
Healthy Youth 2010



Supporting the
21 Critical Adolescent Objectives

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American Medical Association
Physicians dedicated to the health of America



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The National Initiative continues some of the activities begun during discussions among members of the Healthy People 2010 adolescent work group. Many of those discussions focused on bringing about some changes within the social institutions that are influential in young people's lives. Medicine represents a social institution that can assume a major role in improving the health status of adolescents and young adults. This publication is intended to assist physicians who want to participate in supporting the Healthy People 2010 21 Critical Objectives for Adolescents and Young Adults.

In addition to the National Initiative's co-chairs, Casey Hannan, MPH at the Centers for Disease Control and Prevention, Debbie Maise, MPH at the Health Services and Resources Administration, and Jane Park, MPH and Claire Brindis, DrPH both at the National Adolescent Health Information Center, University of California, San Francisco, have been instrumental in assisting with the completion of this publication. Audrey Yowell, PhD, public health analyst at the Maternal and Child Health Bureau and our Partners in Program Planning for Adolescent Health project officer has made this publication possible through our cooperative agreement.

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Foreword

I am pleased that the American Medical Association (AMA) has been involved in the Healthy People project for the past decade. With Healthy People 2000, the AMA was awarded a special grant by the US Public Health Service to promote the health objectives that related to adolescents. We actively participated in the development of Healthy People 2010 and have also committed ourselves to promoting not only the National Initiative to Improve Adolescent Health by the Year 2010, but also the 10 Leading Health Indicators that are part of Healthy people 2010.

The AMA actively supports the Healthy People 2010 goals of increasing the quality and length of life in addition to eliminating health disparities. The AMA has entered into a Memorandum of Understanding (MOU) with the United States Department of Health and Human Services (DHHS) to address health disparities. This publication participates in the MOU, jointly signed by the AMA and David Satcher, MD, Surgeon General of the United States, by featuring the adolescent component of the national health objectives.

As the largest physician organization in the United States, the AMA is in a unique position to encourage physician participation in and support for the national health objectives. This publication includes information about adolescent health status, recommendations for working with state medical societies, suggestions for initiating activities that address the 21 Critical Objectives for Adolescents and Young Adults, sources of programmatic support, communication strategies, and the importance of evaluation.

Interested physicians can use this publication as a resource and a roadmap for addressing the health needs of young people who are 10-24 years of age. It is complementary to other activities of the AMA that are directed at promoting disease prevention and health promotion in clinical practice. Our adolescents and young adults deserve the best that we have to give them.

Arthur Elster, MD, FSAM
Director, Medicine and Public Health
American Medical Association

Introduction

The American Medical Association (AMA) has actively participated in the development of and supported the targets for the national health objectives since their original release in 1979. Physicians' special role in supporting the national health objectives requires them to participate in a large public health initiative that may provide unique benefits for individual patients, especially adolescents and young adults. This publication is intended to offer interested physicians some direction in pursuing activities that address the Healthy People 2010 21 Critical Objectives for Adolescents and Young Adults.

Physicians face a number of challenges to participating actively in health-related activities that take place outside their patient care facilities and research laboratories. Some of the barriers that physicians encounter include competing demands on their time, limited knowledge about adolescent health, lack of resources, and other related issues. *Healthy Youth 2010* features information about the national health objectives especially the adolescent component, offers direction for working with state medical societies, describes the elements of initiating a state-based activity, outlines opportunities for obtaining programmatic support, reviews strategies for publicizing project activities, provides an action plan for implementation, and discusses the importance of program evaluation.

Healthy Youth 2010's seven chapters include resources and references for initiating a project as well as joining a well-established project. Physicians may choose to participate in a single issue like youth violence or support a comprehensive approach that addresses multiple adolescent risk behaviors. Activities may be community-oriented or state-based and they can target a particular age group or address the special needs of young people throughout this developmental period. Physicians can use *Healthy Youth 2010* as a resource for their role as state leaders who direct activities and develop programs. Consulting the recommended resources and completing an action plan can enhance project effectiveness by tracking and evaluating project activities.

Medicine represents an important social system with which young people interact. Physicians can make a difference in the lives of young people by helping to enhance their state's core capacity to support adolescent health programs and increase clinical service delivery opportunities. Programs that physicians promote should stress the elimination of health disparities, a Healthy People 2010 goal, and emphasize positive youth development.

Our young people deserve the best that we can give them. Adolescents and young adults need physician's energy, expertise, commitment, creativity, and unique community standing to bring attention to the issues that are addressed in the *Healthy People 2010* twenty-one critical objectives. *Healthy Youth 2010* can offer physicians some direction for channeling efforts on behalf of young people.

The National Health Objectives

Introduction

The national health objectives have a past, a present, and a future. Their past is a fascinating history of surgeons general bringing attention to the nation's health status by identifying goals to be achieved within a specific decade. Their present is the 467 objectives with specific targets for increasing longevity, improving the quality of life, and eliminating health disparities. Their future is the years beyond the first decade of the 21st century when health disparities are a thing of the past, the leading health indicators are an outdated reference point for well being, and access to health care is universal and unquestioned. This chapter includes a brief historical perspective on the national health objectives, the leading health indicators role as a report care, and specific information about the twenty-one critical objectives for adolescents.

The national health objectives are important for a number of reasons. The health objectives can be quantified and used to assess progress toward meeting their targets. They can be used as a framework for targeting a state or community's most pressing health problems and planning ways to improve them. The objectives themselves are comprehensive and include specific numeric targets that are tracked and evaluated. The health objectives highlight some of our best efforts to prevent disease and promote good health.

Healthy People 2010 Overview

The history of the health objectives dates back to the late 1970's when Julius B Richmond, MD served as the Surgeon General and Assistant Secretary for Health under President Jimmy Carter. At that time, President Carter recognized the increasing advances of medical science in providing treatment and cures for diseases that were previously considered death-sentences. However, the 1979 Surgeon General's Healthy People (1979) report emphasized the importance of disease prevention and health promotion. The Healthy People 2000 initiative was designed to reduce preventable death, diseases and disability and was developed as a broad-based plan to improve the health of all Americans. The

298 specific objectives in 22 separate priority areas had three principle goals including to increase the span of healthy life, reduce health disparities, and achieve access to preventive services.

Healthy People 2010 includes 467 objectives in 28 separate focus areas to be achieved during the first decade of the new millennium. The health objectives are a tool that can help physicians to participate in programs that are developed to improve health. The health objectives serve as the basis for the development of state and community plans.

Healthy People 2010 Goals

Healthy People 2010 is designed to achieve two overarching goals:

- **Goal 1: Increase Quality and Years of Healthy Life**
The first goal of Healthy People 2010 is to help individuals of all ages increase life expectancy and improve their quality of life.
- **Goal 2: Eliminate Health Disparities**
The second goal of Healthy People 2010 is to eliminate health disparities among different segments of the population.

Each of the 28 focus area chapters also contains a concise goal statement. This statement frames the overall purpose of the focus area.

Several aspects of the national health objectives recommend their critical nature, salience, and applicability, including that they were:

- developed through a broad consultation process
- built on the best scientific knowledge
- designed to measure programs over time
- intended for public domain use

Appropriate uses for the national health objectives include:

- measuring health improvement
- developing an agenda that meets local needs
- evaluating programs
- setting a research agenda

Although the national health objectives have been available for more than twenty years, Healthy People 2010 includes:

- health assessment tool
- national report card
- leading health indicators that respond to the number of objectives
- 467 objectives

Leading health indicators include:

- *Physical Activity*
- *Overweight and Obesity*
- *Tobacco Use*
- *Substance Abuse*
- *Responsible Sexual Behavior*
- *Mental Health*
- *Injury and Violence*
- *Environmental Quality*
- *Immunizations*
- *Access to Care*

Progress since 2000 includes:

- 30 year increase in life expectancy since 1900
- 60% success rate with 15% met and 44% well under way for Healthy People 2000

Areas of concern include:

- increases in obesity and diabetes, especially type 2
- increases in childhood obesity and asthma

National Initiative to Improve Adolescent Health by the Year 2010

The National Initiative is predicated upon attaining 21 critical objectives among 10-24 year-olds (e.g., overall mortality, homicides, chlamydia, and use of any tobacco product) and measuring these objectives at the national and state levels. Criteria for selecting the critical objectives include that it is a critical health outcome or contributing risk behavior, and that state level data are available or soon will be available. The initiative relies on several, broad-based national strategies that include publishing annual reviews of state health policies, identifying best policies and practices to attain critical health objectives, integrate youth development efforts, compare findings with international efforts to improve adolescent health, increase state core capacity in adolescent health programs and service delivery, publish state adolescent health performance measures, and publish state progress on critical health objectives.

Critical Objectives for Adolescents

These objectives are divided in a number of categories. They include objectives with critical health outcomes, objectives that feature behaviors that substantially contribute to important health outcomes, and others that address the leading health indicators.

Critical health outcomes

1. (16-03) Reduce deaths of adolescents and young adults who are: 10-14 years, 15-19 years, and 20-24 years.
2. (15-15) Reduce deaths caused by motor vehicle crashes (also a leading health indicator).
3. (26-01) Reduce deaths and injuries cause by alcohol- and drug-related motor vehicle crashes.
4. (18-01) Reduce the suicide rate.
5. (15-32) Reduce homicides: 10-14 years of age, 15-19 years of age (also a leading health indicator).
6. (09-07) Reduce pregnancies among adolescent females.
7. (13-05) Reduce the number of cases of HIV infection among adolescents and adults.
8. (25-01) Reduce the proportion of adolescents and young adults with Chlamydia trachomatis infections.
9. (19-03) Reduce the proportion of children and adolescents who are overweight or obese (also a leading health indicator).

Behaviors that substantially contribute to important health outcomes

10. (15-19) Increase use of safety belts.
11. (26-06) Reduce the proportion of adolescents who report that they rode, during the previous 30 days, with a driver who had been drinking alcohol.
12. (18-02) Reduce the rate of suicide attempts by adolescents.
13. (15-38) Reduce physical fighting among adolescents.
14. (15-39) Reduce weapon carrying by adolescents on school property.
15. (06-02) Reduce the proportion of children and adolescents with disabilities who are reported to be sad, unhappy, or depressed.
16. (18-07) Increase the proportion of children with mental health problems who receive treatment.

Leading health indicators

17. (26-11) Reduce the proportion of persons engaging in binge drinking of alcoholic beverages.
18. (26-10) Reduce past-month use of illicit substances.
19. (25-11) Increase the proportion of adolescents who abstain from sexual intercourse or use condoms if currently sexually active.
20. (27-02) Reduce tobacco use by adolescents.
21. (22-07) Increase the proportion of adolescents who engage in vigorous physical activity that promotes cardiorespiratory fitness 3 or more days per week for 20 or more minutes per occasion.

Objectives that address both critical health outcomes and the leading health indicators

- (15-15) Reduce deaths caused by motor vehicle crashes.
- (15-32) Reduce homicides: 10-14 years of age, 15-19 years of age.
- (19-03) Reduce the proportion of children and adolescents who are overweight or obese.

The 21 Critical Objectives can also be organized by major categories that include:

Unintentional injury

- 15-15 Reduce deaths caused by motor vehicle crashes
- 26-01 Reduce deaths and injuries cause by alcohol- and drug-related motor vehicle crashes
- 26-06 Reduce the proportion of adolescents who report that they rode, during the previous 30 days, with a driver who had been drinking alcohol
- 15-19 Increase use of safety belts

Violence

- 15-32 Reduce homicides: 10-14 years of age, 15-19 years of age
- 15-38 Reduce physical fighting among adolescents
- 15-39 Reduce weapon carrying by adolescents on school property

Substance abuse

- 26-10 Reduce past-month use of illicit substances
- 26-11 Reduce the proportion of persons engaging in binge drinking alcoholic beverages

Reproductive health

- 09-07 Reduce pregnancies among adolescent females
- 25-11 Increase the proportion of adolescents who abstain from sexual intercourse or use condoms if currently sexually active
- 13-05 Reduce the number of cases of HIV infection among adolescents and adults
- 25-01 Reduce the proportion of adolescents and young adults with *Chlamydia trachomatis* infections

Mental health

- 06-02 Reduce the proportion of children and adolescents with disabilities who are reported to be sad, unhappy, or depressed
- 18-01 Reduce the suicide rate
- 18-02 Reduce the rate of suicide attempts by adolescents
- 18-07 Increase the proportion of children with mental health problems who receive treatment

Chronic disease prevention and health promotion

- 19-03 Reduce the proportion of children and adolescents who are overweight or obese
- 22-07 Increase the proportion of adolescents who engage in vigorous physical activity that promotes cardiorespiratory fitness 3 or more days per week for 20 or more minutes per occasion
- 27-02 Reduce tobacco use by adolescents

Overall mortality

- 16-03 Reduce deaths of adolescents and young adults who are 10-14 years, 15-19 years, and 20-14 years

Physicians Role

As guardian's of their patients' health, physicians engage in a special partnership with those who seek their advice for maintaining wellness and overcoming disease. Physicians can directly address individual adolescent's health status through clinical practice. However, physicians can influence the health status of many young people by participating in community activities and state programs that address the 2010 twenty-one critical adolescent objectives. The next several chapters feature descriptions of state medical societies, components of a state adolescent health program, support for and publicity about project activities, program evaluation, and resources.

Adolescent Health Status

Introduction

Adolescents engage in many risky behaviors that may have a negative effect on their health. The Healthy People 2010 critical objectives for adolescents and young adults address some of these risky behaviors. This chapter outlines each of the 21 critical objectives, along with trends over the years, and the 2010 health target. It also provides adolescent health data resources at the national and state levels.

