Dec. 15, 2006
Special Issue – Adolescent Health
*Due to the holidays, the next issue of Pulse will publish on Jan. 15, 2007.*

**AMCHP Updates**

*Message from AMCHP’s President-Elect* – This first adolescent health themed issue of *Pulse* focuses on state-level efforts around strategic planning, capacity assessment, National Stakeholder Meeting results, the National Initiative to Improve Adolescent Health and teen pregnancy prevention. It also includes information on the effort of pediatric practice medical homes to transition youth with special health care needs to adult providers.

AMCHP’s adolescent health work is designed to strengthen state capacity to create programs and policy that effectively support healthy youth. With funding from the Annie E. Casey Foundation, the Centers for Disease Control and Prevention, Division of Adolescent School Health, and the Health Services and Resources Administration, Maternal and Child Health Bureau, AMCHP works with adolescent health coordinators and other maternal and child health professionals in each state to:

- Increase awareness of adolescent health within Title V programs;
- Address adolescent health from a resiliency/asset approach; and
- Strengthen the capacity of Title V programs in state health agencies to partner with schools and youth-serving organizations to prevent behaviors that place school-aged youth at risk for HIV, STDs, unintended pregnancy and other significant health problems.

Our vision for MCH programs is based on the work of the Partnership for Adolescent Health that “all state MCH/family health programs effectively assure that youth are seen as valuable members of their communities whose health and development needs are recognized and supported as a policy priority at the community, state and national levels.”

--Nan Streeter

**Register for the Annual Conference** – *Online registration* is live for the 2007 AMCHP Annual Conference! This year’s conference focuses on *Healthy Communities*. This issue of *Pulse* highlights conference sessions that feature adolescent health:

- *Opening Plenary: A Formula for Success in Improving Adolescent Health: Community Based Approaches to Positive Youth Development*, Claire Brindis, Ph.D., Eduardo González, Jr., MPA, Richard E. Kreipe, MD, and Michael D. Resnick Ph.D.
- *Skills-building session: Collaboration and Community Sustainability in Rural States*
- *Workshops: Engaging Communities in Teen Pregnancy Prevention; Partnerships and Capacity by Design: Building Healthy Communities for Adolescents; Teen Pregnancy Prevention: Promoting Science-Based Approaches; Teens Win When Agencies Talk; and, Tobacco Cessation in Women of Reproductive Age.*

Visit the [conference website](#) to view descriptions of these and other sessions.

**AMCHP Publications** – AMCHP is pleased to announce the availability of *Perinatal HIV Action Learning Labs: Summary Report*. This report highlights state teams’ projects, challenges and lessons learned in the 2004 perinatal HIV action learning lab.
**Trends**

**Transition Issues & Processes for Pediatric Practices/Medical Homes**

- 50% of practices have a policy to transition youth ages 16-25
- 54% have a dedicated staff member in the practice responsible for coordinating transition activities
- 61% have an adult practice to whom they refer youth, based mostly on personal relationship and location

Data from [Healthy and Ready to Work](#) National Resource Center Summer 2006 Questionnaire

**Movers & Shakers**

Melinda Sanders (left) and Patti VanTuinen

**Q: What is each of your roles in the Missouri Department of Health and Senior Services?**

**PV:** I am the state adolescent health coordinator and serve as a consultant across all programs. I work with various programs and staff in the department and other state agencies. I also have programmatic responsibilities in abstinence education, youth development and oversee the contract for adolescent medical consultation services. I think of myself as an ambassador for adolescents. I’m here to make sure that people think of adolescence as a specific developmental stage because many times people think of adolescents as children. I think of myself as an ambassador for adolescents. I not only work with the traditional MCH programs, but also with chronic disease, tobacco, STD/HIV, environmental health, injury and violence prevention programs.

**MS:** I am the administrator of the Section for Healthy Families and Youth in the Division of Community and Public Health. I supervise a lot of programs that address maternal and child health, like CSHCN, newborn screening, adolescent health, injury and violence prevention, genetics, perinatal, and home visiting. I’m also the coordinator for the MCH block grant, not on the budgetary side and I don’t write it, but I edit it and do a final review. If someone wants to use funding from the block grant in a different manner, I’m the first person they have to come to.

**Q: What do you work together on?**

**PV:** We worked together a lot on the system capacity project. Melinda and I are on the core leadership team. More than 25 programs participated to conduct the assessment and to start developing our action plans.

