

Now the Hard Work Begins

Mark Holmes, PhD; Carol Ford, MD

North Carolina is fortunate to have hundreds of policy-makers, researchers, health care professionals, community leaders, students, and adolescent advocates who have given hours of their time to advance the work of the North Carolina Metamorphosis Project (NCMP; available at: <http://www.med.unc.edu/ncmp>). The NCMP comprises the following three projects: the Portrait of Adolescent Health in North Carolina, a parent survey, and the North Carolina Institute of Medicine (NCIOM) Task Force on Adolescent Health.¹ Tangible improvements in the health of North Carolina adolescents can be made by building on the results of these projects. However, because it can be difficult to maintain the level of energy and focus that accompanies a task force's work, and because some of the recommendations and findings generated by the NCMP projects call for state investment (the delivery of which can be challenging during tough fiscal times), the vigilance of stakeholders across the state will be necessary to help continue these efforts to improve the health of North Carolina adolescents.

To help maintain the momentum of the NCMP agenda, two strategies have been employed. The initial strategy involved organization of the first-ever North Carolina Adolescent Health Summit in December 2009. The summit brought together many NCMP supporters to identify strategies for implementing the NCIOM task force recommendations at the state and local levels and to determine the partnerships needed to do this work. To this end, breakout sessions were designed to build strategic partnerships that would endure after the summit. The second strategy involved appointment by the NCMP leadership of an advisory board. The advisory

board, consisting of individuals representing many of the key partners in adolescent health in North Carolina, meets quarterly to track progress on implementation of the recommendations. This structured approach can help encourage continued partnership and focus on implementing the recommendations of the NCIOM task force.

Summit Breakout Sessions

The NCIOM task force report was officially released at the summit. A total of 200 individuals from across the state were in attendance, and activities included plenary presentations and a reactors' panel. After presentation of

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the task force recommendations, attendees were separated into breakout sessions organized around four areas—clinics, schools, families and communities, and state-level public policies—in which the recommendations would be implemented. Attendees brainstormed possible strategies for implementing each of the priority recommendations and any other recommendations that had potential for immediate action. The goals of the breakout sessions were to develop strategies and partnerships that could lead to successful implementation of the recommendations.

Attendees in all four breakout sessions viewed adolescents as critical partners in the implementation of the priority recommendations. Approximately 20 adolescents from across the state attended the summit and breakout sessions, and their input was critical and highly informative. They will serve as key partners (by serving as their own advocates) in implementing the recommended strategies, and finding ways to encourage and support their efforts will be critical.

Mark Holmes, PhD, is the co-principal investigator of the North Carolina Metamorphosis Project and an assistant professor in the Department of Health Policy and Management at the Gillings School of Global Public Health at the University of North Carolina at Chapel Hill. He can be reached at mark_holmes@unc.edu.

Carol Ford, MD, is the original principal investigator of the North Carolina Metamorphosis Project and was an associate professor in the Department of Pediatrics at the School of Medicine and the Department of Maternal and Child Health at the Gillings School of Global Public Health at the University of North Carolina at Chapel Hill. Currently, she is a professor in the Department of Pediatrics and chief of the Division of Adolescent Medicine at the Children's Hospital of Philadelphia. She can be reached at fordc@email.chop.edu.

During the process of identifying strategies and partnerships, many attendees identified NCIOM task force recommendations they were interested in pursuing and met potential partners. A summary of the key points from each of the breakout sessions follows.

Clinics. The priority recommendations yielded by the breakout session about clinics were grouped into two themes: increasing the frequency of annual wellness visits and improving delivery of behavioral health services. One recommended strategy for increasing wellness visits involved expansion of insurance coverage for young adults, and it was noted that versions of national health reform legislation available at the time of the summit included many programs aiming to increase coverage for this group. Another strategy was to leverage adolescents' use of cell phones, to provide a forum for health-information exchange.³ Additional strategies included calling on schools and other community partners to educate parents about the timing of recommended youth check-ups and encouraging the North Carolina Area Health Education Centers program and Community Care of North Carolina to educate health care professionals about the characteristics of a high-quality wellness visit.

Insurer reimbursement policy was cited as a key barrier to improving behavioral health services. Continued innovation in approaches to team-based delivery and collocation of different types of health care professionals were seen as promising strategies for overcoming this obstacle.

Schools. The following three priority recommendations were determined by the school work group: improving school-based health services, funding healthy-schools coordinators, and ensuring that healthy foods are available in schools. To help improve school-based services, session attendees recommended that the North Carolina School Community Health Alliance (available at: <http://ncscha.org/>) take the lead in fostering expansion and improvement of school-based and school-linked health centers. Demonstration of the effectiveness of these centers will be the key to their long-term existence. The North Carolina Education Data Center has much of the data that are needed for effectiveness studies, and graduate students may be great resources for initiating research. One attendee noted that the scope of services delivered in a school can be controversial. For example, at a given school, practitioners may not be permitted to inform students about where to receive contraceptives, yet onsite day care might be available. Ensuring that school-based and school-linked health centers provide care that is necessary and supported by the community will require the efforts of broad-based community partnerships that include local Healthy Carolinians coalitions, local health departments, health-education training programs, local chapters of the Parent-Teacher Association, and students.

