

HEALTH SERVICES COMMITTEE

Senator Judy Lee, Chairperson

Wednesday, October 30, 2013

Roughrider Room, State Capitol

Bismarck, North Dakota

Submitted by: Scott J. Davis, Executive Director, ND Indian Affairs Commission

Greetings, on behalf of the North Dakota Indian Affairs Commission (NDIAC), I want to thank you for allowing me time today in providing a written and oral testimony regarding dental services to our ND Tribal Reservations.

For decades, dental services, dentists and surgeons on our ND reservations have been minimal. My mother who has 25 + years as a dental assistant has seen these dentists come and go all within a year, maybe two years. I've watched this process very closely as a teenager and now into my adulthood. It is a revolving door that still exists today within our Indian Health Services (IHS) units in ND. So I've always asked myself why does this revolving door still exist, and how can remedy services to our Native American populations here in ND? Why don't dentist stay? Is there a way to create a patient-dentist relationship?

For the last three years, my office, the ND Department of Health, Dentaquest and the ND American Dental Association (NDADA) has partnered in creating a plan that addresses dental services to our ND reservations. In September, 2011, we worked very hard in created a Dental Blitz on the Spirit Lake Nation. Dr. Brent Holman will elaborate more on that event. Then on September 2012, we held our first Dakota Oral Care Workshop right here at the Capitol. The goals of our 6 hour workshop was to bring tribal community members together to meet, discuss and create pathways to improving oral health on our tribal reservations. 60 people attended the workshop, which was a great turnout. Attendee's included: tribal community members, speakers, facilitators, support personnel. Representatives from the 5 ND tribes were in attendance. From this workshop a final report was created, (see attachment). And lastly, just last month we held another Dental Blitz on the Standing Rock Sioux Nations. Again, Dr. Holman can elaborate more on that event.

On-going efforts from my office, has been in addressing a barrier(s) for our NDADA, in the area of federal credentialing. For any dentist wanting to work on a reservation within the IHS systems, they need to have federal credentials to do so. The barrier to this process is the length of time, length of the application, the year after year re-application, and having to apply for separate credentials for each of ND reservations. My ask to the fed is simply, how can we create a centralized credentialing system or is there a possible waiver a "state" or in this case, the NDADA apply for? I am still awaiting those answers.

Our continued goal within our partnerships is to recruit and retain NDADA dentists to the ND reservations. We hope that one day, our ND Native American populations will have a long term patient to dentist relationship with local NDADA dentists.

My theory is that our NDADA dentists have long term residency here in ND, and many, if not all, have their practices locally. So let's concentrate on those services, verses relying on the federal processes that do not, and will not, have consistent oral health care to our ND reservations.

We are in a very unique position today in ND. Let's continue to work together, partner and exercise the government to government working relationships in the betterment or oral health care services.

This concludes my testimony, I'd be happy to answer any questions at this time.

Thank you.

DAKOTA ORAL CARE WORKSHOP

Final Report

A final review of the 2012 Dakota Oral Care Workshop
sponsored by the North Dakota Dental Association,
the North Dakota Indian Affairs Commission,
the North Dakota Department of Health and Dentaquest

October 10, 2012

EXECUTIVE SUMMARY

The Dakota Oral Care (DOC) Workshop was held on Tuesday, September 4, 2012. The DOC Workshop was jointly sponsored by the North Dakota Department of Health, DentaQuest Foundation, North Dakota Dental Association, and the North Dakota Indian Affairs Commission. KAT Communications coordinated the workshop.

The goal of the six-hour workshop was to bring tribal members together to meet, discuss, and create pathways to improving oral health in tribal communities. Sixty people including tribal members, speakers, facilitators, and support personnel attended the workshop. Workshop participants included representation from all of North Dakota's Tribes: Standing Rock Sioux Nation, Mandan, Hidatsa and Arikara Nation (Three Affiliated Tribes), Spirit Lake Nation, Turtle Mountain Band of Chippewa Indians and the Trenton Indian Service Area.

Scott Davis, Executive Director of the North Dakota Indian Affairs Commission, opened the workshop. Mr. Davis thanked participants for their attendance and contribution and introduced the day's activities which included three keynote presentations, a breakout session, and an hour long wrap-up session. Keynote presenters included:

- Peggy Peters and Teri Renville, Sisseton-Wahpeton Oyate of the Lake Traverse Band. Presentation topic: "Cavity Free in 2-0-1-3."
- Dr. Terry Dwelle, State Health Officer, North Dakota Department of Health. Presentation topic: "Community Engagement and Oral Health Behaviors."
- Dr. Roger Davies, Chief Dental Officer, Standing Rock Indian Health Service Unit. Presentation topic: "Oral Health Status in the Aberdeen Area."

Following the presentations, a breakout session was conducted with attendees gathering into workgroups based on tribal affiliation. Each breakout session was led by a facilitator and attended by a subject matter expert and note taker. The subject matter expert was in attendance to provide assistance with technical questions.

Group facilitators included:

- Dr. Cheryl Kary, member of Standing Rock Sioux Nation
- Fred Baker, member of the Three Affiliated Tribes
- Helen Hanley, member of the Standing Rock Sioux Nation
- Karla Davis, member of the Turtle Mountain Band of Chippewa Indians

Subject matter experts were:

- Kimberly Yinneman, ND Department of Health
- Robyn Stearns, ND Department of Health
- Hollie Harrington, Public Health Hygienist
- Dr. Joanne Luger, Bridging the Dental Gap

Session planners identified three discussion topics for the breakout session:

- Oral health education
- Oral health awareness
- Oral health preventive services

Each facilitator used a series of questions designed to promote open discussion. The objective was to stimulate discussion and obtain participant perspectives, ideas, and comments regarding the status and improvement of oral health through oral health awareness, education and preventive services within tribal communities.

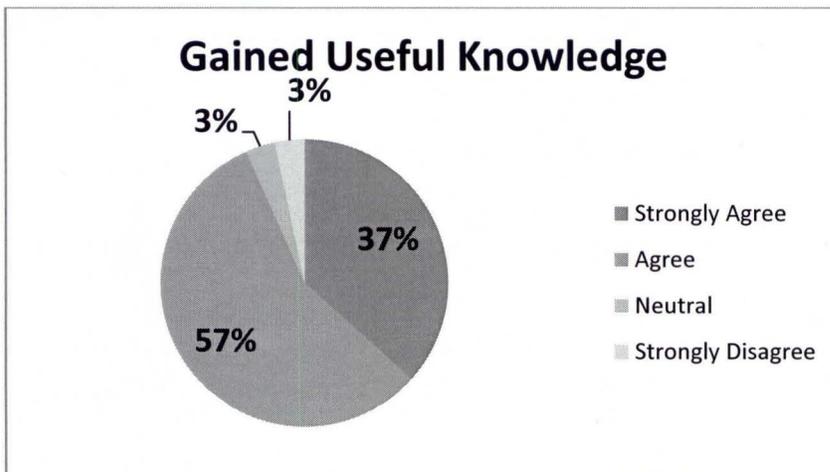
The final workshop session brought the four breakout session groups together to review and discuss group findings. The respective group facilitators presented an overview of the discussions within their group. There was extensive feedback and the overall atmosphere seemed to be one of openness and a willingness to communicate.

A review of participant's responses indicates a consensus of:

- general lack of or poor education regarding oral health care;
- general lack of awareness regarding oral health care;
- fear of dentists based on previous experiences;
- shortage of oral health care providers in tribal communities; and
- a need for improved communication and collaboration.

To determine session effectiveness and for future planning purposes, a workshop evaluation was distributed to gain attendees' perspectives. An initial review of the survey results indicate high marks for facilitators, session planning, content and speakers.

