ARIZONA AMERICAN INDIAN ORAL HEALTH SUMMIT
- FINAL REPORT -

April 21-22, 2011
Radisson Fort McDowell
Fort McDowell Yavapi Nation

"Taking the Lead to Improve Oral Health"

August 2011

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▶ EXECUTIVE SUMMARY

On April 21-22, 2011 a historic statewide Arizona American Indian Oral Health Summit was held at the Fort McDowell Radisson Resort located on the Fort McDowell Yavapai Nation. 114 participants attended the Summit. This was the first time in Arizona state history that a multi-agency sponsored statewide American Indian Oral Health Summit was held. The purpose of convening the Summit was to provide a venue for entities conducting oral health services to come together to share information, network and make recommendations for service improvements, and to provide an opportunity for community leaders to learn about various oral health prevention and treatment models being practiced in Arizona and Alaska.

The agenda was structured with morning educational plenary sessions including a tribal and urban Indian leaders Town Hall panel, a noon hour luncheon speaker, and concurrent afternoon breakout sessions on Day One and two plenary group discussions with one following the other to discuss prevention and treatment strategies and recommendations on Day Two.

The participants agreed that tooth decay continues to be a severe health problem and that health promotion and disease prevention strategies must play a key role in improving the oral health of the Arizona American Indian population. Various strategies were identified including community water fluoridation, school-based sealant programs and oral health education.

Participants identified the need to build community capacity to improve the delivery of community-based culturally responsive oral health services. They asserted the need for more tribal members to be educated and trained in the oral health professions. They also concurred that tribes needed to make oral health a higher priority within their respective health care policy strategies and that Tribal Leadership must be encouraged to promote the importance of oral health as a component of overall health.

There was agreement that an Arizona American Indian Oral Health Coalition should be established which would provide an excellent vehicle to build consensus regarding policy goals and unify the American Indian voice to educate federal and state agency decision makers and elected representatives about the need for American Indian oral health care.

▶ SPONSORS

The members of the Planning Committee and the attendees of the Summit express sincere appreciation to the following sponsors for their generous support in underwriting the expenses of the event:

- Arizona State Dental Hygienists Association
- Delta Dental of Arizona Foundation
- Arizona Dental Association
- Institute for Oral Health
- SRP Corporation
- Pascua Yaqui Tribe
- Native Health
- Basha's
- Office of Minority Health, U.S. Department of Health and Human Services
- Advisory Council on Indian Health Care

▶ INTRODUCTION AND PURPOSE

On April 21-22, 2011 a historic statewide Arizona American Indian Oral Health Summit was held at the Fort McDowell Radisson Resort located on the Fort McDowell Yavapai Nation. 114 participants attended the Summit representing Indian tribes, the Inter Tribal Council of Arizona, Inc. (ITCA), urban Indian health centers, state department agencies, state dental and hygienists associations, Indian Health Service (IHS), private dental practices and one national association. The majority of the attendees were from Arizona. This was the first time in Arizona state history that a multi-agency sponsored statewide American Indian Oral Health Summit was

held. Attendance by more tribal representatives was impacted by budgetary travel restrictions. During the period of the Summit several tribes including the Navajo Nation had off-reservation travel restrictions. See Appendix One for a listing of the Summit attendees.

The purpose of convening the Summit was two-fold. First, to provide a venue for representatives from all entities conducting oral health prevention and treatment services for American Indians in Arizona to come together to share program information, network and make recommendations for service improvements. Second, to provide an opportunity for Arizona American Indian community leaders interested in oral health care to learn about various oral health prevention and treatment models being practiced in Arizona and Alaska.

▶ PLANNING COMMITTEE

A Planning Committee was formed in October of 2010 to plan the event. The Planning Committee membership included tribal representatives from the Pascua Yaqui Tribe and Gila River Indian Community. The committee also included representatives from the Arizona Department of Health Services (ADHS), Arizona Health Care Cost Containment System (AHCCCS), First Things First, Advisory Council on Indian Health, Arizona Dental Association, Arizona State Dental Hygienists' Association, Delta Dental of Arizona Foundation and the Arizona Public Health Association. A core objective of the Committee was to focus the Summit's program around the priorities and interests of tribal leaders, tribal health directors and urban Indian health directors. See Attachment Two for a listing of the Planning Committee members.

