2001 STATE ADOLESCENT HEALTH COORDINATOR SURVEY:

SUMMARY OF RESULTS

Prepared by
National Adolescent Health Information Center
University of California, San Francisco
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The National Adolescent Health Information Center (NAHIC) of the University of California, San Francisco (UCSF) is funded through a Cooperative Agreement with the Maternal and Child Health Bureau (4H06MC00002). Established in October, 1993, it is located within the UCSF School of Medicine where it is operated jointly by the Division of Adolescent Medicine, Department of Pediatrics and the Institute for Health Policy Studies. NAHIC's goal is to improve the health of adolescents by serving as a national resource for adolescent health information and research to assure the integration, synthesis, coordination and dissemination of adolescent health-related information. Major activities include: 1) promoting collaborative relationships with the Maternal and Child Health Bureau, other federal and state agencies, professional and research organizations, private foundations and advocacy groups; 2) collecting, analyzing and disseminating information through short-term and long-term analyses of new policies affecting the adolescent population; and 3) providing technical assistance, consultation and continuing education to states, communities, and providers in content areas that emphasize the needs of adolescents. Throughout its activities, NAHIC emphasizes the needs of special populations who are more adversely affected by the current changes in the social environment for youth and their families.

2001 State Adolescent Health Coordinator Survey:
Summary of Results

INTRODUCTION

This report highlights the key findings of the 2001 State Adolescent Health Coordinator (SAHC) survey. SAHCs provide leadership within state and national agencies as advocates for the improvement of adolescent health, safety, and welfare, while also providing information and consultation to other organizations and agencies regarding comprehensive adolescent health. They are supported by the Title V/ Maternal and Child Health Block Grant, a Federal-State program administered by the federal Maternal and Child Health Bureau (MCHB). The purpose of the survey is to monitor the wide variety of efforts currently underway at the state level under the leadership of state adolescent health coordinators; to identify emerging needs for technical assistance, training, and fund development; and to develop a unique database of strategies and lessons learned.

The SAHC survey was first conducted in 1996—and then in 1999—as a tool to gain feedback from the state adolescent health coordinators on implementation of their MCHB-supported adolescent health programs. The survey was administered from January to September, 2001, to all 58 states and territories. A total of 48 responses were received (46 states and two other jurisdictions).

Highlights

The 2001 survey offers important insights into the work of the coordinators and the context in which they work:

- SAHCs expressed a strong desire to be less categorical in their approach to improving adolescent health. Specific areas in which SAHCs spend most of their time included pregnancy prevention, abstinence, school health and general adolescent health.
- Many SAHCs have adopted a youth development approach. The degree to which they are incorporating youth development concepts varies across the nation.
- Additionally, many SAHCs are using Healthy People 2010 as a framework to help shape their programs.
- Collaborative efforts are being viewed by SAHCs as a key strategy, and they are actively involved in coalitions, interagency groups, and other organizations.
- The primary challenges for SAHCs are lack of resources and competing demands for their time. Despite this, SAHCs generally report an increased focus on adolescence and a high level of involvement in their state MCH programs.

These findings, as well as other significant results, are explored in greater detail throughout this summary. The survey itself is appended to this report. Please note that responses do not always total 48 because some respondents did not answer all the questions.

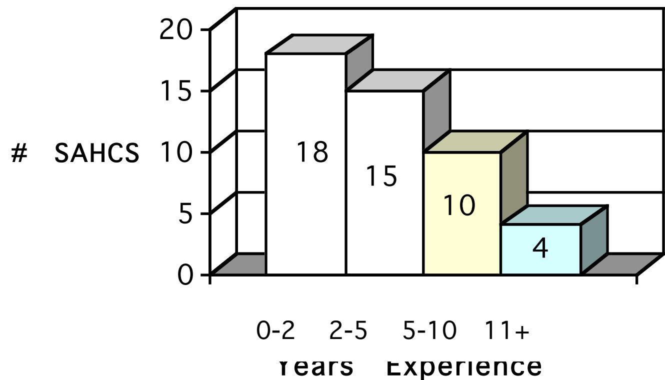
This report is intended to be an internal working document for the State Adolescent Health Coordinator Network and its partner agencies to guide planning, training and related activities.

