



Unique Needs of the Adolescent

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Adolescence is the transitional bridge between childhood and adulthood; it encompasses developmental milestones that are unique to this age group. Healthy cognitive, physical, sexual, and psychosocial development is both a right and a responsibility that must be guaranteed for all adolescents to successfully enter adulthood. There is consensus among national and international organizations that the unique needs of adolescents must be addressed and promoted to ensure the health of all adolescents. This policy statement outlines the special health challenges that adolescents face on their journey and transition to adulthood and provides recommendations for those who care for adolescents, their families, and the communities in which they live.

Adolescence, defined as 11 through 21 years of age,¹ is a critical period of development in a young person's life, one filled with distinctive and pivotal biological, cognitive, emotional, and social changes.² The World Health Organization³; the Office of Adolescent Health of the US Department of Health and Human Services⁴; the Health and Medicine Division of the National Academies of Sciences, Engineering, and Medicine (formerly the Institute of Medicine)^{5,6}; the *Lancet*,⁷ with 4 international academic institutions⁸; and the Society for Adolescent Health and Medicine⁹ have called for a closer examination of the unique health needs of adolescents. In 2018, *Nature* devoted an issue to the advances in the science of adolescence and called for ongoing further study of this important population.¹⁰ As a leader in adolescent health care, the American Academy of Pediatrics (AAP) is motivated to describe why adolescents are a unique and vulnerable population and why it is crucial that the AAP focus on adolescents' health concerns to optimize healthy development during the transition to adulthood. Addressing the unique needs of adolescents with disabilities is outside the scope of this statement; several statements specific to this population are available at <https://pediatrics.aappublications.org/collection/council-children-disabilities>. In addition, specific guidance around the transition to adult health care is not covered in this statement; please refer to the list of transition resources at the end of this document.

abstract

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The need for comprehensive health services for teenagers has been well documented since the 1990s.¹¹⁻¹³ The AAP advocates for the pediatrician to provide the medical home for adolescent primary care.¹⁴ Other professional societies, such as the Society for Adolescent Health and Medicine, the American Academy of Family Physicians, and the American College of Obstetricians and Gynecologists and school-based health initiatives (<https://www.sbh4all.org/>), recognize the unique needs of adolescents. These organizations recommend an increase in adolescent medicine training, along with the Accreditation Committee for Graduate Medical Education. The Accreditation Committee for Graduate Medical Education currently requires only 1 month of adolescent medicine training from a board-certified adolescent medicine specialist for all pediatric residency programs (adolescent medicine; [Core] IV.A.6.[b].[3].[a].[i]); there must be one educational unit).¹⁵ The importance of addressing the physical and mental health of adolescents has become more evident, with investigators in recent studies pointing to the fact that unmet health needs during adolescence and in the transition to adulthood predict not only poor health outcomes as adults but also lower quality of life in adulthood.¹⁶

HEALTH RISKS IN ADOLESCENCE

A hallmark of adolescence is a gradual development toward autonomy and individual adult decision-making. However, adolescents are often faced with situations for which they may not be prepared, and many are likely to be involved in risk-taking behaviors, such as use of alcohol, tobacco, and other drugs and engaging in unprotected sex. Most recently, there is increased concern about the rise in electronic cigarette use among

adolescence.¹⁷ In fact, most health care visits by adolescents to their pediatricians or other health care providers are to seek treatment of conditions or injuries that could have been prevented if screened for and addressed at an earlier comprehensive visit.¹⁸ Although some risk-taking behavior is considered normal in adolescence, engaging in certain types of risky behavior can have adverse and potentially long-term health consequences. The majority of mortality and morbidity during adolescence, which can be prevented, is attributable to unintentional injuries, suicide, and homicide.¹⁹ Approximately 72% of deaths among adolescents are attributable to injuries from motor vehicle crashes, other unintentional and intentional injuries, injuries caused by firearms, injuries influenced by use of alcohol and illicit substances, homicide, or suicide.^{20,21} These causes of death greatly surpass medical etiologies such as cancer, HIV infection, and heart disease in the United States and other industrialized nations.²¹

