



K-STATE
Research and Extension

2015 Kansas State University Adolescent Health Report



“Problem-free isn’t fully prepared. And fully prepared isn’t fully engaged.”

— Karen Pittman

This adolescent health needs assessment and report was prepared by the Kansas Adolescent Health Project for inclusion in the Kansas Title V MCH Plan (2016-2020).

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EXECUTIVE SUMMARY



Guiding Principles of Positive Youth Development

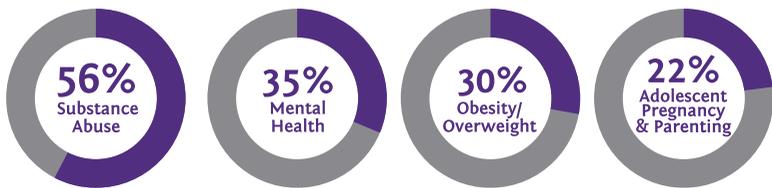
Adolescence is an important developmental stage filled with health opportunities, as well as health risks. During this stage, health behaviors are established that pave the way for adult health, productivity and longevity. Adolescents who thrive have access to caring adults that foster healthy development, and are offered meaningful opportunities to belong and build their competencies and abilities (Lerner, 2008). Instead of being problems to be managed, adolescents are assets to their communities. Consequently, Kansas chose a positive youth development approach for its five-year needs assessment for the 2016–2020 Title V Maternal and Child Health Services Block Grant for the Bureau of Family Health, Kansas Department of Health and Environment. The assessment was conducted by Kansas State University’s Kansas Adolescent Health Project, consisted of: a) a review of existing health data, b) an online community input survey, c) community focus groups, and d) interviews with key individuals and leaders.



Identifying Needs and Issues among Kansas Adolescents

More than 850 respondents* of an online survey, which was open from August to September, 2014, resulted in the following findings:

Top health issues affecting adolescents in their area were:



Top barriers that youth faced to accessing health services were:



(* = 854 respondents were 86.4% female; average age of 49; 60% rural and small town; 22.7% upper middle income; 85 counties represented. A Spanish version of survey was offered, but no Spanish version surveys were received.)

More than 400 Kansans** shared their perspectives through 26 focus groups conducted in Chanute, Dodge City, Great Bend, Hoisington, and Kansas City. Many commonalities exist between youth and adult focus group participants:

(** = 324 of the 401 participants were high school students; 60% female, 63% white, 17% Latino/Hispanic, 7% African American; 2% multi-racial, <1% Asian, American Indian, etc. Focus groups were conducted with high school FCS/advising/study hall classes, local coalitions, Kansas Partnerships for Health conferees, health departments, Young Women on the Move afterschool members, 4-H councils, ESL mothers group, Wyandotte High Health Science III class members.)

The focus group data resulted in the following findings relating to issues, barriers and challenges expressed by youth and by adults (in order of prominence of youth focus group data):

Top health issues included:

- School lunch (portions too small or distasteful food)
- Substance abuse
- Sexuality and reproductive health
- Mental health (including depression and self-injury)
- Obesity
- Overall stress
- Bullying
- Boredom leading to the use of technology
- Wanting real services and information
- Wanting to confide in adults and mentors.

Top barriers and challenges included:

- Lack of information
- Access to services
- Costs too high
- Lack of parental support/skills and awareness
- Embarrassment/shame
- Lack of mentors.



Recommendations and Strategies to Address Adolescent Health

The overall goal is to enhance the health of adolescents and young adults (ages 12 to 22) across the lifespan.

RECOMMENDATION 1: Address the highest priority adolescent health issues. Thus, some of these recommendations are redundant by intent. Each of these health issues is related and should be addressed as such. Men-

tal health was shown to be linked to each of the health issues affecting adolescents, and as a result was ranked as the number one priority to address.

Mental Health

Recommended Strategies/Planned Activities:

- Provide school-based access to confidential mental health screening, referral, and treatment that reduces the stigma and embarrassment often associated with mental illness, emotional disturbances, and seeking treatment.
- Establish networks of skilled, supported adult mentors that are available to adolescents in safe, accessible environments.
- Provide opportunities for adolescents to learn and practice social emotional coping skills in safe, accessible environments.

Substance Abuse

Recommended Strategies/Planned Activities:

- Increase access to substance abuse screening, treatment, and prevention services through co-locating screening, treatment, and prevention services in schools and/or facilities easily accessible to adolescents in out-of-school time.
- Establish networks of skilled, supported adult mentors that are available to adolescents in safe, accessible environments.
- Provide opportunities for adolescents to learn and practice social emotional coping skills in safe, accessible environments.
- Provide opportunities for adolescents to occupy their out-of-school time in pro-social activities, establish pro-social relationships, and gain meaningful skills and competencies.

Sexual and Reproductive Health

Recommended Strategies/Planned Activities:

- Make accurate information on responsible sexual behavior, including the benefits of abstinence, more easily available to youth and their families.
- Support youth development behavioral interventions (for example, social, emotional, or cognitive competence training that promotes pro-social norms, improved decision making, improved communication skills, positive bonding experiences between youth, their peers, or non-parental role models) coordinated with community services to reduce sexual risk behaviors.
- Provide confidential, youth-friendly reproductive health services.

- Encourage communication between adolescents and their parents about reproductive health issues.
- Encourage all providers who serve adolescents to screen sexually active females for chlamydia.

Nutrition and Physical Activity

Recommended Strategies/Planned Activities:

- Increase the availability of healthy food and beverages in sufficient supply in schools.
- Increase opportunities for students to participate in regular physical activity both in and out-of-school (e.g., non-competitive sports leagues, intramural sports).
- Improve adolescents' awareness of good nutrition and physical fitness through relevant and technologically current education during the school day and out-of-school.
- Implement an awareness/information campaign to reduce sedentary recreational screen time among adolescents.

Injury Prevention

Recommended Strategies/Planned Activities:

- Encourage the implementation of policies, procedures, and the evaluation of programs in health-care settings to assess for and intervene with adolescents at risk for suicide.
- Support public awareness campaigns to prevent adolescent self-injury.
- Develop policies and establish prevention activities that work to reduce motor vehicle crash injuries and deaths to adolescents due to distracted driving and/or use of substances.
- Continue to enforce existing laws regarding adolescent drivers, such as mandatory seat belt use and zero tolerance for alcohol use.
- Establish networks of skilled, supported adult mentors that are available to adolescents in safe, accessible environments.
- Provide opportunities for adolescents to learn and practice social emotional coping skills in safe, accessible environments.

RECOMMENDATION 2: *Help families support the health and well-being of their adolescents.*

Recommended Strategies/Planned Activities:

- Increase the availability of information to parents and family members about normative adolescent development, and risk and protective factors for youth.

- Provide support to parents who experience problems, such as relationship, violence, substance abuse and mental health issues, to enable enhanced relationships with their adolescents.
- Provide support to parents who experience problems — such as relationship, violence, substance abuse, and mental health issues — to enable enhanced relationships with their adolescents.
- Using the “Parents as Teachers[®]” model, provide parenting resources and mentors for parents of adolescents.
- Encourage communication between adolescents and their parents about any health issue.
- Provide opportunities for parents to improve their skills in seeking out quality health-related information and services.

RECOMMENDATION 3: *Provide educational environments that prepare youth for healthy adulthood.*

Recommended Strategies/Planned Activities:

- Emphasize social emotional as well as academic competence in the school setting.
- Increase the availability of skill-based health information for youth.
- Support schools to establish and sustain health access points and health services on-site during the school day.
- Increase connections among schools, families, communities, and health providers through programs such as Communities in Schools (CIS)[®], and KU Medical Center’s “Bull Dog/Bull Doc Clinic” at Wyandotte High School.
- Provide school-based access to confidential mental health screening, referral and treatment that reduces the stigma and embarrassment often associated with mental illness, emotional disturbances, and seeking treatment.
- Establish networks of skilled, supported adult mentors that are available to adolescents in safe, accessible environments.
- Provide opportunities for adolescents to learn and practice social emotional coping skills in safe, accessible environments.

RECOMMENDATION 4: *Encourage collaborations and increase community support for those working for and with youth.*

Recommended Strategies/Planned Activities:

- Co-locate services for youth to ease access and decrease embarrassment.
- Support effective afterschool and out-of-school programs.

- Provide assistance to help community programs integrate positive youth development approaches and principles into their service framework.
- Increase youth-related continuing education opportunities for professionals and para-professionals.
- Catalogue agencies, organizations, and programs serving youth, and identify their missions and goals.
- Encourage interdisciplinary teams to provide comprehensive and coordinated services for youth.
- Institute regular interdisciplinary conferences and workshops to encourage development of shared knowledge, language, and goals among networks and communities.
- Include youth in decisions about service integration.
- Expand on the successful “Parents as Teachers” model that provide parenting resources to help parents of adolescents understand the critical importance of their child’s adolescent years.

RECOMMENDATION 5: *Improve the responsiveness, availability, and access of health care to youth*

Recommended Strategies/Planned Activities:

- Use education and outreach to inform youth and parents about health-care options and providers who specialize in serving adolescents.
- Increase training about adolescent health care for providers to ensure youth-friendly, culturally competent health services.
- Create avenues for youth to be involved in discovering and utilizing health-care systems that meet their needs.
- Work with health insurers to widen the concept of well-child visits through adolescence (up to age 24).
- Improve access to comprehensive care including dental, eye/vision, and mental health services.

(Details are included in the full Kansas State Adolescent Health Report, which is available at <http://www.he.k-state.edu/fshs/extension/>)

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Purpose and Planning Process Assessment of Adolescent Health to Aid in Informing Adolescent 5-Year Needs Assessment

In 1995, a coalition of state-level agencies, organizations and networks from across Kansas published the Kansas Adolescent Health Profile which was, at that time, a comprehensive report of the health of Kansas youth ages 10 to 19. This coalition, known as the Kansas Adolescent Health Alliance (KAHA), was comprised of public health, social service, mental health, education, drug/alcohol prevention and treatment professionals and medical staff who volunteered to prepare the report to substantiate the need for a focus on the health and wellbeing of adolescents in the state.

Though the profile was well-received and created some momentum to establish an adolescent health plan for Kansas, the momentum was lost. Other priorities moved to the forefront of public health officials, advocates changed focus, and funding shifts pushed the development of an adolescent health plan further down on the list of perceivably less urgent initiatives.

State Adolescent Health Plan

In 2008 the development of the national Healthy People 2020 health plan brought new interest to topic of adolescent health, and distinct adolescent health focus areas that were included in the 10-year health plan for the nation. The inclusion of adolescent health objectives in the nation's plan was viewed as an acknowledgement that health issues affecting teens were unique from those influencing children. As a result, interest increased about adolescence, positive youth development as well as family and community programs providing opportunities for young people to thrive and develop into contributing adults. At the time that this report was being developed, the national performance measures for the Title V Maternal and Child Health Block Grant were introduced for the population domains of adolescents and young adults. Title V funding now requires states to include adolescent health recommendations and strategies in their health plans.

The assessment process was initiated in 2014 to identify key issues related to the health of adolescents. Information obtained in the assessment process will contribute to the development of KDHE's 2016 to 2020 five-year needs assessment for the Title V Maternal and Child Health Services Block Grant, for the Bureau of Family Health, Kansas Department of Health and Environment, and to a Kansas Adolescent Health Strategic Plan.

The assessment process consisted of: a) review of existing health data, b) online community input survey, c) community focus groups, and d) input from key individuals and leaders. The review of Kansas population data is organized using the Healthy People 2020 adolescent health focus areas, and allows the reader to compare Kansas data to the nation when appropriate. Though the data is useful, it is the information that was collected through the online survey (854 responses) and community focus groups (324 youth of 401 participants) that provide the most important insights. Using an information collection model based on crowd sourcing/collective intelligence, a large amount of data was collected through the survey and focus groups by "crowds" of people who were interested in and aware of adolescent health instead of by participants who were selected by statistical sampling techniques.

In addition, the reader of this report will notice that the results of the online survey and focus groups are not separated by the health areas. This is by intent since many of the health issues that adolescents confront involve several domains of health (physical, social, mental/behavioral) and are influenced by the contexts and social spheres that adolescents live, learn, work, or play in. An example comes from one teen female focus group member in Great Bend who:

... thought her obesity was related to her craving junk food when she got home from school because she didn't get enough food during school lunch. She said that she seemed to just feel calmer when she ate pop and chips after dealing with school. The responsibility of having to take care of her young siblings each day after school was bad enough, but the added stress of having to often help her mother clean hotel rooms at night in order to pay for family expenses when she knew she should be getting her school work done was just too much.

This example illustrates the complexity of the health issues affecting Kansas adolescents, and of the need for state, regional, and local organizations to work together to address the whole-health of adolescents.

GUIDING PRINCIPLES



Adolescence

Adolescence is a critical period for establishing habits with lifelong implications and is an important time for caring adults and communities to intervene as well as help youth establish positive health behaviors (Call, Ridel, Hein, McLoyd, Petersen & Kipke, 2002). Because the biological, cognitive, and social development that happens during adolescence is the foundation for becoming a contributing adult member of society, it is vital that young people thrive in this life period. Though adolescence technically begins at puberty around age 10 or 11, it is unclear when — or if — it ends at a particular age. There is general consensus that adolescence can be divided into three stages associated with human growth and change: a) early adolescence (beginning at age 10 or 11), b) middle adolescence (beginning at 14 or 15 years), and c) late adolescence and young adulthood (ages 18 to 19+) (Steinberg, 2001). However, research has revealed that the brain develops into young adulthood (approximately age 25), so higher order brain functions, such as decision-making, continue to develop well after the teen years. The Centers for Disease Control and Prevention classify 20- to 24-year-olds as adolescents as their health and service needs are similar, and sometimes even greater, than younger youth. The Department of Health and Human Services' Maternal and Child Health Bureau, which is the federal agency that manages Title V, uses the age range of 12 to 22 for adolescence and young adulthood.



The Positive Youth Development Approach

The adolescent health needs assessment undertaken that informs this report was grounded in positive youth development principles. As a whole, those principles acknowledge the vulnerabilities of adolescence, while building the positive potential of young people.

