State Dental Screening Laws for Children: Examining the Trend and Impact

An Update to the 2008 Report

children's dental health project

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This report was authored by Eleanor Fleming, PhD, DDS, MPH.
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Executive Summary

PURPOSE:

» In 2008, the Children's Dental Health Project and Association of State and Territorial Dental Directors published the first report documenting state laws on dental "screening" of school-aged children. The report found that 11 states and the District of Columbia had dental screening laws (DSLs).

» The purpose of this report is to document whether DSLs have expanded and the degree to which these laws are advancing broader goals to improve dental care access and reduce dental diseases.

RESULTS:

» Since 2008, three more states (South Carolina, Utah and West Virginia) have passed DSLs—bringing the number of states with screening laws to 14 and the District of Columbia. At the time this report was published, a DSL bill had passed the Connecticut House of Representatives and a bill had been introduced in the Michigan legislature [1].

» The impact of DSL laws has been mixed. According to the informants we interviewed for this report, the laws are believed to increase parental knowledge of oral health's importance. Yet, despite advocates' good intentions, such laws often do not secure dental homes for children in need.

» Informants reported that without funding to support the screenings, states may lack the workforce capacity to implement and enforce these laws effectively, evaluate the data collected, and use screening law data to improve dental public health practice and programs.

CONCLUSION:

» The momentum behind DSLs appears to have weakened, as the number of states with these laws has increased only slightly over the past 10 years.

» To improve the oral health of children and adolescents, dental advocates and stakeholders may want to consider how these laws could be written and implemented to improve access to care.

» As they consider the impact of a DSL in their states, dental advocates should assess whether there are alternate or complementary ways to address children's unmet oral health needs.

Background

Children's oral health is a key public health priority. Ensuring that kids have access to preventive and restorative dental care services will help children to succeed in life. National data estimates that 43 percent of children aged 6-11 years had at least one dental sealant and 13.3 percent of children and adolescents aged 6–19 years had untreated dental caries in their permanent teeth [2, 3]. Untreated dental caries can cause pain and impact children's ability to speak, eat, and learn [4, 5].

Policymakers, dental professionals and advocates have taken various approaches to ensure children are ready for school, ranging from changing dental insurance coverage and reimbursement rates to revising workforce and licensure policies. Dental screening laws (DSLs) for school-aged children and adolescents are another policy approach. While these laws vary, DSLs function much like vision screening and immunization requirements: before entering school, a child receives a dental screening from a provider who completes a form evaluating the child's oral health; this form is submitted to the school. Depending on the state and the school, the process is either completed or arrangements are made to connect the child with a dental provider to receive needed treatment. The purpose of DSLs is to ensure that school-aged children and adolescents are ready for school without any oral health issues that would impede their abilities to learn and succeed [6]. For children to be school-ready, they need access to dental care services and to have a dental home—a clinic or practice where they are a regular patient.

In 2008, the Children's Dental Health Project (CDHP) and Association of State and Territorial Dental Directors (ASTDD) published the first report documenting state laws on dental screening for school-aged children [7]. The report found that 11 states and the District of Columbia had screening laws. This report reviews changes over the past decade in the number of DSLs to understand what impact these laws have had on children's dental health. Additionally, for advocates who want to develop state DSLs, this report shares lessons learned by key informants in selected states with DSLs.

Methods

This report followed the same methods that were used in the original CDHP-ASTDD report [8]. Legal searches were conducted using LEXIS and Google and the following search terms: “dental screening”, “dental inspection”, “dental program”, “dental examination”, “dental exam”, and combinations of the terms “dental”, “health” and “child”.

