Oral Health Promotion Program
Plan for Kent County Juvenile Detention Center

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Introduction

Kent County Juvenile Detention Center (KCJDC) is a multi-care facility designed to provide temporary care for youth requiring secure custody pending court study and disposition, or pending transfer to another jurisdiction or agency. Detention Center and Juvenile Court have been established in 1963 in Grand Rapids, MI. In 1996, new 24 beds expansion opened, followed by a new courthouse in 2001.

Currently, KCJDC has a bed capacity of 69 with six residential units and employs 104 staff. The majority of workforce is Youth Specialists, but the facility also employs school, medical and mental health personnel. The workforce implements the programs of the facility which are intended to be constructive for youth. These programs include a full schooling program, religious services through interested churches, group-counseling sessions, learning groups, and special activities provided by local civic and college groups. The detention programs are based on the Cognitive Learning Model, designed to change adolescent value and belief systems by examining their thinking before making choices. Other delinquency services and programs include Adolescent Sex Offender Treatment Program (ASOTP), Crisis Intervention Program, Young Delinquent Intervention Program (YDIP), Community Probation, and foster care and institutional placement. One of the core programs implemented at KCJDC is the Nonviolent Crisis Prevention and Intervention (NVCPI) program. This program focuses on early intervention and non-physical ways to avoid or effectively cope with troublesome conduct.
Facility Setting

The facility has classrooms for a year-round school program, computer lab, library (Figure 1), nursing station (with dental chair), game room, and a well-equipped gymnasium.

Figure 1. Kent County Juvenile Detention Center Library

A year-round school program is provided by the Grand Rapids Board of Education. It follows the general educational curriculum based on the level of performance by each individual resident. In addition, Etiquette, Therapeutic Communication, Physical Education, Art Therapy, and Social Skills classes are offered to residents on Fridays. The computer lab is equipped with over twenty computers which are used for educational purposes. Each residential unit is assigned to use library services on a certain day of the week. On Fridays and Saturdays, residents are scheduled for “activity nights,” which might include a movie night, game room activities, gym activities, and ping-pong tournaments. They earn the coupons to participate in any of these activities by displaying positive behaviors. Residents receive an hour of large-muscle exercise (for example, playing basketball, volleyball, circuit training, etc.) on a daily basis in a well-equipped gymnasium.

The nursing station staff provides routine and urgent care to the admitted residents. The residents are assessed by the registered nurses upon arrival and findings are recorded in the charts. The residents are also being monitored by the nurses when taking medications. In addition, the medical doctor treats residents per request on a weekly basis. The nursing station has an on-site dental operator which
represents a room with a dental chair and a sink. The dental health information is very limited at the facility.

**Population Profile**

The population of KCJDC is extremely diverse; yet, it is the population that often passes unnoticed and neglected in terms of health assessments and care provision. 2007 KCJDC Starter Statistics indicates that there were 1,976 secure detention admissions (SDA).\(^4\) Out of these, African Americans represented 1,079 admitted juveniles; followed by Caucasians (546), Hispanics (240), bi-racial group (88), Native Americans (16), and Asian Americans (6). The majority of the admitted juveniles were males (1,520 males versus 456 females). In 2007, the total number of 16-year old juveniles in secure detention admission was 661, followed by 15-year old juveniles (440), 17-year olds (401), 14-year olds (234), and 13-year olds (130). The degree of offenses that juveniles are charged with vary from murder, rape, arson, robbery, aggravated assault to motor vehicle theft, burglary, and larceny. The length of stay at the facility can vary from an hour to a few weeks, depending on the severity of the crime committed and other factors as determined by the referee. The average length of stay at the facility in 2007 was 16 days.