SECTION A: Adolescent Health Coordinator Information

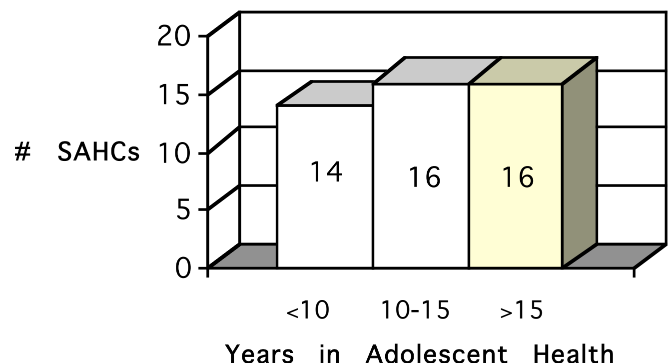
Section A provides an overview of the State Adolescent Health Coordinators (SAHCs) and their state's SAHC position and Adolescent Health Program. SAHCs range considerably in the areas explored in this section.

- **BACKGROUND: Although SAHCs represent a variety of backgrounds, most are in the fields of nursing and health education.**
  The range of backgrounds include:
  - Nursing (16),
  - Health Education/ Public Health Education (14),
  - Administration & Health Policy (9),
  - Education (6),
  - Medicine (2),
  - Social Work (2), and
  - English(1).

- **EXPERIENCE AS SAHC: More than a third (N=18) of SAHCs have worked for two years or less coordinating adolescent health programs for their states. Most SAHCs have been in their position for less than five years (N=33).**
  Range of years in the position:
  - 18 have 0-2 years,
  - 15 have 2-5 years,
  - 10 have 5-10 years, and
  - 4 have 11+ years.



- **ADOLESCENT HEALTH EXPERIENCE: Two-thirds of SAHCs have been working in the field of adolescent health for ten years or more.**
  Range of experience in adolescent health:
  - 14 SAHCs have less than 10 years experience,
  - 16 SAHCs have 10-15 years, and
  - 16 SAHCs have more than 15 years



- **TIME SPENT ON SAHC DUTIES:** Almost all SAHCs are funded to work for the state 100% of their time (N=46). Many SAHCs have competing demands for their time, with less than one fourth (N=11) spending all of their time on SAHC duties. About half of the SAHCs (N=23) reported that they spend 50% or less of their time on adolescent health coordinator duties, and less than a fourth (N=10) spend 51% - 99% of their time on SAHC duties. Regarding funding sources, most SAHCs are funded entirely by Title V (N=30). Only 7 SAHCs are funded entirely by other sources.

- **TIME SPENT ON TECHNICAL ASSISTANCE ACTIVITIES VS. DIRECT SERVICES:** SAHCs vary in the amount of time they spent on technical assistance (TA) and direct services. Just over half of SAHCs (N=25) spend 50% or less of their time on TA, and just under half (N=21) spend 51% - 100% of their time on TA Activities. Similarly, about half of SAHCs report spending 50% or less of their time on direct services, and about half report spending 51-100% of their time on direct services.

- **STAFFING FOR ADOLESCENT HEALTH:**
  - Over half of SAHCs (N=29) report that their position involves supervisory/management duties.

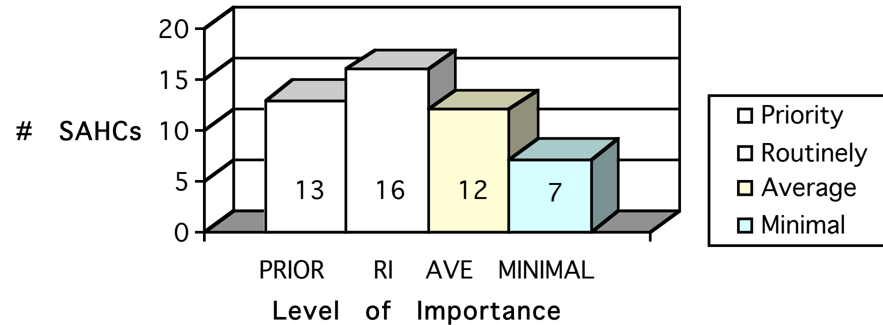
  - PROGRAM STAFF: Most SAHCs (N=40) have at least one full time equivalent (FTE) program staff member working exclusively on adolescent health issues. Only 6 SAHCs have no Program Staff FTEs.

    Range of Program Staff FTEs (PS FTEs):
    - 21 have 0-1 PS FTEs,
    - 9 have 1-2 PS FTEs,
    - 4 have 2-3 PS FTEs, and
    - 12 have more than 3 PS FTEs.