Key informant interviews were conducted with four states’ dental officials who were interviewed in the first report (Georgia, Illinois, Iowa, and New York); dental officials in two other states (Kentucky and Rhode Island); and dental and public health stakeholders from six states (Arkansas, California, Connecticut, Michigan, Ohio, and Wisconsin). Key informant interviews were also done with one national membership organization that supports school-based health. Staff from CDHP provided the contact information for the state dental officials and the national school-based health organization. Stakeholders were identified using multiple approaches:

- CDHP staff identified stakeholders and placed a notice on the American Network of Oral Health Coalitions listserv to solicit insights from oral health coalitions
- Snowball sampling was used; this approach encourages research participants to recruit or recommend other participants

All but one of the hour-long interviews were conducted by telephone. One interview was conducted in-person. For states with DSLs, respondents were asked questions to assess the nature and impact of these laws. These questions covered: 1) key provisions of the law (and whether sustainability, collaboration/integration, and other factors were addressed); 2) challenges to implementation; 3) how screening data are used to inform program and policy activities; and 4) lessons learned to share with advocates in other states who are interested in these laws.

The stakeholders in states without DSLs were asked questions to assess: 1) their perspective of these laws and the value they might add in their state; 2) progress in their state toward enacting DSLs; 3) if no progress was being made, what strategies advocates in their states were pursuing; and 4) the likelihood of their state enacting DSLs. Four of the stakeholders had experience in school-based health and were asked questions about how DSLs fit in that context: 1) implementation and sustainability barriers to DSLs; 2) opportunities from the perspective of school-based health to advance these laws; and 3) for stakeholders in states with DSLs, what impact has these laws had.

Written notes from the informant interviews were reviewed to identify dominant themes related to the impact of DSLs and lessons learned from implementing them [8]. In an iterative process, codes were attached to those themes to identify participants’ perspectives. Qualitative analysis of the interviews was done to the point of saturation, when no new themes emerged [9].

Five states (Iowa, Illinois, Kentucky, New York, and Rhode Island) shared reports and data from their respective screening laws. The reports were reviewed and assessed in the context of the interviews conducted with the state dental program staff. Additionally, these reports were analyzed to determine how screening law data were being used to inform dental public health programmatic work.

> *Many schools lack the workforce capacity to make dental referrals for students.*

Results

STATE LAWS

Table 1 presents the state DSLs. Since 2008, three states (South Carolina, West Virginia, and Utah) have passed DSLs. Effective July 1, 2010, South Carolina implemented the following law:

> *A targeted community health program in three to five counties of need for dental public health education, screening, and treatment referrals in public schools for children in kindergarten, third, seventh, and tenth grades or upon entry into public schools, to require program guidelines to be promulgated in regulations, to require an acknowledgement of dental screening to be issued upon completion of the screening and to require this acknowledgment to be presented to the child's school, to require notification to the child's parent if professional attention is indicated by the screening and it authorized by the child's parents, to provide notification to the community health coordinator to facilitate further attention if needed, and to provide that a screening must be completed unless a child's parent completes an exemption form [10].*

In West Virginia, the Board of Education added a provision to the legislative rule for Health Promotion and Disease Prevention policy. Effective for the 2015-2016 school year:

> *New enterers in West Virginia public school Pre-K or Kindergarten and students progressing to grades 2, 7 and 12 should have on file within 45 days of entry or prior to the first day of school attendance a record of an oral health examination. The following transition plan will request each new enterer in Pre-K and Kindergarten and grades 2, 7 and 12 to show proof of an oral health examination beginning the school year (SY) 2015/16 all new enterers in Pre-K and Kindergarten; beginning SY 2016/17 all students entering grade 2; beginning SY 2017/18 all students entering grade 7; and beginning SY 2018/19 all students entering grade 12. All examination forms shall be signed and dated by the student's dentist and completed within the prior 12 calendar months. If the student does not have proof of an oral health examination during the grade of requirement, the student may be enrolled into the WVDHHR-Oral Health Program's (OHP) Oral Disease Prevention Project. The Oral Health Prevention Project will provide an oral health assessment from a dental provider regardless of the ability to pay if the parent/guardian provides approval/consent for the student to participate [11]. Utah directs local school boards to implement screening procedures. This DSL is not mandatory. A screening can be performed by a local dentist or even a school nurse, according to state code [12].*

TABLE 1:

STATES WITH DENTAL SCREENING LAWS

- California
- District of Columbia
- Georgia
- Illinois
- Iowa
- Kansas
- Kentucky
- Nebraska
- New York
- Oregon
- Pennsylvania
- Rhode Island
- South Carolina
- Utah
- West Virginia

Of the states without DSLs, two states had active bills that never completed the legislative process. In the previous legislative session, DSL bills moved forward in Connecticut [13] and Michigan [14].

