

# Confronting the Consent Conundrum:

## Lessons from a School Oral Health Learning Community

### Introduction

**Schools have long played an important role in the prevention, detection, and early intervention of troubling and preventable health conditions like childhood oral disease.** Despite successful school oral health initiatives, access to oral health services remains a challenge for many students from families with low incomes. Although oral health services and innovation exist within school-based delivery systems across the country, there have been limited opportunities to connect them with one another and systematically spread promising practices, successful strategies, and innovation.

The School-Based Health Alliance, supported by the DentaQuest Foundation, launched an initiative, *“Strengthening School Oral Health Services and Growing the School Oral Health Learning Community,”* in February 2015. The target is the ten largest U.S. school districts, which have more than four million children – and a significant number of high-need students.

The Alliance’s school oral health learning community is a group of providers, sponsors, and school partners from a select number of U.S. school districts who connect virtually and in-person to develop, share, and test innovative and promising practices in school oral health service delivery. Each learning community team is comprised of committed partners that provide and support oral



health within their school district. Seven of the ten targeted school districts that committed to the peer-to-peer learning community include the Los Angeles Unified School District, Miami-Dade Public Schools, Hillsborough County Public Schools, Chicago Public Schools, New York City Department of Education, Clark County School District (Nevada), and Houston Independent School District. Five additional school districts joined the learning community with support from The Duke Endowment: four districts in South Carolina (Clarendon School District One, Clarendon School District Two, Dillon School District, and Manning School District) and one district in North Carolina (Montgomery School District).

In initial interviews conducted by the Alliance, representatives from oral health programs operating in the ten school districts expressed a common interest in achieving higher rates of positive

consent for their oral health care services. Several team representatives reported consent rates that were lower than national average (between 40 to 60 percent, according to the Association for State and Territorial Dental Directors<sup>1</sup>) and expressed concern about the impact of these rates on program use and sustainability. Each school district team committed to work together on a shared focus: to increase school oral health service use by increasing rates of active parental consent.

During the 2016–17 school year, the Alliance challenged the school oral health learning community to design and test innovative tactics that could move the needle on parental consent rates for school oral health services among their programs. By connecting monthly and generously sharing action plans, early wins, and missteps, the learning community teams were inspired to try out new and untested approaches. This document captures some of the ideas that resulted in increased positive parental consents for school oral health services. They are organized by drivers of change, (or “key levers”) as articulated by the DentaQuest Foundation.



1. Association of State and Territorial Dental Directors. 2015. *Best Practice Approach: School-Based Dental Sealant Program*. Reno, NV: Association of State and Territorial Dental Directors. 16 pp. <http://www.astdd.org/docs/bpar-selants-update-03-2015.pdf>.

## School Engagement

**A chief and obvious lesson for any school-community oral health partnership is that education personnel – especially building administrators, teachers and pupil support professionals – are fundamental to success.** Because they control access to students and their families, school employees often hold the key to effective outreach strategies. Engage them in your mission to promote oral health (and eliminate unnecessary learning distractions caused by tooth pain) and you have one of the most ardent champions. Ignore them and you risk dramatically limiting your program’s reach.

The Los Angeles Unified School District (LAUSD) team, in testing direct outreach approaches to families, learned firsthand of the power of the school principal to influence the attitudes and behaviors of students and their parents. Wanting a boost in participation among one of its oral health sites, The L.A. Trust as the program sponsor, set its sights on the building principal and set up time to meet one-on-one. The staff explained the upcoming oral health education and fluoride varnish program and made their pitch: *Would you make an announcement about the program directly to the school?* The principal said yes. During morning announcements, she underscored to her students the value of oral health to their health and academic success. Message received. The consent rate increased by 13 percent – from 57 to 70 percent.

The LAUSD team discovered that connecting the oral health program to an issue of importance to the principal helped create buy-in. Simple, probing questions helped to make the problem and its solutions relatable and actionable: *Did you know how many hours of classroom time are lost to oral disease? Do you know the cost savings we can achieve by reducing the burden of disease among the school population? Have you or a family member ever experienced dental pain?*

## Family Engagement

**Few would argue about the importance of engaging families in their children’s oral health. But making it a reality is a challenge that perplexes many school oral health programs across the country.** After several trials and misfires, the Houston Independent School District (HISD) team – a collaboration between the school district, health department, and local Federally-Qualified Health Centers – found a promising tactic that yielded increases in engagement by their families AND signed consent forms for participation.

