POLICY STATEMENT Organizational Principles to Guide and Define the Child Health Care System and/or Improve the Health of all Children

American Academy of Pediatrics

DEDICATED TO THE HEALTH OF ALL CHILDREN™

The Hospitalized Adolescent

Cora C. Breuner, MD, MPH, FAAP,[a] Elizabeth M. Alderman, MD, FSAHM, FAAP,[b] Jennifer A. Jewell, MD, MS, FAAP,[c]
COMMITTEE ON ADOLESCENCE, COMMITTEE ON HOSPITAL CARE

abstract

This policy statement is the first published statement in the United States on this topic and the authors aim to provide pediatricians with evidence-based information on the unique aspects required to care for hospitalized adolescents. Included in this policy statement is a description of the possible effects hospitalization may have on the developmental and emotional progress of adolescence, the role of the hospital setting, the importance of confidentiality, and issues related to legal/ethical matters and bias and institutional and systemic racism that may occur during hospitalization.

[a]Division of Adolescent Medicine, Departments of Pediatrics and Orthopedics and Sports Medicine, University of Washington and Seattle Children's Hospital, Seattle, Washington; [b]Division of Adolescent Medicine, Department of Pediatrics, Albert Einstein College of Medicine and The Children's Hospital at Montefiore, Bronx, New York; and [c]The Barbara Bush Children's Hospital at Maine Medical Center, MaineHealth, Portland, Maine

Drs Breuner, Alderman, and Jewell conceptualized, wrote, and revised the manuscript, considering input from all reviewers and the board of directors; all authors approved the final manuscript as submitted and agree to be accountable for all aspects of the work.

This document is copyrighted and is property of the American Academy of Pediatrics and its Board of Directors. All authors have filed conflict of interest statements with the American Academy of Pediatrics. Any conflicts have been resolved through a process approved by the Board of Directors. The American Academy of Pediatrics has neither solicited nor accepted any commercial involvement in the development of the content of this publication.

Policy statements from the American Academy of Pediatrics benefit from expertise and resources of liaisons and internal (AAP) and external reviewers. However, policy statements from the American Academy of Pediatrics may not reflect the views of the liaisons or the organizations or government agencies that they represent.

The guidance in this statement does not indicate an exclusive course of treatment or serve as a standard of medical care. Variations, taking into account individual circumstances, may be appropriate.

All policy statements from the American Academy of Pediatrics automatically expire 5 years after publication unless reaffirmed, revised, or retired at or before that time.

DOI: https://doi.org/10.1542/peds.2022-060646

Address correspondence to Cora Collette Breuner, MD, MPH, FAAP. E-mail: cora.breuner@seattlechildrens.org

PEDIATRICS (ISSN Numbers: Print, 0031-4005; Online, 1098-4275).

Copyright © 2023 by the American Academy of Pediatrics

FUNDING: No external funding.

To cite: Breuner CC, Alderman EM, Jewell JA, et al; AAP Committee on Adolescence, Committee on Hospital Care. The Hospitalized Adolescent. *Pediatrics.* 2023;151(2):e2022060646

INTRODUCTION

Fundamental knowledge of adolescent growth and development, as well as an understanding of the legal and ethical issues that affect adolescents, is essential to deliver comprehensive health care to hospitalized adolescents. Because some adolescent patients have fragmented care or lack a medical home, hospitalizations may be opportune times to address acute, chronic, and routine health care needs.[1]

Adolescence is defined as the transition from childhood to adulthood, which results in self-discovery, autonomy, and independence. Adolescents mature biologically/physiologically (puberty), cognitively, and emotionally. During this unique and vulnerable time, special attention is merited to promote confidentiality between adolescents and their medical team to promote healthy mental, physical, and emotional growth.[2,3]

CURRENT STATISTICS

Approximately 1.2 million, or 20%, of all pediatric hospital admissions in the United States are for adolescents 11 to 20 years of age. Adolescents may require hospitalization for acute and chronic illnesses, including medical, surgical, gynecologic, mental health, and substance use disorder diagnoses. Adolescents may be admitted to acute care hospitals

Downloaded from http://publications.aap.org/pediatrics/article-pdf/doi/10.1542/peds.2022-060646/1436106/peds_2022060646.pdf
by guest