A summation of the overall effectiveness of the workshop can be found in the result to the survey statement, "I feel I have gained helpful information/knowledge about oral health care from this workshop," that generated the following results:



This would seem to indicate a highly positive outcome to this effort to further the improvement of oral health care in Indian Country.

TABLE OF CONTENTS

Introduction and Purpose	1
Presentation Summary	2
Breakout Session Overview and Analysis	4
Analysis	9
Evaluation Summary	11
Acknowledgment	14
Appendix	
A-1 List of Attendees	
A-2 List of Planning Committee Members	
A-3 DOC Workshop Agenda	
A-4 Facilitators Guide	
A-5 Speaker's Presentations	

INTRODUCTION AND PURPOSE

The Dakota Oral Care (DOC) Workshop was held on Tuesday, September 4, 2012 at the North Dakota Capitol in the Brynhild Haugland Committee Room. The DOC Workshop was jointly sponsored by:

- North Dakota Department of Health
- DentaQuest Foundation
- North Dakota Dental Association
- North Dakota Indian Affairs Commission

KAT Communications coordinated the workshop.

The goal of the six-hour workshop was to bring tribal community members together to meet, discuss, and create pathways to improving oral health in tribal communities. Sixty (60) people attended the workshop which exceeded the planning group's expectations.

Attendees included:

- tribal community members,
- speakers,
- facilitators, and
- support personnel.

Representatives from all of North Dakota's tribal communities attended:

- Mandan, Hidatsa, Arikara Nation (Three Affiliated Tribes)
- Spirit Lake Nation
- Turtle Mountain Band of Chippewa Indian
- Standing Rock Sioux Nation
- Trenton Indian Services Area

The 2012 Dakota Oral Care Final Report provides information and resources shared during the one-day workshop. Most importantly, the report includes an analysis of information shared about oral health in North Dakota's tribal communities.

Comments, questions, or requests for additional information or alternate formats, may be directed to:

Candace Muggerud
Managing Partner
KAT Communications
1025 North Third Street
Phone: 701.224.9208
Toll-Free: 888.571.5967
candace@katcommunications.com

PRESENTATION SUMMARY

The 2012 DOC Workshop was opened by Mr. Scott Davis, Executive Director, North Dakota Indian Affairs Commission. Mr. Davis greeted the attendees and provided opening remarks regarding the need for focused resources for the oral health of American Indians within tribal communities.

Three keynote presentations followed. They were:

Topic: "Cavity Free in 2-0-1-3"

Presenters: Peggy Peters and Teri Renville
Sisseton-Wahpeton Oyate of the Lake Traverse Band

Ms. Peters and Ms. Renville provided an overview of the Sisseton-Wahpeton Oyate of the Lake Traverse Reservation "Cavity Free in 2-0-1-3" initiative. The funding for the initiative was made possible following the success of the "Healthy Smiles" project (conducted 2006-2008). The three-pronged approach to Cavity Free in 2-0-1-3 focuses on diet and dental hygiene, strengthening tooth enamel, and oral bacteria.

The presenters shared how the success of "Cavity Free in 2-0-1-3" is directly related to the involvement of community members and to the increased involvement of Tribal Council members. Community members have come to accept and depend on the presence of the program.

Topic: "Community Engagement and Oral Health Behaviors"

Presenter: Dr. Terry Dwelle
North Dakota State Health Officer

Dr. Dwelle presented on the philosophy and process of "community engagement and oral health behaviors". He stressed that presenting a problem to a community and pressing them to accept it as their own is not true community engagement. Rather, involving a community in recognizing the problems in their own community, owning them, and then working together to solve them is true community engagement.

Topic: "Oral Health Status in the Aberdeen Area"

Presenter: Dr. Roger Davies *
Chief Dental Officer, Standing Rock Indian Health Service Unit

Dr. Roger Davies spoke on the "Oral Health Status in the Aberdeen Area." In his presentation, Dr. Davies offered general oral health facts and statistics of the American Indian population, overall health problems, and current presence of dental professionals and/or services in the Aberdeen service area. Dr. Davies also made note of current government efforts to monitor the efficacy of those services,

as well as some of the statistics after certain programs were initiated. He concluded his presentation observing that, while there were several efforts garnering positive results, there were still others where improvement was needed particularly in delivery of service. He noted that, by working together, initiatives would go a long way in achieving success.

Comments received on the post-workshop evaluation regarding the keynote addresses indicated appreciation for the presenters' efforts and an overall positive rating. The speakers were identified as being well-prepared and well-informed on their topics.

*Dr. Jan Colton, Aberdeen Area Dental Consultant, Indian Health Service, had originally been scheduled to present, but was unable to attend due to illness.

BREAKOUT SESSION OVERVIEW AND ANALYSIS

A breakout session was conducted with attendees gathering into four workgroups based on tribal affiliation. Each breakout session was led by a facilitator and attended by a subject matter expert and note taker. The subject matter expert was in attendance to assist with technical questions.

Group Facilitators included:

- Dr. Cheryl Kary, member of Standing Rock Sioux Nation
- Fred Baker, member of the Mandan, Hidatsa, Arikara Nation
- Helen Hanley, member of the Standing Rock Sioux Nation
- Karla Davis, member of the Turtle Mountain Band of Chippewa Indians

Subject matter experts were:

- Kimberly Yinneman, ND Department of Health
- Robyn Stearns, ND Department of Health
- Hollie Harrington, Public Health Hygienist
- Dr. Joanne Luger, Bridging the Dental Gap

Hard copy notes and session recordings were compiled for each group. (Text versions of notes are included within the Appendices.)

Session planners identified three discussion topic areas for the breakout session:

- Oral health education
- Oral health awareness
- Oral health preventive services

The Facilitator Guide (See Appendix 4) developed for the workshop contained a series of questions designed to promote open discussion. The objective was to stimulate discussion and obtain perspectives, ideas, and comments regarding the status and improvement of oral health outcomes through oral health awareness, education and preventive services within tribal communities.

A general synopsis of responses are as follows:

TOPIC: COMMUNITY PERCEPTIONS OF THE CURRENT ORAL HEALTH CARE SERVICES

Each group provided a description of the importance of oral health in their community. One group believed 50% of the community members think oral health is important, whereas one group described their community only at a '2' (out of a '10' being the best). Some attendees shared that children and elderly have poor oral health and teenagers have better oral health in their community. In addition, participants stated:

- A need to create a new image about oral health care for people with negative experiences
- A need to improve the perception of oral health care services
- Misinformation about available direct services
- A need to change the perception people have about IHS
- IHS policy on pulling teeth versus saving them
- One group suggested a marketing strategy be developed to help change the perception about the health care delivery system

TOPIC: SPECIAL NUANCES AS IT RELATED TO ORAL HEALTH BARRIERS OR STRENGTHS

There was consensus about the lack of access to care and too few providers to meet the needs. In addition attendees shared:

- How cancellations impact the appointment structure and scheduling appointments is restrictive
- Lack of IHS funds for services and procedures (e.g. dentures and plates)
- Boundaries – state lines impact care when program parameters do not reflect the exterior boundaries of the reservation
- Distance to services
- People access care only when an emergency, but the lack of services is the cause of emergency care, so systemically always working in a crisis mode
- IHS policies that restrict where doctors can provide services
- People are using emergency services to get basic care
- People don't know their dentist
- Some provide emergency services on Saturdays

Other barriers to oral health that are individually driven yet appear to be in response to the delivery system include:

- Length of time to get in for an appointment
- Patients forgetting appointment times because the appointments were scheduled so far from the actual events and no reminders are sent
- Because of past traumatic events, there is a fear of going to the dentist
- Too much waiting, including for emergency care
- Patients have given up on care because they are unable to access services
- Because of the lack of access, this has caused people to believe oral care is unimportant
- Lack of trust or a relationship with the dentist

Several ideas surfaced that dealt with increasing or improving the number of oral health professionals. These included:

- Develop recruitment strategies
- Improve the 'credentialing' process
- Insist on professional working relationships (acceptance of outsiders or American Indians from other tribes)
- Improve the level of local support and hospitality for recruits

- Help getting dentists accepted by the community
- Invite dental professionals to weekly tribal radio programs

TOPIC: HOW COMMUNITY MEMBERS ACCESS INFORMATION AND COMMUNICATION

Some programs currently provide oral health education and awareness (e.g. Head Start, WIC, public health nursing) and tribal communities have different oral health resources (e.g. Dental bus, CHR's do fluoride varnish treatment, screenings at the schools, and oral health educators).