In its planning discussions the Committee emphasized the concepts of collaboration, strategic partnerships and leveraging resources to enhance efficient and cost-effective means of expanding access to care, education and prevention services.

▶ PROGAM FORMAT

Day One was structured with educational plenary sessions in the morning which included a tribal and urban Indian leaders Town Hall panel followed by a noon hour luncheon with a speaker. Concurrent breakout sessions were held in the afternoon. The morning plenary session presenters provided information on the American Indian oral health service delivery system, the statistics status of American Indian children caries, and oral health perspectives from tribal and urban Indian leaders. The noon hour presenter, Congressman Paul Gosar, presented his perspective on the status of the American health care system. The afternoon breakout sessions presenters provided information on four different treatment models which were a tribal PL 93-638 dental clinic, a Teledentistry and Affiliated Practice Dental Hygiene model, Arizona state tobacco tax funded services, and the Alaska Dental Health Aid Therapists program.

Day Two was structured with two plenary group discussions with one following the other. The first was for prevention strategies. The second was for treatment strategies. All attendees participated in each discussion. The prevention strategies discussion covered two age groups, 0-21 and 21+. The treatment strategies discussion covered three age groups, 0-21, 21-64 and 65. Structured discussion questions were used in both discussion sessions. See Attachment Three and Four for a copy of the Summit Agenda and a copy of the Prevention and Treatment Strategies discussion questions.

▶ STATUS OF AMERICAN INDIAN CHILDREN'S ORAL HEALTH

Julia Wacloff, Director, Office of Oral Health, ADHS presented data collected from the 2009 Oral Health Survey of Arizona Pre-School Children and the 2010 "Arizona Healthy Bodies, Healthy Smiles" survey. The following statistics were presented:

- One in ten American Indian children in Arizona has had early childhood tooth decay.
- The average number of decayed teeth was 4 ½ teeth per child, vs. an average of 2 ½ teeth among non-American Indian children.
- American Indian children were significantly less likely to have seen a Dentist during the year prior to their screening (59% vs. 73% for non-American Indian children).
- Significantly more American Indian children have had decay experience compared to non-American Indian children (93% vs. 76%).
- In the last ten years, there has been a ten percent increase in tooth decay experience (from 83% in 2000 to 93% today). This is moving away from the Healthy People target of 42%
- 62% of American Indian third graders were observed to have untreated decay vs. 41% among non-American Indian children. Likewise, 82% of American Indian children were observed to have treated decay vs. 59% of non-American Indian children.

▶ PREVENTION STRATEGIES DISCUSSION

It was agreed to that tooth decay continues to be a severe health problem in the American Indian population and that health promotion and disease prevention strategies must play a key role in improving the oral health of the Arizona American Indian population. Strategies that have been shown to be effective in reducing and controlling tooth decay include use of systemic and topical fluorides and school-based dental sealants. Since 1945, when Grand Rapids, Michigan, first fluoridated its city water supply, fluoridation has been considered the most cost-effective public health measure to reduce dental caries. Sealants have long been shown to be effective in the reduction of tooth decay with school-based sealant programs receiving strong recommendations from the Guide to Community Preventive Services.

For Arizona, little is known about the status of community water fluoridation on tribal reservations with some tribal communities being fluoridated while others are not. Efforts to enhance community education designed to accomplish fluoridation of water supplies would be an effective and practical method for promotion of tooth decay prevention. Use of dietary fluoride supplements were noted as not widely implemented. Efforts to enhance community education on the benefits of fluoride strategies which include grandparents and medicine men may be an effective method for tribal communities.

