National Network of State Adolescent Health Coordinators: Preliminary Report of 2005-06 Assessment

Survey Committee

Trina Anglin, Maternal and Child Health Bureau, Health Resources and Services Administration

Nancy Birkhimer, Adolescent Health Coordinator, Maine

Bob Nystrom, Adolescent Health Coordinator, Oregon

Jane Park, National Adolescent Health Information Center, University of California, San Francisco

Kristin Teipel, State Adolescent Health Resource Center, University of Minnesota

Many thanks to the State Adolescent Health Coordinators who responded to the 2005-06 Assessment of the National Network of State Adolescent Health Coordinators!

This report was prepared by the National Adolescent Health Information Center and is intended to be an internal working document for the National Network of State Adolescent Health Coordinators and its partner agencies to guide planning, training and related activities.

This document was developed with support from the Health Resources and Services Administration, Maternal and Child Health Bureau, Office of Adolescent Health (U45MC 00002).

Suggested citation: National Adolescent Health Information Center. (2007). National Network of State Adolescent Health Coordinators: Preliminary Report of 2005-06 Assessment. San Francisco: University of California, San Francisco.

National Adolescent Health Information Center
NAHIC

National Network of STATE ADOLESCENT HEALTH Coordinators

sahrc
State Adolescent Health Resource Center

Summary of Results

This report highlights the key findings of the 2005-06 National Network of State Adolescent Health Coordinators (NNSAHC) assessment. The State Adolescent Health Coordinators ("Coordinators" or "SAHCs") provide leadership within state agencies to improve adolescent health, safety, and well-being, while also offering information and consultation to other organizations and agencies regarding comprehensive adolescent health. Their positions are largely supported by the Title V/ Maternal and Child Health Block Grant, a Federal-State program administered by the Health Resources and Services Administration's Maternal and Child Health Bureau (HRSA/MCHB). The purpose of the assessment was to describe the variety of adolescent health efforts in states under the Coordinators' leadership and identify emerging needs for technical assistance and training.

The assessment was first conducted in 1996—and then in 1999 and 2001—as a tool to gain information from the SAHCs on the implementation of their HRSA/MCHB-supported adolescent health programs. The current assessment was administered between December 2005 and March 2006 and was made available to all 59 states, territories and jurisdictions. The five main topics of the assessment included: profile of Coordinators and Coordinator positions; major activities; guiding frameworks; environment; and technical assistance priorities. A total of 37 responses were received. The preliminary results were first presented at the NNSAHC meeting in April 2006. This report summarizes findings for the assessment's five main topics. The appendix presents detailed information on responses to the assessment's close-ended questions.

A few highlights about the work of the Coordinators and the context in which they work:

- Most Coordinators are in permanent positions and working more than half time on adolescent health issues.
- Most Coordinators spend at least some time coordinating adolescent health broadly.
- Most Coordinators would like to do more broad coordination and most have adopted a youth development approach.
- Coordinators juggle many categorical programs and many benchmarks and frameworks.
- Coordinators focus on developing and maintaining partnerships.
- Reproductive health/sexuality is a major focus for individual Coordinators. These issues also figure prominently in state policymaker debates on adolescent health.
- Major barriers are lack of time and resources.
- Coordinators generally feel supported in their agencies and report varying levels of support for adolescents and adolescent health in their states.

Section I: Profile of Coordinators and Coordinator positions

Coordinator Position and Tenure

Most Coordinators (36) are in permanent positions. Coordinators have served for a range of tenures:

- 0 < 2 years: 10
- 2 years < 4 years: 11
- 4 years < 8 years: 10
- 8-18 years: 5

Background

Coordinators come from a range of backgrounds, including: public health (10), nursing (7), health education (3), and others cited were psychology, human development and public health, and medicine. Coordinators have spent a range of time in the adolescent health field; eight are relative newcomers, with less than five years in the field; 11 reported between five and ten years in the field; nine reported 10-15 years; and eight have worked in the field for 18-30 years.

Degrees and Certifications

The majority of Coordinators have graduate level degrees. The most common are: clinical (both MD and RN), health education, social work, and business administration.

Time Spent on Adolescent Health Issues

A majority of the Coordinators work for the state full time (32). However, 14 Coordinators spend no more than half of their time on adolescent health, including eight who spend 10-40% of their time on adolescent health. Fifteen SAHCs spend 100% of their time on adolescent health issues. Of the time spent on adolescent health, few SAHCs reported coordinating adolescent health broadly full time. Most report spending time on adolescent-specific and/or adolescent inclusive programs.

Management and Supervision

Most Coordinators manage contracts (25) and have responsibility for budgets (20). Fewer Coordinators supervise staff (15) or manage contract staff (12).

Legislation

Many Coordinators (22) reported responding to legislation. The major legislative issues that Coordinators respond to include:

- reproductive health (teen pregnancy, abstinence, sexual abuse, STDs);
- funding for school-based health centers;
- obesity/nutrition; and
- access to health care services.

Few Coordinators initiate legislation on adolescent health policy (5). Of those that do initiate legislation, the major issues that they focus on include: bullying policy in schools, public policy on teen pregnancy, expansion of school based health centers, and abstinence education.