Trends in Youth Risk Behaviors

21 Critical Objectives for Adolescents and Young Adults

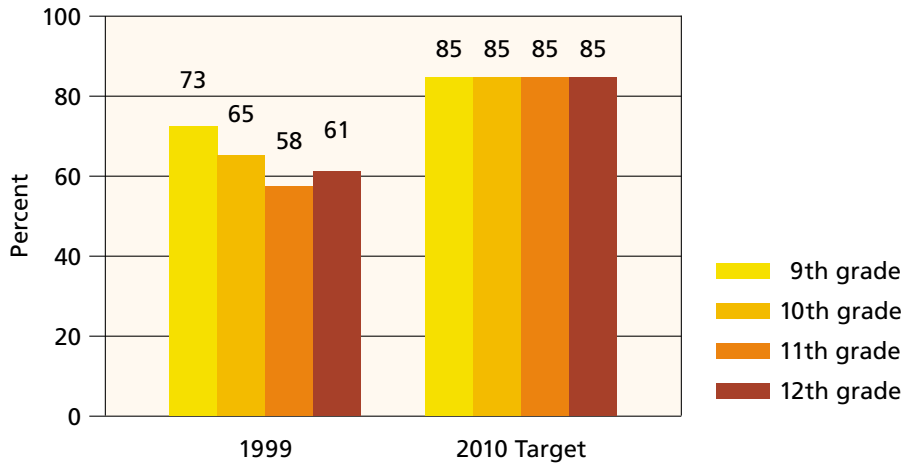
Physical Activity

In 1999, 70 percent of all high school students participated in moderate to vigorous physical activity in the previous 7 days preceding completion of questionnaire. However, data has shown that physical activity decreases during adolescence. Both female and male students in grade 9 were more likely to have engaged in moderate or vigorous physical activity than students in grades 10-12 (MacKay, Fingerhut, Duran, 2000).

Objective 22-07:

Increase the proportion of adolescents who engage in vigorous physical activity that promotes cardiorespiratory fitness 3 or more days per week for 20 or more minutes per occasion

Vigorous Physical Activity in Adolescents



Source: Youth Risk Behavior Surveillance System (YRBSS), CDC, NCCDPHP

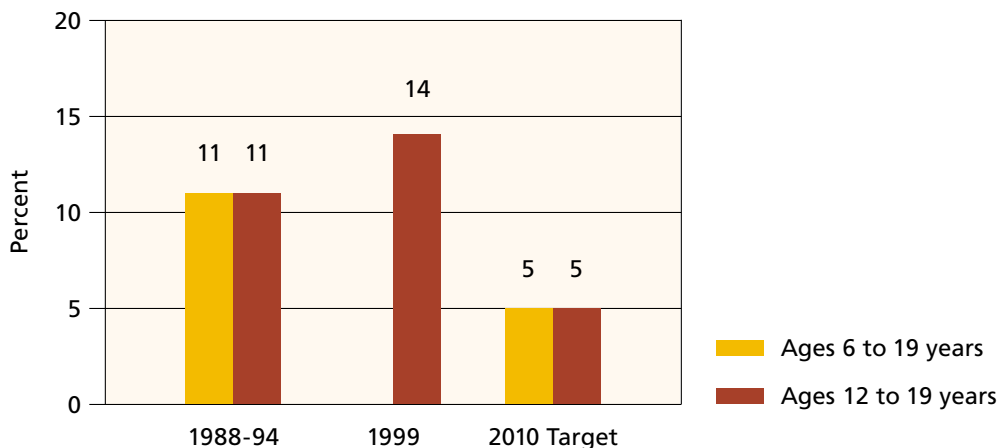
Overweight and Obesity

People who are overweight as teenagers are likely to be overweight as adults. Overweight places people at an increased risk for hypertension, heart disease, diabetes, some cancers, and other physical problems later in life. The prevalence of adolescents (ages 12-19 years) who are overweight has been increasing during the past several years. In the early 1970s, 6.1 percent of adolescents were overweight by contrast to 1988-94 when the percentage rose to 10.5 percent. Consequently, 1 out of every 10 adolescents is considered overweight. Today, data has also shown that males 12-19 years of age are more likely to be overweight than females (11.3% and 9.7%, respectively) (Centers for Disease Control and Prevention, 2000).

Objective 19-03:

Reduce the proportion of children and adolescents who are overweight or obese

Overweight or Obesity in Children and Adolescents



Source: National Health and Nutrition Examination Survey (NHANES), CDC, NCHS

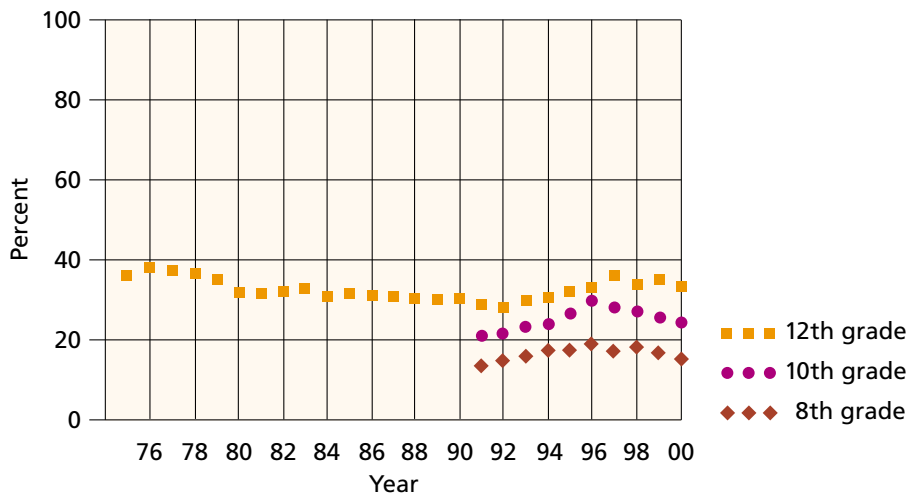
Tobacco Use

Smoking, which is often initiated during the adolescent years, is the single most preventable risk factor for the leading causes of death including heart disease and cancer. Despite these negative consequences, estimates indicate that 6,000 adolescents will experiment with smoking and 3,000 persons younger than 18 years will become daily smokers each day (Centers for Disease Control and Prevention, 2000). Cigarette smoking among adolescents declined during the 1970s and 1980s but increased in the 1990s among white, African American, and Hispanic high school students (Healthy People 2010). In fact, cigarette use among 8th and 10th graders reached its peak in 1996 and among 12th graders in 1997. However, since these high levels were identified, the thirty-day prevalence of smoking has decreased by 30% in 8th grade, 21% in 10th, and 16% in 12th (Johnston, O'Malley, Bachman, 2001). In 1991, 27.5% of adolescents reported smoking cigarettes on at least one day in the preceding 30 days in comparison to 34.8% of adolescents who reported current cigarette use in 1999. In addition, high school students who reported smoking cigarettes on 20 of the 30 days preceding completion of the questionnaire increased from 12.7% in 1991 to 16.8% in 1999 (Centers for Disease Control and Prevention, 2000).

Objective 27-02:

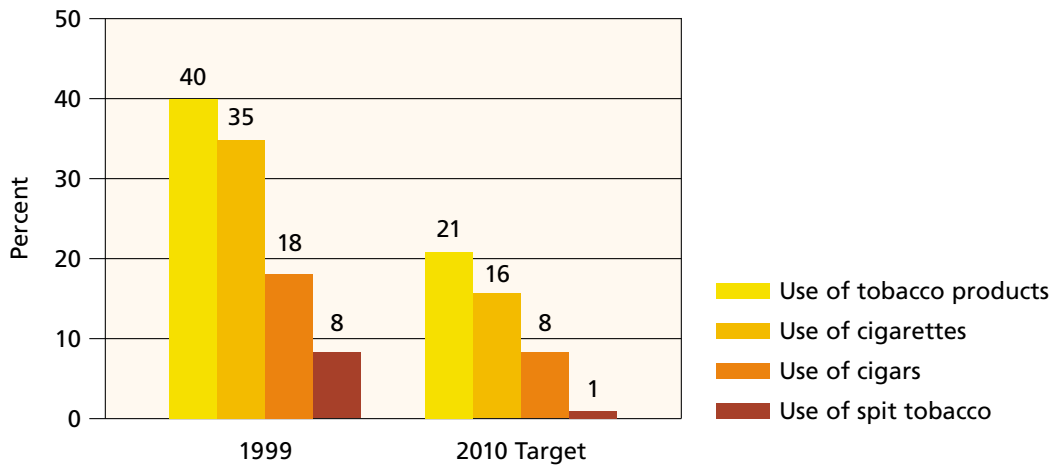
Reduce tobacco use by adolescents

Percent of Eighth, Tenth, and Twelfth Graders Who Used Cigarettes in Past 30 Days



Source: Johnston LD, O'Malley PM, Bachman JG. (2001). *Monitoring the Future national results on adolescent drug use: Overview of key findings, 2000*. (NIH Publication No. 01-4923). Bethesda, MD: National Institute on Drug Abuse.

Adolescent Use of Tobacco Products in Past Month – Students Grade 9 Through 12



Source: Youth Risk Behavior Surveillance System (YRBSS), CDC, NCCDPHP

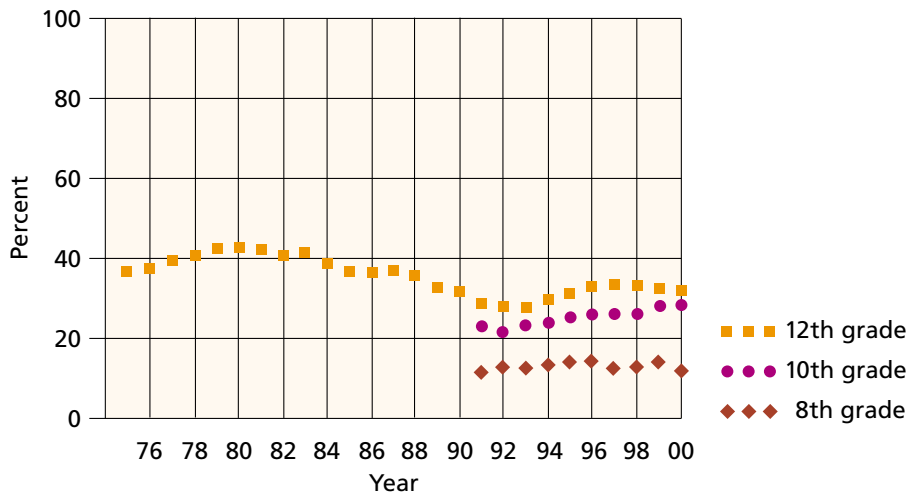
Substance Abuse

Alcohol is the most commonly used psychoactive substance during adolescence. Alcohol use can contribute to many negative consequences for teenagers because of its association with motor vehicle crashes, injuries, deaths, problems in school and the workplace, fighting, and crime (MacKay, Fingerhut, Duran, 2000). In 1998, 19 percent of adolescents ages 12 to 17 years stated that they had drunk alcohol in the past month (Healthy People 2010). In 1999, half of high school students reported drinking in the previous 30 days (48 percent of female students and 52 percent of male students). In 2000, four out of five students (80%) reported having consumed alcohol by the end of high school and about half of the students had done so by 8th grade. Sixty-two percent of 12th grade students and 25 percent of 8th grade students reported that they had been drunk at least once in their life (Johnston, O'Malley, Bachman, 2001). In addition, binge drinking, which is defined as having 5 or more drinks on one occasion, was reported among 28 percent of female students and 35 percent of male students in 1999 (MacKay, Fingerhut, Duran, 2000).

Objective 26-11:

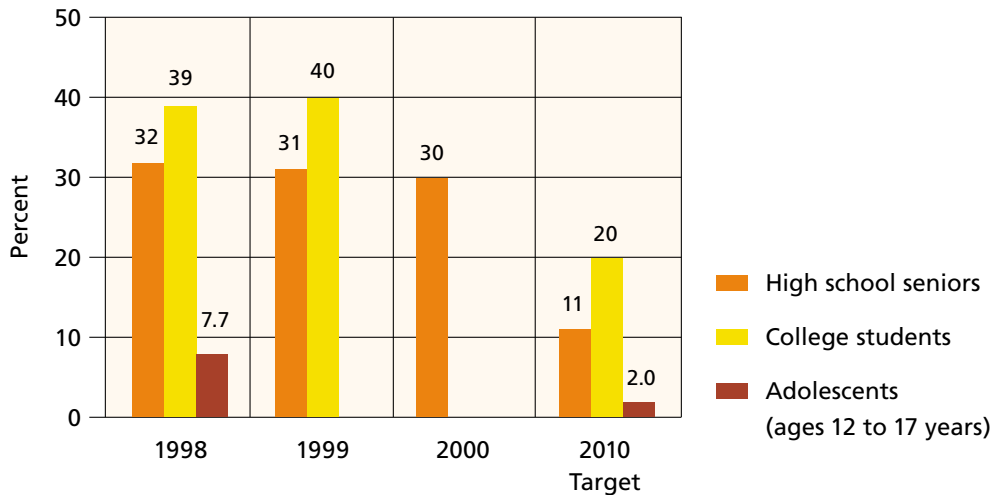
Reduce the proportion of persons engaging in binge drinking of alcoholic beverages

Percent of Eighth, Tenth, and Twelfth Graders Who Had 5+ Drinks in a Row in Previous Two Weeks



Source: Johnston LD, O'Malley PM, Bachman JG. (2001). *Monitoring the Future national results on adolescent drug use: Overview of key findings, 2000*. (NIH Publication No. 01-4923). Bethesda, MD: National Institute on Drug Abuse.

Binge Drinking



Source: Monitoring the Future Study (MTF), NIH, NIDA, National Household Survey on Drug Abuse (NHSDA), SAMHSA

*Not all data given for years 1999 and 2000

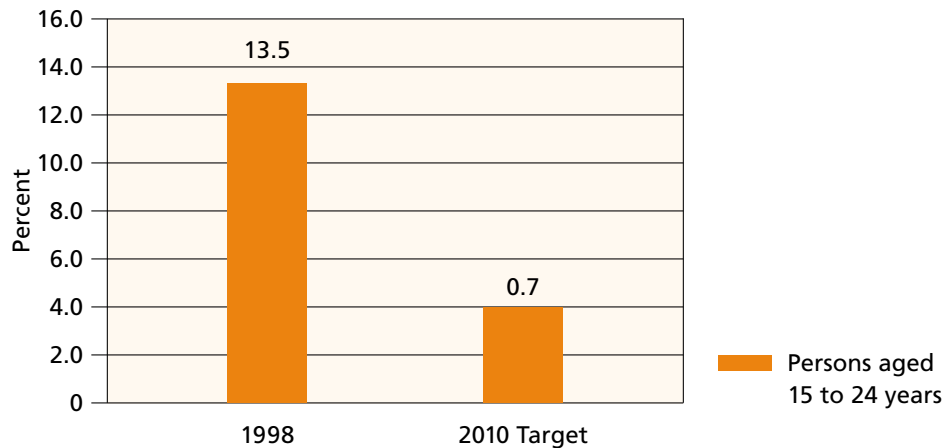
Alcohol use can lead to problems for adolescents who decide to drive under the influence. In 1998, the rate of alcohol-related motor vehicle crash deaths among 15-24 year-olds was 13.5 per 100,000. This rate was a 40% decrease from the 1987 rate of 21.5 per 100,000. Though there are fewer alcohol-related motor vehicle crash deaths among this age group, in 1999, 13.1% of adolescents reported driving at least once after drinking alcohol in the 30 days preceding the survey and 33.1% reported riding at least once with a driver who

had been drinking in the 30 days preceding the survey (Centers for Disease Control and Prevention, 2000). In 1998, 21 percent of the fatally injured drivers aged 15-20 years had blood alcohol concentrations of at least 0.10 grams per deciliter (National Center for Injury Prevention and Control).

