

# State Adolescent Health Coordinate 1996 Profile

## Contents:

1.Summary	page 2
State Adolescent Health Coordinators	page 2
Viewpoints on Medicaid Managed Care and Adolescents	page 2
Priority Issues in Adolescent Health	page 3
Adolescent Pregnancy	page 3
Data and Involvement Related to Special Populations	page 4
2. State Title V Program Contacts for Adolescent Health	page 5
State Adolescent Health Coordinators	page 5
State Title V Directors: Maternal and Child Health(MCH) and Children with Special Health Needs (CSHCN)	page 15
3.Profile Results	page 29
4.Highlights of State Initiatives in Adolescent Health	page 35

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# 1. SUMMARY

## STATE ADOLESCENT HEALTH COORDINATORS PROFILE, 1996

The National Center for Education in Maternal and Child Health in collaboration with the National Adolescent Health Information Center contacted adolescent health coordinators in each state, selected jurisdiction, and the District of Columbia for information about adolescent health issues in the spring of 1996. 43 adolescent health coordinators from 40 states, 2 territories, and the District of Columbia provided information.

### I. STATE ADOLESCENT HEALTH COORDINATORS

The State Adolescent Health Coordinators most often have a nursing background (42%) but health education, social work, public health, and public administration are also represented.

The coordinators have been in their current position a mean of 3.4 years. Just over twenty percent have been on the job for 5 or more years, while a fourth have been on the job less than a year.

The amount of time devoted to adolescent health varies by state. One-third have full time adolescent health positions and in the remaining adolescent health is one part a staff person=s responsibilities. State adolescent health program offices have a mean of 2.7 staff; two-fifths are the only adolescent health staff.

### II. VIEWS ON MEDICAID MANAGED CARE AND ADOLESCENTS

*Although Medicaid managed care is being implemented in nearly every state, very few adolescent health coordinators report their states have made specific allowances for adolescents. Despite this, the coordinators see the implementation of managed care for adolescents as providing about the same standard of care for adolescents as before Medicaid managed care.*

Managed care for Medicaid recipients is being implemented in nearly all states and territories. Two-thirds have already implemented managed care and more

than a fourth are planning on implementing managed care. Only two respondents reported they did not have and did not anticipate managed care being implemented. Most states, 76%, require Medicaid recipients enroll in the state=s managed care plan. In 43% of the states adolescents are able to enroll independent of their parents.

The states are using several different types of managed care programs. HMOs are most frequent (74%) but provider networks through Preferred Provider Organizations or Independent Practice Associations are also common (54%). 21% of the states have county health departments creating managed care systems. Having a primary care provider acting as gatekeeper and/or case manager is the most common component of managed care (86% of the respondents). Roughly half of the states require utilization review, health prevention activities, and a capitated fee to providers. Outreach requirements to certain high risk groups are required by 44% of the states, but risk evaluation at the beginning occurs in only one fifth of the states.

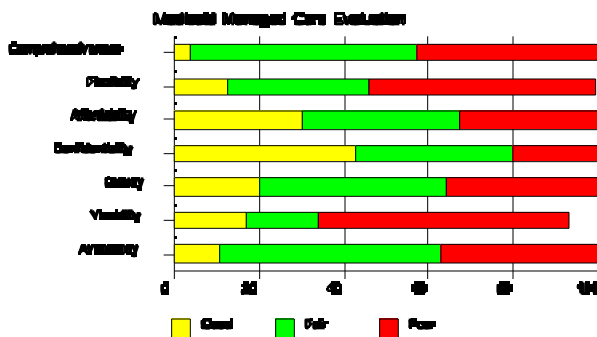
Evaluations are planned or already implemented in most states, but few identified adolescent specific outcome measures. Of 21 responses to an open-ended question about which outcome measures are being used, 29% identified immunizations, 29% listed access to care markers such as percentage of EPSDT exams and timely entry to prenatal care., 19% cited content of care standards such as documentation of health guidance or risk screening, and 24% reported social morbidities such as childbirth, injury, crime, and violence rates.

The coordinators were asked about several issues of particular relevance to adolescents. Confidentiality was not seen as changing in managed care by 95% of the respondents. School-based or linked clinics are included in managed care programs in about 35% of the states, but not included in 43% of the states. Most states have carved out, or exempted, some special populations from managed care programs. Psychiatric services (71%) and special health care needs of the chronically ill or disabled (67%) are the services most frequently carved out of the managed care medical plans.

The coordinators were asked to evaluate their state=s

Medicaid managed care plan according to 7 criteria recommended by the Society of Adolescent Medicine for access to health care (Klein, J.D., Slap, G.B., Elster, A.B., Schonberg, S. K., *Journal of Adolescent Health*, 13, 162-170:1992). These include:

- 1) Availability of age appropriate service
- 2) Visibility of services so that complex planning is not needed to use;
- 3) Quality of service and youth satisfaction in the service
- 4) Confidentiality
- 5) Affordability of services including preventive health



care

- 6) Flexibility to accommodate developmental and cultural differences
- 7) Comprehensiveness and coordination of services to address the range of adolescent health problems.

Only in the area of confidentiality was managed care perceived as *good* (43%) more often than fair (37%) or poor (20%).

Managed care was most often seen as *fair* in availability (52%), quality (44%), affordability (37%), and comprehensiveness (54%) and was most often described as *poor* in visibility (59%) and flexibility (53%). Disadvantages identified through an open-ended question included problems of barriers to care, confusion of how to access the system, low capitation fees making for a lack of providers, and the lack of integration with mental health services. Advantages identified included increased interagency coordination and increased availability of health care for some beneficiaries.

The coordinators were also asked to compare the present managed care plan to the available health care for adolescents *before* managed care on the same criteria. They described the managed care plan as the same as before managed care on all evaluation categories. Among those who did not describe the situation as the same, about the same number reported the situation was

better as reported the situation was worse on each criteria.

### III. PRIORITY ISSUES IN ADOLESCENT HEALTH

*Reproductive health was identified as the top priority in adolescent health in most states, but adolescent health coordinators are involved in a variety of other priority area including assuring access to care, and preventing violence and injuries.*

When asked to list 3 priorities for adolescent health, the coordinators most frequently listed reproductive health including pregnancy prevention, services for pregnant and parenting adolescents and STD/HIV preventive activities. The next most frequently identified priority category includes efforts aimed at improving the systems of care for adolescents by developing primary care, enhancing the core public health functions, and improving access. Almost as frequently mentioned as a priority were violence and injury reduction. Substance abuse prevention, school health programs, and mental health services were also mentioned as priorities.

Highlights of new initiatives in adolescent health provided by each state coordinator is attached.

The National Governor=s Association has proposed to Congress that states not be required to provide Medicaid to poor young people 13 years old and older. The coordinators were asked to predict if their state would continue to provide Medicaid services for those 13 and older if such services were a state option. Nearly half of the coordinators believed their states would continue the programs, 40% were unsure or couldn=t guess, and 12% believed their state would not provide Medicaid to poor adolescents.

### IV. ADOLESCENT PREGNANCY

*Healthy People 2000 identified reducing adolescent pregnancy as an important goal for the nation. Most states have not met these objectives yet, but are using federal resources in attempts to reduce adolescent pregnancy. The coordinators believe the federal role should include funding, highlighting effective programs, and supporting community governmental/private sector coalitions.*

Although there has been a slight recent downward trend in adolescent birth rates nationwide, nearly two-thirds of the states indicated they have not yet reached the *Healthy People Year 2000* objectives for a birth rate among females 15-17 of less than 50 per 100, 000. Nearly one-half of the states have identified a state goal for reducing adolescent pregnancies, births, and/or abortions. 35% of the states reported they have had an increase of births among adolescents less than 15 years old, where as 11% said they have a decrease among this age group. 42% of the states reported decreased the birth rates among 15-19 year olds, but in 23% of the states the rate has increased for this group.

Most states use Title V funds for adolescent pregnancy programs. Nearly two-thirds of the states use these moneys to support a variety of pregnancy-related programs including pregnancy prevention such as community-based prevention education programs, mentoring programs, and family planning including services for pregnant and parenting teens. Improving access to comprehensive programs in schools or community centers has been another way the states have worked toward reducing adolescent pregnancies.

Just prior to the March, 1996 meetings of the State of Adolescent Health Coordinators Network, President Clinton announced a federal/private sector initiative to reduce teen pregnancy. Responding to an open-ended question, the coordinators indicated that they believe the priorities for this initiative should be to fund programs, to highlight the issues and showcase effective programs, and to support community level government/community coalitions. Supporting comprehensive and integrated programs, teaching pregnancy avoidance skills, funding evaluation programs, using the media, providing social services such as transportation, physical and sexual abuse prevention, and substance abuse treatment programs, and emphasizing male involvement and responsibility were all mentioned as important priorities.

## **V. DATA AND INVOLVEMENT RELATING TO SPECIAL POPULATIONS**

*Certain populations of adolescents have poor health status or unique problems of access to health care. These problems may be obscured when overall adolescent health is evaluated, especially if specific data about these groups is not collected. Few adolescent health coordinators indicated their state has the data*

*available to make these distinctions for special populations. When asked about the types of involvement in various aspects of public health work related to these populations, the coordinators reported most of their efforts responding to special populations are related to pregnant and parenting youth.*

The special populations considered included *demographically based groups* such as racial or ethnic groups and urban/rural populations, *legally or institutionally defined defined-status groups* including youth in foster care, incarcerated youth, maltreated youth, learning disabled, and immigrant youth, and *other special populations groups* such as pregnant and parenting, chronically ill and disabled, the mentally ill, and homosexual adolescents.

Most states reported having data in general regarding the overall number of adolescents in their state, a demographic profile of adolescents, their health status, and their risk behaviors. About one fourth reported having data on overall adolescent health care use.