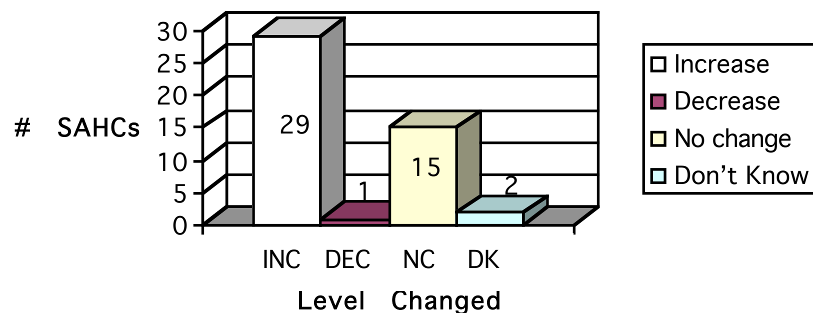
  - CLERICAL/SUPPORT STAFF: Many SAHCs (N=28) have at least one full time equivalent clerical/support staff member working exclusively on adolescent health issues. However, over one third of SAHCs (N=17) reported that they have no clerical/support staff FTEs.

    Range of Clerical Staff FTEs (CS FTEs):
    - 39 have 0-1 CS FTEs,
    - 4 have 1-2 CS FTEs, and
    - 2 have 2-3 CS FTEs.

- **IMPORTANCE OF ADOLESCENT HEALTH IN STATE**: Many SAHCs reported that Adolescent Health is a priority (N=13) or routinely included (N=16) in state program planning and/or funding. Only 7 SAHCs reported that adolescent health is of minimal importance.



- **TRENDS IN EMPHASIS**: Most SAHCs report that emphasis on adolescent health has increased in the last two years (N=29). One third of SAHCs (N=15) have seen no change in the emphasis on adolescent health in their state. Among the 29 SAHCs who reported that the level of emphasis on adolescent health has increased, 13 said that adolescent health is a priority for state program planning and/or funding, 8 said it is routinely included, 5 said it is average, and 3 said it is of minimal importance.



- **OTHER**
  - FUNDING: The majority of SAHCs do not receive funding from other non-governmental sources or foundations. Only 5 SAHCs receive this sort of funding.

  - INTERNET TECHNOLOGY: All SAHCs have access to the World Wide Web, and half reported that they are daily users (N=25). Even though the majority of SAHCs (N=40) use the SAHCN list server often to read messages, only 6 SAHCs use the SAHCN server "often" to send messages. Almost all SAHCS are able to download and print email attachments (N=44).

SAHCs are experienced, committed individuals working to increase their states' commitment to adolescents, but many still have competing demands and relatively little staff.

SECTION B: Youth Development

Section B focuses on how SAHCs are utilizing a youth development framework in their work. Youth development is defined in the survey as those efforts that involve actions/activities aimed at enhancing competence, capacities, caring and citizenship among young people.

- **USING YOUTH DEVELOPMENT FRAMEWORK:** SAHCs use a youth development framework at varying levels across states. Over one third of SAHCs use a youth development framework to guide most of their work (N=19). Another third use the youth development framework for a few specific initiatives (N=16). Less than a third said that they are just beginning to think about how the framework applies to their work, and just one SAHC said that it was not relevant to her/his work. When asked to describe specific programs using a Youth Development approach, SAHCs most frequently mentioned pregnancy prevention programs. Other programs described by SAHCs include preventing suicide and tobacco use.

- **BARRIERS TO USING YOUTH DEVELOPMENT:** SAHCs face various barriers to integrating a youth development approach within state adolescent health activities. The obstacles cited most often by SAHCs were restricted funding (N=35) and lack of resources (N=29). About a third report lack of information/data regarding effectiveness (N=17), lack of awareness on the part of state policymakers (N=16), and lack of skills to implement a youth development approach (N=15).

- **OTHER STATE AGENCIES USING YOUTH DEVELOPMENT FRAMEWORK:** Over half of the SAHCs (N=26) report that other state agencies use a youth development framework in their state. More than a third of SAHCs (N=18) do not know if other agencies utilize the youth development framework. SAHCs most frequently cited agencies focusing on substance abuse, education, and juvenile justice as the ones using youth development.

SECTION C: Overview of Adolescent Health Activities

Section C describes the various activities that SAHCs are involved in, including the adolescent health areas on which they focus and the extent of their collaboration with other agencies.

