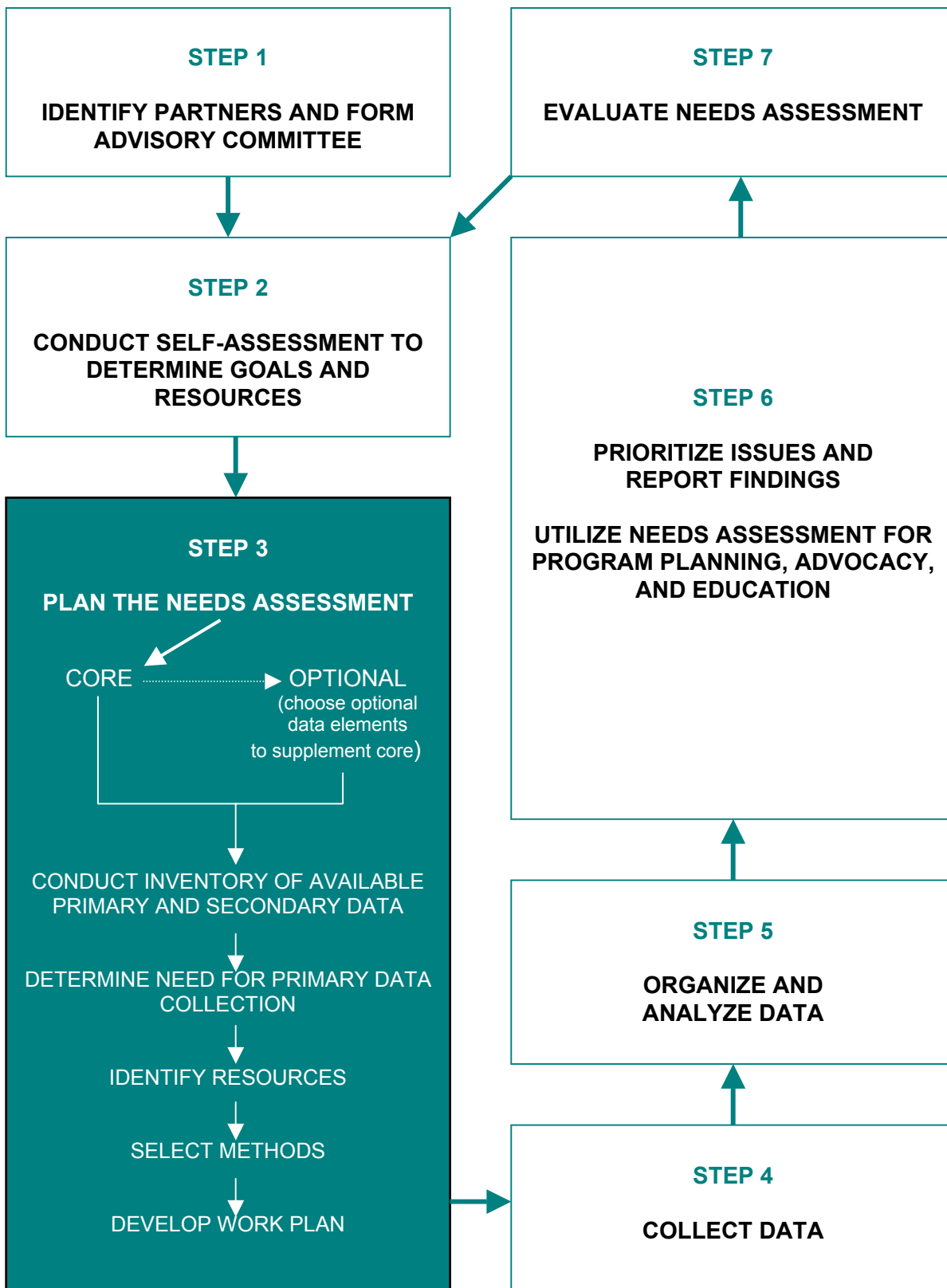


## MODEL ORAL HEALTH NEEDS ASSESSMENT



### STEP 3: PLAN THE NEEDS ASSESSMENT

To know what information to gather, you must develop a needs assessment plan. STEP 3 will guide you through this process by examining these questions:

- ⇒ Of the needs assessment information I want, what is available and what do I need to collect?
- ⇒ Which data collection methods shall I use?

Most programs will find they have information gaps. It may not be feasible to collect all the information necessary to address the issues. Therefore, you must prioritize information gaps (remembering that core elements precede optional) in order to develop a plan to collect the missing pieces. You will use the results of your self-assessment and knowledge of available resources, to decide on a **realistic** approach to needs assessment for your program.

***All users of the model will start with a core set of information that every public oral health program should have for needs assessment.***

*Worksheet 3, the Oral Health Needs Assessment Planning Worksheet*, lists 37 data items drawn from a variety of sources including *Healthy People 2010*, the National Oral Health Surveillance System, and *Healthy Communities 2000: Model Standards*. Additional items are program related, while still others represent general types of information useful in needs assessment (e.g., public perceptions). For each data item listed, the worksheet provides a rationale and indicates acceptable methods for collecting information. Matrix 1 of the worksheet lists the core set of 11 data items for all oral health programs. Recognizing that particular state and local programs have individual information needs,

the model allows optional information elements to be added to the core set according to a given program's needs.

