MODULE FOUR

Building Cross-Institutional Partnerships to Develop and Sustain School- & District-Level Vaccination Clinics

An Introduction to the Theme, Issue, or Problem of Practice

This module showcases the importance of building effective community partnerships as an essential component of addressing declining student vaccination rates. It emphasizes the major implications of such partnerships for addressing problems of practice in general—and the critical need for community representation in efforts to increase vaccination rates. The module emphasizes the power and significance of Communities of Practice as collaborative structures to identify and address significant problems of practice facing schools, districts, and regions. A major focus of this module is the critical importance of streamlining student and family access to vaccination clinics, including examples of state and district efforts to create school-based and community-centered vaccination and health service clinics.

Essential Questions

- Why is it essential for community members to become actively involved in increasing vaccination rates among school children?
- How can educational leaders successfully engage community partners in understanding the importance of this effort and the power of localization of student health services (e.g., school-based clinics)?
- How can districts and schools establish partnerships with community organizations to form Communities of Practice to ensure equitable student and family access to vaccinations and related health services?

Outcomes

Analyze the key components of an effective school-based vaccination clinic as it evolves from initial design and implementation to sustainability.

Explain the significance of community understanding and involvement in addressing the issue of declining student vaccination rates extending from the COVID-19 pandemic and the role of community partners in school-based vaccination clinics.

Identify key strategies and processes that educational leaders can use to engage community partners in addressing the issue of declining student vaccination rates and the development of one or more school-based vaccination clinics.

Form "Communities of Practice" to reinforce community support and engagement in increasing student vaccination rates.

Investigate the use of federal recovery funding sources to create and sustain school-based and/or community health clinics and vaccination sites.

THE POWER OF SCHOOL-BASED VACCINATION & HEALTHCARE CLINICS

The COVID-19 pandemic has raised the stakes for school districts and communities related to ensuring ease of access to healthcare services for students and families. Learning loss, declining vaccination rates, and growing evidence of trauma and mental health disorders are three powerful reasons that traditional ways of operating schools and districts are no longer viable. Unprecedented equity issues are especially evident and troubling, including the lack of easily accessed medical resources and facilities in many urban and rural centers.

The pandemic has also raised the level of income inequality in the United States, preventing many families from having the financial resources, transportation, and accessibility necessary for sustained healthcare and regular check-ups for both children and adults. Schools and districts have taken on an increasingly wider scope of responsibilities—from providing meal service to an expanded range of students and families to expanding exponentially the availability of mental health services to both students and staff.

Inevitably, school leaders will need to consider the possibility of partnering with families, community agencies, and governments at multiple levels to develop, implement, and sustain school and/or district-based health clinics that can provide vaccinations and related services to an expanded base of students. This module explores many of the key issues and processes educational leaders must consider to achieve this goal.

The Importance of Community Partners in Addressing Declining Student Vaccination Rates

When beginning the process of determining how and when to host a school-based vaccine clinic there are many community organizations that would be valuable partners for districts to engage. Local professional medical societies, physician practices, and hospitals can provide information about the vaccination program to their members, patients, and parents. Their leaders can be spokespersons for the media, and their members can even help staff the clinics. The local medical community could also help obtain donations (band aids, gauze, etc) and grants for the program.

In addition, local colleges and universities may be interested in partnering with the district by providing nursing, medical, or other faculty or student support for the clinics or other aspects of the vaccine campaign. The district could consider engaging faculty and students in the area of evaluation to help determine the impact of these clinics on community and student health. The faculty can be effective proponents of the program and can help write grants to enhance sustainability.

Vaccine manufacturers may also be worth connecting with due to their ability to provide small grants to districts that partner with local health departments. These grants could be focused on communication, toolkits and educational information about the vaccines themselves. Vaccine manufacturers may also be interested in providing free giveaways (e.g., stickers, pens, balloons, etc.) for children upon vaccinations. Nonprofit immunization coalitions and advocacy groups, such as the Immunization Action Coalition, also can provide educational materials and advice about influenza and the immunization programs of its partners.

The Benefits of a School-Based Vaccination Clinic

Enabling childhood immunizations to be given during the school day has both significant advantages and challenges. A major advantage is the ability of school-based vaccination clinics to ensure ease of access for students and families to these life-saving health resources. Scheduling of vaccinations can be arranged to ensure minimal interruption to students' time on learning. Additionally, school-based vaccination and health service sites are enormously important in addressing

equity issues, especially in urban and rural areas where accessibility to health services may be limited, cost prohibitive for some families, or challenging because of transportation issues. For example, the district can consider many locations for offering vaccines. Some of the most common are:

- Curbside or parking lot based.
- Gymnasium, cafeteria, auditorium
- Mobile units that may be run by the LDH or a school-based health center

Vaccinating a child during the school day does allow parents to remain at work and avoid having to find transportation for their child to/from a health clinic. It also prevents a child from missing school to go to a clinic and saves the parent money since the school district takes on the cost of funding the immunization.

A majority of school-based clinics identified in the "Case Studies" resource included with this module emphasize the value of the following practices:

- Offer vaccine visits to all siblings in a family group when scheduling an appointment.
- Screen for interest in COVID vaccine at all types of appointments.
- Offer same-day appointments available for students due for immunizations.
- Use sports physicals and well-child visits as an opportunity to update needed immunizations.
- Use time before and after vaccination to screen for social determinants of health, risk assessments, depression, other vaccine needs, and last well-child visit. Consider partners who can serve in this staffing role.
- Make forms available online so that parents/guardians can quickly fill out consents, even from their cell phones.