Attendees stated health fairs were a good way to get information to people as well as leaving information at the post office and schools, posting to Facebook™, and tribal newspapers.

TOPIC: CURRENT NETWORKS AND/OR ALLIANCES TO IMPROVE ORAL HEALTH AWARENESS, EDUCATION AND PREVENTIVE SERVICES

Although there are individual agencies that provide education and preventive services, there does not appear to be any inter-agency concerted efforts to improve oral health outcomes. The one exception to this is one tribal community that has a newly established oral health board. Comments and suggestions included:

- Need leadership to make oral health a priority and believe leadership can have a positive impact on how oral health services are delivered
- Consider utilizing more formal structures such as MOU's for service delivery
- Develop collaboration between agencies that serve similar populations
- Need to improve inter-agency communication, especially with staff turnover (Health Promotion Disease Prevention meetings)
- Establishing an oral health board
- Provide information and education to individuals who struggle with accepting outsiders or who have a hard time coping with change
- Remember there is strength in working together

When discussing the oral health infrastructure, participants also questioned:

- Does everyone know the oral health care being provided
- Who is not receiving oral health treatment in the community
- Who has insurance coverage

Participants had these suggested strategies to improve oral health outcomes:

- Need tribally-based oral health bus
- Need strategies to address chronic problems
- Need to improve transportation for oral health patients
- Need to do more outreach
- Develop methods to meet the needs of the people. For example; provide information and general check-ups at the district level and if needed, refer to dentist

- Special strategies to help those in poverty
- Get creative
- Oral health advocates
- Initiate special screenings to ensure people are at a minimum level
- Provide parents with a report card about their child's teeth
- Improve communication with parents
- Growing our own dentists and oral health care professionals
- Recognition of short and long term solutions

Participants also talked about the community engagement model and the importance of fostering personal responsibility. Also:

- Special projects to generate more parental action and involvement
- How to reach those that need education and awareness
- How to reach people living in poverty that fail to get services
- Special education for parents with babies

TOPIC: THE NEED FOR ORAL HEALTH EDUCATION, AWARENESS, AND PREVENTIVE CARE AND THE ROLE OF PUBLIC AWARENESS AND THE PERCEIVED BENEFIT

Participants expressed a need for oral health awareness, not only for patients, but for other health care providers and had several suggestions on how to increase oral health education and awareness in the communities.

- Everyone needs to learn about all other service providers, including eligibility
- Take advantage of educating captured audiences – WIC, TANF, General Assistance
- Utilize entities such as the commodity program, the diabetes project, CHR's and K-12
- Young parents need special information
- Education about fluoridation
- Utilize health educators to do more health education and promotion
- Develop more education programs that are culturally appropriate and positive, like "Arnold Goes to the Dentist" video
- All education programs should focus on the positive
- Education on oral health needs of the elderly and the unique needs of the elderly
- Educate on the impact of meth, tobacco, and prescription drugs
- Education on how oral health impacts your overall health

Attendees described the types of preventive services:

- Need fluoridation for those who rely on well water
- Fluoridation for those who don't drink tap water
- Acknowledgement to change oral health we need to focus on prevention
- IHS provides sealants to school age children in some communities
- There are few preventive services

Some attendees shared their ideal:

- Everyone would have a complete set of teeth
- Proper access
- Can easily make an appointment
- Can receive preventive care
- Provide oral health education to all age groups
- Treat the whole person
- Patients would be willing to question their dentist
- Getting a dentist you love
- Patients fighting for their teeth, even seeking a second opinion

Finally, as one group stated, "It's never too late to start positive oral health practices."

ANALYSIS

An analysis of attendee responses indicates common perspectives and experiences. Responses and feedback indicate the following:

- General lack of or poor education on and awareness of oral health care.

The responses indicate differing levels of oral health education based on the tribal community. Some communities have taken a more proactive approach to how education and awareness programs are integrated into the community, but there appears to be a disparity from one community to the next.

In general, participants felt that a variety of strategies must be used to increase the understanding of community members on this issue. Some suggested delivery methods include:

- School workshops
- Newspapers/newsletters
- Social media
- Health fairs
- Educational materials (brochure, posters, etc.)
- Oral health screenings

- Fear of dentists based on the services previously rendered.

There is a pattern related to how oral health issues were handled in the past. Historically, extraction appears to be the primary solution to oral health issues as opposed to preventive services or restoration. Because of this, a fear or distrust of dentists spans generations. Participant's perspectives would support the belief that the primary means to overcome this barrier is for consistent services to be put in place which allow for the development of trusting relationships.

- Shortage of oral health care providers in tribal communities.

While some tribal communities have a greater amount of availability to oral health care professionals, the lack of consistent and present professionals impacts the overall oral health care climate. As with any health provider, the development for a personal, trusting relationship serves as the foundation for success. The lack of these relationships minimizes the importance placed on oral health care by that tribal members have.

- Need for improved communication and collaboration.

Understanding and acting on the perceived barriers will be critical to building successful oral health education, awareness and preventive service strategies. These identified barriers include:

- Poverty
- Addiction
- Disease
- Access/Transportation
- Insurance

Based on attendees' comments, any effort to improve communication and collaboration will need to address these issues at a community and state level. Attendees indicated that would be necessary to build an infrastructure of support and should include:

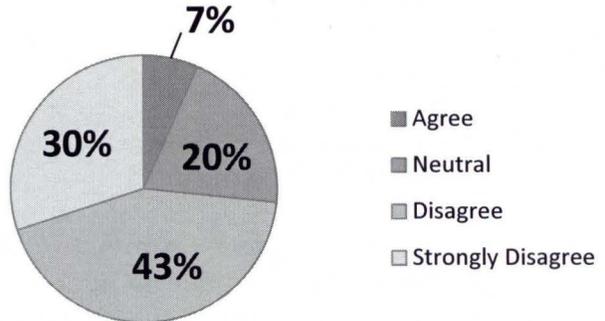
- Tribal leadership and elders
- Community members
- Tribal governmental programs/partners
- Providers
- Schools

EVALUATION SUMMARY

Question 1: I had little to no knowledge of oral health care before this workshop.

Nearly three out of four DOC participants had knowledge about oral health before attending the workshop.

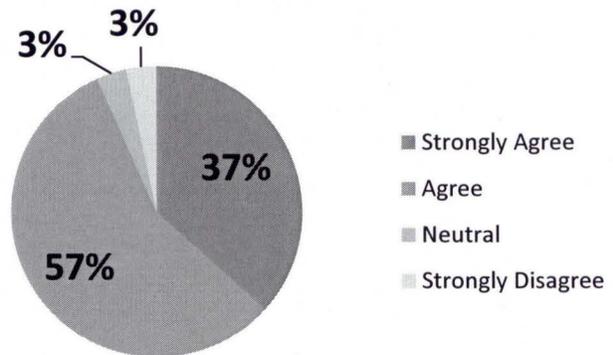
No Prior Oral Health Knowledge



Question 2: I feel I have gained helpful information/knowledge about oral health care from this workshop.

94% agreed they gained helpful knowledge.