Picture students – all volunteers from a local high school – donning wings and wands and educating parents who have come to learn about the importance of oral health. Creativity and fun were the hallmark of the **Tooth Fairy** event, so named by the team to attract elementary school children and their families. The hosts provided dinner, too – an

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obvious marketing device that appeals to busy families. Presenters highlighted oral health basics and the program’s preventive services available to the children directly on school site. Staff offered one-on-one technical assistance to help families navigate the requisite paperwork. “The response from the parents who attended the **Tooth Fairy** event was quite enthusiastic,” reported a member of the Houston team. “*We definitely plan to test this strategy again in the coming school year.*”

The **Tooth Fairy** event has many merits, says the team, beyond providing oral health education to students and families. The tactic engages older students as role models who themselves have the potential to be oral health ambassadors in their high schools. It raises health literacy levels. And, perhaps most importantly, it makes oral health fun for families.

## Community Engagement

**Creating partnerships with the community at large civic groups, religious organizations, businesses, and philanthropy, to name a few serves many purposes in advancing school oral health program goals.** Picture partners – serving as an echo chamber for the importance of prevention and early detection of disease and the value of school-based approaches to reaching all children regardless of their zip code. Partners can also bring much needed program infrastructure and resources to the table. Community partners who represent the interests of families most deeply

affected by health inequity bring credibility and much needed connection (“ears on the ground”) to the program to help bridge language and cultural divides and shed light on issues that prevent parents from consenting to services for their children.

The South Carolina team, composed of four districts and led by the director of Welvista’s Smiles for a Lifetime non profit division, tested a community engagement strategy that targeted local clergy. In rural South Carolina, ministers hold great sway over their congregants and can be powerful champions. The team held a “Ministers Breakfast” to tell the ministers about their congregations’ oral health needs, promote the school oral health programs, and ask for their help in encouraging families to sign up for the services. Despite a few planning hiccups, the pilot effort showed great promise. The school oral health program team lead will test the impact of this strategy again in 2017–18.

The team also hired a community outreach worker to engage with those families and communities in the district with the lowest consent rate returns. The outreach worker was a well-known member of the district and followed up with every family that failed to return consents or returned the consent with a “no.” The community outreach worker leveraged her community ties to gain the trust of families, explained the program’s merits, and offered – if needed – to help the family member to fill out the consent paperwork. The team found

that low literacy levels and a lack of priority and understanding around oral health were major factors that contributed to low consent return rates. The direct, one-to-one touch works wonders. “The families really appreciated the time and care provided by our outreach worker,” said one team member. “In rural districts with high poverty and unemployment rates, this type of personal attention and interaction is rare.”

## Oral Health Education

**Education is a critical component of a successful school oral health program.** Oral health disparities are linked to low health literacy levels, yet finding messages that “stick” and are appropriate for the targeted audiences is a challenge. Research shows that framing oral health messaging in ways that tie facts to points of empathy is important, as is the messenger. The closer the message reflects the voice of the intended audience, the greater its saliency.<sup>2</sup>

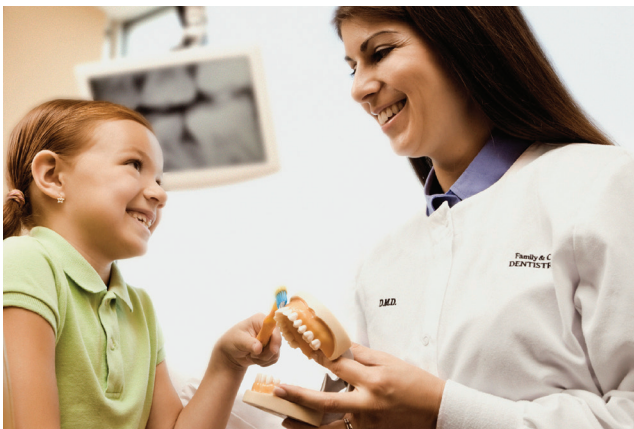
The Chicago Department of Health, Chicago Public Schools (CPS), and the Oral Health Forum comprised the Chicago team. The team pilot-tested several ideas in four schools. Three of the schools had low consent return rates. One school with average consent return rates served as a control. Their strategies combined targeted messaging and oral health education, and increased consent rates in the schools by an average of 15 percentage points. The classroom-based oral health

