EVIDENCE TA BRIEF:
Measures and Strategies around Adolescent Transition of Care

QUERY

Identifying measures and best practices around Adolescent transition of care

This report is designed to act as a conversation starter. The MCH Evidence team is available to examine any portions of this report in more detail. Please do not hesitate to reach out for further discussion.

Included in this report:

- **SPMs and ESMs developed by other states**
- **Priorities** from State Action Plans
- **Evidence-based strategies** pulled from both AMCHP's Innovation Hub and What Works for Health
- **Evidence-based resources** drawn from the MCH Digital Library

State Performance Measures. These SPMs have been developed by other states to address Adolescent Transition of Care. You can review the SPMs to see if any resonate with your goals. Evidence Center staff are available to talk through how you could modify select SPMs to serve your needs.

State	SPM
TN	Number of youth with special health care needs receiving transition services
	Number of transition self-advocates

Evidence-based Strategy Measures. These ESMs have been chosen by other states to address Adolescent Transition of Care. You can review the ESMs to see if any resonate with your goals. Evidence Center staff are available to talk through how you could modify select ESMs to serve your needs.

State	ESM
OR	Young adult with medical complexity/family participation in transition preparation appointments
OK	The number of providers who address transition to adult health care in their practice
CA	Percentage of local MCAH programs that implement a Scope of Work objective focused on CYSHCN public health systems and services.
ND	Percentage of individuals age 14 to 21 served in SHS multidisciplinary clinics that received a transition assessment.
UT	Percentage of children with special health care needs who report the transition plans assisted them (report a change in knowledge, skills or behavior) in transitioning to adulthood.
PR	Percent of YSHCN who receive care at the RPCs and has completed a transition readiness assessment in Puerto Rico by September 2021-2025
AL	Percent of YSHCN enrolled in the State CSHCN program with a transition plan in place.
GA	Percent of youth/young adults enrolled in the Department's Title V program for Children and Youth with Special Health Care Needs (CYSHCN) that transfer to an adult provider.
KS	Percent of youth with special health care needs, ages 12 to 21, who have one or more transition goals achieved on their action plan by the target completion date
MA	Percent of youth ages 14 and older receiving services from the DPH Care Coordination Program who receive health transition information and support from their Care Coordinator
IA	Percent of youth ages 12--21 served by Child Health Specialty Clinics who have completed a transition checklist
NH	Percent of young adults with special health care needs, ages 18-21, who identify an adult health care provider at discharge from the Title V program
WI	Percent of Regional Center information and referral staff who report competence in explaining youth health transition concepts
IL	Percent of provider practices that were provided technical assistance on transition and have incorporated the six Core Elements of Transition into their practices
SC	Percent of pediatric providers that use telehealth to assist CYSHCN transition to adult care
AR	Percent of PCP practices of transition age children (12 through 17) receiving Title V CSHCN services that participate in the Six Core Elements of Health Care Transition self-assessment
TX	Percent of families of transition age youth with special health care needs receiving professional help with their child's transition to adulthood
NJ	Percent of CYSHCN ages 12-17 years served by Special Child Health Services Case Management Units (SCHS CMUs) with at least one transition to adulthood service
MI	Percent of CSHCS clients age 18 to 21 years in selected diagnosis groups that have transferred care from a pediatric to an adult provider
VT	% of CYSHN that have had a transition planning meeting by their 18th birthday
VA	Number of providers in Virginia who have completed the transition training module
IN	Number of participants in Center for Youth and Adults with Conditions of Childhood (CYACC) clinical services
ME	Number of families of 15 - 17 year olds with special health care needs who attend the Supported Decision-Making class
DC	Number of CSHCN provided with transition services
KY	Employ Health Care Transitions (HCT) Process Measurement tool towards assessing progress on implementation of Six Core Elements of Health Care Transitions statewide
HI	Degree to which the Title V Children and Youth with Special Health Needs Section promotes and/or facilitates transition to adult health care for Youth with Special Health Care Needs (YSHCN), related to Six Core Elements of Health Care Transition 2.0
AL	Percent of YSHCN enrolled in State CSHCN program who report satisfaction with their transition experience to adulthood