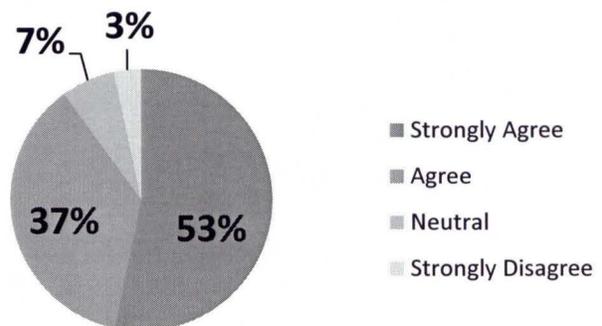
Gained Helpful Information



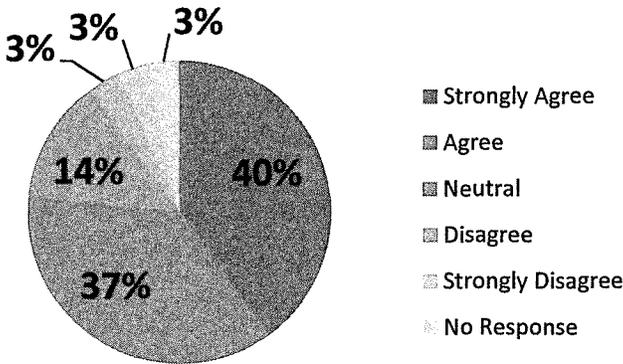
Question 3: The speakers were well-prepared and well-informed on their topics.

90% agreed the speakers were well-prepared and well-informed.

Speakers Well-Prepared and Well-Informed



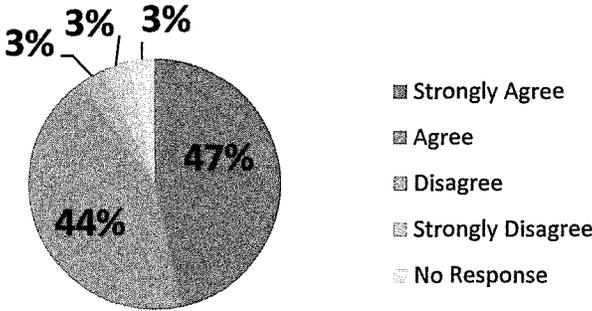
Facilitators Well-Prepared



Question 4: The facilitators were well-prepared and handled their sessions well.

77% agreed the facilitators were well-prepared and well-informed.

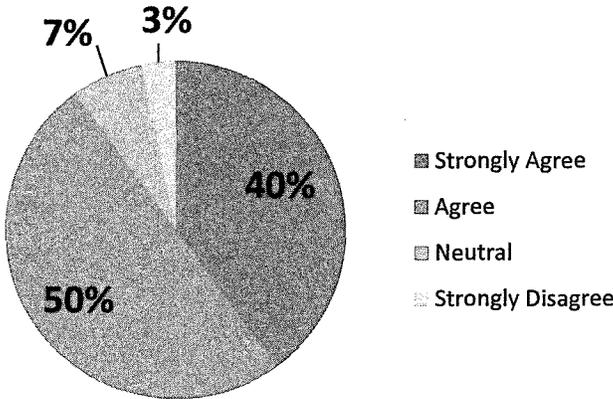
Easy to Share Ideas in Breakouts



Question 5: It was easy to share ideas/information in the breakout sessions.

91% agreed it was easy to share ideas/information in the breakout sessions.

Organization

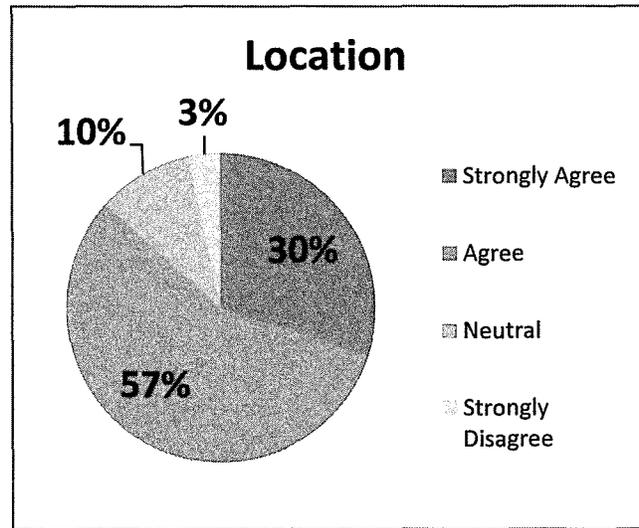


Question 6: The workshop was well-organized and everything that was needed was supplied.

90% agreed the workshop was well-organized and supplied what was needed.

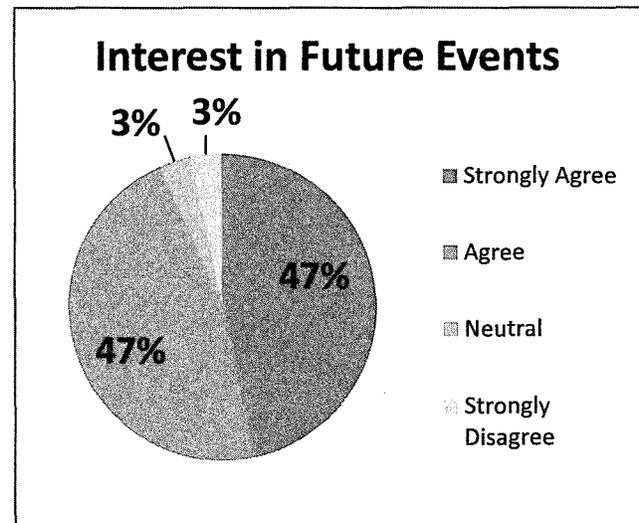
Question 7: I liked the location of the workshop.

87% liked the location of the workshop.



Question 8: I would be interested in attending future oral health care events.

94% would be interested in attending future oral health events.



The overall consensus of the participants in the post workshop evaluation was very positive. The above evaluation results reflect the general opinion that the workshop was satisfactory to above satisfactory.

ACKNOWLEDGMENT

The North Dakota Dental Association, the North Dakota Indian Affairs Commission, the North Dakota Department of Health and the DentaQuest Foundation extend their appreciation to the DOC Workshop attendees, presenters, facilitators and support personnel. Their willingness to be involved and to share their unique perspective and experience was highly beneficial to the overall success of the workshop.

Appendix 1: List of Attendees

Dakota Oral Care Workshop – List of Attendees

First Name	Last Name	City	State	Occupation
Kathy	Keiser	Bismarck	ND	Executive Director, Ronald McDonald Care Mobile, RMHC Bismarck
Stephanie	Jay	St. John	ND	Health Educator for TMBCI
TWYLA	ZAHN	FORT YATES	ND	FIELD HEALTH NURSE
Michaela	Poitra	Belcourt	ND	Dental Assistant
Sydney	Claymore	Fort Yates	ND	Child Development Specialist
Margaret	Gates	Fort Yates	ND	Tribal Health Director
Roger R	Davies	Fort Yates	ND	Dentist
Amber	Kirk	New Town	ND	CHR
Jessica	Spotted Horse	New Town	ND	CHR
Joanne	Luger	Bismarck	ND	Dentist
Maudella	Whitebead	McLaughlin	SD	Dental Hygienist
Jodi	Simpson	Parshall	ND	CHR Director
Debra	Hall-Thompson	New Town	ND	Tribal Health Administrator
Margie	Iverson	New Town	ND	Tribal Health Executive Assistant
Jesse	McLaughlin	Fort Yates	ND	Tribal Health Liaison
Carrie	Stanley	Bismarck	ND	Admin. Asst.-Office for the Elimination of Health Disparities
Dawn	Berg	New Town	ND	CEO
Antonette	Halsey	Fort Totten	ND	Community Member
Terrance	Halsey	Fort Totten	ND	Community Member
Kathryn	Eagle	New Town	ND	Quality Assurance Director
Waheedee	Smith	New Town	ND	CHR
Rebecca	Jensen	New Town	ND	CHR
Cheryl	Donoven	Trenton	ND	CEO Tribal Health
Tracy	Charboneau	Fort Totten	ND	Registered Nurse
Jennifer	Canapi	Fort Totten	ND	Registered Dietician
Joel	Cavanaugh	Fort Totten	ND	Health Fitness Specialist
Kim	Rhoades	Fort Yates	ND	WIC Specialist
Brenda	Finn	Fort Yates (Bismarck)	ND	WIC Director
Donna	Lunday	Belcourt	ND	Tribal Health Educator
Lois	Two Bears	Fort Yates	ND	Health Educator
Greg	Reed	Bismarck	ND	NDDOH Epidemiologist
Carol	White Eagle	Cannon Ball	ND	Office Manager
Darcy	Medicine Stone	Halliday	ND	CHR
Marie	Claymore-Baker	Bismarck	ND	Retired