Objective 26-01:

Reduce deaths and injuries caused by alcohol- and drug-related motor vehicle crashes

Alcohol-Related Motor Vehicle Crash Deaths (per 100,000 population)

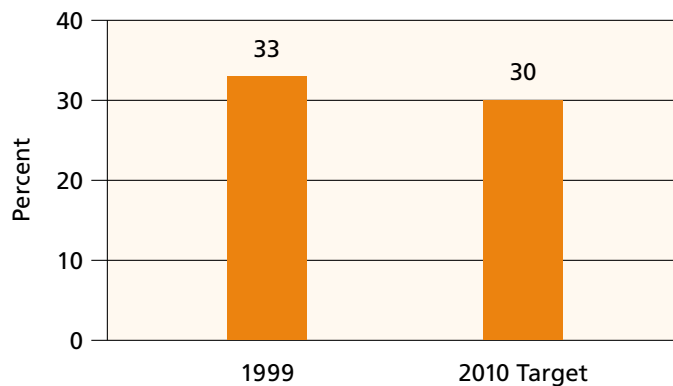


Source: Fatality Analysis Reporting System (FARS); Department of Transportation (DPT); National Highway Traffic Safety Administration (NHTSA); General Estimates System (GES), DOT

Objective 26-06:

Reduce the proportion of adolescents who report that they rode, during the previous 30 days, with a driver who had been drinking alcohol

Adolescents Riding with a Driver Who Has Been Drinking Alcohol – Students Grades 9 through 12

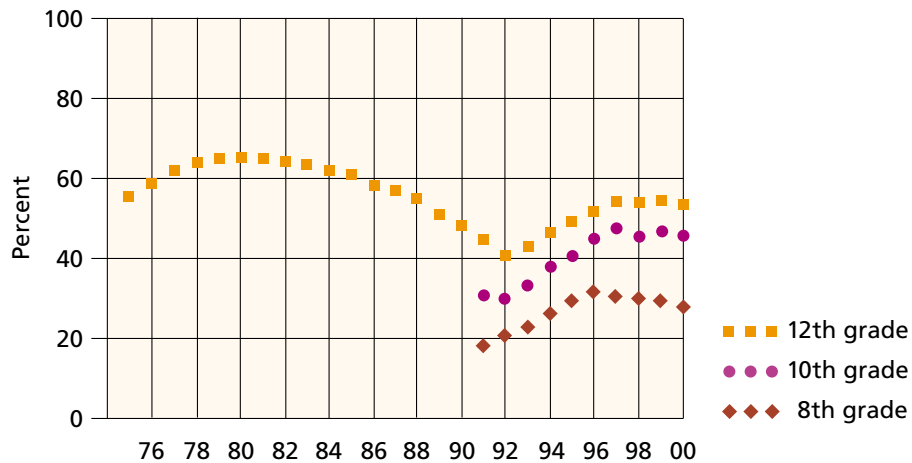


Source: Youth Risk Behavior Surveillance System (YRBSS), CDC, NCCDPHP

In addition to using alcohol, some adolescents also experiment with illicit drugs; marijuana is the most commonly used illicit drug among high school students. In 1998, 10 percent of adolescents aged 12 to 17 years reported using illicit drugs in the past 30 days (Healthy People 2010). In 1999, 47 percent of high school students had used marijuana during their lifetime and 27 percent had used marijuana one or more times in the past 30 days. Marijuana use has increased between 1990 and 1999 among high school students. In 1999, fifty percent more students had used marijuana at least once as compared to 1990 use (47 percent versus 31 percent) and almost twice as many students had used marijuana during the 30 days prior to the survey (27 percent versus 14 percent) (MacKay, Fingerhut, Duran, 2000).

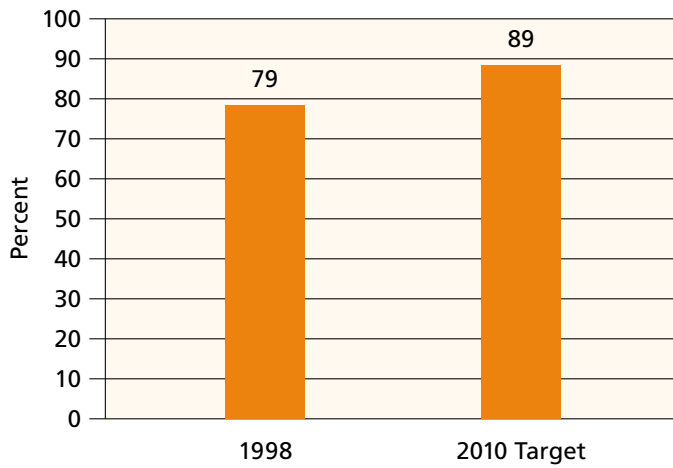
Objective 26-10:
Reduce past-month use of illicit substances

Percent of Eighth, Tenth, and Twelfth Graders Who Used Any Illicit Drug in Lifetime



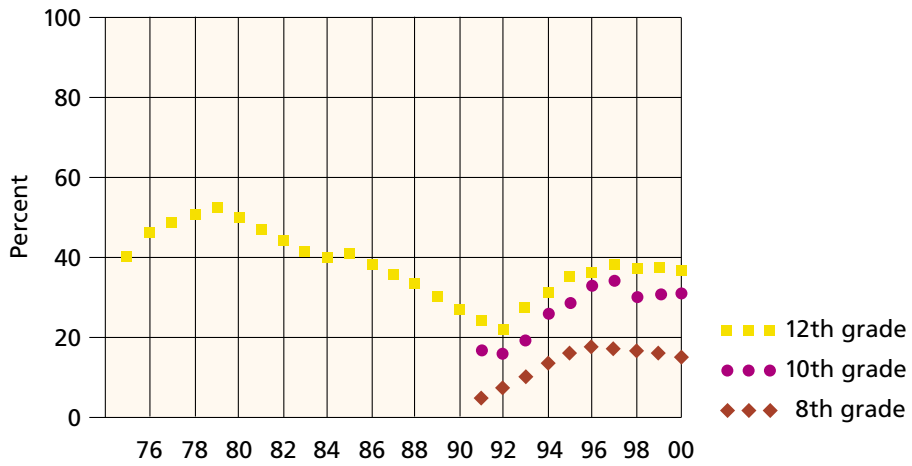
Source: Johnston LD, O'Malley PM, Bachman JG. (2001). *Monitoring the Future national results on adolescent drug use: Overview of key findings, 2000*. (NIH Publication No. 01-4923). Bethesda, MD: National Institute on Drug Abuse.

Adolescents Not Using Alcohol or Illicit Drugs in Past 30 Days (ages 12 to 17 years)



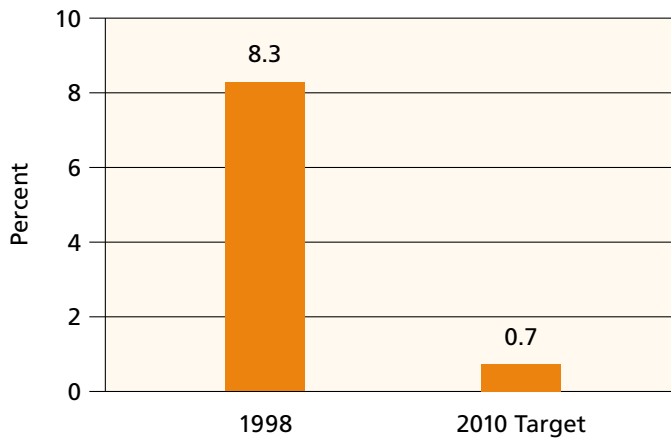
Source: National Household Survey on Drug Abuse (NHSDA), SAMHSA

Percent of Eighth, Tenth, and Twelfth Graders Who Used Marijuana in Last Twelve Months



Source: Johnston LD, O'Malley PM, Bachman JG. (2001). *Monitoring the Future national results on adolescent drug use: Overview of key findings, 2000*. (NIH Publication No. 01-4923). Bethesda, MD: National Institute on Drug Abuse

Adolescents Using Marijuana in Past 30 Days (ages 12 to 17 years)



Source: National Household Survey on Drug Abuse (NHSDA), SAMHSA

Responsible Sexual Behavior

Over the past six years the number of youth who are abstaining from sexual activity and the number of youth who are using condoms if sexually active has increased (Healthy People 2010). In 1999, 50 percent of all high school students reported that they had ever been sexually active. Data shows that sexual activity increases with age. In 1999, 66 percent of female students and 64 percent of male students in the 12th grade reported ever having sexual intercourse compared to 33 percent of female students and 45 percent of male students in the 9th grade (MacKay, Fingerhut, Duran, 2000).

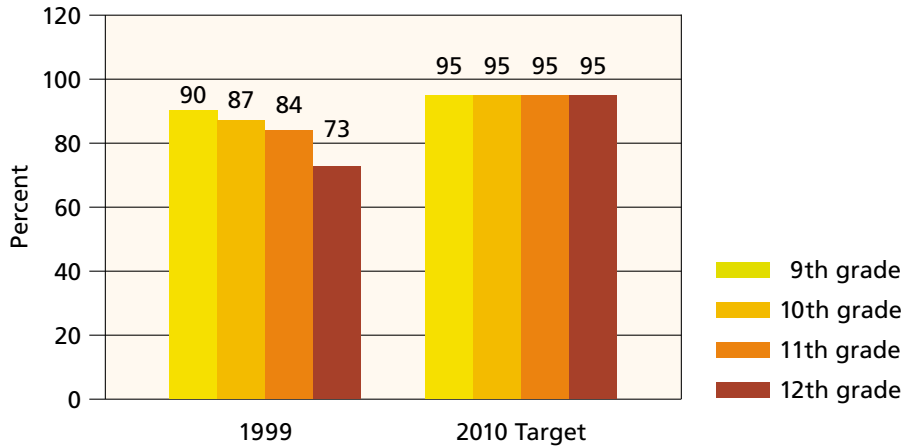
In 1995 approximately one-quarter of teenagers used no form of contraception during their first sexual intercourse and 29 percent of females and 19 percent of males had unprotected recent sexual intercourse (Abma & Sonenstein, 2001). However, in 1999, 58 percent of students who were currently sexually active reported using a condom the last time they had sexual intercourse, an increase from 46 percent for those who responded so in 1991 (Centers for Disease Control and Prevention, 2000).

The number of sexual partners people have can place them at increased risk of contracting a sexually transmitted disease, including HIV. In 1995, almost 40 percent of the sexually experienced female teenagers had had only one sexual partner in their lifetime whereas 14 percent had had six or more partners. However, 27 percent of sexually experienced male teenagers had had only one sexual partner whereas 25 percent had had six or more partners (Abma & Sonenstein, 2001). During 1991-1999, there was an 8 percent decrease in the prevalence of sexual experience among adolescents and a 13 percent decrease in the prevalence of multiple sex partners (four or more sex partners in their lifetime) (MacKay, Fingerhut, Duran, 2000).

Objective 25-11:

Increase the proportion of adolescents who abstain from sexual intercourse or use condoms if currently sexually active

Responsible Adolescent Sexual Behavior

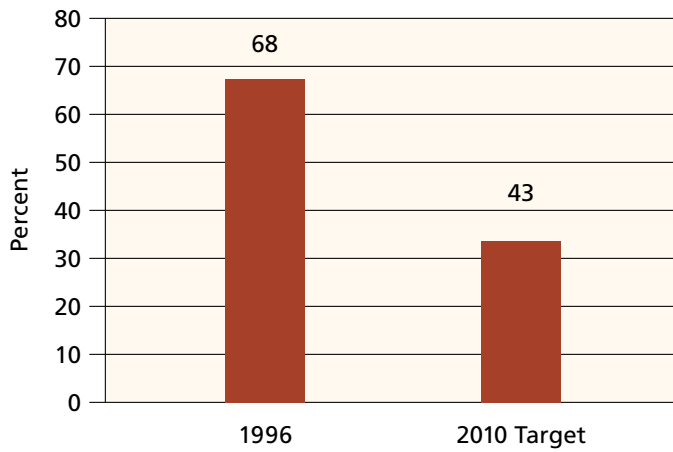


Source: Youth Risk Surveillance System (YRBSS), CDC, NCCDPHP

Sexual activity places adolescents at an increased risk for pregnancy and sexually transmitted diseases (STD), including HIV/AIDS. Chlamydia, a prevalent STD is estimated to infect 308.4 per 100,000 males and 2,359.4 per 100,000 females aged 15-19 and 432.5 per 100,000 males and 1,952.7 per 100,000 females aged 20-24 (Centers for Disease Control and Prevention, 2000). In addition, more than 900,000 adolescents become pregnant each year. Seventy-eight percent of teen pregnancies are unplanned, making up one-fourth of all accidental pregnancies each year (MacKay, Fingerhut, Duran, 2000). In 1998, the birth rate for teens 15-19 years was 51.1 per 1,000 births, which was an 18 percent decline from the 1991 rate of 62.1 per 1,000 (Centers for Disease Control and Prevention, 2000). In addition, the U.S. teen birth rate decreased to a record low in 2000, with the rate being 22 percent lower than the rate in 1999 (National Center for Health Statistics, 2001).

