Appendix A

CENTER FOR PREVENTION AND HEALTH PROMOTION
Oral Health Program
Kate Brown, Governor

Oregon Health Authority

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AGENDA

"Oregon Tribes Dental Health Aide Therapist Pilot Project"
Dental Pilot Project #100
Site Visit: Native American Rehabilitation Association (NARA)
November 6, 2019

Location: NARA Youth Residential Treatment Center NARA – Youth Residential Treatment Center 620 NE 2nd Street Gresham, Oregon 97030		
9:30am-9:35am	Introductions	NPAIHB** NARA** OHA** AC Members**
9:35am-10:05am	Trainee Presentation Dental Health Aide Therapist (DHAT)	DHAT Trainee Kari Douglas, DHAT
10:05am-10:20am	NARA Youth Residential Treatment Center – Presentation, Review of Residential Treatment Center, Treatment Activities,	NARA Youth Residential Treatment Center Program Staff
10:20am-10:35am	NARA Youth Residential Treatment Center – Client Experience	NARA Youth Residential Treatment Center Program Client
10:35am-11:05am	NARA Youth Residential Treatment Center Facility Tour	NARA Youth Residential Treatment Center Program Staff NPAIHB NARA OHA AC Members
11:05am-11:15am	Lunch Executive Session Overview of Process	OHA AC Members
11:15am-1:00pm	Working Lunch Interviews with NPAIHB Project Participants, Supervising Dentists, Trainee, Others*	OHA AC Members Interviewee

* Interviews are a closed-door process; only OHA program staff invited Advisory Committee members and the interviewee may participate

** **NPAIHB** = Northwest Portland Area Indian Health Board
NARA = Native American Rehabilitation Association
OHA = Oregon Health Authority
AC Members = Advisory Committee Members, Oregon Health Authority Dental Pilot Project Advisory Committee

Appendix A

NATIVE AMERICAN REHABILITATION ASSOCIATION of the Northwest, Inc.

Services

NARA Youth Residential Treatment Cen

Project Details:

NARA's Youth Residential Treatment Center is a 24-bed unlocked co-ed facility providing treatment for youth with a primary diagnosis of substance use disorder. We serve Native American/Alaskan Native, and other youth between the ages of 12-17. Length of stay is approximately 90-180 days, dependent on the progress of the youth. We offer a multi-disciplinary treatment […]

Share:

- Our Circle of Services are modeled after the teachings of the medicine wheel; finding balance is our goal.

- Spiritual – We promote and provide youth with access to traditional spiritual and cultural activities such as sweat lodge, fire circle, smudging, prayer, and other culturally specific activities. We honor all cultural and

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spiritual beliefs, and allow youth to participate in the spiritual practices of their choice.

- Physical – Health and wellness are our goal. Youth will have access to NARA medical and dental clinics as needed. We will have daily physical activities on and off site. Our meals are approved by a dietician, who will be available for consults if youth have specific dietary needs.

- Mental – Licensed mental health therapists offer DBT, CBT and seeking safety groups. We offer family and multi-family groups and therapy and Trauma Recovery Empowerment Model (TREM).

- Emotional - We support the youth in their emotional well-being as they work towards becoming substance free through individual, group and family counseling, peer support, conflict resolution and communication skill building.

NARA's Youth Residential Treatment Center is a 24-bed unlocked co-ed facility providing treatment for youth with a primary diagnosis of substance use disorder. We serve Native American/Alaskan Native, and other youth between the ages of 12-17.

- Length of stay is approximately 90-180 days, dependent on the progress of the youth.
- We offer a multi-disciplinary treatment program that includes medical, dental, mental health, education and cultural activities.
- We use a variety evidence based practice counseling modalities.

Treatment Activities

- Alcohol and Drug Counseling
- Mental Health Counseling
- Family Therapy and Multi-Family Groups
- Online Accredited Education Program

NARA YRTC uses several White Bison curriculum's. We offer Sons and Daughters of Tradition, Mending Broken Hearts, The Medicine Wheel and 12 Steps for Youth, and Understanding the Purpose of Life12 Teachings for Native Youth.

Cultural groups include: Cultural arts and crafts, Regalia making, Native American History, Drumming and Songs, Guest Speakers from the Oregon Tribes and our Elders onsite for guidance and support.

Appendix A

620 NE 2nd Street
Gresham, OR 97030
Phone: 971-274-3757
Intake: 503-953-6598

CONTACT US

OREGON ADMINISTRATIVE RULES
OREGON HEALTH AUTHORITY, PUBLIC HEALTH DIVISION
CHAPTER 333

DIVISION 10

HEALTH PROMOTION AND CHRONIC DISEASE PREVENTION

333-010-0700
Dental Pilot Projects: Purpose
(1) The Dental Pilot Projects are intended to evaluate the quality of care, access, cost, workforce, and efficacy by teaching new skills to existing categories of dental personnel; developing new categories of dental personnel; accelerating the training of existing categories of dental personnel; or teaching new oral health care roles to previously untrained persons. The purpose of Dental Pilot Projects are to encourage the development of innovative practices in oral health care delivery systems with a focus on providing care to populations that evidence-based studies have shown have the highest disease rates and the least access to dental care.(2) These rules establish the requirements of Dental Pilot Project applications; the process for reviewing applications; approval or denial of applications; minimum standards for approved projects; evaluation and monitoring of Dental Pilot Projects; suspension or termination of an approved Dental Pilot Project; and discontinuation or closure of a project.
(3) These rules apply to:
(a) Applications for Dental Pilot Projects received on or after December 1, 2018; and
(b) Dental Pilot Projects approved before or after December 1, 2018.
(4) A dental pilot project that was approved and was operating before December 1, 2018 has until June 1, 2019 to come into compliance with the minimum standards in OAR 333-010-0760.
Statutory/Other Authority: 2011 OL Ch. 716
Statutes/Other Implemented: 2011 OL Ch. 716

333-010-0710
Dental Pilot Projects: Definitions
For purposes of OAR 333-010-0700 through 333-010-0820, the following definitions apply:
(1) "Adverse event" means harm caused by dental treatment, regardless of whether it is associated with error or considered preventable.
(2) "Authority" means the Oregon Health Authority.
(3) "Business day" means any 24-hour day other than a Saturday, Sunday or federal or state legal holiday.
(4) "Clinical evaluator" means a dentist, licensed in the State of Oregon or another state, who is responsible for conducting a clinical evaluation of an approved dental pilot project; who is unaffiliated with the project; and who has no financial or commercial interest in the project's outcome.
(5) "Clinical instructor" means a person who:
(a) Is certified or licensed in the field for which clinical instruction is occurring;
(b) Is currently licensed in dentistry or dental hygiene or licensed or certified in another appropriate health discipline; and
(c) Has current knowledge and skill in topics they will teach.

(6) "Clinical phase" means the time period of an approved project where a trainee treats patients, supervised by an instructor, applying knowledge presented by an instructor.
(7) "Complications" means a disease or injury that develops during or after the treatment of an earlier disorder.
(8) "Didactic phase" means the time period of a project during which trainees are presented with an organized body of knowledge by an instructor.
(9) "Employment/utilization phase" means the time period of a project where trainees are applying their didactic and clinical knowledge and skills in an employment setting under the supervision of a supervisor.
(10) "Employment/utilization site" means an Authority approved site for use during the employment/utilization phase that provides care to populations that evidence has shown have the highest disease rates and the least access to dental care. An employment utilization site includes any location where dental health care services are provided by a project's trainees.
(11) "Non-clinical instructor" is a person with specific training or expertise as demonstrated through a degree or experience relevant to the content of instruction.
(12) "Program" means the Dental Pilot Projects Program administered by the Authority.
(13) "Program staff" means the staff of the Authority with responsibility for the Dental Pilot Projects Program.
(14) "Project" means a Dental Pilot Project approved by the Authority.
(15) "Project director" means the individual designated by the sponsor of a dental pilot project who is responsible for the conduct of the dental pilot project staff, instructors, supervisors, and trainees.
(16) "Project Dental Director" means an individual who is actively responsible for oversight of the dental pilot project and who is a dentist or dental hygienist:
(a) Licensed in the State of Oregon; or
(b) A dentist authorized to practice in the State of Oregon but is exempt from state licensure under ORS 679.020 or 679.025; or
(c) A dental hygienist authorized to practice in the State of Oregon but is exempt from state licensure under ORS 680.020.
(17) "Project evaluation" means a systematic method for collecting, analyzing and using data to examine the effectiveness and efficiency of a pilot project by the project sponsor.
(18) "Reviewer" means an individual designated by the Authority to review and comment on all or portions of a project application.
(19) "Sponsor" means an entity that is a non-profit educational institution, professional dental organization, community hospital or clinic, coordinated care organization or dental care organization, tribal organization or clinic that:
(a) Submits a dental pilot project application; and
(b) If a dental pilot project is approved by the Authority, has overall responsibility for ensuring the project complies with these rules.
(20) "Standard operating procedures" means the written documented processes that describe the project's regularly recurring operations to ensure that the operations are carried out correctly and consistently and in accordance with these rules.
(21) "Supervisor" means an individual, licensed in the State of Oregon to practice dentistry, designated by the sponsor to oversee trainees at each approved employment/utilization site, with the skills necessary to teach trainees the scope of practice outlined in the approved project.
(22) "These rules" means OAR 333-010-0700 through 333-010-0820.

