

## **2011 AMCHP and Family Voices National Conference: Designing Effective and Appropriate Systems for Adolescents at the State and Local Levels**

**02/15/2011 Omni Shoreham, Washington, D.C.**

SHARRON CORLE: So it's always tough after going after the lunch session on the last day. We tried to pull out a lot of chairs. This room is kind of big for this session, so anyway, welcome. I'm Sharron Corle. I'm actually the associate director for adolescent health at AMCHP and that sounds like there is a director of adolescent health, but there isn't. That would be me and we're really excited you guys are sticking with us today to be here and our session is Designing Effective and Appropriate Systems for Adolescence at the State and Local Levels and I'm going to be presenting today with my colleague Lissa Pressfield. She is actually—she does all the adolescent health programming at AMCHP, she tells me what to do and my colleague Laura Snebold from the National Association of County and City Health Officials who works on their maternal and child health projects, but also does their adolescent health projects as well, so we're going to be entertaining you today.

And so I'm not going to read you the learning objectives, but basically we want to raise awareness about some frameworks. We want to talk about multi-sectorial adolescent health service coordination, which you guys all know. We want to talk about—we want you guys to talk about actually, which is why we have the sticky wall back there about what you think the existing level of coordination, partnership and how well you think you're doing in your state and then we want you to come up with some ideas on how we can make these better. So these kids look really—do they look weird to you? No, they're real stretched out on this screen. It looks like you know when you blow up a picture and you're like.

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So maternal child and adolescent health, that is the MCAH. Actually there is a state that has a MCAH department. It's California. We had a life course town hall in this room on Sunday and one of the closing comments came from one of the staff at the California Department of Health and he said if we want to move to a life course town hall we need to make the term maternal and child health more inclusive. He is like there is no adolescence in there. It needs to be maternal, child and adolescent health, which I thought was interesting and I had to be honest and tell everyone. I didn't give him \$10 to say that. He just said it on his own, but it certainly is interesting as I've been running the adolescent health programs at AMCHP for the last six years and working in adolescent health for my entire career, which I refuse to tell you how long that is because it makes me old and then Lissa will be able to figure out how old I am, but the MCH community has really changed over that period, but I don't think the paradigm shift has gone far enough. She is like I already know how old you are. But I don't think the paradigm shift has gone far enough to really have an inclusive focus that addresses the entire populations that we should include adolescents and when we say adolescents I think you guys know this. The World Health Organization uses the age range 10 to 24 and why we think it's really critical as the adolescent health person that is working in maternal and child health, this is really the bridge. You do all this great work with kids and we've been doing a lot. Lissa will talk a little bit about what states have been doing around early childhood and then we do all this work with like women to improve their birth outcomes and then we miss that critical period in between where we could kind of be leveraging what we're doing with the young children,

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building on that and preparing them to be entering into adulthood healthy and in great shape and optimal everything and so that's why I'm always advocating for an increased focus on adolescent health.

I got to get my other thing for this. I think some quick stats on who our kids are today. Who are the young people? The adolescent population I think if you guys were at the plenary session yesterday the adolescent population is increasing in numbers. There is a lot more kids and I think it's expected to grow by a million in the next year. That is a lot of kids to deal—to be think about and addressing. They're also increasing in ethnic diversity. I think you guys saw a little bit of that on the panel yesterday. We had a kid who his parents were immigrants from Sierra Leone. We had another young lady who was Egyptian and Bolivian together and just it's fabulous, all this different ethnicities. The characteristics of the adolescent experience are changing, certainly very different to be a young person today; we talk a lot about that, than it was when say I was growing up. We didn't have the internet. We didn't have cell phones. We didn't have computers. We didn't have cars because it was back in the dinosaur ages. We hooked a dinosaur up to the cart and it drove. No, but this generation is characterized by firsts. There is a lot of firsts. They're the first generation to understand terrorism as a domestic issue. That is crazy. I remember studying abroad when I was in college and in London. I spent a semester in London and seeing all those signs about if you see a bag that is unattended report it, all this stuff because the IRA bombings that happened in England. We never had to worry about that here and even when I

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first moved to D.C. like 10 years ago we never had those signs on the Metro. There wasn't that same awareness and yet there is a generation of young people that that's just their reality. In some ways that's scary and in some ways that's I don't know. I guess there might be some pros about that.

This is the first generation to compete in a global economy. I know that we're moving there, but think about what that means and the consequences of that and what we need to be doing to prepare young people to be able to do that. Are we doing the right things? Are we doing what is necessary? And it's interesting going back to the—they're the first generation to really grow up as having cell phones and the internet and like just these social media as just part and parcel of the way that they operate. I mean think about I have a colleague of mine that is from Iran and back in 2009 when everything was going on in Iran how she found out about that was Facebook and I have another—my anesthesiologist who does my waxing she is from Tunisia and all that stuff that was—what is it, esthetician, whatever, you get my—she is someone that takes care of this, that I pay to take care of this, but she is from Tunisia and how she found out that her family members were safe was through Facebook. I just find that so fascinating and how we're finding out what is going on in Egypt and how people are organizing. I mean it's just a different world. I mean it's just a different universe.

I have three nieces that are all teenagers and they don't really talk to each other, they text. They never use their phone for the phone and don't try to call them and have a conversation because that's

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not going to happen and I actually am doing that too, so. This generation is going to be the first generation to grow up in the majority living at—at least part of their childhood in a single-parent home. That is very different and the needs and supports that they have is very different and I think the young person on yesterday's panel really spoke to this, but they live in the shadow of AIDS and HIV and this is reality and he was really what's one thing you want people to know about or if you left this panel today and the audience didn't know about this what would you regret and his statement was we need to be more concerned about this issue and then the first that is really just a fabulous testimony to being in the United States of America is they're the first generation to witness an African-American president. That is pretty awesome. That is pretty awesome given that the Civil Rights Movement is only 40—don't even correct me on my math, but that's pretty amazing that this generation gets to witness things that are exceptional too.