The AAP *Bright Futures: Guidelines for Health Supervision of Infants, Children, and Adolescents* recommends a strength-based approach to screening and counseling around these behaviors that lead to mortality and morbidity in adolescents.^{1,22} However, according to the National Ambulatory Medical Care Survey and the National Hospital Ambulatory Medical Care Survey, only 39% of adolescents received any type of preventive counseling during ambulatory visits.²³ Seventy-one percent of teenagers reported at least 1 potential health risk, yet only 37% of these teenagers reported discussing any of these risks with their pediatrician or primary care physician. Clearly, screening for and counseling around these high-risk behaviors needs to be improved.²⁴

New screening codes for depression, substance use, and alcohol and tobacco use as well as brief intervention services may provide opportunities to receive payment for the services pediatricians are providing to adolescents. These include 96127, brief emotional and behavioral assessment (eg, depression inventory, attention-deficit/hyperactivity disorder scale) with scoring and documentation, per standardized instrument, and 96150, health and behavior assessment (eg, health-focused clinical interview, behavioral observations, psychophysiological monitoring, health-oriented questionnaires).²⁵ However, it is important to recognize that coding for specific diagnoses may be challenging if the patient does not want his or her parent(s) to know the reasons for the clinical visit. Adolescent visits and documentation of visits are confidential to promote better access and to protect the rights of adolescents.²⁶

Another trend in the health status of adolescents (reflecting technological advances in pediatric medical care) is the increasing number of pediatric patients with chronic medical conditions and developmental challenges who enter adolescence. Adolescents with chronic conditions face developmental challenges similar to their healthy peers but may have special educational, vocational, and transitional concerns because of their medical issues.²⁷

The prevalence of chronic medical conditions and developmental and physical disabilities in adolescents is difficult to assess because of the variation of study methodologies and categorical versus noncategorical approaches to the epidemiology of chronic illness.²⁸ According to the National Survey of Children's Health, funded by the US Department of Health and Human Services, almost 31% of adolescents have 1 moderate to severe chronic illness, such as asthma or a mental health

condition.²⁹ Other common chronic illnesses include obesity, cancer, cardiac disease, HIV infection, spastic quadriplegia, and developmental disabilities.³⁰⁻³² One in 4 adolescents with chronic illness has at least 1 unmet health need that may affect physical growth and development, including puberty and overall health status as well as future adult health.³³

Within pediatric practice, integrating adolescent-centered, family-involved approaches into the care of adolescents as well as culturally competent and effective approaches (as outlined in *Bright Futures: Guidelines for Health Supervision of Infants, Children, and Adolescents*) has the potential not only to identify threats to well-being but also to create a space to work with families to bolster opportunities for optimal development of all children.¹ When considering the health challenges adolescents face, it is imperative to take into account not only the ethnic and racial diversity of the adolescent population in the United States but also the social and ecologic factors (eg, socioeconomic status, family composition, parental education and engagement, neighborhood and school environment, religion, earlier childhood trauma and toxic stress, and access to health care).

The Search Foundation has conducted research that suggests that for minority youth, a positive ethnic identity is a critical spark for emergence of the required developmental assets to enable adolescents to develop into successful and contributing adults.^{34,35} This theory is supported by a recent study in *The Journal of Pediatrics* that suggests minority youth are still prone to depression because of isolation and discrimination faced during adolescence while navigating neighborhood and school environments, even when they have educated and supportive parents.³⁶

African American male adolescents have the highest rates of mortality, followed by American Indian, white, Hispanic, and Asian American or Pacific Islander male adolescents, pointing to racial and ethnic disparities in adolescent health and the potential to achieve a healthy adulthood.³⁷

The AAP has previously published policy statements addressing the unique strengths and health disparities that exist for specific groups of adolescents, such as lesbian, gay, bisexual, and transgender youth and those in the juvenile justice system, foster care, and the military.³⁸⁻⁴² Pediatricians must pay attention to how care is delivered to the increasingly diverse adolescent populations to prevent a decline in health status and increase in health care disparities.