Funding

Most positions are substantially supported by State Title V/MCH grants. The salary support for SAHC positions in seven states is independent of Title V/MCHB funding.

Section II: Overview of Adolescent Health Activities

Health Areas and Populations

Coordinators were asked to describe the extent of their involvement in each of 18 areas relevant to adolescent health. Areas most frequently mentioned as a major focus include:

- general adolescent health (21);
- comprehensive pregnancy prevention (16);
- youth development (15); and
- abstinence education (13).

Coordinators identified additional areas as secondary focus:

- mental health (22);
- obesity/overweight prevention (20);
- reducing health disparities (19);
- substance use/abuse (17); and
- school health (17).

Coordinators also focus on different populations relevant to adolescent health. Of 17 population groups, the following were most commonly cited as major foci:

- middle childhood (21);
- low-income youth (16);
- rural youth (15); and
- males (15).

Many cited the above populations as the target for abstinence education and teen pregnancy prevention programs. Coordinators identified additional populations as secondary foci. These include: racial/ethnic minorities (18) and females (15).

> *"This was a hard one for me to answer, because in every effort I do, I try to include all mentioned above. For instance, our Youth Partnership for Health (a diverse group of youth who guide our program) has representation from most of the categories above. In both the mental health and teen motor vehicle efforts we are including parents and focusing on all the above, not one more than another."*

System Capacity

Coordinators were asked to assess time spent on systems capacity activities, given a list of 23 areas categorized into: commitment, partnerships, planning and evaluation, policy and advocacy, education and technical assistance, and surveillance and data systems. Coordinators identified partnerships as a major focus, especially interagency partnerships (29) and partnerships with communities and the private sector (23). A majority of responding Coordinators provides technical assistance (20). Fewer reported engaging in other areas.

Section III: Guiding Frameworks & Benchmarks

Guiding Frameworks

Coordinators noted several frameworks that guide their efforts. These include: NIIAH (29), a youth development framework which focus on developmental assets, resiliency, and protective factors (28), a conceptual framework for adolescent health developed by AMCHP & the Network (23), the MCH pyramid (23), and the 10 essential public health services (22).

Coordinators are also responsible for several benchmarks, including: Title V national and state performance measures (32); Healthy People 2010 state-related indicators/objectives (23); and NIIAH 21 critical health objectives (14).

> *"I find the frameworks and the benchmarks extremely valuable in providing both a conceptual and organizational basis for describing and prioritizing our work. We have actively promoted the Adolescent Health Initiative, 21 critical objectives, and conceptual framework. We use the core functions to describe our adolescent health mission and have mapped our programmatic activities back to those functions. While the benchmarking/p-measure frameworks are numerous, they often overlap and thus reinforce priorities. I really use these concepts in describing our work and focus across the population."*

Strategic Plans

Seventeen states incorporate adolescents into state-wide, topic-specific plans such as suicide, obesity, and tobacco. Coordinators in 15 states said that they were in some stage of creating a strategic plan for adolescent health: five have completed a plan, four are engaged in the planning process and six are preparing to begin a strategic plan.

Youth Development

Many Coordinators (28) are using a youth development approach in their data collection and programs. Coordinators said that the use of a youth development approach is facilitated by state policy makers' and program managers' support of

the youth development approach (18); useful technical assistance resources (17); and good information/data regarding the effectiveness of this approach (13). Coordinators reported on the barriers to using the youth development approach. These include: lack of resources on incorporating youth development (27), restricted funding sources (23), and lack of skilled staff to implement youth development programs (13).

- **National Initiative to Improve Adolescent Health (NIIAH)**
  Coordinators said that NIIAH is a very useful guiding framework. Many Coordinators rated the four goals of the National Initiative as very relevant to their own work. Some Coordinators are using NIIAH to create more awareness in their state, while others are using it as a means of educating other governmental staff about adolescent health. Coordinators reported several barriers to using NIIAH. Most frequently cited barriers are: lack of time (22) and lack of funding (19). Fewer Coordinators cited the following as barriers: not a priority (6), National Initiative too federally identified (4) and others do not know enough about it (4). Many Coordinators want to see how other states are using the National Initiative and would also like some technical assistance on using the Guide.

> *"As a new adolescent health director, I need the National Initiative to guide me in the right direction and/or validate my concerns, frustrations and accomplishments."*

- **System Capacity Tool**
  Most Coordinators are familiar with the system capacity tool (26), and 15 reported using it. Coordinators that have used the tool were using it to help with grant searches, development of a concept paper for planning, addressing local public health department system capacity, and for prevention and health promotion for adolescents. Many Coordinators found this tool to be somewhat useful.

Section IV: Environment

- **Overall Support**
  Most Coordinators (27) rated adolescence in general as a moderate, high or very high priority in their state. Some believe adolescents have become a higher priority (10); most see no change (18). None see a decrease in priority.

- **State Entities**
  Some states have governor's level (12) or other statewide bodies (14) that facilitate adolescent health or youth policy, while others have task forces or working groups that focus on specific issues (17). Teen pregnancy was the most frequently cited issue to have a coordinating body. Other reproductive health issues were mentioned, as were suicide and substance use.

