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**Assessing Oral Health Needs**

**ASTDD Seven-Step Model**

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# INTRODUCTION

## PURPOSE OF THIS ORAL HEALTH NEEDS ASSESSMENT DOCUMENT

Oral health needs assessment is not an end but the initial step in developing a comprehensive oral health action plan. When used effectively, the process provides integrated information about health status and oral health status, the system, policies, and resources. Implicit in oral health needs assessment is the incorporation of risk assessment methods to assist in identifying individuals or groups who are at risk for poor oral health. If conducted successfully, a needs assessment will also help to educate communities about the importance of oral health.

State and local dental programs have conducted and documented well-designed oral health needs assessments in previous decades. The Association of State and Territorial Dental Directors (ASTDD) has developed the Seven-Step Model as one way to assist states in conducting comprehensive oral health needs assessments. The model has been designed with the flexibility to adapt to individual health department's needs, resources, and level of expertise. State and local oral health programs will best meet the needs of communities when tailored to match current needs and to solve current health problems. Plans and resources are best used when targeted to populations currently at risk.

This document has been updated to make needs assessment flexible and manageable. It serves as a step-by-step guide that can be adapted to specific and diverse community needs, objectives, resources, and policies. The results can be used to develop state or local oral health improvement plans as outlined in the [*ASTDD State Oral Health Improvement Plan Toolkit*](https://www.astdd.org/docs/state-oral-health-improvement-plans-toolkit.docx).

## ABOUT THE ASTDD SEVEN-STEP NEEDS ASSESSMENT MODEL

Just as you don't need to read an entire cookbook to prepare a meal, you don't have to use this entire Seven-Step Model to conduct a community oral health needs assessment. After you review the initial set of options, the instructions allow you to easily select those sections that most effectively match your capabilities and goals.

Historically, open-mouth oral health surveys such as the Basic Screening Survey (BSS) have provided useful information about oral health status and served as valid and nationally acceptable measures of oral health surveillance, as certified by the Council of State and Territorial Epidemiologists (CSTE). Surveys that rely on dental screenings can be expensive, time consuming and often unwieldy and sometimes they are unworkable in the context of a state or locality's resources.

***Open mouth oral health surveys are not the only way to assess the status of a population. The oral health needs assessment model offers alternative methods for data collection.***

The Seven-Step Model offers diverse options for data collection. Using a series of worksheets, charts, tables, and tested survey instruments, this needs assessment model provides a tool for state and local health departments to measure the needs of communities and eventually formulate appropriate responses to popu­lations and localities identified as needy or having inequities. The model relies on a systematic data collec­tion, analysis, and prioritization process that is translatable to an action plan. Easily personalized for each user, the model provides a comprehensive process that will identify:

* the extent and types of existing and potential issues
* the current system of services available
* the extent of unmet needs, underused or overused resources, shortcomings of the current system, or the need for policies.

This model provides a step-by-step, logical approach (illustrated in***Figure 1*** *on the next page*). The model is based on a large-scale consensus building process that has involved several state and local dental directors and other public health experts. It is structured around a **core** set of information as well as **optional** information items. A brief background section reviews the concept and importance of needs assessment in oral health planning. The seven steps of the model are described in detail in subsequent sections. The best needs assessment will result from following all the steps in sequence. Some information may be referenced through links to other documents such as an accompanying Excel spreadsheet or a Communication Plan template or to other sites such as the [Community Toolbox](https://ctb.ku.edu/en/table-of-contents) from the Center for Community Health and Development at the University of Kansas. Information not directly related to conducting the seven steps has been placed in the *Appendix* rather than in the body of the document.

## RECOMMENDATIONS FOR PREPARING AN ABBREVIATED HANDOUT TO SHARE

To orient advisory committee members, needs assessment staff, or other colleagues to the use of the Seven-Step Model, we suggest the following pages and worksheets be printed or emailed digitally to capture the essence of the model as it is neither practical nor necessary to reproduce this entire document. The abbreviated “primer” includes:

* Introduction
* Background
* Worksheets 1-4
* Table 1: Summary of Needs Assessment Methods

## FIGURE 1: SEVEN-STEP NEEDS ASSESSMENT MODEL

A diagram of steps and steps

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## **SEVEN-STEP OVERVIEW**

### **STEP 1: Identify Partners/Form an Advisory Committee**

Needs assessment and planning are not effective if they are conducted in isolation. The first step is to decide which people or organizations can provide various perspectives to identify and accomplish goals and objectives and secure "buy-in" from key constituencies. These key constituency groups may later become not only sources of additional resources, but also political support. This seven-step model strongly favors the formation of an advisory committee to help plan and conduct the oral health needs as­sessment. ***Worksheet 1*** aids in identifying committee members.

### STEP 2: Conduct a Self-Assessment

The model provides ***Worksheet 2*** to help identify the goals of the needs assessment. At various points in the model, you will refer to this worksheet to remind you of the designated goals. It includes reasons why a needs assessment should be performed such as fulfilling grant or legislative requirements, updating community needs assessment with current economic and population statistics, justifying program strategies, and educating community members or policymakers.

### STEP 3: Plan the Needs Assessment

Once you have completed the self-assessment and determined your goals, the model provides ***Worksheet 3***to help in deciding what information is needed to make planning decisions. It will help in determining what information is missing, what needs to be collected, and a structured format to select the methods of data collection. The first part of ***Worksheet 3*** is a core set of information along with a brief statement of the rationale for each item. It is important to include all core items in the needs assessment. If not already on hand, acceptable methods are provided for collecting the information. Methods generally are listed in increasing order of resources needed. When available, the simplest and least costly method is to use existing data. Summaries of acceptable alternative methods for data collection also are presented. These summaries will help in selecting methods for gathering missing elements from the core information set. If the needs assessment will go beyond the core set, continue with the sec­ond part of the worksheet, the list of optional data items. The only additional step in the optional section is to decide which data item(s) to add to the core set and then select methods to obtain the information. The third part of the worksheet allows addition of data items not listed in the core and optional data sets.

***Worksheet 4*** helps organize the plan by converting the list of data items selected on *Worksheet 3* into actual data collection activities. The model leads through a step-by-step process to identify the resources necessary for needs assessment and the organizations/individuals responsible for providing those resources. A timeline and calendar are included.

### STEP 4: Collect Data

Detailed instructions, useful examples of survey instruments and other aids are provided to help in effectively planning data collection. An entire manual for conducting an oral health surveillance survey ([Basic Screening Survey)](https://www.astdd.org/basic-screening-survey-tool/) is available if this survey method is selected.

STEP 5: Organize and Analyze Data

This section describes methods for tabulating descriptive statistics and guidance for basic inferential statistics. If the first steps have been followed, carefully analyzing quantitative data for several methods will be straightforward. A set of data summary sheets are provided to help in organizing data according to topic.

### STEP 6: Prioritize Issues and Report Findings

Since there may be different purposes for needs assessment, it is important to prioritize issues and present findings that are tailored to the intended audience. This section highlights key elements in presenting data to various audiences.

STEP 7: Evaluate the Needs Assessment

Evaluation and a final review allow determination of whether goals have accomplished what was intended. This section highlights the fact that needs assessment is continuous.

## ADDITIONAL RESOURCES

Many national organizations have created models for conducting a community needs assessment in addition to the University of Kansas previously linked. For additional information, refer to the following:

* American Hospital Association (2023). [Community Health Assessment Toolkit](https://www.healthycommunities.org/resources/community-health-assessment-toolkit).
* Centers for Disease Control and Prevention (2024). [Community Planning for Health Assessment: Framework and Tools](https://www.cdc.gov/public-health-gateway/php/public-health-strategy/public-health-strategies-for-community-health-assessment-models-frameworks-tools.html).
* National Association of County and City Health Officials. [Community Health Assessment and Improvement Planning](https://www.naccho.org/programs/public-health-infrastructure/performance-improvement/community-health-assessment).

# BACKGROUND

WHAT IS NEED AND NEEDS ASSESSMENT?Need is a concept shaped by the social environment, involving values and judgments. It is influenced by (1) communal agreement on what is an accepted standard; (2) the social and political environment; and (3) the availability of resources and technology to meet these concerns. Thus, need is a condition judged to be undesirable by public consensus. Need may vary from place to place and at separate times because it is subject to the social forces that affect the allocation of resources.

For need to have practical meaning it must be defined in a specific context. For example, **normative need** compares health indicators to a desired standard (e.g., a Healthy People objective); **perceived need** asks potential consumers what issues are problematic; **expressed need**, sometimes known as utilization, is the num­ber of people who seek a service; and **relative need** concerns the equity of services (e.g., comparing state oral health status with a region or another state).

Needs assessment in the health field is not a one-dimensional, tidy package of rules and procedures, but rather a "work in progress." There are many definitions as well as several general approaches for assessing needs. Some experts even substitute the term "problem" for "need" (which suggests the lack of something) because many problems are quantifiable, while others avoid the term "problem" because of its negative connotation.

As used in this model, **needs assessment** is a process that seeks to identify: (1) the extent and types of existing and potential problems in a community, (2) the current system of services available and (3) the extent of unmet needs, underused resources, or shortcomings of the service delivery system. Needs assessment is not an end but the initial step in the devel­opment of a com­prehensive program plan *(****Figure 2****).* The information gained from this preliminary step will be used to plan appropriate systems and services. When used effectively, needs assessment serves to integrate information about health status, sys­tems, policies, and resources.