Adolescence is an important developmental stage filled with health opportunities as well as health risks. It is during this stage that health behaviors are established that affect adult health, productivity, and longevity. Many youth must cope with chronic health issues stemming from genetic and/or physiological origins. Many also live in communities, neighborhoods, and families that pose health risks. However, with positive supports, opportunities, and services, all adolescents can develop into contributing adults. Studies conducted by the Institute for Applied Research in Youth Development at Tufts University reveal that adolescents who thrive: a) have access to caring adults that foster healthy development, b) are offered meaningful opportunities to belong, and c) build their competencies

and abilities (Lerner, 2008). Instead of being problems to be managed, adolescents are assets to their communities. This positive view of adolescence is supported by more than 20 years of research, which has been adopted by several federal agencies (Youth.gov).

Specifically, 18 federal agencies, including the Department of Health and Human Services, have agreed to support the following positive youth development principles:

- Positive youth development enables youth to thrive and flourish in their teen years, and prepares them for a healthy, happy and safe adulthood.
- Positive youth development is intentional. It is important to proactively promote protective factors in young people.
- Positive youth development does not compete with efforts to address risky behaviors and attitudes in youth; rather, it complements these efforts.
- Youth assets are both acknowledged and employed through positive youth development.
- Positive youth development involves youth as active agents. Adults may set the structure, but youth are not just the recipients of services.
- Youth leadership development is a part of positive youth development.
- Positive youth development involves community involvement and engagement.
- Positive youth development involves and engages every element of the community —schools, homes, community members, and others. Young people are valued through this process. Positive youth development is an investment that the community makes in young people. Youth and adults work together to frame the solutions. (Youth.gov)

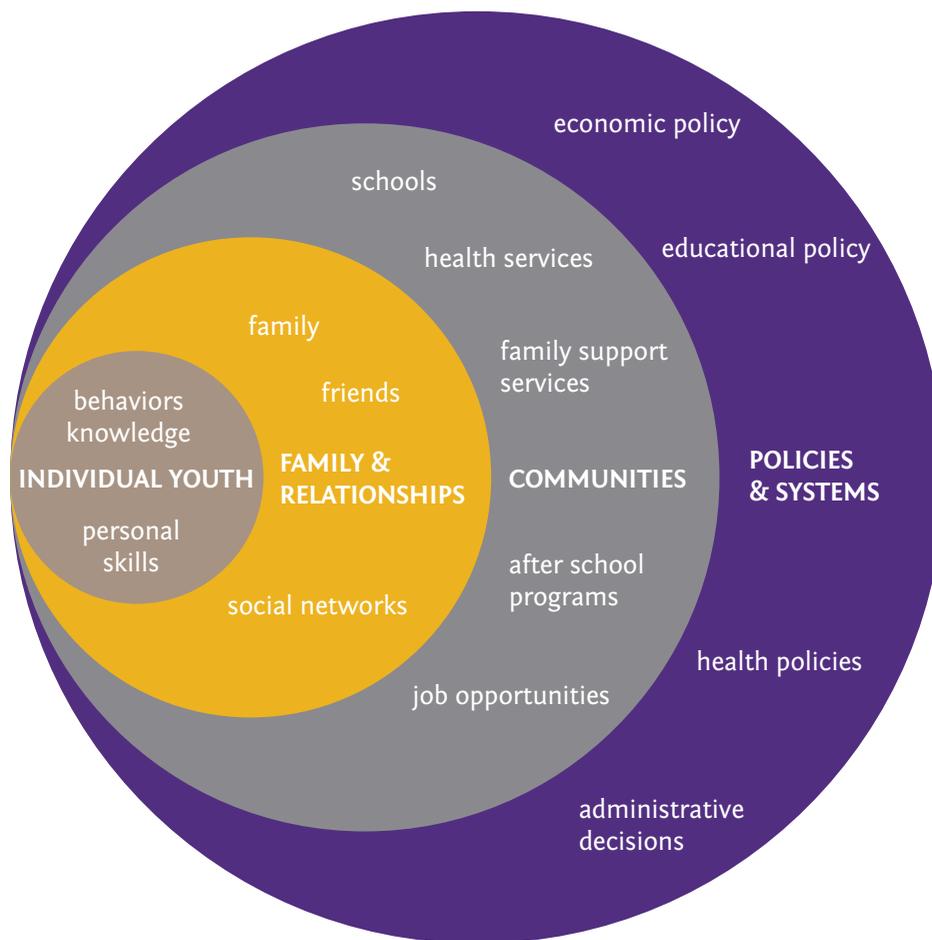




Contexts and Environments

The principles of positive youth development have the most benefit to young people if they are applied to every aspect of a teen's life. As young people grow, they are gradually influenced by their friends, peers, and other adults. Though parents are still important to adolescents, and they continue to provide important models of what it means to be an adult, adolescents grow beyond the sphere of their parents' and family's influence. The socio-ecological model (*Bronfenbrenner, 1979*) describes how a young person's life is nested within social spheres that have some influence over their health and well-being. Opportunities and services that support positive development among adolescents can be intentionally introduced, enhanced, and sustained in any of these social spheres of influence:

- Policies and Systems — Systems-level or macro approaches that are critical to assuring that youth have ongoing access to the resources needed. Health policies, administrative decisions, and educational and economic policies at federal, state, and local levels are components of this sphere.
- Communities — Local resources and supports that are immediately available, such as health services, family support services, schools, after-school programs, and job opportunities, as well as the overall support system that is in place for youth, their friends, and families.
- Family and Relationships — Those who influence the lives of youth directly, and the resources and education that enable those networks and individuals to be supportive allies and advocates for youth.
- Individual Youth — The personal skills, knowledge, and behaviors of each individual young person. It includes personal goal-setting and making responsible and informed decisions from adolescence into adulthood.



Source: Colorado Department of Public Health and Environment. (2012)

Youth Sexual Health in Colorado: A Call to Action. (pg. 24). Denver, CO

<http://co9to25.org/wp-content/uploads/2012/09/Youth-Sexual-Health-in-Colorado-A-Call-to-Action1.pdf>



The Analogy of the Tree

Much like a grove of healthy trees, youth are likely to thrive when the environments and places around them provide essential elements that support their positive growth and development. A primary responsibility of adults who work with youth is to intentionally help enrich the places that influence youth with elements conducive to positive development.

However, while helping to support positive development, caring adults must keep in mind that though some of the places (i.e., families, schools, communities) where youth live and grow may look scary and uninviting to someone who is outside or unfamiliar with the place, youth may thrive because they have acclimated to the elements. Those environments may appear to be harsh and unhealthy, but young people have become resilient and are thriving in them in spite of what an outsider thinks may be an impossible situation.

To be effective, caring adults who want to support positive youth development must know how to “tend the soil” around young people so they grow uniquely healthy and strong.

Adults — whether policy officials, public health experts, teachers, neighbors, coaches, or parents — can help young people grow and thrive into adulthood by intentionally enriching the lives of young people by:

1. Establishing positive and supportive relationships.
2. Ensuring opportunities to belong.
3. Providing appropriate opportunities to build skill.

(The “Big 3” factors of positive youth development, Lerner, R., 2008)



Kansas Adolescent Health Plan and Adolescent Health Needs Assessment for the Kansas Title V MCH plan (2016-2020)

Note: The project that produced this report and plan was screened and approved by the Kansas State University's Institutional Review Board (IRB). The IRB approval is included in the appendices.

Review of Kansas Adolescent Health Data

For the purposes of establishing a basis for planning and informing an online open access survey to be disseminated across the state of Kansas, health outcome data associated with adolescence were identified and reviewed. The data sources used for the review include the Youth Risk Behavior Surveillance Survey (YRBSS), the National Survey of Children's Health (NSCH), and the National Survey of Drug Use and Health (NSDUH). Data from Kansas' Communities That Care (CTC) survey, which measures adolescent behavior, attitudes, and perceptions of risk and community norms, was also used. The CTC survey has been administered in Kansas schools for more than 20 years.

Health Focus Areas from Healthy People 2020

Since 1990, the Federal Centers for Disease Control and Prevention (CDC) has worked with leading health experts to establish strategic health goals for the nation. Those goals and the recommended strategies to reach them have comprised Healthy People health plans every 10 years. As the planning for Healthy People 2020 got underway, a national workgroup determined that adolescents were a unique population with unique health risks and protective factors meriting a distinct focus in the plan (see: www.healthypeople.gov/2020/default.aspx).

Consequently, the Healthy People 2020 plan includes 21 Adolescent Critical Health Objectives (CHOs) across seven focus areas. For each of these focus areas there are indicators, which are proxies for (1) Health Outcomes and (2) Health System Indicators (the influence of policies and practices). The Healthy People 2020 seven focus areas are:

- Healthy Development
- Injury and Violence Prevention
- Mental Health
- Substance Abuse
- Sexual Health
- Prevention of Chronic Diseases of Adulthood
- Health Care

The Social Determinants of Health

To have a thorough understanding of adolescents, it is important to understand how social factors can influence their health. These social factors are called the "social determinants of health" and include the resources that are essential to the health and well-being of individuals, families, and communities. They are the circumstances in which adolescents are born, grow up, attend school, work, and live. Using social determinants of health improves the understanding of health issues as well as the identification of solutions to those issues.

According to the World Health Organization, there are 10 social determinants of health that influence the health of people:

- Economic factors
- Social inclusion
- Education
- Racial or ethnic bias
- Community acceptance of particular behaviors or practices
- Cultural factors
- Influence of mass media
- Politics
- Living conditions
- Geography

World Health Organization (2003) Solid Facts pg. 40-41 (www.euro.who.int/__data/assets/pdf_file/0005/98438/e81384.pdf)

Several data points aligned well with the FFY2016 Title V MCH Block Grant National Performance Measures and are included in this report, although not all data points included mirror national performance measures exactly. Kansas will be tasked to select eight of 15 total national measures for the 2016 to 2020 Title V plan. The selection of those performance measures is to be based on the findings of the state's needs assessment and strategies to be implemented.



Assessment Methods

The review of existing, population data revealed areas of positive improvements for several health issues. For example, some improvements were associated with the decreasing rates of teen pregnancy, tobacco use, unintentional injury, and reported increased levels of physical activity. However, the review of data revealed negative and persistent trends related to increases in behavioral/mental health needs, increases in intentional injury (e.g., suicide, bullying), and obesity. As stated previously, increases in poor health outcomes for adolescents are usually associated with the social determinants of health and the lack of opportunities and services available to adolescents. The review of Kansas data revealed this to be the case for many of the pressing health issues confronting Kansas adolescents.

For the most part, Kansas does not have a system of consistent, uniform data collection and information gathering across the 105 counties to address adolescent health indicators. Furthermore, data pertaining to adolescent health is often collected for different age ranges. For example, one data source may use grade level rather than age, others may lump ages 10 to 19 together, when other sources may segment early adolescence (11 to 14), middle adolescence (14 to 16), with late adolescence (17 to 19). Some data sources may include young adults (20 to 24) in the pool. Adding to the complexity is the fact that many data sources that track the health of youth with special health-care needs (SHCN) do not uniformly define what constitutes “special health-care needs.”

Due to inconsistencies in Kansas’ system of data collection across counties, consistent and reliable county-level data is limited. It is generally known that state level data has limited utility for local planning to address local needs using strategies that can be implemented by local networks and coalitions. Consequently, in addition to the recommendations at the end of this report, it is recommended that:

1. Data consistently use the 12 to 22 age span when defining adolescence.
2. Data be collected at the county level by simply adding a question to surveys asking which county the survey was taken.
3. The capacity for local data gathering for behavioral/mental health that is not only tied to special health-care needs, state-provided health care be increased.
4. An emphasis in data collection in rural and frontier areas, which are unique health contexts and development spheres.
5. Community-level stakeholders and leaders have improved access to data.

Following the review of population data, an open-access electronic survey was made available for anyone in Kansas over the age of 13 to complete via electronic device. After the survey was closed, stakeholder input and comment about the findings derived from the review of data was collected. The review of data and anonymous stakeholder input led to the selection of four areas of the state to hold public input forums. These stakeholder meetings allowed for discussion of data findings and served to generate potential steps to address adolescent health needs and issues through the 2015 to 2020 Kansas Title V plan.

A) Kansas Adolescent Health Community Input Survey

Development, Piloting and Dissemination

A 32-item, open-access electronic survey was developed by integrating the information gathered from our review of the Healthy People 2020, general Kansas health outcome survey data, as well as information not represented, outdated, or missing from the review previously discussed. Questions developed around themes found in the review of data included prompts associated with barriers to receiving care, current health risk topics, and health concerns that have increased in Kansas. Remaining questions not represented in the review of data were created from multiple sources. Several questions regarding demographic data were selected directly from SurveyMonkey.com, the website used to develop, monitor, and collect participant responses. Additionally, questions were asked associated with health-service availability, accessibility, affordability, appropriateness, and acceptability. A copy of survey questions can be found in the appendices.

Survey topics associated with adolescent health were based on similar questions developed for an Adolescent Health Needs Assessment conducted in Columbia, Missouri (Boone County), which can be found at the following link:

<https://www.gocolumbiamo.com/Health/Documents/AdolescentHealthNeedsAssessmentupdated1-1-11.pdf>

Survey items were piloted with a group of university freshmen (ages 18 to 20) as well as several university employees. Individuals who piloted the survey submitted thoughts, comments, and suggestions for survey items. Several edits and revisions were made in response to feedback provided by pilot surveyors. The final survey design provided a multitude of methods to offer thoughts and feedback, including multiple choice, fill-in-the-blank, and open-ended questions asking for reasoning and added thoughts behind answers given. The survey, which was accessible via URL website and QR (quick response) codes, was available in both English and Spanish.

The final survey was disseminated to more than 50 organizational lists, points of contacts, and electronic newsletters via email, flyers with URLs and QR codes, and sample hard copies delivered at conferences, meetings, and public gatherings (e.g., Kansas Youth Suicide Prevention conference, Kansas State Fair, Kansas Public Health Association conference/meeting) for three weeks. This list can be found in the appendices. Additionally, survey participants were asked to continue to encourage others to complete the survey from their respective locations. A link to the survey was also placed on two social media websites, Facebook and Twitter. Kansas State University, the Kansas Heart Association, and the Kansas Enrichment Network are three organizations that included articles and survey access information in their respective online electronic newsletters.