UNIQUE BIOLOGICAL AND PSYCHOSOCIAL CHANGES OCCURRING DURING ADOLESCENCE

Biological and psychosocial changes that occur during adolescence make this age group unique. Research describing the timing and physiology of puberty has been invaluable in revealing not only differences between racial groups but also between adolescents with different chronic conditions.⁴³⁻⁴⁶

Puberty

Puberty is the hallmark of physiologic progression from child to adult body habitus. Chronic conditions, such as obesity and intracranial lesions, or trauma may cause early puberty, which may put the adolescent at risk for engagement in higher-risk behaviors at an earlier age.⁴⁴ Delayed puberty is often a variant of normal development but may also be seen in adolescents with inflammatory bowel disease, eating disorders, and chronic conditions that create malnutrition as well as adolescents who have undergone treatment of malignancies.

Comorbid mental disease (eg, an eating disorder that causes delayed puberty) or medication for psychiatric illness that causes obesity, which may cause early puberty, can complicate optimal adolescent psychosocial development.

Brain Development

The work of Giedd⁴⁷ and others shows that brain development during adolescence is ongoing and affects behavior and health. Because of changes in signaling that relate to the reward system in which the brain motivates behavior and the continuing maturation of the parts of the brain that regulate impulse control, adolescents may have a propensity to be involved with high-risk behaviors and have heightened response to emotionally loaded situations. In addition, adverse childhood experiences can have an impact on brain development, affecting behaviors and health during adolescence.⁴⁸ During adolescence, there is a “pruning” of gray matter and synapses, which makes the brain more efficient.⁴⁷ White matter increases throughout adolescence, which allows the older adolescent and adult brain to conduct more-complex cognitive tasks and adaptive behavior.⁴⁹

Increasingly, studies show that the adolescent brain responds to alcohol and illicit substances differently than adults.^{50,51} This difference may explain the increased risk of binge drinking as well as greater untoward cognitive effects of alcohol and marijuana.

Sexual Orientation and Gender Identification

Sexual (and gender) development is a process that starts early in childhood and involves negotiating and experimenting with identity, relationships, and roles. In early adolescence, people begin to

recognize or become aware of their sexual orientation.^{52,53}

However, some adolescents are still unsure of their sexual attractions, and others struggle with their known sexual attraction. Adolescence is a time of identity formation and experimentation, so labels that one uses for their sexual orientation (eg, gay, straight, bisexual, etc) often do not correlate to actual sexual behaviors and partners. Sexual orientation and behaviors should be assessed by the pediatrician without making assumptions. Adolescents should be allowed to apply and explain the labels they choose to use for sexuality and gender using open-ended questions.^{54–56}

Sexual minority adolescents may engage in heterosexual practices, and heterosexual adolescents may engage in same-sex sexual activity. Depending on their specific behaviors and the gender of various partners, all sexually active adolescents may be at risk for sexually transmitted infections and unplanned pregnancy. Sexual minority youth are at higher risk of sexually transmitted infections and unplanned pregnancy, often because they do not receive education that applies to their sexual behaviors and are less likely to be screened appropriately (<http://www.cdc.gov/healthyyouth/disparities/smy.htm>).^{57,58}

Sexual minority and transgender youth, because of the stigma they face, are also at higher risk of mental health problems, including depression and suicidality, altered body image, and substance use.³⁸

There is strong evidence that when sexual minority and transgender youth feel they cannot express their true selves, they go underground by either hiding or denying their attractions and identity.⁵⁹ When this is combined with reinforcing parental rejection, bullying, etc, it is believed to lead to internalization, low self-

esteem, and ultimately, depression and suicide.⁵⁹ Using an explanation like this places the problem on the societal context, not the adolescent or his or her identity.^{38,39,60,61}

A relatively higher proportion of homeless adolescents are lesbian, gay, bisexual, transgender, and queer or questioning youth.⁶¹ They leave their family homes because of abuse or having been thrown out. These adolescents are at high risk for victimization and often need to engage in unsafe sexual practices to provide themselves food and shelter.⁶¹

Mental health problems may become more pronounced when sexual minority teenagers come out during adolescence to unsupportive family members and friends or health care providers.³⁸ These youth are more likely to experience violence both in their homes and in their schools and communities. Studies have shown that sexual minority youth reveal higher rates of tobacco, alcohol, marijuana, and other illicit substance use.⁶²

