

American Medical Association

Physicians dedicated to the health of America



Healthy Youth 2010



Supporting the
21 Critical Adolescent Objectives

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The National Initiative continues some of the activities begun during discussion 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 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, 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 (MCHB) and our Partners in Program Planning for Adolescent Health (PIPPAH) project officer has helped to make this publication possible through our cooperative agreement (U93MC00104).

This edition of the *Healthy Youth 2010 – Supporting the 21 Critical Adolescent Objectives* has been updated and revised by the authors in addition to Darcy Steinberg, MPH and Therese Woike, American Academy of Pediatrics (AAP), Division of Developmental Pediatrics and Preventive Services. This edition will be included in the AAP workshops to address meeting the targets for the 21 critical adolescent Healthy People 2010 objectives.

Our appreciation also extends to other colleagues and family members who offered recommendations and unending support throughout the completion of this publication.

Foreword

The American Medical Association (AMA) has participated in helping physicians meet the adolescent component of Healthy People since 1990. More than a decade ago the AMA promoted awareness of the health objectives that related to adolescents through a special grant awarded by the US Public Health Service. The AMA actively participated in the development of Healthy People 2010 and has also committed resources to promoting not only the National Initiative to Improve Adolescent Health by the Year 2010, but also actively supporting the 10 leading health indicators that function as a report card for progress made toward meeting the Healthy People 2010 objectives.

The AMA actively supports the Healthy People 2010 goals of increasing the quality and length of life in addition to eliminating health disparities. In 2002 the AMA House of Delegates approved the creation of a program on health disparities. The program resides in the AMA Unit on Medicine and Public Health and fulfills responsibilities outlined in the AMA Memorandum of Understanding (MOU) with the United States Department of Health and Human Services (DHHS) to address health disparities. This publication features information about the adolescent component of the health objectives and also responds to the intent of the MOU.

As the largest professional physician membership organization in the United States, the AMA is in a unique position to encourage physician participation in 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 guide for addressing the health needs of young people who are 10-24 years of age. It is complementary to other activities of the AMA especially the *Roadmaps for Clinical Practice – Case Studies in Disease Prevention and Health Promotion* that addresses the Healthy People 2010 10 leading health indicators.

Introduction

The American Medical Association (AMA) has actively participated in meeting the targets for the Healthy People 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 settings. 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 and concerns. *Healthy Youth 2010* features information about the national health objectives especially the adolescent components, offers direction for working with state medical societies, outlines opportunities for obtaining programmatic support, reviews strategies for publicizing project activities, provides an action for implementation, and discusses the importance of program evaluation.

Healthy Youth 2010's six chapters include resources and references for initiating a project as well as joining a well-established program. Physicians may choose to participate in a single issue that may feature youth violence or to 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 activities that they direct or to assist with program development. 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 rely on the principles of 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 Youth 2010* 21 critical adolescent 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 card, 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

- *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 (eg, 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 caused 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 caused 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 guardians 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 21 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 and the 2010 health targets. 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

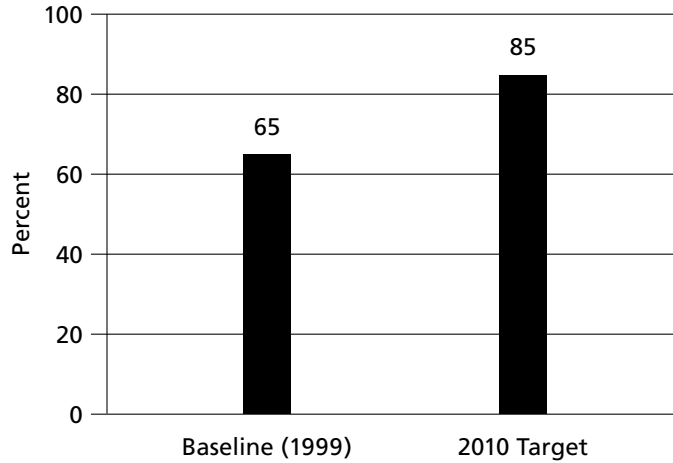
Physical Activity

In 2001, approximately two-thirds of all high school students participated in moderate to vigorous physical activity in the previous 7 days preceding completion of the questionnaire. However, data has shown that physical activity decreases during adolescence. For instance, data from 2001 indicates that 71.9% of 9th graders, 67% of 10th graders, 61% of 11th graders, and 56% of 12th graders reported participating in vigorous physical activity (Grunbaum J, Kann L, Kinchen S, et al, 2002).

