Environmental Scan:  
Addressing the Needs of Adolescents in State Title V Programs

Introduction

In the life course, adolescence constitutes an extended developmental period and an important bridge between childhood and adulthood. This period encompasses youth from 10 to 24 years of age, overlaps with both childhood and adulthood, and is marked by significant physical, cognitive, and psychosocial development. In addition, behaviors that begin in adolescence are likely to persist into adulthood, making adolescence a critical determinant of health in the adult years and an important area of focus for maternal and child health (MCH) programs.

From the establishment of Title V in 1935, state programs served adolescents as part of the population of all children ages zero to 18. In the 1950s, physicians began to recognize the unique developmental traits and health care needs of adolescents, and in 1975 the U.S. Department of Health Services published a report that formally recognized these distinctions. The report outlined adolescent health behavior, prevalent adolescent health challenges, services available for this population, and an analysis of future trends. With the conversion of Title V to a block grant in 1981, states began establishing staff positions dedicated to adolescents within their MCH departments, these positions became known as state adolescent health coordinators.

Title V programs continue to play key roles in promoting the health of adolescents – whether by funding a state adolescent health coordinator position, managing statewide programs targeting adolescents, linking programs within and outside of the state health agency that address adolescent health issues, or all of these.

Despite the long history of adolescent health work in Title V, no recent analysis of specific activities in state Title V adolescent health programs exists. This analysis is more relevant now than ever before. The 2015 transformation of the Title V MCH Services Block Grant has significant implications for the role of Title V programs in promoting the health and well-being of adolescents. The proposed Title V MCH Block Grant guidance, which will be finalized in January 2015, identifies adolescents/young adults up to age 24 as a distinct population domain; under select measures broadens the definition of children to include adolescents up to age 18 or 19 (dependent on national data sources); expands health care transition objectives to encompass youth without as well as youth with special health care needs; and requires that at least one national

* In research and in public health, adolescence is often divided into developmental periods such as adolescence (encompassing ages 10-19) and young adulthood (encompassing ages 20-24), or even more specifically, early adolescence (10-14), middle adolescence (15-17), and late adolescence (18-24). For the purposes of this report the term adolescence will be used and will refer to ages 10-24.
performance measure related to that population be adopted by each state. As of publication, four measures are proposed to meet this requirement: the rate of injury-related hospital admissions per population aged 0 through 19 years, the percent of children ages 6 through 11 and adolescents ages 12 through 17 who are physically active at least 60 minutes per day, the percent of adolescents ages 12 to 17 years who are bullied, and the percent of adolescents with a preventive services visit in the last year. The first two measures listed are applicable to either the Child Health or Adolescent Health population domain.

PURPOSE
This report describes findings from an environmental scanning process, in which data related to adolescents in state Title V MCH Block Grant reports were captured and analyzed in order to identify themes and conclusions and ultimately better understand state adolescent health programming under Title V. The resulting database of adolescent health activities also provides insight into the capacity of states to address the requirements of the revised Title V MCH Block Grant and the shifting needs of young people across the country. The collected data also serve as a reference for AMCHP and partners to link issue-specific work to specific states, and facilitate connections to resources and opportunities. Data analyzed for this report are from fiscal year (FY) 2012.

METHODOLOGY
To ensure accountability for activities funded under Title V, all states and territories are required to report annually on a core set of measures – including performance measures – that describe a specific MCH need that, when successfully addressed, can lead to a better health outcome within a specific time frame. In addition to this quantitative data, state reports include narrative descriptions of activities conducted to support the achievement of each performance measure.

All Title V programs are required to report on 18 National Performance Measures (NPMs). While there are multiple NPMs that measure outcomes for children ages zero to 18, this scan focused on only the three NPMs exclusively related to adolescents:

- NPM 6: The percentage of youth with special health care needs who received the services necessary to make transitions to all aspects of adult life, including adult health care, work, and independence
- NPM 8: The rate of birth (per 1,000) for teenagers aged 15 through 17 years
- NPM 16: The rate (per 100,000) of suicide deaths among youths aged 15 through 19

Areas of Research:
- What types of activities are most common among Title V adolescent health programs?
- What adolescent health issues do Title V programs address?
- What can we learn about adolescent health in the states from Title V MCH Block Grant reports?

