



Emerging Issues in Oral Health



State Laws on Dental “Screening” for School-Aged Children

Tooth decay is the most prevalent chronic condition among children in the United States.ⁱ “More than one-quarter of US preschoolers (28%) have experienced visible cavitiesⁱⁱ well before entering school. The consequences of dental disease have taken a toll on children, their families and communities. This has led policymakers to consider a variety of strategies to address the oral health burden among US children. A policy approach that has received increasing attention in recent years is the development of state laws that require or provide for some form of certification of a dental screening, examination, or assessment for school entry. This Policy Brief was developed for dental public health professionals and others interested in quantitative and qualitative information about these state laws. Information is derived from legal research and key informant interviews completed during May and June of 2008. This analysis addresses state laws only and, therefore, does not capture other policies at the state and local level that may relate to dental requirements or programs for school-aged children.

BACKGROUND

According to the Council of State Governments, in 2007 state lawmakers adopted nearly 70 bills on the topic of oral health.ⁱⁱⁱ Included among these measures are state laws that require parents to provide

certification of an oral health assessment as a condition of school entry (California) and require evidence of a dental screening prior to elementary school and high school (Iowa). A third state (New York) approved a requirement in 2007 that schools request a dental health certificate upon a student’s entrance into school or upon entry into K, 2nd, 4th, 7th, and 10th grades. In April 2008, Kentucky’s Governor signed legislation to require student dental health certificates. These new laws add to the group of laws adopted by states as far back as 1915 (Kansas) and 1945 (Pennsylvania). More recent laws adopted over the last two decades include those in Georgia, Illinois, Nebraska, Oregon, Rhode Island, and the District of Columbia. Overall, about a quarter of the states (12) now have some requirement for a dental certificate for school-aged children.

Terminology and Definitions

The requirement in state law is principally the completion of a form and/or a certificate that demonstrates a screening, examination, or assessment has taken place within the allotted timeframe. While the preponderance of states with dental screening/examination laws require parents to find dental professionals to complete a dental certificate, Kansas, Pennsylvania, and Rhode Island engage school-based dental providers (the history of these laws could not be fully captured in this document).

State laws often do not include definitions of the requisite “screening,” “examination,” or “assessment.” A state law may use a term such as dental “examination,” but the requirement for its dental certificate can be fulfilled by a dental screening or assessment. Radiographs (x-rays) are a widely accepted component of a complete dental *examination* as is conducted by a dentist, whereas dental *screening* or *assessment* (often used interchangeably in these programs) implies a less complete, less technical review not necessarily conducted by a dentist or even a dental professional. It appears that in some instances the choice of form (e.g., Basic Screening Survey form developed by the Association of State and Territorial Dental Directors) effectively defines the requirement. Overall, implementation of screenings rather than examinations appears to be the most common practice. Key informants have indicated their interest in clarifying statutory language to align with what is actually being done in communities.

Rationale

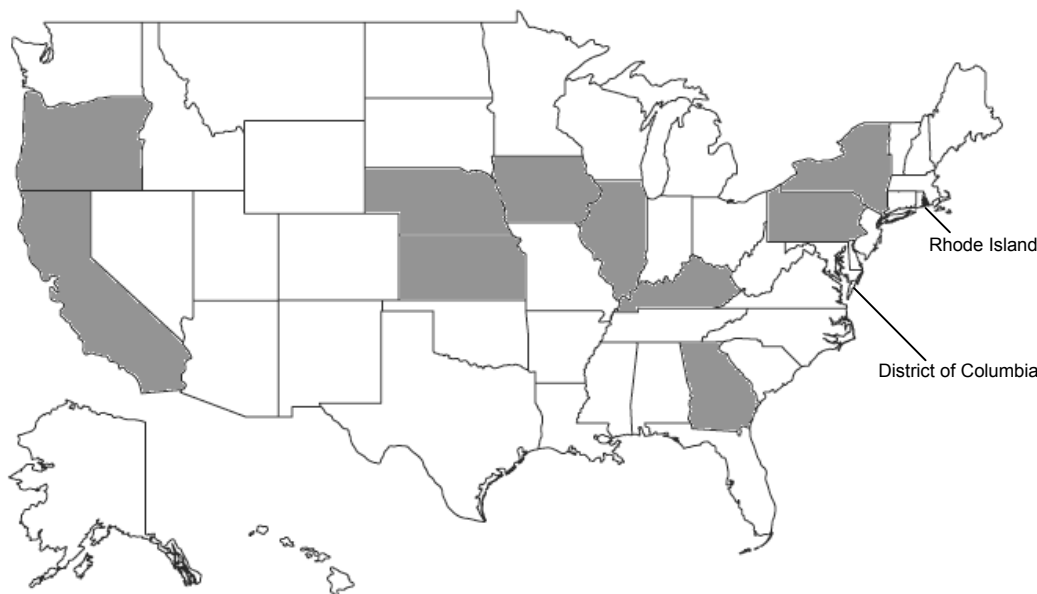
A common rationale for state screening laws is