And I think I spoke about this earlier, but timing does matter. Adolescence is a critical time for health promotion and adolescence it's easy—I think Dr. Freidan from CDC talks about making the healthy choice the only choice or the—how does he put that, but it's like sometimes making the poor choice is the easiest choice. One of the young girls on the panel yesterday she was talking to us at breakfast about they tell us to eat healthy foods and eat fruits and vegetables. She is like, “Well the fruits and vegetables are expensive.” “I can get a giant bag of chips for a dollar.” “I can get 10 bags of Ramen noodles for a dollar, so what am I going to pick when I only have a limited amount of money?”

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“I’m picking the Ramen noodles, so you’re telling me to eat fruits and vegetables, but that’s not necessarily an option.” I just found that interesting that that is the easy choice for her is to buy the chips. And they live in environments that make that challenging because she lives in a community that doesn’t have a—where she doesn’t have access to fresh fruits and vegetables and we need to think about that as folks that design programs and services for adolescents and some of these decisions and consequences and situations that adolescents are in can having long-term results on their lives. We often like to point out things like a teen pregnancy and the impact of that. I don’t have any kids. My husband and I have been married 10 years and because I always think that baby stays with you. It’s not like the cat that you could leave for two 2 days while you’re at the conference here. I can’t put the bowl of food on the floor and expect the baby to crawl over to it. I mean you know and so like it is like this—having a baby when you’re teenager and the baby stays there.

So anyway, so I just wanted to kind of lay some foundation for us, give you little sense of the population that we’re talking about and not that you guys don’t know that, but frame it a little bit. I’m going to turn it over the Laura now who is going to play a little game with you. We want to wake you up.

LAURA SNEBOLD: We’re just about 15 minutes in, so we figured why not ask some questions and give you guys a chance to get some sugar for the afternoon.

SHARRON CORLE: Well can I say something?

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LAURA SNEBOLD: Yes.

SHARRON CORLE: If you were at yesterday's adolescent health planning you are going to rock and roll on this \*\*\*\*. If you weren't you're not.

LAURA SNEBOLD: We figured a little reinforcement was never a bad thing, so the first question for all of you is could you please name five adolescent health risk behaviors or indicators that are trending down in a good way. Some of you are a little soft. I heard smoking. I heard pregnancy. I heard SDIs.

Female: Violence.

LAURA SNEBOLD: Violence, yes.

Female: Unintentional injury.

LAURA SNEBOLD: Unintentional injury, yes and did I hear suicide? No, suicide, okay, well suicide also and right along there with tobacco use in terms of the whole umbrella of substance use is also alcohol use is down. It is, which is a very good thing.

So in what year what year did the adolescent birth rate reach an all time low?

Female: 2010.

LAURA SNEBOLD: 2010, yes.

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Female: \*\*\*\* talk into the mic.

LAURA SNEBOLD: Sure. Is that better? The question was what year did the adolescent birth rate reach an all time low and we had 2010 up here. Sharron.

The next one is what are the three new adolescent health morbidities? Obesity is one. Number two, do you remember a second one? Diabetes would be no. That would under obesity. Stress, did I hear stress? Yes, stress and depression and asthma.

Female: She said it a long time. She said it like two hours ago.

LAURA SNEBOLD: I'm sorry. I didn't hear you.

SHARRON CORLE: \*\*\*\* because I know you like them.

LAURA SNEBOLD: And we have one up here too Sharron.

Female: I don't need it now.

LAURA SNEBOLD: All right, which adolescent health risk behaviors are statistically significantly reduced by both parental and school connectedness? That one actually not for both, but substance use, both. Alcohol fell under that.

Female: Suicide.

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LAURA SNEBOLD: And suicide yes. I have suicidality, which I think could encompass a range and do we remember the third one?

Female: Well it's actually one that \*\*\*\*.

LAURA SNEBOLD: Violence, so suicidality, violence and alcohol use. All right, the last one. What are the three elements of effective youth programs? And these are a very broad description, so if you just kind of want to throw out elements of it, it would be great just to hear.

Female: Connectedness.

LAURA SNEBOLD: Connectedness, mm-hmm.

Female: Positive youth development.

Female: Positive youth development, who said that?

LAURA SNEBOLD: Yeah, definitely positive youth development and then the third one was a little obscure or a little vague. Yes, youth involvement, youth participation and then there was one more aspect of a program that made it particularly effective. I had here the length of it, so the longevity of the program. It needed to be a long-term initiative. They're a little tricky. All right well thank you for taking a break. I guess we'll go back to the presentations now.

LISSA PRESSFIELD: All right, I'm going to talk a little bit about AMCHP's work around systems for adolescent and the first thing I'm going to talk a little bit about is a whitepaper that we wrote, which I know a

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couple of you are involved in or have seen and something I can send out after the session. It was a whitepaper called Making the Case for Comprehensive Systems Approach for Adolescent Health and Well-Being. AMCHP has been supporting a pilot project in Nebraska to actually start to figure out what this comprehensive system might look like in their state and then we have a system capacity assessment tool, which Sharron will talk about in a little while.

So I don't know how many of you have seen this slide. This is actually related to child health, but you have the mom and the dad and kids and the \*\*\*\*\* and then you have all the systems up above and you have education, health and food, social services, child and family services and mental health and probation and I think that this is just a great visualization of the fragmentation that we experience or that families and children and then especially adolescents. We know that it's more fragmented for adolescents and so we like this visual just to—you kind of see things going everywhere and people are going in different places and we think that that's a problem, so when we started doing this work we had several assumptions. We knew that a significant number of adolescents are not being prepared for a successful future and more importantly perhaps is that there are programs and policies that can positively affect these conditions. We also had the assumption that building a comprehensive system would require public action. It would require partners and awareness raising. We knew that we needed political will. We need a lot of pieces in place, but definitely the states were going to be aware this was taking place and so as it says here the states are laboratories for change and can really help think through what this looks like.

