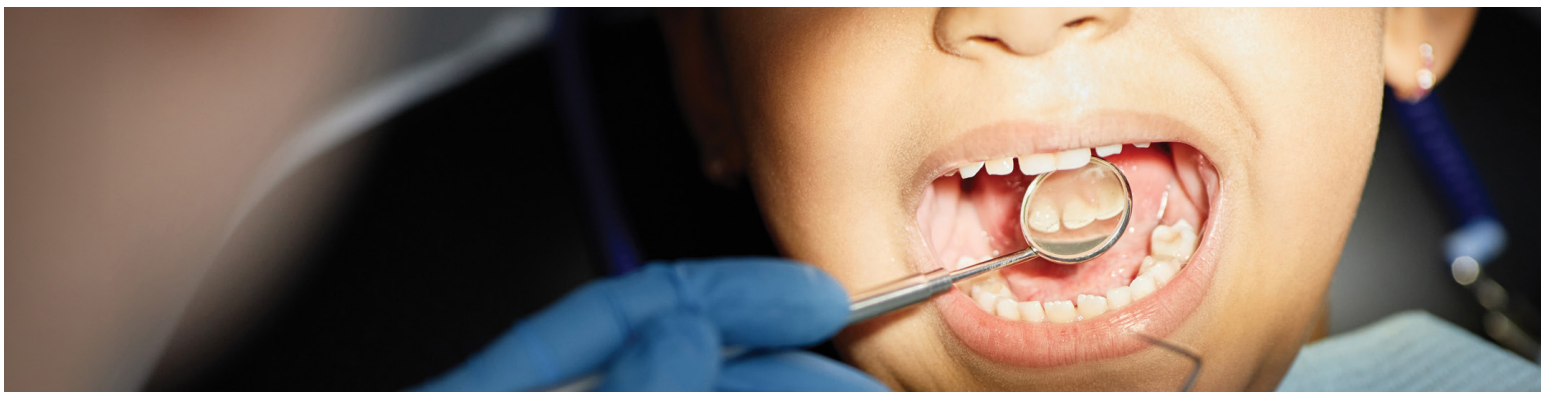
Kindergarten Oral Health Assessment

Insufficient Oversight and Unreliable Data Threaten the Program's Goals

November 2026

REPORT 2025-109



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Grant Parks *State Auditor*

Laura Kearney *Chief Deputy*

November 5, 2026
2025-109

The Governor of California
President pro Tempore of the Senate
Speaker of the Assembly
State Capitol
Sacramento, California 95814

Dear Governor and Legislative Leaders:

As directed by the Joint Legislative Audit Committee, my office conducted an audit of the Kindergarten Oral Health Assessment (KOHA) program. Our assessment focused on six school districts and the California Department of Public Health (DPH), and we determined that unreliable data reported by districts and insufficient statewide oversight of the KOHA program's requirements threaten the goals of the program.

The KOHA program requires public school students in certain grades to obtain an oral health assessment by a qualified dental health professional and provide the results of that assessment to their school districts. In turn, school districts are required to report KOHA program data, including the results of these assessments, to the State or to their county offices of education. However, we found that DPH has not adhered to its plans to use KOHA program data to measure the State's progress in improving childhood oral health. Moreover, despite managing the statewide data system used to store KOHA program data, DPH has not implemented safeguards that would better ensure that the data are complete and reliable. In the absence of effective statewide oversight, the districts we reviewed did not meet their obligations to notify parents of the KOHA program requirements and report reliable KOHA program data to the State. For example, none of the districts provided families with all required information regarding the assessment requirement. Moreover, none of the districts maintained reliable data in all areas required by state law. As such, we were unable to use these districts' data to determine information such as the number of students assessed and found to have dental health needs.

We make several recommendations to establish stronger oversight of the KOHA program. Additionally, because we found that school districts that conduct on-site dental assessments generally have a greater number of assessed students, we make recommendations to the Legislature for how to streamline requirements and incentivize on-site dental assessments.

Respectfully submitted,

GRANT PARKS
California State Auditor

Selected Acronyms Used in This Report

CDE	California Department of Education
DPH	California Department of Public Health
KOHA	Kindergarten Oral Health Assessment
LCAP	Local Control Accountability Plan
LCFF	Local Control Funding Formula
SCOHR	System for California Oral Health Reporting
TK	transitional kindergarten
UCSF	University of California, San Francisco

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Summary

Key Findings and Recommendations

Citing concerns about children's oral health, the State created the Kindergarten Oral Health Assessment (KOHA) program in 2006. The state law that establishes the KOHA program requires public school students enrolled in kindergarten—including those in transitional kindergarten (TK)—and those students enrolling in public school for the first time as first-graders to present proof of having received an oral health assessment by a qualified dental health professional. School districts must notify students' parents or guardians (parents) of this requirement and must submit an annual report on the results of these assessments. However, families can waive the oral health assessment requirement for specific reasons, such as a lack of access to dental health care. The Joint Legislative Audit Committee directed us to perform an audit of the KOHA program at school districts and other supporting entities. To conduct this audit, we reviewed the KOHA program practices at six school districts: Los Angeles Unified School District (Los Angeles), Merced City School District (Merced), Milpitas Unified School District (Milpitas), Oakland Unified School District (Oakland), San Luis Coastal Unified School District (San Luis Coastal), and Woodland Joint Unified School District (Woodland). We also audited the California Department of Public Health (DPH), the California Department of Education (CDE), and county oral health programs funded by DPH. We conclude the following:

DPH and School Districts Have Not Ensured That KOHA Program Data Are Sufficiently Reliable to Determine Statewide Oral Health

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DPH has not maintained reliable KOHA program data nor used available program data to evaluate the State's progress in improving children's oral health. DPH relies on the System for California Oral Health Reporting (SCOHR) to store the KOHA program data that school districts report. However, SCOHR does not validate school district entries, leading to many districts reporting data that appear incorrect when compared to CDE's enrollment data. Additionally, none of the six districts we reviewed have recorded reliable KOHA program data for all required program elements. For example, districts did not track the number of families that waived the oral health assessment requirement or ensure that they recorded the results of all oral health assessments. These problems are compounded by errors in the reports that the districts send to SCOHR, which underscores the pervasiveness of unreliable data about the KOHA program.

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The Absence of Effective Statewide Oversight Has Contributed to Districts' Lack of Compliance With the KOHA Program's Requirements

State law requires public schools to notify parents about the KOHA program requirements using specific language on four standardized forms that CDE and DPH developed. However, the districts we reviewed did not always provide parents with the correct forms. A lack of oversight of the KOHA program has likely contributed to the districts' noncompliance. No state or local entity is assigned responsibility for overseeing the KOHA program, and neither CDE nor DPH perform any oversight activities, such as ensuring that districts appropriately notify families and report correct data. DPH funds county programs that provide some support to school districts, but greater oversight and accountability are necessary to increase district compliance with the KOHA program requirements.

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The Legislature Could Streamline KOHA Requirements and Incentivize On-Site Assessments

We evaluated other school-based health assessment programs—the vision and hearing screening programs—and districts' KOHA efforts to identify best practices that could improve the effectiveness of the KOHA program. One key difference between the other school-based health assessment programs and the KOHA program is that the assessments take place at the school site as a general rule because state law allows qualified school or district personnel to conduct those other health assessments. It was beyond the scope of our audit to conclude on whether school site staff could perform the oral health assessments that the KOHA program requires. However, we noted the value of the oral health assessments occurring at school sites when provided by community providers. Three of the districts we reviewed—Milpitas, San Luis Coastal, and Woodland—conduct districtwide oral health assessment events and report higher rates of assessments completed. However, school districts that host on-site oral health assessment events could benefit from greater clarity in state law so that they can more easily structure their programs to align with the KOHA program requirements.

To address our findings, we have made recommendations to the six districts we reviewed as necessary to improve their KOHA program compliance, as well as to DPH to address some of the oversight gaps we found with the KOHA program. Further, we recommend ways that the Legislature could clarify the KOHA program's requirements for districts conducting on-site dental assessments.

Agency Comments

Although DPH indicated that it would implement most of our recommendations, it stated that it believes additional resources will be needed to implement our recommendation that it ensure the reasonableness of KOHA program results submitted by districts. Milpitas and Oakland indicated that they will implement our recommendations. Los Angeles and San Luis Coastal did not respond directly to our recommendations but did indicate actions they will take to address some of our findings. Merced and Woodland did not provide a response even though we gave them the opportunity to review and respond to the draft report.

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Introduction

Background

Citing concerns about children's oral health, the State created the KOHA program in 2006. When it adopted the law that established the KOHA program, the Legislature noted that California's school children experienced oral disease at twice the rate of school children in other states. The legislative analysis of the bill that created the KOHA program indicates that supporters believed the trend of poor oral health negatively affected students' learning and resulted in lost funding to schools, and that the KOHA program requirements would lay the groundwork for identifying students' oral health needs and revealing barriers to care.

The state law that established the KOHA program requires students who enroll in a public school for the first time in TK, kindergarten, or first grade to provide proof that they have received an *oral health assessment* by a qualified dental health professional. Figure 1 shows the three key pieces of health information that the oral health assessment includes. Additionally, state law allows a parent to excuse their child from providing proof of an oral health assessment. Parents can waive the assessment requirement by indicating to their child's school district that they are doing so because of a financial burden, lack of access to a dental health professional, or nonconsent to the assessment.

After parents obtain the oral health assessment or determine that they will waive the assessment requirement, they must submit proof of the assessment or a statement of their reasons for the waiver to their school district. In turn, school districts are required by law to submit an annual report that details the results of the assessments and the stated reasons for waivers of the requirement, as the text box shows.

The law requires school districts to submit the report to the applicable county office of education or to a system designated by the State's dental director. Since at least 2021, that database has been the SCOHR database. Districts that meet their reporting requirement by reporting to the county office of education are encouraged, but not required by law, to also report to SCOHR.

KOHA Reporting Requirements for Districts

Districts must report the total number of students who…

1. Are subject to the oral health assessment requirement.

And of those students, the number who…

2. Presented proof of an assessment.
3. Could not complete an assessment due to financial burden.
4. Could not complete an assessment due to lack of access to a qualified dental health professional.
5. Could not complete an assessment because their parents did not consent to the assessment.
6. Were assessed and found to have had caries experience.
7. Were assessed and found to have untreated decay.
8. Did not submit either proof of an assessment or a waiver.

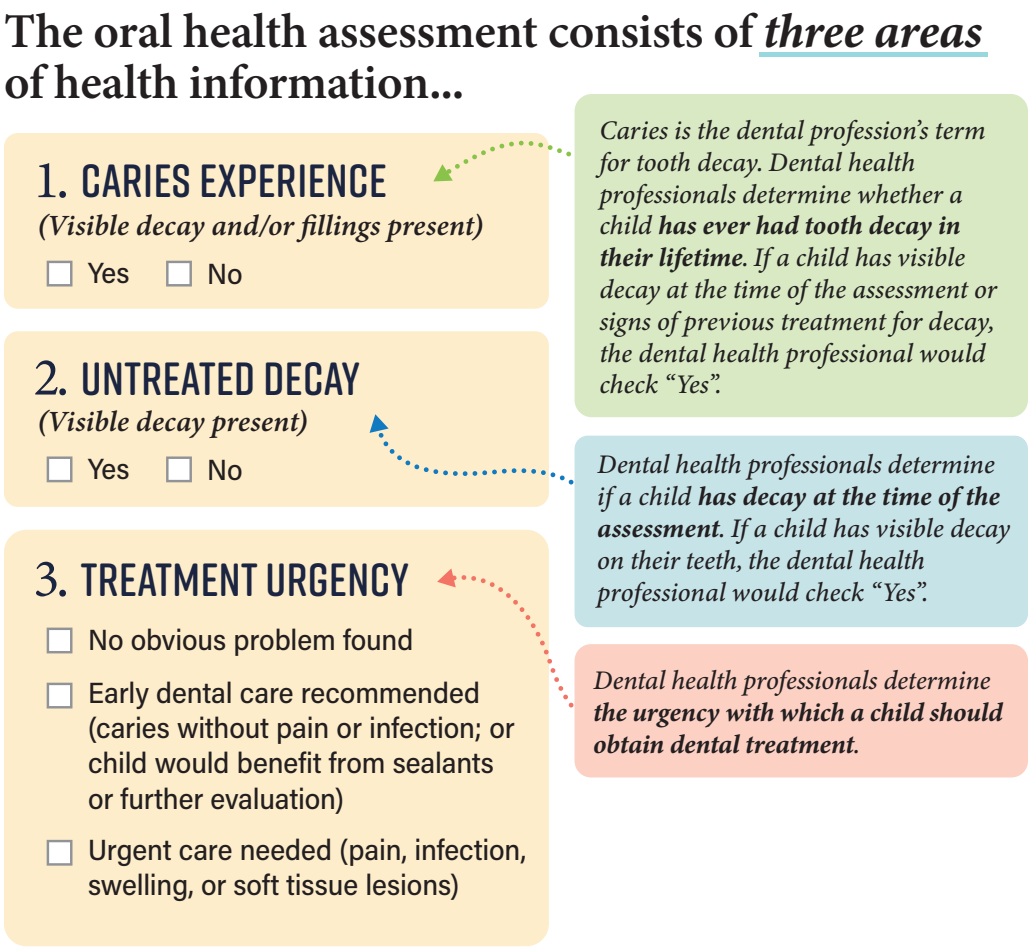
Source: State law.

The KOHA Program's Purpose and Goals

As we indicate earlier, when the Legislature adopted the law that created the KOHA program, supporters of the bill that created it expected that the program would help address poor oral health in children by identifying needs and barriers

to care. Specifically, supporters of the legislation that created the KOHA program believed that it would provide important data that could be used locally to create and develop programs that would best meet the needs of individual communities.

Figure 1
Qualified Dental Professionals Are Expected to Assess Three Areas of Dental Health



Source: KOHA program oral health assessment form and the *KOHA Starter Manual for School Staff.*

The benefits that supporters of the KOHA program legislation believed the program would create are closely connected to the data collection and reporting requirements the Legislature adopted. For example, supporters believed that the KOHA program would reveal dental health needs and barriers to care, and the KOHA program requires the collection of data related to these goals. Specifically, state law requires the collection and reporting of information about children's oral health condition (which are their needs) and reasons why families decline to obtain an oral health assessment, including reasons related to barriers to care. Along with the requirement to notify families about the assessment requirement, these reporting requirements

are the other major responsibility placed on school districts by the law that created the KOHA program. Therefore, even though the program's requirements have been amended occasionally since the Legislature first adopted them, there is a close connection between the KOHA program requirements found in state law and the intent or expectation at the time the Legislature adopted the KOHA program that the program would result in obtaining data that could then be used to facilitate better intervention to improve dental health.

In the time since the Legislature created the KOHA program, some of the entities that support its implementation have developed another goal for the program: finding children a dental home. For example, when we asked DPH what it believed the goal of the KOHA program was, it told us that the goal was to get children's oral health assessed and to find children a dental home. The American Academy of Pediatric Dentistry defines a *dental home* as the ongoing relationship between the dentist and the patient, inclusive of all aspects of oral health care—in other words, a space for a child to obtain recurring dental health care from the same provider.

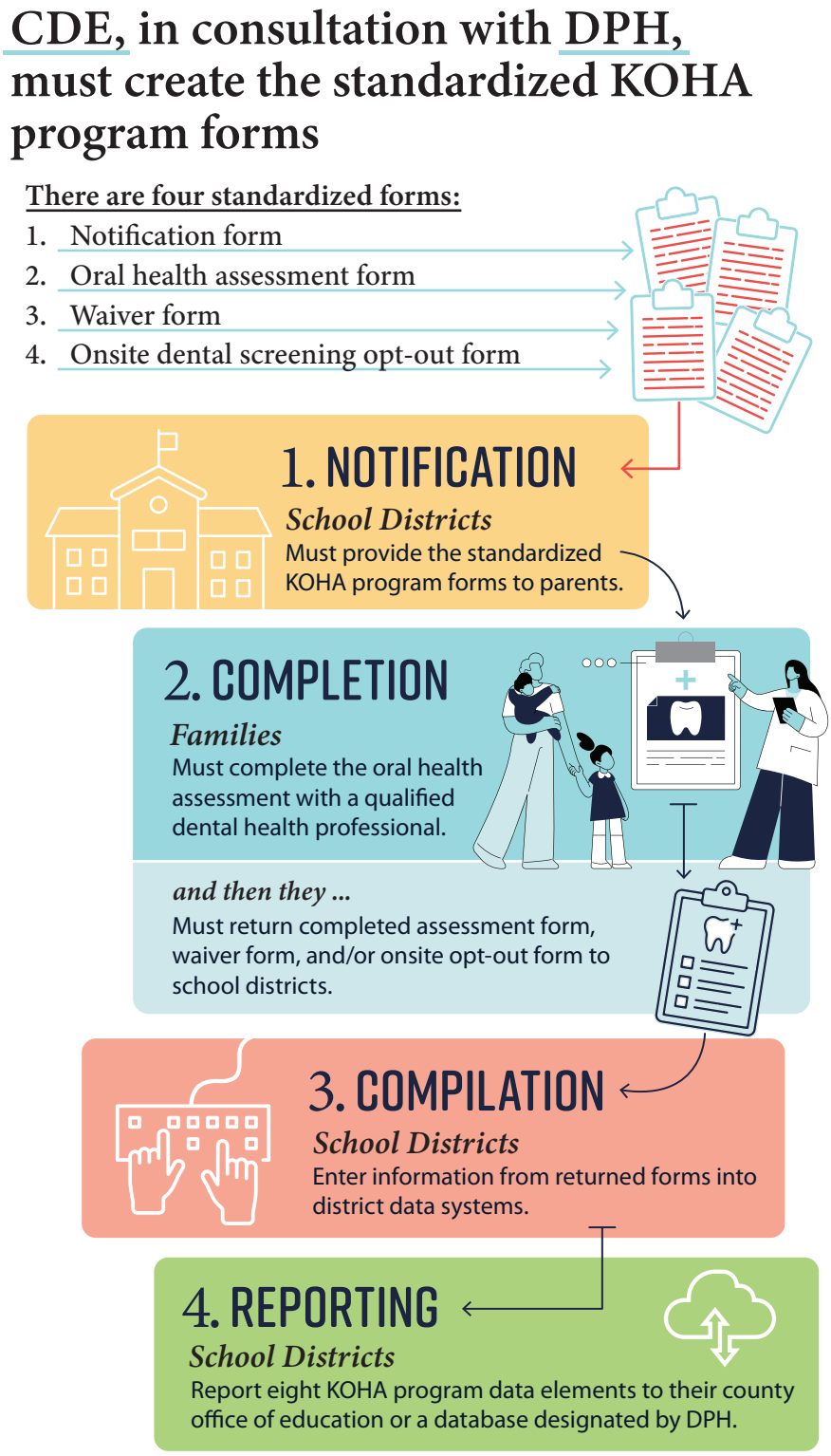
Unlike the close connection between the goals and expectations of the early KOHA program supporters and the program's requirements, there is not a direct connection between the goal of finding a dental home for children and the KOHA program's current requirements. For example, none of the information collected from families or reported by school districts to either their county offices of education or SCOHR includes detail that would allow someone to assess whether a child had a consistent dental provider before they were subject to the KOHA program requirements or whether they found one as a result of the KOHA program. In fact, amendments to the law that established the KOHA program have explicitly acknowledged that school districts may host on-site oral health assessment events that may result in an assessment of the students at that district. On-site dental assessment events are events at which qualified dental health professionals come to schools to perform oral health assessments. As we describe later in this report, these events can be helpful in increasing the number of children assessed. However, they are likely less useful for establishing a dental home as families do not need to seek out the participating provider or visit them at their established practice.

Entities With Responsibilities Related to the KOHA Program

As Figure 2 shows, CDE, DPH, families, and school districts all play key roles in implementing the KOHA program. State law requires CDE, in consultation with DPH and interested people, to develop and revise as necessary a standardized form that includes information for KOHA purposes. CDE has complied with this requirement by developing four forms.[1] These forms include a KOHA notification letter with information about the oral health assessment requirement and the importance of oral health, as well as a form for recording the results of the oral health assessment.

[1] Because CDE has developed multiple forms to administer the KOHA program, we use the term *forms* throughout this report, even though the law requires only a single form.

Figure 2
Different Parties Are Responsible for Key Elements of the KOHA Program



Source: State law and interviews with school districts.