State	ESM
WI	Percent of participants trained on youth health care transition concepts who report a change in knowledge, skills, or intended behavior following the training
AR	Percent of key stakeholders and referral sources who participated in the Title V CSHCN Health Care Transition training with increased knowledge of Health Care Transition and Health Care Transition services provided by Title V CSHCN
IL	Percent of DSCC program participants ages 12-21 with a transition goal included in the person-centered care plan
UT	Percent of adolescents and youth with special health care needs ages 12-18 who receive a transition plan
TN	Number of transition resource kits disseminated
GA	Number of stakeholders, state agencies, and community partners that collaborate with the Department to improve health care transition for youth/young adults with or without special health care needs
ND	Number of educational opportunities provided to health care professionals/providers from Title V regarding health care transition
IN	Number of adult and pediatric providers who have received training in transition services and caring for CYSHCN
AR	Percent of transition age CSHCN (ages 12 through 17) served by Title V CSHCN who received transition services and supports in the past 12 months from Title V CSHCN
WI	Percent of systems or practices that have a transition policy or guideline (formal written commitment)
UT	Percent of providers trained in transition who created a transition policy for the adolescents and youth in their practice
IN	Percent of participants who feel empowered to make decisions effecting their health and well-being
TN	Number of youth with special health care needs receiving transition training
ND	Number of educational opportunities provided to school personnel from Title V regarding health care transition
TX	Decrease percent of families of transition-age youth who have not prepared for medical transition to adulthood
AR	Percent of public school personnel who participated in the Title V CSHCN Health Care Transition training with increased knowledge of Health Care Transition and Health Care Transition services provided by Title V CSHCN

State and Jurisdictional **S**trategies related to Adolescent Transition of Care

State	Priority Needs	Strategies
AL	Lack of or inadequate access to services necessary for CSHCN to transition to all aspects of adult life	• The state CSHCN program staff, including the Parent Consultant, will conduct a transition readiness assessment at age 14 using a standardized tool, administered periodically, and discuss needed self-care skills and changes in adult-centered care. The state CSHCN program staff, including the Parent Consultant, will incorporate transition planning into their existing plan of care, starting at age 14 partnering with youth and families in developing transition goals and preparing and updating a medical summary and emergency care plan. Provide education to families about Teen Transition clinic and the benefits of attending. Provide education to staff to guide implementation of transition strategies. The state CSHCN program staff will identify adult providers to accept program clients, complete a transfer package for youth leaving the program and follow-up with the provider regarding the YSHCN's transfer status. Obtain feedback on transition experience of young adults ages 21-26
AR	Transition to Adulthood	• Conduct Health Care Transition trainings for public school personnel. • Use pre-/post-test results to improve training and evaluate change in knowledge. • Use the Six Core Elements of Health Care Transition self-assessment tools for practitioners from Got Transition to determine the level of support that PCPs of transition age CSHCN (12 through 17) served by Title V CSHCN are offered in transitioning or integrating into an adult health care practice. • Discuss transitioning or integrating CSHCN into adult health care practices and have the practice complete the self-assessment tool over the phone or mail/email the self-assessment tool. • Provide transition resource(s) from Got Transition, the results of their practice's self-assessment, and the aggregate results from all participating practices to each practice that responded to the self assessment tool. • Utilize the Health Care Transition Training needs survey and Health Care Readiness Checklist to obtain input from youth, families, and stakeholders on Health Care Transition Training needs and update the training for the audience being trained. • Administer pre-test and post-tests to determine level of increased learning. • Determine Title V records to be audited using an unduplicated report of Title V Transition age youth (12 through 17) representing 12 months of youth. • Perform annual Quality Improvement (QI) audits of Title V Transition age youth to determine the percentage that received a defined Health Care Transition service in the past 12 months. • Train / re-train staff as necessary.
FL	Improve health care transition for adolescents and young adults with special health care needs to all aspects of adult life	• CMS Title V staff will receive transition education during orientation and annually with completion documented through an electronic reporting system. • Providers are provided with transition education, training, and resources. Promote the six core elements of health care transition per national guidelines. • Educators are provided with transition education, training, and resources. • Assess, develop, monitor, improve quality, and promote public access to transition-specific, age-appropriate education materials to support the aspects of health, work/school, self-determination, and self-management for children with special health care needs.