Design Options for School-Based Vaccination Clinics

Successful school-based vaccination clinics should involve a partnership between the school district and local public health organizations (LDHs). Superintendents should already have strong working relationships with local departments of health because of the COVID-19 pandemic. This makes it easer to begin the conversation of an annual partnership to offer immunizations to students in K-12 schools. Developing multi-year partnerships should be especially encouraged because they will help sustain a program over several years.

Local health departments exist at the city, county, metropolitan, district and tribal level. While they vary significantly in size, scope of programs and funding, all work towards protecting and promoting health in their communities and likely have received funding to prevent the spread of communicable diseases in the community in the past. One of the most important reasons for districts to partner with local health departments is that they have experience with procuring vaccines at the state and federal level. In particular, many of them may already participate in the Vaccines for Children Program (VFC) that is run out of the Centers of Disease Control and allows children who meet the following criteria to receive free vaccines.

As you consider the design, scale-up, and sustainability of school-based clinics in your district, consider the following design options available to you. Your final design choices will

depend on a range of factors, including geographic location, existing and proposed vaccination efforts in your region, staffing, billing and data management issues, and the needs of your particular district and its socio-economic conditions as well as population diversity. Here are the most common design models for school-based vaccination clinics:

1. School-Specific Vaccination Clinics: As we will see in the upcoming Anchorage case study example, vaccination clinics can be school-specific. School nurses are trained and equipped to provide required vaccinations. They are also responsible for data management and community outreach. This design is especially suitable for school districts with a geographically spread-out student population with significant physical separation from school to school as a result of large geographic distances evident across the system. It is essential in this model that partnerships be operational with local health providers, health organizations, and governmental agencies to ensure quality control and alignment with state and federal legislation and policy.

2. District-Based but Location-Specific Clinics: A second model for consideration is the use of multiple vaccination sites that are located within particular school buildings but serving students and families beyond the school's specific service area. For example, one school site might serve clients from multiple schools and communities. Once again, it is useful for partnerships involving local health and governmental agencies to be involved to ensure quality control and appropriate oversight. Record keeping and data management will also be slightly more complex since staff will need to maintain records that extend beyond the immediate population served by the individual school location.

3. Hybrid Models Involving Schools and Local Vaccination Providers: Many of the previous case studies presented in this toolkit reflect hybrid designs. A school district, for example, may elect to partner with a local pharmacy or related vaccination service provider. The benefit of such a model is that it streamlines record keeping and billing issues since that infrastructure is already operational within the partnering organization (e.g., pharmacies, local physicians offices and clinics, etc.). Typically, we see more evidence of hybrid models when vaccination clinics are operational on a limited basis (e.g., at the beginning of an academic year or semester). Such models frequently offer vaccination services at peak times of the academic year or during crisis situations such as the recent COVID pandemic. Models One and Two above more frequently operate on a continual basis with limited services provided during non-peak periods.

4. Integration Models Offering Vaccinations as Part of Comprehensive School-Based Health Clinics: Throughout the United States, we see an emerging emphasis upon this form of vaccination and health service delivery model. Integration models that are part of a comprehensive school-based health clinic represent a major breakthrough in addressing equity issues such as those that emerged during the recent pandemic. Specifically, comprehensive school-based health clinics can offer students and families (especially those with transportation or economic challenges that make it difficult to access community-based health services) a range of health services. Currently, vaccinations have taken an increasingly significant role in the range of services available at such clinics. Funding and staffing for such clinics require major cross-institutional partnerships and a community commitment to sustaining the availability of these comprehensive clinic designs and delivery systems.

Action Steps for Creating a School-Based Vaccination Clinic

A successful school-based vaccination clinic should be a partnership between the school district and local public health agencies. Superintendents should already have strong working relationships with local departments of health because of the COVID-19 pandemic and this makes it easier to begin the conversation of an annual partnership to offer immunizations to students in K-12 schools. Developing multi-year partnerships should be especially encouraged because they will help sustain a program over several years.

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- Medicaid Eligible: A child who is eligible for (or enrolled in) the Medicaid program
- CHIP Enrollees Within a Medicaid Expansion Program: A child who is enrolled in a Children's Health Insurance Program (CHIP) that is part of an expanded Medicaid program
- The Uninsured: A child who has no health insurance coverage
- American Indian or Alaskan Native: As defined by the "Indian Health Care Improvement Act," a child who is of American Indian or Alaska Native descent
- Underinsured: A child who has private health insurance, but the coverage does not include vaccines, a child whose insurance does not cover vaccines otherwise covered by VFC, or a child whose insurance caps vaccine coverage at a certain amount. When that coverage amount is reached,

the child becomes underinsured. Underinsured children may only receive VFC vaccines through a Federally Qualified Health Center (FQHC) or Rural Health Clinic (RHC).

- **Students with Health Insurance:** Students with health insurance can still participate in a school-based vaccine clinic, but the LDH has to ensure that they are charging their insurance for the cost of the vaccine.

A Few Additional Considerations:
School and district leaders have a range of resources available to them in supporting data analysis and interpretation of vaccination rates and trends among their students. For example, what happens with sports physicals for in-school athletics and community sports? Individuals involved in this work can become valuable partners in supporting this work. Name them so they aren't forgotten as part of the community. Similarly, many of us are now comfortable carrying around our vaccination cards, but it's often difficult for parents to put their hands on their children's shot records. By sustaining cross-institutional partnerships, we change that to make vaccine records portable in a way that makes sense. This form of data access is critical in light of frequent moves, changes in providers, and related factors that impact families' ability to track students' immunizations.