School districts are responsible for notifying parents of the assessment requirement and for providing them with the standardized forms. Students may obtain an oral health assessment from a qualified provider of their choice, but as Figure 3 shows, school districts may also offer on-site assessment events—in which dental professionals assess students at school sites—and the results of those assessments then become the student's proof of having received an oral health assessment. At these on-site assessment events, school districts are required to have an oral health assessment completed for all students whose parents have not opted out of participation. We refer to this process as *passive consent*.

State law does not charge DPH or any other state entity with overseeing compliance with the KOHA program's requirements, but DPH has partnered with multiple parties to provide guidance and technical assistance to school districts. First, DPH provides Proposition 56 (Prop 56) grant funding to local oral health programs, which are generally operated by county public health departments (county programs).[2] The terms of these grants require county programs to provide assistance to school districts regarding KOHA program compliance and implementation. For example, DPH expects county programs to assess the number of school districts that do not report KOHA program data to SCOHR, identify target schools for intervention, and provide guidance on KOHA program participation and reporting. These county programs are in turn supported by the University of California, San Francisco (UCSF), with which DPH contracted in 2022 to support county programs with school-linked and school-based dental programs. UCSF has created resources including reporting tools and educational presentations and has made available a statewide KOHA manual that county programs may use or provide to school districts.

In addition to its KOHA program responsibilities and activities, DPH is responsible for the State's efforts to improve dental health. DPH does so through its Office of Oral Health, the mission of which is to improve the oral health of all Californians through evidence-based or evidence-informed prevention, education, and organized community efforts. DPH's planning efforts to fulfill this mission include the State's oral health plan, which describes the activities that DPH will engage in to improve oral health in California, including children's oral health. Among these activities are those that support the oral health assessment required by the KOHA program.

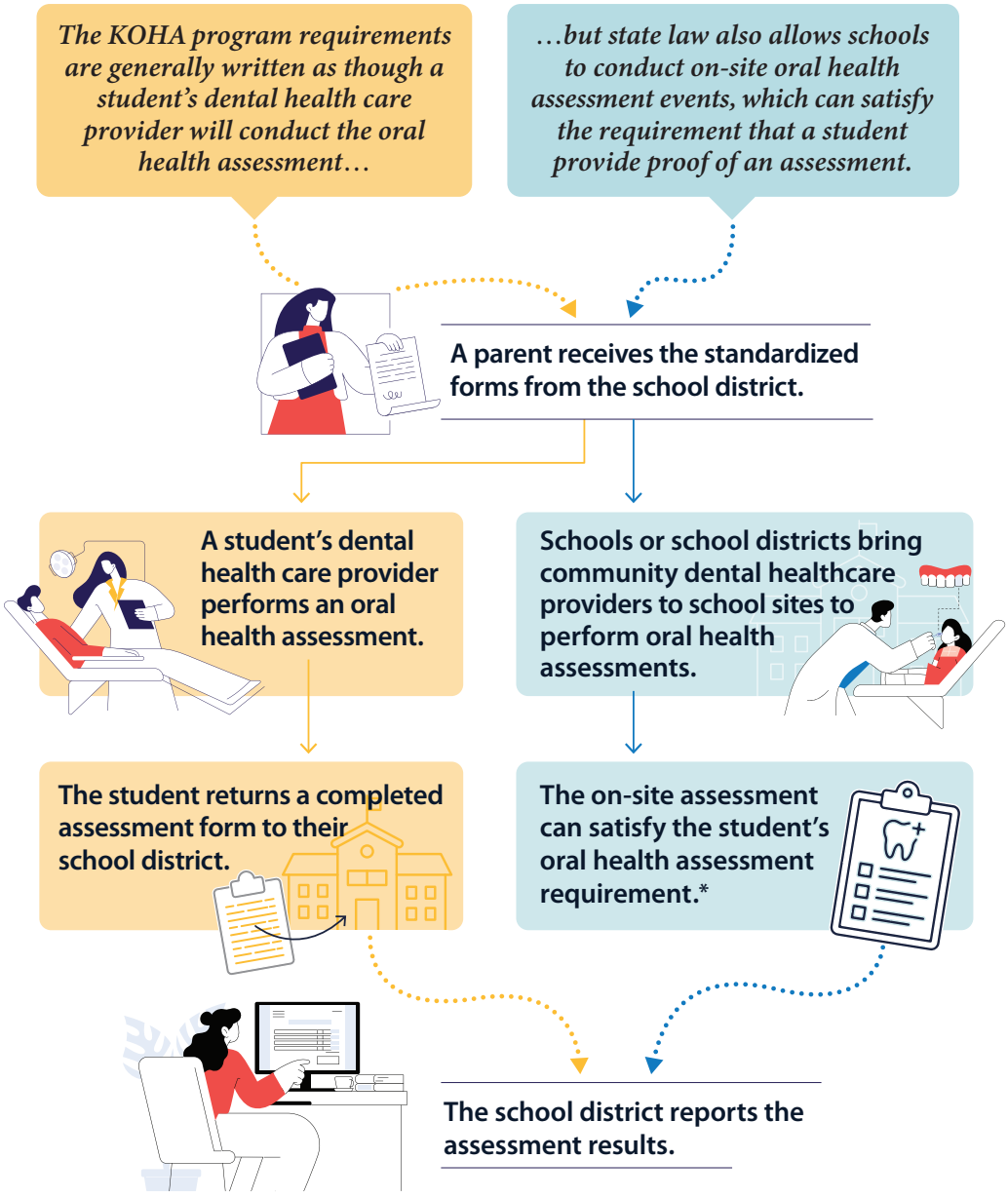
As part of this audit, the Legislature directed us to review the extent to which KOHA program data are reported to the Department of Health Care Services (DHCS), as well as the coordination between various entities—including DHCS—for assisting compliance with KOHA. However, in practice, DHCS plays no role in the administration of the KOHA program. State law establishing the KOHA program does not place any requirements on DHCS the way it does for CDE and DPH. Moreover, DHCS' primary goal is to ensure access to health care for California residents, largely through the administration of Medi-Cal, the State's Medicaid program. As such, DHCS' role falls outside the KOHA program's scope as it is written in the law, which primarily involves identifying children's oral health needs.

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2 In 2016, California voters approved Prop 56, which enacted the California Healthcare, Research and Prevention Tobacco Tax Act of 2016. Prop 56 imposed a tax on tobacco products beginning in 2017, with the intent of saving the lives of Californians by reducing tobacco use and increasing funding for tobacco-use prevention programs, health-related research, and existing health care programs and services that treat tobacco-related and other diseases.

DHCS staff confirmed that the department does not directly interact with districts regarding the KOHA program. They explained that DHCS promotes awareness of and educational support regarding the KOHA program, such as by posting information about KOHA's requirements on its website. Given the above, we found DHCS is not involved in the administration or oversight of the KOHA program.

Figure 3
State Law Provides Two Options for Completing the Oral Health Assessment



Source: State law and review of selected districts' KOHA program practices.

* An on-site assessment does not preclude a student from also receiving an assessment from their dental healthcare provider and returning the results of that assessment to their school district.

Funding for the KOHA Program

As we previously describe, DPH has used Prop 56 funding to require county programs to conduct activities in support of the KOHA program. Prop 56 funding also supports DPH's Office of Oral Health in its administration of the state dental program. At the local level, all school districts receive funding for the KOHA program, but the nature of this funding has changed over time. From fiscal years 2006–07 through 2012–13, the Legislature appropriated $4.4 million annually in the Budget Act to reimburse school districts for required KOHA activities. Starting in fiscal year 2013–14, state funding allocations to school districts were changed to the Local Control Funding Formula (LCFF). The LCFF allocates state and local funding to school districts and consists of grade-specific base funds, supplemental funds, and concentration funds. The LCFF has largely replaced the State's categorical programs funding approach, in which funding for specific programs was restricted to being spent on those programs. Funds allocated under the LCFF are generally unrestricted, meaning that they can be used for any local educational purpose not prohibited by law. Therefore, the KOHA program requirements on school districts are currently funded through the districts' LCFF allocations.

Our Selection of Six Districts to Review for This Audit

The Legislature directed us to review at least four, and up to six, school districts, including two school districts with high KOHA program screening rates and high reporting compliance, one school district with low reporting compliance, and one with a low screening rate. In addition to these factors, we considered geographic diversity and total enrollment when selecting districts. Table 1 lists our selected districts and provides the information that was available to us at the time we made the selections. As we describe in more detail later in our report, the data that appear in the *Measurements of Screening* portion of Table 1 are not accurate. Nonetheless, they were the best data available to us for the purpose of selecting districts for review at the outset of the audit.

Table 1
We Selected Six Districts to Review Based on Their Screening and Reporting Results in Statewide KOHA Data

		MEASUREMENTS OF *SCREENING*			MEASUREMENTS OF *REPORTING*	
		SCHOOL YEAR				
		2022–23	2023–24	2024–25	2024–25 DATA	
DISTRICT	COUNTY	PERCENTAGE OF COMPLETED ASSESSMENTS THE DISTRICT REPORTED TO THE STATE			TOTAL ENROLLED KINDERGARTEN STUDENTS	PERCENTAGE OF ENROLLED KINDERGARTEN STUDENTS THE DISTRICT REPORTED AS ELIGIBLE
High Compliance With Screening and Reporting						
San Luis Coastal	San Luis Obispo	88%	93%	96%	480	103%
Milpitas	Santa Clara	91%	92%	97%	628	95%
Low Compliance With Reporting						
Oakland	Alameda	Not Reported*	Not Reported*	12%	3,122	3%
Low Compliance With Screening						
Merced	Merced	5%	5%	4%	1,063	102%
Additional Selections						
Los Angeles	Los Angeles	13%	14%	36%	32,717	186%†
Woodland	Yolo	86%	85%	88%	602	101%

Source: Auditor analysis of statewide KOHA data, enrollment data, and locations of school districts.

Note: The data in this table are the self-reported data from the SCOHR database that we reviewed at the beginning of our audit when determining which school districts to audit in accordance with the audit objectives' requirements. None of the data shown in the *Measurements of Screening* columns are accurate for any school district, as we explain later in this report.

* Oakland reported results for these years in March and May 2026, after we had used the statewide data to inform our selections of districts to review.

† As we describe later in the report, Los Angeles significantly overreported the number of students eligible for the KOHA program when submitting results to the State.

DPH and School Districts Have Not Ensured That KOHA Program Data Are Sufficiently Reliable to Determine Statewide Oral Health

Key Points:

- The California Department of Public Health (DPH) has not ensured that the Kindergarten Oral Health Assessment (KOHA) program data that school districts report are reliable. For example, school districts have reported data that varies by more than 20 percent from their enrolled kindergarten populations, but DPH has not tracked these submissions.
- DPH has not adhered to its plan to use KOHA data to measure the State's progress in improving childhood oral health, nor has it met its statutory requirement to periodically evaluate the requirements of the KOHA program.
- The six school districts we audited did not maintain reliable data about all aspects of the KOHA program. Most of the districts' local data systems contained incomplete or inaccurate data for metrics such as how many students were assessed. Only Woodland Joint Unified School District (Woodland) maintained reliable data, and these data pertained specifically to Woodland's on-site assessment program.
- All six districts reported incorrect information to the System for California Oral Health Reporting (SCOHR). The magnitude of the reporting errors by Los Angeles Unified School District (Los Angeles) alone skews any statewide analysis of the collective data included in SCOHR.

DPH Has Not Maintained Reliable KOHA Program Data

As the Introduction explains, DPH is responsible for the State's oral health plan. In September 2019, DPH released an oral health surveillance plan that stated that the department would measure the State's progress in improving children's oral health, in part, by using KOHA program data. Therefore, we expected that DPH would take steps to maintain reliable KOHA program data, such as ensuring that districts report all required information. However, we identified three critical deficiencies in the way DPH has managed KOHA program data:

- It has hindered data collection through the design of KOHA program forms.
- It has not tracked unreasonable data and contacted districts to alert them of errors in their reports.
- It has not conducted outreach to ensure that all districts are reporting KOHA program data.

Design of KOHA Program Forms

State law requires the California Department of Education (CDE)—in consultation with DPH and interested people—to develop standardized KOHA program forms that school districts must use. The law requires these forms to contain specific information, such as information about the importance of oral health to overall health and learning. The forms also must include a place for a qualified dental health professional to record the results of an oral health assessment. CDE and DPH updated these forms in 2022, and Table 2 lists the four forms and corresponding requirements in state law.

Table 2
CDE Has Issued Four Forms to Fulfill State Law's Notification Requirements

STATE LAW REQUIRES SCHOOL DISTRICTS TO PROVIDE PARENTS WITH A STANDARDIZED NOTIFICATION FORM THAT INCLUDES…	CDE FORM
An explanation of the KOHA program requirements and information about the importance of primary teeth, the importance of oral health, the Medi-Cal application process, methods for contacting the county health department, and a privacy statement.	*Oral Health Notification Letter* (Notification Form)
A section to be used by a qualified dental health professional to record the results of the oral health assessment.	*Oral Health Assessment Form* (Assessment Form)
A section parents can use to indicate why an assessment could not be completed, including the option to indicate it was because of undue financial burden, a lack of access to a qualified dental health professional, or parental nonconsent.	*Waiver of Oral Health Assessment Requirement* (Waiver Form)
A section that explains that if a school or school district hosts a free on-site oral health assessment event, students will receive an oral health assessment unless a parent opts them out. A section that a parent can use to indicate that they do not consent to their student receiving the on-site oral health assessment. A section describing that the students will not receive dental treatment of any kind at the on-site oral health assessment unless the parent provides informed consent for the treatment.	*On-Site Dental Screening Opt Out Letter* (On-Site Screening Opt Out Form)

Source: State law and review of forms issued by CDE.

A program manager in DPH's Office of Oral Health stated that CDE was initially involved with the development of the 2022 forms, but that DPH, with the assistance of stakeholders, completed their development. Three of the four forms—all but the notification letter—are labeled as having been issued by DPH. The notification letter is not labeled in that manner but rather is designed to be placed on school district letterhead. DPH's perspective was corroborated by CDE. Staff in CDE's Office of School Based Health Programs explained that CDE received the KOHA program forms from DPH and, after a review by CDE's legal counsel, made them available on its website. According to DPH's program manager, several reasons led the department to update the forms in 2022, including changes to state law regarding on-site assessment events and stakeholder feedback about readability.

The 2022 updates resulted in a separate waiver form that parents or guardians (parents) can complete if they want to excuse their child from receiving an oral health assessment. Before the 2022 updates, dental health professionals completing an oral health assessment and parents waiving the oral health assessment requirement would each use different parts of the same form. DPH explained that it separated the waiver option and the assessment option onto different forms because of stakeholder input. According to the program manager, stakeholders believed that parents waived the requirement because the option to waive was located on the same form as the option to obtain an assessment. She explained that DPH made the decision to separate the options onto different forms so that parents would be less likely to waive the requirement. Guidance issued in 2025 by DPH's contractor, the University of California, San Francisco (UCSF) directly stated that the separation of the waiver form "discourages easy waiving."

However, moving the waiver option to a separate form increased the risk that the State and local government entities would not capture important information about access to dental care because school districts might not provide the waiver form to families. In fact, as we discuss later in this report, five of the six districts we reviewed did not provide families with the required waiver form. Similarly, the data that school districts reported to SCOHR show that for school year 2024–25, 22 percent of the reporting districts with 10 or more eligible students did not have a single student waive the oral health assessment requirement. One district in Riverside County reported nearly 1,700 students were subject to the KOHA program requirements, very few of whom completed an assessment; however the district also reported having received no waivers. Although it is possible that some of these districts were reporting accurately, this significant percentage seemingly indicates that there are several other districts that do not provide the waiver forms to families. These statistics are indicators in the data that DPH could have noticed and used to initiate follow up with districts, but did not.

If districts do not provide a waiver form, parents are less likely to provide information about why they choose to opt-out of the KOHA requirement. Some of the available options from which families can choose as a reason when they opt out include financial burden, being unable to find nearby care, or not being able to find a dental professional that takes the family's insurance. Although DPH may have assumed that districts would provide all standardized forms, as is required by state law, its approach would have been better if it had anticipated the potential consequences of revised program requirements, including the possibility of noncompliance with these requirements. When DPH separated the waiver option from the assessment option, it hindered the State and local oral health programs' (county programs) ability to collect and review information about these barriers, which could be used to inform dental health care policy or strategies for increasing the rate of childhood oral health screenings.

Management of SCOHR

Secondly, DPH has not implemented controls to ensure that SCOHR contains quality data. For example, one of the eight elements that districts are required to report is the number of students who are required to submit proof of a completed oral health assessment. One approach to ensuring that districts report a reasonable number

of these students would be to compare the number of students a district reports against the number of enrolled kindergarteners that CDE has on record for that district.[3] These numbers are unlikely to match exactly because the KOHA program requirements do not apply only to kindergarteners. Nonetheless, the comparison could identify a significant variance that may suggest that a district is not reporting correctly. For example, SCOHR could check to see whether the number of students a district reported was within 20 percent of the number of enrolled kindergarten students. However, SCOHR does not perform a comparison of this nature, which precludes the department from identifying unreasonable data submissions.

We identified numerous cases in which a comparison of this nature would have identified districts that were potentially reporting incorrect information and required further review. For example, for school year 2024–25, Los Angeles reported that it had nearly 61,000 students who were required to submit proof of an oral health assessment. However, CDE records showed that the district had only about 33,000 enrolled kindergarten students—or approximately half as many as reported. When we asked Los Angeles about this issue, the district said that, in addition to reporting transitional kindergarten (TK) and kindergarten students, it was also reporting all first-grade students instead of reporting only its first-grade students who had not previously been enrolled in kindergarten, who are the first graders to whom the KOHA program requirements apply. Therefore, Los Angeles's reporting was incorrect, which the district acknowledged when we brought this issue to its attention.

Figure 4 summarizes the approach that DPH could take to address data validation and the results we obtained when applying a 20 percent variance threshold.[4] As the figure shows, many districts reported data that indicate that they may not be correctly reporting on the number of students required to present proof of an oral health assessment. More than 150 of the variances we identified were greater than 100 students, meaning that the district had potentially over or under reported by at least that many students.

As it performs quality checks on the data submitted by school districts, DPH may find that it needs to provide guidance to districts about how to report in light of recent changes to state law. Specifically, in 2025, an update to state law expanded the definition of kindergarten to include students enrolled in TK and provide TK students until the end of their kindergarten year to return proof of having received an oral health assessment. The law specifies that proof of an assessment is only required once during this period of two school years. To ensure proper reporting, districts need to avoid counting TK students that return proof of an oral health assessment in their TK year again in their kindergarten year. Because state law requires students to provide proof of an assessment only once, the students that return such proof in their TK year are not subject to the requirement again in their kindergarten year. If districts do not track these students and their assessments, they could end up reporting incorrect information in a manner very similar to the way that Los Angeles miscounted its first graders.

[3] Beginning in the 2025–26 school year, this comparison would be best performed against the enrolled population of TK and kindergarten students because of a recent change to state law that expanded the KOHA program to TK students.

[4] After reviewing enrollment and SCOHR data, we chose 20 percent as an example threshold for the purpose of demonstrating a method in which DPH could identify potentially unreasonable data. If it were to adopt a practice of reviewing the data in the manner we recommend, we would expect DPH to develop its own appropriate thresholds.

Figure 4
If SCOHR Used Student Population Data to Validate District Submissions, It Could Identify Potentially Problematic Submissions



DATA VALIDATION

To ensure districts are reporting reasonable data, SCOHR could check to see if the number of students a district reported as subject to the KOHA program requirements was close to the number of enrolled kindergarteners.

+/–

EXPECTED VARIATION

There are valid reasons why these data sources would likely not match exactly. For example, the KOHA program requirements also apply to first graders enrolled for the first time in public school. Nonetheless, DPH could establish thresholds for excessive variances that would be indicators of unreasonable data.

Nearly Half of Districts Reported Student Totals That Were Significantly Different Than Their Population Data

67 districts—*11 percent of all reporting districts*—reported students subject to the KOHA program requirements that were at least 21 percent less than the CDE population data. For example, one district reported about 370 students to SCOHR despite enrolling more than 1,100 kindergarteners.

20% Variation Allowance

211 districts—*36 percent of all reporting districts*— reported students subject to the KOHA program requirements that were at least 21 percent higher than the CDE population data. For example, one district reported 610 students to SCOHR despite enrolling only about 350 kindergarteners.