Some IHS facilities are implementing school-based sealant programs with others providing services in local clinics. There is no central repository of information to track which tribal schools have services and which do not. The IHS Early Childhood Caries initiative is to place sealants on both primary and permanent teeth. Other topical fluoride agents targeted at children ages birth through five are being utilized in some segments of tribal communities, including the White Mountain Apache Tribe and Navajo Nation. Daily use of fluoride-containing toothpastes has been shown to be effective in tooth decay prevention.

While the goal of community education is to impact the high rates of tooth decay, it is not always the most direct or effective choice for achieving this goal. Oral health instruction on tribal reservations is available but the concern expressed was that diet and access to junk food is not being addressed. Further, concern was also expressed regarding the lack of an educational focus on prenatal oral health care with expectant mothers, and the role that mothers can play in both the prevention of Early Childhood

Caries (ECC) and building positive oral health care habits among their children.

Several key barriers to receiving preventive dental care were identified including: limited availability of dental providers and facilities; lack of community awareness on the importance of oral health need and the benefits of dental care; and lack of funding to support the hiring of dental providers. A combination of barriers will need to be addressed in order to increase access to prevention strategies.

Various issues were identified regarding legislative, administrative and policy changes needed to improve oral health for the Arizona American Indian population. The main topics of discussion were targeted at efforts to promote access to prevention strategies including fluorides, school-based sealant programs and oral health education while providing flexibility to Tribal populations in order to shape their goals specific to their individuals' needs and priority areas.

▶ TREATMENT STRATEGIES DISCUSSION

Discussion focused on the current status of programs and services in tribal communities, opportunities and strategies for improvement, and potential means of overcoming barriers to care. Additionally, attention was directed toward the issues surrounding dental treatment and services for the elderly. Rampant caries and periodontal disease are frequently present in the older population. This is unfortunate given that fewer options for comprehensive dental services are available for adults than for children. For those who are edentulous or partially edentulous, dentures are often difficult to acquire. Although IHS and tribal dental clinics provide treatment for adults, some costly services are restricted. As a result, preventive measures are important.

The availability and funding of dental/oral health treatment and services varies substantially between tribes and between geographical areas. IHS has worked diligently to provide the most dental services possible within budgetary limits. Priorities have included updating facilities and ensuring adequate professional staff. A particular challenge identified was the recruitment of dental specialists including pediatric dentists, endodontists, and oral surgeons. In some locations, non-IHS providers assume significant roles in the treatment of American Indians. The utilization of local/community providers or those with mobile capabilities could be considered as potential resources. Tribal leadership plays an important role in the overall improvement process.

Participants were unanimous in their opinions of a need for significant improvements in access to dental care for the elderly.

AHCCCS is the state agency that administers both the Medicaid and Children's Health Insurance Program (CHIP) in Arizona. For enrolled members, AHCCCS provides comprehensive dental care for children but currently provides no routine dental treatment for adults. Federal requirements prohibit a variance of benefits based on the race of AHCCCS members; therefore, the same benefits apply to American Indian children as do non-American Indian children.

When AHCCCS makes changes to benefits that are considered "optional," like the adult dental benefits, the changes apply to all members in the affected group, regardless of race designation. Understanding this inability to exempt American Indians from the benefits changes, AHCCCS has requested waiver authority to make an exemption for IHS and 638 services for which the state can claim 100% federal dollars. Until this authority is granted, AHCCCS cannot make payments for the services that are no longer covered and are provided by IHS and 638 facilities.

▶ WORKFORCE PIPELINE AND ADVOCACY DISCUSSION

Participants identified the need to build community capacity to improve the delivery of community-based culturally responsive oral health services. In particular, they asserted the need for more tribal members to be educated and trained as dentists, oral surgeons, hygienists, expanded function dental assistants and community health representatives with dental skills. The consensus was that tribal members have the greatest knowledge and capacity to effectively serve their fellow tribal members. Until tribal members are in the positions of dentists and hygienists, there will continue to be a cultural disconnect between clinics and communities, as well as a disconnect between service delivery processes and the reality of community needs.