to identify children in need of care so that parents can be made aware of the need for treatment. However, state laws do not typically require, fund, and track referrals for further evaluation or treatment as, for example, the Head Start program seeks to do. Many key informants interviewed about their laws identified the conundrum posed by state policies that identify children in need of treatment but do not systematically provide options for their care. Key informants also suggested, however, that screening mandates may increase awareness of oral health among families and policymakers. Research on public perceptions of oral health in response to screening laws would illuminate the effectiveness of screening for this purpose and would assist in determining its value relative to other oral health interventions, particularly when resources are limited.

Evidentiary Gap

The World Health Organization has suggested that school dental screenings could “enable early detection and timely interventions towards oral diseases and conditions, leading to substantial cost savings,”^{iv} but evidence for

State Dental Screening Laws



this desired outcome is lacking. The most extensive studies of school screening effectiveness – both a randomized trial and a historical review – are from England where screenings were nationally mandated for 90 years. According to the British research team, “The evidence from the UK and elsewhere is that while the concept of dental screening is attractive to policymakers, there is no scientific evidence that it leads to improvements in health, either for individual children or for the child population.”^{v,vi} This evidentiary gap is recognized by the American Academy of Pediatric Dentistry (AAPD) in a policy statement (adopted 2003, revised 2008) confirming that “Data [are] not available to determine the effectiveness of various approaches by states that currently encourage school-entry dental examinations.”^{viii} The Centers for Disease Control and Prevention (CDC) has not taken an official position on mandatory school-entry dental screening approaches.

Political Support

Despite general lack of evidence in support of school screenings and a randomized control trial that found evidence against the practice, political support for the practice is strong and widespread as suggested by the adoption of this practice in 12 states. Dental professional organizations such as AAPD and the American Dental Association (ADA) are supportive of this approach. AAPD’s 2008 policy statement recommends “[l]egislation mandating a comprehensive oral health examination by a qualified dentist for every student prior to matriculation into school”^{viii} and the ADA’s 2005 policy “urge[s] state dental associations to sponsor legislation to provide oral health assessments for school children.”^{xi} Stakeholder involvement in the adoption of screening legislation varies across states, but when engaged may include advocacy groups, coalitions, dental associations, parents, and state department(s) and other government officials.

METHODS

Research on Legal Authority and Content of Laws

Research was conducted through a legal search using LEXIS and Westlaw search engines, a literature review using Medline and Google, and directed queries to identify relevant statutes. Identified laws were reviewed based on a content-analysis checklist. Relevant statutory and regulatory provisions were identified using search terms including “dental screening,” “dental inspection,” “dental program,” “dental examination,” “dental exam,” and combinations of the terms “dental,” “health,” and “child.” Key characteristics of the laws are presented in Appendix A.

Westlaw and LEXIS provided access to the relevant statutes and, where available, regulations interpreting the statutes. In addition, websites of the state agencies charged with administering the programs were searched. These websites frequently provided sample forms that helped to confirm the actual administration of the program. Identified forms included screening forms (used to document the dental screening), notification forms (used to communicate the results of the screening to a child’s parent or guardian), waiver forms (used to exempt the child from the screening), and referral forms (used to refer the child for dental services).