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Also developing a comprehensive system for adolescents is key to success. We don't always just want to keep expanding an array of programs. We want to start figuring out how to link them and how to coordinate them and better serve and meet the needs of young people.

So our Emerging Issues Committee at AMCHP created the Adolescent Health Workgroup in 2008 and this was an ad hoc group of experts in adolescent health. We had federal partners, state partners, national partners and we all came together really in response to the challenges that states were facing around fragmentation and this is actually the first thing that I worked on when I came to AMCHP. It was about two and a half years ago and I kind of came in and I didn't know what I was getting myself into, but it was a fabulous experience and we really started out the project and we thought okay we're going to define what a comprehensive systems approach looks like for adolescents. We're going to figure out all the details and we're just going to go from there and we started talking and we started looking at the research and we realized that we really needed to make the case and we needed to look at what had happened with the early childhood comprehensive systems experience and think about what that meant for adolescents and build support and think about some of the components, but we realized we weren't quite ready to layout the whole framework in terms of defining what every state should do and we knew it looked different in each state and so that is kind of where we ended up moving and I think this is a great document and I think a lot of people worked really hard on it. I

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encourage you to read it if you get a chance. It's on our website and then-

SHARRON CORLE: \*\*\*\*, so there is a sign-up sheet and if you guys want me to send you a copy I can, but you can download the whole thing on our website. She knows better than to \*\*\*\*.

LISSA PRESSFIELD: No, that's okay. And the paper really serves as a tool and resource for our members and our partners and the state to raise awareness and to start to build consensus around the need for a comprehensive systems approach. I'll go into some of the recommendations that came out of the process in a couple minutes, but again we built on the lessons that we learned from the early childhood comprehensive systems grants, which now are being implemented in I think 53 states and territories. 52, I was so close, okay, 52 and we looked at the model, I'm sure many of you have seen this, in terms of the areas, the components of the early childhood comprehensive systems approach and what we realized is that while these are really important for children there are unique and complex needs of adolescents and so this might look a little bit different. I'll show you what Nebraska created that is a little bit different, but has some of these same themes involved.

This is the conceptual framework. I love conceptual frameworks and visuals. I know it's a lot to see on a screen, but when we did this work we wanted to look at what systems are important to help build positive settings for youth and positive experiences for youth and so we talked a lot about these throughout this conference and I'm sure you all talk about them in your work, but looking at

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education and health and workforce investment and political systems and child welfare, public safety, juvenile justice, voluntary organizations serving youth and media and really that these are key components and obviously you can't just get them all together and all functioning simultaneously in a coordinated effort at once, but that there has to be work to bring these partners in and look at how we're serving youth.

We also identified characteristics of effective systems and the importance leadership and informed decision making and accountability. We looked at the settings in terms of family, schools, communities, health services, neighborhoods as places where it's really important to reach youth and to reach the people that are in the lives of youth, so we also identified the features of positive settings and those are listed up there, but really all of this needs to aimed at building youth assets and in terms of intellectual, physical, psychological and emotional and social development. Hopefully if we can do this we will improve adolescent health and improve adult outcomes as well.

So the reason, Sharron mentioned some of the reasons why we thought this was so important and I just saw Kristen come in. I just want to acknowledge the Kristen, we're talking about the whitepaper, Kristen was involved and a huge contributor to this effort, so I just want to say hi. So we did this work and we thought it was so important because—and we know it was so important because what we wanted to do is protect and leverage the investment that we have in early childhood. We wanted to promote and create partnerships between federal, local and state

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entities and strengthen the adolescent health infrastructure. We also wanted to identify effective ways to coordinate program services and systems and foster the development of cross service systems and I have my little bridge down on the bottom if you can't see it. Really a comprehensive systems approach is a way to establish a bridge within the lifespan health model where adolescents are really viewed as part of an integrated lifespan continuum rather than a separate independent group.

So our recommendations, and we came up with four recommendations and these were approved by the AMCHP board at the end of 2009 and really the first recommendation was around raising awareness and then refining this kind of model, this framework and what the systems would look like. However, we realized that it would be important to have states kind of pilot this and work through this to be able to get a better picture of what this model would look like, so the first recommendation was to advance the concept to MCHB and other federal partners and encourage them to bring in experts to both internal experts, state partners, research institutes, advocacy organizations, etcetera to define the state-level approach for creating a comprehensive system. The second recommendation was really about leadership and building capacity and support for states, so we were encouraging AMCHP leadership to work with MCHB and other federal partners to consider strategies for providing strong leadership to states in their efforts to develop comprehensive systems that support the positive development, health, safety and well-being of adolescents and we quite a few things that this would include, identifying gaps in services and funding that serve as

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barriers, defining specific outcomes for a comprehensive systems approach, creating, monitoring and evaluation tools, developing resources and developing evidence-based tools and strategies and then the final recommendation was really about funding and looking for a funding stream that wouldn't be a carve-out of the block grant or another siloed funding stream but would be a resource to support and enhance the critical efforts of systems development at the state level. Actually that was the third recommendation. The final recommendation was really about keeping the Adolescent Health Workgroup involved and knowing that this group of experts could be tapped into for further input and support and expertise. So those were the recommendations.