Appendix 2: List of Workshop Planners

DOC Workshop Planners/Workers

1. Candace Muggerud – KAT Communications
2. Theresa Grant – KAT Communications
3. Stu Clark – KAT Communications
4. Sonya White Mountain – KAT Communications
5. Ashley Atkinson – KAT Communications
6. Harley Engelman – KAT Communications
7. Jolene Severson – KAT Communications
8. Joe Cichy – North Dakota Dental Association
9. Kimberlie Yineman – North Dakota Department of Health
10. Mary Bandle – North Dakota Dental Association
11. Bobbie Will – North Dakota Department of Health
12. Scott Davis – North Dakota Commission on Indian Affairs
13. Phyllis Howard – North Dakota Department of Health
14. Karla Davis - Bismarck Public Schools
15. Helen Hanley – North Dakota Commission on Indian Affairs
16. Terry Dwelle – North Dakota Department of Health
17. Sara DeCoteau - *Sisseton-Wahpeton Oyate Cavity-Free in 2-0-1-3*
18. Peggy Peters - *Sisseton-Wahpeton Oyate Cavity-Free in 2-0-1-3*
19. Roger Davies - Standing Rock Service Unit
20. Terri Renville - *Sisseton-Wahpeton Oyate Cavity-Free in 2-0-1-3*
21. Jan Colton - Aberdeen Area Dental Consultant
22. Robyn Stearns - North Dakota Department of Health
23. Erik Cutler - KAT Communications
24. Brandon Yoder – KAT Communications

Appendix 3: DOC Workshop Agenda

DAKOTA ORAL CARE WORKSHOP

Making oral health a priority for Native People

Brynhild Haugland Room
September 4, 2012
10 AM- 4 PM CDT

AGENDA

10:00 **Welcome & Prayer**

Scott Davis, Executive Director
ND Indian Affairs Commission

Invitation for comment from Tribal Leaders

Workshop Keynotes

Peggy Peters and Teri Renville

'Cavity-Free in 2-0-1-3'

Sisseton-Wahpeton Oyate of the Lake Traverse Reservation

11:00 Dr. Terry Dwelle, MD
State Health Officer, ND Department of Health

11:30 **Lunch** (provided by KAT Communications) –
Brynhild Haugland Conference Room

12:30 **Breakout Work Sessions** - Your time to be heard

- Fort Totten Room
- Fort Union Room
- Peace Garden Room

Break

2:15 **Bringing the Pieces Together**

- Brynhild Haugland Room

3:00 Dr. Roger R. Davies, DDS
Chief Dental Officer, Standing Rock Service Unit

4:00 **Adjourn**

Thank you

Appendix 4: Facilitator's Guide

DAKOTA ORAL CARE WORKSHOP

Facilitator Guide

September 4, 2012

Brynhild Haugland Conference Room

State Capitol Building

DAKOTA ORAL CARE WORKSHOP
Brynhild Haugland Conference Room
State Capitol Building
September 4, 2012
10 AM - 4 PM

DOC Purpose:

A person's oral health affects their overall health. It takes an entire tribal community to bring oral health to the forefront.

The goal of the Dakota Oral Care (DOC) Workshop is to bring tribal community members together to meet, discuss, and create pathways to improve oral health.

Facilitator Guide Purpose:

The purpose of the guide is to give facilitators a framework and context about the event. If you have any questions or concerns contact Theresa Grant @ 701.224.9208 or tgrant@katcommunications.com.

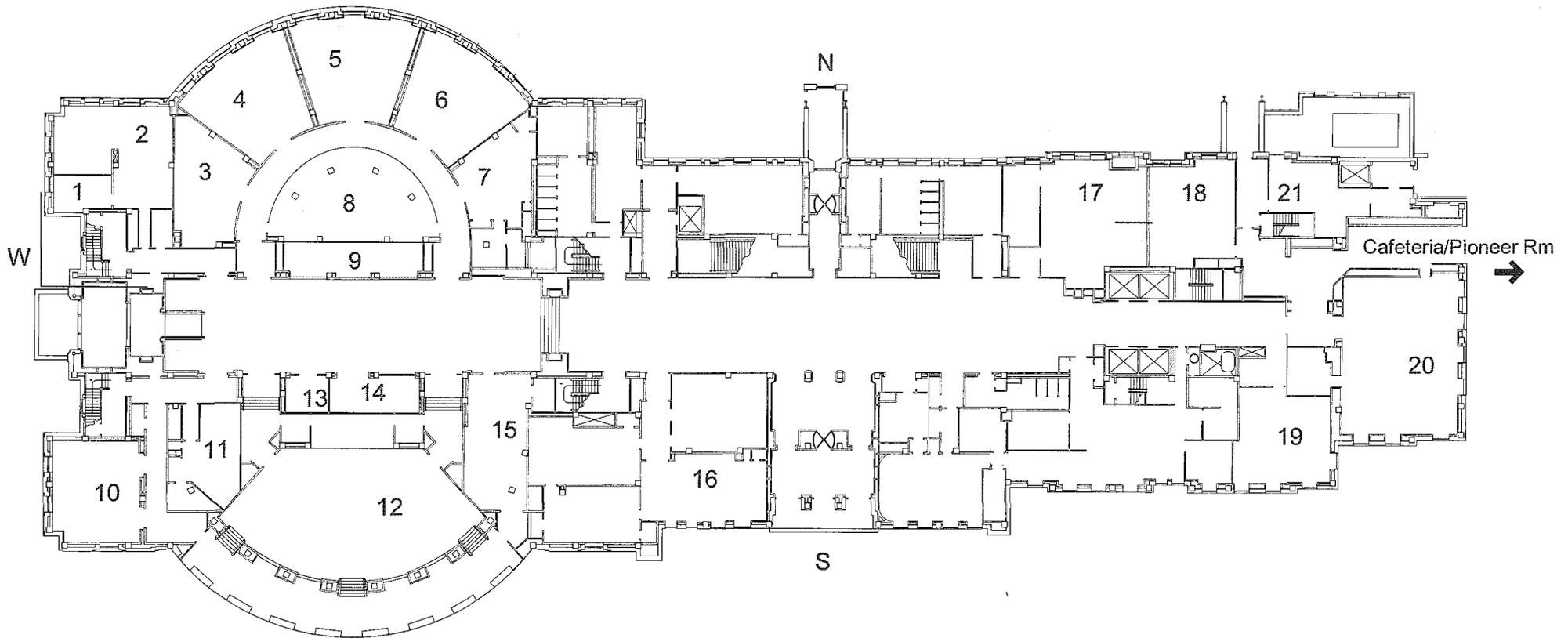
DAKOTA ORAL CARE WORKSHOP
Brynhild Haugland Conference Room
September 4, 2012
10 AM- 4 PM CDT