**Delinquency Risk Factors**

Low socioeconomic status, poverty and/or belonging to racial, cultural, and linguistic minorities are identified as risk factors for juvenile delinquency and violence.\(^5\) Furthermore, external risk factors include having inadequate health care, being abused or neglected, or residing in an unsafe neighborhood.\(^6\) The following risk factors are of current public policy concern in Michigan: poverty, infant and child mortality, access to health care, abuse and neglect, teenage parenthood, crime and delinquency, and tobacco use. Among poor Michigan children about 129,000 are uninsured. This represents an agenda for a discussion on health/oral health needs of the selected population, health disparities, and access to care issues.
Dental Health Disparities

The U.S. Census Bureau estimates that more than 350,000 Michigan children youth live in households with income below the poverty level.\(^6\) Children and adolescents living in poverty are most likely to be affected by dental disease.\(^7\) Low socioeconomic status, minority status, and unemployment are associated with patterns of infrequent preventative dental care and high rates of dental disease.\(^8\) According to the Child Trends Data Bank, 35% of children from poor families, 31% of children from near-poor families, and 18% of children from non-poor families had not been to the dentist within the past year in 2004.\(^9\) In addition, the National Survey of Childhood Health conducted over the phone in 2003-2004 of a nationwide sample of 102,353 children 0 to 17 years old concluded that children in non-English-primary language households were significantly more likely than children in English-primary-language households to be poor (42% vs. 13%) and Latino or Asian/Pacific Islander.\(^10\) Significantly higher proportions of children in non-English-primary-language households had teeth in fair/poor condition (27% vs. 7%), and were uninsured (27% vs. 6%), sporadically insured (20% vs. 10%), and lacked dental insurance (39% vs. 20%). These households made no preventative dental (14% vs. 6%) visits in the previous year. Another report suggests that Latinos, the nation’s largest minority group, have the highest rate of untreated tooth decay and the lowest level of dental visits of all racial and ethnic groups in the United States.\(^11\)

Dental Caries in Adolescents

Dental caries remains to be the single most common chronic childhood disease in the United States.\(^12\) According to the Surgeon’s General Report, 78% of 17-year-olds have had tooth decay, with an average of seven affected surfaces.\(^12\) The majority of Kent County Juvenile Detention adolescents belong
to the high risk decay category. The exact data of decay rates was not available; however, certain conclusions can be drawn from a tabulated report by American Mobile Dental. This program provides dental services one Tuesday of the month to the detention residents who are covered by Medicaid or MIChild state programs. On an average, 12.5 juvenile residents receive dental care per program’s visit to the Detention Center once a month. 2007 tabulated report summarized that 141 KCJDC residents received care provided by American Mobile Dental. The numbers of procedures provided to the juveniles are as followed: sealants per tooth (124); adult prophylaxis (112); initial oral examination (107); intraoral complete series (103); topical fluoride treatment (83); composite one surface posterior (26); child prophylaxis (20), and composite two surface posterior (16). There were also three extractions with closure and one surgical extraction due to gross decay. Kent County Juvenile Detention Center faces a constant challenge of locating a dental home for juveniles for a follow-up treatment.

Less fortunate residents without any type of dental insurance coverage undergo an approval process for required finances by the detention superintendent for emergency dental care. Even though in many cases detention residents require further dental care upon their release, the facility health care personnel had no referral information and were not aware of any providers who would accept Medicaid or MIChild dental plans.

In addition, during a phone interview, KCJDC part-time nurse reported that headaches and abdominal discomfort are the chief health complaints of adolescents admitted to the detention center. In her opinion, the amount of psychotic medications that the residents are taking is much higher compared to their non-confined peers. Some of the residents receive liquid medications that might have a high concentration of sucrose in them, representing an important decay related issue. The nurse appeared to be especially concerned about the residents’ diet. She shared that residents’ diet is very poor; primarily consisting of fast food, carbonated beverages, and high sweets intakes. According to the Youth Risk Behavior Survey (YRBS) of 9th through 12th grade students in public and private schools, 28.9% of
Michigan students drank a can, bottle, or glass of soda or pop at least one time per day.\textsuperscript{15} The nurse also indicated that the diet of the residents is very low in fruits and vegetables. As a state, Michigan’s youth is at greater risk on a national scale to consume fruits and vegetables less than five times per day (83.0\% in Michigan compared to 78.6\% nationwide).\textsuperscript{15} Some adolescents admit to only consuming foods from a chain of local fast food restaurants. High blood pressure is a common health issue for the admitted teenagers. The nurse described their oral health as fair-poor. Oral health questions are a part of standard health questionnaire at the detention center. The nurse estimated 25-30\% of admitted children present with a moderate to severe toothache due to gross decay. For the majority of the confined youth, there is no dental insurance coverage, and the dental health IQ is low.