Students with health insurance can still participate in a school-based vaccine clinic, but not through the Vaccines for Children program. The district must work with LDH to ensure that they are charging their student's private insurance for the cost of the vaccine.

Of note, there are currently ten states that are universal access/universal purchase states (i.e., meaning their Vaccine for Children [VFC] program is open to any child with any insurance or income level, including students with private insurance). The following states offer universal access: Alaska, Idaho, Maine, Massachusetts, New Hampshire, New Mexico, Oregon, Rhode Island, Vermont, and Washington. In these states, the local government purchases all recommended vaccines for all children, including those who are fully insured. Four other states (Connecticut, Florida, South Dakota and Wyoming) have universal select programs that purchase all recommended vaccines for all children with the exception of one or more vaccines.

There are several reasons why it makes sense for the Local Department of Health (LDH) to manage the procurement of the vaccines and partner with districts in the delivery of vaccines to students. An LDH can receive, store, and distribute vaccines as well as discard or return unused vaccine doses. Most health departments have the capacity to store vaccines in large quantities according to manufacturer specifications, whereas most schools do not. Some but not all local health departments have sufficient staff that they can provide leadership and staffing for each clinic.

If the LDH is a partner in the VFC program or a direct grant recipient of this funding then they are already charged with performing the paperwork; ordering, storing and distributing vaccines; complying with changing state and federal regulations; evaluating the performance of the clinic; conducting site visits at the school; and managing the return of any unused vaccinations.

As we will see in the example in New Britain, Connecticut, districts that have school-based health centers may also participate in the VHC program or have the capacity to host school-based vaccination clinics for certain populations of students. However, it is more likely that these school-based health centers offer vaccinations on an ad-hoc basis for students who are behind on required immunizations.

Addressing Staffing Implications

The size and duration of the clinic as well as the partnership the school district has with a local health department all factor into the staffing of the clinic. Some districts have relied heavily on staffing by having local district health workers who bring in their own medical and administrative staff to handle the paperwork and administration of the vaccine. Others prefer to have their school nurses involved in the vaccination process and rely on other K-12 staff members (including educators and administrators) to oversee the clinics. In general, the district needs to ensure they have staff assigned to the following duties:

- Organizing the paperwork for each child ahead of time to ensure a smooth and efficient arrival process
- Organizing the schedule for student vaccinations based on age/class and availability of students and teachers
- Administering the vaccines themselves and associated paperwork with the vaccines
- Providing emergency medical services if needed

If community members are invited to participate in the clinic, staff who can serve as translators would be important additions to include as well. Any non-school personnel engaged in the clinic should meet normal standards for volunteers at the school, including but not exclusive to background checks. Further, for districts with collective bargaining agreements, the district should review any staff members who are required to work longer or different hours or to perform different duties and what is required for their

contractual compensation.

Non-medical, non-public health department staff can also provide invaluable support and assistance in this initiative:

- Assembling, distributing, and collecting vaccine information, consent forms, and other materials
- Communicating with parents/guardians (e.g., to encourage return of consent forms if consent is required prior to the clinic day)
- Assisting with the promotion of the clinics (e.g., placing posters, posting information on school website, communicating with local radio/television/newspaper)
- Assisting with clinic flow and escorting students to and from the vaccination site
- Verifying the identity of each child to be vaccinated to ensure that parental consent was given
- Assisting with the transportation of vaccine and other materials to and from clinic sites
- Providing security
- Tracking and entering vaccination information into immunization registries or other databases.

Medical, non-public health department staff (depending on licensure and training) can also be highly productive contributors to school-level and district-level vaccination clinics and initiatives, including:

- Preparing and/or administering vaccines
- Ensuring that vaccination medical screening eligibility has been met
- Evaluating children for illness when they present to the clinic for vaccination

Document and Data Management

There is a large amount of data to track within a vaccine program year and it is critical that multiple organizations could access data as needed. Since school level data (enrollment, language distribution, class size) may affect many different aspects of the program, one district kept a "master" database with this type of information. All subsequent spreadsheets were tied to this master database that was only accessed by key program staff. This ensured that if information about a school was updated, that information was updated in all possible places. The district uses spreadsheets for the following:

- School communication tracking (assure each school receives the same information on the same timeline)
- Print production and material delivery (e.g. number of promotional materials and consents, by language, to be sent to each school)
- Supplies inventory
- Vaccine inventory
- Vaccine packing projections (how much vaccine of each type should be packed for each school's event)
- Budget resources, oversight, and quality control

Resources for School- & District-Based Vaccination Clinics

This module provides resources that can be used by educational leaders and their staff to address professional development related to helping staff understand and address key logistical issues related to developing and sustaining viable student vaccination clinics. The module includes:

01

Case study summaries of exemplary school- and district-based vaccination and related healthcare clinics, including exemplary sites serving urban and rural populations with limited access to healthcare services

02

An annotated list of potential resources for use by study groups and action research teams engaged in addressing the issues involved with parent and family hesitation and/or delay in vaccinating children

03

A planning guide summarizing key benchmark points related to the development, implementation, and sustainability of school- and district-based healthcare clinics. Such clinics are designed to expedite ease of vaccination access, implementation, and sustainability to promote vaccination access

Like every module in this toolkit, Module Four concludes with a self-reflection questionnaire for educational leaders. This one focuses upon key issues and priorities leaders should consider in designing, funding, and maintaining easy-to-access healthcare services for students and families.