About Title V Programs
State Title V MCH programs have a 77-year history of building comprehensive, integrated systems to ensure the health and well-being of women, children, including children with special health care needs, and their families. All states and U.S. territories receive funds from the Title V Maternal and Child Health Services Block Grant program (Title V MCH Block Grant) to build a comprehensive system of programs, services and supports for these populations. This federal program provides critical funds to states for programs, services, supports and leadership in areas including improving infant and child health outcomes, reducing infant and maternal mortality rates and providing prenatal care to low-income pregnant women. Leveraging the Title V MCH Block Grant can help advance state efforts to improve overall maternal and child health and well-being. This statute authorizes funds for all states and territories to:

- Provide and ensure that mothers and children (in particular those with low income or with limited availability of health services) have access to quality maternal and child health services
- Increase the number of children in low-income households who receive assessments and follow-up diagnostic and treatment services
- Facilitate the development of comprehensive, family-centered, community-based, culturally competent, coordinated systems of care for children and youth with special health care needs

The analysis of activities reported under these three NPMs sought to address the following questions:

• How are states addressing teen birth rates, teen suicide rates, and transition into adulthood for youth with special health care needs?
• How many states reported activities of various types?
• What activities related to transition, teen pregnancy prevention and suicide prevention are most common among the states?

In addition to the 18 NPMs, Title V programs design State Performance Measures (SPMs) to further address their priority needs. A search of the FY 2012 Title V MCH Block Grant state narratives contained in the Title V Information System (TVIS) online database found 161 SPMs related to adolescents (excluding those related to youth with special health care needs) in 58 states and territories.

The analysis of activities reported under SPMs sought to address the following questions:

• What adolescent health issues have states chosen to address with their SPMs?
• What adolescent-specific issues and themes are most common across state program activities?
• How many states have SPMs that address specific adolescent health outcomes?

This environmental scan was based on data reported in FY 2012 Title V MCH Block Grant reports. AMCHP completed a qualitative analysis of the activities reported in narratives under NPM 6, NPM 8, and NPM 16, as well as SPM narratives that included the keywords “adolescent,” “teen” or “youth.” Activities were coded individually and codes grouped into activity areas such as Reproductive Health and School Health.

Data from yearly block grant reports and applications are publicly available on the TVIS website.

RESULTS AND ANALYSIS: NATIONAL PERFORMANCE MEASURES

In activities related to the three National Performance Measures (NPM 6 on transition for youth with special health care needs, NPM 8 on teen birth rates, and NPM 16 on teen suicide rates), the following themes emerged.

Transition from Pediatric to Adult Health Care Addressed with Systemic Approaches

Activities addressing transition for youth with special health care needs (YSHCN) most often involved systemic approaches, training and outreach, and resource development and distribution. Participation in statewide collaborations and coalitions was common across a large percentage of states (68 percent) – in fact, participation in such groups was the type of activity adopted by the largest number of states across all NPM activities. Table 1 provides an overview of the top 10 types of activities reported under NPM 6.

The most common activities under this NPM demonstrate consistency in approaches: 68 percent of states reported participation in statewide collaborations and coalitions and 46 percent of states reported development of trainings and curricula. Activities under this NPM on transition for YSHCN showed the most commonality on types of activities across the states when compared to NPM 8 on teen birth rates and NPM 16 on teen suicide rates.

Successful transition from pediatric to adult health care is one of six core outcomes for children and youth with special health care needs (CYSHCN) established by the Maternal and Child Health Bureau (MCHB) and reiterated in Healthy People 2010 and Healthy People 2020. This emphasis on transition and the body of research on evidence-based approaches to supporting CYSHCN may explain why Title V activities supporting transition for YSHCN are systems-related and reach across sectors.

Activities Addressing Teen Birth Rates Largely Related to Federal Initiatives and Funding

Activities addressing teen birth rates (as reported under NPM 8 specifically) focus more on behavior-change interventions and were most often part of activities aligned
Table 1: Top 10 Types of Activities Under NPM 6
(The percent of YSHCN who received the services necessary to make transitions to all aspects of adult life, including adult health care, work and independence)