(23) "Trainee" means an individual who is part of an existing category of dental personnel; a new category of dental personnel; or a category of previously untrained dental personnel who has agreed to participate in a project and will be taught the scope of practice identified by the project.
(24) "Training program" means an organized educational program within a project that includes at least a didactic phase and a clinical phase.
Statutory/Other Authority: 2011 OL Ch. 716
Statutes/Other Implemented: 2011 OL Ch. 716

333-010-0720
Dental Pilot Projects: Application Procedure
(1) A sponsor who wishes to operate a pilot project must submit an application in a form and manner prescribed by the Authority.
(2) The application must demonstrate how the pilot project will comply with the requirements of these rules.
(3) The Authority will not accept new applications if it determines:
(a) There are a sufficient number of projects to provide a basis for testing the validity of the model as determined by the Authority.
(b) It does not have adequate resources to provide an appropriate level of oversight required by these rules.
(4) An application must include, at a minimum, the following information and documentation:
(a) The goals of the project, including whether the project can achieve at least one of the following:
(A) Teach new skills to existing categories of dental personnel;
(B) Accelerate the training of existing categories of dental personnel;
(C) Teach new oral health care roles to previously untrained personnel; or
(D) Develop new categories of dental personnel.
(b) Sponsor information:
(A) A description of the sponsor, including a copy of an organizational chart that identifies how the project relates organizationally to the sponsor;
(B) A copy of a document verifying the sponsor’s status as a non-profit educational institution, professional dental organization, community hospital or clinic, coordinated care organization or dental care organization, or a tribal organization or clinic;
(C) A description of the functions of the project director, project dental director, instructors, and other project staff;
(D) Documentation of the funding sources for the project;
(E) Documentation of liability insurance relevant to services provided by trainees; and
(F) A statement of previous experience in providing related health care services.
(c) Instructor and Supervisor information:
(A) The criteria used to select instructors and supervisors;
(B) Instructor-to-trainee ratio;
(C) The background of instructors in training techniques and methodology;
(D) The number of proposed supervisors and qualification of supervisors; and
(E) An explanation of how instructors and supervisors will be oriented to their roles and responsibilities and these rules.
(d) A training program that includes, but is not limited to, a description of:
(A) The instructional content required to meet the level of competence;

(B) The skills trainees are to learn;
(C) The methodology utilized in the didactic and clinical phases;
(D) The evaluation process used to determine when trainees have achieved the level of competence;
(E) The amount of time required to complete the didactic and clinical phases; and
(F) The level of competence the trainee shall have before entering the employment/utilization phase of the project.
(e) Trainees:
(A) The criteria that will be used to select trainees;
(B) The number of proposed trainees;
(C) The proposed scope of practice for trainees; and
(D) Information regarding the background check process for participants to determine compliance with OAR 333-010-0760, Minimum Standards.
(g) Employment/utilization sites:
(A) A list of all employment/utilization sites the proposed project intends to use; and
(B) Documentation that shows that each site listed meets the definition of an employment/utilization site.
(h) Costs:
(A) The average cost of preparing a trainee, including but not limited to the costs related to instruction, instructional materials and equipment, space for conducting didactic and clinical phases, and other pertinent costs;
(B) The estimated cost of care provided in the project; the likely cost of this care if performed by the trainees of the project; and the cost for provision of this care by current providers.
(C) A budget narrative that lists costs associated with key project areas, including but not limited to:
(i) Personnel and fringe benefits for project director, project dental director, instructors, and staff associated with the project;
(ii) Contractors and consultants to the project;
(iii) Materials and supplies used in the clinical, didactic, and employment/utilization phases of the project;
(iv) Equipment and other capital costs associated with the project; and
(v) Travel required for implementing and monitoring the project.
(i) An explanation of the feasibility of achieving the project objectives.
(j) A preliminary evaluation plan that includes, but is not limited to:
(A) How the project sponsor will monitor and evaluate the project;
(B) A description of the key project activities and their intended effects;
(C) How the project sponsor intends to use the evaluation results for program improvement and decision making; and
(D) A description of intended patient outcomes and metrics as outlined in the requirements under OAR 333-010-0780, Pilot Project Evaluation and Monitoring by Sponsor.
(k) An identified clinical evaluator who will conduct the clinical evaluation of the project in accordance with the evaluation plan.
Statutory/Other Authority: 2011 OL Ch. 716
Statutes/Other Implemented: 2011 OL Ch. 716

333-010-0730
Dental Pilot Projects: Application Review Process
(1) The Authority shall review an application to determine if it is complete within 60 calendar days from the date the application was received.
(a) If an applicant does not provide all the information required, and the application is considered incomplete, then the Authority shall notify the applicant of the information that is missing and shall allow the applicant 30 calendar days to submit the missing information.
(b) If an applicant does not submit the missing information within the timeframe specified in the notice, then the application shall be rejected as incomplete. An applicant whose application is rejected as incomplete may reapply at any time.
(2) An application deemed complete will continue through a review process.
(3) The Authority may have individuals outside the Authority, including representatives of appropriate professional societies and licensing boards, review applications, but no individual who has contributed to or helped prepare an application will be permitted to conduct a review.
(4) The Authority may request additional information from an applicant during the review process.
(5) Once the Authority completes an application review, a Notice of Intent to provisionally approve or deny an application will be provided to the applicant. The Notice will be sent to interested parties and will be posted for public comment for a period of 30 calendar days, along with a link to the application and other materials submitted by the applicant.
Statutory/Other Authority: 2011 OL Ch. 716
Statutes/Other Implemented: 2011 OL Ch. 716

333-010-0740
Dental Pilot Projects: Project Application Provisional Approval or Denial
(1) Following the close of the public comment period described in OAR 333-010-0730, Application Review Process, the Authority shall review the public comments that were received and issue within 30 calendar days of the close of the public comment period:
(a) A provisional decision to grant approval of an application; or
(b) A denial of the application.
(2) If the application is provisionally approved, the project sponsor must comply with the requirements in OAR 333-010-0750, Provisional Approval; Final Approval, before it can receive final approval. Projects that receive provisional approval may begin to provide didactic training however they may not operate or treat live patients until final approval is received from the Authority.
(3) If the Authority denies the application, the denial must be in writing and must describe the reasons for the denial. An application may be denied for any of these reasons:
(a) The application does not demonstrate that the project can meet the minimum standards or other provisions in these rules;
(b) The application does not demonstrate that the project is financially feasible; or
(c) The Authority has previously approved a similar project.
(4) A sponsor whose project has been denied may not submit a new application within six months from the date the Authority denied the application.
Statutory/Other Authority: 2011 OL Ch. 716
Statutes/Other Implemented: 2011 OL Ch. 716

333-010-0750
Dental Pilot Projects: Provisional Approval; Final Approval
(1) A project sponsor that has been provisionally approved must, within 90 calendar days of provisional project approval, submit the following to the Authority for approval:
(a) A detailed evaluation and monitoring plan that meets the requirements in OAR 333-010-0780, Pilot Project Evaluation and Monitoring by Sponsor.
(b) Written standard operating policies and procedures for the project that ensure compliance with OAR 333-010-0760, Minimum Standards. Standard operating policies and procedures shall include, but are not limited to:
(A) Clinical policies and procedures that describe the steps required for implementation of the project at each site;
(B) Administrative policies and procedures that describe protocols;
(C) Administrative protocols for mandatory record keeping;
(D) Data collection policies and procedure protocols that:
(i) Require data capture and data entry, including identification of the staff positions or other individuals responsible for these activities;
(ii) Define policies for protection and security of patient data;
(E) The protocol for orientating supervisors to their roles and responsibilities; and
(F) The process for ensuring that potential problems and root causes for deviations and non-conformances are identified, possible consequences assessed, actions to prevent recurrence considered, and corrective actions are taken if necessary.
(2) The Authority will review the documentation required in section (1) of this rule and notify the project sponsor if the plan and policies and procedures are acceptable. The Authority may request additional information and may request that the project sponsor revise the plan or policies and procedures to meet the requirements in these rules.
(3) Once the Authority has received an acceptable plan and policies and procedures, it will notify the project sponsor that the project has been approved along with the plan and policies and procedures. The final approval letter shall include:
(a) The permitted scope of the project;
(b) Any conditions the Authority deems are necessary to protect patient safety;
(c) Procedures for which the project will be required to obtain written informed consent for treatment under OAR 333-010-0770, Informed Consent; and
(d) The length of time the project can operate - from between three to five years.
(4) The Authority shall notify the Oregon Board of Dentistry when a project is approved.
Statutory/Other Authority: 2011 OL Ch. 716
Statutes/Other Implemented: 2011 OL Ch. 716