MAJOR FINDINGS FROM KEY INFORMANTS

A total of 18 key informant interviews were conducted. Except for three group interviews, all were individual interviews. Eight individuals worked in state dental public health programs (Georgia, Illinois, Iowa, Kentucky, New York, and Rhode Island); five worked in local dental public health programs (Arkansas, Ohio, and Wisconsin); two represented oral health coalitions (Connecticut and Michigan); two were from school-health programs (California); and one represented a children's advocacy group (New York).

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Addressing unmet need

DSLs require children to receive a dental examination or assessment with the intent of identifying oral health issues and connecting children to a dental home or to a provider for appropriate treatment and care. However, these laws do not always provide a mechanism for connecting children with unmet dental need to a dentist. One informant noted that the dentists who perform the screenings cannot refer children to their own practices for care. This restriction is based on the assumption that dentists would refer kids to their own practices, thus benefiting financially. In an area where there are few Medicaid dental providers, this restriction could create a barrier for connecting children to care. This informant voiced concern that if the dentists providing the screenings cannot treat the children in their private practice clinics, these children have few, if any, options to get needed care. Based on informant interviews, screening requirements alone are unlikely to create a mechanism for connecting children to providers. Some system needs to be in place for proper referrals.

An informant in another state described the problems with creating a list of dental providers that school nurses and others could use to make referrals for children who need follow-up treatment. The state had a large number of licensed dentists, but many were not interested in serving as referral points. For this reason, children who are screened and need dental treatment may not always have a provider for follow-up care. It is incumbent that providers are willing to serve as referral points or as dental homes for these children.

Another informant noted that the low reimbursement rates in their state deter dentists from taking on Medicaid-enrolled children. This shrinks the pool of providers for children in need. A respondent from another state noted that an increase in Medicaid reimbursement has helped to increase the number of children with access to care. However, while the dentists are willing to treat children with Medicaid benefits, getting the children to dental offices remains a barrier. There may be transportation barriers or coordination issues that make access more complicated than just providing a referral. In one state, school nurses have received information on how to use Medicaid care coordinators to connect children with restorative needs to care. This system works, however, only in schools where there are school nurses. One respondent noted: "My school district works to get kids who have urgent care connected to care. But, not all schools make these referrals." Having nurses or other staff at schools who can connect children to providers is critical if screenings are to improve access to dental care. Not all schools have the workforce capacity to make referrals.

Finally, another respondent explained that although most of their state's children are covered by CHIP or Medicaid, many children are not accessing care. For this respondent, educating parents to understand how to use their children's dental benefits is key to addressing unmet need. Some parents might not be aware, for example, that dental care is embedded in their children's Medicaid benefits. When informed of the presence of pediatric dental benefits, 68 percent of parents cited it as a motivating factor for enrolling in Medicaid [15].

Mandatory nature of DSLs

The pros and cons of making DSLs mandatory in nature was a dominant theme across all of the interviews. Unlike vaccination requirements for school-aged children entering school, DSLs do not always mandate compliance as a condition of enrollment. All respondents agreed that children should not be denied access to school if parents do not submit a dental screening form; however, they agreed that this weakens the impact of such laws.

Without the ability to enforce the screening laws, respondents noted that participation becomes voluntary. Consequently, these laws produce an incomplete picture of children's dental health for a given school, school district, and state. One respondent noted that there are "no teeth that bite within this requirement." Another remarked that these laws are not a "sustainable surveillance system for the state." In one state, an informant reported that less than 50 percent of kids were screened in the law's first year, 57 percent in the second year, and 62 percent in the third year. For a state dental director who wants to use data from the screening laws to inform policy, their voluntary nature poses a significant obstacle. As one informant stated: "If you count on the data for public health development, you need a full spectrum of data" with a high response rate. Being voluntary, the value of DSLs as a

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data collection tool for state health departments and oral health programs is diminished.