Size and demographics of special population groups are the areas with the most available data. Two thirds of the states reported having data regarding the size of the African-American, Hispanic-American, and Native American youth populations, and more than half of the states had data regarding the size of Asian/Pacific Islanders, rural, urban, foster, incarcerated, and pregnant/parenting youth populations. Fewer states had information available regarding demographic factors such as poverty rate and marital status. Nearly half of the states had such demographic data regarding African-American youth and pregnant and parenting youth. Few states had data available regarding any special populations= health status, risk behavior, or health care use. Some states had data regarding a few populations-- 26% said they had health status data about African-American, and rural/urban youth, and 28% reported they had risk behavior data about African American youth. Just under a fourth of the states reported having data on the health status, risk behaviors, or health care use of other populations.

The adolescent health coordinators also reported about their level and type of involvement in activities specifically related to adolescent special populations or involvement with special populations as part of other responsibilities. Slightly more than one-half of those responding reported being involved with needs assessment, policy and program planning, consulting,

funding, managing, and evaluating programs related to pregnant and parenting teens.

Some of the other populations the coordinators are most involved with include disabled and chronically ill youth (47% doing needs assessment, 39% involved with policy and program planning), African American youth (42% assessing needs, 37% planning policy and programs) and rural youth (45% assessing needs, 37% planning policy and programs). The coordinators reported less involvement with immigrant, foster, maltreated, incarcerated, homosexual, learning disabled, mentally ill and homeless youth. 10% or less of the coordinators reported involvement in funding, managing, or evaluating programs regarding these populations.

## 2. State Title V Program Contacts for Adolescent Health

### State Adolescent Health Coordinators

(Names updated summer, 1996; length of service as of March, 1996)

#### Alabama

Donna Lippold, B.S.N., M.P.H.  
Director, Division of Child and Adolescent Health  
Alabama Department of Public Health  
434 Monroe Street  
Montgomery, AL 36130-3017

Phone: (334) 242-5661  
Fax: (334) 269-4865

Number of years as SAHC (or in present position):  
3.5; 2 yrs. as SAHC  
Discipline/Specialty: Nursing  
Percent of time devoted to adolescent health: 25%  
Other responsibilities: I have 2 other people that work  
in adolescent health: one at 100% and one at 50%.  
My other responsibilities include School Health  
Consultant and Director of the Division of Child and  
Adolescent Health and all programs within Division.

Number of staff in adolescent health program unit: 2

Membership in professional organizations: American  
School Health Association (ASHA)

#### Alaska

Becky Judd  
Adolescent Health Coordinator

Alaska Department of Health  
1231 Gambell Street  
Anchorage, AK 99501-4627

Phone: (907) 269-3424  
Fax: (907) 269-3432  
Email: bajudd%state@state.ak.us

Number of years as SAHC (or in present position): 4  
Discipline/Specialty: educator; generalist in teen  
health issues.  
Percent of time devoted to adolescent health: 100%  
Number of staff in adolescent health program unit: 1

#### Arizona

Barbara Olson, B.S.N., CHES  
Adolescent Health Consultant/Reproductive Health  
Program Manager  
Arizona Department of Health Services  
Office of Woman's and Children's Health  
411 North 24th Street  
Phoenix, AZ 85008

Phone: (602) 220-6550  
Fax: (602) 220-6551  
Email: bolson@hs.state.az.us.

Number of years as SAHC (or in present position):7  
years  
Discipline/Specialty: Public Health Nursing  
Percent of time devoted to adolescent health: 100%;  
until 5/96-will have additional family planning resp.  
Other responsibilities: family planning

Number of staff in adolescent health program unit: 1

Membership in professional organizations: American Public Health Association (APHA)  
Society for Adolescent Health (SAM)

### **Arkansas**

Robert West, M.D.  
Pediatric Medical Consultant  
Arkansas Department of Health  
Child and Adolescent Health  
4815 West Markham, Slot #17  
Little Rock, AR 72201

Phone: (501) 661-2757  
Fax: (501) 661-2055

Number of years as SAHC (or in present position):  
Discipline/Specialty: pediatrics

### **California**

Larry Dickey, M.D., M.S.W., M.P.H.  
Chief, Child and Adolescent Health Section  
California Department of Health  
Maternal and Child Health Branch  
714 P Street, Room 750  
Sacramento, CA 95814

Phone: (916) 657-1360  
Fax: (916) 657-3069  
Email: ldickey@hw1.cahwnet.gov

Number of years as SAHC (or in present position): 6 months  
Discipline/Specialty: physician, social worker  
Percent of time devoted to adolescent health: 80%  
Other responsibilities: Childhood injury prevention, SIDS

Number of staff in adolescent health program unit: 4

Membership in professional organizations: American Public Health Association (APHA)

### **Colorado**

Barbara Ritchen, R.N., M.A.  
Director, Adolescent Health Program

Colorado Department of Public Health and Environment  
Family and Community Health Services Division  
4300 Cherry Creek Drive, South  
Denver, CO 80222-1530

Phone: (303) 692-2328  
Fax: (303) 782-5576  
Email: barbara.ritchen@state.co.us

Number of years as SAHC (or in present position): 11  
Discipline/Specialty: nursing/health education  
Percent of time devoted to adolescent health: 100%

Number of staff in adolescent health program unit: 3

Membership in professional organizations: American Public Health Association (APHA)  
Society for Adolescent Health (SAM)  
American School Health Association (ASHA)

### **Connecticut**

Lynn Noyes, MSW  
Supervisor, School and Adolescent Health Unit  
Connecticut Department of Public Health  
Bureau of Community Health  
410 Capitol Ave., Mailstop #11 PCR  
Hartford, CT 06134-0308

Phone: (860) 509-8057  
Fax: (860) 509-7720

Number of years as SAHC (or in present position): 10+  
Discipline/Specialty: social work  
Percent of time devoted to adolescent health: 50%  
Other responsibilities: School health, child health.  
There are also 6 other staff in the unit who devote significant amounts of their time to adolescent health activities.

Number of staff in adolescent health program unit: 7 (5+2 clerical)

### **Delaware**

Gloria James, PhD  
Director, School Based Health Centers  
Delaware Department of Health and Social Services  
Division of Public Health  
Jesse Cooper Building, P.O. Box 637

Dover, DE 19903

Phone: (302) 739-3809  
Fax: (302) 739-6617

Number of years as SAHC (or in present position): 2  
Discipline/Specialty: organization, planning and administration  
Percent of time devoted to adolescent health: 100%

Number of staff in adolescent health program unit: 1

Membership in professional organizations: American Public Health Association (APHA)

### **District of Columbia**

Colevia Carter  
Adolescent Health Coordinator  
DHS, Commission of Public Health  
Office of Maternal and Child Health  
800 Ninth Street, SW-Third Floor  
Washington, DC 20024

Phone: (202) 645-5625  
Fax: (202) 645-0525

Number of years as SAHC (or in present position): 2  
Discipline/Specialty: HIV/Substance abuse  
Percent of time devoted to adolescent health: 100%

Membership in professional organizations: American Public Health Association (APHA)

### **Florida**

Sylvia Byrd, RNC, MPH  
Registered Nursing Consultant/Coordinator  
Florida Department of Health and Rehabilitative Services  
Family Health Services School Health Services Program  
1317 Winewood Boulevard  
Tallahassee, FL 32399-0700

Phone: (904) 488-2838  
Fax: (904) 488-2341

Number of years as SAHC (or in present position): 3  
Discipline/Specialty: Nursing  
Percent of time devoted to adolescent health: 60%  
Other responsibilities: quality improvement/technical

assistance for school health program

Number of staff in adolescent health program unit: 8  
(in school health program)

Membership in professional organizations: American School Health Association (ASHA)

### **Georgia**

Michelle H. Ozumba  
Adolescent Health Coordinator  
Georgia Department of Human Resources  
Division of Public Health  
2600 Skyland Drive, N.E.  
Atlanta, GA 30319

Phone: (404) 679-0525  
Fax: (404) 679-0537  
Email: MHO@PH.DHR.STATE.GA.US

Number of years as SAHC (or in present position): 1 year  
Discipline/Specialty: Masters in City and Regional Planning  
Percent of time devoted to adolescent health: 100%

Number of staff in adolescent health program unit: 1

### **Guam**

Fay Carbullido, BSN  
Acting Administrator, Bureau of Family Health & Nsg.Services  
Department of Public Health and Social Services  
Government of Guam  
P.O. Box 2816  
Agana, Guam 96910

Phone: (671) 735-7110/7117  
Fax: (671) 734-7097

Number of years as SAHC (or in present position): 10 months  
Discipline/Specialty: nursing  
Percent of time devoted to adolescent health: 30%  
Other responsibilities: Administrative duties as Acting Administrator

Number of staff in adolescent health program unit: 4

## **Hawaii**

Candice Radner  
Planner/Community Adolescent Program  
State Department of Health  
Family Health Services Div. , School Health Services  
Branch  
741-A Sunset Avenue  
Honolulu, HI 96816

Phone: (808) 733-8339  
Fax: (808) 733-9078

Number of years as SAHC (or in present position): 5  
Discipline/Specialty: social worker  
Percent of time devoted to adolescent health: 100%  
Number of staff in adolescent health program unit: 2

## **Idaho**

Laurel Patterson, R.N., B.S.N.  
Child and Adolescent Health Consultant  
Idaho Bureau of Maternal and Child Health (DHW)  
450 West State Street, 5th Floor  
Boise, ID 83720-0036

Phone: (208) 334-5957  
Fax: (208) 334-6573

Number of years as SAHC (or in present position): 2  
Discipline/Specialty: child and adolescent health  
Percent of time devoted to adolescent health: 50%  
Other responsibilities: Child health

Number of staff in adolescent health program unit: 1.5

## **Illinois**

Judith Redick, M.A.  
Administrator, Adolescent Health Programs  
Illinois Department of Public Health  
Family Health  
535 West Jefferson Street  
Springfield, IL 62761

Phone: (217) 785-5368  
Fax: (217) 782-4890

Number of years as SAHC (or in present position): 4+  
Discipline/Specialty: Administration; education  
Percent of time devoted to adolescent health: 100%

Number of staff in adolescent health program unit: 6  
support

## **Indiana**

Sally J Goss, M.S., CHES  
Adolescent Health Coordinator  
Indiana State Department of Health  
Maternal and Child Health Services  
2 North Meridian Street, suite 700  
Indianapolis, IN 46204

Phone: (317) 233-1374  
Fax: (317) 233-1299

## **Iowa**

Carol Hinton  
Adolescent Health Coordinator  
Iowa Department of Public Health  
Division of Family and Community Health  
Lucas State Office Building, 321 East 12th Street  
Des Moines, IA 50319-0075

Phone: (515)281-6924  
Fax (515)242-6384

## **Kansas**

Linda Ladehoff, CNS, ARNP  
Child and Adolescent Health Consultant  
Kansas Department of Health and Environment  
Children and Families Section  
LSOB 900 S.W. Jackson, Suite 1005  
Topeka, KS 66612-1290

Phone: (913) 296-7433  
Fax: (913) 296-4166

Number of years as SAHC (or in present position): 6  
months in State role with adolescent health  
Discipline/Specialty: Nursing, Child Health  
Percent of time devoted to adolescent health: By Job  
Description 25%; actually <10%  
Other responsibilities: Over 43 counties' child health  
grant (MCH) services; certification coordination for  
child health assessment nurse, provides immunization  
education for volunteer nurses; University liaison for  
child health issues; EPSDT managed care/MCH liaison  
for child and adolescent health; statewide consultant for  
MCH-child health.