CDE POPULATION DATA

Source: State law, SCOHR data for school year 2024–25, and CDE data for school year 2024–25.
Note: We excluded districts with CDE recorded populations that were fewer than 10 students.

Before the State amended the KOHA requirements to incorporate TK students, UCSF, as DPH's contractor, issued guidance in its KOHA starter manual that directed districts to delay reporting about assessments that students returned in their TK year until those students reached kindergarten. UCSF later removed this guidance from the starter manual, but subsequent versions of that manual have not provided detailed guidance on how to report TK students. Further, we observed during our audit that three of the six county programs we reviewed were still using the outdated version of the starter manual containing what is now incorrect guidance on how to report about TK students.

Outreach to Nonreporting Districts

Lastly, DPH has not tracked reporting to ensure that all districts provide KOHA program information. As the Introduction describes, state law requires districts to submit data to SCOHR or to their county office of education. A total of 235 districts—27 percent of the districts that enrolled students subject to the KOHA program requirements—did not report to SCOHR for school year 2024–25, and DPH did not follow up with those districts' county offices of education to determine whether the districts had reported to them instead. Our review found that many of these districts had not done so. Figure 5 summarizes the results of the work we performed.

DPH conveyed its belief that it is not responsible for following up with districts that do not report. Instead, DPH believes that CDE is responsible. We explain our disagreement with DPH's position on CDE's responsibilities in more detail later in this report. Nonetheless, we believe that regular contact with districts that do not report KOHA program data would improve compliance with the law and increase the amount of data collected. As our discussions with 10 nonreporting districts indicate, districts may simply lack an awareness of the reporting requirements.

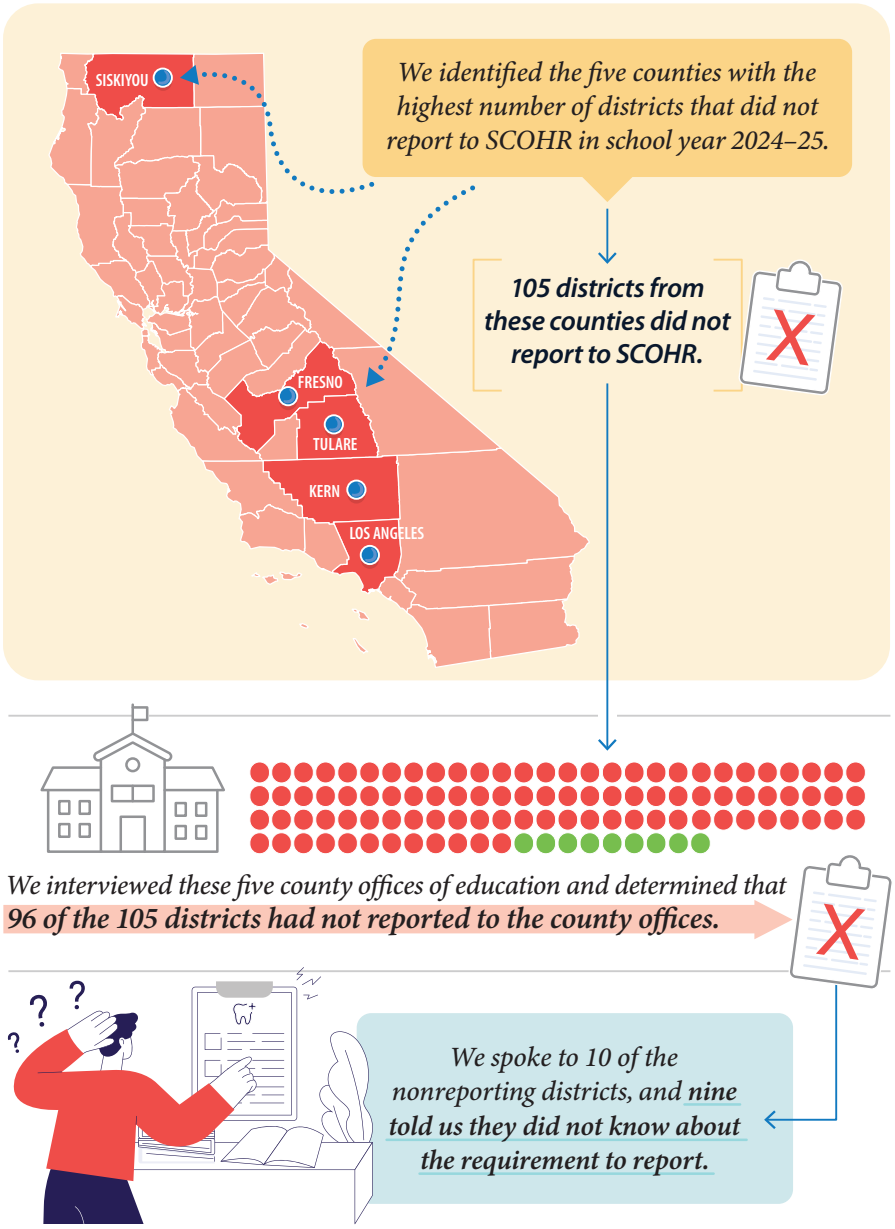
Regardless of which entity conducts the outreach, the State could reduce the work required to identify nonreporting districts. Because state law allows districts the choice of where to report data—either to their county office of education or to SCOHR—program data are disaggregated, thereby complicating oversight and program analysis. This fragmented structure hinders efficient oversight and complicates efforts to improve data quality. If the Legislature amended state law to require districts to report KOHA program information to a single source, it would allow DPH or another oversight entity to more efficiently improve data quality.

DPH Has Not Used KOHA Program Data to Assess Oral Health Conditions and Faces an Unclear Statutory Requirement Regarding Its Use of KOHA Data

We identified two ways in which we expected that DPH would be using KOHA program data to evaluate the condition of oral health among California's children and the KOHA program itself. First, the Office of Oral Health has developed a statewide oral health plan and an associated oral health surveillance plan. The surveillance plan states that the State will use KOHA program data as an indicator of childhood oral health. Second, the law that established the KOHA program

requires DPH to conduct or to provide for the conducting of periodic evaluations of the KOHA program requirements. Therefore, we expected that DPH would have evidence that it had performed the surveillance and assessment envisioned by the statewide oral health plan and that it had conducted the periodic program evaluation required by state law. However, it has not taken adequate action in either area.

Figure 5
Many Districts Did Not Report KOHA Data, and Some Indicated That They Did Not Know About the Reporting Requirement



Source: SCOHR data and interviews with school districts and county offices of education.

KOHA Program Data and the Statewide Oral Health Plan

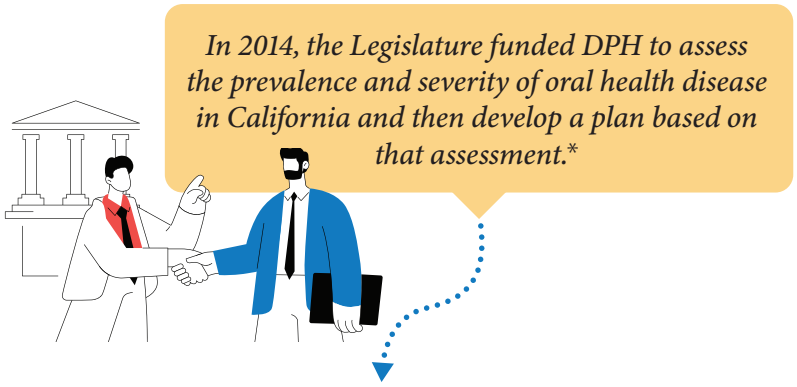
As Figure 6 shows, DPH developed a statewide oral health plan and accompanying data surveillance plan, elements of which relate to oral health among children. In 2019, DPH stated that as part of its oral health plan, it would use KOHA data to measure the State's progress in meeting two goals: reducing the proportion of children who had, at some point in their lives, experienced dental decay and reducing the proportion of children with active, untreated decay.

However, DPH has not used the KOHA program data to track the State's progress in these areas. The 2019 surveillance plan states that it would be effective from 2019 through 2023 and that, during this period, the department would disseminate the data and publish a comprehensive oral disease burden report. However, DPH has not produced regular evaluations of the KOHA program data or a comprehensive report that includes the KOHA program data. When we asked DPH to provide evidence that it had used the KOHA program data to determine trends across a variety of program elements, the department provided two spreadsheets labeled as draft and a recent assessment of the KOHA program data that it had shared in April 2026 with county programs, which was during our audit.

The draft spreadsheets DPH provided were undated and collectively contained data on the KOHA program from school years 2011–12 through 2024–25. However, the spreadsheets did not contain any analysis of the indicators of oral health that the data surveillance plan stated DPH would use. Although the spreadsheets contained counts of the number of assessments that found decay or caries experience, DPH had not performed any analysis or evaluation of those data. The April 2026 assessment included the number of school districts that report to SCOHR, the number of students reporting having received an oral health assessment, and the prevalence of caries experience and untreated decay. However, DPH indicated that it primarily used the KOHA program data to measure the State's progress toward improving the number of districts that report data and the number of students who report having received an oral health assessment. Therefore, DPH did not provide evidence that it has regularly used the prevalence of oral health condition results to measure the State's progress toward reducing the proportion of children with caries experience and untreated decay.

DPH presented two different perspectives on the value of the KOHA program data, which conveyed ambiguity about why it has not used the KOHA program data as it had planned. In one set of statements to us during this audit, staff and leadership in the Office of Oral Health expressed hesitation at using the KOHA data as an authoritative source on the prevalence of oral health disease. These individuals expressed that the KOHA program data were not as robust as other data collection approaches. Specifically, DPH highlighted that the KOHA program data were unreliable for developing population level estimates because of inherent limits in the design of the KOHA program. However, the elements of the KOHA program data collection that DPH highlighted as problematic were knowable at the time DPH drafted the data surveillance plan, making them insufficient explanations for why the department cannot use KOHA program data as the surveillance plan states.

Figure 6
DPH Identified KOHA Program Data as Important for Understanding Oral Health in California



In 2017, DPH released the results of its assessment.
Key findings included:

54%	874,000	1.76 M
Kindergarteners who have experienced tooth decay	School days missed annually due to dental problems	Californians who lived in a dental health professional shortage area

In 2018, DPH released its plan for oral health, and in 2019, it published a data surveillance plan to accompany the 2018 plan.

Percentage at time of goal setting
54%

GOAL
Reduce the proportion of kindergarteners with caries experience to:
43%
Monitored by: KOHA program data

Percentage at time of goal setting
28%

GOAL
Reduce the proportion of kindergarteners with untreated decay to:
22%
Monitored by: KOHA program data

Source: Budget change proposal from budget year 2014, Oral Health Plan, and Oral Health Surveillance Plan.

* This funding was not exclusively for these activities. The available documentation does not clearly delineate the amount of funding specifically for these activities.

Further complicating its response to our questions was a second set of statements DPH made about the value of the KOHA data. In contrast to the first statements, staff and leaders from DPH's Office of Oral Health also stated that the KOHA program provides routinely collected surveillance information that can be used to monitor statewide patterns and trends over time, identify county-level variations, and support program planning and quality improvement efforts. According to DPH, the KOHA program data serve an important surveillance and program-monitoring function by providing information on implementation and participation in the statewide oral health assessment requirement, as well as on oral health findings among children represented in SCOHR. Nonetheless, DPH did not provide us evidence that showed that it had been regularly assessing the KOHA data for these purposes or that it had taken any actions in response to the data about caries experience or decay.

Periodic Evaluation of the KOHA Program Requirements

State law requires DPH to periodically evaluate the KOHA program requirements found in state law. We asked DPH how it fulfills this obligation, and the department explained its belief that the periodic evaluation requirement is vague. When we asked whether it had ever sought clarity from the Legislature about the requirement, DPH did not answer our question. Instead, the Office of Oral Health explained its belief that it had fulfilled the evaluation requirement through the draft spreadsheets we previously describe. As we explain above, these undated spreadsheets do not contain any analysis of the indicators of oral health. They also do not contain any evaluations of the data to reach conclusions about the program. We acknowledge that the requirement for periodic evaluation does not explicitly specify what action DPH should take to perform such an evaluation, and below we describe how the State's adoption of clearer language would likely result in a more useful review of the KOHA program. Nonetheless, we do not believe that DPH has adhered to its obligation to periodically evaluate the KOHA program's requirements.

DPH also asserted that it has equipped county programs to perform their own evaluations of the KOHA program in their jurisdictions. As we describe in the Introduction, DPH funds these programs through grants of Proposition 56 (Prop 56) funding. The county programs are required by the terms of their grants to focus on multiple oral health initiatives, including activities related to monitoring children's oral health and the KOHA program, developing a health improvement plan, and establishing partnerships with dental providers and schools for school-linked dental programs.

Since 2022, DPH has contracted with UCSF to provide support to county programs. As part of its agreement, DPH has required UCSF to coordinate with county programs to implement a results-based accountability framework (accountability framework). The accountability framework, which UCSF's contract specifies that it would implement with the county programs from fiscal year 2022–23 through 2024–25, was a framework designed to enable county programs to share and review data to inform strategies for improving KOHA program performance. According to the leaders of DPH's Office of Oral Health, it was focused on two elements of

the KOHA program: the number and percentage of school districts reporting to SCOHR and the number and percentage of students who provided proof of an oral health assessment. Evidence from UCSF's website indicates that the accountability framework resulted in some county programs reviewing basic KOHA program data for their service areas, such as the percentage of districts reporting KOHA program results or the percentage of students with tooth decay.

DPH's grant conditions required the county programs to review, among other health data, KOHA program data elements such as the number of districts reporting KOHA program data and the results of the oral health assessments, and prepare a related report. Accordingly, we considered whether the county programs had used KOHA program data to inform their public health response. We found that three of the six county programs we reviewed had analyzed indicators of oral health using KOHA program data. Specifically, Santa Clara County analyzed its KOHA program data in a draft Oral Health Needs Assessment Update report to better understand the prevalence of caries experience and untreated decay throughout the county. Based on this analysis and other data, the county's draft report included recommendations to increase its school-based dental assessment programs; provide, through partnerships, oral health education; and improve early intervention and preventive services. Two of the other county programs we reviewed—Merced and San Luis Obispo—stated that they also analyzed indicators of oral health from the KOHA data. However, Merced acknowledged it had only started doing so in 2026.

The remaining three county programs we reviewed—Alameda, Los Angeles, and Yolo—confirmed they did not review oral health indicators in the KOHA data to inform their public health response. Staff from Yolo stated that they review oral health disease data from the KOHA program, but confirmed that they do not use those data to inform the county program's approach to oral health. Staff at both Alameda and Los Angeles cited concerns with the KOHA program data, with Los Angeles's staff indicating concerns with the validity and reliability of the data similar to those DPH expressed. Nonetheless, by requiring the county programs to assess these data, DPH has conveyed that they are important indicators of oral health. Although the data have limitations and may contain inaccuracies, they still provide information that the counties could use to inform their public health response. In fact, DPH has specifically stated that these data serve an important surveillance and program-monitoring function.

In light of this audit's findings, the Legislature should consider amending the law to provide more specific direction to DPH. The Legislature could amend the law to specify how often DPH should perform its KOHA program evaluations, the precise elements of the KOHA program DPH must evaluate, and the expected types of conclusions that DPH should reach. For example, state law could require DPH to produce an evaluation of the KOHA program every three years that includes an assessment of the oral health data, such as the rate of untreated decay. It could further require that DPH report its conclusions about whether the KOHA program is meeting its goals, its recommendations for how the program could be improved, and the steps that it is going to take to achieve better outcomes.

None of the Six Districts We Reviewed Have Collected Reliable KOHA Program Data in All Required Areas

As we describe in the Introduction, state law requires districts to report aggregated KOHA program results for eight specific data elements, including oral health results such as the number of students with caries experience and untreated decay. These data can provide the State with information on the oral health of California's students and better equip the State to address trends or issues that the data reveal, but the data will do so most effectively if they are reliable. As part of this audit, the Joint Legislative Audit Committee (Audit Committee) asked us to use locally available data to report, for our selected districts, information about nine data elements: the eight data elements about which state law requires districts to report and one additional data element, the number of students found to need urgent care.

To report on these nine areas, we first needed to determine whether each district's data about these areas were reliable. Table 3 summarizes the results of our review and shows that none of the districts maintained reliable data for all nine elements. In our professional judgment, the data are so significantly inaccurate or incomplete that they cannot be used to determine the number or percentage of students that should be counted under these nine areas except in a few cases, which we note in the table.

Every district except Woodland maintained KOHA program data in a data system that contained KOHA program information for each individual student who participated in the KOHA program, such as the results of the student's oral health assessment. Woodland did not maintain its KOHA program data in a data system; instead, it maintained aggregated data on the outcomes of its on-site assessment program that it sorted by grade level and school site. Accordingly, our approach to reviewing the reliability of Woodland's data was different from our approach to reviewing the other districts' data.

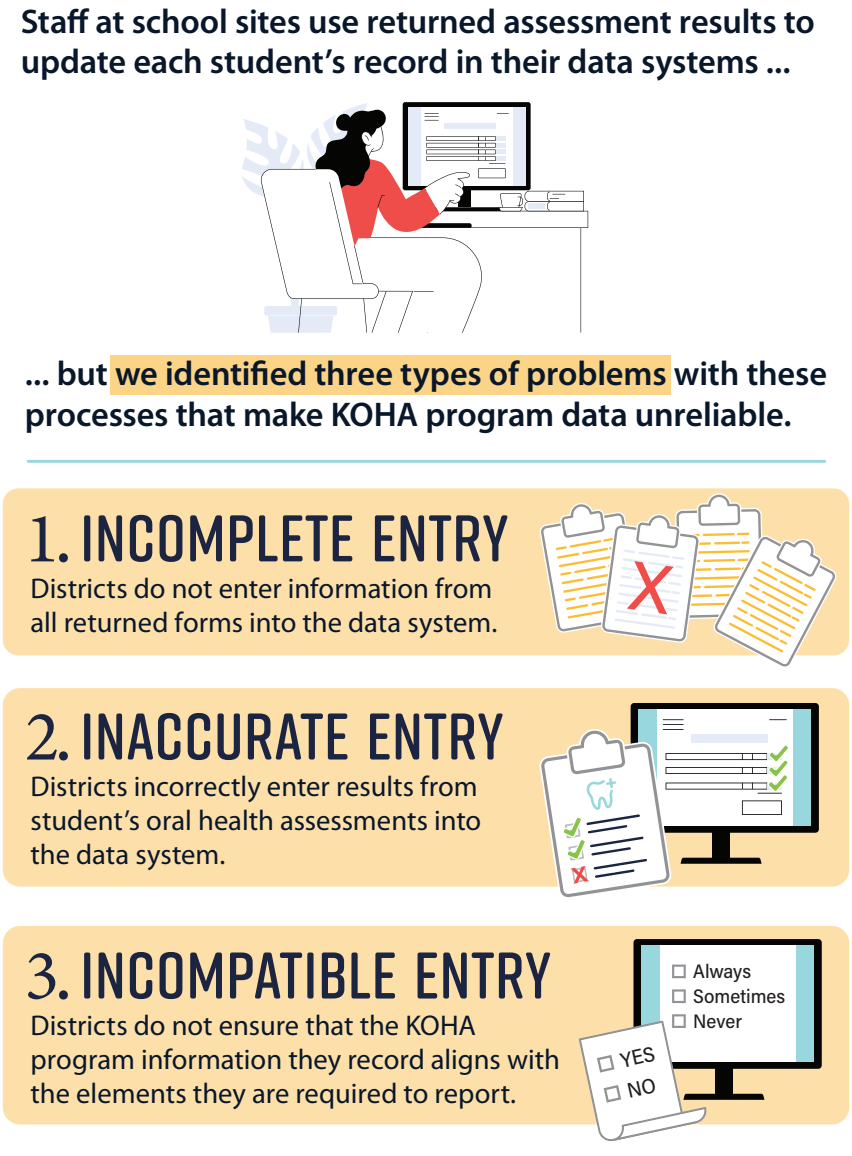
To determine the reliability of the KOHA program data at all districts except Woodland, we compared the KOHA program data from each district's data system to the hard copy KOHA program forms we collected from student files. We conducted these comparisons to determine whether the data were *complete* and *accurate*. We also checked whether the data systems were *compatible*, meaning that they tracked the appropriate data elements. Across the five districts where we conducted this work, we visited 25 school sites and reviewed nearly 250 student files. At Woodland our review consisted of a manual count of the information from all available oral health assessment forms at a selection of five schools and a comparison of these counts to the district's aggregated data. We found that, for the data that Woodland tracked, its data were sufficiently reliable, and we present that data later in this section. We found that the data from the other five districts were unreliable for three reasons, which Figure 7 summarizes. Our review determined that none of the five districts have accurate and complete information. The issues we describe below fundamentally threaten the KOHA program's goal of collecting oral health data. Therefore, the districts we reviewed must take additional actions to establish strong data management processes to ensure that the KOHA program information they receive from students is always accurately uploaded to their data systems.