Description of Respondents

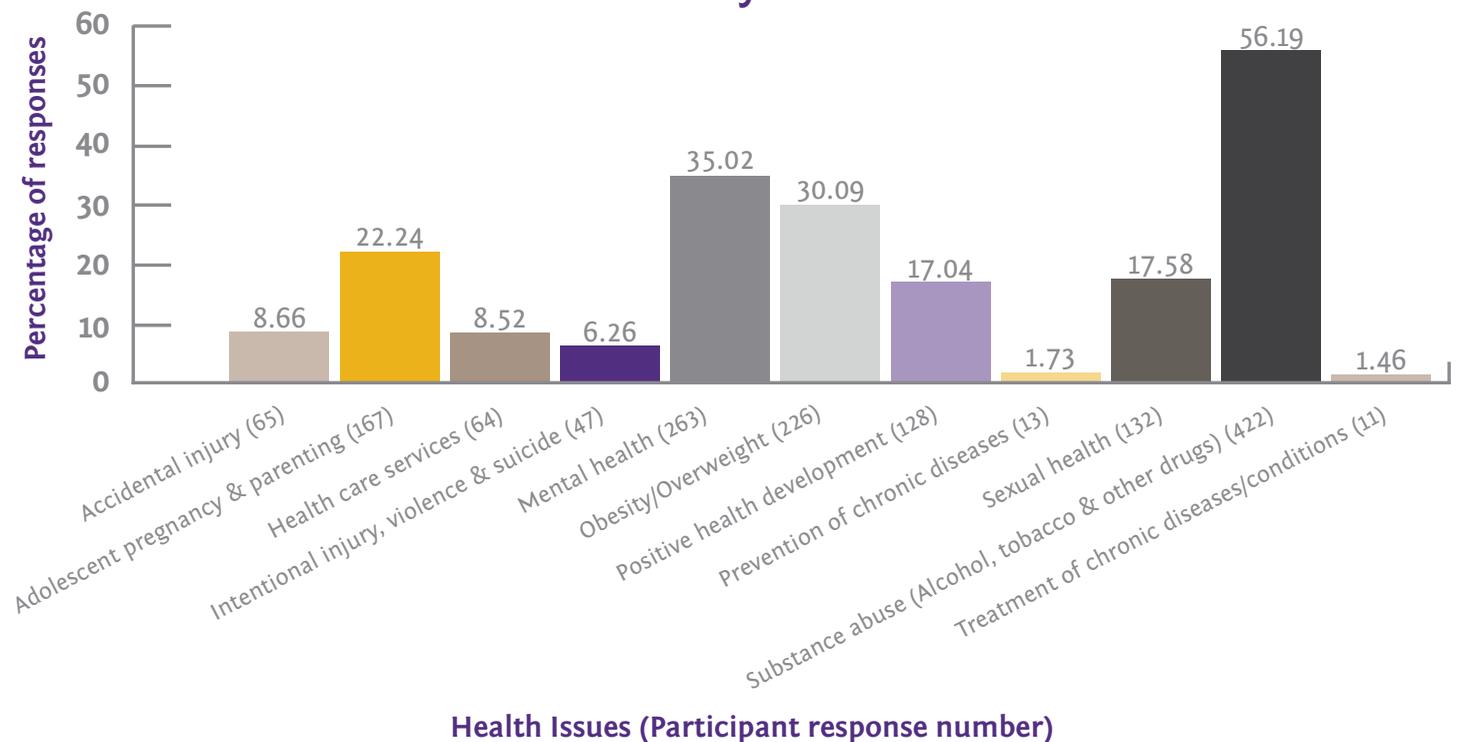
There were 854 respondents to the survey; 748 of the 854 completed every question in the survey. As a formality,

surveys that had questions skipped or left empty were marked as incomplete but were still included in the total survey count. Eighty-three of the 105 Kansas counties were represented in the response data. Of the respondents, a large percentage (86.49%) were female. Respondents ranged from age 11 to 82 with an average age of 49. The majority of the respondents identified themselves as White (90%), while 2.36% identified themselves as African-American, 3.07% Hispanic, 1.42% Asian/Pacific Islander, 1.53% Other. The majority of respondents were also married (70.21%), had completed a college degree (84.43%), were in the upper-middle class of household income (66.28%), and lived in suburban, small town, or rural areas (14.61% lived in urban areas).

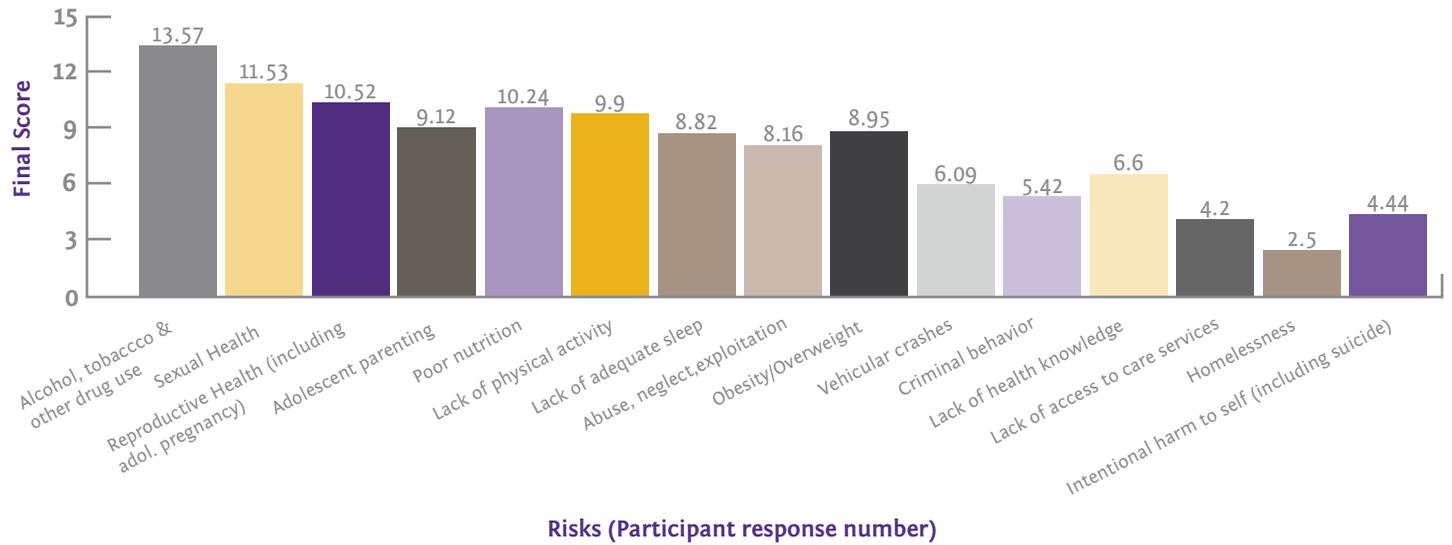
Information Gathered

The following graphs illustrate examples of primary results of the survey.

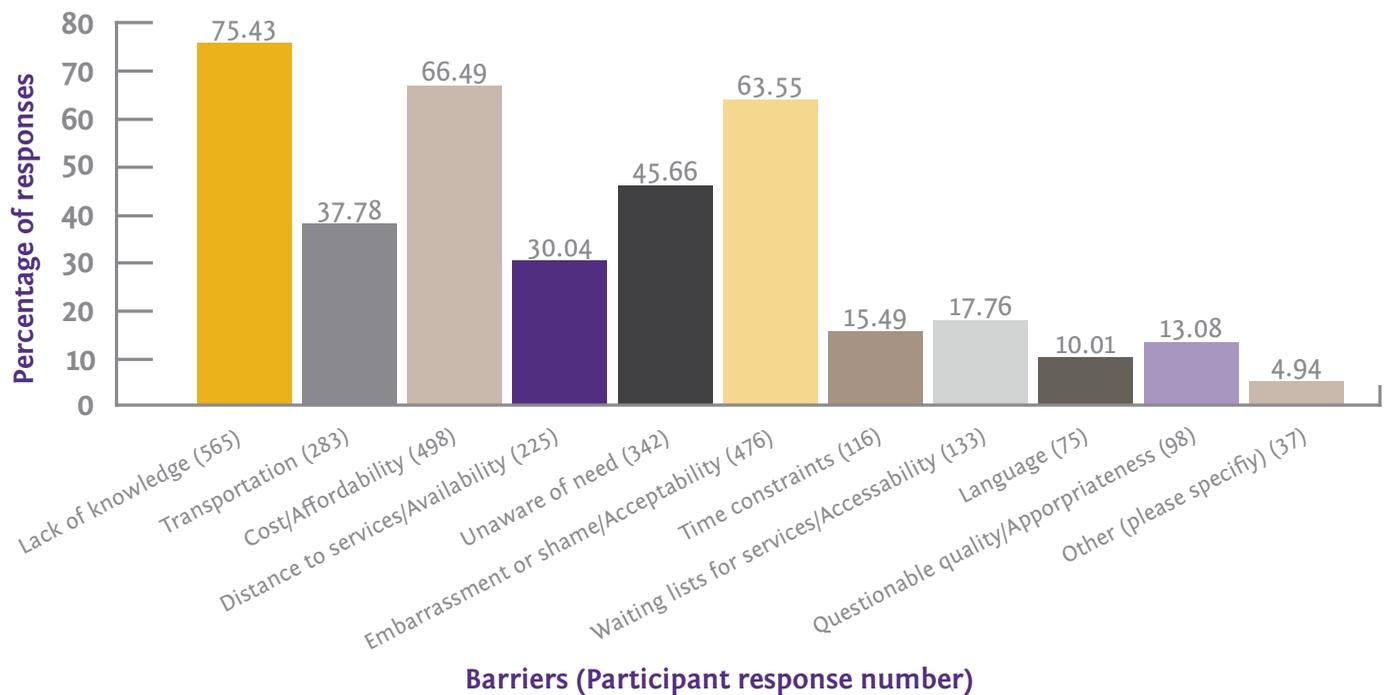
Graph 1 Of the options below, which two health issues do you think impact adolescents in your area the most?



Graph 2 Below are 15 health risk topics which might affect adolescents in your area. Rank what you believe are the top five risks to adolescents with one being the greatest health risk.



Graph 3 What do you think are some of the barriers that youth might face in accessing health services in your area? Choose all that apply.



Analysis and Recommendations

The survey results revealed several themes and topics around adolescent health needs. These themes were identified through the typed comments from survey respondents. The following three categories of Adolescent Health Issues and Needs, Barriers in Accessing Services, and Root Causes fit the scope of responses given and discussed by survey takers.

Adolescent Health Issues and Risks

The majority of responses to question 17 (see Graph 1), “Of the options below, which two health issues do you think impact adolescents in your area the most?”, identified the following eight issues, in order from the highest response rate to the least: substance abuse (56.19%), mental health (35.02%), obesity/overweight (30.09%), adolescent pregnancy and parenting (22.24%), sexual health (17.58%), positive health development (17.04%), adolescent injury (8.66%), health-care services (8.52%).

Survey respondents, who are primarily adults, indicated that the top health risks to adolescents were substances, early sexual activity, pregnancy and adolescent parents, poor nutrition, lack of physical activity, and the resulting obesity, and lack of adequate sleep. These were the top among 15 behavioral, environmental and social risks to good long-term health.

In follow-up commentary sections, many respondents emphasized concerns about their communities’ capacity to successfully diagnose and treat substance abuse problems for adolescents due to lack of available and accessible services, as well as prevention programs for adolescents around substance abuse. Concern associated with mental health care for adolescents was overwhelmingly represented in the survey data. Many respondents included mental health care as a major issue in their region for adolescents and parents, revolving around transitions to adulthood, stressors affecting families, stress management, substance abuse, and suicide.

Mental health concerns seemed to filter into the aforementioned issues around injury and violence, sexual and reproductive health, healthy development education, and a need for prevention. One participant suggested placing more counseling and therapy services in schools for the increasing demand to address mental health needs. Additionally, a large number of respondents mentioned a need for a shift in attitude, specifically regarding mental health. One participant said there is a need for a “positive mental and emotional health initiative.”

Education about healthy development, or the lack thereof, was an issue raised by many respondents. Those concerned with health education and health literacy opportunities for adolescents noted specific needs were for education around

issues of Injury and Violence Prevention, Substance Abuse Prevention, Obesity and Physical Activity, Sexual Health, Reproductive Health, and Teen Pregnancy.

There was concern about not only a lack of educational opportunities for adolescents, but also that existing education was not sufficient nor was it tailored to be attractive or acceptable to youth. Issues of injury and violence prevention were often portrayed through concerns about bullying going on in schools and communities.

Barriers in Accessing Services

Results of the survey highlighted a number of barriers to adolescents accessing services. Lack of knowledge and cost/affordability were the top barriers. Respondents indicated that embarrassment or shame associated with accessing health services was a prevalent barrier, as were unawareness of the need for health services and transportation to get to services.