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education program provided age-appropriate oral health messages that were aimed at shaping positive group norms and generating excitement among students about the upcoming dental visit. Enthused about the event, students were more likely to bring consent forms to their parents' attention and ask to be able to participate in the upcoming dental visit day.

CPS first sent consent forms in the back-to-school packets – an existing standard procedure. They then followed up with a letter introducing the program to school principals and requesting an in-person meeting with school staff to share event details. Once dental visit dates were set, they sent an Oral Health Forum member to every classroom to share news of the upcoming dental visit. Other pre-event marketing included handing out additional consent forms to the students and putting posters up in the main office that advertised the upcoming dental visit date and services and encouraged students to bring consent forms back to the office. Elementary schools placed wristbands on students that read, “CPS Dentist is Coming to Your School. Return Signed Consent/HIPAA Form.” Schools also used robocalls to remind families to return consent forms.



While there was a considerable amount of “sweat equity” that went into developing the collaborative messaging and education process, the Chicago team of oral health professionals, school leaders, and school staff genuinely appreciated the diversity of ideas and deemed them a success. In the upcoming school year, the team will continue to bolster consent return rates by training their contract dentists to use these marketing strategies.

## Data Collection and Use

**Funders and sponsors often use data to plan, develop, and implement programs, establish benchmarks for performance, and set standards for improvements.** One learning community team put their data to work to better understand trends in their school oral health program consent rates. With the aid of cash incentives, the team set up some friendly competition across participating school sites to push the accelerator on progress.

The New York City (NYC) team – a collaboration between school districts, the health department, and for-profit and not-for-profit oral health professionals – tested financial incentives to increase consent rates. The team used health data collected in past years to determine benchmark consent return rates for twelve pilot schools. These benchmarks were then proposed to and agreed upon by each participating school.

2. Krisberg K. 2014. Public Health Messaging: How It Is Said Can Influence Behaviors: Beyond the Facts. *The Nation's Health* 44(6):1–20.



Schools that successfully increased consent rates received a \$1,600 incentive. All twelve participating schools surpassed their benchmarks during the pilot year by increasing their outreach and education efforts. After meeting their benchmarks, the schools received their cash incentives. Three additional oral health provider groups and the schools they serve will participate in the test when repeated during the 2017–18 school year.

In the upcoming year, the NYC team also plans to use data to drive quality assurance across their school oral health programs. The team will use an electronic checklist to evaluate the quality of care provided by the dentists and dental hygienists participating in six programs, and reward those who successfully increase the number of children receiving services (to include dental sealants). The NYC Department of Health is collecting information from the school dental clinic staff to identify additional barriers to student use. Once that information is collected, the NYC team will provide the staff with customized technical assistance designed to attract more students.

## Conclusion

The cornerstone of the learning community's work together is their commitment to both learning and teaching – a robust peer-to-peer exchange of ideas and strategies. These teams have demonstrated that a learning community, singularly focused, can facilitate parental consent and improve oral health service use among our most vulnerable children and adolescents.

## About the School-Based Health Alliance

Founded in 1995, the nonprofit School-Based Health Alliance (SBHA) is the national voice for school-based health care. We work to improve the health of children and youth by advancing and advocating for school-based health care, providing the field with high-quality resources, training, and giving them the motivation and inspiration to excel in their work. All school health care providers, with their distinct expertise, knowledge, and experiences, work at the intersection of education and health care. A critical provider group are the oral health professionals. We at the Alliance believe that providing oral health services in schools can bring substantial benefits. The school oral health programs play a critical role in the prevention, detection, and early intervention of troubling (and preventable) childhood oral disease.