Objective 9-07:
 Reduce pregnancies among adolescent females

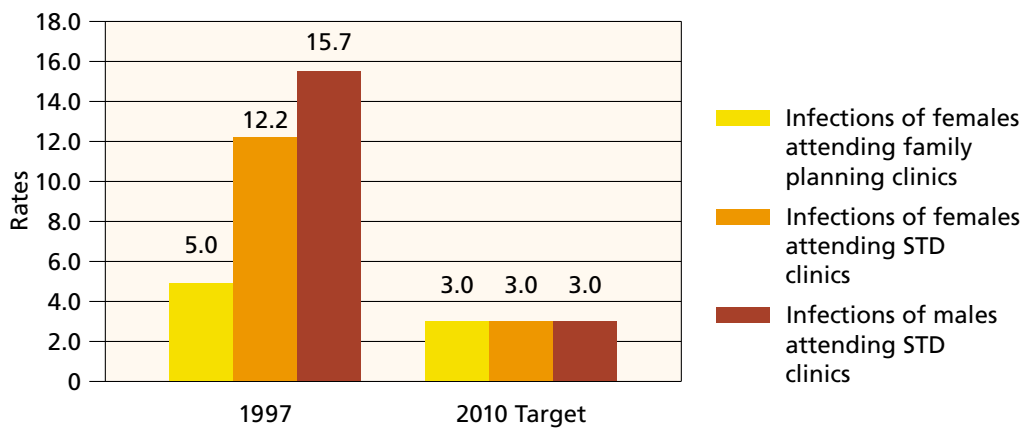
Adolescent Pregnancy (per 1,000 population, ages 15 to 17 years)



Source: National Survey on Family Growth (NSFG), CDC, NCHS, National Vital Statistics System-Nativity (NVSS-N), CDC, NCHS; Abortion Provider Survey, The Alan Guttmacher Institute, Abortion Surveillance Data, CDC, NCCDPHP

Objective 25-01:
 Reduce the proportion of adolescents and young adults with *Chlamydia trachomatis* infections

Chlamydia (ages 15 to 24 years)



Source: STD Surveillance System (STDSS), CDC, NCHSTP

Objective 13-05:

Reduce the number of cases of HIV infection among adolescents and adults

This is considered a developmental objective. Baseline information and the 2010 target will be available by 2004.

Mental Health

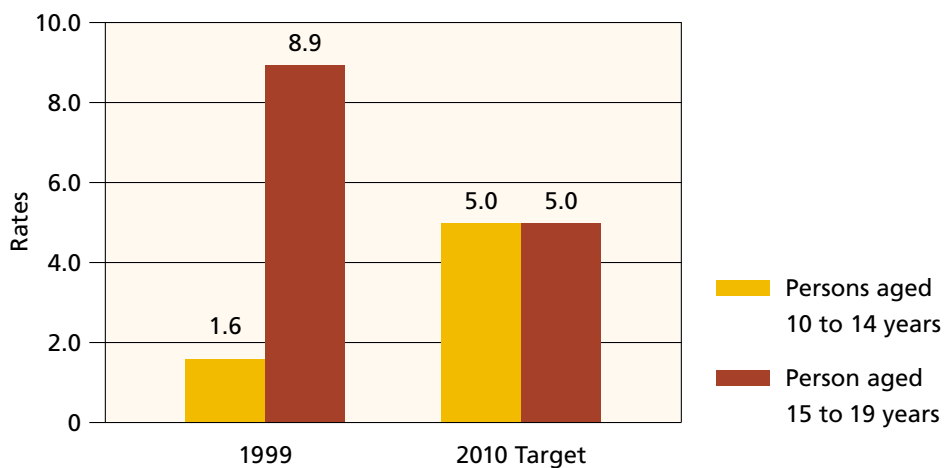
Adolescence is a developmental period during which many changes take place. Some teenagers experience adolescence as stressful and they may experience feelings of hopelessness. These feelings could be a precursor to suicide or suicidal ideation. In fact, suicide is the third leading cause of death for adolescents. In 1999, 28.3% of students reported feeling so sad or hopeless almost every day for at least 2 weeks in a row during the prior 12 months that they stopped engaging in some of their regular activities. Data identifies that females were more likely than males to have these feelings (35.7% versus 21.0%) (Centers for Disease Control and Prevention, 2000).

In 1999 25 percent of female and 14 percent of male adolescents in grades 9-12 reported seriously considering or attempting suicide (MacKay, Fingerhut, Duran, 2000). However, males are more likely to succeed when they attempt suicide; males account for a higher percentage of completed suicides. In 1998, the suicide death rate was 11.1 per 100,000 for persons aged 15-24 years with the male suicide rate in this age group at 18.5 per 100,000 and the female rate at 3.3 per 100,000 (Centers for Disease Control and Prevention, 2000).

Objective 18-01:

Reduce the suicide rate

Suicide (per 100,000 population)

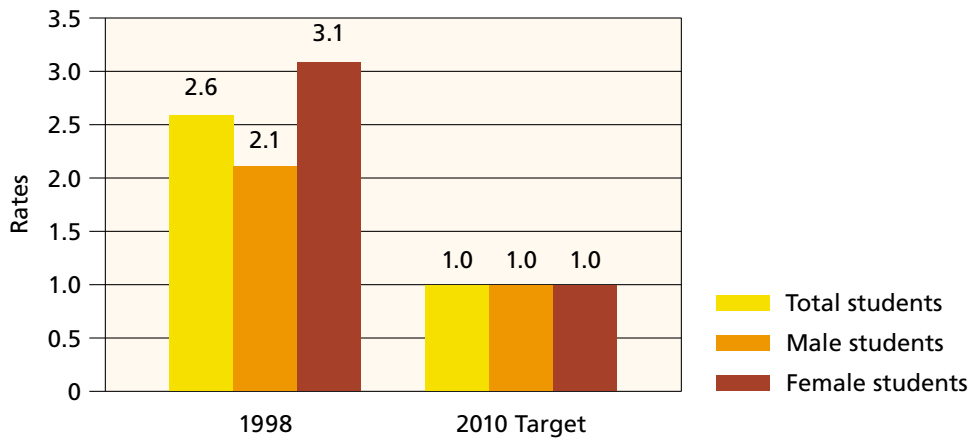


Source: National Vital Statistics System-Mortality (NVSS-M), CDC, NCHS

Objective 18-02:

Reduce the rate of suicide attempts by adolescents

Adolescent Suicide Attempts (students in grades 9 through 12)

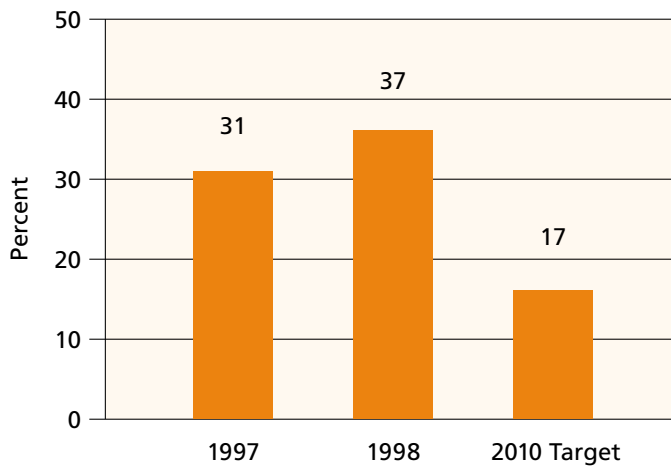


Source: Youth Risk Behavior Surveillance System (YRBSS), CDC, NCCDPHP

Objective 06-02:

Reduce the proportion of children and adolescents with disabilities who are reported to be sad, unhappy, or depressed

Sadness or Depression Among Children with Disabilities (ages 4 to 11 years)



Source: National Health Interview Survey (NHIS), CDC, NCHS

Objective 18-07:

Increase the proportion of children with mental health problems who receive treatment

This is a developmental objective-baseline and 2010 target to be provided by 2004.

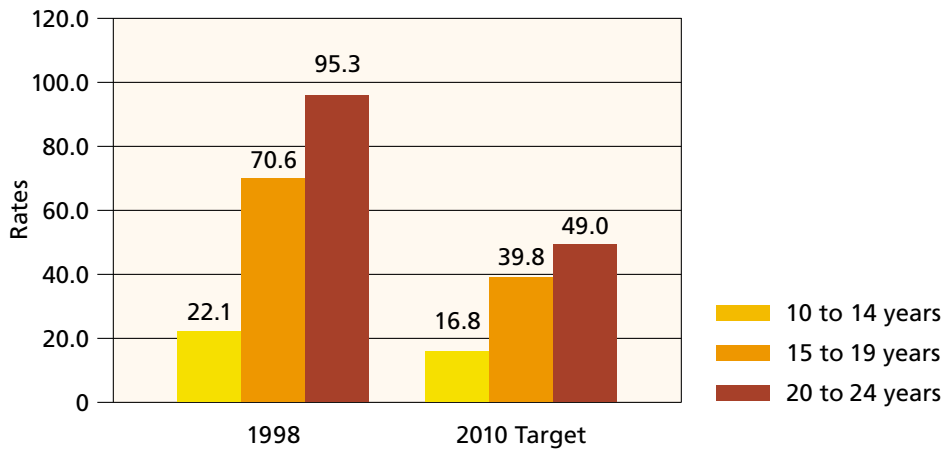
Injury and Violence

The death rate for adolescents ages 15-24 years has decreased since 1980 (115.4 per 100,000), but remained at 82.3 per 100,000 in 1998. Several factors contribute to the cause of death for this age group. These factors include unintentional injury (i.e. motor vehicle crashes), which is the leading cause of death, followed by homicide and suicide (Centers for Disease Control and Prevention, 2000). Also, deaths from injuries increased with age from 47 percent among adolescents 10 years of age to 81 percent among adolescents 18 years of age (MacKay, Fingerhut, Duran, 2000).

Objective 16-03:

Reduce deaths of adolescents and young adults

Adolescent and Young Adult Deaths (per 100,000 population)

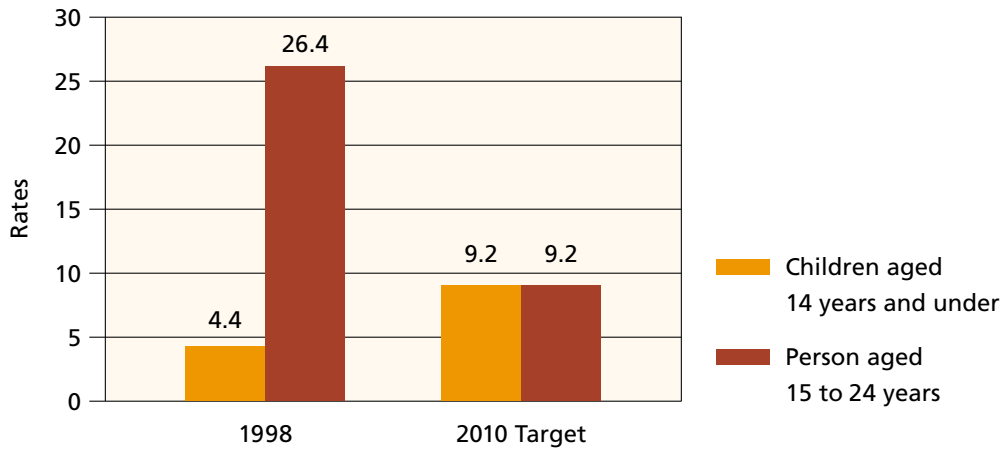


Source: National Vital Statistics System-Mortality (NVSS-M), CDC, NCHS.

Injuries caused by motor vehicle crashes account for a major portion of adolescent and young adult mortality. In 1996, adolescents made up 10 percent of the U.S. population but 15 percent of the deaths from motor vehicle crashes. In 1998, the rate of deaths for those ages 15-24 years due to motor vehicle crashes was 26.9 per 100,000 which was a decline of approximately 40% from the 1980 rate of 44.8 per 100,000 (Centers for Disease Control and Prevention, 2000; MacKay, Fingerhut, Duran, 2000). In 1998, teenage male drivers had a higher death rate (21 per 100,000) than female teenage drivers (10 per 100,000) (National Center for Injury Prevention and Control).

Objective 15-15:
Reduce deaths caused by motor vehicle crashes

Deaths from Motor Vehicle Crashes (per 100,000 standard population)

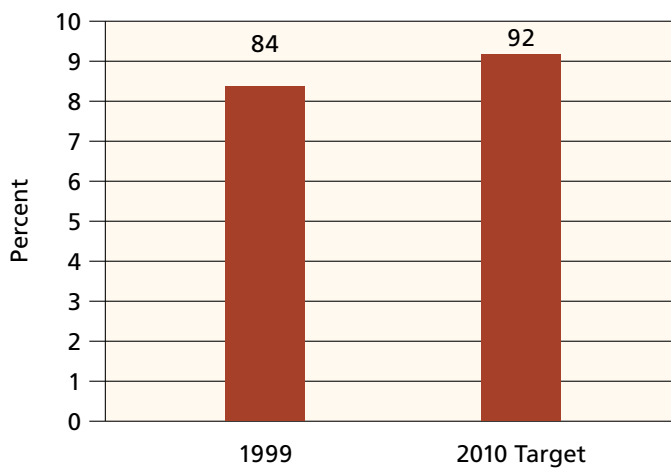


Source: National Vital Statistics System-Mortality (NVSS-M), CDC, NCHS

In 1999, 16 percent of teens reported never or rarely ever wearing a seatbelt when riding in a car or truck driven by someone else (Centers for Disease Control and Prevention, 2000).

Objective 15-19:
Increase use of safety belts

Use of Safety Belts (9th through 12th graders)



Source: National Occupant Protection Use Survey (NOPUS), DOT, NHTSA, Youth Risk Behavior Surveillance System (YRBSS), CDC, NCCDPHP

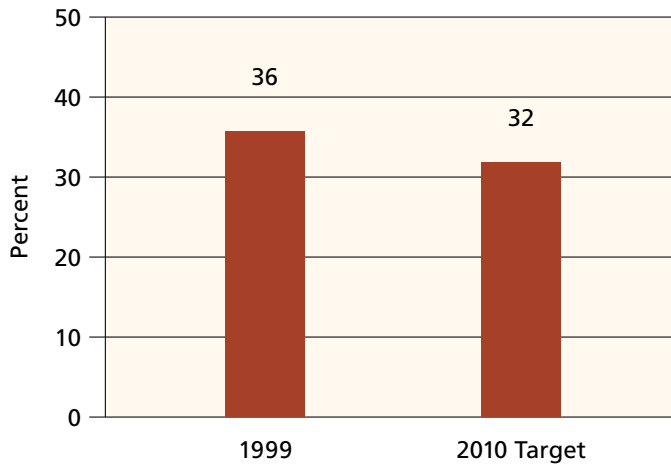
The increase in a series of school shootings over the past few years has heightened awareness of violence among adolescents. However, data is showing a decrease in some signs of violent behavior. For instance, in 1991, 26.1% of students reported carrying a weapon on one or more days in the preceding 30 days; this percentage fell to 17.3% in 1999. In 1993, 7.9% of students reported carrying a gun on one or more days in the preceding 30 days; this percentage declined to 4.9% in 1999. In 1999, 6.9% of students (11% of male students and 3 percent of female students) carried a weapon on school property in the preceding 30 days, which was a decline from the 11.8% in 1993 (Centers for Disease Control and Prevention, 2000; MacKay, Fingerhut, Duran, 2000).

