Made to Save School Pilots Program

A report of efforts and learnings from the field

Index

Overview of Made to Save and the School Pilots Program

Children 5-11 are lagging far behind other age groups in COVID-19 vaccine efforts. From September 2021 to February 2022, Made to Save worked with four diverse communities (in Birmingham, Alabama; Detroit, Michigan; rural Arkansas; and the Mississippi Delta) to encourage, support, and learn from school-based COVID-19 vaccination efforts. We learned many lessons along the way that reinforced the importance of schools in ongoing efforts to increase COVID-19 vaccine uptake and equity among children. We are sharing our lessons, challenges, and the resources created during the pilot to help other schools and communities continue this important work. For a short video that highlights the work of these efforts, please click here.

Key Lessons Learned

Key takeaways from this effort include the following:

- School leadership should support student and community vaccination, including in-school vaccine clinics and emphasize the importance of community protection against disease with the added benefit of keeping kids healthy and able to attend school, which results in fewer lost learning days.
- Community based organizations (CBOs) who are trusted messengers in their community should partner with school leadership to ensure accurate information is shared with parents, build connections with vaccinators and help plan the logistics of setting up a clinic at school. This type of partnership serves to strengthen community, increase access to accurate information and share the work across organizations to ensure equitable access to vaccines.
- Scheduling school based clinics on a regular basis (every 2-3 weeks) gives parents time to get comfortable with the idea of vaccinating children, gives time and space to ask questions, and allows relationships to grow with medical staff who provide vaccines. Our coalition members who held 3 or more clinics noticed that more people came at or after the 3rd clinic than did the first. Showing up regularly built trust in the clinic staff and gave parents time to adjust to seeing staff there and open up with questions. Trust is earned in time. It's worth acknowledging that increasing access through multiple clinics can put a strain on capacity of local vaccinators, but given

low vaccination rates amongst 5-11 year olds, this model may be what is needed to increase rates to ensure high vaccination rates and thus, higher protection against COVID-19 in schools, especially as mask mandates have been recently lifted in many locations. Schools can gauge interest in vaccines ahead of time and school based vaccine clinics may be staffed with just a few healthcare providers depending on interest.

- Build a coalition with other groups, CBOs or partners doing this work. Our coalition members all reported that participating in our coalition (groups across 4 different geographic locations) became a helpful community in itself. Working together towards a common goal that benefits the community you serve is hard work, especially when there is mis or distrust, fear or hesitation. A coalition that can brain-storm challenges, keep each other accountable and motivate each other to continue work that at times feels thankless is helpful.

Background

Made To Save is a campaign to increase COVID-19 vaccine access and vaccination rates within communities of color. It is designed as a time-bound initiative from January 2021 to May 2022 within Civic Nation, a national leader in the effort to inspire, educate, and activate people to create a more inclusive, equitable America.

In the fall of 2021, in anticipation of the FDA's authorization of COVID-19 vaccine for children aged 5-11, and with equity at the center of our work, Made to Save launched an effort in partnership with Community Based Organizations (CBOs), schools, vaccination providers and other community partners in 4 locations to observe, measure and support efforts to ensure COVID-19 vaccine access in school settings along with education and accurate information for parents.

This pilot was implemented in order to build an in-depth, comprehensive understanding of how different engagement tactics are working "in the real world." The pilot was planned in a way that allowed us to observe, measure and capture learnings, document best practices and lessons learned, and provide resources and tools for other partners, grantees and/or schools to implement their own versions.

Why Focus on Schools?

We know schools are trusted messengers in their communities[1] and in some cases a source of wrap-around services for children[2] (free and reduced lunch services, services for special needs children and more in the setting of a Community School). We also know that kids attending schools with leadership that encourages vaccination against COVID-19 are 4 times more likely to be vaccinated.[3] Additionally, individual teachers, school administrators and staff know their students well and how to best communicate with families. For these reasons, we believed it was imperative that when COVID-19 vaccines became available for children ages 5-11, that schools provided, at a minimum, accurate information about the safety and efficacy of COVID-19 vaccines and a strong recommendation for students to receive the vaccine. Additionally, schools could identify additional protective benefits of a highly vaccinated school community including fewer cases of illness (and thus teacher and student absence), reduced educational delay that results from prolonged absences, and reduced likelihood of a requirement to transition to virtual learning (which greatly impacts family life). Ideally schools would be able to partner directly with their local health department and/or other community based organizations to ensure that parents receive timely and accurate information about the vaccine and provide vaccine access at the school.