Melinda is always accessible to me as various issues come up. We also work together on the Council for Adolescent and School Health (CASH) where Melinda is always at the table. This year, we’re both on the AMCHP annual conference planning committee. We’re really there to give a partnership and adolescent health perspective.

**Q: Has Missouri set goals or performance measures around adolescent health?**
M: There are several in the MCH five-year needs assessment that deal with adolescent health. Among the priority needs are mental health, chronic disease prevention, interpersonal violence, adolescent smoking and obesity, and injury prevention.

PV: CASH developed a state framework for adolescent health and works to make sure the five recommendation areas are applied. [see Features article] Our Title V director really likes that document. We’re also integrating adolescent health into the department’s new strategic plan.

MS: I try to make sure we have adolescent health represented in all the appropriate areas, such as at meetings or when issues develop, so that we look at how those things impact adolescents differently than mothers and children.

Q: What innovative work on adolescent health has Missouri been involved in?

PV: Missouri’s MCH adolescent health program has had a contract for adolescent medical and health consultation for more than seven years. While we cannot afford to employ a full-time board-certified adolescent medicine specialist, the contract allows our programs to have access to this expertise. The state adolescent medicine consultant also represents the Missouri chapter of the American Academy of Pediatrics and the regional Society for Adolescent Medicine. And as a result, the seven board-certified adolescent medicine physicians in Missouri are connected to our efforts.

Another innovation is that we have piloted the Teen Outreach Program which is a best practice youth development program, with three local public health agencies that have MCH contracts to address teen pregnancy prevention.

MS: Patti is really innovative too – she thinks about how we can incorporate adolescent health into everything – she does a very good job as an advocate for adolescent health.

Patti is also the next to the immediate past president for the National Network of State Adolescent Health Coordinators. I think with her involvement, it has opened up avenues for good ideas for improving our adolescent health program.

PV: I really have the ideal situation where I don’t have to convince Melinda or Glenda Miller [Title V director] that adolescent health is important. Right now, we would like to encourage AMCHP’s regional directors to invite adolescent health coordinators to be part of regional conference calls as pertinent topics arise. Our goal is to open up communications – while not everything is that specific to adolescents, we need to have a broader interpretation of everyone’s roles.

Q: What kinds of challenges have you faced? How have you addressed them?

MS: Our biggest challenge is financial – we have faced cuts on the state and federal level. This is a challenge as we look at all the great things going on, do capacity assessments and try to figure out how we can accomplish everything, knowing that the funds aren’t what they used to be. It also has been a bit of a benefit because it’s encouraged us to develop partnerships and see how our partners can help us. This has been especially true in our partnerships with the DHSS environmental health and HIV/STD programs.

PV: Through the Regional Stakeholders opportunity, the HIV/STD program staff learned that the adolescent health program was more than abstinence education. This experience really got the HIV/STD program managers excited about increasing focus on adolescent health. They have established a new youth education committee, involved youth in interviewing candidates for the youth health educator position (which has been filled), and designated an adolescent-specific immunization program manager. The whole thing though is making sure that they really understand the importance of youth development.
Staff time is a real challenge. People want to be a part of the work we’re doing, but they only have so much time. People have a hard time saying no to me though!

**Q: Could you talk a little more about your involvement with the National Network of State Adolescent Health Coordinators?**

**PV:** When I was nominated to run for president-elect, not only were the Title V folks supportive, but they also got the approval from the department director’s office so that we had the support for my out-of-state travel and increased time commitment to assume the Network responsibilities. I would encourage anyone who takes on the role to take steps like this. During the time that I was president, the system capacity tool was piloted and developed. We really strengthened our AMCHP and Network partnerships.

The Network gave us access to all the states, Konopka, and the PIPPAH partners. Being in that role we had access to the high-powered people, and that’s what really sold it to our state. The mentoring role was important too – Konopka helped us mentor the new adolescent health coordinators across the states.

**Q: What is your vision for the future of adolescent health?**

**PV:** Our overall vision, created from framework, is that all Missouri adolescents will be healthy, safe and successful. We do that with internal and external partnerships. Even in a time of fewer resources, we need to continue working towards that goal that as state agency. Also the general public and media at large need to promote the positives of adolescents. It’s been a challenge, we know it’s the right thing to do, but our systems aren’t always designed for that. As we work towards that goal, we’re engaging and working with broader groups and making sure everyone understands what’s unique about adolescents.