## FIGURE 2: PROGRAM PLAN CYCLE

**A diagram of a diagram of a program

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## ROLE OF NEEDS ASSESSMENTS

Needs assessment relies on a systematic data collection and analysis process trans­lated into an action plan. Once a problem is identified, the leadership team should relate it to those who make resource allocation decisions. The importance of setting priorities among programs is critical. Since resources are limited, public oral health programs generally can’t investigate all potential oral health problems. Needs assessment provides information to help decision makers know which problems are the most critical. While needs assessment addresses many prominent issues, it is not a hard science. Some types of need, especially those with qualitative dimensions, are difficult to pinpoint and subject to shift in scale over time. What may be a current high priority may not be so in the future.

When undertaking a needs assessment, it is important to use methods that will identify individuals or groups of individuals who are at high risk for poor oral health or are underserved. Ideally, resources will then be geared to populations cur­rently at risk rather than simply to established programs or to 'localities' with a history of high incidence or prevalence of disease.

Needs assessment will help to educate the state or community about the importance of oral health. Incorporating leaders and potential consumers of oral health services into the planning pro­cess helps establish the basis for "ownership" of a resulting program plan. Information obtained can be useful in justifying existing funds and/or program expansion. Needs assessment responds to the public's increasing demand for accountability in the allocation of limited resources.

Many oral health programs are unable to document, demonstrate or evaluate their effectiveness because of lack of data. Local, state, and national programs must use the needs assessment process to establish strong preventive and primary oral health care systems integrated with other health and support services.

***State and local agencies must collaborate on periodic needs assessment to keep a pulse on the population they serve.***

Because of sampling design, some existing national studies can’t adequately identify specific state and local populations with a high prevalence of oral diseases. Therefore, states must find ways to determine the oral health needs of their diverse populations and, at the same time, direct preventive and therapeutic programs to respond to those needs.

Traditionally, oral health needs assessments have been freestanding rather than appearing within the context of an interdisciplinary approach. There are advantages to both strategies. A freestanding oral health survey is likely to provide more detailed information about oral health whereas within a comprehensive needs assessment each health issue can receive only limited attention. If oral health is included as part of a Maternal and Child Health (MCH) or community needs assessment, it fosters integration with other general health services and offers perspective on oral health needs that may be caused by similar risk factors. Some Basic Screening Surveys are now conducted with other health screenings in schools, or the results compared to determine children who might benefit most from integrated services.

# STEP 1: IDENTIFY PARTNERS AND FORM AN ADVISORY COMMITTEE

## ABOUT AN ADVISORY COMMITTEE

Building effective and well-rounded partnerships enables success for a planning effort and for needs assessments. Engaging partners from diverse settings who are representative of the population being served is critical to the success of a needs assessment. Working in collaboration with diverse agencies and entities can ensure buy-in and broaden support for any future planning based on the needs assessment findings. Programs or communities with minimal resources for conducting needs assessment may especially benefit from linking with other interested and invested entities to leverage their expertise, partnerships, resources, and data.

State and local oral health programs should form an advisory committee, which may be an existing oral health coalition. An advisory committee may include representatives from other agencies and organizations, other programs in a state or local health agency, community members, or an existing oral health or other health coalition. The composition should reflect the demographic diversity of the population and should include clinical and public health dental and health practitioners, policymakers, and community leaders or oral health champions. Refer to ***Worksheet 1*** on page 14 for a list of possible state partners.

***Worksheet 1 will need multiple adaptations for specific groups and contacts. Another similar worksheet with need to be created for local advisory committees.***

Committee members' primary role is to make non-binding recommendations for conducting a high-quality oral health needs assessment based on their (and their agencies’) unique perspective. Drawing members from diverse disciplines and perspectives increases the likelihood of innovative approaches and ensures diverse needs are considered; homogeneous groups tend to maintain the status quo rather than accelerate change.

The advantages of an advisory committee are substantial, including:

* Creating advocates for oral health
* Cultivating new and strengthening existing partnerships
* Providing potential key informants for data collection
* Providing additional in-kind resources
* Enhancing formalized communication
* Valuing and incorporating a range of perspectives
* Educating community members and healthcare providers
* Fostering ownership of community needs and outcomes.

## STRUCTURING THE ADVISORY COMMITTEE

***(Adapted from the*** [***American Hospital Association Community Assessment Toolkit***](https://www.healthycommunities.org/resources/community-health-assessment-toolkit)***)***

Provide your advisory committee with structure. First, agree on the charge of the committee (advising vs. steering) internally and communicate it clearly (and reiterate periodically) to all members. Next, in collaboration with the committee members, define group norms, specific roles and responsibilities, participation and attendance guidelines, any expectations of time and effort, and opportunities for various levels of involvement in the committee’s work. If appropriate, leadership and sub-committee assignments can also be defined and determined. Finally, facilitate discussions early in the process to identify and document shared language (appropriate to the community context you are in), decision-making process, and tools and systems to invoke when conflicts arise. These additional steps, while time consuming, can be instrumental in a smoothly functioning advisory committee where all members feel valued and safe to bring forth their unique perspectives. A committee with amount of structure is also expected to be efficient, effective, and productive in helping to plan and implement a high-quality needs assessment on time and on budget.

## INCLUDING COMMUNITY MEMBERS IN THE ADVISORY COMMITTEE

How community engagement is operationalized will vary depending on the context, budget, staff capacity, and more. When including community representatives and members in the advisory committee, it is important to build trust and ensure that the committee is a safe and respectful space for members to participate meaningfully. For example, while some members may not be subject-matter experts in dentistry or public health, they are experts in their community and their lived experience. At regular intervals reflection on the cultural, ethnic, and racial diversity of the population should also be considered. The added value and perspective they bring must be respected and celebrated, and power should be shared across committee members during meetings and decision-making. Logistic accommodation in terms of meeting time, location, transportation, language translations, and other issues will be essential to ensure the committee and its process is an inclusive and equitable space for all participating members. These engagements should be transformational and empowering to community members. The process must also balance the benefit and burden of participation for members.

***Participation in the advisory committee should add value to members (knowledge, relationships, skills, inclusion and belonging) instead of serving solely to extract information and leverage their expertise to accomplish goals.***

## WORKSHEET 1: FORMING A STATE ADVISORY COMMITTEE – POTENTIAL COMMITTEE MEMBERS

|  |  |  |
| --- | --- | --- |
| **Potential Organizations & Agencies** | **Representative** | **Contact Information** |
| **Oral Health Partners** | | |
| State Dental Association |  |  |
| State Dental Board |  |  |
| AAPD, State Chapter |  |  |
| State Dental Hygienists’ Association |  |  |
| Schools of Dentistry |  |  |
| Schools of Dental Hygiene |  |  |
| Other State Agency Dental Personnel (*e.g.*, mental health, corrections, tribal) |  |  |
| Statewide Oral Health Coalitions |  |  |
| Other |  |  |
| **Education Program Partners** | | |
| School of Public Health, Public Policy (or equivalent) |  |  |
| Community Colleges and other trade colleges |  |  |
| State Department of Education |  |  |
| Other Healthcare Universities |  |  |
| Other |  |  |
| **Policy and Advocacy Entities** | | |
| Policymakers (and/or their health portfolio staff) |  |  |
| Advocacy, policy think tanks, and/or grassroots organizations focusing on health topics |  |  |
| Other |  |  |
| **Other Non-profit and Philanthropic Organizations** | | |
| Foundations |  |  |
| Non-profit Organizations |  |  |
| Other |  |  |
| **Other State Programs** | | |
| Maternal and Child Health (Title V) |  |  |
| Children with Special Health Care Needs (CSHCN) |  |  |
| Early and Periodic Screening, Diagnosis and Treatment (EPDST) |  |  |
| Medicaid and SCHIP |  |  |
| Women, Infants, and Children (WIC) |  |  |
| Head Start and Early Head Start |  |  |
| Rural Health Programs |  |  |
| Environmental Health Programs (Water Boards, etc.) |  |  |
| Children and Family Services |  |  |
| Chronic Disease (includes tobacco and oral cancer) |  |  |
| Regional Centers |  |  |
| Aging Services |  |  |
| Tribal Health Boards |  |  |
| Epidemiology & Disease Surveillance |  |  |
| Other |  |  |

# STEP 2: CONDUCT SELF-ASSESSMENT TO DETERMINE GOALS AND RESOURCES

## REFLECT ON PREVIOUS NEEDS ASSESSMENT(S)

Before advancing to the goal setting and planning steps of the needs assessment, reflect and review feedback from previous needs assessment(s), specifically focusing on the most recent one. Reflection is a crucial component of continual learning and an opportunity to learn from previous experiences and insights. If there exists a formal progress tracking and reporting mechanism for the program’s previous needs assessment and strategic plan, leverage those materials to further inform this reflection process. Use any of the following questions in written or oral form adapted from the AHA Community Health Assessment Toolkit to guide your reflection on previous assessments.