Matrices 2, 3 and 4 of the worksheet list 26 optional data items. Matrix 4 also provides the opportunity to add items to your plan. The worksheet will guide you towards selecting the most reasonable methods for collecting the information you need. For items that you select, but lack data, you will choose from alternative data collection methods.

If you have **suitable** data for an item, there is no need to collect more. Therefore, you must first identify any data you have and assess whether they are acceptable. Data may be primary (collected by your program) or secondary (reported by another agency).

***Table 1 provides criteria to help you determine the acceptability of data you may have. Worksheet 3 helps you plan to fill any remaining data gaps.***

	+2.688
	+5.000
	+1.500
	+1.125
	+1.062

### TABLE 1: Considerations for Judging if Existing Data are Suitable for Needs Assessment

#### RELIABILITY

- ⇒ How accurate and complete are the data?

#### TIMELINESS

- ⇒ What is the most recent year and for what other years are data available? Is there a reason to believe the data are no longer representative?

#### COMPARABILITY

- ⇒ Can you compare these data with other data you plan to use (e.g., standard definitions, similar collection methods)?

#### LINKAGE

- ⇒ Do these data contain identifiers that will permit linkage with other data (e.g., patient identifiers, census tract)?

#### VARIABILITY

- ⇒ Have any data elements changed (e.g., definitions, reporting requirements, collection methods)?

#### CONFIDENTIALITY

- ⇒ Do the data implicitly or explicitly identify individuals?

#### AUTOMATION

- ⇒ To what extent are the data computerized and what hardware/software is required to transfer data files?

Needs assessment must consider both quantitative and qualitative measures of health status. Needs assessment experts recommend multiple data collection methods to compensate for the deficiencies of any single method.

Some needs assessment methods are straight forward, while others, especially oral health surveys, are more complex. *Worksheet 3* presents nine methods in increasing order of resources required, from left to right. The nine methods are grouped into four color-coded categories – secondary data (blue), programmatic data (yellow), community input (green), and oral examination surveys (tan). More rigorous methods generally require greater resources, but are more likely to yield more reliable and valid data. The use of an alternative method by a program with limited resources, however, is an acceptable needs assessment trade-off. A description of each method is given, along with information to help you select the best one for you. Whenever possible, it is suggested you consider existing (secondary) data before collecting your own (primary) data. You must determine, however, whether secondary data sources meet your needs.

Before the core and optional sections of *Worksheet 3* are a series of one-page summary descriptions of acceptable alternative methods for collecting information. After considering the alternatives and taking your resources into account, select the most appropriate methods.

***Worksheets 3 and 4 are designed to help you cross the bridge from developing a needs assessment plan to actually carrying out the plan in STEP 4.***

**Worksheet 3 groups nine data collection methods into the following four color-coded categories:**

**SECONDARY DATA – BLUE**

- A. Secondary Data From National or Regional Oral Health Surveys (e.g., NHANES)**
- B. Other Secondary Data (e.g., Medicaid, BRFSS, EPA)**
- C. Demographic Indicators**

**PROGRAMMATIC DATA – YELLOW**

- D. Nonclinical Program Data**
- E. Clinical Program Data**

**COMMUNITY INPUT – GREEN**

- F. Public Comment**
- G. Informant Groups**
- H. Questionnaire/Interview Survey**

**ORAL EXAMINATION SURVEYS – TAN**

- I. Basic Screening Survey**

More information about the methods begins on page 20. Detailed information for each method is explained in STEP 4.

**Worksheet 4 will help you organize your needs assessment plan.** You will start by transferring the decisions you made in *Worksheet 3* and grouping data according to the methods you selected for collecting them. *Worksheet 4* will help you determine how many different data collection activities to undertake, identify the need for additional resources and schedule the start and completion dates for each activity.

Before beginning to collect data, compare your needs assessment plan with your goals as they appear on *Worksheet 2*.

***A useful "hypothetical example" of a needs assessment plan using Worksheets 1 through 4 can be found in the example section of the document.***

## METHOD SUMMARIES

*Table 2*, on the next page, offers a **quick comparison** of the nine methods for data collection used in the model. Pages 22-30 are brief summaries of each method that present information on the following:

- ⇒ **How to perform the method**
- ⇒ **Why this method?**
- ⇒ **Limitations**
- ⇒ **Resources/costs**
- ⇒ **Time to complete**
- ⇒ **Examples of data that you can collect using this method**