333-010-0760
Dental Pilot Projects: Minimum Standards
An approved dental pilot project shall:
(1) Provide for patient safety as follows:
(a) Comply with informed consent in accordance with OAR 333-010-0770, Informed Consent;
(b) Prohibit a trainee from performing procedures the trainee is not capable of performing based on the trainee’s level of education, training and experience, physical or mental disability, or

which are outside of the trainee's approved scope of practice as outlined in the approved application by the Authority;
(c) Provide or arrange for emergency treatment for a patient currently receiving treatment and needs emergency care;
(d) Not use the behavior management technique of Hand Over Mouth (HOM) or Hand Over Mouth Airway Restriction (HOMAR) on any patient;
(e) Comply with ORS 419B.005 to 419B.010 related to the mandatory reporting of child abuse;
(f) Comply with ORS 453.605 to 453.755 or rules adopted pursuant thereto relating to the use of X-ray machines;
(g) Comply with ORS 679.520 or rules adopted pursuant thereto relating to the treatment of dental waste materials;
(h) Comply with ORS 679.535 or rules adopted pursuant thereto relating to the requirement to test heat sterilization devices; and
(i) Ensure that project participants involved in direct patient care:
(A) Have not been convicted of any crimes, within the last 10 years, that is a crime of violence or crime of dishonesty.
(B) Have not been denied or disciplined by a state entity that issues licenses or certificates.
(2) Ensure that participants in the project, including trainees, do not engage in unprofessional conduct as that is defined in ORS 676.150.
(3) Ensure that an accurate patient record is prepared and maintained for each person receiving dental services, regardless of whether any fee is charged. The record shall contain the name of the trainee rendering the service and include, but is not limited to:
(a) Name and address and, if a minor, name of guardian;
(b) Date and description of examination and diagnosis;
(c) An entry that informed consent has been obtained in accordance with OAR 333-010-0770, Informed Consent;
(d) Date and description of treatment or services rendered;
(e) Date and description of all radiographs, study models, and periodontal charting;
(f) Health history; and
(g) Date, name of, quantity of, and strength of all drugs dispensed, administered, or prescribed.
(4) Have a sufficient number and distribution of qualified clinical and non-clinical instructors to meet project objectives, as identified in the approved application.
(5) Provide instruction to trainees following the training program outlined in the approved application by the Authority.
(6) Assure that trainees achieve a minimal level of competence before they are permitted to enter the employment/utilization phase. The sponsor must provide notice to the Authority within 14 business days of a trainee entering the employment/utilization phase. The notice shall include, but is not limited to, the following:
(a) Name, work address, electronic mail address and telephone number of the trainee;
(b) Name, work address, electronic mail address, telephone number and license number of the supervisor;
(c) Information regarding the trainee's responsibilities and limitations under Oregon Laws 2011, chapter 716 and these rules; and
(d) A disclaimer that there is no assurance of a future change in law or regulations that will allow them to practice without a license outside an approved dental pilot project.
(e) Trainee monitoring records shall be provided to the Authority.

(7) Comply with the requirements of the Dental Pilot Projects statute, Oregon Laws 2011, chapter 716; these rules; and the approved application including, but not limited to, the evaluation and monitoring plan.
(8) Evaluate quality of care, access, cost, workforce, and efficacy in accordance with the evaluation and monitoring plan approved by the Authority and as described in OAR 333-010-0780, Pilot Project Evaluation and Monitoring by Sponsor.
(9) Within 24 hours of any incident involving a patient in the care of a trainee which results in any medical occurrence that is life-threatening, requires hospitalization, results in disability or permanent damage, requires medical or surgical intervention or results in death, the sponsor must ensure that a detailed written report, along with the patient's complete dental records, is submitted to the Authority by the supervising dentist.
(10) Submit detailed quarterly monitoring reports in a format prescribed by the Authority that include but are not limited to the following categories for the previous quarter:
(a) Accomplishments or highlights.
(b) Challenges faced and continuous quality improvement activities.
(c) Updated project timeline.
(d) Data reports:
(A) A comprehensive breakdown of each of the data points the project is capturing in its approved evaluation and monitoring plan including anonymized client level data.
(B) Data generated by the clinical evaluator.
(C) Number and type of any adverse event or complication that occurred during the reporting period.
(11) Follow written standard operating policies and procedures approved by the Authority as outlined in OAR 333-010-0750, Provisional Approval; Final Approval.
(12) Use templates and follow guidelines for the submission of documents and other reporting requirements as prescribed by the Authority.
(13) Provide care only at Authority approved employment/utilization sites.
Statutory/Other Authority: 2011 OL Ch. 716
Statutes/Other Implemented: 2011 OL Ch. 716

333-010-0770
Dental Pilot Projects: Informed Consent
(1) A sponsor must ensure that each patient or person legally authorized to provide consent on behalf of the patient:
(a) Is provided written information about the dental pilot project and who will be providing treatment;
(b) Gives written consent to be treated by the dental pilot project trainee; and
(c) Gives informed consent for treatment by the trainee.
(2) Written information about the project and who will be providing treatment must include, but is not limited to:
(a) An explanation of the role and status of the trainee, any certification or licenses a trainee may hold, the education and training of the trainee and the availability of the trainee's supervisor for consultation;
(b) An explanation that the patient can refuse care from a trainee without penalty for such a request; and

(c) A statement that consenting to treatment by a trainee does not constitute assumption of risk by the patient.
(3) At a minimum, the following language must be included on the document that requests consent to be treated by the dental pilot project:

"I _____ [name of patient or person acting on patient's behalf] have received information about this dental pilot project and provider type. I have been given the opportunity to ask questions and have them fully answered. I have read and understand the information and I agree to the trainee of this project providing me treatment."

_____ _____
Signature of patient or person acting on patient's behalf Date

(4) Informed consent for treatment:
(a) Each patient must give informed consent to the procedure. Informed consent means the consent to a procedure obtained by:
(i) Providing a thorough and easily understood explanation to the patient, or patient's guardian, of the proposed procedures, any available alternative procedures and any risks associated with the procedures; and
(ii) Asking the patient, or the patient's guardian, if there are any questions and providing thorough and easily understood answers to all questions asked.
(b) Patient records must document an entry that informed consent for treatment has been obtained and the date the informed consent was obtained. Documentation may be in the form of an acronym such as "PARQ" (Procedure, Alternatives, Risks and Questions) or "SOAP" (Subjective Objective Assessment Plan) or their equivalent;
(c) Informed consent for treatment must be obtained in writing for procedures identified by the Authority in the application approval letter, and such consent must be included and documented in the patient's record; and
(d) A trainee may not perform any procedure for which the patient or patient's guardian has not given informed consent provided; however, in the event of an emergency situation, if the patient is a minor whose guardian is unavailable or the patient is unable to respond, a trainee may render treatment in a reasonable manner according to community standards and in accordance with the trainees approved scope of practice.
Statutory/Other Authority: 2011 OL Ch. 716
Statutes/Other Implemented: 2011 OL Ch. 716

333-010-0780
Dental Pilot Projects: Pilot Project Evaluation and Monitoring by Sponsor
A Project Evaluation and Monitoring Plan required under OAR 333-010-0750, Provisional Approval; Final Approval, must include, but is not limited to:
(1) A logic model to depict the project activities and intended effects;
(2) A description of key evaluation questions to be addressed by the pilot project, including relevant process and outcome measures;
(3) A detailed description of the baseline data and information to be collected about the availability or provision of oral health care services, or both, prior to utilization phase;
(4) A detailed description of baseline data and information to be collected about trainee performance, patient and community satisfaction, and cost effectiveness;

(5) A detailed description of the methodology and data sources to be used in collecting and analyzing the data about trainee performance, acceptance by patients, quality of care and cost effectiveness;
(6) Defined measures to evaluate safety and quality of care provided;
(7) A process for ongoing quarterly monitoring in accordance with OAR 333-010-0760, Minimum Standards; and
(8) A process for regular evaluation of project activities across the lifecycle of the project for continuous quality improvement purposes.
Statutory/Other Authority: 2011 OL Ch. 716
Statutes/Other Implemented: 2011 OL Ch. 716

333-010-0790
Dental Pilot Projects: Authority Responsibilities
(1) Project monitoring. Program staff shall monitor and evaluate approved projects which shall include, but is not limited to:
(a) Periodically requesting written information from the project to ascertain the progress of the project in meeting its stated objectives and in complying with program statutes and regulations:
(b) Periodic, but at least annual, site visits to one or more project offices, employment/utilizations sites, or other locations where trainees are being prepared or utilized; and
(c) Reviewing the quarterly reports submitted by the project as described in OAR 333-010-0760, Minimum Standards.
(2) Advisory committee. The Authority may convene an advisory committee for each approved dental pilot project.
(a) Individuals eligible to serve on an advisory committee include but are not limited to:
(A) Representatives from:
(i) The Oregon Board of Dentistry;
(ii) Professional dental organizations or societies;
(iii) Educational institutions;
(iv) Health systems; and
(v) Individuals representing the target population served by the pilot project.
(B) Individuals with an interest in public health, oral health or expanding access to medical and dental care.
(b) The purpose of the advisory committee is to gather its members' collective knowledge, experience, expertise, and insight to assist the Authority in meeting its responsibilities.
(c) If the Authority convenes an advisory committee it will solicit members for an advisory committee by public announcement; Individuals interested in serving on the committee are required to complete an application.
(d) From the applications received, the Authority will appoint no more than 15 members who are willing to undertake the duties of an advisory committee member and adhere to the committee charter adopted by the Authority. The Authority will notify each applicant in writing whether they have been appointed to the committee.
(e) An advisory committee member must:
(A) Attend meetings;
(B) Review approved pilot project quarterly reports at the request of the Authority;
(C) Attend approved pilot project site visits if invited; and

