# Best Practice Approaches
## for State and Community Oral Health Programs

**astdd**
Where oral health lives

A Best Practice Approach Report describes a public health strategy, assesses the strength of evidence on the effectiveness of the strategy, and uses practice examples to illustrate successful/innovative implementation.

## I.  Best Practice Approach

### State Oral Health Coalitions and Collaborative Partnerships

| Summary of Evidence Supporting State Oral Health Coalitions and Collaborative Partnerships | |
|---|---|
| Research | + |
| Expert Opinion | +++ |
| Field Lessons | ++ |
| Theoretical Rationale | +++ |

See **Attachment A** for details.

## II.  Description

### A.  Coalitions and Collaborative Partnerships Improving Oral Health

In public health, collaborative partnerships (used as a broad term) can take many forms, including coalitions at the state, regional and community levels, alliances among service agencies, consortia of health care providers, grassroots efforts, and broader advocacy initiatives.  The structure of partnerships varies and may include formal organizations with a financial interest or individuals that have formed around a concern or event (1).

Two definitions of a coalition include: "an organization of individuals representing diverse organizations, factions or constituencies who agree to work together in or to achieve a common goal (2)" and "an organization of diverse interest groups that combine their human and materials resources to effect a specific change the members are unable to bring about independently (3)."  Coalitions are inter-organizational, cooperative and synergistic working alliances, united in a shared purpose.  More contemporary standards refer to coalitions as more formal working partnerships and the alliance is considered more long-term and durable (4). Coalitions should be issue oriented, structured, focused to act on specific goals external to the coalition, and committed to recruit member organizations with diverse talents and resources (5).  Coalition members collaborate on behalf of the organization they represent and also for the coalition itself (2).  Coalitions exchange mutually beneficial resources and direct their interventions at multiple levels (i.e., policy change, resource development and environmental changes).

Coalitions may be comprised of organizations, combinations of individuals and organizations, and of other coalitions (4).  Coalitions often form in response to an opportunity or threat.  Coalitions can vary in size from a few to hundreds of persons.  The literature has describe three types of coalitions based on membership: 1) Grassroots coalitions are organized by volunteers in times of crises to pressure policy makers to act, 2) Professional coalitions are formed by professional organizations either in time of crisis or as a long-term approach to increasing their power and influence, and 3) Community-based coalitions of professionals and grassroots leaders are formed to influence more long-term health and welfare practices for their communities, usually initiated by one or more agencies.  Coalitions for health promotion tend to be long-term.  They can be community-based or agency-dominated, bringing agencies, interest groups and individuals together in an alliance to plan and implement prevention strategies to accomplish a purpose.  These coalitions provide planning, coordinating and advocacy functions.

Oral health problems usually involve significant social and cultural factors and require many resources and partners to implement prevention and treatment services.  Building linkages with partners can provide more public recognition and visibility, leverage resources to expand the scope and range of services, provide a more comprehensive approach to programming, enhance clout in advocacy and resource development, enhance competence, avoid duplication of services and fill gaps in service delivery, and accomplish what single members cannot (6).  New providers of public health services, such as managed care organizations, hospitals, nonprofit corporations, churches, and businesses are promising partners to improve oral health (7).

A state oral health coalition or other forms of collaborative partnerships can provide guidance and recommend directions for the state oral health program.  A coalition can identify needs and problems, support priority setting, and help develop a state oral health improvement plan.  Collaborative partnerships can establish and foster relations needed to implement solutions (8,9).  A state oral health coalition should have input from broad-based constituency groups so that oral health becomes a compelling issue beyond the borders of traditional oral health providers and becomes integrated into general health.  Coalition members could include representatives from health agencies, the state public health association, the state dental and dental hygienists societies, health care professional groups, the primary care association, safety net clinics, consumer advocacy groups, communities, businesses, schools, universities, faith-based organizations, hospitals, third party payers, foundations, the media, and the legislature.

The literature points to the importance of coalitions in several ways (2,3,4,10):

1.  Coalitions can enable organizations to become involved in new and broader issues without having the sole responsibility for managing or developing those issues.
2.  Coalitions can demonstrate and develop widespread public support for issues, actions or unmet needs.
3.  Coalitions can maximize the power of individuals and groups through join action (increase the "critical mass" behind a community effort by helping individuals achieve objectives beyond the scope of any one individual or organization.
4.  Coalitions can minimize duplication of effort and services (which can also improve trust and communication among groups that would normally compete with one another).
5.  Coalitions can help mobilize more talents, resources and approaches to influence an issue than any single organization could achieve alone.
6.  Coalitions can provide an avenue for recruiting participants from diverse constituencies, such as political, business, human service, social and religious groups, grassroots groups and individuals.
7.  Coalitions' flexible nature can allow them to exploit new resources in changing situations.

An American Public Health Association publication, *The Spirit of the Coalition*, by Bill Berkowitz, Ph.D., Associate Professor of Psychology, University of Massachusetts, Lowell, and Tom Wolff, Ph.D., Associate Professor of Psychology, University of Massachusetts Medical School, provides public health practitioners and other public health community workers with down-to-earth details of how coalitions work most effectively in everyday practice (11). The introduction states that the document "is about community coalitions, as a way to create change in local community life.  What these coalitions do is join people from different parts of the community to deal with community problems."  The authors state that coalitions do not always succeed, solve the problem or heal the wounds.  They are not magical cures for all community issues.  But they are a structure that can be used to facilitate change in almost every community in one form or another and are a highly utilized vehicle in public health.


## B.  Coalition Development

Coalitions move through three stages of development:  1) formation, 2) implementation or maintenance, and 3) outcomes or institutionalization.  Coalition cycle and recycle through these stages as new members are recruited, plans are renewed and/or new issues are added (12).

Coalitions are heavily influence by contextual factors in the state throughout all stages of development. A Community Coalition Action Theory provides a model of development and maintenance of coalitions based on observed practices of coalition building (13). **Attachment B** provides the theoretical model. **Attachment C** is a set of practice proven propositions (rules) for effective coalition development.

### C. Factors to Enhance Coalitions and Collaborative Partnerships to Improve Health Outcomes

Roussos and Fawcett reviewed published studies on coalitions and collaborative partnerships and reported seven factors that potentially enhance partnerships' ability to improved behavioral and population-level health outcomes (14):

1. **Having a clear vision and mission –** Developing a clear vision and mission is essential for collaborative partnerships. A clear vision and mission may help generate support and awareness for the partnership, reduce conflicting agendas and opposition, help identify allies, and minimize time costs and distractions from appropriate action. Providing stakeholders opportunities to participate in the planning may sustain their participation in the partnership. Periodic review and renewal of the vision and mission allow a partnership to adapt and address emerging issues.

2. **Action planning for community and systems change –** Planning is common to all collaborative partnerships that are successful. Action planning is the process of identifying what community and systems changes to facilitate, who will produce them and by when, and how to gain support and minimize opposition in bringing about changes. Planning should include accountability.