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



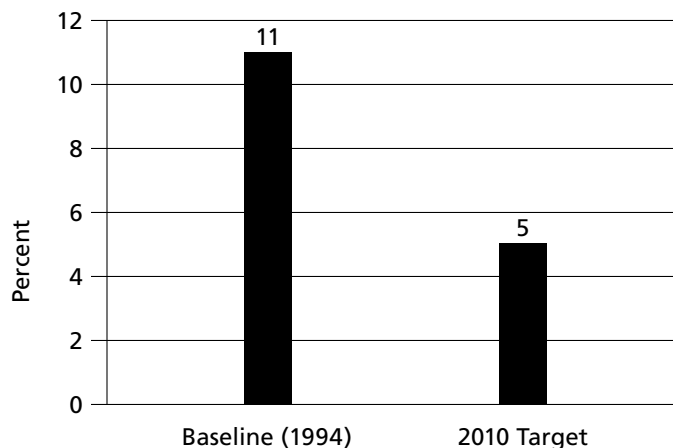
Overweight and Obesity

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 who are overweight has been increasing during the past several years. The percentage of overweight adolescents age 12-19 years old has increased from 5% in 1970 to 14% in 1999. This increase was similar for both male and female adolescents (Centers for Disease Control and Prevention).

Objective 19-03:

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

Overweight or Obesity in Children and Adolescents

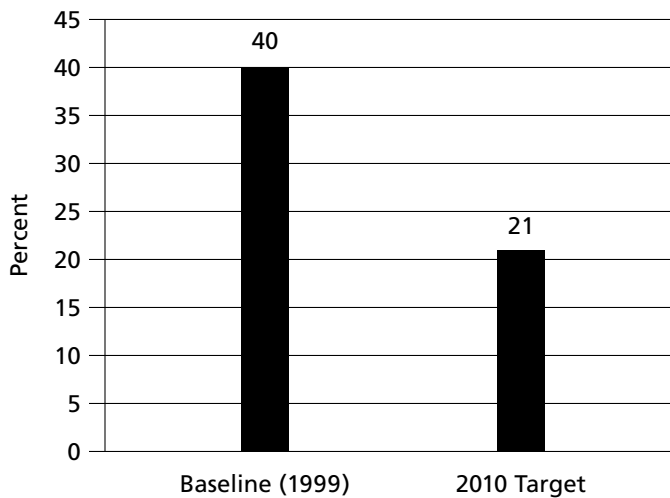


Tobacco Use

Smoking, which is often initiated during the adolescent years, is the single most preventable risk factor for the leading causes of death in the United States including heart disease and cancer. Despite these negative consequences, more than half (57%) of adolescents have tried cigarettes by the 12th grade and 27% of 12th grade students are current smokers (Grunbaum J, Kann L, Kinchen S, et al, 2002). 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. For 12th graders cigarette use reached its peak in 1997. Since 1996 smoking in these grades has fallen off considerably (49% and 42% respectively) (Grunbaum J, Kann L, Kinchen S, et al, 2002).