(including freestanding children's hospitals, children's hospitals within hospitals, adult hospitals, and community-based hospitals with few pediatric beds), rehabilitation hospitals, and psychiatric hospitals. More than 20% of admitted adolescent patients include a mental health diagnosis or a substance use diagnosis.[4] Most admissions are of short duration (<5 days) for patients who have suffered acute illness or injury and are otherwise healthy. Adolescents with chronic medical conditions experience more frequent and longer hospitalizations. Many adolescents who are admitted to the hospital may have learning, intellectual, or developmental disabilities. Hospitalizations increase with age for adolescent females but not for adolescent males, reflecting >275 000 admissions related to pregnancy and childbirth.[4]

THE IMPACT OF HOSPITALIZATIONS

Hospitalization poses challenges to emerging autonomy.[5] Basic decisions about an adolescent's life, including the privacy of protected health care information (ie, the right of individuals to keep information about themselves from being disclosed to unauthorized parties) and confidentiality (ie, having access to that protected information and to prevent it from being shared with unauthorized parties) may be restricted during hospitalizations, which can result in fear, insecurity, and developmental regression.[6] Coping with the stress and lack of independence, autonomy, and dignity during hospitalizations pose unique challenges to the health care team, family, peers, and adolescent patients because control and independence are integral to nearly all tasks of typical adolescence. By constructing and/or modifying existing hospital facilities (eg, private spaces), services (eg, psychological/psychiatric support), and expectations (eg, recognizing adolescents' need for reassurance), hospital personnel can support ongoing adolescent development and encourage adolescents to advocate for themselves by taking appropriate control of their situation.[5,7,8]

HOSPITAL SETTING AND DESIGN OF SERVICES

The ideal setting for hospitalized adolescents is one that addresses their medical, legal psychosocial, confidentiality, privacy, and educational needs while maintaining safety and limiting disruptions to their lives and the developmental tasks of typical adolescence. Dedicated adolescent units or services are 1 strategy to promote these principles by cohorting patients and leveraging the expertise of teams that include registered nurses, certified nursing assistants, licensed practice nurses, physicians, social workers, dieticians, psychologists, child life specialists, etc, who have experience in adolescent health care.[9] However, most adolescents are not admitted to dedicated adolescent units and their care can be equally safe, effective, and patient-centered when the unique needs of adolescents are ensured wherever they are hospitalized.

The accompanying clinical report[10] provides more detail about thoughtful and deliberate hospital care for adolescents who may have learning, intellectual, or developmental disabilities, with an emphasis on the evaluation of their ability to participate in their care and assent to decisions. The accompanying clinical report also includes more in-depth information on hospital care for adolescents who are involved with the juvenile justice system, are in foster or kinship care, identify as lesbian, gay, bisexual, transgender, queer, or questioning (LGBTQ+), have eating disorders, are in need of palliative care, have behavioral health diagnoses, or have sexual and reproductive health concerns.

In one study, adolescents reported that important aspects of their hospital care included confidentiality, communication, and respect. Their perceptions of care on adult units included lacking respect, safety, and effective communication, whereas care on pediatric units was suboptimal because of poor communication by nurses, excessive volume of noise, and too few age-appropriate activities. Overall, adolescents indicated that units dedicated to them provided superior care.[11] Another study revealed that avoiding pain, maintaining contact with friends and family, having choices and effective communication, feeling trust in the care team, being colocated with other adolescents, and providing age-appropriate activities were the most important aspects of hospitalization. In this study, adolescent patients also reinforced that the most important characteristics of their health care team members included honesty, trustworthiness, understanding, caring, respectfulness, careful listening, competence, and being treated as competent teenagers or adolescents.[12]

Hospitalized adolescents are concerned about confidentiality and privacy at a time of development when self-consciousness is high, including routine hygiene tasks, toileting, examinations/interview with medical personnel, phone calls, texting, and video conferencing.[6,13] Efforts to maximize confidentiality and privacy include curtains, private rooms, do-not-disturb signs, ease of bathroom usage with access to menstrual products, deodorant, toothpaste, etc. Allowing long-term adolescent patients to decorate their

Downloaded from http://publications.aap.org/pediatrics/article-pdf/doi/10.1542/peds.2022-060646/1436106/peds_2022060646.pdf
by guest

rooms and wear their own clothes increases the recognition of their underlying individuality and autonomy.[13]

Interactions with peers (friends and partners) and family/caregivers in person or by video chat normalize the hospital experience. Units can encourage peer visits and minimize arbitrary limits on the number of visitors, visiting hours, and activities during visits unless there are concerns about the safety and comfort of the adolescent patient or other nearby patients and families or if the adolescent shows signs of secondary gain from too much attention interfering with the goals of treatment. Hospital policies and procedures should clearly outline which overnight guests are allowed and which are restricted, including parents, siblings, and intimate partners. As advised in general pediatric admissions, parents/primary caregivers of hospitalized adolescents should not be subjected to traditional visiting hours. Staff can encourage adolescents to self-identify the members of their family and their family members' involvement in their care/decisions. Acknowledgment of cultural and religious/spiritual traditions supports these relationships and the level of involvement.[14] Facilitating consistent policies and procedures are followed for all adolescent patients and with each subsequent hospitalization is important for consistency and standardization.