**MS:** I was thinking the same thing and couldn’t have said it better.

**Q: Is there anything else you want to share about yourselves?**

**PV:** Melinda and I both feel very privileged to be “celebrity aunts!” It’s an important role for us! It really represents the MCH populations we work for and it is why we’ve become so passionate about adolescents.

**MS:** Also, they’re just fun! I’m involved with the youth group at our church, and sometimes I think I’m too tired to go and by the time I get there and have been there two minutes, I’m jazzed just like they are.

**Features – States Conducting Innovative Adolescent Health Work**

These states have conducted innovative work in the following areas related to adolescent health:

- California – 5-year-old state strategic plan; system capacity assessment; and, regional stakeholders meeting participant.
- Connecticut – statewide strategic plan.
- Indiana – beginning stages of creating statewide strategic plan.
- Missouri – system capacity assessment; regional stakeholders meeting participant; and, state framework for adolescent health

**California’s** released its adolescent health strategic plan, *Investing in Adolescent Health: A Social Imperative for California’s Future*, in 2001. It was collaboratively developed by the California Adolescent Health Collaborative (AHC), an independent organization that draws its members from the department of health services, health departments, hospitals, universities and
non-profit organizations serving adolescents. Key leadership in the development of the plan was provided by the National Adolescent Health Information Center and the Division of Adolescent Medicine-UCSF; funding for the development and production of the plan was provided by Title V funding through the Department of Health Services (DHS), Maternal, Child and Adolescent Health Services as well as private foundations including The California Wellness Foundation.

The plan draws on in-depth research, interviews and comprehensive national and state data to create eight core recommendations that make youth a policy priority, create opportunities for all youth and improve services for teens. The strategic plan incorporates the 21 critical adolescent health objectives as well as several positive indicators collected through California’s Healthy Kids Survey (the Youth Risk Behavior Survey). Its recommendations include:

- Build strong support for investment in youth;
- Involve youth in the policy process;
- Ensure access to comprehensive, youth-friendly health services;
- Coordinate service delivery systems for teens;
- Build stable families that can support teens;
- Create communities that offer youth positive life options;
- Design schools to promote health and development; and,
- Use data to support responsive programs and policy.

The AHC collected state-specific data on adolescent health and available resources and held forums in Northern and Southern California to get input into recommendation development. It also developed a dissemination strategy, including selecting and training spokespeople to represent the AHC and discuss the strategic plan.

Since the strategic plan’s implementation, the AHC has prioritized mental health and health service providers’ awareness of confidentiality and minor consent laws enabling adolescents to receive care. The AHC maintains a website with local and statewide publications on teens and youth. The strategic plan has been available on the web since its release, and the 2006 Adolescent Health Report Card was recently posted. AHC has also posted three new fact sheets on parent communication, the Mental Health Services Act for Youth and oral health. The website receives approx 1,500 unique visitors per month and the AHC disseminates a quarterly e-newsletter to over 2,000 members throughout the state. The AHC recently conducted the first statewide conference on adolescent health, focused on “The Health Rights of Teens.” This broad theme encouraged the exploration of a variety of health areas and provided an opportunity for youth and adult adolescent health advocates to come together in a mutually enriching environment. Three hundred six participants attended the conference, including 106 youth.

California used the System Capacity Assessment Tool to assess existing state resources. In 2005, Konopka conducted a technical assistance site visit. In many regards, the state has a strong infrastructure of efforts underway that focus on the reduction of teenage pregnancy and other efforts pertain to injury prevention and mental health. However, with significant reductions to Title V funding, state support for the AHC was eliminated in 2006; funding for AHC staff is now derived primarily from private foundations. Until state funding can be restored, it is unlikely that recommendations emerging from the systems capacity assessment can be responded to within state government.