Case Study Examples of School- & District-Based Vaccination & Related Healthcare Clinics

Directions: The following case studies can be used by educational leaders to showcase examples of vaccination and health clinics currently in operation throughout the United States. Study teams and discussion groups can explore a range of questions about each case study, including:

- What are the key structural components of the clinics showcased in this case study?
- What are the potential implications of this case study for our school or district?
- What are the universal components of this case study that might be applied to any school or district vaccination or health clinic?
- What are the unique circumstances described in the case study that may be difficult to replicate?

1. Health and Vaccination Clinics in Kennett School District # 39, Kennett, Missouri: Kennett School District currently has 1,941 students in grades PK through K-12 and a student-teacher ratio of 13 to 1. The Kennett School-Based Health Center has two sites: the Kennett South Elementary Clinic and the Kennett Masterson Elementary Clinic, both of which are open from 7:30 a.m. to 4:00 p.m. Mondays through Fridays. Each of clinics emphasizes both medical and behavioral health services.

   The Kennett Health Clinic model started with a partnership with the local health department, with an initial alignment with kindergarten enrollment—a focus that has continued for over 20 years. Initially, health workers would visit buildings to be on-site for one or two days during the week. This partnership proved especially critical since health department employees had the relevant records to ensure that the child was immunized and could start school on time.

   The services provided by the clinics eventually extended to a more formalized partnership with the SEMO Health Network. School-based clinics were eventually formalized and designed to offer an extended range of vaccinations, including HPV and Meningitis vaccinations. Clinics also began to offer flu clinics for staff, a process that occurred informally for over 10 years before the Kennett Health Clinic model was designed and implemented at the two designated elementary sites. In fact, before COVID, there were several years in which the clinics did close to 1,000 flu shots. Typically, the clinics have 120 staff members out of 280 who get the flu shot there.

   Program leaders emphasize that one of the challenges of a school-based vaccination and health services clinic is to ensure that the partner health agency participates in the VHC program and that it has a way to bill insurance for students who have private insurance and don't qualify for vaccinations through VHC.

   Kennett is proudest of its efforts to ensure that students receive flu vaccinations. Ensuring the success of the clinic requires considerable parent and family outreach. For example, clinic personnel sometimes do a robocall with parents regarding flu consents. They have also sent a letter a couple of weeks before the vaccine and say: "We have a consent on file for your child and want to make sure your child still wants to have the vaccination." The ones for whom they don't have consent forms, they say: "We don't have a consent form at this time, but are you interested in your child getting the flu shot?"

   In advance of the clinics, school nurses go through the consent form and make certain that it's all filled out. They prepare a folder of each child with name/date of birth and order information by classroom. When the health care agency arrives, they usually bring their own nurses and have their own person who focuses on appropriate documentation. The vaccination process can move quickly because they also have school staff pulling students from their classes to take them to the vaccine site in the building. The district vaccination clinics can give 200 flu shots in 1.5 hours. The agency provides the administration of the vaccine.

One issue the district had to overcome was an increased level of missing or unaccounted for students as part of the vaccination process. For example, if many students are absent, the FOHC has offered to come back and do an extra day to ensure students are vaccinated. However, scheduling another clinic is not an easy process.

2. Vaccination Initiatives in Lockwood Schools, Montana (https://www.lockwoodschool.org): Lockwood Schools is located just east of Billings, Montana. Over 1,300 students (K-10) attend school on the single campus. After granting funding approval in 2018, the school district opened the Lockwood High School to students in August 2020. The new school has 400 students, but the challenge of COVID-19 continues to impact the district.

For example, during the 2021 opening, two percent of those students became ill in a single day, with the local hospital required to take 212 students away for contact tracing and reporting results to the county health department. Additionally, 50% of students in the district receive Free and Reduced Lunch, necessitating delivery of health and related services in alternative settings to traditional clinics and other resource facilities. The large percentage also accounts for lower required vaccination rates than typical suburban school districts. Additionally, the district has recently experienced a major increase in the request for religious exemptions related to required vaccinations.

The district offers a van/mobile clinic for vaccinations since the community has no medical facilities other than a dentist and chiropractor. Currently, the area has no pharmacy, and Billings, Montana, the largest accessible city, is also difficult to access for many residents. The result is that Lockwood has joined in a partnership with the Sisters of Charity of Levinworth to offer a medical clinic in an 8,000-foot facility convenient to residents.

Given the lack of medical resources and facilities, the school district is making strides to provide health maintenance services to staff and families. For example, the district does a big health screening process (including flu shots) every year and also offers cholesterol screenings in its high school gym.

Messaging is a key component of Lockwood's approach to the vaccination issue. For example, with its vaccination campaign, staff members just present the facts: Here is when and where we will offer a vaccination clinic. Staff members are encouraged to present information in a straightforward way. Leaders also cite positive and ongoing communication and outreach to staff to ensure consistency of messaging and parent/community outreach. Information is put out through the district's regular website, social media, as well as a calling system (i.e., emails to parents along with phone calls).

According to district leaders, a key reason for doing this work and ensuring its sustainability is vaccination equity. They reinforce that the equity commitment is a chief reason for developing the new clinic. There is a clear realization that without such a facility, upper middle-class students would receive health services, but the 55% of students from lower socioeconomic circumstances would not receive services because of issues such as travel, financial resources, and logistics.

Case Study Examples of School-Based Vaccination Clinics

Directions: The following additional case studies emphasize the unique as well as universal features of a school-based/ school-level vaccination clinic (SLV). In considering these components, you may wish to use the following guide questions:

- Why did leadership elect to use a school-based approach to vaccination clinics?
- To what extent does the SLV model reflect the priorities presented in district-level approaches?
- How does a school-based clinic provide unique opportunities as well as challenges for district leadership?
- In comparing the two approaches, which one seems to be the best fit for your district?

