

*Substitute House Bill 1951*

# **Visual Screening of Children in Public Schools—Final Report**

December 2006



Division of Community and Family Health  
Office of Maternal and Child Health

Substitute House Bill 1951  
**Visual Screening of Children in Public Schools—Final  
Report**

December 2006



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## **Acknowledgments**

This report and the resulting recommendations are the culmination of the dedicated work of the Vision Screening for Children Expert Workgroup that met monthly from September 2005 through August 2006 to complete their task. They have dutifully and systematically analyzed the issues to develop the comments and recommendations that are included in this report. Each one gave generously of their time, expertise and knowledge to provide the necessary input to complete this project in a timely manner.

A list of Workgroup members can be found in Appendix A.

Lastly, acknowledgement is given to Debbie Roper, Secretary Administrative in Department of Health/Child & Adolescent Health section, who provided support to the workgroup by arranging meeting space, typing summary minutes, arranging travel for participants and accomplishing the many tasks that support successful meetings.

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## Executive Summary

In 2005, the Legislature enacted Substitute House Bill 1951 (SHB 1951), which directed the Department of Health to convene a workgroup to reevaluate visual screening of children in public schools and make any recommendations regarding changes to the current vision screening rules under the authority of the State Board of Health. In passing this act, the legislature recognized the importance of vision and the importance of vision screening to detect disorders that may significantly impact a child's life skills, including the ability to learn.

SHB 1951 required the workgroup to consider, at a minimum:

- The benefits of complete eye exams on public school children.
- When visual screening, complete eye exams, or both, should take place in preschool or kindergarten through high school to ensure readiness to learn.
- What screening techniques would be appropriate in a school setting.

### **Recommendations A, B and C address those considerations:**

- A-1 Any child failing the school vision screening at any age will be referred for a comprehensive exam as follow-up. Mandating comprehensive eye examinations for all children entering school is currently prohibitive due to cost.
- B-1 Expand screening to pre-school age by requiring proof of screening or exam within 12 months prior to entry into kindergarten or initial entry into school. No child will be excluded from school entry for failure to produce proof of screening or exam.
- B-2 Maintain the current screening schedule for distance acuity at kindergarten, and grades one, two, three, five, and seven. For children who produce proof of screening or exam at school entry, distance acuity screening in kindergarten or Grade 1 may be waived. In addition, screening will be expanded to require stereo vision testing in Grade 1, and color vision testing for Red-Green Color Deficiency in males in Grade 1 or Grade 2. New resources are required to support this recommendation.
- C-1 All vision screening programs should be allowed to adopt evidence-based screening techniques and tools (in addition to those required) as described in professional preferred practice patterns.

### **In the course of their discussions, the workgroup also developed the following additional policy considerations:**

- D-1 Recommend a Current Procedural Terminology (CPT) code for vision screening be established on a national level. Establishing vision screening as a billable procedure would help ensure that providers include it as part of well-child visits to

detect children at an early age and have a more systematic way of identifying children for follow-up care.

- D-2 Explore with the Washington State Insurance Commissioner a proposal that insurance companies be required to compensate vision screening as a covered medical benefit.
- E-1 Develop and provide educational information for parents to inform them of school-age vision problems. New resources are required to support development and dissemination of these materials.
- F-1 Develop standards for vision screening process in Washington State and for training of screeners to promote quality assurance and support consistency among programs. New resources are required to support development of the process, provide on-going training and make the standards available.
- G-1 Parents of children with neurodevelopmental delays should be encouraged through the use of anticipatory guidance to seek a comprehensive eye exam for their children in lieu of screening, when appropriate. In addition, a parent-oriented checklist could be developed and distributed through schools to alert parents on what to watch for in their children that may indicate visual difficulties.

The final report contains the full recommendations put forth by the workgroup.

## Introduction

### Vision Disorders from a National Perspective

Vision disorders are the fourth most prevalent or widespread class of disability in the United States and the most prevalent handicapping conditions in childhood.<sup>1</sup> Normal visual development requires the brain to receive equally clear, focused images from both eyes simultaneously in order for visual pathways to develop properly. Vision screening and comprehensive eye examinations can detect conditions that may lead to permanent and irreversible visual deficit. Permanent and irreversible visual deficits may adversely affect school performance. Early detection increases the likelihood for effective treatment and decreases the negative impact of these disorders.

Vision problems are common among children and affect nearly 13.5 million children nationwide. The U.S. Preventive Services Task Force (USPSTF) has identified that visual impairment in young children affects five to ten percent of all preschoolers. Many of these vision problems are treatable.

The most common vision disorders seen in children are amblyopia, strabismus and refractive errors. Amblyopia (“lazy eye”) is a serious public health problem and the most serious of the three vision disorders listed. It is the leading cause of monocular vision loss in America. It is estimated that amblyopia affects five percent of the general U.S. population and three to five percent of preschool age children (200,000 of four million preschool children in the U.S.), while an estimated two to four percent of the nation’s children have strabismus (misalignment). The incidence of refractive errors is higher than amblyopia or strabismus, but the consequences are much less severe. The frequency of occurrence of these disorders in “high risk” groups such as economically and socially disadvantaged children is higher (up to ten percent).

Vision loss from amblyopia occurs when focusing problems, eye misalignment, or diseases of the eye interfere with normal development of the brain’s vision center. Only during the critical period of brain development early in life can the detection and treatment of amblyopia prevent life-long vision loss. After age nine, it is generally too late to restore vision. An estimated five million adults have irreversible vision loss due to undetected amblyopia, and over 40 million children nationwide are at risk for permanent vision loss.

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<sup>1</sup> The Vision in Preschoolers Study Group: Comparison of Preschool Vision Screening Tests as Administered by Licensed Eye Care Professionals in the Vision in Preschoolers Study. *Ophthalmology* 111: 637-650, 2004

# **Challenges in Describing the Extent of the Problem Among School Aged Children in Washington**

## **Role of Standards of Practice for Vision Screening in Washington Schools**

There are neither national standards for school vision screening, nor state standards of practice that school districts are required to follow. As a result, equipment, methods, techniques and quality of screening vary widely from district to district and from school to school. Although Washington Administrative Code (WAC) rules mandate screening frequency, schools may choose to screen children in additional grades if resources allow. Distance visual acuity is the only vision screening the WAC rules mandate. There is no permissive language in the WAC about using equipment other than the Standard Snellen or Snellen E chart. However, many schools screen for other vision problems, such as color vision, if they desire and have the resources.

Usually nurses perform screening, but some districts also engage other non-health school staff, health assistants, and parent volunteers to screen in schools. There is a wide disparity in the background, training, preparation, and experience of screeners. There is also no uniform standard of competency for screeners.

Vision testing is recorded on forms and kept in each student's educational file. There is no requirement that districts report the results to Office of Superintendent of Public Instruction (OSPI) in order to obtain statewide data. OSPI has developed model forms, but schools are not mandated to use these forms and often develop their own. Even if data were collected, there is no standard method for collecting vision screening results and the usefulness of the data would be questionable because of lack of uniformity and standards of practice.

Schools or districts do not consistently track how many children fail screenings and are referred for more comprehensive exams, how many of those children referred actually received follow-up care, and how many of those children required further treatment. Therefore, it is difficult to determine how widespread vision problems are among children in Washington State.

## **Vision Screening as a Public Health Practice**

Screening is a primary prevention activity<sup>2</sup> and a sound public health practice that can lead to early intervention.

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<sup>2</sup> Prevention strategies can either be primary, secondary or tertiary in nature. Primary prevention activities usually involve identifying a condition or disease in a general population. Secondary or tertiary activities involve a specific subset of a general population such as people who are at higher risk.

There is evidence and professional support for identifying visual defects at an early age. The historical purpose of vision screening is to detect and treat vision problems in order to improve quality of life and may enhance learning. Evidence is inconsistent about the relationship of early detection and treatment of vision problems to learning; there is strong evidence that early detection and treatment improves the quality of life.

Early childhood is the most critical period of development for the vision system. When a child reaches the age of nine or ten years, the vision system is developed. Early vision screening helps prevent blindness and permanent impairment from most eye diseases. Eye disorders can be reduced or prevented with early detection and treatment. From a public health standpoint, vision screening is an appropriate and necessary activity.

## **Issues Regarding Current Approaches to Vision Screening**

Currently there is an increase in the amount of social and political momentum to improve the way we screen our nation's children for vision disorders. Several states have enacted legislation or amended laws to require screening or comprehensive exams prior to school entry. Several other states are considering similar legislation in the next year.

There are three major approaches to identifying children with vision problems:

- School-based vision screening programs.
- Community-based or office-based screening programs.
- Comprehensive eye exams performed by an optometrist or ophthalmologist.

A major difficulty in determining the benefits of vision screening versus comprehensive eye exams for school-age children is that there are conflicting recommendations among health professionals about the best strategies to use to detect vision problems among large groups of children. The American Optometric Association and the American Public Health Association recommend comprehensive vision examinations for all children starting at six months of age and at regular intervals thereafter. The American Academy of Pediatrics and the American Academy of Ophthalmology support vision screenings for all children by age three and at regular intervals after that age.

In addition, there are differing opinions about what screening tools are most effective, who should be performing the screenings, what are the most cost effective tools to use in a school setting, who should assume the cost of referrals for comprehensive eye exams, and at what age screening should begin. There are studies underway by the National Institute of Health and other health entities to address some of these issues and to gather data, but there currently is no sufficient body of research available to answer the many important questions that are critical to establishing good public policy.

In developing their final recommendations for the legislature and State Board of Health (SBOH), the workgroup systematically addressed these issues using evidenced-based and scientifically-based decision making whenever possible.

This report summarizes the findings, conclusions, and recommendations of the Vision Screening for Children Expert Workgroup.

## **Meeting the Legislative Requirements of SHB1951**

The legislation directed the Department of Health (DOH) to convene a workgroup to “reevaluate visual screening of children in public schools and make any recommendations regarding changes to the rules.” In passing this act, the legislature recognized the importance of vision and the importance of vision screening to detect disorders that may significantly impact a child’s life skills, including the ability to learn. Specifically, the workgroup was asked to:

- Consider the benefits of complete eye exams for public school children.
- Consider when visual screening, complete eye exams, or both should take place in preschool or kindergarten through high school in order to ensure children are best prepared for the learning environment.
- Consider what screening techniques would be appropriate in a school setting.

Department of Health staff consulted with Office of Superintendent of Public Instruction, the State Board of Health (SBOH), the Optometric Physicians of Washington, and the Washington Academy of Eye Physicians and Surgeons to develop recommendations. The legislation required that a preliminary report be made to SBOH and the legislature by December 2005, and final recommendations be made by December 2006.

DOH invited experts and interested persons from the following groups to serve on the workgroup:

- Office of Superintendent of Public Instruction (OSPI)
- State Board of Health (SBOH)
- Department of Health (DOH) Children with Special Health Care Needs Program
- Pediatric Ophthalmology
- Pediatric Optometry
- DOH Optometry Board
- DOH Medical Quality Assurance Commission (MQAC)
- School Nurse Organization of Washington (SNOW)
- Education Service District School Nurse Corps Supervisors (SNCS)
- National Association of Pediatric Nurse Practitioners (NAPNP)
- Washington Chapter of the American Academy of Pediatricians (WCAAP)

Representatives of NAPNP, WCAAP and DOH MQAC all declined the invitation to participate because of previous commitments.

The workgroup met monthly from September 2005 through August 2006.

## **Processes Used to Gather Information**

In developing recommendations to the SBOH and the legislature, the workgroup considered the following questions:

- What are the most common vision disorders among school-aged children in Washington?
- What screening is available for these disorders?
- What screening tools are appropriate in a school setting?
- Should screening, complete eye exams, or both, take place in preschool through high school? What are the benefits and barriers of each?
- How can parental involvement in providing for their children's eye care be increased?
- How do the current rules and authorities address the common disorders seen in school age children? What is missing?
- How does current screening required by WAC address the common disorders seen in school-age children? What is missing?

The workgroup completed and reviewed an extensive literature review and synthesized their research. Documents reviewed and discussed included position statements, state and federal policies, research surveys and studies, articles, and guidelines. For consistency of recommendations and best practices, the workgroup reviewed three comprehensive documents:

- The National Institute of Health/National Eye Institute Vision in Preschoolers Study—a three phase study over a period of six years involving 1,400 preschoolers.
- To See or Not to See: Screening the Vision of Children in School—a comprehensive guideline published in July 2005 by the National Association of School Nurses (NASN). Reviewers included pediatric ophthalmologists, pediatric optometrists, school nurses and representatives from the U.S. Department of Education and U.S. Department of Health and Human Services.
- Guidelines for vision screening from Prevent Blindness America.

The workgroup also discussed applicable legal authority to determine whether recommendations would require a change in the current Washington Administrative Code (WAC) or Revised Code of Washington (RCW). In Washington State, RCW 28A.210.020 governs the vision screening for children in public schools. It grants school

boards the authority to require screening for visual acuity of “all children attending schools in their districts...” This statute requires the State Board of Health (SBOH) to consult with the Office of Superintendent of Public Instruction (OSPI) regarding the specifics of the administration of the screenings including the qualifications of the persons who provide the screenings.

The specific rules governing this statute (WAC 246-760) are under the jurisdiction and authority of the SBOH. They require screening to be conducted in kindergarten, and in grades one, two, three, five and seven; or anytime a child shows signs of vision loss. In addition, if resources permit, schools may annually screen children in other grade levels. These regulations also specify the frequency of screening, the equipment to be used, the procedure, the referral process for failed screenings and the qualifications of vision screening personnel. Currently, ophthalmologists, optometrists, opticians and others with a conflict of interest are prohibited from performing vision screening in a school setting.

Guest speakers from Washington State agencies, including public education presented the following information to the group:

- How school screening works in practice in the real world (two school nurses from Benton-Franklin and King counties).
- The jurisdictional boundaries and regulations for preschoolers (Healthy Child Care Washington, Department of Social and Health Services/Division of Childcare and Early Learning, Community, Trade and Economic Development/Early Childhood Education and Assistance Program).
- Regulations around the new Disabilities Education Improvement Act law and special education regulations (Office of the Superintendent of Public Instruction).

In addition to Washington State experts, the workgroup consulted with Massachusetts and Minnesota. These states recently enacted legislation requiring comprehensive vision exams prior to school entry and have found creative ways to fund those initiatives.

A broad array of stakeholders were asked for input. Executive Diversity Services/MGS Consulting developed a process for stakeholder engagement for the workgroup (See Appendix D). A database of stakeholders including parents, school administrators, school staff, local school boards, educational service districts, and private providers was compiled. Once the workgroup completed draft recommendations, input was gathered from a broader stakeholder audience using a variety of media that included a web-based survey, focus groups, and individual interviews with stakeholders.

Final recommendations were reached by consensus.

## Recommendations and Additional Issues for Consideration

While the legislation asked to consider three issues, the expert workgroup also considered other related issues and has offered recommendations for consideration on these as well.

### I. Recommendations to meet the minimum requirements of SHB1951

ISSUE A: Consider the benefits of complete eye exams for public school children.

- **Recommendation A-1:** Complete eye exams for children are considered the gold standard<sup>3</sup> by most health care providers; however, the cost, access to providers, and resources needed to provide or mandate comprehensive examinations for all children is currently prohibitive. Children who fail the school screening at any age will be referred for a comprehensive exam as specified in the current WAC rules.

ISSUE B: Consider when visual screening, complete eye exams, or both, should take place in preschool or kindergarten through high school in order to ensure children are best prepared for the learning environment.

- **Recommendation B-1:** Require proof of screening or exam prior to school entry.

Support earlier detection of vision-threatening disorders through expanded screening to preschool age by requiring proof of screening or exam within 12 months prior to entry into kindergarten or initial entry into school. No child will be excluded from school entry for failure to produce proof of screening or exam.

This recommendation requires a change to both the RCW and the WAC rules. The RCW currently only gives authority for screening vision for “children attending school” and not for preschool-age children.

Research shows that earlier diagnosis of treatable vision-threatening childhood diseases allows for more effective treatment of these disorders. Preschool screening is also supported in a Healthy People 2010 objective, a set of national health objectives promoted by the U.S. Department of Health and Human Services. Position statements from American Academy of Ophthalmology, American Optometric Association, American Public Health Association, and American Academy of Pediatrics also support early detection and treatment of vision problems through screening of preschool-age children. Other states including Kentucky, Michigan, Kansas, Washington DC, and Massachusetts have

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<sup>3</sup> A number of professional provider organizations support this premise. Complete eye exams are diagnostic in nature and are performed by credentialed professionals using sophisticated equipment. Screening is often performed by lay persons whose purpose is to identify potential problems and refer for more comprehensive testing.

implemented preschool vision screening requirements and could provide valuable information on their experience.

While the expert workgroup strongly supports this recommendation, they also acknowledge the barriers to implementation at this time. Some of the factors to consider to ensure the success of an RCW change and implementation plan are offered below:

- ▶ Timing of reforms proposed by Washington Learns Early Learning Council, which could impact this recommendation.
- ▶ The newly created Department of Early Learning may have authority for preschool-age children, but is not yet up and running. If they have the authority, they must be consulted.
- ▶ Concerns of stakeholders, particularly school nurses and administrators, about the burden to schools and lack of resources will need to be addressed.

DOH contracted with MGS Consulting Services to gather stakeholder input on the issue of whether children should have their vision screened before they enter kindergarten (option one) or upon their first entry into public school (option two). For option one, the major concerns cited by all of the stakeholder groups was cost to parents and schools, follow-up and access to providers and implementation concerns. (See Appendix D for the full report).

▪ **Recommendation B-2:** Expanded Screening and Screening Tools

Maintain the current screening schedule for distance acuity at kindergarten, and grades one, two, three, five, and seven. For children who produce proof of screening or exam at school entry, screening for distance acuity in kindergarten or Grade 1 may be waived.

In addition to distance acuity, screening in school should be expanded to require stereo vision testing in Grade 1, and color vision testing for Red-Green Color Deficiency in males in Grade 1 or Grade 2. Any child who fails the vision screening at any age will be referred for a comprehensive eye exam. This recommendation will require a WAC change.

Resources will need to be allocated to support stereo vision and color vision testing in each school as part of the vision screening process. Increased resource needs include new tools for screening stereo vision and color deficiency as well as increased time for school nurses to screen or supervise screening activities.

As with recommendation B-1, MGS gathered stakeholder input on the proposal to expand the vision screening that currently takes place at school for children in kindergarten and grades, one, two, three, five, and seven. The major concerns cited by stakeholder groups were training, accuracy, liability, and cost to parents and schools.

For recommendations B-1 and B-2, the stakeholder groups comprised of parents, health care professionals, and eye care professionals indicated moderate support, but had

significant concerns regarding how these options would be implemented. The stakeholder group of school personnel generally did not support either option.

ISSUE C: Consider what screening techniques would be appropriate in a school setting.

- **Recommendation C-1:** All vision screening programs should be allowed to adopt evidence-based screening techniques and tools (in addition to those required for distance visual acuity testing, stereo vision testing and color vision testing for Red-Green Color Deficiency) as described in professional preferred practice patterns. These techniques and tools may include:
  - ▶ Near vision testing (Grade 2 and above)
  - ▶ Autorefraction
  - ▶ Photoscreening
  - ▶ Computerized testing tools
  - ▶ Cover testing
  - ▶ Parental checklist for vision problems

This recommendation requires a WAC change.

## II. Other issues considered by the Expert Workgroup

ISSUE D: Reimbursement for Providers for Vision Screening

- **Recommendation D-1:** A Current Procedural Terminology (CPT) code for vision screening should be established on a national level. Establishment of a CPT code for vision screening as a billable procedure would help ensure that providers include it as part of well-child visits to detect children at an early age who require further examination and treatment and have a more systematic way of identifying children for follow-up care.
- **Recommendation D-2:** After further analysis, including input from stakeholders, explore with the Washington State Insurance Commissioner a proposal that insurance companies be required to compensate vision screening as a covered medical benefit.

ISSUE E: Educational Information for Parents

- **Recommendation E-1:** Provide educational information to parents to inform them of school-age vision problems. There is no authority to require creating and distributing information for parents. Information could be developed, in consultation with OSPI, Washington Academy of Eye Physicians and Surgeons (WAEPS), and Optometric Physicians of Washington (OPW) to be distributed in schools as part of the communication to parents that occurs at the start of each school year. In order to provide this information, new resources are required to support the development and dissemination of these materials. Schools are already required to provide a broad array of information to parents.

#### ISSUE F: Standards for Screening, Training of Screeners

- **Recommendation F-1:** Develop standards and a process to train both lay and professional screeners.

Currently no national or state standards for the vision screening process or for training lay and professional screeners. Lay screeners might include parents, Lion's Club members, or other members of the community. Professional screeners include school nurses, physicians, and professional staff in vision care offices. Developing standards would promote quality assurance and support consistency among programs. Standards could be developed, in consultation with OSPI, the Department of Early Learning, SBOH, WAEPS and OPW. New resources would need to be allocated to support development of the process, provide on-going training, and make the standards available. The American Academy of Pediatrics (AAP) standards for vision screening should be recommended in any educational documents and be used to guide standards development for vision screening in Washington State.

#### ISSUE G: Anticipatory Guidance for Parents.

- **Recommendation G-1:** Although no consistent definition of “neurodevelopmental delay” is used in Washington State, it is understood that children with diagnosed neurodevelopmental delays often have vision problems as well as other disabilities. Parents of these children should be encouraged through the use of anticipatory guidance to seek a comprehensive eye exam for their children in lieu of screening when appropriate. Additionally, a parent-oriented checklist could be provided to alert parents on what to watch for in their children that may indicate visual difficulties. This checklist could be distributed in a variety of ways including posting to websites, sending home with other school information, or posting in provider offices.

## **Conclusion**

Screening children for visual deficits at an early age is good public health practice, can prevent permanent visual deficits due to certain conditions, and has the potential to enhance a child's readiness to learn. The workgroup recommends requiring proof of screening or an exam prior to school entry, and expanded screening and associated tools to evaluate for some conditions.

This report contained a number of other considerations to complement the work accomplished under Substitute House Bill 1951. One important consideration would be educating providers, parents, and the larger community about the importance of vision screening. Furthermore, there should be efforts to enhance the overall quality of vision screening and a commitment to evaluate the outcome of these efforts.

