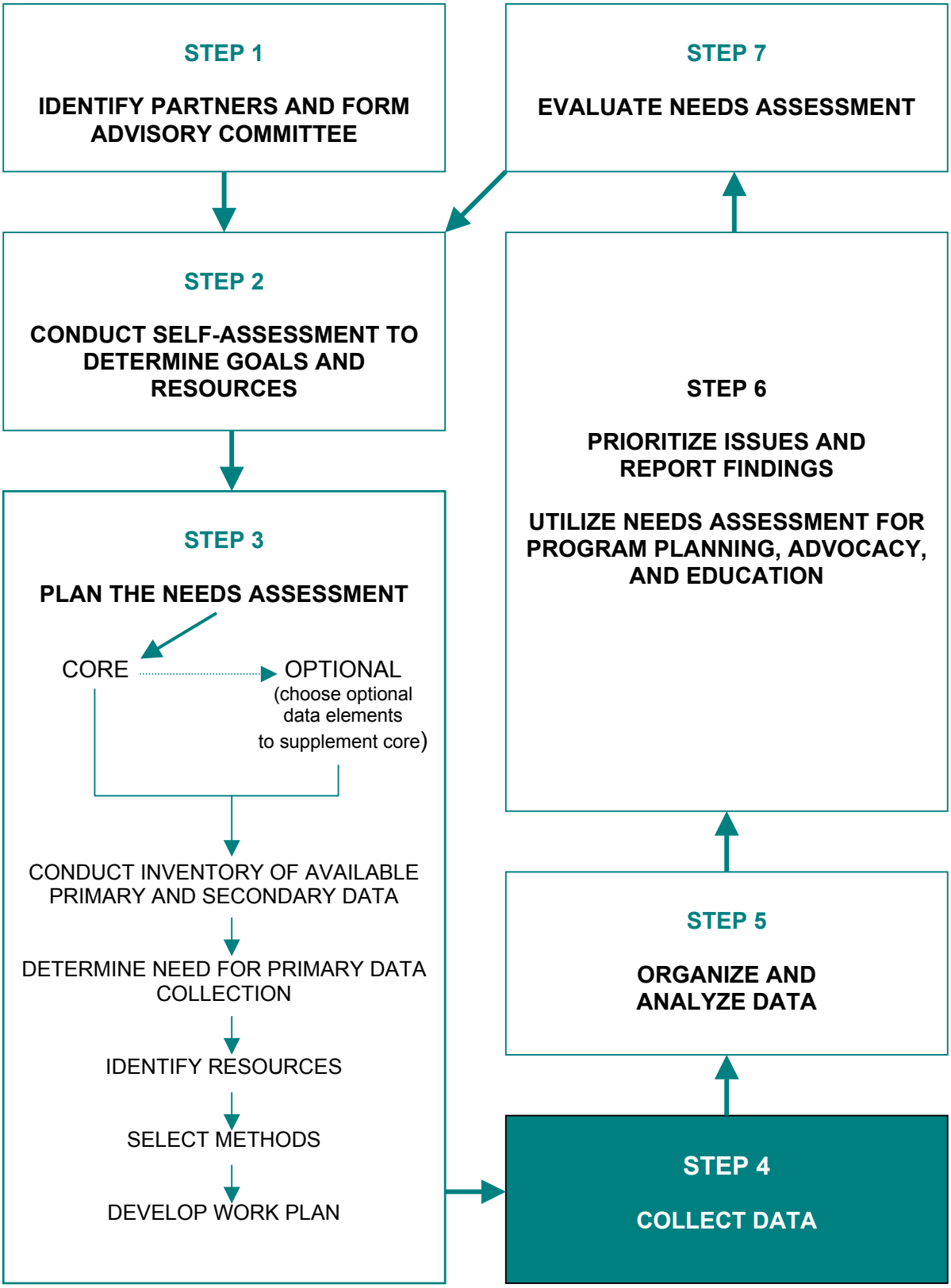
MODEL ORAL HEALTH NEEDS ASSESSMENT



STEP 4: COLLECT DATA

STEP 4 guides you through carrying out the needs assessment plan you developed in STEP 3. Each method for collecting specific data items selected on *Worksheet 3* is detailed in STEP 4. This section is divided into sub-sections, one for each of the nine data collection methods (A-I) summarized on pages 22-30.

For example, the first sub-section "A" provides information on how to obtain data for any items that you chose to collect via *Secondary Data from National or Regional Oral Health Surveys*. For items that you decided to collect by means of *Questionnaires or Interview Surveys*, you would look for specific item numbers (1-37) in sub-section "H", and so on.

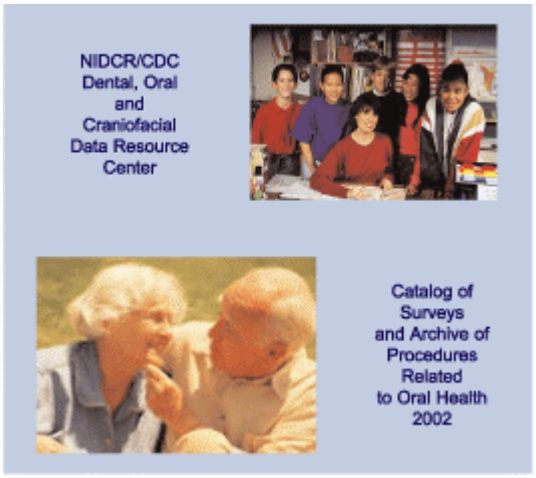
A good starting point in the data collection process is to obtain and look at the CD-ROM *Catalog of Surveys Related to Oral Health*, produced by the Dental, Oral, and Craniofacial Data Resource Center – a collaborative effort between NIDCR and CDC. The Catalog contains a description of all the surveys related to oral health including source, purpose, sample design, and contact person.

Upon completion of the data collection step of the needs assessment, STEP 5 will help you summarize your data for analysis and interpretation.

A good starting point in the data collection process is to obtain and look at ... Catalog of Surveys Related to Oral Health, produced by the Dental, Oral, and Craniofacial Data Resource Center.

During the data collection process it is important to keep both primary and secondary data users apprised of the needs assessment process. Primary users should be regularly updated on the needs assessment process and findings. Doing so provides information on each person's perception about the importance of any findings. It allows incorporation of relevant concerns into the needs assessment methods. It may be a good idea to keep a written log indicating whenever either primary users or relevant secondary users are contacted. This log should record what each person wants to learn from the oral health needs assessment and why. Different users may wish different information.. Periodic contact with primary users will let you know of any perceived controversies arising from the needs assessment activity and soothe those concerns. It is important to avoid surprises in the final report.

Other users, who may not have a clear idea of what they want from the process, may still become potential advocates for the oral health program when they know more about the needs assessment process.



A. SECONDARY DATA FROM NATIONAL OR REGIONAL ORAL HEALTH SURVEYS

When program resources are too limited to undertake primary data collection, the findings of other surveys can be used to approximate the oral health status of your population. Although national data are generally less persuasive than state or local data, they are preferable to no estimates at all.

Table 3 provides oral health status data from the third National Health and Nutrition Examination Survey (NHANES III). This information has been used as baseline for many of the *Healthy People 2010* objectives. The Division of Oral Health, Centers for Disease Control and Prevention, can be contacted to inquire about data updates.

Additional information regarding monitoring data for tracking the *Healthy People 2010* objectives can be found through DATA2010 - an interactive database system developed by staff of the Division of Health Promotion Statistics at the National Center for Health Statistics.

DATA2010 can be accessed at the following website: wonder.cdc.gov/DATA2010/.

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. Local health departments and dental institutions are other potential sources of secondary data.

Reference citations for a variety of oral health status studies are listed on pages 43-45.

Oral Health Status Data Items (Worksheet 3)

CELL NO.	DATA ITEM / TYPE OF INFORMATION
Core	
2-A	% of children with untreated decay
3-A	% of children with dental caries experience
5-A	% of children with sealant on 1+ permanent molar teeth
Optional	
14-A	% of children needing dental treatment according to urgency of need
15-A	% of children with oral injuries
16-A	% of children with enamel fluorosis
17-A	% of adults (women of childbearing age) with destructive periodontal disease
18-A	% of adults who have had a tooth extracted because of caries or periodontal disease
19-A	% of older adults who have had all their natural teeth extracted

For the purpose of this model, findings of previous oral health surveys conducted by your agency are considered primary data collection methods.

NECESSARY RESOURCES FOR SECONDARY DATA FROM NATIONAL OR REGIONAL ORAL HEALTH SURVEYS

If you select **secondary data from national or regional oral health surveys** as a needs assessment method, then you will need:

1) People - Only minimum personnel are required to transpose information from *Table 3*; verify from national sources that this information is the latest available; look up current data on the National Oral Health Surveillance System or DATA2010; look up references from the list on pages 43-45 and contact city/county health departments, dental and dental hygiene schools and dental organizations within the state to determine whether other recent clinical surveys exist.

2) Supplies and Equipment – A computer with internet access.

3) Additional Funding - None required.