Respondents also noted challenges with the age or grade at which dental screenings are required. DSLs are typically written for students entering school for the first time or starting particular milestone grades (e.g., entering middle and high school). Often, states have focused dental screening requirements on kindergarteners, third and ninth graders, and students transferring into the school district. However, one respondent noted that participation rates decreased significantly for older students. Others noted that ninth grade is a tough grade to get compliance. Respondents were not able to identify a specific reason why this age group poses such a challenge.

Factors influencing state adoption of DSLs

Respondents gave various reasons for why less than one-third of the states have DSLs. For one respondent, DSLs can create a tough-to-answer question: "what do we do with the kids we identify?" Because these laws typically lack a case management component, there is a perception that DSLs are simply "paper mandates." Without a reliable a mechanism to connect children to care, these laws may not achieve the impact envisioned by advocates. Lacking that ability, DSLs quantify a problem of need without providing a reliable means for establishing dental homes.

Other policy priorities may push DSLs to the backburner in some states, as advocates turn their attention to other vulnerable populations. One respondent noted that interest in children's dental health has diminished in their state—turning, instead, to advocacy for expanding adult Medicaid dental benefits and growing the dental workforce with mid-level providers.

For advocates in non-DSL states, respondents noted that the political landscape in their states caused them to focus on other issues. In one state where there is a strong movement seeking to reduce regulation (especially mandates), an informant felt legislators might perceive DSLs as governmental overreach. Dental advocates facing such circumstances often turn to other initiatives that don't require new laws, such as dental sealant programs and other school-based health programs. These opt-in programs are not perceived as regulatory efforts, and, therefore, can have an impact on population-level health without legislation. In this political environment, oral health advocates have shifted their focus from changing policy and implementing new laws to improving dental health within the confines of existing authority.

Building Coalitions

Whether the DSL was new or old, most respondents cited the importance of building coalitions in passing and implementing these laws. DSLs often break new ground by encouraging a state department of education and a state oral health program to collaborate for the first time. The education department oversees the screening law from the perspective of schools. The state oral health program may be responsible for recruiting providers, developing the form that dental providers will complete, and other oral health-related aspects of the screening law.

One respondent reported that their state decided to focus on children's health more globally and making oral health a part of the broader "culture of health" was a necessary first step. Integrating oral health into larger public health conversations can be one way to identify non-traditional allies, engaging stakeholders far beyond the dental sector who might lend their support to DSLs or other oral health initiatives.

Implementation Challenges

State laws also vary in terms of the department or agency responsible for implementing the law. In one state, the health department exercised administrative authority over the DSL, making it a true public health project. But in the majority of states, the department of education implements the law, collects the data, and produces any reports. Regardless of the department overseeing implementation, informants cited the need for departments of education and state oral health programs to collaborate in various ways, including reaching agreement on:

- the form used to conduct the dental screening
- the system to collect the form data
- how the results of the screening are disseminated, and
- what procedures will be followed in connecting students to care, especially in school-based health settings

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» Efforts are underway in one state to evaluate the administrative burden of these laws to ensure that implementation does not place unintended burdens on state government agencies or budgets.

While many of the informants focused on the interactions between state government agencies, cooperation is also needed at the school district level. State government staff often exercise administrative oversight of the law, but school administrators and staff are largely responsible for ensuring that parents participate, collecting the forms, and submitting those forms to the appropriate state agencies when necessary. Only one state described using a real-time data collection system in which the dental providers enter the screening data using Epi Info, a statistical software package. Most states still rely on paper forms that must be collected and processed.