AGENDA (DRAFT)

- 9:45 Pre-session photo montage
- 10:00 Prayer
Greeting & Housekeeping
- Opening remarks
Scott Davis, Executive Director
ND Indian Affairs Commission
- Invitation to Tribal Leaders for comments
1st video presentation [5 min.]
- Workshop Keynotes**
Dr. Jan Colton, DMD, Area Dental Consultant
- Dr. Terry Dwelle, MD [scheduled for 11:00 to 11:30]
State Health Officer, ND Department of Health
- Peggy Peters and Teri Renville
'Cavity-Free in 2-0-1-3 '
Sisseton-Wahpeton Oyate of the Lake Traverse Reservation
- Lunch (provided) - Brynhild Haugland Conference Room
- 1:00 2nd video presentation [5 min.]
Breakout Sessions [Facilitators, SME's and note takers]
- Fort Totten Room (Blue)
 - Fort Union Room (Green)
 - Peace Garden Room (Orange)
- Break
- Bringing the Pieces Together
 Brynhild Haugland Conference Room
- 3:30 Hand out resources
- 4:00 Adjourn

NORTH DAKOTA STATE CAPITOL

GROUND FLOOR



- | | | | |
|------------------------|-------------------------|----------------------------|------------------------------------|
| 1. Doctor's Exam Room | 6. Fort Totten Room | 11. Press Studio | 16. Missouri River Room |
| 2. Legislative Study | 7. Press Room | 12. Brynhild Haugland Room | 17. Harvest Room (Senate Appro.) |
| 3. Roosevelt Park Room | 8. Medora Room | 13. Vending Area | 18. Red River Room |
| 4. Ft. Union Room | 9. Joint Bill & Journal | 14. Public Coat Room | 19. Sakakawea Room |
| 5. Peace Garden Room | 10. Fort Lincoln Room | 15. Lewis & Clark Room | 20. Rough Rider Room(House Appro.) |
| | | | 21. Mail Room |

FACILITATOR-TECHNICAL ADVISOR TEAMS

Group	Facilitator	Subject Matter Expert (SME)	Note Taker
Fort Totten Rm. - Blue	Fred Baker 701-898-1431	Dr. Jan Colton, IHS	Mary Bandle
Fort Union Rm. - Green	Helen Hanley 701-328-2428	Kim Yineman, DOH	Merle Botone <i>Pending</i>
Peace Garden Rm. - Orange	Karla Davis 701-323-4000	Robin Stearns, DOH	Ashley Kopp
TBD	Cheryl Kary	TBD	Stu Clark
Alternates	Erik Cutler 701-224-9208		Ashley Atkinson

Facilitator Expectations:

The first breakout session will be roughly 90 minutes in length followed by a brief break. The second session 'Bringing the Pieces Together' is a summation of the first breakout session and wrap-up lasting roughly 60 minutes.

We ask the facilitators to actively promote participant discussion and engagement in group activities. It will be important to encourage group interaction while respecting the individual perspective of those participating. Remember to treat session participants the way they like to be treated.

Statement on Confidentiality:

Please be aware that comments made by session participants reflecting items of a personal nature, or those reflecting professional experiences that are specific in nature, should be held in strict confidence.

Statement Regarding Reasonable Accommodations:

In compliance with the Americans with Disabilities Act (ADA) and other legal mandates, the sponsors of this workshop are committed to working with session participants with disabilities to provide effective reasonable accommodations.

It is the responsibility of the session participant to request the reasonable accommodation if needed.

Outcomes we hope to achieve as a result of work sessions

Session Outcomes	Facilitator Notes
The need for oral health education, awareness, and preventive care will be further defined.	
Community perceptions of the current oral health care services will be discussed.	
Current networks and/or structures key to improving oral health awareness, education and preventive services will be noted.	
The role of public awareness and the perceived benefit will be discussed.	
Identification of strategic alliances and networks will be noted.	
Special nuances, as it relates to oral health barriers or strengths, in each community (including leadership) will be documented.	
How community members access information and communication will be discussed.	

Overall outcome:

The goal is to increase oral health awareness to North Dakota’s tribal providers [morning session] and to obtain their perspective to improve oral

health outcomes through oral health awareness, education and preventive services at the tribal level [afternoon session].

BREAKOUT SESSION

OPENING REFLECTION as you prepare yourself to facilitate

A leader who has sight must also have vision.

A leader who hears must also listen.

A leader who speaks must also lend voice to those who have none.

SESSION OBJECTIVE

'...obtain participant perspective, ideas, suggestions, comments to improve oral health outcomes through oral health awareness, education and preventive services at the tribal level'

SESSION ACTIVITIES

- Introductions

- Housekeeping
 1. Reminder the discussion will be recorded, followed by a transcript with no identifying information.
 2. Review the United Tribes CEU forms.

- Please review Session Objectives – see above.

- Recognize individual interpretation of:
 - 1) Oral Health Education
 - 2) Oral Health Awareness, and
 - 3) Oral Health Preventive Services

- Facilitator Discussion Questions – see page 9.

- Be prepared to offer group feedback in the 'Bringing the Pieces Together' in the final session.

TOPIC AREAS

For facilitator use –

ORAL HEALTH

A state of being free from chronic mouth and facial pain, oral and throat cancer, oral sores, birth defects such as cleft lip and palate, periodontal (gum) disease, tooth decay and tooth loss, and other diseases and disorders that affect the oral cavity. Risk factors for oral diseases include unhealthy diet, tobacco use, harmful alcohol use, and poor oral hygiene.

ORAL HEALTH EDUCATION

Education- The process of receiving or giving systematic instruction, esp. at a school or university: "a new system of public education".

ORAL HEALTH AWARENESS

Awareness-Having knowledge of; "he had no awareness of his mistakes"; "his sudden consciousness of the problem he faced"; "their intelligence and general knowingness was impressive.

ORAL HEALTH PREVENTIVE SERVICES

Prevention Services are community water fluoridation, sealants, fluoride varnish. Brushing and flossing are prevention and oral care.

FACILITATOR LED DISCUSSION QUESTIONS:

- How important is oral health in your community? Why?

- Should it be more important? If so, how can we make it more important?
- Do you think your community members have good oral health? Why or why not?
- What are barriers to good oral health?
- Who do you think are the most forgotten when it comes to receiving oral health services?
- What materials are currently available in your communities that educate people about oral health?
- If you snap your fingers, what would your community's oral health care system look like?
- Who in your community do you think should be involved in an effort to build more awareness on the importance good oral health? How do we involve them?
- What oral health resources are available in your community? What should be created to meet the need?
- What do you think are the best ways to get information to community members?
- How do Dentists get to your community?
- What is the state of your dental office in your community?

'BRINGING THE PIECES TOGETHER' SESSION

OPENING REFLECTION as you prepare yourself to facilitate

"Knowledge is rooted in all things—the world is a library."-LAKOTA proverb

"I want you to go on and build onto all that's going on today because it makes the tomorrow." Edna Gordon

SESSION OBJECTIVE

To share `... participant perspective, ideas, suggestions, comments to improve oral health outcomes through oral health awareness, education and preventive services at the tribal level'

SESSION ACTIVITIES

- Report the findings of his/her respective workgroup
- Seek additional group insights.
- Identify the next steps to be taken.

The workshop prepares to close – turnover to emcee.