3. **Developing and supporting leadership** – Leadership is most often reported as a key factor for effective collaborative partnerships. An individual or core group of members can provide leadership for a collaborative partnership. By using democratic and consensus decision-making methods, leaders may increase members' satisfaction, broaden community participation, and improve overall coalition effectiveness. Different leadership skills may be useful during different stages of partnership development. The early stages of coalition development may require greater facilitation and listening skills to help engage a diverse membership. Later, when a partnership has developed a strong identity and presence, negotiation and advocacy skills may be more helpful in bringing about changes. Partnership may benefit from a leadership team that includes various people with a variety of experiences and skills. Also, developing champions who work within a specific sector or for a specific objective can disperse leadership among all members of a partnership. Successful leadership inspires commitment and action, builds broad-based involvement, and sustains hope and participation. (Collaborative leadership training for the coalition members, written job descriptions for the leaders, and elected and rotating leadership will help build coalition leadership.)

4. **Documentation and ongoing feedback on progress –** Although community health partnerships aim to improve population-level outcomes, a long period of time is usually needed to observe the distant outcomes. Documentation and evaluation of intermediate outcomes is also important for a partnership by providing feedback on what is and is not working and guiding day-to-day activities. Tracking intermediate outcomes can help document progress, celebrate accomplishments, identify barriers, and redirect efforts to more effective activities.

5. **Technical assistance and support –** Technical assistance and support enhance the partnership's competencies for community assessment, member recruitment, leadership development, meeting facilitation, action planning, program development and implementation, evaluation, social marketing, and fundraising. Such assistance is often provided by professionals outside a partnership or by the partnership's members with the expertise. Written materials, manuals, tip sheets, and other resources have been developed for coalition builders, such as the Community Tool Box (http://ctb.ku.edu/) addressing needs of community health and the development of coalitions, Coalition Building Tip Sheets (http://www.tomwolff.com/healthy-communities-tools-and-resources.html#free) which are summaries of key points on many critical issues in seeking collaborative solution, and Community Roots for Oral Health – Guidelines for Successful Coalitions

(http://www.doh.wa.gov/cfh/Oral_Health/Community_Roots.htm), a document developed by the Washington State Department of Health providing guidelines for building and sustaining a successful oral health coalition.

6. **Securing financial resources for work –** The sustainability of a partnership and its capacity to do work will depend on its ability to secure financial resources. Resources are often used to hire community organizers and mobilizers who can facilitate community and systems changes and implement interventions. Several studies found an increased rate of community changes (such as new programs and policies) when staff and community organizers were hired by collaborative partnerships. The financial security of a partnership may depend on its ability to demonstrate its value to the community and its contribution to making community changes.

7. **Making outcomes matter –** Collaborative partnerships often begin because community health outcomes matter to a core group of individuals and organizations. The more the outcomes are promoted by a partnership to community members, grant makers, and influential leaders, the more likely the partnership is successful in securing human and financial support. Documenting community-relevant indicators of success and providing regular reports to community stakeholders, funding organizations, the media, and state/local government can make outcomes matter. Ongoing and systematic evaluation of coalition activities is needed to report outcomes and demonstrate the coalition's value to the community.

Mattessich and Monsey also reviewed research literature and reported factors influencing successful collaboration (15). The authors' working definition of *collaboration* is "a mutually beneficial and well-defined relationship entered into by two or more organizations to achieve common goals." The relationship includes a commitment to a definition of mutual relationships and goals, a jointly developed structure and shared responsibility, mutual authority and accountability for success, and sharing of resources and rewards. Nineteen factors that influence the success of collaborations are reported. The factors are grouped into six categories:

I. **Factors Related to the Environment**

    A. History of collaboration or cooperation in the community
    B. Collaboration group seen as a leader in the community
    C. Political/social climate favorable

2. **Factors Related to Membership Characteristics**

    A. Mutual respect, understanding, and trust
    B. Appropriate cross-section of members
    C. Members see collaboration as in their self-interest
    D. Ability to compromise

3. **Factors Related to Process/Structure**

    A. Members share a stake in both process and outcome
    B. Multiple layers of decision-making
    C. Flexibility
    D. Development of clear roles and policy guidelines
    E. Adaptability

4. **Factors Related to Communication**

    A. Open and frequent communication
    B. Established informal and formal communication links

5.  **Factors Related to Purpose**

    A.  Concrete, attainable goals and objectives
    B.  Shared vision
    C.  Unique purpose

6.  **Factors Related to Resources**

    A.  Sufficient funds
    B.  Skilled convener

**Attachment D** provides additional details of each factor including a brief description and identifying the number of studies which identified the factor as important to collaboration's success.

Other qualitative analyses of published articles also described core competencies and processes needed for collaborative partnerships to be successful (16-21).  **Attachment E** describes information provided in a workbook on coalition building, *From the Group Up! A Workbook on Coalition Building & Community Development*, edited by Gillian Kaye and Tom Wolff, Ph.D.  The Workbook offers ideas, frameworks, and exercises for coalition building (22).

## D.  Oral Health Coalition Framework

Centers for Disease Control and Prevention (CDC), Division of Oral Health has developed a framework for oral health coalition (see **Attachment F**).  The resource tool is also available from: http://www.cdc.gov/oralhealth/state_programs/infrastructure/activity4.htm (23). The framework provides a reference for recruiting coalition members to have a broad-based representation of stakeholders who will bring a range of knowledge and skills for improving oral health.  In addition, the framework illustrates diverse areas of activities that a coalition's workgroups may address and various outputs that reflect an active coalition.

## E.  State Oral Health Coalitions Among the States

1.  **The Association of State and Territorial Dental Directors (ASTDD)** conducted a survey in 1999 to assess states' gaps in their dental public health infrastructure and capacity.  Of the 43 states responding, 20 (47.6%) states reported having an oral health coalition with a broad-based representation of stakeholders and constituents to guide, review and direct activities to improve oral health (7).

2.  **Oral Health America** (a national and independent organization dedicated to improving oral health) published an Oral Health Report in 2003 to call greater policy attention to areas of need in prevention, access to care, infrastructure, oral health status, and oral health policies across the country.  The 2003 Oral Health Report Card showed that among the states and District of Columbia:

    - 34 states reported having a state oral health coalition that meets regularly and represents government agencies, health departments, private organizations, providers, communities and consumers
    - 5 states reported having a state oral health coalition that meets regularly and represents government agencies, health departments, private organizations, providers, and either communities or consumers
    - 5 states reported having a state oral health coalition that meets regularly and represents government agencies, health departments, private organizations, and providers, but does not represent communities or consumers
    - 5 states reported that they do not have an oral health coalition
    - 2 states without information

The [report card](http://www.oralhealthamerica.org/) can be accessed at http://www.oralhealthamerica.org/ (24).

3. **Oral Health America** convened a "Coalition Best Practices Workshop" in 2001, aimed to assist states and communities with developing coalitions and to strengthen oral health coalitions. This effort was supported by CDC funding. Twenty-five states were represented. These states reported having oral health-specific coalitions (either state, regional or local in focus) and/or health care coalitions that address oral health issues. Their coalitions generally included fewer than 50 individual members but Illinois, California and Kentucky reported more than 100 members. Number of organizations participating in the coalitions ranged from 15 to 60. Coalition members included stakeholders from outside the dental professions. Frequency with which the coalitions met varied from monthly to quarterly or 2-3 times a year. Coalition governance ranged widely with state coalitions having boards of directors, chairs/co-chairs, and subcommittees. A synopsis of the workshop is available on http://www.oralhealthamerica.org/pdf/BestPractices.pdf (24).