Objective 27-02: Reduce tobacco use by adolescents

Tobacco Use by Adolescents



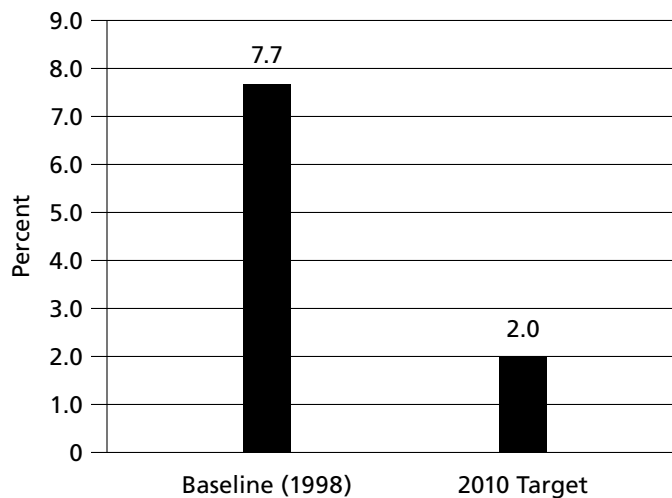
Substance Abuse

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% of adolescents aged 12 to 17 years stated that they had drunk alcohol in the past month (Healthy People 2010). In 2002, 20% of 8th graders, 35% of 10th graders, and 49% of 12th graders admitted to drinking an alcoholic beverage in the 30 day period prior to the survey (Johnston LD, O'Malley PM, Bachman JG, 2003). Between 1992 and 1998 binge drinking rose by about 4% among students in 12th grade. In addition, there was a slight increase in binge drinking among 8th graders between 1991(13%) and 1996 (16%). For students in 10th

grade, 21% reported binge drinking in 1992 and 26% reported binge drinking in 1998. There had been only a slight decline in binge drinking among all high students until 2002 when it dropped appreciably for all students surveyed (Johnston LD, O'Malley PM, Bachman JG, 2003).

Objective 26-11: Reduce the proportion of persons engaging in binge drinking of alcoholic beverages

Binge Drinking Among Adolescents



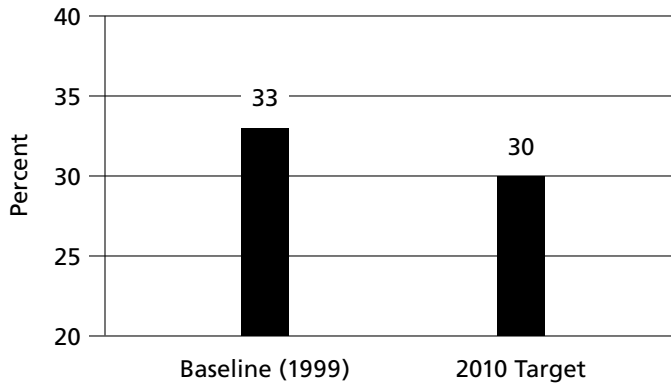
Alcohol use can lead to problems for adolescents who decide to drive under the influence. In 2002, 24% of drivers age 15-20 years, who were killed in crashes were intoxicated (National Center for Statistics and Analysis, 2002). Among teenagers 16-19 years, 25% of fatally injured male drivers and 14% of fatally injured female drivers in 2001, had blood alcohol concentrations at or above 0.08 percent (Insurance Institute for Highway Safety). In addition, more than one in three teenagers has ridden with a driver who has been drinking alcohol (Everett SA, Shults RA, et al, 2001). Drivers who have been drinking alcohol are also less likely to use restraints (National Center for Statistics and Analysis, 2002).

Objective 26-01: Reduce deaths and injuries caused by alcohol- and drug-related motor vehicle crashes

Note: The baseline year for data for this objective was 1998 when the rate was 13.5 per 100,000. A 2010 target is not provided for the adolescent/young adult age group.

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

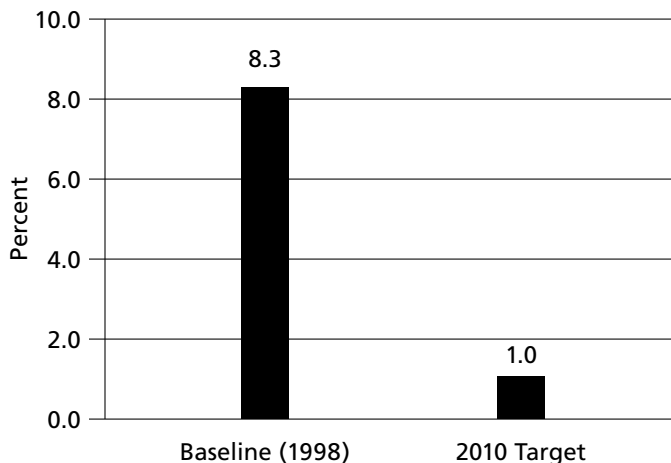
Adolescents Who Rode with a Driver Who Had Been Drinking Alcohol



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 2001, 23.9% of high school students reported using marijuana in the past 30 days (Grunbaum J, Kann L, Kinchen S, et al, 2002). After an increase in the 1990s, annual prevalence rates peaked in 1996 at 8th grade and in 1997 for 10th and 12th grade students. There has been a very modest decline since those peak levels (Johnson LD, O'Malley PM, Bachman, JG, 2003). Fifty-five percent of youth aged 12 to 17 years reported that it would be fairly easy or very easy to obtain marijuana if they wanted to get some. More sixteen and seventeen year olds reported that it would be very easy or fairly easy compared to other age groups (Substance Abuse and Mental Health Services Administration).