According to one audience member, nationally there are approximately 400 dentists employed by the Indian Health Service and 150 Dentists employed by Tribal health programs. Of these 550 Dentists, less than 70 are known to be American Indian. It can be further noted that if the American Indian patient population were to have the same number of Indian Dentists providing services—as the non-Indian population has non-Indian Dentists—there would have to be 1,200 Indian dentists. These statistics reveal the enormity of the education and workforce challenge facing Indian Country.

Participants identified the need to jointly advocate for regulatory reform and public policies that would enhance both IHS and tribal capacity to provide prevention and treatment services to isolated populations, young children and elders. They also concurred that tribes needed to make oral health a higher priority within their respective health care policy strategies. Participants welcomed the idea of advocating with a larger and more diverse group of stakeholders as a means of amplifying their voices and leveraging a broader base of support for regulatory reform and policy goals.

While it is important to note that the Indian health care delivery system is primarily driven by federal laws and regulations, state laws and regulations involving licensure and Medicaid are still a significant priority. Therefore an advocacy strategy must be equally focused on both federal and state levels.

▶ EVALUATIONS SUMMARY

Evaluations were received from a total of 46 respondents, which included 4 persons identified as "Tribal Officials; 16 Dentists; 14 Hygienists and 12 individuals identified as "other."

Respondents were asked to evaluate the program content in general. Respondents were asked to rates the following statements either excellent, good, fair or poor. Percentage responses are indicated. In general, by a relatively large margin, participants gave the program high marks.

	Excellent	Good	Fair	Poor
Program met stated objectives	43.4%	45.6%	6.5%	2.1%
Program content was current	50.0%	43.4%	6.5%	
Usefulness of information	45.6%	45.6%	6.5%	
Program length was appropriate	32.6%	50.0%	13.0%	2.1%
Value of Information	41.3%	45.6%	6.5%	
Organization of information	36.9%	41.3%	17.4%	

Respondents were asked to rate speaker effectiveness in general. They were not asked to evaluate individual speakers or presenters. Several respondents recommended that future evaluations provide an opportunity to rate individual presenters.

	Excellent	Good	Fair	Poor
Communication of information by speakers	32.6%	50.0%		
Mastery of subject by speakers	50.0%	36.9%	4.3%	
Enough time for questions	47.8%	34.7%	6.5%	4.3%

Individual commenter's noted that there was a large amount of material to be covered in a limited time and the format made for a long day. Several respondents expressed a desire to be able to attend each of the Day One afternoon breakout sessions and suggested that the next program should have more smaller groups. One individual suggested that all sessions be conducted as general sessions to maximize exposure to issues covered in breakouts. Others suggested that there should be more sessions that were conducted interactively with the audience.

Some respondents noted that the timing of the Summit during Holy Week was an impediment to attendance. Others noted that efforts should be undertaken to maximize tribal member attendance and that there should be more input and presentations from tribal leaders, ITCA, IHS and tribal programs.

Overall, comments were positive. 95% of the respondents indicated that that would attend another conference.

▸ RECOMMENDATIONS

Prevention Strategies: The following strategies were proposed to enhance prevention efforts:

1. Support community water fluoridation as the cornerstone for the prevention of tooth decay in tribal communities.
2. Consider school fluoride mouth rinse programs as an alternative where fluoridation of the public water supply is not feasible.
3. Facilitate the use of health educators, Head Start personnel, First Things First personnel, case workers, community health representatives, and dental personnel for educational opportunities.
4. Implement Head Start brushing programs in childcare settings.
5. Integrate oral health services with other existing health services professionals including dieticians, pharmacists, OB/GYNs, affiliated practice dental hygienists and physicians.
6. Initiate oral health program collaboration with wellness programs, parenting classes, diabetes and tobacco prevention.
7. Incorporate knowledge about nutrition and tooth decay with other nutritional recommendations that are culturally and geographically sensitive.