## **Appendices**

- A. Expert Workgroup Members
- B. Copy of Substitute House Bill 1951
- C. Cost-Benefit Analysis
- D. Glossary of Terms
- E. Report of Stakeholder Engagement Process

## APPENDIX A—Expert Workgroup Members

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# APPENDIX B—Copy of Substitute House Bill 1951

## SUBSTITUTE HOUSE BILL 1951

AS AMENDED BY THE SENATE

Passed Legislature - 2005 Regular Session

**State of Washington 59th Legislature 2005 Regular Session**

**By** House Committee on Education (originally sponsored by  
Representatives Quall, Talcott, Haler, Morrell, Campbell,  
O'Brien, Hankins, Kagi and McDermott)

READ FIRST TIME 03/07/05.

1 AN ACT Relating to vision exams for school-aged children; and  
2 creating new sections.

3 BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF WASHINGTON:

4 NEW SECTION. **Sec. 1.** The legislature finds that:

5 (1) Vision is one of the primary senses used in the early learning  
6 process;

7 (2) Vision problems affecting preschool and school-age children can  
8 impact a child's ability to learn;

9 (3) Economically disadvantaged children have less access to health  
10 care and therefore, may have a proportionally greater likelihood of  
11 having undiagnosed vision problems that may affect their ability to  
12 learn;

13 (4) Vision problems in young children can be misinterpreted as  
14 neurodevelopmental delay or as learning disabilities; and

15 (5) Current screening for visual acuity at distance is insufficient  
16 to detect all vision defects.

17 NEW SECTION. **Sec. 2.** (1) The department of health shall convene

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1 a work group to reevaluate visual screening of children in public  
2 schools and make any recommendations regarding changes to the rules.

3 In developing its recommendations, the work group shall, at a minimum:

4 (a) Consider the benefits of complete eye exams on public school  
5 children;

6 (b) Consider when visual screening, complete eye exams, or both  
7 should take place in preschool or kindergarten through high school in  
8 order to ensure children are best prepared for the learning  
9 environment; and

10 (c) Consider what screening techniques would be appropriate in a  
11 school setting.

12 (2) In developing the recommendations, the department of health  
13 shall consult with the office of the superintendent of public  
14 instruction, the state board of health, the optometric physicians of  
15 Washington, and the Washington academy of eye physicians and surgeons.

16 (3) The work group shall make a preliminary report to the  
17 legislature and the state board of health by December 1, 2005. The  
18 work group shall make final recommendations to the legislature and to  
19 the state board of health by December 1, 2006.

20 (4) If specific funding for this act is not referenced by bill or  
21 chapter number in the biennial omnibus appropriations act by June 30,  
22 2005, this act is null and void.

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**APPENDIX C—Cost and Benefit Discussion**

**Cost and Benefit Discussion  
on Vision Screening of School-Age Children**

September 2006

# **Cost and Benefit Discussion on Vision Screening of School-Age Children**

September 2006

## **Cost and Benefit Assumptions, Methodology, and Data**

This section will look at costs and benefits of the key recommendations developed by the Vision Screening for Children Expert Workgroup: 1) requiring screening or exams prior to school entry; and 2) expanding screening and screening tools.

### **Assumptions**

Costs of either screening or comprehensive exams can be one-time costs or ongoing. Costs are also associated with leaving visual impairments untreated. Benefits are most often realized over time. Benefits may include identifying the need for vision treatment that might have otherwise gone undetected, as well as the benefits of obtaining treatment sooner rather than later. Additionally, benefits may include not only actual financial costs and benefits, but those that are intangible to which a financial value is associated such as ability to engage in appropriate developmental activities or compete in the job market.

### **Methodology**

The basis of this analysis is derived from a model for determining cost effectiveness developed by Abt Associates, Inc. for the Vision Council of America on the impact and cost of eye exams for children (2004). It is the most definitive analysis in the literature and helps to quantify some of the direct and indirect costs associated with screening, exams, and treatment<sup>17</sup>. The visual impairment that was analyzed for this model was amblyopia. This visual deficit was also identified by the workgroup as one of the most common in children and one that can have devastating effects if not treated early.

In this model, cost effectiveness is assessed using a cost-utility analysis in which the benefits associated with an intervention, which result from earlier detection and treatment, are compared against the costs associated with the exams. The goal of this analysis was to evaluate whether the improvements in health that might result from comprehensive exams justify the expenditures relative to other choices.

Benefits are measured in terms of additional quality using a quality adjusted life years (QALY) measurement. A QALY takes into account the quantity and the quality of life generated by healthcare interventions, and provides a common unit of measurement for comparing the benefits that rise from various interventions. The scale used is generally zero to one, where zero is defined as being equivalent to death and one as equivalent to optimal health. When combined with information on costs of the interventions, it is possible to calculate the cost per quality adjusted life year. While this measure has limitations, it allows for measuring marginal costs and benefits of one intervention over another.

In the U.S., there is no standard accepted threshold for QALY; however, it is commonly accepted that a cost effectiveness of \$50,000 or less per QALY is considered cost effective. A cost effectiveness of \$20,000 or less per QALY is considered very cost effective.

Cost effectiveness of various interventions for amblyopia depends on several parameters<sup>17</sup>:

1. ***Prevalence of amblyopia:*** Few studies have measured the prevalence using a large, nationally representative sample. The studies available vary in their estimated prevalence with a range from 3 percent to 5 per cent. Prevent Blindness America, the nation's leading volunteer eye health and safety organization dedicated to fighting blindness and saving sight, estimates prevalence for amblyopia of 1.6 per cent to 3.6 per cent. They identify that this prevalence is higher in the medically underserved.
2. ***Sensitivity and specificity of comprehensive exams and vision screenings:*** While the concern about the quality of routine vision screening is a major reason for supporting comprehensive eye exams, there are limitations in the literature and the literature is not conclusive on this topic.
3. ***Costs associated with vision screenings, comprehensive exams and treatment:*** Comprehensive eye exams are commonly used as the "gold standard" to measure the performance of vision screenings because it is assumed that they are more accurate and more sensitive than screenings. By using comprehensive eye exams as a "gold standard", it is assumed they have higher sensitivity and specificity (see Appendix A). Because comprehensive eye exams are provided by either an ophthalmologist or an optometrist, the children at least have an initial contact with a professional provider. This does not, however, ensure that follow-up care is accessed by parents.
4. ***Probability of success of the treatment and age at which treatment is initiated:*** Success of treatment and long-term benefits depends on the age the condition is identified and treatment. The earlier the identification, the more benefit derived from treatment.

#### **Costs of Community-based or Office-based Screening (includes well-child exams, Lion's Club sponsored events, other community programs)**

Before discussing the cost-benefit of school based screening, it is important to look at alternative venues for screening and the costs and benefits associated with them. The cost in 2004 dollars for community screening programs was estimated at \$15.00 per child. Additional cost estimates associated with screening include subsequent eye exams as part of usual eye care (\$47), costs associated with false positive screenings (\$6) and cost of treatment (\$29) for a screening cost per child of \$97<sup>17</sup>. This cost is much less than comparable costs for a comprehensive exam which total \$259. (See breakdown of costs in next section).

In terms of testing reliability, screening tests have a sensitivity measure of 65 per cent and a specificity measure of 90 per cent compared to comprehensive exams which have a sensitivity measure of 95 per cent and a specificity measure of 98 per cent<sup>17</sup>. The lower the sensitivity, the more children with vision problems are missed and not referred for appropriate follow up care. The higher the specificity, the fewer false positives occur. It

follows, then, that screening tests are less reliable in picking up all of the children who may have a problem and also have a higher likelihood of a false positive referral by identifying children for a condition that does not actually exist.

While screening programs clearly cost less per successful treatment than comprehensive exams, these higher rates of false positive referrals generate additional costs but no benefits in terms of treating amblyopia. In addition, more children are missed who actually should be referred for a condition. There is also a cost associated with those children that are left undetected and untreated.

Additionally, little is known about how children are screened in community or office programs and how many are referred for diagnostic follow-up. Charges for provider visits are generally wrapped into Early Periodic Screening Diagnosis and Treatment (EPSDT) exams and paid for by private or public insurance.

### **Costs to Schools for Vision Screening**

School-based screening programs are provided at no charge to parents, are intended to identify children at risk for a condition, and are provided when the prevalence of a condition is substantial. Costs of vision screening in schools can include several considerations<sup>1</sup>:

#### ***1. Cost to school districts to conduct the screening***

- ❑ Staff time for preparation (possibly parent notification, set up of room(s), training of volunteers).
- ❑ Staff time for screening.
- ❑ Staff time for follow-up (documentation, referral letter, follow-up with parents).
- ❑ Building costs (heat, light, room space, phone).
- ❑ Miscellaneous supplies (screening tools, forms, copying).

#### ***2. Cost to children's health and well being and time in schools***

- ❑ Cost of having children out of class.
- ❑ Cost of false positives—children who do not need treatment but are referred for treatment.
- ❑ Cost of false negatives—children who passed the screening but need treatment.
- ❑ Cost to parents for complete eye exam if referred (time off work, transportation, fee, follow-up appointments).

In the National Association of School Nurses (NASN) Guidelines, 2005, a cost analysis of vision screening in schools is provided<sup>1</sup>. It assumes a screening program with one nurse, one health aide and screening for 500 students. Because costs vary across the country, cost averages were used in the calculations. The screening time used was five days with two days of preparation and planning, and three days for referral of students and follow-up. The total cost of the screening was calculated at \$3,266.25. This averaged out to \$466.61 per day or \$6.53 per student. Using the cost of \$15 per

screening in a community program, it would appear that screening in a school is more cost effective.

Several studies using reimbursement codes as reference points reinforced this finding and concluded that screening in schools is far less expensive than comparable screening in other venues of the health care systems<sup>19</sup>. It is estimated that the provision of health services in schools in many U.S. school districts is less than 1 per cent of the district's annual budget, and the percentage of health services dollars devoted strictly to screening activities is a fraction of that<sup>19</sup>.

Consideration needs to be given, however, to the wide variety of quality measures in place in each school which influences the reliability of the screening. Many schools use parent or staff volunteers who may not be well trained and who do not have good inter-rater reliability. The decreased quality may result in a higher number of false negatives (those children who were not detected but should have been) as well as a higher number of false positives (those children who were detected but should not have been). It should be noted also that the screening environment is often not ideal to minimize noise and distractions that can particularly influence younger children.

In the 2004-05 school year in Washington State, 194 districts out of a total of 296 districts reported to the Office of Superintendent of Public Instruction (OSPI) that 127,989 students in grades K, 1,2,3,5, and 7 were screened for vision. Using an average of \$6.53 per student, the total cost to those schools reporting was \$835,768.17. (Washington State data from OSPI School Nurse Corps). As noted in Section II, it is widely understood that untreated visual deficits can affect the quality of life and influence future activities and choices. It is less obvious and less supported by evidence that detection of vision deficits improves educational learning outcomes which is the primary concern of school administrators and school boards. If the cost associated with staff and student time necessary for vision screening cannot be justified in terms of educational outcomes, it will be less likely to be viewed as a priority activity by school administrators.

The cost for referrals is also a concern for school districts. While this is generally the responsibility of the parent, if a child is special education eligible, schools may be responsible to cover the cost of a comprehensive exam as part of an educational assessment if the exam is found to be educationally relevant. With 9,000 students deemed eligible for special education every year in Washington State, and the cost of a comprehensive exam estimated at \$175, the cost to the schools could be as high as \$157,500 if only 10 per cent of those eligible students are referred for comprehensive eye exams.

### **Benefits of a School Screening Program**

The benefits of a school screening program are significant compared to a community or office-based screening program<sup>19</sup>. There is ready access to the target population and it provides for screening a large number of students who would not have access to other screening venues—students are a captive audience for several hours each day. Several

studies confirm that approximately 75 per cent of all students with vision problems were first identified in a school setting<sup>19</sup>. Part of the reason for this is that pediatricians often defer screening, particularly on younger children, to schools. Another reason is that screenings at schools are part of a well established and known system. There are also larger numbers of three and four year olds enrolled in publicly or privately funded programs that are attached to schools or known by them, so there is increasingly more access to this younger population group. In addition, as many school nurses will attest, vision screening failure may lead to the discovery of other health related problems that have not been identified, i.e., vision may be only one of several problems the student is experiencing.

### **Cost of Comprehensive Exams**

The cost of comprehensive exams using Medicaid reimbursement data for 2004 was \$85. The cost of a comprehensive eye exam using other insurance rates is approximately \$175. Additional cost estimates associated with an exam include subsequent eye exam as part of usual eye care (\$47), costs associated with false positive exam (\$2), and treatment costs (\$35) for a total cost per child of \$259<sup>17</sup>.

The cost per QALY for a comprehensive exam was estimated at \$28,727 more than for vision screening<sup>17</sup>. In looking at the value and benefit, although the cost is much higher per child, a much higher percentage of children with conditions requiring follow-up are identified through a comprehensive exam than through screening. In addition, there are fewer false positives because of the higher specificity of the tests used, the controlled environment, and the professional status of the person conducting the exam.

### **Costs Associated with Treatment**

It is well known and documented in the literature that earlier detection and treatment for amblyopia is beneficial; however, the American Academy of Ophthalmology indicates that amblyopia is amenable to treatment only up to nine or ten years of age.

Early detection increases the likelihood of effective treatment, decreases the negative impact and leads to a better outcome than later treatment. Treatment may include one or more of the following: patching, eye drops, glasses, surgery. The treatment outcome is a function of initial visual acuity and type of amblyopia, treatment efficacy, duration, and compliance.

There is little data available on the lifetime costs of treating amblyopia. A study published in the February 2004 issue of *Pediatrics*<sup>21</sup> estimated the total mean cost of amblyopia treatment was \$1,623. This cost estimate includes medical treatment, physician charges, anesthesia charges, surgical center fees, and postoperative medication. The costs are assumed to vary based on the age at which treatment begins, but are otherwise the same whether the patient was referred from a comprehensive exam or a vision screening.

Other less tangible costs are also associated with a failure to detect and treat a child at an early age resulting in irreversible visual defects, an increased risk of blindness, and later

restrictions in educational and occupational opportunities across the lifespan<sup>17</sup>. According to a fact sheet developed by the American Academy of Pediatrics Project Universal Preschool Vision Screening, "...children with...impaired vision may have greater difficulty learning, have trouble participating in organized sports and recreational activities, have limited employment options, may have increased morbidity or mortality due to accidents, and have difficulty with psychosocial development.<sup>20</sup>" One CDC supported study reported in the January 2004 Morbidity and Mortality Weekly Report<sup>22</sup> (MMWR) calculated the total average lifetime costs of a person with vision impairment at \$601,000. Only a small fraction of this could be attributed to medical costs. The majority of the costs were non-medical direct costs (i.e. home modifications) and non-medical indirect costs (special education, decreased mobility and decreased employability).

One outward sign of amblyopia can be crossed eyes. Studies have proven crossed-eyed individuals are perceived as less intelligent and discriminated against academically, professionally, and socially. Emotional consequences may include children being viewed as "abnormal", interpersonal skills being affected including decreased self-confidence and poor eye contact, and parents that experience guilt and blame themselves for not detecting problems earlier<sup>10</sup>.

In terms of professional discrimination, some professions require good binocular vision and therefore exclude persons with visual defects. One 2001 study on the effect of amblyopia on career choices identified 30 occupations into which visual requirements would restrict persons with amblyopia from entering the field<sup>17</sup>. Income levels of individuals are also affected. Data from the National Academy of Sciences national Health Interview Survey (2001) suggests that visual impairment is associated with lower income. The mean income was \$3,600 per year less for those individuals with a visual impairment (excluding blindness).

One 1997 study at University of Oxford also suggested negative aspects to treatment. Quality of life might be reduced because wearing glasses and intermittent patching has a negative impact. Children in the study did not like wearing glasses or patches and parents were distressed at enforcing these measures<sup>17</sup>. However, other studies conclude that there is insufficient data to understand what might happen to children whose amblyopia goes untreated.

At an approximate treatment cost of \$1,600 and a 75 per cent chance of successful treatment if begun early, the gain in terms of QALYs associated with successful treatment of amblyopia are relatively high and treatment can be considered highly cost effective<sup>17</sup>. The cost per QALY is calculated at between \$1800 and \$2281, which is very cost effective. This suggests that the screening or exam program that gets the most children into treatment is the most cost effective intervention. Additional costs associated with comprehensive exams may be offset by the gains that result from additional children who are successfully identified and treated.

## Discussion

There are three major approaches to identifying children with vision problems:

- School-based vision screening programs.
- Community-based or office-based screening programs (well-child visits, Lions Club).
- Comprehensive exams by optometrist or ophthalmologist.

Each of these approaches has its benefits and its challenges. We know that early childhood is the most critical period of development for the vision system. When a child reaches the age of nine or ten years, the vision system has finished developing and it is not usually possible to make improvements to counteract the effects of amblyopia. Early diagnosis and treatment is critical to improving or restoring vision to normal. If left untreated permanent reduction in sight, loss of depth perception, and possibly functional blindness can occur.

Vision is critical for conducting activities of daily living, and affects developmental learning, communication, work life, health, and quality of life<sup>6</sup>. The cost of blindness is substantial and potentially devastating to the individual in terms of lost opportunity and income, and to society through disability and support payments<sup>10</sup>.

The Centers for Disease Control and Prevention (CDC) has analyzed data from multiple surveys and reports to estimate the direct and indirect economic costs associated with four developmental disabilities including visual impairment. The estimated lifetime cost in 2003 dollars for a person born with visual impairment in 2000 is expected to total \$566,000. (These are costs attributable to the impairment above ordinary costs incurred by unaffected persons in the U.S. population). This underscores the need to reduce the prevalence of these conditions and prevent development of secondary conditions<sup>7</sup>.

While the benefits of vision screening and comprehensive vision exams can be quantified and demonstrated, barriers exist that influence how and when children are screened or examined and prevent programs or services from being implemented successfully. These barriers need to be addressed and overcome to assure that early detection and treatment occurs universally and routinely. They include:

- ***Adequacy of optometrist and ophthalmologist workforce to provide exams and follow-up treatment:*** Even in urban areas, there are not enough eye care providers to provide follow-up treatment. The wait time for appointments is often several months. Even if a provider is available, not all providers will see children and not all providers will accept medical coupons. The number of physicians available per 100,000 in various locales was identified by Department of Health (DOH) Office of Community and Rural Health data from 2005. In urban areas there were 74 primary care physicians and 135 specialty physicians. In rural areas there were 62 primary care physicians and 78 specialty physicians.

- ❑ **Barriers in rural areas:** According to DOH Office of Community and Rural Health data from 2005, 12.5 per cent of the state population (784,000 persons) resided in rural counties which comprise 59.4 per cent of Washington’s land area. There are fewer providers in rural areas so parents may need to travel great distances for an appointment. Lack of personal and public transportation can be a significant barrier for families.
- ❑ **Poverty and access to care:** According to DOH Office of Community and Rural Health data for 2005, rural populations (12.5 per cent of the state population) are more likely to live in poverty (below 100 per cent of the Federal Poverty Level) and have significantly lower median incomes. In addition, rural populations are more likely to be enrolled in Medicaid and lack health insurance. According to Children’s Alliance Child Facts, in Washington State, an estimated 138,385 school-aged children (aged 5 to 17) live in poverty. This represents nearly 13 per cent of all school children in Washington (US Census Bureau estimates, 2003). Also, children with health insurance tend to be in better health, which leads to improved school health. In Washington State, 167,000 children (10 per cent of children under 19) have no health insurance.
- ❑ **Compliance by pediatricians in following their own professional standards for screening and referral<sup>15</sup>:** The American Academy of Ophthalmology recommends that all children have their vision checked by their pediatrician, family physician or ophthalmologist at or before their fourth birthday. However, pediatricians who do have access to this population often defer visual screening because of the challenge in evaluating young and sometimes uncooperative children. A random sample survey sent to 1,491 physicians nationwide indicated that many pediatricians do not follow AAP guidelines for vision screening and referral, especially in younger children. Two-thirds of pediatricians do not begin visual acuity testing at age three years as recommended, and about one-fifth do not test until age five years. In addition, one-fourth do not perform cover tests or stereopsis testing at any age.
- ❑ **Preschool-aged access:** Even though visual disorders among preschool-aged children are common, screening of this age group remains infrequent<sup>8</sup>. While schools have increasing access to three and four year olds, preschoolers as a whole are a non-captive audience, i.e., they do not gather in any particular place, and it is difficult to collect data on numbers and results.
- ❑ **Parental information and follow-up:** Low follow-up rates and delayed treatment are typical. The rate that has typically been reported is 33 per cent. Treatment is often delayed two years or more after repeated letters and follow-up<sup>18</sup>.

### **Screening and Comprehensive Eye Exams are Cost Effective**

Although eye exams are more costly than screening, by using a QALY measurement for determining cost effectiveness, eye exams and screening are both considered to be very cost effective.

Even though they are more costly to perform, comprehensive eye exams are considered by all eye care professionals to be the “gold standard” for detecting amblyopia and other vision problems in children<sup>17</sup>. Several studies also suggest that eye exams are more effective than vision screenings in terms of ensuring appropriate treatment for amblyopia. However, as previously noted, barriers including lack of providers, lack of access to providers, and lack of insurance to pay for exams provide the impetus to look at screening programs as a more cost effective alternative.

The treatment of amblyopia, compared with the cost of managing other common, chronic health problems, is moderately inexpensive and, therefore, very cost effective<sup>19</sup>. As a result, spending additional dollars on interventions that detect and treat large numbers of children with amblyopia are also highly cost effective.

Therefore, the screening or exam program that gets the most children into treatment is the most cost effective intervention. Additional costs associated with comprehensive exams may be offset by the gains that result from additional children who are successfully identified and treated.

The professional organizations for pediatricians, optometrists, and family practice physicians all agree that vision screening as opposed to a full eye exam for every child is a more cost effective way to protect children and extend precious health care resources<sup>10</sup>. Pediatric ophthalmologists are divided on the benefits of screening programs.

### **Quality Assurance of Screening Programs is Limited and Outcomes are Difficult to Quantify**

There is an absence of evaluative studies in the U.S. looking at the efficacy of vision screening in schools, and little is known about the wide variety of community screening programs. A lack of standardization of vision screening methods and techniques make it difficult to determine outcome measures to evaluate program effectiveness. Many of the recent studies come from countries with universal health care. Studies need to be done that look at the cost-effectiveness of publicly funded programs

With no state (or national) standards in place, there is a lack of quality control and standardization. Screeners lack the training and competency to conduct screenings with consistent quality and there are no national or state standards of competency for vision screeners to assure an assessment of consistent quality<sup>10</sup>.

Traditional vision screening tests are influenced by the competency and interpretation of the screener, the response of the child and the environment in which testing occurs. In addition, traditional vision screening tests require a cooperative and verbal child<sup>3</sup>. It is more difficult to get accurate results if the child is pre-verbal, uncooperative, or unable to follow directions as are the pre-school age children. Screening tests also lack the specificity and sensitivity of more sophisticated tools so that they produce a significantly higher percentage of false positives and false negatives. While new testing tools such as photoscreeners and autorefractors are being developed which rely less on screener's skills and a child's cooperation, they are very costly, require more time per child, and are not designed to detect evidence of amblyopia, one of the most common and most treatable vision defects that has devastating consequences if not treated.

