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Defining Young Adulthood

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Abstract

Young adulthood is a unique developmental period that occurs between the ages of 18 and 25 years, during which there are key developmental tasks that allow the young adult to participate in self-exploration and identity formation. Currently, among various organizations there are differing definitions and age range inclusions for young adulthood, which cause confusion during program development, healthcare service delivery, and research. Young adulthood should be categorized separately from adolescence and adulthood, because young adults have lower rates of healthcare utilization and worse health outcomes related to preventable causes of morbidity and mortality than the surrounding age groups. Young adults experience relatively high rates of injuries, mental health issues, substance use, and sexual/reproductive health conditions. Due to their increased likelihood of risk-taking behavior and related poor health outcomes, young adults are in a vulnerable state. Nurse practitioners, specifically family nurse practitioners, can best meet the health needs of young adults as they are trained to provide whole-person care while emphasizing education and health promotion across the life continuum. Moving forward, nurse practitioners can and should be leaders in providing healthcare services to young adults to improve their health outcomes.

Defining Young Adulthood

Young adulthood is a unique developmental period that occurs between the ages of 18 to 25 years, during the transition from adolescence to adulthood. This period is characterized by key developmental tasks that allow the young adult to participate in self-exploration to cultivate a personal identity and belief system, all the while gaining independence and autonomy. Even though most of the 31.2 million persons between the ages of 18 to 24 years (Federal Interagency Forum on Child and Family Statistics [Child Stats], 2014) are healthy, young adults experience increased rates of preventable morbidity and mortality from motor vehicle accidents, homicide, sexually transmitted infections (STIs), substance use, and mental health issues (Institute of Medicine [IOM] & National Research Council [NRC], 2014). Additionally, for young adults who engage in risky behaviors and unhealthy lifestyle choices, there may be lasting health consequences for decades to come. There is also substantial room for improvement within the current healthcare delivery system as demonstrated by lower rates of health insurance coverage among young adults (Commonwealth Fund, 2016), lower utilization of healthcare services among young adults (Lau, Adams, Boscardin, & Irwin, 2014), and poorer health outcomes among this age group when compared to adolescents and middle-aged adults (Child Stats, 2014; IOM & NRC, 2014). Nurse practitioners' (NP) focus on health promotion and caring for vulnerable populations makes them well positioned to improve the care and health outcomes of young adults.

In order to optimize care, young adulthood needs to be recognized as its own distinct developmental period. Young adults differ from adolescents and middle-aged adults because they experience their own unique developmental tasks and have higher rates of risk-taking behaviors, which places them at greater risk for preventable causes of morbidity and mortality.

Additionally, there should be a standardized definition of young adulthood that is used across disciplines to provide clarity for program development, service delivery, and research. The aim of this paper is to present an overview of young adulthood and to highlight the specialized healthcare needs of this age group. In the following sections the definition of young adulthood, the theoretical context of young adulthood, the developmental tasks of young adulthood, the health status of young adults, and the healthcare delivery system for young adults will be discussed. Lastly, a case will be made as to why nurse practitioners are well positioned to provide optimal care for young adults in a transitional stage.

Nomenclature

As discussed by Curtis (2015), there are varying definitions for the developmental period ranging from adolescence to young adulthood. Even among notable international and national health organizations, there is not a standardized definition for adolescence and young adulthood. For example, the World Health Organization (2014) broadly defines young people as those between the ages of 10 and 24 years but specifies that the term adolescent includes only those in their second decade of life, ages 10 through 19 years. Whereas, the United Nations uses the terminology youth, which includes those aged 15 through 24 years (United Nations Department of Economic and Social Affairs, n.d.). On a national level, The United States Office of Disease Prevention and Health Promotion (2018) defines adolescents as those aged 10 to 17 years and young adults as those aged 18 to 25 years in its Healthy People 2020 goals. However, The United States Health and Human Services Office of Adolescent Health (2016) defines young adolescents as those 10 to 14 years of age and older adolescents as those 15 to 19 years of age. The Society for Adolescent Health and Medicine (2015) includes all young people between the ages of 10 to 25 years as adolescents. Conversely, The American Academy of Pediatrics (2017)