<table>
<thead>
<tr>
<th>Top 10 Types of Activities Under NPM 6</th>
<th>% of states reporting at least 1 activity in this area (N=59)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Participation in Statewide Collaborations &amp; Coalitions</td>
<td>68</td>
</tr>
<tr>
<td>Development of Trainings &amp; Curricula</td>
<td>46</td>
</tr>
<tr>
<td>Distribution of Resources</td>
<td>44</td>
</tr>
<tr>
<td>Implementation of or Participation in Conferences, Fairs, Seminars and Summits</td>
<td>39</td>
</tr>
<tr>
<td>Development and Creation of Resources</td>
<td>39</td>
</tr>
<tr>
<td>Practical Transition Tools (checklists, etc.)</td>
<td>31</td>
</tr>
<tr>
<td>Creation/Dissemination of Online Resources &amp; Websites</td>
<td>31</td>
</tr>
<tr>
<td>Direct Services: Transition Planning and Specialists</td>
<td>27</td>
</tr>
<tr>
<td>Collaboration with Medical Providers (including pediatricians and adult health care providers)</td>
<td>25</td>
</tr>
<tr>
<td>Development/Implementation of Consultation &amp; Referral System</td>
<td>20</td>
</tr>
</tbody>
</table>

Table 2: Top 10 Types of Activities Under NPM 8
(The rate of birth [per 1,000] for teenagers aged 15-17)

<table>
<thead>
<tr>
<th>Top 10 Types of Activities Under NPM 8</th>
<th>% of states reporting at least 1 activity in this area (N=59)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Personal Responsibility Education Program (PREP)</td>
<td>36</td>
</tr>
<tr>
<td>Abstinence Education/Abstinence Programs</td>
<td>27</td>
</tr>
<tr>
<td>Implementation of Evidence-Based Models/Programs</td>
<td>25</td>
</tr>
<tr>
<td>Family Planning Programs</td>
<td>25</td>
</tr>
<tr>
<td>Skills Training, Peer Leadership Training and Other Types of Training</td>
<td>19</td>
</tr>
<tr>
<td>Implementation of or Participation in Conferences, Summits and Other Events</td>
<td>17</td>
</tr>
<tr>
<td>Community and Youth Outreach</td>
<td>17</td>
</tr>
<tr>
<td>Data Collection and Analysis</td>
<td>15</td>
</tr>
<tr>
<td>Educational Programs</td>
<td>15</td>
</tr>
<tr>
<td>Reproductive Health Information and/or Services</td>
<td>15</td>
</tr>
</tbody>
</table>

In some states, these federal programs represent the largest source of funds for adolescent health activities. In FY 2012, grantees in the states received a total of $75 million via the TPPP; grantees are community-based organizations, state agencies and tribal entities. Even when community-based or other organizations are the primary recipients, state MCH programs typically play a role in supporting program implementation and/or evaluation. Through the PREP program state and territorial governments are awarded a cumulative $55 million each year (via a formula allocation). AEGP requires states to match every $4 in federal funds with $3 from state funds, and this funding is requested as part of the Title V MCH Block Grant. In FY 2012, 36 states and five territories received a total of $50 million.7

Figure 2 provides an overview of the top 10 types of activities reported under NPM 8. While PREP was commonly explicitly noted in narratives, states rarely noted activities funded directly by TPPP. Therefore, even though activities noted below may have been supported by TPPP funding, TPPP was not identified as a specific type of activity.

Activities under this NPM emphasized evidence-based models and programs, family planning programs, as well as skills training, peer leadership training, and other types of training. These activities reflect the requirements of federal funding agreements and the substantial body of research on evidence-based pregnancy prevention interventions. Federal awards focus on curriculum-based education programs (with PREP and TPPP requiring curriculum supported by rigorous scientific research), general youth development approaches, and adult preparation subjects (such as healthy relationships and financial literacy), which explains why these themes appear in the activities analysis. Decades of extensive research on interventions to decrease the sexual risk behaviors of young people produced multiple evidence-based interventions that target a range of specific youth populations, including youth in foster programs, rural and urban youth, and Latino and African American
In addition, 17 states noted Garrett Lee Smith (GLS) suicide prevention grants or other grants awarded by the federal Substance Abuse and Mental Health Services Administration (SAMHSA) as significant drivers of suicide prevention activities. GLS grants support suicide prevention activities in college campus, state, and tribal communities. Currently there are 150 grantees, 68 are state and tribal agencies and 82 are campuses.

### RESULTS AND ANALYSIS: STATE PERFORMANCE MEASURES

States prioritize a wide variety of issues and implement a diverse range of approaches to adolescent health issues in their SPMs, reflecting the diversity of populations and adolescent health needs across states. Figure 1 shows the adolescent-specific issues most commonly addressed in state program activities; the chart notes both the percent of activities identified in SPM that related to each topic, and the number of states with at least one activity of that type included in SPM narratives.