Nurses and others who staff school-based health programs may be a key linchpin for implementing DSLs—whether it concerns referring students to dental providers or engaging teachers and parents to complete screening forms. Because "schools are a place of trust," parents and communities are willing to listen to a teacher or school nurse, and follow their suggestions. In this regard, school nurses are important stakeholders to collaborate with so that parents and teachers can understand the value of dental screenings. However, in many states, school-based health partners are not always included in the oral health coalitions that tend to advocate for these laws.

Political Champions

A dominant theme from advocates in both DSL and non-DSL states was the importance of finding the appropriate political champions. Respondents working on bills at the state level described the value of having a champion in the legislature. One respondent was pleased to have found a representative "willing to fight and put in the work."

Political champions are key in drafting a bill's language, building coalitions, and navigating the legislative process. According to interviewees, these champions included state representatives with personal dental experiences with children, and a newly elected legislator who proposed a screening bill after being contacted by a dental hygienist.

One advocate noted that their state's leading champion was not a legislator but a dental insurer. In this state, the insurer has provided support by funding a study of the issue, hiring communications staff and a lobbyist, and publicizing the need. One respondent noted: "You have to find the best advocates to speak on behalf of the bill."

KEY FINDINGS FROM PROGRAM DATA

Data collected in DSL states could help inform program and policy priorities for state oral health programs, coalitions, children's advocates and other stakeholders. With this perspective, state dental program staff were asked how they use the data from the dental screenings. Many of the states struggled to answer this question. In all but one state, implementation of the DSL was housed in the education department, which posed a major barrier to oral health officials' ability to access the data and use it to plan or restructure programs. Additionally, several informants questioned how useful the screening form data were. One state dental program reported having updated its form so the data might be more useful. Another state dental program described a joint venture between the health department and the education department to create a form similar to the ASTDD's basic screening form. For this respondent, changing the form made it "easier to compare data."

Using the data from the DSLs has been further complicated by workforce capacity issues. A number of state oral health programs lack the dedicated staff to oversee the administration of a DSL and to collaborate

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with education department staff. One state oral health program, for example, lost a staff position leaving it unable to evaluate data. Although the state had produced reports in the past, this staff vacancy was a factor in why those reports ceased. In state oral health programs with limited staff, their ability to provide oversight over the laws or to facilitate children's access to a dental home is hampered. Often, the adequate staffing of state oral health programs is an overlooked aspect of DSLs.

Of the state reports reviewed, the majority provided counts and percentages of screenings completed. The reports offered either composite state-level data or county-level data. One state's report of compliance provided data on:

- the children's treatment needs (three categories: no obvious problem, require dental care, or require urgent dental care)
- the provider type (health care professional who provided the screening), and
- exception certificates at the school and county level

Another state report provided counts on the number of students who received the required dental examination and their specific dental outcomes (students with or without dental sealants, caries experience, and untreated caries). This report also had information on the number of students with scheduled appointments.

IMPACT OF DSLs

When asked about the impact of the DSLs in their states, respondents did not describe measurable results. Only one state dental program described how the screening laws have fostered other programmatic surveillance activities and school-based prevention programs. Otherwise, the state programs were consistent in not observing clear benefits to programmatic or service activities.

However, respondents did report that DSLs indirectly educated parents on the importance of their children's oral health. One respondent noted that having parents complete the form creates a teachable moment: "The law activates the parents to do something." The outreach done to engage school nurses and teachers may also have a positive effect by raising their awareness about the overall importance of oral health and the need for preventive services.

Discussion

State DSLs are intended to ensure that school children are healthy and do not have any unattended dental issues that would prevent them from succeeding in school. Undergirding DSLs is the intention to establish dental homes for children. If a dental professional performs a screening on a child and sees untreated decay, they should be able to refer the child to a provider to both treat the conditions noted during the screening and provide preventative services. According to one respondent, a barrier to implementing their state's DSL was the inability of providers to refer screened children to their own practice. This underscores the problem of ensuring that DSLs successfully connect children to care, especially in areas where participating dental providers may be scarce.