Table 3
The Districts We Reviewed Did Not Maintain Quality KOHA Data

DISTRICT	STUDENTS SUBJECT TO KOHA REQUIREMENT	STUDENTS WHO PROVIDED PROOF OF ASSESSMENT	STUDENTS WITH UNTREATED DECAY	STUDENTS WITH CARIES EXPERIENCE	STUDENTS WITH URGENT NEED FOR CARE	STUDENTS WITH WAIVERS OF THE ASSESSMENT BECAUSE OF ...			STUDENTS WHO DID NOT RETURN AN ASSESSMENT OR WAIVER
						FINANCIAL BURDEN	*LACK OF ACCESS*	*NON-CONSENT*	
Los Angeles	**Complete** The number of students subject to the KOHA requirement was 100,271 from school years 2022–23 through 2024–25.	**Incomplete** The district did not enter into its data system the information from 18 of the 39 forms we reviewed.	**Incompatible** The district's data system does not include options that allow staff to distinctly count the students who have decay at the time of their assessment.	**Incomplete** The district did not enter into its data system the information from 18 of the 39 forms we reviewed.	**Not Tracked** The district's data system does not track this result.	**Incomplete** The district did not enter into its data system the information for 18 of the 39 forms we reviewed.			**Cannot Calculate** Because the district did not enter information from all assessment and waiver forms, we cannot determine the total number of students who did not return a form.
Merced	**Not Tracked**	**Incomplete** The district did not enter into its data system the information from nine of the 36 forms we reviewed.							
Milpitas	**Not Tracked**	**Incomplete** The district did not enter into its data system the information from eight of the 39 forms we reviewed. **Incompatible / Inaccurate** The district enters information from on-site assessment events into its data system. However, the data the district uses to populate its data system does not directly address the question of caries experience, leading to many illogical entries in the data system. Further, the district did not enter accurate information about treatment urgency. We reviewed forms for five students, and the information in the data system about treatment urgency was incorrect for all five.				**Not Tracked** The district's data system only includes free form text fields to track waiver information and does not systematically categorize this waiver information.			
Oakland	**Not Tracked**	**Incomplete** The district stated that some schools do not report assessment results into the district's data system. We visited four schools without KOHA program results in the data system and found that at three schools, only two of the 90 student files we reviewed showed evidence of an oral health assessment or waiver. However, at the remaining school, we found oral health assessments in nine of 30 selected students files, but the school had not entered information from those assessments into the district's data system.							
San Luis Coastal	**Not Tracked**	**Complete** The district received a total of 1,116 proofs of assessment from school years 2022–23 through 2024–25.	**Inaccurate** The district entered into its data system inaccurate oral health assessment results from six of the 30 assessment forms we reviewed.			**Not Tracked** The district does not distribute waivers to parents or track the reasons for waivers in its data system.			**Cannot Calculate** Because the district does not track waivers, we cannot determine the number of students who did not return a waiver form.
Woodland	**Not Tracked**	**Accurate / Complete** The district only records assessments obtained during on-site events. We reviewed the district's assessment results and found them generally accurate and complete.				**Not Tracked** The district only records assessments obtained during on-site events, and therefore does not collect or report waiver data.			**Not Tracked** Because the district only records assessments obtained during on-site events, it does not track the students who otherwise do not return an assessment.

Source: Auditor analysis of district KOHA data.

Figure 7
Districts Have Introduced Data Errors Because of Poor Data Management



Source: Review of selected districts' KOHA processes, data systems, and KOHA data.

Problems With the Data's Completeness

For each district except Woodland, we collected hard copies of oral health assessment and waiver forms from the student files maintained by the district and then reviewed the district's data to determine whether it had recorded the information from these forms. This step checks whether the districts' data are *complete*, meaning whether the districts' KOHA program data included information about all assessments and waivers that students returned.

Four of the five districts with data systems—all but San Luis Coastal Unified School District (San Luis Coastal)—did not enter the information from all of our selected forms into their data systems, as Table 3 shows. This means that these districts' data were missing KOHA program results that the districts should have recorded. For example, we obtained KOHA program forms for 39 students in Los Angeles but did not find the information for 18—nearly half—of these forms in the district's data.

In another example, district staff at the Oakland Unified School District (Oakland) stated that school staff do not always enter KOHA program information into its data system, and our review verified this account. We visited four Oakland school sites that had not recorded any KOHA program information during our audit period and reviewed the contents of 30 student files at each school site. If the data for these schools were correct, we would expect to find no KOHA program forms in these student files. However, if student files contained KOHA program forms, that would mean that the school site had not entered the information from the forms into the data system. At three of the four schools, we found almost no forms: only two of the 90 student files contained a KOHA program form. However, we found nine KOHA program forms in the 30 student files we reviewed at the fourth school, but we could not find any of the information from these forms in the district's data. Therefore, we concluded that Oakland's data were incomplete. Although district staff explained that school staff receive training on reporting KOHA program results into the district's data system, a staff member from the school where we identified the nine unentered forms stated that they did not believe it was their responsibility to enter the information from oral health assessment forms into the district's data system and had never observed this entry being done by others.

Problems With the Data's Accuracy

To review the accuracy of the districts' data, we compared the information from a selection of KOHA program forms to the information in the districts' data systems to determine whether staff had entered the data correctly. As Figure 7 notes, some districts did not always correctly enter results from returned oral health assessments into their data systems. For example, San Luis Coastal inaccurately recorded results for six of 30 oral health assessments we reviewed. One oral health assessment form we reviewed showed that the student did not have any untreated decay at the time of the assessment but had experienced caries in the past. However, the district recorded in its data system that this student had decay at the time of the assessment and had never had caries experience. District staff confirmed that the inaccurate results we found were generally the result of human error.

Problems With Data Compatibility

Lastly, we also performed a more general review of each district's KOHA program forms, data, and data systems, to assess whether the district had aligned these elements to properly record KOHA program results. The standardized oral health assessment form includes questions about whether the assessed student has visible decay or caries experience, as well as the urgency of treatment required. Similarly,

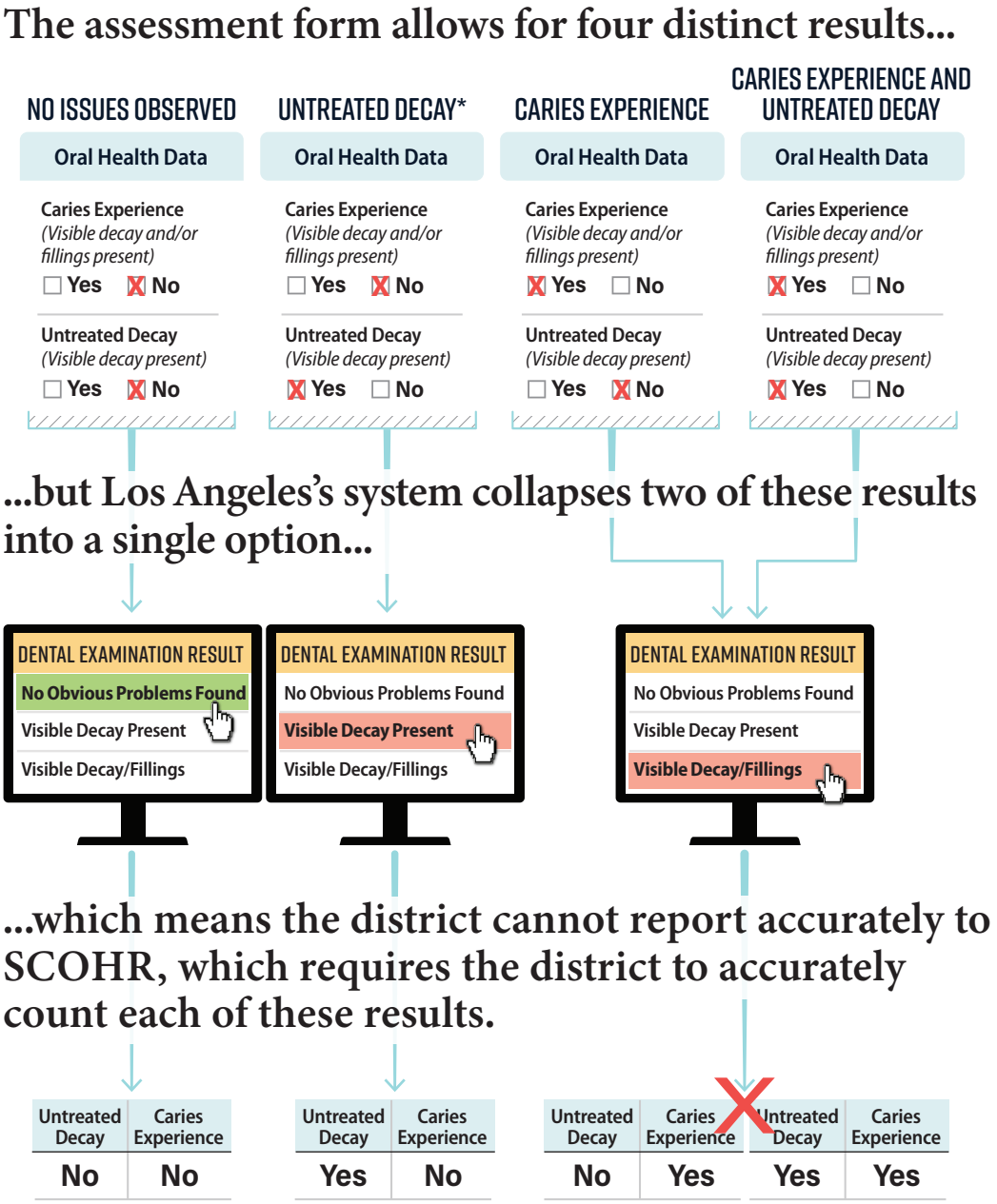
the standardized waiver form includes questions about why a family is waiving the oral health assessment requirement and includes reasons such as lack of access or financial constraints. These possible results on the standardized KOHA program forms generally correspond to the data elements that state law requires districts to collect. Therefore, to facilitate compliance with state law, a district's data system and approach to inputting data must allow district staff to record all possible results for all questions on the standardized forms, which we refer to as *compatibility*.

We found that two districts did not ensure that their oral health assessment results and data systems aligned with state reporting requirements, impeding their ability to correctly report KOHA program data. For example, Milpitas Unified School District (Milpitas) recorded assessment results for hundreds of students annually who received their oral health assessments through on-site assessment events. When we asked the district how it recorded results from these assessments in its data system, the district explained that the organization that conducted the assessments provided the district with a spreadsheet that contained the assessment results. The district then imported this spreadsheet into its data system.

However, those assessment results did not align with the required KOHA information, leading the district to record incorrect data. Specifically, the assessment results did not directly answer the question about caries experience. Instead, the spreadsheet included independent conclusions about whether a student had visible decay and whether they had past treatment for decay (fillings). As Figure 1 shows, students with active decay at the time of the assessment should be recorded as having caries experience regardless of whether they have fillings. Even though the assessment data the district received did not make conclusions about caries experience, the district used the information about fillings as a response to the caries experience question. As a result, many students had incorrect entries for caries experience. At one Milpitas school we reviewed, the district's data for school year 2023–24 did not correctly identify more than half of the 39 students who should have been recorded as having caries experience. Accordingly, Milpitas's on-site assessment results are incompatible with the results expected by the standardized form and SCOHR, and the district recorded inaccurate information for a significant number of its students.

At Los Angeles, we found that the district's data system had not been designed to accurately capture all information from the oral health assessment form. Specifically, its data system does not allow district staff to record individual results for untreated decay, caries experience, and treatment urgency. As Figure 8 shows, the district collapsed the first two of these entries into one column labeled "Dental Examination Result" that allows for the selection of one of three options: visible decay, visible decay/fillings, and no obvious problem found. Despite visible decay being one of the possible results, Figure 8 shows how this framework does not provide the district with the ability to discretely identify the students who have visible decay at the time of their assessment.

Figure 8
Los Angeles's Data System Does Not Allow Schools to Record All Possible Results From the Assessment Form



Source: Oral health assessment form, Los Angeles's data, and SCOHR data.

* This combination of responses is illogical because students with untreated decay also have caries experience. We depict this option because a dental health professional may choose these responses, and we would not expect the district to alter the results of the assessment when entering information into its data system. Additionally, SCOHR generally contains information at aggregate levels, meaning that it will not detect individual instances of illogical responses.

Woodland's KOHA Data

Woodland does not track all of the data elements on which we were asked to report. Specifically, Woodland did not track the number of families that submitted waivers. However, the district maintained reliable data about other elements we were asked to review. Woodland performs an on-site dental assessment for all kindergarten students—a process we describe later in the report—and then aggregates the results for each school, including the total number of kindergarten students at each school assessed and found to have decay or caries experience. To determine the reliability of Woodland's data, we obtained all hard copy oral health assessment forms at five schools; calculated the total number of students assessed and found to have decay or caries experience, as well as the treatment urgency noted during the assessments; and then compared these results to the aggregated amounts Woodland documented for these five schools. Our summation of the information from the forms we reviewed was substantively similar to the district's data. Table 4 shows the data from Woodland.

Table 4
Woodland's On-Site Assessment Results Indicate a Large Percentage of Kindergarteners Received an Oral Health Assessment

SCHOOL YEAR	KINDERGARTENERS ENROLLED	KINDERGARTENERS ASSESSED	PERCENTAGE ASSESSED	ACTIVE DECAY	CARIES EXPERIENCE	URGENT TREATMENT NEEDED
2022–23*	559	446	80%	155 (35%)	268 (60%)	39 (9%)
2023–24	674	543	81%	143 (26%)	298 (55%)	44 (8%)
2024–25	606	480	79%	138 (29%)	307 (64%)	27 (6%)

Source: Woodland KOHA program data.

* The 2022–23 results do not include results for two of Woodland's 12 elementary schools because a different provider conducted assessments at those schools, and that provider gave the results for those schools to a staff member who has since retired. As a result, the district did not have access to those data.

The Districts Reported Questionable Data to the State, Diminishing the Value of the Analysis of SCOHR Data

The deficiencies we describe in the previous section relate to school districts' efforts to collect and record KOHA program information in their data systems. After school districts receive this information, state law requires them to report specified data elements to either their county office of education or SCOHR. All six school districts we audited have reported to SCOHR, which allows various entities, including county programs and CDE, to access and review these districts' KOHA data. To determine whether the six school districts we audited were meeting the KOHA program's reporting requirements, we reviewed their practices for submitting KOHA data to SCOHR.

Reporting Discrepancies

We expected that the six districts' local data would be the basis of their reports to SCOHR and that the local data would therefore align with the data that the districts reported to SCOHR. However, we found that the districts' local data and their reports to SCOHR often did not align. To assess this area, we compared the information from each district's data system for key KOHA program elements, such as number of students assessed and number of students with visible decay, to the information the district submitted to SCOHR. We found that five of the six districts reported data to SCOHR that was significantly different from their local data. Figure 9 shows the type of discrepancies we identified between the data districts reported to SCOHR and the data in their systems. Although we did not identify any substantive discrepancies between Merced City School District's (Merced) local data and its reports to SCOHR, because of the data quality issues we describe earlier, we still conclude that the data the district reported to SCOHR were inaccurate.

Los Angeles's reporting discrepancies were so significant that they would affect any analysis one might perform of statewide oral health using the KOHA program's data. We previously explain that Los Angeles reported an unreasonably high number of students who were subject to the KOHA program's requirements. We also identified another issue: the district overreported the number of students who presented proof of an oral health assessment. The text box shows the size of Los Angeles's reporting error compared to the total number of assessments that all districts throughout the State reported to SCOHR. The magnitude of Los Angeles's reporting error is large enough that it disproportionately inflates the statewide rate at which students were assessed in the years we reviewed. A calculation of the statewide assessment rate in any of these years would include from 2.7 to 8.6 percent more assessments than local data indicate were actually completed.

Los Angeles's Reporting Errors Significantly Affect the Total Statewide Annual Assessments Recorded in SCOHR

School Year 2022–23

- *Los Angeles's reporting error:* 7,000 students
- *Percentage of statewide reported assessments:* 5.1%

School Year 2023–24

- *Los Angeles's reporting error:* 4,400 students
- *Percentage of statewide reported assessments:* 2.7%

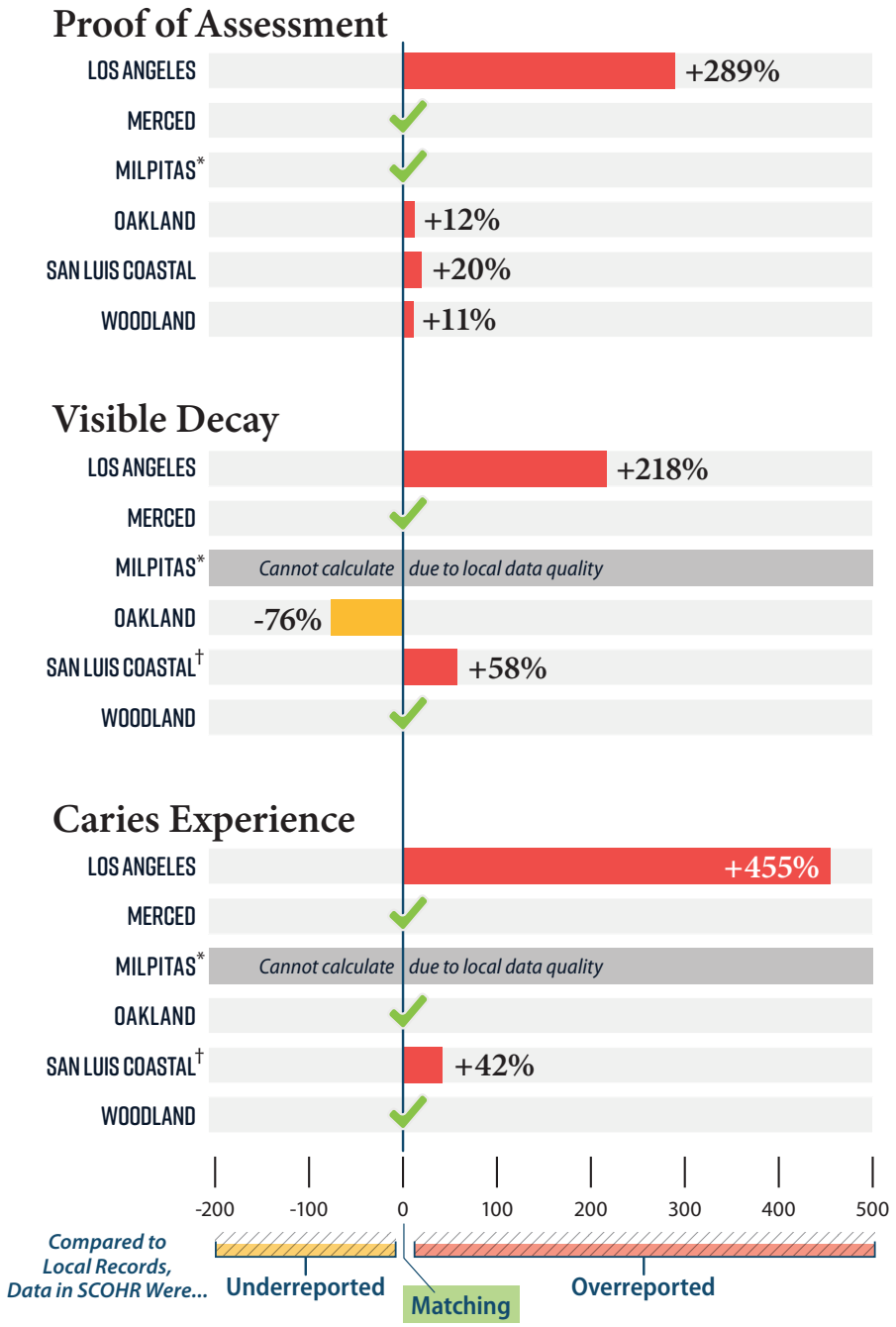
School Year 2024–25

- *Los Angeles's reporting error:* 16,200 students
- *Percentage of statewide reported assessments:* 8.6%

Source: Data from SCOHR and Los Angeles.