divides adolescence into three subcategories: early adolescence (11-14 years), middle adolescence (15-17 years), and late adolescence (18-21 years). Furthermore, The Centers for Disease Control and Prevention (CDC) Division of Adolescent and School Health collects data on students in the 9th through 12th grades for the Youth Risk Behavior Surveillance System Survey (CDC, 2017). Regardless of the nomenclature used, young adults are continually overlooked or grouped with younger cohorts under the umbrella terms of youth, young people, or adolescents. It is paramount to recognize that young adults experience their own unique developmental tasks which differentiate them from adolescents and middle-aged adults.

It is evident from reviewing the above list, there is no standardized or universal definition for adolescents or young adults. Often young adults are inappropriately categorized as adolescents, which has serious consequences beyond personal and interorganizational confusion. For example, if programs are developed for the overarching population of youth or young people, the distinct development stages of adolescence and young adulthood, which each have unique health promotion and anticipatory guidance requirements, are overlooked. Additionally, research outcomes may be skewed with the inclusion or exclusion of overly broad age ranges, thus limiting the interpretation and generalizability of the results. Lastly, funding for young adult specific research projects may be limited without a clear and consistent conceptual definition. It is not acceptable to simply assume that what applies to adolescents or middle-aged adults also applies to young adults, and in doing so, opportunities are missed to specifically tailor policies, research, and programs.

Theoretical Context

The concept of adolescence was first defined by G. Stanley Hall in his seminal work, *Adolescence* (1904), where he described this period as a “new birth” during which rapid changes

occur from the ages of 14 to 24 years (Arnett, 2006; Baxter, 2008). There were limitations to Hall's theory because several concepts within psychology had yet to be researched or evidenced by scientific findings (Arnett, 2006). It was not until the mid-1900s that the concept of young adulthood was discussed by theorists.

With advancements in scientific research in the mid-20th century, Erik Erikson published his theory on psychological human development that involved eight sequential stages. In adolescence, development is centered around identity formation versus role confusion (Austrian, 2008). During this timeframe, adolescents participate in role experimentation and are heavily influenced by their peers, opportunities, and culture (Austrian, 2008). If adolescents are successful, a sense of self and societal belonging are identified (Austrian, 2008). However, if adolescents are unsuccessful, role confusion occurs (Austrian, 2008) and the passage into adulthood is delayed. Once an identity is formed, the adolescent transitions into a young adult and reaches the next stage of development: intimacy versus isolation. Here, the young adult must learn to form partnerships with others while maintaining a balance between intimacy (love) and independence (productive work). In this stage, the young adult may conflict with the "other" and become isolated (Austrian, 2008). These developmental stages are still applicable today, but the timing of identity formation may be delayed into young adulthood due to societal and cultural changes.

Coupled with Erikson's developmental theories, Lawrence Kohlberg proposed his theory regarding the sequential stages of moral development. In adolescence, people move from the conventional stage, which encompasses following the rules in order to gain approval, to the postconventional stage, which involves forming an internal sense of moral judgement (Austrian, 2008). The transition from conventional to postconventional occurs between the ages of 13 and

16 years when persons begin to identify principles and values that are important to the respective individual such as justice, reciprocity, equality, dignity, and respect (Austrian, 2008). Upon later review, Kohlberg realized that many adults never reach the postconventional stage of moral development, because higher levels of theoretical reflection must be achieved (Austrian, 2008).

During the same timeframe, Kenneth Keniston postulated about a developmental stage in which he called, youth. Up until that point, he felt there was no term that adequately captured the defining period between late adolescence and young/early adulthood. Modern technology, prosperity, consumerism, social unrest, and advanced education were recognized as contributing factors leading to this limbo phase in life (Keniston, 1970). Keniston identified several major themes that defined the period of youthhood: exploration of role development, nonconformity to societal roles, transformation of oneself, adoption of an experimental and testing attitude, estrangement from society, and refusal of acculturation (Keniston, 1970). However, Arnett (2000) criticized Keniston's theory for being overly influenced by the cultural context in which it was developed, rather than describing universal characteristics that remain consistent throughout the decades.

