to new ideas
- Collaborative decision making (consensus)
- Replicate other successful relationships
- Multi-level relationships (local, state, regional, national)
- Interagency relationships (e.g. involve AI/AN people on committees involve o.h. professionals on tribal o.h. programs)
- Common/shared purpose
- “Transparency” (honesty)
- Study of etiology of ECC+ disparities for Indian children
- Partnerships with universities and other to write the grants + lead the research
 - Advocacy from shareholders to make AI/AN oral research disparities a priority
- Partnerships (potential): oral health disparities center funded by NCDR
 - Explore possibility of a designated center focusing on AI/AN oral Health disparities center
 - Everyone could write a letter to support it.
- Gain media attention to increase awareness about this disparity and its causes
- Promote implementation of best practices immediately rather than awaiting results of studies
 - Utilize chronic care model
 - Utilize community based participatory research model
- Investigate co-occurring aspects of oral health and diabetes
- Other areas of research: periodontal disease, implementation of protocols utilized elsewhere in I/T/U dental clinics. Third party reimbursement strategies, making dental care standard for diabetes management and making it a 3rd party requirement
- Review the existing research, data and information that reinforces concepts that oral health is essential to overall health
 - 3rd party administrators need to be convinced this is true
- Constituents need to include the Tribal Councils health boards and Tribal Members
- Additional resources need to be provided to I/T/u to apply best practices and keep the data to determine which sets of interventions work. This work needs to be done in a collaborative manner between agencies with the funds, I/T/U administrators and providers and the Tribal Communities. Mobilize public private and third party reimbursements partners
- The more I/T/U sites that participate will generate more data
- Representation of current data needs to be presented to the policy makers within DHSS as well as to legislators
- The 1999 Oral Health Survey needs to be re-done. Current baseline data is essential
 - Survey instrument needs to be revised to address causes in addition to end result such as plaque samples from head start students, new mothers, etc.
- Need to establish ongoing monitoring systems

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- Need to establish ongoing monitoring process for infectious causes/symptoms over time
 - New mothers
 - Infants
 - Head start
 - Throughout life span
- Form a task force on ECC with IHS taking the lead but also involving ADA, CDC, tribal governments and other constituents
 - Let’s do something but quit ignoring

Trust

- Share information (education and understanding of role and expertise)
- Mutual respect
- Open, direct, timely communication
- “Agree to disagree” (focus on common ground)
- Shared benefits and liabilities (accountability)
- Inter and intra organizational communication, education and relationship building
- Accepted process for interacting/making decisions
- Equity/parity (equal stake)
- Clear expectations

Meaningful Tribal Empowerment in the policy making process:

- Realizing the federal obligation to provide oral health care to AI/AN peoples in a manner that encourages and assists tribes in asserting as much control as they choose in ensuring that this obligation is both met and afford the same level of care enjoyed by the majority of Americans
- Create ways for Tribal organizations to collaborate with the ADA and State Dental Societies on Tribal Oral Health needs when they advocate in Washington/state capitols
- Create ways for the dental profession to collaborate with tribal organizations in oral health policy and workforce needs.
- Provide opportunities for tribes to collaborate on policy development
- Develop ways to educate AI/AN dentists and dental team members on ways to bridge the communication gap between the dental profession and tribal leaders

Next Steps

The conference participants discussed next steps to continue the work of the conference. Virtually 100% of the participants agreed that they would be willing to continue to participate in working groups to continue to develop the seven keys areas identified in the conference:

1. Prevention
2. Entitlement to ownership
3. Dental workforce
4. Research
5. Collaboration/Education
6. Advocacy
7. Funding

Because many people did not get their first choice of work groups in the conference itself it was understood that some might want to shift to different groups for their continuing work. The American Dental Association representatives agreed to support the group in continuing to be in communication with each other as these groups developed.



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