Most adolescents identify by and express a gender that conforms to their anatomic sex. However, some adolescents experience gender dysphoria with their anatomic sex when entering puberty. As they consider transgender options, they are at an increased risk of mental or emotional health problems, including depression and suicidality, victimization and violence, eating disorders, substance use, and unaccepting or intolerant family members and peers. Crucial to the successful navigation of gender dysphoria issues are health care providers who can assist transgender youth and families to achieve safe, healthy transitioning both in the postponement of puberty, when indicated, and in transitioning to preferred gender with psychosocial and behavioral support.⁵⁹

Legal Status

Adolescence heralds a change of legal status, in which the age of 18 or 19 years transforms legal status from minors to adults with full legal privileges and obligations related to health care. However, certain states afford minors the right to confidentiality and consent to or for reproductive and mental health and substance use treatment confidential health services.^{26,63} Generally, minors may receive confidential screening and care for sexually transmitted infections in all 50 states and the District of Columbia. However, accessing contraception to prevent unwanted pregnancy as well as the ability to self-consent to pregnancy options counseling, prenatal care, and termination of pregnancy vary between states.⁶⁴ These discrepancies also exist in accessing outpatient mental health and substance use services. Many adolescents in need of these services do not know they may have the right to access them on their own and may avoid interaction with the health care system to assist with reproductive and mental health concerns.¹⁶ Delaying such care leads to adverse health outcomes.¹⁶ A recent survey confirms that adolescents value private time with their health care providers, with confidentiality assurances by health care providers.⁶⁵ The need for office policies in negotiating private time was suggested. Moreover, health care providers reported needing more education in the provision of confidential services.⁶⁶ Adolescents in foster care may also be limited in their autonomous access to confidential services, which varies state to state.⁴¹ In certain states, pregnant and parenting adolescents may have the right to consent for their care and the care of their child (<https://www.guttmacher.org/state-policy/explore/minors-rights-parents>, [4](https://www.schoolhouseconnection.org/state-laws-on-minor-consent-for-routine-</p></div><div data-bbox=)

medical-care/). Few adolescents are considered emancipated minors and, thereby, entitled to all legal privileges of adults.⁶⁷

Mental Health and Emotional Well-being

Mental health and emotional well-being, in combination with issues pertaining to sexual and reproductive health, violence and unintentional injury, substance use, eating disorders, and obesity, create potential challenges to adolescents' healthy emotional and physical development.⁶⁸ Approximately 20% of adolescents have a diagnosable mental health disorder.⁶⁹ Many mental health disorders present initially during adolescence. Twenty-five percent of adults with mood disorder had their first major depressive episode during adolescence.⁷⁰

Suicide is the second leading cause of death in adolescents, resulting in more than 5700 deaths in 2016.⁷¹ Between 2007 and 2016, the overall suicide rate for children and adolescents ages 10 to 19 years increased by 56%.⁷¹ Older adolescents (15–19 years of age) are at an increased risk of suicide, with a rate of 5 in 100 000 for girls and 20 in 100 000 for boys.⁷¹ According to the 2017 Youth Risk Behavior Survey of high school students, 7.4% of high school students attempted suicide in the last 12 months, and 13.6% made a suicide plan.⁷² Adolescents with parents in the military were at increased risk of suicidal ideation (odds ratio [OR]: 1.43; 95% confidence interval [CI]: 1.37–1.49), making a plan to harm themselves (OR: 1.19; 95% CI: 1.06–1.34), attempting suicide (OR: 1.67; 95% CI: 1.43–1.95), and an attempted suicide that required medical treatment.⁷³

Eating disorders typically present in the adolescent years. Although the incidence of eating disorders is low compared with depression, anxiety,

and other mental health problems, these problems are often comorbid with eating disorders.⁷⁴ Moreover, the incidence of anorexia nervosa, bulimia nervosa, and other disordered eating is becoming more prevalent in formerly obese teenagers, male teenagers, and teenagers from lower socioeconomic groups.^{75–77}

