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Joint Legislative Audit Committee
1020 N Street
Room 107
Sacramento, CA 95814

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Dear Chair and Members:

I respectfully request that the Joint Legislative Audit Committee approve an audit to evaluate the effectiveness of the Kindergarten Oral Health Assessment (KOHA) Program, administered by local educational agencies as required by the Education Code (EDC).

Oral Health in Children. Oral health is an integral part of the overall health of children. Poor oral health in children is significantly associated with absenteeism, contributing to millions of lost school hours per year.

Cavities (also known as caries and tooth decay) are the most common chronic condition experienced by children. Untreated cavities can cause pain and infections that may lead to problems with eating, speaking, playing and learning. Research shows children who have poor oral health often miss more school and receive lower grades than children who don't.

Evidence indicates that California is woefully above the United States (US) target and US baseline for caries experienced in young children. According to the federal Healthy People 2020 oral health objectives, for the indicator "dental caries experience" for children ages 3 to 5, the US target is 30%. The US baseline is 33.3%, only slightly above the target, whereas the California baseline is a whopping 53.6%. Focusing in on the "untreated dental decay" indicator, in children ages 3 to 5, the US target is 21.4%, whereas the US Baseline is 23.8% and the California baseline is 27.9%. A national survey from 2020–21 found that 14.8% of the state's children ages one to 17 had decayed teeth or cavities ranking 47th out of 51 among all the states and the District of Columbia.

In addition to far worse outcomes in children's oral health overall, California communities experience wide disparities. Children from communities of color and Spanish-speaking households are more likely to experience tooth decay. Latinx children have the highest prevalence of tooth decay, with more than 72% who have experienced some form of tooth decay compared to 40% of white children. Black children have the highest prevalence of untreated tooth decay – over one in four (26%) of Black children

had untreated tooth decay, nearly double the rate of white children (14%). Among Asian American children, 17% experience untreated decay and 50% experience tooth decay, compared to 14% and 40% of white children, respectively. Language disparities also impact the ability for children and families to access dental care. Tooth decay is more prevalent in children from Spanish speaking households (79%) compared to children in English speaking households (52%). Despite facing the greatest inequities, Latinx and Black children also have the lowest rates of accessing dental sealants – a protective coating that helps keep cavities from forming in the first place.

The American Academy of Pediatric Dentists recommends a clinical oral examination as soon as a child's teeth erupt and no later than 12 months, and every six months thereafter throughout childhood. However, many children do not have regular dental care and do not receive clinical oral examinations.

Legislative History. In 2006, the Legislature passed the KOHA requirement through AB 1433 (Emmerson), Chapter 413, Statutes of 2006. Specifically, AB 1433 required a student attending a public school while in kindergarten or first grade (if not previously enrolled) to present proof of having received an oral health assessment by a licensed dentist or other dental professional no earlier than 12 months prior to the date of the initial enrollment. This assessment was intended to support student academic success by ensuring every child has at least one screening in early childhood designed to detect, and intervene to address, oral health problems. SB 379 (Atkins), Chapter 772, Statutes of 2017, provided school districts additional flexibility to improve compliance with the KOHA requirement by allowing districts to provide onsite KOHA screening using passive consent, such that parents or guardians of students would need to notify the school that they do not want their child screened. AB 2630 (Bonta), Chapter 868, Statutes of 2024, updated the KOHA requirements to reflect that many students enter school in transitional kindergarten, clarifying that the requirement for proof of a student's oral health assessment upon first enrollment must occur once during the two-year kindergarten program.

Concerns about KOHA Implementation. The KOHA statute requires oral health assessments to be performed by a licensed or registered dental health professional, and proof of assessment is due on an annual basis by May 31. Local educational agencies (LEAs) are required to report data to a system designated by the state dental director for the collection of those reports or the county office of education of the county in which the school district is located, or both. County offices of education that receive reports are encouraged to report KOHA data to the State Office of Oral Health. The reports required in statute are aggregated and include data on total number of pupils who receive an oral health assessment and the total number who did not complete the assessment and their reasons for non-completion.

The California Oral Health Plan 2018-2028, informed by an statewide expert advisory committee and published by the California Department of Public Health (DPH), Office of Oral Health, includes "tracking progress and improving performance of compliance with the kindergarten dental assessment" as a specific strategy to improve children's oral

health, and lists the KOHA among the evidence-based programs and best practice approaches that the state should identify, maintain, and expand.

Although state law and policy recognize the critical importance of the KOHA, compliance with KOHA requirements unfortunately appears spotty. For many districts, available data, which is not posted by DPH or another state agency, indicate a majority of parents are not complying with the requirement. Currently, the requirement can be waived with options including: I cannot find a dental office that will take my child's dental insurance plan; I cannot afford an assessment for my child; I cannot find the time to get to a dentist (e.g., cannot get the time off from work, the dentist does not have convenient office hours); I cannot get to a dentist easily (e.g., do not have transportation, located too far away); I do not believe my child would benefit from an assessment; and, other (please specify the reason not listed above for why you are seeking a waiver of this assessment for your child). For many other districts, there is no data available whatsoever.

Given that KOHA provides an opportunity to help reduce dental disease in children, improve children's health overall, reduce chronic absenteeism, and improve school readiness, the low level of compliance is a matter of statewide concern.

There has not been an audit of the KOHA to see whether or not it is operating efficiently and effectively to achieve its mission of ensuring universal dental screening in early childhood and early intervention when problems are found.