Treatment Strategies: The following strategies were proposed to enhance treatment options:

1. Insure that information on treatment options and benefits are readily available and easily accessible.
2. Include information on substance abuse and the effect of tobacco use on teeth and surrounding oral tissue.
3. Encourage Tribal leaders to continue to consult with state and federal administrative agencies in order to acquire adequate funding to support residency programs, hire dental specialists, create pilot programs, etc.
4. Encourage Tribal leaders to promote the importance of oral health as a component of overall health and communicate the importance of adequate dental care as a significant contributor to quality of life for American Indians.
5. Encourage Tribal leadership to play a significant role in encouraging young American Indians to seek careers in oral health care.
6. Incorporate oral health disease prevention education into programs at senior centers and geriatric clinics, and in diabetes programs.

7. Consider surveying elders and treatment facilities to identify specific needs and availability of services for the elderly.

Education and Workforce Pipeline: Build the oral health capacity of Arizona American Indian communities by creating an education and workforce pipeline for American Indian students and adults.

1. Inform and educate young American Indian students about oral health care careers and how they can become oral health professionals.
2. Recruit, support and mentor American Indian students as a means of promoting access to education, academic excellence, successful completion of necessary academic programs, and the attainment of necessary degrees.
3. Train and develop a highly skilled and competent oral health workforce.

Advocacy: Support establishment of an Arizona American Indian Oral Health Coalition comprised of tribes, urban Indian organizations and key public and private sector stakeholders which would provide an excellent vehicle to:

1. Monitor federal and state funding opportunities, regulatory proceedings and legislation, and inform tribal and community leaders about timely and important opportunities and calls for action.
2. Build consensus regarding short-term and long-term policy goals, objectives and strategies for resource development, regulatory reform, and policy development.
3. Unify and amplify American Indian voices to strategically educate and inform opinion leaders and decision makers in administrative agencies and elected representatives.
4. Encourage the Navajo Nation and ITCA to conduct leadership roles in the development and facilitation of the Coalition given their significant involvement in regulatory and public policy affairs at the state and federal levels for Arizona tribes.

▸ CONCLUSION

The Summit focused on capacity building issues, peer-to-peer mentorship and collaborative problem solving. The participants: (1) shared new oral health data and analysis for Arizona Indian communities, (2) discussed strategies and lessons learned for enhancing service delivery efficiency and cost-effectiveness, and expanding the reach of services into tribal and urban communities, and (3) examined opportunities, concerns and policy issues presented by the Affordable Care and the Permanent Reauthorization of the Indian Health Care and Improvement Act. Collectively the participants identified strategies and recommendations to remove barriers and enhance oral health care for Arizona's American Indian people.