Most recently, Jeffery Arnett (2000) developed the theory of emerging adulthood. He argued that this timeframe is a distinct phase of transition for those aged 18 to 25 years, who are neither adolescents nor adults. Emerging adulthood is characterized by individual variability, semi-autonomy, identity exploration, and changing worldviews. The transition from emerging adulthood to adulthood occurs when young people obtain stable housing, complete schooling, establish a career, form a committed romantic relationship, accept responsibility for oneself, and gain financial independence. This theory resulted from demographic changes that deferred the age of onset in attaining the aforementioned adulthood milestones. Notably, this phenomenon of

delayed entry into adulthood is seen mostly in industrialized countries, with great variability between countries due to cultural norms (Arnett, 2011).

While early theorists did not differentiate a period of young adulthood, more current theorists have acknowledged that young adults differ from adolescents developmentally. This is likely due to demographic and cultural changes that have taken place over the last several decades. Examples of such changes include, high rates of post-secondary education as well as an increasing timeframe when one begins to live independently, enters into a career, marries, and has children (Arnett, 2000). As a result, many of the developmental tasks formerly known to be associated with adolescence are now occurring in young adulthood.

Developmental Tasks

The theories named above help to illuminate the complexity of young adulthood. This is a period of immense physical, psychological, cognitive, and emotional growth. Specifically, young adults are presented with the task of successfully transitioning into adulthood. This transition most notably occurs through the process of meaning making and identity formation.

Meaning Making

Meaning making is described as the "ability to reflect upon the larger implications of a particular event" (Lawford & Ramey, 2015, p. 1396) and apply the lessons learned to current behavior and decision-making. As a result, one finds purpose in life's experiences (Alea & Bluck, 2013). This skill develops in late adolescence and young adulthood with the onset of abstract thought related to increased cognitive growth (Alea & Bluck, 2013; Lawford & Ramey, 2015). Additionally, meaning making is directly related to the development of self that forms during this timeframe (Lawford & Ramey, 2015). Due to its significance during young adulthood, meaning making is a key developmental task for this life stage.

Because meaning making is critical for development, Lawford and Ramey (2015), explored factors that could impact meaning making among a sample of Canadian adolescents and young adults. In this study, there were 160 adolescent participants with a mean age of 17.2 years, and 266 young adult participants with a mean age of 20 years (Lawford & Ramey, 2015). The adolescents were recruited from community organizations to take part in a larger study about decision making activities (Lawford & Ramey, 2015). The young adults were recruited from a university and were mostly social sciences students (Lawford & Ramey, 2015). The authors examined correlations between meaning making, activity engagement, and generativity in adolescents and young adults. Generativity is defined as the desire to positively impact the world and benefit future generations (Lawford & Ramey, 2015). Notably, generativity and activity engagement were positively correlated to meaning making in both age groups (Lawford & Ramey, 2015). However, adolescents were significantly more concerned about generativity than young adults were concerned (Lawford & Ramey, 2015). The authors speculated that adolescents are often first exposed to and begin to understand the needs of the community during this phase in life, which could increase their concern for generativity when compared to young adults. Overall, adolescents and young adults have greater a propensity for meaning making when they participate in activities, feel engaged in such activities, and care for the wellbeing of future generations.

Identity Formation

Without doubt, young adulthood is marked by immense change in one's life, more so than in any other period (Arnett, 2000). People have many new experiences during this time including living independently, blossoming romantic relationships, as well as having new physical surroundings, social groups, and careers. Some even get married, become parents, or

buy a home. To successfully navigate this period of transition into adulthood, one must actively participate in identity formation. The process of forming an identity, along with healthy family/social relationships, is necessary for developing a solid foundation because of the significant influence it has over life's outcomes and successes (Scales, Benson, Oesterle, Hill, Hawkins, & Pashak, 2016).