* What elements of the assessment worked well?
* What elements should be done differently this cycle?
* To what extent did the needs assessment inform improvement plans or strategies?
* Did your implementation strategies (developed based on the needs assessment) achieve their intended impact? Why or why not?
* How successful were the community engagement efforts in the last cycle? Were community members engaged throughout the assessment?
* To what extent were program partners and other groups receptive to the needs assessment findings? Did others outside your program use the report to inform their own work?
* Are there additional organizations with whom you could partner?

Consider integrating this step into existing meetings or convenings of relevant individuals and partners. Consider using breakout groups to discuss select questions and facilitate a full-group discussion to identify lessons learned, action steps, things to avoid and other issues when planning this needs assessment.

## DEFINE THE ‘COMMUNITY’

Define what ‘community’ means as it relates to the needs assessment. Consider geographic areas, age groups, and other population characteristics that will be the focus of the needs assessment. This might be a function of a program’s charge, funder’s expectations/requirements, budget, and scope. Doing so will help determine the scope of the assessment, appropriate strategies for effective data collection, and plans for community selection and engagement. For example, you might determine that you only have the charge and capacity to address the oral health care needs of children, in which case, you would define your community for the community needs assessment to be children ages 0-18 years.

***The*** [***Community Toolbox’s***](https://ctb.ku.edu/en/table-of-contents/assessment/assessing-community-needs-and-resources/describe-the-community/main) ***section on “Understanding and Describing the Community” offers a detailed process for effectively and equitably engaging the community in the needs assessment process.***

## DETERMINE GOALS AND MOTIVATIONS FOR CONDUCTING A NEEDS ASSESSMENT

Before starting data collection or analyzing existing data, it is important to determine goals or purposes for the needs assessment. ***Worksheet 2***asks you to consider why you want to conduct a needs assessment and what you hope to gain from it. The worksheet will help you focus on your goals. It not only helps start your needs assessment thinking process, but also will be used as an important evaluation tool throughout this manual. The goals you identify should indicate what factors are likely to influence decisions about the needs assessment plan. For example, if collecting data in a timely fashion is most important, you may select a less rigorous needs assessment method and prioritize existing data sources over collecting primary data.

For ***Worksheet 2*** on the next page each member of the core team or the advisory committee can complete this assessment and then average the scores for each stated goal. Rank these goals to determine the top 2-3 goals, facilitate discussions if there is misalignment in proposed goals across members, and reach a consensus before moving forward to STEP 3.

## WORKSHEET 2: DETERMINING NEEDS ASSESSMENT GOALS

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| TO WHAT EXTENT DO YOU HOPE TO ACCOMPLISH EACH OF THE FOLLOWING THROUGH THE NEEDS ASSESSMENT? (circle the most appropriate number on the scale for each item) | | | | | |
|  | Not at all Moderate High | | | | |
| Fulfill the requirements of the MCH Block Grant | 1 | 2 | 3 | 4 | 5 |
| Fulfill other grant or contract requirements | 1 | 2 | 3 | 4 | 5 |
| Fulfill expectations of administration / legislature | 1 | 2 | 3 | 4 | 5 |
| Fulfill expectations of community members | 1 | 2 | 3 | 4 | 5 |
| Network with other programs / agencies / organizations | 1 | 2 | 3 | 4 | 5 |
| Build a constituency for addressing oral health issues | 1 | 2 | 3 | 4 | 5 |
| Establish baseline data | 1 | 2 | 3 | 4 | 5 |
| Update existing data | 1 | 2 | 3 | 4 | 5 |
| Inform strategic program planning & implementation | 1 | 2 | 3 | 4 | 5 |
| Collect valid (accurate) / reliable (reproducible) data | 1 | 2 | 3 | 4 | 5 |
| Prioritize programs | 1 | 2 | 3 | 4 | 5 |
| Collect data in a timely fashion | 1 | 2 | 3 | 4 | 5 |
| Justify budget (maintenance / expansion / reallocation) | 1 | 2 | 3 | 4 | 5 |
| Increase visibility of program in agency or organization | 1 | 2 | 3 | 4 | 5 |
| Deploy resources to specific populations | 1 | 2 | 3 | 4 | 5 |
| Monitor compliance with legal requirements | 1 | 2 | 3 | 4 | 5 |
| Publish findings in professional journal(s) | 1 | 2 | 3 | 4 | 5 |
| Educate decision makers | 1 | 2 | 3 | 4 | 5 |
| Educate community members | 1 | 2 | 3 | 4 | 5 |
| Generalize findings to target population | 1 | 2 | 3 | 4 | 5 |
| Evaluate existing programs | 1 | 2 | 3 | 4 | 5 |
| Other | 1 | 2 | 3 | 4 | 5 |

# 

# 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:

* What data are needed to meet the needs assessment goals and to answer desired questions about the oral health needs of the populations of interest?
* Of the needs assessment information wanted, what is available and what do we need to collect?
* What is the quality of the information available?
* Which data collection methods shall we use? Which methods will yield data of desired quality and utility?
* What combination of needs assessment information, sources and methods will enable us to complete the project on time and on budget while ensuring multiple aspects of oral health are assessed?

Most states and communities will find they have information gaps. It may not be feasible to collect all the information necessary to address the issues. Use the results of the self-assessment and knowledge of available resources and leverage partnerships to decide on a **realistic** approach to collect data for the needs assessment.

As you develop the plan for this needs assessment, follow these steps:

* Review the list of indicators and identify priority indicators. Include as many of the “core” indicators as feasible and meaningful.
* Identify availability and access to data for each of the chosen indicators. Also identify access to levels of data available (e.g., by key sociodemographic variables, geography).
* Identify information and data gaps.
* Determine ideal and most feasible methods for gathering data on indicators where data are not available.
* Develop a data collection plan.

## REVIEW THE LIST OF INDICATORS AND IDENTIFY PRIORITY INDICATORS

***IMPORTANT: The Seven-Step model includes an*** [***Oral Health Needs Assessment Planning Workbook***](https://www.astdd.org/docs/7-step-model-planning-workbook.xlsx)***. Make sure that you download this manual and the Workbook.***

The *Oral Health Needs Assessment Planning Workbook* lists 35 data items drawn from a variety of sources including [Healthy People 2030](https://health.gov/healthypeople/objectives-and-data/browse-objectives/oral-conditions), the [National Oral Health Surveillance System](https://www.cdc.gov/oralhealthdata/overview/nohss.html), and various standards put forth for oral health such as the [MCH Title V National Performance Measures](https://www.astdd.org/docs/mch-npm-combined-summary-and-detailed-overview-03-20-2015.pdf). Indicators have been prioritized further based on their availability at the state level. Additional items are program related, while still others represent general types of information useful in needs assessment (*e.g*., public perceptions). ***Recognizing that state and local programs have individual information needs, the model allows optional information elements to be added to the core set according to given needs.***

The **first tab** of the *Workbook***(INDICATOR LIST)** includes a master list of indicators along with the rationale behind its inclusion. Use this worksheet to prioritize/choose indicators.

## IDENTIFY AVAILABILITY AND ACCESS TO DATA FOR EACH OF THE CHOSEN INDICATORS

The **second tab** of the *Workbook***(DATA AVAILABILITY WORKSHEET)** indicates best data sources, enables determination of the data available, and identifies data gaps (needing data collection).

Use the following criteria to help determine the acceptability of available data for the needs assessment. *Note that not every indicator/data source needs to meet all criteria. Depending on what you want from a particular indicator/data source, pick the criteria that matches the need.*

* **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 of the population’s oral health needs?
* **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 geographic identifiers that will permit linkage with other data (e.g., census tract, county)?
* **VARIABILITY:** Have any data elements changed over various periods of data collection (e.g., definitions, reporting requirements, collection methods)? Is it clear what statistical adjustments are needed to ensure data are comparable across years/periods of data collection?
* **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?

## IDENTIFY INFORMATION AND DATA GAPS

The **third tab** of the Workbook **(METHODS SELECTION WORKSHEET)** lists acceptable methods for collecting information (if not already available) and offers a template to plan data aggregation and collection.

Table 1 groups nine data collection methods into four general categories: secondary data, programmatic data, community/partner input, and oral screening surveys. This Table will guide you towards selecting the most reasonable methods for collecting the information needed. For items selected, but that lack data, choose from alternative data collection methods.