▶ APPENDIX 1

Beverly Allen	Sacaton, AZ
Clara Allen	Bayfield, CO
Allan Allford	Glendale, AZ
Michael Allison	Phoenix, AZ
Donald Altman	Phoenix, AZ
Connie Baine	Overgaard, AZ
Demetra Barr	Fountain Hills, AZ
Amanda Barrera	Parker, AZ
Anh Thu Becker	Phoenix, AZ
Lisa Begay	Mesa, AZ
Bryan Bennett	Phoenix, AZ
Robert Birdwell	Glendale, AZ
Laurie Buckles	Mesa, AZ
Priscilla Capitan	Scottsdale, AZ
Alexa Carrara	Tucson , AZ
Richard Champany	Shiprock, NM
Carol Chicharello	Phoenix, AZ
Joe Cichy	Bismark, ND
Larry Clausen	Phoenix, AZ
Kerri Comet	Winterhaven, CA
Mary Cosaboom	Cave Creek, AZ
Laverne Dallas	Laveen, AZ
Sosa Nita Diaz	Winterhaven, CA
Kevin Earle	Scottsdale, AZ
Ernesto Escala	Tucson, AZ
Gary Feldman	Glendale, AZ
Joyce Flieger	Tucson, AZ
Shelly Fritz	Albuquerque, NM
Russell Gilpatrick	Peoria, AZ
Ray Gist	Chicago, IL
Murray Greer Minot	ND
Deidre Greyeyes	Phoenix, AZ
Jan Grutzius	Phoenix, AZ
Lydia Guerra	Phoenix, AZ
Todd Hartsfield	Surprise, AZ
Latanya Hatathli	Tempe, AZ
Maryam Hesari	Phoenix, AZ
Debbie Holexa	Fountain Hills, AZ
Roy Holexa	Fountain Hills, AZ
Jon Holtzee	Chicago, IL
Joseph Hosek	Tucson, AZ
Allison House	Phoenix, AZ
Reuben Howard	Tucson, AZ
Mary Joyce Howato	Kykotsmovi, AZ
Fred Hubbard	Phoenix, AZ
Dan Huber	Phoenix, AZ
Chas Jewett	Rapid City, SD
Rex Lee Jim	Window Rock, AZ
Lyn Johnson	Flagstaff, AZ
Amanda Jones	Glendale, AZ
David Jordan	Boston, MA
Colette Keith	Rapid City, SD
Jocelynn Key	Mesa, AZ
Philip Kinlichee	Window Rock, AZ
Naomi Lane	Phoenix, AZ
Ron Latin	Scottsdale, AZ
David Leard	Flagastaff, AZ
Charlie Leonard	Washington, DC
Shira Levy	Washington, DC
John Lewis	Phoenix, AZ
Christopher Lomahquahu	Sacaton, AZ
Fileberto Lopez	Tucson, AZ
Dawn Lorenzo	Scottsdale, AZ
Sharon Lynch	Phoenix, AZ

Liza Mahfouz	Queen Creek, AZ
Linda Markle	Crownpoint, NM
Sherrilla Mckinley	Phoenix, AZ
Romalda Miguel	Sells, AZ
Wayne Mitchell	Phoenix, AZ
Patricia Molina	Guadalupe, AZ
Teresa Molina	Tucson, AZ
Alida Montiel	Phoenix, AZ
Mark Moores	Albuquerque, NM
Heshmat Mortazavi	Sells, AZ
Sheila Murphy	Phoenix, AZ
Angela Nam	Phoenix, AZ
Judith Nelson	Tucson, AZ
Joel Nichols	Prescott Valley, AZ
Laura Nichols	Prescott Valley, AZ
Christina Perez	San Francisco, CA
Sandi Perez	Glendale, AZ
Margaret Perry	Tucson, AZ
April Pohlman	Flagstaff, AZ
Stephine Poston	Bernalillo, NM
Brian Powley	Paradise Valley, AZ
Jessica Quijada	Phoenix, AZ
Gary Quinn	Sells, AZ
Barbara Raper	Tucson, AZ
William Rhodes	AZ
Claudia Richter	Tucson, AZ
Kirk Robertson	Flagstaff, AZ
Robert Robin	AZ
Keisha Robinson	Phoenix, AZ
Naomi Roeder	Whiteriver, AZ
Kirsten Roling	Phoenix, AZ
Beverly Russell	Phoenix, AZ
Deanna Sangster	Phoenix, AZ
Gregory Schwartz	Marana, AZ
Bryan Shanahan	Flagstaff, AZ
Cheryle Singer	Mesa, AZ
Judy Singer	Camp Verde, AZ
Randall Smith	Parker, AZ
Ken Snyder	Scottsdale, AZ
Fred Summerfelt	Flagstaff, AZ
Bridget Swanberg-austin	Mesa, AZ
Julie Tang	Mesa, AZ
Richard Tatum	Apache Junction, AZ
Sid Temlock	Tucson, AZ
Alberta Tippeconnic	Phoenix, AZ
Ronald Toepke	Tucson, AZ
Timothy Toepke	Lac Du Flambeau, WI
Ranee Tuscano	Phoenix, AZ
Kade Twist	Tempe, AZ
Mary Tyler	Holbrook, AZ
Marta Urbina	Phoenix, AZ
Emma Violante	Glendale, AZ
Julia Wacloff	Phoenix, AZ
Gwenlynn Werner	Tempe, AZ
Judy White	Phoenix, AZ
Maggie Wilcox	Ft. Mohave, AZ
Bonnie Williams	Tempe, AZ
Sheralyn Williams	Sacaton, AZ
Alyssa York	Phoenix, AZ
Sharon Zastrow	Scottsdale, AZ
Christina Zeigler	Apache Junction, AZ