		• Assess, develop, monitor, improve quality, and promote community-based resources and other supports necessary to facilitate and achieve successful health care transition for patients and families with special health care needs. • Promote growth in the youth voice and program involvement at the community, state, and national level for health and education transition specific activities.
ID	Promote smooth transition through the life course for CSHCN	• Partner with Idaho Parents Unlimited - IPUL (State's Family to Family Resource Center) to increase family engagement, provide caregiver/parent education, assist with family navigation, provide Title V program consultation. • Partner with IPUL to develop digital resources that empower teens and young adults to take an active role in their transition into adulthood. • Support the Idaho Children's Special Health Program to provide financial support to uninsured CSHCN for payment of eligible medical claims. • Participate on the state's Emergency Medical Services for Children (EMSC) Advisory Board to represent the CSHCN population.
IL	Strengthen transition planning and services for children and youth with special health care needs	• Promote public education on transition services through use of social media and outreach presentations at community organizations. • Partner with health care providers to educate and support practice initiatives focused on preparation for transition to adulthood, including providing technical assistance to practices on using the 6 Core Elements of Transition 3.0 Toolkit for Providers, and developing youth- focused educational resources for provider practices.
KY	Transition services for CYSHCN and transition education for all children	• Survey pediatricians on their transitions awareness and processes to inform education efforts for pediatricians and CYSHCN. • Identify challenges for transition using the HCT tool by community providers. • Based on survey results, develop and provide education regarding successful transition process and use of HCT tool for evaluation of transition outcomes. • Repeat survey evaluation.
ME	Support adolescents with SHN's transition to adult care	• Build provider awareness on importance of purposefully transitioning CSHN adolescent medical care to adult care. • Increase collaboration between Medicaid and Title V.
MA	Support effective health-related transition to adulthood for adolescents with special health needs	• Increase access to health transition resources and information for families, youth, and providers. • Provide culturally and linguistically appropriate services and supports to youth and their families based on individual needs prior to and throughout the transition process. • Engage youth and young adults with special health needs and their families to ensure youth voice in efforts to strengthen the system and aligns services around health transition. • Engage internal (MDPH programs serving transition age youth) and external partners (clinicians, non-medical providers, sister agencies) to strengthen the system and align services around health transition for young adults.
PR	Increase the number of YSHCN who receive adequate support and services for their	• Continue implementing the six core elements of Got Transition at the RPCs. • The Health Care Transition Committee (HCTC) will continue developing the Transition Guide for RPCs health care providers.

	transition to adult health care	• Explore possibilities to develop collaboration with agencies and community organizations associated with transition to adulthood. • Communicate with youth through focal groups and other means to know their opinions, priorities, and recommendations.
SC	Enhance and expand transition in care/services for CYSHCN from pediatric/adolescent to adulthood	• Support telehealth efforts that provide transition care access for CYSHCN. • Collaborate with the SC Telehealth Alliance to identify telehealth specialist networks for CYSHCN.
TN	Improve transition from pediatric to adult care among children with special health care needs	• Inform, educate and link YSHCN, families and providers to available transition resources and services, and how to access those services. • Promote successful transition through educational opportunities and self-advocacy training. • Inform, educate and link YSHCN, families and providers to available transition resources and services, and how to access those services. • Promote successful transition through educational opportunities and self-advocacy training.
TX	Improve transition planning and support services for children, adolescents, and young adults, including those with special health care needs	• Assess level of CYSHCN and family understanding of transition from pediatric to adult health care. • Educate and reach out to families of CYSHCN to improve understanding of transition from pediatric to adult health care. • Support families to improve provision of youth transition services from pediatric to adult health care. • Assess level of CYSHCN providers' understanding of transition from pediatric to adult health care. • Educate and reach out to providers of CYSHCN to improve understanding of transition from pediatric to adult health care.
UT	Transition to adulthood	• CSHCN Bureau to create a stakeholder work group to organize and unify existing educational materials and market on importance of transition to adulthood. • Determine best practices for educating the public, including medical and behavioral health providers, on the importance of transition to adulthood through a variety of traditional and on-line marketing, informational, and educational modules. • Work group to evaluate and select database to collect statewide data on transition efforts. • Survey families of transition-age youth who have been trained on the unified transition curriculum to assess skill development and progress toward reaching transition goals.

AMCHP's Innovation Station

Title	Link	Category
Oregon Youth Transition Program	https://www.amchpinnovation.org/database-entry/oregon-youth-transition-program/	Best
Texas Children's Hospital Healthcare Transition Planning Tool	https://www.amchpinnovation.org/database-entry/texas-childrens-hospital-healthcare-transition-planning-tool/	Best
Got Transition's Six Core Elements of Health Care Transition in Medicaid Managed Care	https://www.amchpinnovation.org/database-entry/got-transitions-six-core-elements-of-health-care-transition-in-medicaid-managed-care/	Promising
Rhode Island Department of Health Internship Program for Youth With Special Healthcare Needs	https://www.amchpinnovation.org/database-entry/rhode-island-department-of-health-internship-program-for-youth-with-special-healthcare-needs/	Promising
Adolescent Champion Model	https://www.amchpinnovation.org/database-entry/adolescent-champion-model/	Promising
Youth Advisory Council	https://www.amchpinnovation.org/database-entry/youth-advisory-council/	Emerging
Transition Interagency Group Envisioning Realization of Self (T.I.G.E.R.S.)	https://www.amchpinnovation.org/database-entry/transition-interagency-group-envisioning-realization-of-self-t-i-g-e-r-s/	Emerging
Youth and Young Adult Transition – Children's Medical Service	https://www.amchpinnovation.org/database-entry/youth-and-young-adult-transition-childrens-medical-service/	Emerging
Dare to Dream Youth: Leadership Development Initiative	https://www.amchpinnovation.org/database-entry/dare-to-dream-youth-leadership-development-initiative/	Emerging
Patch Toolkits: Patch For Teens & Patch for Parents – Helping Teens and Their Parents Understand Adolescent Rights and	https://www.amchpinnovation.org/database-entry/patch-toolkits-patch-for-teens-patch-for-parents-helping-teens-and-their-parents-understand-adolescent-rights-responsibilities-in-health-care-settings/	Cutting-Edge