*Detailed information on each of the nine methods is provided in STEP 4.*



**TABLE 2: Summary of Needs Assessment Methods**

<b>METHOD</b>	<b>PURPOSE</b>	<b>COST</b>	<b>TIME INVOLVED</b>	<b>ADVANTAGES</b>
<b>A. Secondary Data From National Or Regional Oral Health Surveys</b>	Needs or problem analysis	Very Inexpensive	Extremely Fast	Data readily available
<b>B. Other Secondary Data</b>	Needs or problem analysis	Inexpensive	Fast to Moderate	Data available (self-reported and other fiscal or regulatory information)
<b>C. Demographic Indicators</b>	Needs or problem analysis	Inexpensive	Very Fast	Data available from public documents
<b>D. Analyzing Non-clinical Data</b>	Resources analysis	Inexpensive to Moderate	Fast	Can also use for annual reports; trend analysis of activities
<b>E. Analyzing Clinical Program Data</b>	Resources analysis	Inexpensive to Moderate	Moderate	Can also use for annual reports; understand extent of services provided
<b>F. Public Comment</b>	Needs or problem analysis	Inexpensive	Moderate	Invitation of public input and exchange
<b>G. Informant Groups</b>	Needs or problem analysis	Inexpensive to Moderate	Fast to Moderate	Minimal preparation time; facilitates communication from providers and consumers
<b>H. Questionnaire/ Interview Survey</b>	Needs or problem analysis	Moderate	Moderate	Relatively good way to obtain information about knowledge and behavior
<b>I. Basic Screening Survey</b>	Needs or problem analysis	Moderate to Expensive	Moderate to Slow	Assesses individuals; good estimate of population if probability sampling is used

## A. SECONDARY DATA FROM NATIONAL OR REGIONAL ORAL HEALTH SURVEYS

*This method reports data collected in national and/or regional health surveys that include an oral health component, such as the National Health and Nutrition Examination Survey (NHANES), along with surveys from other states.*

### HOW TO PERFORM THIS METHOD

Oral health status data from the third National Health and Nutrition Examination Survey (NHANES III) has been published in several peer-reviewed journals. These data, in terms of the *Healthy People 2010* oral health objectives, are presented in Table 3. The Division of Oral Health, Centers for Disease Control and Prevention, can be contacted to inquire about data updates.

Another source of secondary data is the National Oral Health Surveillance System (NOHSS). This surveillance system is a cooperative effort between the Association of State and Territorial Dental Directors and the Division of Oral Health, CDC. The NOHSS can be accessed at the following website – [www.cdc.gov/nohss](http://www.cdc.gov/nohss). Local health departments and dental education institutions are other potential sources of secondary data.

### WHY THIS METHOD?

When resources are too limited for primary data collection, this method provides an approximation of the extent of oral diseases that exist in your region.

### LIMITATIONS

National data are less persuasive than state or local data when advocating for resources. Sampling designs of national surveys usually preclude reporting data in a state-specific manner. Regional findings, when available, may not reflect your state or locality. Additionally, national data may become outdated.

### RESOURCES/COST

Because the data are provided with this model, the cost of collection is negligible. The availability of more recent data should be explored by the program.

### TIME TO COMPLETE

Telephone calls to determine the existence of updated data can be made within hours.

### EXAMPLES OF DATA THAT YOU CAN COLLECT USING THIS METHOD

- ⇒ Oral Health Status: Caries experience, untreated caries, sealant prevalence, gingivitis, destructive periodontal diseases, fluorosis, oral injuries, ECC prevalence.

*A full description of this method starts on page 40.*



**B. OTHER SECONDARY DATA**

*This category refers to information that has been collected by another agency or organization.*

**HOW TO PERFORM THIS METHOD**

Once secondary data have been located, obtain and record the information in an appropriate format. The model lists a number of potential secondary data sources for specific types of information on pages 53-54.

**WHY THIS METHOD?**

This is a fast way to collect information on a subject that is regulated or managed by another agency or program. Such data often are reported periodically and can be analyzed to determine trends.

**LIMITATIONS**

The availability of some secondary data may not be well known, especially if they are not published.

**RESOURCES/COST**

Costs will be minimal.

**TIME TO COMPLETE**

A few hours to a few days will be needed, depending on the volume of information. The form in which data are obtained influences the ability to manipulate and analyze them.

**EXAMPLES OF DATA THAT YOU CAN COLLECT WITH THIS METHOD**

- ⇒ Medicaid: Enrollment, EPSDT participation, provider participation, dental expenditures, service mix, sealant utilization.
- ⇒ EPA: Fluoridated water systems, population served, compliance with standards.
- ⇒ Department of Education/School Administration: Enrollment, free/reduced cost meal participation, children entering school with oral screenings.
- ⇒ State Dental Board: Number of licensed dentists and dental hygienists, by county.
- ⇒ Head Start: Enrollment, compliance with standards and referrals/completed care.
- ⇒ Universities/Other Agencies and Organizations that Conduct Research: Smokeless tobacco use, utilization of services, infection control practices, dental insurance data.
- ⇒ State Primary Care Association: Dental health professional shortage areas (HPSA), community and migrant health centers (C/MHC).