And so the next step after this paper, we've been disseminating it. We've been taking it to MCHB. We've been trying to move this work forward and part of that is a pilot project. I don't know if you can see that map up there. You can. That is Nebraska. Nebraska has been piloting some efforts and AMCHP has been supporting and they came up with rather than the daisy model, they came up with the components of a comprehensive system and put it into an iPhone looking thing. I think that's an iPhone right.

Female: Well it's \*\*\*\*.

LISSA PRESSFIELD: Okay, so some kind of phone and their components are physical, mental and oral healthcare, community support, education and career development, social, emotional development, health promotion and population based services and family support and education and I know that Nebraska has had a lot of successes and

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a lot of challenges. There is a lot to be learned about how to do this, but they've built some really strong partnerships and commitment. They have more to do in terms of building support from leadership and up the chain and finding funding, but they've really made some great progress and worked with a number of partners to start to sort through some of these things.

So I'm going to pass it on to Sharron to talk about systems capacity assessment tool.

SHARRON CORLE: So can you tell Lissa is losing steam here?

LISSA PRESSFIELD: Really?

SHARRON CORLE: Yeah. Anyway, so Nebraska, there is tons of lessons learned there, but the more interesting thing is when going back to Lissa's comment about states are laboratories for change is anytime you want to try to do something different or new or have an innovation it's really challenging to get other people to buy into that. It goes back to this concept of how you frame that and what's in that for me and you would think the idea of having comprehensive systems or coordinated systems was be a no-brainer, right. Like wow, we're going to do our jobs more effectively and efficiently. We're going to serve adolescents. We'll better be able to serve them. We'll reduce duplication of services and all this stuff. It's not an easy sell because people want to protect their turf. Well how is that going to impact me? We know the theory around change. I'm studying organizational development right now and this whole concept of change and how people are afraid of change and how

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engage people in change and there is so much research on this it's crazy and they're hitting that wall now. It's like how do we get people to buy into this? And that's something we'll have to consider moving forward.

But anyway, one of the things I wanted to make sure that I mentioned. I couldn't do this comprehensive systems approach without this. AMCHP has had this tool and then were are partners with the National Network of State Adolescent Health Coordinators, which some of them are here today, thanks guys, and the State Adolescent Health Resource Center. Kristen has been really instrumental in this, but what this is and we just re-launched this. We revised it and re-launched it in 2010, but what this is, is this is a tool that helps states and well, local soon to be able to assess six capacity areas that they need to have in order to effectively address adolescent health and its commitment to adolescent health. I mean really going back to the comprehensive systems approach why would you want to spend all that time to design a comprehensive system if you're really not committed to adolescent health or your commitment really needs some work?

Data and surveillance systems, we've been doing a lot of work in another project, Lissa and I, around HIV, teen pregnancy and STD prevention among adolescents and man they all use different data, so how do you get a picture of how the adolescent reproductive and sexual health when pregnancy data uses this age range and HIV uses this range and STD uses this range and I know one of our states that Lissa is working with, California, the people on the project were like we're just going to make our own picture of the

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data and of course their epidemiologists were like horrified, “You can’t do that.” “You cannot do that with the data.”, and they freaked out, but then they actually got them onboard to kind of help them think about how they might be able to kind of overlay that data in a way that wouldn’t scare other epidemiologists.

Education and technical assistance, how well are they able to kind of do this? Program planning and evaluation we know is critical, policy and advocacy and then partnerships and nine states have used this tool to varying levels of success. Some of them have gone on and developed quality improvement plans. Some of them haven’t. Some of them have just done the assessment that is as far as it went. Kristen can tell you more about that, but what the exciting thing was in the revision of this tool and kind of why we’re partnering with NACCHO on this session is because what we realized is that it has utility not only to the states, but to locals and one state, Oregon, did assess their local capacity to address adolescent health because it happens at all levels and you need to—if we’re really going to have this commitment to adolescent health it needs to be kind of grassroots and from the top, bottom up, top down, everything and so anything that we are creating we have a strong partner with NACCHO in that we want to make this something that would be—something that local health departments could utilize also because they’re doing a lot of the work on the ground and not only that, but we had a brilliant idea when we were doing this, preparing this session together that Laura will tell you about.

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You can find this on the website as well. We don't have printed copies of this, but one of the neat things we did when we redid it is the way it used to happen is someone—and AMCHP State Adolescent Health Resource Center we can come to your state and do this if you're interested and walk you through the system capacity assessment tool, but one of the neat things we did when we revised it is there is a guide now, so there is a facilitator guide and then there is a participant guide for the people that are participating in your meeting and you could do the meeting yourself, so you could do this with like all of your adolescent health programs or you could do this with one small program that you work with to assess all of these areas, so it's really a very useful tool that you can use in a lot of different ways and if you ever want to talk to me about using it give me a call.

And now I'm going to turn it over to Laura. Laura is like, "Finally."

LAURA SNEBOLD: Hi again everyone and thank you Sharron and Lissa for setting the stage for a project that I'm really excited to tell you about. Just as a very quick overview NACCHO is the National Association for County and City Health Departments, so there are about 2,800 throughout the entire United States and we serve as the membership organization for them, so we help them with their programmatic work and we also serve as a voice for local health departments when it comes to talking about national policies.

So the Adolescent Health Infrastructure Project actually stemmed from an Institute of Medicine report that was published in 2008

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called Missing Opportunities. Is anyone familiar with the report? Excellent and if you recall there were a whole set of recommendations and specifically recommendation number four was related to strengthening the capacity at the local level for improved coordination of adolescent health services and also integration of those services among the community and so since NACCHO is—one of our large focus areas in to build capacity for local health departments we thought that this was a nice niche for us to focus on as an adolescent health project for our area.

So again the aim of this project is to strengthen capacity at the local level so that health departments can work better with their partners and improve not just the infrastructure, but ultimately the health of the adolescents in their communities, so the two goals in this case were to improve the community level coordination and integration of these services and then again internal to the Health Department, helping them to build the capacity to do this work in the community.