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

Adolescent Use of Illicit Substances (Marijuana)



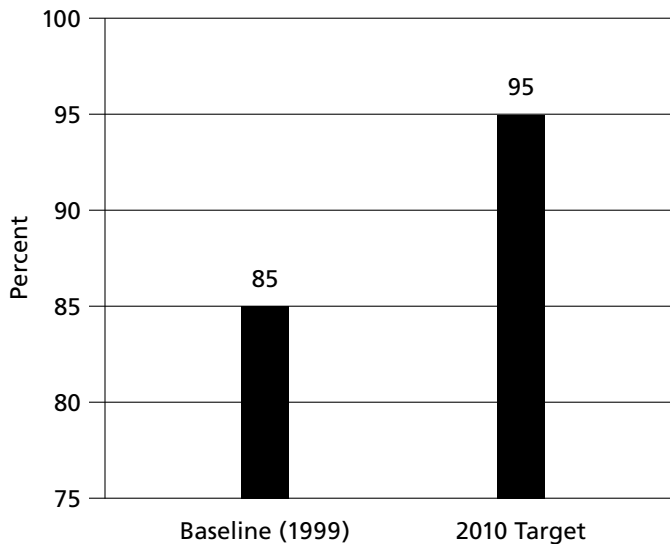
Responsible Sexual Behavior

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 2001, 46 percent of all high school students reported that they had been sexually active (Grunbaum, J, Kann L, Kinchen S, et al, 2002). Of the 33.4% of currently sexually active teenagers in 2001, 57.9% reported that they or their partner had used a condom during their last sexual intercourse. Male students were more likely than female students to report condom use (Grunbaum J, Kann L, Kinchen SA, et al, 2002).

The number of sexual partners people have can place them at increased risk of contracting a sexually transmitted disease, including HIV. In 2001 89% of high school students reported being taught about acquired immunodeficiency syndrome (AIDS) or HIV infection (Grunbaum J, Kann, L, Kinchen S, et al, 2002). During 1991-1999, there was an 8% decrease in the prevalence of sexual experience among adolescents and a 13% 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

Adolescents Who Abstained from Sexual Intercourse or Used Condoms

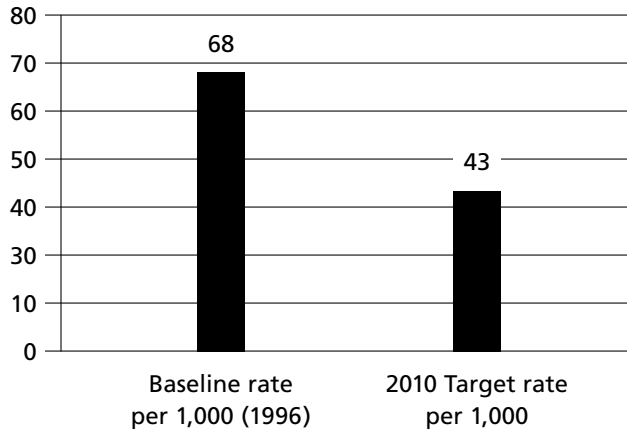


Sexual activity places adolescents at an increased risk for pregnancy and sexually transmitted diseases (STD), including HIV/AIDS. Teenage girls have the highest rates of chlamydial infection. It is estimated that as many as one in ten adolescent girls tested for Chlamydia were infected. In states that collect age specific data, 15 to 19 year-old girls represent 46% of infections and 20 to 24 year-old women present 33% of infections (Centers for Disease Control and Prevention, 2001).

In 2001, there were 455,158 births to adolescents in the United States. This is a decline of about 15% since the most recent peak in the birth rate in 1990 (Child Trends, 2002). The United States pregnancy rate for teenagers ages 15-19 decreased 27% between 1990 and 1999. In 1990 the rate was 117 pregnancies per 1,000 females ages 15-19. Since then the pregnancy rate has decreased to 86 pregnancies per 1,000 females ages 15-19 (Henshaw SK, 2001).