"Therapeutic play" is a defining principle for child life specialists who provide age- and developmentally appropriate recreational activities for adolescents. These activities involve mastery of skills (such as reading books, using art supplies, playing video/computer games, using social media, streaming movies and shows/series, and using apps), decrease the stress of hospitalization, and demonstrate expertise in nonhospital-related activities and allow for the maintenance of peer relationships.[15,16] Many certified professionals, including child life specialists and art and music therapists, are experts in developing and implementing these types of psychosocial interventions and promoting essential therapeutic relationships.

Despite the efforts to stabilize the experience for hospitalized adolescents, safety and protection are paramount, including the more commonly reported risks that all hospitalized patients face, such as hospital-acquired infections, medication errors, diagnostic mistakes, etc.[17] Adolescent patients hospitalized with mental health emergencies are at risk for self or other harm and behavioral escalation. Specific interventions to mitigate harm include a standardized approach and consistent processes, such as the utilization of order sets/ assessment tools/protocols, 1:1 monitoring, mitigating environmental safety risks, consistent communication between care providers, and documented safety searches.[18]

Little data exist on the role family members and other caregivers play in the day-to-day care of hospitalized adolescents. However, it is known that family members and other caregivers prefer to continue the caregiving activities that they performed before the hospitalization, such as supporting activities of daily living and providing emotional guidance. The caregivers of medically complex adolescents want to collaborate and be involved in the provision of medications, feedings, and activities of daily living.[19,20]

PATIENT CARE FROM ADMISSION TO DISCHARGE

A stable and informed hospital environment with clear expectations, as well as consistent medical teams and schedules during hospitalizations, may result in increased trust and adherence to treatment regimens.[21] In Australia, nurses caring for hospitalized adolescents in adult hospitals developed a comprehensive admission assessment tool, the Youth Care Plan, which is updated at admission, throughout the hospitalization, and at the time of subsequent admissions.[22] The Youth Care Plan is aimed to improve the hospital experience of adolescents hospitalized in an adult hospital by allowing the medical team to understand the adolescent and aid with discharge planning activities. Such longitudinal documents enhance patient care throughout hospitalization, at the time of discharge, and during subsequent admissions and are especially important when health care team members are less familiar with patients and/or if high-risk behaviors or environments (home, schools, etc) exist.

The care for adolescent patients requires coordination between the medical home and the hospital-based team. The importance of coordination and communication between the medical home/primary care physician and the hospital team cannot be overstated. A well-defined communication strategy enhances patient care at the time of hospital admission and discharge and prevents confusion with mixed messages and misrepresentation of information. In addition to providing insight into patients' medical, psychosocial, developmental, and educational histories, pediatricians in the medical home can assist with complex medical decision-making

Downloaded from http://publications.aap.org/pediatrics/article-pdf/doi/10.1542/peds.2022-060646/1436106/peds_2022060646.pdf
by guest

and can address hospital concerns and follow-up needs.[1,23]

ACCESS TO TRAINED STAFF WITH ADOLESCENT HEALTH EXPERTISE

All adolescent inpatients, regardless of diagnosis or hospital type, benefit from care by pediatricians who are familiar with the adolescent patients' diagnoses, can address contraception and other sexual health needs, if applicable, and can identify immunization delays and other outstanding wellness needs during hospitalization through a HEADSSS (home, education, activity, drug use, sexuality, suicide, safety/violence risk) assessment.[22,24,25] In some cases, more specific adolescent care from a fellowship-trained adolescent medicine specialist, peds/adolescent obstetric/gynecology specialist, adolescent psychiatrist/psychologist, or an eating disorder specialist/team, may enhance the care of certain hospitalized adolescents.[26,27] When direct access to an adolescent specialist is not guaranteed, discussions about patient care with providers who have adolescent expertise can be arranged by phone or other telehealth options. Input with policy and guideline development from adolescent specialists will improve the care for adolescent hospitalized patients and for specific medical/disease conditions.