1. Anchorage School District (Alaska): Anchorage SD is Alaska' largest district, serving families in Anchorage, Eagle River, and Girdwood. The district manages all public schools within the Municipality of Anchorage and is the 97th largest school district in the United States, serving nearly 50,000 students in over 90 schools. The district's student population includes the following: 41% White, 5% Black, 11% Hispanic, 17% Asian/Pacific Islander, 9% American Indian/Alaska Native, and 15.78% Multi-Ethnic. The district serves approximately 8,6000 students with special needs who are eligible for Special Education services. The district's English Language Learner program serves approximately 5,800 students. Nearly all Anchorage students are now eligible for free breakfast and lunch.

   The district offers a comprehensive set of vaccination options for students and families through the Vaccines for Children program. According to Jen Patronas, Senior Health Services Officer, the district initially had Pertussis practice rounds in anticipation of COVID pandemic, working closely with regional leaders. However, the district currently offers all required student vaccines, including a commitment to keeping a limited number on hand in schools.

   According to Jen Petronis and Kathy Bell, Assistant Directors of Anchorage Health Care Services, the district administered 72,000 vaccinations between 2020 to the present. Anchorage decided to offer a comprehensive vaccination program for students and families since parents were experiencing challenges in getting their children to clinics for vaccinations. Additionally, Medicaid now pays for all vaccines in the state for free. Although health providers can charge a $25 vaccination fee, they cannot bill if a family cannot afford that charge.

   The district is also in the process of expanding available vaccination services. For example, the district just ordered 16,000 vaccines for schools.

   Parent outreach, engagement, and communication are a critical part of improving vaccination rates in the district. For example, Anchorage requires elementary parents to be present during vaccinations since incidents have occurred where students forged parents' signatures (i.e., parents cannot write in English or do not understand the value of vaccines). The district also now uses Parent Teacher Conferences to emphasize the value of flu and other vaccinations. Staff members also use pick-up and drop-offs at school as opportunities to encourage vaccinations. Nurses are especially effective at recognizing opportunities to promote vaccinations. For

example, one high school nurse has integrated vaccination opportunities into a health fair she has coordinated since many high school students and parents attend the fair.

Petronis and Bell also stress the critical importance of pre-planning in order to make district-supported vaccination clinics successful. This process requires logistical management and a high level of communication that include outreach campaigns to parents. They also emphasize the value of cross-institutional partnerships involving local health services and agencies, pharmacies, and governmental offices. A coherent, integrated approach to the process can ensure that vaccine hesitancy and misconceptions are addressed in a timely manner. It also reinforces the power of partnerships in acquiring and sustaining funding and support resources (e.g., refrigeration) needed for long-term sustainability.

In a large district like Anchorage, the health team gives significant discretion to individual school nurses for determining how they do family outreach. They believe that the nurses at individual schools will best know how to connect with families about the vaccination opportunities available to them—and assuage any concerns they may have about vaccinations. They also have discretion about when they offer vaccinations, with some choosing to offer them in the evenings.

Anchorage is the only school district in the state to have state-required vaccinations readily available in its district. It serves the largest population in the state, and its administration supports this initiative. Leaders interviewed emphasize that superintendent, school board, and related administrator support is the number one requirement for building and sustaining a school-based vaccination program.

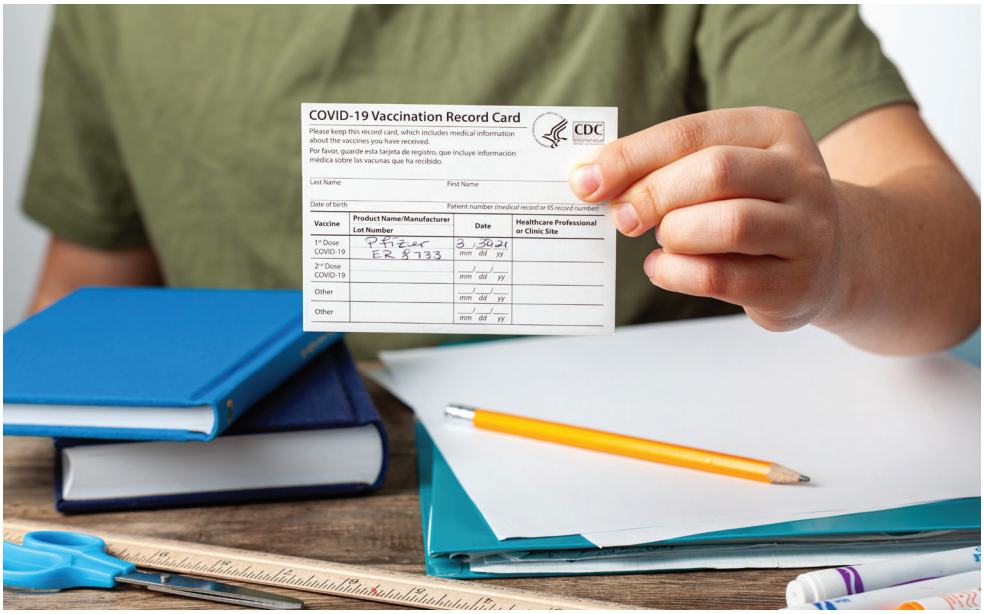
2. **Palm Springs Independent School District (California):** The Palm Springs Independent School District (PSUSD) serves 21,705 students with a majority Hispanic population. It has 1,273 staff members with 1,269.5 FTEs. The district currently has 21,042 (i.e., 89%) of its students identified as qualified for the Free and Reduced Meal Program. Currently, 5,676 students are classified as English Learners. Ten to twelve percent of the student population is identified as Special Education. The district provides support for students who have special health needs, as well as expressing a deep commitment to promoting positive health for all students.