Appendix 5: Presentations

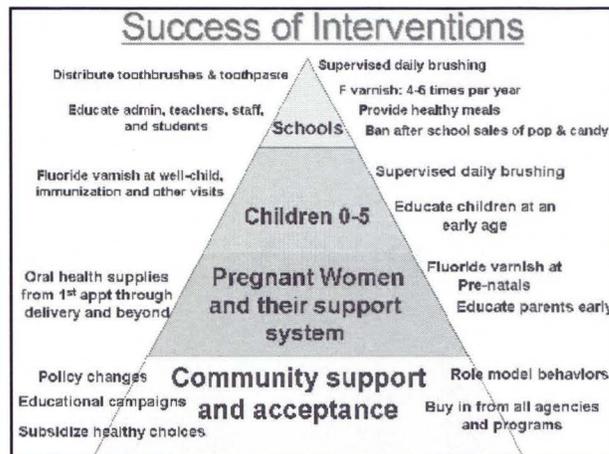
Cavity-Free 2012



Why we feel it's working




◊ *Taking steps to Good Oral Health*



Because of Healthy Smiles 2006-2008, we had huge support from tribal members and council for Cavity-Free

The community became invested when they realized their own tribal members were playing an active role in both the study and the project portion of *Cavity-Free*




To the community, *Cavity-Free* was a natural progression

Pre-school, kindergarten and 1st grade children who participated with Healthy Smiles see their younger siblings enrolled in *Cavity-Free*. The families have come to expect that this service is available and they make use of it.



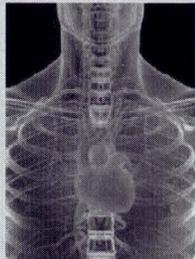


Show how the spread of infection happens with examples

Tooth infection spreads to other parts of your body via the blood stream



Bacteria growing in the mouth can be inhaled causing respiratory diseases such as bacterial pneumonia.



Highlight topics that are important to tribal members

There are good reasons, beside your own dental health, to take extra care during your pregnancy. **Some research suggests that serious gum disease (periodontal disease) is linked to premature birth and low birth weight.**



Diabetics are more likely to have periodontal disease than non-diabetics. Periodontal disease is often considered the sixth complication of diabetes.

A respected elder and CHR manager coined the term: **"It takes all three to be Cavity-Free"**, which quickly became the catch phrase on our rez.

We have the support of our elders and, because they want a better life for takoja tawapi, they influence the younger members of tiospaye qa tiwahe tawapi.



Our own wolf pack

We provide Fluoride Varnish and sight screenings along with oral health supplies and referrals to dental for entire families at pow-wows and other events.



Reaching out to the young



Our own wolf pack

Personalize Permission Forms

Fluoride Varnish Application and Sight Screening for Children at Kristy's home day-care

PARENT or GUARDIAN: Please complete and sign the Parental Permission for fluoride varnish treatment program below.

Parental Permission

I give my son or daughter, _____, permission to have fluoride varnish placed on his or her teeth at my child's home day-care by a trained staff or provider from the Cavity-Free in 2013 study and project. I have read the participation flyers and understand the procedure. I understand the Cavity-Free program is a preventive program and the product is safe and effective.

Preventive Dental Treatment Authorization

I hereby authorize trained staff or providers to apply the fluoride varnish product to prevent dental caries and arrest incipient decay. I understand that the consent and authorization herein granted do not include major procedures. I also read the flyers and information on the product and consider it safe. This is considered a high-risk community for oral diseases and participation in this preventive program will help reduce the high rate of dental caries in our community.

Has your child ever received Fluoride Varnish on his or her teeth before: _____

I have read the general information and hereby agree to all policies of the Head Start center concerning medical/dental and preventive treatment including the above authorization for the dental preventive program...

Parent or guardian's name (please print): _____

Phone numbers where you can be reached at all times: _____

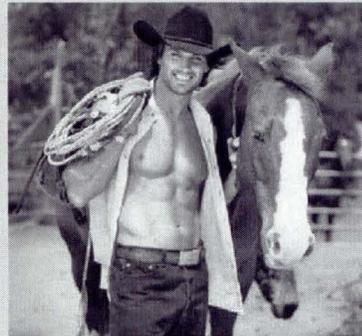
Parent or guardian's signature: _____

Date: _____

Name of an additional emergency contact: _____

Your Dentist Name and phone number: _____

We are invited by our tribal schools to present at classes and attend their events. We've become known as "The Healthy Teeth Kungsi" Each presentation also involves site screenings, FV, supplies, and referrals



At the district meetings, we give regular updates, education, site screenings, FV, and provide supplies

Get those babies to the dentist by age 1 or by their first tooth



Don't forget to use humor!

Create buy-in by training caregivers how to clean their children's gums and teeth. They will in turn show their friends and families.



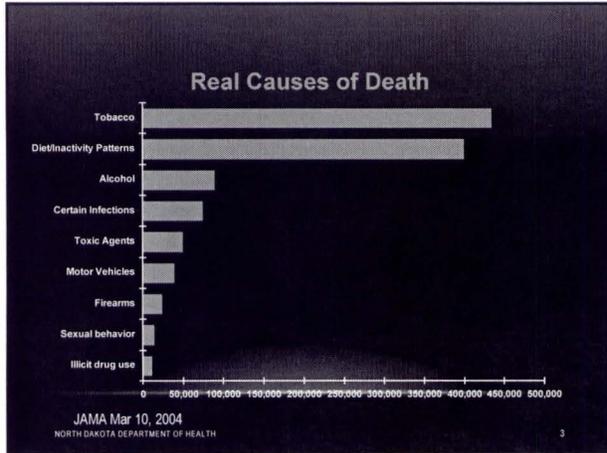
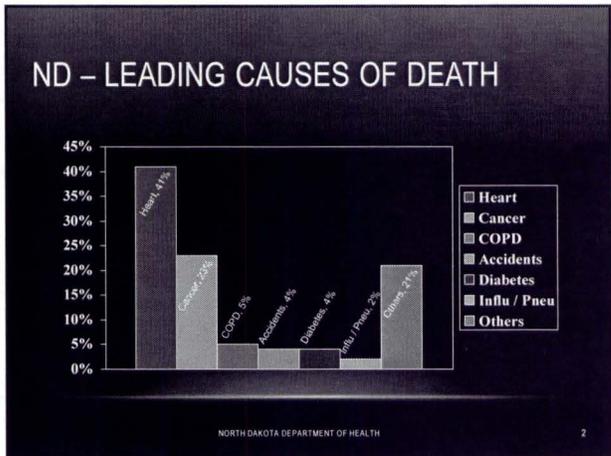
Give them the tools to do this at home.

The success of *Cavity-Free and Healthy Smiles* also depended on the support of outside funding. We want to thank the Delta Dental Philanthropic fund, the South Dakota Dept. of Health, and Indian Health Services.



COMMUNITY ENGAGEMENT AND ORAL HEALTH BEHAVIORS

Terry L Dwelle MD MPH TM FAAP CPH
State Health Officer
North Dakota Department of Health



CARDIOVASCULAR RISK FACTORS

	N American	White	All
High BP	27.3%	26.2%	26.1%
High Chol	32.8%	30.8%	30.6%
Smokes	45.1%	22.6%	23.2%
Overweight	70.6%	59.9%	60.4%
Sedentary	62.9%	55.3%	55.9%
Diabetes	11.5%	4.6%	5.2%
At least 1 Risk factor	94%	92%	92%

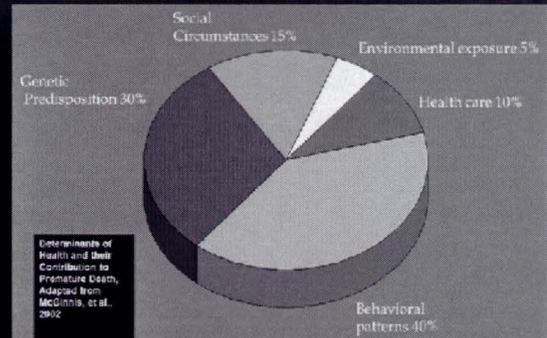
ND Dept of Health

ORAL HEALTH AND HEART DISEASE AND STROKE

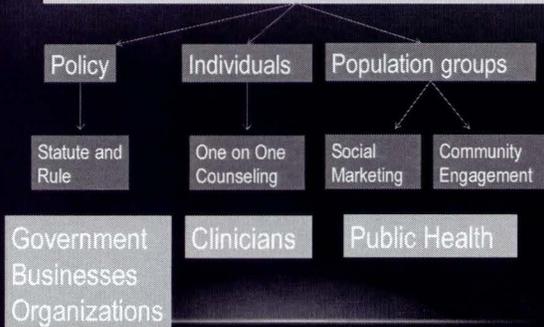
- Poor oral health may contribute to heart disease
- Oral bacteria can enhance plaques and cause heart attacks / strokes

http://www.health.harvard.edu/press_releases/heart-disease-oral_health, 1998-2012
 Mayo Foundation for Medical Education and Research. All rights reserved