What Works for Health

Paid Family Leave	https://www.countyhealthrankings.org/take-action-to-improve-health/what-works-for-health/strategies/paid-family-leave	Scientifically Supported
Nurse-Family Partnership	https://www.countyhealthrankings.org/take-action-to-improve-health/what-works-for-health/strategies/nurse-family-partnership-nfp	Scientifically Supported
Earned Income Tax Credit	https://www.countyhealthrankings.org/take-action-to-improve-health/what-works-for-health/strategies/earned-income-tax-credit-eitc	Scientifically Supported
Preconception Education Interventions	https://www.countyhealthrankings.org/take-action-to-improve-health/what-works-for-health/strategies/preconception-education-interventions	Some Evidence
Community Health Workers	https://www.countyhealthrankings.org/take-action-to-improve-health/what-works-for-health/strategies/community-health-workers	Some Evidence
Magnolia Project	https://www.countyhealthrankings.org/take-action-to-improve-health/what-works-for-health/strategies/magnolia-project	Expert Opinion

Resources for Increasing Workforce Capacity around Adolescent Transition of Care

Six Core Elements of Health Care Transition: https://www.gottransition.org/six-core-elements/

AMCHP's implementation toolkit for National Performance Measure 12: Percent of adolescents with and without special healthcare needs who received services necessary to make transitions to care. This toolkit contains examples of strategies state Title V programs can use to address National Performance Measure 12: Percent of adolescents with and without special health care needs who received services necessary to make transitions to adult care. Strategies are listed in these categories: (1) youth and family education and leadership development; (2) health care professional workforce development; (3) care coordination; (4) communications and social media; and (5) measurement and assessment.
https://create.piktochart.com/output/34444572-npm-12-implementation-toolkit

Medicaid contract language to expand the availability of pediatric-to-adult transitional care. This document describes contract language options states can use to provide for the availability of pediatric-to-adult transitional care, in the areas of definitions, member services and education, provider networks, covered services, care coordination, and quality and evaluation. Appendices list actual 2018/2019 contract language on the same topics from selected states.
https://www.thenationalalliance.org/publications/2020/9/11/medicaid-managed-care-contract-language-transition-care

Incorporating pediatric-to-adult transition into NCQA patient-centered medical home recognition: 2019 update: This resource is intended to facilitate the application of nationally-recognized transition tools to address specific criteria developed by the National Committee for Quality Assurance (NCQA) in their 2017 Patient-Centered Medical Home standards. Contents include NCQA criteria and guidance cross-walked with relevant sample tools. Topics include team-based care and practice organization, knowing and managing patients, patient-centered access and continuity, care management and support, care coordination and care transitions, and performance measurement and quality improvement. Descriptions of the tools are also provided.
http://gottransition.org/resource/incorporating-hct-into-hcqa-2019

Healthcare transition: Building a program for adolescents and young adults with chronic illness and disability. This book addresses aspects of transitioning from pediatric to adult health care for adolescents and young adults with chronic illness or disability. It includes a framework, tools, and case-based examples to inform developing and evaluating a health-care-transition (HCT)-planning program that can be implemented regardless of an individual's disease or disability. Selected topics include defining successful transition, financing transition, special issues in transition, and models of HCT programs. One chapter provides an overview of the Dental Education in the Care of Persons with Disabilities Program at the University of Washington School of Dentistry.
https://link.springer.com/book/10.1007%20%2F978-3-319-72868-1

EVIDENCE TA BRIEF:
Measures and Strategies around Adolescent Well-Visit

QUERY

Identifying measures and best practices around Adolescent Well-Visit

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Evidence-based Strategy Measures. These ESMs have been chosen by other states to address Adolescent Well-Visit. You can review the ESMs to see if any resonate with your goals. Evidence Center staff are available to talk through how you could modify select ESMs to serve your needs.