Title V

In 28 states the Title V needs assessment identified adolescent health priorities and the assessments led to adolescent-health specific performance measures. About half of the Coordinators (19) rated their state Title V program's priority on adolescent health as high or very high, while others rated it as a moderate priority (11). About half (19) see no change in the priority placed on adolescents; 11 believe the priority has increased.

Facilitating & Challenging Factors

Almost all Coordinators surveyed said that their MCH Director was supportive of adolescent health (33) and most also said that their agency leadership was supportive of adolescent health (20). The top reported challenges were:

- inadequate resources (i.e., other than staff) (25),
- inadequate staff (i.e., number and capacity) (24),
- stakeholders too focused on single issues (19), and
- insufficient data/reporting systems (12).

Legislative Priorities

When asked about current legislative priorities, Coordinators most frequently cited reproductive health concerns (e.g., consent to receive health care services, sexuality education, and teen pregnancy prevention). Others issues include: mental health/suicide, physical activity/obesity, bullying/violence and under-age drinking.

Overall Environment

Coordinators reported that they felt very supported by their work environment; however several said that they were somewhat limited on adolescent health either by the leadership/funding or the placement of adolescent health within their department.

"I feel completely supported by MCH leadership and am glad that there is a full time position to address adolescent health."

"[My state] environment is not supportive of adolescent health at this time. No strong advocacy groups are currently pushing for adolescent health. Until more advocacy is available, there is not much hope for change."

Section V: Technical Assistance

Top Priorities for Technical Assistance

The priority topic areas reported by Coordinators include: mental health (19), youth development (17), and obesity prevention (14). Coordinators reported that their top priority populations include: racial and ethnic minorities (19), rural youth (11), and low-income youth (10).

Technical Assistance Needs

The priorities for systems capacity reported by Coordinators include: increasing staff capacity (14), adolescent health advisory committee (14), partnering with youth and low-income youth (13), and partnering with communities and the private sector (12).

Conclusion

This summary clearly demonstrates the wide variability and richness of experience among the State Adolescent Health Coordinators. Apart from providing a brief profile of their multiple roles, tasks and responsibilities, the assessment identifies areas for additional training and assistance. The information in this report, and more detailed analyses, will be used by the Network and its partner organizations to help raise the visibility of Coordinators and expand their capacity as they play a key role in states' efforts to improve adolescent health.

APPENDIX

National Adolescent Health Information Center
NAHIC

National Network of State Adolescent Health Coordinators

sahrc
State Adolescent Health Resource Center

National Network of State Adolescent Health Coordinators: Preliminary Report of 2005-06 Assessment Appendix

Section I: SAHC Position and Person

1. **Are you the permanent AHC?** Yes: 36 No: 1

2. **How long have you served as the AHC?**
   - 9 mos – 18 mos: 10
   - 2 yrs 2 mos – 3 yrs 11 mos: 11
   - 4 yrs – 7 yrs 4 mos: 10
   - 8-18 yrs: 5

3. **Are you**: Male: 6 Female: 30

4. **What is your primary background discipline (How do you identify yourself professionally**)?
   - Public Health (10)
   - Nursing (7)
   - Health Education (3)
   - Social Work (2)
   - Bureau Chief in the area of child and adolescent services
   - Public admin.
   - Medicine, pediatrics, public health
   - Mental and Behavioral Health
   - Medical doctor & public health
   - Nursing, school health
   - Psychology
   - Social Work/Health Services Administration
   - Nurse Public Health
   - Health Professional
   - Human Development
   - Social work/health administration/public health policy
   - Education, Public Health
   - Medical and Public Health
   - Nutrition

5. **What degrees and certifications do you have? (please indicate field, e.g., B.S. Nursing, Certified Health Education Specialist [CHES])**
   - MD
   - MD, Internal Medicine and Public Health/Preventive Medicine
   - Certified School Nurse
   - BSN (2)
   - BSN, MPA
   - RN, BSN
   - RN, BSN, MPH
   - Masters in Nursing
   - RN, AS Business, BS Individualized Studies, MPH, CHES
   - RN, MS in Health Administration
   - MSW/LCSW

- B.A. Health Education & M.S.W
- B.A. Sociology, Master of Social Work
- B.A. Sociology/Social Work; M.A. Health Services Administration; Licensed Social Worker (LSW)
- Masters of Science in Social Work and Health Services Administration
- Business Administration with follow-up courses in social work
- B.S. Education
- Masters of Education
- M.Ed., CHES
- MD, MPH (Epidemiology), FAAP (Fellow AAP)
- MPH (4)
- MPH, MPA
- MPH; certified family planning counselor
- B.A. Spanish, MPH degree is pending (thesis needs to be completed)
- Masters of Human Services (MHS)
- Masters in Human Development
- M.S. Community Health Promotion, CHES
- BA, Psychology, 9 hours masters
- B.S. Biology/Chemistry, M.A. Biology
- B.A Humanities, M.A. Applied Behavioral Science
- M.S. Health Administration, B.S. Biology
- MS, Human Nutrition

6. How long have you worked in adolescent health throughout your career, including experience in your present position? ___years ____months

- 1-5 years: 11
- 5-9 years: 8
- 10-15 years: 9
- 18 – 30 years: 8

7. Do you work for the state full time? Yes: 35 No: 2

7.a If you are <u>not</u> full time, how many hours a week do you work for the state?