Number of staff in adolescent health program unit: 1- just me. I work closely with a school-health consultant plus a pregnancy prevention coordinator.

### **Kentucky**

Jennifer Bryson  
Section Supervisor, Maternal and Child Health  
Kentucky Department of Human Resources  
275 East Main Street  
Frankfort, KY 40621

Phone: (502) 564-2154  
Fax: (502) 564-8389

### **Louisiana**

Sylvia Sterne, M.A.  
Director, Adolescent and School Health  
Louisiana Office of Public Health  
Family Health Services  
325 Loyola Ave, Room 612  
New Orleans, LA 70112

Phone: (504) 568-6068  
Fax: (504) 568-6185

Number of years as SAHC (or in present position): 4  
Discipline/Specialty: Admin  
Percent of time devoted to adolescent health: 85%  
Other responsibilities: School health services, K-12  
15%

Number of staff in adolescent health program unit: 3

Membership in professional organizations: American  
Public Health Association (APHA)

### **Maine**

DeEtte Hall, R.N., M.N., P.N.P.  
Director, Teen and Young Adult Health Program  
Department of Human Services  
Community and Family Health  
151 Capitol Street  
Augusta, ME 04333

Phone: (207) 287-3311  
Fax: (207) 287-5355  
Email: deette.hall@state.me.us

Number of years as SAHC (or in present position): 8  
Discipline/Specialty: Nursing  
Percent of time devoted to adolescent health: 95%  
Other responsibilities: Family planning

Number of staff in adolescent health program unit: 2.5

### **Maryland**

Harriet Highsmith, R. N.  
School and Adolescent Health Nurse Consultant  
Maryland Department of Health and Mental Hygiene  
Office of Children's Health  
201 West Preston Street, Room 423 H  
Baltimore, MD 21201

Phone: (410) 225-6748  
Fax: (410) 333-7956

### **Massachusetts**

Dianne Hagan  
Director, Adolescent Health  
Massachusetts Department of Public Health  
250 Washington Street, 4th Floor  
Boston, MA 02108-4619

Phone: (617) 624-5478  
Fax: (617) 624-5075

Number of years as SAHC (or in present position): 3  
Discipline/Specialty: adolescent health  
Percent of time devoted to adolescent health: 100%

Number of staff in adolescent health program unit: 5

Membership in professional organizations: American  
Public Health Association (APHA)

### **Michigan**

Nell Pizzo, R.D., M.P.H.  
Adolescent Health Coordinator  
Michigan Department of Community Health  
Family and Community Health  
3423 M.L. King, Jr. Boulevard  
Lansing, MI 48909

Phone: (517) 335-8906 or (517) 335-8911  
Fax: (517) 335-9222

Number of years as SAHC (or in present position): 4  
Discipline/Specialty: public health/nutrition  
Percent of time devoted to adolescent health: 100%  
Number of staff in adolescent health program unit: 4

### **Minnesota**

Jean Cronje, MSN  
Supervisor, Child Health Programs  
Minnesota Department of Health  
717 Delaware Street, S.E.  
Minneapolis, MN 55440

Phone: (612) 623-5542  
Fax: (612) 623-5442

### **Mississippi**

Sam Valentine, MHS  
Director  
Bureau of Child and Adolescent Health  
Mississippi Department of Health  
P.O. Box 1700  
Jackson, MS 39215-1700

Phone: (601) 960-7464  
Fax: (601) 354-6104

Number of years as SAHC (or in present position): 1  
Discipline/Specialty: health administration  
Percent of time devoted to adolescent health: 10% or less  
Other responsibilities: All child health programs

Number of staff in adolescent health program unit: 1

Membership in professional organizations: American Public Health Association (APHA)

### **Missouri**

Nela Beetem, R.N.C.  
Child and Adolescent Health Coordinator  
Missouri Department of Health  
Division of Maternal, Child and Family Health  
1730 East Elm, P.O. Box 570  
Jefferson City, MO 65101

Phone: (573) 751-6213  
Fax: (573) 526-5348

Email: nbeetem@aol.com

Number of years as SAHC (or in present position): 2.5

Discipline/Specialty: Nursing  
Percent of time devoted to adolescent health: 50%  
Other responsibilities: School health nursing consultation, child health program

Number of staff in adolescent health program unit:  
Part time Adolescent Coordinator, Part time clerical

Membership in professional organizations: American School Health Association (ASHA)

### **Montana**

Elaine Fordyce, R.N., M.S.N.  
Public Health Nurse Consultant  
Montana Department of Health and Environmental Sciences  
Cogswell Building  
Helena, MT 59620

Phone: (406) 444-0983  
Fax: (406) 444-2606

### **Nebraska**

Carol Iverson, M.S.N., R.N.  
School and Adolescent Health Coordinator  
Nebraska Department of Health  
Family Health Section - School and Adolescent Health  
301 Centennial Mall, P.O. Box 95007  
Lincoln, NE 68509-5007

Phone: (402) 471-0160  
Fax: (402) 471-7049  
Email: doh5154@vmhost.state.cdp.ne.us.

Number of years as SAHC (or in present position): 0.5  
Discipline/Specialty: Nursing  
Percent of time devoted to adolescent health: 50%  
Other responsibilities: School health - consultation with 500+ school nurses - 946 school districts. Collaboration with DOE, DSS, DPI, University College of Nursing, professional nursing and education associations.

Number of staff in adolescent health program unit: .5  
FTE RN - .5 FTE secretary

Membership in professional organizations: American Public Health Association (APHA)  
American School Health Association (ASHA)

### **Nevada**

Heidi Sakelarios, CHES  
Child and Adolescent Coordinator  
Nevada State Health Division, Family Health Services Bureau  
Department of Human Resources  
505 East King Street  
Carson City, NV 89710

Phone: (702) 687-4885  
Fax: (702) 687-1383

Number of years as SAHC (or in present position): 1.5  
Discipline/Specialty: Health Education  
Percent of time devoted to adolescent health: 70%  
Other responsibilities: 20% child health; 10% special projects

Number of staff in adolescent health program unit: 1

### **New Hampshire**

Maureen Angelini, C.P.N.P., C.N.M., M.P.H.  
Adolescent Health Contact  
New Hampshire Division of Public Health Service  
Bureau of Maternal and Child Health  
6 Hazen Drive  
Concord, NH 03301

Phone: (603) 668-6629  
Fax: (603) 271-3745

### **New Jersey**

Elaine Eldred, M.S.H.A., R.N.  
Public Health Nurse Consultant  
New Jersey Department of Health  
Family Health Services, Child and Adolescent Health Services  
50 East State Street, CN364  
Trenton, NJ 08060

Phone: (609) 292-1723  
Fax: (609) 292-3580 or 9288

Number of years as SAHC (or in present position): <1  
Discipline/Specialty: Nursing - Public Health  
Percent of time devoted to adolescent health: 100%

Number of staff in adolescent health program unit: 1.  
Combined with child health services and reproductive health.

### **New Mexico**

Karen Gaylord  
Adolescent Health Program Manager  
New Mexico Department of Health  
Public Health Division, MCH  
1190 St. Francis Drive, Runnels Bldg.  
Santa Fe, NM 87502

Phone: (505) 827-2356  
Fax: (505) 827-2329

Number of years as SAHC (or in present position): 5  
Discipline/Specialty: Adolescent Health Education, Systems of Prevention

Percent of time devoted to adolescent health: 100%

Number of staff in adolescent health program unit: 4  
(Mgr., Health Ed., Secy, Data/Training Spec.)

Membership in professional organizations: American Public Health Association (APHA)

### **New York**

Lorraine McCann  
Adolescent Health Coordinator  
New York State Department of Health  
Corning Tower  
Empire State Plaza, Room 208  
Albany, NY 12237

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### **North Carolina**

Duncan Shaw, M.P.H.  
Adolescent Health Coordinator  
NC Department of Environment, Health and Natural Resources  
Division of Maternal and Child Health

1330 St. Mary's Street, P.O. Box 27687  
Raleigh, NC 27611-7687

Phone: (919) 715-3423  
Fax: (919) 715-3049

Number of years as SAHC (or in present position): 3  
Percent of time devoted to adolescent health: 50%  
Other responsibilities: Other school health, contracts administration, budgetary guidance.