Additionally, when COVID-19 vaccine became available for 5-11 year olds (on November 2, 2021), mass vaccination sites that had previously been available to vaccinate people 18+ starting in January of 2021 had largely closed. Because the initial vaccine order amount was higher than the expected use and scheduling COVID-19 vaccines with pediatricians would be a challenge given their limited time to see patients, it became clear that only a small percentage of pediatricians were signed up to receive vaccinations for this population. COVID-19 vaccines for this age group would be largely available through a network of pharmacies, large medical groups with the ability to set up clinics, health centers, public health departments and children's hospitals. While these locations could serve a large number of children, access barriers still exist for many families (including but not limited to transportation, scheduling, access to accurate information, and language access.) Given

[1] Community Members Trusted by African American Parents for Vaccine Advice
[2] Establish Community Schools and Wraparound Supports
[3] KFF Vaccine Monitor: Winter 2021 Update on Parents' Views of Vaccines for Kids

that by this point in the pandemic, it was clear that vaccine clinics could "pop-up," schools, with the space, infrastructure, trusted messengers, and a large number of children to be vaccinated, would be ideal settings to vaccinate children in a community all at the same time, thus providing protection against COVID-19 quickly and uniformly.

Made to Save's mission, partner network, technical expertise and guidance aligned well to implement and guide our pilot locations to provide hyper-local support with community-led ownership and positive results for their community. For schools, this type of partnership could provide a way to keep kids in school safely and reduce the burden of COVID-19 within the community without having to become public health experts themselves.

How we built our pilot

The school pilot program goal was to ensure kids ages 5-11 had equitable access to COVID-19 vaccines through school-based vaccine clinics with the added benefit of ensuring their parents had access to accurate information about the vaccines using trusted messengers in their communities. Trusted messengers came through partnerships in the community - individuals working in community based organizations, local trusted health clinics, local pediatricians and family physicians, vaccinators, health navigators, community health workers, local health departments and other local trusted organizations and individuals, including school leadership and staff. All participating coalition members gave their time voluntarily but saw the potential for collaboration across groups.

Made to Save observed and helped strengthen partnerships in 4 locations and offered additional support throughout the pilot period by measuring increases in vaccine rates, learning what barriers existed and providing resources as requested. Made to Save encouraged building trust within and amongst community members using the TEO method at the center of all communications.

Our Plan

The pilot plan involved 4 main steps. These steps were implemented by each pilot location as capacity and interest allowed. Variations by location can be seen in each individual location's timeline and metrics document.

In addition to the steps outlined below, the coalition of 4 locations and Made to Save staff met every other Wednesday to share new resources and information, report on progress and help each other think through challenges. Made to Save led these calls and shared resources including planning and tracking documents, links to online training and events, and written resources that could be shared with parents and others.

Step 1: Initial survey - An initial survey was suggested to pilot locations to collect vaccination rates amongst the school community including adult vaccination rates, vaccination rates of 12-17 year olds and the intent to vaccinate kids 5-11 years old. Also included in the survey was a question asking if parents would be open to having their children vaccinated at the school and any reasons why they did or did not intend to vaccinate their children. The survey results would be used to inform how to best move forward with communication and vaccination.

Step 2: Sharing accurate information with parents - Using information from the survey, we encouraged pilot locations to target messages to parents about the safety and efficacy of the vaccines through flyers, emails, school social media posts and meetings. We encouraged pilot leads to make healthcare professionals available to answer questions from parents with fears, doubts or additional questions about the vaccine.

Step 3: School located vaccination clinics - Through a partnership with a local vaccinator (health clinic, mobile health unit, local pharmacy or hospital or school based health clinic), a vaccination clinic would be scheduled and run at a school at a time that was convenient for the students and parents. Healthcare professionals should be on hand to answer questions if the clinic happened outside of school hours and if outside school hours, include access to vaccines for community members.

Step 4: Follow up survey - Follow up efforts from steps 2-3 with a survey to measure any changes in vaccination rates in all age groups, ask where parents had children vaccinated and what sources of information were helpful in making the decision to vaccinate (if applicable). We used this as one possible measure of success of the pilot program.