4. State oral health coalitions have supported the development and implementation of state plans. State coalitions have worked to convene stakeholders, supported development of strategies and action steps for state plans, and endorsed/approved state plans. States that have worked closely with their coalition to develop the state plan include: Arkansas, Colorado, Georgia, Illinois, Michigan, Missouri, New Hampshire, Nevada, and South Carolina (25).

## F.  Evaluation of Coalitions

Evaluation of state oral health coalitions provides information to enable states to develop and maintain coalitions as effectively and efficiently as possible (26). Evaluation of coalitions, which should include their outcomes and impacts, will help states determine what works and what does not work. Reasons for conducting an evaluation of coalitions include:

- Evaluation can build capacity within both the coalition and the community.
- Evaluation can determine whether objectives are achieved and can be used to improve coalition intervention.
- Evaluation provides accountability to community, funding agencies and stakeholders that can later increase community awareness and support.
- Evaluation can be used to educate leaders and lawmakers and inform their policy decision.
- Evaluation contributes to the scientific base and increases our understanding of what makes coalitions effective.

There are many levels on which a coalition may be evaluated. Questions for an evaluation may ask about: 1) measures of coalition effectiveness in structure and function such as engaging members and implementing activities, 2) impacts from specific projects implemented by the coalition, 3) outcomes related to changes in community policies, practices and environment, and 4) outcomes related to health status indicators such as incidence of caries. Ideally, the evaluation of a coalition would respond to questions related to all these levels; however, the number of questions that can be addressed will depend on availability of resources and the feasibility of collecting specific type of information. The scope of the evaluation may also be guided by the maturity of the coalition (the development or formation stage, the implementation or maintenance stage, and the outcomes or institutionalization phase). An evaluation consultant is highly recommended to guide and support the evaluation process.

The following steps will contribute to establishing a more effective evaluation:

- Establish an evaluation plan from the onset.
- Obtain buy-in from stakeholder to build commitment to evaluation.
- Fund staff time to make evaluation a priority.
- Engage priority population to help create measures and generate reliable data.
- Report evaluation results clearly and often to the community.
- Be flexible and creative.

Indictors of coalition effectiveness reflect a coalition's attainment of its mission, goals and objectives.

## G.  Initiatives and Coordinated Efforts

Many initiatives and coordinated efforts recognize that collaborative partnerships are essential for improving oral health.  State dental summits illustrate one such effort.  Oral Health America's coalition development represents another such effort.

### 1.  State Dental/Oral Health Summits

The Health Resources and Services Administration (HRSA)/Maternal and Child Health Bureau (MCHB) and the Centers for Medicare and Medicaid Services (CMS), in cooperation with ASTDD, have sponsored nearly thirty state dental summits.  The dental summits were intended to provide a platform to bring together stakeholders to share information, collaborate on statewide problem solving, and develop specific oral health strategic plans around oral health issues, especially for children's oral health.  The expectation of dental summits was to develop partnerships between State policy makers, legislators, Medicaid, the Women Infants and Children (WIC) program, Head Start (HS), the dental profession, state health programs, safety-net providers, and consumers that would ultimately lead to long-term strategies and actions for improving oral health and dental access.

Between 2001 and 2005, 21 states held dental summits.  Some the dental summits had more than 100 participants.  The impact of these dental summits was evaluated in 2003 (an Executive Summary of the evaluation report is available).  Among these states, the summit formats varied.  However, common aspects to the summit format included:

- Setting summit goals,
- Scheduling one to two days for the summit with support by event planners and facilitators,
- Inviting critical stakeholders to have a fair representation and balanced views,
- Having a participatory, inclusive planning process to engage key stakeholder groups early, and
- Disseminating the summit results to participants.

In addition, the majority of the states reported that their summit outcomes have enhanced coalition development and/or broaden stakeholder partnerships, heightened visibility of oral health among policymakers, stimulated the development of oral health committees, workgroups and task forces, and strongly influenced the development of state oral health or strategic action plans.  Other outcomes included increased visibility of oral health among the public, creation of community-based and school-based programs, expansion of preventive services, and effective use of oral health data.  The following resource information includes individual state experiences to support future planning efforts for dental summits:

- Summaries of dental summits (search by key words by entering "dental summit" )
- Final reports of the dental summits
- Materials from the National Maternal and Child Oral Health Resource Center

### 2.  Oral Health America

Oral Health America (OHA) supports coalition development (24).  Serving as a coalition consultant, OHA provides technical assistance and resource development for coalitions and communities seeking to address oral health issues and acts as a neutral convener for both traditional and non-traditional entities.  Consultation helps coalitions in understanding the business of coalition, facilitating issue resolution, developing bylaw, conducting strategic planning, and seeking funding.

With the support of a cooperative agreement with CDC, OHA has provided technical assistance for oral health coalitions to Alaska, Arkansas, Colorado, Illinois, Michigan, New York, Nevada, North Dakota,

Oregon, South Carolina, Texas, Rhode Island and the Republic of Palau. In 2004, OHA held a conference on partnership development for coalition members across the country, providing an opportunity for sharing best practices and successful strategies.

### 3. CDC Cooperative Agreement

The CDC, Division of Oral Health provides cooperative agreement funding to 12 states and a U.S. territory (funding began in 2003 and renewable for up to five years). The cooperative agreement is designed to facilitate the development of core capacity infrastructure, which in turn leads to strengthening the state/territorial oral health programs and reducing oral health inequalities of the state/territorial residents. The 13 grantees include: Alaska, Arkansas, Colorado, Illinois, Michigan, Nevada, New York, North Dakota, Oregon, Rhode Island, South Carolina, Texas, and the Republic of Palau. The CDC funding is renewable for up to five years and supports improvement of basic state oral health services (e.g., supporting program leadership, adding additional program staff, monitoring oral health risk factors, developing prevention programs, and evaluating programs).

Grantees have used CDC funding to establish and sustain their state/territorial oral health coalitions. The following grantees have developed coalitions: Alaska, Arkansas, Colorado, Illinois, Michigan, Nevada, New York, North Dakota, South Carolina, Texas, and Palau.

CDC is also working with the 13 grantees to evaluate practices funded by the cooperative agreement. A CDC evaluation project is developing tools and templates to help evaluate outcomes and impact of practices implemented by the funded states and territory. Practices being evaluated include the state oral health coalition, the state oral health plan, and school-based dental sealant programs. The tools and templates will be made available to other states as resource to build their evaluation capacity.

### 4. SOHCS Grant

The Health Resources and Services Administration's (HRSA) Maternal and Child Health Bureau (MCHB), through its State Oral Health Collaborative Systems (SOHCS) grant program, awarded funds to state oral health programs. The purpose of the grants was three-fold:

- Support states in developing, implementing or enhancing efforts to integrate oral health into state Maternal and Child Health programs;
- Address Maternal and Child Health Bureau performance measures in oral health; and
- Stimulate action toward implementation of the Surgeon General's "National Call to Act to Promote Oral Health" as it affects women and children.