(D) Comply with any confidentiality requirements established by the Authority.
(3) Site visits.
(a) Site visits shall include, but are not limited to:
(A) Determination that adequate patient safeguards are being utilized;
(B) Validation that the project is complying with the approved or amended application;
(C) Interviews with project participants and recipients of care; and
(D) Reviews of patient records to monitor for patient safety, quality of care, minimum standard of care and compliance with the approved or amended application.
(b) If the Authority has convened an advisory committee, representatives of the committee may be invited by the Authority to participate in the site visit though the Authority may, at its discretion, limit the number of members who can participate;
(c) Written notification of the date, purpose and principal members of the site visit team shall be sent to the project director at least 90 calendar days prior to the date of the site visit;
(d) Plans to interview trainees, supervisors, and patients or to review patient records shall be made in advance through the project director;
(e) An unannounced site visit may be conducted by program staff if program staff have concerns about patient or trainee safety;
(f) The Authority will provide the project sponsor with at least 14 business days to submit to the Authority required patient records, data or other documents as required for the site visit; and
(g) Following a site visit the Authority will:
(A) Within 60 calendar days, issue a written preliminary report to the sponsor of findings of the site visit, any deficiencies that were found, and provide the sponsor with the opportunity to submit a plan of corrective action;
(i) A signed plan of correction must be received by the Authority within 30 calendar days from the date the preliminary report of findings was provided to the project sponsor;
(ii) The Authority shall determine if the written plan of correction is acceptable no later than 30 calendar days after receipt. If the plan of correction is not acceptable to the Authority, the Authority shall notify the project sponsor in writing and request that the plan of correction be modified and resubmitted no later than 10 business days from the date the letter of non-acceptance was mailed to the project sponsor;
(iii) The project sponsor shall correct all deficiencies within 30 calendar days from the date of correction provided by the Authority, unless an extension of time is requested from the Authority. A request for such an extension shall be submitted in writing and must accompany the plan of correction.
(iv) If the project sponsor does not come into compliance by the date of correction reflected on the approved plan of correction, the Authority may propose to suspend or terminate the project as defined under OAR 333-010-0820, Suspension or Termination of Project.
(B) Within 90 calendar days of receipt of a plan of correction, issue a final report to the sponsor; and
(C) If there are no corrections needed, the Authority will issue a final report within 180 calendar days.
Statutory/Other Authority: 2011 OL Ch. 716
Statutes/Other Implemented: 2011 OL Ch. 716

333-010-0800
Dental Pilot Projects: Project Modifications

(1) Any modifications to an approved project shall be submitted in writing to program staff, except as specified in section (4) of this rule. All modifications require Authority approval. Modifications include, but are not limited to the following:
(a) Changes in selection criteria for trainees, supervisors, or employment/utilization sites;
(b) Addition of employment/utilization sites; and
(c) Changes in the scope of practice for trainees.~~;~~
(2) Upon receipt of a request for a modification approval, the Authority will inform the project sponsor in writing on the timeline for review of the request and decision response deadline.
(3) If the Authority has convened an advisory committee for an approved project, the Authority may confer with the advisory committee regarding the proposed modification.
(4) Changes in project staff or instructors are not considered a modification and do not require prior approval by program staff, but shall be reported to the program staff within two weeks after the change occurs along with the curriculum vitae for the new project staff and instructors.
(5) The Authority may approve or deny a request for modification. A modification may be denied if:
(a) It does not demonstrate that the project can meet the minimum standards or other provisions in these rules; or
(b) The modification would result in a substantial change to underlying purpose and scope of the pilot project as originally approved.
(6) Projects are not permitted to implement the proposed modification until approval has been rendered by the Authority.
Statutory/Other Authority: 2011 OL Ch. 716
Statutes/Other Implemented: 2011 OL Ch. 716

333-010-0810
Dental Pilot Projects: Discontinuation or Completion of Project
(1) An approved project must notify the Authority in writing if it intends to discontinue its status as a Dental Pilot Project, at least 60 calendar days prior to discontinuation. Notification must include a closing report that includes, but is not limited to:
(a) The reasons for discontinuation as a pilot project;
(b) A summary of pilot project activities including the number of persons who entered the employment/utilization phase; and
(c) A description of the plan to inform trainees of the project's discontinuation and that they are precluded from performing the skills authorized under the pilot project after discontinuation unless the provider type has been legalized by the State of Oregon.
(2) The project must obtain written acknowledgement from trainees regarding notification of the project's discontinuation and preclusion from performing skills authorized under the pilot project after discontinuation, unless the provider type has been legalized and the trainee has met necessary licensure requirements.
(3) Project completion. A project sponsor must provide a full report of findings to the Authority within 180 calendar days of the completion of the project in a format prescribed by the Authority.
Statutory/Other Authority: 2011 OL Ch. 716
Statutes/Other Implemented: 2011 OL Ch. 716

333-010-0820
Dental Pilot Projects: Suspension or Termination of Project
(1) A pilot project may be suspended or terminated for violation of 2011 Oregon Laws, chapter 716 or any of these rules.
(2) Failure of a sponsor or anyone involved with an approved pilot project to cooperate with a reasonable request for records, interviews or a site visit is grounds for the Authority to suspend or terminate a project. Failure to cooperate includes, but is not limited to, failure to provide information or documents in a manner requested by the Authority or within the timeframe requested by the Authority.
(3) If the Authority determines that a dental pilot project is in violation of 2011 Oregon Laws, chapter 716 or these rules, the Authority may:
(a) Require the sponsor to implement an approved corrective action plan in accordance with OAR 333-010-0790, Authority Responsibilities; or
(b) Issue a Notice of Proposed Suspension or Notice of Proposed Termination in accordance with ORS 183.411 through 183.470.
(4) A sponsor who receives a Notice may request an informal meeting with the Authority. A request for an informal meeting does not toll the period for filing a timely request for a contested case hearing as described in section (5) of this rule.
(5) If the Authority issues a Notice of Proposed Suspension or Notice of Proposed Termination the sponsor is entitled to a contested case hearing as provided under ORS chapter 183. The sponsor has 30 calendar days to request a hearing.
(6) If the Authority terminates a dental pilot project, the order shall specify when, if ever, the sponsor may reapply for approval of a dental pilot project.
Statutory/Other Authority: 2011 OL Ch. 716
Statutes/Other Implemented: 2011 OL Ch. 716

PUBLIC HEALTH DIVISION
Oral Health Unit
Kate Brown, Governor

ADVERSE EVENT REPORTING:
A sponsor must report severe Adverse Events to the Oregon Health Authority program staff the day they occur as outlined in OAR 333-010-0710. Adverse Event reports are prepared by project sponsor personnel with the intent that such reports will not contain information regarding the patient's identity. The information will be prepared as a brief anecdotal account to be submitted to the Oregon Health Authority.

"Adverse event" means harm caused by dental treatment, regardless of whether it is associated with error or considered preventable as defined under 333-010-0710.

Adverse Events may be categorized by severity in relation to patient harm as shown in Figure 1. Adverse Events or Suspected Adverse Events that classified as severe temporary or permanent harm (E2 or higher) must be reported to OHA the day they occur or are found to have occurred. Other Adverse Events or Suspected Adverse Events must be reported in a timely fashion.

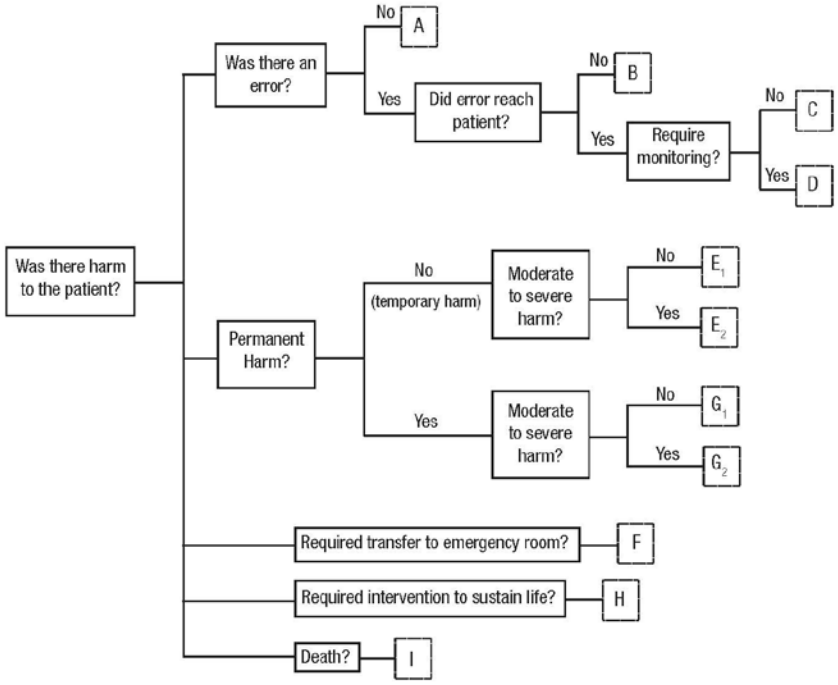
OHA staff will then work with project staff to determine if the incident is an Adverse Event and to finalize Adverse Event severity and category classifications based upon submitted narratives and patient chart documents.

INSTRUCTIONS:
1. Contact Program Staff via telephone (971-673-1563) or email on the date of the incident.
2. Complete Adverse Event Reporting Form and Submit the Completed Form via secured email to sarah.e.kowalski@state.or.us. Additional attachments must be in PDF format.
3. If the incident is determined by OHA to be an Adverse Event, a sponsor must perform and later submit a Root Cause Analysis of the incident.

Dental Pilot Project:	
Reporting Date:	
Date of Incident:	
Address of Incident:	
Incident Description: Please be as specific as possible	
Procedure Name(s) and CDT Code(s) performed on patient:	

AE Severity	Review Dental Adverse Severity Tree and choose the most appropriate category.	