   The decision to develop and sustain school-based vaccination clinics in the district resulted from a combination of factors. California has some of the strictest requirements for vaccinations in the United States. According to Laura Dyson, a Registered Supervising Nurse for the district, "We foresee there may be pushback. We have a high vaccination rate, but we are keeping track of the information as we acquire it. For the other required vaccines, we did see a drop in vaccination rates. We allowed students to continue in enrollment because of getting students to doctors' offices (many on virtual). If they are in-person, they must be compliant. I have a lot of students not in compliance. Early August of 2021, more than a thousand kids were non-compliant. We partnered with BORREGO Health and other partners—piggy backing with COVID, as well as flu and other vaccinations."

   Borrego Health (i.e., the local health organization with clinics in Cochella Valley where the district is located) has established and reinforced a community partnership with the district and other local organizations to ensure vaccination success. This multi-year initiative ensures ease of access to vaccinations via school sites while ensuring that Borrego Health is responsible for billing and parallel record keeping and compliance with state requirements.

   What is required of the district and what are the various roles that partners play? How in the past has the district accessed the opportunities the resources and options inherent in such a partnership? The district conducts twice yearly meetings with Borrego Health, correlating dates and clinic options to ensure that they are compatible for school schedules and Borrego resources. In light of recent conditions, the clinics now require that parents sign up for vaccinations rather than previous walk-in options. According to Laura Dyson, the result has been a decline in participation for some parents and families.

Typically, PSUSD and Borrego offer vaccination clinics a couple times a year, including options for both required entry-level vaccinations and additional options to ensure that all students entering seventh grade have their required vaccinations. The district also ensures that all students who need them get required doctors visit. A physician must be on site if this process occurs. Mobile vaccination vans are also used, including options for Borrego to request a room inside schools (e.g., cafeteria, gym) since vans fill up quickly.



Usually, Borrego will identify how many students are non-compliant with state immunization laws and will try to provide incentives to encourage greater vaccination rates. One way they do this is by offering a Thanksgiving dinner package at each school site. When students are vaccine compliant, they can be entered into a raffle to receive a full Thanksgiving dinner. The same process occurs again at Christmas time. Vaccination clinic leaders confirm the value of such incentives as motivators to ensure the greatest levels of participation as possible.

The partnership with Borrego ensures that communication and outreach to parents and community members are maximized. Borrego typically takes care of outreach, including calling parent phone calls and handling forms for signature by parents. Nurses help in publicizing options. The district also has a letter it sends out about clinics that families can access. In the spring they also offer the clinics—so early planning is essential.

Social media is essential to family and community outreach. For example, the district uses its Communications Coordinator to create flyers and do promotions via Facebook. Clinics typically run from 10:00 a.m. to 5:00 p.m. At middle school, the district typically runs three to six or seven clinics annually. The range of available times has been a major benefit for parents and families to accommodate their schedules and work hours.

3. New Britain School District (Connecticut): New Britain School District is a public school system located in New Britain, Connecticut. It has a student population of 10,032 in grades PK-12 with a student-teacher ratio of 14 to 1. The district has one high school, three middle schools, and ten elementary schools. It currently ranks as the 31st most diverse school district in Connecticut out of a total 130 districts. 100% of the district's students receive Free or Reduced Lunch.

   New Britain's population is 65% Latino. It has a high level of need related to Special Education as well as mental health. The district also serves a high proportion of immigrants, especially Middle Eastern families coming from Yemen. Students frequently display physical needs and mental health needs extending from trauma.

   Ensuring student and family access to healthcare services is a priority for Superintendent Nancy Sarra. During her tenure, she ensured that every school (when it is renovated) contains a health center. Parents also now have access to some critical wrap-around services in every school. The district chose to prioritize childhood immunizations and healthcare services to promote family engagement. The district has examined persistent problems such as Pre-K students getting ill with contagious outbreaks and illness—and has sought solutions to these issues.

   When a parent registers their child for school in New Britain, the parent is asked whether they would be interested in accessing school-based health services. In addition, they are making appointments for families to register students to ensure that district healthcare workers are there to facilitate the central registration process. They also provide translations in multiple languages of services and healthcare opportunities available to families. Parents acknowledge the value of this one-stop shop approach, including the availability of buses to promote ease of access to the centers.

   The New Britain school-based health centers can service any family residing in the district, providing immunizations to reduce students who are noncompliant with state immunization laws. Chronic absenteeism is a key performance indicator in the state accountability system for increasing the achievement of the district.

Suggested Resources for Study Groups & Action Research Teams

Directions: The following suggested materials and resources are ideal starting points for school and central office-based study groups and action research teams investigating strategies and processes for designing, implementing, and sustaining school-based and district-based healthcare clinics, including expanded access for students and families to required vaccinations:

1. Overviews of Successful Strategies and Examples of School-Based and District-Level Vaccination Programs: The following resources provide detailed suggestions and recommendations for developing, implementing, and sustaining successful vaccination clinics at the school and community levels:

   - https://www.astho.org/Programs/Preparedness/Public-Health-Emergency-Law/Public-Health-and-Schools-Toolkit/Vaccination-Clinics-in-Schools/
   - Here is an example of how to set up a school-based vaccine clinic: https://drive.google.com/file/d/1xbtwakMKkgJX-iv5JF6ubmkKOYcSlmhR9/view

2. Promoting Parental Support and Buy-In for School- or District-Based Vaccination Clinics: The linchpin of successful school vaccination efforts is obtaining parental consent and buy-in. It is important that districts begin these efforts as early as possible, starting with the first week of school. There benefits to distributing school vaccine materials at the beginning of the school year along with other back-to-school forms and information. One example would a letter from the principal or superintendent to parents that could be similar to this one: http://preventchildhoodinfluenza.org/keep-flu-out-of-school/school-resources/communication-templates-tools-resources/letter-home-english.docx. Similar to other information designed for parents, all information around school vaccination efforts should be translated into different languages spoken by families in the district to maximize parental understanding.