Teenagers with mental health issues may have subsequent poor school performance, school dropout, difficult family relationships, involvement in the juvenile justice system, substance use, and high-risk sexual behaviors.⁷⁸ Almost 70% of youth in the juvenile justice system have a diagnosed mental health disorder.^{79,80}

Rates of serious mental health disorders among homeless youth range from 19% to 50%.^{81,82} Homeless youth have a high need for treatment but rarely use formal treatment programs for medical, mental, and substance use services.⁸¹ Confidentiality is also an issue for adolescents, as evidenced by the fact that in adolescents to whom confidentiality is not assured, there is a higher prevalence of depressive symptoms, suicidal thoughts, and suicide attempts.⁸³ There is a paucity of adequately trained mental health professionals to care for adolescents with these mental health challenges.⁸⁴ In addition, coverage for mental health services by insurance plans can be variable.⁷⁸

Morbidity From High-Risk Sexual Activity

Multiple factors, including the increase in use of long-acting reversible contraception, have resulted in the teenage pregnancy rate decreasing in the United States over the past 20 years.^{85,86} However, pregnancy still contributes to delays in educational and career success for adolescents. Moreover, pregnant teenagers are more likely to delay

seeking medical care, putting them at risk for pregnancy-related health problems and putting their children at risk for prematurity and other negative birth outcomes.⁸⁷

Adolescents continue to have the highest rates of sexually transmitted infections (eg, gonorrhea and *Chlamydia*).⁸⁸ Although screening most sexually active adolescents for *Chlamydia* infection is covered by the Patient Protection and Affordable Care Act (Pub L No. 111–148 [2010]) and recommended by the AAP *Bright Futures: Guidelines for Health Supervision of Infants, Children, and Adolescents*, adolescent concerns about billing and confidentiality are obstacles to medical screening.^{1,89} Pediatricians can refer to AAP guidance to find appropriate codes for payment for providing adolescent health services (https://www.aap.org/en-us/Documents/coding_factsheet_adolescenthealth.pdf).

THE ADOLESCENT MEDICAL HOME

Consideration of the unique health risks as well as the biological and psychosocial elements of adolescence allows the AAP-endorsed patient-centered medical home (PCMH) to serve as an ideal conceptual framework by which a primary care practice can maximize the quality, efficiency, and patient experience of care. In 2007, the AAP joined the American Academy of Family Physicians, the American College of Physicians, and the American Osteopathic Association to endorse the “Joint Principals of the Patient-Centered Medical Home,” which describes 7 core characteristics: (1) personal physician for every patient; (2) physician-directed medical practice; (3) whole person orientation; (4) care is coordinated and/or integrated; (5) quality and safety are hallmarks of PCMH care; (6)

enhanced access to care; and (7) appropriate payment for providing PCMH care.⁹⁰ The AAP, American Academy of Family Physicians, and American College of Physicians assert that optimal health care is achieved when each person, at every age, receives developmentally appropriate care.⁹¹ Pediatricians provide quality adolescent care when they maintain relationships with families and with their patients and, thus, help patients develop autonomy, responsibility, and an adult identity.⁹² Issues unique to adolescence to consider within the PCMH model include the following: adolescent-oriented developmentally appropriate care, which may require longer appointment times; confidentiality of health care visits, health records, billing, and the location where adolescents receive care; providers who offer such care; and the transition to adult care.^{91,93} Moreover, using a strengths-based approach in the care of adolescents, as well as capitalizing on resiliency, is instrumental to maintaining the health of the individual adolescent.⁹⁴

Schools have an important role for adolescents who either do not have access to a PCMH or do not use their access to receive recommended preventive services. School-based health centers and school-based mental health services can meet the needs of adolescents who do not have a PCMH or can coordinate school-based health services with the PCMH if the student has one. School nurses can help identify and refer adolescents who need these services.⁹⁵

Financing health care of the adolescent can be challenging. Please see the detailed AAP policy statement on reforms in health care financing with the ultimate goal to improve the health care of all adolescents.⁹²

RECOMMENDATIONS

On the basis of the unique biological and psychosocial aspects of adolescence, the AAP supports the following:

1. continued recognition by international and national organizations, including the AAP, the Society for Adolescent Health and Medicine, the American College of Obstetricians and Gynecologists, the North American Society for Pediatric and Adolescent Gynecology, and the American Academy of Family Physicians, of the need for policies and advocacy related to adolescent health and well-being;
2. sustained funding for research to further elucidate the biological basis of the growth and development of adolescents and how they affect adolescent behavior;
3. educational programs and adequate financial compensation for pediatricians and other health care professionals to support them in providing evidence-based, quality primary care for adolescents;
4. pediatricians receiving training on how to maintain the clinical setting as a “safe space,” particularly in terms of confidentiality, especially when working with lesbian, gay, bisexual, transgender, and queer or questioning adolescents;
5. the role of schools, including school nurses and school-based health centers, and their role in promoting healthy adolescent development and providing access to health care;
6. further education, training, and advocacy for mental health care services that specifically address the needs of adolescents, preferably as part of a medical home model, stressing the

importance of mental health for all youth;

7. federal confidentiality protection for mental health and reproductive services, as is currently provided in many states;
8. innovative postresidency training programs to increase the number of adolescent-trained pediatric providers in the workforce;
9. improved access to medical homes for all adolescents to ensure access to preventive medical care;
10. affiliation of middle and high schools with a physician trained to care for adolescents, unless the student already has access to comprehensive adolescent health services;
11. education for pediatricians so that they are aware of the laws regarding confidential care of adolescents in their states; and
12. familiarity with community resources for confidential reproductive and mental health care if they cannot provide confidential care themselves. Pediatricians who are unable to provide these services should learn about local community resources that provide confidential reproductive and mental health care.

The AAP recommends the following strategies targeted at improving financing for the health care of adolescents:

1. Federal and state agencies should increase their efforts to further reduce the number of adolescents who are not insured or who lack comprehensive and affordable health insurance.
2. The Centers for Medicare and Medicaid Services should implement its regulatory authority to update its standards for essential health benefits, as defined in the Patient Protection

and Affordable Care Act, in the 2 categories of mental and behavioral health services and pediatric services. These essential health benefits should be consistent with the full scope of benefits outlined in *Bright Futures: Guidelines for Health Supervision of Infants, Children, and Adolescents* (including health supervision visits, recommended immunizations, screening for high-risk conditions, and adequate counseling and treatment of conditions related to sexual, reproductive, mental, and behavioral health and substance use disorder). In this way, all adolescents can access the full range of services needed during this developmentally critical period to secure optimal physical and mental health on entry into midadulthood.

3. All health plans should provide preventive services without member cost sharing. In addition, to reduce financial barriers to care for adolescents, payers should limit the burden on families by reducing or eliminating copayments and eliminating coinsurance for visits related to anticipatory guidance and/or treatment of sexual and reproductive health, behavioral health, and immunization visits.
4. To provide sufficient payment to physicians and other health care providers for medical services to adolescents, insurers' claims systems should recognize and pay for all preventive medicine *Current Procedural Terminology* codes related to services for health and behavior assessment, counseling, risk screening, and/or appropriate interventions recommended in *Bright Futures: Guidelines for Health Supervision of Infants, Children, and Adolescents*. These services should not be bundled under a single health maintenance

Current Procedural Terminology code.

5. Government and private insurance payers should increase the relative value unit allocation and level of payment for pediatricians delivering care and clinical preventive services to adolescents to a level that is commensurate with the time and effort expended, including health maintenance services, screening, and counseling.
6. The Centers for Medicare and Medicaid Services should mandate that payers provide enhanced access to cost-effective and clinically sound behavioral health services for adolescents, ensure that payment for all mental health services is more equitable with payment provided for medical and surgical services, and ensure that pediatricians are paid for mental health services provided during health maintenance and follow-up visits.