During a personal interview with the Detention Superintendent, he mentioned that abscessed teeth requiring immediate treatment are common occurrences amongst the facility residents.\textsuperscript{16} He made a request to cover the dietary component as it relates to the residents’ oral health and general health during the educational program implementation. Matt Fenske requested to direct the educational program towards the residents, as well as staff members.

\textit{Periodontal Disease in Adolescents}

Often, periodontal disease is thought of as an adult problem. However, periodontal diseases are among the most frequent oral diseases affecting children and adolescents.\textsuperscript{17} Dental plaque-induced gingival diseases and aggressive periodontitis are the most common periodontal diseases affecting children and adolescents.\textsuperscript{17} Studies indicate that nearly all children and adolescents have gingivitis.\textsuperscript{18} Evidence shows that periodontal disease may increase during adolescence due to lack of motivation to practice good oral hygiene.\textsuperscript{18} In addition, hormonal fluctuations during puberty and risk taking behavior can place adolescents at greater risk for developing periodontal disease.
KCJDC nurse described residents’ oral hygiene as fair-poor. She also stated that the residents could greatly benefit from oral hygiene instructions to improve their oral hygiene. She reported that halitosis is a frequent complaint of the residents. In addition, many medications that residents are taking can cause xerostomia, increasing their risk of plaque accumulation in the oral cavity. Being in a confined and structured environment, similar to the one at Kent County Juvenile Detention, can be very stressful for the adolescents. It is important to check the residents for signs of teeth grinding. Grinding can increase the risk of developing periodontal disease at an early age.

Interestingly, there is a positive correlation between socioeconomic position and periodontal diseases among adolescents. In a study with 9,203 Chilean high school students, the occurrence of all periodontal outcomes investigated followed social gradients, and paternal income and parental education were the most influential variables. Another recent study involving 582 Turkish adolescents indicated a strong correlation between the oral health behaviors, socioeconomic and sociodemographic factors, and the oral health status of Turkish adolescents. Since the majority of KCJDC adolescents generally come from low socioeconomic class and often engage in risk taking behaviors (for example, smoking), they are likely to be at an increased risk for developing periodontal diseases. Early diagnosis is crucial for successful treatment of periodontal diseases. KCJDC adolescents, their parents, and the facility employees should be educated in depth about the prevention of periodontal diseases.

**Adolescent Tobacco Use and Oral Cancer**

Smoking is a very common addictive habit among U.S. adolescents today. Unfortunately, many health risk behaviors that youth starts engaging in during adolescence continue into adulthood. The Youth Risk Behavior Survey (YRBS) of 9th through 12th grade students indicates that 20% of the U.S. students are current cigarette users. Overall, the prevalence of current frequent cigarette use is higher among white (10.4%) than black (3.9%) and Hispanic (4.2%) students. The prevalence of current cigarette
smoking is higher among 10th grade (7.0%), 11th grade (10.1%), and 12th grade (12.2%) than 9th grade (4.3%) students.

Smokeless tobacco use (e.g., chewing tobacco, snuff, or dip) accounts for 7.9% of the U.S. students. In Michigan, 8.9% of 9th-12th graders use smokeless tobacco.\textsuperscript{15}

Approximately 50% of KCJDC residents smoke on a regular basis.\textsuperscript{14} This compares to 18% of current cigarette users amongst Michigan students grades 9th through 12th.\textsuperscript{15}

Cigarette smoking has long been associated with a variety of oral conditions including periodontal disease and oral cancer. For example, the severity of periodontal disease is directly associated with the amount of daily smoked cigarettes and the duration of smoking in adolescents and adults.\textsuperscript{22} In a study conducted on 517 high-school students in Croatia, smokers had significantly more sextants with calculus (1.47) than non-smokers (1.59). The annual attachment loss in regular and intensive smokers measured 0.07mm, considering that oral hygiene habits did not differ between smokers and non-smokers.

There is a strong association between smoking and oral cancer, with approximately 8,000 deaths each year attributed to oral cancer.\textsuperscript{23} Oral cancer is associated with one of the lowest 5-year survival rates of all cancers. Usually people are over the age 40 at the time of cancer discovery; however, oral cancer occurs in younger individuals as well. Smokeless tobacco use is associated with oral cancer in younger individuals. At least 75% of individuals diagnosed with oral cancer are tobacco users. Furthermore, tobacco is the greatest preventable cause of cancer morbidity and mortality.