### **School Vision Screening Should Continue Even Though Barriers Exist**

In their 2004 report, the Amblyopia Foundation concluded that there were compelling benefits to performing mass vision screening for school-aged children as well as pre-school children<sup>10</sup>. While schools may acknowledge the benefit, they have limited funding to meet an increasing number of mandates. The student and staff hours devoted to in-school screenings may not be seen as cost effective by school boards and school administrators.

In terms of screening standardization, there is a complete absence of widely endorsed, age-comprehensive (birth-22) set of national standards for school screening that recommend methodology, frequency of screening, visual functions to assess, and criteria for referral. There also are no comprehensive recommendations or clinical practice standards endorsed by all the professional groups that identify specific criteria to be used in screening programs. Without that,

it is difficult to collect data to help answer some of the Washington specific questions on prevalence, referral practices, and screening processes.

While there is a lack of screening standardization, the U.S. Preventive Services Task Force found no evidence of any harm resulting from screening or from false-positive results. They concluded that the benefits of screening are likely to outweigh any potential harm<sup>3</sup>.

### **More Studies and Data Are Needed to Evaluate Outcomes of Screening Programs**

Currently, there is an unprecedented amount of social and political momentum to improve the way we screen our nation's children for vision disorders. Increasing the number of children that receive vision screenings is a stated goal of U.S. Department of Health and Human Services Healthy People 2010 Initiative and Project Universal Pre-School Vision Screening<sup>10</sup>.

Recognizing the shortcomings of current vision screening programs, legislation has been introduced in some states to mandate full eye examinations for all children prior to entering school. Although such legislation appears laudable at first glance, it is prohibitively expensive to implement on a national scale using public funds. At a conservative estimate of \$50-\$100 per child, such a program would cost billions of dollars every year.

A number of states, including Washington, are looking at creative and cost effective ways to address vision problems in children. Thirty-nine states and Washington D.C. are moving toward recommendations to provide screening prior to school entry and periodically thereafter<sup>18</sup>. This is one of the recommendations put forward by the Vision Screening Expert Workgroup. How creatively states decide to fund mandates will influence the success of the program that is implemented. Kentucky was the first state to mandate comprehensive eye exams for all children entering school. The state provides funds for those families who are uninsured. Massachusetts also requires comprehensive eye exams prior to school entry and funds their initiative with their tobacco settlement dollars.

Recently, an innovative model for vision screening based on a finder fee system was proposed at the March 2006 meeting of the American Academy of Physicians and Ophthalmologic Surgeons by Dr. David L. Guyton. The model proposed that there would be a payer or source of funds (government, third party payer, Medicaid) that would pay a finder's fee to screeners to detect children who require further examination and treatment, and who would facilitate them through the system. It would cut down on the low rate of follow-up and eliminate the unwillingness of governmental agencies to pay for screening or full eye exams on large numbers of normal children. This model would take the pressure off of schools, provide some incentive for providers to screen their young patients, and assure a more systematic way of identifying children for follow-up care.

There is insufficient research to definitively answer many important questions that are critical to establishing public policy. Washington State and the nation need to find the public will to spend time and funding on the issue. There needs to be a collaborative approach between professionals and community<sup>18</sup>. Perhaps at least equal emphasis needs to be placed on referral and follow-up as on screening.

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## APPENDIX D—Glossary of Terms\*\*

<b>Amblyogenic Risk Factors</b>	Factors that contribute to or are the result of amblyopia; may include strabismus, significant refractive error, or media opacities.
<b>Amblyopia</b>	Reduced vision from lack of use in an otherwise normal eye. Also known as “lazy eye”.
<b>Autorefractor</b>	A new technology consisting of a small, portable light-weight vision assessment system capable of detecting refractive errors. The portable autorefractor is a miniature version of refractors used in professional eye care practices.
<b>Binocular Coordination</b>	The ability to use both eyes together.
<b>CPT Codes</b>	Current Procedural Terminology codes which are developed by an editorial branch of the American Medical Association. They are used as standards to interpret and report medical procedures and services for billing purposes.
<b>Distance Vision</b>	The ability to see clearly and comfortably beyond arm’s reach.
<b>EPSDT</b>	Early Periodic Screening Diagnosis and Treatment; this is Medicaid’s child health component to fit the standards of pediatric care and meet the physical, emotional, and developmental needs of low-income children. Federal guidelines require that Medicaid cover a very comprehensive set of benefits and services for children.
<b>Eye/Hand Coordination</b>	The ability to use the eyes and hands together.
<b>Eye Movement Skills</b>	The ability to aim the eyes correctly, move them smoothly across a page, and shift them quickly and accurately from one object to another.
<b>Focusing Skills</b>	The ability to keep both eyes accurately focused at the proper distance in order to see clearly and change focus quickly.
<b>Hyperopia</b>	Also known as “farsightedness” where objects that are near are unclear.
<b>Incidence Rate</b>	Number of persons developing a condition within a period of time divided by the total number at risk during that time. It describes the continuing occurrence of new or developing cases.
<b>Myopia</b>	The most common vision problem among school-age children; also know as “nearsightedness” where object that are far away appear unclear.
<b>Near Vision</b>	The ability to see comfortably at 10 to 13 inches.

<b>Ophthalmology</b>	A branch of medicine specializing in the anatomy, function and diseases of the eye.
<b>Ophthalmologist</b>	A medical doctor who specializes in eye and vision care. Ophthalmologists are specially trained to provide the full spectrum of eye care, from prescribing glasses and contact lenses to complex and delicate eye surgery. In addition to medical school and a one-year internship, all ophthalmologists spend at least three years of residency in a hospital. Some ophthalmologists may sub-specialize in a specific area of eye care.
<b>Optometry</b>	A health care field that specializes in examining, diagnosing, treating and managing some diseases and disorders of the visual system, the eye and associated structures as well as diagnose related systemic conditions.
<b>Optometrist</b>	A health care professional that examines the internal and external structure of the eyes to diagnose eye diseases, systemic diseases, and vision conditions. Optometrists complete pre-professional undergraduate degrees as well as an optometry residency.
<b>Opticians</b>	Technicians trained to fit eyeglass lenses, frames, and contact lenses as prescribed by an ophthalmologist or optometrist. They either complete a 2-year optician degree and/or receive on-the-job training. They are not qualified to diagnose or treat eye diseases.
<b>Peripheral Awareness</b>	The ability to be aware of things located to the side of the eyes while looking straight ahead.
<b>Prevalence Rate</b>	Refers to the number of persons in a group or population with a disease divided by the total number of persons in the group. It is a snapshot of all cases.
<b>Red/Green Color Deficiency</b>	Color vision deficiency is a condition in which certain colors cannot be distinguished, and is most commonly due to an inherited condition. Red/Green color blindness is by far the most common form and occurs in about 99% of cases where color vision deficiency exists.
<b>Refractive Error</b>	A category of vision problems that refers to a loss of visual acuity. The loss of acuity is due to improper light refraction as a result of the shape of the eye. The result is a blurred image. These types of errors are eye disorders.
<b>Screening</b>	The use of quick and simple testing procedures to identify and separate persons who are apparently well, but who may be at risk of a disease, from those who probably do not have the disease.
<b>Sensitivity</b>	Refers to the measure of a screening test that assesses the percentage of children whose condition will be missed by the screening method. The lower the sensitivity, the more children with vision problems are missed and not referred for appropriate follow up care.

<b>Specificity</b>	Refers to the measure of a screening test that assesses the percentage of false positives; i.e., those children who are referred for a condition that does not actually exist.
<b>Stereo Vision</b>	Refers to both eyes working together to provide visual perception in three dimensions; depth perception
<b>Strabismus</b>	Misaligned eye(s) that either turn inward or outward.
<b>Vision Problems or Abnormalities</b>	A general term used to describe a broad range of vision related abnormalities that may include correctable conditions such as near and farsightedness, disorders, diseases, impairment and blindness.
<b>Vision Impairment</b>	The measured visual acuity of 20/70 or worse, with correction, in the better eye. Vision impairment means that a person's eyesight cannot be corrected to a "normal" level. It is a loss of vision that makes it hard or impossible to do daily tasks without specialized adaptations. Vision impairment may be caused by a loss of visual acuity, where the eye does not see objects as clearly as usual. It may also be caused by a loss of visual field, where the eye cannot see as wide an area as usual without moving the eyes or turning the head.
<b>Visual Acuity</b>	Clarity of sight, generally referring to the ability to see things clearly from a specific distance.

\*\*The majority of definitions are from the American Academy of Ophthalmology, American Optometrists Association, National Library of Medicine/Medline Plus, Centers for Disease Control and Prevention, American Academy of Pediatrics and National Association of School Nurses Vision Screening Guidelines 2005 .

**APPENDIX E—Report of Stakeholder Engagement Process (Hard Copy)**



**MGS** consulting

*clarify, refine, act*

## **Final Report**

# **Department of Health Stakeholder Engagement Process**

August 28, 2006

Prepared for the Department of health  
by MGS Consulting Services

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# Executive Summary

In April 2005, the Legislature enacted Substitute House Bill 1951. It requires the Department of Health (DOH) to convene a work group to reevaluate visual screening of children in public schools and make any recommendations regarding changes to the rules. In developing its recommendations, the work group must consider, at a minimum: (1) the benefits of complete eye exams on public school children, (2) when visual screening, complete eye exams, or both should take place in preschool or kindergarten through high school to ensure children are prepared to learn, and (3) what screening techniques would be appropriate in a school setting. In order to gather feedback from stakeholders regarding these issues, the Department of Health contracted with MGS Consulting Services to perform a Stakeholder Engagement Process.

Through online surveys, meetings, interviews, and a focus group MGS gathered data from the following key stakeholder groups in Washington State:

- Health and Eye Care Providers
- School Personnel
- Parents

Health and Eye Care Providers and School Personnel were then divided into professional subsets to provide an accurate representation of who did and did not support the Expert Work Group's two proposed options regarding vision screening for public school children. The following table illustrates these varying levels of support:

Stakeholder Group	% in Support of Option 1 <sup>1</sup>	% in Support of Option 2 <sup>2</sup>
Superintendent	17%	0%
School Administrators	22%	30%
School Nurses/ Supervisors	30%	31%
Special Needs	33%	45%
Parents	44%	71%
Ophthalmologists	46%	81%
Pediatricians/Family Practitioners	50%	85%
Optometrists/Opticians	92%	86%

More than two thirds of survey respondents made comments, 90% of which express concern about one or both options. **Overall, the findings of this stakeholder engagement process suggested that, for both Options, stakeholders indicate moderate support with significant concerns regarding implementation.**

<sup>1</sup> Superintendent: n= 6; Administrators: n= 23; School Nurses/Supervisors: n= 403; Special Needs: n= 12; Parents: n=122; Ophthalmologist: n= 57; Pediatrician/ Family Practitioners: n= 146; Optometrists and Opticians: n= 132

<sup>2</sup> Superintendent: n=5; Administrators: n= 23; School Nurses/Supervisors: n= 396; Special Needs: n= 11; Parents: n=121; Ophthalmologist: n= 56; Pediatrician/ Family Practitioners: n= 147; Optometrists and Opticians: n= 131

# Summary of Findings

This stakeholder engagement process had four goals:

1. Uncover glaring obstacles that would impede the realization of the likely recommendations of the working committee;
2. Analyze any issues pertaining to regional and/or other specific subsets of the population to identify information which would be useful for the committee to consider when making their final recommendations;
3. Provide stakeholders with the understanding that they are likely to be impacted by upcoming changes in this area;
4. Discover any advantages or opportunities for implementation should the legislature approve the recommendations.

## ***Stakeholder Groups***

In order to begin gathering information to address these four main goals, MGS and the Executive Work Group identified key stakeholders. The three main categories of stakeholders engaged through this process were:<sup>3</sup>

### *Health and Eye Care Providers*

The following subsets of Health and Eye Care Providers responded to the on-line survey:

- Optometrist (31% of respondents)
- Pediatricians (23% of respondents)
- Family Practitioners who see children (21% of respondents)
- Ophthalmologist (16% of respondents)
- Optician (7% of respondents)
- Other (3% of respondents)

Health and Eye Care Providers from thirty-two (32) counties<sup>4</sup> across Washington responded to the survey, resulting in the following trends:

- 74% said they practice in a rural location
- 50% said many of their patients are ESL
- 72% said their patients are predominantly insured

It is interesting to note that while most Parent and School Personnel respondents said they were from urban areas, the Health and Eye Care Providers who replied were predominately located in rural areas. Another difference between Health and Eye Care Providers and Parents is the predomination of ESL. Only 2% of Parents said English was their family's second language, compared to 50% of Health and Eye Care Providers who said many of their patients are English language learners. These differences between the

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<sup>3</sup> Further information regarding these methods, outreach, process, and response groups can be found in the "Methodology" section of this report.

<sup>4</sup> See Appendix I for a map illustrating respondents by county for all three stakeholder groups.

groups do not affect the validity of the data, but are important to keep in mind when interpreting results.

### *School Personnel*

Surveys were completed by school nurses (85% of school responses came from nurses), school nurse corp supervisors, principals, vice principals, district administrators, superintendents, school administrators, and other school personnel.

The majority of school respondents are from urban areas, and there is high representation from elementary school personnel, through many school personnel reported working in more than one school. School personnel from thirty-seven (37) counties in Washington State responded to the survey with the following results:

- 66% of respondents said their school is located in an urban area;
- 82% said they work for an elementary school;
- 59% said they work for a middle school;
- 51% said they work for a high school.

### *Parents*

Parents from seventeen (17) counties across Washington State responded to the on-line survey. While this representation is geographically diverse, the parents who responded had several characteristics in common:

- 61% of parents said they lived in an urban area;
- 94% of parents said their family had health insurance;
- 98% said their family owned their own vehicle;
- 85% said they knew where to take their child for eye care.

These responses indicate that while parents from all over the state took part in the survey, rural, uninsured, and lower-income families are underrepresented.

### ***General Findings***

These three stakeholder groups (Parents, Health and Eye Care Providers, and School Personnel) completed a total of 986 surveys from June 1 to July 27, 2006. The survey consisted of two sets of questions which were phrased slightly differently for each stakeholder group.<sup>5</sup> Each set of questions focused on one of two proposed options regarding vision screening for children in public schools. Of the 986 respondents, 630 made a comment in one or more of the three open-ended questions in each survey. Of these comments, 90% expressed concern about one or both of the options.

**Option 1** focused on the proposal that children will have their **vision screened before they enter kindergarten** or upon their first entry into public school. **Option 2** focused on the proposal to have the **expanded vision screening take place at school** for children

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<sup>5</sup> To read each question for each stakeholder group, see Appendix A.

in grades K, 1, 2, 3, 5 and 7. The following overview indicates which stakeholder groups are in support of each option, and highlight their main concerns.

Option 1

In order to gain a full and accurate understanding of which stakeholders were in support of Option 1, the data must be broken down into the various subsets of professionals for **Health and Eye Care Providers** and **School Personnel** (there are no subsets for the Parent group). The following table illustrates levels of support for Option 1 from each of these subsets:

Stakeholder Group	% in Support of Option 1
Superintendent	17%
School Administrators	22%
School Nurses and Supervisors	30%
Special Needs (in Schools)	33%
Parents	44%
Ophthalmologists	46%
Pediatricians/Family Practitioners who see children	50%
<b>Optometrists/Opticians</b>	<b>92%</b>

The only group who expressed support<sup>6</sup> for Option 1 was Optometrists/Opticians.

**Concerns Regarding Implementation – Option 1**

The following comments demonstrate that even those respondents who indicated support for Option 1 expressed significant concerns. The tables below demonstrate the number of comments made by each stakeholder group and their major concerns regarding Option 1. As you can see, cost, tracking, staff time, and other implementation concerns are seen repeatedly. **Note that Cost to Parents and Schools was one of the top 3 concerns for each stakeholder group.**

*“Schools are a good place to perform tests/screening.”*  
 ~ Rich Kovar, MD  
 Country Doctor Community Clinic, Seattle, WA

Of the 372 Health and Eye Care Providers respondents 57% chose to add comments to the survey. While the majority of the comments were singular in nature there were some themes in the comments that are noteworthy, as indicated in the tables below:

<sup>6</sup> “Support” is defined as: Over 50% of the respondents in a stakeholder category are in agreement with the Option.

<b>Option 1 - Comment Categories (All Health and Eye Care Providers)</b>			
	<b>count</b>	<b>percent of comments</b>	<b>percent of survey respondents</b>
<b>Total comments</b>	<b>213</b>	<b>100%</b>	<b>57%</b>
<b>Costs to parents and schools</b>	<b>30</b>	<b>14%</b>	<b>8%</b>
Good idea	25	12%	7%
Not convinced of benefit or need	23	11%	6%
Eye care professional should do it	22	10%	6%
Training/Accuracy/Liability	20	8%	5%
Follow-up/Access to Provider	11	5%	3%
Time	6	3%	2%
Be clear about difference between screening and exam	6	3%	2%
Kindergarten is too late	6	3%	2%
Follow-up/Access to Provider	11	5%	1%
Bad idea	4	2%	1%
Other	46	22%	12%

*“The nurses are already trying to screen for distance, scoliosis and handle all the other special needs of the kids (diabetics, etc) that putting this added evaluation on them is not feasible. They don’t have time for the other mandates to which they must attend.”*

*~ Puget Sound Nurse Leaders Group*

Of the School Personnel respondents, 241 respondents made comments regarding Option1. Many expressed multiple concerns, as seen in the table below:

<b>Option 1 - Comment Categories (School Personnel)</b>			
	<b>count</b>	<b>percent of comments</b>	<b>percent of survey respondents</b>
<b>Total comments</b>	<b>241</b>	<b>100%</b>	<b>100%</b>
<b>Implementation Concerns</b>	<b>224</b>	<b>93%</b>	<b>93%</b>
<b>Costs to parents and schools</b>	<b>138</b>	<b>57%</b>	<b>57%</b>
<b>Follow up/Access to provider</b>	<b>69</b>	<b>29%</b>	<b>29%</b>
Training/Accuracy/Liability	36	15%	15%
Good idea	32	13%	13%
Other	21	9%	9%
Not convinced of need or benefit	19	8%	8%
Bad idea	16	7%	7%

Of the 34 Special Educators who responded, 22 chose to make comments on Option 1. They tended to cite multiple concerns which are reflected in the numbers below:

<b>Option 1 - Comment Categories (Special Educators)</b>			
	<b>count</b>	<b>percent of comments</b>	<b>percent of survey respondents</b>
<b>Total comments</b>	<b>34</b>	<b>100%</b>	<b>14%</b>
<b>Implementation</b>	<b>14</b>	<b>41%</b>	<b>6%</b>
<b>Cost to Parents and Schools</b>	<b>8</b>	<b>24%</b>	<b>3%</b>
<b>Other</b>	<b>8</b>	<b>24%</b>	<b>3%</b>
Nurse/Staff bandwidth	6	18%	2%
Good Idea	3	9%	1%
Not convinced of need or benefit	3	9%	1%
Training/Accuracy	2	6%	1%

*“Doing it at school is a great way to do it if it is funded. If the school is required to do it and there is no funding for it, there will be implementation difficulties.”*

*~ Ron Washington  
Superintendent of Schools in  
Inchelium, WA*

Of the 29 Non Nurse school personnel who responded, 16 chose to comment on Option 1. They tended to cite multiple concerns, which are reflected in the numbers below:

<b>Option 1 - Comment Categories (Non Nurse Personnel)</b>			
	<b>count</b>	<b>percent of comments</b>	<b>percent of survey respondents</b>
<b>Total comments</b>	<b>16</b>	<b>100%</b>	<b>7%</b>
<b>Implementation</b>	<b>12</b>	<b>75%</b>	<b>5%</b>
<b>Cost to Parents and Schools</b>	<b>6</b>	<b>38%</b>	<b>2%</b>
<b>Nurse/Staff bandwidth</b>	<b>6</b>	<b>38%</b>	<b>2%</b>
<b>Not convinced of need or benefit</b>	<b>2</b>	<b>13%</b>	<b>1%</b>

*“They believe that volunteers, unless they are professionals, are not (in most cases) able to pick up the subtly in children’s behavior that tell you the child should be referred on to a health care provider for further testing.”*

*~ Puget Sound Nurse Leaders Group*

Of the 411 school nurses who responded, 241 chose to make comments on Option 1. They tended to cite multiple concerns, which are reflected in the numbers below.

<b>Option 1 - Comment Categories (Nurse)</b>			
	<b>count</b>	<b>percent of comments</b>	<b>percent of survey respondents</b>
<b>Total comments</b>	<b>241</b>	<b>100%</b>	<b>100%</b>
<b>Implementation Concerns</b>	<b>224</b>	<b>93%</b>	<b>93%</b>
<b>Costs to parents and schools</b>	<b>138</b>	<b>57%</b>	<b>57%</b>
<b>Follow up/Access to provider</b>	<b>69</b>	<b>29%</b>	<b>29%</b>
Training/Accuracy/Liability	36	15%	15%
Good idea	32	13%	13%
Other	21	9%	9%
Not convinced of need or benefit	19	8%	8%
Bad idea	16	7%	7%

*“It would be like vaccinations – which is difficult.”*

*~ Focus Group, Director of Special Programs, Republic, WA*

Of the 159 respondents, 59 chose to make comments on Option 1. They tended to cite multiple concerns, which are reflected in the tables below:

<b>Option 1 - Comment Categories (Parents)</b>			
	<b>count</b>	<b>percent of comments</b>	<b>percent of survey respondents</b>
<b>Total comments</b>	<b>59</b>	<b>100%</b>	<b>16%</b>
<b>Cost to parents and schools</b>	<b>13</b>	<b>22%</b>	<b>3%</b>
Good idea if funded	11	19%	3%
Training/Accuracy	7	12%	2%
No unfunded mandate	6	10%	2%
Doctors should screen	2	3%	1%
It's parents' responsibility	2	3%	1%
Not realistic	2	3%	1%
Other	16	27%	4%

Option 2

Again, when looking at the levels of support for Option 2, the data must be broken down into the various subsets of professionals for the **Health and Eye Care Providers** and **School Personnel** (there are no subsets for the Parent) stakeholder groups. The following table illustrates levels of support for Option 2 from each of these subsets:

<b>Stakeholder Group</b>	<b>% in Support of Option 2</b>
Superintendent	0%
School Administrators	30%
School Nurses and Supervisors	31%
Special Needs (in Schools)	45%
<b>Parents</b>	<b>71%</b>
<b>Pediatricians/Family Practitioners</b>	<b>81%</b>
<b>Optometrists/Opticians</b>	<b>85%</b>
<b>Ophthalmologists</b>	<b>86%</b>

As the table indicates, Pediatricians and Family Practitioners, Ophthalmologists, Optometrists/Opticians, and Parents are in support of Option 2.