State	ESM
IN	The percent of health care providers who report knowledge, behavior, and confidence change in adolescent health care after Adolescent Champion Model training
OK	The number of adolescents trained on Teen Pregnancy Prevention/Positive Youth Development curriculum
NH	Percentage of adolescents ages 12-21 at MCH-contracted health centers who have at least one comprehensive well-care visit with a PCP or an OB/GYN practitioner during the measurement year
PR	Percent of youths in schools and communities reached with the PR Youth Health Literacy Toolkit (PR-YHLT) that increase their awareness regarding how to use the health care system (pre-post survey) in Puerto Rico by September 2021-2025
NY	Percent of youth-serving programs that provide training on adult preparation subjects, such as accessing health insurance, maintaining their routine preventive medical visits, healthy relationships, effective communication, financial literacy, etc.
AK	Percent of students who have a comprehensive wellness visit at school-based health centers
MA	Percent of School Based Health Center clients who are male
NV	Percent of Medicaid EPSDT eligible adolescents, ages 12 through 17, who received at least one initial or periodic screen
CA	Percent of AFLP participants who received a referral for preventive services
ND	Percent of adolescents served in Title X clinics
CT	Percent of adolescents 12 through 17 with at least one completed BMI at time of medical visit at all school-based health centers
OH	Percent of adolescents (12-17) served by Medicaid with adolescent well visit
KS	Percent of adolescent program participants, ages 12 through 17, that had a well-visit during the past 12 months
WI	Percent of Adolescent Champion Model sites that obtain Adolescent Centered Environment certification
IA	Partner with at least two other organizations or agencies, including but not limited to family planning, substance abuse, youth serving organizations, parent and family organizations, universities, and/or community colleges to promote adolescent well
SC	Number of telehealth providers that adopt a standard of care for adolescents
VT	Number of public schools implementing the PATCH for Teens curriculum as part of their Health Education Curriculum
AZ	Number of healthcare clinics implementing University of Michigan's Adolescent Champion Model at their sites
MS	Number of clinic sites engaged in youth-centered care quality improvement cycles
NC	Number of adolescents receiving a preventive medical visit in the past year at a local health department or school health center
IL	Number of adolescents (ages 10-21) served by school-based health centers
WA	Increase the percent of tenth graders in school districts with active DOH-supported interventions who have accessed health care in the past year
PA	In schools with a Health Resource Center (HRC), the percent of youth within that school utilizing HRC services
DE	Finalize the School Based Health Center Strategic Plan, which is anchored in best-practices
HI	Develop and disseminate a teen-centered, Adolescent Resource Toolkit (ART) in collaboration with community health and youth service providers to promote adolescent health and annual wellness visits
MN	Average depression screening rate (percentage of well-visits where depression screenings are occurring) in clinics participating in the state's Collaborative Improvement and Innovation Network (CoIIN) project
PA	Number of young adult and adolescent males receiving trainings through Coaching Boys into Men Curriculum
PA	The percentage of adolescents aged 21 years of age or younger at risk of unintended pregnancy who are provided a most effective or moderately effective contraceptive method

PA	The percentage of adolescents aged 21 years of age or younger at risk of unintended pregnancy who are provided a LARC method
WY	Percentage of clinics receiving Adolescent Centered Environment certification
NY	Percent of youth-serving programs that engage youth, particularly youth representative of populations impacted by health disparities, in program planning and implementation
SC	Percent of school districts that offer telehealth services and access to students
WI	Percent of providers responding who agree or strongly agree that they have been able to provide care that better addresses the needs, preferences, and concerns of their teen patients because of the PATCH for Providers Program
NC	Percent of adolescents who had a behavioral health screening at time of preventive care visit
CT	Percent of adolescents 12 through 17 with a depression screening at the time of medical visit at all school-based health centers
PA	Number of referrals provided to school and community-based resources (HRCs)
AZ	Number of engagement activities that promote adolescent preventive medical visits
IL	Number of adolescents (ages 10-21) receiving a well visit through services provided by grantees of the adolescent health program
DE	Number of adolescent receiving servicecs at a school-based health center who have a risk health assessments completed
PA	Percent of visits that include counseling (HRCs)
WY	Percent of clinics showing improvement in at least 50% of selected topics through the ACE-AP
DE	Increase the # of unique m-health health visits provided to SBHC enrollees
WY	% of participating ACE-AP clinics who focus efforts on Behavioral Health Clinical Practices
PA	Number of trainers trained in the Olweus Bullying Prevention Program
PA	Number of youth participating in the Olweus Bullying Prevention Program (OBPP) at a community-based organization