States that have use the SOHCS funding to support development of coalitions/collaborative partnerships included: District of Columbia, Massachusetts, Missouri, Texas, Utah, Vermont and Wyoming.

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# III. Guidelines & Recommendations from Authoritative Sources

## A. The Surgeon General's Report on Oral Health

The Surgeon General's Report on Oral Health states (27): All Americans can benefit from the development of a National Oral Health Plan to improve quality of life and eliminate health disparities by facilitating collaborations among individual, health care providers, communities, and policy makers at all levels of society and by taking advantage of existing initiatives. Everyone has a role in improving and promoting oral health. Together we can work to broaden public understanding of the importance of oral

health and its relevance to general health and well-being, and to ensure that existing and future preventive, diagnostic, and treatment measures for oral diseases and disorders are made available to all Americans.  The report further promotes building an effective health infrastructure that meets the oral health needs of all Americans and using public-private partnerships to improve the oral health of those who still suffer disproportionately from oral diseases.

## B.  A National Call to Action to Promote Oral Health

*A National Call to Action to Promote Oral Health*, a report released by the Office of the Surgeon General in April 2003, proposed five actions in its call for a response to act.  One of the actions is to "increase collaborations" by linking the private and public sectors to capitalize on the talent and resources of each partner.  Proposed implementation strategies include building and nurturing broad-based coalitions as well as promoting state-based coalitions for others to use as models (28).

## C.  State and Territorial Dental Directors

State dental directors or state dental consultants from 43 states responded to an ASTDD survey and identified ten essential elements that would build infrastructure and capacity to achieve Healthy People 2010 Oral Health Objectives.  These elements reflect the public health core functions of assessment, policy development and assurance.  One of these top elements is building linkages with partners interested in reducing the burden of oral diseases by establishing a state oral health advisory committee, community coalitions, and governmental workgroups (7).

## D.  Oral Health America

Over the past decade, Oral Health America has recognized the vital role of launching and nurturing coalitions in fulfilling its mission and in improving Americans' oral and overall health status.  The national organization's broad goal is to work with all oral health coalitions needing assistance to identify their communities' oral health needs and to develop programs aimed at improving oral health for all Americans (24).

## E.  American Public Health Association

A new book published by the American Public Health Association, *The Spirit of Coalitions*, provides public health practitioners and other public health community workers details of how coalitions work most effectively. Step-by-step guidance is provided for practitioners involved in coalition building. Actual samples of materials that coalitions have used, such as planning documents, membership brochures and publicity flyers, are provided as models that can be adapted for use (11).

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# IV. Research Evidence

In the public health field, Kreuter et al. and Roussos and Fawcett have reported reviews of the research literature on collaborative partnerships (29):

1.  Kreuter et al. reviewed 68 qualifying studies from an initial sample of 137 studies on health status or health systems changes attributable to collaborations (30).  They found less than 10% of the cases

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documented such change occurred. They stated that the published literature on coalition strategies offer only marginal evidence that such approaches lead to health status/health systems change.

2. Roussos and Fawcett reviewed 34 separate studies describing the effects of 252 collaborative partnerships and reached the following conclusions (14):

   - Findings are insufficient to make strong conclusions about the effects of partnerships on population-level outcomes.
   - Only limited empirical evidence exists on their effectiveness in improving community-level outcomes.
   - Collaborative partnerships can contribute to widespread changes in a variety of health behaviors, but the magnitude of these effects may not be as great as intended.
   - Weak outcomes, contradictory results, or null effects were found in the most methodologically rigorous studies.

Overall, the documented research evidence for positive coalition or partnership outcomes is weak. The lack of positive evidence points to the need for more research (14,29).

Little research evaluating measurement tools for assessing effectiveness of community coalitions and partnerships has been reported. Granner and Sharpe (31) reviewed measurement tools for coalitions, finding that the largest numbers of measures assess coalition characteristics and the least numbers of measures assess coalition impact and outcomes. They found that published measures often lacked information regarding validity and reliability and found that valid and reliable tools that can be applied across multiple coalitions are necessary in order to achieve a better understanding of the association among factors influencing optimal functioning of coalitions and community health impacts and outcomes.

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# V. Best Practice Criteria

For the best practice approach of **State Oral Health Coalitions and Collaborative Partnerships**, the ASTDD Best Practices Committee has proposed the following initial review standards for five best practice criteria (21,32,33):

**1. Impact/Effectiveness:**

   - The collaborative partnership has a well-articulated shared vision.
   - The collaborative partnership has an action plan developed through participation of the members and tracks outcome achievements related to the action plan.
   - Leadership has built broad-based involvement to strengthen the collaborative partnership.

**2. Efficiency:**

   - Funding or in-kind sources have been acquired for coordination and programmatic activities of the collaborative partnership.

**3. Demonstrated Sustainability:**

   - Policy is in place that supports the collaborative partnership.

**4. Collaboration/Integration:**

   - Members recruited for the collaborative partnership show broad-based representation of constituency and stakeholders.

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- Collaborative partnership demonstrates leverage of resources.

**5. Objectives/Rationale:**

- Linking of collaborative partnership's goals and objectives to the state's oral health goals and objectives.

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# VI. State Practice Examples

During the first phase of the ASTDD Best Practices Project, states submitted descriptions of their successful practices to share their experiences and implementation strategies. The following practice examples illustrate various elements or dimensions of the best practice approach for **State Oral Health Coalitions and Collaborative Partnerships**. These reported success stories should be viewed in the context of the state's and program's environment, infrastructure and resources. End-users are encouraged to review the practice descriptions (click on the links of the practice names) and adapt ideas for a better fit to their states and programs.

## A. Summary Listing of Practice Examples

See **Figure 1**. Each practice name is linked to a detailed description report.

**Figure 1.**

## State Practice Examples of
## State Oral Health Coalitions and Collaborative Partnerships

| Item | Practice Name | State | Practice # |
|---|---|---|---|
| **State Oral Health Coalitions:** | | | |
| 1. | Saving the Dental Program: Georgia's Experience and Support of the Oral Health Coalition | GA | 12001 |
| 2. | Statewide Coalition Development – IFLOSS Coalition: Communities Working Together to Improve Oral Health | IL | 16002 |
| 3. | Michigan's Statewide Oral Health Coalition Development | MI | 25003 |
| 4. | Montana Dental Summits | MT | 29001 |
| 5. | Nevada's Oral Health Coalitions | NV | 31005 |
| 6. | New Jersey Oral Health Coalition | NJ | 33003 |
| 7. | Oregon's State Oral Health Coalition | OR | 40004 |
| 8. | Washington State Oral Health Coalition | WA | 54003 |
| **Collaborative Partnerships Developed through Commissions and Task Forces:** | | | |
| 1. | Colorado Commission on Children's Dental Health | CO | 07001 |
| 2. | Massachusetts Special Legislative Commission on Oral Health | MA | 24001 |
| 3. | Health Care Commission's Dental Care Access Improvement Committee | DE | 09001 |
| 4. | Director of Health's Task Force on Access to Dental Care | OH | 38003 |
| **Collaborative Partnerships with Focus on a Specific Aspect of Oral Health:** | | | |
| 1. | Incorporating Oral and Pharyngeal Cancer into a State Comprehensive Control Plan | IL | 16003 |
| 2. | The Maryland Oral Cancer Prevention Coalition's Needs Assessment Efforts | MD | 23003 |
| 3. | The Oral Cancer Consortium | NJ | 33016 |
| 4. | National Governors Association (NGA) Policy Academy on Oral Health Care for Children | MN | 26001 |
| 5. | Prevent Abuse and Neglect through Dental Awareness (P.A.N.D.A.) | AR | 05002 |