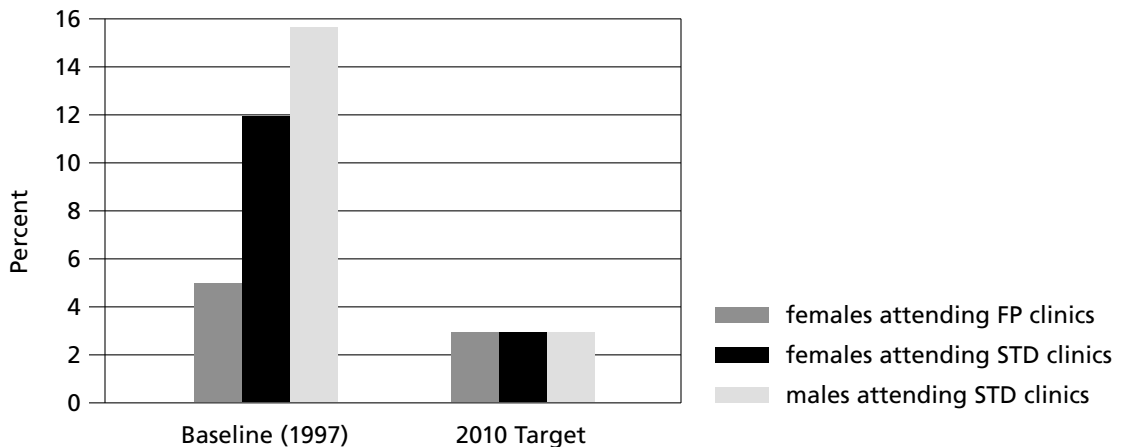
Objective 9-07: Reduce pregnancies among adolescent females

Pregnancy Rates of Adolescent Females



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

Chlamydia Trachomatis Infections Among Adolescents and Young Adults



Objective 13-05: Reduce the number of cases of HIV infection among adolescents and adults

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

Mental Health

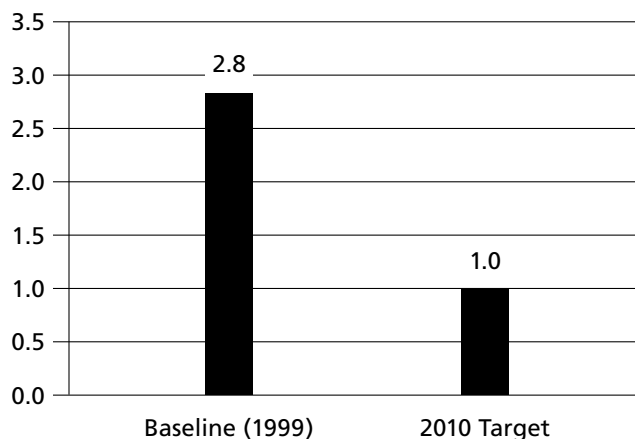
Adolescence is a developmental period during which many changes take place. Some teenagers experience adolescence as stressful and they may experience feeling of hopelessness. These feelings could be a precursor to suicide or suicidal ideation. In fact, suicide is the third leading cause of death for adolescents (Centers for Disease Control and Prevention). In 2001, 28.3% of high school students in the United States had felt so sad or hopeless almost every day for ≥ 2 weeks in a row that they stopped doing some of their usual activities (Grunbaum J, Kann L, Kinchen S, et al, 2002). Female students (34.5%) were significantly more likely than male students (21.6%) to have felt sad or hopeless almost every day for ≥ 2 weeks. This sex difference was found for all the racial/ethnic and grade subpopulations. Males are more likely to succeed when they attempt suicide; males account for a higher percentage of completed suicides (Grunbaum J, Kann L, Kinchen S, et al, 2002).

Objective 18-01: Reduce the suicide rate

Note: A 2010 target is not provided for the adolescent/young adult age group. For 1998, the baseline year, the suicide rate was 1.6 per 100,000 for 10 to 14 year olds, 8.9 per 100,000 for 15 to 19 year olds and 13.6 per 100,000 for 20 to 24 year olds.

Objective 18-02: Reduce the rate of suicide attempts by adolescents

Rate of Suicide Attempts by Adolescents



Objective 06-02: Reduce the proportion of children and adolescents with disabilities who are reported to be sad, unhappy, or depressed

Note: Baseline and target inclusive of age groups outside of adolescent—young adult parameters.