* Secondary Data
  + Secondary data from national or regional surveys (e.g., NHANES, NCHS, BRFSS)
  + Other secondary data (e.g., Medicaid)
  + Demographic indicators (e.g., U.S. Census)
* Programmatic Data
  + Non-clinical program data
  + Clinical program information
* Community/Partner Input
  + Key informant interviews or focus groups
  + Surveys (open and close-ended)
* Oral Screening Surveys
  + Basic Screening Survey

## TABLE 1: SUMMARY OF NEEDS ASSESSMENT METHODS

| **METHOD** | **PURPOSE** | **COST** | **TIME INVOLVED** | **ADVANTAGES** | **LIMITATIONS** |
| --- | --- | --- | --- | --- | --- |
| **A. Secondary Data from National or Regional Oral Health Surveys** | Needs or problem analysis | Low | Extremely Fast | Data readily available | Sampling can often preclude reporting data at the state or local level. |
| **B. Other Secondary Data\*** | Needs or problem analysis | Low | Fast to Moderate | Data available (self- reported and other fiscal or regulatory information) | Data may not be easily accessible and available. Long proposals and approvals might be needed for certain governmental data such as Medicaid. |
| **C. Demographic Indicators** | Needs or problem analysis | Low | Very Fast | Data available from public documents | Correlation between demographic indicators and disease prevalence may be weak. Census data are increasingly less reliable over time. |
| **D. Nonclinical Program Data**  e.g., clients served through health education, WIC, other programs | Resources analysis | Moderate | Fast | Can use for annual reports; trend analysis of activities | Data are only as valid as the record-keeping practices. Data may not be comparable to other forms of data due to varied data definitions. |
| **E. Clinical Program Information**  This does not refer to clinical data, but to facilities, staffing, services offered, productivity, insurance accepted, etc. | Resources analysis | Moderate | Moderate | Can use for annual reports; understand the extent of services provided | Logistics of gathering insights from clinics can be cumbersome and they may not have the information readily available or be resistant to provide it. |
| **G. Key Informant Interview or Focus Groups**  Use this method to 1) meet a data gap where quantitative data is unavailable and challenging to collect; and/or 2) to explain, elaborate and better contextualize quantitative data. | Needs or problem analysis | Moderate to high | Fast to Moderate | Minimal preparation time; add deeper nuance and context to quantitative data | Eliciting participation can be challenging. Transcribing, analyzing, and interpreting data requires specific skills and capacity. Sampling for representativeness is challenging with limited resources. |
| **H. Surveys (open or close-ended)**  Can be conducted by community members, dental professionals, agency staff and leadership, program staff, school nurses, community-based orgs and more. | Needs or problem analysis | Moderate to high (depending on sample and mode) | Moderate | Relatively effective way to obtain information about knowledge and behavior | Surveys can be time consuming with much effort to plan and implement. Sampling rigor affects the ability to generalize findings. This method may require human subjects review clearance. |
| **I. Basic Screening Survey (BSS)** | Needs or problem analysis | High | Moderate to Slow | Assesses individuals; good estimate of population if probability sampling is used | Data from screenings may underestimate prevalence of dental disease and presence of sealants. Requires effort to plan and implement, especially around school issues. BSS should not require human subjects review clearance. |

\* Other secondary data can include:

* Medicaid: Enrollment, EPSDT participation, provider participation, expanded benefits, dental expenditures, service mix, sealant utilization.
* Department of Education/School Administration: Enrollment, National School Lunch Program 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, children with urgent dental needs (based on assessments).
* Universities/Other Agencies and Organizations that Conduct Research: Tobacco or vaping use, use of evidence-based preventive services, infection control practices, dental insurance data.
* State Primary Care Association: Dental health professional shortage areas (D-HPSA), community and migrant health centers (C/MHC).
* American/State/Local Dental or Dental Hygienists’ Association: demographics (of members), practice characteristics., insurance plan participation.

**Note:** This model and document do not go into the depth of each method of data collection and assumes there is capacity within the needs assessment project to understand the nuances and conduct of each method. Relevant resources for conducting some methods are offered in the next step (STEP 4: Collect the data).

## DEVELOP A DATA COLLECTION PLAN

The **fourth and final tab** of the *Workbook* (**DATA PLANNING)** will help to organize the needs assessment plan. Start by transferring the decisions made in the “methods selection” tab and group data according to the methods selected for collecting them. This step will help 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 the needs assessment plan with the goals as they appear on *Worksheet 2* in STEP 2.

***While prioritizing and focusing on secondary data heavily to ensure the needs assessment is feasible to conduct, you may choose to collect primary data (especially qualitative) from key partners to better contextualize the data. These qualitative indicators, although labeled as “optional” in the indicator list, can be vital to help fill additional gaps in the data and mitigate the shortcomings of primary and/or secondary quantitative data***

# STEP 4: COLLECT DATA

STEP 4 guides you through conducting the needs assessment plan developed in STEP 3. Key methods for collecting specific data items selected in STEP 3 are detailed here. This section is intended to be a starting point. Engage with analysts, epidemiologists, statisticians, or other relevant team members to determine the best course of action for collecting data for the needs assessment project. This section includes guidance for conducting publicly available secondary data sources.

During the data collection process, keep both primary and secondary data users apprised of the needs assessment process. Engage with and regularly update the advisory committee on the needs assessment process and findings. Doing so provides insight into their perceptions about the importance of emerging findings and allows incorporation of relevant concerns into the needs assessment methods. This can help 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 oral health issues when they know more about the needs assessment process.

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

## PUBLICLY AVAILABLE SECONDARY DATA SOURCES:

The [ASTDD Data Surveillance Reference Guide](https://www.astdd.org/docs/data-surveillance-reference-guide.pdf) and the [National Oral Health Data Portal](https://www.nationaloralhealthdataportal.net/) maintain a comprehensive list of data sources, most publicly available, as well as available data/metrics. Reference these and cross-tabulate with indicators chosen for the needs assessment to access secondary data.

The *Appendix* starting on page 42 provide additional guidance on various forms of primary data collection including conducting:

* Key informant interviews
* Focus group discussions
* Survey studies
* Basic Screening Survey.

# STEP 5: ORGANIZE AND ANALYZE (TRIANGULATE) DATA

In conducting an oral health needs assessment, thorough analysis, summarization, and triangulation of data are essential steps to derive meaningful insights. These processes not only help in understanding the current oral health status of the state or community but also aid in identifying key areas for intervention and resource allocation.

This document will not go into details about the methods, approaches and tools for conducting qualitative and quantitative analyses. Enlist the expertise of professionals with these capacities and skills. Ensure that data collected are analyzed, validated, and summarized with utmost care and that rigor, validity and reliability are considered. In this section, the concept of triangulation of data for needs assessment is addressed and an example of a data summary table is provided for context.

Triangulation in the context of a needs assessment involves using multiple data sources or methods to validate findings and ensure the credibility and reliability of the assessment. Here are several ways to triangulate data for a needs assessment:

* Multiple Data Sources: Gather information from various sources such as interviews, focus groups, surveys, observations, and existing literature. Each data source provides a perspective on needs, strengths, and challenges.
* Mixed Methods: Combine quantitative and qualitative data collection and analysis methods. For example, supplement qualitative interviews and focus groups with quantitative surveys to gather broader insights and validate qualitative findings.
* Participant Validation: Conduct member checking or participant validation to verify the accuracy and relevance of findings with community members or partners. Present preliminary findings to key individuals and groups and solicit feedback to ensure their perspectives are accurately represented.
* Comparative Analysis: Compare data from different sources or methods to identify common patterns, discrepancies, or contradictions. For example, compare findings from interviews with survey responses to assess consistency and validity.
* Expert Review: Seek input from subject matter experts or partners who have knowledge or expertise relevant to the needs assessment. Their insights can help validate findings and provide additional context or interpretation.

***Triangulating data through these methods can enhance the validity, reliability, and credibility of the needs assessment findings, providing a more comprehensive understanding of the community's needs and informing more effective interventions and strategies.***

Once the data are analyzed and triangulated, organize the data in a manner that enables effective communication of findings in various formats discussed in the following section. Create summary tables, meaningful data visualizations, and written interpretations of data. This process will also support effective sharing of findings to key partners to support the prioritization process.

# STEP 6: PRIORITIZE ISSUES AND REPORT FINDINGS

After data have been collected and analyzed, (STEPS 4 and 5), prioritize the problems and needs identified. This will complete the needs assessment phase before transitioning into reporting and evaluation. In this section, prioritization and reporting will be addressed separately, and the next step (STEP 7) will address evaluation of the needs assessment.

## STEP 6A: PRIORITIZE ISSUES

Prioritization is an integral part of a program planning process. Because most states and communities have limited available resources, prioritization helps to identify which problems need to be addressed first, and which problems when addressed will yield the most significant benefits for key population groups.

Prioritization uses an objective, rational approach. Problems to be assessed are identified based on a scientific assessment, objectives and goals of the needs assessment, and recognition of state and community perceptions. The process seeks to be stakeholder-engaged throughout.

Prioritizing oral health problems can:

* Create a structure that systematizes the priority-setting process, helping groups make decisions about where to target resources based on sound evidence, not anecdotal information, political whims or available funding.
* Help agencies and programs (often underfunded and overworked) avoid focusing only on the “crisis of the day” created by public, media, or legislator perceptions.
* Ensure the rational allocation of resources based on data and stakeholder input.
* Set priorities that are more likely to reflect the realities, needs, and expectations of the state or community.
* Increase community and partner awareness and buy-in for oral health issues and priority topics.

A systematic, partner-engaged, and intentional prioritization process ensures not missing any nuance that only certain partners may know. Representatives of the state or community and those most impacted by issues may have a better sense of what matters and which issues genuinely have the biggest impact on people's lives.

### WHO TO INVOLVE

Participation helps to ensure commitment. Broad representation of partners identified in STEP 1 must be involved in the prioritization process. As noted previously, the advisory committee should reflect the cultural, ethnic, and racial diversity of the state or community represented.

Since several perspectives and individual biases may exist among planning group members, a skilled person with strong facilitation and conflict resolution skills should guide this process and manage the discussions and decisions. An objective approach helps to ensure that the process is organized, fair, and inclusive. The facilitator should help plan the meeting, monitor interpersonal dynamics, and mediate conflicts between members to ensure collaboration. Power differentials among members of the community, agency staff and partners should be considered. Efforts to prioritize voices that have been historically marginalized or are not adequately represented in the data or in the advisory committee are important.