These facts about tobacco use are not a common knowledge for many people, especially among adolescents. Therefore, it is necessary to educate young smokers about the negative consequences and harmful side effects that smoking has.
Conclusion

The findings of the oral health needs assessment of Kent County Detention juveniles are very relevant. Poor oral health among children and adolescents has been tied to poor performance in school and poor social relationships.⁹ The needs identified in this discussion directly relate to the needs listed in the Healthy People 2010 Oral Health Objectives.²⁴

Healthy People 2010 Oral Health Objectives, Kent County Juvenile Detention community profile and oral health needs assessment clearly indicate the need for educational services/program for the employees, residents and parents of the selected population. Adolescent oral health promotion is multifaceted and challenging it its nature. It is influenced by many factors. Some factors can be altered, such as better oral hygiene habits, tobacco use, diet modifications; others are not easy to change, such as poverty level, health illiteracy, and child neglect and abuse. Adolescence is an imperative stage of life for many young adults: a stage of personality establishment. At this stage, any positive intervention can affect adolescent’s life choices and make a change that one will remember forever.


Community Asset Map

Community Assets

- Kent County Health Department
- Healthy Kids Dental Program (working with residents at KCJD)

Physical Surroundings

- Nursing Station
- Dental Operatory (Dental chair+sink)
- Bulletin Boards in the On-site Classrooms
- On-Site Computer Lab
- On-Site Library
- Educational programs in the “game room” with TV

Individuals

- Matthew Fenske, Superintendent
- Penny DeMario, Program Director
- Sally Hicks, RN
- Charlotte Wyche, UM Faculty
- Derek Stiles, youth specialist
- Sara Rydman, President of GR DH Society

Community Assets (continues)

- Grand Rapids Dental Hygienists’ Society
- Pine Rest Christian Services (Grand Rapids, MI)
- Bethany Christian Services Grand Rapids, MI
- Grand Valley Dental Care (Grand Rapids, MI): Accepts Medicaid, MIChild, and MIChild Delta Dental
- Ottawa County Juvenile Detention
- Lutheran Child and Family Service of Michigan (Kentwood, MI)
- General Nutrition Center, Grand Rapids, MI
- Kent District Library, Grand Rapids, MI
- American Red Cross (1050 Fuller Ave. NE, Grand Rapids, MI)
- Michigan Juvenile Detention Association (Flint, MI)
- National Partnership for Juvenile Services (East Lansing, MI)
**Program Plan**

**Kent County Juvenile Detention Community Program Goal:** To increase the availability of educational information pertaining to risk factors related to oral diseases for employees, residents, and parents at Kent County Juvenile Detention Center.

*Healthy People 2010 Health Objectives*¹ list the following oral health objectives in regards to addressing dental disease in adolescents:

21-1: *Reduce the proportion of adolescents with dental caries experience in their permanent teeth.* The baseline data suggests that 61 percent of adolescents aged 15 years had dental caries experience in 1988-94. Since high decay rates are prevalent among detention population due to poor diet and increased soft drink consumption, this objective becomes especially pertinent to the selected population.

21-2: *Reduce the proportion of adolescents with untreated dental decay in their permanent teeth.* Twenty percent of adolescents aged 15 years had untreated dental decay in 1988-94. Follow-up care and treatment is challenging with detention residents due to difficulties associated with finding dental providers who accept state sponsored dental plans. However, detention medical personnel should inform and possibly provide some kind of documentation of the resident’s oral health needs to their parents. Also, referral information should be available for the parents. This will help insure that untreated dental needs will be addressed upon resident’s release from the detention.

21-5: *Reduce periodontal disease.* The baseline data of 1988-94 suggests of 48% occurrence of gingivitis and 22% occurrence of destructive periodontal disease in adults aged 35 to 44. Periodontal disease education is crucial for this age group, as well as their parents. Educating parents about periodontal disease prevention becomes of utmost importance, as the adolescents encounter lack of motivation to maintain good oral hygiene during their teenage years.
21-6: Increase the proportion of oral and pharyngeal cancers detected at the earliest stage.

During 1990-95, 35 percent of oral and pharyngeal cancers (stage I, localized) were detected. Regardless of juvenile’s smoking habits, adolescents and their parents should be educated on the importance of regular dental visits and oral cancer examinations. For adolescents, the visual aids (e.g., pictures of different stages of oral cancer) might be especially helpful. For the parents, facts about oral cancer, associated statistics and parental guidance information can be beneficial.