Identity formation is now occurring in young adulthood as opposed to adolescence. A meta-analysis conducted by Kroger, Martinussen, and Marcia (2010), examined 72 research articles and identified several patterns of identity formation. The researchers found that during the transition from late adolescence to young adulthood, people generally moved from identity diffusion to identity achievement. More specifically, at 18 years of age there was a decrease in identity achievement to a mean proportion of 0.17, which then steadily increased until the age of 22 years to a mean proportion of 0.34 (Kroger et al., 2010). There was a second period of slightly decreased identity achievement to a mean proportion of 0.31 during the age range of 23 to 29 years (Kroger et al., 2010). Finally, from ages 30 to 36 years, there was a significant rate of identity achievement to a mean proportion of 0.47 (Kroger et al., 2010). These findings mirror patterns of change in young adults' lives. Identity achievement initially drops at the beginning of a new transition such as completing secondary education and beginning tertiary education (at age 18), but then steadily increases thereafter, until age 22. At this point, many people experience another change as they finish tertiary schooling and either transition into graduate education or start careers, which is represented by a slight decrease in identity achievement until the age of 29 years. Finally, from ages 30 to 36 years, as people feel more settled in their adult roles, identity achievement increases. This supports the notion that identity formation continues well into adulthood.

Identify diffusion is defined as having no commitment to a particular identity (Beyers & Luyckx, 2015). Individuals in identify diffusion may or may not be in the process of exploring identity alternatives (Kroger et al., 2010) and are more susceptible to outside pressures/influences (Carlsson, Wangqvist, & Frisen, 2015). When identity diffusion occurs, young adults are at risk for negative outcomes. Carlsson et al. (2015) sampled seven males between the ages of 25 and 29 years who remained in identity diffusion to determine the consequences of delayed identity achievement. The participants reported moderate distress about long-term goals at age 25 years and continued to feel moderate distress about long-term goals as well as career decisions at age 29 years (Carlsson et al., 2015). Notably, due to identity diffusion, participants failed to make investments in their future, perceived they had little control over their lives, and avoided changing their life conditions (Carlsson et al., 2015). Additionally, most of the participants who experienced identity diffusion were also unable to participate in meaning making (Carlsson et al., 2015). Their identity diffusion caused them to live their lives "on hold" and remain in limbo

Risk factors for remaining in identity diffusion include ruminative exploration and reconsideration of commitment. Ruminative exploration is defined as constant worrying without being able to make a decision, and reconsideration of commitment is defined as reassessing whether a current commitment suits oneself (Beyers & Luyckx, 2015). To better determine the correlation between ruminative exploration, reconsideration of commitment, and identity malformation, a cross-sectional study was conducted with 4,289 Belgian participants aged between 14 and 30 years (Beyers & Luyckx, 2015). Most of the participants were either high school (75.1%) or university (20.4%) students (Beyers & Luyckx, 2015). Study results identified that those who experienced ruminative exploration were more likely to have lower self-esteem,

higher depressive symptoms, weaker commitments, and lower confidence in previous commitments (Beyers & Luyckx, 2015). Regression analysis found that those who exhibited a strong sense of reconsideration were more likely to make weaker commitments and have less confidence in their commitments. Notably, an older age was associated with increased commitment making and confidence in one's commitments. The findings of this study provide insight into the risk factors that lead to suboptimal identity formation, especially for adolescents and young adults.