Figure 1. Dental Adverse Event Severity Categories



Category	Description of Dental Adverse Event Severity Categories using the Dental AE severity tree
A	No errors
B	Error with no impact on patient
C	Error with minimal/mild impact to patient; does not require monitoring
D	Error with moderate to severe impact to patient; requires monitoring
E_1	Temporary (reversible or transient) minimal/mild harm to the patient
E_2	Temporary (reversible or transient) moderate to severe harm to the patient
F	Harm to the patient that required transfer to emergency room and/or prolonged hospitalization
G_1	Permanent minimal/mild patient harm
G_2	Permanent moderate to severe patient harm
H	Intervention required to sustain life
I	Patient death

Adapted from: Kalenderian E, Obadan-Udoh E, Maramaldi P, et al. Classifying Adverse Events in the Dental Office [published online ahead of print, 2017 Jun 30]. J Patient Saf. 2017;10.1097/PTS.0000000000000407. doi:10.1097/PTS.0000000000000407

Contact Name:	
Email:	

Project Manager Signature/Date

Examples of Adverse Events may include but are not limited to:

Example:	Possible Severity Category*:
Administration of medication, anesthetic, chemical that is in a dosage that results in a reaction	E1, E2
Allergic reactions to dental materials	E2, F
Anesthetizing the wrong site (only if harm occurs)	E1, E2
Aspiration/Ingestion of Foreign Body	E2
Bleeding that is uncontrolled or prolonged and requires intervention	E1, E2
Damage to tooth or bone	G1, G2
Death due to overdose of anesthesia	I
Foreign Body Response: object retained at site of treatment—file separation, overhang	E2
Infections that escalate after treatment or arise post-operatively	E1, E2
Infections with fluctuant swelling requiring I & D	E2
Laceration of lip/tongue/cheek during dental procedure	E1, E2, G1, G2
Pain following extraction/RCT without proper pain management	E2
Painful dry socket	E1, E2
Paresthesia following a dental procedure	G2
Paresthesia that presents with numbness with or without pain: triggered by report of tingling, paresthesia, dysesthesia, numbness, palsy between 0-30 days after a treatment/procedure	G2
Perforation of tooth due to endodontic treatment	E2
Peri-implantitis	E2
RCT on wrong tooth	G1, G2
Sinus infections (resulting from perforations or communications with oral cavity)	E2
Space infections: submandibular	E2, F
Tissue necrosis due to bleaching or rubber dam clamp	G1, G2
Wrong procedure/patient	G2
Wrong tooth extraction	G2

**Examples and possible severity category assigned in the table do not necessarily contain all of the information. For example, an allergic reaction to dental materials may be a localized reaction that was managed in the dental office. It may also mean that the patient required transfer to a hospital as the reaction was systemic and required management in a hospital. Chart notes provide more information to the scenario and are used to determine the severity category.*

The following are not considered Adverse Events:

- Causes or precursors to AEs (Underlying conditions)
- Errors
- Near Misses
- Poor/unacceptable quality of Care
- Natural course of disease

Dental Health Aide Therapist
Practice Agreement Template

Individual instructions:

Service	Supervision: Instructions	CHAP-CB Standard	Dentist Initial and Date	DHAT Initial and Date
Topical fluoride application	General: Providing topical fluorides, including gels, foam, varnish and rinses.	2.30.110		
Diet education	General: As it relates to oral health	2.30.110		
OHI	General: Oral hygiene instructions	2.30.110		
Taking medical and dental history	General: Problem- specific medical and dental history taking as it relates to oral health	2.30.210		
Charting	General: Dental charting and patient record documentation	2.30.210		
Sterilization	General: Instrument handling and sterilization procedures, maintain validation tests and logs	2.30.210		
Photographs	General: Intraoral and extraoral	2.30.210		
Sealants	General: Placement and maintenance using appropriate material, technique and occlusion	2.30.220		
Prophy	General: Toothbrush, hand scaling, ultrasonic or piezoelectric cleaning and rubber cup polishing of the coronal/ exposed surfaces of teeth **Report prior to treatment if:** • If pocketing is greater than 4 mm • If subgingival calculus is clinically or radiographically evident • If teeth have more than class I mobility • If bone loss is more than 10%	2.30.230		
Radiographs	General: Panoramic, extraoral, and intraoral	2.30.240		
ART	General: Use of hand instruments for excavation of gross caries. Mixing, placing and contouring appropriate restorative material • For teeth with asymptomatic decay	2.30.260		

Dental Health Aide Therapist
Practice Agreement Template

	or clearly reversible pulpitis and patient behavior or equipment availability indicates • Or as initial caries control as part of a sequenced treatment plan			
SSC	General: Stainless Steel Crown prep, fit and placement • Deciduous teeth • Permanent teeth	2.30.550		
Restorations	General: Excavate and place restorations using material appropriate for patient and the tooth, with appropriate bonding agents when indicated: • Composites(Resin, RMGI and GI) • Amalgams Cusp protected amalgams	2.30.610		
Diagnosis and treatment of caries	General: Observations must be documented that support the assessment and a plan for treatment, not just restoration, must be written	2.30.610		
Pulpotomies	General: On deciduous teeth	2.30.610		
Uncomplicated extractions	Indirect: 1) All extractions will be performed under the indirect supervision of the trainee's dentist. Indirect supervision is defined under ORS 679.010 as supervision requiring that a dentist authorize the procedures and that a dentist be on the premises while the procedures are performed. 2) For primary and permanent tooth extractions, the DHAT will first receive and document authorization from the supervising dentist. 3) For primary teeth, the trainee may perform non-surgical extractions on teeth that exhibit some degree of mobility. The trainee will not extract a tooth if it is unerupted, impacted, fractured or decayed to the gumline, or needs to be sectioned for removal. 4) For permanent teeth, the trainee may perform non-surgical extractions of periodontally diseased teeth with evidence of bone loss and +2 degree of mobility. The trainee will not extract a tooth if it is unerupted, impacted, fractured or decayed to the gumline, or needs to be			

Dental Health Aide Therapist
Practice Agreement Template

	sectioned for removal.			
Emergency services	General: To alleviate pain and infection	2.30.610		
Local anesthesia	General: For intraoral procedures	2.30.610		
Space maintenance	General: Recognize and treat conditions needing space maintenance	2.30.610		
Maintain dental equipment	General: Maintain and repair user-serviceable parts to typical fixed and portable dental equipment	2.30.610		
Community program development	General: Development and carrying out a community oral health education and disease prevention program	2.30.610		

WHITE BISON

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DONATE (/Donate.aspx)

Substance Abuse Treatment Centers across the country have taken steps to become a **Wellbriety Certified Treatment Center**. They have met specific criteria by utilizing principles, methods and resources from the Wellbriety approach within their programs. White Bison receives inquiries on a weekly basis for referrals to residential treatment services. We refer individuals and families to our Wellbriety Certified Treatment Centers to assist Native Americans/Alaska Natives in finding treatment *by using culturally-based approaches*. Each year White Bison reassesses Wellbriety Certified Treatment Centers to ensure all requirements are continuously being met.

By sending clients to Wellbriety Certified Treatment Centers it means that these centers are guaranteed to:

1. Include culturally-based Wellbriety curriculum, including:
    a. The Medicine Wheel and 12 Steps course, materials and related counseling
    b. Mending Broken Hearts course, materials and related counseling
    c. Warrior Down/Recovery Coach course, materials and related counseling
    d. 'The Red Road to Wellbriety: In the Native American Way' and the supplementary workbook.
2. Employ at least one individual of Native American ancestry;
3. Provide individual counseling for clients;
4. Provide access to a Native American Elder, who conducts ceremonies and provides teachings;
5. Incorporate traditional Native American healing practices (smudging, pipe ceremony, sweat lodge, etc.);
6. Establish aftercare plans by providing community referrals for continuous self-care; and,
7. Ensure all counselors are trained in and incorporate culturally-based curriculum, including
    a. Medicine Wheel and 12 Steps Programs
    b. Mending Broken Hearts
    c. Warrior Down/Recovery Coach course
    d. 'The Red Road to Wellbriety: In the Native American Way' study groups/circles.

2018 Wellbriety Certified Treatment Centers

(http://www.voanr.org/native-american-services/)

Volunteers of America Northern Rockies offers services specifically designed for Native Americans through their Native American Cultural Enhancement Program (NACEP). The NACEP is intended to teach those struggling with alcohol, drugs or gambling addiction(s) to integrate the teachings from NACEP to get clean and sober. This Wellbriety Certified Treatment Center is located in Sheridan, Wyoming. To learn more about the NACEP program at Volunteers of American Northern Rockies, please click on their logo.

(http://www.naranorthwest.org/)

The **Native American Rehabilitation Association of the Northwest, Inc.** (NARA) provides education, physical and mental health services and substance abuse treatment that is culturally appropriate to Native Americans. NARA is a Native American owned and operated agency located in Portland, Oregon. All services are guided by their Cultural Director who trains and consults with staff on cultural competence and provides cultural programming or clients. To learn more about NARA, please click on their logo.

(http://www.nctribalhealth.org/services-by-department/behavioral-health-department/)

The **Northern Cheyenne Recovery Center** specializes in the treatment of substance, drug and alcohol abuse for Native Americans. This center Incorporates cultural treatment components in their outpatient, inpatient and continuing care programs. This Wellbriety Certified Treatment Center is located in Lame Deer, Montana. To learn more about the Northern Cheyenne Recovery Center, please click on their logo.