***Concerns about implementation – Option 2***

Again, the majority of comments made (even by respondents who expressed support for this Option) raised various concerns. The following tables demonstrate the number of comments made by each stakeholder group and their major concerns regarding Option 2. **Note that “Training/Accuracy/Liability” and “Cost to Parents and Schools” are listed in the top 3 concerns for each stakeholder group:**

*“They think they would be the best candidate to train the nurses but it is currently prohibited by legislation.”*

*~ WA Academy of Eye Physicians and Surgeons*

Of the 372 medical personnel respondents, 44% chose to add comments to the survey. The majority of the comments were singular in nature. They tended to cite multiple concerns, which are reflected in the tables below:

<b>Option 2 - Comment Categories (All Health and Eye Care Providers)</b>			
	<b>count</b>	<b>percent of comments</b>	<b>percent of survey respondents</b>
<b>Total comments</b>	<b>164</b>	<b>100%</b>	<b>44%</b>
<b>Training/Accuracy/Liability</b>	<b>44</b>	<b>27%</b>	<b>12%</b>
Implementation	18	11%	5%
Cost to parents and schools	14	9%	4%
Good idea if funded	13	8%	3%
Eye care professional should do it	12	7%	3%
Bad Idea	9	5%	2%
Not appropriate for schools to do	6	4%	2%
Not convinced of benefit or need	6	4%	2%
False sense of security for parents	5	3%	1%
Other	37	23%	10%

For the School Personnel group, 215 respondents made comments. Many expressed multiple concerns, as seen in the table below:

<b>Option 2 - Comment Categories (School Personnel)</b>			
	<b>count</b>	<b>percent of comments</b>	<b>percent of survey respondents</b>
<b>Total comments</b>	<b>215</b>	<b>100%</b>	<b>58%</b>
<b>Cost to parents and schools</b>	<b>125</b>	<b>58%</b>	<b>34%</b>
<b>Implementation</b>	<b>112</b>	<b>52%</b>	<b>30%</b>
<b>Training/Accuracy/Liability</b>	<b>44</b>	<b>20%</b>	<b>12%</b>
Not convinced of benefit or need	42	20%	11%
Other	24	11%	6%
Follow up/Access to Provider	22	10%	6%
Good idea if funded	14	7%	4%
Not appropriate for schools to do	13	6%	3%
Bad Idea	8	4%	2%
False sense of security for parents	5	2%	1%

*“It is great to do as many grades as possible. When children are learning to read it is essential to know if they can focus near not just far.”*

*~ Focus Group, Director of Special Programs, Republic, WA*

Of the 34 Special Educators who responded, 18 chose to comment on Option Number 2. They tended to cite multiple concerns, which are reflected in the numbers below:

<b>Option 2 - Comment Categories (Special Educators)</b>			
	<b>count</b>	<b>percent of comments</b>	<b>percent of survey respondents</b>
<b>Total comments</b>	<b>18</b>	<b>100%</b>	<b>5%</b>
<b>Cost to Parents and Schools</b>	<b>13</b>	<b>72%</b>	<b>3%</b>
<b>Implementation</b>	<b>8</b>	<b>44%</b>	<b>2%</b>
Good Idea	5	28%	1%
Other	4	22%	1%
Training/Accuracy	2	11%	1%
Not convinced of need or benefit	2	11%	1%
Out of class time	1	6%	0%

*“This will be time consuming... Paying for this service...how can we do this?”*

*~ Focus Group, Director of Special Programs, Republic, WA*

Of the 29 Non Nurses who responded, 18 chose to make comments regarding Option 2. They tended to cite multiple concerns which are reflected in the numbers below:

<b>Option 2 - Comment Categories (Non Nurse Personnel)</b>			
	<b>count</b>	<b>percent of comments</b>	<b>percent of survey respondents</b>
<b>Total comments</b>	<b>18</b>	<b>100%</b>	<b>5%</b>
<b>Cost to Parents and Schools</b>	<b>7</b>	<b>39%</b>	<b>2%</b>
<b>Implementation</b>	<b>5</b>	<b>28%</b>	<b>1%</b>
<b>Nurse/Staff bandwidth</b>	<b>3</b>	<b>17%</b>	<b>1%</b>
Not appropriate in schools	2	11%	1%
Out of class time	1	6%	0%
Implementation	1	6%	0%
Not convinced of need or benefit	1	6%	0%

Of the 411 school nurses who responded, 215 chose to comment on Option 2. They tended to cite multiple concerns which are reflected in the numbers below:

<b>Option 2 - Comment Categories (Nurses)</b>			
	<b>count</b>	<b>percent of comments</b>	<b>percent of survey respondents</b>
<b>Total comments</b>	<b>215</b>	<b>100%</b>	<b>58%</b>
<b>Cost to parents and schools</b>	<b>125</b>	<b>58%</b>	<b>34%</b>
<b>Implementation</b>	<b>112</b>	<b>52%</b>	<b>30%</b>
<b>Training/Accuracy/Liability</b>	<b>44</b>	<b>20%</b>	<b>12%</b>
Not convinced of benefit or need	42	20%	11%
Other	24	11%	6%
Follow up/Access to Provider	22	10%	6%
Good idea if funded	14	7%	4%
Not appropriate for schools to do	13	6%	3%
Bad Idea	8	4%	2%
False sense of security for parents	5	2%	1%

*“Ultimately this will not be a big problem for most of the parents if the Indian Health is able to provide these services for them before entering school. There are some parents who will have a very difficult time (those who aren’t included in Indian Health).”*

*~ Ron Washington  
Superintendent of Schools in Inchelium, WA*

Of the 159 respondents, 50 made comments regarding Option 2. Many comments expressed multiple issues, as illustrated in the table below:

<b>Option 2 - Comment Categories (Parents)</b>			
	<b>count</b>	<b>percent of comments</b>	<b>percent of survey respondents</b>
<b>Total comments</b>	<b>50</b>	<b>100%</b>	<b>13%</b>
<b>Cost to parents and schools</b>	<b>11</b>	<b>22%</b>	<b>3%</b>
Good idea if funded	10	20%	3%
Training/Accuracy	9	18%	2%
School setting inappropriate	7	14%	2%
Other	13	26%	3%

# A further look at Key Stakeholder Groups – Option 1

## **Health and Eye Care Providers**

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As previously indicated, this stakeholder group is comprised of respondents from the following categories:

- Optometrists
- Pediatricians
- Family Practitioners who see children
- Ophthalmologists
- Opticians

These respondents were grouped into the following subsets:

- Family Practitioners and Pediatricians
- Optometrists and Opticians
- Ophthalmologists

From the tables below one can see that:

- Issues regarding equipment are a concern for Family Practitioners and Pediatricians;
- Optometrists and Opticians agree with every question set forth, and the percentage of those who disagree never rises above 8%:
- Ophthalmologists expressed high levels of comfort regarding equipment and training.

<b>Family Practitioners and Pediatricians</b>	<b>Agree</b>	<b>Neutral</b>	<b>Disagree</b>
This would impact my practice in a good way.	<b>40%</b>	39%	21%
This would NOT provide a cost barrier for a substantial number of the parents I see in my practice.	<b>47%</b>	13%	40%
I already have all the tools and equipment necessary to perform comprehensive eye exams.	31%	10%	<b>59%</b>
It would be easy for my office to acquire the required equipment.	24%	<b>38%</b>	<b>38%</b>
It would be easy to acquire the technical training necessary.	<b>37%</b>	35%	29%
This would help relationships between parents/guardians and vision care providers.	<b>48%</b>	37%	15%
This is the best way to ensure that childhood eye disorders are caught in time.	<b>50%</b>	29%	21%

<b>Optometrists and Opticians</b>	<b>Agree</b>	<b>Neutral</b>	<b>Disagree</b>
This would impact my practice in a good way.	<b>77%</b>	20%	2%
This would NOT provide a cost barrier for a substantial number of the parents I see in my practice.	<b>76%</b>	17%	8%
I already have all the tools and equipment necessary to perform comprehensive eye exams.	<b>98%</b>	2%	1%
It would be easy for my office to acquire the required equipment.	<b>80%</b>	20%	0%
It would be easy to acquire the technical training necessary.	<b>86%</b>	12%	2%
This would help relationships between parents/guardians and vision care providers.	<b>92%</b>	8%	1%
This is the best way to ensure that childhood eye disorders are caught in time.	<b>92%</b>	5%	3%

<b>Ophthalmologist</b>	<b>Agree</b>	<b>Neutral</b>	<b>Disagree</b>
This would impact my practice in a good way.	26%	<b>44%</b>	30%
This would NOT provide a cost barrier for a substantial number of the parents I see in my practice.	32%	28%	<b>40%</b>
I already have all the tools and equipment necessary to perform comprehensive eye exams.	<b>100%</b>	0%	0%
It would be easy for my office to acquire the required equipment.	<b>63%</b>	35%	2%
It would be easy to acquire the technical training necessary.	<b>74%</b>	24%	2%
This would help relationships between parents/guardians and vision care providers.	<b>49%</b>	26%	25%
This is the best way to ensure that childhood eye disorders are caught in time.	<b>46%</b>	25%	30%

## **School Personnel**

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The School Personnel stakeholder group was composed of the following professional subsets:

- School Nurses
- School Nurse Corp Supervisors
- Principal
- Vice Principal
- District Administrator
- Superintendent
- School Administrator
- Other

These categories were sorted into three main subsets: 1) School Nurses and School Nurse Corp Supervisors; 2) Administrators, and 3) Special Needs Only. Overall, School Personnel were not in support of Option 1. The following tables illustrate their specific areas of concern:

<b>School Nurses and Nurse Corp Supervisors</b>	<b>Agree</b>	<b>Neutral</b>	<b>Disagree</b>
The cost to the parents/guardians in my school district will be difficult to bear.	<b>71%</b>	16%	13%
Tracking parent/guardian compliance will be difficult.	<b>79%</b>	8%	13%
This will hurt the relationships between parent/guardians and the school.	<b>36%</b>	<b>36%</b>	28%
It doesn't matter if there are negative consequences as long as vision care for public school kids is improved.	30%	26%	<b>44%</b>

<b>School Administrators</b>	<b>Agree</b>	<b>Neutral</b>	<b>Disagree</b>
The cost to the parents/guardians in my school district will be difficult to bear.	<b>79%</b>	11%	11%
Tracking parent/guardian compliance will be difficult.	<b>74%</b>	7%	19%
This will hurt the relationships between parent/guardians and the school.	<b>48%</b>	33%	19%
It doesn't matter if there are negative consequences as long as vision care for public school kids is improved.	23%	23%	<b>54%</b>

<b>Special Needs Only</b>	<b>Agree</b>	<b>Neutral</b>	<b>Disagree</b>
The cost to the parents/guardians in my school district will be difficult to bear.	<b>83%</b>	0%	17%
Tracking parent/guardian compliance will be difficult.	<b>42%</b>	17%	<b>42%</b>
This will hurt the relationships between parent/guardians and the school.	25%	25%	<b>50%</b>
It doesn't matter if there are negative consequences as long as vision care for public school kids is improved.	<b>33%</b>	<b>33%</b>	<b>33%</b>

## Parents

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As indicated in the previous section, the majority of parents were not in agreement with Option 1. The following section will take a deeper look at their responses and draw out what they support and where their concerns lie:

All Parents	Agree	Neutral	Disagree
It would be easy for my family to pay for this vision screening.	53%	22%	25%
Cost doesn't matter if it means better vision care for public school kids.	47%	27%	27%
It is easy to take my kids to a doctor.	68%	15%	17%
It would be easy to make time for this.	54%	27%	19%
This would improve relationships between parents/guardians and the schools.	27%	40%	33%
This would improve relationships between parent/guardians and doctors.	30%	53%	17%
I would be in favor of this change.	44%	29%	27%

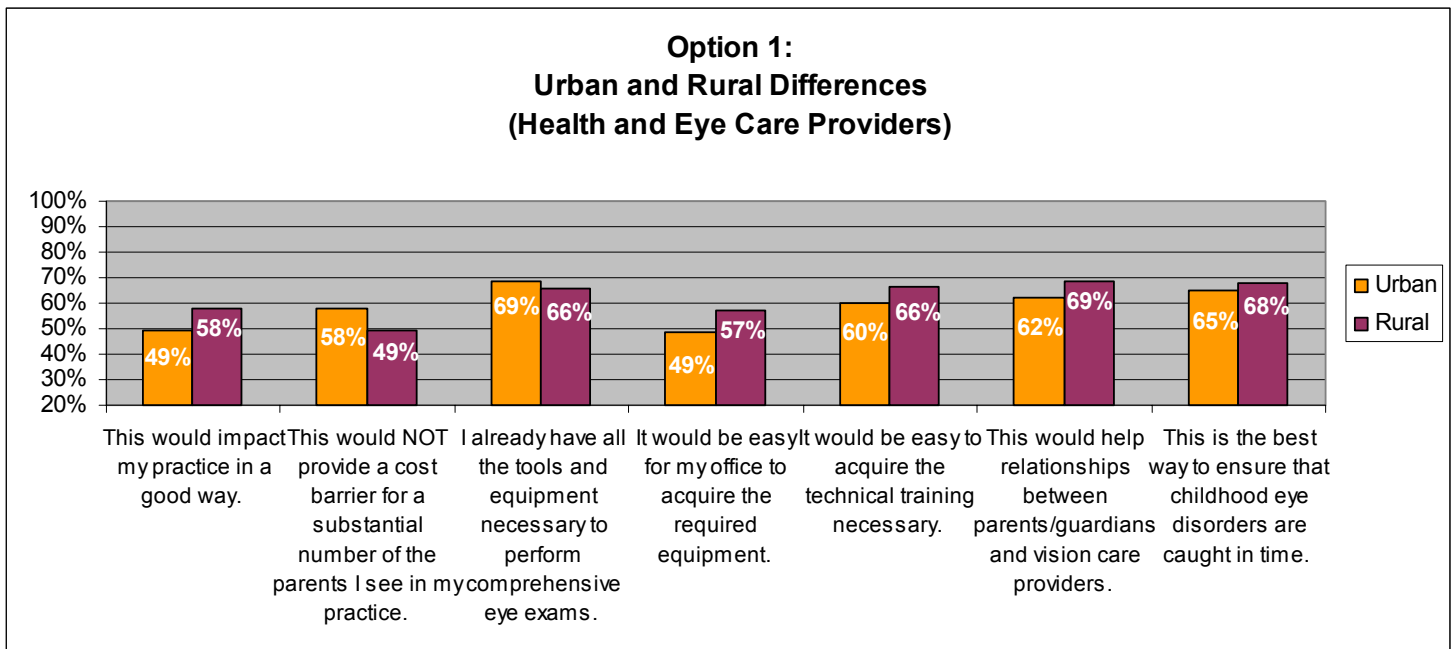
It should be noted that 61% of parents said they live in an urban area, and 94% said their family had health insurance.

## Urban/Rural - Geographic Differences <sup>7</sup>

In order to understand geographical difference for Option 1, we will look at the responses from urban and rural stakeholders in each group (Health and Eye Care Providers, School Personnel, and Parents). Each survey respondent self identified themselves as either urban or rural.

There were virtually no differences in the responses given by urban and rural stakeholders in the Health and Eye Care Providers or School Personnel groups (including a breakdown for the professionals subsets “School Nurses and School Nurse Corp Supervisors ” and “School Administrators and Superintendents”), as demonstrated on the following four graphs:

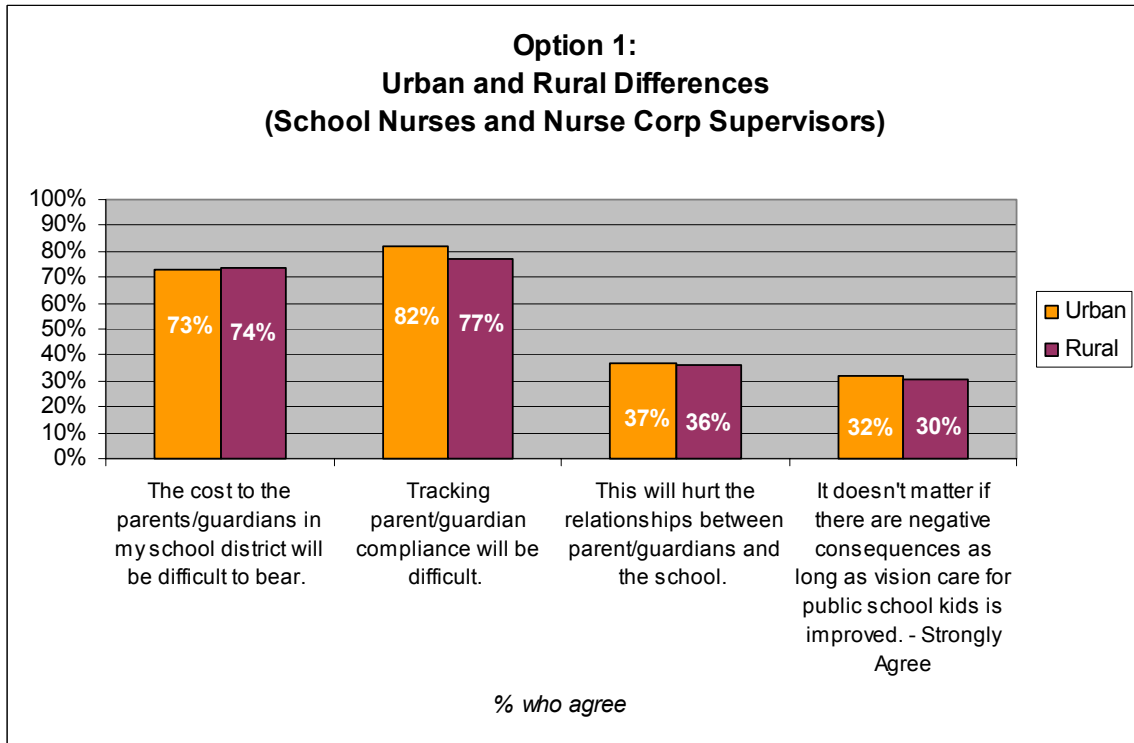
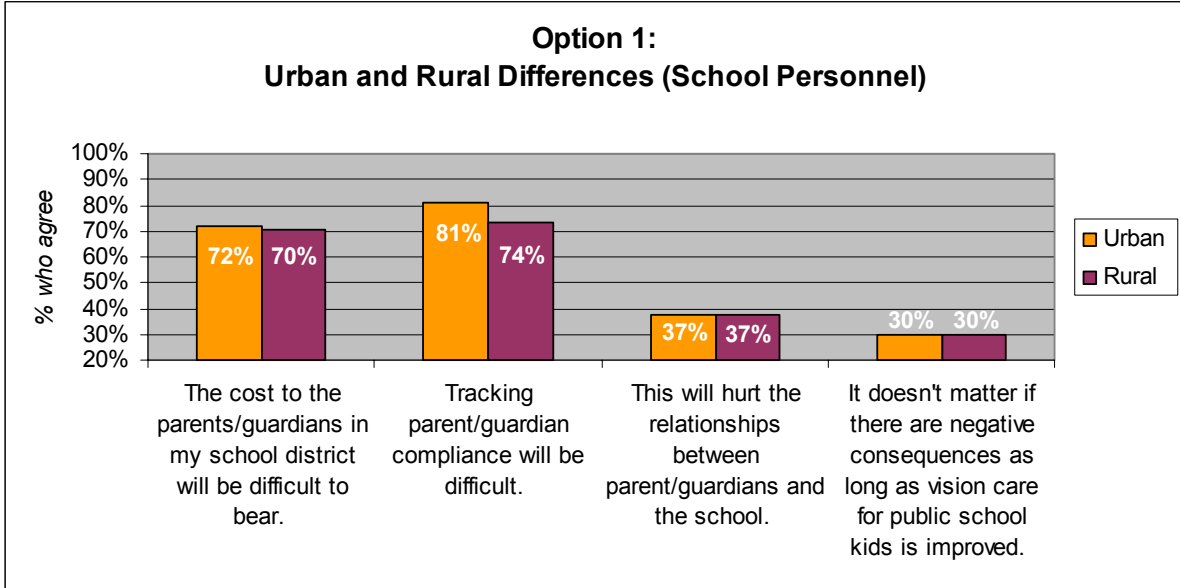
### Health and Eye Care Providers <sup>8</sup>



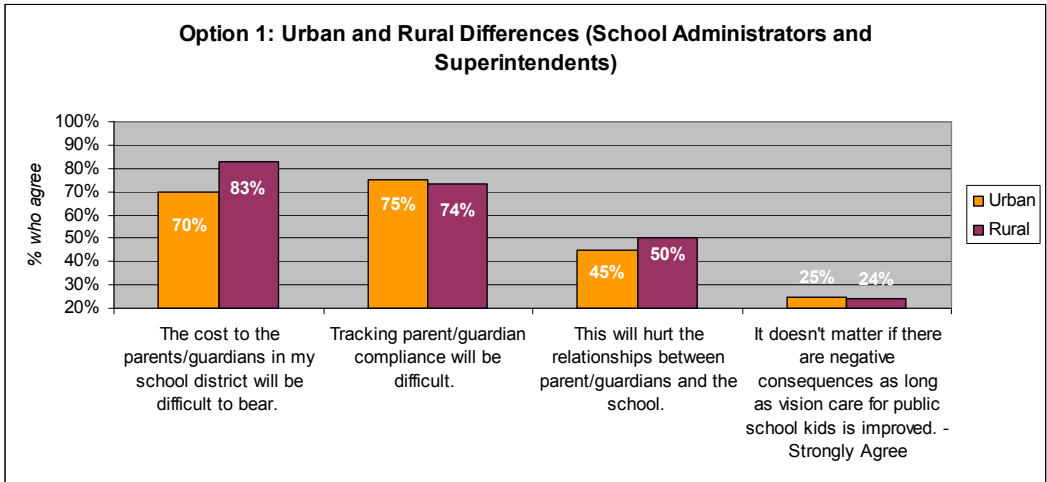
<sup>7</sup> According to the 2000 US Census, , 82% of WA State’s population lives in urban areas, 18% live in rural areas.