- 23 hours & 30 hours

8. Of the total hours you work each week, for what percent do you work on adolescent health issues?

- 10-40%: 8
- 50%: 6
- 78-98%: 8
- 100%: 15

9. Of the total hours you work each week, for what percent do you work on:

a. Coordinating adolescent health broadly

- 0-15%: 7
- 20-30%: 11
- 40-50%: 9
- 60-85%: 5
- 100%: 4

b. Adolescent-specific programs (e.g., abstinence)

- 0-15%: 10
- 20-35%: 6
- 40-50%: 9
- 60-80%: 4

c. Adolescent-inclusive programs (e.g., school health)
- 0-15%: 12
- 15-25%: 11
- 30-95%: 5

d. Other populations (e.g., WIC program)
- 0-5%: 9
- 10-20%: 6
- 50%: 1

e. Other (%)
- 0-10%: 7
- 20-40%: 3
- 50%: 3
- 73-100%: 2

- **Other (type):**
  - Lead poisoning
  - MCH
  - Injury, FASD, BIH-FIMR, FIMR and other duties
  - County Health Department site review team activities
  - Management functions, Genetics
  - Meetings, conferences, trainings
  - Strategic planning
  - Teen pregnancy
  - Early Childhood

10. In your work *as AHC*, do you:

a. supervise staff?
No: 22 Yes: 15, If yes, how many: 1-4: 11; 5-10: 4

b. manage contract staff?
No: 25 Yes: 12; If yes, how many: 1-4: 6; 6-13: 4;

c. manage contracts?
No: 12 Yes: 25 If yes, how many: 1-8: 12; 10-23: 8, 50-65: 2, 202: 1

d. have responsibility for a budget?
No: 17 Yes: 20

11. In your work *as AHC*, do you:

a. respond to legislation regarding adolescent health policy? Yes: 22 No: 15
b. initiate legislative action on adolescent health policy? Yes: 5 No: 32

12. How is your position funded? Please give percentages.

MCH Block Grant/Title V (%):

- 0-33%: 4
- 50%: 4
- 57-95%: 4
- 100: 16
- (missing 9)

Other(%):

- 5-43: 4
- 50%: 4
- 67-96%: 2
- 100%: 7
- (missing 20)

Other sources of funding:

- Medicaid Match
- Medicaid - EPSDT
- Title 19 and 21
- SAMHSA Youth Suicide Prevention Grant
- MCHB Mental Health Grant
- Other grants
- Abstinence Education (3)
- State (2)
- State General Funds (4)
- State Administrative Account
- State Dollars-tobacco settlement
- SECCS Grant
- CDC-DASH-CSHP
- Preventive Health & Health Services BG

Section II: Overview of Adolescent Health Activities
The second section asks about the priority topics and populations your position focuses on, as well as systems capacity issues for adolescent health.

1. How would you characterize your focus on the following topic areas?

Major focus – I spend a significant amount of time on this topic (may include a budget, major responsibilities, taking a leading role within your agency or the state)
For topic marked "major focus": please briefly describe the activities that you work on.
Secondary focus – I spend a fair amount of time on this topic (e.g., not the lead, but actively involved, partner with others who focus on this topic)
Minor Focus – I occasionally work on this topic, (e.g., attend some meetings, stay in the loop)
No Focus – I rarely or never address this topic

Topic	Major Focus	Secondary Focus	Minor Focus	No Focus
Health Areas				
a. General adolescent health	**21**	11	4	X
b. School health	9	**17**	8	2
c. Youth development (e.g., resiliency, protective factors, assets)	**15**	13	7	1
d. Reducing health disparities	4	**19**	12	1
e. Chronic disease/conditions & disabilities (e.g., asthma, diabetes, traumatic brain & spinal cord injury)	1	11	17	7
f. Injury prevention	3	9	19	5
g. Violence prevention	3	**14**	18	1
h. Suicide prevention	6	**14**	16	X
i. Mental health	5	**22**	8	1
j. Substance use/abuse (alcohol & other drugs)	3	**17**	13	3
k. Tobacco	1	14	18	3
l. Abstinence-only education	**13**	6	8	9
m. Comprehensive pregnancy prevention	**16**	12	2	6
n. Family planning	6	8	13	9
o. STDs/HIV/AIDS	3	**15**	14	4
p. Overweight/obesity prevention	2	**20**	11	3
q. Nutrition	2	**15**	16	3
r. Physical activity	2	**16**	16	2
s. Other: _____	1	5	1	1
Health Care Services				
t. Access to care	9	11	13	3
u. Consent & confidentiality	4	12	12	8
v. Medicaid/SCHIP	2	10	12	10
w. School-based health centers	5	7	14	10
x. Clinical preventive services	3	12	11	10
y. Immunizations	X	9	16	11
z. Other: _____				

Health Areas - other
- Juvenile Justice
- Youth Risk Behavior Survey
- Transition
- Surveillance-YRBS
- EPSDT

Health Care Services - other
- Oral health

2. How would you characterize your focus on the following specific populations?

Major focus: I spend a significant amount of time on this population and have specific activities and/or budgets that are dedicated it.
For topic marked "major focus": please describe the activities and projects that you work on.
Secondary focus: I incorporate the needs of this population into all or most of the work I do, but do not have any projects or activities that focus specifically on this population.
Minor Focus: I occasionally work on the needs of this population, which I address by incorporating them into some of the work I do.
No focus: I rarely or never address this specific population. Others in my health agency may do so.