## B.  Highlights of the Practice Examples

### 1.   State Oral Health Coalitions

GA   Saving the Dental Program: Georgia's Experience and Support of the Oral Health Coalition
(Practice #12001)
The Georgia Oral Health Coalition was established to build and support state oral health
infrastructure.  The Coalition helped retained the state oral health program and reinstate funding to
the program in 1997 and 2001, facilitated the development of a state oral health plan, increased
funding for the Georgia Oral Health Prevention Program, and increased dental Medicaid fees.

IL   Statewide Coalition Development – IFLOSS Coalition: Communities Working Together to Improve
Oral Health (Practice #16002)
IFLOSS Coalition is a statewide public-private partnership of key stakeholders concerned about
oral health in Illinois.  The coalition and its partners together have realized successes that include:
increased Medicaid reimbursement rates, added limited restorative adult services to Medicaid,
assisted communities in developing dental HPSA designations and loan repayment programs, and
developed a Marketing Plan to raise public awareness of the importance of oral health.

MI   Michigan's Statewide Oral Health Coalition Development (Practice #25003)
The Michigan Oral Health Coalition represents a diverse group of private and public individuals and
entities within the state dedicated to addressing oral disease, treatment and prevention.  While the
Michigan Primary Care Association supports the Coalition, the Coalition's agenda and activities are
owned and decided by the participants.  The Coalition's kick-off was in December 2003.  The
mission of the Coalition is "to improve oral health in Michigan by focusing on prevention, health
promotion, surveillance, access, and the link between oral health and total health."  The Coalition
has a Steering Committee meeting at least quarterly, has workgroups meeting regularly, and has
the entire Coalition membership meeting at least bi-annually.  The Coalition and its partners have
been the backbone of the oral health infrastructure in Michigan.

MT   Montana Dental Summits (Practice #29001)
The Dental Summit in 1999 engaged the state in a national oral health initiative.  The Summit
resulted in establishing a state oral health coalition and developing the Montana Dental Action
Plan.  The Coalition removed pre-authorization for Medicaid dental services, increased the dental
benefit for the Children's Health Insurance Program, and established a full time state dental
director position. A second Dental Summit and continued efforts of the coalition, which gained a
broader oral health focus, led to the development of a state oral health plan in 2006 as a roadmap
for promoting oral health, preventing oral diseases, and improving access to dental services.

NV   Nevada's Oral Health Coalitions (Practice # 31005)
The 2004 Nevada State Oral Health Plan was developed to provide goals and objectives to guide
oral health promotion activities throughout the state.  Due to geographic challenges and the
diversity of the communities within Nevada, implementation of the plan by one statewide oral health
coalition was perceived by stakeholders as an ineffective and undesirable approach to address the
oral health needs of local communities.  In response, the State has partnered with stakeholders to
develop an overarching State Oral Health Advisory Committee (OHAC) and local oral health
coalitions that address the needs of the State and local communities.  Six community-based
coalitions represent all counties of the state.

NJ   New Jersey Oral Health Coalition (Practice #33003)
The mission of the Coalition is to foster and promote the equitable access of quality oral health
care services throughout New Jersey.  Activities address both comprehensive treatment and dental
disease preventive modalities provided by public oral health programs and private practices.  The
Coalition's achievements include conducting an oral health summit in 2001 and developing a
manual, "Improving the Oral Health of all New Jerseyans."

OR    Oregon's State Oral Health Coalition (Practice #40004)
      Building off the success of statewide oral health summit in 2004, the Oregon State Oral Health
      Program, with guidance from its Oral Health Advisory Board (OHAB) began development of a
      broad based statewide oral health coalition (SOHC) in 2005. The OHAB expanded membership to
      form a Coalition Steering Committee which coordinated the planning of three major activities: 1)
      release of the first ever state oral health plan, 2) the convening of a second oral health summit, and
      3) the launch of the first ever statewide oral health coalition.

WA    Washington State Oral Health Coalition (Practice #54003)
      The Coalition is broad-based group of organizations and individuals with a mission to promote
      optimal oral health for Washington State residents.  Coalition has educated decision makers at the
      legislative and state agency levels and successfully advocated for increased Medicaid funding,
      developed tools and support systems for communities, and added oral health components to the
      State Board of Health's Recommended Children's Preventive Services.


## 2.  Collaborative Partnerships Developed through Commissions and Task Forces

CO    Colorado Commission on Children's Dental Health (Practice #07001)
      In 2000, the Governor of Colorado supported a commission to address children's oral health that
      included dental benefits, financial resources needed, service delivery systems, and service
      utilization.  The commission had representation from dentists, dental hygienists, the dental school,
      public health nurses, legislators and business executive and was successful with having five
      legislative initiatives funded.  These initiatives included a dental loan repayment program,
      expansion of a dental safety net, and dental benefits in the State Children's Health Insurance
      Program.

MA    Massachusetts Special Legislative Commission on Oral Health (Practice # 24001)
      In 1998, Massachusetts Legislature appointed the Commission with members representing a
      variety of heath and non-health professional organization, state legislators, government agencies,
      community advocates, and public and private dental provider networks.  The Commission
      submitted recommendations that resulted in increasing funding for Medicaid reimbursement rates,
      expanding safety net provider sites, establishing a sealant demonstration project, and incorporating
      oral health for the Enhanced School Health Programs.

DE    Health Care Commission's Dental Care Access Improvement Committee (Practice #09001)
      The Health Care Commission's purpose is to promote accessible, affordable, quality health care for
      the Delaware's residents.  The Commission formed a Dental Care Access Improvement Committee
      to study ways to improve access to dental care and make recommendations.  The Committee's
      efforts resulted in passage of two key bills allowing for development of alternative methods for
      dental licensure and developing programs that included dentist recruitment and loan repayment.

OH    Director of Health's Task Force on Access to Dental Care (Practice #38003)
      In 1999, Ohio's Director of Health appointed the Task Force.  The Task Force formulated
      recommendations that included improving Medicaid and the State Children's Health Insurance
      Program, dental care delivery system, community action for oral health access, and public
      awareness of oral health.  A state action plan was developed based on the task force
      recommendations.  The Task Force's efforts raised access to dental care to one of the top ten
      priorities of the Ohio Department of Health.  The Ohio Dental Association passed a resolution to
      take action to implement the Task Force's recommendations.