We had two broad activities that we intended to accomplish with the project. One was developing a set of recommendation that health departments could use as guidelines for improving not just their capacity, but then again the coordination and integration of adolescent health services in the community and then also because all this work is happening really at the ground level our plan is to create a web-based toolkit that would accessible to all health departments and to their partners to take the lessons learned and whether it was using other organization's toolkits or fact sheets or other adolescent health friendly resources that are available

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everything would be housed on this one website and they will be free for download and for use by the health departments.

The advisory board that we have this project has fabulous members, one of which is in our audience and my co-presenter Sharron is a member of our expert panel. There are 13 members and we really intended to create a multidisciplinary panel, so similar to perhaps a team of partners that would be working in a community, so we have people from public health, from the private sector. We have representatives from academia, education and we also have a representative from Adolescent Health Law. So that's where panel essentially guides all of our activities. We've two in depth, in person meetings and they also have participated in conference calls and provide feedback on the resources from the project.

As I mentioned, we had in-person meetings and our first one was last January 2010. We spent two days really bringing out all the ideas and I suppose considerations that we would need to move forward with when we talk about what does it really mean to have a coordinated—the ideal coordinated and integrated adolescent health infrastructure and we actually divided our discussions into these six domains and we started off with adolescent immunizations because it was a very focused area, but it had one that we could expand to the rest of the topics here simply because when you think about adolescent immunizations we know that immunizing adolescents is actually one issue for adolescents, so perhaps if a teenager were to come in for another visit, perhaps maybe an SDI test if they were behind on their meningococcal

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vaccine that would be a chance to vaccinate and vice versa, if they were to come in for a vaccine it might be a chance to do a check in on their risk behaviors and so forth, so that was kind of the needle and the hook that we used to then broaden the conversation to talk about how are these services delivered, what are the partnerships that might sustain some of these efforts to promote adolescent health and then getting into more detail about how adolescents are screened for their health and how they're referred to other resources.

After the in-person meeting was over we actually had come up with a set of 14 recommendations and we set those aside and then we said okay we've had these incredible and very productive conversations with our expert panel, let's take a chance and talk with some youth who are in the community and we had an intern working with us from George Washington University and she was tremendously helpful in gathering some other participants who came in to NACCHO one night for a focus group. We had some pizza and we had some great discussion over 90 minutes and we essentially went through some of the same topics that we had discussed during our in-person meeting. We spent a little bit more time talking about confidentiality with them and especially their experiences when interacting with providers.

These are some of the main themes that came out of the focus group and you'll see they felt that they didn't have enough time and attention during the visits which might be something general that all of the United States population might feel when they go to see a provider, but what I've highlighted here is the one that's just

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at the bottom. It's in italics and it says that being asked the right screening questions, they are being asked the right screening questions, but the tools and techniques could be improved and when I was going through my slides I really thought that this echoed the comment that we heard in yesterday's panel from one of the youths who said that it's not just about what—the information that you're trying to get across to us, but it's how you say it, it's the resources that you give us or don't give us, it's really the way that that message is put across that matters, so I thought that that was a nice point to highlight.

And here I wanted to just read two quick quotes from the focus group to highlight their participation a little bit more. One person said, "The nurse comes in and talks to me, the one who does the electronic records, which is fine, but she doesn't really make eye contact with me." "She is always like typing and then when she comes in it's like very just like got to get out of here, see you later, bye." So she felt a little bit rushed in that case. The next quote the participant said, "I tried a clinic and now I'm at a hospital and I would say I love the physicians at the clinic better." "They didn't baby me at all." "My doctor would just tell me as it is on whatever topics, sex, whatever." "He just talked to me about it, no problems." So obviously this adolescent was noticing a changed environment and her level of comfort and her ability to talk about these issues that are so important.

As we moved on with the project we convened for a second in-person meeting and this was just this past October. We had the chance to go to Miami, Florida, which was a great location for

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some good brainstorming and we took the chance to revisit the recommendations and as I mentioned, we came up with 14 and it was really great to now have heard Lissa and Sharron's experience because you just realize that there is so much value in revisiting the direction that you're taking and really asking yourself okay are we on the right track and essentially 14 recommendations. To put that towards the local health department or any community organization, well how do we do that and what does this mean? It's not something that is tangible and that can easily implemented so in addition to the fact that the recommendations were quite long and very rich I would say. Since we had met the last time Health Reform had passed and the funding for teen pregnancy prevention had come out, so they are very substantial contextual changes that had happened as well which definitely warranted some more discussion.

So what I've done here is just kind of broken down the major themes that came out of our second in-person meeting and I think will really guide the development of our toolkit and activities that our Health Department demonstration sites will be doing towards the end of the project. The three things I have here are people, systems and funding and when I say people it may be a little colloquial, but I basically just mean relationships. It would be looking at the Health Department what are the relationships within the Health Department that make adolescent health a priority. How do the Health Department workers engage with adolescents and similarly, how is that engagement happening at the community level and then what is it about those relationships that allow the

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Health Department to really be a leader and an advocate for adolescents at the local level?

And systems, the second one is certainly everything that we've been talking about today. What is it that the Health Department can do? What can it be involved in that really supports this coordination and the strengthening of an infrastructure to make sure that adolescents get the services they need, they are provided in an adolescent friendly way and these are services that really enable them to mature in to healthy adults and we definitely talked about how although adolescents are a unique field to work within the themes for systems building crosscut every area and for local health departments in particular this is a very busy time for accreditation. This is really off and within the accreditation world there are different assessments that have to be done. There are different benchmarks that have to be met and it involves collecting data. It's all of those systems level activities that the adolescent health fields can be aware of and start to integrate with the help build a stronger infrastructure for their particular services.