When we asked Los Angeles about its process for reporting KOHA program data, staff explained that they obtain a KOHA program report from a district data system and then upload it to SCOHR. Similar to its explanation about overreporting the total number of students subject to the KOHA program requirements, the district indicated that the report it used to submit information to SCOHR included students for more than just the single year during which they submitted proof of an oral health assessment. This means that information about a single student subject to the KOHA program requirements could be reported to SCOHR in multiple years, causing Los Angeles to overreport. The district staff to whom we spoke indicated that the district was not planning to correct the data it had previously submitted, but until it does so, any analysis of the statewide assessment rate using the SCOHR data will be incorrect.

Figure 9
The Districts' Data Reporting to SCOHR Did Not Always Match Their Local Records



Source: District data from SCOHR and local data systems for each of the districts for school year 2024–25.

Note: We determined that a district's report to SCOHR was matching if it was within 5 percent of the information in its local data system or if the difference in the reported value to the local value was within 10 students. These data are from school year 2024–25, which we found to be illustrative of similar discrepancies we discovered in the other years of our audit period.

* The local data Milpitas provided us included many instances in which a single student had recorded results from multiple assessments, often with different recorded results. We could not reliably correct the data to allow for a comparison of local data to SCOHR data for visible decay and caries experience. Additionally, although the figure shows that Milpitas's proof of assessments data matched for school year 2024–25, the district's local data for proof of assessments did not match what it reported to SCOHR in school years 2022–23 and 2023–24.

† The local data San Luis Coastal provided us included many instances in which students had recorded results from multiple assessments. We used these data to determine the number of students showing proof of at least one assessment, allowing us to compare the number of students with a proof of assessment in San Luis Coastal's local data to its report to SCOHR. Unlike at Milpitas, for visible decay and caries experience, we counted all assessment results in the local data, even when that meant we counted the results from more than one assessment per student. Therefore, our comparison between the local data and SCOHR for visible decay and caries experience understates the discrepancy that there would have been if we had counted only one assessment per student.

The discrepancies we found at San Luis Coastal are likely the result of poor processes for reporting to SCOHR. For example, we found that San Luis Coastal does not use the information in its data system as the only source for preparing its report to SCOHR. The lead credentialed nurse explained that she uses district-created spreadsheets that document assessments completed during an on-site assessment in conjunction with the district's data system to arrive at the final amounts she reports to SCOHR. However, the lead credentialed nurse confirmed that she does not maintain the calculations she uses to arrive at the number of completed assessments that she reports to SCOHR, and that she cannot account for discrepancies between the district's data system and SCOHR. In addition, the local KOHA data San Luis Coastal provided us included a large number of instances in which it had recorded two assessments for a single student. Because of the issues we describe with San Luis Coastal's reporting process, it is unclear how the district accounts for students with multiple entries when reporting to SCOHR.

We found that Milpitas had similarly unclear processes for reporting its local KOHA data to SCOHR and that Milpitas's local data also included students with multiple assessments. According to both district staff and the district's guidelines for its staff, its on-site school health clerks are responsible for tallying KOHA program data outside of the district's data system and submitting those totals to the district nurses for submission to SCOHR. However, having staff track KOHA program data in a separate location from the data system that they already use to record the oral health assessment results increases the likelihood of errors in reporting. Further, district staff stated that the district does not have a standardized process for school staff to follow when providing their KOHA program data to the district. Because we found that Milpitas's local data included students with two or even three assessments recorded, the district's unclear processes for reporting raise concerns that staff will report inaccurate oral health results to SCOHR. We note in Figure 9 our inability to account for these duplicates when comparing the district's local data on the number of students with visible decay and caries experience against the data the district reported to SCOHR for these indicators.

Merced reports the data directly from its data system to SCOHR. Merced provided a procedure that outlined how the district reported to SCOHR, which included using the district's data to determine the totals for KOHA's reportable categories. The district informed us that this procedure was outdated, but when we asked district staff about their current processes, the process they described was similar to the process from the outdated procedure. Although the district would likely benefit from updating its procedure, we do not take issue with the district's approach because we found no major discrepancies between Merced's local data and the information it reported to SCOHR.

Other Reporting Errors

We identified problems with how Oakland and Woodland reported to SCOHR that are unrelated to the other districts' issues. Specifically, we found that Oakland had reported very little information to SCOHR for the school years we reviewed until after the start of our audit. At the beginning of our audit, we found that Oakland

had not reported any KOHA program data to SCOHR for school years 2022–23 and 2023–24 and that for school year 2024–25, it had reported data for only two of its 50 schools. After meeting with district staff at Oakland, they explained that the district had experienced a reporting issue but had since uploaded all its KOHA data for the previous years. We obtained an updated SCOHR data report which shows that Oakland reported its KOHA data for school years 2022–23 through 2024–25, but it did so from March 2026 to May 2026, well past the statutory deadline for reporting for those years.

Woodland also had errors in reporting. Woodland explained that it only reports to SCOHR about the assessments done at its on-site assessment events and not any assessments that are conducted outside of these events. During our audit, we observed that Woodland focused nearly all its KOHA program efforts on its on-site assessment program. Our review of oral health assessment forms from five schools across a three-year period identified 20 students who submitted assessments completed by their dentist and who were not assessed during the district's on-site assessment events. In total, Woodland enrolled more than 750 students in kindergarten across these same schools and years, meaning that the total unreported assessments were minimal. Nonetheless, the district's reporting practice means that it is not reporting all of the information that state law requires it to report.

Woodland's other reporting error was more significant. When reporting to SCOHR, Woodland reported students absent from school on the on-site assessment day as having presented proof of an assessment, even though these students were not assessed. For school year 2024–25, this practice resulted in the district reporting 53 more students as having presented proof of an assessment than it should have reported, thus increasing Woodland's total by 11 percent.

The individual responsible for Woodland's on-site program explained that she received guidance from another individual who was trained to use SCOHR to report absent students as receiving an assessment. She stated that the explanation she received was that students who were absent did return proof of an assessment, but that the assessment form was blank. This understanding is at odds with state law, which clearly requires districts to report the number of the students who received an assessment. Although we found Woodland's local data to be generally reliable—in other words, the district accurately and completely recorded the results from its on-site assessments—its processes for reporting to SCOHR result in the district reporting inaccurate KOHA program data to the State.

Given the breadth of these issues and their impact on statewide KOHA data, five of the six districts we reviewed will need to revise their processes to ensure that they report more reliable data. Statewide entities that could access and use these data to adjust their activities regarding the KOHA program include CDE and DPH. However, the potential usefulness of these data to these departments is negated when districts report unreliable data.

Districts Generally Do Not Have Processes to Evaluate Their KOHA Data

As part of this audit, we were asked to review districts' processes for evaluating their KOHA program data for purposes of informing improvements to their KOHA program efforts and whether they align with best practices. State law does not require districts to use their data to evaluate adherence to the KOHA program requirements, but doing so would allow districts to better understand gaps or barriers that threaten their ability to comply with the KOHA program requirements. Identifying and responding to threats to compliance is a best practice for government entities.

To determine districts' efforts in this area, we asked each district whether it monitors or evaluates its KOHA data. Two of the districts—Merced and Woodland—confirmed they do not review their KOHA data. Merced shared that it was aware that its KOHA participation rate is low but that it is not able to engage in the follow-up activities that would raise its participation rate because of competing priorities.

The other four districts asserted they had processes for reviewing their data. For example, Los Angeles, Milpitas, and San Luis Coastal stated that they expect their health clerks or nursing staff to run reports of returned assessments from the district data system to determine which students have not returned an assessment. However, the districts have not formalized these expectations in policy. Similarly, Los Angeles and Oakland both stated that they review their KOHA data to determine which schools have not uploaded assessment results so that staff may follow up with them. However, only Los Angeles was able to provide evidence that it had followed up with schools. Given that—as we previously describe—some Oakland schools do not report the results they receive, Oakland's process appears to be of limited effectiveness.

Although at least some of the districts we reviewed stated they have informal processes for reviewing their KOHA program data to increase the number of assessments they report, their lack of formal processes and significant data problems we identified during this audit indicate that more can be done. Because the districts we reviewed must revise their processes for collecting, processing, and reporting their KOHA data to resolve the issues we noted, the districts should similarly consider establishing formal processes for reviewing their own data with the goal of increasing both the number of assessed students as well as the reliability of their reported data.

Recommendations

Legislature

To ensure that the State can more efficiently and effectively oversee KOHA program reporting, the Legislature should amend state law to require school districts to report all KOHA data to the single database designated by the state dental director.

To ensure regular evaluation of the KOHA program, the Legislature should amend state law to specify the frequency of DPH's program evaluation and the specific elements that evaluation should include. These elements should also take into consideration DPH's recommendations for improvements to the program. For example, the Legislature could specify evaluations should occur once every three years and contain an analysis of specified oral health indicators, such as caries experience, that determines the rates of the oral health indicators among assessed students and compares those rates to historical rates to establish a trend. The Legislature could also specify that the evaluation include information about how many school districts report KOHA program results.

DPH

To ensure that the State, local governments, and other stakeholders have access to as much KOHA program data as possible, DPH should, by March 2027, develop and propose for CDE's approval a standardized KOHA program form that includes both the oral health assessment and the waiver component. This form should replace the existing separate oral health assessment and waiver forms.

To ensure that school districts submit reasonable KOHA program results, DPH should annually compare districts' reports to SCOHR with CDE enrollment data starting January 2027 to identify district reports that fall outside of a tolerable range. Based on this information, DPH should annually do the following:

- Identify the districts with significant variances from the CDE enrollment data.
- Notify these districts that they may have submitted incorrect data, explain the basis for the notice, and request they complete any necessary revisions to their reports.
- Notify the county programs associated with these districts and request them to offer technical assistance with improving the district's reporting procedures.

To ensure that the KOHA program data are as complete as possible, DPH should, beginning in January 2027, and at least annually thereafter, contact districts that did not report KOHA program data to remind them of their reporting obligations and encourage them to report as required. If DPH believes that contact from county programs would be more effective, it should work in coordination with the county programs to ensure that this communication occurs. DPH should also publish a list of nonreporting districts on its website and update that list annually.

To ensure that stakeholders have access to the data that DPH established would be used to measure progress in meeting the State's oral health goals, DPH should, by March 2027 begin regularly publishing on its website annual analyses of the KOHA program data in the areas of caries experience and visible decay. These analyses should explain any limitations of the data that DPH believes are important.

After the first annual analysis, subsequent analyses should include trends from the previous years such that the public can determine whether oral health conditions are improving year-over-year.

School Districts

To ensure that they record complete and accurate KOHA program data that facilitate their compliance with reporting requirements, the districts we identify below should take the following actions by March 2027:

- Los Angeles, Merced, Milpitas, Oakland, and San Luis Coastal should adopt procedures to regularly review whether staff are entering complete and accurate KOHA program information in their data systems.
- Los Angeles should modify its data system to track the assessment results of caries experience and visible decay as separate results.
- Milpitas should ensure that the oral health assessment results that it accepts from screening providers and families include all of the information needed to report all required data.
- Woodland should begin recording waiver information as part of its KOHA program.

To ensure that their annual reports provide the State, local governments, and other stakeholders with correct KOHA program data, the districts we identify below should take the following actions by March 2027:

- Los Angeles should correct the issues that cause its data system to overstate the number of its KOHA-eligible and assessed students.
- Milpitas and San Luis Coastal should adopt procedures for reporting KOHA results to SCOHR that rely directly on the data in their data systems.
- Oakland should adopt procedures for reporting annually as required.
- Woodland should adopt procedures to report information about all oral health assessments that it receives from students and not report absent students as having received an oral health assessment through its on-site assessment program.

To ensure that they identify opportunities to improve KOHA program participation and their own compliance with KOHA program requirements, Los Angeles, Merced, Milpitas, Oakland, San Luis Coastal, and Woodland should, by March 2027, adopt procedures to review their KOHA program data at least twice a year to identify students that have yet to complete an assessment so that the district may provide reminders to those students about the assessment requirement.

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The Absence of Effective Statewide Oversight Has Contributed to Districts' Lack of Compliance With the KOHA Program's Requirements

Key Points:

- The districts did not consistently provide parents with the standardized KOHA forms required by law which in some cases meant that parents were not provided important information about oral health and the KOHA program.
- None of the districts had formalized processes for following up with families that did not return oral health assessment forms or that returned waivers indicating a barrier to obtaining an assessment.
- Neither CDE nor DPH perform oversight activities related to the KOHA program, likely leading to the district noncompliance we identified and challenging the State's ability to identify and address local and statewide shortcomings in the KOHA program.

Districts Have Not Consistently Notified Parents About KOHA Program Requirements or Provided Them With the Correct Forms

As the Introduction describes, school districts are responsible for notifying students and parents about the oral health assessment requirement. State law requires that public schools use the standardized notification form developed by CDE, and in practice there are four such forms. The notification form describes the oral health assessment requirement and provides resources to assist families in finding a dentist, and the on-site opt-out form explains that students will be assessed at any on-site oral health assessment event the district hosts unless the student's family affirmatively opts them out of the screening. The other two standardized forms—the assessment form and waiver form—are the forms families complete to satisfy the KOHA program requirements. As such, it is critical that districts provide all four standardized forms to ensure that families are fully aware of the KOHA program requirements, including their option to waive the requirement. We therefore reviewed the districts' efforts in three areas: use of the standardized forms, notification of all families about the KOHA program, and accessibility of information in all required languages.

Required KOHA Forms

To assess the notification practices at the districts we reviewed, we first asked each district which of the standardized KOHA program forms they provided to families. None of the six districts we reviewed used all four required standardized notification forms. Instead, as Table 5 summarizes, the districts varied in the types of forms they provided: current standardized forms, outdated standardized forms, their own

versions of forms, or no forms. Because they did not use all required forms, none of the districts we reviewed were compliant with state law. Further, in some cases, families lacked the required notice of important information about the KOHA program or available resources that could assist them in identifying dental health care for their child.

Table 5
The Districts Did Not All Use the Standardized KOHA Forms as State Law Requires

	LOS ANGELES	MERCED	MILPITAS	OAKLAND	SAN LUIS COASTAL	WOODLAND
Notification Form	Locally developed form	Outdated standardized form	None used	None used	None used	Locally developed form
Assessment Form	Locally developed form	Outdated standardized form	Current standardized form	Outdated standardized form	Current standardized form	Current standardized form
Waiver Form	Locally developed form	None used*	Current standardized form	None used*	None used	None used
Opt-Out Letter	Locally developed form	None used	Locally developed form	Locally developed form	Locally developed form	Locally developed form

Source: District enrollment materials, health forms, and websites.

Note: This table shows the forms districts claimed to use to fulfill the KOHA requirements, even in cases where we could not validate the district provided these forms to all KOHA-eligible students. At some districts, we were unable to verify the extent to which all school sites provided forms to families. For example, we were unable to verify the extent to which San Luis Coastal provided forms to parents, given its practice of verbally notifying families of the KOHA program's requirements.

* This district did not use the standardized waiver form. However, because the district used the outdated assessment form, which combined the assessment and waiver responses, the district provided some notification of the waiver option.

As Table 5 shows, none of the six districts used the correct notification form, with three districts—Milpitas, Oakland, and San Luis Coastal—not providing families with any notification form. The notification form includes important information for families about the oral health assessment requirement, resources that families enrolled in Medi-Cal can use to locate a dentist, and advice about maintaining good oral health. By not providing this information to families, districts risk that the families will not understand the KOHA program requirements, struggle to locate a dentist, or miss important oral health guidance.

We also identified that districts frequently used locally developed forms instead of the required standardized forms. Los Angeles used four locally developed forms instead of using any of the standardized forms, and four other districts used a locally developed on-site screening opt-out form instead of the opt-out letter published by CDE. The forms Los Angeles developed generally aligned with the standardized forms they replaced and state law's requirements for notification. For example, the notification letter that Los Angeles developed is, in some parts, a word-for-word duplicate of the standardized notification form. In the instances in

which Los Angeles's letter differed from the standardized letter, we did not identify any significant omitted information or any added information that would mislead or misinform families about the KOHA program or oral health.

When we asked Los Angeles why it was not using any of the required KOHA program forms, an attorney for the district explained that the district prefers to customize its forms to better reflect the concerns of its student population and families as well as applicable legal parameters. This attorney also shared the district's perspective that while state law expressly requires the use of the notification form, the law was not as explicit regarding use of the other forms. We disagree that state law does not require the use of all of the forms and note that the district could achieve compliance with the law while addressing local concerns by distributing the standardized forms and then supplementing those forms with any additional guidance or materials it believes are necessary.

However, the on-site opt-out forms developed by Milpitas, Oakland, and Woodland omit important information included on the standardized form. Specifically, these districts' forms do not specify that families can complete the oral health assessment requirement by having their student assessed on-site, which is information the standardized form includes. Consequently, parents receiving these forms may not understand that they do not need to bring their child to a dentist to complete the oral health assessment requirement and can instead rely on the district's on-site assessment to complete the requirement. These discrepancies illustrate how districts that do not use the standardized forms as state law requires may provide incorrect or incomplete information to families about the KOHA program's requirements.

The six districts provided varied responses when we asked why they did not use the required forms to notify families about the KOHA program. For example, the lead nurse at San Luis Coastal explained that her district does not provide all required forms because the district does not believe that doing so would ensure meaningful notification. She clarified that she believed that providing all of the forms could inhibit participation because of the many forms families receive during enrollment. At Merced, the district nurse explained that changing roles and responsibilities and staff turnover may have resulted in miscommunication or misunderstanding of the notification requirements. The Merced nurse further stated that school nurses likely did not have the bandwidth to ensure that the correct forms were provided. Woodland and Oakland did not answer our questions about why they did not provide all required forms.

Notification of the KOHA Program Requirements

We also evaluated whether the districts informed all families about the oral health assessment requirement. Until January 2025, school districts were explicitly required to notify only families of students in kindergarten or enrolling in public school for the first time as a first grader. Beginning in January 2025, the Legislature expanded the definition of *kindergarten*, for the purpose of the KOHA program, to include students enrolled in TK, and it gave those students until the end of their kindergarten year to submit proof of an oral health assessment. Accordingly, we expected that

the school districts we audited would be able to prove that they notified families of students at least once in the TK and kindergarten years, and in the first grade when applicable.

Of the six districts we audited, only two—Los Angeles and Milpitas—demonstrated that they had processes for notifying all students at least once in the TK and kindergarten years and in the first grade if necessary. Los Angeles's KOHA program policy informs schools that they are required to notify families and suggests that they include the district's KOHA program forms alongside other enrollment materials. We verified that three of Los Angeles's schools included at least some of the forms. At Milpitas, the district's online enrollment guidance for families informs all families of TK, kindergarten, and first-grade students about the KOHA program.

Two other districts—Merced and Woodland—notify families at least once during the TK and kindergarten grades but do not notify families of applicable first-graders. Both Merced and Woodland notify kindergarten families about the oral health assessment requirement during enrollment. Woodland's enrollment form also notifies families enrolling in TK. When we asked Merced's district nurse why the district did not notify first graders enrolling in public school for the first time, she explained that it was an oversight as the enrollment of these students is uncommon. However, Merced's district nurse stated it plans to update its process to ensure these students receive the KOHA information when registering. Woodland similarly expressed that enrollments of such first graders were rare. However, the district confirmed that it did not have a process to identify those students at the time of enrollment to ensure that they received the KOHA information.

The remaining two districts we reviewed—Oakland and San Luis Coastal—could not provide evidence that they notified families about the KOHA program. Similar to staff from the other districts, Oakland's health services program manager claimed that the district notifies families of the KOHA program requirements during its enrollment process. However, the health services program manager could not provide any evidence that the enrollment process included a KOHA program notification. Moreover, the district's executive director of enrollment explained that no KOHA program information is provided at enrollment. The health services program manager also claimed to include information about the KOHA program in the district's parent guide, but we found no evidence of this information in the district's most recent parent guide, nor could the district provide any examples of past guides. Therefore, we concluded that Oakland could not provide sufficient evidence that it notifies students subject to the KOHA program requirements.

San Luis Coastal did not claim to notify families of the KOHA program requirements through its enrollment process. Instead, the district explained that its practice was to orally notify families of the KOHA program requirements at its TK-kindergarten welcome events for prospective students. Because of San Luis Coastal's oral notification practice, we are unable to verify what information the district provided to students, which students were informed of the assessment requirements during the audit period, and the extent to which any provided materials complied with KOHA program requirements. Nevertheless, we concluded that the district did not inform all KOHA program eligible students because it acknowledged that its process

did not include applicable first graders and that it also did not provide information about the KOHA program requirements to TK and kindergarten families unable to attend the welcome events.