<sup>8</sup> Urban Health Care Professionals: n= 267  
Rural Health Care Professionals: n= 96

*School Personnel<sup>9</sup>*

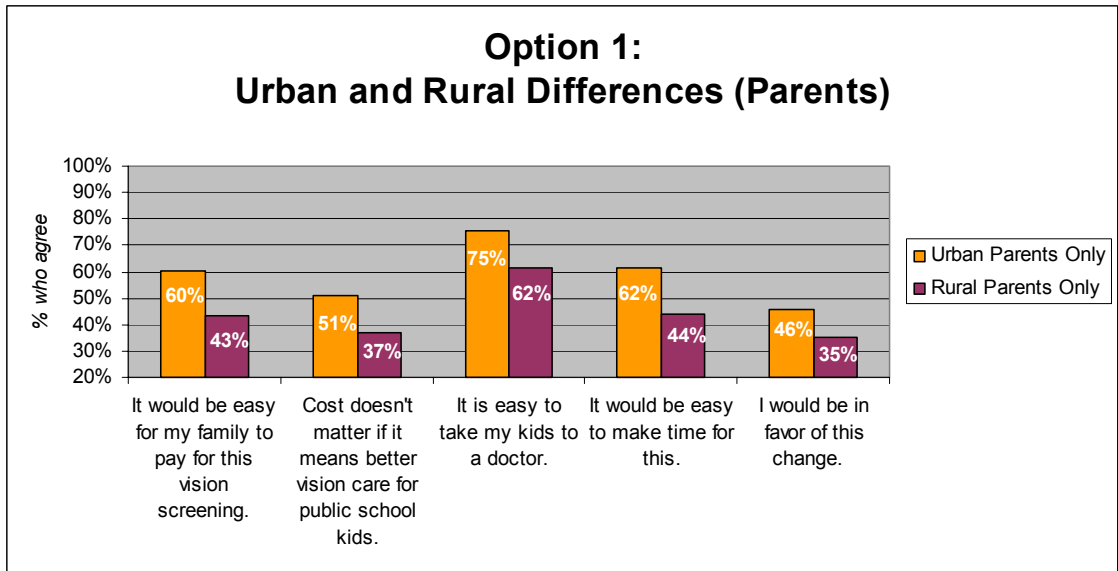


<sup>9</sup> Urban School Personnel: n = 305  
Rural School Personnel: n = 188



**Parents<sup>10</sup>**

There were differences, however, between urban and rural Parent responses. Higher percentages of urban parents said that it is easy for them to pay for vision screening, take their child to the doctor, make time for this screening, and that cost doesn't matter if vision care is improved for children. The following graph illustrates these differences:



This urban/rural division also indicates that while over all 44% of parents over all were supportive of Option 1, only 35% of rural parents said they supported it. Clearly, **rural parents are less supportive of Option 1, and foresee more challenges than urban parents.**

<sup>10</sup> Urban Parents: n= 73  
Rural Parents : n = 43

# A further look at Key Stakeholder Groups – Option 2

## Health and Eye Care Providers

As previously indicated, this stakeholder group is comprised of respondents from the following categories:

- Optometrists
- Pediatricians
- Family Practitioners who see children
- Ophthalmologists
- Opticians

These respondents were grouped into the following subsets:

- Family Practitioners and Pediatricians
- Optometrists and Opticians
- Ophthalmologists

From the tables below one can see that:

- Family Practitioners and Pediatricians and Optometrists and Opticians believed that this Option will benefit parents and guardians. They also indicated that it will be a challenge for schools to acquire the equipment and training needed, and that this option will be time consuming for schools.
- Ophthalmologists thought that it will be easy for schools to acquire the needed equipment and training, yet they agreed that the time requirement school will face associated with Option 2 will be significant.

<b>Family Care Practitioners and Pediatricians</b>	<b>Agree</b>	<b>Neutral</b>	<b>Disagree</b>
This will increase the number of referrals to my practice.	<b>52%</b>	23%	24%
This will be beneficial to parents/guardians.	<b>77%</b>	16%	7%
It will be easy for schools to access tools and equipment.	23%	35%	<b>41%</b>
It will be easy for school nurses and volunteers to acquire the technical training necessary.	26%	36%	<b>38%</b>
The additional time required is not significant.	10%	24%	<b>66%</b>
This will help the relationship between parent/guardians and vision care providers	37%	<b>48%</b>	15%
If the recommendation improves vision care for public school children, then I support it	<b>81%</b>	14%	5%

<b>Optometrists and Opticians</b>	<b>Agree</b>	<b>Neutral</b>	<b>Disagree</b>
This will increase the number of referrals to my practice.	<b>62%</b>	36%	2%
This will be beneficial to parents/guardians.	<b>80%</b>	15%	5%
It will be easy for schools to access tools and equipment.	34%	30%	<b>37%</b>
It will be easy for school nurses and volunteers to acquire the technical training necessary.	26%	28%	<b>46%</b>
The additional time required is not significant.	23%	22%	<b>55%</b>
This will help the relationship between parent/guardians and vision care providers	<b>54%</b>	31%	15%
If the recommendation improves vision care for public school children, then I support it	<b>85%</b>	11%	5%

<b>Ophthalmologist</b>	<b>Agree</b>	<b>Neutral</b>	<b>Disagree</b>
This will increase the number of referrals to my practice.	<b>61%</b>	29%	11%
This will be beneficial to parents/guardians.	<b>61%</b>	23%	16%
It will be easy for schools to access tools and equipment.	<b>41%</b>	20%	39%
It will be easy for school nurses and volunteers to acquire the technical training necessary.	<b>52%</b>	14%	34%
The additional time required is not significant.	25%	15%	<b>60%</b>
This will help the relationship between parent/guardians and vision care providers	34%	<b>46%</b>	20%
If the recommendation improves vision care for public school children, then I support it	<b>86%</b>	9%	5%

## **School Personnel**

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As was the case with Option 1, the School Personnel stakeholder group was composed of the following professional categories:

- School Nurses
- School Nurse Corp Supervisors
- Principal
- Vice Principal
- District Administrator
- Superintendent
- School Administrator
- Other

These categories were grouped into three main subsets: 1) School Nurses and School Nurse Corp Supervisors; 2) Administrators, and 3) Special Needs Only. Overall, School Personnel were not in support of Option 2. The following tables illustrate their specific areas of concern:

- School nurses and Nurse Corp Supervisor’s number one concern was that tracking parent/guardian compliance will be difficult;
- Costs were the number one concern of Administrators and Special Needs Only personnel;

<b>School Nurses and Nurse Corp Supervisors</b>	<b>Agree</b>	<b>Neutral</b>	<b>Disagree</b>
The cost to the parents/guardians in my school district will be difficult to bear.	<b>71%</b>	16%	13%
Tracking parent/guardian compliance will be difficult.	<b>79%</b>	8%	13%
This will hurt the relationships between parent/guardians and the school.	<b>36%</b>	<b>36%</b>	28%
It doesn't matter if there are negative consequences as long as vision care for public school kids is improved.	30%	26%	<b>44%</b>

<b>School Administrators</b>	<b>Agree</b>	<b>Neutral</b>	<b>Disagree</b>
The cost to the parents/guardians in my school district will be difficult to bear.	<b>79%</b>	11%	11%
Tracking parent/guardian compliance will be difficult.	<b>74%</b>	7%	19%
This will hurt the relationships between parent/guardians and the school.	<b>48%</b>	33%	19%
It doesn't matter if there are negative consequences as long as vision care for public school kids is improved.	23%	23%	<b>54%</b>

<b>Special Needs Only</b>	<b>Agree</b>	<b>Neutral</b>	<b>Disagree</b>
The cost to the parents/guardians in my school district will be difficult to bear.	<b>83%</b>	0%	17%
Tracking parent/guardian compliance will be difficult.	<b>42%</b>	17%	<b>42%</b>
This will hurt the relationships between parent/guardians and the school.	25%	25%	<b>50%</b>
It doesn't matter if there are negative consequences as long as vision care for public school kids is improved.	<b>33%</b>	<b>33%</b>	<b>33%</b>

## **Parents**

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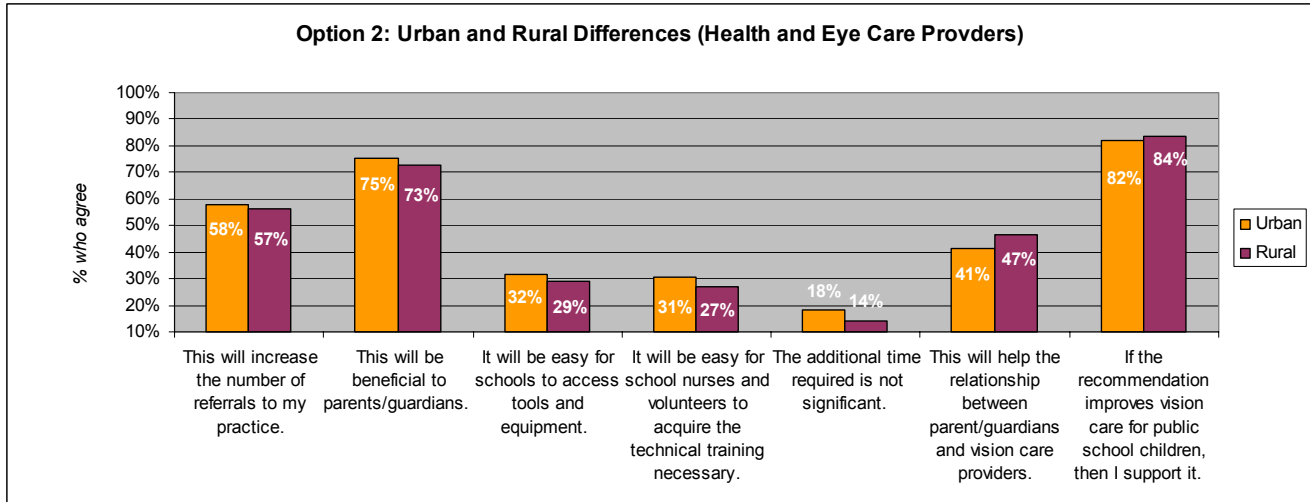
Parents were strongly in agreement with Option 2. The following table further details their opinions surrounding specific aspect of this option:

<b>All Parents</b>	<b>Agree</b>	<b>Neutral</b>	<b>Disagree</b>
This would hurt relationships between schools and parent/guardians.	4%	25%	<b>71%</b>
It would be hard for schools to pay for this change.	<b>63%</b>	27%	11%
This would hurt the relationship between parent/guardian and doctors.	2%	27%	<b>70%</b>
It doesn't matter if the changes cost more, as long as care for public school kids gets better.	<b>50%</b>	36%	13%
I would be in favor of this change.	<b>71%</b>	22%	7%

## Urban/Rural - Geographic Differences

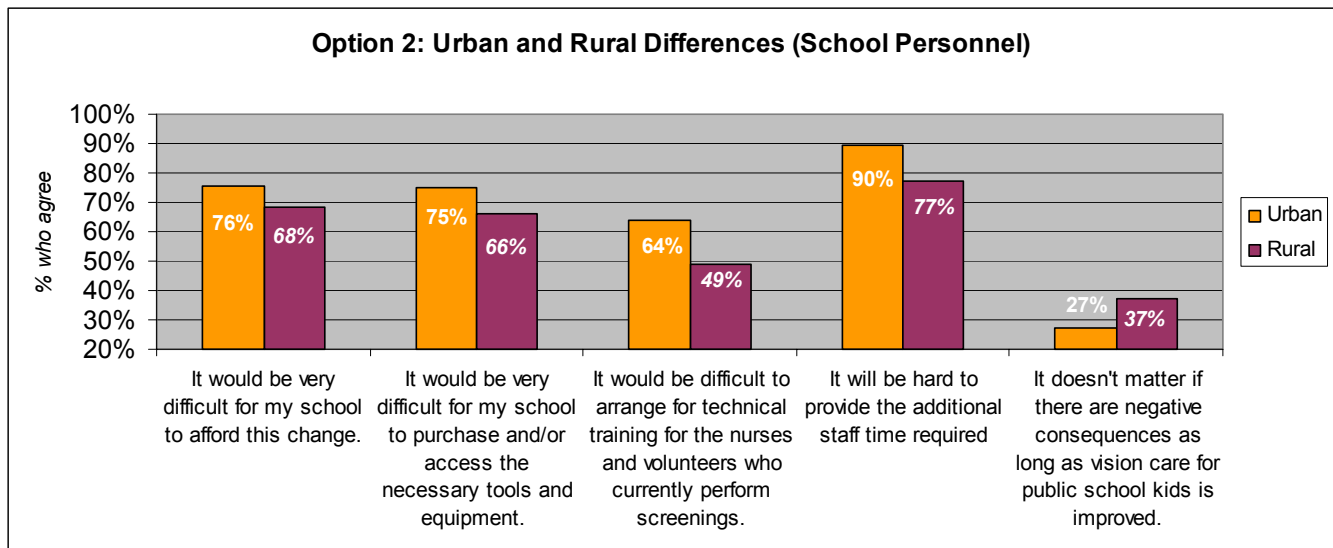
### Health and Eye Care Providers

For Option 2 there were no significant differences between rural and urban respondents in the Health and Eye Care Providers stakeholder group:

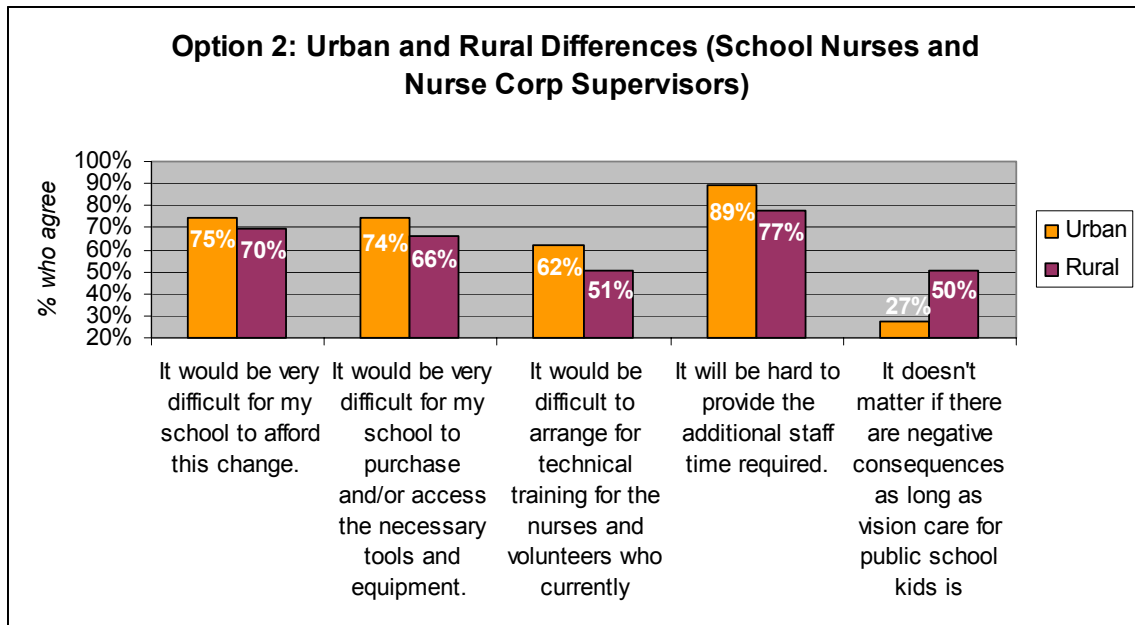
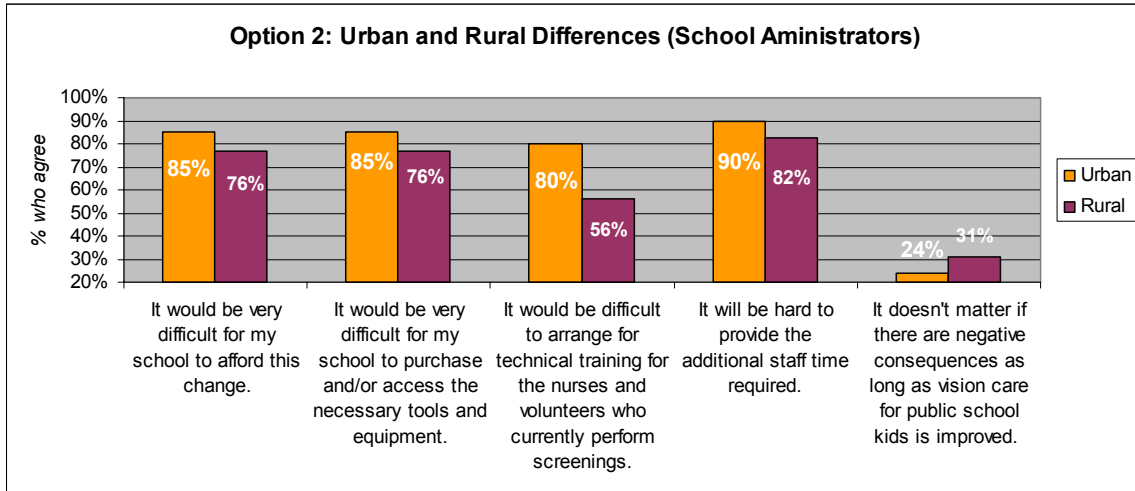


### School Personnel

The School Personnel stakeholders had some variance between urban and rural respondents; most noticeably regarding the issue of obtaining technical training (see arrows on the graphs below). Overall, urban School Personnel indicated higher levels of difficulty regarding Option 2 than rural respondents:



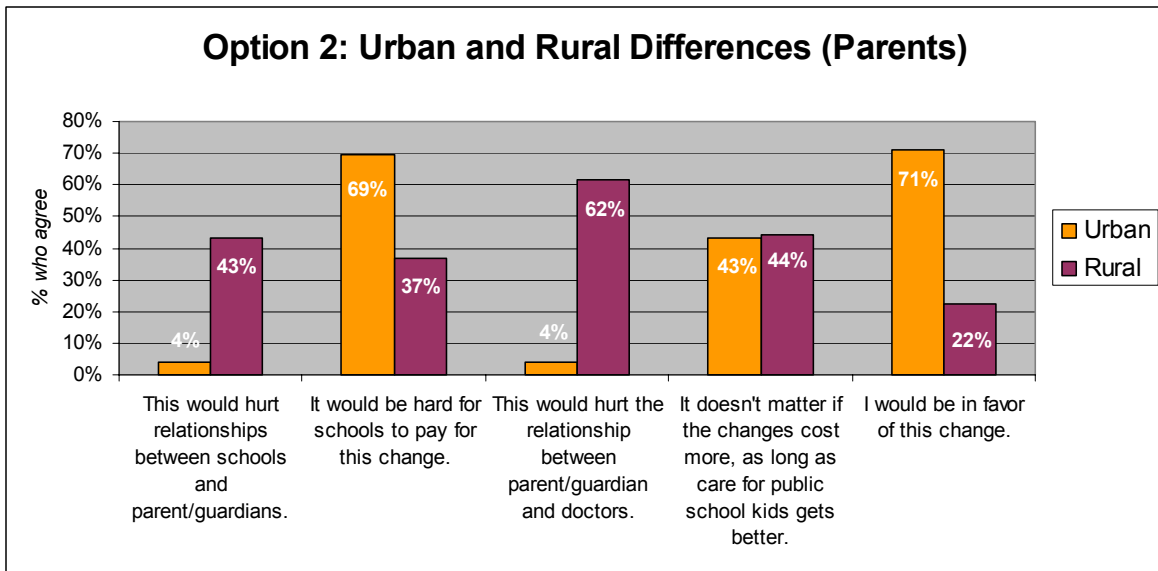
These trends continue when the subsets “School Administrators” and “School Nurses and Nurse Corp Supervisors” are examined individually. Again, training remains a concern for urban respondents, and urban respondents identify more challenges with Option 2 than their rural counterparts:



**Parents**

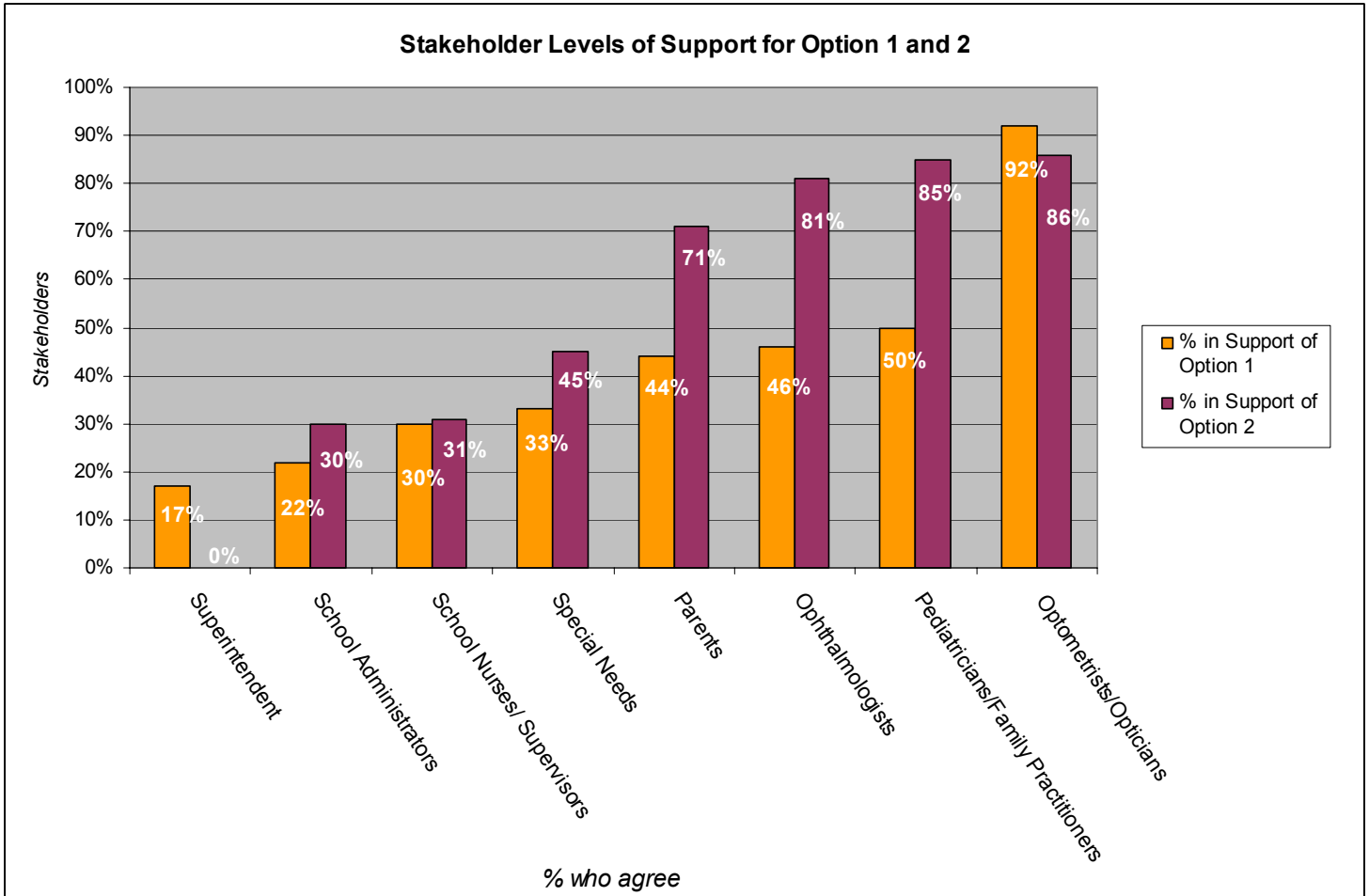
There are several large differences between the responses given by urban and rural parents:

- Nearly twice as many urban parents felt that Option 2 will be hard for schools to pay for;
- Rural parents were much more concerned about the affects Option 2 will have on relationships between parents/guardian and doctors, and between parents/guardian and doctors;
- 71% of urban parents and only 22% of rural parents supported Option 2.