Number of staff in adolescent health program unit: 4

### **North Dakota**

Carolyn Lean, R.N., B.S.N.  
Adolescent Health Coordinator, School Health Program Director  
North Dakota Department of Health  
Maternal and Child Health  
600 East Boulevard Avenue  
Bismarck, ND 58505-0200

Phone: (701) 328-4528  
Fax: (701) 328-1412  
Email: msmailcarolynl@ranch.state.nd.us

Number of years as SAHC (or in present position): 7 months  
Percent of time devoted to adolescent health: 40%  
Other responsibilities: 40% school health programs coordination, 10% providing continuing education to local health department staff, 10% general maternal and child health activities

Number of staff in adolescent health program unit: 1

Membership in professional organizations: American Public Health Association (APHA)

### **Ohio**

Donna Solovan-Gleason, Ph.D.  
Adolescent Health Program Coordinator  
Ohio Department of Health  
Family and Community Health Services  
246 North High Street, 6th Floor  
Columbus, OH 43266-0588

Phone: (614) 728-6817  
Fax: (614) 644-9850

Number of years as SAHC (or in present position): 1  
Discipline/Specialty: Adolescent Health  
Percent of time devoted to adolescent health: 100%

Number of staff in adolescent health program unit: 1

Membership in professional organizations: Society for Adolescent Health (SAM)

### **Oklahoma**

Marilyn Lanphier, R.N., M.P.H., F.S.A.M.  
Director, Adolescent Health Division  
Oklahoma State Department of Health  
Child Health and Guidance Service  
1000 N.E. 10th Street  
Oklahoma City, OK 73117-1299

Phone: (405) 271-4471  
Fax: (405) 271-6199

Number of years as SAHC (or in present position): 15  
Discipline/Specialty: BSN, MPH  
Percent of time devoted to adolescent health: 100%  
Adolescent/School Health

Number of staff in adolescent health program unit: 3

Membership in professional organizations: Society for Adolescent Medicine (SAM)

### **Oregon**

Tammy Alexander, M.Ed.  
Adolescent Health Coordinator  
Oregon Health Division  
Department of Human Resources  
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Portland, OR 97232

Phone: (503) 731-4584  
Fax: (605) 731-4083  
Email: tammis.p.alexander@state.or.us

Number of years as SAHC (or in present position): 3  
Discipline/Specialty: Health Education  
Percent of time devoted to adolescent health: 100%

Number of staff in adolescent health program unit: 3

### **Pennsylvania**

Ivonne Bucher, RN  
Adolescent Health Coordinator  
Pennsylvania Department of Health  
Division of Maternal and Child Health  
725 Health and Welfare Building, P.O. Box 90  
Harrisburg, PA 17108

Phone: (717) 772-2762  
Fax: (717) 772-0323

Number of years as SAHC (or in present position): 3  
(just starting as AHC)  
Discipline/Specialty: Nursing; Health Program  
Administrator II  
Percent of time devoted to adolescent health: 25-30%  
(projected)  
Other responsibilities: Child health-MCO; substance  
abuse and adolescents; smoking cessation; local Title  
V agency-Child Health Component

Number of staff in adolescent health program unit: 1

### **Puerto Rico**

Nyvea Silva, PhD  
Health Education Consultant  
Puerto Rico Department of Health/SAMPSPF  
Mother, Child and Adolescent Division  
Call Box 70184  
San Juan, PR 00936-8184

Phone: (809) 274-5632  
Fax: (809) 765-2861

Number of years as SAHC (or in present position): 4  
months  
Discipline/Specialty: Health Promotion  
Percent of time devoted to adolescent health: 20%  
Other responsibilities: I am a consultant for 5 other  
divisions within the Dept of Health.

Number of staff in adolescent health program unit: 3

Membership in professional organizations: American  
Public Health Association (APHA)  
American School Health Association (ASHA)

### **Rhode Island**

Jan Shedd, M.Ed.  
Adolescent Health Program Coordinator

Rhode Island Department of Health  
Division of Family Planning  
3 Capitol Hill  
Providence, RI 02908

Phone: (401) 277-1185 ext 115  
Fax: (401) 277-1442

Number of years as SAHC (or in present position): 2  
Discipline/Specialty: Community Health Education  
and Administration  
Percent of time devoted to adolescent health: 50%  
Other responsibilities: Family Planning Administrator

Number of staff in adolescent health program unit: 2

### **South Carolina**

Sarah Cooper  
Director, Women and Children's Services  
SC Department of Health and Environmental Control  
Division of Women's and Children's Services  
Robert Mills Building, Box 101106  
Columbia, SC 29211

Phone: (803) 737-4033  
Fax: (803) 734-3255

Number of years as SAHC (or in present position): No  
one at present, recruiting

Membership in professional organizations: American  
Public Health Association (APHA)  
American School Health Association (ASHA)

### **South Dakota**

Denise White, R.N.  
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South Dakota Department of Health  
445 East Capitol Avenue  
Pierre, SD 57501-3185

Phone: (605) 773-3737  
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Email: denisew@doh.state.sd.us

Number of years as SAHC (or in present position): 9  
months  
Discipline/Specialty: RN  
Percent of time devoted to adolescent health: 50%  
Other responsibilities: SSDI Grant Coordinator

Number of staff in adolescent health program unit: 1

### **Tennessee**

Deborah Johnson  
Director, Child and Adolescent Health  
Maternal and Child Health  
5th Floor Cordell Hull Building  
Nashville, TN 37247-4701

Phone: (615) 741-7335  
Fax: (615) 532-7189

Number of years as SAHC (or in present position):  
1.5  
Percent of time devoted to adolescent health: 10% or  
less at present time.  
Other responsibilities: Child Health, including child  
health services in local health departments, Child  
Fatality Review, Family Support Home Visiting  
Programs, (School Health now moved to another  
section)

Number of staff in adolescent health program unit: 1

### **Texas**

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### **Utah**

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Number of years as SAHC (or in present position): <1  
Discipline/Specialty: Nursing  
Percent of time devoted to adolescent health: 20%  
Other responsibilities: Child, Adolescent

Number of staff in adolescent health program unit: 7

Membership in professional organizations: American  
School Health Association (ASHA)

### **Vermont**

Patricia Berry, MPH  
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Division of Community Public Health  
Vermont Department of Health  
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Fax: (802) 863-7425  
Email: pberry@vdhvax.vdh.state.vt.us

Number of years as SAHC (or in present position):  
12+  
Discipline/Specialty: Public Health Administration  
Percent of time devoted to adolescent health: 10-20%  
Other responsibilities: Epidemiology, Immunization,  
Lead screening, Prenatal, Early Childhood, WIC,  
EPSDT, Environmental health, Refugee health

Number of staff in adolescent health program unit: 2

Membership in professional organizations: American  
Public Health Association (APHA)  
American School Health Association (ASHA)

### **Virginia**

Elisabeth Hutton, Ph.D., R.N.C.  
Adolescent Health Nurse Consultant  
Virginia Department of Health  
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Phone: (804) 786-7367  
Fax: (804) 371-6031  
Email: ehutton@vdh.state.va.us

Number of years as SAHC (or in present position):  
2.5

Discipline/Specialty: Community Health Nursing,  
Public Administration, Adolescent and Adult  
Education

Percent of time devoted to adolescent health: 85%  
Other responsibilities: Monitor, review and consult  
with four primary care programs (community based) for  
children and adolescents, serve in other division  
projects and VDH Nursing Council.

Number of staff in adolescent health program unit: 1

Membership in professional organizations: American  
Public Health Association (APHA)

### **Washington**

Judy Schoder, R.N., M.N.  
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Washington State Department of Health  
Community and Family Health - Child and Adolescent  
Health  
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Olympia, WA 98504-7880

Phone: (360) 586-1255  
Fax: (360) 586-7868  
Email: jls2303@hub.doh.wa.gov

Number of years as SAHC (or in present position):  
8.5s

Discipline/Specialty: Public Health Nursing  
Percent of time devoted to adolescent health: 80%  
Other responsibilities: Public Health Nursing

Number of staff in adolescent health program unit: 1

Membership in professional organizations: American  
Public Health Association (APHA)

### **West Virginia**

J. Nelson Parker, M.S.  
Program Director, Adolescent Health Initiative  
Department of Health and Human Resources  
Bureau for Public Health, Office of MCH  
1411 Virginia Street, East  
Charleston, WV 25301-3013

Phone: (304) 558-5388  
Fax: (304) 558-2183

Number of years as SAHC (or in present position): 3  
Discipline/Specialty: Rehabilitation counseling

Percent of time devoted to adolescent health: 100%

Number of staff in adolescent health program unit: 1  
Program Director, 8 Adolescent health specialists

Membership in professional organizations: American  
School Health Association (ASHA)

### **Wisconsin**

Sharon L. Lidberg, A.A., B.S.  
Adolescent Health Program Consultant  
Department of Health and Family Services  
Division of Health  
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Madison, WI 53703-3044

Phone: (608) 267-2204  
Fax: (608) 267-3824  
Email: CDC P.C Wonder SLL9

Number of years as SAHC (or in present position): 1.5  
Discipline/Specialty: Varied public health experience  
(communicable diseases, environmental health, MCH)  
Percent of time devoted to adolescent health: 100%

Number of staff in adolescent health program unit: 1

Membership in professional organizations: Society for  
Adolescent Health (SAM)

### **Wyoming**

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Phone: (307) 777-6326  
Fax: (307) 777-5402  
Email: pshera@missc.state.wy.us

Number of years as SAHC (or in present position): 1  
Discipline/Specialty: Social Work/Child  
Advocacy/Policy Planning  
Percent of time devoted to adolescent health: 30%  
Other responsibilities: Management of SSDI, Home  
Visiting, Family Planning and Injury Prevention Pgm

Number of staff in adolescent health program unit: 1

Membership in professional organizations: American School Health Association (ASHA)

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## **State Title V Directors: MCH and CSHN Directors**

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### **Alaska**

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### **Arizona**

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### **Colorado**

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Joan Mcgill, MS, RD  
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Health Care Program for Children with Special Health  
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### **Connecticut**

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410 Capitol Avenue - MS #11 FHS  
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### **District of Columbia**

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### **Delaware**

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Community Health Care Access Section  
Family Health Services  
Delaware Health and Social Services  
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### **Florida**