Accessibility of Information

We also reviewed whether the six districts had KOHA program information readily available, which included whether this information was provided in multiple languages and whether the districts had KOHA program information on their websites. We found that five of the districts had information about the oral health assessment on their websites and five had information related to the KOHA program in their parent handbooks.

In addition, we reviewed the extent to which districts complied with a key language access requirement. State law requires that when 15 percent or more of a school's students speak a single primary language other than English, that school must provide all notices sent to parents of those students in that other language. Each of the six districts that we audited had schools that met the 15 percent threshold for their Spanish-speaking students, meaning that each of the districts had schools that needed to provide KOHA program information in Spanish.

Because none of the districts could demonstrate that they provided all of the standardized forms to families, the districts could not show that they provided all required information in *any* language. Nonetheless, we reviewed the extent to which the districts provided the information they did give to families in both English and Spanish. We found districts could almost always provide us with translated copies of the forms that they distributed in English. The only exceptions were at Milpitas and Woodland where the districts did not provide Spanish language versions of all of the standardized forms those districts otherwise provided in English in their enrollment materials. At Milpitas, the district did not have a translated version of the waiver form, and Woodland did not have a translated version of the oral health assessment form.

Districts Could Improve Their Efforts to Follow Up on Unreturned KOHA Program Forms

As part of this audit, the Legislature requested that we review districts' efforts to follow up on the KOHA program requirements, as well as whether they exhibit any best practices when following up with parents who cannot complete the oral health assessment because of financial or access barriers. Although state law places no obligation on districts to follow up with students who do not return a completed assessment or waiver, establishing a process to do so would likely increase participation in the KOHA program. Similarly, although there is no requirement to do so, districts could assist families in completing oral health assessments by providing them with resources that address their needs. However, we generally found that districts do not have standardized policies for following up in these areas.

Of the six districts we reviewed, none had established procedures for following up with families who had not returned a completed assessment form. However, districts were able to provide varying levels of evidence to support that they had done so. For example, San Luis Coastal staff provided a school nurse activity calendar that included instructions to staff to follow up with students about the oral health assessment and also provided a reminder asking parents to complete the assessment or return a waiver form. Staff at Los Angeles, Milpitas and Oakland similarly explained that schools follow up with or remind families when students have not returned forms; when we spoke to school staff at these districts, they confirmed that they did so. In contrast, although Woodland's district staff also asserted that school staff are responsible for following up on unreturned forms, staff at three schools indicated they do not follow up. Lastly, although Merced provided us a reminder letter for parents, district staff confirmed the district does not provide the letter to parents and does not otherwise follow up on unreturned assessment forms.

Each district except for Merced indicated that if students waived the oral health assessment requirement due to a financial burden or lack of access to a dentist, the district would refer them to community dental resources or, in Los Angeles's case, district-provided dental services. Los Angeles, Milpitas, and Oakland each provided lists of community resources they stated that they share with students, and Los Angeles was also able to provide evidence that it had provided these resources to a student without dental care because of insurance barriers. However, none of the districts have formalized their practices into standard policy to address situations when students waive the assessment requirement because of financial burden or access barriers. Referring students who lack access to dental care to known dental resources may improve these students' ability to obtain needed care—a valuable outcome. The districts we reviewed could provide greater assurance that they provide all students facing access barriers with the necessary referrals by formalizing this practice in policy.

The districts' lack of formalized processes for following up on unreturned KOHA program forms and for assisting families who cannot complete the assessments reduces the likelihood their students will complete the assessment requirement. This in turn results in the districts' collection of fewer assessments which then decreases the amount of data the districts can report to the State or use for local evaluation. The districts could address these shortcomings by formalizing in writing their practices for following up with students in those instances when students do not or are not able to complete the assessment.

Districts Stated That Resource Constraints Challenge Their Ability to Oversee the KOHA Program

In previous sections of this report, we describe shortcomings in the six districts' management of their KOHA program data and detail their noncompliance with the notification requirement in State law. In light of these issues, we considered whether any financial barriers were preventing districts from effectively operating the KOHA program and complying with state law.

To fulfill their statutory requirements, these districts have placed KOHA responsibilities on various district or school site staff, including district or school nurses. Five districts—all except Woodland—indicated they faced some form of a resource barrier to successful implementation of the KOHA program. For example, Merced's district nurse shared that the current workload of its staff members, with some nurses assigned to up to three schools, has limited its ability to allocate adequate time or attention to the KOHA program. Similarly, Milpitas shared that it has only two district nurses, and they recently became responsible for conducting the State's required hearing and vision screenings. Milpitas explained that this condition has made it difficult to allocate more time to the KOHA program, but that the district believes it can still do so by reworking how it engages with the KOHA program's requirements.

As we describe in the Introduction, the KOHA program is funded by each district's allocation through the Local Control Funding Formula (LCFF). These allocations are available for any legally permissible local educational purpose, and therefore districts can use these resources to fulfill the KOHA program requirements. As an accompanying element to the LCFF allocations, state law requires each school district to prepare a Local Control Accountability Plan (LCAP) that describes the district's annual goals and the specific actions the district will take to achieve its goals, as well as the funding provided for these actions. We reviewed the LCAPs for the six districts for school years 2022–23 through 2025–26 and found that none contained any references to the districts' KOHA efforts, meaning that they did not devote financial resources discretely to KOHA. Similarly, when we reviewed each district's annual budget for school years 2022–23 through 2025–26, we found that none had explicitly budgeted for the KOHA program. Accordingly, we could not reliably identify the resources that each of the six districts has dedicated to administering the KOHA program.

Under the requirements of state law at the time we conducted this audit, school districts had a relatively limited set of responsibilities under the KOHA program. Figure 10 summarizes these responsibilities. Specifically, the districts were responsible for notifying parents about the KOHA program requirements using forms that CDE previously developed and then collecting and reporting information that families provided. We acknowledge that the KOHA program is not the only program that district staff must implement. Nonetheless, we believe that districts can comply with the current requirements in a cost-effective manner. For example, school districts could include the most up-to-date forms, published by CDE, in their enrollment packages or enrollment systems so that families are proactively notified. In addition, school districts could ensure that the data they collect are more accurate by creating system-level checks for illogical or unreasonable entries before reporting those data to the State. Improper data collection affects the State's ability to achieve the intent of the KOHA program, as inaccurate data depicts an inaccurate representation of childhood oral health.

Figure 10
Districts Are Funded for Their Statutory Responsibilities But Not Other Potentially Beneficial Activities

Funded Requirements

Notify parents about the KOHA program using existing forms



Accurately record results of returned oral health assessments and waivers to report to the county office of education or SCOHR



Districts can use low-cost approaches to comply with these requirements.

Unfunded Practices

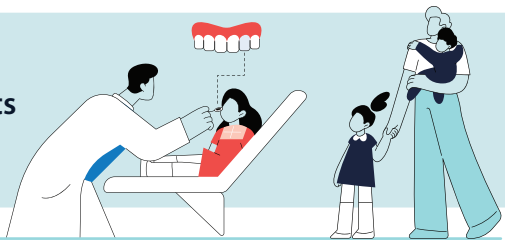
Follow up with families that do not return oral health assessment results



Follow up with families to ensure that students receive dental care



Host on-site assessment events



These practices may be more difficult for districts given that they are not directly funded.

Source: State law.

However, performing additional activities beyond the legally required elements of the KOHA program is likely to entail higher costs, and school districts do not currently receive funding to perform these actions. These additional activities that are not required by state law include following up with families who have not returned oral health assessments to encourage their participation, following up with families to ensure that students have received dental care for problems identified during an assessment, and hosting on-site assessment events. In other areas of this report, we describe the likely benefits of some of these actions. In particular, following up with families that have not completed an oral health assessment would likely increase participation in the KOHA program, and on-site assessment events can increase the percentage of students who are assessed. Although having more districts adopt these practices could yield positive results, the State would need to consider the costs of these activities and how it might provide additional funding to school districts if it were to make them required actions.

Neither CDE nor DPH Perform Oversight Activities Related to the KOHA Program

The noncompliance with the KOHA program's requirements by the six districts we audited is likely a result of limited statewide oversight of the KOHA program. Oversight activities are critical for ensuring the effectiveness of a program and minimizing risks that threaten the program's goals. As we indicate in the Introduction, when it was created, supporters of the KOHA program expected that it would generate data on children's oral health conditions that could help shape future programs. However, the issues we previously describe—including districts' weak data management and reporting processes and their noncompliance with KOHA's notification processes—threaten the State's and local entities' ability to receive meaningful data from the KOHA program. If there were an entity responsible for statewide administration of the KOHA program, it could establish oversight activities, such as determining whether districts are providing all standardized KOHA forms as required by law and whether the data districts report are accurate and complete.

CDE and DPH's Existing Authority and Oversight

No provision in the state law establishing the KOHA program charges CDE, DPH, or any other entity with the responsibility of being an oversight agency or enforcing compliance. Moreover, the state law establishing the KOHA program does not establish consequences for noncompliance, such as when families do not obtain an oral health assessment or waiver, or when districts do not properly notify families. Therefore, there are no direct enforcement mechanisms available for either districts or state entities to ensure compliance with the KOHA program's requirements. In the absence of a clearly specified entity for administering the KOHA program or specific mechanisms for ensuring compliance, we reviewed the oversight activities CDE and DPH do conduct so that we could better understand the specific gaps that exist and how they may be addressed.

When we asked CDE and DPH about their efforts to oversee the KOHA program, staff from both departments expressed their belief that they lacked the necessary authority and funding. CDE staff explained that the department is not involved in the administration of the KOHA program and that the State does not provide funding to support its implementation of the KOHA program. They further confirmed that the department does not participate in any oversight of the KOHA program. When we reviewed CDE's activities related to the KOHA program, we found that although the department met its statutory obligation to make the standardized KOHA program forms publicly available, it does not conduct further activities to administer or oversee the KOHA program.

DPH similarly explained that it takes no action to enforce KOHA compliance. DPH staff explained that because the department does not have authority to provide oversight or compel compliance, it has not taken any actions to oversee compliance with the KOHA program. Instead, DPH stated that it has mainly provided support for KOHA program implementation.

DPH expressed its belief that CDE has the authority to oversee the KOHA program and compel districts' compliance, and that CDE is therefore positioned to oversee and ensure compliance with the KOHA program's requirements. DPH explained that it believed CDE has this authority because the statute establishing the KOHA program is located within the Education Code. However, this determination is incorrect; CDE is not empowered to oversee compliance of the KOHA program simply because the program's authorizing statutes are in the Education Code. In fact, CDE is not empowered by the state law that created the KOHA program, nor through any other general authority we reviewed, to compel compliance with the KOHA program's requirements.

DPH also indicated that it believed that school districts would be more likely to follow instruction or guidance about the KOHA program if it were issued by CDE and not DPH. However, when we asked DPH whether it had reached out to school districts to convey information about the KOHA program, it acknowledged that it had only coauthored two reminder letters along with CDE and that it had not sent any other communication to school districts in the last five years. Accordingly, we did not find a compelling reason to believe that school districts would not heed guidance or reminders about the KOHA program if they were to come from DPH.

DPH's Existing KOHA Program Activities

We believe that in practice, DPH has become the leader for the KOHA program and is the State's best choice for overseeing the program. As we previously describe, DPH designated the SCOHR database for program data reporting, helped to develop the standardized forms, provides funding to county programs that support school districts' implementation of the KOHA program, and contracts with UCSF to provide support to those county programs. Further, the State's Oral Health Office—which has a mission to improve California's oral health—is located within DPH.

Because the KOHA program is fundamentally a program addressing oral health, we believe that it would be fitting for the State to place any new oversight responsibilities for the KOHA program on DPH.

DPH has generally supported the KOHA program through the 2022–2027 Moving California Oral Health Forward grant (oral health grant). The oral health grant requires county programs to take the specific actions shown in the text box. Although these activities do not specifically charge the county programs with ensuring that districts comply with KOHA's requirements, several of the activities require the county programs to monitor districts' reporting efforts. For example, the oral health grant requires county programs to assess the number of schools not reporting their oral health assessment results to SCOHR and then identify target schools for intervention.

KOHA Program Activities That County Programs Must Conduct Under the Oral Health Grant

- Assessing the number of schools currently not reporting oral health assessment results to SCOHR.
- Identifying current processes of participating schools and best practices.
- Identifying target schools for intervention.
- Identifying successful strategies to increase the number of oral health assessments, and identifying barriers and challenges to progress.

Source: Oral health grant materials.

The county programs we audited provided evidence that they supported districts' reporting efforts, including by sending emails to districts about their reporting to SCOHR. These activities align with DPH's focus on increasing the number of districts that submit KOHA program data to SCOHR and increasing the number of students who are assessed. In fact, this focus and these efforts seem to have had a positive effect. DPH's analysis indicates that the percentage of districts reporting KOHA program data to SCOHR increased from 46 percent in 2022 to 68 percent in 2025.

The oral health grant does not require county programs to oversee whether districts have met KOHA's notification requirements, and five of the county programs we reviewed confirmed they did not perform oversight activities in this area. Alameda, the county program associated with Oakland, claimed to perform this oversight, but it could not provide evidence of doing so.

Although we agree that DPH lacks the authority to compel school districts to comply with the KOHA program requirements, monitoring for compliance and issuing regular reminders to districts about the requirements would still likely improve their attention to and awareness of the program. As we describe earlier, some of the districts that had not reported to either SCOHR or their county office of education told us they were unaware of the reporting requirements. DPH could leverage its current efforts through county programs and UCSF to promote awareness.

Prop 56 Resource Constraints

When we asked DPH whether it was feasible for it to increase its oversight by expecting the county programs to perform more KOHA-related activities, department staff shared that funding constraints would complicate its ability to do so. As we explain in the Introduction, DPH uses Prop 56 funding for its oral health

grants. DPH staff stated that decreases in the amount of available funding from Prop 56 would limit the number of activities required under the grant. When we analyzed Prop 56 funding, we found that total annual revenue decreased by about 45 percent from fiscal years 2017–18 through 2024–25. DPH stated that this trend has resulted in a 50 percent decrease in funding for county programs and that the upcoming grant cycle for its next grant—starting in 2027—will therefore not require county programs to conduct any activities related to the KOHA program. Instead, the request for application for the upcoming grant allows county programs to select a single activity to focus on from a list of 20 possible activities, one of which is the KOHA program. Accordingly, DPH believes that directing additional responsibility to county programs for overseeing districts' compliance with KOHA's notification and reporting requirements is not feasible.

Forty-nine of the 60 county programs that applied for funding in the new grant cycle indicated they would use some of the amounts awarded to promote the KOHA program. However, it is reasonable to expect that with reduced levels of funding, each county program would likely curtail its activities from recent years. Therefore, we believe that it would be helpful to the Legislature for DPH to develop a report of the currently funded KOHA support activities and cost estimates for increasing county program activity. As we describe earlier, DPH's effort to focus on increases in SCOHR reporting through the county program activities has been successful. Further support for county program activities could produce similar positive results, especially if DPH focused the county program activities on the issues presented in this report.

DPH expressed its perspective that it faces similar funding constraints when describing to us its own ability to conduct KOHA program activities. In response to the recommendations we make earlier in this report, DPH explained its perspective that it would require additional funding to fulfill the recommendations. We present each of these recommendations in the text box and explain why we believe that the costs DPH would incur to implement the recommendations would be minimal. We do not believe that these activities would constitute a full-time burden for any single individual throughout the year. Therefore, we believe that DPH is well positioned to use its existing resources to implement these recommendations before seeking additional funding from the Legislature.

Our Assessment of the Likely Costs to DPH of Implementing Our Recommendations

1. **Consolidate the oral health assessment and waiver forms:** One-time costs to study the consolidation, consult with stakeholders, and coordinate with CDE, but no ongoing costs.
2. **Review the SCOHR data for unreasonable data submissions and contact districts to encourage more accurate reporting:** Minimal annual costs to compare the SCOHR data to enrollment data and send notifications to districts.
3. **Review the data reported to SCOHR and county offices of education to identify districts that do not report and send reminders:** Minimal annual costs to identify nonreporting districts and contact them to remind them of their obligations.
4. **Analyze KOHA program data and publish annual results:** Minimal annual costs to review the submitted data, analyze key elements of the data, and publish reports on the results of that analysis.

Recommendations

Legislature

To provide clarity on the department responsible for overseeing the KOHA program's performance, the Legislature should amend state law to identify DPH as the state entity responsible for oversight of the KOHA program.

School Districts

To ensure that families are provided with all required information regarding the KOHA program, the school districts we reviewed should do the following by January 2027:

- Revise their enrollment materials for TK, kindergarten, and first-graders to include all of the standardized forms published by CDE.
- Adopt procedures that direct staff to verify annually that the standardized forms the districts are using are the most up-to-date versions.
- Include translations of the standardized forms in all languages for which the districts are required to provide information to families.

To ensure that they address any barriers that families may face in obtaining an oral health assessment, the school districts we reviewed should, by January 2027, adopt procedures for tracking whether families have returned oral health assessment forms or waivers and reminding those who have not done so to submit either form. The procedures should also direct staff to contact families that submit waivers indicating barriers to accessing care and offer them dental health care resources.

DPH

To provide for complete funding for KOHA support activities, DPH should submit a budget change proposal to the Legislature seeking funding for county program grants. DPH should describe the current level of Prop 56 funding the department provides to county programs for KOHA program support activities and a proposal for how much additional annual funding would be necessary to fully fund KOHA program support activities, including activities that address the concerns detailed in this audit report.

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The Legislature Could Streamline KOHA Requirements and Incentivize On-Site Assessments

Key Points:

- On-site dental assessments—in which districts facilitate the completion of the oral health assessment at school sites—appear to result in a greater number of students assessed, although conducting these types of events may not be feasible for all districts.
- Districts that do conduct on-site dental assessments would benefit from clarifications to state law that better explain the notification and reporting requirements to which these districts are subject.

Other School-Based Health Assessment Programs and District Best Practices Show How the KOHA Program Could Operate More Effectively

State law and regulations require districts to test the vision and hearing of enrolled students at various grade levels, such as second and fifth grade.[5] In addition to specifying the grade levels of these screenings, state law and regulations establish who may perform them and the methods that can be used to conduct the assessment. We reviewed the requirements state law establishes for hearing and vision screenings to determine whether similar requirements could allow the KOHA program to operate more effectively. There is one key difference between the KOHA and hearing and vision screenings: as Table 6 shows, qualified district or school employees are allowed to conduct hearing and vision screenings, whereas the KOHA program requires the student to present proof of having received an oral health assessment by a licensed dentist or other licensed or registered dental health professional. In practice, therefore, completion of an oral health assessment—including finding a dentist, obtaining the assessment, and returning the assessment form to the school—is the responsibility of a student's parents.

The six districts we reviewed all attested to using district staff, school personnel, or, in the case of Milpitas, community providers to perform hearing and vision screenings. We refer to the hearing and vision screenings as *school-based screenings*. Woodland's director of student support services shared her perspective that because school districts can conduct the hearing and vision screenings on site and with district personnel, school districts can ensure that most of the eligible students are assessed. Staff at Los Angeles provided similar perspective. It was beyond the scope of this audit to conclude whether school district or site employees, including nurses,

[5] State law also contains provisions for the screening of scoliosis by school districts. However, the State suspended funding for scoliosis screenings in 2010. The Department of Finance notified districts in each year during our audit period of the suspended funding and informed them that they are no longer required to implement or give effect to scoliosis screenings. Accordingly, we limit our discussion here to hearing and vision screenings.

are qualified or could reasonably become qualified to administer on-site dental assessment programs. Nonetheless, it is notable that having screenings occur at the school site is part of what makes hearing and vision screenings successful.

Table 6
State Law Generally Allows School Staff to Complete Health-Related Screenings and Requires Referrals Based on the Results of These Screenings

		SELECTED SCHOOL HEALTH SCREENINGS		
AREAS OF INTEREST	KOHA	HEARING	VISION	SCOLIOSIS*
Does the screening or assessment require the data collected to be externally reported?	YES	YES	NO	NO
Can a school district or school site employee conduct the screening or assessment?	NO	YES	YES	YES
Is there a referral process in place for students based on their screening or assessment results?	YES	YES	YES	YES

Source: State laws and regulations.