### CHALLENGES TO IMPLEMENTATION

Lack of time, exclusiveness, and diversity are three challenges groups face when implementing a prioritization process. Several meetings may be needed to develop and define the prioritization criteria, vote, and reach consensus. Timelines will need to be factored into the overall needs assessment planning.

### PRIORITIZATION APPROACH

There are several approaches and techniques available to prioritize health problems. In this model, the prioritization approach adapted from the Health Problems Prioritization Matrix is described in detail. This was developed by The Family Health Outcomes Project, Department of Family and Community Medicine, University of California, San Francisco, 1999. Assess the value, applicability, and fit of each prioritization model and technique, and use the best-suited one. The following list highlights various techniques.

* **Health Problems Prioritization Matrix:** This is one of the more popular techniques and is used when multiple criteria need to be considered during the prioritization process. This method, albeit complex, is more comprehensive and accounts for criteria with varying degrees of importance. ***This document offers a detailed description of this method with an example and worksheets.***
* **Multi-voting Technique:** Used when there is a long list of problems that need to be prioritized and narrowed into a short list of needs. This technique can bring issues that are popular/favored across various people but not necessarily their top priority.
* **Strategy Grids:** This places the focus on strategic priorities, i.e., needs/problems, that when addressed, could yield the most meaningful results. This tool can be especially relevant to projects that have limited resources to implement a future oral health plan and help them focus on the most significant actions.
* **Nominal Group Technique (Delbeq Technique)**: This approach is helpful in the early stages of prioritization when it's necessary to brainstorm ideas quickly and it's important to take into account input from several people. This technique can also serve as a precursor to multi-voting; after generating initial priority ideas, the group can engage in multi-voting to narrow the top priorities from the needs assessment. The nominal group technique is also effective in granting all members of the committee equal power/weight in the prioritization process.
* **Hanlon Method:** Developed by J. J. Hanlon, this method accounts for baseline data and numerical values in the prioritization process, yielding a more objective list that potentially is better primed for health planning and implementation than most other techniques. In this method, health problems are prioritized first by criteria selected by the group and then by five feasibility factors, the PEARL test - **P**ropriety, **E**conomics, **A**ccessibility, **R**esources, and **L**egality.

For more information on each of the techniques, refer to the following resources:

* [NACCHO Guide to Prioritization Techniques](https://www.naccho.org/uploads/downloadable-resources/Gudie-to-Prioritization-Techniques.pdf)
* [Community Toolbox Decision Making Processes](https://ctb.ku.edu/en/table-of-contents/assessment/assessing-community-needs-and-resources/criteria-and-processes-to-set-priorities/tools) .

### HEALTH PROBLEMS PRIORITIZATION MATRIX

The Health Problems Prioritization Matrix is a framework to objectively score, rank, and prioritize health problems. Steps in this process include (1) selecting criteria, (2) developing scoring criteria, (3) weighting the criteria, (4) reviewing the data, (5) completing the matrix, and (6) arriving at group consensus on several health problems from which to develop program interventions. Refer to page 35 for a sample Health Problems Prioritization Matrix.

1. **Selecting Criteria:**Criteria are standards for making a judgment and can serve as guidelines for decision-making. Criteria are meant to be flexible and context-specific, that is, criteria you use might and should be custom-fit for your needs. Selecting criteria beforehand is an important step in having an objective process for prioritization. Since criteria can be defined in several ways, participants need to agree on definitions. The group should brainstorm and select a set of criteria that each member can apply in prioritizing the identified oral health problems. The goal of the group is to reach consensus on a manageable number of criteria (six to eight).

While there are several ways for a group to reach a decision (e.g., voting, leader deciding), using a consensus approach is the most recommended. It allows the group to discuss and debate the possibilities until everyone reaches agreement. When everyone in the group is part of the solution, they are more likely to support a final decision they helped create.

The following list (from the [Community Toolbox](https://ctb.ku.edu/en)) can serve as a starting point for the group to adapt, expand, modify and identify relevant criteria relevant.

* Seriousness of the issue.
* Frequency of the issue – rare, affecting most of the state or community, confined to a single area, targeting a single population group.
* Cost of the issue– in dollars, in time spent, in social costs (e.g., lost productivity from illness)
* Feasibility of affecting the issue.
* Resources needed to address the issue adequately.
* State or community perception of the issue’s importance.
* Readiness to recognize and address the issue.
* Long-term impact of the issue.
* Long-term benefit of the project effort.
* Fit of addressing the issue with the project’s vision and mission.
* Possibility of an intervention causing unintended negative consequences

1. **Developing Scoring Criteria:** For each criterion a scoring mechanism must be developed. By using scores, the question, “How applicable is the criterion to the problem?” is answered. There are two approaches to applying scores for each criterion.

* Approach 1: Criteria apply or don’t apply. Each criterion is given a 0=NO (low) or 1=YES (high)
* Approach 2 Criteria are scored using a range of values. If a criterion applies, then the score indicates the degree to which it applies, such as for Trends Increasing:
* 1 = Rapid decrease in past 5 years
* 2 = Moderate/slow decrease in past 5 years
* 3 = No change in past 5 years
* 4 = Moderate/slow increase in past 5 years
* 5 = Rapid increase in past 5 years.

1. **Weighting the Criteria:** If some criteria are considered more important than others by members of the group, assign weights to reflect this importance. For example, the group may feel that a criterion (e.g., trends increasing) is more important than another (e.g., high incidence/prevalence). A range of different weights will also be useful in identifying problem areas. Each criterion should be assigned one of the following weights.

* 1 = important
* 2 = very important
* 3 = most important.

The numeric score for each criterion derived from either Approach 1 or Approach 2 is then multiplied by the weight *(refer to Table 3 for an example of scoring and weighting).*

1. **Reviewing the Data:** The data could be presented in a one to two-page summary in an easy-to-read format. Presenting data in the form of an interactive Power-Point presentation or webinar would also be beneficial in ensuring everyone understands the findings. Wherever possible and appropriate, breakdowns by demographic characteristics (e.g., age, race, geographic area) should be presented. Indicate statistical significance where appropriate.

1. **Complete the Matrix:** The next step in the prioritization process is to complete the Health Problems Prioritization Matrix using the following steps.
   * + - Enter the criteria identified in the cells across the top; “Criterion #1” might be High Incidence/Prevalence, Criterion # 2 might be Trends Increasing, etc.
       - Enter the problem areas (% children with obvious need for dental care, % children with dental caries) in the cells in the column entitled “Problem.”
       - Enter the weights that have been assigned to each criterion in the cells directly under “C1,” “C2,” “C3,” etc. Assume the group determined that “Trends Increasing” is weighted 3. Therefore enter “3” in the cell directly under “C1.”
       - For a criterion such as “Trends Increasing,” decide to what extent the problem meets the criteria on a scale of 1 to 5.
       - Next multiply the score (1 to 5) by the weight given the criterion (1 to 3) and
       - Write the result in the scoring box. In this example, Trends Increasing = moderate/slow increase in the past five years = 4. Multiply 4 x 3 (=12).
       - Under the column entitled “Total,” the weighted scores for the criteria for each problem will be summed.
       - Continue with the other criteria for the problem of dental caries.
       - Add the scores for each criterion for dental caries. Enter this in “Total Scores.”
       - Complete the same steps for the other problems.

Everyone submits the matrix to the facilitator. Individuals do not rank the total scores at this time. When all participants have completed the matrix, the facilitator adds the total scores for each problem and transfers the figures to a new “master” Health Problem Prioritization Matrix. The facilitator ranks the problems based upon their total scores from the group. Those with the highest scores are the highest priority.

1. **Discuss Results and Reach Consensus:** The whole group reviews the problems with the highest scores and reaches consensus on the appropriateness of the list and a reasonable number for which to develop interventions. The quantitative scoring process may create an illusion of pure objectivity in a process that is partially subjective. Therefore, it is wise to review the results of the scoring process and provide opportunity for discussion among members to amend the prioritized list by consensus. The group also must decide where to “draw the line” in terms of the number of priority needs to tackle. The number selected will depend on both financial and staffing resources available.

### FINAL THOUGHTS ABOUT PRIORITIZATION

The result of this, or any other prioritization process, is based more on art than science. Even though the process quantifies the results, it does not mean this is the absolute correct response. Based on the context of the state and community, current needs, and other factors, criteria and priorities will change.