Reports issued by states on the topic of children’s health were reviewed. Many described the dental screening program as one of several programs aimed at improving children’s health. In addition, results from the key informant interviews were reviewed as a source of background information.

Key Informant Interviews

Key informant interviews were conducted in six states (CA, GA, IL, IA, NY, and PA) selected to represent a mix of old and new laws as well as demographic diversity. The interviews, conducted either on site or by telephone, included six questions framed to identify: 1) factors that led to passage of the law; 2) key

provisions of the law (and whether sustainability, collaboration/integration, and other factors are addressed); 3) challenges to implementation; 4) identified or expected benefits; 5) outreach and messaging; and 6) lessons learned. Respondents were provided the questions prior to the interview and responses were compiled into individual State Profiles for each state [Appendix B]. Although the interviews were conducted with oral health officials considered knowledgeable about the statute in their state, information provided is limited to what was reported at one point in time by that person(s).

KEY FINDINGS

Political Champions

A key element to passage of state dental screening laws as identified by key informants was the engagement of political champions. Sustained efforts of state coalitions or dental organizations often provided the momentum necessary for champions and for eventual enactment, as many laws were passed only after numerous attempts.

Political Champions

In Illinois, although the school screening requirement had been in the state oral health plan, the Lieutenant Governor was able to lead the effort through passage in the legislature. The bill had failed in the legislature a decade prior due to the opposition of school administrators.

California Dental Association (CDA) took the lead by sponsoring a dental screening bill following passage of the Illinois statute. The CDA worked on a “doable” bill focused on gathering support, collecting data, and identifying holes in the system. They were successful after working for two years to pass a bill with funding for a kindergarten/school entry dental assessment.

Mandates

Based on available information, Oregon is the only state identified with a dental “screening” law that does not have some mandatory requirement. Closer scrutiny of the laws

reveals that the mandatory nature of the requirements of the various laws is not always straightforward. For example, New York’s recently-enacted law requires that schools distribute dental health certificates to students to be completed, but does not mandate a parental response.

Demonstrating Compliance

Compliance with the laws is uniformly established through some form of a certificate – details of which are more likely referenced or specified in regulations, school board policies, or other policies. The laws by definition stress establishing proof of an exam or screening – not typically for a school-based screening (although that is an option in some states). It appears that states are moving toward screenings rather than exams.

State laws are fairly evenly divided between those that cover only public school students and those that include some or all students in private schools. Waiver provisions – based on religious, financial, or other considerations – are included in the majority of state laws. The inclusion of some but not all schools, waivers, and limited or no sanctions in laws reduces the utility of this approach for surveillance purposes and can be expected to affect compliance over time.

Financing and Workforce

If and how each state finances implementation of its screening mandate could not be fully captured in this document. Key informants did make clear, however, that the cost of screening itself is a challenge for the same “at-risk” families who have difficulty accessing treatment for dental disease. Uninsured and underinsured families in states with a screening mandate (and without the potential for school-based screening) may have few, if any, affordable options to comply with the law if, for example, free screening is unavailable and area dentists are unlikely to take new Medicaid patients. (Exercising waiver options is one potential consequence of this circumstance.) States have taken some action to expand “scope of practice” options and to recruit volunteer dental professionals to assist

in meeting the demand generated by these laws. Across state laws, the statutory description of professionals eligible to conduct the screening, assessment or examination varies. Licensed dentists are uniformly required for “examinations;” however, a range of others can conduct “screenings” and “assessments,” either in cooperation with or independent of dentists.

Dental Screening Personnel

Iowa will implement their dental screening mandate in close collaboration with the state’s I-Smile program. I-Smile coordinators, part-time community-based dental hygienists, will help schools and families coordinate screenings and follow-up treatment, if needed.

New York is receiving help from the New York State Dental Foundation to create a list of dentists willing to provide screenings on a “free or reduced cost basis.” Potential also exists to enable registered dental hygienists to conduct screenings in public health settings.