Objective 18-07: Increase the proportion of children with mental health problems who receive treatment

Note: This is a developmental objective; baseline and 2010 target to be provided by 2004.

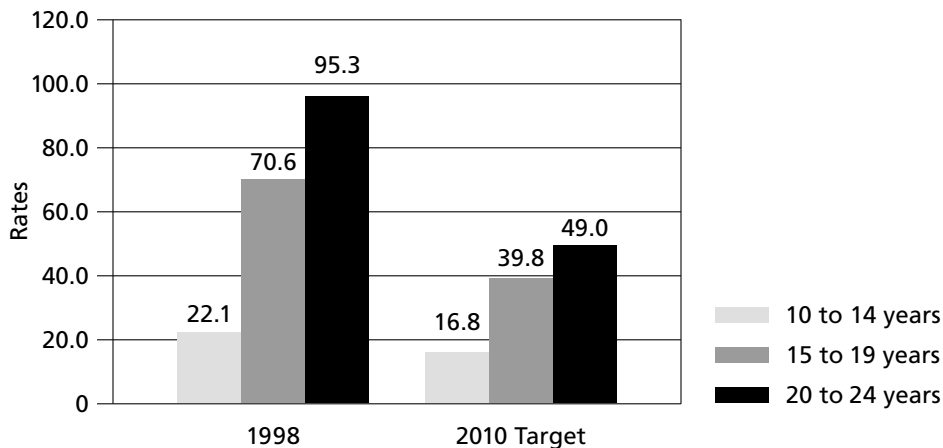
Injury and Violence

In 2000, more than 400,000 youth between the ages of 10 and 19 were injured as a result of violence (Centers for Disease Control and Prevention). Among high school students 4% reported being injured seriously enough in a physical fight to require medical treatment by a physician or nurse (Grunbaum J, Kann, L, Kinchen S, et al, 2002).

The mortality rate for adolescents has steadily declined throughout the 1990s, from 89 deaths per 100,000 in 1991 to 67 deaths per 100,000 in 2000 (Interagency Forum on Child and Family Statistics, 2002).

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.

For 15 to 20 year olds motor vehicle crashes are the leading cause of death (National Center for Statistics and Analysis, 2002). Fourteen percent of all drivers involved in fatal crashes in 2002 were drivers who were 15 to 20 years old.

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

Note: A 2010 target is not provided for the adolescent/young adult age group. For the baseline year of 1998 the rate of deaths caused by motor vehicle crashes is 26.4 per 100,000.

In 2001, 14.1% of high school students reported that they rarely or never wore seat belts when riding in a car as a passenger. Male adolescents are more likely than female adolescents to have rarely or never worn seat belts (Grunbaum J, Kann L, Kinchen S, et al, 2002).

Objective 15-19: Increase use of safety belts

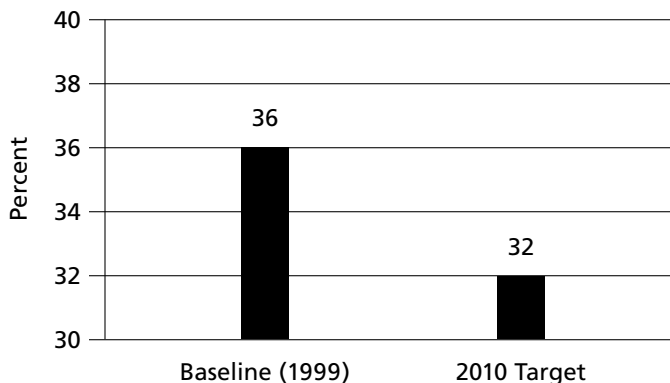
Note: A 2010 target is not provided for the adolescent/young adult age group. The baseline percentage for this objective is eighty-four.

School shootings over the past few years have heightened awareness of violence among adolescents. Nationwide, 17.4% of high school students had carried a weapon (eg, a gun, knife, or club) on ≥ 1 of the 30 days preceding the survey. Male students (29.3%) are significantly more likely than female students (6.2%) to have carried a weapon to school (Grunbaum J, Kann L, Kinchen S, et al, 2002).