***Prioritization is more about the process of bringing together the opinions of a broad representation of people to agree to act on one or more health problems.***

## TABLE 2: SAMPLE CRITERIA & LEVELS TO PRIORITIZE ORAL HEALTH PROBLEMS

|  |
| --- |
| *Criterion 1:* Amenable to intervention or intervention proven effective by research. The degree to which a problem is amenable to an intervention and/or an effective intervention exists.   * No known effective intervention exists. * Promising intervention exists, but it is unclear whether it can be applied to the population in question. * Intervention with a proven efficacy exists, but probably can’t be applied to the population in question. * Intervention with a proven efficacy exists but it is unclear whether it can be applied to the population in question. * Intervention with a proven efficacy exists and can be applied to population in question. |
| *Criterion 2:* High incidence or prevalence. The level of incidence or prevalence of the health problem.   * Low incidence or prevalence. * Moderate incidence or prevalence in some subgroups. * Moderate incidence or prevalence in all groups. * High incidence or prevalence in some subgroups. * High incidence or prevalence in all subgroups. |
| *Criterion 3:* Severity of consequences. The level of severity of consequences of the health problem.   * Not life threatening or debilitating to individuals or society. * Slightly debilitating to individuals or society. * Moderately debilitating to individuals or society. * Life threatening or debilitating to individuals or society. * Life threatening and debilitating to individuals or society. |
| *Criterion 4:* State or Community identified needs or perception of problem. The extent to which the state or community has identified a need or the existence of the problem.   * Not perceived as a health problem; an effort to address would be opposed. * Not perceived as a health problem; efforts to address it would be opposed. * Recognized as a health problem; any effort to address it would be opposed. * Recognized as a health problem; efforts to address it would not be opposed. * Recognized as a health problem; efforts to address it would be welcome |
| *Criterion 5:* Resources are available. The extent to which resources are available for use in implementing an intervention.   * No resources available. * Minimal resources available. * Moderate level of resources available. * Many resources available. * Very high level of resources available. |
| *Criterion 6:* Costliness of treatment. The costliness of treatment.   * No cost for treatment. * Minimal cost of treatment. * Moderate cost of treatment. * High cost of treatment. * Very high cost of treatment. |
| *Criterion 7:* Trends Increasing. The extent to which trends are increasing or decreasing.   * Rapid decrease in past five years. |

## TABLE 3: EXAMPLES OF CRITERION SCORING AND WEIGHTING

|  |  |  |  |
| --- | --- | --- | --- |
| **Criterion Scoring – Approach 1** | | | |
| Health Problem/Criterion | High Prevalence | Trend Increasing | Total |
| Children with Caries Experience | 0 | 0 | 0 |
| Children with Untreated Decay | 1 | 0 | 1 |

|  |  |  |  |
| --- | --- | --- | --- |
| **Criterion Scoring – Approach 2** | | | |
| Health Problem/Criterion | High Prevalence | Trend Increasing | Total |
| Children with Caries Experience | 4 | 2 | 6 |
| Children with Untreated Decay | 4 | 3 | 7 |

|  |  |  |  |
| --- | --- | --- | --- |
| **Criterion Weighting (using scoring from Approach 2)** | | | |
| Health Problem/Criterion | Severe Consequences (2) | Trend Increasing (3) | Total |
| Children with Caries Experience | 4 X 2 = 8 | 2 X 3 = 6 | 14 |
| Children with Untreated Decay | 4 X 2 = 8 | 3 X 3 = 6 | 17 |

## 

## STEP 6B: REPORT FINDINGS

Needs assessment findings generally are used for at least one of three purposes: (1) program planning, (2) program advocacy, and (3) raising awareness/buy-in across diverse audiences. While the needs assessment findings should play an important role in program planning, it is beyond the scope of this document to detail how they should be incorporated into a formal oral health planning document. An example of an oral health data summary sheet is shown on the last page of this section.

***As a basis for program planning, needs assessment reports should identify and measure the extent of needs that could be addressed by the oral health resources of the state or community.***

This section will focus on program advocacy and public education. This advice can be used to report key findings to decision makers within the primary audience(s).

### KNOW YOUR AUDIENCE

Communicating the findings to the primary audience(s) such as health department personnel, other professionals, legislators, members of the media, or the public is important. The information should address issues the audience perceives to be important and be delivered in a timely manner in a form that is easily understood.

Knowing how to present information to the intended audience is crucial. For example, city councils may not be interested in probability sampling or the internal and external validity of the data collected. They are interested, however, in how their constituencies will react to the data and recommendations. An academic audience, on the other hand, may be very interested in the methods used to collect information. What state leaders may interpret as involvement and commitment may appear to academics as flaws in the research design.

### WHO WILL USE THE INFORMATION

Needs assessment findings generally will be reported to both primary and secondary users of the information. **Primary users** will require a detailed description of the methods and findings and a summary of the needs assessment efforts. Primary users at the state level may be the maternal and child health director, a program dental advisory committee, or state dental public health employees and decision makers within the health department. Use information for decision makers such as health officers to convince them not only that a problem exists, but that it needs to be acted upon. Local primary users might be oral health coalition leaders, city council members, Head Start health staff, or an FQHC director.**Secondary users** are other individuals, groups and organizations that have a vested interest in the results. Some secondary users may be state and local dental, dental hygienist, or public health associations; academic health centers; other program staff within the health department; special interest/advocacy groups who represent children with special health care needs; tribal health boards, and legislators. While it is important to focus on primary users, secondary users often are more powerful allies.

*The Media:* While some people still receive their information from the newspaper or TV news media, social media or the Internet is most likely the principal way the public learns about findings from an oral health needs assessment. When talking or writing about the needs assessment, use clear, concise, plain language. Remember to address the most important information at the beginning. Talk or write about who is served by oral health programs, implications of the needs assessment findings, and why this is new information that applies to the audience. If working in health departments or other agencies, many have an information lead who serves as liaison and gatekeeper to the media. Plan time for any required approvals and revisions from this liaison or other administrators.

### WHAT INFORMATION WILL THEY USE

No single report about the oral health needs assessment findings will satisfy all purposes for all audiences. In preparing a report, be sure to give primary users, especially decision makers, the data they need to draw conclusions. If the information is important for program policy and requires decisions by managers, make clear recommendations within the report. Remember, however, needs assessment is only one step in the planning process. Be selective in identifying which points require immediate action. It may be necessary to postpone specific action until additional parts of the puzzle are collected and interpreted within the bigger picture of the health department. Finally, restate key findings at several points to maximize audience exposure to this information. Choose the best visual format to highlight the most critical findings.

***Written Reports****:* While few primary users will read the entire written report, a technical and detailed report still is necessary and may be a useful reference. Charts and graphs help deliver a clear, precise message. Place an executive summary prior to the report narrative. The summary should highlight major findings, implications and recommendations in a clear, concise way. It should contain graphs/visuals highlighting the most important findings. In addition to an executive summary, an abbreviated supplement, such as an infographic, tailoring key points of particular concern to specific groups will be helpful. Secondary users should first be given an abbreviated version of the report. If they would like more detailed information, a more detailed version can then be provided.

Consider using someone with expertise in graphic design and who has online graphics software to format the cover and text and any charts or graphs that will appear throughout the document. A professional appearance is important.

A well written needs assessment report can be modified for several purposes, including the Maternal and Child Health Block Grant application. Such a document will place the oral health program in a more advantageous position for inclusion of both successful and problematic program activities. The implications of findings from the oral health needs assessment must be clearly stated. If the assessment was conducted to highlight a decision or problem, the findings should be directly tied to that decision or problem. List a question that was to be addressed in the needs assessment process, and then under that question summarize the findings that correspond with it. For example, if primary data collection efforts show that occlusal caries is a problem for children, recommend initiating a dental sealant program to lessen the problem. A more traditional format in the development of a long-range program plan is to simply state what the findings mean in terms of what actions should follow, what policy decisions should be made, or the likelihood of various alternatives.

The credibility of the document is particularly important when findings are controversial. To enhance the document's credibility, an extensive methods section should be provided as an appendix to clearly describe the steps taken in conducting the assessment. This is especially true for oral health programs that collect primary data for the needs assessment. For example, a flow chart showing the steps of the oral health needs assessment could be included. Any unusual techniques employed should be amply justified. For example, if the categories of oral health needs are defined differently than specified in the oral health literature, the reason behind this must be explained.

Begin each chapter, subsection, and paragraph with the most important point. Highlight key phrases and statements. Use active verbs whenever possible. They strengthen the importance of the findings. Write clearly and concisely using non-technical words. If technical terms are unavoidable, explain them in simple language.

To keep members of the professional associations abreast of the activities around the needs assessment, communicate with the editors of the respective association’s newsletter or journal, if there is one, about submitting an article summarizing the needs assessment findings.

***Oral Presentation****:* If you give an oral presentation about the needs assessment findings, tell your audience only what it needs to know. Restate the most important findings at least twice during the presentation. Use available/preferred modes of visual presentation (slides, interactive dashboards etc.) with visually appealing handouts to maintain audience interest.

Whatever visual media is used should be large enough so the most distant person in the audience can read it easily, and the message should be clear and concise. Too much information on any one slide causes the audience to lose interest.

People learn and remember best when they are active participants in the learning process. Therefore, some form of audience participation such as having an active question and answer period should be considered.

### WHEN WILL THE INFORMATION BE USED

Ideally, needs assessment results should be announced as soon as the process is complete and approved by administrative sponsors. Since needs assessment is an ongoing process, considerations such as annual health department prioritization of projects or a bill introduced in the legislature should be kept in mind when deciding the date of release for the report. For example, in state health departments it may be a good idea to release findings to coincide with the development of objectives for the next cycle of the Maternal and Child Health Block Grant application. For local health departments it may be appropriate to release the information when the health department's or city council’s budget is coming under review. If the information is released to coincide with a deadline for an application or budget, prepare summary sheets that can be incorporated into the document. The release of needs assessment data may be the only window of opportunity to point out the oral needs of various segments of the population. Have your program planning ideas ready upon release of the data.