21-8: Increase the proportion of children who have received dental sealants on their molar teeth.

The baseline data suggests that 15 percent of adolescents aged 14 years had dental sealants on molars in 1988-94. Parents of the KCJDC adolescents should be educated about dental sealants and their purpose. Most of the residents could benefit from dental sealants placed on both sets of permanent molars. Parents should be informed that most state programs (e.g., MIChild) cover dental sealant placement under the age of 15.

21-10: Increase the proportion of children and adults who use the oral health care system each year. The baseline data of 1996 suggests that 48% of children aged 2 to 17 years have had dental visit in previous year.

21-12: Increase the proportion of low-income children and adolescents who received any preventative dental service during the past year. Detention residents and their parents generally have low dental IQ and might not realize the importance of preventative dental care. Their parents should be encouraged to apply for dental state programs for their children to receive preventative dental services regularly.¹

In addition, Healthy People 2010 Related Objectives from Other Focus Areas are important to the discussion of identified oral health needs in adolescent population at the detention center.¹ They include educational and community-based aspects, such as counseling about health behaviors, patient and family
education, health literacy, and culturally appropriate and linguistically competent community health promotion programs. These Objectives should be followed closely when developing community health promotion programs for the diverse adolescent population at KCJDC. Related Objectives also address nutrition and overweight issues, discussing fruit and vegetable intakes, as well as meals and snacks at schools. Oral health messages could be incorporated into diet discussions during school activities at the facility. Tobacco use topic includes multiple objectives applicable to the detention population, such as smoking cessation by adolescents, smoke-free and tobacco-free schools, enforcement of illegal tobacco sales to minors laws, and retail license suspension for sales to minors.

Healthy People 2010 Oral Health Objectives and other Focus Area Objectives are followed closely throughout the oral health promotion program planning and their concepts are incorporated into the program vision, goal, and objectives.
### Table 1 - Program Objectives, Evaluation, and Activities

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<tr>
<th>Objectives (by number)</th>
<th>Evaluation Measures/Outcome Indicators</th>
<th>Activities/Strategies</th>
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| **1.** By the end of the program, increase knowledge of risk factors associated with oral diseases to at least 90% of Kent County Juvenile Detention residents, their parents, and employees. | Via developed questionnaire: It will measure the knowledge of dental related risk factors before and after the oral health promotion program for KCJDC residents, their parents, and employees.  
Target/Outcome Indicator: Residents and their parents will indicate increase in their knowledge by answering 80% of the questions correctly; employees will indicate increase in their knowledge by answering 90% of the questions correctly. | -Show a PowerPoint Presentation on dental caries, periodontal disease, and tobacco use in adolescents;  
-Distribute pamphlets on oral diseases and associated risk factors;  
-Discuss alternatives to sugary carbonated beverages through offering samples of certain kinds of vitamin water (and other healthy snacks);  
-Distribute samples of floss and toothbrushes along with oral hygiene instruction sheets attached (written directions and visuals);  
-Offer tobacco cessation help;  
-Utilize on-site computer lab to access oral health information web-sites;  
-Send a list of oral health information web-sites for residents to access upon their release from the detention. |
| **2.** By the end of the program, compile and distribute a list of dental resources for residents' referrals in order to increase follow-up care. | Count the number of referral resources that were identified and added to the newly composed list during the program implementation. Calculate the number of residents who receive the referral list by the end of the program. | -Gather information about dentists/dental clinics who accept state sponsored insurance plans around the area and in greater West Michigan area;  
-Contact local/state dental and dental hygiene schools;  
-Contact Kent and Ottawa County Health Departments;  
-Obtain referral forms (multiple copies) from all possible resources;  
-Combine gathered information into a referral list of dental resources;  
-Instruct nurses, youth specialists and American Mobile Dental to provide residents and their parents with referral forms when necessary. |
| **3.** By the end of the program, substitute healthy alternatives to decay promoting snacks at least one day per week at KCJDC cafeteria. | By the end of the program, count the days of the week during 7-week interval when the healthy snacks have been offered to the detention residents (based on the information provided by the cafeteria staff). Total them and analyze the results. | -Distribute diet related caries prevention information to the employees at KCJDC;  
-Discuss healthy alternatives to decay promoting snacks;  
-Offer samples of healthier alternatives. |
**Program Narrative**

**Objective 1 Activity Discussion**

Objective 1 calls for in-depth education for residents, their parents, and employees at KCJDC on oral diseases and associated risk factors for this age group. A PowerPoint presentation will be used to provide an engaging learning environment, as well as an inclusive slide show with vivid illustrations. It will cover identified oral health needs, including dental caries, periodontal disease, and tobacco use among adolescents. There will be time allotted for questions/answers session for the residents and staff present.