In addition, NACCHO actually has a really neat infrastructure project called MAPP. It stands for Mobilizing for Action Through—Sharron, I forgot this during our rehearsal and now Sharron has made me forget again. Excuse me. Mobilizing for Action through Planning and Partnerships and that is just another example of a separate solely infrastructure tool that can be used or applied to improving infrastructure for adolescent services. And of course throughout this, as we talked about earlier, upholding those principles of positive youth development certainly should be

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carried throughout all the activities. And then lastly, funding and particularly here I think as was mentioned in the state activities before you can take any action it's a matter of figuring out okay what are we working with, what do we have that is already existing and what is missing and how we can we leverage the resources that may be available that we don't know about.

So as I mentioned, we really are hoping to create a toolkit and a resource that can be put into action and be used, something that is very tangible and I had outlined before some of the major themes that came out of our discussions in the past two in-person meetings and so what I listed for you here are again some major themes and what we're considering could be chapters for this toolkit. So should a health department and their partners be looking to work on this issue they could use this as a guideline to decide which area they wanted to focus on. In addition, we have a checklist, which would help the Health Department or a youth agency assess the extent to which their services are adolescent friendly and so we're hoping to establish a connection between that, so if you take the assessment tool, if you do the assessment it will help you figure out where in the continuum you are in terms of your adolescent friendly services and then it could possibly link you to the component that you need to address first, but these essentially go from the micro to the macro level talking first about adolescent healthcare and service delivery and then moving up towards coordinating the involvement, all of the relevant key stakeholders, which for our expert panel really involved getting engaged with the state, with the national level and with the federal level as well.

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These are just some next steps for us. As I mentioned we intend to have a toolkit and that toolkit will be tested at two local health departments. We also hope to have a Ning site. Is anyone familiar with Ning? So if you don't know the experience that I've had with it is actually NACCHO's Health Equity and Social Justice Team and it's really a very dynamic part of the work that they do. It's a professional platform I'd say that is maybe similar to Facebook that requires a log in and this Ning site that NACCHO has for Health Equity is specific only to local Health Department members, but what we would hope for is that this could serve as more of a crosscutting venue for all of the relevant key stakeholders in adolescent health, so while the toolkit might be more used at the community level this could be a chance for everyone interested in this issue to have a conversation, to share resources and to connect with one another.

And then we do intend to put a report out of what the expert panel has shared with us in the past two meetings and the idea that we were just thinking about is perhaps if there is a whitepaper at the state level that really makes the case for why their needs to be an investment in support of adolescent health we could mirror that with the same support that is coming from the local level and perhaps have a more comprehensive document for why the advocacy is needed.

So I think Sharron now is going to come up and talk about the intersection, but if you any questions about our project in particular please don't hesitate to get in touch.

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SHARRON CORLE: So thanks Laura and it was really exciting to be part of that—your expert panel, especially going to Miami where we were actually like stared at constantly, our group of mostly women because we had the most clothes on. I swear to you. Normally like you have like little clothes on and you're the one that gets stared at, but we were the most clothed people and I think everyone was staring at us like what are they doing, going to a wedding or something because everyone had on really tiny clothes there. I couldn't live there. I'd have to—I'd have serious body image issues.

Anyway, the overlap of our work, what is exciting about working in Washington D.C. and having all these other associations and organizations so close to us, they are two blocks away and we often will be at their office and doing lunch, is that it allows us to kind of meet more regularly and talk about things and when we started talking about our adolescent health work we were like hey wow we could do this and leverage this and so I think Laura kind of talked—we talked about this in different places, but I just wanted to kind of point it out in a very pointed out, is that we are going to kind of package the whitepaper that we did with some of the recommendations that are coming out that came out of their expert panel, so it comes from the local and state level, so we're mirroring. What message that we're saying is hey health departments need to be doing this wherever you're working. And so we're really excited about that and then also like the system capacity assessment tool and really we're going to be piloting with—well meeting with four or five local health departments and taking them through the tool and saying what would need to be tweaked, what resources and tools would you need to be able to

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use to use this at the local level, which it's really exciting to be partnering, to be able to kind of really have this commitment to adolescent health, so that's kind of the overlap and intersect and it's really exciting to have these adolescent health advocates at NACCHO because they cover so many issues, but they're not really specifically committed to any population, so it's really exciting to have the relationship and recognize that kind of passion over there.

So we actually want to wake you up a little bit again because that's what I do. I want you to just take a minute and you're not allowed to take too long because you'll go to sleep. Take a few minutes and think about the programs and services in your state that strive to protect and promote the health and well-being of adolescents, your state or if you're at the local level, wherever you are. I put state because we're state MCH programs and think about what is the current level of coordination among adolescent health services and systems in your state. Is it like the fragmented systems where there is all these opportunities to lose these young people? What about the strength of partnerships that influence adolescent health? Do you have partners and are all the relevant people invited to the table? Are you invited to all the relevant tables; you have a seat at the table? And think about what is your current capacity to address adolescent health and we're not talking just money, but really how—what is your capacity. We know state budgets have been decimated and I think adolescent health has been one of the ones that has been cut the most and then so take a few minutes to think about this just on your own and I really want you to think about—when you're thinking about all this has your state succeeded in

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meeting the needs of adolescents? Are you meeting the needs of adolescents? And when you're thinking about this what seems to be the most critical aspect or aspects of successfully meeting the needs of adolescents? So what is absolutely critical that needs to happen in order to successfully meet the needs? And I'm going to give you a hint. It's something around coordination, partnerships and capacity, but think about it in your own context and then we're going to have you kind of get together in dyads or triads and do something after that, so just I'm going to give you like two minutes.