Table 3: Secondary Data, Related to Dental Caries and Other Oral Conditions

Healthy People 2010 Category	Data Source		
	NHANES III 1988-1994	NHIS 1997	BRFSS 1999
CARIES EXPERIENCE			
Proportion of children aged 2-4 years with dental caries experience	18%		
Proportion of children aged 6-8 years with dental caries experience in either their primary or permanent dentition	52%		
Proportion of adolescents aged 15 years with dental caries experience in their permanent teeth	61%		
UNTREATED DECAY			
Proportion of children aged 2-4 years with untreated dental decay	16%		
Proportion of children aged 6-8 years with untreated dental decay in either their primary or permanent dentition	29%		
Proportion of adolescents aged 15 years with dental caries experience in their permanent teeth	20%		
Proportion of adults with untreated decay	27%		
DENTAL SEALANTS			
Proportion of children aged 8 years who have received dental sealants on their molar teeth	23%		
Proportion of adolescents aged 14 years who have received dental sealants on their molar teeth	15%		
TOOTH LOSS			
Proportion of adults aged 35-44 years who have never had a permanent tooth extracted because of dental caries or periodontal disease	31%		
Proportion of adults aged 65-74 years who have had all their natural teeth extracted		26%	24%
PERIODONTAL DISEASE			
Proportion of adults aged 35-44 years with gingivitis	48%		
Proportion of adults aged 35-44 with destructive periodontal disease	22%		

REFERENCE CITATIONS FOR PUBLISHED ORAL EPIDEMIOLOGICAL STUDIES

BACKGROUND

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CATALOG OF SURVEYS

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B. OTHER SECONDARY DATA

Other sources of secondary data can be diverse. For example, data collected for administrative purposes by a state Medicaid agency, or an interview or mail survey conducted by a federal agency may be useful. These data sources are differentiated from those in method A by the fact that they are not from clinical oral health surveys.

Secondary data may be the only practical method for obtaining some types of information.

When using secondary data, you must adapt your needs to the data rather than the data to your needs. For instance, while a state dental director may be interested in targeting counties for a dental sealant program, the data which are available, for example from Medicaid, may not be reported by county or other geographic subdivision. The form in which data are obtained influences your ability to manipulate and analyze them.

Tables 4A-4E, on pages 49-52 provide secondary data from **national** surveys for some of the following data items and types of information in the box below.

Secondary data related to item 12-B is available from the National Medical Care Expenditure Survey, 1987 and the Medical Expenditure Panel Survey - a series of national probability surveys conducted by AHRQ on the financing and utilization of medical care in the United States.

Secondary Data Items – National Data (Worksheet 3)

CELL NO.	DATA ITEM / TYPE OF INFORMATION
Core	
4-B	% of people served by community water systems with optical fluoride
5-B	% of children with sealant on 1+ permanent molar teeth
Optional	
12-B	# (%) of children below ___%** of poverty who are uninsured (or underinsured) for preventive and restorative services
23-B	% of adolescents / young adults using smokeless tobacco
24-B	% compliance with community water fluoridation standards
26-B	% of people not on fluoridated water who use topical or systemic fluoride
29-B	% of women (childbearing age) using the oral health care system
30-B	existence of a system for recording and referring infants with cleft lip/palate

** Per state/local planning standards (*e.g.,* 100%, 185%, 200%)

Secondary Data Items – State/Local Data (Worksheet 3)

CELL NO.	DATA ITEM / TYPE OF INFORMATION
Core	
1-B	description of population
6-B	# of dental providers in a state (by county or other division)
7-B	dentist participation in Medicaid program (number participating and level of participation)
8-B	# (%) of children under age 19 years at or below 200% of FPL who receive preventive dental services
9-B	description of public resources for dental care
10-B	% of children entering school programs for first time who have received an oral screening, referral and follow-up
11-B	perceived oral health needs of consumers and their assessment of accessibility, acceptability and affordability of oral health care received
Optional	
12-B	# (%) of children below ___%** of poverty who are uninsured (or underinsured) for preventive and restorative services
13-B	# (%) of preschool children in: 1) Head Start program and 2) other day care programs
20-B	% of oral and pharyngeal cancers detected at the earliest stage
23-B	% of adolescents / young adults using smokeless tobacco
26-B	% of people not on fluoridated water who use topical or systemic fluoride
27-B	dental health professional shortage areas
28-B	% of Head Start children completing dental care
29-B	% of women (childbearing age) using the oral health care system
31-B	# of public dental disease prevention programs (*e.g.,* fluoride mouthrinse, educational, sealants) and # of individuals served
36-B	organizations that sponsor sporting and recreational events that require head, face, eye and mouth protection
37-B	school-based health centers with an oral health component

** Per state/local planning standards (*e.g.,* 100%, 185%, 200%)

Data from several different national surveys are now available through the world-wide-web. For example, the Medical Expenditure Panel Survey can be accessed at the following site: www.meps.ahcpr.gov. The website for the National Center for Health Statistics (www.cdc.gov/nchs) contains information from the National Health and Nutrition Examination Survey (NHANES), the National Health Interview Survey (NHIS) and several other national health related surveys. CDC also has a computerized information system (*CDC Wonder*) that will allow you to access their mainframe computer to read stored data (wonder.cdc.gov). The Dental, Oral, and Craniofacial Data Resource Center (NIDCR/CDC) has published the *Catalog of Surveys Related to Oral Health* – a CD-ROM that contains a list of all known oral health related surveys.

According to a 1992 ASTDD survey of state dental directors, only six states or territories require an oral examination at the time of school entrance. These include: District of Columbia, Georgia, Kansas, Maryland, Pennsylvania and Rhode Island. When answering data element 10-B please check with local and state departments of education to verify the existence of an oral health ordinance. The education department also may collect and maintain compliance records.

In addition, numerous other potential sources of secondary data, both public and private, exist. Suggestions for obtaining secondary data for specific items are listed on *Table 5* (pages 53-54).

Information is constantly being updated and revised. Many of the data items within this subsection should be reviewed on an annual basis.

NECESSARY RESOURCES FOR OTHER SECONDARY DATA

If you choose **other secondary data** as a needs assessment method for one or more data elements, you will need the following resources:

1) People - Someone to transpose data from *Tables 4A-4E*; determine which other data elements should be collected; contact other agencies (listed in *Table 5*) to get their data and compile, store and track this information.

2) Supplies and Equipment - A computer with database software to store and manipulate information plus internet access.

3) Additional Funding - You may need to purchase some information; for example, a list of dental professionals from the state dental board.

Good working relationships with other state or local agencies that collect relevant oral health data will facilitate acquiring information for your needs assessment. Make certain your requests are specific.

Table 4A: Number of persons and percentage of the population receiving optimally fluoridated water through public water systems (PWS), by state - 2000

State	Fluoridated Population	Total PWS Population	Percentage Fluoridated	Rank
Alabama	3,967,059	4,447,100	89.2	15
Alaska	270,099	489,371	55.2	38
Arizona	2,700,354	4,869,065	55.5	37
Arkansas	1,455,767	2,431,477	59.9	34
California	9,551,961	33,238,057	28.7	46
Colorado	2,852,386	3,708,061	76.9	25
Connecticut	2,398,227	2,701,178	88.8	16
Delaware	505,747	624,923	80.9	22
District of Columbia	595,000	595,000	100.0	1
Florida	9,407,494	15,033,574	62.6	32
Georgia	6,161,139	6,634,635	92.9	9
Hawaii	109,147	1,211,537	9.0	50
Idaho	383,720	845,780	45.4	43
Illinois	10,453,837	11,192,286	93.4	7
Indiana	4,232,907	4,441,502	95.3	5
Iowa	2,181,649	2,390,661	91.3	10
Kansas	1,513,306	2,421,274	62.5	33
Kentucky	3,235,053	3,367,812	96.1	3
Louisiana	2,375,702	4,468,976	53.2	41
Maine	466,208	618,033	75.4	27
Maryland	4,124,953	4,547,908	90.7	12
Massachusetts	3,546,099	6,349,097	55.8	36
Michigan	6,568,151	7,242,531	90.7	12
Minnesota	3,714,465	3,780,942	98.2	2
Mississippi	1,227,268	2,665,075	46.0	42
Missouri	4,502,722	5,595,211	80.5	23
Montana	143,092	645,452	22.2	48
Nebraska	966,262	1,243,713	77.7	24
Nevada	1,078,479	1,637,105	65.9	30
New Hampshire	347,007	807,438	43.0	44
New Jersey	1,120,410	7,208,514	15.5	49
New Mexico	1,187,404	1,548,084	76.7	26
New York	12,000,000	17,690,198	67.8	29
North Carolina	4,862,220	5,837,936	83.3	21
North Dakota	531,738	557,595	95.4	4
Ohio	8,355,002	9,535,188	87.6	18
Oklahoma	2,164,330	2,900,000	74.6	28
Oregon	612,485	2,700,000	22.7	47
Pennsylvania	5,825,328	10,750,095	54.2	39
Rhode Island	842,797	989,786	85.1	20
South Carolina	3,086,974	3,383,434	91.2	11
South Dakota	553,503	626,221	88.4	17
Tennessee	4,749,493	5,025,998	94.5	6
Texas	11,868,046	18,072,680	65.7	31
Utah	43,816	2,233,169	2.0	51
Vermont	240,579	443,901	54.2	39
Virginia	5,677,551	6,085,436	93.3	8
Washington	2,844,893	4,925,540	57.8	35
West Virginia	1,207,000	1,387,000	87.0	19
Wisconsin	3,108,738	3,481,285	89.3	14
Wyoming	149,774	493,782	30.3	45
Total	162,067,341	246,120,616	65.8	

Source: Population receiving optimally fluoridated public drinking water - United States, 2000. MMWR 2002;51:144-7.