Specific Populations	Major Focus	Secondary Focus	Minor Focus	No Focus
a. Families/parents of teens	3	14	13	6
b. Females	5	15	11	5
c. Males	15	13	6	2
d. Racial & ethnic minorities	10	18	5	3
e. Urban youth	13	14	3	6
f. Rural youth	15	15	4	2
g. Low-income youth	16	12	5	2
h. Middle childhood (e.g., ages 5-11)	21	10	3	2
i. Young adults (e.g., ages 20-24)	12	10	9	4
j. College students	0	11	15	10
k. Youth with special health care needs	4	9	16	7
l. Parenting teens	5	13	11	7
m. Gay, lesbian, bisexual & transgender youth	4	10	16	6
n. Youth in foster care	2	9	14	11
o. Immigrant/refugee youth	2	7	14	12
p. Homeless/runaway youth	2	8	18	8
q. Delinquent/incarcerated youth	2	10	17	7
r. Other: _____	0	0	1	1

Specific Populations
- Grandparents raising grandchildren

3. This question asks about systems capacity building activities. Below we have listed several areas, organized by the System Capacity Assessment for Adolescent Health: Public Health Improvement Tool developed by the Network and AMCHP. How would you characterize your focus on the areas listed below?

Major focus – I spend a significant amount of time doing this.
For topic marked "major focus": please briefly describe the activities and projects that you work on.

Secondary focus – I occasionally work on this.

Minor Focus – I rarely or never do this.

Area	Major Focus	Secondary Focus	Minor Focus
Commitment			
a. Increasing staff capacity (e.g., increasing number of adolescent health staff, training adolescent health staff)	10	12	14
Partnerships			
b. Facilitating interagency partnerships	**29**	6	1
c. Partnering with communities & the private sector	**23**	10	3
d. Partnering with youth	11	16	9
e. Partnering with families	5	16	15
f. Adolescent health advisory committee (if major, please indicate which sectors are represented)	11	9	16
Planning & Evaluation			
g. Needs & assets assessment (state or local)	14	16	6
h. Program development	14	17	5
i. Evaluation (e.g., programs, services, public information campaigns)	12	17	7
j. Integrating health issues (e.g., pregnancy & STD prevention; primary care & mental health services)	13	18	5
Policy & Advocacy			
k. Administrative policy (e.g., developing standards, procedures, rules)	10	14	12
l. Legislation (e.g., providing testimony, drafting bills, providing information)	1	16	19
m. Advocacy (e.g., providing information)	5	17	14
Education & Technical Assistance			
n. Providing technical assistance	**20**	13	3
o. Providing training	12	17	7
p. Communication & public relations (e.g., promoting adolescent health & sharing information)	6	23	7
q. Supporting local infrastructure (e.g., local health department staff & community coalitions)	10	15	10
Surveillance & Data Systems			
r. Monitoring & surveillance (e.g., YRBS)	12	15	9

Area	Major Focus	Secondary Focus	Minor Focus
s. Increasing access to data (e.g., information dissemination, fact sheets, data warehousing, GIS)	10	18	8
t. Developing questions & indicators (e.g., adapting YRBS to your state's needs, developing youth assets indicators)	7	21	8
u. Integrating surveys	6	10	19
v. Data analysis	8	12	15
w. Translating data results for program/policy development	11	13	11
x. Other: _____	0	0	0

Section III: Guiding Frameworks & Benchmarks

This section asks about the frameworks that guide your work as AHC.

1a. What frameworks do you use to guide your work? Please check all that apply.

National Initiative to Improve Adolescent and Young Adult Health by the Year 2010	29
Conceptual Framework for Adolescent Health (developed by AMCHP & The Network)	23
MCH Pyramid (foundation for the Title V/MCH Block Grant)	23
Three Core Public Health Functions (Institute of Medicine)	12
10 Essential Public Health Services to Promote MCH (Johns Hopkins University)	22
A Youth Development framework (Developmental Assets, Resiliency, Protective Factors)	28
A Prevention framework (may include risk and protective factors specific to risk behaviors)	18
Other: _____	2
▪ I am using a prevention framework to cover that state framework or other state efforts, legislation or efforts that include the above items that support the state plan. ▪ EPSDT Federal mandate	

1b. What adolescent health related benchmarks/performance measures does your state use for accountability? Please check all that apply.