Advocates and policymakers should consider screening, referral, and treatment policies that take into account state and local dynamics. This may require giving dental hygienists and mid-level providers the authority to provide the screenings and having dentists provide the restorative care. Depending on the workforce capacity and licensure laws, advocates for DSLs should consider who should perform the screenings and who should provide treatment; if there are limitations in a state, those issues should be considered when advocates are working with legislators to develop the DSL language.

DSLs often lack the mechanisms to connect children to care and to establish a dental home. As a result, a child may be screened and a form completed without follow-up. In this way, DSLs can miss the mark in ensuring dental homes for children. If advocates intend for such laws to help connect children to dental homes, they should understand the barriers and challenges they may face in setting up mechanisms for referrals. Additionally, engaging state dental associations, working with licensure boards, and collaborating with the state Medicaid program may be useful strategies for advocates pursuing DSLs.

Unlike laws for vaccinations, DSLs are not mandatory, and there is no penalty for children, parents, or schools without completed dental screening forms. If a child does not receive a screening, the child is not prevented from attending school. Schools without 100-percent screened children are not sanctioned. While none of the informants suggested that children should be penalized for not receiving a screening, DSLs lack an enforcement mechanism to ensure that children are screened. As advocates consider if DSLs are appropriate for their state, they may want to ask what outcome they seek: screening itself or screening to improve access to care? Advocates might also weigh the pros and cons of making a DSL mandatory.

DSLs often lack the mechanisms to connect children to care or establish a dental home.

The decision to seek a state DSL is not a simple one for advocates or health stakeholders. If a state has other pressing dental needs or if the political climate prohibits legislation that might be perceived as heavy-handed, stakeholders and advocates could choose to focus on other strategies. Sealant programs or other school-based health or community-level strategies may be more fruitful objectives.

For DSLs to be effective, states should ensure they have supportive structures established, including dental sealant programs that are active; dental hygienists who are able to work at the top of their licensure scope; school-based health programs that are effective; and an active oral health coalition that effectively frames the challenges that DSLs are intended to address. DSLs require facilitating oral health professionals to perform the screenings and ensuring the cooperation of schools to implement these laws. Their success may also depend on raising oral health to a public health priority. DSLs may not be the best advocacy goal for a group until these practices and structures are in place.

Moving forward with legislation requires a champion. This point was highlighted in the 2008 report and reiterated by

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respondents in *this* report. In addition to finding the right champion, identifying the best storytellers may also help secure passage of DSLs. As one respondent explained, a dental hygienist who shared their stories shined a light on unmet oral health needs, successfully encouraging a new legislator to sponsor the bill in that state. Of course, dental professionals who serve as legislators are ideal people to start the conversation, but advocates should not stop their outreach there. Cultivating relationships with someone who has a passion for health or health equity issues can pay dividends. In addition, dental insurers may have relationships with legislators who could be champions and help build a winning coalition. Identifying the strongest legislative champions and storytellers is an essential part of any advocacy plan.

Many of the state dental directors and oral health stakeholders who were interviewed discussed the role that organized dentistry can play in advocating for DSLs. While they emphasized that dental providers and dental associations could be important champions, they also offered a few words of caution. In pushing for the legislation, dentists are sometimes perceived as advocating for their financial self-interest.

Dental providers must be willing to provide these screenings and, depending on the intent of the law, willing to provide dental homes for children in need. If dental providers do not have the capacity in their practices to screen children, or if the Medicaid reimbursements are so low as to discourage them from serving as dental homes for kids from low-wage families, DSL advocates may want to address these issues prior to seeking legislation. As our respondents described, getting dental providers to provide the care needed to implement these laws is no easy task.

For DSLs to have measurable impact, advocates should ensure that there is a regulatory authority that can oversee the law's implementation. Moreover, advocates should strive to create mechanisms both to enforce the law and to connect children to dental homes. Adding these provisions to DSLs, however, may increase their fiscal impact and dissuade legislators from supporting the bill. Advocates must weigh carefully this tension. To improve children's access to dental care, they may have to accept a fiscal note being attached to the bill and endure multiple rounds of debate and coalition-building in a legislative session. In the process, legislators will have a critical role to play to ensure that a proposed DSL will meet the needs of school and oral health stakeholders. They should consider opportunities to include language in the bill about data collection, evaluation, and identifying which state agencies will have the authority to administer and enforce the law.