Teen pregnancy prevention and reproductive health represent the most common activity areas by more than five percentage points (19 percent each compared to 14 percent for the third most common activity area, school health). However, they appear in SPMs in less than half of the states – teen pregnancy prevention in 20 states and reproductive health in 19 states.

AMCHP also analyzed the specific activities that states reported within each of the 10 activity areas noted above. Following is a review of the results and key findings, organized by activity area. Subcategories will not sum to the total N because an activity may be described by multiple subcategories. The purpose of this review is to show the array of activities under each topic area above.

### Teen Pregnancy Prevention

**SPM Activities Illustrate the Diversity of State Approaches to Teen Pregnancy Prevention**

Analysis of SPM activities related to teen pregnancy prevention revealed a wide range of activities and interventions applied in the states. The most common activity group is the “Other TPP Activities” group, illustrating the diversity of approaches used in states. These approaches may be used in addition to specific programs such as PREP or Teen Outreach Program (TOP) and included: abstinence education/programs, counseling, evidence-based models/programs, mentoring, parents, sexual violence, statewide initiatives, training, underserved populations, and conferences. PREP was the most common specific program activity under TPP (25 percent). Education, family planning, programs for

---

### Table 3: Top 10 Types of Activities Under NPM 16

(The rate [per 100,000] of suicide deaths among youths aged 15-19)

<table>
<thead>
<tr>
<th>Top 10 Types of Activities Under NPM 16</th>
<th>% of states reporting at least 1 activity in this area (N=59)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Suicide Prevention Trainings</td>
<td>36</td>
</tr>
<tr>
<td>Issue-Specific Collaboration with Statewide Partners/Coalition</td>
<td>36</td>
</tr>
<tr>
<td>Outreach To/Collaboration With Schools</td>
<td>32</td>
</tr>
<tr>
<td>Data Collection and Analysis</td>
<td>27</td>
</tr>
<tr>
<td>Development or Implementation of a Statewide Plan to Address Suicide Among Youth</td>
<td>27</td>
</tr>
<tr>
<td>Development and/or Distribution of Prevention Materials</td>
<td>22</td>
</tr>
<tr>
<td>Mental Health Services</td>
<td>22</td>
</tr>
<tr>
<td>Technical Assistance to Local Health Departments, Community Organizations, Grantees or Coalitions</td>
<td>15</td>
</tr>
<tr>
<td>Collaboration with State Fatality Review Committee</td>
<td>15</td>
</tr>
<tr>
<td>Local Suicide Prevention Coalitions</td>
<td>15</td>
</tr>
</tbody>
</table>
pregnant and parenting teens (which receive funding from the U.S. Department of Health and Human Services (HHS) Office of Adolescent Health Pregnant and Parenting Teens grants), the TOP (an evidence-based curriculum suitable for all youth populations and focused on healthy behaviors, life skills, and a sense of purpose), and peer programs were other common activities.

Reviewing the TPP measures themselves, states have not created SPMs redundant to NPM 8, but instead selected measures of population-specific and systems-level drivers of high teen birth rates, including high school graduation rates, unintended pregnancy, repeat pregnancies, positive youth development, and contraceptive use.

Reproductive Health

Reproductive Health Activities Span the Life Course and Approaches

Adolescent populations are included in reproductive health activities that span types of approaches and reach across the life course. The most common activities included general reproductive health activities and sexual health

Figure 1: Top 10 Activity Areas: Percent of All Activities as Identified in SPM Narratives, 2011-2012

<table>
<thead>
<tr>
<th>Activity Area</th>
<th>States</th>
</tr>
</thead>
<tbody>
<tr>
<td>Teen Pregnancy Prevention</td>
<td>20</td>
</tr>
<tr>
<td>Reproductive Health</td>
<td>19</td>
</tr>
<tr>
<td>School Health</td>
<td>14</td>
</tr>
<tr>
<td>YSHCN</td>
<td>13</td>
</tr>
<tr>
<td>Obesity/Overweight/Healthy Weight</td>
<td>12</td>
</tr>
<tr>
<td>Positive Youth Development</td>
<td>13</td>
</tr>
<tr>
<td>Substance Abuse</td>
<td>12</td>
</tr>
<tr>
<td>Hunger/Healthy Food/Food Assistance</td>
<td>8</td>
</tr>
<tr>
<td>Injury Prevention</td>
<td>7</td>
</tr>
<tr>
<td>Youth Leadership</td>
<td>7</td>
</tr>
</tbody>
</table>

Figure 2: Reproductive Health Activities as Described in SPM Narratives, 2011-2012 (N=34)
activities, followed by family planning, preconception health, interconception health and care, and reproductive life plans. Activities in the “Other Activities” category included folic acid promotion, reproductive health plans, and sex education training. Figure 2 illustrates the breakdown of reproductive health activities related to adolescents.