Data and Follow-up

The ability to meet the demands of follow-up and treatment was identified repeatedly as a challenge states face emanating from universal screenings. Even if follow-up and treatment are stated goals for screening, current state laws generally do not require data on whether students receive needed dental care. Further, most state laws do not provide funding for referral, treatment, or follow-up services. Responsibility for data collection that is required is either not specified or is left to individual school districts in the majority of states, which raises questions about the buy-in of school personnel to collect the data, the consistency of data collection, and the ability to establish meaningful surveillance from school certificate reports.

The development of uniform protocols for calibration, periodicity, reporting, and data collection often appear to be an afterthought to the enactment of the laws. Of particular concern for the utility of school screenings for surveillance is the lack of standardized diagnostic criteria and calibration of the

examining personnel. The few states in which laws (or related regulations/policies) stress compliance and data collection report a heavy workload; this raises questions about resource allocation in the absence of evidence for effectiveness.

Frequency of Examinations

Periodicity ranges from a one-time requirement upon entry to school to annual examinations. Deadlines are established either in statute or through statutory authority to schools to set such timeframes. The initial and periodic screening of children outlined in law or regulation is determined by multiple factors including ease of implementation, available data systems, and political will. Some states chose natural points of screening, such as school entry, and may expand screenings to meet other health-related milestones. Regardless of the number and frequency of screenings, states have limited capacity or motivation to enforce the requirement.

Dental Screening Periodicity

In Illinois, the original intent of the law was to coordinate the dental screenings with the physical exam requirement (K, 5th, and 9th grades). However, because the state sealant program targeted K, 2nd and 6th grades, the law was changed to match the sealant program. Illinois is also one of the only states that “may” withhold report cards for 2nd and 6th graders for non-compliance. Recent school reports show 80% of children were screened, 10% were exempt through waivers, and 10% received no screening. Data are unavailable on sanctions for non-compliance.

Regulatory Responsibility

The identified responsible regulatory agencies are most frequently departments of health or education or some combination thereof. States appear to have given differing levels of consideration to the implications of the existing public health infrastructure and school systems (particularly where school nurses are involved), with some more attuned to successful integration than others. Some key informants expressed that the success of school screening can hinge on the buy-in of school

nurses due to the increasing need to engage them in activities including supervising or monitoring screenings, data collection, and scheduling.

Public Health Infrastructure

Georgia found that a strong determinant of compliance with the dental screening mandate was the presence of school nurses. Communities with strong school nurses may provide the necessary follow-up and/or screening when it is not available elsewhere.

Pennsylvania had a robust dental public health infrastructure in place in 1945 when its law was initially passed. However, over time the six regional dentists and hygienists were eliminated. Dental screenings have shifted from being school-based to 70% completion in private dental offices (schools contract with dentists and hygienists to perform screening in schools for families that choose that option.)

When asked about sustainability of the dental screening laws, key informants expressed their concern that with limited or no funding available for basic public health infrastructure, the extent to which these systems can be built or maintained is unclear.

DISCUSSION

Key informants observed that a positive aspect of their screening laws is the elevation of children's oral health to the policy spotlight; those involved with newer laws described the process of winning passage as creating a "dental moment." However, at issue is the expenditure of political will in obtaining screening laws at the expense of enacting other oral health policies and programs. Whether the political success inherent in obtaining screening legislation also translates into a measurable public health success is a key question, particularly in the reported absence of scientific data on the public health impact of the various screening approaches. This evidentiary gap points to the importance of identifying both the **purpose** of school dental screening policies and a **process** for measuring their effectiveness.