* School districts are no longer required to perform scoliosis screenings because the State ceased funding for this requirement. Nonetheless, we were asked to compare KOHA requirements to those of the scoliosis screening.

Our review of best practices at each of the districts further suggests that assessments at school sites may remove certain barriers that prevent students from obtaining an oral health assessment. We reviewed whether the KOHA processes of three school districts—San Luis Coastal, Milpitas, and Woodland—could be best practices given the high assessment rates these districts reported in the statewide KOHA data. As we previously describe, we found issues with how these three districts reported their KOHA data to SCOHR. Nonetheless, these districts reported to SCOHR comparatively higher oral health assessment rates than the other three districts we reviewed.[6]

As we explain in the Introduction, districts that host on-site dental assessments can use passive consent to complete a student's oral health assessment. Milpitas, San Luis Coastal, and Woodland attested that their on-site dental assessment programs use passive consent—meaning that it is the parent's responsibility to opt out of the assessment program and the student will receive an assessment if that action is not taken. These districts conduct their on-site dental assessments in a way that—like the processes for school-based hearing and vision screenings—places responsibility for completing the assessment on districts and schools, not on families. As a result, on-site dental assessments may remove some of the barriers preventing students from obtaining an oral health assessment. For example, as the KOHA waiver form notes, students and their parents may not have access to a dentist because of insurance or financial reasons or other access issues. However, districts

6 Los Angeles and Oakland reported that they also use on-site dental assessments, but not for all school sites.

that use on-site dental assessments address these barriers by removing the logistical complexity that may prevent a student from obtaining the oral health assessment from a private dental provider.

Staff at Milpitas and San Luis Coastal agreed that on-site dental assessments have been beneficial to their oral health assessment rates. San Luis Coastal's lead nurse stated that most of the district's oral health assessments are completed through its on-site dental assessment program and estimated that only 20 percent of its completed oral health assessments are from families that obtained them independently. Milpitas shared a similar perspective. It noted that when it reduced its on-site dental assessment program to three school sites in the 2025–26 school year because its community partner experienced budget constraints, the district's KOHA program participation rate decreased.

Woodland's approach is another example of the potential benefits of using on-site dental assessments to complete students' oral health assessments. At Woodland, a community dental organization assesses all kindergarten students at an on-site event. The agreement the district has with its community provider requires staff from the community provider to complete the oral health assessments and compile the results for each school in a format that allows for reporting to SCOHR. This process has allowed Woodland to effectively complete an oral health assessment for its intended target population of kindergarten students resulting in the district's reported high assessment rate we describe earlier.

Changes to State Law Could Clarify the Requirements for Districts That Choose to Operate On-Site Assessment Programs

As the Introduction describes, the Legislature designed the KOHA program to collect information on children's oral health. As we describe above, on-site dental assessment programs can remove some of the barriers that may prevent students from obtaining an oral health assessment from a dental provider. We believe that on-site dental assessment programs—in specific circumstances—can be a beneficial tool in capturing a significant amount of data on the conditions of children's oral health. Accordingly, we focused our review on the potential benefits of the type of on-site dental assessment programs we reviewed at Milpitas, San Luis Coastal, and Woodland.

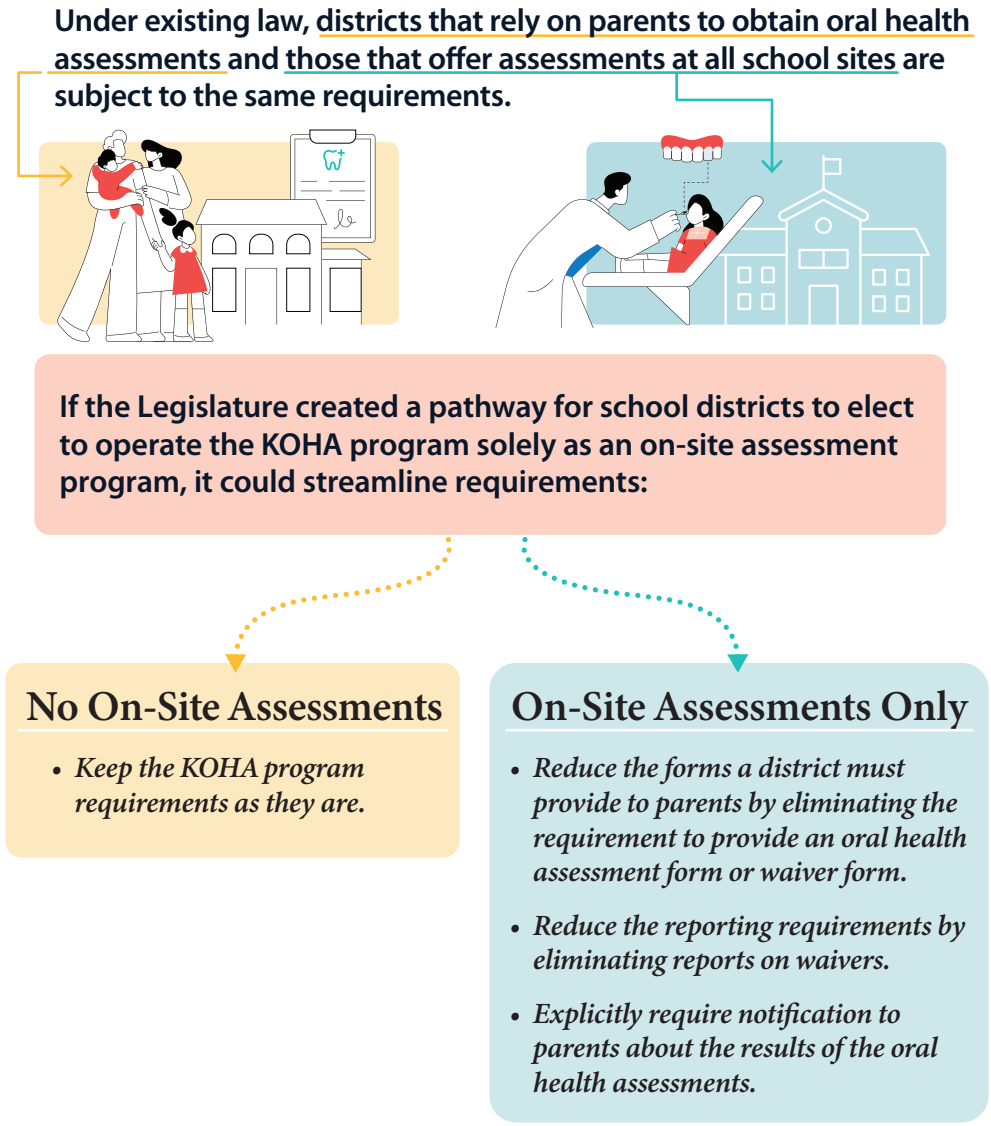
All three districts' on-site dental assessment programs were established through partnerships with local community dental providers or community organizations. A noteworthy aspect of these partnerships was that none came at a direct cost to the school districts. In other words, the only costs incurred by Milpitas, San Luis Coastal, and Woodland were the administrative costs associated with establishing the partnerships and coordinating the dental assessment events. For example, all three districts attested to establishing a formal agreement with their assessment providers and using their staff's time to notify parents of the assessments, schedule and coordinate the assessments, assist with assessment day activities, and notify parents of identified oral health defects.

Although on-site assessment programs have been a benefit to Milpitas, San Luis Coastal, and Woodland, such programs may not be possible for all school districts. Merced's nursing staff shared with us that the district previously hosted an on-site assessment event but that because of the effort necessary to coordinate the event, the district does not believe that hosting additional events would benefit its community. More directly, the district indicated that there were mismatched expectations for families about the level of care that would be provided at the event, which district staff believed burdened students who needed care. More generally, school districts in other parts of the State may find it difficult to find a provider who is able or willing to dedicate time to conduct on-site dental assessments. State law restricts a dentist from generating referrals or benefitting financially from the provision of an on-site dental assessment by prohibiting the dentist from soliciting or advising treatment by the dentist for any condition discovered during the on-site assessment. In areas of the State where dental providers are not as common, districts may have difficulty finding dental providers to provide free assessments when the providers cannot legally direct families to their dental practices. As a result, we do not conclude that the State should consider mandating the implementation of on-site dental assessments statewide.

However, as Figure 11 shows, we found that the State could modify the existing KOHA statutes to create clearer requirements for school districts that choose to operate on-site dental assessment programs. For example, state law requires that schools provide the parents of all KOHA-eligible students with standardized forms, which must include a space for a qualified dental health professional to record information about the assessment. Therefore, districts that conduct on-site dental assessments must decide how to record and report data for any students who obtain an oral health assessment from both a personal dentist and an on-site assessment. In fact, we found this exact scenario occurred several times at Milpitas, San Luis Coastal, and Woodland. However, state law does not provide clarity on what districts should do in this scenario. These districts outlined differing processes for reporting their assessment data when students have multiple completed assessments. San Luis Coastal's lead nurse explained that the district would report the results of whichever assessment was most recent or more complete. Milpitas's nurses stated that the district would report the information from the assessment the student's family obtained rather than the information from the on-site assessment, and staff from Woodland shared that the district reports only the assessments it collects through its on-site dental assessment program.

Moreover, state law requires that all school districts report on KOHA-eligible students who have waived the requirement to obtain an oral health assessment for one or more reasons. These include financial burden and lack of access to care, reasons that do not apply in cases where a student can receive a free assessment at their school. The waiver form allows parents to notify their school district that they will not be obtaining their own oral health assessment. State law includes an additional separate option for parents that do not consent to their student receiving an on-site assessment, which is facilitated through the on-site opt out form.

Figure 11
Changes to the KOHA Program's Requirements Could Streamline Requirements for Districts That Elect to Operate On-Site Assessment Programs



Source: State law and review of practices at selected districts.

However, under the current law, school districts that host districtwide assessment events and provide access to free assessments must still provide parents with a waiver form. This creates a situation in which a parent may return the waiver form, indicating that they cannot independently obtain an assessment for their student because of financial or access constraints, and a district would be required to report that information even though that same student was assessed at an on-site event. The Legislature could therefore clarify and streamline the requirements for districts with

on-site assessment programs by requiring that these districts provide the on-site opt out form, but not the waiver form, and then report the number of students whose parents did not consent to the on-site assessment.

Additionally, state law requires school districts to report health defects to parents if the districts note them. This provision applies to cases in which a district's on-site assessment program finds problems with a student's oral health. However, the state law that established the KOHA program does not reference this notification requirement or otherwise clarify that districts that find oral health defects during an on-site assessment must notify parents. Therefore, districts could mistakenly believe that they are not required to report to families about oral health issues the district finds during an on-site assessment even though they are legally required to do so under existing law. To reduce possible confusion, the State could amend the law that establishes the KOHA program to either reference existing state law requiring reporting defects or explicitly require parental notification of oral health problems.

Milpitas offered contradictory explanations of the district's follow-up process. District nursing staff shared that it was the oral health assessment provider's responsibility to contact families of students whose assessment identified a need for urgent care. However, a staff member at one school site stated that the assessment provider informed them of the students whose families needed to be contacted and that this staff member would contact the families and send the student home with a letter about their assessment. San Luis Coastal and Woodland both explained their processes for connecting students with identified oral health defects to oral health resources for follow-up care. The districts provided evidence of times when they each followed up with parents after on-site assessments. However, Woodland confirmed that it does not track its follow-up in its data system, which decreases the ease with which the district could track the consistency of its follow up activities. San Luis Coastal's follow-up process is formalized in a written procedure and the district expects that its staff will track follow-up activities in its data system. However, when we reviewed the data the district had tracked, we found that it included notes identifying that the district had contacted the family in only 40 percent of the cases in which the data indicated the student required a referral for further treatment.

Accordingly, we believe that the Legislature could revise state law to establish separate administrative requirements for those districts that choose to offer a districtwide on-site dental assessment program. For example, the Legislature could clarify that districts that use these programs are subject to different notification and reporting requirements than districts that have families obtain their own oral health assessments. Moreover, these revisions could establish more explicit requirements for notifying parents of oral health defects identified during on-site dental assessments. In making these changes, the Legislature could encourage districts to adopt on-site dental assessment programs—which may result in additional students being assessed—by clarifying and streamlining the requirements that districts are subject to when offering these programs.

In addition, the Legislature could potentially incentivize more on-site assessments by having the State offer compensation to providers for their time in conducting these events. In September 2021, DPH notified county programs that it would

allow them to apply for funding for stipends that they could award to dental health professionals for providing assessment services. DPH stated that 11 county programs received stipends, which resulted in the screening of tens of thousands of students across multiple school years. This effort demonstrated that the additional funding was successful in increasing the number of students who received an assessment. In light of the decline in Prop 56 funding that we previously describe, we find it unlikely that DPH would have the flexibility to provide such stipends itself. However, if the Legislature wants to incentivize providers to deliver assessment services at school sites, it could appropriate funding for a stipend program that DPH and county programs could administer.

Recommendations

To clarify and streamline the requirements for school districts that host districtwide oral health assessments, the Legislature should amend state law to achieve the following:

- Create the option for school districts to meet the KOHA program requirements exclusively through partnerships with qualified dental professionals who provide on-site assessment services for the districts' students.
- Clarify that districts that elect to comply with the KOHA program requirements through on-site assessments are not subject to the same notification requirements as districts that elect to have families obtain their own oral health assessments. Specifically, the law should allow districts that offer on-site assessment programs to be exempt from the requirement to provide families with a form to take to their own dental provider or a form for waiving the oral health assessment requirement. The law should also require these districts to provide families with a form that informs them of the on-site assessment and allows families the opportunities to opt out of the assessment.
- Require that districts that elect to comply with the KOHA program requirements through on-site assessments notify parents of the assessment results, including any health issues identified by the assessor, and of the importance of having their child visit a dentist.
- Specify that districts that elect to comply with the KOHA program requirements through on-site assessments must report the following information at the end of each year:
  - The number of students subject to the oral health assessment requirement.
  - The number of those students who were assessed.
    - The number found through an assessment to have visible decay.
    - The number found through an assessment to have caries experience.
  - The number who submitted an opt-out form and therefore were not assessed.

If the Legislature desires to incentivize more on-site dental assessments for the KOHA program, it should consider appropriating funding for a grant or stipend program that DPH and county programs could use to compensate dental health care providers for performing on-site assessment activities.

We conducted this performance audit in accordance with generally accepted government auditing standards and under the authority vested in the California State Auditor by Government Code section 8543 et seq. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on the audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

Respectfully submitted,



GRANT PARKS
California State Auditor

November 5, 2026

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Appendix

Scope and Methodology

The Audit Committee directed the California State Auditor to conduct an audit of local compliance with the KOHA program. Specifically, the Audit Committee asked us to evaluate compliance with KOHA program requirements related to notification and reporting information and to identify best practices that could improve the KOHA program. The table lists the objectives that the Audit Committee approved and the methods we used to address them. Unless otherwise stated in the table or elsewhere in the report, statements and conclusions about items selected for review should not be projected to the population.

Table
Audit Objectives and the Methods Used to Address Them

	AUDIT OBJECTIVE	METHOD
1	Review and evaluate the laws, rules, and regulations significant to the audit objectives.	Reviewed the laws, rules, and regulations significant to the audit objectives including the state law that established the KOHA program.
2	For up to six local educational agencies (LEA), including at least two with evidence of high compliance with KOHA reporting and high screening rates, at least one with low overall KOHA screening rates, and at least one with low compliance with data reporting, evaluate the extent to which schools and districts are complying with the statutory requirements of KOHA by reviewing and evaluating the following: a. The processes utilized for notification of parents/guardians of the assessment requirement and provision of related health, insurance, and contact information, including whether such information was provided in multiple languages as required. b. The processes for notifying, following up, collecting and reporting required information, and whether those processes comply with all statutory requirements. c. The barriers that may exist to participation at all relevant levels in the above reviews, including whether there are language or accessibility barriers to accessing information, lack of clear statutory requirements, inability to find oral health professionals to complete the KOHA, and cost or lack of funding for KOHA. d. The resources allocated for administration of all requirements of KOHA, how such resources are prioritized, and whether such funds are identified in LCAP priority funding or LCFF funding. e. The processes that are in place at the state and local level to evaluate compliance with KOHA requirements and any enforcement mechanisms available and utilized.	• Obtained data from SCOHR related to the KOHA program and from CDE related to enrollment. Reviewed these data to determine which school districts exhibited the characteristics listed in the audit objective, such as high assessment rates. Assessed other relevant information, including geographic location and total enrollment. Selected six districts to review, as shown in Table 1. • Determined that to comply with the KOHA program's notification requirements, school districts must provide parents with information related to the oral health assessment requirement, health insurance, and contact information for additional resources. • Interviewed staff at each school district and reviewed related documentation to identify each districts' processes for complying with the KOHA program's notification requirements, including providing these notices in other languages when required; following up on unreturned assessments; and reporting KOHA results. • Attempted to review districts' local data to determine whether cost or access barriers caused students' inability to complete the oral health assessment. Determined that these data were unreliable. • Interviewed district staff to learn about barriers to implementing the KOHA program, including those affecting districts' ability to comply with the KOHA program's requirements. • Interviewed staff and reviewed districts' LCAPs and annual budgets to analyze how districts funded their KOHA efforts and determine whether districts allocated funding discretely for KOHA. • Interviewed staff at the county programs associated with the selected districts to identify activities the county programs had engaged in and the funding used, if any, to support those activities. • Interviewed staff at CDE and DPH and reviewed relevant documentation to identify and evaluate their processes for ensuring statewide KOHA program compliance and conducting oversight. • Interviewed district staff and reviewed relevant documents to evaluate each selected school district's attested process for monitoring KOHA program compliance and performance.

continued on next page . . .

	AUDIT OBJECTIVE	METHOD
3	For the selected agencies, evaluate the level of compliance with the KOHA screening requirement. Using the data available at the district and county level, determine the following: a. The number of children in the LEA's jurisdiction subject to the KOHA requirement, including those who have untreated decay, who have an urgent need for care, and for whom parents or guardians waived the oral assessment and the reasons for the waivers. b. The number of assessments completed, and the numbers of children for whom there both were no waiver or assessment completed.	Obtained a selection of hard-copy assessment and waiver forms from each district as well as exports from districts' data systems. Compared districts' local KOHA program data against the hard-copy assessment and waiver forms we obtained to determine whether districts completely and accurately recorded these results in their data systems. Because we found that the districts' data were generally not sufficiently reliable for answering this audit objective, we do not report most of these data, as we describe in more detail in Table 3.
4	Evaluate the data collection system used to collect KOHA data, such as SCOHR, and the processes used at all relevant levels for collection and data entry to determine whether these processes comply with existing requirements and relevant best practices. Additionally, identify the processes used by LEAs to evaluate the data for purposes of informing any changes to processes or improvement efforts, and whether this aligns with best practices. a. As part of the above analysis, evaluate where and to whom the relevant data are being reported, whether such reporting complies with existing requirements, and identify any gaps in reporting that prevent data from being reported to entities that need it, including but not limited to county-based oral health programs, Department of Health Care Services and Medi-Cal, DPH, and CDE.	• Selected 10 school districts that did not report KOHA results to either SCOHR or their county office of education and interviewed staff at these districts to determine why they did not report. We selected these districts from among the five counties with the most nonreporting districts and considered their enrollment to obtain a variety of district sizes. • Reviewed statewide KOHA program data in SCOHR and interviewed the contractor that operates SCOHR to evaluate the data's reliability and determine whether SCOHR includes data validation controls. • Compared each district's local KOHA program data to the data these districts reported to SCOHR to identify discrepancies. • Interviewed selected school districts and reviewed documentation to determine the extent to which they have evaluated their KOHA data to inform improvement efforts, and the manner in which they have reported their local KOHA data. • Reviewed how the county programs associated with the selected districts used the districts' reported KOHA program data to evaluate and improve local oral health outcomes.
5	For those LEAs that report higher compliance with KOHA, evaluate whether there are best practices that can be used in other areas to improve processes and gain compliance, including practices related to allocation and availability of resources, on-site screening, and passive versus active opt-out procedures. In addition, evaluate whether any of the reviewed LEAs exhibit best practices with respect to follow-up practices for parents or guardians who cite financial burdens or lack of access to care or have students with an urgent need for care. Additionally, evaluate these processes relative to other potential best practices within the State or other programs to increase compliance, such as hearing, vision, or scoliosis screening requirements.	• Evaluated the KOHA practices at the two districts we selected for their high compliance rates in SCOHR—Milpitas and San Luis Coastal—to determine whether their practices could be considered best practices for other districts. • Evaluated the six selected school districts' practices for responding when students waive the assessment requirement or when a student's assessment identifies an urgent dental need to identify possible best practices. • Reviewed state law to determine whether statutory requirements for school-based vision, hearing, and scoliosis screenings include best practices for the KOHA program. • Interviewed staff at the six selected school districts to understand their practices regarding school-based vision and hearing screenings as well as their perspectives on whether the KOHA program could benefit from the adoption of identified practices.