21 Critical Health Objectives for Adolescents and Young Adults	14
State-related objectives and indicators associated with Healthy People 2010	23
Title V/MCH national and state performance measures	32
Other state specific benchmarks or performance measures. Please describe: _____	7

▪ State Performance Measures (PM) for our [my state] MCH:
  ▪ STATE PM #1- The percent of unintended pregnancy.
  ▪ STATE PM #2- The percent of women who abstain from alcohol use in pregnancy.
  ▪ STATE PM #3- The percent of WIC infants who are breastfed at six months.
  ▪ STATE PM #4- The percent of state fetal/infant/child deaths reviewed for preventability by local review teams.
  ▪ STATE PM #5- The percent of facilities using standardized domestic violence screening tool as part of care assessment and planning.
  ▪ STATE PM #6- The percent of two year old children screened for lead.
  ▪ STATE PM #7- The percent of Medicaid eligible children who receive dental services as part of their comprehensive services.
  ▪ STATE PM #8- The percent of pregnant women who abstain from cigarette smoking.
▪ Survey data of the uninsured; [my state] school nurse report, CMS 416
▪ [My state] Marks: indicators on child well-being
▪ [My state] Office of Policy & Management Outcome Measures
▪ I am working to ensure that the 21 Critical Health Objectives are integrated into the measures in the dept.
▪ YRBS Survey
▪ The main benchmark that we us is the 2010 benchmarks which is the same as the Title v benchmarks around teen pregnancy. I am trying to move towards using the 21 critical health objectives as well as the 40 developmental assets.
▪ Cost per number of visits to SBHCs/year.	

Other: _____	8

▪ Kids Count

State/Territory Strategic Plan for Adolescent Health

2. What steps has your State/Territory taken towards developing a state-wide Strategic Plan for adolescent health? Please check all that apply:

We do not have a Strategic Plan and currently have no plans to begin this process. (if you have no Strategic Plans and not plans to begin, please skip to question 3, Youth Development)	0
We include adolescence in relevant state strategic plans for health.	17
Are these plans currently being used? ▪ Yes: 14 ▪ No: 2 ▪ Don't Know/Not Sure: 3	
We are preparing for an Adolescent Health Strategic Planning process.	6
We are currently engaged in a Adolescent Health Strategic Planning process.	4
We have completed a Strategic Plan for Adolescent Health. Please give the year completed: ▪ 1@: 2001, 2003, 2004, 2005, plus one responded "in progress"	5
Are you currently implementing the plan? ▪ Yes: 6 ▪ No: 31	

Youth Development

3. Has your state adapted your YRBS or other surveillance instruments to include one or more measures of positive development and support (e.g., assets and protective factors)? check one:

Yes	14
We are working on including positive measures.	6
No, we have not included positive measures.	10
Our state does not use YRBS or other surveillance instruments.	0
I don't know.	5

4. To what extent is a youth development framework or perspective being used in your work as an Adolescent Health Coordinator? Generally speaking, Youth Development refers to actions/activities aimed at increasing supportive relationships and opportunities for youth through enhancing competence, capacities, caring, and citizenship. (check one)

It is being used to guide most of my work at this time. (see pop up)	14
It is being used to guide a few specific initiatives or activities. (see pop up)	11
We are just beginning to think about this perspective and how it applies to our work.	10
It really is not relevant to our work at this time.	1

5. What are the most important factors affecting integration of a youth development approach in your state, both positively and negatively? Please check up to three most important facilitating and challenging factors.

Facilitating factors (check up to three most important)		Challenging factors (check up to three most important)	
Flexible funding sources	10	Restricted funding sources (e.g., they are too categorical)	23
Staff skilled in implementing youth development programs	11	Lack of skilled staff needed to implement youth development programs	13
Useful technical resources (e.g., programs, data collection tools) on incorporating youth development approaches	17	Lack of resources (e.g., programs, data collection tools) on incorporating youth development approaches	27
Good information/data regarding effectiveness of this approach	13	Not enough information/data regarding effectiveness of this approach	10
State policymakers/program managers aware of approach	11	State policymakers/program managers not aware of approach	7
State policymakers/program managers supportive of approach	18	State policymakers/program managers not supportive of approach	7
Non-governmental programs/personnel aware of approach	9	Non-governmental programs/personnel not aware of approach	6
Non-governmental programs/personnel supportive of approach	11	Non-governmental programs/personnel not supportive of approach	3
Other facilitating factors:_____ ▪ Funding earmarked for this approach.	1	Other challenging factors:_____ ▪ Local capacity, additional funding at a sufficient level to ensure providers are duly compensated and programs can be expanded into needy communities. ▪ The curriculum is in the process of development to start training personnel. ▪ Staff are busy creating school based health centers and see youth development as an add-on responsibility. ▪ Lack of communication among inside and outside potential partners. Turf issues! ▪ My work is focused on clinical services.	5
There are no facilitating factors.	0	There are no challenging factors.	0

NIIAH responses

6. The National Initiative has four goals, listed below. How relevant are these goals to your work?

	Very relevant	Somewhat relevant	Not very relevant	Not at all relevant
Elevate national, state and community focus and commitment to the health, safety, and well-being of adolescents, young adults and their families.	27	8	1	-
Increase access to quality health care, including comprehensive general health, oral health, mental health and substance abuse prevention and treatment services.	27	6	3	-
Improve health and safety outcomes in areas defined by the 21 Critical Health Objectives (i.e., mortality, injury, violence, substance abuse & mental health, reproductive health, tobacco, nutrition & physical activity).	23	13		-
Eliminate health disparities among adolescents and young adults, and for these age groups compared to other age groups.	24	9	2	1
7. Overall, how relevant is the National Initiative to your work?	24	11	-	-

9. What are the barriers to using the National Initiative in your work? Check all that apply.

Lack of funding	19
Lack of time	22
The National Initiative is not "home grown," it is too federally identified	4
My supervisors do not see the National Initiative as a priority	6
I don't know enough about it	4
Other	8

9. Other response *(note: 8 SAHCs checked "other" and 9 wrote in the "other" box)*

Lack time/Resources

- We cannot fully adopt all aspects due to lack of resources. However, we are able to co-mingle our work and that of sister state agencies to ensure over the state we are working in the elements of the initiative.
- Biggest barrier is not having worker bees out in the field that report to me on adolescent health. I just have volunteers who have added this work on top of everything else they are asked to do.
- Position vacant.