Purpose

One key informant stated succinctly that "if states are going to think about a screening program, they really need to think about what they want to accomplish." If the purpose is, for example, to ensure that children are in good oral health and ready to learn, "without appropriate follow-up care, requiring oral health examinations is insufficient to ensure school readiness," as AAPD has articulated.^x Further, evidence that dental disease is often well established prior to age two suggests that more intensive risk assessment and disease management for pre-schoolers is an important consideration. The District of Columbia's program is currently targeting oral health outcomes among both its pre-school and school-aged populations as a component of school readiness.^{xi}

Process for Measurement: Criteria for Program Development

Suggesting that continued support represents "blind faith" in the screening process because it has "felt like the right thing to do," the British research team previously described calls for a set of benchmarks "to evaluate the merits of individual screening programs scientifically:

- The purpose of the screening program should be defined.
- There should be evidence that the screening program improves health.
- It should reduce population morbidity.
- Participants should be aware of risks/benefits.
- The program should be acceptable to all stakeholders.
- The quality of the program should be assured.
- The program should be tailored to local need.
- Treatment should be available.
- The program should be cost-effective."^{xii}

In the US, states will have to address both the purpose of their screening laws and the limitations of their data collection and measurement efforts to meet many of the

above objectives. The “Policy Considerations” list that follows attempts to capture relevant topic areas based on review of state laws and key informant interviews. At a minimum, states need to ensure that data are both usable and useful, which corresponds to: how representative the screened children are of all children, inter-examiner reliability, and the quality of compliance and record keeping. Usable and useful data will also identify whether the oral health status of a child has changed over time, the capacity to triage children into necessary care, and progress in assessing health outcomes after care.

As noted in the literature, without clarity as to the public health purpose of a screening mandate and without rigorous methods and evaluation of screening approaches, our understanding of the impact of the various screening approaches will remain limited. Dental health professionals can help to bring these critical issues to light.

POLICY CONSIDERATIONS

Listed below are a series of topic areas that are pertinent to current state dental screening laws in the US and of potential usefulness in meeting benchmarks for screening as suggested by a UK National Screening Committee.

- ☞ **Purpose**: Is the public health purpose of the policy clear?
- ☞ **System Model**: What do you know about the models (school based, private, or other) and how they work? What steps are necessary to achieve buy-in from state/local agencies and dental providers who will be responsible for the mandate? If health care reform is under discussion, how would such a system fit?
- ☞ **Compliance**: Does the policy support uniform compliance and enable tracking and surveillance?
- ☞ **Definitions**: What is required: screening, assessment, or exam? What professionals are required to meet the prerequisites for fulfilling the requirement?
- ☞ **Periodicity**: When and how often is it required? What are the short and long-term implications on workload, tracking, and surveillance with the proposed timing and frequency?
- ☞ **Timing**: Is there adequate time for planning prior to implementation – including infrastructure, reporting, systems integration, etc.? Will all agencies and systems be involved in planning and determining timelines?
- ☞ **Notification/Referral**: What is required and who will be accountable?
- ☞ **Financing**: What are the short and long-term costs? Is funding designated for implementation? Is funding sustainable? Are costs reimbursable by Medicaid and SCHIP?
- ☞ **Data Collection**: Will data collection enhance compliance efforts? Will data collection assist in tracking? Will data collection build or support a valid surveillance system?
- ☞ **Evaluation**: What measure(s) of effectiveness will you use? Will your evaluation contribute to the larger body of research on effectiveness?

SUMMARY OF STATE LAWS REQUIRING STUDENT DENTAL SCREENINGS

State	Required	Requirement ⁱ	Persons Who May Conduct	Students Subject to	Frequency	Deadline	Waiver	Maintenance of Data	Regulatory Agency	Legal Authority/ Effective Date
California	Yes	Certificate	Licensed dentist or other licensed or registered dental health professional operating within the scope of his or her practice	Public school students only	Kindergarten (or first grade if student did not attend public kindergarten)	May 31 of first school year Exam may not have occurred earlier than 12 months prior to enrollment	Financial burden Lack of access Lack of parental consent	County office of education	Department of Education	Cal. Educ. Code § 49452.8 (2006) Effective January 1, 2007
District of Columbia	Yes	Certificate	Physician or certified nurse practitioner Note: <i>The DC Health Certificate clarifies that screenings completed by a primary care provider do not replace a comprehensive exam by a dentist.</i>	Public and private school students	Pre-kindergarten Kindergarten 1st grade 3rd grade 5th grade 7th grade 9th grade 11th grade	Prior to beginning of school year Exam may not have occurred earlier than 150 days prior to enrollment	Religious	Individual schools	Department of Health	D.C. Code § 38-602 (2008) Effective December 3, 1985

ⁱ“Certificate” means that the student must provide officials with certification that the required examination was conducted. “School-based examination” means that the dental examination is conducted by the school system.