State and Jurisdictional **S**trategies related to Adolescent Well-Visit

State	Priority Needs	Strategies
DE	Increase the number of adolescents receiving a preventative well-visit annually to support their social, emotional and physical well-being	• Partner with adolescent serving organizations or agencies, including but not limited to family planning, substance abuse and/or community colleges to promote adolescent well visits • Complete strategic plan for SBHCs • Improve data collection at SBHCs • Communicate with and share resources with school nurses statewide to promote adolescent well visits • Provide school-based access to confidential mental health screening, referral and treatment that reduces stigma and embarrassment often associated with mental illness, emotional disturbances and seeking treatment • Ensure adolescents are enrolled in a health insurance program • Use media strategies (e.g., facebook and instagram posts, websites) in conjunction with other strategies to promote comprehensive adolescent well visits and healthy lifestyles • Partner with SBHC and other interested providers to educate and encourage pediatric providers to incorporate transition into routine adolescent well visits
DC	Improving access to healthcare among adolescents.	• Introduce early connections to a medical home through care coordination and collaboration (e.g home visiting, CBOs) • Provide practice-based navigation services to families of children in accessing and coordinating medical care and community resources • Work with SBHCs to implement adolescent-friendly approaches including confidential services; a safe, non-judgmental clinic environment; and the availability of services that address adolescents' most prevalent needs (sexual and mental health services) in the school • Assist students with finding an adult therapist and checking eligibility to enroll in Medicaid (transition) • Collaborate with universities to assist with connecting students to adult medical homes • Train pediatric/adult providers around transition • Work with school health services (school nurses and SBHCs) to provide transition planning to seniors • Build communications/media to promote transition
HI	Improve the healthy development, health, safety, and well-being of adolescents	• Collaboration. Develop partnerships with community health and youth service providers to promote adolescent health and annual wellness visits • Engagement. Work with adolescents and youth service providers to develop and disseminate informational resources to promote access to adolescent preventive services • Workforce Development. Provide resources, training, and learning opportunities for adolescent caregivers, community health workers, and other service providers to promote teen-centered, annual wellness visits
IL	Assure access to a system of care that is youth-friendly and youth-responsive to assist adolescents in	• Facilitate the Illinois Adolescent Health Program (AHP) to increase adolescents' access to preventive and primary through adolescent-friendly clinics that provide comprehensive well- care visits, address behavioral, social, and environmental determinants of health

	learning and adopting healthy behaviors	• Collaborate with the Illinois Chapter of the American Academy of Pediatrics to encourage providers to adopt Lesbian, Gay, Bisexual and Transgender and adolescent-friendly services and spaces • Certify and support school-based and school-linked health centers to expand access to primary health care, mental health, and oral health services for Illinois children and adolescents • Support the implementation of the Chicago Healthy Adolescents and Teens (CHAT) program to improve sexual health education, sexually transmitted infections (STIs) screening, linkage to health care services, and access to condoms among CDPH adolescent-serving partners
KS	Adolescent and young adults have access to and utilize integrated, holistic, patient-centered care to support physical, social and emotional health	• Engage partners to promote a stronger cross-system recommendation to conduct complete annual well visits during adolescence utilizing all elements of the Bright FuturesTM guidelines • Conduct annual provider educational efforts to support provider knowledge acquisition regarding the importance of comprehensive, quality adolescent well visits and the Bright FuturesTM Guidelines • Support the development of a peer-to-peer awareness campaign, developed and delivered by adolescents and young adults, to express the importance of comprehensive, quality well visits and youth-inspired environments • Engage local health agencies to implement youth-friendly care approaches from the Adolescent Health Institute in their facilities • Partner with adolescents and young adults to identify, develop, and disseminate standardized guidance and educational materials focused on empowerment and health promotion (e.g., healthy living and eating, physical activity, mental health, substance use, social media, healthy relationships) • Increase awareness of adolescents and young adults about services and programs available to them in their community that are including and accessible to them through 2-1-1 and 1-800-CHILDREN resources and disseminate/share with youth-serving organizations and partners • Distribute The Future is Now THINK BIG – Preparing for Transition Planning workbooks to schools for distribution during enrollment, orientation, and/or other appropriate events • Partner with prevention initiatives to provide events/programs and develop community-based education classes, designed with adolescent and young adult input, to reduce risky behaviors and support youth in gaining important skills necessary for transition to adulthood (e.g., budgeting, independent living skills, furthering education, gaining employment, stress management, healthy relationships) • Develop protocols for MCH local agencies to identify when an adolescent or young adult might need behavioral health services, make referrals to treatment when needed, assure timely access to care, and offer support to families throughout the process • Partner with other state agencies and community-based organizations to promote resources that reduce the stigma and embarrassment often perceived as associated with mental illness, emotional disturbances, and seeking treatment • Promote evidence-based suicide prevention initiatives and accessible crisis services through school and out-of-school activities
LA	Improve adolescent mental health and well-being	• Develop a common message for adolescent mental health by creating shared priorities for mental health services and statewide culture change