In addition to carrying a weapon, physical fighting can be an indicator of violent-related behavior. The percentage of adolescents that were involved in a physical fight in the preceding year was 35.7% in 1999, which was a decline from 42.5% in 1991. Students involved in physical fights on school property in the preceding year also decreased from 16.2% in 1993 to 14.2% in 1999 (Centers for Disease Control and Prevention, 2000).

Objective 15-38:

Reduce physical fighting among adolescents

Physical Fighting Among Adolescents (grades 9 through 12)

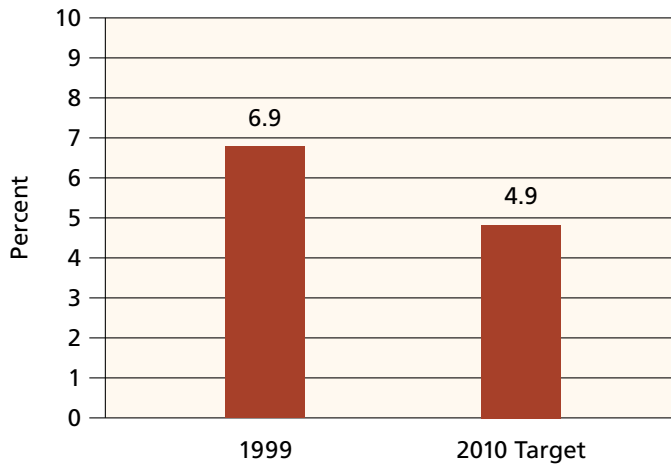


Source: Youth Risk Behavior Surveillance System (YRBSS), CDC, NCCDPHP

Objective 15-39:

Reduce weapon carrying by adolescents on school property

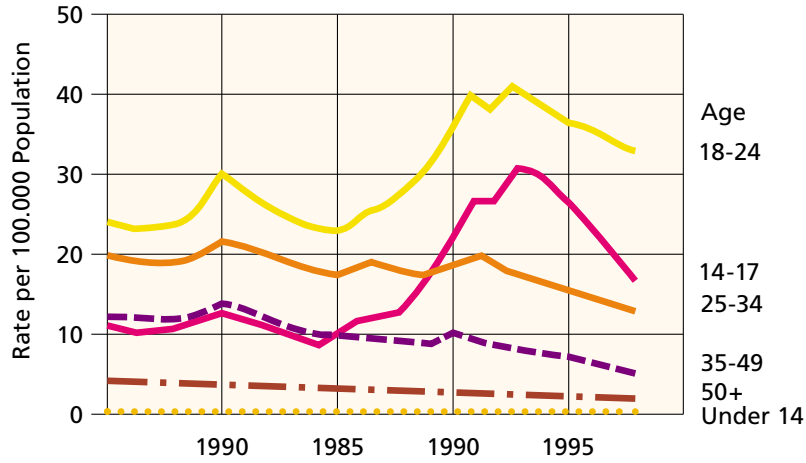
Weapon Carrying by Adolescents on School Property (grades 9 through 12)



Source: Youth Risk Behavior Surveillance System (YRBSS), CDC, NCCDPHP

Homicide rates among teenagers ages 15-19 years reached record-high levels in the latter half of the 1980s and continue to be among the highest recorded rates in the US for this age group (National Center for Injury Prevention and Control). Homicide was the third leading cause of death among children ages 5 to 14 years in 1997 (Healthy People 2010). In 1998, the age-adjusted homicide rate declined almost 9 percent to 7.3 homicides per 100,000 population. This was a continuation of the downward trend that started in the early 1990s (MacKay, Fingerhut, Duran, 2000). The following chart illustrates that homicide rates for teenagers and young adults increased in the late 1980's while the rates for older age groups decreased.

Homicide Offending by Age, 1976-97 (rate per 100,000 population)

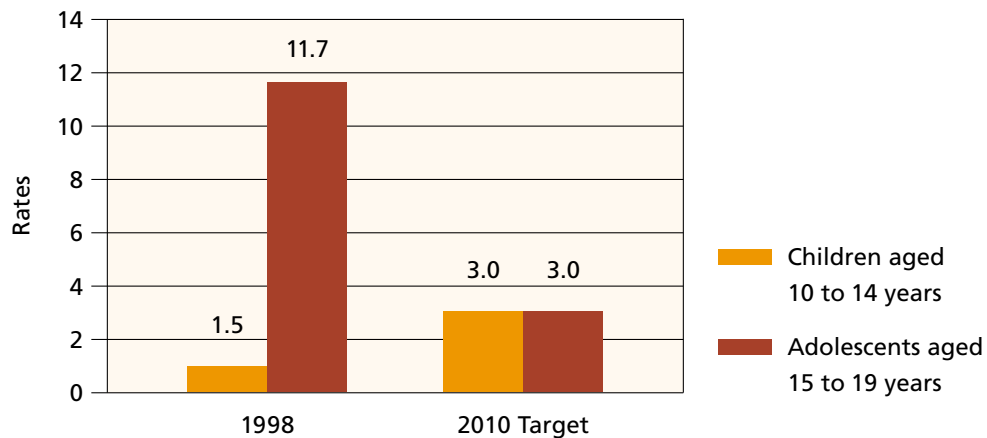


Source: Fox JA, Zawitz MW. *Homicide trends in the United States*. U.S. Department of Justice, Bureau of Justice Statistics; 1999.

Objective 15-32:

Reduce homicides 10 to 14 year olds and 15 to 19 year olds

Homicides (per 100,000 standard population)



Source: National Vital Statistics System-Mortality (NVSS-M), CDC, NCHS, FBI Uniform Crime Reports, U.S. Department of Justice

Adolescent Health Data Resources

Adolescent Health Chartbook, Health United States, 2000

The Adolescent Health Chartbook presents national trends and health statistics of the United States adolescent population, 10-19 years of age. It includes tables and racial and ethnic data. The Chartbook is available at the Health, United States Web site at:

www.cdc.gov/nchs/products/pubs/pubd/hus/hus.htm

The publication is produced by the United States Department of Health and Human Services, Centers for Disease Control and Prevention, National Center for Health Statistics in Hyattsville, Maryland.

America's Children: Key National Indicators of Well-being

The Interagency Forum on Child and Family Statistics prepares this annual report as a collaborative effort by 20 Federal agencies. The report offers a comprehensive set of indicators of well being for America's children and includes eight contextual measures that describe the changing population, family characteristics, and the context in which US children are living. This report is available at:

www.childstats.gov.

Monitoring the Future Study

The Monitoring the Future Study is a continuous study that reports the behaviors, attitudes, and values of American high school students, college students, and young adults. The study surveys about 50,000 8th, 10th, and 12th grade students each year (12th grade students since 1975 and 8th and 10th grade students since 1991). The research is conducted by the Institute for Social Research, University of Michigan and can be accessed at:

www.monitoringthefuture.org

National Household Survey on Drug Abuse

The Substance Abuse and Mental Health Statistics, Office of Applied Studies provides the latest national statistics on alcohol, tobacco, and illegal drug use. The information can be accessed at:

www.samhsa.gov/oas/oasftp.htm

The National Longitudinal Study of Adolescent Health (ADD HEALTH)

The Add Health Survey is a comprehensive school-based study of the health-related behaviors of adolescents in the United States. In the first phase of the study 90,000 students in grades 7 through 12 in 134 US schools answered brief questionnaires regarding their health, friendship, self-esteem, and future expectations. During the first phase administrators at the participating schools also completed questionnaires regarding school policies, teacher characteristics, health service availability, and student body characteristics. The second phase of the study involved 20,000 in-home interviews of students during April and December of 1995 (Wave 1) and April and August of 1996 (Wave 2). Phase three of the survey is planned for 2001 and will include the entire original sample group. The monograph, *Protecting Teens: Beyond Race, Income and Family Structure* by Trisha Beuhring, PhD, Robert W. Blum, MD, MPH, PhD, and Peggy Mann Rinehart was produced using these data with grant support from the Robert Wood Johnson Foundation. Copies of this report are available by contacting Add Health, c/o Center for Adolescent Health, University of Minnesota, 200 Oak Street, SE, Suite 260, Minneapolis, MN 55455-2002, or by email at:

aph@umn.edu

National Survey of Family Growth (NSFG)

The National Survey of Family Growth (NSFG) is conducted periodically to collect data from women ages 15-44 years. The survey asks about factors affecting pregnancy and women's health in the US. The survey is sponsored by the National Center for Health Statistics and data from the survey can be accessed at:

www.cdc.gov/nchs/nsfg.htm

Youth Risk Behavior Surveillance System (YRBS)

The US Youth Risk Behavior Surveillance System (YRBS) monitors six categories of youth and young adult health risk behaviors. These six categories include behaviors that contribute to unintentional and intentional injuries; alcohol and other drug use; tobacco use; sexual behaviors that contribute to unintended pregnancy and sexually transmitted diseases (STDs) (including human immunodeficiency virus (HIV)); unhealthy dietary behaviors; and physical activity. The Centers for Disease Control and Prevention (CDC) oversees the YRBS school-based surveys that are conducted by education and health agencies. The latest YRBS survey data are available through the Morbidity and Mortality Weekly Reports (MMWR) and through their Web site at:

www.cdc.gov/mmwr

State Adolescent Health Data

Child Trends

Child Trends released a document titled *2001 Facts at a Glance*. This report provides the latest teen birth data for every state and the 150 largest U.S. cities and has comparisons of teen childbearing in the United States with teen birth rates in other developed nations. The report can be accessed at:

www.childtrends.org/HomePg.asp

or by calling (202) 362-5580 for a faxed copy.

Children's Defense Fund

Children's Defense Fund offers state and national-level data related to children. The data allow readers to look at their own state and what areas need improvement, compare their situation to other states, look at the national average, and then encourage their elected officials (at the federal, state, and local level) to do more for children. The Children's Defense Fund published the *2000 Children in the States* data book with the 2001 edition, scheduled for release in September 2001. Their Web site can be accessed at:

<http://www.childrensdefense.org/statesdata.htm>

The site includes a US map that allows users to click on a particular state and identify information that ranks their state in health insurance coverage, teen births, and firearm deaths. The *2001 Children in the States* data book can be ordered on-line or by calling (202) 662-3652.

Community Health Status Indicators (CHSI) Reports and Report Database

The Community Health Status Indicators (CHSI) Reports and Report Database is available on CD-ROM; it provides information on the health status of all 3,082 counties in the US. CHSI includes information on the causes of death, life expectancy, teen mothers, and other data. This database allows counties to compare their health status with similar "peer counties", the nation, and Healthy People 2010 objectives. The CHSI Reports were funded by the Health Resources and Services Administration. Contributors to CHSI include the Association of State and Territorial Health Officials, the National Association of County and City Health Officials, and the Public Health Foundation. This web site can be accessed at:

www.communityhealth.hrsa.gov

2001 KIDS COUNT

KIDS COUNT is a product of the Annie E. Casey Foundation which provides national and state-by-state data on the status of children living in the US. The annual KIDS COUNT Data Book provides benchmarks of child well-being in the areas of education, social, economic, and physical health. State-level data are also available through specially funded projects that provide detailed data on children and their well-being at the state level. Information on KIDS COUNT is available at the KIDS Count Web site at:

www.kidscount.org

Through the KIDS COUNT online interactive database users can view graphs, maps, rankings, state profiles and download raw data.

Healthy People 2010 Toolkit: A Field Guide to Health Planning

The Toolkit provides guidance, tools, and resources to states, territories, and tribes for developing and promoting state-specific Healthy People 2010 plans. The guide contains practical tools, national and state examples, checklists, tips and resources to get started; engage partners; set priorities, objectives, and targets; manage and sustain the initiative; publish and promote the plan; and measure progress. The Toolkit was developed by the Public Health Foundation with assistance from the US Department of Health and Human Services' Office of Disease Prevention and Health Promotion. The Toolkit can be accessed online at:

www.health.gov/healthypeople/state/toolkit

or by contacting the Public Health Foundation toll-free at (877) 252-1200 (item RM-005) or by visiting the online bookstore at:

<http://bookstore.phf.org>.

Henry J Kaiser Family Foundation

The Henry J Kaiser Family Foundation provides an Internet resource that offers current health information for all 50 states, District of Columbia, and the US territories. Data can be accessed from State Health Facts Online, at:

www.statehealthfacts.kff.org

This site provides health policy information on a broad range of issues such as managed care, health insurance coverage and the uninsured, Medicaid, Medicare, women's health, minority health, and HIV/AIDS. Users can view information for a single state or compare and rank data across all 50 states and compare it to US totals. Information on more than 200 topics is displayed in tables, rankings, graphs, or color-coded maps; and it can be downloaded for customized comparisons.

National Campaign to Prevent Teen Pregnancy

The goal of the National Campaign to Prevent Teen Pregnancy is to improve the well-being of children, youth, and families by reducing teenage pregnancy. Their Web site is located at:

www.teenpregnancy.org

It provides access to state-by-state data on teenage pregnancy and childbearing. The Campaign has produced several informative publications in the past few years and these are described on their Web site.

Physicians Role

Interested physicians can utilize the resources in this chapter in a variety of ways. This information can be presented at medical meetings to encourage physician participation in county or state activities that are linked to the national health objectives. Multidisciplinary groups of professionals with an existing adolescent health programs may want to include this information in grant applications related to the twenty-one critical objectives.

Physicians can also use this information to create a platform for increasing community awareness about adolescent risk behaviors and the role of the health objectives in improving their lives. Physicians could use this information as a resource for their adolescent patients and educate them about preventive measures they could take to improve their health. Subsequent chapters include additional information about working with state medical societies, obtaining support for programs, publicizing adolescent activities, and developing plans for implementation.

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Chapter 3

Organized Medicine

Introduction

Every state, the District of Columbia, Guam, Puerto Rico, and the Virgin Islands have medical societies. These medical societies are professional organizations that represent and unify their state physician members. Many state medical societies sponsor scientific meetings, conferences on professional issues, and provide continuing medical education programs.

Typically, state medical societies are directed by a House of Delegates that meets annually to debate and vote on resolutions that set policy and programmatic direction for the Board of Trustees. Houses of Delegates include state society members who are elected by their respective county medical societies. Houses of Delegates adopt resolutions that become policies for their state medical societies.

Most physicians who have a strong identification with organized medicine begin their careers with county medical associations. These physicians continue their work at the state level as a delegate from their county medical association or by participating directly in state medical society committees. Think about physicians' relationships with state medical societies and state medical specialty organizations when considering how to participate in activities related to the adolescent component of the 2010 national health objectives.