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Family Health Services (HSSH)  
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### **Georgia**

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### **Guam**

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Fay G.Carbullido  
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**Hawaii**

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**Iowa**

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**Idaho**

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**Illinois**

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## **Indiana**

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## **Kansas**

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## **Kentucky**

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## **Louisiana**

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## **Massachusetts**

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### **Maryland**

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### **Maine**

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### **Michigan**

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### **Minnesota**

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### **Missouri**

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# 3. PROFILE RESULTS

## I. STATE ADOLESCENT HEALTH COORDINATORS

### 1. Public Health Region

43 surveys returned from these Public Health Regions (states, jurisdictions, and District of Columbia):

Region	N=	Total in region
I	5	6
II	2	4
III	5	6
IV	6	8
V	4	6
VI	4	5
VII	3	4
VIII	5	6
IX	5	8
X	4	4

### 2. Number of years as Adolescent Health Coordinator:

Mean=3.4 years

	N=42	%
< 1 year	10	24
1 to 1.9 years	7	17
2 to 2.9 year	5	13
3 to 3.9 years	8	19
4 to 4.9	3	7
5 or more years	9	21

### 3. Discipline/Specialty of Adolescent Health Coordinator:

	N=45	%
Nursing and public health nursing	19	42
Health education	6	14
Social Work	5	12
Medicine	2	5
Public Health	4	10
Administration	3	7

Other 6  
14

(Greater number of responses than surveys because several listed more than one disciplines)

### 4. Percentage of time devoted to adolescent health:

Mean=63%

	N=43	%
25% or less	9	21
50%	11	26
51-75%	3	7
76-99	5	12
100%	15	35

### 5. Number of staff in adolescent health program unit:

Mean=2.7 persons

	N=41	%
<1 staff	3	7
1	16	39
1.5 to 3	5	12
4	6	15
5-10	11	27

### 6. Professional organization memberships of Adolescent Health Coordinators:

	N=
America Public Health Association	15
Society of Adolescent Medicine	5
American School Health Association	12
American School Nurse Association	5
Association of MCH Programs	4
National and state nursing organizations	10
Other public health organizations	7

## II. MEDICAID MANAGED CARE IMPLEMENTATION

### 1. The status of Medicaid managed care:

	N=	%
Implemented	28	65
Planning	12	28
Debating	1	2
No managed care	2	5

### 2. Mandatory vs optional enrollment in Medicaid Managed Care plans:

	N=	%
Mandatory	28	76
Optional	4	11
Variable	3	8
Undetermined	2	5

### 3. Components of Medicaid Managed Care plans:

	N=35	%
Provider networks (PPO, IPA, etc)	19	54
Health Maintenance Organizations(HMO)	26	74
Fee for Service with utilization review	11	31
County Health Dept created systems	7	21
Primary provider as gatekeeper	30	86
Providers receive capitate fee*	19	56
Approvals required for most referrals	18	52
Referrals only to designated specialists	13	37
Risk evaluation at the beginning	7	20
Outreach required to high risk groups*	15	44
Health education/prevention required*	17	50

\*n=34

### 4. Enrollment path for adolescents:

	N=37	%
Enrollment only through families	18	49
Independent enrollment possible	16	43
undetermined	3	8

### 5. Evaluation Planned:

	N=32	%
Yes	24	77
No	2	6
Not yet	5	16

### 6. Evaluation status:

	N=30	%
completed	6	20
planned	19	63
unknown	5	8

### 7. Outcome measures: (open-ended question)

	N=	%
Immunizations	6	29
Access to care markers (EPSDT, prenatal care, etc)	6	29
Content of care standards (guidance, screening, HEDIS)	4	19
Social morbidities (Birth, injury, crime, violence rates)	5	24

### 8. Confidentiality:

Confidential adolescent consent for certain problems such as STD or pregnancy?	N=22	%
---	------	---

Yes	21	96
No	1	4

Is this confidentiality policy different under Medicaid managed care program?

	N=26	%
Yes	2	7
No	24	93

Confidential eligibility based on adolescent's assets rather than parents assets?

	N=19	%
Yes	10	53
No	9	47

Is this confidentiality policy different under Medicaid managed care program?

	N=24	%
Yes	1	4
No	23	96

### 9. To what extent are school based health clinics included in state's managed care plan?

	N=37	%
Included	13	35
not included/no SBHC	16	43
undetermined	3	8
not determined	5	13

### 10. Are some groups carved out?

	N=36	%
Yes	32	89
No	2	6
Undetermined	2	6

### 11. Which groups are carved out?

	N=30	%
Special health care needs	20	67
Foster care youth	10	33
Sensitive services		
Sexually Transmitted Infection	12	40
Family planning/perinatal	12	40
Psychiatric care (N=31)	22	71
Substance Abuse treatment (N=31)	9	31
Other (pharmacy, dental, EPSDT, immunizations)	10	33

### 12. How well do you think your state=s managed care plan fulfills or will fulfill the Society of Adolescent Medicine=s criteria for evaluating health care reform?

	N=	Good	Fair	Poor
Availability	27	11%	52%	38%
Visibility	29	17	17	59

Quality	25	20	44	36
Confidentiality	26	43	37	20
Afford ability	27	30	37	33
Flexibility	30	13	33	53
Comprehensiveness	28	4	54	43

**13. Do you think health care for adolescents under this managed care plan is better, the same, or worse than before the MEDICAID managed care plan?**

	N=	Better	Same	Worse
Availability	24	17%	62%	17%
Visibility	24	17	58	25
Quality	23	22	65	22
Confidentiality	23	4	96	0
Afford ability	24	17	79	4
Flexibility	24	12	71	17
Comprehensiveness	22	23	59	18

**14. Other adolescent specific components**

	N=33	%
No	21	64
Unknown	9	27
SBHC	2	6
EPSDT for adolescents	1	3

**15. Advantages experienced** (open-ended question)

	N=15	%
Availability advantages (for certain areas, groups)	5	33
Quality (having medical home, primary care)	4	27
Confidentiality (regarding family planning)	1	7
Afford ability (more covered)	2	13
Comprehensiveness (more interagency coordination)	3	20

**Disadvantages Experienced**

	N=26	%
Availability disadvantages (barriers, low capitation, lack of providers)	11	42
Visibility (confusing systems, lack of clarity re providers)	4	15
Quality (lack of adolescent comfort with providers)	1	4
Confidentiality	3	12
Comprehensiveness (lack of mental health integration; coordination with special health care needs; SBHC decreased)	8	27

**III. CURRENT ISSUES IN ADOLESCENT HEALTH**

**1. Top 3 priorities in the state for adolescent health:**

(open-ended question)

N=123

total responses in this category--

Reproductive Health	35
pregnancy prevention	28
services for pregnant and parenting teens	3
STD/HIV prevention	4
Improve systems of care for adolescents	25
develop primary care	3
enhance core public health functions	7
improve access to care	15
Injury prevention	24
injury	4
violence and homicide	14
suicide	6
Substance abuse prevention	12
SBHC, clinics, education	10
Mental health	10
mental health services	5
mental health enhancement	5
(assets, resilience, self esteem, role models)	
Health education and prevention	3
Risk behavior reduction	3
Juvenile justice	1

**2. Would state pick-up health care for teenagers if Congress passed the proposal to cover only pregnant women and children under 13?**

	N=43	%
Yes (definitely and probably)	21	49
No (definitely not and probably not)	5	12
Too close to call	7	16
Unable to guess, don't know	10	23

**3. Highlights of State Initiatives:** [See attached Section 4, page 34]

**IV. ADOLESCENT PREGNANCY**

**1. How could the federal government and/or private sector enhance state=s adolescent pregnancy**

**prevention efforts** (Open ended question)  
N=105 total responses

Fund programs	26
Highlight issues and showcase effective programs	10
Support community/government coalitions	8
Support comprehensive and integrated services	7
Support skill-based programs to avoid pregnancy	7
Use media	6
Support evaluation regarding effectiveness	6
Provide supportive services (outreach, transportation, abuse prevention, substance abuse programs, recreation programs)	6
Emphasize male involvement (responsibility, mentoring, enforce sex laws to protect adolescents)	5
Support employment programs	4
Improve schools and support school health	5
Support parental education and involvement	3
Follow certain principles	10
(Stress sexual responsibility; divide sex/romance; involve adolescents; don't mandate abstinence programs; avoid categorical programs; keep family centered; unlink from abortion debate; don't require parental consent for services)	
Support training in adolescent health	2

**2. How does state compare to the Healthy People  
2000 objective to reduce pregnancies among females  
age 15-17 to <50 per 1000**

	N=38	%
Better	14	37
Not yet	24	63

(Several noted that state monitors births, not pregnancies)

**3. Does state have it own objective to reduce  
adolescent pregnancies**

	N=43	%
Yes	22	51
No/no answer	21	49

**4. Trends in adolescent pregnancy in state:**

	Increased		Decreased	
	N=43	%	N=43	%
younger adolescents <15	15	35	5	12
older adolescents 15-19	10	23	18	

**5. Does state use Title V funds for programs related  
to adolescent pregnancy.**

	N=43	%
Yes	36	84
No	7	16

**How does your state use these Title V funds ?**

(Open-ended question)

N=56 total responses

Responses in category--

Teen Pregnancy	33
Prevention	23
Services for pregnant and parenting Teens	10
Improve access to comprehensive care	16
Provide direct services	3
Develop infrastructures for adolescent health	5
Develop school-based/linked health care	8
Preventive health/health education	3
Other	4
(Hotline development, improve health care quality, risk assessment, support young people with resources)	

## V. DATA AND INVOLVEMENT REGARDING SPECIAL POPULATIONS

1. Does your state have adolescent specific data regarding these populations?

Percentage of state and territory Adolescent Health Coordinators responding "Yes". N=39 Percentages are rounded

POPULATION	Size of this adolescent population?	Demographics of this adolescent population (i.e. poverty rate, marital status, etc)	Health Status or Health problems of adolescents?	Risk Behavior
All Adolescents	97%	77%	55%	82%
African American	85	51	26	28
Asian/Pacific Islander	64	36	13	20
Native American	72	38	15	23
Hispanic American	72	38	15	20
Rural	64	38	26	23
Urban	64	38	26	23
Immigrant	18	5	5	8
Foster	54	26	10	5
Maltreated	38	13	10	8
Incarcerated	64	31	20	10
Homosexual	3	3	5	3
Pregnant & parenting	59	46	23	20
Disabled/chronically ill	44	18	15	8
Learning Disabled	41	15	8	3
Mentally ill	31	18	8	10
Homeless/Runaway	20	10	8	10

2. What type of involvement in activities specifically regarding adolescent special populations have you or your office had?