3. The Power of Immunization Managers as Partners: Successful school-level and district-level vaccination services are inevitably implemented with partners, including pharmacies already equipped to handle patient registration and consent processes with electronic or online platforms. The hyperlink included with this resource provides readers access to a comprehensive resource collection and report highlighting reflections by immunization managers involved in school- and district-level vaccination services. Participants found it helpful when consent forms could be completed and shared electronically through apps such as VaxCare or input-adapted PDFs that parents can sign and return directly to schools or their partners. PrepMod was also mentioned as a helpful clinic management system for parent consent, scheduling, and data tracking and sharing with IIS.

   Other participants shared that it is helpful when partners allow parents to give consent by phone. Among school-level vaccination service providers who handled parental consent without a partner, several found it useful to collect consent for both COVID-19 doses on the same form, reducing back-and-forth with parents and increasing completion of the series. Participants also shared that onsite paper consent was easier to obtain when there was a large area for families to fill out paperwork, allowing for physical distancing, and SLV staff on hand to assist with forms. This resource collection can be accessed using the link: https://cdn.ymaws.com/www.immunizationmanagers.org/resource/collection/C51290B5-3749-4FC1-8F88-330CF4266E05/SLV_Roundtable_Report.pdf

4. Sample Data Collection and Program Evaluation Resources: This set of resources can be accessed via https://www.shootheflu.org/toolkit/evaluation-tools/. Materials include (a) a school staff survey meant for the primary school point of contact. A paper version can be handed to them to fill out while the child or family is there being vaccinated. The survey can also be sent electronically after the vaccine day. Online survey software such as SurveyMonkey or SurveyGizmo provided survey analytics but surveys can also be sent at no cost using Google Forms; (b) a parent/guardian survey and consent form: The consent form includes the question: "May we contact you for feedback on how to improve this program?" If the parent or guardian indicates "yes" and provides an email address, an electronic survey can be sent in English and Spanish. This is an easy process but excludes parents/guardians who do not consent as well as provide a valid email address, which may bias your results. Data-entry staff can create a spreadsheet for the provided email addresses and use online survey software to send the survey and track/analyze results. A free Google

Form is also an option; and (c) Ideas for Program Evaluation: To assess overall how implementation of the program went, all staff and volunteers can be sent a general survey. If you use an online scheduling software, this can be sent through that software.

5. Document and Data Collection Management: This resource includes a sample report that can be used to track vaccinations, vaccine temperature and staffing during the day of vaccination: https://www.shootheflu.org/toolkit/operational-documents/

   This report can be used by site leaders to track vaccinations, vaccine temperature and staffing during the vaccine day. On the backside of the report is a sign in sheet for all volunteers and staff. It is important to have a record of all individuals assisting with vaccine days as well as their contact information. If there were to be an incident and you need to investigate, you need to be able to interview anyone assisting with vaccination efforts. Additionally, the sign-in sheet can yield valuable information about the type of staff, number of staff, and staff time to aid in staff planning for future campaigns.

6. Ideas for Communicating About the Vaccination Process and Offering Vaccines in Your School or District: The following resources may be useful in exploring tips and strategies for communicating about the importance of the vaccination process and dispelling misconceptions and misunderstandings about vaccines. In addition, the Education Week resources are good discussion starters for staff, parents, and community members exploring the issue of school- and district-based vaccination clinics and services:

   - https://www.edweek.org/leadership/a-vaccine-for-kids-is-coming-6-things-to-know-about-administering-the-shot-in-your-school/2021/09
   - https://www.edweek.org/leadership/Covid-19-vaccine-clinics-a-blueprint-for-schools/2021/02

7. Considerations for Planning School-Located Vaccination Clinics/CDC: https://www.cdc.gov This CDC publication showcases information for planning and implementing school-located vaccination clinics (SLVs) for all routinely recommended vaccines as well as COVID-19 vaccinations. This resource also includes a modifiable template for communication materials that districts can use in the process of developing and implementing one or more clinics. The resource includes recommendations for the following:

   - Background Information
   - SLV Planning Considerations
   - Establishing SLV Leadership and Partnerships
   - Legal Issues Related to Minors, School Staff, and Volunteers
   - Ideas for Reinforcing Effective Communication
   - Training and Professional Development
   - Additional Resources for Use by Planning Teams

8. Guide to On-Site Vaccination Clinics for Schools—We Can Do This: https://www.wecandothis.hhs.gov This guide emphasizes strategies for offering school-based COVID-19 vaccinations but is applicable to the development and implementation of a comprehensive school-level vaccination clinic for all required vaccinations. Suggestions include ideas for hosting pop-up COVID-19 clinics for students returning to school, partnering with nearby providers, an on-site vaccination toolkit, and strategies for community engagement. Highlights include:

   - A Comprehensive On-Line Library of Resources
   - Strategies for Aligning Support from the CDC
   - Suggestions for Supports Available Through National Education and Public Health Organizations
   - A Comprehensive Planning Guide for School-Based Vaccination Clinics