(https://www.newdirectionsforwomen.org/)

New Directions for Women offers personalized and trauma-specific support for Native American women with substance use disorders. The staff at New Directions for Women have received training in the various philosophes of Native American societies and ensure that their knowledge is updated regularly. Women of all ages, pregnant women in any trimester, and women with their dependent children can receive services at New Directions for Women. This facility was founded as a non-profit organization in 1977 and is located in Costa Mesa, California. To learn more about New Directions for Women, please click on their logo.

(https://www.breakawayhealth.com/home.htm)

Over the past 32 years **BreakAway**, a comprehensive outpatient facility has helped thousands of individuals and families. Our comprehensive behavioral health services are designed to serve both adolescents and adults who suffer from substance abuse, dependency, sexual trauma, PTSD, eating disorders, anxiety, depression and other psychiatric and behavioral disorders. BreakAway individualizes each client's treatment plan for their own personal needs and unique lifestyle.

(https://oregontrailrecovery.com/?utm_source=GMBlisting&utm_medium=organic)

Oregon Trail Recovery aims to ensure a safe environment where our clients can work on their substance addictions. During treatment, we assist them in utilizing the tools necessary to remain alcohol and drug free long-term. We employ strength-based trauma informed therapies to continue to engage our clients in their recovery process. We have peer support staff available for them to connect with while in treatment and for support in building resources in the community. Our trained clinical staff commits themselves to the growth and wellness of our clients. We are blessed to offer a variety of curriculums; including several from White Bison. We also have PCTD (Pacific Crest Trail Detox, which is a 7-to-10-day process. We're there with you every step of the way to lend support and guidance during this challenging process. Our program is done in a home-like environment with delicious home cooked "nutritious" food with a focus on helping each individual feel as comfortable as possible.

(https://7summitpathways.com/)

7 Summit Pathways Wellbriety program is an Indigenous-led, Native American culturally-based recovery program developed around traditionally appropriate sacred teachings. These personalized and trauma-specific healing teachings will include sweat lodges, pipe and fire ceremonies, and talking circles. As a Wellbriety certified treatment center, we incorporate the 12 steps of recovery into traditional medicine wheel teachings and practices.

(https://royallifecenters.com/tribal-healing)

Royal Life Centers Royal Life Centers is a renowned CARF, Joint Commission, and NAATP accredited treatment addiction provider with facilities located in Arizona and Washington. Our program offers an integrated continuum of care that guides our guests through each stage of early sobriety. Royal Life Center's complete spectrum of care includes Medical Detox, Residential Inpatient, Partial Hospitalization (PHP), Intensive Outpatient (IOP), Outpatient (OP), and Sober Living. **"Because We Care,"** we are centered in a holistic approach to the recovery of mind, body, and spirit. Services currently incorporated into our program include equine therapy, sober music studios, case management, yoga, employment assistance, GED guidance, legal aid services, and tribal healing. Led by certified instructors, our tribal

Menu

healing program honors the spirit, traditions, and values of the Native American culture by incorporating Wellbriety groups, tribal beading, drum circles, dream catchers, and sweat lodge ceremonies. Honor the power of your voice and begin your journey with us today!

More

For more information please read our Requirements for Certification (/files/CertifiedTreatmentCriteria_2014.pdf) or contact info@WhiteBison.org (mailto:info@whitebison.org?subject=Re: Requirements for Certification)

If your facility is interested in becoming a Wellbriety Certified Treatment Center, please contact info@WhiteBison.org (mailto:info@whitebison.org?subject=Re: Requirements for Certification).

(/WellBriety.aspx) (/Default.aspx)

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CALENDAR (https://tools1.whitebison.org:11433/LoginFormGuest.aspx?UserName=Training)

DAILY MEDITATIONS (http://wellbriety.com/meditations/)

Wellbriety Certified Treatment Centers (/WellBrietyAffiliateTreatment.aspx/)

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✱ White Bison Inc., is a Combined Federal Campaign (CFC) Member #11364 ✱

ABOUT

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White Bison, Inc., is an American Indian/Alaska Native non-profit charitable organization operating under the provisions of 501(c)3 of the Internal Revenue Code and is based in Colorado Springs, Colorado. Through White Bison, it's Founder and President Don Coyhis, Mohican Nation, has offered healing resources to Native America since 1988. White Bison offers sobriety, recovery, addictions prevention, and wellness/Wellbriety learning resources to the Native American/Alaska Native community nationwide. Many non-Native people also use White Bison's healing resource products, attend its learning circles, and volunteer their services. White Bison is a NAADAC approved provider (#64009) and a Combined Federal Campaign (CFC) Member #11364.

The White Bison Vision

We are a Native American operated 501(c)3 nonprofit company dedicated to creating and sustaining a grassroots Wellbriety Movement that provides culturally based healing to the next seven generations of Indigenous People.

White Bison is a proud facilitator of the Wellbriety Movement. Wellbriety means to be sober and well. Wellbriety teaches that we must find sobriety from addictions to alcohol and other drugs and recover from the harmful effects of drugs and alcohol on individuals, families and whole communities. The "Well" part of Wellbriety is the inspiration to go on beyond sobriety and recovery, committing to a life of wellness and healing everyday.

Meet Our Leaders

Don Coyhis, Mohican Nation, is the President and Founder of White Bison, Inc., an American Indian non-profit organization, located in Colorado Springs, CO. Don originally set out to raise awareness and treat alcoholism among Indian youth on the reservations. After studying the underlying causes

of alcoholism, White Bison's mission expanded to include drug addiction, dysfunctional families and relationships, as well as the American Indian suicide rate. From this, the Wellbriety Movement was born. The teachings of Wellbriety go beyond being sober to include thriving in the community and being balanced emotionally, mentally, physical and spiritually. Over the past 26 years, Don has developed a series of culturally-based programs to address recovery and treatment, youth prevention and treatment, programs for healthy families, and healing from unresolved grief and traumatic loss due to intergenerational trauma. These programs are designed help with all facets of family healing and have been implemented throughout the United States and Canada. Don Coyhis was the 2009 winner of the Purpose Prize Award, which was created in 2005 by Encore.org, with funding from the John Templeton Foundation and The Atlantic Philanthropies, to showcase the value of experience and disprove outdated notions that innovation is the sole province of the young. It's for those with the drive to make change and the experience to know how to do it. Don's life experiences have enabled him to author several books addressing recovery, treatment, and prevention of alcoholism and substance abuse for adults, youth and families. He has been called upon to provide technical assistance by national policy organizations such as the White House Office of Drug Control Policy, Substance Abuse and Mental Health Services Administration (SAMHSA), as well as other national recovery organizations to develop prevention and recovery programs for Native American/Alaska Native communities. Don has dedicated his life to raising awareness about all issues surrounding alcohol and drug abuse, how it impacts the family system, and most importantly how families and communities can heal from these issues.

Appendix D

White Bison's Philosophy

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We believe...

Mother Earth is governed by a set of Principles, Laws and Values
Leadership exists to serve the people first
Leadership existence is to ensure that information (Truth) is given to the people
Changes are the result of implementing Natural laws
All Native people believe in a Supreme Being
In the Elders and teachings as a guiding force to direct ourselves, families and communities
That there is a natural order running the universe
That our traditional ways were knowledgeable about the natural order
When the community leads, the leaders will follow
Alcohol and drugs are destroying us and we want to recover
That change comes from within the individual, the family and the community
That within each person, family and community is the innate knowledge for well being
The solution resides within each community
Interconnectedness - it takes everyone to heal the community
Healing will take place through he application of cultural and spiritual knowledge
Alcohol is a symptom...not the cause, drugs are a symptom...not the cause, Domestic Violence is a symptom...not the cause.
To "heal a community" it needs to deal with the cause
That the Circle and the Four Directions are the Teachers
In the Four Laws of Change
Change is from within
In order for development to occur, it must be preceded by a vision
A great learning must take place
You must create a Healing Forest
OUR CULTURE IS PREVENTION

WHITE BISON COUNCIL OF ELDERS

Meet the Elders

Della Bad Wound Oglala Lakota - Employed in the human services field for 50 years working with women, children, youth and elderly. Her employment included the founding of Western South Dakota Senior Services in western South Dakota as the program director for 17 Nutrition sites for the elders. Denver Indian Health & Family Services,

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Winyan Wasaka-Women's Alcohol Prevention Program, Seventh Generation Project, University of Denver; Elderhealth Program with Four World's Development, Inc. in Lethbridge, Canada, and as a Native Sister with the Native American Cancer Research Project. She has been working with the documentation and preservation of the Lakota Language with the University of Colorado in Boulder for the past 6 years.

Della has one son, Michael and his significant other, one younger sister, one younger brother, many nieces and nephews, grandchildren and great grandchildren. Her extended family includes hunka sisters, hunka children and grandchildren. Hunka-making of a relative-adopted.

Dr. Henrietta Mann (N. Cheyenne) has been an integral part of the development of the Wellbriety family programs (Families of Tradition, Mothers of Tradition, Fathers of Tradition, Sons of Tradition and Daughters of Tradition). Her sharing of teachings of the Cycle of Life provided the framework for these trainings. After years as a professor and an advocate for Native sovereignty and wellness, Dr. Henrietta came out of retirement to start a the Cheyenne / Arapaho tribal community college. She does the ceremonies and songs. She also reminds us what we stand for: "We do not need to remain locked into those areas where we feel a great deal of anger and hostility to the dominant population because as White Bison says, we have to forgive the unforgivable. There are many that have and there are many who are yet to do that. Only when we forgive the unforgivable can we really say we are healing, that we have addressed that one aspect of our life. Saying we can forgive, now we can heal."