School Health

Title V School-Based Initiatives Include Health Care, Screening and General Health Promotion in Schools

School health is a broad area that encompasses many issues affecting school-age youth, including safe school environments, physical education and nutrition. Schools remain the most efficient and effective way to reach large groups of adolescents and their parents, making them a consistent focus for public health interventions. The two most common activities under the School Health activity area were Coordinated School Health and School Based Health Centers (each 38 percent, n=16).

Coordinated School Health (CSH) is a framework created and promoted by the Centers for Disease Control and Prevention (CDC). CSH includes eight components: health education, physical education, nutrition services, health services, psychological and social services, healthy and safe school environments, health promotion for staff, and family/community involvement. From 2008-2013 the CDC awarded competitive CSH grants to state health departments, and Title V/MCH divisions were often either the direct CSH grantee or closely involved with the grantee agencies to support CSH activities in schools.

School Based Health Centers (SBHCs), located in schools or on school grounds, seek to become integral parts of the school in cooperation with school and community leadership, and provide clinical and comprehensive health services to students. In some states the Title V/MCH division manages SBHCs statewide. In states where Title V is not directly responsible for SBHCs, Title V staff support SBHC oversight and contribute to SBHC-based interventions. A smaller number of activities related to general school health activities (13 percent), general school based health care (which describes care in a school setting but not necessarily in a SBHC, and screening (6 percent each).

Youth with Special Health Care Needs

Title V Programs Dive Deeper into Transition and Quality Care Issues for YSHCN and Their Families

AMCHP did not analyze subcategories of YSHCN activities. However, an analysis of the SPMs revealed that 13 states have a total of 14 SPMs with activities specifically related to YSHCN. Only four of those SPMs addressed transition (the 2011 AMCHP Issue Brief “Environmental Scan: How State Title V Programs Are Responding to Autism Spectrum Disorder and Other Developmental Disabilities” provides further information on how states address transition to adulthood). The remaining nine SPMs addressed a range of drivers and factors related to quality care for YSHCN: access to community-based services, systems of care, self-management skills, access to care coordination services, developmental screening, depression screening, and data collection. With transition covered by NPM 6, states have taken advantage of the opportunity to collect more nuanced data on determinants of quality care and transition for YSHCN.

Obesity, Overweight and Healthy Weight

Physical Activity is Dominant Focus of Title V Activities Addressing Weight Issues in Adolescents

Fifth most common, this activity area reflects that the obesity epidemic and its relationship to poor outcomes for mothers, children, and adolescents remain significant challenges and priorities for state health departments. Title V activities in this area focus most often on physical activity (53 percent, n=19), followed by obesity in general (37 percent) and healthy weight (11 percent). In the new Title V MCH Block Grant guidance, the NPM previously focused on child obesity (NPM 14: Percentage of children, ages two to five years, receiving WIC services with a body mass index at or above the 85th percentile) was eliminated and a new NPM added that measures physical activity rather than obesity or overweight (NPM 11: Percent of children ages six to 11 years and adolescents ages 12 to 17 years who are physically active at least 60 minutes per day). This may represent a shift, also indicated in SPM results in this category, toward measuring the interventions that address obesity and overweight (such as physical activity) rather than simply measuring the negative outcomes – obesity and overweight rates.

Positive Youth Development

Positive Youth Development Approaches Adopted as Both Programs and Methods

Positive Youth Development (PYD) is a conceptual and practical approach to programming with and for adolescents. PYD is based on evidence that positive influences in the lives of adolescents increase their resiliency to adverse experiences and negative influences and equip them with skills for a healthy adulthood. Activities in this area were not analyzed by subcategory. However, within activities reported, PYD appeared both as an approach to working with young people (where PYD principles are applied to programs serving adolescents) and as a content area for increasing the capacity of adults who work with young people (where adults such
as health agency staff and partners receive training on PYD principles and approaches). Even federal agencies that support state adolescent health programming institutionalized PYD: the Administration on Children, Youth, and Families Family and Youth Services Bureau promotes the use of PYD in its own programs and among grantees, federal agencies, and state and local partners. In addition, three states have SPMs that specifically reference the application of PYD principles to adolescent health programming.