Educational pamphlets on oral diseases and associated risk factors will be distributed to the residents, parents, and employees following the PowerPoint presentation. In addition to the pamphlets from the dental companies, personal educational pamphlets might be developed by incorporating some of the PowerPoint presentation slides.

A full educational session is planned to be dedicated to each of the oral diseases and risk taking behaviors discussed: dental decay, periodontal disease, and tobacco use among adolescents. During the dental decay education session, a special emphasis will be made on healthy alternatives to decay promoting snacks. Considering the budget allowances, samples of healthier alternatives obtained from the companies might be offered to the audience and cafeteria staff. There would be two tables set up in front of the audience. One table would contain decay promoting snacks that are currently offered to the juveniles at the detention. The other table would represent samples of healthier choices that residents and employees could try out. This will open up the door for a discussion and in time might initiate positive dietary changes in the menu of the detention cafeteria. During the periodontal disease education session, the emphasis will be made on establishing good oral hygiene habits early in life in order to prevent periodontal disease onset. Floss samples and toothbrushes with attached oral hygiene instruction sheets
(including written directions and visual aids) will be distributed among the residents. If available, xylitol gum samples would be offered to the residents and its benefits would be explained. Oral hygiene instruction session using plastic mouth model will follow. During the tobacco use discussion, PowerPoint presentation slides with oral cancer illustrations will be revisited. Emphasis on risk taking behaviors during teenage years and their negative consequences will be made. Motivational interviewing techniques would be incorporated during this discussion. The residents will be informed about smoking cessation program and other help available.

**Objective 2 Activity Discussion**

Information on any local dentists/dental offices and clinics that accept new patients with state sponsored insurance plans will be collected. The nurses and other detention staff will be informed about local dental offices and clinics that accept Medicaid, MIChild, and Healthy Kids Dental plans. Multiple referral forms will be provided. Furthermore, research of other Western Michigan resources will be conducted and the findings will be added to the newly composed list of resources.

Initiating contact with local/state dental and dental hygiene schools will take place. Certain dental care (preventative or restorative) to underserved populations might be provided through them. Referral forms and contact information will be obtained and provided to the Kent County Juvenile Detention Center. Kent County Health Department and Ottawa County Health Department might be helpful in providing contact information for any other providers for underserved populations in the state of Michigan. They will be contacted as well. Once all possible resources are identified and referral information is obtained, the resources will be organized according to their location and specialty on a referral list. Detention nurses, youth specialists and American Mobile Dental health care providers will be instructed to dispense referral forms for follow-up treatment for every resident who requires further dental care.
Objective 3 Activity Discussion

To address decay promoting snack choices at KCJDC cafeteria, diet related caries prevention information will be distributed to the employees at KCJDC. It is very important to discuss healthy alternatives and cost-efficient snack choices with the Detention Superintendent who is responsible for the facility budget, as well as the cafeteria meal planner who is responsible for making food choices. For instance, “Crystal light” packages added to the tap water will be discussed as one of the healthier and cost-efficient options for the adolescent population. Considering the program budget allowances, samples of healthier alternatives obtained from the companies could be offered to the cafeteria staff.

To summarize, the outlined activities have been thought out to assist many adolescents, their parents, and the detention staff to take a path towards improvement and making more educated choices in regards to their oral and general health.
References

Kent County Juvenile Detention Center Timeline for Oral Health Promotion Community Program

July 2008-February 2009

1. Build Initial Contact with Facility
   • July 21 – 28, 2008
     o Establish initial contact with Detention Superintendent via email.
     o Set up an appointment for personal communication.
   • August 1, 2008
     o Take detention tour.
     o Establish rapport with staff.
     o Collect initial information about the facility.
     o Have Memorandum of Understanding signed by Superintendent.