Table 4B: Other Secondary Data From National Surveys

National Health Interview Survey, 1989						
AGES	**5-B**	**22-B**				**25-B**
	% of children with sealant on 1+ permanent teeth	**% of people not on fluoridated water who use topical or systemic fluoride**				**% of women (child- bearing age) utilizing oral health system**
		School Fluoride Mouthrinse[1]	**Home Fluoride Mouthrinse[1]**	**Fluoride Supplement[1]**	**Fluoride Toothpaste (1986, NHIS)[1]**	**Dental visit less than one year ago**
ALL AGES (<18)	10.9%[2]	10.9%	8.6%	9.7%		
<2	----				33.4	
2-4	1.1	2.0	3.7	16.4	91.2	
5-8	10.1	16.4	8.9	13.5		
9-11	18.2	19.0	10.5	9.1	93.7	
12-14	15.2	11.1	10.4	4.7		
15-17	10.9	4.0	9.5	2.6		
18- 34						62.0
35-44						66.1

[1] Regardless of whether or not the community is optimally fluoridated. For the home fluoride mouthrinse, this percentage is calculated for those individuals who were able to name a fluoride mouthrinse from a list of mouthrinses.
[2] Primary or permanent dentition

Table 4C: Other Secondary Data From National Surveys – Smokeless Tobacco Use

Age Group or Grade	Data Source* & Year	Percent who report using smokeless tobacco		
		Ever Used	Used Past Year	Used Past Month
ALL GENDERS				
12 & older	NHSDA, 2000	18.5	4.5	3.4
12-17	NHSDA, 2000	8.6	4.4	2.1
18-25	NHSDA, 2000	23.6	8.0	5.0
26 & older	NHSDA, 2000	19.1	3.9	3.3
26-34	NHSDA, 2000	26.7	6.4	5.2
35 & older	NHSDA, 2000	17.2	3.3	2.9
9th grade	YRBSS, 2001	NA	NA	6.6
10th grade	YRBSS, 2001	NA	NA	8.7
11th grade	YRBSS, 2001	NA	NA	9.0
12th grade	YRBSS, 2001	NA	NA	8.7
9th – 12th grade	YRBSS, 2001	NA	NA	8.2
MALE				
12 & older	NHSDA, 2000	32.5	8.4	6.5
12-17	NHSDA, 2000	13.3	7.3	3.8
18-25	NHSDA, 2000	38.2	14.7	9.7
9th – 12th grade	YRBSS, 2001	NA	NA	14.8
FEMALE				
12 & older	NHSDA, 2000	5.6	0.8	0.5
12-17	NHSDA, 2000	3.5	1.5	0.3
18-25	NHSDA, 2000	9.1	1.3	0.4
9th – 12th grade	YRBSS, 2001	NA	NA	1.9

* NHSDA = National Household Survey of Drug Abuse; www.samhsa.gov
* YRBSS = Youth Risk Behavior Surveillance System; apps.nccd.cdc.gov/YRBSS/

Table 4D: Other Secondary Data From National Surveys – Dental Visits

Healthy People 2010 Category	Data Source	
	NHIS 1997	BRFSS 1999
USE OF THE ORAL HEALTH CARE SYSTEM		
Proportion of children aged 2-17 years that visited a dentist during the previous year	73%	
Proportion of adults aged 18 years and older that visited a dentist during the previous year		68%
Proportion of adults aged 18 years and older that had their teeth cleaned during the previous year		69%

Table 4E: Expenditures and Sources of Payment for Dental Services, United States, 1998

Population Characteristic	Population in thousands	Percent with expense	Mean annual total expense per person with expense	Percent distribution of total expenses by source of payment				
				Out of pocket	Private insurance[b]	Medicare	Medicaid	Other[c]
Total	273,534	41.1	436	51.7	42	0.3	3.1	3.1
AGE IN YEARS								
Under 6	23,732	20.5	159	29.1	46.9	0.0*	20	4.0*
6-17	48,696	50.2	473	42.5	48.9	0.0*	6.6	1.9
18-44	108,767	38.9	388	47.8	46.8	0.0*	2.5	2.9
45-64	58,029	47.7	494	52.2	43	0.1*	1	3.8
65 and over	34,309	38	505	79.1	14.8	1.8	0.4*	3.9*
SEX								
Male	133,614	37.7	424	50.3	42.5	0.2*	3.1	3.8
Female	139,919	44.3	446	52.7	41.5	0.3	3	2.4
RACE/ETHNICITY								
White and Other	207,018	46	453	52.4	42.4	0.2	1.9	3
Black	34,458	26.8	326	44.9	40.4	0.3*	10.4	3.9*
Hispanic	32,058	24.7	365	47.7	36.2	1.1*	12	3.1*
HEALTH INSURANCE STATUS[d]								
<65, Any private	178,020	48.5	443	45.9	51.2	0.0*	0.4	2.4
<65, Public only	28,918	27.2	220	19.2	0.0*	0.6*	76.5	3.7
<65, Uninsured	32,286	15.7	491	90	0.0*	0.0*	0.0*	10
POVERTY STATUS[e]								
Negative or Poor	35,303	25	323	50.8	11.7	0.3*	32.4	4.9
Near-poor	11,611	25.8	305	59.2	22.1	0.1*	17.9	0.7*
Low income	36,826	26	382	61.9	26.6	0.7*	7.3	3.5*
Middle income	88,324	40.5	422	53.6	42.8	0.3*	0.8	2.5
High income	101,470	54.4	480	49	47.5	0.2	0.1	3.2
METROPOLITAN STATISTICAL AREA (MSA)								
MSA	218,775	42.3	452	50.4	43.1	0.3	3.1	3.1
Non-MSA	52,217	37.6	365	58.8	35.3	0.0*	2.7	3.1
CENSUS REGION								
Northeast	52,503	42.9	459	52.6	40	0.1*	3.8	3.5
Midwest	63,871	47	362	46.2	49.1	0.2*	1.7	2.7
South	95,475	35.8	417	58.3	35.6	0.4*	1.9	3.7
West	61,685	41.6	528	48.3	44.4	0.3*	4.7	2.2

a Expenses for any type of dental providers are included unless noted in title.
b Private insurance includes CHAMPUS and CHAMPVA (Armed-Forces-related coverage).
c Other includes other public programs such as Department of Veterans Affairs (except CHAMPVA); other Federal sources (Indian Health Service, military treatment facilities, and other care provided by the Federal Government); other State and local sources (community and neighborhood clinics, State and local health departments, and State programs other than Medicaid); and other public (Medicaid payments reported for persons who were not enrolled in the Medicaid program at any time during the year). Other also includes Worker's Compensation; other unclassified sources (*e.g.,* automobile, homeowner's, liability, and other miscellaneous or unknown sources); and other private insurance.
d Uninsured refers to persons uninsured during the entire year. Public and private health insurance categories refer to individuals with public or private insurance at any time during the period; individuals with both public and private insurance and those with CHAMPUS or CHAMPVA (Armed-Forces-related coverage) are classified as having insurance.
e Poor refers to incomes below the Federal poverty line; near poor, over the poverty line through 125 percent of the poverty line; low income, over 125 percent through 200 percent of the poverty line; middle income, over 200 percent to 400 percent of the poverty line; and high income, over 400 percent of the poverty line.
* Relative standard error equal to or greater than 30%.

Source: *Medical Expenditure Panel Survey.* September 2002. Agency for Healthcare Research and Quality.
http://www.meps.ahrq.gov/mepsnet/tc/cache/e50935d04db3a77f.htm.