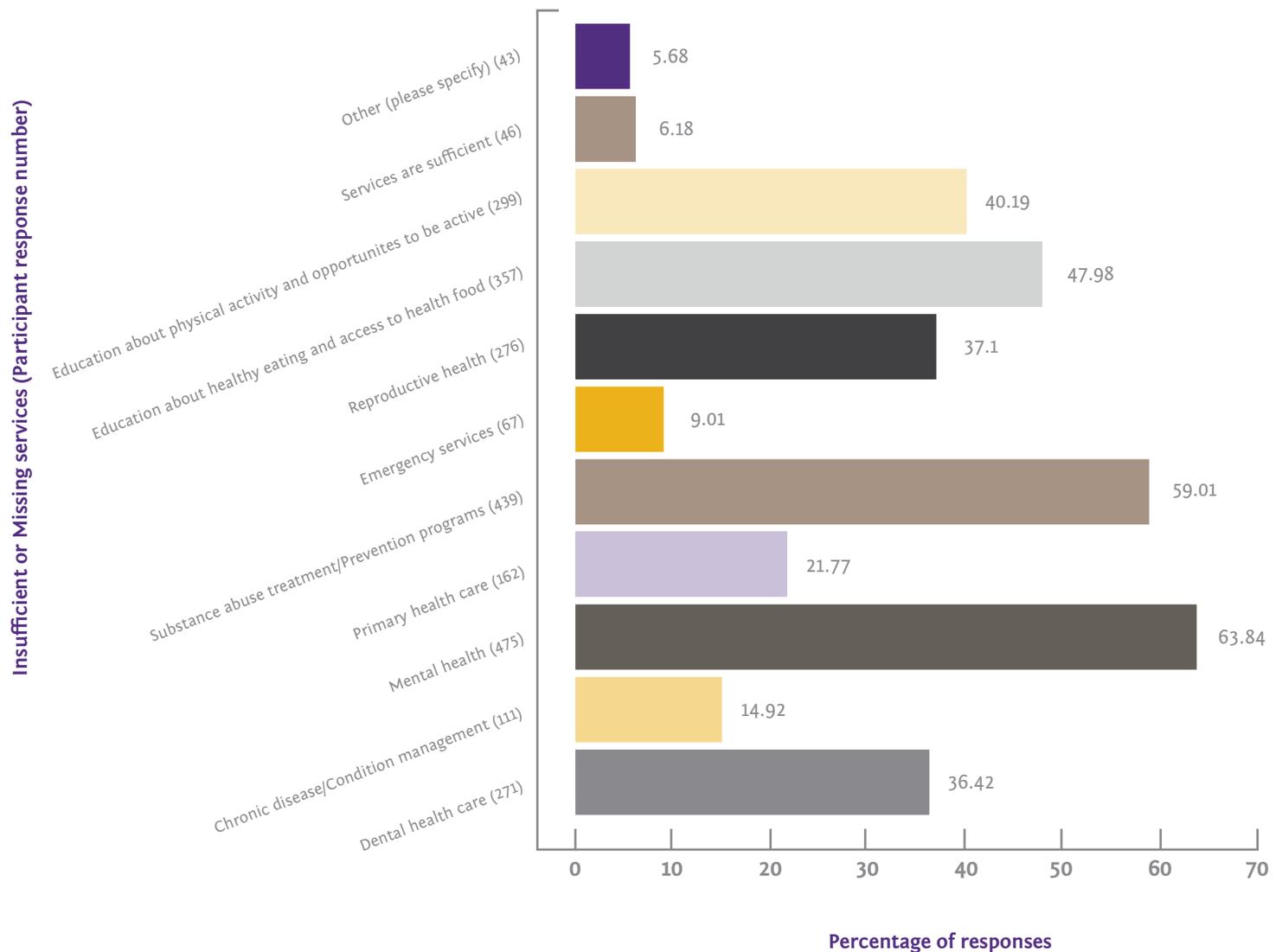
Another barrier mentioned by multiple survey takers was poor marketing or a lack of marketing for services that are offered in their communities. Many reported not knowing what services are available because of a lack of literature or advertising. One participant recommended providing “awareness campaigns about various topics that adolescents have access to and will actually learn from.” Following a similar theme to appropriateness of marketing and advertising, many participants said that multiple services in their communities have limited resources around different languages and cultures. This lack of diverse materials further limits accessibility for minority groups in communities across the state. A large number of participants included in their typed responses that their community lacked doctors and service providers who were trained to provide the variety of services that adolescents needed.

The answers to survey question 23, “Where do you think health services are insufficient or missing for adolescents in your area “Choose all that apply” are in Graph 4.

These responses reveal concern for affordability, availability, and appropriateness. Respondents reported that care providers may not be available because services are too expensive, doctors who can effectively aid adolescents in health issues are too far away or not available, and that many of the doctors, physicians, and care providers in their communities are better trained to serve infants and the elderly as opposed to treating the complex health issues challenging adolescents. Compounding access to services is the high turnover rate of local physicians in many rural areas as well as a lack of communication between providers. One participant said, “[The] health department is difficult to access. [We] need [an] urgent-care clinic and low-cost clinic for ongoing health care outside/in place of ER visits.”

Graph 4

Where do you think health services are insufficient or missing for adolescents in your areas? Choose all that apply.



Another participant recommended providing “a central registry for all services to be accessible in a way that is easy to identify,” such as a medical home. Another participant noted, “Encourage local funding for support/coordination of care/services. Encourage private providers to offer coordination of care.”

Root Causes

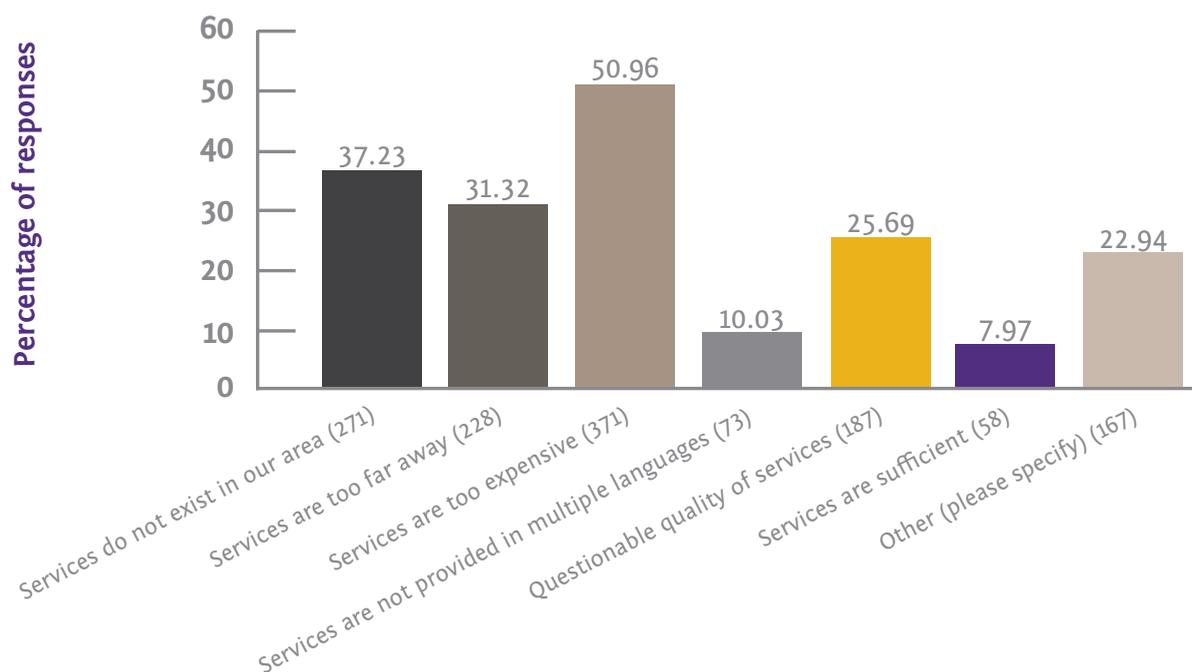
The issues and barriers mentioned previously all seemed to stem from several root causes that were consistent across survey responses. A root cause spanning several adolescent health topics was lack of awareness. Respondents reported believing that lack of awareness of the issues facing adolescents, of services provided, and about adolescence as a developmental stage was a key issue in their areas. Many respondents noted that they are not confident that people are aware of adolescence as a developmental stage. One participant said, “Adolescents should be the focus of

decreasing health risks . . . they are the future.” Thus, many people reported they do not think services are sought out because many are not aware of the need for services. This lack of awareness also ties into an overarching root cause reported that respondents do not believe adolescent health is a priority in their areas.

Reports of adolescent health not being a priority were often linked to beliefs that parents are often not attentive enough to the needs of adolescents and are too busy, stressed, and are ultimately dealing with their own health problems. One participant said, “There is a need to focus on positive parenting. With a tougher economy, both adults are working and spend less time at home. This day and age it truly takes a community to raise a child . . .” Another participant said, “All adults should be modeling the healthy behaviors we want adolescents to follow and do.” While respondents noted the negative attribute of a lack of

Graph 5

Based on your answers to the pervious questions, what are the reasons for services being insufficient?



Insufficient or Missing Services (Participant response number)

parental attention and involvement with adolescents, many also noted that parents are just doing the best with what they have, and, therefore, doing the best they can to survive.

Poverty aligns closely with the root causes mentioned previously. Many respondents noted that people are dealing with basic human needs and merely attempting to survive. Therefore, those struggling with poverty are not at a place in which they can begin to think about preventative care, making it a low priority for not only themselves, but for their adolescents as well. When the cost of services is considered too expensive, it is often related to the level of poverty in the area. Graph 5 reflects survey responses to question 24 asking, “Based on your answer to the previous question, what are the reasons for these services being insufficient?”

Respondent Recommendations

Respondents provided an array of recommendations and possible solutions for addressing the health issues facing adolescents in their areas. Many respondents commented on the ability to make a difference in their community focusing on their area schools. Recommendations included using the school buildings as locations to prioritize adolescent health and educate community members on the issues facing their communities. A large percentage of

respondents recognized that the school was often at the center of community activities and is where the adolescents in their communities are for a large percentage of time. One participant recommended providing “more educational opportunities in school and churches or other organizations where adolescents frequent.” Many also recommended promoting preventative care in schools and not only educating adolescents themselves, but also educating their parents.

Improving parental attitudes and practices was mentioned often in the survey results. One participant said, “The community can do a lot but the end result is holding parents responsible for what the child does or does not do . . . the parents need to be accountable — working or not.” Another participant suggested to, “Keep working on the adults so they are more aware of what is needed, what is available, and how to access services.” This shift in focus on educating parents about the health issues facing adolescents and the importance of preventative care was offered as a solution to overcoming the lack of knowledge across the state about adolescence as a developmental stage, health issues in their communities concerning adolescents, services to address the issues, and how to access those services.

A number of respondent comments provide a rich array of recommendations and potential solutions:

- Use social media for appropriate outreach to teens; communication with adolescents is key.
- Community collaboration is crucial.
- Outreach to teens should be face-to-face in places where they naturally gather.
- Activities and programs must be attractive and “cool” enough to “grab” teens.
- Services should be scaled for rural and frontier areas — full services may not be necessary nor may be possible, especially if there is nothing else available.
- School personnel, including staff, need to have education about youth and positive development.
- Use a whole-health approach, include dental, eye, nutritional, and behavioral health with physical preventative services.

In addition to respondents listing issues and concerns, a number of positive comments were contributed. Though they were not among the majority of comments provided (10 of more than 1,100 submitted), there was acknowledgment and appreciation for the work currently being done in schools to improve the health of adolescents. Many respondents commented that they are grateful that their community has the medical providers and health staff that it did. One said, “Our doctor is the best and provides the help we need.” Some remarked that their community has effective coalitions and collaborations and that parents are involved. There were also suggestions for programs and services included among the comments, such as the BullDoc/ Bulldog school-based health clinic at the Wyandotte High School, the Heartland Healthy Neighborhood Coalition, PACES mental health in Newton, and the former LINKS effort in Kansas City.

Overall Recommendations

Offered below are several interpretations and takeaways based on the information and insight gained from the content analysis of the community input survey.

Issues are Systemic. As reflected in the responses of survey takers, several issues facing Kansas adolescents affect and are affected by the vast array of systems in which the youth is involved. Issues of availability, accessibility, affordability, appropriateness, and acceptability are all interconnected in terms of adolescent health needs. For instance, a youth may not be able to receive care because of an inability to obtain transportation to get to those services (Accessibility). The lack of transportation to access health services may be a result of financial strains such as health of the parents, education costs, job opportunities in the area, or numerous others systems the adolescent and their family is facing (Affordability). The need for transportation assistance may also be fueled by the desire to

see a medical professional who is specialized in the health topic, requiring them to travel a great distance (Availability, Appropriateness, and Acceptability). Again, this example provides a picture of how issues facing Kansans are systemic and must be addressed systemically.

Attitude Influences Outcomes. Attitudes regarding specific health issues affect communities and influences the health of adolescents in those areas. Parents’ and caretakers’ lack of knowledge and awareness of services were often coupled with attitudes of frustration, despair, and hopelessness. Thus, those individuals simply do not pursue preventative care for their adolescents, let alone themselves. Attitudes regarding certain areas of health also affect how help is sought out. Stigmas attached to specific aspects of health care (e.g., mental health, low-income families) proves to be a barrier in victims seeking assistance. One participant mentioned that “pride and negative stigma[s]” interfere with “getting help for mental health or substance abuse.” The same participant said “denial, apathy,” or lack of awareness prevented participants from knowing “what to do, where to go and what resources are available for help.” Another participant said “stigmas need to be erased so people will get themselves help.”

Priority. Many recognize the need for adolescent health to be of high priority in their communities and note the difficulty in prioritizing preventative care. Furthermore, many respondents noted that a lot of good can be done through collaboration. One participant said, “Integration and cooperation are needed — systems need to organize and communicate with one another because many of the issues share risks and protective factors.” Additionally, one survey participant mentioned that “health maintained at a young age will benefit that person and others for the rest of their life.” In putting these themes together, it seems that while adolescent health issues have not been as high a priority in the past, individuals and communities throughout the state recognize the need to improve services and knowledge around adolescence moving forward.

B) Community Focus Groups with adolescents, parents, citizens/stakeholders

Development, Piloting and Selection of Communities

Four focus group questions were developed and tailored to complement the questions asked through the online survey. Kansas Adolescent Health Project staff worked with local collaborators and contacts (e.g., public health departments, extension personnel, family and consumer sciences school faculty, mental health center staff, medical school colleagues) to schedule the focus groups, recruit participants, and communicate the intent of the project to local media. Context regarding the project’s objective to gain a more complete understanding of the holistic health

needs of Kansas adolescents was provided to community contacts, as well as background information pertaining to the online survey. The focus group questions were formulated based on the online survey results. Following a pilot of the questions in Kansas City, Missouri, with a group of community volunteers for youth, 26 groups in five communities yielded insights and comments from 401 participants. Of the 401 participants, 324 were youth (ages 12 to 18) and 77 were adults. There was an intentional effort to gather the input of youth (objective of adult opinion) due to the vast amount of adult respondent commentary collected through the online survey. The communities where the focus groups were conducted were strategically selected by the Kansas Department of Health and Environment staff to provide data where response to the online survey was lacking. Specifically, the locations of Chanute, Dodge City, Great Bend/Hoisington, and Wyandotte County were selected due to lower survey-response rates in these areas, and to collect more data from Hispanic-speaking populations as well as inner-city and rural areas of Kansas.