All right, so you'll notice that we have chairs back here. What I want you guys to do is pick someone that you don't know or two people that you don't know or that you know and want to know a little better and we want you to kind of contemplate and Lissa and Laura are back there, what steps need to be taken to improve the extent to which your state can establish program, services and partnerships, so thinking back to the critical aspects. What can we do to improve this in your state or what needs to be done if you're making recommendations to us? And I go back to Andy Goodman's presentation on storytelling and he had the six areas and I really like this framework. He had the nature of our challenge story. Well we kind of told you a little bit about that in going through why we came up with this whitepaper and started the work that we did. How we started, Lissa told you I brought her on as an intern to do this work because I was like I am not looking through that research and writing a paper. I don't have the time. So a success story like Nebraska is one state that is really doing this and performance, I guess we haven't gotten there yet. We're

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missing that story, but you guys are going to help us write the striving to improve story by helping us think through kind of what steps need to be taken in your states and that really helps us to get a sense of what we need to be doing at the state and local level and to continue this work and advocating for a comprehensive approach to adolescent health.

So with that said move back to Laura, she is back there napping. She needs someone to keep her busy and so what we want you to do is pair up with one or two people that you don't know or want to talk to and kind of write down some things. What people do we need to talk to? What systems or sectors do we need to work together that aren't? What messages need to be heard at the community, local, state and national levels and what, if any, behaviors need to be changed? So take a—write a couple down.

[INAUDIBLE MEETING IN BACK OF ROOM]

LISSA PRESSFIELD: All right, well thanks everyone for sticking with us this afternoon all the way to the end. I saw some great discussion and some great ideas, so we're going to just go over what is on the wall. I may ask whoever put the item up to tell us a little bit about it, but we definitely want to look at the ideas that you all have generated. So again the question was just what steps need to be taken to improve the extent in which your state can establish programs, services and partnerships that better meet the needs of adolescents. So in terms of what people we need to talk to we have families, businesses, other people internally to acknowledge the adolescent population, young people again. No, we had families and then young people,

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component providers and training programs, directors of public health, so making sure that we have kind of the top and support from leadership and support at multiple levels. Foster care is an important—some of these, the systems and the people might overlap, but I think that it gives us the idea. School health and administrators, community colleges and universities a great resource, private providers, community health centers, family planning programs, so we're really seeing a wide, wide range of people that we need to be connecting with and that we need to be working with, substance abuse treatment, treatment professionals. Treatment and what?

Female: Prevention.

LISSA PRESSFIELD: And prevention, Yes, thank you.

Female: Why aren't we working with these people? If we're not working with them now why aren't we? What is getting in our way? Is it that there isn't this commitment to adolescent health to begin with, so that they don't recognize they should be working with them? I don't know.

Female: I was telling Kristen that we haven't had a person solely dedicated adolescent health in about 12, 13 years. It has always been a shared duty as it still is, with other responsibilities. We've also had a barrier with our superintendant of education being an elected official and therefore the ability of the staff to collaborate and even feel safe communicating with other departments has been dependent on that person's philosophy, so there hasn't been that consistency from one transition to the other.

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Female: \*\*\*\* of the state \*\*\*\* health coordinator. I'm from region two, New York, New Jersey, Puerto Rico and the Virgin Islands and Kristen is still a strong adolescent health coordinator in New York State, but we have challenges in getting those persons designated because of the changes, personal changes at the state health department level, but does that mean that we should not ask for that or what is your sense because even a shared position, having a person who is a contact person that you can get for conference calls, that you can share materials, that you can link with each other is that something that you think would be helpful?

Female: I think it's the responsibility of each of the local health departments. In the time that I've been in my position I've had additional responsibilities added to my position, but I've always maintained because I think that longevity is getting really critical in these positions and I know a few years ago we had a third turnover every year and that's significant and I think that states need to think about keeping people in positions even if—I've accepted a whole new—half my job is perinatal health, but I still try to keep myself with the adolescents to get that stability within the state and I think that is very important. One of the things I wanted to mention when you were commenting about why aren't we working with some of these people. I'm just going to give an example that we've had a real pullback from our state substance abuse and alcoholism agency because they have increasing needs with returning veteran population coming into communities and the families, so I think that we have to really look at the impact that other emerging health issues are having on our systems and how we're taking very

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limited resources and having to stretch them so far with social problems that I don't think we really were anticipating we'd be dealing with in this day and age.

LISSA PRESSFIELD: That is a great point. Thank you. I know we're running low on time, so I think I'm going to—you have one more point.

Female: You mentioned universities, but don't forget \*\*\*\*.

LISSA PRESSFIELD: So LEAH actually came up in two places which I think is great that you're bringing that up. I heard a couple of people talking about the LEAH projects as resources, absolutely. I'm going to let Laura take one of her categories and then we'll probably have to wrap up.

LAURA SNEBOLD: And I think what I might do actually is just follow-up quickly with the systems and sectors because there seem to be some overlap with the people. Again LEAH is mentioned here. Once system that was suggested was foster care, also business, identifying key people in the state agencies and appropriate community based organizations to coordinate with. I also see—this is really interesting and actually in my research for this project I found a lot of really helpful resources from the Children with Special Healthcare Needs literature because there has been so much extensive research done on creating systems that really work and have been put into place and have been evaluated. I mean there is a tremendous amount of opportunity there I think to learn from that, from that field and perhaps broaden it just to a wider scale so

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that it is more inclusive of the general population, but that's exciting to see.

The last one here is asset mapping of prevention, treatment programs that are being administered by other state agencies and I think that gets to what we talked about earlier is before you can even start anything you really need to inventory what you have and that mapping process of looking to see what services are out there, where they are, if there is any duplication and then also what is being done in other states that could helpful to your own.