# Conclusions and Talking Points

The following graph provides an overview of the levels of support expressed for each Option by each stakeholder group:



For both options, the stakeholders indicate moderate support with significant concerns regarding implementation. This is especially true for the School Personnel who do not support either option.

## Talking Points

### Obstacles

One of the main intentions of this stakeholder engagement process was to discover obstacles that could impede the successful implementation of the recommendations of the working committee. Many of these obstacles came to light in the three open-ended survey questions. As previously mentioned, of the 986 survey respondents 630 made one or more comment, and 90% of those comments indicated a concern of some sort. The following two tables provide a summary of the concerns for Option 1 and Option 2:

<b>Option Number 1 - Comment Categories</b>			
	<b>count</b>	<b>percent of comments</b>	<b>percent of survey respondents</b>
<b>Total comments</b>	<b>551</b>	<b>100%</b>	<b>100%</b>
<b>Implementation</b>	<b>268</b>	<b>49%</b>	<b>49%</b>
<b>Cost to Parents and Schools</b>	<b>201</b>	<b>36%</b>	<b>36%</b>
<b>Other</b>	<b>93</b>	<b>17%</b>	<b>17%</b>
<b>Follow up/Access to provider</b>	<b>91</b>	<b>17%</b>	<b>17%</b>
<b>Good Idea</b>	<b>71</b>	<b>13%</b>	<b>13%</b>
Training/Accuracy/Liability	68	12%	12%
Not convinced of benefit or need	47	9%	9%
Doctors/Eye Care should screen	24	4%	4%
Bad idea	20	4%	4%
<b>Option Number 2 - Comment Categories</b>			
	<b>count</b>	<b>percent of comments</b>	<b>percent of survey respondents</b>
<b>Total comments</b>	<b>465</b>	<b>100%</b>	<b>100%</b>
<b>Cost to Parents and Schools</b>	<b>170</b>	<b>37%</b>	<b>37%</b>
<b>Implementation</b>	<b>147</b>	<b>32%</b>	<b>32%</b>
Training/Accuracy/Liability	99	21%	21%
Other	80	17%	17%
Not convinced of benefit or need	79	17%	17%
Good Idea if funded	42	9%	9%
Not appropriate for schools to do	28	6%	6%
Follow up/Access to Provider	22	5%	5%
Bad Idea	17	4%	4%
Eye care professional should do it	12	3%	3%
False sense of security for parents	10	2%	2%

**The top two obstacles reported are Implementation concerns and Cost to Parents and Schools.** Even those in support of the either option acknowledged and expressed concern about the successful implementation of the proposals. Significant stakeholder concerns related to implementation and cost included:

**Implementation**

- Training
- Staffing
- Tracking/Accuracy/Liability
- Nurse Time – nurse/student ratio, nurse time in each school
- Implementation Process

**Cost to Parents and Schools**

- Staff Time
- Equipment
- Uninsured and underinsured parents/guardians

***Regional Issues***

*Health and Eye Care Providers*

- Option 1 - There was no significant difference in support for Option 1 between urban and rural Health and Eye Care Providers.
- Option 2 - There was no significant difference in support for Option 2 between urban and rural Health and Eye Care Providers .

*School Personnel groups*

- Option 1 - There was no significant difference in support for Option 1 between urban and rural School Personnel.
- Option 2 - The School Personnel stakeholders have some variance between urban and rural respondents, most noticeably regarding training. Overall, urban School Personnel indicate higher levels of difficulty regarding Option 2 than rural respondents:
  - Training is a particularly strong concern for School Administrators, School Nurses and Nurse Corp Supervisors, and they identify more challenges with Option 2 than their rural counterparts

### *Parents*

- Option 1 - Rural parents were less supportive of Option 1, and foresaw more challenges than urban parents.
  - Higher percentages of urban parents said that it is easy for them to pay for vision screening, take their child to the doctor, make time for this screening, and that cost doesn't matter if vision care is improved for children.
  - 44% of all parents were supportive of Option 1, but only 35% of rural parents support it.
- Option 2 – This was the area of greatest divergence regarding urban and rural differences.
  - 71% of urban parents support Option 2
  - 22% of rural parents support Option 2.
  - Nearly twice as many urban parents feel that Option 2 will be hard for schools to afford.
  - Rural parents are much more concerned about the affects Option 2 will have on relationships between parents/guardian and doctors, and between parents/guardian and doctors.

### *Advantages or Opportunities*

While there was great concern about implementation, several respondents suggested ways to implement the proposed increase in vision screening that would mitigate some of the difficulties they imagined. Please see Appendix H for a list of all the suggestions from each stakeholder group.

# Methodology

The objective of this project is to enable a wider investigation of stakeholder feedback, and to provide information to the Expert Work Group about potential obstacles or challenges to the recommendations they may pass on to the Legislature regarding increased vision screening requirements for public school children. Another fundamental goal of this project is to increase participating stakeholders' understanding of the upcoming discussion and potential legislation which will affect them, in order to allow them enough time to begin to plan for the challenges involved in implementing any legislated changes.

Acting on behalf of Executive Diversity Services, MGS Consulting Services designed, implemented, analyzed and produced a stakeholder feedback process and summary report.

## ***Stakeholder Outreach***

MGS worked with the Department of Health to identify the following key stakeholders:

- School Nurses
- School Administrators
- Parents
- Ophthalmologists
- Optometrists
- Pediatricians/ Family Physicians who see children

The original goal for stakeholder outreach was to reach at least 350 people with information about the process and to get usable feedback from a minimum of 100 - 150 stakeholders representing a sample of these groups. Ultimately, *over 2,000 stakeholders were reached and 986 useable on-line surveys were completed*, far surpassing the original goal.<sup>11</sup>

## ***Data Collection***

A variety of methods were utilized to generate this feedback, including:

- **Electronic Surveys.**<sup>12</sup> MGS created three different surveys, one for each stakeholder group (Health and Eye Care Providers, School Personnel, and Parents). Hard copies of the School Personnel survey were taken to the Snohomish School Nurse Supervisor meeting. HeadStart parents in three counties (Thurston, Lewis and Mason) were also given hard copies of the survey to

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<sup>11</sup> See Appendix B for a complete list of stakeholder groups who were contacted and invited to participate in the on-line survey.

<sup>12</sup> See Appendix C to view each of the surveys.

complete. Data was entered into the online form by MGS staff. All other surveys were completed online using SurveyMonkey.

- **In person interviews.**<sup>13</sup> **MGS staff conducted two in person interview:**
  - Ron Washington, Superintendent of Schools in Inchelium, WA
  - Dr. Rich Kovar, Country Doctor Community Clinic in Seattle, WA
  
- **Regional Group Meetings.**<sup>14</sup> MGS staff attended the following regional meetings:
  - Puget Sound Nurse Leaders Group from Snohomish County (the meeting was held in Bellevue, WA).
  - Washington Academy of Eye Physicians and Surgeons meeting in Seattle, WA.
  
- **Focus Group.**<sup>15</sup> MGS staff conducted a focus group in Republic, Washington for the directors of special programs.

### ***Data Analysis***

The survey responses were downloaded from Survey Monkey into MS Excel and analyzed. Each survey contained three open ended questions. The comments were coded and divided into categories based on common themes, suggestions, and concerns. All the original data has been given to Beth Seimon at the Department of Health. A sampling of comments from each stakeholder group has been attached as Appendix G.

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<sup>13</sup> See Appendix D for full interview notes.

<sup>14</sup> See Appendix E for meeting notes from all the regional meetings attended by MGS staff.

<sup>15</sup> See Appendix F for meeting notes for the focus group.

**Appendix A**  
**Option 1 and Option 2 Wording for Each Stakeholder Group**

## **Option 1**

- **Health and Eye Care Providers**

The first possibility that the Department of Health is considering, is to require that children have their vision screened BEFORE they enter kindergarten or upon their first entry into public school. This would mean that parents/guardians would be responsible for having their child's vision examined before entering school and provide the school with a certificate. It also could mean that parents/guardians may request vision screening as part of a Well Child visit and additional training and tools/equipment may be necessary for your office. Please tell how you feel about each statement.

- **School Personnel**

The first possibility that the Department of Health is considering, is to require that children have their vision screened BEFORE they enter kindergarten or upon their first entry into public school. This would mean that parents/guardians would be responsible for having their child's vision examined before entering school and provide the school with a certificate. If a child enters school without a certificate, the school may have to provide screening. Please tell how you feel about each statement.

- **Parents**

The first possibility that the Department of Health is considering, is to require that children have their vision screened BEFORE they enter kindergarten or upon their first entry into public school. This would mean that parents/guardians would be responsible for having their child's vision examined before entering school and provide the school with a certificate. This could increase the likelihood of detecting vision disorders. Please tell how this possibility might affect you.

## **Option 2**

- **Health and Eye Care Providers**

The second change that the Department of Health is considering, is to have the expanded vision screening take place at school for children in grades K, 1, 2, 3, 5 and 7. For parents this would mean that children would have more vision testing in school than they currently have. This might increase the likelihood of detecting more vision problems and conditions. It may mean that schools purchase or access additional equipment and/or tools and provide training for school employees, nurses and volunteers. Please indicate how you feel about the following statements.

- **School Personnel**

The second change that the Department of Health is considering is to have the expanded vision screening take place at school for children in grades K, 1, 2, 3, 5 and 7. For parents this would mean that children would have more vision testing in school than they currently have. This might increase the likelihood of detecting more vision problems and conditions. It may mean that schools purchase or access additional equipment and/or tools and provide training for school employees, nurses and volunteers. Please tell us how you feel about the following statements.

- **Parents**

The second change that the Department of Health is considering, is to have the expanded vision screening take place at school for children in grades K, 1, 2, 3, 5 and 7. For parents this would mean that your children would have more vision testing in school than they currently have. This might increase the likelihood of detecting more vision problems and conditions. For schools, this may require them to buy additional equipment and provide more training for school employees, nurses and volunteers. Please tell us how this possibility might affect you.

**Appendix B**  
**Groups Invited to Participate in the On-Line Survey**

Association of Washington School Principals  
Catholic Community Services  
ESD Early Childhood and Spec. Ed. Programs  
ESD School Superintendents  
Gov. Task Force on Early Learning  
Headstart groups in Thurston, Lewis, and Mason Co  
Homeschool Association of Washington  
Institute for Family Development  
King County Academy of Family Practitioners  
Learning Disability Assoc. of Wash.  
Optometric Physicians of Wash.  
OSPI Health Services and Early Childhood programs  
Otolaryngologists Association of Washington  
Rural Health Association  
School Nurse Corps Supervisors  
School Nurse Organization of Washington (SNOW)  
Snohomish County Health District  
Snohomish County YWCA  
Special Ed. coalitions  
Washington Association of Headstart & ECEAP Programs  
Washington Academy of Eye Physicians and Surgeons  
Washington Association of Family Practice Physicians  
Washington Association of School Administrators  
Washington Chapter of American Academy of Pediatrics  
Washington School Counselors Association  
Washington State PTA  
Washington Education Association  
Washington PAVE (Parent Advocacy group)  
Washington State School Director's Assoc.

**Appendix C**  
**Survey for each Stakeholder Group**  
**(Health and Eye Care Professionals, School Personnel, and Parents)**

**Health and Eye Care Professionals**

In order to improve vision and vision screening for children, the Washington State Legislature has required the Department of Health to recommend changes to vision screening procedures for school age children in public schools.

The purpose of this survey is to understand what you think about possible vision screening options.

There are 10 questions in this survey. It should only take about 5 to 10 minutes of your time to complete it. Your input will help the Department of Health understand the benefits and challenges of any possible changes that it may recommend to the Washington State Legislature. Thank you for your time and assistance.

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Please tell us a little about yourself.

**1. This survey is being sent to parties identified as professionals in the fields of family practice, pediatrics and eye care.**

**Please identify your profession.**

**2. Please tell us:**

The city in which you practice	<input type="text"/>
The county in which you practice	<input type="text"/>
The number of patient visits per year	<input type="text"/>

**3. In your practice how many staff are qualified to perform vision screenings?**

None	1-3	4-5	6-10	More than 10
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

**4. In your practice how many staff are qualified to perform eye examinations?**

None	1-3	4-5	6-10	More than 10
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

**5. Please check the box that describes your practice or your patients.**

	Yes	No	N/A
I practice in an urban location	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I practice in a rural location	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Many of my patients speak English as a second language	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
My patients are predominantly insured	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
My patients are predominantly uninsured	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

I have an equal number of insured/uninsured patients.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Many of my patients travel long distance for care	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
A substantial number of my patients only make appointments when they have a problem (as opposed to routine check ups)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

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The information on this page will help you answer the remaining questions in this survey.

Currently in Washington State, children's distance vision is tested in public school. The Department of Health is considering expanding this vision screening to test for the six most common vision disorders.

These additional vision conditions are: Amblyopia, Strabismus, Refractive Error, Accommodation of Focus, Convergence and Eye-Hand Coordination.

The Department of Health is considering two possible changes.

The first possibility is that parents be required to have children's vision screened before their children start school (this includes kindergarten). The second possibility is that these expanded screening services be provided by the school.

These next questions are about these two possibilities, and the impact that they might have.

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**6. The first possibility that the Department of Health is considering, is to require that children have their vision screened BEFORE they enter kindergarten or upon their first entry into public school.**

**This would mean that parents/guardians would be responsible for having their child's vision examined before entering school and provide the school with a certificate.**

**It also could mean that parents/guardians may request vision screening as part of a Well Child visit and additional training and tools/equipment may be necessary for your office.**

**Please tell how you feel about each statement.**

	Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree
This would impact my practice in a good way.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
This would NOT provide a cost barrier for a substantial number of the parents I see in my practice.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I already have all the tools and equipment necessary to perform comprehensive eye exams.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
It would be easy for my office to acquire the required equipment.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
It would be easy to acquire the	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

technical training necessary.

This would help relationships between parents/guardians and vision care providers.



This is the best way to ensure that childhood eye disorders are caught in time.



**7. Are there other potential impacts you foresee?**

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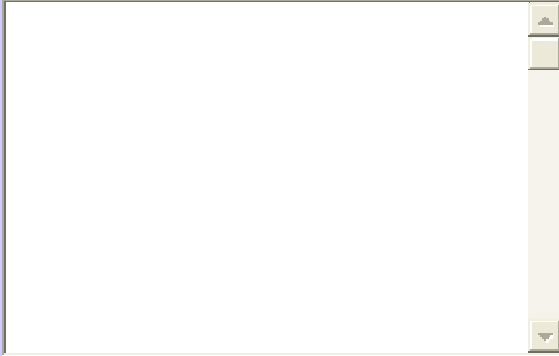
**8. The second change that the Department of Health is considering, is to have the expanded vision screening take place at school for children in grades K, 1, 2, 3, 5 and 7.**

**For parents this would mean that children would have more vision testing in school than they currently have. This might increase the likelihood of detecting more vision problems and conditions. It may mean that schools purchase or access additional equipment and/or tools and provide training for school employees, nurses and volunteers.**

**Please indicate how you feel about the following statements.**


	Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree
This will increase the number of referrals to my practice.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
This will be beneficial to parents/guardians.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
It will be easy for schools to access tools and equipment.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
It will be easy for school nurses and volunteers to acquire the technical training necessary.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
The additional time required is not significant.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
This will help the relationship between parent/guardians and vision care providers.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
If the recommendation improves vision care for public school children, then I support it.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

**9. Are there other potential impacts you foresee?**



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**10. Please tell us anything you would like us to consider.**



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## School Personnel

In order to improve vision and vision screening for children, the Washington State Legislature has required the Department of Health to recommend changes to vision screening procedures for school age children in public schools.

The purpose of this survey is to understand what you think about possible vision screening options.

There are 9 questions in this survey. It should only take about 5 to 10 minutes of your time to complete it. Your input will help the Department of Health understand the benefits and challenges of any possible changes that it may recommend to the Washington State Legislature. Thank you for your time and assistance.

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Please tell us a little about yourself.

**1. This survey is being sent to School Administrators and School Nurses.**

**Please tell us your role in the school and/or school district.**

**2. Please tell us the following:**

The school district in which you work	<input type="text"/>
The county or counties in which you work	<input type="text"/>
Grade levels in your school(s)	<input type="text"/>

**3. If ESD is applicable to you, please indicate which one.**

**4. Please check all boxes that describe your school or district and the population served.**

	Yes	No	N/A
My school is in an urban location.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
My school is in a rural location.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I work for an elementary school.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I work for an middle school.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I work for a high school.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Many of the students in my school/district speak English as a second language.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
More than 1/2 the students in my school qualify for free or reduced cost lunch.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

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The information on this page will help you answer the remaining questions in this survey.

Currently in Washington State, children's distance vision is tested in public school. The Department of Health is considering expanding this vision screening to test for the six most common vision disorders.

These additional vision conditions are: Amblyopia (lazy eye), Strabismus (cross-eye), Refractive Error (focusing problems) , Accommodation of Focus (ability to change focus), Convergence (ability to pull eyes together) and Eye-Hand Coordination (use of eyes to direct movement).

The Department of Health is considering two possible changes.

The first possibility is that parents be required to have children's vision screened before their children start school (this includes kindergarten). The second possibility is that these expanded screening services be provided by the school.

These next questions are about these two possibilities, and the impact that they might have.

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**5. The first possibility that the Department of Health is considering, is to require that children have their vision screened BEFORE they enter kindergarten or upon their first entry into public school.**

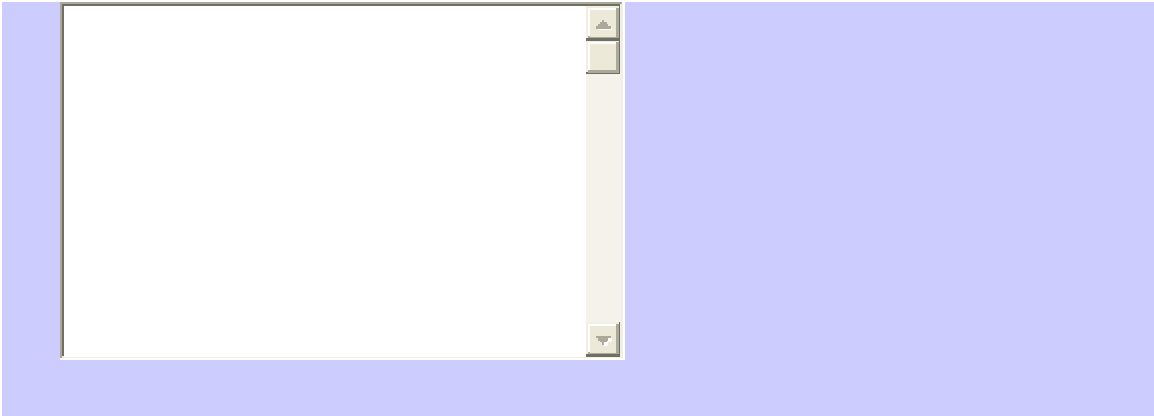
**This would mean that parents/guardians would be responsible for having their child's vision examined before entering school and provide the school with a certificate. If a child enters school without a certificate, the school**

may have to provide screening.

Please tell how you feel about each statement.

	Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree
The cost to the parents/guardians in my school district will be difficult to bear.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Tracking parent/guardian compliance will be difficult.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
This will hurt the relationships between parent/guardians and the school.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
It doesn't matter if there are negative consequences as long as vision care for public school kids is improved.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

**6. Are there other potential impacts you foresee?**



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**7. The second change that the Department of Health is considering is to have the expanded vision screening take place at school for children in grades K, 1, 2, 3, 5 and 7.**

**For parents this would mean that children would have more vision testing in school than they currently have. This might increase the likelihood of detecting more vision problems and conditions. It may mean that schools purchase or access additional equipment and/or tools and provide training for school employees, nurses and volunteers.**

**Please tell us how you feel about the following statements.**

	Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree
It would be very difficult for my school to afford this change.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
It would be very difficult for my school to purchase and/or access the necessary tools and equipment.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
It would be difficult to	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

arrange for technical training for the nurses and volunteers who currently perform screenings.

It will be hard to provide the additional staff time required.

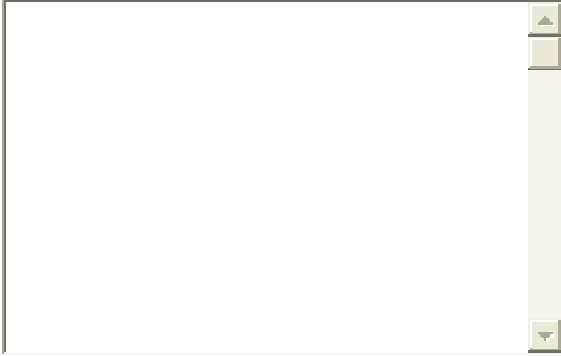
It doesn't matter if there are negative consequences as long as vision care for public school kids is improved.

**8. Are there other potential impacts you foresee?**

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**9. Please tell us anything else you'd like us to consider.**



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**Parents**

In order to improve vision and vision screening for children, the Washington State Legislature has required the Department of Health to recommend changes to vision screening procedures for school age children in public schools.

The purpose of this survey is to understand what parents want and need in terms of vision screening for their children.

There are 7 questions in this survey. It should only take about 5 to 10 minutes of your time to complete it. Your input will help the Department of Health understand the benefits and challenges of any possible changes that it may recommend to the Washington State Legislature. Thank you for your time and assistance.