## 3.  Collaborative Partnerships with Focus on a Specific Aspect of Oral Health

IL    Incorporating Oral and Pharyngeal Cancer into a State Comprehensive Control Plan (Practice
      #16003)

In Illinois, a cancer control partnership represents public, private, professional and voluntary agencies along with policymakers concerned about cancer. The partnership was invited by the Illinois Dept. of Public Health Division of Chronic Disease Prevention and Control to develop a comprehensive state cancer control plan. The oral health community was well represented in the partnership and oral cancer was incorporated in the state plan.

MD    The Maryland Oral Cancer Prevention Coalition's Needs Assessment Efforts (Practice #23003)
The Coalition, with small grants from each represented institution, conducted a needs assessment on oral cancer. Efforts included assessing available funds and educational materials, determining the interest of individuals and agencies, reviewing state epidemiological data from the Cancer Registry, and conducting surveys of care providers and the public to determine knowledge and practices for oral cancer prevention and early detection. The needs assessment led to the inclusion of oral cancer as one of the targeted cancers by the state's Tobacco Settlement Fund Program and the passing of legislation for an Oral Cancer Prevention Initiative.

NJ    The Oral Cancer Consortium (Practice #33016)
The Consortium, created by the New Jersey Dental School and other major regional dental schools, aims to raise the consciousness of providers and the public for need of periodic oral cancer examinations, changes in risk factors and identification/treatment of existing disease. The Consortium administers free oral cancer screenings at the New Jersey Dental School along with 29 other institutional sites and sponsors continuing education programs.

MN    National Governors Association (NGA) Policy Academy on Oral Health Care for Children (Practice #26001)
The NGA Policy Academy on Oral Health Care for Children required Minnesota to assemble a state team. The team included: a legislator, the state dental director, a practicing pediatric dentist, representatives from the Governor's Office, the Department of Human Resources, the state dental association, community programs and a HMO health plan. Accomplishments made through the Minnesota team's efforts included the development of a strategic plan to address oral health care coverage and services, passage of legislation to improve the dental workforce, enhanced reimbursement rates for "critical access providers" who delivered a high volume of dental services to public dental program recipients, expansion of community-based dental clinics, and establishment of dental access grants.

AR    Prevent Abuse and Neglect through Dental Awareness (P.A.N.D.A.) (Practice #05002)
The PANDA Program increases awareness in the dental and other communities to provide information on recognition and appropriate intervention in family violence, and prevents abuse and neglect in all populations. Activities are coordinated through the new PANDA coalition in Arkansas. Coalition members include the Department of Health, state dental association, state dental hygienists' association, Arkansas Advocates for Children and Families, Delta Dental Plan and the Department of Human Services.

## Date of Report: August 5, 2008

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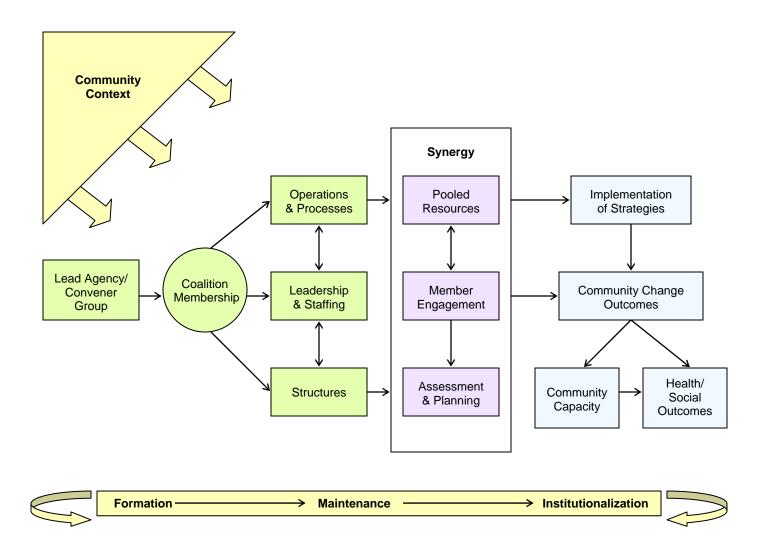
## Strength of Evidence Supporting Best Practice Approaches

The ASTDD Best Practices Committee took a broader view of evidence to support best practice approaches for building effective state and community oral health programs. The Committee evaluated evidence in four categories: research, expert opinion, field lessons and theoretical rationale. Although all best practice approaches reported have a strong theoretical rationale, the strength of evidence from research, expert opinion and field lessons fall within a spectrum. On one end of the spectrum are promising best practice approaches, which may be supported by little research, a beginning of agreement in expert opinion, and very few field lessons evaluating effectiveness. On the other end of the spectrum are proven best practice approaches, ones that are supported by strong research, extensive expert opinion from multiple authoritative sources, and solid field lessons evaluating effectiveness.

| Promising Best Practice Approaches | | | Proven Best Practice Approaches | |
|---|---|---|---|---|
| Research | + | | Research | +++ |
| Expert Opinion | + | | Expert Opinion | +++ |
| Field Lessons | + | | Field Lessons | +++ |
| Theoretical Rationale | +++ | | Theoretical Rationale | +++ |

Research
+       A few studies in dental public health or other disciplines reporting effectiveness.
++      Descriptive review of scientific literature supporting effectiveness.
+++     Systematic review of scientific literature supporting effectiveness.

Expert Opinion
+       An expert group or general professional opinion supporting the practice.
++      One authoritative source (such as a national organization or agency) supporting the practice.
+++     Multiple authoritative sources (including national organizations, agencies or initiatives) supporting the practice.

Field Lessons
+       Successes in state practices reported without evaluation documenting effectiveness.
++      Evaluation by a few states separately documenting effectiveness.
+++     Cluster evaluation of several states (group evaluation) documenting effectiveness.

Theoretical Rationale
+++     Only practices which are linked by strong causal reasoning to the desired outcome of improving oral health and total well-being of priority populations will be reported on this website.

# Community Coalition Action Theory
# Butterfloss & Kegler, 2002

Source:  Butterfoss FD, Kegler MC. Toward a Comprehensive Understanding of Community Coalitions: Moving from Practice to Theory. In DiClemente RJ, Crosby RA, Kelger MC. (Eds.) Emerging Theories in Health Promotion Practice and Research. San Francisco, CA: Jossey-Bass Publishers, 2002:157-193. (Community Coalition Action Theory)