*A full description of this method starts on page 46.*



## C. DEMOGRAPHIC INDICATORS

***With the demographic analysis, inferences of need are drawn from descriptive statistics found in public records or reports (e.g., U.S. Census).***

### HOW TO PERFORM THIS METHOD

U.S. Bureau of the Census statistics are available at the state and local level ([www.census.gov](http://www.census.gov)). Demographic information already may be part of your state Title V MCH Block Grant application.

### WHY THIS METHOD?

Demographic data provide information about the general population. These data can be used for targeting program activities based on economic need or other factors.

### LIMITATIONS

Correlation between demographic indicators and disease prevalence may be weak. Also, census data are increasingly less reliable over time.

### RESOURCES/COST

This method is largely a paper exercise that requires little in the way of resources.

### TIME TO COMPLETE

A few hours.

### EXAMPLES OF DATA THAT YOU CAN COLLECT USING THIS METHOD

- ⇒ Demographic: Population distribution by age, race, sex, according to county or smaller unit; population at or below a percentage poverty level consistent with state or local planning standards (e.g., 100%, 185%, 200%); number of single-parent families; number of children in day care.

***A full description of this method starts on page 55.***

## D. NONCLINICAL PROGRAM DATA

*This method uses data collected by programs to describe oral health promotion and disease prevention activities of organized oral health programs. The description may include information related to scope of services, accessibility, and effectiveness at reaching target population(s). These data are useful for assessing resources for systems development.*

### HOW TO PERFORM THIS METHOD

This method requires the routine recording of the number of services and individuals served using standardized reporting. Data from regional/local sites usually are aggregated at a central office. Sample data collection forms start on page 57.

### WHY THIS METHOD?

This is a simple method for describing the current system. When compared with demographic data, the extent to which programs reach their target populations can be estimated. Data are easy to collect and minimal resources are required.

### LIMITATIONS

Data are as valid and reliable as the record keeping and standardization of definitions.

### RESOURCES/COST

For programs that already have a data collection mechanism in place, this method should not require any significant additional resources. Other programs typically could redirect a small amount of time to tabulate data. Spreadsheet software and a personal computer are helpful but not necessary.

### TIME TO COMPLETE

The time necessary would vary with the extent of analysis.

### EXAMPLES OF DATA THAT YOU CAN COLLECT USING THIS METHOD

- ⇒ Nonclinical program description: Clients served by programs of health education, fluoride mouthrinse or varnish, smokeless tobacco education, mouthguard construction, etc.

*A full description of this method starts on page 56.*

**E. CLINICAL PROGRAM DATA**

***This method uses clinical program records to estimate oral health status and service utilization. Information can be abstracted from patient records as a means of estimating oral health status. Other program data are used to indicate service utilization. In addition, nonclinical descriptions of programs (e.g., facilities, staffing, hours of operation) are part of this method.***

**HOW TO PERFORM THIS METHOD**

A sample of patient charts is reviewed and information is abstracted. A data recording form is provided on page 63. Staff must be trained on its use. Information on the number and type of services provided can be drawn from program statistics (samples start on page 64).

**WHY THIS METHOD?**

This method provides a relatively low resource approach to estimating disease levels. The sample represents a group (users of public or nonprofit dental clinics) of potentially high-need individuals that safety net programs are likely to target. Data on utilization and services provided, as well as program descriptions of, can be obtained using this method.

**LIMITATIONS**

The sampling bias (solely care seekers in dental clinics) will severely limit the ability to generalize about the findings. This method may require human subjects review clearance.

**RESOURCES/COST**

Most costs will be in-kind. This method requires cooperating dental clinics, a dentist, dental hygienist or other qualified individual to review and abstract records. Access to a personal computer with database software and clerical staff to enter data will be very helpful.

**TIME TO COMPLETE**

The entire process can be done within a few weeks to months and will depend on the number of clinics submitting data and the number of records or patients included.

**EXAMPLES OF DATA THAT YOU CAN COLLECT USING THIS METHOD**

- ⇒ Oral Health Status: Caries experience, untreated caries, sealant prevalence, gingivitis, periodontal diseases, fluorosis, oral injuries.
- ⇒ Utilization: Type and number of clinical services performed, including sealants placed in a sealant program; nature of care received (e.g., episodic, recall).
- ⇒ Nonclinical information about clinical programs: Hours of operation, appointment waiting time, types of payment accepted, number/type of staff, etc.

***A full description of this method starts on page 61.***

## F. PUBLIC COMMENT

***This method invites the general public to participate in meetings where needs and services are discussed. Written comments via mail or email may be submitted whether or not an individual attends the public meeting.***

### HOW TO PERFORM THIS METHOD

Through notices published in newspapers or other vehicles, the public is notified in advance of the purpose, location and date(s) of the hearing(s). Meeting sites and times should be convenient. Language interpreters may be needed or you may want to schedule meetings for non-English speaking groups in their native language. A moderator establishes rules for testimony and summarizes the testimony after the hearing. Testimony may be recorded by a tape recorder or a court reporter.