### Substance Abuse

#### Alcohol Abuse Primary Focus of Substance Abuse Programs

Alcohol abuse accounted for 64 percent of substance abuse activities (n=22). Activities targeted binge drinking and alcohol abuse, and also included alcohol use screening and general alcohol use prevention. The remaining 36 percent of reported activities in this category were general substance abuse prevention activities (not including tobacco or smoking prevention activities). Substance abuse prevention is not typically an area of focus for Title V programs, except when related to maternal health among MCH populations, and most substance abuse prevention activities are housed under separate divisions of state health departments. However, alcohol and drug abuse remain important to adolescent health outcomes. A 2014 analysis of trends in adolescent health showed that national measures of substance use among adolescents changed very little over the past decade. Further analysis of Title V activities is needed in order to make recommendations on how state MCH programs can expand their impact on adolescent substance abuse outcomes.

### Hunger, Healthy Food and Food Assistance

#### Title V Programs Address Hunger and Food Insecurity Among Adolescent and School Populations

The most common activities in this area related to nutrition (54 percent, n=13). Food insecurity (15 percent) also was addressed in activities. Other activities in this category were equally common (8 percent each): food access, food assistance and “farm to school” programs, which bring food from local farms into school cafeterias along with nutrition education activities. Hunger and food insecurity have an important relationship to obesity. Food insecurity is defined by limited or uncertain access to food, and is connected to an array of poor outcomes for both children and adults. In adolescents food insecurity is connected to higher rates of depressive disorder and suicidal symptoms, and hunger is connected to lower math scores among other behavioral outcomes. The relationship between hunger and obesity, and the impacts of hunger on adolescent development, support the need for effective partnerships between MCH departments, education and school lunch programs, obesity and chronic disease partners, and agencies addressing hunger and nutrition.*

### Injury Prevention

#### Adolescent Injury Prevention Prioritizes Motor Vehicle Safety for Drivers and Passengers

The largest single category of activities in this area was defined as general injury prevention (29 percent, n=14). While this analysis separated out specific programs, when examined by theme nearly half of injury prevention activities (43 percent) focused on drivers and passengers of motor vehicles: drinking and driving (14 percent), graduated driver licensing (14 percent), passenger safety (7 percent), and all-terrain vehicle (ATV) safety (7 percent). Two other areas related to bicycle, motorcycle, ATV and skateboarding activities: bike safety (7 percent) and helmet use (7 percent). States also reported activities addressing unintentional injury (7 percent). While injury prevention spans the life course, adolescent health programming reflects the unique activities that lead to injuries among adolescents and the fact that motor vehicle accidents are the leading cause of death for adolescents.**

### Youth Leadership

#### Title V Programs Create Youth Leadership Opportunities within Adolescent Health Initiatives

Distinct from PYD, the youth leadership activity area described specific activities that formally assign leadership roles to young people and build leadership skills. General youth leadership development was the most commonly reported activity (38 percent, n=8). Peer education programs accounted for 25 percent of these activities. Notably, 13 percent of activities included roles for young people as formal youth consultants. States also reported on two specific youth leadership programs, Students Taking Charge and Diabetes Youth Ambassadors (13 percent each). Students Taking Charge is a national program that engages high school students in taking action to make their schools healthier places and educate their peers and themselves on healthy habits. The Diabetes Youth Ambassador program brings youth with diabetes together to learn about the condition and how to manage it, while also training them to educate peers within their schools and communities (the model may be replicated with youth with other chronic conditions). These activities and programs show that Title V programs are not only espousing a PYD approach but actively seeking ways to incorporate leadership opportunities for young people into health promotion activities.