9. **School-Based Health Alliance—School-Based Vaccines and Immunizations:** https://www.sbh4all.org This guide includes a wide range of online resources for use in the design, development, and implementation of school-based vaccination clinics and services. Readers can access general information as well as specific templates and example resources from throughout the United States. Resources include the following:

    - CDC Immunization Schedules
    - Vaccine Information Statements
    - Federal Law Requiring Vaccine Information Statements
    - Resources for Administering Adolescent COVID-19 Vaccines at Schools
    - Examples and Resources from the School-Based Healthcare Field

10. **School-Based Vaccination Programmes:** A Systematic Review of the Evidence on Organisation and Delivery in High Income Countries (Sarah Perman, Simon Turner, and Naomi J. Fulop): https://www.ncbi.nih.gov This comprehensive meta-analysis presents a systematic review of evidence on school-based vaccination programs in order to understand the influence of organizational factors on the delivery of programs. This report focuses on childhood and adolescent vaccination programs delivered in schools, considers organization factors that influence the preparation or delivery of programs, emphasizes programs found in high-income countries, and has been peer reviewed. Topics emphasized include:

    - Organizational Models and Institutional Relationships
    - Infrastructure Implications
    - Staffing and Workforce Capacity
    - Program Financing Options
    - Communication with Parents and Students
    - Implications and Recommendations Generated Through This Research Study

Planning Guide for Implementing a School-Level Vaccination Clinic

Directions: Educational leaders can use the following planning guide with staff to identify key priorities in designing, developing, implementing, and sustaining a successful school- or district-level vaccination clinic. The following rating scale can be used as a discussion point to build consensus about the current status of each key component:

3= Fully Operational and Sustainable

2= Operational but in Need of Expansion and Refinement

1= Beginning with Extensive Need for Expansion and Refinement

0= Not Operational at This Point

_____ 1. We have developed a rationale for developing and implementing one or more school- and/or district-level vaccination clinics.

_____ 2. We have engaged major stakeholder groups in supporting the development of one or more vaccination clinics.

_____ 3. We have ensured that parent, family, and community members have a voice in the design and implementation of the clinic(s) we are proposing.

_____ 4. We have engaged key partners (e.g., health agencies, government agencies, community organizations, etc.) in supporting this initiative.

_____ 5. We have ensured that funding for one or more vaccination clinics is available currently to address all major requirements for a successful operation.

_____ 6. We have made certain that staffing is available and well trained to deliver vaccinations.

_____ 7. We are ensuring that data management systems are in place to monitor vaccination delivery and communicate vaccination data to appropriate government agencies.

_____ 8. We are ensuring that all legal mandates related to the vaccination process are in place to ensure alignment with local and state policy, regulations, and laws.

_____ 9. We have partnered with other organizations (including local pharmacies and health clinics) to expand the potential access to vaccinations for students.

_____ 10. We have integrated quality control and program evaluation processes, including a data dashboard, to monitor the impact of our clinic(s) upon student vaccination rates.

_____ 11. We are ensuring that an effective outreach and communication plan is in place to ensure that all community members are informed about our work and the availability for their children of needed vaccinations.

_____ 12. We are collaborating with a variety of organizations to ensure that community misperceptions and misunderstandings about vaccinations are successfully addressed.

_____ 13. We are locating clinics in geographically accessible areas, including ensuring that all families have transportation and related issues addressed.

_____ 14. If we offer a range of vaccination options (including required vaccinations for school entry), we have worked with local insurance providers to address billing issues.

_____ 15. We have integrated our commitment to sustaining our clinic(s) beyond the duration of ESSER and other relief funding sources, i.e., integrating this priority into our long-range fiscal management and operational budget processes.

End-of-Module Self-Reflection Questionnaire

Directions: As an educational leader, use this self-reflective questionnaire to explore the following essential question: To what extent are you committed to the concept of school- and/or district-level vaccination clinics in your district? Use the following rating scale to assess your current level of knowledge, skill, and understanding of key issues related to this issue:

4= I have a clear understanding of the value of SLVs and can articulate their purpose and need to constituents and staff.

3= I understand this issue and have started to work with my staff to explore options for clinic development and/or expand available vaccination resources to students.

2= I am beginning to understand the significance of this issue, but I have not worked with staff to address it.

1= I am just becoming aware of this issue as a problem of practice, and I need to do much more work in understanding and addressing it.

_____ 1. I can provide a clear rationale for school- and/or district-level vaccination clinics (SLVs) in my district.

_____ 2. I can identify key components for the design, implementation, and sustainability of SLVs that are specific to the needs and resources of my district.

_____ 3. I can explain to parents and family members as well as community stakeholder groups the value of SLVs and the need for them to support this idea.

_____ 4. I can articulate to my board and district leaders the action steps I would recommend to begin and/or expand our current work with vaccinations of students.

_____ 5. I have begun to work with other administrators and staff members in my district to determine ways to design and/or expand our work with student vaccinations.

_____ 6. I can articulate funding sources and budget requirements for one or more SLVs in my district.

_____ 7. I understand key strategies and related communication processes proven successful in promoting parent, family, and community support of SLVs.

_____ 8. I am working with my staff to ensure that they are prepared to address effectively expressed concerns from parents and family members related to the concept of an SLV.

_____ 9. I am working with cross-institutional partners to elicit their feedback and support for the range of support resources required to sustain an SLV (e.g., staffing, training, facilities, insurance issues, data collection and analysis, etc.).

_____ 10. I understand ways in which we can work with health agencies, governmental agencies, pharmacies, and other organizations to expand student vaccination rates.