California was involved in the 2003 Regional Stakeholders Meeting. The state adolescent health coordinator, representing DHS, the chief of the Health Promotion Unit, STD Control Branch, and a representative from the Department of Education all attended the meeting. After the meetings, the group met internally to further collaborate and share information around adolescent sexual health issues; they formed the adolescent sexual health workgroup. This group continues to meet, and its membership has expanded to include those outside DHS, including providers and university-based researchers. Currently, the workgroup is focusing on ways to enhance coordination across programs and departments as well as share information.
Because the National Adolescent Health Information Center at UCSF was very involved in the production of *Improving the Health of Adolescents and Young Adults: A Guide for States and Communities* as well as California’s strategic plan, and was the host organization for the AHC at that time, many of the efforts’ themes overlap. For example, both documents include a focus on utilizing available data to develop profiles and prioritize AHC activities, as well as engaging different stakeholders to raise the visibility and commitment to adolescents throughout the state. As the AHC represents a relatively small venture in terms of existing resources and staffing, AHC’s major role is to convene, to broker information, and to help improve providers’ capacity to offer high quality health services.

**Connecticut** finalized their state adolescent health strategic plan in May 2005. The plan identified three priority issues and suggested strategies to address these issues. Action Teams will address each priority issue. In November, a kickoff meeting was held to promote the plan to diverse stakeholders and recruit members for each action team. An interagency workgroup will also be convened to coordinate adolescent health activities within the agency.

**Indiana** is at the beginning stages of the statewide work on adolescent health. Their new adolescent health coalition kicked off development of the state plan for adolescent health in early October. Kristin Teipel, project coordinator from the Konopka Institute for Best Practices in Adolescent Health, and Lloyd J. Kolbe, founding director of CDC Division of Adolescent and School Health, assisted in the facilitation of this first meeting which brought together individuals from throughout the state who work with adolescents and youth in a variety of settings such as schools, health care organizations, the juvenile justice system and community organizations. Since then, a planning committee, nominated by the state health commissioner, has been established to lead the larger group in identifying the tasks to be accomplished to move development of the state plan for adolescent health forward. The publication, *Improving the Health of Adolescents & Young Adults: A Guide for States and Communities*, created by the National Initiative to Improve Adolescent Health, has been a guide and excellent resource as this initiative moves forward to develop Indiana’s state adolescent health plan over the next two years.

The **Missouri** Department of Health and Senior Services (DHSS) used the System Capacity for Adolescent Health Public Health Improvement Tool to assess its department-wide capacity to address adolescent health. The initiative is endorsed by Missouri’s Title V and MCH management, is coordinated by the adolescent health program, and involves more than 25 programs that serve adolescents and young adults, ages 10 to 24. Invited partners from other state organizations and departments also participated. Konopka Institute for Best Practices in Adolescent Health staff facilitated a series of assessment and action planning meetings, and a comprehensive assessment of all six capacity areas was successfully completed. Several months later, a group work session was convened to prioritize key issues from the assessment results and to begin the quality improvement action planning process. Logic models were developed to address identified priorities, and quality improvement action plans will be implemented in 2007.

The process was a catalyst for increased communication among individuals and programs across the department to collaboratively work on adolescent health issues. Two department-wide teams were recommended from the assessment: the Adolescent Health Leadership Crosswalk Team, including staff with strong expertise and programs most critical to adolescent health; and, an Adolescent and School Health Collaborative of essentially all programs that affect the health of adolescents. These teams will increase staff knowledge, expertise and best practices in adolescent health and facilitate opportunities to work across traditionally categorical programs to implement integrated approaches to improve the health of adolescents. Additionally, the framework and several activities in the logic models are being integrated within the new DHSS strategic plan.
Positive outcomes have also come from the state’s participation in the regional stakeholders meetings. Missouri’s STD/HIV and Unintended Teen Pregnancy Prevention (SHUTPP) team includes representation from the state departments of public health and education. The strongest collaboration and integration of efforts has been among Department of Health and Senior Services’ adolescent health program, STD/HIV prevention programs, and their shared partnerships. Efforts of existing statewide groups including the State HIV Community Planning Group/Youth Subcommittee and the Council for Adolescent and School Health (CASH) have been integrated. The state cosponsored a regional conference on teaching HIV, STD and human sexuality education with Iowa, Kansas and Nebraska. Missouri has now secured funding to hire a full-time youth health educator to coordinate this initiative and implement youth involvement strategies. The DHSS HIV/STD and adolescent health programs developed a joint state budget request to support healthy youth development and peer leadership programs, as well as school and parent education resources to comprehensively address the health of adolescents and young adults.