Table 5: Sources of Secondary Data at the National, State and Local Level

Cell No.	Data Item/Type of Information	Source(s) of Information
CORE		
1-B	description of population	• United States Census Bureau, www.census.gov
4-B	% of people served by community water systems with optical fluoride	• National Oral Health Surveillance System, www. cdc.gov/nohss
5-B	% of children with sealant on 1+ permanent molar teeth	• National Oral Health Surveillance System, www.cdc.gov/nohss • National Health and Nutrition Examination Survey, www.cdc.gov/nchs • Data2010, www.cdc.gov/data2010
6-B	# of dental providers in a state (by county or other division)	• State Board of Dental Examiners
7-B	dentist participation in Medicaid program (number participating and level of participation)	• State Medicaid Agency
8-B	# (%) of children under age 19 years at or below 200% of FPL who receive preventive dental services	• State Medicaid Agency
9-B	description of public resources for dental care	• Primary Care Association
10-B	% of children that have visited a dentist during the previous year	• State Board of Education • Head Start Association • YRBS
11-B	perceived oral health needs of consumers and their assessment of accessibility, acceptability and affordability of oral health care received	• State and local health department studies
OPTIONAL		
12-B	# (%) of children below ___%** of poverty who are uninsured (or underinsured) for preventive and restorative services	• Medical Expenditure Panel Survey, www.meps.ahrq.gov
13-B	# (%) of preschool children in: 1) Head Start program and 2) other day care programs	• State Head Start Association • Day Care License Board
20-B	% of oral and pharyngeal cancers detected at the earliest stage	• State Cancer Registry
23-B	% of adolescents / adults using smokeless tobacco	• National Household Survey on Drug Abuse, www.samhsa.gov • Youth Risk Behavior Surveillance System, apps.nccd.cdc.gov/YRBSS • Behavioral Risk Factor Surveillance System, www.cdc.gov/brfss/
24-B	% compliance with community water fluoridation standards	• State EPA or other state agency that monitors water standards
25-B	% of parents/caregivers who use infant feeding practices that prevent ECC	• State and local health department studies • WIC program

Cell No.	Data Item/Type of Information	Source(s) of Information
26-B	% of people not on fluoridated water who use topical or systemic fluoride	• State and local health department studies
27-B	dental health professional shortage areas	• State Primary Care Association • State Health Department • Office of Statewide Health Planning • USPHS Regional Dental Consultant
28-B	% of Head Start children completing dental care	• State Head Start Association
29-B	% of women (childbearing age) using the oral health care system	• State Medicaid Agency • Insurance companies • Prenatal clinics • PRAMS
30-B	existence of a system for recording and referring infants with cleft lip/palate	• NCHS National Hospital Discharge Survey • State CSHCH Agency
31-B	# of public dental disease prevention programs (*e.g.,* fluoride mouthrinse, educational, sealants) and # of individuals served	• State and Local Health Departments
36-B	organizations that sponsor sporting and recreational events that require head, face, eye and mouth protection	• High School/College Athletic Associations
37-B	school-based health centers with an oral health component	• State and Local Health Departments

C. DEMOGRAPHIC INDICATORS

Demography is the statistical science dealing with the distribution, density, vital statistics and other descriptors of populations. The 7-step model treats demographic indicators separately from *Other Secondary Data* (B) because most demographic data come from a single source - *The United States Census.* Generally, states have a repository of census data that may be maintained in the agency responsible for planning.

You may also find that your state's Title V MCH Services Block Grant application or the centralized health planning section of the state health department has the demographic information you need. If, however, you must assemble it on your own, refer to the website for the U.S. Census (www.census.gov).

CELL NO.	DATA ITEM/TYPE OF INFORMATION
CORE	
1-C	Description of population

NECESSARY RESOURCES FOR DEMOGRAPHIC INDICATORS

If you choose **demographic indicators** as a needs assessment method, then you will need minimal resources, specifically:

1) People - Someone to develop a list of desired demographic information and then request it; and also check with other private resources if targeting is required at a very specific level.

2) Supplies and Equipment - A computer with internet access.

3) Additional Funding - Not required.

D. NONCLINICAL PROGRAM DATA

This method uses **primary data** collected by your program to describe organized oral health promotion and disease prevention activities. Often programs record the number of services and individuals served, for administrative purposes, using standardized forms.

Typically, nonclinical program data relate to accessibility, scope of services and effectiveness at reaching target populations.

Types of information for which nonclinical program data may be useful are:

CELL NO.	DATA ITEM/TYPE OF INFORMATION
CORE	
5-D	% of children with sealant on 1+ permanent molar teeth
10-D	% children that have visited a dentist during the previous year
OPTIONAL	
24-D	% compliance with community water fluoridation standards
31-D	# of public dental disease prevention programs and # of individuals served

If your program records are not sufficiently organized, you may wish to use some or all of the *Sample Data Reporting Forms 1-5,* to summarize your nonclinical program data related to data item 31.

NECESSARY RESOURCES FOR NONCLINICAL PROGRAM DATA

If you choose **nonclinical program data** as a needs assessment method you will need the following resources:

1) People - Someone to determine what data are available from public health dental programs statewide; collaborate with other public dental programs to develop a common data reporting form; and maintain databases for each activity.

   The number of person-hours (FTE's) required for collecting nonclinical program data will vary with the amount of existing data and the presence of an ongoing program to collect data.

   If you will be developing a common reporting form to collect data from multiple local programs, it would be wise to obtain input from others involved before finalizing the form.

2) Supplies/Equipment - These data should be stored in a computer database for easy analysis.

3) Additional Funding -To buy a computer and software, if you don't already have it.

SAMPLE DATA REPORTING FORM 1

ORAL HEALTH SCREENING/EXAMINATION FOR INITIAL SCHOOL ENTRY

Entry Grade Level Month _____

Year _____

LOCATION	ENROLLMENT	# SCREENED/ EXAMINED UPON ENTRY
TOTAL		

SAMPLE DATA REPORTING FORM 2

EDUCATIONAL PROGRAMS (31-D)
NUMBER OF PARTICIPANTS/NONCLINICAL SETTINGS

Year _____

Location _____

SUBJECT AREA	Preschool #	School Age #	Hospital #	WIC #	Other #
General Oral Health Education (*e.g.,* brushing or flossing instruction)					
Fluoride					
Smokeless Tobacco					
Early Childhood Caries					
Dietary/Nutrition					
Other					
TOTAL					

SAMPLE DATA REPORTING FORM 3

FLUORIDE MOUTHRINSE PROGRAM (31-D)

Year _____

SCHOOL (CITY/TOWN)	GRADES	# CLASSES	# CHILDREN*	FLUORIDATED?
TOTAL				

* This represents those children who participated _____ weeks during the year.

SAMPLE DATA REPORTING FORM 4

SPORTS MOUTHGUARD PROGRAMS (31-D)

Year _____

ORGANIZATION	ADDRESS	PHONE	CONTACT PERSON	NUMBER SERVED
TOTAL				

E. CLINICAL PROGRAM DATA

This method uses information from patient records to estimate oral health status and service utilization. In addition, organizational characteristics of clinical programs describe accessibility and are part of this method. Sample forms for both types of clinical program data are included in this sub-section. People who review clinical records must be trained prior to the collection of these data.

Analyzing clinical program data from patient records provides a relatively low resource approach to estimating disease levels. The sample represents a group of potentially high need individuals that public programs are likely to target. Data on utilization and services, as well as descriptions of public programs, can be obtained only by using this method.

To coordinate the collection of this information requires cooperating dental clinics and either a dentist, dental hygienist or other qualified individual. Because definitions may vary considerably among clinical sites, a clear definition for each item is essential.

Clinical program data can be used to collect the data items in the box below:

CELL NO.	DATA ITEM/TYPE OF INFORMATION
CORE	
2-E	% of children with untreated decay
3-E	% of children with caries experience
5-E	% of children with sealant on 1+ permanent teeth
9-E	description of public resources for dental care
OPTIONAL	
14-E	% of children needing dental treatment according to urgency of need
15-E	% of children with oral injuries
16-E	% of children with dental fluorosis
17-E	% of adults (women of childbearing age) with destructive periodontal disease
18-E	% of adults who have had a tooth extracted because of caries or periodontal disease
19-E	% of older adults who have had all their natural teeth extracted
20-E	% of oral and pharyngeal cancers detected at the earliest stage
27-E	# of public dental disease prevention programs and # of individuals served (sealants only)

Page 63 provides an abstract form for a clinical record review of your clinical programs. The most straightforward approach is to pull all of the dental charts for clients seen during a specified period of time (*e.g.*, one week - one month). An alternative is to examine a certain number of records. Appointment books will help to identify clients. Dental personnel reviewing the chart should be familiar with the codes and symbols used at that facil-

ity to properly interpret progress notes, radiographs and any dental diagram or treatment plan. Unfilled teeth and treatment urgency should be assessed from the initial visit for that episode of care.

If the data cannot be interpreted, this should be marked in the last column entitled "missing data/incomplete chart".

There are two methods for classifying treatment urgency; a four level categorization developed by the ADA and a three level categorization developed by ASTDD for the Basic Screening Survey (BSS). The abstract review form has four categories, but you can choose to use the BSS three-category system if that meets your needs better.

ADA Treatment Urgency Codes:

Class 1 – Apparently requires no dental treatment
Class 2 – Requires treatment but not of an urgent nature
Class 3 – Requires early treatment
Class 4 – Requires immediate dental treatment

BSS Treatment Urgency Codes:

Code 0 – No obvious problems
Code 1 – Early dental care is needed within several weeks. Caries without accompanying signs or symptoms, individuals with spontaneous bleeding of the gums, suspicious white or red soft tissue area, or an ill fitting denture.
Code 2 – Urgent/emergency care is needed within 24 hours. Signs or symptoms that include pain, infection, swelling, or soft tissue ulceration of more than two weeks duration.

Although this needs assessment exercise is not a quality assurance tool, it can be used for that purpose. For programs interested in guidance for the quality assurance of their clinical component, a valuable resource is: Demby NA, Rosenthal M, Angello M. *A comprehensive quality assurance system for practicing dentists: a clinical outcomes management approach.* New York NY: The Clinical Directors Network, Inc, 1990. This publication can be ordered at the CDN website, www.cdnetwork.org.