***Don't postpone communicating your findings until all the oral health needs assessment data have been collected and analyzed. Significant trends in preliminary findings can be communicated to users before a final report is completed.***

Effective reporting and communication must be ongoing, from the initial planning to the completion of this round of needs assessment. Whatever information has been collected should be cataloged for historical trends. A written account of all the activities should be maintained to orient new staff and to use for subsequent needs assessments.

## HEALTH PROBLEM PRIORITIZATION MATRIX – SAMPLE

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Criterion 1: | | | | Criterion 4: | | | | |
| Criterion 2: | | | | Criterion 5: | | | | |
| Criterion 3: | | | | Criterion 6: | | | | |
| Problem | Prioritization Criteria: In the line below C1, C2, etc. record weights as appropriate. Multiply weight by score for each problem and all criteria. | | | | | | | Total Scores |
|  | C1  ( ) | C2  ( ) | C3  ( ) | | C4  ( ) | C5  ( ) | C6  ( ) |  |
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## ORAL HEALTH DATA SUMMARY SHEET – EXAMPLE

***Oral Health Issue****:* Third graders with untreated decay

***Description & Broad Look at Issue****:* Untreated decay can result in needless pain and suffering, difficulty speaking and chewing, and increased cost of care. In Samplestate, 75% of tooth decay is found in only 17% of the children. To some extent, this measure indicates how much children are benefiting from prevention (fluorides and sealants), but mostly it measures the degree to which they are receiving needed dental care.

***Prevalence:*** In Samplestate, 24% of third graders have untreated decay.

***Comparison****:* The prevalence of untreated decay in Samplestate (24%) is higher than the national average (18%) for children aged 8 years.

***Trend****:* The oral health of Samplestate’s children is improving. The percentage of third graders with untreated decay has decreased from 31% (2000) to 24% (2024).

***Disparities****:*

* Race: 18% of White children and 29% of Latinx children in 3rd grade have untreated decay.
* Geographic: 35% of children in rural counties have untreated dental caries vs. 18% in other areas.
* Family Income: the most dramatic disparity exists between students who are income-eligible for the National School Lunch Program (NSLP) and those not eligible: 34% of third graders eligible for NSLP have untreated decay, compared to only 17% of third graders not eligible.

***Perceived Needs****:*

* Consumers: Parents of nearly one out of every five 3rd grade students (19%) screened indicated that their children did not get the dental care they needed in the last 12 months.
* Samplestate Family Health Survey: Do not have data for 3rd graders; however, dental was the number one unmet health care need for children up to 18 years of age.
* Household Survey: Three out of every ten Samplestate adults did not see a dentist in the past year.
* Focus Groups: Parents of both the 0-3 year-olds and 4-14 year-olds identified access to dental care as a significant health issue.
* Key Informant Surveys: legislators, administration, health commissioners, and public health providers identified access to dental care as a health issue in Samplestate.

***Expressed Needs through Service Utilization****:* 56% of safety net dental care programs have waiting lists for initial appointments. Waits are typically 1-3 months, but some exceed 6 months.

***Other Pertinent Information****:*Survey of school nurses in Samplestate’s highest risk schools estimated that only 50% of the students referred for treatment received needed dental care. They cited 1) family’s inadequate money/insurance to pay for dental care, and 2) dental care being a low priority for the families as the most important barriers to the children receiving needed care.

***Limitations of the Data (sample vs. population****):* The data were based on a sample of more than 10,000 3rd grade students. The limitations of these data reflect those of the sampling process and requirements for parental consent. Owing, in part, to the large sample size, the state level data generally yielded tight 95% confidence intervals.

***Brief Analysis of the Significance and Recommendation*** *(“should we worry or not”):* Unless stopped by dental treatment or early reversal, the carious infection will continue to destroy the tooth, resulting in pain and acute infection. One in every four children in Samplestate have an obvious need for dental care. Samplestate data have shown that 75% of tooth decay is concentrated in only 17% of children (primarily those of minority groups, low-income and lower education families). The fact that children eligible for NSLP are twice as likely to have an obvious need for dental care as children not eligible points to the disparity that exists for lower income families and rural residents. Targeting these groups for prevention and treatment programs will significantly reduce the prevalence of untreated dental caries.

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# STEP 7: EVALUATE THE NEEDS ASSESSMENT

In general, three aspects of the needs assessment can be evaluated -- the plan, the process, and the outcome. Given some pre-planning, people can engage in evaluation and ongoing learning and adaptation throughout the lifecycle of the project. Following STEPS 1-3, **assess the needs assessment plan** and address evaluation questions such as:

***In addition to being intentional in planning and executing a needs assessment, it is vital that the needs assessment project be evaluated.***

* Have partners been adequately engaged in the planning process?
* Does the plan define and acknowledge the needs of the state or community appropriately?
* Is the plan comprehensive and detailed enough to support smooth implementation?
* Is the plan aligned with the goals and objectives identified in STEP 2?

Next, the **needs assessment process** can be evaluated through periodic checks throughout the implementation of STEPS 4-6. This type of evaluation can help assess if the project is progressing as intended, if adaptations and course corrections are needed, and if there are opportunities to make the process more efficient and effective. Some key evaluation questions that can be answered here are:

* Is the project being implemented as intended/planned – on schedule and on budget?
* Are the data collection instruments sound, and is an adequate and appropriate amount of information being gathered?
* Are the relevant staff and partners supporting the needs assessment as expected?
* What communications are being issued, and are the audiences finding them useful?
* What kind of assistance does the project team need?

Finally, a more comprehensive aspect is the evaluation of the **needs assessment outcomes**, that is, a summative evaluation of the needs assessment project. This type of effort would be conducted after the project is complete. Key questions here could be:

* Have you accomplished what you had planned?
* What could be done differently next time?
* If problems surfaced that can be addressed, what steps are planned to address those concerns?
* To what extent is the needs assessment information valuable and useful to key partners?
* What are some ways in which the needs assessment findings were used to plan programs and improve oral health of key populations?

The team’s capacity (e.g., skill, budget, time), will determine the scale of the evaluation. In this document, we offer some tools and checklists to help any program conduct an evaluation of its needs assessment for helping with future projects and adding context to the needs assessment findings. Three evaluation checklists are provided on the following pages. The first restates the priorities from *Worksheet 2* and helps determine if they were accomplished. The second checklist focuses on completion of the core and selective optional data items and asks which method might be used next time. The third checklist asks questions addressing landmarks along the way and is helpful in maintaining a historical perspective to the needs assessment. Most of these questions, which follow the seven steps of the oral health needs assessment, relate to process rather than to outcome.

## TABLE 4: EVALUATION CHECKLIST 1

|  |  |  |
| --- | --- | --- |
| **WORKSHEET 2 ITEMS**  **(List the goals identified for your needs assessment)** | **ORIGINAL SCORE** | **Did the needs assessment accomplish this intent? Add pertinent comments and lessons learned?** |
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## TABLE 5: EVALUATION CHECKLIST 2

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| --- | --- | --- | --- |
| **Data Items/Types of Information**  **(Worksheet 3)** | **Did you accomplish this (Y/N)?** | **Needs Assessment Method Used** | **Would you recommend using this method for the next needs assessment? Other pertinent comments.** |
| **CORE** |  |  |  |
| 1. Description of population |  |  |  |
| 2. % of children with untreated decay |  |  |  |
| 3. % of children with caries experience |  |  |  |
| 4. % of people served by community water systems with optimal fluoride |  |  |  |
| 5. % of children with sealant on 1+ permanent molars |  |  |  |
| 6. # of dental providers in the state (by county or other division) |  |  |  |
| 1. Dentist participation in Medicaid program (number participating and level of participation) |  |  |  |
| 1. # (%) of children under age 19 years at or below 200% of FPL who receive preventive dental services |  |  |  |
| 1. Description of public resources for dental care |  |  |  |
| 1. % children that have visited a dentist during the previous year |  |  |  |
| 1. Perceived oral health needs of consumers and their assessment of accessibility, acceptability and appropriateness of oral health care received |  |  |  |
| **OPTIONAL** |  |  |  |
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## TABLE 6: EVALUATION CHECKLIST 3

The following questions/prompts for each step of the process are intended to be adapted, narrowed (based on the evaluation context) and used to facilitate a learning session or discussion between team members and advisory committee members.