Percentage of state and territory Adolescent Health Coordinators indicating any involvement regarding population. n=38 percentages rounded

Population	Needs Assessment	Policy or Program Planning	Consulting regarding this adolescent population	Funding programs targeted for this population	Managing program targeted toward this population
Adolescents	92%	79%	84%	68%	68%

African American	42	37	37	29	21
Asian/Pacific Islander	29	24	24	21	18
Native American	34	26	21	21	18
Hispanic American	32	24	24	21	21
Rural	45	37	40	29	34
Urban	40	34	29	24	26
Immigrant	10	8.9	5	5	5
Foster	21	8	13	8	8
Maltreated	20	16	18	10	10
Incarcerated	29	24	26	8	8
Homosexual	24	24	26	10	8
Pregnant &parenting	62	68	55	60	50
Disabled/chronically ill	47	39	37	26	21
Learning Disabled	18	10	16	8	5
Mentally ill	21	16	16	10	5
Homeless/Runaway	21	18	13	5	5

## 4. State Initiatives in Adolescent Health

The adolescent health coordinators were asked to describe new initiatives in their state regarding adolescent health. Here are their responses:

### Alabama

The State Perinatal Association initiated a grant program where communities can submit or apply for grants to target infant mortality. 50% of the money has to be used to prevent teen pregnancy.

"Improving Adolescent Health Services for Parenting Teens Through Training" has been funded for the last 2 years with \$25,000 each year. Title V funds are funding UAB Division of Adolescent Medicine to go to three different sites each year to train health providers in public health on adolescent issues. A training manual is provided for each participant. After the training, each participant will have the opportunity to complete a mini clinical practicum at the Teen-Tot

Clinic at UAB.

### Alaska

Juvenile Justice.

YRBS (first time survey conducted 1995).

Adolescent data integration demonstration project. (Continuing) support for citizens advisory group -- Alaska Adolescent Health Advisory Committee (after State plan was completed). Native American should read Native Alaskan on all charts pertaining to Alaska.

### Arizona

C 92 certified adolescent health trainers - The Arizona Prevention Resource Center has a contract to provide scholarship assistance so training can be provided and to provide support to trainers - "De-mystifying Adolescence Facts and Fiction" formerly "Basic Concepts in Identifying Health Needs of Adolescents." One community college offering it

this semester with an application to the community college district for an Adolescent Certificate Program.

- C The adolescent coalition considering moving outside ADHS to its own 501C3 organization.
- C Arizona Medical Association beginning to plan for pre-screening tools for physicians use with adolescent patients.
- C Teen pregnancy prevention has died in legislature so far.
- C HIV/AIDS Education used to be mandatory, now is not.
- C Mandatory treatment as an adult for most juveniles under consideration.
- C Pilot program for DES (Economic Security) Juvenile Justice, Probation and Behavioral Health began. Each worker trained in all areas.

### Arkansas

*Training:* The School Health Staff Development project (MCHB funded) conducted during the past year has provided for a.) adolescent health workshops targeted to health department, school and other community personnel to be conducted in all regions of the state; b.) participation by all ADH school-based clinic personnel in a 3-day Amini-preceptorship@ conducted by Division of Adolescent Medicine staff at Arkansas Children's Hospital; c.) a large school and adolescent health conference featuring nationally recognized speakers February 15-16, 1996 which attracted more than 300 participants from around the state; d.) team-building workshops to be conducted for school/health personnel during the spring of this year.

*System Development:* Adolescent coordinator has worked with system development coordinator to assure that adolescent health needs are addressed by local planning committees in place in the state's neediest counties.

*Other:* "Common Ground" a state-funded adolescent violence prevention initiative being coordinated through the Dept. of Health Office of Disability Prevention; still in organizational phase; will probably involve mini-grants to communities determined by state-level advisory group.

### California

*Teen pregnancy prevention* - Governor has proposed \$34 million for ACommunity Challenge Grants@ to prevent teen pregnancy. \$15 million for media campaign to also address male involvement in pregnancy prevention. \$6 million for increased prosecution of statutory rape. \$2 million for creation of

State Department of Health Services/Education have received CDC grant to coordinate school-linked health services.

### Colorado

*School-based health centers*--Colorado is working diligently to establish ongoing funding mechanisms for school-based health centers, with both public and private managed care systems as partners at the table. Kaiser sponsored a study to look at differences in utilization and quality of care by two separate groups of teens: Denver teens enrolled in Kaiser (without access to a school-based health center) and teens with access to both Kaiser and one of the Denver School-Based health centers. The primary differences discovered were that students with access to a school-based health center had more preventive visits, higher assessment levels for high risk behaviors, much higher use of mental health and substance abuse services, and significantly lower use of urgent and emergency room care. These results are very important for the policy discussions being held about the role of managed care organizations in school-based health centers. They will be published in the near future.

*Training in Community based health planning*--The Adolescent Health Program staff are conducting trainings for county health department and county nursing service staffs and other multi disciplinary professionals in community-based planning for child health--applying the community development strategies they have been using for a number of years in adolescent health for the broader populations, including special training for programs providing services for children with special health care needs.

### *Adolescent Maternity Program for Prevention of Abuse and Neglect*

Catherine Stevens-Simmon, M.D. (address on file)  
The Colorado Adolescent Maternity Program for Prevention of Abuse and Neglect (CAMP-PAN) is a

multi disciplinary prenatal and postnatal care program which utilizes a case management format to combine the professional services of physicians, nurses, nurse midwives, social workers, a dietician, and outreach workers. CAMP-PAN addresses three critical issues in MCH; the large number of preterm births, the high rate of recidivism, school failure and welfare dependency among adolescent parents, and high rate of abuse and neglect among the children of adolescent parents. CAMP-PAN serves an urban community; the geographic service areas include metropolitan Denver and the surrounding suburban communities. The program targets an ethnically mixed population of families in the Denver metropolitan area in which a young woman conceives before she is 19 years of age. CAMP-PAN has the potential to reduce the incidence of preterm and low birth weight deliveries and to increase the number of adolescent parents who graduate from high school and become active, productive community members and nurturing, non-abusive parents.

#### *The Florence Crittenton School*

Sally Hodson, Ed.D. (address on file)

The Florence Crittenton School is an alternative school for Denver's pregnant and parenting teens. The program is comprehensive in nature, providing academic education, day care services, parenting education, career development and job training, prenatal and general health education, prenatal health care services, infant health and child care education, and mental health counseling. The program serves approximately 250 clients per calendar year. The community outreach project includes primary and secondary teen pregnancy prevention activities. In addition, the program serves as an information and referral source for the community. This project assists teen parents in completing their education, achieving economic self-sufficiency, and delivering and raising healthy babies.

#### *Young Parents Program*

Cheryl Anne Richards (address on file)

Young Parents Program targets Mesa County's pregnant women and young parents (females age 22 and under; males age 25 and under), and also includes an adolescent pregnancy prevention component which primarily targets high school students. Young Parents goals are to prevent low birth weight babies, repeat pregnancies and school dropouts, and attain healthy parent-baby relationships. The program provides comprehensive prenatal and parent education for Mesa County's young parents, including health, safety, and decision making skills using a peer self-help approach.

Young Parents enables participants to be economically and emotionally self sufficient, by teaching problem solving and decision making skills so that they can make personal, career, and health choices. The result is a better quality of life for parents and children and enormous taxpayer savings. The program helps young parents build and maintain constructive lifestyles and has a powerful impact on preventing child abuse.

#### *Rocky Mountain Center for Health Promotion and Education*

Mary A. Doyen (address on file)

The main goal of the Rocky Mountain Center (RMC) is to promote the implementation of research-based, effective comprehensive health education for youths in grades 7-12 throughout the state of Colorado. In the 1995-96 project year, RMC will continue its commitment to training in the modules comprising the Teenage Health Teaching Modules, as well as compatible curricula including Healthy Sexuality; Avoiding STD: Risks, Rights and Responsibilities; Reducing the Risk; Be Proud! Be Responsible!; and POWER Moves. Since its inception, RMC has provided teacher training and technical assistance to Colorado school districts, including clients from 75% of Colorado's 176 school districts, as well as several private schools and other governmental agencies (e.g. Division of Youth Services).

#### *School-Based Health Centers*

MCH supports school-based health centers in three different parts of the state--Denver, the San Luis Valley, and Commerce City. All of these programs provide classroom health education related to teen pregnancy prevention, identify students at risk of pregnancy, and either provide contraceptive services for sexually active students (in the San Luis Valley and Commerce City) or provide information on pelvic exams and referrals for contraceptives (Denver).

#### **Connecticut**

C Our expanded school health services demonstration projects were summarized in the most recent SAHCN newsletter.

C See additional comments, RWJ Foundation, Making the Grade in CT project abstract (for 4 year implementation phase).

C We presently have 40 licensed SBHCS (preK-12) 1 to open in April and 4 more over the Summer.

C 13 adolescent pregnancy prevention and young

parent programs continue with several adding male outreach and service components. Greater attention is being devoted to the older age of males in contributing to this issue.

C CT is one of the AMA GAPS pilot states. We participated in the train the trainer in the fall and are training SBHC staff to implement it in the high schools. We will also send a TOT team this spring for High/Middle School GAPS training.

C We are also implementing L. Wildey's Adolescent Health Training.