▶ APPENDIX 2

Arizona American Indian Oral Health Summit Planning Committee

Co-Chairs:

Fred Hubbard, Executive Director, Advisory Council on Indian Health Care

Kevin Earle, Executive Director, Arizona Dental Association

Members:

Michael Allison, Native American Liaison, Arizona Department of Health Services

Julia Wacloff, RDH, Office of Oral Health, Arizona Department of Health Services

Ronald Toepke, DDS, Pascua Yaqui Health Center

Gary Quinn, Exec. Director, Tohono O'Odham Nation Dept. of Health

Jan Grutzius, RDH, President, Arizona State Dental Hygienists' Association

Laurie Buckles, RDH, Arizona State Dental Hygienists' Association

Sharon Zastrow, RDH, Arizona State Dental Hygienists' Association

Michelle Panico, RDH, Arizona State Dental Hygienists' Association

Laverne Dallas, Director, Health Resource Center, Gila River Indian Community

Deanna Sangster, Health Services Administrator, Native American Community Health Center

Michael McCluskey, Department of Health, Colorado River Indian Tribe

Cynthia Antone, Health Resource Center, Gila River Indian Community

Heshmat Mortazavi, DDS, IHS Sells Hospital Dental Clinic

Joyce Flieger, RDH, Arizona Public Health Association

Robert Birdwell, Dental Director, AHCCCS

Carol Chicharello, Tribal Relations Liaison, AHCCCS

Sandi Perez, PhD, Delta Dental of Arizona Foundation

Beverly Russell, Senior Tribal Liaison, First Things First

Kade Twist, High Ground Consulting/ Arizona Dental Association

Lydia Guerra, Administrative Assistant, Advisory Council on Indian Health Care

▶ APPENDIX 3

Agenda
ARIZONA AMERICAN INDIAN ORAL HEALTH SUMMIT

DAY ONE (April 21)

8:30 A.M. Welcome

Michael Allison, Native American Liaison, Arizona Department of Health Services EMCEE

Opening Blessing

Harry Antone, Gila River Indian Community

Keynote Presentation

Dr. John Molina, CEO, Phoenix Indian Medical Center, Indian Health Service

9:15 A.M Systems of Oral Health Care

Fred Hubbard, Executive Director, Advisory Council on Indian Health Care

9:45 A.M. The State of Children's Oral Health in Arizona

Julia Wacloff, Office Chief, Office of Oral Health, Arizona Department of Health Services

10:15A.M. Break

10:30 A.M. Early Childhood Caries: What the Data Shows

Rick Champany, Dental Chief, Navajo Area Indian Health Service

11:00 A.M. Tribal Leaders Town Hall
Laverne Dallas, Director, Health Resource Department, Gila River Indian Community (Moderator)

Tribal/Urban Representatives

- o Rex Lee Jim, Vice President, Navajo Nation
- o Amanda Barrera, Tribal Council Member, Colorado River Indian Tribes
- o Robert Robin, CEO, Native Americans for Community Action, Inc.