- **FACILITATING FACTORS:** SAHCs believe that the most important factors facilitating action on adolescent health are good cross-agency collaboration (N=15) and active state- or community-based coalitions (N=12). Other facilitating factors seen as more important include supportive leadership (N=10), good data collection (N=10), and personal skills or resources (N=6).

- **BARRIERS: When asked about the most important challenges to promoting adolescent health in their state, SAHCs most often reported limited financial resources (N=15), inadequate staffing/human resources (N=13), and lack of political consensus (N=11).**

- **RELATIONSHIPS WITH OTHER AGENCIES/DEPARTMENTS:** Reflecting the value they place on collaboration, SAHCs report extensive collaboration with many other state agencies. Agencies mentioned most often include school health (N=28), family planning (N=22), and education (N=20). SAHCs most often reported no collaboration with human rights (N=27), transportation/highways (N=26), housing/ community development (N=25), and labor (N=24).

- **AREAS OF ADOLESCENT HEALTH IN WHICH SAHCs SPEND TIME:**
  - SAHCs were asked to identify the areas of adolescent health in which they spend the most time. The six areas mentioned most often were pregnancy prevention (N=19), abstinence (N=17), school health (N=14), general adolescent health (N=13), youth development (N=11), suicide prevention (N=11), and access to care (N=9).
  - SAHCs were also asked to identify those areas that they felt were most important. The same six areas were named most often, although in a slightly different order: youth development (N=20), general adolescent health (N=13), pregnancy prevention (N=10), access to care (N=9), school health (N=8), and suicide prevention (N=7).

- **INVOLVING PARENTS AND YOUTH:** Two thirds of SAHCs (N=31) reported involving parents and youth, often through advisory boards and focus groups. Several SAHCs stated that they have educational materials for parents. Half of the SAHCs reported that their office coordinates the activities that involve the parents.

- **COLLABORATION WITH STATE DATA CONTACTS:** In January 2000, a conference was held for State Adolescent Health Coordinators and State Data Contacts, in Austin, Texas. Of the 30 states where both the SAHC and data contact attended the conference, 26 reported working "very" or "somewhat closely" since then.

SECTION D: MCH/Title V Plan

Section D provides information about the SAHCs involvement with the MCH/Title V plan.

- **TITLE V INVOLVEMENT:** Most SAHCs reported that they and/or their predecessor were involved in developing all the components of their Title V Block Grant application (N=29-40, depending on component).

- **PRIORITY OF ADOLESCENT HEALTH IN MCH/TITLE V PLAN:** Most SAHCs reported that their state plans place a "moderate" to "very high" priority on adolescent health (N=44). Only 4 SAHCs believe that adolescent health is "low" or "not" on the list of priorities for their plan. SAHCs were asked whether the level of emphasis on adolescent health has changed since the last five-year MCH plan. Just under half of

SAHCs (N=23) feel that the emphasis has increased; about one fourth of SAHCs feel there has been no change in the emphasis (N=13); and just two SAHCs believe that emphasis has decreased. About one fifth (N=10) do not know if the emphasis has changed.

SECTION E: Healthy People 2010

Section E provides information about how states are incorporating the Healthy People 2010 21 Critical Objectives for Adolescent and Young Adults. The scope of activities related to the Critical Objectives varies, but most states are using them to some extent.

- **FAMILIARITY WITH 21 CRITICAL OBJECTIVES AND NATIONAL INITIATIVE:** Most SAHCs (N=39) reported that they are familiar with the 21 Critical Objectives for Adolescents and Young Adults within the Healthy People 2010. When asked about the "National Initiative to Improve Adolescent Health by the Year 2010," over half of the SAHCs (N=26) responded that they are familiar with the initiative, and about one third (N=14) have heard about the initiative, but are not sure what it is. Six SAHCs had not heard of the National Initiative.

- **STATE/TERRITORY ACTIVITY RELATED TO THE 21 CRITICAL OBJECTIVES:** SAHCs reported varying levels of activity related to the 21 Critical Objectives. About two thirds of SAHCs are collecting baseline data on the Critical Objectives (N=31) and monitoring progress (N=33). About half are using the Objectives to develop specific objectives for adolescents (N=27) or to target program design or funding (N=22).

- **CONSISTENCY OF OBJECTIVES WITH STATE/TERRITORY PRIORITIES:** SAHCs were asked about the level of consistency between the Critical Objectives and their state/territory priorities for adolescent health. Two thirds of SAHCs (N=32) feel that the objectives are "very much" or "somewhat" consistent with the priorities. Some SAHCs do not know if there is any consistency (N=5), or feel that their state/territory priorities are not clearly defined (N=6).