2. Identify Resources
   • September 2 – 8, 2008
     o Identify key individuals and organizations.
     o Establish initial contact with community partners.

3. Collect Community Profile Information and Conduct Oral Health Needs Assessment
   • September 2 – 22, 2008
     o Present vivid community and facility background.
     o Involve primary and secondary information sources.
     o Identify key oral health needs.
     o Relate findings to Healthy People 2010 OH Objectives.

4. Formulate Community Plan Goal
   • September 14 – 22, 2008
     o Define a goal related to prioritized health needs.

5. Develop a Program Plan
   • September 22 – 29, 2008
     o Finalize program goal.
     o Examine HP 2010 OH and Focus Area Objectives.
     o Associate appropriate evaluation measures and intervention activities with objectives.
     o Provide detailed explanation of planned activities.
     o Combine program plan with oral health assessment findings.

6. Develop a Program Budget
   • September 29 – October 6, 2008
     o Develop a hypothetical program budget.

7. Contact Resources for Donations
   • October 1 – 6, 2008
     o Initially contact identified resource for program related donations.
   • November 1 – 30, 2008
     o Continue to search for dental samples via contacting identified resources.

8. Finalize Comprehensive Community Plan
   • October 7 – 13, 2008
     o Develop a program timeline.
     o Finalize comprehensive community plan using instructor’s and colleagues’ feedback.
9. **Submit Comprehensive Program Plan for Agency Review and Sign Field Placement Agreement**
   - **October 14 – 20, 2008**
     - Request Matt Fenske’s feedback.
     - Request Superintendent to sign the agreement, valid from Jan 7th – Feb 20th 2009.

10. **Prepare Educational Course Materials**
    - **October 22 – 29, 2008**
      - Request educational materials on caries, periodontal disease, and smoking cessation.
      - Search for online ‘free’ images and request permission to use for PP presentation.
    - **December 1, 2008 – January 1, 2009**
      - Complete PP slideshow on OH diseases (including visuals).

11. **Conduct Research of Dental Referral Resources and Request Referral Forms**
    - **December 1 – 20, 2008**
      - Contact local dental clinics, dental and DH schools, health departments.
      - Request referral forms to be sent via mail.

12. **Contact Food Companies and Purchase Food Snacks used during Program Implementation**
    - **October 22 – 29, 2008**
      - Call local food companies and obtain dietary content information and prices.
    - **December 20, 2008 – January 6, 2009**
      - Check for available samples (Vitamin Water, Crystal List, etc).
      - Purchase items as the budget allows.
      - Check with detention cafeteria staff (via email) for samples of current sugary snacks to use for display purposes.

13. **Finalize Preparations for Program Implementation**
    - **January 2 – 6, 2009**
      - Make multiple copies of educational materials and referral forms.

14. **Implement the Program**
    - **January 7 – 13, 2009**
      - Build rapport.
      - Establish relationships with staff.
      - Meet residents.
    - **January 14 – 20, 2009**
      - Objective 1 Activities: *Dental Decay Week*
      - Distribute diet-related prevention information to the employees at cafeteria.
      - Discuss healthy alternatives with cafeteria staff.
      - Offer healthier alternatives.
      - Discuss incorporating healthier alternatives with meal planner and Superintendent.
    - **January 21 – 27, 2009**
      - Objective 1 Activities: *Perio Disease Week*
    - **January 27 – February 3, 2009**
      - Objective 1 Activities: *Tobacco Use Week*
      - *Meet the Parents Week*: educational session to summarize main points of each week discussion and emphasize importance of parental guidance.
      - Finalize the referral list.
    - **February 4 – 10, 2009**
      - *Employees Only*: provide referral forms and a composed list to the employees with instructions for use.
      - Re-visit Objective 3 Activities with cafeteria staff.

15. **Evaluate Program Outcomes**
• **February 11 – 17, 2009**
  o Evaluate program outcomes using evaluation measures identified in the Objective Chart on page 16.
  o Administer questionnaires to the employees and residents. If the same residents are not present, then questionnaires should be given to the employees only.
  o Evaluate dental resources list.
  o Evaluate changes in snack choices offered at the cafeteria.

16. **Conclude the Program**

• **February 20, 2009**
  o Present program results and its analysis to staff.
  o Thank staff and celebrate program completion.