### **Delaware**

Alliance for adolescent pregnancy prevention:  
Media campaign using campaign for our children materials  
Parent training  
"mini grants@ to local communities to implement programs  
annual conference  
resource center - programs, materials, etc.

### **District of Columbia**

Town meetings, forums, work groups to address all of the above [priorities in adolescent health].

### **Florida**

C Several Florida counties are taking advantage of private/public partnerships with hospitals, community health centers, universities and other local businesses to provide adolescent care in school-based settings. Private businesses provide either staffing for centers, money for staff to be hired by the county public health units, or assistance through mobile clinics that rotate between designated schools. Universities provide assistance in numerous sites through medical vans staffed by student interns and student nurse practitioners.

C Healthy Start Coalitions bring community members, businesses, and professionals together as task forces and ad hoc committees to develop strategies to reduce teen pregnancy. Most of the service delivery plans for Healthy Start Coalitions include action plans for teen pregnancy prevention.

C The State Health Office School Health Program provides at least one state wide training

conference for school health providers each year. This year the conference is provided through a cooperative agreement with the Florida School Health Association.

C The State Health Office School Health Program is coordinating regional trainings across the state utilizing the Basic Concepts for Identifying Adolescent Health Problems Curriculum. Seven teams of teachers from multiple health related disciplines and all regions of the state are providing the classes.

C The State Health Office participates in an Interagency Task Force that provides educational materials to blitz the state during teen pregnancy awareness week. (Coincides with the White Ribbon Campaign) One of the goals of the Task Force is to increase awareness of the role of victimization in teen pregnancies.

C Florida is in the first year of funding the ENABL program which uses the Postponing Sexual Involvement Curriculum to delay sexual involvement.

C Expansion of the Comprehensive School Health Services Projects whose mandated goals are to reduce teen pregnancy, increase access to health services for students in medically underserved communities, and promote student health.

### **Georgia**

There is currently an initiative of the Department of Human Resources to improve service delivery systems across agency lines. Issues such as eligibility determination, common intake, integrated information systems and improved coordination of services between health, welfare and employment services.

### **Guam**

The Family Planning Program currently works hand-in-hand with the school health counselors of the six high schools on island. Pregnancy test kits are provided to the counselors to administer to those adolescents requesting a test. Those who have negative results are then referred to Public Health for further FP services, particularly for getting on a contraceptive method. The FP Program is currently in the process of conducting a needs assessment to identify those unmet needs on island. There is no

fee for service for adolescents 19 and below at Public Health. They are seen right away for services.

### Hawaii

C An Adolescent Wellness Team has been meeting to develop a state Adolescent Wellness Action Plan.

Strategies within this plan will support the integration of initiatives for youth and the development of policies supporting identified needs and services. Following its implementation, the plans progress will be monitored and barriers addressed to ensure the continuation of a framework supporting adolescent wellness in our State.

C Working with other departments, agencies, and community to develop a teen pregnancy prevention plan which would integrate with State Adolescent Wellness Plan.

C Working with other departments and agencies to strengthen standardized and collaborative data collection efforts. Two School-Based Health Service Centers at Kapaa and Hahuku High and Intermediate Schools. They provide risk assessment screening, preventive health, education, counseling, referral, and care coordination. Enrollment for both schools is over 3,600.

C Perinatal Support Services - comprehensive services for low income high risk pregnant women - outreach and enrollment in health insurance, health assessment, nutritional counseling, health education, psycho-social assessment and care coordination.

C Teen Intervention Program - comprehensive services for pregnant and parenting teens 18 years and younger, their parents and partners. Services include counseling, education, case management, and peer advocacy work.

### Idaho

Adolescent pregnancy prevention: Governor appointed council.

Focus: abstinence

Media campaign with abstinence message started 1/15/96.

### Kansas

Public/Private Initiatives through Kansas Adolescent Health Alliance (KAHA). The next project is newspaper insert/paper re: Status of Adolescent Health

in Kansas; also, Update KAHA Profile.

### Louisiana

*The Adolescent Health Initiative of the Louisiana Office of Public Health*

Using successful models from other states, a core group of Office of Public Health representatives and external advisors has developed an Adolescent Health Initiative for Louisiana. The initiative facilitates a coordinated, multi-disciplinary approach to adolescent health care, disease prevention and health promotion in the state. It provides an infrastructure to enable local communities to more effectively and efficiently address adolescent health needs.

The collection and dissemination of data is an essential part of the initiative. Obtaining information on both adolescent health issues and on current adolescent health activities is a priority. The state public health office will serve as a central repository for such information. The use of statewide teen health questionnaires and adolescent focus groups, coupled with the collection of adolescent health statistics, will provide communities, parents, politicians and policy makers with a clear picture of adolescent health in Louisiana. With technical assistance from the Office of Public Health, regional and local communities will then be responsible for identifying and prioritizing teen health needs. Local community coalitions will design, implement and evaluate comprehensive, holistic adolescent health projects or activities.

Currently, there are many state and local projects that emphasize different aspects of adolescent health. Some focus on teenage pregnancy or teen parenting, while others may focus on HIV/AIDS, tobacco control, conflict resolution, cardiovascular health, or on the maintenance of school-based health clinics. The Adolescent Health Initiative allows for the planning, development, implementation and evaluation of these activities in a coordinated, collaborative fashion. In addition, the initiative broadens the scope of cooperation to include the Office of Mental Health, the Office of Alcohol and Substance Abuse, the Office of Youth Services, and so on. Such team-building efforts are necessary to merge the work of all agencies working with the common goal to ensure health and happiness for Louisiana's youth. A survey of existing activities and resources across public health programs and external agencies, therefore, has already begun. Information from this survey will be developed into a guide to use as a springboard for networking and

collaboration, and as a means to reduce duplication of services and/or activities.

It is important to remember that this initiative is not about starting a new project or designing a new program. This initiative is an attempt to coordinate resources and activities that are already in place to better serve the state's adolescents. Furthermore, the initiative is a vehicle for grassroots, local-level health planning, as communities begin to decide for themselves what is needed to keep their youth healthy and safe. For example, communities could decide that they need to remove video poker machines from their bars, or move the high school away from the Superfund site, or begin a community garden, or start a truly comprehensive peer education program. Final projects are intended to be from and for local communities. The Office of Public Health, therefore, is assisting in this effort, but is not dictating its path. For more information, please contact Natasha Sakolsky, MPH, at 504/568-6636.

### Maine

The Governor's Task Force on the Prevention of Youth Suicide and Self-Destructive Behavior was commissioned last year. The Task Force was led by the Dept. of Mental Health/Mental Retardation. There was a significant involvement of teens. A report was issued in early September, 1996.

The Commission of Human Services has formed a Departmental Task Force on Adolescent Pregnancy. The Task Force is working to coordinate activities to better address this issue.

The Bureau of Health received a SPRANS grant from MCHB to develop a state infrastructure that would support mental health services through school-based health centers. A cooperative agreement with the University of Southern Maine has been established to carry out this project.

### Massachusetts

Working with Medicaid to move to a unit rate to increase Medicaid coverage.

Double \$s for primary pregnancy prevention from \$2m to \$4m:

Cevaluation design for FY'97 implementation;

C comprehensive prevention MIS for community

health coalitions and adolescent services.

### Michigan

- C Creating a plan to expand participation in Medicaid and secure a role within the managed care system for adolescent health centers.
- C Michigan Abstinence Partnership with emphasis on inviting communities to become partners. Six communities have been targeted for community support, technical assistance and media messages.
- C Plans are underway to add Guidelines for Adolescent Preventive Services (GAPs) as a minimum program requirement for Adolescent Health Centers.
- C Implementing School Health Care On-Line, a school-based clinic management information system as a part of our adolescent health center data programs.
- C Abstinence only curriculum added to the MI Model, the comprehensive school-based health program.

### Minnesota

- C Minnesota care is a premium subsidy health insurance program for families with children (20yo and less) who are not eligible for Medicaid and whose family income is less than 275% of the appropriate Federal poverty guidelines.
- C Collaborative plans are required of all HMOs on an annual basis. These plans are to document how the HMOs are helping to realize public health goals in the geographic (county or counties) area in which their enrollees reside.
- C The HMOs have an HMO Council that is facilitating managed care working with local public health, SBCs, etc. to do selected population-based projects.
- C Foundations associated with HMOs are contributing financial resources to selected projects, many of which involve children and adolescents.
- C Through the 1115 waiver process, pregnant women and children on Minnesota care at less than 275 percent of poverty are eligible for medical

assistance (Medicaid) funding.

## Missouri

*Access to care* - Collaborative practice agreements between physicians and nurses.

*Caring Communities* - Establishing "full service school" programs through Acommunity partnerships@ with school as hub.

*School Health Funding* - to increase access to care

94-95	\$5.4 million	Increased school nurse coverage
95-96	4.2 million	From 50% to 80% by 95-96.
96-97	5.4 million	Goal-100% coverage

Also vehicle to add mental health, social work components.

*Outreach Education* - State revenue funds used for training health care providers in adolescent health issues, or direct education programs to adolescents, e.g., high risk behaviors.

*Family Planning Initiatives* - State funding to increase services and to provide abstinence based programs in schools and communities.

## Nebraska

*Access to Care* - Family Planning added new clinic site. Currently NE has 11 funded sites + 18 satellites. RWJ Grant and HCFA funding via Office of Rural Health is enabling the implementation of 6 primary care networks to increase rural capacity to meet health needs.

*Public/Private Initiatives* - Community Health Services Plan is collaborative effort of public and private entities. Good Beginnings is a home visitation program which fosters community partnerships to address health, education and social service needs teen mothers enrolled. PACT funds have been distributed to communities for violence prevention activities. Quality Assurance - Child/Adolescent Death Review Board activated. Will impact on safety interventions with adolescents.

*System Development* - Community Health Services Plan creates 6 regional boards to identify local strengths and weaknesses for delivery of health services in each region. Pass-through federal funding will assist regions in meeting identified needs. State Systems Development Initiative (SSDI) -

implementing a system for medical transition of children with special needs. Family Preservation funds address high risk adolescents in 3 counties and 1 Native American community.