State Medical Societies

When the Healthy People 2000 national health objectives were released a little more than 10 years ago, many state medical societies demonstrated their support for the health objectives by sponsoring activities for their members. These projects ranged from raising professional's general awareness about the objectives to programs that were designed to meet specific objectives' target goals. A number of physicians chose to participate in state health department projects as representatives of their state medical societies.

Many state medical societies are currently planning and implementing projects that address the national health objectives for 2010. Interested physicians who want to partici-

pate in these activities can contact their state medical societies. Most state medical society projects are coordinated by a staff member and are assigned to a specific committee.

Physicians who are currently active in their state medical societies probably know which committee is planning activities related to the national health objectives. Other physicians may choose to get better acquainted with their state medical society because of the society's commitment to the health objectives. Some interested physicians may direct their state society's programs because of their own personal commitment. A few physicians may choose to work at the county level by focusing on specific objectives that relate directly to adolescents.

A state medical society is an excellent place to begin investigating what is happening at the state level relative to the national health objectives. Most state medical societies have close working relationships with state departments of health because of their shared interests in the health of state residents. Consequently, state medical societies are probably planning some activities related to Healthy People 2010. Physicians with an interest in the adolescent component of 2010 can contact their state medical societies.

Medical Specialty Societies

Medical specialty organizations represent physicians who share a common medical discipline. Physician members of medical specialty associations have probably had similar residency training experiences and typically have common goals for their profession. Specialty organizations vote on member resolutions to make policy decisions, offer continuing medical education courses, promote the science in their respective medical field, and contribute to the educational requirements for physician specialists.

Many national medical specialty associations have state chapters, especially the larger organizations that address primary care issues. For instance, physicians who are pediatricians, family practice physicians, obstetricians/gynecologists, or internists are likely to be members of or well acquainted with the activities of their national medical association's state chapters. In addition to the multiple legislative and advocacy issues that these state chapters address, their agendas may also include activities that are directed toward meeting the national health objectives' targets.

Contacting medical specialty associations' state chapters is another place that interested physicians can inquire about opportunities for participating in national health objective activities. Primary care medical associations are likely to have physician representatives that participate in state health 2010 strategic plans. In fact, some state chapters of national medical specialty associations may have their own 2010 activities that address specific patient populations or target the leading health indicators.

Physicians with a special interest in adolescents may wish to contact their regional chapter of the Society for Adolescent Medicine (SAM). SAM has eight regional chapters around

the country. Information about the regional chapters can be accessed on the SAM Web site at:

www.adolescenthealth.org

The SAM Web site includes policy information in addition to numerous other resources.

2010 Committee Activities

Some physicians may have a special interest in one of the leading health indicators such as tobacco or responsible sexual behavior. Several of the 21 critical adolescent objectives are listed in these two leading health indicators. Physicians with special interests can contact their state medical society, state medical specialty chapter, or both to determine where they can participate in on-going activities.

Although medical society structures may vary slightly from state to state, most societies include a public health committee. These are the committees most likely to address the national health objectives, so interested physicians may wish to direct their initial inquiries to the staff members who coordinates this committee. Some state medical societies may have more than one committee that is addressing the national health objectives and others may have no organized activities at this time.

Policy Development

Many issues related to the twenty-one critical objectives can be addressed by developing position statements or creating policy. For instance, some state medical societies may choose to hold a press conference to announce their support for the objectives. Specialty societies may undertake state projects that support individual objectives related to a particular health topic. A medical society 2010 committee may decide to support a number of objectives that relate to adolescent health problems in their particular state. Regardless of the intent, developing policies through organized medicine usually follows a particular series of activities.

The AMA procedure is illustrative because many state medical societies follow a similar process for policy development. The foundation for most of the decision-making processes at the AMA annual meeting follows a consent calendar. The consent calendar includes recommendations—adopt, not adopt, refer, file, amend, etc—about handling items of business. Individual delegates may extract items from the consent calendar so that they can be considered for discussion. The House of Delegates accepts the amended consent calendar and acts on it as indicated in the document. The Speaker and Vice Speaker preside over the House of Delegates meetings and they conduct business according to a parliamentary procedure.

Many reference committees conduct their business prior to the official opening of the House of Delegates. Reference committees offer delegates an opportunity to discuss and debate items on the consent calendar. Reference committees conclude their business by preparing a report for the House that details their recommendations. These reports form the basis of the House of Delegates debate and action.

State-level policy can be very influential in the course of attention given to the 21 critical objectives. Consequently, interested physicians should consider using the organized medicine system for policy development to further interest in the adolescent objectives. Physicians can work through their state medical society or state chapter of their specialty society to introduce resolutions that address the critical objectives. Those physicians who are not delegates to their respective Houses of Delegates can contact current delegates and discuss issues of potential mutual interest.

Resources

Physicians with a special interest in the adolescent component of the national health objectives often need the type of support that is more tangible than their enthusiasm for and interest in the topic. Most projects require some type of resources to get started and maintain their activities. Resources take many forms and none of them should be overlooked.

Resources include a structure to address issues. State medical societies support committees whose members may be interested in this topic. The medical society staff member who coordinates a committee can ask the committee chairman to provide agenda time to discuss the topic and notify committee members who may share an interest in the health objectives.

People or human resources are another component that is necessary to initiate and maintain a project. Networking introductions can connect professionals who share an interest in the national health objectives. Colleagues may introduce interested physicians to other professionals who are working to meet the health objectives in their respective states. State medical society members may also make introductions to colleagues who share an interest in a special population like adolescents, one of the leading health indicators, or a specific health concern like asthma, teen pregnancy, or suicide.

Funding for a project is another resource. Sources of funding are available at the city, county, state, and federal levels. Local funding can come from organized social service clubs including the Rotary, Lions, and Kiwanis organizations, hospitals, and community trusts. Chapter 5 includes more extensive information about obtaining funding for specific programmatic activities.

Because project outcomes are essential to determine, access to evaluators is another resource. Program evaluators should join a project from its inception so that progress can be determined throughout a project's history. Local universities and state health departments are appropriate places to inquire about obtaining the services of a professional program evaluator.

Physicians Role

Physicians who want to actively support the 2010 adolescent objectives should inquire about planned projects with their state medical society. A number of different state medical society committees may currently be addressing adolescents as a special population or have an interest in one of the leading health indicators for which young people are at special risk. Developing policy that addresses the critical objectives is an excellent strategy for bringing state attention to adolescent health. Resources ensure the successful maintenance and evaluation of project activities.

State Adolescent Initiatives

Introduction

Adolescent health activities take place in a variety of locations throughout a state. Some of these places are easy to identify and others are more challenging to locate. For instance, each state health department has a state adolescent health coordinator who is well acquainted with state-based adolescent activities. Many university psychology departments have professors who are devoting considerable research time and energy to adolescent health issues. School-based health centers in middle and high schools are also actively involved in adolescent health concerns. In addition to state medical societies, universities, and medical facilities, physicians should consider interacting with the faith community and youth-serving organizations to share their interest in the adolescent component of the national health objectives. This chapter is designed to help interested physicians identify programs that may have an on-going interest in adolescent health issues.

State Public Health Programs

State health departments typically address a number of adolescent-specific concerns. These health issues may include everything from state child health insurance enrollment to drug awareness and immunizations. Many of these programs are coordinated with other state agencies including the department of education, law enforcement, and highway safety.

State adolescent health coordinators can provide excellent resources to interested physicians. They are aware of most adolescent programming activities throughout their state. A listing of state adolescent health coordinators is included on page 76.

Comprehensive Programs

Comprehensive programs address more than one issue. For instance, state adolescent health programs may address family planning, alcohol and drug abuse, violence, and tobacco control. All of these issues are reflected in the 21 critical health objectives. Comprehensive programs may be preventive in nature or can be oriented toward intervention and treatment.

Single Issue Programs

These types of programs concentrate on one health issue as it relates to the adolescent population in a state. Typical programs feature teen pregnancy, violence prevention, and HIV awareness. A number of these programs are initiated in a large urban area and are later adopted state-wide after they are evaluated. Other programs develop through community consortiums that include multiple groups who address tobacco control or drug trafficking. Interested parents who have lost a child to a particular disease or avoidable injury may initiate programs to address the situation. Examples of these programs include drunk driving awareness and suicide prevention.

Some of these programs move from a community to state level while others eventually assume national status and include state chapters. A few programs focus on youth development and they include health components that address physical fitness, nutrition, and abstinence from tobacco, alcohol and drug use. Many of these programs are on-going and others have a shorter duration.

Stakeholders

Successful programs include a number of critical components. One of these components is including people with a vested interest in the problem and its solution. Stakeholders represent various constituencies and may include interested business owners and employers, school administrators and teachers, juvenile court judges and law enforcement officials, mental health clinicians, youth advocates, clergy and activists in the faith community, and medical and other health professionals.

Stakeholders should be included in activities because of their experience, potential expertise, and passion for the adolescent population in general or an adolescent issue in particular. Many stakeholders have taken a particular issue and created a foundation to fund research or started a national movement to bring awareness to a special health issue. Some stakeholders are powerbrokers and knowing who can do what to support a project is critical information.

Powerbrokers

Powerbrokers can help support adolescent programs by contributing their considerable influence to an initiative. Powerbroker influence may be related to money, personal connections, professional relationships, community status, or elected office. These are important people with whom to interact and establish relationships because they can get things done or keep them from happening.

Identifying powerbrokers and making contact with them can be very important to the success of an adolescent project. Powerbrokers are often high-profile community members although some prefer to remain rather anonymous. Because powerbrokers may be committed to more than one project, an adolescent project may have only one opportunity to describe its work so introductions should not be taken for granted.

Physicians Role

Physicians who want to support the Healthy People 2010 twenty-one critical adolescent objectives should consider where they wish to concentrate their energies and the issue of interest to them. For instance, physicians who are active state medical society members may wish to participate in on-going programs that include partnerships among medicine, education, and public health. Other physicians may wish to initiate a community project that addresses a single health topic in which they have a special interest or expertise. Physicians who choose to initiate their own activities are well advised to form a task force of professionals with credibility, power brokers who can support this project, and interested community stakeholders who share their concerns.

Chapter 5

Support for Programs

Introduction

Successful programs depend upon different kinds of support. Chapter 4 described a number of adolescent program formats that include community or state initiatives, are comprehensive or address a single issue, and consider the importance of including people who can help make a difference. This chapter addresses sources of funding for initiating, publicizing, maintaining, and evaluating programs that address the twenty-one critical adolescent Healthy People 2010 objectives.

Funding Sources

Local

Experts recommend that identifying local resources is often the best place to begin a search for funding. There are thousands of smaller and local foundations that are more likely to accept unsolicited proposals for grants than larger foundations. The Regional Association of Grantmakers (RAGS) provides listings of foundations in particular geographical areas. In addition, local RAGS often provide consulting and training services (Ross, 2001). For more information contact The Forum of Regional Associations of Grantmakers, 1828 L Street, NW, Suite 300, Washington, DC 20036, (202) 466-6512 or visit their Web site at:

www.rag.org

National

The Healthy People 2010 Web site provides funding updates that specifically target the national health objectives. For example, in the summer of 2001 the United States Department of Health and Human Services (DHHS) announced a new “micro-grant” approach to enlist community support for achieving the Healthy People 2010 goals. These micro-grants can provide up to \$2,010 each in support of local group efforts to promote health education, quality care, access to care, and other projects that address

the far-reaching national health goals. Faith-based organizations will be among those eligible to apply for funding.

This new initiative is being launched with a two-year pilot project. If successful, the approach could be expanded nationally. DHHS will commit between \$500,000 to \$700,000 to a pilot project in 2001 in order to study the potential of the micro-grant approach to further the goals of Healthy People 2010. This money will be distributed to local, non-profit organizations—and coalitions of such groups—in different geographic areas to support programs designed to increase the quality and years of healthy life of residents and to eliminate health disparities. More information including the Federal Register notice is available at:

www.health.gov/healthypeople

Federal Funding Resources

Federal Commons

The Federal Commons is an Internet gateway to government programs and funding opportunities. The National Institutes of Health, General Services Administration, National Science Foundation, Office of Naval Research and the U.S. Department of Transportation developed Federal Commons. The Web is at:

www.cfda.gov/federalcommons/index.html.

Federal Register

The Federal Register is the official government publication that announces proposed and final regulations, notices of funding availability (NOFAs), legal notices from federal agencies, and presidential proclamations and executive orders. The Federal Register is available online at:

www.access.gpo.gov/su_docs/aces/aces140.html

Subscriptions to the Federal Register are available by calling the Superintendents of Documents, United States Government Printing Office (GPO) at (202) 512-1800.

GrantsNet

The DHHS Office of Grants Management developed GrantsNet as an online resource for finding information on DHHS and other federal grant programs. The Catalog of Federal Domestic Assistance (CFDA), compiled and maintained by the General Services Administration, is also available at the GrantsNet Web site. The GrantsNet Web site is at:

www.hhs.gov/grantsnet/grantinfo.htm

Health Resources and Services Administration (HRSA) Preview Guide

United States Health Resources and Services Administration (HRSA) publishes Preview Guide on their Web site at:

www.hrsa.gov/grants.htm

This guide provides profiles of HRSA discretionary grant programs and also answers frequently asked questions regarding HRSA-related grants. HRSA also offers a Preview Guide Mailing List that can be subscribed to by sending an email to hrsagac@hrsa.gov.

National Institutes of Health (NIH) Guide for Grants and Contracts

NIH announces its available funding in the weekly NIH Guide for Grants and Contracts. This guide is available for viewing online at:

<http://grants.nih.gov/grants/guide/index.cfm>

The table of contents for each week's Guide is available by e-mail. For more information on receiving this email update visit the NIH Guide for Grants and Contracts Web site at the address noted above. More information is also available by calling the NIH Grants Information Office at (301) 435-0714.

Non-Government Grantmakers

Community Foundations

Community foundations are 501(c)(3) organizations that make grants for charitable purposes in a specific community or region. The funds are usually derived from many donors and held in an endowment that is independently administered; income earned by the endowment is then used to make grants. Although a community foundation may be classified by the IRS as a private foundation, most are classified as public charities (The Foundation Center, 2001).

Corporate

Corporate grantmakers include company-sponsored foundations and corporate giving programs. A company-sponsored foundation (or corporate foundation) is a private foundation whose assets are derived primarily from the contributions of a for-profit business. A company-sponsored foundation may maintain close ties with its parent company, but is considered an independent organization with its own endowment and as such is subject to the same rules and regulations as other private foundations. Corporate giving programs are grantmaking programs established and administered within a for-profit business organization (The Foundation Center, 2001).