- **21 CRITICAL OBJECTIVES & STATE POLICIES/PROGRAMS:** Most SAHCs (N=33) believe the Critical Objectives will affect their state's or territory's adolescent health policies/programs "very much" or "somewhat." Eleven SAHCs believe the Critical Objectives will affect their adolescent health policies/programs "very little" (N=7) or "not at all" (N=1), and three were "not sure".

  - <u>SPECIFIC OBJECTIVES & STATE POLICIES/PROGRAMS</u>: SAHCs were asked whether specific Objectives (grouped into categories) would be used to shape their states' programs. SAHCs anticipate using the Critical Objectives related to reproductive health most often (N=25), followed by mental health/suicide (N=24), chronic disease prevention (N=23), mortality (N=22), injuries (N=21), tobacco use (N=21), interpersonal violence (N=16) and substance use (N=14).

  - <u>TITLE V</u>: SAHCs were asked to indicate which of the 21 Critical Objectives were being used to guide the state Title V needs assessment process. The Objectives most often being used in this process were those in the mental health/suicide area (N=23), followed by reproductive health (N=22), injuries (N=21), mortality (N=20), tobacco use (N=19), chronic disease prevention (N=17), interpersonal violence (N=15), and substance use (N=14).

- **COMMENTS**: Some SAHC comments cited the need for a greater youth development component in the Objectives. A few comments noted that primary responsibility for certain Objectives falls within other departments.

- **AREAS THAT ARE HIGHEST PRIORITY & NEED MOST ATTENTION:** SAHCs were asked to identify the Critical Objectives that were the highest priority and those that needed the most attention in their state/territory. The Critical Objectives most often cited as "high priority" were those in the mental health/suicide area (N=14), followed by reproductive health (N=11), and tobacco (N=8). SAHCs feel that the areas needing the most attention in their state/territory are mental health/suicide (N=19), chronic disease prevention (N=8), and reproductive health (N=6).

- **STATES' NEEDS AND ASSETS FOR ACHIEVING THE 21 CRITICAL OBJECTIVES**

  - MONITORING THE 21 CRITICAL OBJECTIVES: While over half of the SAHCs (N=28) reported insufficient staffing to measure or monitor the Objectives, most also reported having other important strengths. These include having good working relationship with the data contact (N=34), good intra-agency (N=36) and inter-agency (N=33) collaboration, and staff competency (N=27).

  - FACILITATING FACTORS: SAHCs were asked what they anticipate to be the most important factors that will facilitate their state/territory achieving the Critical Objectives. Among the numerous choices offered in the survey, they were more likely to choose good data collection and reporting systems (N=17), supportive leadership (N=16), adequate staff and other resources (N=13), and good cross-agency collaboration (N=13).

  - CHALLENGES ACHIEVING 21 CRITICAL OBJECTIVES: The most important challenges in achieving the Critical Objectives for their state/territory are inadequate staffing/human resources (N=18), competing demands/priorities (N=18), and limited financial resources (N=15).

  - ADDITIONAL SUPPORT STAFF: Given that one of the challenges in achieving the Objectives is inadequate staffing, over two thirds of the SAHCs (N=33) reported that they need additional staff to support their state's 2010 Adolescent Health Initiative. One third of SAHCs feel they need a full time clerical/support staff person (N=15) and/or a full time professional/program staff person (N=15) for their state's Initiative.

SECTION F: State/Territory Strategic Plan for Adolescent Health

In Section F, SAHC were asked to describe their progress toward creating a strategic plan for adolescent health, as well as to identify barriers to developing a plan.

- **PROGRESS TOWARDS PLAN DEVELOPMENT:** SAHCs reported undertaking a range of efforts related to strategic plan development. Among 48 states/territories, only four states have completed a strategic plan and another four have drafted plans that are in the process of being reviewed. A third of SAHCs reported some progress toward developing a strategic plan (N=16), and half the states have not begun developing a plan (N=23). Several SAHCs commented that they anticipate completing a plan in the next 1-2 years.

- **BARRIERS TO IMPLEMENTATION OF PLAN:** SAHCs who were in the progress of developing a plan were asked to list the barriers they face in completing a plan. Lack of time was most frequently cited, and a few SAHCs also mentioned the need for commitment of leadership.

- **TIME NEEDED FOR COMPLETION OF PLAN:** Of the four states/territories with completed strategic plans, two SAHCs reported that it took 1 year to complete the plan, one SAHC said it took 1.5 years, and one SAHC said it took 2 years.