Pages 64-65 provide forms for collecting and organizing information about dental clinic facilities to help describe public resources for dental care (9-E).

NECESSARY RESOURCES FOR CLINICAL PROGRAM DATA

If you choose **clinical program data** as a needs assessment method for one or more data elements, then you will need the following:

1) People - Someone to determine what data are available from public dental programs statewide; develop a common data reporting form or software; maintain databases for each activity; and (if you are conducting a clinical record review) work with other public agencies to develop the protocol for selecting and recording the information.

   Some states maintain clinical program data for services operated or funded by the state dental program. Clinic hours, number of providers, eligibility criteria and extent of services should be part of the data collected. Additionally, it may be useful to know the number of children who required restorative services or dental sealants during their initial visit to the dental facility.

   A computer programmer may be necessary to manipulate clinical records for data collection. If no one with computer expertise exists within the dental health program, ask one of your "partners" for assistance.

2) Supplies/Equipment - This information should be stored on a computerized database.

3) Additional Funding - Most of the potential personnel costs should be "in-kind" from other state and local public dental facilities.

SAMPLE DATA REPORTING FORM 5

ABSTRACT FORM FOR CLINICAL RECORD REVIEW

of records reviewed_____ Date of Audit _____

Reviewer(s) _____ Patient visits from / / to / /

_____

_____

	2-E	3-E	5-E	14-E				15-E	17-E	18-E 19-E	
Age	# teeth with untreated caries	# dft + # DMFT	# permanent molars with sealant	Treatment Urgency				Oral Injury (Y/N)	Destructive perio disease (Y/N)	# teeth missing	Missing data or incomplete chart (Y/N)
				1	2	3	4				

SAMPLE DATA REPORTING FORM 6

DESCRIPTION OF PUBLIC HEALTH DENTAL CLINIC PROGRAM
A. ORGANIZATIONAL INFORMATION FOR CLINICAL PROGRAM (9-E)

Site Name _____

Location _____

Telephone _____ Fax _____

HOURS OF OPERATION

Day	Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
Hours							

Full Time Equivalents (defined as minimally working _____ hours per week)

Dentist ..... _____
Dental hygienist..... _____
Dental assistant..... _____
Clerical ..... _____
Other ..... _____

Approximate Appointment Waiting Time (days/weeks)

Initial appointment ..... _____
Second appointment ..... _____
Emergency visit..... _____

clinical patients treated annually .... _____ Reference Dates: __/__/__ to __/__/__

patient visits annually..... _____

Describe any Potential Physical Barriers for Patients

_____

_____

_____

_____

SAMPLE DATA REPORTING FORM 6 (continued)

DESCRIPTION OF PUBLIC HEALTH DENTAL CLINIC PROGRAM
B. ELIGIBILITY CRITERIA FOR CLINICAL PROGRAM (9-E)

CLINIC _____

	Yes	No	Comments
Financial			
Low Income			
Medicaid			
Sliding Fee Scale			
Other, _____			
Age			
Children			
Adolescents			
Adults			
Preventive Recall			
Children			
Adolescents			
Adults			
Special Cases			
Extent of Services			
Preventive (*e.g.,* prophy, fluoride)			
Emergency			
Basic Restorative			
Fixed Prosthetics			
Removable Prosthetics			
Endodontics			
Oral Surgery			
Orthodontics			
Pediatric Dentistry			
Periodontics			

F. PUBLIC COMMENT

Public hearings or town hall meetings invite interested citizens to take part in meetings where needs and services are discussed. Written comments also may be submitted. Through this process, program managers can learn about the 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.

The public is notified about the purpose, location and date(s) of the meeting(s) by publishing notices in the newspaper and announcements in other media. The format for notices and the timeline for announcements may vary by location. The meetings should be held at times convenient to the public. A sample announcement is found on page 68. At the hearing, a moderator establishes rules for testimony and then summarizes written and oral testimony afterwards. Testimony also may be recorded by a tape recorder or a court reporter.

Public hearings encourage consumer participation and can increase community awareness of issues. Generally, they are 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 request public comment on the MCH Block Grant application. The opportunity for public comment for each State Title V program offers Title V funded oral health programs the ability to gain additional information. Check with the MCH director to find out more about format of the meetings.

Types of information that can be gathered through the public comment process include:

CELL NO.	DATA ITEM/TYPE OF INFORMATION
CORE	
11-F	perceived oral health needs of consumers and their assessment of accessibility, acceptability and affordability of oral health care received
OPTIONAL	
32-F	perceptions of key informants (*e.g.,* government officials, community leaders)
33-F	perceptions of oral health care providers (*e.g.,* dentists, dental hygienists)
34-F	perceptions of school personnel (*e.g.,* teachers, nurses, principals)
35-F	perceptions of health care providers (*e.g.,* pediatricians, nurse practitioners)

The perceptions of dentists, dental hygienists, and public health professionals are essential when planning many oral health activities, especially those with a clinical component. You might hold a hearing or town hall meeting at state dental, dental hygienist, or public health association meetings to discuss local or statewide dental health issues. If you do so, plan the selected topic several months in advance with organizers of the meeting. This contact may also open other doors within these organizations to work on projects of interest. Following the meetings, submit written feedback about the findings to the Executive

Council of the organization and to the editor of the professional journal or newsletter.

Steps for Conducting a Public Hearing:

1. ***Establish the date, time and location for each hearing.***
2. ***Publish a hearing notice in local newspapers or media. It should include the purpose of the public hearing, the date, time and location of each meeting, as well as a contact person.***
3. ***Provide an opportunity for written comments for those who are unable to attend the hearings.***
4. ***At each hearing, give a concise overview of the purpose followed by clear procedural ground rules.***

NECESSARY RESOURCES FOR PUBLIC COMMENT

If you choose **public comment** as a needs assessment method, the following resources are necessary:

1) People - Someone to organize the meetings. This includes publicity for the event, coordinating the hearing, arranging for representatives from other appropriate agencies to attend, setting a formal agenda and providing a summary of comments afterwards.

   If the dental program relies on the MCH Block Grant public hearing process, no human resources are required from the dental health program. It is important, however, to maintain a liaison with the person responsible for the MCH public hearings in order to respond to any oral health issues that may arise.

2) Supplies/Equipment - A tape recording of the meeting may be helpful when writing the summary.

3) Additional Funding - Newspaper advertising may be an additional cost. Only rarely is a court reporter required to transcribe the testimony. Meeting space also is needed but may be available in public buildings at no charge.

SAMPLE HEARING NOTICE

DATE

FOR IMMEDIATE RELEASE:
Contact: M.J. Sweeney
Samplestate Department of Health
Public Affairs Officer
999-123-4567

MATERNAL AND CHILD HEALTH (MCH) BLOCK GRANT PUBLIC HEARINGS

The state department of health will hold public hearings in Alpha and Beta for public comment on the proposed fiscal year 2002 MCH Services Block Grant for Samplestate.

Wednesday, May 22, 1995
State Office Building # J
Room 1234
State & Capitol Streets
Alpha, Samplestate
10 a.m. - 2 p.m.

Thursday, May 23, 1995
Regional Office Building
Room 4321
305 W. 12th Avenue
Beta, Samplestate
11 a.m. - 3 p.m.

This federal grant application assesses the maternal and child health needs of Samplestate and proposes objectives, activities and a budget to meet these needs.

Anyone wanting a copy of the proposed application should write:

OFFICE OF MATERNAL AND CHILD HEALTH
Samplestate Department of Health
999 Main Street
Alpha, Samplestate

Written comments may be mailed to:

OFFICE OF MATERNAL AND CHILD HEALTH
Samplestate Department of Health
999 Main Street
Alpha, Samplestate

G. INFORMANT GROUPS

Through informant groups, qualitative and quantitative information are gathered. This section describes techniques for using three different processes for informant groups:

1) Nominal Group Process
2) Focus Groups
3) Delphi Technique.

Each has its own purposes, advantages and disadvantages. Informant group processes can be used to elicit information on the following items:

Informant groups provide qualitative information as perceived by the participants.

CELL NO.	DATA ITEM/TYPE OF INFORMATION
CORE	
11-G	perceived oral health needs of consumers and their assessment of accessibility, acceptability and affordability of health care received
OPTIONAL	
30-G	existence of a system for recording and referring infants with cleft lip/cleft palate
32-G	perceptions of key informants (*e.g.,* government officials, community leaders)
33-G	perception of oral health care providers (*e.g.,* dentists, dental hygienists)
34-G	perceptions of school personnel (*e.g.* teachers, nurses, principals)
35-G	perceptions of health care providers (*e.g.,* pediatricians, well-child clinic providers, nurse practitioners)
36-G	organizations that sponsor sporting and recreational events that require head, face, eye, and mouth protection
37-G	school-based health centers with an oral health component

The following information provides an overview of how to conduct each of the three group processes. References for additional reading are provided.