State	Required	Requirement ⁱ	Persons Who May Conduct	Students Subject to	Frequency	Deadline	Waiver	Maintenance of Data	Regulatory Agency	Legal Authority/ Effective Date
Georgia	Yes	Certificate	A Georgia licensed: dentist in private or public health practice, a public health dental hygienist or a physician or registered nurse in public health or private practice	Public school students only	Entry into school system	Within 4 months of enrollment Exam may not have occurred earlier than 1 year prior to enrollment	Religious Physical disability that contraindicates performance of dental exam Prior private examination	Not specified by statute or regulations	Department of Human Resources	Ga. Code Ann. § 20-2-770 (2008) Ga. Comp. R. & Regs. 290-5-31.01-09 (2008) Effective July 31, 1974
Illinois	Yes	Certificate	Licensed dentist	Public, private, and parochial school students	Kindergarten 2nd grade 6th grade	May 15 of the school year Exam may not have occurred earlier than 18 months prior to deadline	Religious Undue burden Lack of access	Board of Education and Department of Public Health	Department of Public Health	105 Ill. Comp. Stat. 5/27-8.1 (2008) 77 Ill. Admin. Code 665.410 (2008) Effective July 1, 2005

State	Required	Requirement ⁱ	Persons Who May Conduct	Students Subject to	Frequency	Deadline	Waiver	Maintenance of Data	Regulatory Agency	Legal Authority/ Effective Date
Iowa	Yes	Certificate	For elementary school screening, a licensed dentist, dental hygienist, physician or nurse For high school screening, a licensed dentist or dental hygienist	Public and nonpublic school students	Elementary school High school	Prior to beginning of school year For elementary school students, screening must have occurred between the ages of 3 and 6 For high school students, screening must have occurred within previous year	Religious Financial hardship	Iowa Department of Public Health Iowa Department of Public Health	Department of Public Health	Iowa Code § 135.17 (2008) Iowa Admin. Code 641-51.1 (2008) Effective July 1, 2008
Kansas	Yes	School-based examination	Licensed dentist	All children	1st grade 2nd grade	Scheduled by school	Prior private examination	Individual school boards	Individual boards of education and county superintendent of public instruction	Kan. Stat. Ann. § 72-5201 (2008) <i>Statute drafted in 1915 -- effective date not available</i>
Kentucky	Yes	Certificate	Dentist, dental hygienist, physician, registered nurse, advanced registered nurse practitioner, or physician assistant	Public school students only	Entry into school system	January 1 of first school year	Not specified by statute	Not specified by statute	Kentucky Board of Education	Ky. Rev. Stat. Ann. § 156.160 (as amended by HB 186) Effective 2010-2011 school year

State	Required	Requirement ⁱ	Persons Who May Conduct	Students Subject to	Frequency	Deadline	Waiver	Maintenance of Data	Regulatory Agency	Legal Authority/ Effective Date
Nebraska	Yes	School-based examination	Not specified by statute	Public school students only	Not specified by statute	Scheduled for first quarter of each school year	Not specified by statute	Not specified by statute	Department of Health and Human Services	Neb. Rev. Stat. Ann. § 79-248 (2008) <i>Effective date not available</i>
New York	Yes	Certificate	Licensed dentist	Public school students only	Entry into school 2nd grade 4th grade 7th grade 10th grade	Thirty days after start of school year Examination may not have occurred earlier than 12 months prior to beginning of school year.	Religious	Individual schools	State Education Department	N.Y. Educ. Law § 903 (2008) N.Y. Comp. Codes R. & Regs. tit. 8, § 136.3 Effective September 1, 2008
Oregon	No state-wide requirement. May be required by individual school board	School-based examination	Not specified by statute	Public school students only	Annual exams	Not specified by statute	Lack of parental consent	Individual school boards	Individual school boards	Or. Rev. Stat. § 336.390 (2007) Enacted 1965