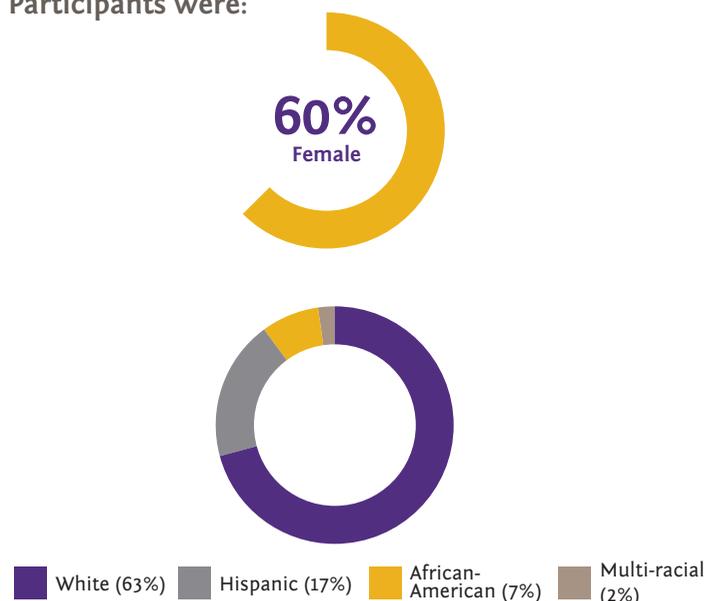
The youth focus groups were conducted in Wyandotte High School, Great Bend High School, Hoisington High School, and Chanute High School during family and consumer science and health science classes, advising, and study hall during normal school hours, as well as during early-release time. Youth focus groups were also conducted with the Wyandotte County 4-H youth council and an after-school group in Wyandotte County known as “Young Women on the Move.” Adult focus groups were conducted in and in association with a multi-organizational health partnership in Kansas City, 4-H adult councils, and selected adults representative of health care, public health officials, youth ministers, school nurses, county attorneys, extension agents, one director of a local recreation center, school counselors, after-school coaches, principals, educators, and mental health providers. Many of the adults identified that they were also parents of middle to high school aged youth in the community. Two shared that they were currently foster parents.

Focus groups were held during a two-week time span in October 2014, as follows:

- Chanute — Four youth/high school groups (75 participants); one adult group (11 participants)
- Dodge City — Two youth/middle-high school groups (47 participants); two adult groups (31 participants; one group conducted in Spanish)
- Great Bend — Ten youth/high school groups (161 participants); one adult group (9 participants)
- Hoisington — One youth group/high school (9 participants)

- Wyandotte county — Three youth/middle-high school groups (32 participants); two adult groups (26 participants)

Participants were:



The focus groups provided an atmosphere conducive to hearing what teens know and personally feel about health services and issues, specifically pertaining to their own experiences, as well as experiences of those within their age group. The focus groups were moderated by trained university students relatively close in age to the participants so as to create comfortable group discussion. The moderators sat with the participants in discussion circles to foster a sense of belonging, safety, and equality. Prior to beginning the group discussion, the moderators briefly explained the project and the purpose of the focus group and how the information would be used. Participants were informed that the focus groups, online survey data, and previously existing data were to be collected and combined to ensure that the new state health plan, and the consequent services that will be available to youth, are based on correct and pertinent information with a new emphasis on adolescent health. The focus group participants were made aware that their comments would be recorded by a scribe, as well as an audio recording device, to maintain the integrity and accuracy of the project. Participants were also informed that their comments would remain anonymous and that their information and contributions to the discussion would be protected and confidential. Informed consent forms were given to each participant. Each participant was also given a list of the questions being discussed, which include the following:

For Youth and Adults

What do you consider to be the most important health issues for teens today? These health issues can include

health matters relating to the seven adolescent health focus areas (HP 2020), which are healthy development, injury and violence prevention, mental health, substance abuse, sexual and reproductive health, prevention of chronic diseases of adulthood, and health care.

1. For Youth and Adults:

What do you think are gaps in health services for youth?

2. For Youth:

What barriers or challenges do you or your friends face that keep you from being healthy?

3. For Adults:

What barriers or challenges are teens facing that keep them from being healthy?

4. For Youth and Adults:

What recommendations or suggestions do you have to address these barriers or challenges?

5. For Youth and Adults:

Is there anything else you want to say about adolescent health or your experiences related to health services for adolescents?

These discussions averaged about 45 minutes per group. Participants were encouraged to use their personal experiences and knowledge regarding adolescence to recommend a list of potential ways to address the health issues, gaps, and barriers to receiving services and to obtaining better health, as discussed in the first three questions. Moderators assured the participants that there was no right or wrong answer to any of the questions, and that the participants' personal input was important in creating and implementing interventions and programs that would be suited to the specific needs of each community.

Information Gathered

Public-health theory and practice suggest that programs and interventions directed at adolescents are most effective when they are informed by the perspectives of those they serve: adolescents. The following selected quotes illustrate the collective “voice” of the 324 adolescent Kansans who participated in the groups. These quotes are grouped within common themes found throughout each focus group.

Needs and Issues expressed by Youth

School lunch

- They don't feed us enough at lunch, or the food is gross. When I don't eat I get irritated and don't like to be around people and I'm ornery. I think that could be part of the reason there's so much bullying, all the kids are hungry and grumpy. (Female, Great Bend High School student)
- The food at lunch is nasty. It's processed. It's fake fruit. When I eat fruit at home, I like it. When I get fruit here, it tastes so dry or it's hard, it's gross. (Female, Chanute High School student)

Drugs, substances

- Everybody does drugs. Everyone does marijuana, it's not a big deal. (Male, Great Bend High School student)
- We learn to do alcohol and drugs from our older siblings, friends, and parents. (Female, Great Bend/Hoisington High School student)

Sexuality, pregnancy

- Teen pregnancy is a big issue. Babies are having babies. (Female, Wyandotte High School student)
- The sex-ed videos are old, and we've seen them before, we're not learning anything new or worthwhile. (Female, Wyandotte High School Student)



- We need sex-ed earlier, more frequently, and that's realistic. (Female, Wyandotte High School student)
- We need real sex education. You can tell us over and over again to not have sex. (Female, Dodge City High School student)

Mental health, depression, self-injury

- Bullying leads to self-harm and suicide. (Female, Great Bend High School student)
- Cutting is a big issue. I've seen girls cutting in the bathroom four or so times this year already. (Female, Great Bend High School student)
- It's hard to trust adults. They either overreact or are they're in denial about their kid being depressed or having some kind of mental illness. (Male, Chanute High School student)
- I see a lot of really sad people all the time. Just depressed, sad, kinda hopeless. (Female, Chanute High School student)

Obesity

- Sometimes being depressed leads to obesity. Then you eat more. (Female, Wyandotte county)

Bullying

- A lot of kids make fun of you about your weight. If you're obese, kids treat you different. (Female, Chanute High School).
- I get told all the time that I'm gonna be the next school bomber. I don't know why kids say that, maybe 'cause I'm quiet and keep to myself. I don't like the way I'm treated. (Male, Great Bend High School)

Boredom leading to use of technology

- With teens not being so active, they don't get enough sleep 'cause they are on technology. (Female, Wyandotte County, Young Women on the Move)

Stress, expectations of parents, teachers

- Drugs, sex, self-harm, suicide, bullying, even eating . . . we don't know how to deal with stress. It's an escape. (Male, Chanute High School student)
- Teens need a way to "de-bottle" their stress. We need stress management techniques. (Male Wyandotte 4-H club youth member)
- School stress can make kids depressed. (Female, Wyandotte County).

Wanting "real" services and information

- We want people to "be real" with us. Tell us about the real life-threatening consequences of teen pregnancy. Teens need to know what it's really like to have a baby. What it's really like to have an STD. (Female, Wyandotte County, Young Women on the Move)

Wanting to confide in adults, mentors, someone who "understands"

- Kids are afraid to talk about their issues, afraid of judgment, they don't feel comfortable talking about their health concerns and don't know who to go to. (Male, Wyandotte county 4-H youth club member).
- What we really need is someone who's been through what we're going through . . . someone who actually understands us. (Female, Chanute High School student)
- We want to feel understood, we need to have someone to talk to that won't judge us. (Female, Dodge City High School)

Adult education

- Kids have adults in the home. They may have "parents," but not parents. (Female Wyandotte High School student who used emphasis.)
- Parents need to be taught along with the youth. (Female, Dodge City High School student)

Many of the needs expressed by youth are overlapping. The focus group data demonstrates how systemic each health need is. For example, one student shared that school stress can result in youth experiencing symptoms of depression. Another student pointed out that depression can lead to emotional eating, which can lead to obesity. One student said that obesity was a major reason youth were bullied in her high school, and multiple students pointed out that bullying was a large contributing factor to the epidemic of self-harm and suicide ideation.



Analysis and Recommendations

Following completion of all of the focus groups, project staff met to conduct an inductive thematic analysis of the data. Going through each transcript, team members selected the common themes of note and then compared them to the themes selected by others. What emerged from the analysis were the following common issues, service gaps, barriers, and potential solutions from both adolescent and adult focus group participants (each is listed in order of prominence of focus group data):

Students communicated mixed opinions as to the extremity of drug use in their communities, particularly regarding marijuana. Some students perceived any and all drug use as an issue, and other students mentioned the use of illegal substances as a common and harmless occurrence.

Needs and Issues Expressed by Youth

- School lunch
- Substance abuse
- Sexuality, pregnancy

- Mental health, depression, self-injury
- Obesity
- Overall Stress
- Bullying
- Boredom → leading to use of technology
- Wanting real services and information
- Wanting to confide in adults, mentors

Needs and Issues Observed by Adults

- Substance abuse
- Physical activity
- Mental health
- Coping and life skills
- Needing real services and information about sexual health
- Health Literacy
- Mentors
- Consistency
- Technology and its use

Barriers and Challenges Expressed by Youth

- Not knowing where to go for services
- Lack of information
- Lack of access to services
- Lack of ways to pay for services
- Transportation
- Lack of parental support, awareness
- Peer influence, embarrassment, shame
- “Cool” factor

Barriers and Challenges Observed by Adults

- Parents who lack skills
- Parents who are stressed, distracted
- Lack of credible information; unawareness
- Lack of access to services
- Complexity of getting services (wait lists, economic “cliffs”, stipulations/strings)
- Lack of mentors

Recommendations and Solutions Expressed by Youth

- Mentoring
- Increase access to real and relevant information; straightforward communication
- Stress management/coping and life skills education
- Improved school lunch: quality and quantity
- Relationship education

Recommendations and Solutions Expressed by Adults

- Mentoring
- Increase access to real and relevant information
- Parent education
- Stress management/coping and life skills education
- Integrated, holistic, affordable services available and accessible to youth

Mentoring (Suggestion from Youth and Adults)

Feeling uncomfortable to confide in adults or concerns about confidentiality regarding personal health issues was mentioned as a barrier to seeking help. Many youth expressed a desire for someone to confide in that “understands.” Adults also expressed a perceived need for youth to have a mentor to guide and serve them through the difficulties of adolescence. The unanimous opinion that teens are in need of mentors was the most heavily discussed recommendation by both youth and adults. Mentors can serve many purposes and consequently provide support and assistance with accessing services and addressing many of the health issues discussed.

Access to Real and Relevant Information (Suggestion from Youth and Adult)

Youth in the focus groups mentioned the need for “real” and relevant information, specifically regarding sexual education and health-care services available. Students mentioned the issue of insufficient sexual education, specifically sexual education that was not relevant or updated. Multiple participants mentioned that the sexual education videos and information being delivered is outdated or irrelevant. Students and adults suggested increasing the frequency that sexual education is delivered, as well as beginning sexual education earlier in students’ academic careers, as early as junior high for all youth. Students and youth also suggested altering the communication of information regarding health-care services to methods more accessible and pertinent to today’s use of technology. Survey and focus group participants both suggested using technology to disseminate health-care information regarding available services and information.

Parent Education (Suggestion from Youth and Adults)

Female students in the Young Women on the Move focus group in Wyandotte County discussed the negative effects of poverty in multiple areas of their lives. One student pointed out that she had bad grades in school because she had to assist in financially providing for her family when her mother requested help with housemaid work. A different student pointed out that her poor grades were a result of lack of sleep because she was required to babysit her younger siblings while her parents were at work. The girls proceeded to discuss how they felt overwhelmed by trying to juggle their parents’ duties and their own school

and social responsibilities, as well. Parental unawareness and lack of skills was a prominent issue discussed in the focus groups, and parental education was consequently a unified solution to this issue. Parental education would address the barriers and challenges found commonly throughout the focus groups — mainly parental stress, distraction, and lack of skills. The recommendation from focus group participants to increase parent education paralleled those of the online survey participants.

Stress Management, Life Skills Education (Suggestion from Youth and Adult)

In every focus group conducted, adult and youth alike, the conversation was eventually directed by participants toward the issue of drugs, substance abuse, and sexual health among adolescents in conjunction with stress management. One female youth said drugs and alcohol were used as an escape because they couldn't handle all the pressure of normal life, and the depression that comes with feeling overwhelmed all the time. Many adult participants relayed deep concern specifically regarding alcohol consumption. Multiple students discussed their first exposure to drugs and alcohol stemming from the home, with noteworthy observations from students that they learned to cope with stress by using drugs and/or alcohol from their parents, siblings, or friends. Stress management was a common theme discussed throughout the focus groups. Many youth revealed feeling overwhelmed with school work, demands from parents, peer pressure, bullying, sleep deprivation, and especially combating feelings of hopelessness and/or depression. Causes of feelings of depression were attributed mainly to dysfunction within the family, bullying at school, excessive stress, and boredom, among many others. Multiple students mentioned seeking romantic relationships involving sexual behavior as an antidote for flooding feelings of stress and other negative emotions. Youth and adults alike expressed a need to teach youth stress management techniques along with life skills to efficiently cope with the demands of school, family, work, and life in general. One student phrased this by saying “teens need a way to ‘de-bottle’ their stress.” Comments regarding the need for teen stress management techniques from adult and youth focus group participants mirrored those from the online survey data.