1) NOMINAL GROUP PROCESS

Before the start of a meeting using Nominal Group Process, the facilitator should: prepare the room; procure the necessary supplies; and prepare an introductory statement to clarify the purpose of the exercise and the importance of each person in the process. Tables should be arranged to accommodate seven to 10 persons. A flip chart should be set up at one end of the table. Other supplies needed include masking tape, index cards and pens and paper for each participant. The facilitator should make everyone feel comfortable but still focused on the outcome.

Through the Nominal Group Process, a group can express opinions and reach consensus on an issue.

After introductory remarks, the facilitator asks the participants to think about a particular

question (*e.g.*, how to improve access to dental care for children of low-income families). In addition to being read by the facilitator, the question also should be presented in written form – either on a flip chart or in a typed form given to each person. Give the group about five minutes to work independently and in silence writing in brief phrases about ways to correct the problem. The facilitator should remind participants that this part of the exercise must be conducted in silence. The facilitator should restrict any comments concerning the question so no inherent bias in the responses exists.

Following the writing phase of the exercise, each participant, in a round-robin, gives one response. The round-robin method allows for equal participation, separates ideas from personalities, allows for conflicting ideas and increases the generation of potential solutions. Each brief statement should be written on the flip chart so everyone can see it. All ideas should be listed as presented, but without allowing additional input at this time. The round-robin continues until all ideas are exhausted.

The next stage is to have limited discussion about each idea. The facilitator reads the first idea and asks for any questions or clarifications. The purpose of this approach is to enhance clarification with minimal discussion. The facilitator needs to limit any lobbying for a particular idea and pace the group so there is time for clarification of each item.

Once each idea has been clarified, each participant should select a certain number of ideas for priority consideration. For example, if 12 ideas are on the list, choose five. The facilitator gives each participant that number of index cards. Each person, working in silence, writes down the number of the idea and also selects his/her first choice of solutions. Once everyone has decided on five ideas, they should then rank those ideas from 5 (highest priority) to 1 (lowest priority). The index cards from all participants should then be shuffled and each idea should be scored. If participants agree, the process should be concluded and the facilitator should summarize the priority solutions.

If the balloting reveals inconsistencies, the ideas perceived as receiving either too many or too few votes should be briefly discussed. Then each person once again casts his/her ballot for the priority ideas. Ballots again are shuffled and the balloting listed on the flip chart. With this outcome, the facilitator brings closure to the procedure.

For a complete explanation of the Nominal Group process please read: Guidelines for Conducting NGT Meetings: by Delbecq AL, Van de Ven AH, Gustafson DH. In: *Organizational Behavior and the Practice of Management*. 4th edition. Hampton DR, Summer CE, Webber RA. Scott, Forsman and Company (IL), 1982.

2) FOCUS GROUP

Focus groups have been an important component of marketing research for a long time. They were developed in recognition that consumer decisions are made in a social context, often growing out of discussions with other people. Focus groups provide valuable input about marketing strategies in the public sector.

Focus groups bring people together to elicit perceptions and ideas without attempting to develop consensus.

Focus groups allow and encourage self-disclosure in a non-judgmental, permissive group environment. They provide some insight on why certain opinions are held and provide valuable qualitative information about program development and implementation. Focus groups are particularly appropriate when you want to learn how people react to an experience, idea or event. They allow professionals to see reality from the client's point of view.

Focus groups have some common elements: participants share common characteristics; participants are unknown to each other; groups should have a skilled facilitator; qualitative rather than quantitative data are collected; and no conscientious attempt is made to achieve unanimity at the conclusion of the meeting.

Several different focus groups are usually convened on a topic.

Although it may not appear so, the focus group process is highly organized. A small task force first determines the purpose of the focus group and the types of questions to ask. As with any type of information-seeking process, pretesting the questions is crucial.

Participants are selected on the basis of some common characteristics *(e.g.,* demographic variables, users or nonusers of neighborhood health center services). This screening process generally is performed by telephone. For example, the local dental director wants to understand why there is a low participation rate in the public sector sealant program. Through a cooperative agreement with the local school board, a list of schoolchildren is made available. In turn, a person within the program is assigned to contact families of non-participants from several schools and grades. The screener asks a few introductory questions that would elicit whether or not the person fits into a common group (*e.g.,* gender, paid worker versus homemaker), whether or not they are familiar with dental sealants and if they are willing to participate in a special, one-hour meeting with a group of similar individuals to discuss preventing dental disease in children. Some form of incentive, such as money or a free supply of toothbrushes and toothpaste for the family, generally is required for cooperation. If the person is willing, then the meeting time, date and precise location is provided. The person is told who is sponsoring the meeting and that there will not be any products sold at this gathering. Based on responses to a few questions, persons are placed in the focus group to provide some homogeneity among group members. **No mention is made that this is a focus group.**

The best size for focus groups is between seven and 10 people. This allows ample opportunity to comment on issues and share experiences and attitudes. **Homogeneity rather than diversity is essential**. There tends to be less inhibition among individuals who perceive themselves to be in a peer group. Also, the participants should not know each other, thus avoiding responding to questions based on previous discussions with each other.

The facilitator must have considerable group process skills. This person should be congenial and able to relate to the participants. The facilitator should underscore at the start of the meeting that each of the participants was invited because they share common characteristics and experiences and there are no right or wrong answers to the questions that will be asked. Furthermore, the facilitator invites the participants to share differing points of view

To start, the facilitator should create a friendly environment with some small talk. Body language and interaction among the participants should be noted. The facilitator can then solicit input from those who tend to be less verbal. The facilitator uses five to 10 predetermined open-ended questions throughout the meeting. Although these questions should appear spontaneous, they are arranged to flow in a natural sequence and help achieve information that can be cross-referenced with other focus groups. The facilitator asks what or how group members feel about the subject rather than why.

At the conclusion of the meeting, the facilitator briefly summarizes the main points of the discussion and asks if perceptions are accurate. The facilitator doesn't force consensus upon the group. Finally, the facilitator thanks group members for their participation and reinforces that this meeting, along with others,

will provide invaluable information in the structuring of future programs. Each participant then receives any promised incentive.

Having an assistant moderator will greatly enhance the success of focus groups. This person takes comprehensive notes of the discussion, operates a tape recorder if appropriate, and takes care of all logistics for the meeting. Conducting other focus groups with different participants can help determine trends or dissimilarities among groups.

For further information concerning focus groups, review the brochures about survey research available on the American Statistical Association website:
www.amstat.org/sections/srms/

NECESSARY RESOURCES FOR FOCUS GROUPS OR NOMINAL GROUP PROCESS

If you choose either a focus group or nominal group process as a needs assessment method, then you will need:

1) People - Someone to act as a facilitator. If an outside facilitator is hired, someone will need to negotiate the contract; write clear objectives; obtain telephone lists of potentialparticipants; determine the number of groups needed; solicit participants for the meetings; secure a meeting room for each meeting; provide name tags, note cards and pencils for the participants and a blackboard or flip chart for the facilitator; and serve as a recorder at the meeting.

2) Supplies/Equipment - A tape recorder to tape the focus groups; an easel and pad, markers and masking tape; name tags, note cards and pencils for the participants.

3) Additional Funding - Will be necessary for paying a contractor if you lack or a resource person with facilitation skills and experience.

3) DELPHI TECHNIQUE

The Delphi Technique is a written exercise addressing important issues by a group of experts in a field or discipline. The technique uses repeated questioning and feedback by mail, email or fax to arrive at consensus without holding face-to-face meetings. Only the coordinator knows the participants. Thus, it minimizes the effect of strong personalities. Individuals selected for this technique should possess excellent writing skills. A detailed hypothetical example of the Delphi Technique is located in the *Appendix*.

For more information please read:*The Delphi Method: Techniques and Applications* by Linstone HA and Turoff M. Reading, MA: Addison Wesley, 1975.

NECESSARY RESOURCES FOR DELPHI TECHNIQUE

If you chose **Delphi Technique** as a needs assessment method, then you will need:

1) People - Someone to determine the objective and the question(s) to be asked; to contact qualified individuals to ask them to participate; coordinate thecorrespondence; contact individuals who don't respond in a timely manner; compile the responses; and provide feedback to the participants upon completion of the project.

2) Supplies/Equipment - access to a computer with word processing software.

3) Additional Funding - Should be minimal for this method, especially is using email; however, postage costs increase with each mailing.

H. QUESTIONNAIRE/INTERVIEW SURVEY

Surveys, either written or oral, are a versatile method for assessing knowledge and attitudes on a variety of subjects. Questionnaires also can be used to elicit unpublished secondary data from respondents. There are three basic ways to conduct a survey: (1) self-administered questionnaires, usually mailed or emailed; (2) telephone interviews; and (3) face-to-face interviews.

Proper development of a questionnaire requires time and expertise. You can save time by using or adapting pretested questionnaires, or by including questions on an established survey such as the Behavioral Risk Factor Surveillance System (BRFSS), the Youth Risk Behavior Surveillance System (YRBSS) or the Pregnancy Risk Assessment Monitoring System (PRAMS). You should keep in mind that those most likely to respond to questionnaire/interview surveys are of higher social status and have a relatively stable residence. Since many health problems are aggravated in lower socio-economic groups, the sample may not be representative of your target population. Finally, check with your agency to determine whether institutional approval is required before initiating the project and whether there is a **human subjects protocol** you must follow.