---

* Household Food Insecurity is one of 59 Life Course Indicators selected by AMCHP and a National Expert Panel in 2013. See the AMCHP Life Course Metrics project website for more information.
ENVIRONMENTAL SCAN: Addressing the Needs of Adolescents in State Title V Programs

PREVALENCE OF STATES WITH ADOLESCENT-FOCUSED STATE PERFORMANCE MEASURES

The Majority of States Have Two to Four SPMs Related to Adolescents

A final analysis examined the prevalence of multiple adolescent-specific SPMs across states. Figure 3 shows that the majority of states (a total of 37 states or 52 percent of states) have two, three, or four SPMs related to adolescents. Only one state has no SPM related to adolescent health, and two states have the maximum found, with seven SPMs related to adolescents. More states have more than four adolescent-specific SPMs (13 states or 22 percent) than have fewer than four (9 states or 16 percent).

CONCLUSIONS

Reproductive Health and Pregnancy Prevention Remain Top Priorities

Reproductive health for adolescents aligns with state MCH programs that address preconception health and maternal health for all women of childbearing age. Title V programs consistently play a role in efforts to address teen pregnancy prevention in the states, and often lead efforts supported by federal funding. States are required to report on their activities to reduce teen birth rates under NPM 8, yet 20 states also choose to measure and report on an SPM related to teen pregnancy prevention. The fact that 20 states elected to create a separate SPM highlights the focus placed on this issue by state leaders in response to increased national attention to teen pregnancy prevention. In 2010, the CDC identified teen pregnancy prevention as a priority “winnable battle” – one of seven public health issues with both significant population health impacts and proven, effective strategies available to address them. Currently, states have statewide initiatives (such as a statewide coalition or task force) to address teen pregnancy. However, as the SPM findings illustrate, while there is national consensus that teen pregnancy merits ongoing investment of state and federal resources, strategies at the state level differ considerably.

Title V Adolescent Health Activities Reflect Flexibility of Block Grant and Diversity of States

The results of this environmental scan illustrate the interdisciplinary nature of MCH and state health departments. Title V programs play leadership and/or advisory roles in a wide range of adolescent health activities across the country. The variety of topics seen in SPMs suggests that adolescent health priorities vary from state to state and therefore the needs of adolescents (which inform state priorities) also vary. In addition, Title V was structured as a block grant in order to allow states the flexibility to address state-specific MCH needs identified in the five-year needs assessments. Title V programming therefore reflects the diversity of state populations as a whole and adolescent populations in particular.

Title V Programs Increasingly Apply Positive Youth Development Principles

The prevalence of youth leadership programs may be related to the increasing adoption of PYD principles and the application of extensive PYD research conducted since the 1990s. PYD appears in state block grant narratives across SPMs, states and territories, and issue areas, indicating the achievement of a high level of commitment to and investment in PYD approaches and programs in state Title V programs.

2015 Title V MCH Block Grant Transformation Provides Opportunity for States to Advance Adolescent Health Goals

By giving greater attention to adolescent and young adult populations, incorporating NPMs on adolescent-specific issues, and emphasizing the importance of health care transition for all youth, Block Grant transformation has provided an opportunity for states to delve more deeply into adolescent health issues. While the NPMs exclusive to
Adolescent Health are specific to bullying and preventive care, they intersect with and can therefore bring more attention and resources to a number of other adolescent health issues including mental health and depression, suicide prevention, youth-friendly clinical services, and adolescent immunizations. Through the development of state-initiated structure/process measures, states will more explicitly measure the activities they use to impact the NPMs and ultimately improve National Outcome Measures. Finally, states still have the opportunity to select SPMs that reflect the unique needs of their adolescent health populations.

**ADDITIONAL RESOURCE**

AMCHP presented a webinar on the environmental scan in April 2014. The webinar slides and recording are available on the AMCHP website: [http://www.amchp.org/programsandtopics/AdolescentHealth](http://www.amchp.org/programsandtopics/AdolescentHealth).

Pie charts detailing the activities reported in each of the top 10 State Performance Measure activity areas are available here: [http://www.amchp.org/programsandtopics/AdolescentHealth/Documents/AH Environmental Scan SPM Top 10 Activity Area pie charts.pdf](http://www.amchp.org/programsandtopics/AdolescentHealth/Documents/AH Environmental Scan SPM Top 10 Activity Area pie charts.pdf).

**ACKNOWLEDGEMENTS**

This publication was supported by cooperative agreement U45MC06854 from MCHB. Its contents are solely the responsibility of the author and do not necessarily represent the official views of MCHB.
REFERENCES & ENDNOTES


REFERENCES & ENDNOTES cont

16 Data provided by staff of the National Campaign to Prevent Teen and Unplanned Pregnancy and Advocates for Youth: http://www.advocatesforyouth.org/state-organization-contacts