Measurement

Our guiding principle of using survey research for the schools pilots program was to provide the opportunity for each pilot location to conduct a baseline and follow-up survey to meet their needs.

MTS provided templates for surveys and consent forms, which were available in digital and hard copy print formats in both English and Spanish. Each location made individual decisions about whether it was appropriate and capacity was available to distribute the survey in the format that was best suited for their audiences. MTS also supported data analysis and interpretation for each location when it was desired by the pilot locations and learnings were also shared with the broader schools pilot coalition during coalition calls and with school pilot partner organizations throughout the program.

Detroit and Rural Arkansas locations utilized MTS survey templates. Arkansas requested paper copies as internet connections are not reliable and paper is still preferred. Birmingham City Schools implemented their own survey but built some of their questions off of our survey. Delta Health Centers decided not to survey their school population on account of being an over surveyed region and the fact that their organization already has strong ties within the school system.

Baseline Survey

The purpose of the baseline survey was to collect an initial pulse of parents' intentions to vaccinate their children and their potential openness to vaccinating their children at school. Concerns and misinformation that were shared in the open-ended section were used to

inform materials in outreach. Data was collected between November - December 2021, which was shortly after the Pfizer vaccine was given emergency use authorization for 5-11 years.

Families were invited to complete one survey per household. The surveys were anonymous though parents were asked to indicate which school(s) their children attended.

Follow-Up Survey

The purpose of the follow-up survey was to assess the potential impact of vaccine outreach in each location. In addition to asking similar questions to examine movement that might have resulted from the school outreach efforts, we collected information about exposure and helpfulness of vaccine outreach materials.

Similar to the baseline survey, families were invited to complete one survey per household. The surveys were anonymous though parents did indicate which school(s) their children attended. We did not specifically seek to contact the same families (as the surveys are anonymous). The surveys were collected February - March of 2022.

Opportunities and Challenges of Measurement

Collecting original data has many advantages, though does create additional capacity demands that need to be weighed when deciding to pursue a research component to a vaccine program.

Baseline survey data allowed locations to both develop opportunities and identify potential challenges in vaccine outreach. For example, for both Rural Arkansas and Detroit, the majority of adults in the household had already been vaccinated, even though most children (in both age groups) had not. This evidence indicated audiences in this location may not necessarily need to be convinced about the utility or safety of the vaccines in general, but emphasizing the importance of vaccines for youth specifically. Responses to open-ended prompts also highlighted misinformed beliefs that could be addressed in vaccine outreach as well. These insights can streamline planned vaccine programming and costs.

Follow up survey data allowed locations to see the potential impact of their outreach. Vaccination rates at baseline and follow-up can be compared and participants can identify what sources of information, events, or resources prompted vaccine decisions.

Most importantly, data is most useful when a location can be confident it can get large buy-in for participation where the sample data would adequately represent the location. One should avoid relying on completely voluntary responding (as only those most interested would participate). If communities are resistant to taking surveys, locations would need to have a larger capacity to do more pervasive outreach, such as the Rural Arkansas team. It may not be worth the strain on time and resources if adequate measurement cannot be obtained. Stronger research designs could also consider doing "intervention" and "control" locations where outcomes could be compared or compare a specific household's responses at Time 1 and Time 2 (rather than at aggregate), though would require even more resources and capacity. These more intricate designs should only be used when trying to scale a program to more locations, ensuring it is worth the investment.

Individual location timelines and metrics

The coalition of school pilots included partners from 4 locations: Birmingham Alabama, Rural Arkansas, Detroit Michigan and the Mississippi Delta region. Participants from each location were invited to attend bi-weekly meetings facilitated by Made to Save. Coalition meetings were a space to share information, resources, ideas, wins and challenges as well as progress in all 4 steps of the plan. Each individual location timeline and metrics document linked below provides a snapshot of the distinct work done and any data that was collected in that location.

1. **Alabama**
2. **Arkansas**
3. **Michigan**
4. **Mississippi**

What we learned - Challenges

Made to Save and all pilot locations had successes and challenges along the way, but together we shared the wins and supported each other through the challenges by thinking through solutions or providing expertise and/or resources. Every location approached the goal slightly differently but all have had an impact in their communities. In addition to the school pilot program, other MTS grantees worked with their local school districts and schools to coordinate sharing of accurate information and vaccinations on school grounds.