In addition to carrying a weapon, physical fighting can be an indicator of violent-related behavior. Among high school students nationwide, 33.2% had been in a physical fight ≥ 1 times during the 12 months preceding the survey. Students in grades 9 and 10 were significantly more likely than students in grades 11 and 12 to report having been in a physical fight (Grunbaum J, Kann L, Kinchen S, et al, 2002).

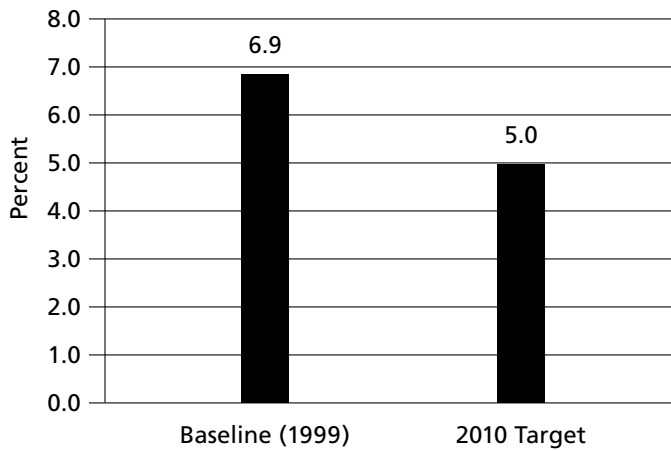
Objective 15-38: Reduce physical fighting among adolescents

Physical Fighting Among Adolescents



Objective 15-39: Reduce weapon carrying by adolescents on school property

Weapon Carrying on School Property by Adolescents



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 is the second leading cause of death for youth 10 to 19 years and the number one cause of death among African American youth ages 15 to 24 years. Homicide was the third leading cause of death among children ages 5 to 14 years in 1997 (Healthy People 2010). In 1999, 82% of homicide victims 15 to 19 years were killed by firearms (Centers for Disease Control and Prevention).

Objective 15-32: Reduce homicides—10 to 14 year olds and 15 to 19 year olds

Note: A 2010 target is not provided for the adolescent/young adult age group. In 1998, the baseline year, the homicide rate was 1.5 per 100,000 for 10 to 14 year olds and 11.7 per 100,000 for 15 to 19 year olds.

Adolescent health data resources

Health, United States, 2000 Adolescent Health Chartbook

The Adolescent Health Chartbook presents national trends and health statistics of the United States adolescent population, 10 to 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 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 secondary 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:

<http://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, marijuana and other drug abuse. In addition, it provides information on drug related emergency department episodes, medical examiner cases, and the national substance abuse treatment system. Information on this survey can be found at:

www.drugabusestatistics.samhsa.gov

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 grades 7 through 12 in the United States. Add Health has been funded by the National Institute of Child Health and Human Development (NICHD) and 17 other federal agencies. Field work for Waves I and II was conducted by the National Opinion Research Center of the University of Chicago. Wave III field work was conducted by the Research Triangle Institute (RTI). Currently data has been collected in four surveys during Wave I (conducted from September 1994 through December 1995), two surveys during Wave II (conducted from April 1996 through August 1996), and data collected at Wave III (conducted from August 2001 through April 2002). For more information on Add Health Survey go to:

www.cpc.unc.edu/projects/addhealth/

or send an email to:

addhealth@unc.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) infection); unhealthy dietary behaviors; and physical activity. The survey is conducted every two years during the spring semester and provides data representative of 9th through 12th grade students in public and private schools in the United States. 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 provides *Facts at A Glance*. This report provides the latest teen birth data for every state and the 150 largest US 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

Children's Defense Fund

Children's Defense Fund offers state and national-level data related to children. The data allows readers to view information from their own state, 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 also publishes a number of materials with useful information on adolescent health issues. Their Web site can be accessed at:

www.childrensdefense.org/statesdata.htm

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 resource can be ordered online at:

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

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 is also available through specially funded projects that provide detailed data on children and their well being at the state level. Through the KIDS COUNT online interactive database users can view graphs, maps, rankings, state profiles and download raw data. Information on KIDS COUNT is available at the KIDS COUNT Web site at:

www.kidscount.org

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).

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 program 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 participate 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. A listing of the state medical societies is available on the American Medical Association's Web site at:

www.ama-assn.org/ama/pub/category/7630.html.

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. For additional information on medical organizations with an interest in adolescent health issues visit the AMA's Adolescent Health Web site at:

www.ama-assn.org/go/adolescenthealth

and select the related links category.