SECTION G: SCHIP

In Section G, SAHCs provided information about their State's Children's Health Insurance Program (SCHIP).

- **INVOLVEMENT IN SCHIP:** SAHCs were asked about their involvement in designing, implementing, and/or evaluating their state/territory SCHIP program. Over half of the SAHCs (N=27) reported no involvement with SCHIP, and most of the other SAHCs (N=20) said they have been "very" (N=5) or "somewhat" (N=15) involved.

- **CURRENT INVOLVEMENT IN SCHIP:** Over half of the SAHCs (N=29) reported no current involvement in SCHIP. About one third of SAHCs (N=15) said they are currently involved in SCHIP.

- **SCHIP ADDRESSING ADOLESCENT HEALTH ISSUES:** When asked how well their state's SCHIP program addresses various issues in adolescent health services, SAHCs generally felt SCHIP did not address adolescent issues/services well. Among the issues most frequently cited as not being adequately addressed are: school based health centers (N=20), mental health services for adolescents (N=19), identification and inclusion of adolescent-oriented providers (N=17), and health needs of parents (N=17). However, SAHCs reported that some issues are addressed "very well" or

"adequately." These include confidentiality (N=23), outreach and enrollment for adolescents (N=20), and reproductive health care (N=20).

SECTION H: SAHC Competencies/Training Needs

Section H provides information about the areas in which SAHCs need technical assistance (TA) as well as those areas in which they can provide TA. Areas addressed include adolescent health topics, as well as related skills and government programs.

- **TA PRIORITIES FOR ADOLESCENT HEALTH TOPICS:** SAHCs were asked to indicate their level of interest in receiving or providing TA in a number of adolescent health areas. The two areas where SAHCs most often reported needing "significant training" were mental health/prevention (N=11) and youth development (N=10). In addition, more SAHCs identified these as areas in which "they could use additional assistance" (N=20 and 27 for mental health/prevention and youth development, respectively). Other areas in which SAHCs indicated needing "significant" or "additional training" include legal issues (N=31) and violence prevention (N=27). SAHCs reported that they feel comfortable providing consultation for pregnancy prevention/abstinence (N=15), school health (N=13), access to care (N=10), and primary care/prevention (N=10).

- **TA PRIORITIES FOR YOUTH DEVELOPMENT:** SAHCs were asked to indicate their interest in receiving or providing TA in using a youth development approach for specific areas of adolescent health. Areas most frequently cited by SAHCs were the following: access to care (N=27), comprehensive health education (N=25), prevention of mental health problems (N=24), violence prevention (N=24), injury prevention (N=21) and primary care/prevention. SAHCs reported that they feel comfortable providing consultation for using a youth development approach for pregnancy prevention/abstinence (N=9) and family planning/contraception (N=7).

- **TA PRIORITIES FOR SKILL AREAS:** SAHCs were also asked to identify priority areas for training/technical assistance skills. The areas most often cited as "high priority/need significant TA" were social marketing/public information campaigns (N=13), program evaluation (N=12), and external funding (N=9). Other areas where SAHCs "could use additional training" include: needs assessment/planning (N=27), leadership (N=23), cultural competency (N=22), and management (N=21). SAHCs reported that they feel comfortable providing consultation for working with community coalitions/local initiatives (N=9), leadership (N=8), management (N=8), and advocacy (N=8).

- **TA PRIORITIES FOR PUBLIC POLICY & FEDERAL PROGRAMS:** SAHCs were asked about TA needs related to topics grouped under "Public Health/Public Policy and Federal Programs/Initiatives." More than half of SAHCs expressed interest in TA for abstinence education (N=30) and policy development (N=28). About half of the SAHCs reported interest in TA for quality assurance/improvement (N=23) and Healthy People 2010 (N=22). SAHCs reported that they feel comfortable providing consultation in the following areas: core public health function (N=10), abstinence education (N=9), and policy development (N=7).

CONCLUSION

This summary clearly demonstrates the wide variability and richness of experience among the State Adolescent Health Coordinators. Apart from providing a brief profile of their multiple roles, tasks and responsibilities, the survey identifies areas for additional training. It also helps to identify a number of internal resources that might be useful for sharing experiences and expertise across the Network. Clearly, this information will be used by the Network and its partner organizations to help plan for expanding the internal capacity of SAHCs as they play a key role in states' efforts to improve adolescent health.