Request for Audit. An audit to evaluate the reasons for the persistent lack of compliance with the KOHA is needed to determine what can be done to assure that children entering the school system and their families are able to complete this assessment and are provided with the resources needed to support oral health. The audit should use available data to identify and survey at least four and up to six LEAs, including at least two LEAs with evidence of high compliance with KOHA reporting and high screening rates, at least one LEA that reports low overall KOHA screening rates, and at least one LEA with low compliance with data collection and reporting. The audit should also address the overall design of the KOHA process and the roles and responsibilities of various local and state entities involved in the KOHA process, with an eye toward opportunities to improve the rate of KOHA screening and connection to dental care when indicated by the screening. Specifically, at a minimum, the audit should address the following issues:

Overall Effectiveness. Is there evidence the KOHA requirement has been effective in ensuring California children are being screened for oral health issues and connected to dental care as needed as they enter school?

Implementation and Compliance

1) Assess to what extent schools and districts are complying with statutory requirements of the KOHA, including:

a) Notifying parents/guardians of the assessment requirement, including the information on the importance of oral health, relevant contact information, and information about applying to Medi-Cal and other public programs. Is information provided in multiple languages when required by current law (>15% of enrolled pupils speak another language)?

b) Annual reporting requirements, including all specific elements required in EDC § 49452.8 (e).

c) Whether districts are submitting reports to a system designated by the state dental director or to the county office of education, or both, as required by EDC § 49452.8 (e), or neither.

2) Identify how parents are informed about KOHA. Specifically, is this done as part of annual notification per EDC § 48980 or in a separate notification?

3) Identify barriers to compliance or participation at each of the following levels: family, school, district, and COE level, including possible language barriers and accessibility of accessing or submitting forms.

4) Assess whether schools and districts are allocating the resources required to effectively administer the requirements of the KOHA statute. To what extent do school districts identify KOHA as a priority in the Local Control Accountability Plan (LCAP) or allocate funds or resources specifically to comply with KOHA or conduct KOHA screening? If not identified in the LCAP as a priority for Local Control Funding Formula (LCFF) funds, what resources are schools using to comply with KOHA?

5) How many eligible school sites reported KOHA data? Of the eligible school sites that did not report KOHA data, what were the reasons for not reporting data?

6) Does the state have effective enforcement mechanisms available under current authority and resources to increase compliance with the KOHA requirement by schools?

7) Describe DPH's implementation of the requirement to conduct periodic evaluations of the KOHA requirements, as required in EDC § 49452.8(j).

Data

1) Analyze the level of compliance of families with the KOHA screening requirement. This analysis should examine and draw conclusions from KOHA data, at the district and county level, including total numbers and percentages of:

a) Children in the school district or county subject to the KOHA requirement;

b) KOHAs completed;

c) Children subject to the KOHA requirement who have untreated decay;

d) Children subject to the KOHA requirement entering kindergarten who are documented as having an urgent need for care;

e) Children whose parents/guardians who waived the oral assessment, and their cited reasons for excusing their child from the assessment; and,

f) Children whose parents or guardians did not waive nor complete the oral assessment.

2) Is the data collection system effective and efficient? How is data from KOHA forms collected and entered at the school and district level? Who does the data entry (e.g., school nurse, clerical school staff, local oral health program, dental provider, etc.) and are there opportunities to improve this process?

3) How has KOHA data been used to inform the Office of Oral Health at DPH and the California Department of Education (CDE)?

4) Is KOHA data complete and timely enough to inform evaluation and improvement efforts?

Partnership and Best Practices

1) Review the best practices of districts that report higher compliance with the KOHA, including whether these high-compliance districts conduct onsite screening and, if they do, whether these districts are implementing passive (opt-out) consent of parents or guardians for the screening.

2) How are dental providers informed about and encouraged to fill out KOHA forms? How are other health providers (e.g., pediatricians, school nurses, etc.) informed about KOHA?

3) What is the formal and/or informal role of local county-based oral health programs in supporting implementation of the KOHA, and has the state supported these efforts with resources, leadership, and/or technical assistance?

4) What is the extent of the informal role Department of Health Care Services and the Medi-Cal program play in supporting meaningful implementation of the KOHA?

5) What is the extent of the role of CDE plays in supporting implementation of the KOHA?

6) What, if any, follow-up is typically done for students whose parent/guardian say they could not complete an assessment due to financial burden or due to lack of access to dental care? Are there options for improving this process?

7) For children identified via KOHA as having an urgent need, who, if anyone, follows up to ensure that child receives care?

8) What, if any, regions of the state have implemented programs that have been effective at meeting KOHA's goal of ensuring young children are universally screened for oral health issues and triaged to dental care as needed? Are there documented best practices or promising approaches, including school-based programs and those used by other state child oral health assessment programs, that the state could consider to improve the rate of screening and referral?

9) What, if any, are the barriers to structuring KOHA – a dental screening –in the same way as hearing, vision and scoliosis screenings in schools, as articulated in EDC? Is there evidence that schools would prefer school-based dental screening programs?

10) Is there a statewide structure for evaluating, discussing, and improving compliance with the KOHA and improving needed referrals to care, and is it adequate? Are there further opportunities to integrate KOHA with other programs and efforts?

11) Are the roles and responsibilities of the various actors delineated in the KOHA statute including CDE, DPH, public schools, school districts, and COEs clear, appropriately resourced, and aligned with each entity's mission? Is additional clarity needed to ensure KOHA meaningfully achieves the goal of ensuring a universal oral health screening at school entry?

Thank you for your consideration. For any questions relating to this request, please contact me or my Senior Consultant, Eliza Brooks at 916-319-2087 or eliza.brooks@asm.ca.gov.

Sincerely,

MIA BONTA
Assemblymember, 18th Assembly District
2025.04.17 EB