Grantmaking Public Charities

One of the primary purposes of public charities is to operate grants programs benefiting unrelated organizations or individuals. There is no legal or IRS definition of a public foundation, but such a designation is needed to encompass the growing number of grant-making institutions that are “not a private foundation” (The Foundation Center, 2001).

Private Foundations

Private foundations are non-governmental, nonprofit organizations with an endowment (usually donated from a single source, such as an individual, family, or corporation) and a program managed by its own trustees or directors. Private foundations are established to maintain or aid social, educational, religious, or other charitable activities serving the common welfare, primarily through the making of grants (The Foundation Center, 2001).

Non-Government Funding Sources

Other sources of funding include grants from private foundations, corporate grantmakers, community foundations and public charities. The following paragraphs include descriptions for the sources of funding information for these types of grants.

Foundation Center

The Foundation Center Website links to individual grantmaker Web sites. Users can search the site by grantmaker type. Results are listed alphabetically by state. The Web site is:

<http://fdncenter.org/funders>

For an extensive description of The Foundation Center including information on its free educational programs at its regional offices call (212) 620-4230 or (800) 424-9836.

The Forum of Regional Associations of Grantmakers (RAGS)

The Forum of Regional Associations of Grantmakers is a membership association of the nation’s largest RAGs. RAGs are associations of area grantmakers including more than 3,400 nationwide. These RAGS affiliate to enhance the effectiveness of private philanthropy in their regions. Information for grantseekers including information on individual RAGs is available on their Web site at:

www.rag.org

Telephone calls can be directed to (202) 467-0383.

Grantsmanship Center (TGCI)

The Grantsmanship Center is the Internet home of TGCI. TGCI offers grantsmanship training and publications related to grants and proposal writing. The Web site offers training information and funding resources including links to available state and community funding. The Web site is located at:

www.tgci.com

More information is also available by calling (213) 482-9860 or by writing Grantsmanship Center, P.O. Box 17220, Los Angeles, CA 90017.

Physicians Role

Physicians can use the information in this chapter by applying for funding directly or sharing the resources with a group of interested professionals. Adolescent data outlined in Chapter 2 can supplement a grant application in addition to some of the reference material in other chapters and the Appendix. Physicians can certainly donate time, scientific knowledge, and creative energy to adolescent programming; however, activities that are under-funded typically experience more difficulties than programs with adequate budgets to accommodate expenses for meetings, communications and marketing, consultants, evaluation, and other legitimate costs.

References

Ross H. (2001). Where to begin the search for funding: What grantseekers need to know. *Closing the Gap*, April/May. U.S. Department of Health and Human Services Office of Minority Health, 2001.

The Foundation Center (2001). The Foundation Center Web site. Information obtained August 2001 <http://www.fdncenter.org>.

Communications Strategies

Introduction

Communicating is the cornerstone of any advocacy project. As part of the Healthy People 2010 initiative, this information was developed to encourage physicians to share information with members of the communities where they live and with professional organizations. This chapter provides information on effective communication strategies and ideas for promoting Healthy People 2010.

Healthy People 2010 Is News Worthy

A close look at the Healthy People 2010 key health indicators demonstrates that the objectives have something for everyone. In fact, each objective is a fully equipped vehicle. Planning is all it takes to maximize the public relations mileage.

Consider the following recommendations to make your own news with the national health objectives.

- **Get specific.** Pinpoint an objective or the entire set of 21 objectives that relate to your programs, planned or existing. Because Healthy People 2010 is a national initiative with a high profile, it can breathe new life into established adolescent projects and lend direction to new ideas.
- **Do your research.** Give your city, county, or state a goal to reach. In other words, localize. Perhaps you are focusing on teen pregnancy. How big is the problem where you live? How far do you have to go? These local facts and figures will fuel your future successes.
- **The 21 critical objectives set national goals with recognized high priority.** So use and reuse them to justify your own efforts. Get press coverage by appointing a committee to review the objectives; then publicly announce your support through a news release or press conference. Take that a step further and refer to the objectives whenever appropriate. Announcing a new program? Reviewing the year's achievements? Advocating for adolescents or raising funds? Refer to the critical objectives chapter and verse.

- **Form a 2010 adolescent health committee or coalition with other community and public health groups.** A news conference announcing the new group could outline your locale's health profile. Follow-ups might include a Healthy People Week with public forums, health fairs, and fundraisers. Consider inviting the media to join your coalition or committee, guaranteeing coverage for your efforts.
- **The 21 objectives offer many ideas if you identify the right approach.** If you have a working relationship with a TV news producer, propose a week-long Healthy People series, offering help with interview subjects and background materials. Plan a mini-media tour, scheduling appointments with editorial boards, talk show hosts, and other reports to discuss the objectives. You could even establish a critical objectives speakers bureau and promote it to powerbrokers.

The success of the objectives is in their use. Find as many ways as possible to have 2010 take adolescent activities where you want them to go.

(Adapted from Brock C. Making the News. *Target 2000: A Newsletter of the AMA Healthier Youth by the Year 2000 Project*. Chicago, Ill: American Medical Association. 1990; 1(3): 6).

Writing Effective News Releases

News releases can act as a primary tool for communicating with media. At first glance, news releases seem simple: Write a story and submit it to the media. Effective news releases, however, deserve a second glance. Whether you want to promote a specific Healthy People 2010 event or raise community awareness about the adolescent objectives on a regular basis, an effective news release will increase your chance of getting your story "placed."

Consider these steps for writing effective news releases.

- **Decide on your objective**
Adolescent health and related Healthy People 2010 objectives are your issue. When it comes to a reporter though, adolescent health is just one issue in a mountain of potential news stories. Your objective then is pulling adolescent health to the top-however briefly-and providing the reporter with a story idea. That should be the objective of every news release you write.
- **Ask yourself if the story is really newsworthy**
Reporters may not agree with what you consider important. Stand back from your story and assume the role of reporter for a few minutes. What would a reporter find interesting about this story? What question would a reporter ask? How would the headline read? What is controversial about the story? Reporters will not pay attention to releases with no news.

- **Build your story**
Are you satisfied with your answers to the questions in the previous paragraph? If not, get back to the drawing board. Find the news “hook” that will sell your story. Draft a local celebrity to endorse your cause. Identify compelling local statistics, using the resources in this monograph, that dramatize the adolescent problem. Make your headline!
- **Write your lead**
The first paragraph of your news release is called the lead. The lead puts your news up front and answers questions related to who, what, when, where, and how. If you have done your homework in the preceding steps, the lead should write itself. An effective lead tells a reporter to stop and read.
- **Build the release**
Releases should be built like inverted pyramids. The most important item comes first, the least important comes last. Building from your lead, tell your story from the top to bottom. Keep sentences and paragraphs short and concise. Final paragraphs are the place for plugs; for instance, you can identify your organization, its membership, and purpose.
- **Polish**
Identify a contact at the top of every news release. Include a name and phone number and email address. News releases should be double-spaced with generous margins for easy reading. If possible, keep the release to one page. Proofread it for accuracy and typographical errors. Different organizations use widely different formats for news releases, so check with your state medical society to determine their format and consider their recommendations.

(Adapted from Brock C. Effective News Releases. *Target 2000: A Newsletter of the AMA Healthier Youth by the Year 2000 Project*. Chicago, Ill: American Medical Association. 1990; 1(2): 6).

Effective Speechmaking

The idea of speaking to a group provokes panic and anxiety in many people. However, speeches can be an invaluable way to share the Healthy People 2010 message and get your community excited about working together to achieve the adolescent objectives. To help you prepare well-received speeches, consider these recommendations.

Preparing your speech

A good speech is a work of art. It paints a detailed picture that stirs emotion and inspires action. However, a good speech also needs to have a structure that makes its message unmistakable. To ensure that your audience appreciates and understands your message, think of the speech as having three parts.

In the *introduction*, you want to:

- get attention and interest
- reveal the topic
- establish credibility and goodwill
- preview the body of the speech

In the *body*, you want to:

- summarize each main point (limit to three)
- explain the who, what, where, when and why through sub-points
- use transitions between each main point

In the *conclusion*, you need to:

- signal the end of the speech
- reinforce the central idea
- summarize the main points
- deliver a call to action

In general, use simple, everyday English and an active voice to keep your message concise and compelling. If you use statistics, keep them to a minimum and make them memorable. Try to get inside your audience's mind by researching the group and finding the best way to make a point to them. Most importantly, establish a connection with the audience by complimenting them, showing you have something in common, and making them feel that you understand them. Share personal experiences, thoughts, stories, and anecdotes to which you believe that audience can relate.

Delivering the speech

The speeches most likely to succeed are those that are well-prepared. Consequently, the best-prepared speech can fail to move an audience if it is delivered poorly. To connect with your audience, think of yourself as “conversing” with them in much the same way as you would with a single person. Consider these ways to achieve this effect, enabling your audience to truly respond to your message.

- Try to develop a natural reading style with a conversational quality.
- Make frequent eye contact with the audience.
- Use gestures frequently. Gestures have to be large to reach those in the back row of the audience.
- If you use a podium, don't use it as a leaning post. Assume a centered standing position. Rest your arms comfortably on the podium in a position that allows movement. Try stepping away from the podium to connect with your audience.

- Mark your speech for emphasis, gestures, breathing pauses. Remember that pauses allow the audience to catch up and make the transition from one point to the next.
- Avoid reading the speech word-for-word by marking or underlining key points.
- Consider using slides or making power point presentations. This allows you to refer the audience to the screen and you can provide hand-out's so that the audience can listen instead of taking notes.
- Practice, Practice, Practice! You will be a more effective spokesperson if you are comfortable with your material and are aware of your own voice and phrasing.
- Try to leave your audience with one central thought, message, or idea. This may be highlighted through memorable phrases or through a delivery that calls attention to its importance. By becoming an effective speaker on behalf of youth, you are taking a big step toward helping your community's youth to be healthier by the year 2010.

(Adapted from Brock C. Effective Speechmaking. *Target 2000: A Newsletter of the AMA Healthier Youth by the Year 2000 Project*. Chicago, Ill: American Medical Association. 1991; 2(1): 5).

Physicians Role

Physicians can serve as excellent spokespersons for adolescent projects that are linked to Healthy People 2010. Using the media to publicize an activity is an important aspect of any program's success. This chapter reviewed some principles for writing news releases and making speeches. The following chapter includes additional information about initiating a project, tracking its progress, and evaluating its impact.

References

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Chapter 7

Medicine's Investment in Youth

Introduction

Physicians' unique role in raising public awareness about the twenty-one critical adolescent health objectives has been reviewed throughout this publication's previous chapters. This final chapter proposes an action plan for participation and describes the importance of evaluation. In an effort to consolidate recommendations, references are made to other chapters, and resources are reviewed.

Action Plan

Physicians who want to actively participate in helping to meet the national health objectives' targets can approach this task by completing an action plan. The following paragraphs include descriptions of an action plan's components. This action plan is intended as a guide with flexible components that can accommodate strategic differences and availability of resources.

Action plans can help physicians translate their interests about a health issue into action. Ideas can become reality by adding the dimensions of time, resources, and feedback that are action plan components. Focusing on a particular health condition or set of related objectives facilitates meeting the targets for the twenty-one critical adolescent objectives.

The first step in this action plan process is the identification of intended goals or a statement of purpose. These statements are typically broad and can be considered a mission statement or description of purpose. Although goals are an essential aspect of any project, this task does not have to be daunting or delay getting started. Physicians can consult any of the boards of directors or advisory groups on which they currently serve to obtain examples of goals that can be modified to complete this assignment. Also, physicians who plan to collaborate with a community organization can utilize that agency's current adolescent goals or mission statement to fulfill this recommended step in the action plan process. For instance, a regional medical center may include a goal related to providing family planning services to community residents.

The second step in an action plan is the completion of objectives. Objectives are not as broad as goals because they describe a goal's operational components. Most goals include two or three objectives each. They address specific approaches for meeting goals and may include time lines. For instance, the regional medical center that provides family planning services may include objectives related to adolescent health. Their objectives may include statements similar to these: offer semi-annual adolescent pregnancy prevention information through educational outreach programs to local high schools; review adolescent contraception administration policies annually; provide sexually transmitted disease screening and treatment to adolescent patients.

The third step in an action plan is the identification of activities. Activities identify the steps necessary to complete objectives. For instance, to meet an objective related to offering semi-annual adolescent pregnancy prevention information, several activities must be planned, implemented, and evaluated. Activities may include contacting the local high schools, obtaining permission to offer the programs, identifying and confirming speakers, and evaluating the activity to determine future plans. All of these activities take time and require human and financial resources. Because most activities have a price tag, they require careful consideration and planning.

The fourth step in an action plan is evaluation of the completed activities. Evaluation is an activity that should be undertaken throughout the planning process; however, a summary evaluation is essential at the conclusion of any project. Evaluating a project includes asking participants about their reactions to the activities, reviewing timelines and financial resources in addition to soliciting feedback about what could have been done differently. A project assessment asks about the extent to which a project goal was achieved, objectives were met, and activities were completed. Recommendations focus on what could have been done differently to improve a project on the basis of time, human resources, and financial support.

An evaluation report is an important component of any project because it summarizes a project's outcomes from a variety of perspectives and it includes valuable recommendations. The complexity of a project determines the comprehensiveness of an evaluation report. However, almost any project that a physician undertakes to improve the health of adolescents requires an evaluation report to document its impact. Evaluation data can be considered the conclusion of one project and provide information for the beginning of another project.

Sample Action Plan

Action Plan for the 21 Critical Adolescent Objectives

Topic of Interest:

Related 2010 Health Objectives:

Goal:

Project Objectives

1.

2.

3.

Project Activities

1.

2.

3.

4.

Time Line

Right now:

This week:

Within the month:

By the end of the quarter:

Within 6 months:

By the end of the year:

Human resources

Individuals:

Stakeholders:

Powerbrokers:

Organizational Resources

County medical society:

State medical society:

Medical clinic:

Hospital/medical center:

Health department:

Community agency:

Faith community:

Youth-serving organization:

Law enforcement:

Mental health:

Drug treatment:

Public schools:

Other:

Financial Resources

Community service club: _____

Local foundation: _____

State grant: _____

National grant: _____

Other: _____

Media

News releases: _____

Speeches: _____

Evaluation

Your assessment: _____

Your recommendations: _____

Participant reactions: _____

Participant recommendations: _____

Recipient assessment: _____

Recipient recommendations: _____

Funder assessment: _____

Funder recommendations: _____

Physicians Role

Physicians can assume an active role in initiating a project that addresses the Healthy People 2010 twenty-one critical adolescent objectives. An activity to which physicians devote their non-clinical time deserves careful planning and evaluation to ensure success. Completing an action plan includes everything from detailing a project's overall goals to those smaller activities that can be more challenging to track. Although evaluation ideally takes place throughout the life of a project, it clearly should be an integral aspect of bringing closure to any professional activity. Evaluation answers questions related to what happened, what did not happen, what could have been different, and what could improve the project in the future.