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 member 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 4 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.

Chapter 4

Support for Programs

Introduction

Successful programs depend upon different kinds of support. This chapter addresses sources of funding for initiating, publicizing, maintaining, and evaluating programs that address the 21 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 provides consulting and training services (Ross, 2001). For more information contact The Forum of Regional Associations of Grantmakers, 1111 19th Street, NW, Suite 650, Washington, DC 20036, 202 467-1120 or visit their Web site at:

www.rag.org

National

The Healthy People 2010 Web site provides information on Healthy People 2010 activities and funding updates that specifically target the national health objectives. The Healthy People 2010 Web site is www.healthypeople.gov

Federal funding resources

Federal Commons

The Federal Commons is an Internet grants management portal serving the grantee organization community. The Federal Commons Web site address 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.gpoaccess.gov/fr/index.html.

For information on subscriptions to the Federal Register call the United States Government Printing Office order desk at 866 512-1800.

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)

United States Health Resources and Services Administration (HRSA) has developed a funding opportunities Web site at:

www.hrsa.gov/grants/default.htm

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.html>

Office of Minority Health Resource Center (OMHRC)

The OMHRC has developed a funding guide to assist people who are seeking funding for health-related projects and activities. The funding guide is available by calling 800 444-6422. The OMHRC Web site is at:

www.omhrc.gov

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 organization 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 Web site links to individual grantmaker Web sites. Users can search the site by grantmaker type. The Web site address is:

<http://fdncenter.org/funders>

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 202 467-1120.

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. 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.

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Chapter 5

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

- 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.
- 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.
- 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.

Chapter 6

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.

Resources

American Academy of Pediatrics

www.aap.org

Bright Futures—prevention and health promotion for infants, children, adolescents and their families:

www.brightfutures.aap.org

Adolescent Health Activities:

Materials, activities, and advocacy

www.aap.org/sections/adol/

www.aap.org/advocacy/ahproject/ahproject.htm

American Medical Association

www.ama-assn.org

AMA Adolescent Health Web site:

www.ama-assn.org/go/adolescenthealth

AMA Public Health Web site:

www.ama-assn.org/go/publichealth

State Medical Society listing with links to each society:

www.ama-assn.org/ama/pub/category/7630.html

AMA PolicyFinder Web site:

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

Centers for Disease Control and Prevention Division of Adolescent and School Health

www.cdc.gov/nccdphp/dash/index.htm

Children's Defense Fund

www.childrensdefense.org

Child Trends

www.childtrends.org/

Federal Commons

Internet gateway to government programs and funding opportunities

www.cfda.gov/federalcommons/index.html

Federal Interagency Forum on Child and Family Statistics

www.childstats.gov

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.

<http://fdncenter.org/funders>

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.

www.tgci.com

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.

www.hhs.gov/grantsnet/roadmap/index.html

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.

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

Healthy People 2010

www.healthypeople.gov

Healthy People 2010 Toolkit: A Field Guide to Health Planning

www.health.gov/healthypeople/state/toolkit

Henry J Kaiser Family Foundation

www.kff.org

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.

www.aecf.org/kidscount/

**Konopka Institute for Best Practices in Adolescent Health
State Adolescent Health Resource Center**

www.allaboutkids.umn.edu/konopka/

Maternal and Child Health Library

www.mchlibrary.info/KnowledgePaths/

Monitoring the Future Study

<http://monitoringthefuture.org/>

National Campaign to Prevent Teen Pregnancy

www.teenpregnancy.org

National Adolescent Health Information Center

<http://youth.ucsf.edu/nahic/>

National Household Survey on Drug Use and Health

www.samhsa.gov/oas/oasftp.htm

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

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

The National Longitudinal Study of Adolescent Health (ADD HEALTH)

www.cpc.unc.edu/projects/addhealth/

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

National Survey of Family Growth (NSFG)

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.

www.hrsa.gov/grants.htm

Society for Adolescent Medicine (SAM)

www.adolescenthealth.org

Youth Risk Behavior Surveillance System (YRBS):

www.cdc.gov/mmwr/preview/mmwrhtml/ss5104a1.htm

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**The most current information about state coordinators can be found at:
www.healthypeople.gov/HPScripts/StateContact.asp

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