|  |
| --- |
| **STEP 1: IDENTIFY PARTNERS/FORM ADVISORY COMMITTEE**   * Did the majority of the Advisory Committee play an active role throughout the needs assessment? * Were members asked and willing to assist in the collection of data? * What specific issues did the committee surface that had not been part of their programmatic activities previously? * Did the Advisory Committee consist of appropriate representatives? * Was the MCH program or other program collaborators given adequate opportunity to coordinate efforts in collecting mutually beneficial information? * Was the size of the Advisory Committee manageable? * Did the Advisory Committee feel they had a voice in the needs assessment project? * Approximately how many new organizations were included during the process? * Which of these may you work with collaboratively on other projects? * Were you and the Advisory Committee realistic about the expectations of the needs assessment? |
| **STEP 2: CONDUCT A SELF-ASSESSMENT TO DETERMINE GOALS**   * Did you or others periodically return to *Worksheet 2* to review the goals? * Which goals if any were re-ranked because of the return to *Worksheet 2* |
| **STEP 3: PLAN THE NEEDS ASSESSMENT**   * Of the **core** data items –   + Which were successfully collected? Why?   + Which were not successfully collected? Why? * Of the **optional** data items –   + Which were successfully collected? Why?   + Which were not successfully collected? Why? * Were the timelines reasonable? * Were the estimates for human resources and budgets reasonable? |
| **STEP 4: COLLECT DATA**   * Was some information collected for all the core items? * Did data collection for some of the optional items come at the expense of core data items? |
| **STEP 5: ORGANIZE AND ANALYZE DATA**   * If primary data were collected, were sampling and statistical analyses conducted accurately? * Were results shared with the Advisory Committee to support collective interpretation? How effective was this process? |
| **STEP 6: REPORT FINDINGS**   * Who to, where and how were the report findings communicated? * Have specific findings and recommendations from the needs assessment been clearly articulated to appropriate interested parties? * Are all materials accessible, ADA compliant and available in open-source formats? * Are the report findings being incorporated into other reports or needs assessment summaries? * Have external reviewers been asked to review and comment about the needs assessment process and findings? |

# APPENDIX

## CONDUCTING EFFECTIVE KEY INFORMANT INTERVIEWS

Key informant interviews are a valuable qualitative method for gathering in-depth insights from individuals who possess expert knowledge or lived experiences relevant to the issue. When conducting key informant interviews as part of an oral health needs assessment, careful planning and execution are essential to ensure the collection of meaningful data. Key steps and considerations for effectively planning and conducting key informant interviews are outlined below.

1. Define Objectives and Identify Key Informants:

* Clearly define the objectives of the key informant interviews, specifying the information needed and the purpose of gathering it. From STEP 3, think about the specific indicator(s) you are measuring using this method.
* Identify individuals who possess relevant expertise, perspectives, or experiences that align with the objectives of the assessment. These may include oral health professionals, community leaders, policymakers, representatives from local health organizations, and individuals from marginalized or underserved populations.

2. Develop Interview Guides or Protocols:

* Create structured interview guides containing a series of open-ended questions designed to elicit detailed responses from key informants.
* Tailor questions to address specific aspects of oral health needs, challenges, resources, and potential solutions relevant to the assessment objectives.
* Consider including probes to encourage informants to elaborate on responses and provide deeper insights.
* Have members of the Advisory Committee or others review the questions and the protocol.

4. Schedule and Conduct Interviews:

* Schedule interviews at times convenient for key informants, allowing for flexibility to accommodate their availability.
* Conduct interviews in a private and comfortable setting conducive to open dialogue. Be open to conducting interviews via video conferencing if it is more convenient for either party.
* Encourage informants to share their experiences, opinions, and suggestions freely, while guiding the conversation to ensure all relevant topics are covered.
* Conducting key informant interviews requires more than just asking questions; it involves creating an environment conducive to open and honest dialogue. Here are some best practices for conducting interviews and facilitating meaningful conversations:
  + Establish Rapport and Build Trust:
    - Begin the interview by introducing yourself and explaining the purpose of the discussion.
    - Take time to build rapport with the key informant by showing genuine interest in their perspectives and experiences.
    - Use active listening techniques such as nodding, paraphrasing, and summarizing to demonstrate understanding and empathy.
    - Assure the informant of confidentiality and emphasize that their input is valuable for informing oral health initiatives.
  + Foster a Comfortable Environment
    - Ensure that the seating arrangement is comfortable and conducive to a relaxed conversation.
    - Offer refreshments and breaks if necessary, to make the informant feel at ease and appreciated.
  + Practice Active Listening
    - Listen attentively to the informant's responses without interrupting, allowing them to express their thoughts fully.
    - Show empathy and understanding by acknowledging their experiences and emotions.
    - Encourage the informant to elaborate on their answers by asking follow-up questions or requesting examples.
  + Maintain Neutrality and Avoid Leading Questions
    - Remain neutral and objective throughout the interview, refraining from expressing personal opinions or biases.
    - Avoid asking leading questions that may prompt a specific desired response, as this can compromise the integrity of the data.

5. Ensure Data Privacy and Confidentiality:

* Take measures to protect the privacy and confidentiality of informants' personal information and interview responses.
* Store interview recordings, transcripts, and any identifiable data securely, using encryption and password protection where necessary.
* Avoid disclosing informants' identities or sharing sensitive information without their explicit consent.
* Adhere to ethical guidelines and legal requirements regarding the collection, storage, and sharing of interview data.

## CONDUCTING EFFECTIVE FOCUS GROUP DISCUSSIONS

Focus group discussions, while similar to key informant interviews in some ways (defining the purpose, developing a guide/protocol etc.), differ in terms of their approach, purpose and data collection dynamics.

* Focus groups involve group interactions among a small number of participants (typically 6-12 individuals) facilitated by a moderator. Participants are encouraged to engage in discussions, share their perspectives, and react to each other's comments. The group dynamic allows for the exploration of shared experiences, group norms, and consensus or dissenting opinions on the topic of interest.
* Focus groups are commonly used to explore group norms, attitudes, perceptions, and experiences related to a specific topic. They are particularly useful for understanding social dynamics, consensus building, and diverse perspectives within a group context.
* In focus group, participants interact with each other, building upon and reacting to each other's responses. The group dynamic can stimulate discussion, generate new ideas, and uncover shared beliefs or cultural norms.

When planning a needs assessment that involves focus groups, there are several sampling options to consider. These options help ensure that the focus groups represent diverse perspectives and experiences relevant to the needs assessment objectives. Below is a brief overview of sampling options for focus groups in needs assessments:

* 1. Purposive Sampling:
  + Purposive sampling involves deliberately selecting participants who possess specific characteristics or experiences relevant to the research objectives.
  + You may choose participants based on criteria such as age, gender, socioeconomic status, geographic location, or expertise in the subject matter.
  + This sampling method allows focusing on specific groups or individuals who can provide valuable insights into the needs and priorities related to oral health.
* 2. Stratified Sampling:
  + Stratified sampling involves dividing the target population into homogeneous groups (strata) based on certain characteristics such as age, ethnicity, or occupation.
  + Next, randomly select participants from each stratum to ensure representation from diverse demographic groups.
  + This sampling method helps ensure that the focus groups reflect the demographic diversity of the population, allowing for a comprehensive exploration of oral health needs across different groups.
* 3. Snowball Sampling:
  + Snowball sampling involves recruiting participants through referrals from initial participants or key informants who have knowledge of the target population.
  + Participants are asked to nominate others who may be interested or qualified to participate in the focus groups.
  + This sampling method is useful for reaching populations that may be difficult to access through traditional sampling approaches, such as marginalized or hidden populations.
* 4. Convenience Sampling:
  + Convenience sampling involves recruiting participants who are readily available and accessible to the researcher.
  + Participants may be recruited from places such as community centers, healthcare facilities, or social media platforms.
  + While convenient, this sampling method may introduce bias as participants may not be representative of the broader population.
* 5. Maximum Variation Sampling:
  + Maximum variation sampling involves purposefully selecting participants who vary widely in terms of characteristics such as age, socioeconomic status, or geographic location.
  + This sampling method aims to capture a broad range of perspectives and experiences within the focus groups, allowing for a comprehensive exploration of oral health needs.

Each of these sampling options has its advantages and limitations, and in collaboration with your team and the Advisory Committee, carefully consider which approach aligns best with the needs assessment objectives, chosen indicators, target population, and resources available for recruitment and data collection. Additionally, you may choose to combine multiple sampling methods to enhance the representativeness and richness of the focus group data, resources permitting.

## CONDUCTING EFFECTIVE SURVEY STUDIES

Surveys, either written or oral, are a versatile method for assessing knowledge and attitudes on many subjects. Questionnaires also can be used to elicit unpublished secondary data from respondents.

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). Keep in mind that those most likely to respond to questionnaire surveys are of higher education and have a relatively higher socioeconomic status. Since many health problems are aggravated in lower socioeconomic groups, the sample may not be representative of the intended population. If administered through an agency, check to determine whether institutional approval is required before initiating the project and whether there is a human subjects protocol you must follow.

***General Keys to Success Common to All Survey Techniques***:

* The 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 and can identify differences among subgroups.

***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. Avoid double-barreled questions. Otherwise known as a double direct question or compound question — a double-barreled question is one that essentially includes more than one topic and is asking about two different issues, while only allowing a single answer. For example: “How much do you enjoy collecting and analyzing data?”
* Make sure there is an appropriate answer for each question. If you are uncertain that 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 intended audience. Make sure the questions address constructs or indicators of interest.

***Techniques for Increasing Response Rate***

* 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, devoid of typographical and formatting errors.
* 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.
* Follow up with non-respondents.

## IMPLEMENTING THE 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 oral health care access data in a high-quality and 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 healthcare 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 -- passive or active (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 (e.g., older adults BSS), a medical history must be taken to determine if prophylactic antibiotics are appropriate.

The information gathered through a screening survey is at a level consistent with Healthy People 2030 measures. 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 via 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 whole population.

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’s website](https://www.astdd.org/basic-screening-survey-tool/). The ASTDD also provides additional resources and sometimes technical assistance to agencies willing to implement the BSS in their state/locality.