Breakout participants believed that the Healthy Schools division of the North Carolina Department of Public

Instruction was the natural partner to take the lead in the effort to fund healthy-schools coordinators. One of the key challenges in this area is to educate legislators, policy-makers, and local education leaders about the distinct role played by these coordinators and how it differs from that of healthy-living coordinators and school health advisory committees.

There was general agreement that local philanthropies with an interest in improving the school food environment would be ideal leaders in the creation of strategies to ensure that schools provide healthy food. A three-stage process—solicitation of proposals, development of innovative interventions based on the most-promising proposals, and evaluation of the interventions' efficacy at the local level—was envisioned to determine which programs were fiscally sound and could be expanded across the state. Several North Carolina schools were recommended as pilot sites.

Families and communities. Two priority recommendations were considered during the breakout session addressing families and communities. The first was to ensure that programs were evidence based and appropriate for their target populations. Attendees noted that these goals can sometimes conflict—although most evidence-based programs translate reasonably well to most populations, some programs developed and tested elsewhere may not be a good fit for North Carolina. Philanthropies were again seen as the proper leader in this area by funding evidence-based programs, encouraging collaboration among multiple stakeholders, and supporting fidelity to the model by providing technical assistance when possible. Many of North Carolina's larger foundations, such as Prevent Child Abuse North Carolina,⁴ are already moving in this direction and could provide leadership to local and regional funders.

The second recommendation emphasized the need for evidence-based violence-prevention programs. The North Carolina Department of Juvenile Justice and Prevention (DJJDP) allocates funds to Juvenile Crime Prevention Councils (JCPCs) in each North Carolina county to support community-based sanctions (ie, alternatives to incarceration) and community-level programs for preventing delinquency and substance abuse. Similar to foundations and other funding agencies, JCPCs have tremendous influence over the quality of the programs they support. Accordingly, JCPCs should work with the DJJDP to focus funding efforts on evidence-based programs and should include representatives in local health partnerships to ensure that the funded programs are having their intended effects. Although the DJJDP was identified as the appropriate leader for implementation of this recommendation, individuals can contribute at the community level. For example, members of the public can influence the work of JCPCs by educating members about the importance of evidence-based programs or by trying to become members of their local JCPC.

State-level public policies. The policy work group was charged with discussing the implementation of two priority recommendations. The first addressed improving driver-education courses. Because the North Carolina Child Fatality Task Force has played an active role in this area, it was considered a natural leader of this initiative, with key partners including the North Carolina Department of Transportation, the North Carolina State Highway Patrol, the Governor's Highway Safety Program, and the University of North Carolina Highway Safety Research Center. The second recommendation was to reduce the incidence of sexually transmitted diseases and unintended pregnancies among adolescents. The Healthy Youth Act⁵ was seen as a tremendous victory for adolescent health because it allows the delivery of evidence-based curricula and programs, and attendees thought that the Adolescent Pregnancy Prevention Campaign of North Carolina should take the lead on monitoring provisions in the Act to ensure it is as effective as possible. The North Carolina Division of Public Health was suggested as the lead agency for activities to prevent sexually transmitted diseases among adolescents. With regard to the prevention of unintended pregnancy, a number of strategies were suggested. For example, one attendee cited a recent policy change in Wisconsin that increased access to contraceptives driven largely by student advocacy and involvement.

Advisory Board

Part of the grant provided by the Duke Endowment in support of the NCIOM task force was dedicated to implementation of the task force recommendations. In addition to in-kind support from other partners, these resources increase the likelihood that progress on implementation will be made in a timely manner. The advisory board has met twice since the summit, reviewing progress in carrying out the recommendations and identifying opportunities for collaboration. In addition, the NCIOM will conduct a follow-up meeting with all members of the Task Force on Adolescent Health in late 2011 or in 2012 to track progress of the recommendations. Even in the past six months, a number of recommendations have met with some success. For example, the John Rex Endowment recently awarded a grant to YES! (Youth Empowered Solutions) to help them advocate for evidence-based programs in Wake County, and the Healthful Living Course of Study (available at: <http://www.ncpublicschools.org/curriculum/healthfulliving/scos>), a curriculum guide that includes the competencies for physical education and health education, is under revision. The advisory board serves as a focal point of efforts to ensure that progress on these key strategies continue. For more information about the advisory board and about how to partner with the NCMP, please visit the NCMP Web site. **NCMJ**

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