### WHY THIS METHOD?

Public hearings encourage consumer participation and increase community awareness of issues. This method is a quick means to solicit input and generate an official record of comments about programs and community perceptions. State Title V programs are required to solicit public comment on the MCH Block Grant application.

### LIMITATIONS

The information is the perception and opinion of interested individuals rather than the community at large. It is often difficult to generate interest in attending a public hearing on issues such as oral health alone.

### RESOURCES/COST

The major costs for this method are the notices published in the newspaper and a court reporter, if required by law. When included in the MCH Block Grant public comment process, there is no real additional cost.

### TIME TO COMPLETE

With no complications, the entire process can be accomplished in one to two months. Each hearing requires a few hours and testimony must be summarized afterwards.

### EXAMPLES OF DATA YOU CAN COLLECT USING THIS METHOD

- ⇒ Perceptions of consumers, oral health care providers, MCH services providers, school personnel or community leaders concerning the need for oral health services or the accessibility/acceptability of existing services.

***A full description of this method starts on page 66.***

## G. INFORMANT GROUPS

*The informant group method includes several structured processes through which information is gathered to represent a larger group.*

### HOW TO PERFORM THIS METHOD

- ⇒ Nominal Group Process and Focus Groups: (1) identify or employ a skilled facilitator to run the meeting; (2) determine questions for the group; (3) summarize and interpret information gained. Consensus may or may not be reached. A program may wish to hold a series of regional group meetings.
- ⇒ Delphi Technique: (1) develop questionnaires and cover letters (samples are located in the *Appendix*); (2) select individuals to receive them; (3) mail questionnaires; (4) tabulate results after each mailing (there are usually two or three); (5) interpret results; (6) send final results to participants.

### WHY THIS METHOD?

Informant groups provide qualitative information as perceived by the individuals participating in the groups. The Delphi Technique is used when meetings are not practical or strong personalities are likely to dominate.

### LIMITATIONS

The success of a Nominal Group Process technique and Focus Groups hinge on the group composition and the facilitator. The Delphi Technique requires good writing skills by the participants and the ability of the coordinator to tabulate and distribute information rapidly.

### RESOURCES/COST

A skilled facilitator may be available at little or no cost through not-for-profit agencies. Otherwise, a facilitator must be hired. A staff person, or the facilitator, must summarize the proceedings. Someone must develop and mail questionnaires and summarize findings from Delphi Technique surveys.

### TIME TO COMPLETE

Each focus group takes approximately 4 - 6 weeks to organize. The number of groups determines the total time. A Delphi Technique survey takes 2 - 3 months or longer, depending on the cooperation of the participants.

### EXAMPLES OF DATA YOU CAN COLLECT USING THIS METHOD

- ⇒ Perceptions of consumers, oral health care providers, MCH services providers, school personnel or community leaders about the need for oral health services or the accessibility/acceptability of services.

*A full description of this method starts on page 69.*

**H. QUESTIONNAIRE/INTERVIEW SURVEY**

*With this method, carefully designed sets of questions are used to elicit information. Questionnaires can be administered through mail surveys, email surveys or personal interviews (face-to-face or by telephone). Sample size may influence whether you choose an interview or a mail survey.*

**HOW TO PERFORM THIS METHOD**

A carefully worded questionnaire is posed to a randomly selected sample either by: (1) mailing or emailing the questionnaire with a cover letter; (2) conducting telephone interviews; or (3) through face-to-face interviews. For mail or email surveys, a second questionnaire generally is sent to non-responders. Data are entered into a database prior to analysis.

**WHY THIS METHOD?**

This is a versatile method for assessing knowledge, attitudes, and self-reported behaviors on a variety of subjects. Questionnaires also can be used to elicit unpublished secondary data. The Behavioral Risk Factor Surveillance System (BRFSS), the Youth Risk Behavior Surveillance System (YRBS), and the Pregnancy Risk Assessment Monitoring System (PRAMS) may be existing instruments to which questions can be added.

**LIMITATIONS**

It is time consuming and difficult to construct questions that are easy to answer yet provide valid and reliable information. Sampling rigor affects the ability to generalize findings. This method may require human subjects review clearance

**RESOURCES/COSTS**

Major costs are in developing the survey instrument, data entry and data analysis. Postage costs accompany a mail survey. The use of professional interviewers would be an additional cost.

**TIME TO COMPLETE**

Developing and pilot testing a questionnaire can take two months or longer. By using pretested questions (from BRFSS, PRAMS other questionnaires), the time for development can be greatly reduced. Two mailings plus time for responses takes about two months. Emailing is much quicker. The amount of time necessary for analysis is variable.

**EXAMPLES OF DATA YOU CAN COLLECT USING THIS METHOD**

- ⇒ Public: Use of smokeless tobacco, topical fluorides, oral health care services; infant feeding practices; acceptability of oral health care; perceived oral health status; dental benefit coverage.
- ⇒ Dental professionals: Attitudes about public financing systems, willingness to treat young or special needs children, and other aspects of practice.
- ⇒ MCH service providers: Perceptions about oral health needs of clients and barriers to accessing dental care.
- ⇒ Agencies/Organizations: Availability and utilization of services that they provide (e.g., dental disease prevention programs, public dental treatment programs, compliance with fluoridation standards, number of licensed providers); head, face, eye and mouth protection requirements of recreational programs.