Young Adult Health

Due to the dynamic state of young adulthood, young people in this developmental stage are at an increased risk for poor health outcomes. Risky health behaviors are often first adopted in adolescence, but become increasingly more common and escalate in severity during young adulthood (Schwartz et al., 2010). With newfound independence, young adults may engage in heavy alcohol use, illicit drug use, unprotected sexual activity, and driving while under the influence. Characteristics specific to identity exploration can significantly impact such risky health behaviors. Research conducted by Gates, Corbin, and Fromme (2016) found that experimentation and self-focus were risk factors for heavy drinking and alcohol-related problems. Conversely, Schwartz et al. (2010) determined that college students who reported positive identify formation/identify consolidation were less likely to binge drink, use marijuana, use hard drugs, use inhalants, use prescription drugs, have unprotected sex, have casual sex, have sex while intoxicated, drive while impaired, or ride with an impaired driver. Healthcare professionals must understand that many young adults are still in the process of identity formation, which can have a significant influence on the increased amount of risky health behaviors they exhibit.

Health Status

Surprising to most, young adults have poorer health outcomes in several aspects when compared to adolescents and middle-aged adults. Often as the direct consequence of risky health behaviors, young adults have the highest rates of morbidity and mortality from motor vehicle accidents, homicides, mental health issues, STIs, and substance abuse when compared to all other age groups (IOM & NRC, 2014). Moreover, patterns of behavior and lifestyle choices established in young adulthood have significant influence over one's health and wellbeing across his or her lifespan (IOM & NRC, 2014). For example, low levels of physical activity and unhealthy eating habits contribute to rising obesity rates and have long-term consequences that often result in poor health outcomes later in life (IOM & NRC, 2014). In the following sections, the healthcare topics that are most pertinent to young adults will be reviewed in further detail.

Injuries. In this section, motor vehicle crashes (MVC) are discussed at length; whereas, suicides are discussed in subsequent sections and homicides are not addressed in this manuscript because this is not a prevalent risk factor within the community where the doctoral project is taking place. Unintentional injuries (MVCs) and intentional injuries (homicides and suicides) are the highest causes of mortality among young adults aged 18 to 24 years, accounting for 76% of all young adults' deaths (Child Stats, 2014). Researchers reported that adolescents and young adults are at increased risk for MVCs due to several risk factors: inexperience, risky driving behaviors, distracted driving (e.g. cell phone use), driving with peer-aged passengers, nighttime and weekend driving, driving while under the influence of substances, non-use of seatbelts, and certain medical conditions such as attention deficit hyperactivity disorder (Alderman & Johnston, 2018; Shope & Bingham, 2008). Over the last several decades, there have been considerable public health efforts to decrease MVCs, which reduced the rate of MVC fatalities among young

adults from 36.1 per 100,000 persons in 1990 to 19.0 per 100,000 persons in 2010 (Child Stats, 2010). Despite the nearly 50% decrease in MVC fatalities, MVCs are still the leading mechanism of injury that result in fatality for young adults (Child Stats, 2014). Due to this, they remain a significant threat to young adults' safety and wellbeing.

Substance use. Nationwide, about 25% of males and 17% of females between the ages of 18 to 24 years were diagnosed with a substance use disorder in 2012 (Child Stats, 2014). Substance use disorders include both alcohol and illicit drug use or abuse. The prevalence of substance use is higher in young adults than it is in adolescents or middle-aged adults (IOM & NRC, 2014; National Institute for Health Care Management [NIHCM], 2006). A comprehensive systematic review concluded that the following characteristics are risk factors for substance use in young adults: male gender, Caucasian ethnicity, a family history of substance use/abuse, co-occurring mental health disorders, societal non-conformity, childhood abuse/neglect, familial conflict, and low commitment to school (Stone, Becker, Huber, & Catalano, 2012). Furthermore, living outside of the familial home, unemployment, and attending college were predictive factors for substance use in young adulthood (Stone et al., 2012). Substance use among young adults contributes to injuries, poisonings, and death in this population.