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Please tell us a little about yourself.

In what city do you live?

In what county do you live?

What school(s) do your child/children attend?

**2. For each line below, please check the box that best describes your current situation.**

	Yes	No	N/A
I live in an urban area.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I live in a rural area.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
My family speaks English as a second language.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
My family has health insurance.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
My family receives state or federal assistance. (e.g Medicaid, food stamps, Social Security, etc.)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
My family travels long distances for vision care.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
We rely on public transportation.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
We have our own vehicle.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I know where to bring my child for eye care.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

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The information on this page will help you answer the remaining

questions in this survey.

Currently in Washington State, children's distance vision is tested in public school. The Department of Health is considering expanding this vision screening to test for six common vision disorders.

These vision disorders are: Amblyopia (lazy eye), Strabismus (cross-eye), Refractive Error (focusing problems) , Accommodation of Focus (ability to change focus), Convergence (ability to pull eyes together) and Eye-Hand Coordination (use of eyes to direct movement).

The Department of Health is considering two possible changes to screening procedures.

The first possibility is that parents be required to have children's vision screened before their children start school (this includes kindergarten). The second possibility is that these expanded screening services be provided by the school.

These next questions are about these two possibilities, and the impact that either of these possibilities might have on you.

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**3. The first possibility that the Department of Health is considering, is to require that children have their vision screened BEFORE they enter kindergarten or upon their first entry into public school.**

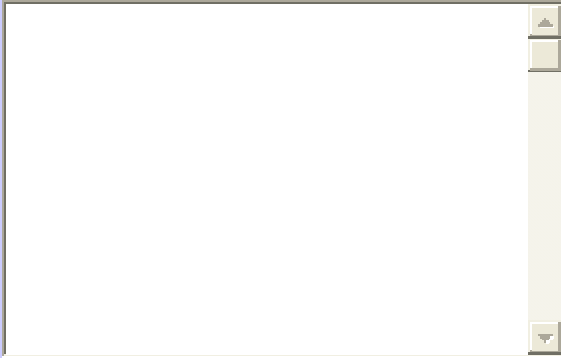
**This would mean that parents/guardians would be responsible for having their child's vision examined before entering school and provide the school with a certificate. This could increase the likelihood of detecting vision disorders.**

**Please tell how this possibility might affect you.**

Strongly Agree    Agree    Neutral    Disagree    Strongly Disagree

It would be easy for my family to pay for this vision screening.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Cost doesn't matter if it means better vision care for public school kids.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
It is easy to take my kids to a doctor.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
It would be easy to make time for this.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
This would improve relationships between parents/guardians and the schools.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
This would improve relationships between parent/guardians and doctors.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I would be in favor of this change.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

**4. Is there anything else that might effect your family or that we should know if the Department of Health recommends that parents get children's vision screened before starting school?**



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**5. The second change that the Department of Health is considering, is to have the expanded vision screening take place at school for children in grades K, 1, 2, 3, 5 and 7.**

**For parents this would mean that your children would have more vision testing in school than they currently have. This might increase the likelihood of detecting more vision problems and conditions. For schools, this may require them to buy additional equipment and provide more training for school employees, nurses and volunteers.**

**Please tell us how this possibility might affect you.**

	Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree
This would hurt relationships between schools and parent/guardians.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
It would be hard for schools to pay for this change.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
This would hurt the relationship between parent/guardian and doctors.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

**Appendix D**  
**Notes from Interviews**

**Interview 1:**

Conversation with Ron Washington  
Superintendent of Schools in Inchelium, WA  
ESD 101  
June 7, 2006

**How it happens in Inchelium**

- A school nurse is at the school once a week.
- All the vision screening is done by her in mid to late September or early October. Every year she screens all K-8 students.
- Screening is optional for students/parents 9-12.
- They screen for distance using the Snellen chart. Not sure of other tests.
- If the nurse finds something of concern – they notify the parent and if they are part of the Indian Health, they get referred to the Ophthalmologist or Optometrist. If they are not they get referred outside of that.
- Most students (90%) are part of Indian Health. They have health coverage.

***Concerns***

**Costs to Parents**

- Ultimately this will not be a big problem for most of the parents if the Indian Health is able to provide these services for them before entering school. There are some parents who will have a very difficult time (those who aren't included in Indian Health).
- Indian Health Clinic – if they are members or descendents, they have free medical health care. An Ophthalmologist used to go to the Indian Health Clinic once a week – not sure if that is still happening but if not, they get referred and it's paid for.

**Cost to Schools**

- Doing it at school is a great way to do it *if it is funded*. If the school is required to do it and there is no funding for it, there will be implementation difficulties.

- The equipment and training needs to be paid for in order for this to work. Time isn't a huge issue – he doesn't know how long the nurse spends now doing screening (2 days probably).
- He's not sure what the rest of it would take...if it adds a few days onto it – that would be a consideration.

### **Follow-Up**

- There are individual students who have learning problems – but if the school believes it is vision related they do a good job following up with the parent.
- Parents do follow-up. If kids need glasses, the superintendent is part of a club/network that helps them obtain glasses.

### ***Questions that came up***

- Who's funding this?
- How do families who face hardship get help?
- Needs more information – what kind of equipment. \$200 equipment or \$4000?
- Days of training or weeks for new tests?

## **Interview 2:**

Meeting with Dr. Rich Kovar  
Country Doctor Community Clinic  
June 28, 2006

### **Core recommendations:**

- Parent Advocacy training – to educate parents on the need for them to advocate on behalf of their children’s vision and hearing needs.
- Health professional training – worked through professional associations – to educate them about how to perform tests or refer as appropriate. Also an educational initiative around issues that are of particular import from birth through age 9.
- Children see ophthalmologist or optometrists by age 4.
- Enhance screening/exams done in schools – update technology and provide technical training to volunteers.
- Mobile auto refractor that volunteers bring to schools.
  
- All physicians are frustrated because they aren’t able to do a good job screening. The Well Child visits take 15 minutes and are basically to identify issues that are worthy of referrals. Physicians who see children are relying on parents’ perception and ability to advocate for their children.

### ***Access to Kids***

- We can track who is born and identify kids at risk.
- Schools are a good place to perform tests/screening.

### ***Strategy***

- Academy of Pediatrics and WA Academy of Family Practitioners look for resolutions. They could support one about vision and hearing of children. It could go out to all membership for support.
  
- Target organized Associations to implement advocacy and education campaigns
  - Nurse practitioners
  - Physicians Assistants
  - Pediatricians
  - Family Physicians

### ***Noteworthy***

Dr. Kovar is a good contact for future communication within the community of physicians who see children.

**Appendix E**  
**Notes from Regional Meetings Attended by MGS Staff**

Meeting with the Puget Sound Nurse Leaders Group

Last meeting of the year

June 2, 2006

**Concerns:**

***Utilization of Volunteers in vision screening procedures***

- In the WAC it says that professionals will do hearing screening whereas when referring to vision screening the WAC uses the word “volunteers” meaning that both professionals and volunteers can be used to screen vision.
- The nurses don’t believe that vision is any less important than hearing and to allow volunteers to come into our schools and do vision screening when studies have shown that 80% of what children learn is through the visual processing of information is not wise.
- They believe that volunteers, unless they are professionals, are not (in most cases) able to pick up the subtly in children’s behavior that tell you the child should be referred on to a health care provider for further testing.

***Time***

- The nurses are already trying to screen for distance, scoliosis and handle all the other special needs of the kids (diabetics, etc) that putting this added evaluation on them is not feasible. They don’t have time for the other mandates to which they must attend.

***Money***

- They were angry thinking about an unfunded mandate. They are already doing more than they get paid for.

## **Meeting with WA Academy of Eye Physicians and Surgeons**

Coordinated through David Epley, MD.

June 9, 2006

### **Main Points:**

- Train school nurses to do the most common tests for amblyopia.
- Not as important to test for convergence, hand-eye coordination, accommodation, or strabismus.
- Don't waste time color testing girls.
- As a group, they are generally supportive of the possible changes.

### ***Training***

- They think they would be the best candidate to train these nurses but it is currently prohibited by legislation.

**Appendix F**  
**Focus Group Notes**

**Focus Group**  
**Director of Special Programs,**  
**school physical therapist and the school psychologist**  
**Middle School**  
**Republic, WA**

**Population you see**

- Native Americans
- ESL
- Developmentally challenged

**How referrals are handled -**

- If a child is suspected of having a learning disability, they are required to do a vision screening test – this is paid for by the school. This process delays diagnosis 1-5 days (they have a nurse once a week). It isn't always apparent if it is vision or learning disability.
- 52 kids were given vision referrals at this school this year.
- They are required to give 3 different referrals...two local referrals and one in Spokane.

***Regarding Question 1 - vision screening being required before entry into kindergarten.***

**Pros**

- Every year at the end of spring they are required by law to do ChildFind...every school district – has options about implementation but all have to do it.
- The school nurse is usually there, but isn't always possible. This is open to all school aged kids and the testing is all developmental...cognitive and motor, communication, personal/social, and adaptive skills are tested. If they believe that there is a vision issue based on their observation they make referrals.
- This would target mostly 3-5 year olds.

### **Cons**

- It would be like vaccinations – which is difficult.
- This option could work If it were set up at clinics on certain days and if it were paid for or the families had help. It would be hard if they had to go to Spokane or Tonasket for the service.
- Unrealistic if unfunded.

### ***Regarding Question 2 – expanded vision screening being required K, 1, 2, 3, 5 and 7<sup>th</sup> grade.***

### **Pros**

- It is great to do as many grades as possible. When children are learning to read it is essential to know if they can focus near not just far. Snellen only addresses far.
- They need to know this early – it effects concentration.
- Parents would be responsive...especially in this area – to have this service in the schools...

### **Cons**

- This will be time consuming.
- Time out of class is a concern. There is a lot of pressure to pass the WASL. Is there a way for this to happen without taking the kids out?
- Educating the teachers – key.
- Paying for this service...how can we do this?
- Maybe address dysgraphia earlier and would need less resource intention Occupational Therapy.

### ***Where are vision services?***

- Two OD's have offices here but don't occupy it every day. They are here once or twice a week.

**Appendix G: Sample Comments**

**Option 1 (Non-Nurse School Personnel)**

Profession	County	Comment
Principal	Whatcom	Another unfunded mandate. We have a part time nurse in our district. Already much of her time is spent administrating and not nursing. Office staff continue to respond to unfunded mandates and this will be one more. You have heard it all before so I'll stop at this.
Principal	Clark	Currently we have a hard enough time trying to get parents to have proper immunizations so an addition wouldnt be welcome.
Principal	King	If school starting dates are delayed due to the required vision test, I foresee students missing valuable education time as they wait for doctor's appointments.
Principal	Benton	Just like with immunizations, there need to be free public clinics provided for low-income families where students can have their eyesight checked. This is NOT an area that schools can be asked to fill in the slack. We have a school nurse only a few hours a week and that is going to be cut back again this year. So, schools don't have the personnel to do eye exams.
Principal	Snohomish	Nurse and Secretarial duties will increase as they will need to check registrations for compliance, and then follow-up with parents and/or schedule testing.
Principal	Whatcom Co.	Opinion: It would be best to establish a relationship with the family and then address vision needs as they present themselves.
School Administrator	Yakima	Additional paperwork and personnel time to check parent compliance. Occasional misplaced paperwork at school, creating negative parent relations..
School Administrator	King	The cost to the school district and the district nurses time will be very difficult. Volunteers are not possible here and so we rely heavily on the nurses which takes away time from other health assessments and treatments
School Administrator	Snohomish	There are huge impacts for requiring parents of low income or middle income families to pay for vision exams. If the State is going to require it then they need to provide a way for parents to pay for it. Once again, it's another unfunded mandate both for private families and school districts.
Superintendent		Our parents and caregivers cannot afford basic health care and, therefore, misuse the emergency rooms at our local hospitals. This requirement will create further inequity for parents across this State to access public education for their children.
Superintendent	Grays Harbor, Lewis, Mason, Pacific, Thurston,	The need to exclude students if their parents do not comply. That would seem to undermine the purpose of such a requirement.
Superintendent	king	This will clearly take staff time away from current priorities at the very time we cannot meet curent obligations. This will bring inevitable paper work at a level that is way beyond what we can handle.
Superintendent	Ferry	What help would be offered to those families that the cost would be a hardship for?
Vice Principal	Clark	A lot of paper work and nurse or secretary time spent contacting parents out of compliance.
Vice Principal	Clark	Staffing and being able to do it all.
Vice Principal	Clark County	This district has many financial issues and more responsibility will be difficult.

**Option 2 (Non-Nurse School Personnel)**

Profession	County	Comment
Principal	Whatcom	Schools continue to become a social service agency sans funding. This is another addition to that trend.
Principal	Clark	Our school district cannot pass levies and I cannot afford to run my building so additional costs associated with more screening would be a burden on my building and my district. This would be another unfunded mandate.
Principal	King	From the conversations I have had with my school nurse, many of these conditions are usually detected in the normal screening or an unusual screening leads to a referral to a doctor's exam.
Principal	Snohomish	I am unclear as to what equipment you are considering as well as the cost, so keep that in mind as you evaluate my responses.
School Administrator	Yakima	Difficult to answer, not knowing estimate of costs and equipment involved.
School Administrator	King	The cost is too great for us. The nurses barely have the time for the Life Threatening conditions they deal with daily.
School Administrator	Snohomish	We do not have the necessary staff to fulfill this component.
District Administrator	Yakima	Vision care is a duty of the health care system, not the educational system. Education is enough of a challenge without taking another day away for a vision screen process, not to say anything of the costs.
Superintendent	Grays Harbor, Lewis, Mason, Pacific, Thurston,	Please, please, please no more unfunded mandates. If it is important enough to require, it should be important enough to fund.
Superintendent	king	This cannot be allowed to override the present work that schools are tackling. The state requirements and the federal requirements are already unfunded and this would be a huge distraction. Do not use the schools for every social cause -- even if the cause is a good one. Budgets are already impossible and every district is making significant cuts. Do not add another financial and staffing burden on the schools. We do not have the money.
Superintendent		If the state or another organization wants the vision program, the state must fully fund it. School districts already have too many unfunded mandates as it is.
Vice Principal	Clark County	Time constraints with limited staff.

### Option 1 (Health and Eye Care Providers)

Profession	County	# of patients per year	Comment
Ophthalmologist	Clark	6000	The 6 most common vision disorders listed by the Dept of Health is a false premise. With nearly 30 years in practice I have rarely seen any adverse consequences of accommodation and convergence problems and the eye-hand coordination is a bogus disorder. It invites fleecing the public and is a good revenue source for the likes of optometrists.
Family practioner who sees children	King	3600	Depends on the extent of the required exam... if simple vision screening and routine Well-Child eye exam... no big deal. If it involves full visual testing and dilation of eyes... good luck.
Family practioner who sees children	King	1500	Very Very difficult to get kids appointments with ophthalmologists - takes up to 6 months for routine problems.
Pediatrician	King	8,000	Vision screening is not an issue for us; gettting children seen for diagnostic evaluations by vision specialists who take Medicaid AND are comfortable assessing children is a big issue. Also, our families need interpreters for the parent and often for the child in order to do a good diagnostic exam.
Pediatrician	Snohomish	?- just started a few months ago	For some reason, my patient population has difficulty being current on vaccinations and hearing screens in the school often go without follow up. I don't know where the break in the system lies- the healthcare system, the schools or the families. on the one hand, I think vision screening has the same possible pitfalls. On the other hand, there are children who will likely be identified earlier.
Optician	kitsap	6000	Allow Licensed Dispensing Opticians perform vision screenings using vision screening tools. Also allow licensed dispensing opticians to do vison screenings at other locations other than their respective offices
Family practioner who sees children	King	1200	It is often difficult to get kids in to see primary care physicians for well child exams. Other than a standard snellen eye chart test, we do not have the capacity or the time to provide comprehensive eye exams. This would require another visit to another provider and would need to be covered by medicaid and subsidized in some other way for children without any insurance. We have had challenges finding low-cost vision care.

Family practioner who sees children	Chelan	3000	If DOH via the legislature wants this to be accomplished, then issue vouchers and pay for it. I would not want to see a child with a vision problem to not be screened but we cannot get kids with dental caries the care they need. The school nurse could easily be trained to perform this exam.
Ophthalmologist	Spokane	400 new practice	Would be an additional burden on low income families. Primary care providers may stop screening young children in their offices to help save time as they anticipate children will be evaluated before kindergarten. This may cause certain visual problems to be missed until the child is older (5yo).
Pediatrician	King	3400	We started emphasizing vision screens in all patients 3 years and older in the past 2 years. Our detection rate has improved dramatically with minimal staff impact. I think that vision disorders should be identified at the patients medical home BEFORE school entry.
Pediatrician	King	4000	I think a pediatrician's office would be better trained and equipped to screen eyes than nurses and parent volunteers taught to do this only once a year.
Ophthalmologist	USA	6000	It will overwhelm the few pediatric eye care providers in the state, thus force non-pediatric eye care providers to muddle their way through a pediatric exam, resulting in potentially poorer care than no care at all.
Ophthalmologist	Chelan	6000	I strongly disagree with the state mandating eye care in this regard. The cost to the state to provide this care through Medicaid/DSHS would be large. I strongly believe that this is a bill put forward by the state Academy of Optometry to promote the welfare of its members and they are hiding behind the veneer of patient safety. I believe the most cost effective way to provide this service would be to beef up the screeners at the schools. Either use technicians that have passed state training or use technicians from our offices.
Optometrist	Spokane	2,600	You are confusing the issue of examinations vs. screening in the above questions: This makes it difficult to answer the questions consistently and meaningfully thus impacting the validity of this survey. Most learning activity involves reading and takes place at near point...most current screening is done at far point...any screening or examination HAS to to include near point evaluation to evaluate the student's near point status if you are truly looking at potential problems for school related visual performance. Simple acuity measurement is not sufficient. There are simple, time efficient, inexpensive methods to screen at near point...use them. Of course, exams would be better IF they meet the criteria of testing at near point (have a simple form that doctors are required to fill out that says more than simple acuity was checked at near point). Cost could be a big issue...either for the schools or for the parents, depending on which group ends up being responsible for ensuring the APPROPRIATE screening and/or exam testing is being done. These can be reduced by enlisting the aid and

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## Option 2 (Health and Eye Care Providers)

Profession	County	# of patients per year	Comment
Pediatric Nurse Practitioner	Spokane	4800	Schools are already required to do too much. They have little time left to actually teach kids. This will be an additional expense to the schools. There will be a problem of kids who miss the screening. The major problem I see is that with minimally trained volunteers there will be an over abundance of unnecessary referrals to their primary provider or eye specialist. Then this will increase the cost to the patient and eventually increase the cost of health care and insurance!
Family practioner who sees children	King	1500	If the screening is implemented, I think it imperative to get ophthalmologists to agree to take these kids as patients regardless of insurance or medical coupon status - otherwise there are a bunch of frustrated parents and primary care providers.
Ophthalmologist	Clallam	1200	Why you would have the schools measure eye-hand coordination and accommodation is beyond any scientific reason and more to do with milking the system for all its worth.
Optician	King	8000	The downside to this option is that it will take public school resources, ie: our tax dollars. The potential for a political backlash due to the public money spent would be a real possibility.
Family practioner who sees children	king	3600	If this is done in the schools, they will need a tremendous amount of support. As a parent, I volunteered on vision screening day and helped the nurse on a number of occasions. It was near chaos simply doing the eye chart/finger direction testing. I almost can not imagine doing this in the schools without a travelling team or a significant increase in nursing resources at the school.
Pediatrician	King	2000	I like this option better because if it is done in the school it would have to be funded by the legislature and would therefore be better for all my uninsured patients.
Pediatrician	Thurston	3000 per doctor	We get a lot of referrals for children who fail their vision or hearing screen or scoliosis is detected at school. The vision and hearing screens are often done in the gym with lots of other people around them, and I feel that a lot of kids end up in our office because a good screen was not done. However, my poor vision was detected at school in first grade, so there are occasional children who are picked up by the school screening. Of all the screenings the school does, I think the vision screen has the biggest impact (ie, fewest false failed vision screens with the biggest return of picking up poor vision).
Pediatrician	Pierce	2250	If the service is provided by the schools, the learning curve will be much steeper and the cost less efficient than if primary care providers were to provide the service. If insurance providers will pay for the upgraded exam, primary care provider should be the one to perform it. As it stands now, most primary care providers screen for visual acuity and variations of strabismus/amblyopia, but my answers to the survey assume a more subspecialist-level approach to the exam.

Family practioner who sees children	King	unknown	School nurses and/or volunteers would require fairly extensive training to provide the necessary screening. However, I foresee more resources being put into training workers in schools than would be provided to health care providers. If done properly, it is more likely that in-school testing would be more uniform and consistent than doctors' office screening.
Optometrist	Yakima	4000	Making sure the school nurses and volunteers are adquetly trained will be difficult. At my children's school, PTA parents actually do the current screening. I used to oversee optometry students from Pacific University College of Optometry as they preformed screening in the public and private schools around Western Oregon. I wanted to do screenings like that here in Yakima, but found out that as on Optometrist I am not allowed to participate in public school screenings. I can't even be a PTA volunteer with the distance only screening the school currently does. I recommend that someone on the legislative committee contact Pacific University to find out more information on their screenings. If the legislature decides on improved screenings over required exams, they could potentially get help from local optometric and ophthalmologic societies as far as volunteering to help training screeners, and/or attend screenings to help oversee the process.

Optometrist	Clallam	aver. Fifteen hundred exams	Neither school nurses or volunteers have the training or professional judgement skills needed to detect some of the conditions to be tested. If less skilled persons do the testing and more skilled persons interpret the results, that might suffice.
Family practioner who sees children	King	4000	I feel the schools are already massively burdened and ill equipped to provide health related services. Without a major budget overhaul and adding a full time RX to each and every school, I do not see how this would benefit kids. Volunteers will never be as good at accurately screening kids for complex and sometimes tricky eye disorders as health care professionals are. It almost makes more sense to have the schools vaccinate on site and shift the eye exams and hearing exams all to the doctor's office where they can be done with more precision.
Optometrist	Clark	2500	Dentists and medical doctors don't delegate comprehensive exams to school personnel, neither should eye care professionals.
Optometrist	Whatcom	2000	I have volunteered in private schools to help with vision screenings and the understanding of the staff, sometimes nurses is very poor. Studies have shown public school screening are a worse measure of vision than just asking the childs teacher. I had a 7 child who passed a school vision screening but was blind in one eye from a congenital retinal defect. His parents were dumfounded. In there defense he appeared to be significantly ADHD and difficult to evaluate. My impression is school vision screenings are so poorly done and the technical understanding sufficiently complex opometrists should be contracted to supervise the vision screenings. A training course for school nurses would need to be significantly more than a weekend seminar. more like a month, to ensure they have the understanding of the vision system and limitations of the testing equipment. Optometry school is 4 years of training specific to the eye AFTER college.