# Toward a Comprehensive Understanding of Community Coalitions

| Constructs and Propositions Related to Community Coalition Formation, Structure, and Processes | |
|---|---|
| **Constructs** | **Propositions** |
| Stages of development | 1. Coalitions develop in specific stages and recycle through these stages as new members are recruited, plans are renewed, and new issues are added. |
| | 2. At each stage, specific factors enhance coalition function and progression to the next stage. |
| Community content | 3. Coalitions are heavily influenced by contextual factors in the community throughout all stages of development. |
| Lead agency/convener group | 4. Coalitions form when a lead agency or convening group responds to an opportunity, threat, or mandate. |
| | 5. Coalition formation is more likely when the lead agency or convening organization provides technical assistance, financial or material support, credibility, and valuable networks and contracts. |
| | 6. Coalition formation is likely to be more successful when the convener group enlists community gatekeepers who thoroughly understand the community to help develop credibility and trust with others in the community. |
| Coalition membership | 7. Coalition formation usually begins by recruiting a core group of people who are committed to resolving the health or social issue. |
| | 8. More effective coalitions result when the core group expands to include a broad constituency of participants who represent diverse interest groups, agencies, organizations, and institutions. |
| Coalition operation and processes | 9. Open and frequent communication among staff and members helps to create a positive organizational climate, ensures that benefits outweigh costs, and makes pooling of resources, ember engagement, and effective assessment and planning more likely. |
| | 10. Shared and formalized decision-making processes help create a positive organizational climate, ensure that benefits outweigh costs, and make pooling of resources, ember engagement, and effective assessment and planning more likely. |
| | 11. Conflict management helps to create a positive organizational climate, ensures that benefits outweigh costs, and achieves pooling of resources, ember engagement, and effective assessment and planning. |
| | 12. The benefits of participation must outweigh the costs to make pooling of resources, member engagement, and effective assessment and planning more likely. |
| | 13. Positive relationships among members are likely to create a positive coalition climate. |
| Leadership and staffing | 14. Strong leadership from a team of staff and members improves coalition functioning and makes pooling of resources, member engagement, and effective assessment and planning more likely. |
| | 15. Paid staff who have the interpersonal and organizational skills to facilitate the collaborative process improve coalition functioning and increase pooling of resources, member engagement, and effective assessment and planning. |
| Structures | 16. Formalized rules, roles, structures and procedures make pooling resources, member engagement, and effective assessment and planning more likely. |

| Constructs and Propositions Related to Community Coalition Interventions and Outcomes ||
|---|---|
| **Constructs** | **Propositions** |
| Pooled member and external resources | 17. The synergistic pooling of member and community resources prompts effective assessment, planning, and implementation of strategies. |
| Member engagement | 18. Satisfied and committed members will participate more fully in the work of the coalition. |
| Assessment and planning | 19. Successful implementation of strategies is more likely when comprehensive assessment and planning occur. |
| Implementation of strategies | 20. Coalitions are more likely to create changes in community policies, practices, and environment when they direct interventions at multiple levels. |
| Community change outcomes | 21. Coalitions that are able to change community policies, practices, and environment are more likely to increase capacity and improve health and social outcomes. |
| Health and social outcomes | 22. The ultimate indicator of coalition effectiveness is the improvement in health and social outcomes. |
| Community capacity | 23. As a result of participating in successful coalitions, community members and organizations develop capacity and build social capital that can be applied to other health and social issues. |

Source: Butterfoss FD, Kegler MC. Toward a Comprehensive Understanding of Community Coalitions: Moving from Practice to Theory. In DiClemente RJ, Crosby RA, Kelger MC. (Eds.) Emerging Theories in Health Promotion Practice and Research. San Francisco, CA: Jossey-Bass Publishers, 2002:157-193. (Community Coalition Action Theory)

# Factors Influencing the Success of Collaboration

| Number of Studies that Identify the Factor | Categories |
|---|---|
| | **I.  Factors Related to the ENVIRONMENT** |
| ✓✓✓✓✓ | **A. History of collaboration or cooperation in the community.** |
| | A history of collaboration or cooperation exists in the community and offers the potential collaborative partners an understanding of the roles and expectations required in collaboration and enables them to trust the process. |
| ✓✓✓ | **B. Collaboration group seen as a leader in the community.** |
| | The collaboration group (and by implication, the agencies in the group) is perceived within the community as a leader – at least related to the goals and activities it intends to accomplish. |
| ✓✓✓ | **C. Political/social climate favorable.** |
| | Political leaders, opinion-makers, persons who control resources, and the general public support (or at least do not oppose) the mission of the collaborative group. |
| | **2. Factors Related to MEMBERHSIP CHARACTERISTICS** |
| ✓✓✓✓✓✓✓✓✓ | **A. Mutual respect, understanding, and trust.** |
| | Members of the collaborative group share an understanding and respect for each other and their respective organizations: how they operate, their cultural norms and values, limitations, and expectations. |
| ✓✓✓✓✓✓✓✓✓ | **B. Appropriate cross-section of members.** |
| | The collaborative group includes representatives from each segment of the community who will be affected by its activities. |
| ✓✓✓✓✓ | **C. Members see collaboration as in their self-interest.** |
| | Collaborative partners believe the benefits of collaboration will offset cost such as loss of autonomy and "turf." |
| ✓✓✓ | **D. Ability to compromise.** |
| | Collaborating partners are able to compromise, since the many decisions within a collaborative effort cannot possibly fit the preferences of every member perfectly. |
| | **3. Factors Related to PROCESS/STRUCTURE** |
| ✓✓✓✓✓ | **A. Members share a stake in both process and outcome.** |
| | Members of a collaborative group feel "ownership" of both the way the group works and the results or products of its work. |
| ✓✓✓✓✓ | **B. Multiple layers of decision-making.** |
| | Every level (upper management, middle management, operations) within each organization in the collaborative group participates in decision-making. |

| | |
|---|---|
| ✓✓✓✓ | **C. Flexibility.** |
| | The collaborative group remains open to varied ways of organizing itself and accomplishing its work. |
| ✓✓✓✓ | **D. Development of clear roles and policy guidelines.** |
| | The collaborating partners clearly understand their roles, rights, and responsibilities; and how to carry out those responsibilities. |
| ✓✓✓ | **E. Adaptability.** |
| | The collaborative group has the ability to sustain itself in the midst of major changes, even If it needs to change some major goals, members, etc., in order to deal with changing conditions. |
| | **4. Factors Related to COMMUNICATION** |
| ✓✓✓✓✓✓✓ | **A. Open and frequent communication.** |
| | Collaborative group members interact often, update one another, discuss issues openly, and convey all necessary information to one another and to people outside the group. |
| ✓✓✓✓ | **B. Established informal and formal communication links.** |
| | Channels of communication exist on paper, so that information flow occurs.  In addition, members establish personal connections – producing a better, more informed, and cohesive group working on a common project. |
| | **5. Factors Related to PURPOSE** |
| ✓✓✓✓ | **A. Concrete, attainable goals and objectives.** |
| | Goals and objectives of the collaborative group are clear to all partners, and can realistically be attained. |
| ✓✓✓ | **B. Shared vision.** |
| | Collaborating partners have the same vision, with clearly agreed upon mission, objectives and strategy.  The shared vision may exist at the outset of collaboration; or the partners may develop a vision as they work together. |
| ✓✓✓ | **C. Unique purpose.** |
| | The mission and goals or approach of the collaborative group differ, at least in part, form the mission and goals or approach of the member organizations. |
| | **6. Factors Related to RESOURCES** |
| ✓✓✓✓✓✓ | **A. Sufficient funds.** |
| | The collaborative group has an adequate, consistent financial base to support its operations. |
| ✓✓✓✓✓✓ | **B. Skilled convener.** |
| | The individual who convenes the collaborative group has organizing and interpersonal skills, and caries out the role with fairness. Because of these characteristics (and others), the convener is granted respect or "legitimacy" from the collaborative partners. |

Source:  Mattessich PW and Monsey BR. Collaboration: What Makes It Work – A Review of Research Literature on Factors Influencing Successful Collaboration. Amberst H. Wilder Foundation, St. Paul, Minnesota.