12:30 P.M. Luncheon

Address: Honorable Paul Gosar, US House of Representative

1:45 P.M. The Affordable Care Act and the Permanent Reauthorization of the Indian Health Care Improvement Act

Gary Quinn, Executive Director, Tohono O'odham Nation Department of Health and Human Services

2:45 P.M. Concurrent Breakout Sessions

- o Maximizing Success in a 638 Dental Clinic. Dr. Ronald Toepke, Dental Director, Pascua Yaqui Tribal Health Center
- o Teledentistry and Affiliated Practice Dental Hygiene. Dr. Kirk Robertson, Around the Mountain Pediatric Dentistry. Dr. Fred Summerfeld, Northern Arizona University
- o Dental Health Aide Therapists. Dr. Todd Hartsfield, AT Still University
- o Oral Health Strategies and First Things First. Beverly Russell, Tribal Liaison, First Things First

3:45 P.M Break

4:00 P.M. Repeat of Breakout Sessions

5:30 P.M. Reception

Remarks: John Lewis, Exec. Director, Inter Tribal Council of Arizona, Inc.

DAY TWO (April 22)

7:00 A.M. Continental Breakfast

EMCEE: Fred Hubbard, Director, Advisory Council on Indian Health Care

8: 00 A.M. Day One Recap and Day Two Goals

8:30 A.M. Prevention Strategies – Two concurrent breakout sessions

- o Under 21 of Age
- o 21 and Over

10:00 A.M. Break

10:15 A.M. Treatment Strategies – Three concurrent breakout sessions

- o Under 21 of Age
- o 21-64 Years of Age
- o 65 and Over Years of Age

11:45 A.M. Breakout Reports

12:30 P.M. Closing Prayer/Adjournment

Harry Antone, Tribal Elder, Gila River Indian Community

▶ APPENDIX 4: PREVENTION STRATEGIES BREAKOUT QUESTIONS

Children (0-20 year of age)

1. What programs and/or services are working well in tribal communities? For example school base sealants and community fluoridations.
2. What other services are needed to address health issues in tribal communities such as diabetes and obesity?
3. What needs to be done to sustain what is working in tribal communities? What barriers need to be overcome?
4. What needs to be done to secure services not currently being provided? Are legislative and administrative changes need?

Adults (20+ year of age)

1. What programs and/or services are working well in tribal communities? For example water fluoridation and topical teeth application.
2. What other services are needed to address health issues in tribal communities such as diabetes, obesity, health literacy, routine care, caries, prenatal care, oral cancer, etc.?
3. What needs to be done to sustain what is working in tribal communities? What barriers need to be overcome?
4. What needs to be done to secure services not currently being provided? Are legislative and administrative changes needed?

▶ TREATMENT STRATEGIES BREAKOUT QUESTIONS

Children (0-20 years of age)

1. What programs and/or services are working well in tribal communities? For example telemedicine, Community Dental Health Coordinator program, Affiliated Practice Program, Alaska Dental Health Aide Therapist, IHS, and 638 programs.
2. What other services are needed to address health issues in tribal communities such as nutritional counseling and in-home care for diabetes and obesity?
3. What needs to be done to sustain what is working in tribal communities? What barriers need to be overcome such as access to treatment?
4. What needs to be done to secure services not currently being provided in tribal communities? Are legislative and administrative changes needed?

Adults (20+ years of age)

1. What programs and/or services are working well in tribal communities? For example telemedicine, Community Dental Health Coordinator program, Affiliated Practice program, Alaska Dental Health Adie Therapist, IHS and 638 programs.

2. What other services are needed to address health issues in tribal communities such as nutritional counseling and in-home care for diabetes and obesity?

3. What needs to be done to sustain what is working in tribal communities? What barriers need to be overcome such as ability to access treatment?

4. What needs to be done to secure services not currently being provided in tribal communities? Are legislative and administrative changes needed?

Elders (65 and Over)

1. What is needed in tribal communities to increase access to oral health services for elderly patients? For example more AHCCCS providers and dental community understanding of access issues facing the elderly.

2. What is needed in tribal communities to increase the number of dental providers providing comprehensive services for elderly patients? For example more Arizona dentists and staff trained in treating elderly patients and development of in-office protocols to integrate elderly patients in the dental delivery system.

3. What is needed in tribal communities to increase oral health literacy and family motivation related to health care for elderly family members?

4. What needs to be done to secure services not currently being provided in tribal communities? Are legislative and administrative changes needed?