*A full description of this method starts on page 73.*

## I. BASIC SCREENING SURVEY

**Screenings are intended to identify obvious dental or oral problems and the need for care, and are conducted by dentists, dental hygienists, or other appropriate health care workers in accordance with applicable state law. Screenings frequently are done in school or community settings.**

### HOW TO PERFORM THIS METHOD

School screenings often require advance arrangements with school administration as well as parental consent. Typically, a dentist, dental hygienist, or nurse inspects an individual's mouth for obvious dental problems using a standard set of criteria.

### WHY THIS METHOD?

Screenings are common activities in schools, often scheduled by health departments or dental societies, particularly during Children's Dental Health Month (February). The information gathered through a screening survey is at a level consistent with monitoring the national health objectives found in the United States Public Health Service's *Healthy People* document.

### LIMITATIONS

Oral screenings are unlikely to identify conditions not visually apparent. The data from screenings, therefore, may underestimate the prevalence of dental disease and the presence of sealants.

Convenience sampling compromises the ability to generalize the findings. This method may require human subjects review clearance. Since consent is necessary, some self-selection bias may occur.

### RESOURCES/COST

Costs generally are related to personnel (coordinator and screeners), travel, instruments and supplies, infection control supplies and data management/analysis. If volunteer dentists or dental hygienists conduct the screenings, the primary cost will be for a person to coordinate the survey and handle the data.

### TIME TO COMPLETE

On the day of a screening, one person can screen approximately 30 - 50 individuals per hour. The number of sites/subjects screened will determine the time requirement. When screenings are conducted in schools, or other sites, additional time must be allotted for advance contacts, distribution and collection of consent forms.

### EXAMPLES OF DATA YOU CAN COLLECT USING THIS METHOD

- ⇒ Oral Health Status: Caries experience, untreated caries, sealant prevalence, oral injuries, fluorosis, need for dental care (treatment urgency), periodontal disease, tooth loss.

***A full description and samples of survey forms/letters are found in "Basic Screening Surveys: An Approach to Monitoring Community Oral Health". The Basic Screening Survey manual and videotape may be ordered from ASTDD.***



## INSTRUCTIONS FOR COMPLETING WORKSHEET #3

As discussed on pages 17-19 of the manual, Worksheet 3 is designed to help you choose which methods of data collection you will use for the core and optional data items you (and your advisory committee) have chosen.

Worksheet 3 consists of five pages, this instruction page plus four pages with the **data items** and corresponding **data collection methods** (one for the core items and three for the optional items). The three pages with the data items and data collection methods are formatted for 17" X 11" paper. You can print them on smaller paper by selecting "Scale to Paper Size" from your print menu.

On the worksheet, there are 37 data items listed in the left column. Each item is followed by a rationale for collecting the data. Across the top of the worksheet, lettered A – I, are the nine data collection methods in increasing order of resources required, from left to right. The nine methods are grouped into four color-coded categories: secondary data (blue); programmatic data (yellow); community input (green); and basic screening survey (gold).

Every lightly shaded cell on Worksheet 3 is labeled with a unique number-letter combination (e.g. 6B, 11G). The number-letter combinations are called **data item / method combinations**. Each labeled cell contains the page in STEP 4 where the instructions on how to collect particular data begin.

On the first matrix, choose which methods you will use to collect data for each of the **core** items (#1-11) by marking the "box" in the appropriate lightly shaded cell. The "box" in each data collection cell is a text box and you can electronically add an X to any box you choose.

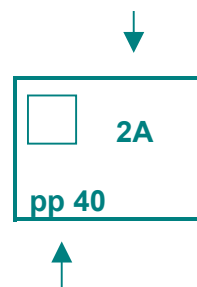
On the second, third, and fourth matrix, place a check in the column next to the optional data items (#12-37) you have

chosen, and then determine which data collection method(s) you will use for each of them. Mark the "box" in the appropriate lightly shaded cell. The "box" in each data collection cell is a text box and you can electronically add an X to any box you choose.

On the fourth matrix, add other optional data items you have chosen, and then determine which data collection method(s) you will use.

### KEY

Data Item / Method Code



A detailed description of how to collect data using method A begins on page 40 (Step 4).