Data items/types of information that lend themselves to collection by questionnaire/ interview surveys are shown in the box below and on page 74:

CELL NO.	DATA ITEM/TYPE OF INFORMATION
CORE	
2-H	% of children with untreated decay
3-H	% of children with caries experience
5-H	% of children with sealant on 1+ permanent teeth
7-H	dentist participation in Medicaid program
9-H	description of public resources for dental care
10-H	% of children that have visited a dentist during the previous year
11-H	perceived oral health needs of consumers and their assessment of accessibility, acceptability and affordability of health care received
OPTIONAL	
12-H	# (%) of children below ___%* of poverty who are uninsured (or underinsured) fore preventive and restorative services
15-H	% of children with oral injuries
18-H	% of adults who have had a tooth extracted because of dental caries or periodontal disease
19-H	% of older adults who have had all their natural teeth extracted

* Per state/local planning standards (e.g., 100%, 185%, 200%)

CELL NO.	DATA ITEM/TYPE OF INFORMATION
OPTIONAL (CONTINUED)	
20-H	% of oral and pharyngeal cancers detected at the earliest stage
21-H	% of adults who report having an oral cancer exam in the last 12 months
22-H	% of children and adults who use the oral health care system each year
23-H	% of adolescents/young adults using smokeless tobacco
25-H	% of parents/caregivers who use infant feeding practices that prevent ECC
26-H	% of people not on fluoridated water who use topical or systemic fluoride
28-H	% of Head Start children completing dental care
29-H	% of women (childbearing age) utilizing oral health care system
30-H	existence of a system for recording and referring infants with cleft lip/palate
31-H	# of public dental disease prevention programs (*e.g.,* fluoride mouthrinse, educational, sealants) and # of individuals served
32-H	perceptions of key informants (*e.g.,* government officials, community leaders)
33-H	perceptions of oral health care providers (*e.g.,* dentists, dental hygienists)
34-H	perceptions of school personnel (*e.g.,* teachers, nurses, principals)
35-H	perceptions of health care providers (*e.g.,* pediatricians, nurse practitioners)
36-H	organizations that sponsor sporting and recreational events that require head, face, eye and mouth protection
37-H	school-based health centers with an oral health component

Information on survey research including mail and telephone surveys can be found on the American Statistical Association website: www.amstat.org/sections/srms/

General Keys to Success Common to All Survey Techniques

- ***The interview or questionnaire motivates the people surveyed to participate and provide accurate information.***
- ***The format follows a logical sequence that is easy to read and interpret and includes precise directions.***
- ***The questions are written in a manner to yield valid and reliable responses.***
- ***The survey allows for relatively easy interpretation of the findings.***
- ***The sample is representative and large enough that appropriate inferences can be made.***
- ***The survey elicits answers to the question(s) of interest to you and can identify differences among subgroups.***

Several data items can be obtained from a single questionnaire. The following list groups data items according to potential target groups for questionnaires/interview surveys:

Target Group	Data Items/Types of Information
General Public	***2, 3, 5, 11, 12, 15, 18, 19, 21, 22, 23, 25, 26, 29***
Dental Professionals	***7, 33***
MCH Service Providers	***32, 35***
Agencies/Organizations	***9, 10, 24, 28, 30, 31, 34, 36, 37***

1) SELF-ADMINISTERED QUESTIONNAIRE (MAIL/EMAIL SURVEY)

Once a clear hypothesis for the questionnaire has beendeveloped, you need to decide whether to use open-ended or closed-ended questions. Open-ended questions allow the interviewer to obtain more information, but some people may not take the time to answer them. Additionally, open-ended questions may be more difficult to analyze. Closed-ended questions are more likely to be answered, but they generally force the individual to make a single choice. A well-structured questionnaire is the fastest method to learn about the sampled population. It also is an easy way to quantitatively analyze the responses. For confidentiality, surveys should be mailed to each member of the study or sent as individual emails, not as part of a distribution list.

Rules of Thumb for Questions in a Questionnaire

- **Start with a question that is easy, non-threatening and interesting.**
- **Difficult or potentially objectionable questions should be near the end.**
- **Similar questions should be grouped by subject.**
- **Make sure each of the responses can fit in only one category.**
- **Make sure there is an appropriate answer for each question. If you are uncertain you have included all possible responses, add "other _____" as the last response.**
- **Respondents should have the opportunity to make additional comments.**

Wording is crucial in a questionnaire. Use simple sentences rather than compound or complex sentences. Make sure directions are clear. Pretest all questions for validity with members of the target audience. Make sure the questions address your hypothesis.

Often it is advantageous to incorporate oral health questions in other questionnaires such as the *Youth Risk Behavior Survey*.

Techniques for Increasing Response Rate in a Mailed or Emailed Survey

- **Keep the survey short. Some surveys indicate how long it should take to complete them.**
- **Provide a concise, yet persuasive, cover letter that includes the name and telephone number/email address of a contact person. Inform participants their responses will be confidential and thank them for participating.**
- **The cover letter and questionnaire should look neat and professional.**
- **Pretest the questionnaire, making sure all items are clearly worded and easily understood.**
- **Provide an incentive to participate.**
- **For mailed surveys, send a self-addressed stamped envelope with the survey.**
- **Use first-class, not bulk-rate postage. Questionnaires with postage stamps have a higher rate of return than metered postage.**
- **Follow up with non-respondents.**

Procedures to Follow for Conducting a Mail Survey

1. **Questionnaire:**
   - either adapt an existing questionnaire or develop your own. In either case, be sure your questions:
     - provide the information you want
     - are clearly written;
   - place a code number on each survey to identify non-responders for next mailing.

2. **Construct a cover letter:**
   - clearly state the purpose of the survey;
   - be persuasive;
   - specify a telephone number or email address for a contact person;
   - specify a desired return deadline (2-3 weeks after mailing);
   - thank participants for their cooperation.

3. **Pretest:**
   - pretest with people who are similar to the population you will survey;
   - a pretest sample of about 25 should be sufficient to identify problems;
   - make revisions to address any problems identified in pretest.

4. **Sampling:**
   - consult with a statistician to determine size and type of sample.

5. **Mailing:**
   - either obtain mailing labels or generate your own (two sets for two mailings);
   - purchase stamps and envelopes;
   - address and stamp return envelopes;
   - inform/solicit cooperation of appropriate agencies/organizations;
   - purchase receiving stamp to track return date of survey.

6. **Set up database for entering responses.**

7. **Follow-up:**
   - postcard;
   - second questionnaire - cover letter to non-responders;
   - more aggressive follow-up (*e.g.,* telephone).

NECESSARY RESOURCES FOR MAIL SURVEYS

If you choose a **mail or email survey** as a needs assessment method, you will need:

1) People - Someone to oversee the development of the questionnaire; obtain a mailing/email list so sample populations can be selected; choose a method for selecting individuals from the list if you are using a sample; format/print the questionnaire and address the envelopes or enter the email addresses. Someone needs to be able to set up a database to enter responses, analyze data and produce reports.

2) Supplies/Equipment - A personal computer with database software is necessary (CDC's *Epi Info* software is free and can serve most programs' needs); and envelopes for two mailings. Make sure the questionnaire fits into the return envelope.

3) Additional Funding - If the statistical expertise for data analysis is not available in your agency or on an in-kind basis, you may need funding to contract with an individual for that purpose; postage for two mailings, including the return postage if you mail the survey.

2) TELEPHONE INTERVIEWS

Telephone surveys are an excellent way to reach a large number of people. Your sample, however, may be biased by the differences between people who do and do not have a telephone. In some instances it is possible to pay a per-question fee to have your iems added to a larger telephone survey such as the CDC Behavioral Risk Factor Surveillance System (BRFSS), a telephone poll conducted by most state health departments.

The survey format is very important. A sample telephone survey is provided in the *Appendix*.

Interviews may need to be conducted in additional languages. The questions for each language need to be pretested separately with the intended audience to make sure the translations are accurate and culturally appropriate

Having skilled interviewers who will not bias responses is important. If you are not using a professional polling agency, potential interviewers need to be trained.

If you choose an outside contractor to perform the telephone survey, know how the data will be analyzed. For example, will there be some cross-tabulation that may be important for planning purposes?

Tips for Telephone Interviewing

- Train the interviewers for consistency in delivery.
- Introduce each section with a sentence explaining the intent of the series of related questions.
- Use transitional phrases (e.g., "Now I have some questions about dental care") when introducing a series of questions.
- Keep the questions and possible responses as short as possible.
- Avoid asking questions that require the rank ordering of more than four items.
- Have a mixture of closed- and open-ended questions so individuals can better express themselves about a series of related questions.
- The best time to contact people for a telephone survey is either between 6 and 9 p.m. on weeknights or during the day on weekends.
- Properly thank the respondent at the conclusion of the interview.