STAFF INTERACTION WITH PATIENTS AND THEIR FAMILIES/CAREGIVERS

It is important that all hospital personnel show respect and consideration for adolescent patients and their families.[13] Recognizing their lack of control and the withdrawal of their burgeoning independence, adolescents are apt to react negatively to inconsistent schedules and changes in previously confirmed arrangements, such as staff assignments, the timing of rounds/procedures, etc. By demonstrating understanding and empathy for their situation, adolescents and their families are likely to feel less resentment and behave more positively in stressful situations. Clear, frequent, and consistent communication eases relationships with inpatient pediatricians and other health care staff.[28] Specifically, adolescent inpatients identify that nurses' interactions and attention to the adolescents' dignity are paramount to their overall satisfaction.[13]

RACISM, IMPLICIT BIAS, AND MICROAGGRESSION AND THE HOSPITALIZED ADOLESCENT

Pediatricians and other health care providers, hospitals, and health care systems are not insulated from the microaggressions, implicit bias, and racism that drives health inequities and injustice or from the accompanying economic, political, and social conditions that fuel racism and result in health inequities.[29,30] In hospitalized Black, Indigenous, and People of Color adolescents, little data exist about overt individual or systemic racism. From longitudinal studies, there is evidence that youth are deeply affected by exposure to racism, implicit bias, and microaggression. The disruption to the social and emotional development of youth, whether racism is structural, institutional, or interpersonal, may be more enhanced in the hospitalized adolescent,[31] with persistent negative effects on outcome.[32] Microaggression can also occur in LGBTQ+ hospitalized adolescents. Continued research is necessary to assess the impact of perceived/observed experiences of discrimination on adolescent inpatient health outcomes and the impact of workforce training and development on patient satisfaction, trust, health care utilization, and tolerance.[33]

EDUCATIONAL SERVICES

For most adolescents who attend high school or college, education is a central tenet of their identity and daily activity (especially during the academic year); education is a primary "job" of most adolescents. Securing educational services is important during adolescents' hospitalization.[9,34] Maintaining their academic standing and graduating with their peers often is achievable when educational services are readily available in inpatient settings. Many hospitals that care for adolescents have access to teachers and/or tutors who can assist with completing and submitting assignments/tests and with advocating for educational needs, modifications, and exceptions with teachers, school administrators, and school districts.[35,36] Virtual telecommunication strategies encourage and support school attendance remotely during prolonged hospital stays.[37] By controlling the educational experience, hospitalized adolescents may continue their education with minimal disruptions.

LEGAL AND ETHICAL MATTERS

Legal and ethical matters often involve respecting minor adolescents' (<18 years of age in most states) requests for privacy (including undergoing examinations without parents/caregivers present), confidentiality (communicating information without parents/caregivers knowledge), and specific consent/nonconsent and assent/dissent for treatment. Pediatricians should be aware of their states' laws that include confidentiality and consent to treat minors for certain conditions (such as family planning/contraception, sexually transmitted infections, prenatal care, adoption services, pregnancy termination, substance use/abuse, and mental health) without parent/caregiver involvement (https://www.aap.org/

Downloaded from http://publications.aap.org/pediatrics/article-pdf/doi/10.1542/peds.2022-060646/1436106/peds_2022060646.pdf
by guest

en-us/advocacy-and-policy/aap-health-initiatives/healthy-foster-care-america/Documents/Confidentiality_Laws.pdf and https://www.guttmacher.org/united-states/teens/state-policies-teens).

Confidentiality between a provider and a patient should be respected, with few exceptions, such as the risk of harm to oneself or others.[38,39] Discussion of how the 21st Century Cures Act final rules impact confidentiality, because of its statutory prohibition on "information blocking," must occur with all adolescent patients and their families/caregivers.[40] Federal and state laws govern many aspects of minor adolescent confidentiality. The inpatient environment challenges efforts at maintaining adolescents' confidentiality. Routine aspects of hospitalization, such as patient- and family-centered rounds, multiple physicians involved in patients' care, and the discharge process, place confidentiality at risk. Careful attention by physicians, trainees, nursing staff, and care managers includes discussions without parent/caregiver presence.[41] Documentation in the medical record of confidential discussions and care should be recorded in a safe/clearly demarcated confidential portion of the chart that is unavailable to parents/caregivers. Pediatricians have a role in engaging their local health care organizations and, at times, electronic health record vendors, to advocate that electronic health records allow provisions for sequestered portions of the health record,[42–44] including mechanisms to appropriately and confidentially bill for provided services.