NIIAH needs to be adopted/Supported/Integrated at other levels:

- Members of collaborations don't see it as something that is theirs, maybe because it is seen as just about health. I offered it but had no takers.
- My supervisors only hear about the National Initiative from me.
- I need to somehow get this connected to my Division's Administrator's list of 2006 priorities.
- Adolescents are not the priority in [my state] or at [my state's] Department of Health.

National Initiative barriers/Other response

- My own competence and understanding of how to be effective at implementing it.
- Spanish Translation needed.

11. Please indicate how much you use the 2010 Guide in your work:

	Extensively	Some	Haven't yet, but I plan to	Haven't yet, no plans to
a. I use the 2010 Guide in my technical assistance/training work with state and local partners.	6	14	9	4
b. I use the 2010 Guide for advocacy in my state (e.g., for raising visibility of adolescents in my state).	4	11	7	11
c. I use the 2010 Guide as a reference tool.	10	19	3	2
d. Other _____	1	1	-	-
▪ Reports linking the YRBS and how we're doing in our state.				

12. Have you been involved in efforts to disseminate the 2010 Guide?
Yes : 21 No: 16

If Yes,
12.a To whom have you disseminated the 2010 Guide? Please check all that apply:

Colleagues within my agency	20
Other state agencies	17
Youth-serving programs	12
Advocates	6
Other	1 (no elaboration)

System Capacity Tool
AMCHP, in collaboration with the Network developed the "System Capacity for Adolescent Health: Public Health Improvement Tool" (the "System Capacity Tool"). The tool is designed primarily for Title V MCH/family health program staff, including MCH and Children with Special Health Care Needs (CSHCN) Directors, Adolescent Health Coordinators, and other public health program managers.

13. Are you familiar with the System Capacity Tool?

Yes, I am familiar with the tool.	26
I have heard of it, but I am not familiar with it.	7
I haven't heard of it.	2

14. Are you using (or have you used) the System Capacity Tool?

Yes	15
No, I have not used the Tool	22

15. How useful do you find the System Capacity Tool? Check one:

Very useful	10
Somewhat useful	18
Not very useful	0

.

Section IV. Environment

The aim of this section is to better understand the environment in which you work and the support for adolescent health in your state. Questions focus on the structure and funding of your adolescent health programs, and the priority placed on adolescent health in your state.

Priority

1. **Within your state/territory, how high a priority is placed on adolescence in general through state program planning and/or funding? (check one)**

   4-Very high 6-High 17-Moderate 7-Low 1-Not a priority 1-Don't know

   1.a. Has this level of emphasis changed during the past two years? (check one)

   10-Yes, increased 0-Yes, decreased 18- No change 3- Don't know

2. **Within your state/territory's health agency, how high a priority is placed on adolescent health through state program planning and/or funding? (check one)**

   5-Very high 6-High 16-Moderate 8-Low 1-Not a priority 0-Don't know

   2.a. Has this level of emphasis changed during the past two years? (check one)

   12-Yes, increased 0-Yes, decreased 20-No change 2-Don't know

Coordination

3. **We would like to learn about state-wide bodies that coordinate and/or facilitate adolescent health or youth policy. Does your state/territory have:**

   a. **a Governor's Children's Cabinet (or similar agency/entity) that coordinates and/or facilitates policies related to adolescent health or youth in general?**
      12-Yes 18-No 6-Don't know/Not sure

   b. **a policy coordinating body below the governors' level that coordinates and/or facilitates policies related to adolescent health or youth in general?**

      14-Yes 14-No 8-Don't know/Not sure

   c. **a smaller policy coordinating body for a specific topic, issue or population relevant to adolescent health or youth in general (e.g., teen pregnancy, minority youth)?**

      15-Yes 14-No 7-Don't know/Not sure

Title V/MCH Block Grant

The following questions refer to the Title V/MCH Block Grant applications, including the needs assessments, that were due in July 2005.

4. **Did your Title V/MCH needs assessment identify adolescent health issues as a priority area?**

   28-Yes 4-No 3-Don't know

5. **Did your Title V/MCH needs assessment lead to any adolescent-specific state performance measures?**

   28-Yes 5-No 3-Don't know

6. **In your opinion, how high a priority does your State or Territory's Title V/MCH Application**

place on adolescent health?