Tips for Preparing the Telephone Survey

- Pretest with people who are similar to the population you will survey.
- Fix any problems identified in the pretest.
- Consult with a statistician to determine sample size and selection method.
- Leave space at the top of the survey to record the name and telephone number of the individual contacted; name of interviewer; date and time of day contacted; prior contact attempts; and follow-up date and time if the individual has been rescheduled.
- Design an introductory paragraph that names who the interviewer represents; the survey purpose; the anonymity of the results; approximately how long the survey will take; that the exchange is voluntary; and asks if this time is convenient.
- Use non-technical, clear language.
- On the survey form, clearly distinguish between instructions for the interviewer and words to be read to the interviewee.
- Provide adequate blank space between instructions, questions and areas for responses.

Make it easy for the interviewer to record the responses. Remember, some individuals may refuse to answer or have no opinion about particular questions. Leave space between questions for additional comments by the interviewer.

NECESSARY RESOURCES FOR TELEPHONE INTERVIEW SURVEYS

If you choose a **telephone interview survey** as a needs assessment method, you will need:

People - Telephone interviews are labor intensive. You will need someone to oversee the development of the questionnaire and sampling tasks. If you hire an outside service, someone should manage contract negotiations.

A person who is able to set up a database, enter responses and produce reports is also necessary.

2) Supplies/Equipment - If you do the survey in-house and have a sample of sufficient size, you will need the same type of computer hardware and software listed under *Necessary Resources for Mail Surveys* in order to analyze the data.

3) Additional Funding - If you contract with another agency to conduct your survey, funding will be necessary.

3) FACE-TO-FACE INTERVIEW SURVEYS

Face-to-face interviews are important when probing is necessary after certain questions and when the information is complex. This method is more costly than either written or telephone surveys because it requires travel, takes more time to administer and is more difficult to analyze. Additionally, interviewer bias is a greater risk because many open-ended questions are used. The interviewer may not ask the questions objectively, or may record the response subjectively. Train all interviewers to be consistent to minimize any systematic bias.

Although costly, face-to-face interviews are the best way to elicit complex information.

Because of the cost, it may be best to intermingle open-ended and closed-ended questions. Since open-ended questions generally are used only for complex items, this helps reduce costs. It also allows for baseline comparison with other methods (*e.g.,* telephone survey) that may use identical questions.

Face-to-face interviews are advantageous with key people in the community. First, if the interviewer is part of an oral health unit, it puts a name and a face with the oral health program and the community representative. Second, it gives the oral health person the opportunity to educate the key informant upon completion of the interview about some of the services of the oral health program.

Feedback either to the community or the individual is critical. It shows the program follows through with its projects and each person involved was important in the process.

The following references provide additional information about conducting face-to-face interview surveys:

American Statistical Association. *What is a Survey?* Brochures about Survey Research. www.amstat.org/sections/srms/.

Sproull NL. *Handbook of Research Methods: A Guide for Practitioners and Students in the Social Sciences*. Scarecrow Press (Rowman and Littlefield Publishing), Lanham, MD, 2002.

An example of a face-to-face interview is found in the *Appendix*.

NECESSARY RESOURCES FOR FACE-TO-FACE INTERVIEW SURVEYS

1) People - Face-to-face interviews are labor intensive. Because travel is required to perform this type of survey and personal interviews generally take longer than anticipated, it can be a drain on personnel time.

2) Supplies and Equipment -Transportation.

3) Additional Funding - If this is to be conducted by an outside consultant, consider the sample size when requesting funds for this survey.

I. BASIC SCREENING SURVEY

The Basic Screening Survey (BSS) is an oral health surveillance model developed by the Association of State and Territorial Dental Directors. By using the BSS model, states can obtain community level oral health status and dental care access data in a cost-effective manner.

Before embarking on a screening survey, it is important to understand its limitations. A dental screening is not a thorough clinical examination and does not involve making a clinical diagnosis resulting in a treatment plan. A screening is intended to identify obvious dental or oral lesions/problems, and is conducted by dentists, dental hygienists, or other appropriate health care workers, in accordance with applicable state law.

Screenings are often done in school or community settings, which requires advance arrangements with program administrators as well as parental consent (if applicable). Screenings can be done using gloves, disposable mirrors or tongue depressors, and a simple light source such as a flashlight. If periodontal screenings are being done, a medical history must be taken to determine if prophylactic antibiotics are appropriate.

Using the BSS, data on the items in the following box can be collected through screenings.

CELL NO.	DATA ITEM/TYPE OF INFORMATION
CORE	
2-I	% of children with untreated decay
3-I	% of children with dental caries experience
5-I	% of children with sealant on 1+ permanent teeth
OPTIONAL	
14-I	% of children needing dental treatment according to urgency of need
15-I	% of children with oral injuries
16-I	% of children with enamel fluorosis
17-I	% of women (childbearing age) with destructive periodontal diseases
18-I	% of adults who have had a tooth extracted because of dental caries or periodontal disease
19-I	% of older adults who have had all their natural teeth extracted

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. Surveys are cross-sectional (looking at a population at a point in time), and descriptive (intended for determining estimates of oral health status for a defined population).

One item that must be considered when implementing a survey is the sampling strategy. A survey can be completed on a convenience sample to obtain a rough estimate of oral

health; but for the survey to be representative of a population it must be based on a ***probability sample*** of the target population.

Screening a convenience sample, rather than a probability sample, will be faster and less expensive but will not provide information that can be extrapolated to the population as a whole.

An important aspect of an oral screening is using a sound infection control policy. In most cases, screening procedures assume that the screener will not touch the person being screened with his or her hands. It is best, however, to wear gloves during this procedure in the event the screener inadvertently comes into contact with saliva or the mouth. When there is no physical contact, it is not necessary to change gloves between screening individuals (although many schools and participants will expect gloves to be changed after each person screened). If, however, a gloved hand touches the mouth's mucous membrane, lips or saliva, gloves must be removed and hands must be washed or rubbed with an antiseptic hand rinse before putting on a new pair of gloves and screening the next person. For more information on infection control, refer to the following manuscript: Summers CJ, Gooch BF, Marianos DW, Malvitz DM, Bond WW. Practical infection control in oral health surveys and screenings. J Am Dent Assoc 1994;125:1213-7.

The *Dental Screening Report*, on page 82, can be used to record information at individual screening locations and the *Dental Screening Program Summary Report*, on page 83, can be used to sum up data from many locations.

NECESSARY RESOURCES FOR DENTAL SCREENING

If you choose a **dental screening** as a needs assessment method, you will need the following resources:

1) People - Someone to determine which data are to be collected; select a reliable screening mechanism; select examiners and arrange for their training; coordinate the selection of participating sites and make all necessary arrangements; develop recording forms and consent forms for each participant; arrange the transport of any equipment, chairs, lights and supplies; conduct infection control procedures; and give each participant in the screening a form which summarizes the findings in lay terminology.

   The number of personnel necessary for dental screenings can vary considerably depending on the size and sample selection of the population, the extent to which examiners are standardized and the need to transport equipment to many different locations. Using volunteers could help reduce expenses.

2) Supplies/Equipment – Disposable mirrors or tongue depressors, a good light source (flashlight or portable dental light), and gloves are required. Programs may opt to use disposable explorers, periodontal probes, or toothpicks to evaluate the presence of dental sealants. Although not necessary, portable dental chairs may be available on loan as an in-kind contribution from one of your needs assessment partners. Appropriate personal protective equipment and disinfection/sterilization supplies are also necessary. In addition, a computer with database and analysis software is required.

3) Additional Funding - Should be minimal if you have volunteer examiners and recorders. If disposable supplies are not donated, they will need to be purchased.

Detailed information on how to conduct an oral health screening, along with sample forms and a data entry program, can be found in ASTDD's publication "Basic Screening Surveys: An Approach to Monitoring Community Health," available for purchase from ASTDD at www.astdd.org.

SAMPLE DENTAL SCREENING REPORT

Location

____ School – Grade _____ Date _____/_____/_____

____ Head Start

____ Shopping Mall

____ Other _____ Examiner _____

City/Town _____ Name of School _____

As you screen each person, mark (slash) one number in each appropriate category. Each page can be used for up to 30 people. In schools, use a ***separate form for each grade***.

1. Number with **untreated decay**

   1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30

2. Number with a **history of dental caries** – one or more teeth with decay or fillings

   1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30

3. Number with one or more **sealants** in permanent molars

   1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30

4. Dental **treatment urgency** (only one category per person)

   NONE
   1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30

   EARLY
   1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30

   URGENT
   1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30

Total number screened: _____

Please return completed form to: _____

_____

_____

SAMPLE DENTAL SCREENING PROGRAM SUMMARY

Grade _____ Year _____

County	School (City/Town)	# screened	# with un-treated decay	# with caries history	# with sealants	# with Treatment Urgency		
						None	Early	Urgent
TOTAL								

Percent of children with untreated decay (# with untreated decay / # screened): _____
Percent of children with caries history (# with caries history / # screened): _____
Percent of children with sealants (# with sealants / # screened): _____
Percent of children with no treatment need (# with none / # screened): _____
Percent of children with early treatment need (# with early / # screened): _____
Percent of children with urgent treatment need (# with urgent / # screened): _____