APPENDIX: ONLINE RESOURCES

AMERICAN ACADEMY OF PEDIATRICS

- Confidentiality Protections for Adolescents and Young Adults in the Health Care Billing and Insurance Claims Process: <http://pediatrics.aappublications.org/content/137/5/e20160593>
- Office-Based Care for Lesbian, Gay, Bisexual, Transgender, and Questioning Youth: <http://pediatrics.aappublications.org/content/pediatrics/132/1/e297.full.pdf>

SOCIETY FOR ADOLESCENT HEALTH AND MEDICINE

Resources for adolescents and parents are online resources aimed specifically at adolescents and their parents. Health care providers and youth-serving professionals can offer these additional resources or print a 1-page reference sheet (PDF) for adolescents and parents looking for

additional information, including support groups, peer networks, helplines, treatment locators, and advocacy opportunities.

- Mental Health Resources for Adolescents: <http://www.adolescenthealth.org/Topics-in-Adolescent-Health/Mental-Health/Mental-Health-Resources-For-Adolesc.aspx>
- Mental Health Resources for Parents of Adolescents: <http://www.adolescenthealth.org/Topics-in-Adolescent-Health/Mental-Health/Mental-Health-Resources-For-Parents-of-Adolescents.aspx>
- Substance Use Resources for Adolescents: <http://www.adolescenthealth.org/Topics-in-Adolescent-Health/Substance-Use/Substance-Use-Resources-For-Adolesc.aspx>
- Substance Use Resources for Parents of Adolescents: <http://www.adolescenthealth.org/Topics-in-Adolescent-Health/Substance-Use/Substance-Use-Resources-For-Parents-of-Adolesc.aspx>
- Confidentiality in Health Care Resources for Adolescents and Parents of Adolescents: <http://www.adolescenthealth.org/Topics-in-Adolescent-Health/Confidentiality/Confidentiality-Resources-For-Adolesc.aspx>
- Sexual and Reproductive Health Resources for Adolescents: <http://www.adolescenthealth.org/Topics-in-Adolescent-Health/Sexual-Reproductive-Health/Sexual-Reproductive-Health-Resources-For-Adolesc.aspx>
- Sexual and Reproductive Health Resources for Parents of Adolescents: <http://www.adolescenthealth.org/Topics-in-Adolescent-Health/Sexual-Reproductive-Health/SandRH-Resources-For-Parents-of-Adolesc.aspx>
- Physical and Psychosocial Development Resources for

Adolescents: <http://www.adolescenthealth.org/Topics-in-Adolescent-Health/Physical-and-Psychosocial-Development/Physical-Psychosocial-Development-Resources-For-Adolesc.aspx>

- Physical and Psychosocial Development Resources for Parents of Adolescents: <http://www.adolescenthealth.org/Topics-in-Adolescent-Health/Physical-and-Psychosocial-Development/Physical-Psych-Resources-For-Parents-of-Adolesc.aspx>

TRANSITION RESOURCES

General Resources

- National Health Care Transition Center (www.gottransition.org)
- Family Voices, Inc (www.familyvoices.org)
- National Alliance to Advance Adolescent Health (www.thenationalalliance.org)

Transition Care Plans

- AAP/National Center for Medical Home Implementation (www.medicalhomeinfo.org/how/care_delivery/transitions.aspx)
- British Columbia Ministry of Children and Family Development, "Transition Planning for Youth With Special Needs" (www.mcf.gov).

bc.ca/spec_needs/pdf/support_guide.pdf)

- University of Washington, Adolescent Health Transition Project (<http://depts.washington.edu/healthtr>)

Transition Assessment and Evaluation Tools

- AAP/National Center for Medical Home Implementation (www.medicalhomeinfo.org/health/trans.html)
- JaxHATS, evaluation tools for youth and caregivers and training materials for medical providers (www.jaxhats.ufl.edu/docs)
- Texas Children's Hospital transition template (<http://leah.mchtraining.net/bcm/resources/tracs>)
- Carolina Health and Transition Project (www.mahec.net/quality/chat.aspx?a=10)
- University of Washington, Adolescent Health Transition Project (<http://depts.washington.edu/healthtr>)
- Wisconsin Community of Practice on Transition (www.waisman.wisc.edu/wrc/pdf/pubs/THCL.pdf)

NATIONAL ALLIANCE TO END HOMELESSNESS

- <http://www.endhomelessness.org/>

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ABBREVIATIONS

AAP: American Academy of Pediatrics
CI: confidence interval
OR: odds ratio
PCMH: Patient-Centered Medical Home

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