Common challenging scenarios include requests to withhold information by adolescents from parents/caregivers or by parents/caregivers from adolescent patients, including when discussing discharge instructions that are of a confidential nature that are meant to be shared with the adolescent only. Additionally, the American Academy of Pediatrics discourages withholding medical information from competent, developmentally appropriate adolescent patients in nearly all circumstances.[45]

Including adolescents <18 years of age in their health care decisions in a way that is developmentally appropriate is an important step in transitioning to adult care. Despite most adolescents being unable to consent to procedures, medication, and treatment plans, medical teams are urged to seek assent from their adolescent patients and are discouraged from providing care without attempts to reconcile conflicts between adolescents, their families, and their care teams. The extent of an adolescent's involvement is based on their age, developmental level, and severity of illness. Extending invitations for adolescent patients <18 years of age to attend family and discharge meetings demonstrates the importance of the patient's engagement in their care.

States have provisions to allow minors to consent to certain medical care such as reproductive health, mental health, substance use, and other concerns. In other situations, adolescents may prefer to shift the focus of care or treatment, specifically painful or life-prolonging interventions. Although most adolescents under the age of majority (18 years of age for all states except Nebraska and Alabama, where 19 years is the age of majority, and Mississippi, where the age of majority is 21 years) require parental/caregiver consent to refuse recommended treatments (such as chemotherapy, dialysis, or transplantation), obtaining assent from adolescent patients is preferred. Sometimes, consultation with an ethicist and/or legal counsel is necessary.

A subset of minors is legally emancipated, meaning that the minor can make all medical decisions for themselves. Separately, minors who are still under the direct financial and daily care of their parents/caregivers may have "mature minor" status. Individual state law determines the emancipation of minors and mature minor status. For adolescents 18 years and older who are competent, the Health Insurance Portability and Accountability Act regulations prohibit disclosure of any medical information to others, including parents, without the adolescent's consent. It is important to consider the least restrictive alternatives for decision making with power of attorney and guardianship when appropriate. Moreover, these adolescents may consider designating a health care proxy, if they do not have one, regardless of the reason for hospitalization.

TRANSITIONS FROM CHILDREN'S HOSPITALS TO ADULT FACILITIES

There may be a reluctance to transition from pediatric hospitals and pediatric specialty services to adult hospitals and adult specialty services (or adult units/specialty services within a hospital), just as there is when transitioning to adult care providers in the outpatient setting. Adolescent inpatients rely on a network of familiar hospital-based health care providers, child life specialists, teachers, nursing, and ancillary staff. This familiar, hospital-based community can assist adolescents and their families as they transition to adult facilities/units. Mechanisms to ease this transition include openly discussing the transition, communicating with

Downloaded from http://publications.aap.org/pediatrics/article-pdf/doi/10.1542/peds.2022-060646/1436106/peds_2022060646.pdf
by guest

personnel at the adult facility/unit, providing written inpatient transition plans (passports, summaries, and emergency medical plans [https://www.gottransition.org/resourceGet.cfm?id=227]),[46] accompanying patients and families on tours of adult facilities/units, and offering reassurance during initial hospitalization at adult facilities/units. The authors of one study suggest a checklist for inpatient transition activities that includes developing and implementing transition policies, tracking and monitoring transition activities, assessing transition readiness, patient-centered planning (touring the inpatient facility, planning conferences between providers, addressing insurance barriers, discussing specific policies for parent involvement, etc), and, finally, transferring.[46] Developing a program to standardize the transition of adolescents' hospital care from pediatric to adult facilities/units may be useful for a subset of adolescent patients with frequent and ongoing hospital needs.

CONCLUSIONS

The hospitalized adolescent has unique and essential needs that are different from those of the younger pediatric inpatient. It is important that those who care for hospitalized adolescents have knowledge, experience, and compassion when dealing with the multifaceted and nuanced needs of this population.