When Improving the Health of Adolescents & Young Adults: A Guide for States and Communities was released, CASH was in the process of developing a state framework for adolescent health. Much of the information, especially Chapter 3 of the guide, informed the development of the Missouri State Framework for Promoting the Health of Adolescents. More recently, the framework and guide were presented to the Missouri Injury and Violence Prevention Advisory Committee to inform the development of a strategic plan. Because the majority of the 21 critical health objectives to improve the health of adolescents and young adults relate to fatal and non-fatal injuries and violence, the guide is a helpful resource document to support statewide planning efforts.

**Ask an Expert**

**Q:** How do you, if at all, define adolescent medical home?

**A:** One of our experts responded that “a medical home is defined as a regular source of care, either a physician, mid-level practitioner or a clinic and a means of financial coverage for that care, i.e., SCHIP, Medicaid, insurance, etc.” and that this definition should apply to adolescents.

Another of our experts adapted the American Academy of Pediatrics’s definition of a medical home for adolescents. The adaptation reads:

**A medical home for an adolescent includes:**

- A partnership between the family and the adolescent’s primary health care professional, in which the adolescent gradually assumes increasing responsibility in a developmentally appropriate manner;
- Relationships based on mutual trust and respect;
- Connections to supports and services to meet the non-medical and medical needs of the adolescent and the family;
- Respect for a family’s cultural and religious beliefs;
- After hours and weekend access to medical consultation;
- Families who feel supported in caring for their adolescent; and,
- Primary health care professionals coordinating care with a team of other care providers.

Through this partnership, the primary health care professional can help the adolescent and family access and coordinate specialty care, educational services, in and out of home care, family support, and other public and private community services that are important to the overall health of the adolescent and family.

A medical home is not a building, house or hospital, but rather an approach to providing
A medical home is defined as primary care that is **accessible, continuous, comprehensive, family-centered, coordinated, compassionate and culturally effective.**

*Do you have questions for our experts? Submit them to Mara Gandal.*

**Get Involved**

### National Stakeholders Meeting –

The overall goal of the National Stakeholder Meeting (NSM), organized by AMCHP, the National Alliance of State and Territorial AIDS Directors, the National Coalition of STD Directors, and the Society of State Directors of Physical Education, Health and Recreation, is to strengthen communication and collaboration between state departments of education and health to support and improve HIV, STD and unintended pregnancy prevention for school-aged youth. This highly evaluated meeting and follow-up process is back for 2007 and accepting applications! The April 12-13, 2007 NSM is designed for states that have not participated in a previous NSM, formerly called a regional stakeholders meeting. We are in the process of planning a reconvene meeting for Jan. 2008 for those who have participated in the past. You register as a team, so if you are unsure of your counterpart or have other questions, please don’t hesitate to call the planners. Contact information is included in the [application](#). The 2007 NSM will be held in San Francisco, Calif. **Deadline: Feb. 2, 2007**

### Apply for a DATA Mini-Grant –

AMCHP is accepting applications for the Data and Assessment Technical Assistance (DATA) Mini-Grant Program to increase the ability of state MCH and CSHCN professionals to use epidemiology and surveillance data to support policies and programs serving MCH populations. The DATA Program will award grants of up to $5000 on a reimbursement basis to coordinate and conduct internal capacity-building activities in data and assessment, such as skills trainings, institutional assessments or surveillance program enhancement.

DATA Mini-Grant activities must directly address one or more of the following technical areas: data collection and analysis; cost-effectiveness and cost benefit analysis; electronic data organization and transfer; data and surveillance systems development; MCH epidemiology; needs assessment; performance measures and indicators; program evaluation; quality assurance; or, small area analysis. Desired products and outcomes from DATA include: 1) tools and training materials that increase knowledge and skills in MCH data and assessment; 2) diffusion of best practices in the collection, analysis and use of MCH data; and, 3) increased state capacity to translate MCH data into action.

All U.S. state and territorial MCH and CSHCN departments are encouraged to apply. Only one application can be submitted per state or territory per year, and no single state or territory may receive a mini-grant more than twice in a five-year period. Partner states and regions are encouraged to apply; only two partner states and two regions can qualify per funding period. Applications are due Dec. 31. Visit the [DATA Mini-Grants Web site](#) for more information and application materials.