MD	Adolescent Well Visit	• Continue the Healthy Kids Program under the EPSDT Program to enhance the quality of health services delivered by Medicaid providers. Continue the Sexual Risk Avoidance Education grant program to promote sexual risk avoidance. Continue the Personal Responsibility and Education Program to promote positive youth development. Implement the Maryland Optimal Adolescent Health Program to reduce teen pregnancy • Continue to support local health department's school based health services. Continue to track and monitor adolescents screened for mental/behavioral health through Medicaid data
MI	Expand access to developmental, behavioral, and mental health services through routine screening, strong referral networks, well-informed providers, and integrated service delivery systems	• Provide Title V funding to local health departments to address developmental, behavioral, and mental health needs • Provide resources to Regional Perinatal Quality Collaboratives to implement and expand use of universal perinatal screening at prenatal care clinics within their respective regions B2) Provide resources to Regional Perinatal Quality Collaboratives to implement and expand telehealth services inclusive of behavioral and mental health within their respective regions • Engage behavioral health stakeholders to assure issues and concerns related to children with special health care needs are represented
NM	Support the breadth of program and services that address behavioral health conditions in the adolescent population	• Increase knowledge and awareness of youth suicide and prevention through the Annual Youth Peer to Peer Helper Trainings for 400 youth • Increase youth resiliency through program activities using the 6 Step Helping Skills" to assist peers • Continue to update, refine and develop other evaluation tools for the PYD guiding principles, 40 developmental assets
ND	To Increase the percent of adolescents who have a preventive medical visits	• Engage tribal nations and other existing adolescent groups to consult in activities related to adolescent health • Engage with Title X partners with similar activities to build and/or expand on current activities • By September 30, 2021, Title V will utilize various methods of data collection to identify and overcome barriers to accessing mental/behavioral health services for adolescents •
PR	Improve health and wellbeing of adolescents	• Review the Youth Health Promoters Project (YHPP) curriculum to incorporate additional strategies/ activities related to bullying prevention and mental health/wellbeing • Increase awareness about mental health/wellbeing and bullying prevention in youth and adults, including parents/caregivers and health care providers • Develop a comprehensive project that incorporate youth, parents, and school communities that promote school connectedness, respect, healthy relationships and equity to eradicate bullying to be implemented in a youth health promoters YHPP in collaboration with Department of Education • Develop Youth Intervention Guides to promote resilience and reduce youth trauma after stressful events • Develop and disseminate an Emergency Preparedness and Response guide that takes into account the needs of adolescents and young adults • Empower youth to adopt healthy behaviors through positive youth development initiatives

		• Establish collaboration with MCAH stakeholders to implement PR Youth Health Literacy Toolkit (YHLT) to provide knowledge about how to use the health care system • Increase awareness of youth health and wellbeing issues including the annual healthcare visit through educational activities and multi media campaign • Implement the Puerto Rico Youth Friendly Healthcare Services Guidelines in a pilot project in FHQC • Collaborate with CSHN Transition to Adult Healthcare Services Committee to assist all youths as they transition from pediatric to adult centered care services in Puerto Rico • Develop and disseminate an Emergency Preparedness and Response guide that takes into account the needs of adolescents and young adultss
SC	Improve coordinated and comprehensive health promotion efforts among the child and adolescent populations	• Establish interagency partnerships to improve coordination between oral health services and well child visits • Increase the physical activity among children, working with internal partners and school districts • Build resilience among South Carolina children through safe and supportive environments • Strengthen anti-bullying efforts by partnering with the Institute for Child Success to draft a white paper on the impact/cost of bullying • Raise awareness regarding the perpetuation and victimization of bullying and their effects through the publication of white papers • Strengthen availability and access to telehealth services for adolescents, including those with special health care needs • Partner with the Telehealth Alliance to develop standards of care for adolescent health • Increase access to youth-centric telehealth services across all 46 counties
WA	Optimize the health and well-being of children and adolescents, using holistic approaches	• Promote use of the Bright Futures guidelines for adolescents among providers • Support and enhance efforts to increase health literacy among adolescents and young adults • Increase the proportion of Washington adolescents who receive appropriate, evidence-based clinical preventive services • Promote preventive care screening and wellness visits for adolescents and young adults • Foster measurable quality improvements in preventive care across the health system to increase adolescent and young adult-friendly care • Promote school-based health strategies to serve adolescent populations where they are • Identify and develop methods to monitor systems and data gaps and improvements needed in adolescent health • Include adolescents in this work through strategies such as building and supporting a youth advisory council and identify other meaningful ways to engage the population to be served • Promote use of the evidence based practice guidelines to adolescent health providers