Mental health. One in every five young adults aged 18 to 25 years have been diagnosed with a mental health disorder (Stroud, 2014). Specifically, 9% of all young adults suffered from a major depressive episode (MDE) in 2012 alone (Child Stats, 2014). Females experienced MDEs at nearly twice the rate of males (Child Stats, 2014). Moreover, young adults were more likely than adolescents to commit suicide and more likely than middle-aged adults to think, plan, and attempt suicide (IOM & NRC, 2014). In 2010, suicide rates were highest among White, non-Hispanic males (24.7 per 100,000) and females (5.0 per 100,00) when compared to their African

American and Hispanic counterparts (Child Stats, 2014). Young adulthood is also when symptoms of serious psychological disorders, such as schizophrenia, begin to present (IOM & NRC, 2014). Unfortunately, despite the high prevalence rate of mental health disorders in this age group, many young adults do not receive the care they need. An investigation of young adult health completed by the IOM found that of those young adults who were diagnosed with a mental health disorder, only one-fourth actively received treatment (IOM & NRC, 2014). Furthermore, young adults are more likely to discontinue mental health treatment when compared to adolescents and middle-aged adults (IOM & NRC, 2014). Mental health disorders among young adults significantly contribute to the disease burden within this age group.

Reproductive health. Sexual activity rates are higher among young adults than adolescents (NIHCM, 2006). However, condom use remains low as 32.9% of young adults use condoms only and another 11.9% of young adults use condoms in addition to another form of hormonal birth control as their current method of contraception (Child Stats, 2014). This low percentage of condom usage contributes to an estimated 10 million new cases of STIs every year among adolescents and young adults aged 15 to 24 years (Centers for Disease Control and Prevention [CDC], 2013) with young adults having the highest rates of STIs compared to any other age group (IOM & NRC, 2014). Research suggests that young adults who postponed sexual intercourse until an average age of 22 years, had lower rates of lifetime STIs, lower past-year STIs, and lower past-year concurrent relationships (Haydon, Herring, & Halpen, 2012). Conversely, those who initiated early sexual activity had a higher lifetime risk of an STI diagnosis (Haydon et al., 2012).

While pregnancy rates have decreased over the last several decades, the birth rates for unmarried women 18 to 19 years of age and 20 to 24 years of age remain high at 45.8 per 1000

and 64.7 per 1000, respectively (Child Stats, 2014). Additionally, young adult females have the highest rates of abortions compared to other age groups, this is especially true for African American females (NIHCM, 2006). Young adults are at especially high risk for poor reproductive health outcomes due to concern regarding confidentiality, multiple sex partners, and limited access to healthcare services (CDC, 2013).

Nutritional status. The average percentage of body mass index (BMI) has increased significantly over the last several decades. This trend is especially evident among young adults, as nearly 40% of those aged 18 to 25 years are considered obese (Stroud, 2014). Racial and ethnic minorities are at greater risk for being obese (Child Stats, 2014; IOM & NRC, 2014). Obesity contributes to increased rates of heart disease, diabetes, stroke, arthritis, depression, gallbladder disease, pain, and sleep apnea (CDC, 2015). Not only to do these sequalae lead to a decreased quality of life, they also translate to higher rates of early morbidity and mortality (CDC, 2015). Notably, physical inactivity and unhealthy eating habits that are established in young adulthood often carry over into middle-aged and older adulthood, causing increased vulnerability to poor health outcomes (IOM & NRC, 2014).

Conversely, adolescents and young adults may also struggle with eating disorders (ED) such as anorexia nervosa and bulimia nervosa. The peak age of onset for EDs is between 15 to 19 years, with females being at significantly greater risk than males (Martin & Golden, 2014). Adolescents and young adults with EDs have high rates of comorbid suicidal ideation, increased fracture risk due to low bone mineral density, and electrolyte abnormalities, which all lead to an increased healthcare burden (Martin & Golden, 2014; Swanson et al., 2011). It is imperative for healthcare providers to emphasize healthy lifestyle choices for adolescents and young adults to decrease rates of both obesity and EDs.