WHITE BISON TRAINER BIOS

Meet Our Trainers

Sparrow Goudey (Tsalagi/Cherokee/Wyandot) is the founder of Waya Nv-No-Hi (Wolf Road) Healing the Circle Workshops. With 25 years of continued sobriety, she has developed and conducts workshops for both Native and non-Native communities that assist adults and adolescents, affected by drugs, alcohol, eating disorders and mental illness by incorporating curriculum, traditional arts and spirituality as tools for change, growth and recovery. Sparrow is also a trainer for White Bison and the Wellbriety Training Institute. She facilitates Mending Broken Hearts, Medicine Wheel & 12 Steps, Mothers of Tradition, Daughters of Tradition and Wellbriety Celebrating Families curriculums and is devoted to helping individuals and communities that suffer from addiction and trauma.

Darryl Lickers a member of the Turtle Clan is originally from the Six Nations of the Grand River Mohawk Territory in southwestern Ontario Canada. He is of Tuscarora descent, and presently makes his home in Blackfalds, Alberta with his wife Karen. Darryl has recently retired from service with the Canadian Federal Government after 40+ years of service, both with the military (25 years) and his recent position with Corrections Canada as an Aboriginal Correctional Program Officer (23 years). On December 1st, 2015, Darryl completed his career at Pê Sâkâstêw Centre Healing Lodge in Mâskwâcîs, Alberta where he delivered substance abuse, family violence, violence prevention (In Search of Your Warrior) programs as well as White Bison programs Medicine Wheel & 12 Steps, Fathers of Tradition and Mending Broken Hearts. Darryl believes he is fulfilling his purpose in life as a helper by using his experiences and knowledge to help Native people heal from the effects of addiction and other abuses. Darryl has been a friend of Bill W. for the past 40 years (May 11, 1976). We are honoured to have Darryl as one of our Canadian trainers.

Andrea Alexander, is Seminole/Creek, a member of the Seminole nation of Oklahoma. She has provided training and consulted with tribal communities, state and private prisons, treatment centers, governmental agencies, and the recovery community at large. She is skilled in individual, group and family counseling specifically focusing on behavior related to substance use and/or criminal behavior, case management, treatment and discharge planning, assessment, liaison work with court systems. She is an experienced facilitator in Relapse Prevention, Early Recovery; both matrix models of treatment. Experience also includes inpatient treatment to sober living. She assisted in working with the implementation and operation of the Muscogee Creek Nation Reintegration Program for offender reentry, the first native American tribal reentry program, also, initiative coordinator at Seminole Nation of Oklahoma Methamphetamine and Suicide Prevention Initiative. From

this, she gained experience with family, juvenile, adult and mental health special courts programs. She is an experienced Wellbriety Circles of Recovery program facilitator with White Bison, Inc. programs in a variety of settings. She has a Bachelor of Arts-Sociology with a Substance Abuse Studies option-University of Central Oklahoma and an Associate in Applied Science-Alcohol & Substance Abuse Counseling-Oklahoma State University-OKC.

TANYA SCHUR, MA, is a Blackfeet-Métis mother of two grown children. She follows a cultural way of life and the traditional teachings of the medicine wheel under the guidance of elders from Blackfoot and Cree Nations. She is committed to Urban Indigenous Community Development and the empowerment of Indigenous people. She is a Health Rhythms ™ facilitator, Leadership on the Medicine Wheel facilitator, Emotional Intelligence and Diversity trainer, certified Mediator with Aiskapimohkiihs (Siksika Justice) and facilitates Medicine Wheel and 12 Steps at the Friendship Centre in Red Deer. She holds a MA in Leadership Studies from the Royal Roads University, Victoria. Her focus of research explored building cohesive teams from diverse work groups, transformational change, strategic planning, leadership development and organization design. Her work in program design has included facilitating Urban Aboriginal Pre-Employment Programs for the Red Deer Aboriginal Employment Services, creation of the Aboriginal Youth Leadership Certification and implementation of the Urban Aboriginal Voices Society urban governance model. Since completing the The Canadian Women's Foundation Leadership Institute Tanya has turned her energy to designing the Community Development strategy for Asooahum Crossing Indigenous Cultural neighbourhood in Red Deer. Tanya is currently serving as the Director of Asooahum Crossing at the Red Deer Native Friendship Centre.

Brennan Ireland, is Bear Clan from the Oneida Nation of the Thames, Ontario, Canada. Brennan received and learned the Huadasunee way of life through his grandfather which he passes on to his five children family and community. Brennan is an Addictions and Mental Health Counsellor at Southwest Ontario Aboriginal Health Access Centre and certified Indigenous Addictions Specialist and Canadian Certified Addictions Counsellor. Brennan has over 21 years of continued sobriety and uses the Wellbriety Programs to support self and community.

Mary (Hummingbird) Thompson, is an enrolled member of the Kiowa Tribe of Oklahoma. Although Ms. Thompson was born and raised amongst her own Tribal people, using her tradition and cultural ways; she has lived in Sacramento since 1987 learning and working in the community serving California Natives as well as other Tribal people. Throughout her career she has presented on Domestic Violence, White Bison's Daughters of Tradition, Domestic Violence, Positive Indian Parenting, Youth leadership Development. Mary has received her training and certification as a Domestic Violence Advocate through Harrington House and as a Domestic Violence Peer Counselor through WEAVE

(Women Escaping a Violent Environment). She has obtained her AA degree as a Paralegal through MTI School of Business and Technology and is currently, working on getting her A degree as a Substance Abuse Counselor through Breining Institute while being a Youth Advocate. Currently, she sits on the Board of Directors for the Native Dads Network and the Advisor to the newly forming Sacramento United Natives Youth Leadership Council. Ms. Thompson has spent many years working with women, youth and families and has found this to be her passion and has made a life-long commitment to being of service. Mary has over 26 years of sobriety.

Winona Stevens, is a member of the Ho-Chunk Nation of Wisconsin. She has been the Program Manager for the Dept. of Correction's Native American Religious Program since 2013. She is responsible for the religious services across 21 Native American Circles across Washington State. Winona received her Master's Degree in Social Work at the University of Washington. In addition to facilitating the Department of Corrections Native circles activities, she has held many positions which include Adjunct Professor at Northwest Indian College, New Directions Anger Management Group Facilitator, and White Bison Recovery Coach for Intergenerational Trauma and the 12 Step Medicine Wheel Program for Men and Women. Mrs. Stevens directed efforts in working closely with tribal communities and currently serves on a number of boards including Huy, Council for First Inhabitants Rights and Equality, and the University of Washington's Native American Advisory Board. Her commitment to serving the Native American population impacted by incarceration led her to recently launch HEAL for Reentry (Helping Enhance Aboriginal Lives) a nonprofit committed to assisting tribal people upon release from prison.

Albert G. Titman, Nisenon/ Miwok/ Maidu/ Pit River/Mexica, is the lead addictions counselor at the Sacramento Native American Health Center Inc. He is a Registered Addiction Specialist through the Breining Institute of CA and a State Board Certified Alcohol and Drug Abuse Counselor CADC II. He is the Chairman of the Board of Directors for the Native Dads Network. He also provides alcohol/drug abuse assessments, diagnosis, and treatment to individuals, couples, families, and groups to achieve more satisfying and productive marriage, family, and social adjustment. He enjoys Miwok traditional ceremonial singing and dancing and cooking for his family. Albert provides culturally sensitive services and is blessed with the opportunity to incorporate Native American wellness modalities in his work. He is currently a trainer for White Bison's Wellbriety Training Institute, and has over 12 years of experience in implementing the Medicine Wheel & 12 Steps program in his community.