*Training* - (1) Comprehensive Health Education Team Training (CHETT): addresses schools' multi-disciplinary programs for sequential, K-12 health education, health services, healthy and safe environment, physical activity, nutrition, healthy sexuality, counseling/mentoring and social services, health promotion for staff/ community, parent and community involvement. Specific application to adolescent issues: preventing teen pregnancy, HIV and other STDs, violence, injury, depression/suicide, tobacco-alcohol and other drug use, eating disorders, and sedentary lifestyles. 300+ teams trained. (2) School Nurse Achievement Program (SNAP): Home study course from University of Colorado enhancing school nurses' skills in serving and youth with special needs. NDOH consultant adds nursing procedures update and shadowing experience with clinical nurse specialists during summer months. (3) Expanded Certification for School Nurses: Enables them to teach Health Occupations. Will enhance services and education to youth in rural Nebraska especially. (4) HIV Update for Rural Nurses: NDOH consultant's collaborative effort with UNMC College of Nursing. Ten statewide workshops for community, school and hospital nurses; enhanced networking capability and knowledge of each other's roles with HIV clients/families. (5) Guidelines developed for distribution to School Nurses: Eating Disorders (October, 1995); Roles for School Nurses in Adolescent Pregnancy Prevention, Intervention & Support (Fall, 1996). (6) 4th Annual Interdisciplinary Adolescent Conference: concentrates on adolescent issues -- stresses positive approaches to mental health, parenting, violence and pregnancy prevention. (7) Facts & Myths of Adolescence: Cincinnati curriculum replicated (Spring, 1996) in Eastern and Western region. (8) Postponing Sexual Involvement: statewide multi-disciplinary training. (9) Illusion Theater Group: High school students perform sexual decision-making and violence prevention acts. Research based evaluation shows positive impact; will be published in 1996. (10) Psycho-social Assessment Skills Seminars for School Nurses; Alcohol, Tobacco & Other Drugs Workshop for School Nurses (presented in five regions of the state). NDOH consultant wrote PH&HS grant to fund psychiatric consultation/education programs for school/community on selective basis.

## Nevada

The Family Health Services Bureau is funding two adolescent clinics. The clinics are located in the 2 largest counties of the state - encompassing 80% of the state's population. Health Care and education is available at no or a reduced cost. Care is not denied due to an inability to pay.

A Teen Pregnancy Prevention initiative has been launched. The plan was developed by the State Health Division and the Office of the Attorney General. The plan calls for the state to act as a catalyst for communities to examine and address their needs pertaining to teen pregnancy prevention. Involvement of youth, parents, and adult males has been linked to each phase of implementation. Funding will be solicited by and distributed through a Public Health Foundation. A Youth Advisory Council will also be created to advise the Governor and other state agencies on issues and programs related to adolescent health and wellness. A statewide media campaign will be developed for Spanish and English speaking audiences. Public-Private partnerships will be of tremendous assistance in this endeavor.

#### **New Jersey**

Adolescent Enhanced Services Program, a joint program of the Departments of Health and Human Services (Medicaid), integrates an assessment of adolescent risk behavior with routine family planning services in State funded Family Planning Agencies and the 11 Federally Qualified Health Centers in New Jersey.

*Key services* - comprehensive risk behavior assessment, education and counseling, follow-up for all identified risks

*Components* - healthy life style, injury prevention, violence prevention, mental health issues as well as STD and pregnancy prevention concerns and is offered at initial and annual family planning visits. Appropriate education and counseling and referral follow-up are provided at all medical visits. Supplemental Medicaid reimbursement for all eligible teens is provided and is based on the intensity of counseling activities. However, this additional package of services is mandated for all adolescents served. Medicaid reimbursement for the initial or annual assessment is double the rates for revisit updates. Revisits for follow up of identified risks can be scheduled monthly and will be reimbursed for up to twelve visits annually. Medicaid has delegated the

quality assurance activities to the Department of Health, Family Planning Program for this initiative. Program evaluation will include chart review and outcome evaluation.

The Adolescent Health Team is in the process of conducting a survey of adolescent initiative/services funded by the DOH, and plans are being made to form an Alliance which will consist of state, governmental, and community- based providers.

#### **New Mexico**

Youth involvement in planning.  
Resiliency/assets building for communities to support youth.

#### **North Carolina**

CCreating new SB/SL Health Centers through public/private partnerships. Will probably be getting private foundation funding (e.g., Duke Endowment) for at least the next 3 years. Currently, have state funds for these health centers. This public/private initiative is the hottest thing now. As a result, access to care for teens should improve.

C We have 23 adolescent pregnancy prevention projects. We have had 7 rounds of funding for these kinds of projects. The annual appropriation is \$1.4 million.

C We have been selected to pilot the implementation of GAPS in our SB/SL Health Centers and our local health departments. This pilot project is a big deal.

#### **North Dakota**

A pilot study of an HMO Managed Care Plan in one county of the state is being implemented.

#### **Ohio**

*Access to Care* - The Department of Health is meeting with independent MEDICAID HMO's to aid in establishing collaborative linkages with local health departments and hospitals and school-based health centers to provide services for MEDICAID eligible children. MEDICAID HMO's are interested in reaching children to provide required EPSDT screenings and are welcoming opportunities to negotiate with the public health sector to increase access to health care. Beginning negotiations have

proved favorable for continued progress in this area.

*Training* - The School Adolescent Health Unit at the Ohio of Health is partnering with the Violence Prevention Institute of Wright State University to implement a ATrain-the-Trainer@ Program for creating a school-based violence prevention program throughout Ohio. This initiative entitled P.A.C.T. (Positive Adolescent Choices Training) is funded through a grant from MCHB to offer this training to five states including: Ohio, Kentucky, Michigan, Georgia, Florida. The goal of this initiative is to prepare leaders within each state for roles in training and support for school-based child and adolescent violence prevention programs.

### **Oklahoma**

- C Public private initiative for Teen Pregnancy Prevention
- C Development of public/private/foundation funding of school health/health education.

### **Puerto Rico**

The MCH Program is working in activities aimed at System Development.

The Comprehensive Adolescent Program is providing training to health professionals and school staff in order to improve their skills on how to appropriately deal with the most common adolescent health problems.

### **Rhode Island**

RIDH is implementing an adolescent health initiative in 2 high risk urban communities called Town Teen Networks. Networks of collaborating organizations will pull together and build upon existing community resources. Programs will provide:

1. Education, discussion and support sessions for small groups of at risk youths.
2. Parent Education and Effectiveness Training
3. An intensive and personalized mentoring program for boys
4. A teen birth follow-up coordinator. Programs must also provide for: substance abuse counseling, domestic and sexual abuse counseling, treatment for mental illness, reading remediation and academic support, family planning and treatment for STD's.

RIDH is also implementing a free pregnancy testing, risk assessment, referral and follow-up program in Title X family planning clinics. The hope is to get at risk teens with a positive pregnancy test into early prenatal care (RItE Care) and to provide family planning and other risk reduction services to the teen with a negative pregnancy test.

### **South Dakota**

Currently, South Dakota is in the process of privatizing public health services in targeted areas. This will allow collaboration between the Department of Health, local health care providers, county commissions and a local community health council to strengthen the current health system. Systems development will provide technical assistance and funds to assure accessible, affordable health care services for infants, children, adolescents and their families.

### **Utah**

- C Media campaign focusing on adolescence.
- C MCH staff participation in medicaid managed care evaluation.
- C EPSDT availability statewide through schools via FACT initiative (Family, Agencies, Communities Together)
- C School Nurse Bill suggesting collaborative relationships.

### **Vermont**

- CSchool-based health clinics (RWJ grant)
- CFocus on assuring access to mental health
- CBeginning to look at comprehensive mental health needs of children and adolescents including periodic screening, prevention, and assessment of resiliency/protective factors
- CSSDI/community needs assessment by school districts
- C Adolescent Health training (Cincinnati curriculum) of M.D's, school nurses, etc.
- C Continuation and expansion of Medicaid financing of certain school activities through contracts with Department of Health, Department of Mental Health , and Department of Education.
- C Expansion of Carnegie Middle Grade initiative.

### **Virginia**

Statewide efforts are on incarceration of juvenile offenders and to Aget tough@ on crime, and

privatization of services.

Local community efforts are on access to health care, public/private initiatives to develop programs, and training of providers and consumers. For example, school/community services to increase health care access in school divisions. The Virginia Department of Education provides funding each year for two year local pilot program initiatives to provide health-care services to school-aged children.

### **Washington**

The State DOH received \$1m to implement portions of the Washington State Youth Suicide Prevention Plan. A community needs assessment is being completed by local health jurisdictions prior to the implementation of prevention activities.

The adolescent health coordinator is facilitating meetings with representatives of juvenile justice and health care providers. A major effort of this group is to collect data on the health needs of teens in the juvenile justice system.

Training and technical assistance on the transition issues for adolescents with special health care needs are being provided through a contract with the U.W. Division of Adolescent Medicine.

### **West Virginia**

Self instructional packets (Health Modules) to help youth workers teach prevention, health education, and supportive activities. Samples can be provided on request.

Adolescent Health Profile.  
Adolescent Injury Profile.

### **Wisconsin**

C The state is presently involved in a mid-decade review of HEALTHIER PEOPLE IN WISCONSIN: A Public Health Agenda for the Year 2000.

C The rewrite and adoption of Wisconsin State Statutes. For the first time ever, Wisconsin now has a Maternal and Child Health Chapter.

C Statewide public health needs assessment.

### **Wyoming**

C Refocus of attention on primary and preventive care -- especially in injury prevention for the population aged 0-18.

C No managed care in Wyoming Medicaid -- none likely. Hostile provider climate at present.

C Systems development @ approach being used in planning and providing family planning services -- especially to prevent teen pregnancy.

C Near future-emphasis on teen violence and teen suicide.