### Title V Directors: Jump on the Bandwagon - Nominate Your Family Delegate –

Four states - Alabama, Illinois, Texas and Washington - have already nominated their AMCHP family delegate, and you should join them! The recent AMCHP bylaws change increased states' membership from four to five delegates, with the new delegate seat reserved for a family liaison. MCH and CSHCN directors can now let AMCHP know the person who will fill that fifth seat. The definition of a family liaison is outlined in the bylaws change as:

> A “family liaison” is an individual whose role is to represent the perspective of families in Title V agency activities, including policy and program development. A family liaison is not a Title V employee serving a general administrative role, but someone whose official responsibilities include issues of family involvement in
maternal and child health (MCH) or children with special health care needs (CSHCN) programs. Title and employment status may differ by state; family liaisons may be agency staff, employed by a partner organization, employed through a contract or subcontract, a volunteer, or another role.

Only those who fit this definition are eligible for the fifth seat. The board of directors approved this definition at the July 2006 board meeting; the definition was adopted to ensure that anyone serving in the fifth delegate seat truly represents families.

In states where the MCH and CSHCN are in different organizations: the Title V MCH and CSHCN Directors will collaborate on the designation of the family delegate. States that choose not to have a family liaison cannot use the fifth seat for any other type of member.

Dues: This bylaws change does not affect states’ AMCHP dues. States continue to pay the dues as approved at the annual AMCHP Business Meeting.

Voting rights: The family liaison delegate will have the same voting rights as any other AMCHP delegate and can serve on the board and committees in the same ways.

Process for submitting your 5th delegate
Please send the following information to Mara Gandal:
If you already have a family representative as a delegate in your state AMCHP membership:
Who is the family representative?
Would you like that person to take the fifth delegate seat? Y/N
Who would you like to nominate as your new standard delegate? (include name, title, address, phone and email)
If a family representative is not already a delegate:
Who would you like to nominate for this position? (include name, title, address, phone and email)

Funding
Community Access to Child Health Implementation Funds – The American Academy of Pediatrics is accepting proposals for this program which provides grants up to $10,000 to support pediatricians in the planning or pilot stages of the implementation of community-based child health initiatives. Deadline: Jan. 31, 2007

Leadership Education in Adolescent Health (LEAH) – This program provides interdisciplinary leadership training for at least five core professional disciplines in the areas of adolescent medicine, psychology, nursing, nutrition and social work at the graduate and postgraduate levels to prepare them for leadership roles in clinical services, research, training and development of health services for adolescents, including those with special health care needs. The training is designed to integrate biological, developmental, mental health, social, economic, educational and environmental issues within a public health framework. Deadline: Feb. 2, 2007

MCH Distance Learning – This program supports the development, implementation, creative utilization, application and evaluation of distance education opportunities for MCH professionals by public or nonprofit private institutions of higher learning. At least one grant will be targeted towards the translation of new evidence-based knowledge into MCH policy and practice. Deadline: Feb. 2, 2007

Oral Health Leadership – These grants will focus on pediatric dentistry leadership training through the support of: postdoctoral pediatric dentistry training for leadership roles in education, research, public health administration, advocacy and public service related to MCH oral health programs, particularly for children with special health care needs and the Head Start population; the development and dissemination of curricula, teaching models and other educational resources to enhance MCH oral health programs; and, the continuing education, consultation and
technical assistance in pediatric oral health which address the needs of the MCH community, including Head Start. **Deadline: Feb. 2, 2007**

**Assuring Better Child Health and Development (ABCD) Screening Academy** – The National Academy for State Health Policy (NASHP) seeks applications from state Medicaid agencies and partners for the ABCD Screening Academy, a 15-month initiative. NASHP will select up to 20 states interested in implementing the policies and practices needed to make the use of standardized screening tools the standard of practice in well-child care. Participating states will receive technical assistance, opportunities to exchange expertise and experience with other states, and national recognition of their efforts. **Deadline: March 1, 2007**

**Publications & Resources**

**Oregon Adolescent Health Resources:**

**Rational Enquirer** – This is an annual publication of the Teen Pregnancy Task Force. The adolescent health program is the lead agency guiding the content and the production of the Rational Enquirer. Adolescent health partnered with youth, Planned Parenthood, Teen Pregnancy Prevention and other community groups to produce the latest issue, *Start Early, Stay Late*, providing multiple and vibrant voices on healthy teen relationships, youth activism and empowerment, pregnancy prevention efforts, and others related to adolescent sexuality.

**Healthy Kids Learn Better** - The coordinated school health program developed this video to showcase its program. It highlights three schools that have actively participated in Healthy Kids Learn Better by focusing on changes in school environments to promote physical activity and healthy eating.