State	Required	Requirement ⁱ	Persons Who May Conduct	Students Subject to	Frequency	Deadline	Waiver	Maintenance of Data	Regulatory Agency	Legal Authority/ Effective Date
Pennsylvania	Yes	School-based examination	School dentist, who is a doctor of dental surgery or dental medicine legally qualified to practice dentistry in Pennsylvania and who is appointed or approved by the Secretary of Health	Public and nonpublic school students	Entry into school system 3rd grade 7th grade	Scheduled by school	Religious Prior private examination	Individual school districts and joint school boards	Secretary of Health and Super. of Public Instruction	24 Pa. Cons. Stat. § 14-1403 (2007) 28 Pa. Code § 23.3 (recodified 1949) Enacted 1945
Rhode Island	Yes	School-based examination	Dentist or licensed dental hygienist with at least three years of clinical experience	Public and nonpublic school students	Annual exams through 5 th grade At least one exam between 6 th grade and 10 th grade	Scheduled by school	Prior private examination	Individual schools	Department of Health and Department of Education	R.I. Gen. Laws § 16-21-9 (2008) 14-000-011 R.I. Code R. § 13 (2008) <i>Effective date not available</i>

APPENDIX B

STATE KEY INFORMANT INTERVIEWS

California

The California Dental Association (CDA) successfully sponsored legislation in 2006 to require oral health assessments for students entering public school for the first time (kindergarten or 1st grade). CDA continues to be active in the law's implementation and outreach as part of an Implementation Team. Beginning on January 1, 2007, schools must notify parents/guardians about the new requirement, and assessment requirements are to be completed by May 31 of the school year (or within the 12 months prior to school entry). The assessment requirement can be fulfilled by private dental examination or a screening performed by a licensed or registered dental professional operating within their scope of practice (currently dentists and hygienists). There is no penalty for failing to comply with the law. A waiver is available and some concern was expressed for a potential unintended consequence that families may be opting out of sealant/varnish programs at the same time they are opting out of the assessment requirement. Schools are required to provide educational and resource materials to families in addition to collecting and aggregating data that are submitted to county education offices. Key informants interviewed noted that a uniform, downloadable reporting system would be preferable to the existing, individualized approaches. Systems of triage and referral are not incorporated in the law; however, such systems are recommended in materials developed around the requirement. The administrative requirements of the program are supported (at about \$8.49 per child) by state funding (Proposition 98 funding in the amount of \$4.4 million in the 2006-07 budget). The Department of Public Health is charged with

evaluating the program and submitting a report to the Legislature of its findings by January 1, 2010.

Georgia

Students entering first grade (or a Georgia public school for the first time) are required to have a dental examination. Although definitions are not included in the law, statute and regulations address both dental examinations and screenings. Either a dental screening or examination is acceptable. Options to conduct the "examination" are included in two categories: 1) Public health: dentist, hygienist, PH/School RN or 2) Private Practitioner: dentist, physician. A 2001 Georgia State Law Review article describes scope of practice changes that were supported by both dentists and hygienists).^{xiii} Data collection is not addressed by the law or regulations; however, key informants noted that a first-time audit was completed in 2005. Audit results included information that most children had completed the required form upon school entry, but there were few records providing information on referrals or documenting completion of follow-up care. Experience and observations of the key informants suggest that school nurses were a strong determinant of compliance with the requirement, as well as any potential follow up. It was also noted that health fairs and local health departments have been effective in conducting outreach and supporting collaboration among public and private providers to implement the law. Questions of sustainability persist because the mandate is not supported by funding and does not require data collection.

Illinois

In 2004, the Lieutenant Governor successfully championed the issue of dental screening based on strategies outlined in the Illinois Oral Health Plan (2002). A similar bill had failed in the legislature a decade previously. A large stakeholders group was engaged to advocate for the law and was later involved in drafting administrative rules and outreach. The new law required all children entering kindergarten, 2nd grade, and 6th grade to complete a dental screening prior to May 15th of that year. Illinois is one of the few states that specifies a sanction for noncompliance (schools “may” hold report cards for 2nd and 6th graders who do not comply); however, data are not available on the extent to which sanctions are implemented. Key informants indicated that achieving compliance and data collection are very complex and time consuming. This was stressed in light of the overarching concern that there is no evidence of effectiveness of the policy.