WORKSHEET #3 – CORE: DEVELOPING THE NEEDS ASSESSMENT PLAN			METHODS FOR DATA COLLECTION								
MATRIX 1 DATA ITEMS/TYPES OF INFORMATION			A	B	C	D	E	F	G	H	I
			Secondary Data from National Oral Health Surveys (e.g., NHANES)	Other Secondary Data (e.g., Medicaid, EPA, Board of Dentistry)	Demographic Indicators (e.g., Census, Board of Education)	Nonclinical Program Data	Clinical Program Data (e.g. patient records)	Public Comment	Informant Groups	Questionnaire/ Interview Survey	Basic Screening Survey
CORE INFORMATION	RATIONALE FOR COLLECTING INFORMATION	The lightly shaded boxes represent acceptable methods for data collection. Place an X in the text box for the method that you chose.									
1	<b>DEMOGRAPHICS</b> description of population (e.g., age, race, SES, school enrollment)	To provide perspective about the underlying population. Useful when targeting populations for oral health programs; serves as a denominator in developing population estimates.		<input type="checkbox"/> 1B pp 46	<input type="checkbox"/> 1C pp 55						
2	<b>ORAL HEALTH STATUS</b> % of children with untreated decay	To indicate the degree of access to, and utilization of, dental treatment services.	<input type="checkbox"/> 2A pp 40				<input type="checkbox"/> 2E pp 61			<input type="checkbox"/> 2H pp 73	<input type="checkbox"/> 2I pp 80
3	% of children who have dental caries experience	To describe the overall caries prevalence and indicate the degree of need for preventive programs.	<input type="checkbox"/> 3A pp 40				<input type="checkbox"/> 3E pp 61			<input type="checkbox"/> 3H pp 73	<input type="checkbox"/> 3I pp 80
4	<b>RISK REDUCTION</b> % of people served by community water systems with optimally fluoridated water	To indicate the need for community water fluoridation, a cornerstone for dental public health programs. Information also is useful in targeting school-based and individualized fluoride strategies.		<input type="checkbox"/> 4B pp 46							
5	% of children with sealant on 1+ permanent molar teeth	To indicate the degree of access to, and dentist utilization of, an important caries preventive method. Sealants prevent caries on the most susceptible tooth surfaces.	<input type="checkbox"/> 5A pp 40	<input type="checkbox"/> 5B pp 46		<input type="checkbox"/> 5D pp 56	<input type="checkbox"/> 5E pp 61			<input type="checkbox"/> 5H pp 73	<input type="checkbox"/> 5I pp 80
6	<b>SYSTEMS DEVELOPMENT / ACCESS</b> # of dental providers in a state (by county or other division)	To indicate the number of general dentists and dental specialists. In combination with population data, this will provide an initial indicator of dentally underserved areas.		<input type="checkbox"/> 6B pp 46							
7	dentist participation in Medicaid program (number participating and level of participation)	To indicate availability of dental care services through the largest public financing system of dental care for a vulnerable population, lower SES families.		<input type="checkbox"/> 7B pp 46						<input type="checkbox"/> 7H pp 73	
8	# (%) of children under age 19 years at or below 200% of FPL who receive preventive dental services	To indicate the degree of access to, and utilization of, different types of dental care services through the largest public financing system of dental care for a vulnerable population, lower SES children.		<input type="checkbox"/> 8B pp 46							
9	description of public resources for dental care (e.g., C/MHCs, local health departments, dental school clinics)	To describe the public system of preventive and primary dental care services. An understanding of all resources is an important first step in developing systems of primary oral health care services.		<input type="checkbox"/> 9B pp 46			<input type="checkbox"/> 9E pp 61			<input type="checkbox"/> 9H pp 73	
10	% of children that have visited a dentist during the previous year	To assess the effectiveness of a potential mechanism for: 1) identifying children who have not entered the primary dental care system, and 2) linking them with a source of care at an early age.		<input type="checkbox"/> 10B pp 46		<input type="checkbox"/> 10D pp 56				<input type="checkbox"/> 10H pp 73	
11	perceived oral health needs of consumers and their assessment of accessibility, acceptability and affordability of oral health care received.	To provide perspective on the extent to which services meet the population's perceived needs. This information is critical to the development of family-centered system of primary care.		<input type="checkbox"/> 11B pp 46				<input type="checkbox"/> 11F pp 66	<input type="checkbox"/> 11G pp 69	<input type="checkbox"/> 11H pp 73	