DETERMINANTS OF HEALTH

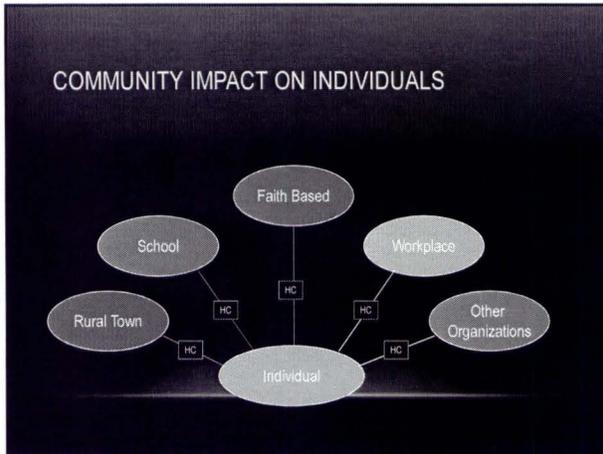


CHANGING RISKY BEHAVIORS



ENGAGEMENT VERSUS COERCION

- Coercion – the use of physical or moral force to compel to act or assent (Webster’s Third International Dictionary)
- Engagement – facilitation of communities to own their problems and solutions
- “Engaging a community is ultimately about facilitating community-driven action.” (Principles of Community Engagement, Second Edition, NIH Publication No. 11-7782, June, 2011, pp. 52).



- #### COMMUNITY ENGAGEMENT CONCEPTS
- Engagement versus coercion
 - Community empowerment
 - Process not project
 - Relief versus development
 - External funding
 - Definition of a community
 - Community engagement facilitators and cross cultural communications
 - Selective primary healthcare versus comprehensive programs
 - Communications model and transfer of meaning
 - Definition of culture
 - Seven dimensions of cultural distance
 - Culture shock
 - Social marketing and community engagement
 - Horizontal communication system
 - Four levels of message identification
 - Perceived and real needs
 - Bridging
 - Organizations and structures
 - Stages of change, activities and evaluation
 - LePSA(S)
 - Five groups of communities
 - Coalition building
 - Community engagement operational structure
 - Overview of community engagement
- NORTH DAKOTA DEPARTMENT OF HEALTH 10

ORAL HEALTH STATUS IN THE ABERDEEN AREA

Jan C. Colton, DMD, PhD
Aberdeen Area Dental Consultant

Objectives

- Provide general facts about oral health in the Aberdeen Area
- Provide specific data about oral health in children in the Aberdeen Area
- Present both strengths and weaknesses of our dental programs

GENERAL FACTS

- In South Dakota, NA's comprise approximately 9% of the population.
- Two-thirds of that population reside on one of the nine reservations.
- There are currently 19 dental programs in the Area (three are in ND, two are in NE and there is one in the planning stages for IA).

GENERAL FACTS, con't

- Generally, 11 % of the adult population is diabetic.
- Roughly 28 % of the diabetic population had an oral exam during the past year
- There is currently one opening for a dental officer in the Area (several openings are anticipated at a new facility) and no openings for dental hygiene in the Area.

PROVISION OF DENTAL SERVICES

- Current ratio of dentists to patients (average) in the Aberdeen Area is 1:3,400.
- The IHS recommends a ratio of 1:1,200.
- Current ratio of dental hygienists to patients (average) in the Aberdeen Area is 1: 9,300.
- Unaware of a specific IHS recommendation for the latter ratio.

GOVERNMENT PERFORMANCE AND RESULTS ACT (GPRA)

- A variety of measures utilized to review how we are doing.
- Dental has three specific benchmarks we are to meet.
- These are access, dental sealants and topical fluoride applications.
- GPRA year runs from July 1st to June 30th.

GPRA

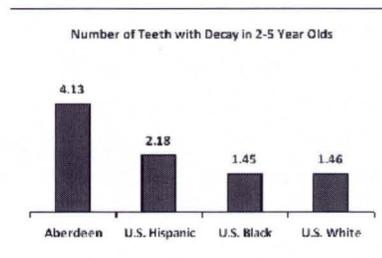
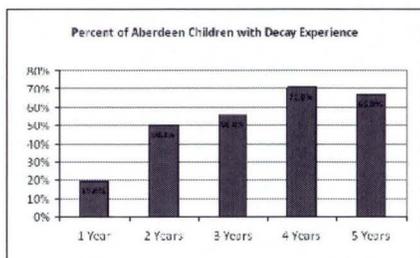
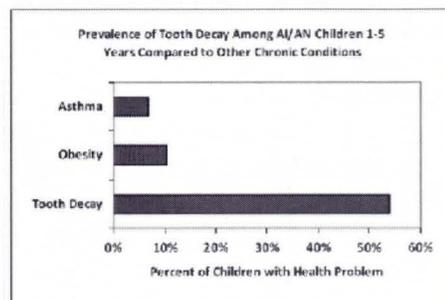
- Aberdeen Area exceeded all three goals for the 2010-2011 GPRA year.
- Well on the way to exceeding our goals for the 2011-2012 GPRA year.
- Results of 2 quarters:
- Access – 22,273/34,197
- Sealants – 17,326/22,616
- Tp Fluoride – 10,619/12,671

GPRA, con't

- Access goal, however, is only at 27%.
- Programs in the Area that did not meet any of their goals.
- Programs that went well beyond their goals.

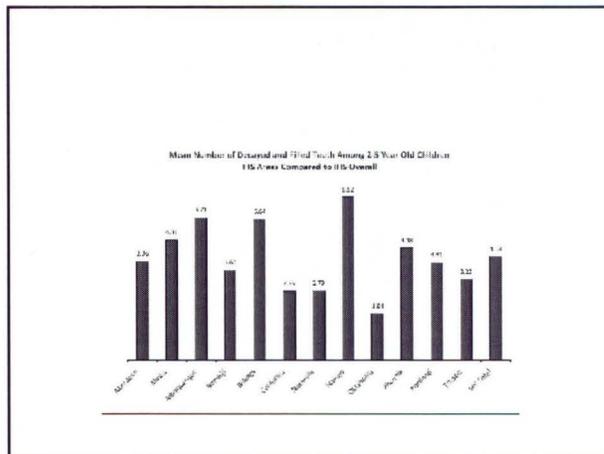
ORAL HEALTH SURVEILLANCE PROJECT

- Initiated by IHS.
- Attempt to provide documented evidence of oral health statistics for IHS.
- Take 10 years to complete.
- Currently in second phase – k – 3rd grade
- Initial phase looked at children from 1 to 5 years of age.



Oral Health Status of 1 – 5 year Old Children in the Aberdeen Area

- 53% of the children have tooth decay experience.
- 36% have untreated decay.
- 2% of the children have an urgent need for dental care (pain, infection, swelling).
- Children in the Aberdeen Area have, on average, more than three teeth with decay experience



SUMMARY

- There are some things we are doing well.
- There are some things we are not doing well.
- We need to look for ways in which to improve our delivery of services.
- We need to work together...this meeting is a good example