Nevertheless, Illinois has been progressively building their surveillance database, allowing for some future trend analysis and more local tracking (schools send data to the State Board of Education, which sends data to the Department of Health for interpretation). Schools report 80% compliance, with 10% opting to waive the requirement. Although there have been challenges when implementing changes in the school systems, the law has been credited with improving the coordination between the dental sealant program and schools. Key informants emphasized the importance of collaboration with school nurses. Sustainability is considered promising in light of increased Medicaid reimbursement rates for exams (a lawsuit resulted in an increase from \$9 to \$28 per exam) and the school-based dental sealant program.

Iowa

In 2007, Iowa passed a dental screening law as one strategy for achieving a dental home for all children (a 2005 law). Implementation began July 1, 2008 and requires children entering elementary and high school to receive a dental screening. Screenings can be completed by medical and dental professionals including nurses, physicians, mid-level primary care professionals, dental hygienists, and dentists. The coordination and referrals of children seeking screening and those in need of a referral will be closely tied to the state’s existing I-Smile program that funds part-time dental hygienists in communities across the state. The state program and I-Smile coordinators are anticipating a high number of children in need of dental treatment during the first year of the screening mandate, and they remain concerned about an adequate workforce to treat the identified children. The local boards of health or their designee are responsible for auditing school records for compliance; however there are no penalties for families that do not comply with the law. Data will be collected and aggregated with the intention of building a data surveillance system in coming years.

New York

Jumpstarted by a legislative “champion” in the New York legislature, the New York law succeeded on its second attempt. In 2007, the law was passed with an implementation date of September 1, 2008. The law requires children in public schools to be certified as in “fit condition” by a licensed dentist to attend school. Schools must distribute dental health certificates to students; however it is not mandatory for parents to return the form to the school. (Note that New York City, which has had a dental program that is detailed in New York City regulations, is

exempt from the law.) Certificates must be requested after entering Kindergarten and 2nd, 4th, 7th, and 10th grades – a periodicity that offers significant potential for surveillance. The Departments of Education and Health are charged with compiling and maintaining a list of dentists available to complete the requirements of the certificate “on a free or reduced cost basis” for families that are unable to return a certificate for their child (and the New York State Dental Foundation is assisting with this effort). Potential also exists to enable registered dental hygienists to conduct screenings in public health settings. The approach taken in New York reportedly met the criteria of avoiding a “burden on local school taxes,” according to New York Senate Education Committee Chairman Stephen Saland.^{xiv}

Pennsylvania

Act 425, enacted in 1945, established a requirement for a dental exam in all schools every two years, based on the concept that a “major objective of education is the achievement of health.” Until the mid-1990s Pennsylvania had state-supported dental hygienists in each of their six health regions who assisted in fulfilling the mandate. However, in the 1990s hygienists were removed from most health regions – along with the dentists that were removed from the health regions decades before. The program has changed over its long history, with less funding provided for dental programs and more focus in schools on meeting federal “No Child Left Behind” (NCLB) requirements (noting that since 1991 schools have been reimbursed under PA’s Public School Code at about 23% of claimed costs). Currently, children in kindergarten or 1st grade, 3rd grade, and 7th grade who do not see a private dentist receive a school-based screening or examination. Key

informants noted that over 70% of the dental screenings completed are done in private dental offices. Referral data are available in Pennsylvania for students who are seen in schools by dentists and more than half (55.4%) were reportedly referred for further dental evaluation/treatment (with a completion rate of 21.4% of families that replied). In-school screens by dental hygienists generated a referral rate of 25.4% and a completion rate of these referrals of 21.6%.^{xv} Key informants emphasized that the intent of Pennsylvania’s law is that schools view the mandate for a dental exam as a screening function, not to position schools as dental providers.

Endnotes

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