DSLs that are mandatory may create unintended burdens for parents. The burden may be financial if parents or caregivers must pay for screening. The hardship may be in time if they struggle to find providers to do the screening and complete the form. Some thought must be given to supporting parents and families to successfully access care. Allowing pediatricians and other medical providers to provide dental screenings for children could help reduce the burden for parents to find a dentist. Ensuring dental providers are part of local health departments and other safety-net care locations may also lift barriers to compliance. Moreover, such integration of dental care may allow children to be vaccinated, receive a vision screening and a dental screening in one location. One advocate described an annual community event that included dental screenings and the completion of the form at a back-to-school event. Involving parents and caregivers in the advocacy process may be one way to discuss and address unintended costs to families, as well as to build community support for the screening law.

Supporting parents may include educating them about the importance of oral health in their children's lives and how to access oral health care. The respondents suggested that children may have Medicaid dental benefits but face barriers to care. Patient navigators might be deployed to answer parents' questions and help them to understand how their public or private dental insurance works. If parents routinely take their children to medical visits using their Medicaid benefits, medical providers could encourage parents to prioritize their children's oral health. Medical practices may also have health care navigators who can help connect parents and their children to dental homes.

Because the underlying intent of DSLs is to improve access to dental care, bills should include some mechanism raising the odds that children with unmet dental needs are connected with a provider. As previously

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mentioned in this report, finding dental homes for children is shaped by multiple factors. These dynamics include Medicaid reimbursement rates for dental providers, an adequate dental workforce, and dentists' willingness to accept children from low-wage families into their practices.

Additionally, DSLs should designate an agency or group responsible for connecting children in need with dental providers. The respondents noted that school nurses and dental care coordinators typically serve in this de facto role. For many school nurses, success in guiding children to dental homes depends upon available resources, such as having updated lists of providers. It may also depend on whether nurses or other school staff have the available time to make referrals, given the many other responsibilities they have. Dental care coordinators do not exist in all states' oral health programs.

DSLs have the potential to collect data that strengthens state dental programs' surveillance, planning and projects. Yet informant interviews revealed only one example of data from screening forms being used to inform practice. Typically, the data are collected in compliance with the law but are not used in a purposeful way. One respondent said their state used the ASTDD Basic Screening Survey form, which could be one way to increase the odds that the collected data can be captured for surveillance and programmatic purposes.

Additionally, having the forms created with input by the state dental program or other dental stakeholders may improve the usefulness of the data collected. If used for surveillance purposes, the data must be standardized, and providers trained to collect the data. If the data are meant to assess the state of children's dental health, more robust forms may be needed. The ASTDD screening form might be the most appropriate one for programs to use to ensure that data from the screenings is compatible with other state surveillance data.

The public health workforce is another issue that determines whether the DSL data is utilized. State dental programs may not have the staff capacity to evaluate the dental screening data. Moreover, if the education department collects the data, the software or format it uses can limit the ability of people outside the department to access and analyze this information. Advocates for DSLs may want to consider electronic data collection and evaluation as one way to complete the screenings. Depending on the capacity of each state entity, electronic data collection may be an extra cost associated with the law.

For the DSL-related data to be meaningful, the education department and state dental program need to collaborate. Collaboration would apply to developing the form and using the data to drive oral health strategies for children. More importantly, education and dental stakeholders should be engaged when a dental screening bill is drafted and moves through the legislative process. Respondents from one state reported that the state dental association was a crucial player in coordinating the state's DSL, which fostered a level of engagement with dental stakeholders that was not noted in other states.

Broad coalitions are critical in the advancement of DSLs. The oral health coalitions that may lead campaigns for dental screening laws often include a variety of stakeholders from dental professionals—in both private practice and safety-net settings—to public health advocates and advocates for specific populations. School nurses and other school-based health advocates can also be valuable collaborators to ensure these laws have the intended impact.