WORKSHEET #3 – OPTIONAL: DEVELOPING THE NEEDS ASSESSMENT PLAN			METHODS FOR DATA COLLECTION								
MATRIX 2 DATA ITEMS/TYPES OF INFORMATION			A	B	C	D	E	F	G	H	I
			Secondary Data from National Oral Health Surveys (e.g., NHANES)	Other Secondary Data (e.g., Medicaid, EPA, Board of Dentistry)	Demographic Indicators (e.g., Census, Board of Education)	Nonclinical Program Data	Clinical Program Data (e.g. patient records)	Public Comment	Informant Groups	Questionnaire/ Interview Survey	Basic Screening Survey
	<b>OPTIONAL INFORMATION</b> Review the items and check the box to the right of each item that you want to include.	<input checked="" type="checkbox"/>	<b>RATIONALE FOR COLLECTING OPTIONAL INFORMATION</b> The lightly shaded boxes represent acceptable methods for data collection. Place an X in the text box for the method that you chose.								
12	<b>DEMOGRAPHICS</b> # (%) of children below ____% of poverty who are uninsured (or underinsured) for oral health services			<input type="checkbox"/> 12B pp 46						<input type="checkbox"/> 12H pp 73	
13	# (%) of preschool children in: 1) Head Start program, and 2) other day care programs			<input type="checkbox"/> 13B pp 46							
14	<b>ORAL HEALTH STATUS</b> % of children needing dental treatment according to urgency of need		<input type="checkbox"/> 14A pp 40					<input type="checkbox"/> 14E pp 61			<input type="checkbox"/> 14I pp 80
15	% of children with oral injuries		<input type="checkbox"/> 15A pp 40					<input type="checkbox"/> 15E pp 61		<input type="checkbox"/> 15H pp 73	<input type="checkbox"/> 15I pp 80
16	% of children with dental fluorosis		<input type="checkbox"/> 16A pp 40					<input type="checkbox"/> 16E pp 61			<input type="checkbox"/> 16I pp 80
17	% of adults (women of childbearing age) with gingivitis and/or destructive periodontal disease		<input type="checkbox"/> 17A pp 40					<input type="checkbox"/> 17E pp 61			<input type="checkbox"/> 17I pp 80
18	% of adults who have had a tooth extracted because of dental caries or periodontal disease		<input type="checkbox"/> 18A pp 40					<input type="checkbox"/> 18E pp 61		<input type="checkbox"/> 18H pp 73	<input type="checkbox"/> 18I pp 80
19	% of older adults who have had all their natural teeth extracted		<input type="checkbox"/> 19A pp 40					<input type="checkbox"/> 19E pp 61		<input type="checkbox"/> 19H pp 73	<input type="checkbox"/> 19I pp 80
20	% of oral and pharyngeal cancers detected at the earliest stage			<input type="checkbox"/> 20B pp 46				<input type="checkbox"/> 20E pp 61		<input type="checkbox"/> 20H pp 73	
21	<b>RISK REDUCTION</b> % of adults who report having an oral cancer exam in the last 12 months									<input type="checkbox"/> 21H pp 73	
22	% of children & adults who use the oral health care system each year									<input type="checkbox"/> 22H pp 73	

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MATRIX 3 DATA ITEMS/TYPES OF INFORMATION			A	B	C	D	E	F	G	H	I
			Secondary Data from National Oral Health Surveys (e.g., NHANES)	Other Secondary Data (e.g., Medicaid, EPA, Board of Dentistry)	Demographic Indicators (e.g., Census, Board of Education)	Nonclinical Program Data	Clinical Program Data (e.g. patient records)	Public Comment	Informant Groups	Questionnaire/ Interview Survey	Basic Screening Survey
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23	<b>RISK REDUCTION (CONT)</b> % of adolescents / young adults using smokeless tobacco			<input type="checkbox"/> 23B pp 46						<input type="checkbox"/> 23H pp 73	
24	% compliance with community water fluoridation standards			<input type="checkbox"/> 24B pp 46			<input type="checkbox"/> 24D pp 56				
25	% of parents / caregivers who use infant feeding practices that prevent ECC									<input type="checkbox"/> 25H pp 73	
26	% of people not on fluoridated water who use topical or systemic fluoride			<input type="checkbox"/> 26B pp 46						<input type="checkbox"/> 26H pp 73	
27	<b>SYSTEMS DEVELOPMENT / ACCESS</b> dental health professional shortage areas (HPSA)			<input type="checkbox"/> 27B pp 46							
28	% of Head Start children completing dental care			<input type="checkbox"/> 28B pp 46						<input type="checkbox"/> 28H pp 73	
29	% of women (childbearing age) utilizing oral health care system			<input type="checkbox"/> 29B pp 46						<input type="checkbox"/> 29H pp 73	
30	existence of a system for recording and referring infants with cleft lip/ palate			<input type="checkbox"/> 30B pp 46					<input type="checkbox"/> 30G pp 69	<input type="checkbox"/> 30H pp 73	
31	# of public dental disease prevention programs (e.g., fluoride mouthrinse, educational, sealants ) and # of individuals served			<input type="checkbox"/> 31B pp 46			<input type="checkbox"/> 31D pp 56	<input type="checkbox"/> 31E pp 61		<input type="checkbox"/> 31H pp 73	
32	perceptions of key informants (e.g., government officials, community leaders)							<input type="checkbox"/> 32F pp 66	<input type="checkbox"/> 32G pp 69	<input type="checkbox"/> 32H pp 73	
33	perceptions of oral health care providers (e.g., dentists, dental hygienists)							<input type="checkbox"/> 33F pp 66	<input type="checkbox"/> 33G pp 69	<input type="checkbox"/> 33H pp 73	







## **STOP**

***Before you proceed with data collection, step back and look at your needs assessment plan (Worksheets 3 and 4). Does your plan outline a needs assessment that:***

- 1.  
Meets the goals you scored as being of high importance on Worksheet 2?***
- 2.  
Falls within your resources?***
- 3.  
Is practical?***
- 4.  
Provides information on multiple aspects of oral health?***