Appendix D

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Daily Meditation

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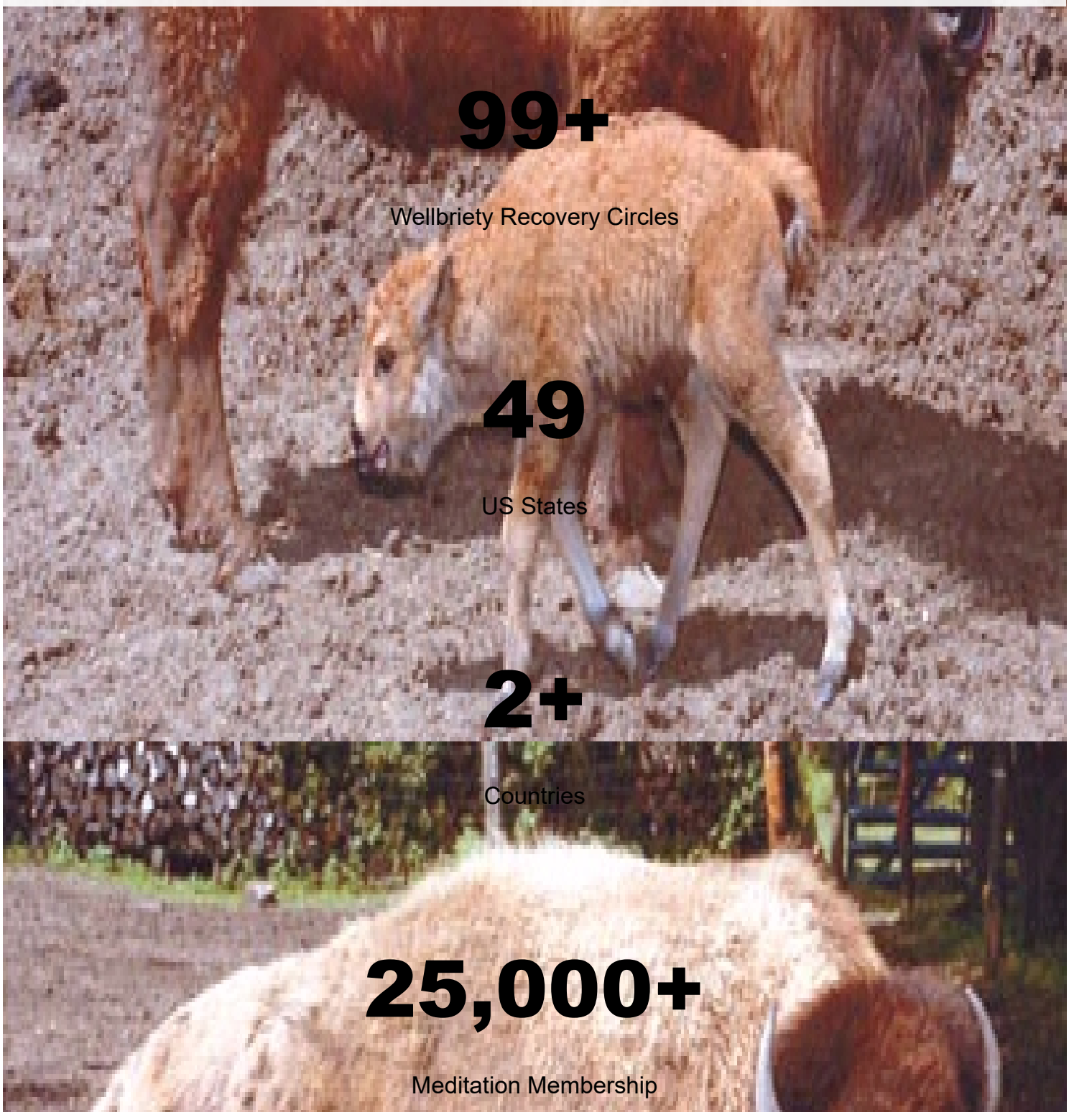

CONTACT US

White Bison - A sustainable grassroots Wellbriety Movement that provides culturally based healing to the next seven generations of Indigenous people.

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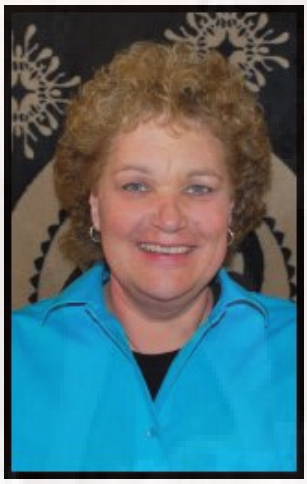
Board of Directors

Henry C. Lozano has had the honor to serve on the White Bison Board of Directors for over 25 years. Henry is of Apache, Tarahumara, and European descent. He was named Deputy Assistant to the President and the Director to the USA Freedom Corps. Prior to his tenure as Director, he was appointed by President Bush and confirmed by the Senate to serve on the Board of Directors for the Corporation for National & Community Service. He was also appointed by President Clinton to serve on the President's Advisory Commission on Drug-Free Communities and appointed as Co-Chair of the Commission by President Bush. He has served as a Senior Advisor to the Founder of U.N.I.T.Y. and currently serves on the Board of Trustees.

Dan Griffin has worked in the mental health and addictions field for over two decades. He is recognized internationally as an expert on males and trauma. In the fall of 2015, Griffin was honored to be named as a senior fellow

at The Meadows. He is the owner, founder, and lead consultant of Griffin Recovery Enterprises, Inc. He served as the state drug court coordinator for the Minnesota Drug Court Initiative, from 2002 to 2010, and was also the judicial branch's expert on addiction and recovery. Griffin was awarded Hazelden's first training fellowship for addiction counseling in 1998. He has worked in a variety of areas in the addictions field: research, case management, public advocacy, recovery courts, teaching, and counseling. Griffin's latest book, A Man's Way through Relationships, is the first trauma-informed book written to help men create healthy relationships while navigating the challenges of internalizing the "Man Rules." Griffin is also the author, A Man's Way through the Twelve Steps, is the first trauma-informed book to take a holistic look at men's recovery. He also co-authored Helping Men Recover, the first comprehensive gender-responsive and trauma-informed curriculum for men. Griffin's graduate work was centered on the social construction of masculinity in the culture of Alcoholics Anonymous. In 2012, Griffin was one of national experts invited by SAMHSA to help build a consensus definition of the terms "trauma" and "trauma-informed." Griffin was a founding member of Faces and Voices of Recovery and served as a Minnesota delegate at the first National Recovery Summit in St. Paul in 2001. He served on SAMHSA's National Recovery Month Committee for over ten years. In 2004, Griffin was one of 100 experts invited from around the country to create a consensus definition of recovery from addiction for SAMHSA. Griffin helped to start the first recovery advocacy organization in Minnesota, RecoveryWorks, in 2001. The President's Award winner in 2006 for leadership in the addiction and recovery field in Minnesota, Griffin lives in Minnesota with his wife, Nancy, and his daughter, Grace, and has been in long-term recovery since he graduated college in May of 1994. Dan's areas of expertise include: men's issues, trauma and trauma-informed services, addiction and recovery, recovery courts and other treatment courts, working with and understanding the twelve step culture, and the special needs of young people in recovery.

Marlin Farley is from the White Earth Reservation in northwest Minnesota. He has over 27 years of experience in working in the fields of adolescent treatment of emotional/behavioral disorders, family based social work, chemical dependency, restorative justice practices, and as a trainer/consultant in the wellness field. He is the president of Black Stone Consulting. Marlin is also a film producer/director and is the principal owner of Painted Sky Productions. Marlin is a board member and Master Trainer for White Bison Inc. and is a leader in the national Wellbriety Movement.



Barbara Plested Ph.D. is Affiliate Faculty at Colorado State University, and co-owner of Council Oak Training and Evaluation, Inc. She has thirty years of experience, serving both as an administrator as well as a therapist in the fields of mental health and substance abuse in addition to her 25 years of research experience. She serves as an evaluator and grant writer for several Native American programs and is one of the primary developers of the Community Readiness model. She has conducted community research using the model on a variety of issues: intimate partner violence, HIV/AIDS prevention, methamphetamine prevention, drug and alcohol prevention and environmental trauma. She has utilized thea model in over 3,000 communities in all fifty states, and 41 countries. Barbara has published extensively and has served on Roslyn Carter's panel on intergenerational caregiving as well as serving as a participant in First Lady Laura Bush's "Helping Americas Youth" initiative.

Pamela Jumper Thurman, Ph.D., a Western Cherokee, is a Senior Affiliate Faculty scholar at Colorado State University and President of Council Oak Training and Evaluations, Inc., a female and American Indian owned company. She is an award winning artist and has exhibited in New York and Washington, D. C. She has 30 years of experience in mental health, substance abuse/epidemiology research, and Capacity Building Assistance, as well as 35 years in the provision of direct treatment and prevention services as well as community work. She is a co-developer and co-author of the Community Readiness Model and has applied the model in over 3,000 communities throughout the US as well as over 41 communities internationally. She has worked with cultural issues utilizing community readiness, community participatory research, prevention of ATOD, methamphetamine treatment and prevention, prevention of violence and victimization, rural women's concerns, HIV/AIDS, and solvent abuse. She currently serves or has served as principal investigator or co-principal investigator for 18 federally funded grants that examine community/grassroots prevention of intimate partner violence, state wide initiatives to prevent methamphetamine use, epidemiology of American Indian substance use, prevention of HIV/AIDS, and epidemiology and prevention of solvent use among youth. She has served as a member of the National CSAT Advisory Council and was also a member of one of Roslyn Carter's Caregiving Panels as well as participating in First Lady Laura Bush's "Helping Americas Youth" initiative. She worked collaboratively with Ohio's First Lady, Hope Taft in the integration of community readiness into Mrs. Taft's Building Bridges Statewide Project to reduce underage drinking throughout the State of Ohio. Dr. Jumper-Thurman was the recipient of a lifetime achievement award from the Capitol Hill Alumni Association, was selected as one of the Indian Elders of 2015 by AARP and was the recipient of Oklahoma State University's Distinguished American Indian Alumni of 2017. She is the Co-Editor of Cherokee National Treasures: in their own words, a volume of stories about traditional Cherokee artists. She has published extensively on a variety of topics in various books chapters and journals and has co-produced a DVD on Community Readiness

and over 25 public service announcements for HIV testing as well as coordinating the launch of a National Native HIV/AIDS Awareness Day for the past 5 years.

Nicole "Nicky" Bowman, (Lunaape/Mohican) is the daughter of Peter Bowman (Stockbridge Munsee Band of the Mohican Indians) and Kathleen Bowman, granddaughter of Morris “Mose” Bowman, and great-granddaughter of Beaumont Bowman. **Her academic lodge sits at the intersection of truth, spirituality, traditional knowledge, sovereignty, governance, and evaluation.** She comes from a long line of entrepreneurial, activist, community- and family-centered people. Her spirit name is Waapalaneexkweew Neeka Ha Newetkaski Newa Opalanwuuk (Flying Eagle Woman Accompanied by the Four Eagles). She’s been a proud resident of Shawano County (S-M Reservation, Morgan Siding, Gresham, and Shawano, Wisconsin) for over four decades. Nicky is a traditional Lunaape/Mohican woman who has been an active Indigenous community member for 40 years and an Indigenous evaluator over two decades.