4-Very high 15-High 11-Moderate 6-Low 0-Not a priority

7. **Has this level of emphasis changed over the last five years (since the last needs assessment and setting of priority areas)?**

11-Yes, increased 0-Yes, decreased 19-No change 3-Don't know

Facilitating and Challenging Environmental Factors

9. **What are the most important environmental factors that affect your work, both positively & negatively? Please check up to four most important facilitating and challenging factors.**

facilitating factors (check up to four most important)		challenging factors (check up to four most important)	
Agency leadership is supportive of adolescent health	20	Agency leadership is not supportive of adolescent health	6
MCH director is supportive of AH	33	MCH director is not supportive of AH	1
Existence of strong community/state coalitions	0	Strong community/state coalitions do not exist	3
Strong collaboration among state agencies	15	Weak collaboration among state agencies	10
Stakeholders approach AH broadly	7	Stakeholders too focused on single issues	19
Good data collection/reporting systems	17	Insufficient data/reporting systems	12
Adequate staff (e.g., number, capacity)	1	Inadequate staff (e.g., number, capacity)	24
Adequate resources (other than staff)	0	Inadequate resources (other than staff)	25
Other facilitating factors:_____ ▪ There are several new very good collaborative groups focused on youth development and adolescent sexual health. ▪ Collaboration among state agencies is developing.	2	Other challenging factors:_____ ▪ I don't want to say that MCH Director is not supportive of adolescent health, just that it is not a main priority. ▪ Competition with young children's issues. ▪ Fragmentation of adolescent health programs throughout the agency. ▪ Recruitment with adolescent health background. ▪ Agency leadership verbally expresses support but there are no action steps taken.	5
There are no facilitating factors.	0	There are no challenging factors.	0

Section V. Technical Assistance Priorities

This Section assesses your priorities for technical assistance (TA). The results will be helpful for MCHB grantees who provide technical assistance to State Adolescent Health Coordinators.

1. Topic areas: Please choose up to four topic areas that are your highest TA priorities.

a. General adolescent health	3
b. School health	6
c. Youth development (e.g., resiliency, protective factors, assets)	**17**
d. Reducing health disparities	0
e. Chronic disease/conditions & disabilities (e.g., asthma, diabetes, traumatic brain & spinal cord injury)	5
f. Injury prevention	5
g. Violence prevention	4
h. Suicide prevention	9
i. Mental health	**19**
j. Substance use/abuse (alcohol & other drugs)	5
k. Tobacco	0
l. Abstinence-only education	3
m. Comprehensive pregnancy prevention	10
n. Family planning	0
o. STDs/HIV/AIDS	3
p. Overweight/obesity prevention	**14**
q. Nutrition	0
r. Physical activity	2
s. Access to care	6
t. Consent & confidentiality	5
u. Medicaid/SCHIP	3
v. School-based health centers	4
w. Clinical preventive services	3
x. Immunizations	1
y. Oher:_____	7

- Strategic planning
- Infrastructure development

2. Specific Populations: Please choose up to three populations that are your highest TA priorities.

a. Families/parents of teens	16
b. Females	4
c. Males	3
d. Racial & ethnic minorities	**19**
e. Urban youth	6
f. Rural youth	**11**
g. Low-income youth	**10**
h. Middle childhood (e.g., ages 5-11)	8
i. Young adults (e.g., ages 20-24)	7
j. College students	0
k. Youth with special health care needs	5
l. Parenting teens	2

m. Gay, lesbian, bisexual & transgender youth	6
n. Youth in foster care	5
o. Immigrant/refugee youth	4
p. Homeless/runaway youth	1
q. Delinquent/incarcerated youth	2
r. Other: _____	1
10 - 24 year olds	

3. Systems Capacity Building: Please choose up to <u>four topic areas</u> that are your highest TA priorities.

Area	
Commitment	
a. Increasing staff capacity (e.g., increasing number of adolescent health staff, training adolescent health staff)	**14**
Partnerships	
b. Facilitating interagency partnerships	0
c. Partnering with communities & the private sector	**12**
d. Partnering with youth	**13**
e. Partnering with families	5
f. Adolescent health advisory committee	**14**
Planning & Evaluation	
g. Needs & assets assessment (state or local)	8
h. Program development	8
i. Evaluation (e.g., programs, services, public information campaigns)	7
j. Integrating health issues (e.g., pregnancy & STD prevention; primary care & mental health services)	9
Policy & Advocacy	
k. Administrative policy (e.g., developing standards, procedures, rules)	1
l. Legislation (e.g., providing testimony, drafting bills, providing information)	0
m. Advocacy (e.g., providing information)	1
Education & Technical Assistance	
n. Providing technical assistance	5
o. Providing training	4
p. Communication & public relations (e.g., promoting adolescent health & sharing information)	2
q. Supporting local infrastructure (e.g., local health department staff & community coalitions)	9
Surveillance & Data Systems	
r. Monitoring & surveillance (e.g., YRBS)	0
s. Increasing access to data (e.g., information dissemination, fact sheets, data warehousing, GIS)	4
t. Developing questions & indicators (e.g., adapting YRBS to your state's needs, developing youth assets indicators)	3
u. Integrating surveys	1
v. Data analysis	1
w. Translating data results for program/policy development	2
x. Other TA priority in system capacity building: _____	1

Area	
Strategic Planning	

The final four questions asked about adolescent health websites and other resources that are available from states. We plan to synthesize this information in a separate publication.