Integrated, Holistic, Affordable Services Accessible to Youth (Suggestion from Youth and Adults)

Adults in the focus groups mentioned the need for access to real and relevant services. Increasing health literacy for health-care consumers in conjunction with accessibility to available health services was a suggestion made by many focus group participants, especially adult participants in affiliation with the public health system at the public health Partnerships Conference. Students expressed concerns

about seeking health care related to any and all of the above-mentioned issues due to fear of judgment from other students, especially seeking health care from a source that would reveal economic insecurity. As mentioned in the survey data, transportation to health-care services was expressed in the focus groups as a barrier to receiving health-care services, and increasing access to all available services was a recommendation made by most survey and focus group participants. Medical homes or medical health homes were recommended by many survey and focus group participants as a solution to integrating health-care services. Medical homes would create a source where all services are accessed from the same location, therefore increasing accessibility and requiring health-care workers to adopt a more holistic view of health that reflects the more diverse population and multiple facets of health needs in the community. Wyandotte High School possesses an in-school medical home known as the “BullDoc/Bulldog (school mascot) Clinic,” where students are able to seek health-care services including therapy, dental care, vaccination administration, basic check-ups, and other services.

Increased Quality and Quantity of School Lunch (Suggestion from Youth)

As mentioned in many of the quotes above, school lunch was portrayed by most focus group participants as a health issue. Students in the focus groups relayed frustrations about feeling hungry after lunch because of decreased portion sizes. One student discussed feeling irritable and short-tempered at school due to hunger, and how this has affected other areas of her life, specifically her social interactions with others and her capacity to perform academically. She also connected the issue of hunger leading to irritability to a potential causation factor for bullying, another main issue discussed by many youth in the focus groups. Another student mentioned feeling a lack of concern and care from authorities in the school system because of the perceived lack of effort and care given to preparing school lunch. Obesity was discussed in many groups as a problem related to school lunch. Students hypothesized obesity was due to increased cravings for unhealthy snacks and foods because the food served at school is not tasteful or satiating. Students also observed the portion sizes being too small, so they revert to the nearest convenience store or fast-food chain to obtain more food, where unhealthy food options are abundant. Youth unanimously suggested that school lunch quality and quantity be increased.

Relationship Skills (Suggestions from Youth)

One female Great Bend High School student said youth are not getting enough attention at home, so they look for attention from other people, which “leads to teens having sex, seeking love, or just someone to give them attention.” A student in the Wyandotte County 4-H youth council said

youth “don’t know the difference between love and lust.” Youth in the focus groups agreed that relationship education would assist them with the emotional toll that comes with seeking validation, attention, and love, potentially in the wrong places and in counterproductive ways.

The similarities between the comments of youth focus group participants and those from adults provide direction for state planning recommendations and potential strategies. As there is agreement between the generations about the leading adolescent health issues, barriers to improved health, and potential solutions, agreement to take action is the next logical step. Multiple similarities between the online survey data and the focus group data also merits implementing strategies that integrate the input from the participants of the Kansas Adolescent Health Project. An adult focus group member from Great Bend voiced urgency in taking that action when she said, “They’re good kids who are losing the ‘umph’ and spark from their eyes.”



Kansas Department of Health and Environment Staff

In order to have input from Kansas public health leaders and to gather their perspectives about the information that had been collected, 15 Kansas Department of Health and Environment (KDHE) staff were invited to review the report information prior to submission. Following a review of the data, KDHE staff contributed their individual perspectives of the top three adolescent health issues in Kansas:

- Mental Health and Behavioral Health (depression, suicide, self-harm, adverse childhood experiences); eleven submissions
- Prevention of Chronic Diseases (obesity, lack of physical activity, poor nutrition and poor oral health); seven submissions
- Injury — unintentional and intentional (dating violence, bullying, motor vehicle crashes, suicide, self-harm); five submissions
- Sexual and Reproductive Health (sexuality, STDs, STIs, teen pregnancy); four submissions
- Substance Abuse (drugs, alcohol, tobacco); four submissions

This group’s identification of the issues associated with mental and behavioral health was consistent with the online survey and focus group data. However, the lower rank of issues related to substance abuse may have been because of the professional focus of the group members who worked primarily in areas of chronic disease reduction and prevention.

As for recommendations and potential solutions, the KDHE staff group identified mentoring, opportunities for “real” information, parent education, and access to health

education and health services, which were in alignment with the recommendations provided by survey respondents and focus group participants.

Interviews were conducted with officials from the Kansas Academy of Family Physicians, and Kansas – American Academy of Pediatrics focusing on the access that adolescents (as well as those with special health-care needs) have to health services provided through a medical home. Though Kansas established pilot medical home model sites, issues related to cost-recovery, integration of electronic records instead of simply co-locating services, and practitioners being more familiar with diagnosis-based health care versus a panel/public health approaches have created barriers to more practices moving to a medical home model. Additionally, inconsistent definitions of “medical home” and “health home” led to some confusion between public-funded health home approaches and patient-center medical homes.

Department of Family Medicine, University of Kansas Medical School

A brief interview was conducted with a member of the Department of Family Medicine, University of Kansas Medical School about the issues affecting the sustainability of the high school-based health clinic at Wyandotte High School known as the “BullDoc/Bulldog (school mascot) Clinic”. Though the clinic, which is located in Wyandotte County, is successful and receives positive feedback from students as well as health providers, the clinic is at risk due to insecure funding. The interviewee said that for the long-term health of adolescents, health-care providers need to:

- a. think bigger than themselves (i.e., establish partnerships),**
- b. move to a social-ecological model,**
- c. address the social determinants of health,**
- d. have optimism and perseverance,**
- e. recruit heavier parental involvement in schools and adolescents’ lives, and**
- f. innovate ways to gain active parental consent to collect data revolving around adolescent health to inform future interventions that advocate for the whole-health of youth ages 12 to 19.**

National leaders were also consulted for the needs assessment and development of the plan. Kristin Tipel, State Adolescent Health Resource Center, University of Minnesota and former adolescent health consultant for the national Maternal and Child Health Bureau, provided copies of well-developed adolescent health plans from 19 states. Review of the plans provided best practices for adolescent health plans.

Recommendations and Strategies

The results of the Kansas adolescent health needs assessment reveal some trends — both positive and negative — for young people in the state. For example:

- Consistent, targeted, and collaborative efforts have reduced the use of tobacco among adolescents, fewer teens are having pregnancies, there are more opportunities for healthier diets and improved levels of physical activity, and youth with special health-care needs have increasing access to health care through medical homes.
- However, adults are aware of and are concerned about the effects that stress, technology, hurried lifestyles, and strained families have on the physical and mental health of Kansas adolescents.
- More importantly, teens themselves state that they need to have adult mentors who are honest with them about matters of health and well-being. Kansas youth know they are uninformed about their own health, but they don't know how to access services and supports when they need them. Kansas youth also know that without skilled and available parents, quality learning environments, and opportunities to improve their health while young, they will have diminished health as adults. The teens also are motivated to learn and apply healthy habits for a lifetime.

In sum, the needs assessment revealed agreement across many sectors that the health of Kansas adolescents matter, and that young people require a network of collaborative and caring adults to assure that health.

The following recommendations represent a synthesis of the results from the review of population data, survey responses, key informant interviews, and focus groups conducted over several months. Redundancy in some of the recommendations is intentional so that service providers, educators, decision-makers and parents are aware that these recommendations address systematic issues and provide numerous opportunities to positively impact the health of Kansas youth.

Additionally, contact with a national leader in adolescent health planning resulted in access to adolescent health plans from 19 other states. Following a review of those plans, and in consultation with the national expert, a group of recommendations from five of the state-level adolescent health plans were considered. Those recommendations align well with the recommendations provided by key leaders, adult and youth participants. Though it is attractive to simply adopt the recommendations of other states, contextual factors such as experiences, culture, resources, political history, goals, and attitudes of the implementers require that even the best recommendations and evidence-based



strategies be adapted. Consequently, the following recommendations and strategies are recommendations tailored to Kansas, but align with recommendations in plans from: California (2002), Minnesota (2002), New Hampshire (2005), Indiana (2009), and Ohio (2013) [see Title V State Profiles at: <http://www.amchp.org/Policy-Advocacy/MCHAdvocacy/Pages/StateProfiles.aspx>]

GOAL – Enhance the health of adolescents and young adults (ages 12 to 22) across the lifespan.

“Everyone smokes pot or does drugs. Kids do drugs to escape stress or bad things happening at home...or to have fun or fit in. There’s nothing to do in this town.”

Chanute youth focus group member

“We want people to ‘be real’ with us. They need to tell us about the real-life consequences of teen pregnancy. Teens need to know what it’s really like to have a baby, what it’s really like to have an STD. They sugar-coat it when they teach you about sex, and they need to just be real with us. It’s not enough to tell us to not have sex.”

Wyandotte County (Young Women on the Move) youth focus group member

“They don’t feed us enough at lunch, or the food is gross. When I don’t have enough to eat I get irritated and don’t like to be around people. I think that can lead to bullying too.”

Great Bend youth focus group member

Recommendation 1:

Address the highest priority adolescent health issues. In order of priority: mental health, substance use, reproductive/sexual health, nutrition and physical activity, and injury prevention.

Mental Health

Limited coping skills and increasing stress affect the mental and behavioral health of adolescents. There is a direct association between poor mental health and the use of substances for self-medication, poor physical health, and increases in self-injury and suicide attempts.

- **Priority Objective:**
Improve the mental health of adolescents.
- **National Performance Measure:**
Percent of adolescents ages 12 to 17 with a preventive medical visit (adolescent well visit) in the past year
Percent of adolescents, ages 12 through 17, who are

bullied or who bully others

- **Long-Term Outcome Measures:**
Rate (per 100,000) of suicide deaths among adolescents ages 15 to 19
Rate (per 100,000) of suicide attempts among adolescents ages 15 to 19
Percent of adolescents with a mental/behavioral condition who receive treatment or counseling
Proportion of adolescents aged 12 to 17 years who experience major depressive episodes (MDEs)

Recommended Strategies/Planned Activities:

- » Provide school-based access to confidential mental health screening, referral, and treatment that reduces the stigma and embarrassment often associated with mental illness, emotional disturbances, and seeking treatment.
- » Establish networks of skilled, supported adult and peer mentors that are available to adolescents in safe, accessible environments.
- » Provide opportunities for adolescents to learn and practice social emotional coping skills in safe, accessible environments.

Substance Abuse

Experimentation with substances (alcohol, illicit prescription drugs, illegal substances, tobacco, and other drugs) can lead to addiction and long-term health problems. Adolescents who consistently use substances are more likely to continue substance use into adulthood, and are at risk for inability to establish and sustain positive relationships, dropping out from school, and lost productivity.

- **Priority Objective:**
Decrease use of substances among adolescents by reducing risk behaviors related to use of alcohol, illicit prescription drugs, illegal substances, tobacco, and other drugs.
- **National Performance Measure:**
Percent of adolescents ages 12 to 17 with a preventive medical visit (adolescent well visit) in the past year
- **Long-term Outcome Measures:**
Percent of illicit drug use among persons aged 12 to 17
Percent of adolescents engaging in binge drinking during the past 30 days
Percent of adolescents who used tobacco products in the past 30 days
Percent of adolescents who needed alcohol and/or illicit drug treatment and received specialty treatment for abuse or dependence in the past year

Recommended Strategies/Planned Activities:

- » Increase access to substance abuse screening, treatment, and prevention services through co-locating screening,

treatment, and prevention services in schools and/or facilities easily accessible to adolescents in out-of-school time.

- » Establish networks of skilled, supported adult and peer mentors that are available to adolescents in safe, accessible environments.
- » Provide opportunities for adolescents to learn and practice social emotional coping skills in safe, accessible environments.
- » Provide opportunities for adolescents to occupy their out-of-school time in pro-social activities, establish pro-social relationships, and gain meaningful skills and competencies.

Sexual and Reproductive Health

Without effective protective practices and relevant sexual health education, sexual activity in early adolescence can result in sexually transmitted diseases and infections, early pregnancy, and poor reproductive health into adulthood. Moreover, an important task of adolescence is learning how to establish positive relationships, and an ability to distinguish between intimate and sexual relationships.

- **Priority Objective:**
Reduce the risk of early pregnancy and sexually transmitted diseases and infections among adolescents, while establishing positive relationships.
- **National Performance Measure:**
Percent of adolescents ages 12 to 17 with a preventive medical visit (adolescent well visit) in the past year
- **Long-term Outcome Measures:**
Rate of birth (per 1,000) for adolescent females ages 15 to 17
Rate of pregnancy for adolescent females ages 15 to 17
Proportion of sexually active persons aged 15 to 19 years who use condoms and hormonal or intrauterine contraception to both effectively prevent pregnancy and provide barrier protection against disease
Percentage of adolescents who talked to a parent or guardian about reproductive health topics before they were 18 years old
Proportion of adolescents who received formal instruction on reproductive health topics before they were 18 years old

Recommended Strategies/Planned Activities:

- » Make accurate information and relationship education available on responsible sexual behavior, including the benefits of abstinence, more easily available to youth and their families.
- » Support youth development behavioral interventions (i.e., social, emotional, or cognitive competence training that promotes pro-social norms, improved and

intentional decision making, improved communication skills, positive bonding experiences between youth, their peers, or non-parental role models) coordinated with community services to reduce sexual risk behaviors.

- » Provide confidential, youth-friendly reproductive health services.
- » Encourage communication between adolescents and their parents about reproductive health issues.
- » Encourage all providers who serve adolescents to screen sexually active females for chlamydia.

Nutrition and physical activity

Poor nutrition and low levels of physical activity can lead to adolescents who are overweight and obese, which puts them at risk for chronic conditions and diseases such as diabetes and heart disease. Poor body image and eating disorders may be associated with poor nutritional habits and lack of positive physical health habits.