Recommendations

1. Hospital administrations, along with clinicians experienced in caring for adolescents, including pediatricians, advanced practice practitioners (ie, nurse practitioners and physician assistants), and adolescent medicine specialists, should assist in the design of hospital settings and in the development and implementation of policies and guidelines for inpatient adolescents.
2. Hospitalist training should include modules on adolescent health and wellness.
3. Researchers should aggregate demographic data to describe new and ongoing trends in adolescent hospitalizations and identify specific areas of focus to improve patient care and physician/staff training.
4. Care of adolescents in the hospital setting should be centered around confidentiality, including knowledge of state confidentiality laws regarding adolescents, privacy, dignity, and respect for adolescent patients and their families. For those with intellectual or developmental disabilities, care should be centered around their ability to participate in their care and assent to decisions.
5. Involvement with the primary care provider. Connecting adolescents to their primary care medical home for follow-up and ongoing care is an essential part of hospital discharge.
6. Ongoing antiracist, antimicroaggression/implicit bias training of physicians and other adolescent hospital caregivers is imperative.
7. Typical adolescent activities, including attending to their educational needs, recreational needs (such as making available age-appropriate reading materials, games, music, arts, and electronics), and visitation needs by family and friends during hospitalization, should continue as much as possible.
8. Personnel caring for adolescents, including adolescents in foster or kinship care, have a responsibility to understand the moral, ethical, legal, and developmental framework of adolescent patients' medical decision-making, consent, assent, and refusal of treatment.
9. Transition, when appropriate, from pediatric to adult-oriented providers and hospitals should occur through standardized mechanisms while inpatient, including a readiness checklist.

LEAD AUTHORS

Cora C. Breuner, MD, MPH, FAAP
Elizabeth M. Alderman, MD, FSAHM, FAAP
Jennifer Jewell, MD, FAAP

COMMITTEE ON ADOLESCENCE, 2021–2022

Elizabeth M. Alderman, MD, FSAHM, FAAP, chairperson
Elise Berlan, MD, FAAP
Richard J. Chung, MD, FAAP
Michael Colburn, MD, MEd, FAAP
Laura K. Grubb, MD, MPH, FAAP
Janet Lee, MD, FAAP
Stephenie B. Wallace, MD, MSPH, FAAP

FORMER COMMITTEE ON ADOLESCENCE MEMBERS, 2019–2020

Makia Powers, MD, MPH
Krishna K. Upadhya, MD, FAAP

LIAISONS

Anne-Marie Amies, MD, American College of Obstetricians and Gynecologists
Liwei L. Hua, MD, PhD, American Academy of Child and Adolescent Psychiatry
Ellie Vyver, MD, Canadian Pediatric Society
Seema Menon, MD, North American Society of Pediatric and Adolescent Gynecology
Lauren B. Zapata, PhD, MSPH, Centers for Disease Control and Prevention
Maria Rahmandar, MD, FAAP, Section on Adolescent Health

STAFF

Karen Smith
James Baumberger, MPP

Downloaded from http://publications.aap.org/pediatrics/article-pdf/doi/10.1542/peds.2022-060646/1436106/peds_2022060646.pdf
by guest

AAP COMMITTEE ON HOSPITAL CARE, 2021–2022

Daniel A. Rauch, MD, FAAP, Chairperson
Samantha House, DO, FAAP
Benson Hsu, MD, MBA, FCCM, FAAP, AAP Section on Critical Care member
Melissa Mauro-Small, MD, FAAP, AAP Section on Hospital Medicine member
Nerian Ortiz-Mato, MD, FAAP
Charles Vinocur, MD, FAAP, FACS
Nicole Webb, MD, FAAP

FORMER COMMITTEE ON HOSPITAL CARE MEMBER, 2020–2021

Kimberly Ernst, MD, MSMI, FAAP
Vinh Lam, MD, FAAP

LIAISONS

Michael S. Leonard, MD, MS, FAAP, representative to The Joint Commission
Karen Castleberry, family representative
Nancy Hanson, Children's Hospital Association
Kristin Hittle Gigli, PhD, RN, CPNP-AC, CCRN, National Association of Pediatric Nurse Practitioners
Barbara Romito, MA, CCLS, Association of Child Life Professionals

STAFF

S. Niccole Alexander, MPP

ABBREVIATIONS

AAP: American Academy of Pediatrics
HEADSSS: home, education, activity, drug use, sexuality, suicide, safety/violence risk
LGBTQ+: lesbian, gay, bisexual, transgender, queer, or questioning

CONFLICT OF INTEREST DISCLOSURES: The authors have indicated they have no potential conflicts of interest relevant to this article to disclose.

COMPANION PAPER: A companion to this article can be found online at www.pediatrics.org/cgi/doi/10.1542/peds.2022-060647.