**School-Based Health Center 2006 Status Report** – In 2006, the state celebrated 20 years of School-Based Health Centers (SBHCs). Since their inception in 1986, SBHCs have grown from eight centers mostly focused on reducing teen pregnancy to 45 centers providing a wide array of primary physical and mental health care services. This annual report highlights the activities and accomplishments of the SBHCs, provides feedback from students using the centers, and traces their 20-year evolution.

**Adolescent Health E-mail List** – This new email distribution list from the National Association of County and City Health Officials will disseminate resources and provide opportunities for information exchange regarding training events, conferences, research, data, technical assistance, funding opportunities and other resources valuable to health departments working to improve health outcomes among adolescents. The list will highlight problem-focused resources and those that address broader cross-cutting and contextual issues known to affect adolescent health. The list will go out at a minimum bi-weekly. To subscribe, send an email to adolescent-health-sub@lists.naccho.org and type “subscribe” in the subject line.

**Suicide and Mortality Fact Sheets** – The National Adolescent Health Information Center at UCSF released updated versions of these fact sheets on adolescents and young adults. They provide the latest data on suicide and mortality with breakdowns by age, gender, and race and ethnicity, as well as trends.

**Acculturation and Sexual and Reproductive Health Among Latino Youth** – This article presents a review of existing research on how acculturation influences the sexual and reproductive health of Latina teenagers. It seeks to answer the following questions: what is the relationship between acculturation and the sexual and reproductive health of Latino youth in the United States; what acculturation theories have been employed to explain the relationship; and, what measures of acculturation have been used, and which best explain variations in sexual and reproductive health outcomes?
**Folic Acid Campaign Materials** – The Folic Acid Now! campaign offers an online media tool kit and consumer materials that community programs can customize and use during National Folic Acid Awareness Week, Jan. 8-14, 2007.

**The Health and Well-Being of Children in Rural Areas** – This new chartbook, based on parent reports from the National Survey of Children’s Health, presents national and state level data on the health status, health care use and risk factors experienced by infants, children and adolescents who reside in rural areas. More detailed analyses of the survey results are available from the Data Resource Center on Child and Adolescent Health.

**Cultural and Linguistic Competence Policy Assessment (CLCPA) and Guide** – These resources are available from the National Center for Cultural Competence (NCCC). The CLCPA is intended to support health care organizations to: improve health care access and utilization; enhance the quality of services within culturally diverse and underserved communities; and, promote cultural and linguistic competence as essential approaches in the elimination of health disparities. The Guide for Using the CLCPA provides step-by-step instructions on how to conduct an organizational self-assessment process. In addition to the PDF versions, the NCCC can provide consultation to conduct self-assessment processes, on-site or online.

**Medicaid Policies and Mental Health Service Use Among Children in the Child Welfare System** - This article in *Children and Youth Services Review* presents findings from an analysis of the effects of Medicaid managed care policies on access to ambulatory and inpatient mental health services among children in child welfare environments. The authors found that access to mental health services already falls below need for children in child welfare environments.

**Calendar**

**AMCHP Annual Conference**
AMCHP  
March 3-7, 2007  
Arlington, Va.  
Join leaders in maternal and child health, public health practitioners, and family advocates for information filled workshops led by researchers, federal officials, advocates, health care providers and directors of state programs. The theme of the 2007 conference is Healthy Communities.

**Forum for Improving Children’s Health Care**
NICHQ  
March 19-21, 2007  
San Francisco, Calif.  
With the theme of *Taking Flight: Achieving Excellence in Health Care for All Children*, the Forum promises to provide opportunities to learn, to share, to be inspired, and to network with others who care deeply about improving the quality of children’s health care.

**We Thrive With a Little Help From Our Friends - National Network of State Adolescent Health Coordinators Annual Meeting**
NNSAHC  
March 22-24  
Tuscon, Ariz.  
As a forum for showcasing strategies for improving adolescent health, the NNSAHC annual meeting is considered one of the key strategies to promote and implement the goals of the National Initiative to Improve Adolescent Health by the Year 2010. Each year, the NNSAHC Annual Meeting brings together adolescent health professionals from nearly every state agency, and some territories. Meeting participants and speakers also include national partners from federal agencies, non-profit organizations and other leaders in the field of adolescent and maternal and child health.