# A Workbook on Coalition Building & Community Development

*From The Group Up! A Workbook on Coalition Building & Community Development* is a Workbook supported by the W.K. Kellogg Foundation and AHEC/Community Partners, Inc.  The Workbook shares with practitioners in the field ideas, frameworks, and exercises for community building and community development. The Workbook also provides worksheets for individuals and their communities to use in examining their existing efforts and in finding ways to improve them.

The following provides a brief description of each Chapter of the Workbook:

| *From The Group Up!* <br> *A Workbook on Coalition Building & Community Development* | |
|---|---|
| **Chapter** | **Description** |
| 1 | **Coalition Building: One Path to Empowered and Healthy Communities** <br> Describes some of the crisis facing communities today and articulates the goal for most community development and coalition building, which is building healthy communities.  A worksheet helps clarify a coalition's agenda. |
| 2 | **Coalition Building: Is this really empowerment?** <br> Looks at the assumptions underlying coalition building, and clarifies what a coalition is, what is collaboration, and what is empowerment.  Worksheets guide a self-assessment process to allow coalitions to determine their present status covering goals and objectives, membership, communication, decision making, leadership and leadership development, use of resources, coalition activities, and coalition outcomes. |
| 3 | **Principles of Success in Building Community Coalitions** <br> Describes principles of success for building community coalitions, such as clear coalition mission and goals, strong leadership, and a need for hope, celebration, time and persistence. |
| 4 | **Barriers To Coalition Building and Strategies To Overcome Them** <br> Illustrates a range of barriers for those trying to create coalitions in communities, such as turf battles.  Coalition development will need to understand and appreciate such barriers, and develop appropriate strategies and interventions to overcome them. A Worksheet helps identify barriers to success for a coalition. |
| 5 | **Multicultural Issues in Coalitions** <br> Assesses the issue of multicultural coalitions and articulates a range of barriers that are likely to occur, and strategies that a coalition can use to prevent difficulties from occurring while supporting multicultural coalition development.  Worksheets help to measure how prepared is a coalition for multicultural work, identify areas for improvement, create ground rules for group behavior and coalition operations, explore stereotypes, be better aware of differences, and understand the realities of oppression. |
| 6 | **Dealing with Conflict in Coalitions** <br> Discusses the need to deal with the issue of conflict in coalitions.  A framework is provided for categorizing and finding creative and successful approaches to dealing with conflicts as them emerge in coalition development.  Worksheets help translate "You-Messages" to "I-Messages" to avoid accusations in communication,  learn ways of handling conflict, and open a dialogue about conflict and approaches to problem solving, |

| 7 | **Involving and Mobilizing The Grassroots**<br>Provides a clear framework and suggestions for involving and mobilizing the grassroots citizens.  Outreach strategies described are well tested approaches that have successfully engaged citizens.  Worksheets guide the understanding of why people participate in groups and organizations, identify the organized and unorganized sectors of communities, and develop a comprehensive community outreach action plan |
|---|---|
| 8 | **Community Assessment: A Key Tool for Mobilization and Involvement**<br>Spells out an innovative community assessment technique that is a key tool for involving and mobilizing the grassroots.  The social reconnaissance approach is a well tested technique that has worked in both rural and urban areas and provided both a "kickoff" for community development efforts and a solid base for building community support. |
| 9 | **Developing Action Plans for Your Community Coalitions**<br>Describes the development of action plans for community coalition.  Information supports a coalition planning process step-by-step.  Worksheets guide setting an agenda for an action planning meeting, identifying problems and issues, developing strategies, and preparing an action plan. |
| 10 | **Monitoring and Evaluation of the Coalition Activities and Success**<br>Provides a monitoring and evaluation system for coalitions that helps to answer some of the key process and outcome questions that occur in community-based efforts.  Worksheets offer ways to track coalition's actions and accomplishments including an event log, a format for key participant interviews, data reporting, and a satisfaction survey of the coalition. |
| 11 | **Resources**<br>Provides an annotated bibliography of resource manuals which every coalition needs to know about. |

Source:  Kaye G and Wolff T (Eds.). From The Group Up! A Workbook on Coalition Building & Community Development.  AHEC/Community Partners, Inc., Amherst, MA.  United Book Press, 2002.

Source: CDC, Division of Oral Health, http://www.cdc.gov/oralhealth/state_programs/infrastructure/activity4.htm (accessed July 1, 2008)

# Oral Health Coalition Framework

**Members to include**

| GOVERNMENT | COMMUNITY | EDUCATION | PROVIDERS | PUBLIC | THIRD-PARTY PAYERS | POLICY | HIGHER/PROFESSIONAL EDUCATION |
|---|---|---|---|---|---|---|---|
| State/Local Health Dept Inter-agency and/or Interdepart-mental, Steering Committee, Environmental Health, Dept of Education, Dept of Social Services | Local Community Health Depts, Community-based Clinics, Community Water Supervisors/managers, Business leaders, Faith-based orgs, Foundations | Local School Administra-tor, PTA, School Nurse Association, Dept of Education, Dept of Higher Education, Regional Staff | Dentists, Dental hygienists, Physicians, Hospitals and their Respective Associations | Foundations, Consumer Advocates, Patient Care Advocates, Organizations that promote oral health, Organizations that promote improved QOL, John Q Public | Managed care, Insurance, Medicaid | State and Federal: Legislators, Policy Advocates, Local and Community Policy Makers | PRC, Universities, Dental and Dental Hygiene Schools, Nursing Schools, Medical Schools and Allied Health Schools |

## Working Groups – Areas to Address:

| | | | | |
|---|---|---|---|---|
| ASSESSMENT | POLICY | PROGRAMS | FUNDING | COMMUNICATIONS/MARKETING |
| INFANTS | CHILDREN | ADULTS | AGING POPULATION | |
| EDUCATION | SURVEILLANCE | CARIES | PERIODONTAL DISEASE | ORAL CANCER    INJURY |
| INFECTION CONTROL | ACCESS | POPULATION-BASED, EVIDENCE-BASED PREVENTION PROGRAMS | | |
| WATER FLUORIDATION | SEALANT PROGRAMS | EVALUATION | INFRASTRUCTURE DEVELOPMENT | |

**Considered an active coalition if these outputs are identified**

- WRITTEN VISION/MISSION STATEMENTS
- WRITTEN PRIORITIES/PLANS/STRATEGIES
- IDENTIFIED STAKEHOLDERS
- IDENTIFIED RESPONSIBILITY FOR IMPLEMENTATION
- SUSTAINABILITY (funding and institutionalization)
- COMMUNICATION

- VISABILITY
- EVALUATION
- LEGISLATIVE ACTIVITY
- PRODUCTS & IMPACT
- S.M.A.R.T. ACTION PLANS
- MAINTENANCE OF MEMBERSHIP