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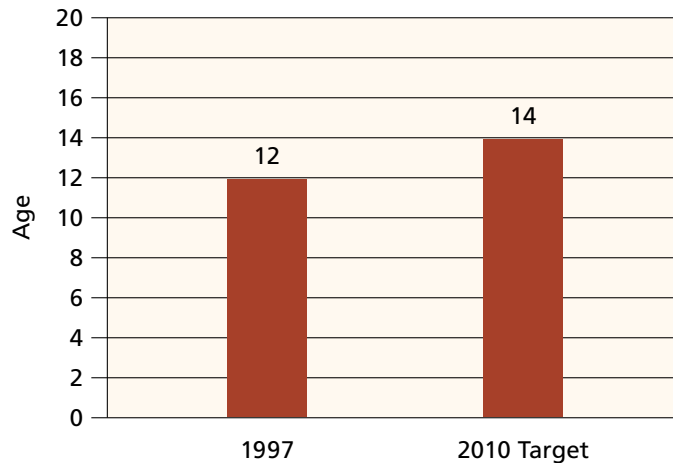
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Appendix

Related Objectives and Graphs for Adolescent Health

Objective 27-04a:

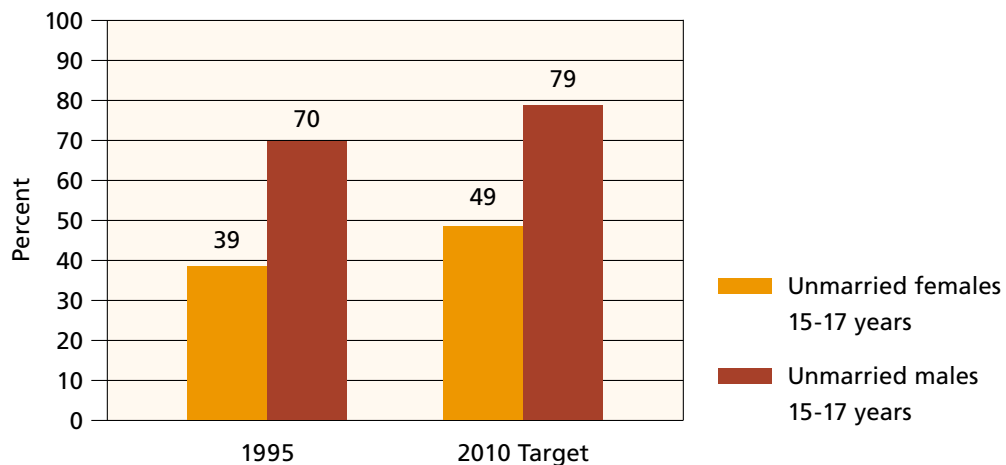
Average age at first tobacco use of adolescents (ages 12 to 17 years)



Source: National Household Survey on Drug Abuse (NHSDA), SAMHSA

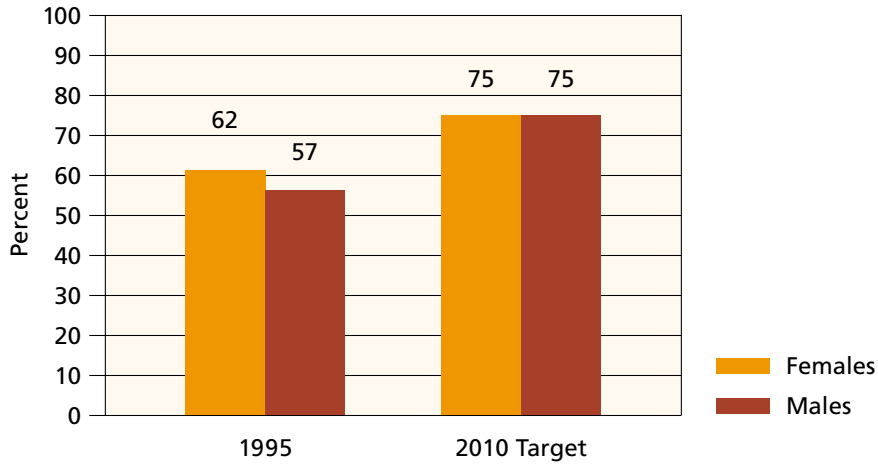
Objective 9-10e, 9-10f:

Pregnancy prevention and STD protection – condom use at last intercourse



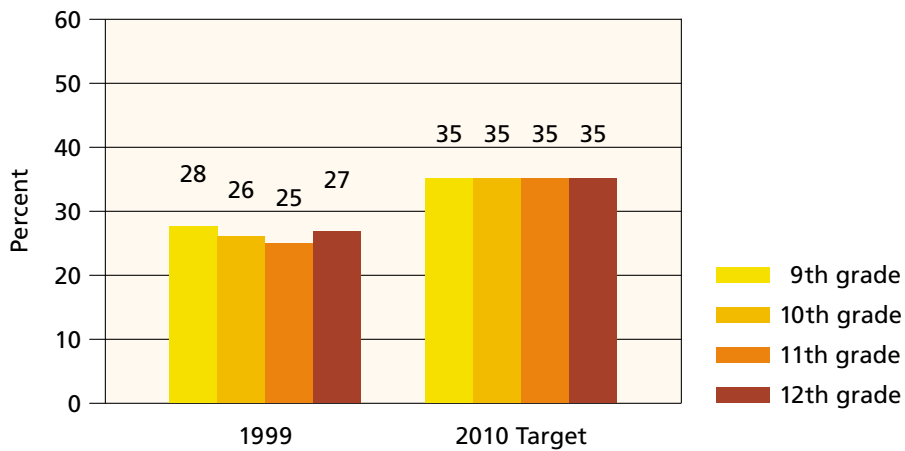
Source: National Survey on Family Growth (NSFG), CDC, NCHS, National Survey of Adolescent Males (NSAM), Urban Institute

Objective 9-09a, 9-09b:
Abstinence among adolescents – ages 15 to 17 years



Source: National Survey on Family Growth (NSFG), CDC, NCHS, National Survey of Adolescent Males (NSAM), Urban Institute

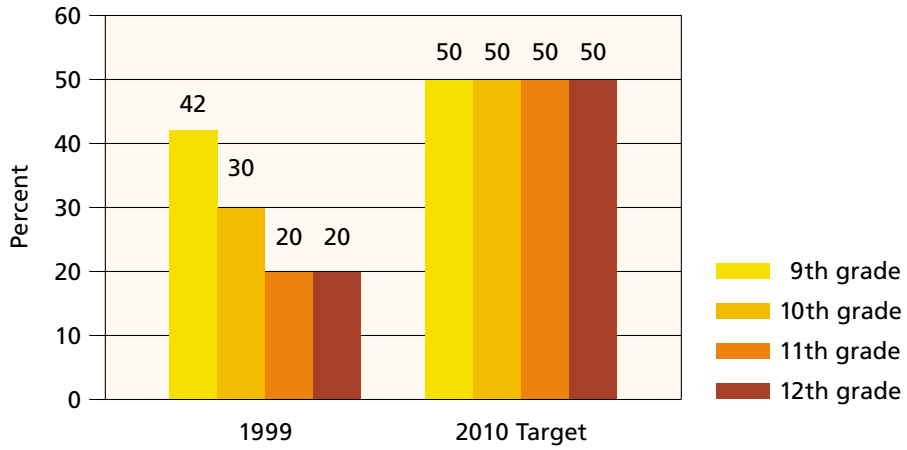
Objective 22-06:
Moderate physical activity in adolescents – students grade 9 through 12



Source: Youth Risk Behavior Surveillance System (YRBSS), CDC, NCCDPHP

Objective 22-09:

Participation in daily physical education in schools – students grades 9 through 12



Source: Youth Risk Behavior Surveillance System (YRBSS), CDC, NCCDPHP

Resources

AMA Sites

State, County, and Regional Medical Societies and National Medical Specialty Societies located on the Organizational Medicine Web sites at:

www.ama-assn.org/ama/pub/article/3958-3926.html

Medicine and Public Health activities Web site:

www.ama-assn.org/go/publichealth

AMA Policy Finder Web site at:

www.ama-assn.org/apps/pf_online/pf_line

Children's Defense Fund:

2000 Children in the States data book with the 2001 edition, scheduled for release in September 2001. Their Web site can be accessed at:

www.childrensdefense.org/statesdata.htm

Child Trends:

2001 Facts at A Glance. The report can be accessed by calling (202) 362-5580 for a faxed copy or online at:

www.childtrends.org/HomePg.asp

Community Health Status Indicators (CHSI) Reports and Report Database:

This resource can be ordered online at:

<http://bookstore.phf.org/prod156.htm>

Federal Commons:

Internet gateway to government programs and funding opportunities. Available at:

www.cfda.gov/federalcommons/index.html

Federal Interagency Forum on Child and Family Statistics:

America's Children: Key National Indicators of Well-Being, 2001. Available at:

www.childstats.gov

Federal Register:

Official government publication that announces proposed and final regulations, notices of funding availability (NOFAs), legal notices from federal agencies, and presidential proclamations and executive orders. The Federal Register is available at:

www.access.gpo.gov/su_docs/aces/aces140.html

Subscriptions to the Federal Register are available by calling the Superintendents of Documents, United States Government Printing Office (GPO) at (202) 512-1800.

Forum of Regional Associations of Grantmakers:

Membership association of the nation's largest RAGs—associations of area grantmakers. Information for grantseekers including information on individual RAGs is available by calling (202) 467-0383 or by visiting their Web site at:

www.rag.org

Foundation Center:

The Foundation Center Web site provides links to individual grantmaker Web sites. Also, users can search the site by grantmaker type and results are listed alphabetically by state. The Web site is:

<http://fdncenter.org/funders>

For an extensive description of The Foundation Center including information on its free educational programs at its regional offices call (212) 620-4230 or (800) 424-9836.

Grantsmanship Center:

Grantsmanship Center is the Internet home of TGCI. TGCI offers grantsmanship training and publications related to grants and proposal writing. The Web site offers training information and funding resources including links to available state and community funding. The Web site is located at:

www.tgci.com

More information is also available by calling (213) 482-9860 or by writing Grantsmanship Center, P.O. Box 17220, Los Angeles, CA 90017.

GrantsNet:

An online resource for finding information on DHHS and other federal grant programs. The Catalog of Federal Domestic Assistance (CFDA), compiled and maintained by the General Services Administration, is also available at the GrantsNet Web site. The GrantsNet Web site is at:

www.hhs.gov/grantsnet/grantinfo.htm

Health, United States, 2000-Adolescent Health Chartbook:

MacKay AP, Fingerhut LA, Duran CR. *Adolescent Health Chartbook. Health United States, 2000*. Hyattsville, Md: National Center for Health Statistics; 2000. Available at:

www.cdc.gov/nchs/products/pubs/pubd/hus/hus.htm

Healthy People:

The Web site is available at:

www.health.gov/healthypeople

Healthy People 2010:

A Powerpoint presentation which can be used for presentations on Healthy People 2010 is available at:

www.health.gov/healthypeople/Implementation/slides/May_2001_files/frame.htm

Healthy People 2010 Toolkit: A Field Guide to Health Planning:

The Toolkit could be accessed online at:

www.health.gov/healthypeople/state/toolkit

or by contacting the Public Health Foundation toll-free at (877) 252-1200 (item RM-005) or by visiting the online bookstore at

<http://bookstore.phf.org>

Henry J Kaiser Family Foundation:

The Henry J. Kaiser Family Foundation provides an Internet resource that offers current health information for all 50 states, District of Columbia, and the US territories. Data can be accessed from State Health Facts Online, at:

www.statehealthfacts.kff.org

2001 KIDS COUNT:

KIDS COUNT is a product of the Annie E. Casey Foundation, which provides national and state-by-state data on the status of children living in the US. Information on KIDS COUNT is available at:

www.kidscount.org

Monitoring the Future Study:

Available at:

www.monitoringthefuture.org

National Campaign to Prevent Teen Pregnancy:

The Web site is available at:

www.teenpregnancy.org

National Household Survey on Drug Abuse:

Available at:

www.samhsa.gov/oas/oasftp.htm

National Institutes of Health (NIH) Guide for Grants and Contracts:

This is available at:

<http://grants.nih.gov/grants/guide/index.html>

The table of contents for each week's Guide is available by e-mail. For more information on receiving this e-mail update visit the NIH Guide for Grants and Contracts Web site at the address noted above. More information is also available by calling the NIH Grants Information Office at (301) 435-0714.

The National Longitudinal Study of Adolescent Health (ADD HEALTH):

Protecting Teens: Beyond Race, Income and Family Structure by Trisha Beuhring, PhD, Robert W. Blum, MD, MPH, PhD, and Peggy Mann Rinehart was produced using these data with grant support from the Robert Wood Johnson Foundation. Copies of this report are available by contacting Add Health, c/o Center for Adolescent Health, University of Minnesota, 200 Oak Street, SE, Suite 260, Minneapolis, MN 55455-2002, or by e-mail at:

aph@umn.edu

National Survey of Family Growth (NSFG):

The survey can be accessed at:

www.cdc.gov/nchs/nsfg.htm

Preview Guide:

This is published by the United States Health Resources and Services Administration (HRSA) and it provides profiles of HRSA discretionary grant programs and answers frequently asked questions regarding HRSA-related grants. It is available at:

www.hrsa.gov/grants.htm

or you can subscribe to the Preview Guide mailing list by e-mailing:

hrsagac@hrsa.gov

Society for Adolescent Medicine (SAM):

SAM has eight regional chapters around the country. Information about the regional chapters can be accessed on the SAM Web site at:

www.adolescenthealth.org

US Department of Health and Human Services:

The United States Department of Health and Human Services announced a new “micro-grant” approach to enlist community support for achieving the Healthy People 2010 goals. More information including the Federal Register notice is available at:

www.health.gov/healthypeople

Youth Risk Behavior Surveillance System (YRBS):

The latest YRBS survey data are available through the Morbidity and Mortality Weekly Reports (MMWR) and through their Web site at:

www.cdc.gov/mmwr

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