	AUDIT OBJECTIVE	METHOD
6	Evaluate the roles that relevant LEAs play in ensuring adequate processes for information and assessments, as well as provision of resources, to assist with compliance with KOHA, including, to the extent possible, dental and health providers, county-based oral health programs, Department of Health Care Services and Medi-Cal, DPH, and CDE. As part of this evaluation, determine whether there are opportunities to improve communication or partnerships to better ensure compliance with KOHA.	• Interviewed relevant staff at DPH, CDE, and the Department of Health Care Services to determine their involvement with LEAs regarding KOHA compliance. • Interviewed representatives for the California Partnership for Oral Health to obtain their perspectives on how statewide and local entities work with school districts to support the KOHA program. • Interviewed the six selected school districts to determine the extent to which state and local entities involved with KOHA have supported school districts' implementation of KOHA. • Interviewed staff and reviewed documentation at the county programs associated with selected districts to determine the extent to which local programs supported districts' compliance with the KOHA program's requirements.

Source: Audit workpapers.

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CDPH

Health and Human Services Agency
California Department of Public Health

Erica Pan, MD, MPH
Director and State Public Health Officer

Gavin Newsom
Governor

October 20, 2026

Grant Parks*
California State Auditor
621 Capitol Mall, Suite 1200
Sacramento, CA 95814

Dear Mr. Parks:

The California Department of Public Health (DPH) has reviewed the California State Auditor's (CSA) draft report for *#2025-109 Kindergarten Oral Health Assessment (KOHA).* DPH appreciates the thorough review conducted by the audit team and values the opportunity to consider the report's recommendations for strengthening the KOHA program.

Recommendation #1
To ensure that the State, local governments, and other stakeholders can access as much KOHA program data as possible, by March 2027 DPH should develop and propose for the California Department of Education's (CDE) approval a standardized KOHA program form that includes both the oral health assessment and the waiver component. This form should replace the existing separate oral health assessment and waiver forms.

Management Response:
In collaboration with relevant partners and stakeholders, including critical partners such as the California Department of Education (CDE), DPH will develop and propose a standardized KOHA program form that includes both the oral health assessment and waiver components for CDE approval.

Recommendation #2
To ensure that school districts submit reasonable KOHA program results, by January 2027 DPH should annually compare districts' reports to the System for California Oral Health Reporting (SCOHR) with CDE enrollment data to identify district reports that fall outside of a tolerable range. Based on this information, DPH should annually do the following:

- Identify the districts with significant variances from the CDE enrollment data.

* California State Auditor's comments appear on page 69.

Grant Parks
Page 2
October 20, 2026

- Notify these districts that they may have submitted incorrect data, explain the basis for the notice, and request they complete any necessary revisions to their reports.
- Notify the county programs associated with these districts and request them to offer technical assistance with improving the district's reporting procedures.

Management Response:

① Upon receipt of adequate resources to conduct the comparative analyses, including additional analytical capability and any necessary IT projects or contracts to enhance the SCOHR database, and with the coordination and collaboration of CDE, DPH would annually perform the auditor's recommended tasks.

Recommendation #3

To ensure that the KOHA program data are as complete as possible, beginning in January 2027, and at least annually thereafter, DPH should contact districts that did not report KOHA program data to remind them of their reporting obligations and encourage them to report as required. If DPH believes that contact from county programs would be more effective, it should work in coordination with the county programs to ensure that this communication occurs. DPH should also publish a list of nonreporting districts on its website and update that list annually.

Management Response:

DPH agrees that solutions are needed to achieve more complete KOHA program data.
② Because CDE maintains contact information for school districts and has ongoing relationships with them, DPH will pursue collaboration with CDE to contact districts that have not reported KOHA program data, remind them of their reporting obligations, and encourage them to report as required.

If DPH determines that contact from county programs would be more effective, DPH will
② coordinate with the county programs and CDE to deliver this communication.

② DPH will also evaluate, in consultation with CDE and legal counsel, the appropriate method and legal authority for publicly identifying verified nonreporting districts.

Recommendation #4

To ensure that stakeholders have access to the data that DPH established would be used to measure progress in meeting the State's oral health goals, by March 2027, DPH should begin regularly publishing on its website annual analyses of the KOHA program data in the areas of caries experience and visible decay. These analyses should explain any limitations of the data that DPH believes are important. After the first annual analysis, subsequent analyses should include trends from previous years such that the public can determine whether oral health conditions are improving year-over-year.

Management Response:

DPH will regularly publish annual analyses of KOHA program data on its website in the areas of caries experience and visible decay, acknowledging and explaining the data

limitations that DPH believes are important, including the limitations of KOHA data in describing caries experience and visible decay.

To the extent the KOHA data allows and would be appropriate to display, subsequent analyses will also include year-over-year trends regarding caries experience and visible decay. ③

Recommendation #5
To provide for complete funding for KOHA support activities, DPH should submit a budget change proposal to the Legislature seeking funding for county program grants. DPH should describe the current level of Prop 56 funding the department provides to county programs for KOHA program support activities and a proposal for how much additional annual funding would be necessary to fully fund KOHA program support activities, including activities that address the concerns detailed in this audit report.

Management Response:
Proposition 56 funding decreased by more than 45 percent between fiscal years 2017-18 and 2024-25. This decline resulted in a 50 percent reduction in funding for local health programs.

DPH appreciates this recommendation and agrees that additional resources would better position local jurisdictions to increase their capacity to support local KOHA activities.

We appreciate the opportunity to respond to the audit and thank the auditors for their assessment. If you have any questions, please contact Rob Hughes, Deputy Director, Office of Compliance, at (916) 306-2251.

Sincerely,

Erica Pan, MD, MPH
Director and State Public Health Officer

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Comments

CALIFORNIA STATE AUDITOR'S COMMENTS ON THE RESPONSE FROM THE CALIFORNIA DEPARTMENT OF PUBLIC HEALTH

To provide clarity and perspective, we are commenting on the response to our audit report from DPH. The numbers below correspond with the numbers we have placed in the margin of its response.

We disagree with DPH that it will need additional resources to implement our recommendation. As we state on page 50, we believe that DPH's implementation costs are likely to be minimal and that the activities associated with our recommendations would not constitute a full-time burden for any single individual. Thus, we stand by our conclusion that DPH is well positioned to use its existing resources to implement our recommendations. ①

The collaboration DPH states it will pursue with CDE is not required for DPH to successfully implement this recommendation. As we conclude on page 48, we did not identify a compelling reason to believe that school districts would not heed guidance or reminders about the KOHA program if they were to come from DPH. ②

Although DPH agrees with our recommendation to publish annual analyses of KOHA program data, it states that it will only publish year-over-year trends if appropriate to do so. DPH does not provide further context for this statement and we are uncertain as to why reporting on these trends would be inappropriate. As we explain on page 20, DPH shared an assessment of KOHA program data with county programs in April 2026. That assessment included year-over-year trends for caries experience and untreated decay. As such, we stand by our recommendation that DPH publicly report on these trends, including reporting any limitations of the data that DPH believes are important. ③

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Los Angeles Unified School District
Medical Services Division

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Andrés E. Chait
Superintendent

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Kelly Gonez
Tanya Ortiz Franklin

Joel E. Cisneros, LCSW
Executive Director

October 21, 2026*

In response to the Kindergarten Oral Health Assessment (KOHA) audit, the District has developed corresponding action plans addressing each section detailed within the report.

Section on Resource Constraints

Although LCFF resources for KOHA are not directly identified in the District's LCAP, LAUSD has committed significant resources through general fund and Medi-Cal reimbursement dollars to support the KOHA program. It should be noted that the state has not issued guidance indicating the KOHA program must be specifically identified in LCAPs. (1)

Plan of Action

- Explore opportunities to include KOHA-related goals and activities within future LCAP planning.
- Implement system validation checks to identify illogical or incomplete entries before reporting.
- Will review existing workflows and update procedures consistent with the audit findings and recommendations.

Section on Parent Notification

A. Use of Standardized KOHA Forms

Plan of Action

- Review all enrollment forms and KOHA-related materials.
- Review district-created forms and align where possible with CDE standardized forms. (2)
- Establish an annual review process to verify forms are current and compliant with state requirements. It should be noted that the state-issued forms did not address legislative changes to the opt in/opt out process for this screening, resulting in the District creating its own form to ensure compliance. (3)
- Will review existing workflows and update procedures consistent with the audit findings and recommendations

* California State Auditor's comments appear on page 75.

B. Notification of the KOHA Requirement

Plan of Action

- Continue current notification practices through enrollment packets and parent/student handbooks.
- Monitor school-site implementation to ensure consistent notification to TK, K, and first-time 1st graders in a public school.
- Will review existing workflows and update procedures consistent with the audit findings and recommendations.

C. Accessibility of Information

Plan of Action

- Translate all required KOHA standardized forms into applicable languages.
- Will review existing workflows and update procedures consistent with the audit findings and recommendations.

Section on Follow Up

Plan of Action

- Develop and implement districtwide KOHA staff trainings.
- Will review existing workflows and update procedures consistent with the audit findings and recommendations.
- Continue providing families with information about low-cost or free dental services.
- Maintain documentation of follow-up efforts.

Section on Use of KOHA Data:

Plan of Action

- Develop and implement a KOHA data review guideline or policy.
- Will review existing workflows and update procedures consistent with the audit findings and recommendations.

Section on Data Collection:

A. Problem with Data Completeness

Plan of Action

- Train school-site staff on KOHA documentation requirements.
- Establish a standardized process for recording all returned assessment forms and waivers.
- Will review existing workflows and update procedures consistent the audit findings and recommendations.

B. Problems with Data Accuracy

Plan of Action

- Train staff in proper data entry procedures once system modifications are implemented.
- Will review existing workflows and update procedures consistent with the audit findings and recommendations.

Section on Reporting to SCOHR

Plan of Action

- Reprogram and configure the reporting system.
- Will review existing workflows and update procedures consistent with the audit findings and recommendations.

Section on Best Practices

The audit identified a notable district practice that supports student health compliance efforts. The district's ability to conduct vision and hearing screenings internally has strengthened program implementation. Nursing staff have periodically deployed teams of nurses to schools to ensure required screenings are completed for all eligible students.

Best Practice to Continue

- Maintain the use of nursing teams to support schools with screening compliance.
- Consider applying a similar team-based approach to KOHA compliance monitoring and follow-up activities.
- Utilize successful screening workflows as a model for oral health assessment tracking and reporting.

Sincerely,

J. Cisneros, LCSW

Joel E. Cisneros
Executive Director

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Comments

CALIFORNIA STATE AUDITOR'S COMMENTS ON THE RESPONSE FROM THE LOS ANGELES UNIFIED SCHOOL DISTRICT

To provide clarity and perspective, we are commenting on the response to our audit report from Los Angeles. The numbers below correspond with the numbers we have placed in the margin of its response.

We could not reliably corroborate Los Angeles's claims that it has committed significant resources to support the KOHA program. As we state on page 45, we were unable to do so because the district has not included these amounts in its LCAP or annual budget. (1)

Los Angeles's response indicates that it will not adopt our recommendation that it provide families with the standardized forms published by CDE. As described throughout our report, state law requires districts to provide families with all four standardized forms. Until Los Angeles does so, it will remain out of compliance with state law. (2)

Los Angeles suggests that CDE's standardized forms are not fully compliant with state law. As part of our audit, we compared the standardized forms to state law and found they were generally compliant. Thus, we stand by our recommendation that Los Angeles provide the standardized forms to families as required by state law. (3)

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MILPITAS
UNIFIED SCHOOL DISTRICT

October 20, 2026

Grant Parks, California State Auditor
California State Auditor's Office
621 Capitol Mall, Suite 1200
Sacramento, CA 95814

Subject: Milpitas Unified School District Response to Confidential Draft Report No. 2025-109

Dear Mr. Parks:

Milpitas Unified School District has reviewed the draft report on implementation of the Kindergarten Oral Health Assessment (KOHA) program and appreciates the opportunity to respond. The district has read the report, confirms its findings, and is ready and willing to implement all of the recommendations. The district also appreciates the report's recognition of our efforts to notify all families in TK, kindergarten, and first grade of the KOHA requirement via our online enrollment guidance and through information included on our website and in our parent handbook.

The district made a good-faith effort to report KOHA data accurately and in line with state requirements. We recognize that our procedures did not always achieve that, and we accept the audit's findings. The district is committed to strengthening its practices so that its reporting is complete and accurate.

Implementation has already begun. The district was already utilizing two of the four standardized forms and is preparing to include all four required standardized forms in its enrollment packages for TK, kindergarten, and first-grade students. The district also plans to make the forms digitally fillable, so that families may complete the Oral Health form without printing and scanning.

By January 2027, the district will:

- Adopt a procedure directing staff to verify annually that the standardized forms in use are the most current versions published by CDE.
- Provide translations of the standardized forms in all languages for which the district is required to provide information to families.

Milpitas Unified School District
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- Update its front office staff handbook to include procedures for tracking returned oral health assessment forms and waivers, following up with families who have not returned either, and offering dental health care resources to families whose waivers indicate barriers to care.

By March 2027, the district will:

- Adopt procedures to regularly review whether staff are entering complete and accurate KOHA information in its data system, and include procedures for entering data from the Oral Health forms in the staff handbook.
- Work with HKF to ensure that the reports it shares following screenings contain the information the district needs to report to SCOHR.
- Collaborate with the Technology department to align the reporting fields in its data management system with the categories required by SCOHR, and adopt procedures for reporting directly from the data in that system.
- Review KOHA data at least twice a year to identify students who have not yet completed an assessment and send reminders to their families.

These procedures will be applied consistently across all district sites so that requirements are clear to staff and families.

The district appreciates the opportunity to improve its systems to better serve its students and community and looks forward to sharing its implementation progress. Please direct any follow-up to the undersigned below.

Respectfully,

Brian White
Executive Director, Inclusive Services for All Learners
Milpitas Unified School District

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OAKLAND UNIFIED SCHOOL DISTRICT
Community Schools, Thriving Students

Health Services

October 20, 2026

Grant Parks
California State Auditor
621 Capitol Mall, Suite 1200
Sacramento, CA 95814

RESPONSE TO THE CALIFORNIA STATE AUDITOR ASSESSMENT REPORT #2025-109

Dear Mr. Parks:

Oakland Unified School District (OUSD) submits this response to the California State Auditor's (CSA) assessment report number 2025-109, titled *"The Kindergarten Oral Health Assessment Report"*. Oakland Unified School District's mission is to build a Full-Service Community District focused on high academic achievement, while serving the whole child, eliminating inequity, and providing each child with excellent teachers, every day. OUSD is committed to supporting the whole child and ensuring that all children in Oakland thrive by improving upon existing systems for KOHA program implementation. OUSD understands that oral health is an important aspect of overall wellness for our students and strives to eliminate inequities and reduce barriers so that every child has access to quality education. OUSD agrees with the recommendations put forth by the auditor as outlined below.

OUSD agrees with the recommendation to adopt procedures to regularly review whether staff are entering complete and accurate KOHA program information in its data system to ensure complete and accurate KOHA program data that facilitates compliance with reporting requirements.

OUSD agrees with the recommendation to adopt procedures for reporting annually as required. OUSD will adopt procedures to review KOHA program data at least twice yearly to determine the students who have yet to complete an assessment so that the district may provide reminders to those students about the assessment requirement.

OUSD agrees that in order to ensure families are provided with all required information regarding the KOHA program, by January 2027, Oakland should do the following

- Revise its enrollment materials for TK, kindergarten, and first graders to include all standardized forms published by the CDE.
- Adopt procedures that direct staff to verify that the standardized forms the district is using are the most up-to-date versions.
- Include translations of standardized forms in all languages for which the district is required to provide information to families.

To ensure that it addresses any barriers families may face in obtaining an oral health assessment, by January 2027, Oakland should adopt procedures for tracking whether families have returned oral health assessment forms or waivers and reminding those who have not done so to submit either form. The procedures should also

OAKLAND UNIFIED SCHOOL DISTRICT
Community Schools, Thriving Students

Health Services

direct staff to contact families that submit waivers indicating barriers to accessing care to offer them dental health care resources.

Oakland Unified School District will continue to improve our existing protocols, procedures, and community partnerships to develop a sustainable KOHA workflow. Our goal is to identify gaps, understand barriers, and provide support to ensure that our students have an optimal learning experience.

Sincerely,

Ariel Thomas
Director, Health Services

Paris Pryor
Program Manager, Health Services

SAN LUIS COASTAL
UNIFIED SCHOOL DISTRICT

Student Support Services

10/20/26

To Grant Parks,*

It was a pleasure to work with the State KOHA Audit Team. I know the aspects of the KOHA program we do well; certainly this report shows areas where we need to improve.

Please find comments re: 1015-109 Agency Draft below:

Page 10: ①
1. We have written procedures for notification of the four unique KOHA forms/communications and will implement this in November 2026.

Page 17:
1. We currently do not have the same staff as that in 2024-2025, which may, in and of itself, right some of the data discrepancies.
2. Nevertheless, the nurse team will review proper and accurate data entry of KOHA data this school year to ensure data entered in the student information system (SIS) is truly the data reported on the KOHA form.

Pages 17 and 18:
1. The number of TK/Kindergartners reported to SCOHR is taken from October CBEDS. However, the actual number of these students who have matriculated usually differs. It follows the number of completed KOHAs may differ, as a result. ②

Page 20:
1. Clarification: The data obtained at the on-site dental screenings are added to the SIS. The SIS is queried for KOHA results. These are reported to SCOHR. ③
2. Describes multiple KOHA entries for the same student, which is true because parents will submit a completed KOHA after the school-site dental screening even though it has been communicated that the KOHA will be completed at the school event. These multiple data are highlighted, and only one of the entries is counted for the student. This is a process, thus far, that has been manually accomplished. ④

Thank you,
Grace Van Doren,
District School Health Services Lead

* California State Auditor's comments appear on page 83.

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Comments

CALIFORNIA STATE AUDITOR'S COMMENTS ON THE RESPONSE FROM THE SAN LUIS COASTAL UNIFIED SCHOOL DISTRICT

To provide clarity and perspective, we are commenting on the response to our audit report from San Luis Coastal. The numbers below correspond with the numbers we have placed in the margin of its response.

We provided San Luis Coastal a redacted copy of our draft report when requesting its response. Therefore, the page numbers that the district cites in its response do not align with this final report. (1)

San Luis Coastal misunderstands the analysis we present in Figure 9 and describe on pages 31 through 33 regarding its reporting to SCOHR. In its response, the district explains reasons for differences in the total number of students enrolled in TK and kindergarten (which it states it derives from the California Basic Educational Data System) in comparison to the total number of students completing an oral health assessment. However, as we indicate on page 31 and in Figure 9 on page 32, our analysis compared the district's local data for the number of proofs of assessment they received to the number the district reported to SCOHR; we found the district significantly overreported to SCOHR the number of students with proofs of assessment. (2)

In its response, the district seeks to clarify our description of its process for reporting its KOHA program results to SCOHR. That description, which appears on page 33, is based on perspective that the lead credentialed nurse provided during our audit. As we show in Figure 9 on page 32, the district's local data did not match what it reported to SCOHR. Accordingly, we question the validity of the district's assertion that it relied only on its local data when reporting to SCOHR. We stand by our recommendation that the district develop procedures for reporting KOHA results to SCOHR that rely directly on the data in its data system. (3)

The evidence we collected from San Luis Coastal indicates that its assertion that it reports only one assessment per student to SCOHR is inaccurate. Specifically, as we describe on page 33, the district's local data include a large number of instances in which it had recorded two assessments for a single student. As we explain in Figure 9 on page 32, the difference between the district's local data and SCOHR is understated because we did not remove these duplicate entries from our analysis. In other words, if the district were removing duplicate entries—as it asserts in its response—we would have identified an even greater discrepancy when comparing its local data to SCOHR. Therefore, we stand by our conclusion on page 33 that it is unclear how San Luis Coastal's reporting process accounts for students with multiple entries when reporting to SCOHR. (4)