- **Priority Objective:**
Improve the overall health of adolescents through healthy eating and physical activity.
- **National Performance Measures:**
Percent of adolescents ages 12 to 17 who are physically active to least 60 minutes per day
Percent of adolescents ages 12 to 17 who had a preventive dental visit in the past year
Percent of adolescents ages 12 to 17 with a preventive medical visit (adolescent well visit) in the past year
- **Long-term Outcome Measures:**
Percent of adolescents who are overweight or obese (BMI at or above the 85th percentile)
Percent of adolescents who meet current federal physical activity guidelines for aerobic physical activity

Recommended Strategies/Planned Activities:

- » Increase the availability of healthy food and beverages in sufficient supply in schools.
- » Increase opportunities for students to participate in regular physical activity both in and out of school (e.g., non-competitive sports leagues, intermural).
- » Improve adolescents' awareness of good nutrition and physical fitness through relevant and technologically current education during the school day and out of school.
- » Implement an awareness/information campaign to reduce sedentary recreational screen time among adolescents.

Injury Prevention

Unintentional injuries (i.e. vehicle, recreational, firearm) are often due to distraction, impaired judgment due to substance use, or lack of preparation and skill necessary to avoid injury. Intentional and self-inflicted injury is associated with poor coping skills and need for support networks, which include mental health services. avoid injury. Intentional and self-inflicted injury is associated with poor coping skills and need for support networks, which include mental health services.

- **Priority Objective:**

Prevent unintentional and intentional injury among adolescents.

- **National Performance Measures:**

Rate of hospitalization for non-fatal injury per 100,000 among adolescents ages 10 to 19

Percent of adolescents ages 12 to 17 who are bullied or who bully others

- **Long-term Outcome Measures:**

Rate of mortality for adolescents ages 10 to 19

Rate of motor vehicle mortality for adolescents ages 15 to 19

Percent of adolescents (ages 15 to 17) who were in a physical fight on school property in the past 12 months
Rate (per 100,000) of suicide deaths among adolescents ages 15 to 19

Rate (per 100,000) of suicide attempts among adolescents ages 15 to 19

Recommended Strategies/Planned Activities:

- » Encourage the implementation of policies, procedures, and the evaluation of programs in health-care settings to assess for and intervene with adolescents at risk for suicide.
- » Support public awareness campaigns to prevent adolescent self-injury.
- » Develop policies and establish prevention activities that work to reduce motor vehicle crash injuries and deaths to adolescents due to distracted driving and/or use of substances.
- » Continue to enforce existing laws regarding adolescent drivers, such as mandatory seat belt use and zero tolerance for alcohol use.
- » Establish networks of skilled, supported adult and peer mentors that are available to adolescents in safe, accessible environments.
- » Provide opportunities for adolescents to learn and practice social emotional coping skills in safe, accessible environments.

Recommendation 2:

Help families support the health and well-being of their adolescents.

Parents and family members model the positive and negative health behaviors that adolescents experiment with and adopt. Though sometimes unspoken, adolescents desire and value their parents' discussion of health issues, health literacy and health care so they are better able to transition to adulthood healthy and informed. Parents who are literate in healthy development and adolescence have the ability to better help their teens. However, adolescents often know when their families are unprepared and unequipped to provide helpful information and guidance. In these situations, adolescents should have access to non-parental adults who can provide pro-social guidance.

- **Priority Objective:**

Every adolescent will have at least one parent or caring adult consistently in their lives with whom they can talk about serious problems and learn how to establish positive health habits for a life time.

- **National Performance Measure:**

Percent of adolescents ages 12 to 17 with a preventive medical visit (adolescent well visit) in the past year
Percent of adolescents who are adequately insured

- **Long-term Outcome Measures:**

Percent of adolescents aged 12 to 17 years who had an adult in their lives with whom they could talk about serious problems

Proportion of parents who attend events and activities in which their adolescents participate

Recommended Strategies/Planned Activities:

- » Increase the availability of information to parents and family members about normative adolescent development, risk, and protective factors for youth.
- » Provide support to parents who experience problems, such as relationship violence, substance abuse, and mental health issues, to enable enhanced relationships with their adolescents.
- » Expand on the successful "Parents as Teachers" model to: provide parenting resources to help parents further understand the critical importance of their child's adolescent years, create opportunities for family engagement through personal visits and group connections, make available periodic health screenings to families and adolescents that may not otherwise seek preventative care, link families and adolescents with community resources and services beyond their current scope, and provide mentoring opportunities to community members.
- » Encourage communication between adolescents and their parents about any health issue.

- » Provide opportunities for parents to improve their skills in seeking out quality health-related information and services.

“I think we need to start by focusing on where teens are spending a majority of their time already – in the schools.”

Wyandotte County (Partnerships Health Conference) adult focus group member

Recommendation 3:

Provide educational environments that prepare youth for healthy adulthood.

Adolescents usually spend a great part of their waking hours each day at school where health content is taught, health behaviors are learned, and healthy environments influence their well-being. Educational environments, both in and out of school, can be safe and accessible places for the delivery of health services as well as places that inspire young people to consider medical and public health careers.

- **Priority Objective:**

Educational environments are safe and accessible places where health issues can be addressed, health services can be provided, and health careers can be inspired.

- **National Performance Measures:**

Percent of adolescents, ages 12 to 17, physically active at least 60 minutes per day
 Percent of adolescents, ages 12 to 17, who are bullied or who bully others

- **Long-term Outcome Measures:**

Percent of students who graduate with a regular diploma four years after starting 9th grade.
 Percent of adolescents (ages 12 to 17) years missed 11 or more whole school days due to illness or injury in the previous 12 months
 Percent of adolescents (ages 12 to 17) years with parents who reported that they felt their child was usually or always safe at school
 Proportion of middle and high schools prohibiting harassment based on a student’s sexual orientation or gender identity

Recommended Strategies/Action Plans:

- » Emphasize social emotional as well as academic competence in the school setting.
- » Increase the availability of skill-based health information for youth.

- » Support schools to establish and sustain health access points and health services on-site during the school day.
- » Increase connections among schools, families, communities, and health providers through programs such as Communities in Schools (CIS), KU Medical Center’s “BullDoc/BullDog (school mascot) clinic” at Wyandotte High School.
- » Provide school-based access to confidential mental-health screening, referral, and treatment that reduces the stigma and embarrassment often associated with mental illness, emotional disturbances, and seeking treatment.
- » Establish networks of skilled, supported adult and peer mentors that are available to adolescents in safe, accessible environments.
- » Provide opportunities for adolescents to learn and practice social emotional coping skills in safe, accessible environments.

“In communities, it used to be the job of the church to provide extra needs for families and children. They provided many needs. But now it is more government based, and there aren’t enough resources in just one organization or church to meet all the needs. There is not enough collaboration. Half of the food pantries are run by churches.”

Dodge City adult focus group member

Recommendation 4:

Encourage collaborations and increase community support for those working for and with youth.

Adolescents thrive best when networks of support in communities work collaboratively. Integrated referral, screening, treatment, maintenance, and prevention services help adolescents and their families address health risks and improve health outcomes.

- **Priority Objective:**

Collaborations and community networks that support adolescent health are readily accessible, and function with the interests of youth in mind.

- **National Performance Measure:**

Percent of adolescents ages 12 to 17 with a preventive medical visit (adolescent well visit) in the past year

- **Long-term Outcome Measure:**

Percent of families of adolescents who report the community-based service systems are organized so they can use them easily
Percent of youth with or without special health-care needs receiving health care in a well-functioning system
Adolescents who have an adult in their lives with whom they can talk about serious problems

Recommended Strategies/Planned Activities:

- » Co-locate services for youth to ease access and decrease embarrassment.
- » Support effective afterschool and out-of-school programs.
- » Provide assistance to help community programs integrate positive youth development approaches and principles into their service framework.
- » Increase youth-related continuing education opportunities for professionals and para-professionals.
- » Catalogue agencies, organizations, and programs serving youth, and identify their missions and goals.
- » Encourage interdisciplinary teams to provide comprehensive and coordinated services for youth.
- » Institute regular interdisciplinary conferences and workshops to encourage development of shared knowledge, language, and goals among networks and communities.
- » Include youth in decisions about service integration.
- » Expand on the successful Parents as Teachers model to help parents of adolescents understand the critical

importance of their child's adolescent years, create opportunities for family engagement through personal visits and group connections, make available periodic health screenings to families and adolescents that may not otherwise seek preventative care, link families and adolescents with community resources and services beyond their current scope, and provide mentoring opportunities to community members.

Recommendation 5:

Improve the responsiveness, availability, and access of health care to youth.

As adolescents transition from pediatric to adult health-care systems, it's essential that health providers understand the unique health needs and issues of adolescence. Cross-disciplinary training and professional development in adolescence and positive youth development will improve positive health status for adolescents and young adults.

- **Priority Objective:**

All adolescents and their families will have access to health providers who understand and value the positive development of adolescents, and who will support adolescents' transition to adulthood.

- **National Performance Measure:**

Percent of adolescents ages 12 to 17 with a preventive medical visit (adolescent well visit) in the past year
Percent of adolescents with or without special health-care needs having a medical home
Percent of adolescents with or without special health-care needs who received services necessary to make transitions to adult health care
Percent of adolescents who are adequately insured



“One real issue is health literacy; even if you have those clinics, how do you mentally access it? See it in a real way? Understanding the health-care process is a huge issue. Going along with health literacy... in order to take the holistic approach of main health issues, let’s attack it as main issues, I think that is a thought we need to come up with in access gaps. Health literacy would close the gaps of all this.”

Wyandotte County (Partnerships Health Conference) adult focus group member

• **Long-term Outcome Measures:**

Percent of adolescents with or without special health-care needs receiving care in a well-functioning system
Percent of adolescents with special health-care needs whose health-care provider has discussed transition planning for pediatric to adult health care
Percent of youth whose doctors usually or always encourages the development of age appropriate self-management skills

Recommended Strategies/Planned Activities:

- » Use education and outreach to inform youth and parents about health-care options and providers who specialize in serving adolescents.
- » Increase training about adolescent health care for providers to ensure youth-friendly, culturally competent health services.
- » Create avenues for youth to be involved in discovering and utilizing health-care systems that meet their needs.
- » Work with health insurers to widen the concept of well-child visits through adolescence (up to age 24).
- » Improve access to comprehensive care including dental, eye/vision and mental health services.

APPENDICES

A. Institutional Review Board (IRB) Approval

(The project that produced this report and plan was screened and approved by the Kansas State University's Institutional Review Board)



TO: Elaine Johannes
FSHS
343 Justin

FROM: Rick Scheidt, Chair
Committee on Research Involving Human Subjects

DATE: 08/18/2014

RE: Approval of Proposal Entitled, "Kansas Adolescent Health Needs Assessment and Strategic Plan Pilot project."

The Committee on Research Involving Human Subjects has reviewed your proposal and has granted full approval. This proposal is **approved for one year from the date of this correspondence, pending "continuing review."**

APPROVAL DATE: 08/18/2014
EXPIRATION DATE: 08/18/2015

Several months prior to the expiration date listed, the IRB will solicit information from you for federally mandated "**continuing review**" of the research. Based on the review, the IRB may approve the activity for another year. **If continuing IRB approval is not granted, or the IRB fails to perform the continuing review before the expiration date noted above, the project will expire and the activity involving human subjects must be terminated on that date. Consequently, it is critical that you are responsive to the IRB request for information for continuing review if you want your project to continue.**

In giving its approval, the Committee has determined that:

- There is no more than minimal risk to the subjects.
- There is greater than minimal risk to the subjects.

This approval applies only to the proposal currently on file as written. Any change or modification affecting human subjects must be approved by the IRB prior to implementation. All approved proposals are subject to continuing review at least annually, which may include the examination of records connected with the project. Announced post-approval monitoring may be performed during the course of this approval period by URCO staff. Injuries, unanticipated problems or adverse events involving risk to subjects or to others must be reported immediately to the Chair of the IRB and / or the URCO.

B. Data Sources

National data and resources:

1. Healthy People 2020 (federal health plan) Adolescent Health Outcomes: www.healthypeople.gov/2020/topicsobjectives2020/overview.aspx?topicid=2
2. 2011 Kansas YRBSS Data (national site): <http://nccd.cdc.gov/youthonline/App/Results.aspx?TT=A&OUT=0&SID=HS&QID=QQ&LID=KS&YID=2011&LID2=&YID2=&COL=S&ROW1=&ROW2=&HT=QQ&LCT=&FS=&FR=1&FG=1&FSL=&FRL=&FGL=&PV=&T-ST=False&C1=&C2=&QP=G&DP=1&VA=CI&CS=Y&SYID=&EYID=&SC=DEFAULT&SO=ASC>
3. National Center for Medical Home Implementation (Kansas data): www.medicalhomeinfo.org/state_pages/kansas.aspx
4. Preconception health-care indicators: www.cste.org/?PreconIndicators
5. Life course perspective indicators: www.amchp.org/programsandtopics/data-assessment/Pages/LifeCourseIndicators.aspx

Kansas data and resources:

1. KDHE Maternal and Child Health 2015 needs assessment report (see Appendix B): www.datacounts.net/mch2015/documents/MCH2015_Report.pdf
2. KDHE - Kansas Health Matters: www.kansashealthmatters.org
3. KDHE - Kansas Information for Communities: <http://kic.kdhe.state.ks.us/kic/>
4. KDHE - Public Health Informatics: www.kdheks.gov/phi/index.htm
5. KSDE (Department of Education) - Healthy Kansas Schools (YRBS data): www.kshealthykids.org/HKS_Menus/HKS_YRBS.html
6. KADS (Aging and Disability Services) - Kansas Communities that Care (drug and alcohol data): beta.ctcdata.org
7. Kansas Child and Family Wellbeing Indicators (report that Jared Anderson led): <http://www.dcf.ks.gov/Newsroom/Documents/Childhood-Poverty-Task-Force/State%20of%20the%20Family%20Report%20Child%20and%20Family%20Wellbeing%20Indicators%20by%20Dr%20Jared%20Anderson.pdf>
8. Kansas data in the national County Health Rankings and Roadmaps site (Robert Wood Johnson Foundation/Univ. of Wisconsin): countyhealthrankings.org
Kansas Health Rankings report (2014 data spread sheet): www.countyhealthrankings.org/sites/default/files/state/downloads/CHR2014_KS_v2.pdf
9. Kansas Health Institute (health insurance, poverty information): <http://www.khi.org/>
10. Kansas Action for Children - Kids Count data: <http://kac.org/?s=Kids+Count>

C. Kansas Adolescent Health Community Survey (English Version)

Welcome to the Kansas Adolescent Health Community Input Survey

Kansas State University, with support from the Bureau of Family Health at the Kansas Department of Health and Environment, asks for your help to gather information about the health needs of adolescents (ages 10-21) across Kansas. We invite any adult or adolescent living in Kansas to complete this survey of 30 questions, which will take less than 10 minutes. The survey results will tell us what Kansans' think are the health needs of adolescents and what could be done about them.