Okay, we're almost done, but just to wrap up really quickly I see messages here, inclusion of youth, having messages come from the local to the state level. Again, make sure that all messages are youth focused. Prevention, while it's an important message it's challenging to communicate and that, I'm sure, could be a whole other conversation. The state needs to involve again the local level and local agencies in their planning activities and then here is a message or a comment here about messaging and the question is how do you build political will and again if your message is prevention how do you build political will around that and here definitely the importance of consistent messaging so that people hear the message and then they identify you and your agency with that and they know what you're about. Sharron.

SHARRON CORLE: \*\*\*\* comment about the \*\*\*\*. \*\*\*\* but why is there not \*\*\*\*, but what am I doing as a director of adolescent health to answer that \*\*\*\*, so something, whatever I'm doing \*\*\*\* is working, but \*\*\*\*. Speak softly and carry a big bat, but I speak loudly and I

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don't carry a bat. I don't ever need it, but no, but I mean what is not working? What is \*\*\*\*\* or what could we be doing better that? You know what I mean? Like something when you said that was like a light \*\*\*\*\*.

LAURA SNEBOLD: Well just a thought. I don't know that this is exactly the answer, but you talk about women and pregnant women and babies. It's so warm and fuzzy and then there is this gap for the adolescents and the young people from 10 to 24 because it has this stigma attached to it that their so difficult and challenging and they are going to resist any programming or services that we can provide to them, which we know is not true, but I think it's a kind of separation between warm and fuzzy and babies and mommies and it's so wonderful, but the real challenge of working with young people that kind of makes us want to step back for minute, which I think that messaging is hard, but then how do you depict what a young person is. I think painting a picture or kind of the poster child for a young person is really difficult because it's diverse.

Female: But we have taken for granted, going back to your comment, but we should be working with moms and babies. We don't even need to make that case that this is what \*\*\*\*\* programs should be focusing on, but and yet we need to make that case repeatedly that they should also be focusing on adolescents and it goes beyond just yeah, I worked in the schools and I met people that were like, "You're going to work in a middle school." "I hate those kids." These are teachers. "I hate those kids when they start going through puberty." It would be the elementary people that were doing their elementary certification and they'd be like, "They're crazy." Like these are

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educators that talk about adolescents, so I get that, but what is this you know even recognizing that they're a population we should be working with. No one is going to say you shouldn't be working with that pregnant mom. No one is going to say you shouldn't be working with that. You know what I mean? They are going to prioritize that.

Joe: I'd just like to draw a parallel. With early childhood and the \*\*\*\* around some neighborhoods where they talk about brain development and how plastic the brain is in setting up the trajectories, but there is a parallel process in adolescence that \*\*\*\* recognized for what it is and there is \*\*\*\* neurons and the realignment of the executive functions and \*\*\*\* where \*\*\*\* into adulthood and our expectations of adult like behaviors \*\*\*\*, but I think one of the key things is that there is a biological change going on in their brains \*\*\*\* that happens. Try from 12 ½ to 16 ½ \*\*\*\* you can't even talk to them.

SHARRON CORLE: So this is actually Joe's Job is. He has a \*\*\*\*.

Joe: Not anymore.

SHARRON CORLE: Not anymore. You guys \*\*\*\*\*,

Joe: \*\*\*\*.

SHARRON CORLE: Katrina never even told me that. See you had to tell me that. Welcome aboard. We are really excited to have you and actually going back to where \*\*\*\* came from. It was that research around

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neurons that got people excited and said we need to pay attention to young children. We're not doing enough. That really was what \*\*\*\* that message. They just need to find something similar in adolescent health and if it's not the brain development what is that \*\*\*\* critical, so why aren't we monopolizing on that?

Joe: But it is brain development. What that means is that they're not that \*\*\*\*. The kids they are vulnerable \*\*\*\* brain \*\*\*\*.

[INAUDIBLE CONVERSATION]

Female: Well no, it is. I think the one thing I was going to say was that I had like an aha moment awhile ago starting with perinatal health and really looking at these outcomes and you realize. My background is maternity and besides public health and you could always say before the pregnant women were healthy. They came to a pregnancy healthy and it was like that aha moment that we don't have that anymore. Our adolescent health state is a lot of what Dr. \*\*\*\* is wonderful, but when you think about it we have heavier adolescents. They weigh more. We're starting to see—who ever thought we'd see type-two diabetes. I've been in this a few more years than you have, but whoever thought we'd see type-two diabetes in adolescents. I was unheard of. It was something that our elderly, not even our middle aged, so I think that there are some messages here. In New York State about a year and a half ago we did a campaign on billboards all over the state that said one in two sexually active women—or one in two sexually active New Yorkers have an STD by age 25 and if you don't think those billboards caught people's attention because one and two that

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means it's either me or you and it really, really—it really it hit people to say. We're always trying to promote a positive spin on things to sit back and say we're not necessarily keeping pace. Obesity is such a major issue in the community.

Female: And I think it's \*\*\*\*\*, but the brain development concepts are so abstract to so many people that it's not until you actually have the young people in the community say this is how I perceive myself, this is how I perceive that you adults perceive me and then this is how the adults perceive how they're doing within the life of the young people and when there is that strong disconnect and the community sees that data that means the most and that is where I found \*\*\*\*\* the most leverage because they're like we have done a crappy job, we have not raised our young people to be healthy, prosperous, responsible young adults. We have \*\*\*\*\* to have a negative image of themselves. We have raised them to not have the connections that we feel like we're trying to get \*\*\*\*\* and so that's where I see adults really \*\*\*\*\* take ownership of it and so I think it's trying to put that level in conjunction with really what is going on and helping them understand why it is so complicated to have a young person and then realize, but-

Female: And I also think \*\*\*\*\* with how you send the messages. I know that you-