## Option 1 (Parents)

Profession	County	Comment
Vancouver	Clark	for me a family that has health care this would not be a problem - but for the family that does not have medical insurance it may be a problem. what will be in place to assist those families that do not have coverage - and if it is required - it may have an effect on kids making it to school - you ask above if the cost matters - for some one who does not have health coverage it will - and if they have more than one child...
Kent	King	As an elementary school volunteer I have assisted school nurses to screen students and it is a daunting task! Our school nurses are stretched too thin and overwhelmed with unmet healthcare needs of some students. Requiring screening prior to kindergarten could improve learning by identifying (and hopefully treating) vision problems early on. I think it is a good idea and it would not have been a problem for my upper middle class family. Unfortunately this requirement could be a burden for many families in our community; low income, immigrants, etc.
Gig Harbor	Pierce	It would be a travesty to require parents to get their children's vision tested because there are many parents for whom transportation and medical services are very difficult to get. This would make an already difficult life even more difficult to add this to public school entrance.
Bonney Lake	Pierce	There is a definite problem locating quality eye doctors who will accept Medicaid. It would be easier for families if the schools set up clinics for the screening and have ophthalmologists there who will accept Medicaid. Alternately, the schools could arrange with some ophthalmologists to have a screening clinic day at their office where they would take Medicaid or income based fees.
Walla Walla	Walla Walla	My family would be ok as we have vision in our health policy, but many families in my area are without that coverage. I think for the general public benefit it would be better if the public schools did this whole screening at no cost to the families or on a sliding fee scale
Unknown	Unknown	I think this would be a great service to be AVAILABLE at the school--perhaps give people a choice--either they provide proof of vision screening or the school will do it. I have five children--four are wearing glasses or contacts and the fifth no doubt will be soon. Even with yearly checks, my fourth should have probably been in glasses a year before it actually happened.
Goldendale	Klickitat	Not all parents can afford some of these requirements nor can many school districts

Bremerton	Kitsap	I'm less concerned about how this change would affect my own family/child, as we have some vision coverage on his health insurance. I'm VERY concerned about how this change would affect low-income families, families w/o insurance and families with at-risk children. I think it would be very unfortunate to place another barrier to getting ALL children enrolled in school!
Seattle	King	this would not be an issue for my family as my children already have strabismus diagnosis and receive regular vision care. HOWEVER, I see this being a significant issue for many families and believe that some accommodations need to be made for children to receive screening at school. Ironically, it's likely that the people who have access and time to complete these types of surveys are going to be more likely to have access to vision and health care. because my son's strabismus negatively affected his development and treatment positively affected his development, I am supportive of finding ways to screen for vision issues.

**Option 2 (Parents)**

City	County	Comment
Richland	Benton	It is unfair to burden public schools with this additional expense. It's bad enough that funding inadequate to cover basic education, special education, assessments, school transportation and construction. Schools cannot afford this added burden, especially if schools don't even have their own nurses or counselors.
Warden	Grant	There needs to be good training available for the screeners so that there aren't alot of mistakes made.
Kent	King	It is a great idea. I would be great for kids! However, I have serious concerns about this being another unfunded mandate for our overburdened public schools. Our schools are unable to keep up with the demands under the No Child Left Behind Act nor the increased academic standards and graduation requirements as it is now. So before it is instituted ensure there is adequate funding for the nurses and equipment!!!!
Seattle	King	I think it is important that public schools play a role in some of this very basic provision of preventative health care but, I wouldn't say 'it doesn't matter if the cost is more' because of course it matters - we need to deal with the reality that our WA state population continues to say it is okay to underfund schools - so it does matter - when we at the very same time ask them to do more, and more with less and less. I have no great solution to offer other than we could value our kids education more and agree to provide more funding to schools. Unfunded mandates can be pretty stressful for all involved.
Sammamish	King	I worry about the cost and the accuracy of the tests for these specific conditions. I like the idea of the testing being done repeatedly for the various grades. Children's eye change so much over the years.
Goldendale	Klickitat	Consider what the costs to the school districts would be and what other programs will be affected if the money is spent on equipment. I believe the vision requirement is good, but most school district budgets are stretched at best.
Bonney Lake	Pierce	If the schools provide vision screening it should be with ophthalmologists, not just school employees. Maybe the doctors would volunteer for a day. If they did they would probably get more patients in their office for follow-ups. Screening is not what corrects vision problems; it is the follow-up care.
Friday Harbor	San Juan	The schools do not have the ability to do this now
Spokane	Spokane	My child is non verbal so feedback during any medical screening is difficult...I would be curious as to the experience these screeners have working with children with severe or profound disabilities...at one time my child was labeled visually impaired and the professionals(at school)treated him like a very low vision student/we now realize he could see fine all along...he just could not tell the screeners
Yelm	Thurston	I think its about time we embarked on a collaborative eye screening endeavor with parents. Perhaps many of the reading problems children experience is due to poor eye care. The time has come to support children more comprehensively and their parents through better and more affordable health care programs. Thank you for the opportunity to comment.

**Option 1 (School Nurses)**

Profession	County	Comment
School Nurse	King	State mandates for screening are good as long as they are funded. The problem is that they are not. I would fully support this measure if there was funding for nurses in school and also funding for students who were found with abnormal findings to have care. What good does it do to case find problems when there is erosion of the services to kids. Most employed people do not have vision insurance. Parents do want to take care of their children but when it is a choice of one essential good or service and another then who are we to dictate what is right for them. If you create any more barriers to school attendance then you do not serve the students. Please fully evaluate the unintended consequences of such regulations prior to legislation. The controversy about kids ability to accommodate near to far must be worked through before requiring that.
School Nurse	King	DSHS financial assistance for low income families does not offer vision coverage. How will low income families provide their children with this mandate? Where is the school district to turn to find the funding to provide this service to low income children?
School Nurse	Thurston	If students are allowed to enter without the screening and the school district will then be required to provide the screening, there would be little incentive to comply with the requirement of having it done prior to school entry.
School Nurse	Spokane	Given the number of students we have per nurse (approximately 3000 students) this would be time consuming to do more screening tasks as well as the follow-up. Most vision problems are already picked up with the present screening. If they fail, a referral is made. Parents will not get the certificate once they know that the school will provide the screening. Adding more tasks to the nurse's role will not produce enough results to make the time it takes worthwhile.
School Nurse	Asotin	There are not enough Drs to adequately accommodate all of our school children. Also if schools do this, not enough time and nursing hours to complete .
School Nurse	Snohomish	Many of our students do not access to health care, including no vision care. In theory, it would be great to have every child have a comprehensive eye exam before attending school, but it is not realistic. If the student could not/does not get an eye exam, it would fall onto the school to provide it, so why should the parent go out and get an eye exam if the school would do it anyway?? Schools are already tracking so many things: Immunizations, emergency preparedness forms, internet approval, etc etc etc.
School Nurse	King	If you are talking about Ophthalmologist and or Optometry exams by a specialist and then I can see big problems with that. I don't think most of the Pediatricians have eye exam equipment in their office and that would mean two visits, one for the referral and the specialist visit. That would indeed be WAY too much for most of the parents at my school. Fewer than 40 % of them get a pre Kindergarten general exam that is suggested but not required. I believe that parents should be responsible for the health care of their children and if we begin doing BASIC exams such as these we will be going down a path that will end up with the STATE 'via the school' providing unnecessary tests at the tax payers expense.

School Nurse	King	Yes. Who would be responsible for tracking kids who are in compliance and those who are not? It cannot be added to the school nurse role--it's really a clerical job. Then, who/how to force parents to get the required screening?
School Nurse	Clark	Parents would greatly resent this imposition. This would put another load on the school offices for compliance. Many already resent being required to present proof of immunizations. Would this be covered by free clinics? Immunizations are required, but the health dept and free clinics assist with students without insurance or finances to purchase these.
School Nurse	Kitsap	Having children screened before entering kindergarten is a good idea, but not to the extent of the level previously described. That is excessive for an initial screening and very expensive.
School Nurse	Benton	The lowest income families will have medical coupons so the cost should not impact them and the benefit will be huge. There are some families that fall between the cracks though as they may not have vision insurance and unable to afford an exam. Increased availability of programs for this group would be very helpful.
School Nurse	Grays Harbor	This would be an excellent chance to help families access 'Healthy Kids' medical coverage through DSHS, if they can't afford a professional vision exam.
School Nurse	Clark	What is the liability to the nurses if there is an error in the proposed expanded vision screening? We are not trained to do anything more than distant vision screenings. I am under the impression that vision screening, to the extent it is being proposed, would not be that accurate in a 5 year old. If true, wouldn't it be a waste of resources (both parent and school district) to require this on a 5 year old. We have enough trouble getting parents to comply with the requirements of immunizations and medications and health care plans. We do not need to add more requirements to the school nurses when we are understaffed as it is!!
School Nurse	Franklin	Will outside resources still offer their services to students? (ie-free vision exams, glasses) These opportunities are made available to schools for students-will this be jeopardized? Will there be support for smaller school districts to assist in providing the extended vision screenings if parents do not? I know that I am stretched to capacity with the workload I have now, the need of these families is so overwhelming for them as well as for the school district. The reality is that when some of these new requirements are made for the state as a whole, the impact on smaller, less populated areas do not receive, thru revenues, adequate monies to provide what is needed. Please consider this when trying to address this issue. If the extended screening is approved, will there be trainings for the school nurses for these screenings?

## Option 2 (School Nurses)

Profession	County	Comment
School Nurse	Snohomish	I would be delighted to be able to provide this kind of service IF there is better school nurse staffing. At our current level of staffing we cannot provide this service without sacrificing another area of our service...which is also mandated by the state w/o additional funding. I do not see being able to rely on parent volunteers to accurately provide this additional screening; I simply don't have the reliability of volunteers.
School Nurse	Kitsap	I do not think that schools should be put in the position of having to do such an extensive screening. We are schools, not a doctor's office.
School Nurse	King	Where is the additional funding going to come from to support this change? I see our district having a difficult time making ends meet as is. Volunteers are becoming more difficult to find for health screenings. On this date 6/7/06 I am still completing my screenings for this year due to a drop in volunteer help this year.
School Nurse	Pierce	The state has not even considered the impact to the nurse and the amount of time this would take. Another new requirement but yet there is no money to back it by the state legislation especially since there is still not even a mandated student to nurse ratio. All nurses are in the business to help care for and improve all school kids health issues but the reality of time and the lack of support for mandated school nurses at the state level should be looked at first before additional new screening mandates are considered...
School Nurse	Spokane	A cost analysis should be done as a pilot study before the changes are made to see if this expanded screening is feasible.
School Nurse	Yakima	The increased staff time will inhibit implementation and intended benefits of additional screenings. It will also interfere with benefits of current basic screening services that are currently being conducted by competing with resources. I would like to have opportunity to review statistics that provide convincing argument for the economic and outcome-based cost effectiveness of increased vision screenings in the school setting.
School Nurse	Kitsap	As resources for schools continue to decrease & demands increase, I fear this will be one more unfunded mandate.
School Nurse	Snohomish	Purchase training and MAINTAINANCE of equipment is very costly, much less the time it takes to screen each child. However the work only BEGINS then: the nurses need to find referral sources for children who need eye exams, and the resources are few and far between
School Nurse	Clark	It is nearly impossible to find enough volunteers as it is. It is very difficult (time-wise) to be able to adequately train the volunteers now. Additional testing would create huge problems.

School Nurse	King	My district is cutting costs and nursing hours are on the chopping block. This extra cost of equipment and extra hours required to screen FIVE grade levels would have a SEVERE negative impact on the ability I currently have to give services to Sp Ed students, continue with medications in the office, and assess sick kids. I would be better serving my students to do distance vision screening only and use my contacts with teachers as they identify students with problems and referring them directly to their MD for evaluation.
School Nurse	King	There are currently not even enough volunteers to assist with the screenings we do. Where will the additional people and time come from? Nurses are already serving multiple buildings with minimal time to do what is required. If we look at this seriously, we must also look at financing more nurse time in buildings.
School Nurse	King	Students may miss a lot of school if they are prevented from attending because they do not have a certificate. Families may choose just to keep their students home. Is it possible screening could be set up at the school on the first day. Also alerting Community Clinics could result in this being done during regular check ups or when students get immunizations. If they sent the info directly to the school district or had a state registry that schools had access to, it would eliminate the parents needing to bring in paperwork.
School Nurse	Clark	If this is an unfunded mandate then other nursing care would be lost. I do not feel this could be justified to say that schoolwide extended vision screening is more important than other nursing care. There are medical concerns related to safety, health care plans and student care that supercede this need. A student with vision concerns is referred to a specialist for further testing. We often assist in the student accessing this care. Further testing in school would not meet the basic need of the school which is to teach.
School Nurse	Benton	I would be very concerned about the quality of the expanded vision screening in a school. I would also be concerned about liability. What if the screen missed something significant? Space and time are limited in a school. The expanded screening will require both.

## Appendix H: Suggestions

### Suggestions

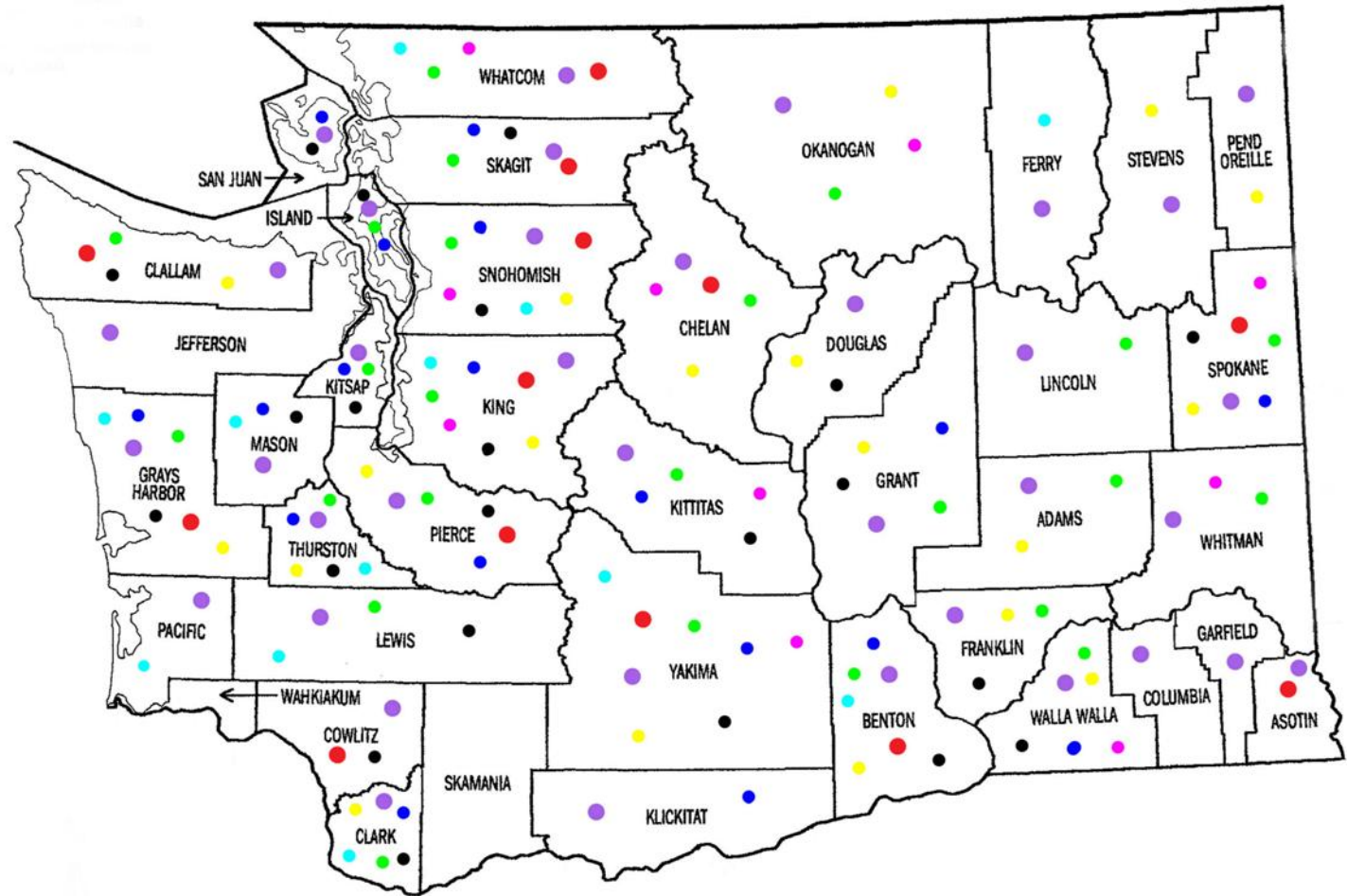
Profession	County	Suggestion
Optometrist	Thurston	Summer crunch time to get the eye exam completed. I would have a strong recommendation to have the exam before kindergarten but require it before first grade to allow a full year for parents to complete the exam.
Optometrist	Whatcom	I have been in practice over 20 years and will retire soon. It has surprised me many times how bad a child's vision can get before a parent will bring them in. I believe the parent knows there is a problem but don't want to spend the money for an eye exam. The liability for our office to do only a screening without dilating a child's eyes is huge. A common cause of lawsuits against eye doctors is failure to detect a disease because of inadequate exam. A compromise might be to require an eye exam before grade 2 instead of before kindergarten.
Ophthalmologist	Yakima	Many children have Hyperopia, or far-sightedness. They see distance just fine, but can't see clearly at near point. Children in grade school need to have their near vision tested as well. A near-point card is inexpensive and easy to teach any volunteer or staff. It takes 1 to 2 minutes to perform. Thank you, Yvonne Schnellbach, L.D.O. Chairperson for Near Vision Matters Committee for Washington State
Optometrist	King and Skagit	Ophthalmologists and optometric physicians are clearly better equipped to detect the listed eye disorders than non-professionals who assist current vision screening programs in schools. If vision problems are found, there should be a mechanism in place to avoid self-referral -- with an objective listing of vision care providers than can be provided parents.
Ophthalmologist	King	I would suggest limiting the school screening to amblyopia and strabismus, with the training of the school personnel limited to the detection of these two conditions. This would not require any special equipment. If either condition is found, then the child should be referred to a vision care provider.

Family practioner who sees children	King	Our schools are already doing too much (mandated initiatives) with too little (money, personnel, etc). I think having the exams at school increases the likelihood of catching and treating eye problems for children but I think asking the schools to be responsible for health care as well as education is a mistake, especially if they are not given the money and expertise to do this. I think optometrists and ophthalmologists should oversee the setting up of such a program.
Family practioner who sees children	Gray's Harbor	Have any form include a very specific checklist (each possible abnormality that should be screened with a separate nl and abn box.) Helps me, the provider, be sure I am addressing each concern.
Ophthalmologist	Yakima	Maybe starting with near vision testing would be the first step. This test can also detect Amblyopia, Strabismus, or an Accomodative Dysfunction, when conducted properly. One nurse I interviewed, said they should only test for near vision and not distance, since most of the learning requires reading and writing. It would be obvious the child couldn't see the overhead or blackboard. Yvonne Schnellbach, L.D.O.
Optometrist	King	If this were to be expanded in the elementary system, consider doing this during the physical education period and train the PE teacher and school nurses to be screeners with volunteer parents filling easier tasks at the event. Also consider bringing in professionals to oversee the screening and check the cases that fail to prevent over referrals.
Optometrist	Benton	it may be necessary to have a licensed OD oversee training and monitor the first few of these screenings to ensure they are being done correctly. Contacting local optometric societies would allow all who wanted to the ability to participate. This would ensure the children are recieving the care you are envisioning
Parent	Pierce	Exophoria is a common problem for children with autism but often goes undiagnosed.
Parent	Thurston	I would recommend that the state sub-contract with vision screening providers for greater cost efficacy and that mobile vision screening be available to rural areas. Have the Lotto folks pay for it...they are getting over big time in this state. (see California's lotto system for comparision)
Parent	Unknown	I think this would be a great service to be AVAILABLE at the school--perhaps give people a choice--either they provide proof of vision screening or the school will do it. I have five children--four are wearing glasses or contacts and the fifth no doubt will be soon. Even with yearly checks, my fourth should have probably been in glasses a year before it actually happened.

Parent	Island	Perhaps donations could be solicited from local health care providers. Services in training personnel or tax deductible donations would help offset costs to the school district.
Parent	Thurston	Let's figure out how to pay for it...NCLB and the Children's Defense Fund should also be explored at the federal level.
School Nurse	King	Could mobile vision screenings by vision specialists be performed at the school during Kindergarten roundup? Could mobile vision screenings as above be available to families at Rite Aid or Walgreen Store parking lots?
School Nurse	Clark	Many of the eye problems addressed need to be corrected by the age of 6 yrs for other than cosmetic correction. It would be better to have students screened in kindergarten and perhaps GR 1 by trained school nurses performing test for strabismus, muscle balance and amblyopia, and do the traditional distance screen visioning in 3,5,7.
School Nurse	King	Maybe they could consider making it a requirement for school. If parent cannot get completed then have school nurse do it but allow them to bill the state for the time involved just as a clinic would bill it.
School Nurse	Klickitat	ESD112 has a van that drives to the different school districts for hearing screening, couldn't the same thing be done for vision?
School Nurse	Snohomish	Perhaps community vision providers could be asked to volunteer to conduct these expanded screenings. I realize that might appear to be an endorsement for a specific doctor, but if they all participated in the screenings it would not show favoritism.
School Nurse	King	For amblyopia why not have someone screen all of the children in Head Start programs. Most children see the doctor prior to entering kindergarten. I think that the doctor could do all of the screenings that you have mentioned.
School Nurse	King	Have you thought about how disruptive this will be to the student's education? This will require them to be pulled out of classes 1 or more times (if re-checks are required) for an extended period of time. I have neither the time, equipment or the training to do this properly. With regards to amblyopia, it is preferable to diagnose this early (age 2 or 3); kindergarten is a bit late! I am a huge advocate of health care for children. A more appropriate way of doing this might be to provide free universal health care coverage for all children and let their doctors provide the exams outside of school.



# Appendix I: Department of Health Stakeholder Engagement Process Distribution Map of Stakeholder Group Representation in Washington State Counties.



### Stakeholder Key

- Parents
- School Nurses
- School Admin/Superintendents
- Pediatricians
- Physicians who see children
- Ophthalmologists
- Optometrists
- Opticians