Planning and tracking

In the process of developing the plan, MTS built a series of forms to track participants, outreach and vaccine clinic information in Airtable (our customer relationship management (CRM) platform). This platform, while easy to use, was an additional step that individuals had to do in order to share information with our team and ultimately was not used for the duration of the pilot. When we realized that this platform would not be utilized, we created a simple checklist that included the information we hoped to collect and shared it with the coalition. That guide provided a set of expectations, but we ended up collecting information about outreach efforts by diligently taking notes during our coalition meetings and requesting vaccination numbers either just after events or after each location's efforts timeline document was finalized.

Timing of vaccine authorization for 5-11 year olds

Given that the authorization of COVID-19 vaccines for 5-11 year olds came in early November meant that schools had to get accurate information out to parents during a busy season - Thanksgiving holidays and winter holidays made it difficult to schedule information sessions and clinics in late November through early January.

In mid-December the Omicron variant hit the US and caused many schools to close in early January due to school staffing shortages. Some clinics that had been working on

vaccinations had to pivot to providing capacity for testing during the surge. In addition, winter weather also created a challenge in locations like Detroit where it was clearly unsafe to hold a clinic indoors at the peak of the Omicron surge, and so drive-thru clinics were set up and workers had to work in sub-freezing temperatures.

Feedback from coalition members about the pilot

In wrapping up the pilot program, Made to Save conducted interviews with members of the coalition to collect data, information and lessons learned throughout the pilot. In those interviews, we also asked whether being part of the coalition with Made to Save was helpful, what impact it had in their work on the ground and what, if anything, they would have done differently. Leaders from each location indicated that the coalition was helpful in sharing ideas, challenges and problem solving in addition to having a community dedicated to doing this work that provided motivation and accountability.

Conclusions

The Made to Save School Pilots Program aimed to observe, support and learn lessons from how school based COVID-19 vaccination clinics could be built in partnership with community based organizations, increase awareness with accurate information about COVID-19 vaccines, ensure equitable access to vaccines for children 5-11 years old and impact local vaccination rates. In the process, we formed a community of COVID-19 vaccine educators, vaccinators and champions as we navigated ways to ensure access. We learned that leaning on others who are doing the same work in different locations can be a motivator and creates community that is necessary as the work to convince folks to get vaccinated becomes harder. Schools are excellent locations to work in for ensuring equitable access to vaccines for parents who cannot take time to schedule or find transportation to other vaccinators. School leaders have a stake in keeping their school community safe including staff, students and families, but need help from other community trusted sources to help educate families while they work hard to keep kids safe in schools. It's hard work, but building community partnerships with the goal of increasing vaccination rates in children ages 5-11 is well worth the effort, especially as masking mandates are being dropped and vaccination rates amongst this age group are not sufficient to limit spread in indoor settings. As we see

the BA.2 variant increasing across the country (which is more contagious than even the BA.1 variant), the time is now to implement school-wide efforts to vaccinate children and avoid massive spread.

MTS Staff on this project

- Public Health Partnerships:
    - Diana Newhart, Director of Public Health Partnerships and School Pilots Co-Lead
    - Sarah Kumi, Public Health Team Intern (Winter 2021/22 and Spring '22)
    - Yael Rabin, Public Health Team Intern (Spring '22)
- Program:
    - Jess Montgomery, Deputy Director of Program and School Pilots Co-Lead
    - Adriyanna Andreus, Regional Program Director (AL, MS)
    - Susana Raquel Berger, Regional Program Director (LA)
    - Terryn Hall, Regional Program Director (MI)
- Training:
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    - Raelyn Roberson, Training Consultant, Training host for AR Department of Education training
- Research and Impact:
    - LeeAnn Sangalang, Director of Research and School Pilots Research Lead
    - Megan Canfield, Research and Impact Intern (Spring '22)
- Digi/Comms:
    - Francisco Hernandez - Digital Associate, Video lead

Addenda:

All documents linked below (including this report) are housed on our website.

1. Project Timeline
2. Surveys
    a. Initial survey in English
    b. Initial survey in Spanish

    c. Follow-up survey in English
3. Alabama: Birmingham City Schools Timeline and Efforts
4. Rural Arkansas Timeline and Efforts (including survey results)
5. Michigan: Detroit Change Initiative Timeline and Efforts (including survey results)
6. Mississippi: Delta Health Centers (Rural MS) Timeline and Efforts
7. MTS Shared Documents and Resources