REFERENCES

1. Rauch DA; Committee on Hospital Care; Section on Hospital Medicine. Physician's role in coordinating care of hospitalized children. *Pediatrics*. 2018;142(2): e20181503
2. Alderman EM, Breuner CC; Committee on Adolescence. Unique needs of the adolescent. *Pediatrics*. 2019;144(6): e20193150
3. Hagan JF, Shaw JS, Duncan PM, eds. *Bright Futures: Guidelines for Health Supervision of Infants, Children, and Adolescents*, 4th ed. Itasca, IL: American Academy of Pediatrics; 2017
4. Agency for Healthcare Research and Quality. Healthcare Cost and Utilization Project (HCUP). Available at: www.hcup-us.ahrq.gov/kidoverview.jsp. Accessed February 22, 2022
5. Jamalimoghadam N, Yektatalab S, Momennasab M, et al. How do hospitalized adolescents feel safe? A qualitative study. *J Nurs Res*. 2019; 27(2):e14
6. Hutton A. The private adolescent: privacy needs of adolescents in hospitals. *J Pediatr Nurs*. 2002;17(1):67–72
7. Fisher M. *AAP Textbook of Adolescent Health Care*. Washington, DC: American Academy of Pediatrics; 2011
8. Hofmann AD, Gabriel HP, Becker RD. *The Hospitalized Adolescent: A Guide to Managing the Ill and Injured Youth*. New York, NY: Free Press; 1976
9. Fisher M, Kaufman M. Adolescent inpatient units: a position statement of the Society for Adolescent Medicine. *J Adolesc Health*. 1996;18(4):307–308
10. Breuner C; American Academy of Pediatrics, Committee on Adolescence. Clinical report. The hospitalized adolescent. *Pediatrics*. 2022, In press
11. Viner RM. Do adolescent inpatient wards make a difference? Findings from a national young patient survey. *Pediatrics*. 2007;120(4):749–755
12. van Staa A, Jedeloo S, van der Stege H; On Your Own Feet Research Group. "What we want": chronically ill adolescents' preferences and priorities for improving health care. *Patient Prefer Adherence*. 2011;5:291–305
13. Jamalimoghadam N, Yektatalab S, Momennasab M, et al. Hospitalized adolescents' perception of dignity: a qualitative study. *Nurs Ethics*. 2019;26(3): 728–737
14. Canino I, Spurlock J. *Culturally Diverse Children and Adolescents*. New York, NY: Guilford Press; 2000
15. Romito B, Jewell J, Jackson M; AAP Committee on Hospital Care; Association of Child Life Professionals. Child life services. *Pediatrics*. 2021;147(1): 2020040261
16. Goldstein N, Collins T. Making videotapes: an activity for hospitalized adolescents. *Am J Occup Ther*. 1982; 36(8):530–533
17. Schatkoski AM, Wegner W, Algeri S, Pedro EN. Safety and protection for hospitalized children: literature review. *Rev Lat Am Enfermagem*. 2009;17(3):410–416
18. Noelck M, Velazquez-Campbell M, Austin JP. A quality improvement initiative to reduce safety events among adolescents hospitalized after a suicide attempt. *Hosp Pediatr*. 2019;9(5):365–372
19. Vasli P, Salsali M. Parents' participation in taking care of hospitalized children: A concept analysis with hybrid model. *Iran J Nurs Midwifery Res*. 2014;19(2): 139–144

Downloaded from http://publications.aap.org/pediatrics/article-pdf/doi/10.1542/peds.2022-060646/1436106/peds_2022060646.pdf
by guest

20. Power N, Franck L. Parent participation in the care of hospitalized children: a systematic review. *J Adv Nurs.* 2008;62(6):622–641

21. Sudhakar-Krishnan V, Rudolf MC Jr. How important is continuity of care? *Arch Dis Child.* 2007;92(5):381–383

22. Sturrock T, Masterson L, Steinbeck K. Adolescent appropriate care in an adult hospital: the use of a youth care plan. *Aust J Adv Nurs.* 2007;24(3):49–53

23. Harlan G, Srivastava R, Harrison L, et al. Pediatric hospitalists and primary care providers: a communication needs assessment. *J Hosp Med.* 2009;4(3): 187–193

24. Sawyer SM, Ambresin A-E, Bennett KE, Patton GC. A measurement framework for quality health care for adolescents in hospital. *J Adolesc Health.* 2014; 55(4):484–490