Recommendations

1. Sharing best practices is vital to ensure that DSLs are effectively written and implemented. Advocates seeking to advance legislation in their states said they contacted stakeholders in DSL states for guidance on choosing appropriate language for their bill and how to promote it. Additionally, a workshop at the National Oral Health Conference or a webinar series featuring representatives from DSL states could be valuable to states exploring such laws. Developing a specific advocacy toolkit for this work may also be useful.

2. States with DSLs should have the capacity to evaluate them. Such evaluations could identify best practices. Unfortunately, of the respondents interviewed for this report, none of them talked about any formal evaluation plans for their screening laws. Only two states had plans in place to undertake a review of their laws. Supporting states in evaluating these laws may require investments to develop greater capacity in epidemiology for oral health programs. The Council of State and Territorial Epidemiologists has called for building the chronic disease epidemiology capacity in state health departments [16]. Exploring if this work could include oral health programs may be a first step to making DSL evaluations a standard practice.

These programs could also collect better data to describe the effect of the screening laws on dental care access and oral health status. Identifying the best measures to assess impact would be an important first step. State dental programs may be able to apply the findings of DSL evaluations to improve the effectiveness of other efforts like sealant programs. State programs may also be able to develop memoranda of understanding with schools and dental providers to ensure that screenings can be done, appropriate data can be collected, and procedures are in place to find children a dental home.

States with DSLs should have the capacity to evaluate them and identify best practices.

3. Advocates should strive to build diverse coalitions and staff capacity. Bringing non-dental providers into coalitions and tapping their perspectives during the planning stage are critical steps. School-based health practitioners should be part of a DSL coalition. This coalition can also seek to increase the staff capacity in state oral health programs. Staff are needed to: evaluate the screening laws, work with education department staff on implementing the laws, and develop a mechanism to establish dental homes for children.

4. Finally, DSLs present opportunities for medical and dental providers to play different, yet mutually supportive, roles to improve children's oral health. For example, pediatricians can perform dental screenings. Medical providers can also refer children for dental care. As for their part, dental providers can take several steps to make DSLs more meaningful, including enrolling as Medicaid providers. Increasing the pool of Medicaid providers helps more children have a dental home. Moreover, dental providers can support appropriate changes in the state licensure policies that allow dental hygienists and mid-level providers to provide screenings and identify untreated decay and other dental issues that children may have. States wishing to undertake such actions might conduct a dental needs assessment to identify any licensure, access to care, and reimbursement issues that could hinder the success of DSLs.

Limitations

This report has certain limitations. Not all states with DSLs were contacted. A survey of all state dental programs may provide additional insights to understand the impact of these laws. While various dental and school-based health stakeholders were interviewed for this report, the author did not interview legislators who were champions of these laws; education department officials who implement them; parents; or school officials whose responsibilities are not focused on health services. Perspectives from these groups may enhance our understanding of the impact DSLs are making.

Conclusion

Since the 2008 report, four states have passed a DSL, and at least one state has legislation in process. Although DSLs are used to help ensure that children's oral health does not impede their ability to learn, these laws also present an opportunity to connect children in need with a dental home. Indeed, various supporters of DSLs cite the "dental home" objective as a reason for seeking such laws. Unfortunately, based on our analysis, there is no data to support the view that these laws improve access or the oral health status of children.

Ensuring that DSLs have a more meaningful, long-term impact requires several ingredients — improving data collection, creating mechanisms to refer children to dental homes, and developing the capacity to implement and evaluate these laws. As one respondent noted, DSLs need "teeth."

Dental practitioners, advocates, state dental programs, and medical providers have important roles to play in ensuring that DSLs fulfill their intended goal of identifying children's dental problems, connecting them to necessary care, and demonstrating value to families and state programs alike.

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1020 19th Street NW, Suite 400
Washington, DC 20036
202-833-8288

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