AMCHP's Innovation Station		
Title	**Link**	**Category**
Core Patch Package – A Replicable, Youth-Driven Intervention To Improve The Way Adolescents Receive, Experience, And Utilize Health Care	https://www.amchpinnovation.org/database-entry/core-patch-package-a-replicable-youth-driven-intervention-to-improve-the-way-adolescents-receive-experience-and-utilize-health-care/	Best
Path Youth Advocacy Fellowship – A Model to Support & Engage Young People in Adolescent Health Conversations at Community & State Level	https://www.amchpinnovation.org/database-entry/patch-youth-advocacy-fellowship-a-model-to-support-engage-young-people-in-adolescent-health-conversations-at-community-state-levels/	Promising
VCHIP- Youth Health Improvement Initiative	https://www.amchpinnovation.org/database-entry/vchip-youth-health-improvement-initiative/	Promising
Adolescent Champion Model	https://www.amchpinnovation.org/database-entry/adolescent-champion-model/	Promising
Adolescent-Centered Environment Assessment Process (ACE-AP)	https://www.amchpinnovation.org/database-entry/adolescent-centered-environment-assessment-process-ace-ap/	Emerging
4 What's Next	https://www.amchpinnovation.org/database-entry/4-whats-next/	Cutting-Edge
Patch Toolkits: Patch For Teens & Patch for Parents – Helping Teens and Their Parents Understand Adolescent Rights & Responsibilities in Health Care Setting	https://www.amchpinnovation.org/database-entry/patch-toolkits-patch-for-teens-patch-for-parents-helping-teens-and-their-parents-understand-adolescent-rights-responsibilities-in-health-care-settings/	Cutting-Edge
What Works for Health		
Nurse-Family Partnership	https://www.countyhealthrankings.org/take-action-to-improve-health/what-works-for-health/strategies/nurse-family-partnership-nfp	Scientifically Supported
Value-based Insurance Design	https://www.countyhealthrankings.org/take-action-to-improve-health/what-works-for-health/strategies/value-based-insurance-design	Scientifically Supported
Telemedicine	https://www.countyhealthrankings.org/take-action-to-improve-health/what-works-for-health/strategies/telemedicine	Scientifically Supported

Resources for Increasing Workforce Capacity around Adolescent Well-Visit

Bright Futures Tool and Resource Kit. This companion to the most current edition of the Bright Futures Guidelines for Health Supervision of Infants, Children and Adolescents, the national standard for well-child care provides updated forms and materials relate to preventive health supervision and health screening for infants, children, and adolescents. These include pre-visit questionnaires, visit documentation forms, parent and patient handouts, supplemental education handouts, and medical screening reference tables.
https://brightfutures.aap.org/materials-and-tools/tool-and-resource-kit/Pages/default.aspx

Healthy development and well-child support chart. This reference chart offers practice-friendly tools to support the pediatric well-child visit. It is designed to be consistent with Bright Futures: Guidelines for Health Supervision of Infants, Children, and Adolescents, 4th edition.
https://shop.aap.org/aap-healthy-development-and-well-child-support-chart-paperback/

Transforming health care for adolescents and young adults: Change package concepts, strategies, and materials to improve access to and quality of preventive services. This set of slides describes change concepts and implementation strategies for increasing awareness, knowledge and perceived benefit of the annual well-visit (AWV) for adolescents and young adults. Initial slides are narrated via audio, rest are visual only.
http://prometheustrain.com/amchp-cp/changepkgs-final-11-02/story_html5.html

Strengthen the evidence for maternal and child health programs: National performance measure 10 adolescent well visit evidence review. This evidence review looks at interventions designed to increase the percentage of adolescents, ages 12 through 17, who received a preventive medical visit in the past year. Contents include an introduction and background; review methods and results, including search results, characteristics of studies reviewed, intervention components, summary of study results, and evidence rating and evidence continuum; and implications of the review.
https://www.mchevidence.org/documents/reviews/npm_10_adolescent_well_visit_evidence_review_may_2018.pdf

Summary of factors influencing well-care performance in top-performing state Medicaid programs. This report summarizes factors influencing adolescent well-care performance in six top-performing state Medicaid programs. State Medicaid officials from the states with the highest adolescent well-care visit performance – RI, CT, TX, NY, NH, and MA – were interviewed to understand the factors contributing to their success.
https://www.thenationalalliance.org/publications/2020/1/3/summary-of-factors-influencing-adolescent-well-care-performance-in-top-performing-state-medicaid-programs