You can move through the survey at your own pace, and can go back to items to change your answers. But, you cannot save your answers, close the survey and then come back to finish it at a later time. So, once you begin the survey you need to finish it in one sitting. The survey website will be available to until September 15, 2014, so please invite others to participate.

When you complete this anonymous survey your responses will be compiled with others from across the state. Your identity will not be known, and you will not receive additional communication from K-State University research team members. However, if you would like to know more about the survey and the work underway for healthier adolescents, contact:

Dr. Elaine Johannes, Associate Professor | Youth Development
School of Family Studies and Human Services,
Kansas State University,
ejohanne@ksu.edu
785-532-7720.

Thank you for sharing your opinions through the Kansas Adolescent Health Community Input Survey. To learn more about the partnership between Kansas State University and the Bureau of Family Health, KDHE or to know more about the university's informed consent requirements pertaining to this survey feel free to contact Dr. Elaine Johannes.

Note: Definitions for certain items within the questions can be found at the end of the survey. You can refer to the definitions page as needed and return to the specific question you were on at any point while taking the survey.

*Open boxes imply typed responses from survey participants

Q1: What is your age?

Q2: What is your gender?

- Male
- Female
- Transgender
- Would rather not say

Q3: What is your primary language? That is, what language do you speak most at home?

- English
- Spanish
- Other (please specify)

Q4: How would you classify yourself?

- Arab
- Asian/Pacific Islander
- Black/African American
- Hispanic
- Indigenous/Aboriginal
- Latino
- White/Caucasian
- Would rather not say
- Other (please specify)

Q5: Which of the following best describes your current relationship status?

- Married
- Widowed
- Divorced
- Separated
- In a domestic partnership
- Dating
- Single, but cohabitating with significant other
- Single, never married
- Other (please specify)

Q6: What is the highest level of school you have completed or the highest degree you have received?

- Less than high school degree
- High school degree or equivalent (e.g. GED)
- Some college but no degree
- Vocational Technical degree
- Associate's degree
- Bachelor's degree
- Master's degree
- Doctoral degree
- Other professional degree (please specify)

Q7: What is your current household income in U.S. dollars?

- Less than \$10,000
- \$10,000 to \$19,999
- \$20,000 to \$29,999
- \$30,000 to \$39,999
- \$40,000 to \$49,999
- \$50,000 to \$74,999
- \$75,000 to \$99,999
- \$100,000 to \$150,000
- Over \$150,000
- Would rather not say
- Do not know

Q8: What state do you currently live in?

Q9: What county do you currently live in?

Q10: How long have you been living there?

- Less than 5 years
- 5-10 years
- 11-19 years
- 20-29 years
- 30-39 years
- More than 40 years
- Do not know

Q11: Which of the following best describes the area you live in?

- Urban
- Suburban
- Rural/Country
- Small Town

Q12: How many people including yourself currently live in your household?

Q13: How many children under 16 years old live in your household? Note: If you are under 16 years of age include yourself in the total.

- None
- 1
- 2
- 3
- 4 or more

Q14: Are you or an immediate family member currently military connected?

- Yes
- No

Q15: If yes, to which branch are you connected?

- I am not military connected
- Air Force
- Army
- Coast Guard
- Civilian Worker
- Marines
- Navy

Q16: To which component are you connected?

- Active Duty
- National Guard or Reserves
- I am not military connected

Q17: Of the options below, which 2 health issues do you think impacts adolescents in your area most?

- Accidental injury
- Adolescent pregnancy and parenting
- Health care services
- Intentional injury, violence, suicide
- Mental health
- Obesity/Overweight
- Positive healthy development
- Prevention of chronic diseases
- Sexual health
- Substance abuse (including alcohol, tobacco and other drugs)
- Treatment of chronic

Q18: Do you believe that adolescent health is a priority or gets enough attention in your area?

- Yes
- No

Q19: Based on your answer to question 18, why or why do you not believe that adolescent health is a priority in your area?

Q20: Where do you believe adolescents get most of their health information? Choose your top 2.

- School/Classes
- Peers/Friends
- Family
- Health care provider
- Social media (Facebook, Twitter, YouTube)
- Other media (TV, magazines, movies, books)
- Other (please specify)

Q21: What do you think are some of the barriers that youth might face in accessing health services in your area? Choose all that apply.

- School/Classes
- Lack of knowledge about services
- Transportation
- Cost/Affordability
- Distance to services/Availability
- Unaware of need
- Embarrassment or shame/Acceptability
- Time constraints
- Waiting list for services/Accessibility
- Language
- Questionable quality/Appropriateness
- Other (please specify)

Q22: Below are 15 health risk topics which might affect adolescents in your area. Rank what you believe are the top 5 health risks to adolescents, with 1 being the greatest health risk.

- Alcohol, tobacco & other drug use
- Sexual health
- Reproductive health (including adolescent pregnancy)
- Adolescent parenting
- Poor nutrition
- Lack of physical activity
- Lack of adequate sleep
- Abuse/Neglect/Exploitation
- Obesity/Overweight
- Vehicular crashes
- Criminal behavior
- Lack of health knowledge
- Lack of health care services
- Homelessness
- Intentional harm to self (including suicide)

Q23: Where do you think health services are insufficient or missing for adolescents in your area?

- Dental health care
- Chronic disease/
Condition management
- Mental health
- Primary health care
- Substance abuse
treatment and/or
prevention programs
- Emergency services
- Reproductive health
- Education about
healthy eating and
access to healthy food
- Education about
physical activity and
opportunities to be
physically active
- Services are sufficient
- Other (please specify)

Q24: Based on your answer to the previous question, what are the reasons for these services being insufficient? Choose all that apply.

- Services do not exist in
our area
- Services are too far
away
- Services are too
expensive
- Services are not
provided in multiple
languages
- Questionable quality of
services
- Services are sufficient
- Other (please specify)

Q25: Are you or do you have a child with special health care needs?

- Yes
- No

Q26: Based on your response to the previous question, do you or does your immediate family receive coordinated, ongoing, comprehensive care within a medical home?

- Yes
- No

Q27: Would you say that you have adequate private and/or public health insurance to pay for services?

- Yes
- No

Q28: Would you say that your community-based health service systems are organized so that you can use them easily?

- Yes
- No

Q29: If no, what recommendations do you have to make your community-based services easier to use?

Q30: To address adolescent health risks, should organizations/services in your area be:

- Doing more
- Doing less
- Continuing the same
- I do not know what is
being done
- Other (please specify)

Q31: If you think that organizations/services should be doing more to address adolescent health risks, what suggestions would you have?

Q32: What additional comments or recommendations do you have to improve the health of adolescents in Kansas?

Survey Definitions

Adolescents: Individuals between 10-21 years of age (KDHE).

Child abuse/neglect/exploitation: Child abuse is any physical injury, physical neglect, emotional injury, or sexual act inflicted upon a child.

Physical Abuse: The infliction of physical, mental, or emotional harm, or the causing of a deterioration of a child, and may include, but shall not be limited to, maltreatment or exploiting a child to the extent that the child's health or emotional well-being is endangered.

Neglect: Acts or omissions by a parent, guardian, or person responsible for the care of a child that results in harm to a child or presents a likelihood of harm, and the acts or omissions are not due solely to the lack of financial means of the child's parents or other custodian.

Sexual Abuse/Exploitation: Any contact or interaction with a child in which the child is being used for the sexual stimulation of the perpetrator, the child, or another person. Sexual abuse includes allowing, permitting, or encouraging a child to engage in prostitution or to be photographed, filmed, or depicted in pornographic material

Emotional Abuse: Includes the infliction of physical, mental, or emotional harm or the causing of a deterioration of a child and may include, but is not limited to, maltreatment or exploiting a child to the extent that the child's health or emotional well-being is endangered.

Abandonment: To forsake, desert, or cease providing care for the child without making appropriate provisions for substitute care.

Child with special health care needs: Children and youth with special health care needs (CYSHCN) are defined as: "those who have or are at increased risk for a chronic physical, development, behavioral, or emotional condition and who also require health and related services of a type or amount beyond that required by children generally"

Chronic Diseases, Conditions: Chronic conditions are conditions, both physical and cognitive, that last a year or more and require ongoing medical attention and/or limit activities of daily living.

Homelessness: An individual or family who lacks a fixed, regular, and adequate nighttime residence.

Medical Home: A partnership approach with families to provide primary health care that is accessible, family centered, coordinated, comprehensive, continuous, compassionate and culturally effective.

Obesity/Overweight: For children and adolescents (aged 2—19 years) is defined as a BMI (body mass index) at or above the 85th percentile and lower than the 95th percentile for children of the same age and sex. Obesity is defined as a BMI at or above the 95th percentile for children of the same age and sex.

Primary Care: Care provided by physicians specifically trained for and skilled in comprehensive first contact and continuing care for persons with any undiagnosed sign, symptom, or health concern not limited by problem origin (biological, behavioral, or social), organ system, or diagnosis.

Reproductive Health: Addresses the reproductive processes, functions and system at all stages of life. Reproductive health, therefore, implies that people are able to have a responsible, satisfying and safe sex life and that they have the capability to reproduce and the freedom to decide if, when and how often to do so.

Sexual Health: A state of physical, emotional, mental and social well-being in relation to sexuality; it is not merely the absence of disease, dysfunction or infirmity.

Thank you!

Kansas Adolescent Health Needs Assessment & Strategic Plan Pilot project: March 31-October 31, 2014.

This project, funded by the Bureau of Family Health, Kansas Department of Health and Environment (Dr. Debbie Richardson; drichardson@ksu.edu; 785-296-1311), gathers information about the health of adolescents (ages 10-21) in Kansas. Information collected from existing data sets, through an anonymous online survey and through some community meetings will help Kansas in its application for federal funds to support the maternal and child health goals of the state during 2015-2020. The current goals and plan for Kansas are available at: <http://www.kdheks.gov/bfh/>

Staff at Kansas State University are helping the Bureau of Family Health, Kansas Department of Health and Environment prepare for this application by:

- a. reviewing existing data from websites and reports,
- b. collecting new information from people like you through an anonymous online survey, and
- c. asking people in selected communities to comment on what the review of data and information reveal about the health of people ages 15-18 in Kansas.

Other than sharing your time and comments, there is little risk to you if you choose to participate in this project by answering questions on the online, anonymous survey or by participating in a local meeting. You will not be asked your name, but you will be asked by K-State staff to give your age, gender, race, ethnicity and county of residence. Your identity will NOT be connected your survey or meeting comments. If you have questions, please contact:

* Dr. Elaine Johannes; Principal Investigator, Kansas State University; ejohanne@ksu.edu; 785-532-7720

* Dr. Rick Scheidt, Chair, Committee on Research Involving Human Subjects, 203 Fairchild Hall, Kansas State University, Manhattan, KS 66506, (785) 532-3224

* Dr. Jerry Jaax, Associate Vice President for Research Compliance and University Veterinarian, 203 Fairchild Hall, Kansas State University, Manhattan, KS 66506, (785) 532-3224

D. List of Organizations, Individuals, and Networks Receiving the Survey

Survey distributed to:

Kansas Enrichment Network
United Way – Salina
KS School Counselors Association (Kent Reed)
Kansas 4-H
Greenbush
KS Academy of Family Physicians
KS Department of Education (Mark Thompson)
Kansas Youth Suicide Prevention state team
Kansas Children’s Service League
Kansas Bullying Prevention Task Force
Heart of America Indian Center (Thomas Ed Smith)
United Methodist Health Ministry
KS FFA
KS FCCLA
KS AFCS
Kansas National Guard Family and Youth Programs
Kansas Operation Military Kids
KS State High School Activities Association
KS DARE/Attorney General’s Office (Jerry Tenbrink)
Coronado Area Council America Boys Scouts
KU Department of Educational Psychology
KSU School of Family Studies and Human Services
KPHA
Kansas Gay Straight Alliance
KS Association of School Boards
KS Library Association
Kansas State Library
Johnson County Library
United Way – Kansas City
Unity Way – Wyandotte County
Youth Build – KCKS
Harvey County Health Department

Families Together
KS Action for Healthy Kids
KS Department of Health and Environment (10 contacts and Sec. Robert Moser)
KS Action for Children
Kansas Regional Prevention Centers
KS Chapter of American Academy of Pediatrics
KS Hospital Association
K-State Research and Extension
KS School Social Workers Association
KS Boys and Girls Club Alliance
Assoc. of Community Mental Health Centers in Kansas
Iroquois Center (community mental health center)
KS ATFACS (Teachers of Family and Consumer Sciences)
USD 417 (Council Grove)
Rice County Coalition of Children and Families
Safe Streets
Department of Corrections - Juvenile Justice
KS Maternal Child Health Council (Dr. Cooley)
KS Department of Children and Family – KS Youth Advisory Council
KS Youth Soccer
DCCCA
Additionally:
Kansas Radio Network program (Sept. 12 “Identifying Adolescent Health Needs”)
K-State Today (university newsletter)
American Heart Association (state newsletter)
Kansas State Fair booth (flyer distribution)
KS Youth Suicide Prevention Conference (Salina)
KS Poverty Conference (Topeka)
Facebook
Twitter

E. References and Resources

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Teenagers

pg. 8: iStock Photos

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Group of teenagers

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