25. Kimberly A. Caring for adolescents in the adult intensive care unit. *Crit Care Nurse.* 2002;22(2):80–99, 83–94, 96–99

26. Hargreaves DS, McDonagh JE, Viner RM. Validation of You're Welcome quality criteria for adolescent health services using data from national inpatient surveys in England. *J Adolesc Health.* 2013;52(1):50–57.e1

27. American Academy of Child and Adolescent Psychiatry. Inpatient hospital treatment of children and adolescents. Available at: https://www.aacap.org/aacap/Policy_Statements/1989/Inpatient_Hospital_Treatment_of_Children_and_Adolescents.aspx. Accessed February 22, 2022

28. Solan LG, Beck AF, Shardo SA, et al; H20 Study Group. H20 Study Group. Caregiver perspectives on communication during hospitalization at an academic pediatric institution: a qualitative study. *J Hosp Med.* 2018;13(5):304–311

29. Hardeman RR, Medina EM, Kozhimannil KB. Structural racism and supporting black lives—the role of health professionals. *N Engl J Med.* 2016;375(22): 2113–2115

30. Trent M, Dooley DG, Dougé J; Section on Adolescent Health; Council on Community Pediatrics; Committee on Adolescence. The impact of racism on child and adolescent health. *Pediatrics.* 2019;144(2):e20191765

31. Berry OO, Londoño Tobón A, Njoroge WFM. Social determinants of health: the impact of racism on early childhood mental health. *Curr Psychiatry Rep.* 2021;23(5):23

32. Malawa Z, Gaarde J, Spellen S. Racism as a root cause approach: a new framework. *Pediatrics.* 2021;147(1): e2020015602

33. Heard-Garris N, Williams DR, Davis M. Structuring research to address discrimination as a factor in child and adolescent health. *JAMA Pediatr.* 2018; 172(10):910–912

34. Findlay S, Pinzon J, Goldberg E, Frappier JY. Issues of care for hospitalized youth. *Paediatr Child Health.* 2008;13(1):61–68

35. Ratnapalan S, Rayar MS, Crawley M. Educational services for hospitalized children. *Paediatr Child Health.* 2009; 14(7):433–436

36. Hopkins L, Nisselle A, Zazryn T, Green J. Hospitalised adolescents - a framework for assessing educational risk. *Youth Stud Aust.* 2013;32(1):37–45

37. Maor D, Mitchem K. Hospitalized adolescents' use of mobile technologies for learning, communication, and well-being. *J Adolesc Res.* 2020; 35(2):225–247

38. Ford C, English A, Sigman G. Confidential health care for adolescents: position paper for the society for adolescent medicine. *J Adolesc Health.* 2004;35(2):160–167

39. Maslyanskaya S, Alderman EM. Confidentiality and consent in the care of the adolescent patient. *Pediatr Rev.* 2019;40(10):508–516

40. Pageler NM, Webber EC, Lund DP. Implications of the 21st Century Cures Act in pediatrics. *Pediatrics.* 2021;147(3): e2020034199

41. Talib HJ, Silver EJ, Alderman EM. Challenges to adolescent confidentiality in a children's hospital. *Hosp Pediatr.* 2016; 6(8):490–495

42. Gray SH, Pasternak RH, Gooding HC, et al; Society for Adolescent Health and Medicine. Recommendations for electronic health record use for delivery of adolescent health care. *J Adolesc Health.* 2014;54(4):487–490

43. American College of Obstetricians and Gynecologists. Confidentiality in adolescent health care. ACOG Committee Opinion No. 803. American College of Obstetricians and Gynecologists. *Obstet Gynecol.* 2020;135:e171–e177

44. Blythe MJ, Del Beccaro MA; Committee on Adolescence; Council on Clinical and Information Technology. Standards for health information technology to ensure adolescent privacy. *Pediatrics.* 2012;130(5):987–990

45. Jalkut MK, Allen PJ. Transition from pediatric to adult health care for adolescents with congenital heart disease: a review of the literature and clinical implications. *Pediatr Nurs.* 2009;35(6): 381–387

46. Coller RJ, Ahrens S, Ehlenbach ML, et al. Transitioning from general pediatric to adult-oriented inpatient care: national survey of US children's hospitals. *J Hosp Med.* 2018;13(1):13–20

Downloaded from http://publications.aap.org/pediatrics/article-pdf/doi/10.1542/peds.2022-060646/1436106/peds_2022060646.pdf
by guest