Healthcare Access and Utilization

Despite young adults having high rates of preventable causes of morbidity and mortality, healthcare access and utilization rates have remained inadequate over the last several decades. In 2009, prior to the implementation of the Affordable Care Act (ACA), almost 15 million young adults (19-29 years of age) did not have health insurance coverage (English & Park, 2012). This directly impacted healthcare service utilization rates as 45% of young adults reported they delayed seeking healthcare services due to fear of associated costs (English & Park, 2012). Moreover, young adults, when compared to adolescents, had lower rates of healthcare utilization, but higher rates of per capita expenditure (Lau et al., 2014). Minority populations experienced even further inequities. Young adults of ethnic minorities were less likely to utilize any form of healthcare, and young adults of low socioeconomic status had significantly higher rates of healthcare expenditures as well as utilization of emergency care services (Lau et al., 2014). In fact, 58% of uninsured young adults reported they were struggling to pay for their incurred healthcare bills (English & Park, 2012). These figures indicated there was much room for improvement with the implementation of the ACA in 2010.

From 2010 to 2016, after the full rollout of the ACA, 6.1 million additional young adults enrolled for health insurance coverage, bringing the total of uninsured young adults down from 26% to 13.9% (Uberoi, Finegold, & Gee, 2016). With the implementation of the ACA, evidence-based screenings and counseling, immunizations recommended by the Advisory Committee on Immunization Practices, and women's health services recommended by the Health Resources & Services Administration are now fully covered as preventative care services (Harris et al., 2017). More specifically, these services include depression screening, cholesterol screening, hypertension screening, obesity screening, specific cancer screenings, HIV screening, STI

screening, tobacco screening, nutritional screening, and violence screening (English & Park, 2012; Harris et al., 2017). With these changes, Lau, Adams, Park, Boscardin, and Irwin (2014) sought to determine if the increase in health insurance coverage after the first year the ACA would translate to an increase in healthcare utilization among young adults aged 18 to 25 years. For this study, the authors used data from the Medical Expenditures Panel Survey, which is a nationally representative survey, from the years of 2009 and 2011. The sample size of young adults pre-ACA implementation in 2009 was 3768 participants, and the sample size of young adults post-ACA implementation in 2011 was 3717 participants (Lau, Adams, Park, Boscardin, & Irwin, 2014). The results of the study were inconsistent. Annual routine examinations, hypertension screenings, and the influenza vaccination did not increase to a significant level; whereas, cholesterol screening and annual dental exams both increased to significant level (Lau, Adams, Park, Boscardin, & Irwin, 2014). The authors postulated that a larger collection of data from a longer period of time may show more significant results.

Even with the enactment of the ACA, young adults still have the highest uninsured rates compared to all other age groups (Commonwealth Fund, 2016). According to a Commonwealth Fund (2016) analysis, uninsured rates remain higher than anticipated due to undocumented immigrants who are ineligible for Medicaid benefits, continued state restrictions on Medicaid eligibility, lack of awareness, and fear about affordability. With this information, it becomes increasingly clear that healthcare providers must identify unique ways to provide affordable healthcare services to this vulnerable population.

Nurse Practitioners as Young Adult Healthcare Providers

Young adults are a vulnerable population because of the significant developmental changes that occur during this timeframe as well as their participation in risk-taking behavior that

can lead to poor health outcomes later in adulthood. In a review of evidence, the NRC and IOM (2009) identified current missed opportunities within the healthcare delivery system for adolescents aged 10 to 19 years. In summation, the NRC and IOM committee (2009) found that most of the care provided to adolescents aged 10 to 19 years is fragmented and problem-orientated, focuses on acute issues, and poorly addresses education regarding health promotion topics and the avoidance of risky behaviors that are common among this age group. Additionally, many healthcare providers have not been specifically trained to work with this unique population and, therefore, lack the necessary communication skills and knowledge of the anticipatory guidance relevant to adolescents and young adults (NRC & IOM, 2009). In fact, research suggests that the recommended guidelines for screenings, counseling, and health education services are inconsistently provided to this age group (NRC & IOM, 2009). Instead, healthcare providers rely on patients to start conversations about their partaking in risky behaviors and any associated health concerns (NRC & IOM, 2009). This practice leads to poor rapport and distrust between the provider and the patient. Due to the inadequacy of the care provided, it becomes difficult to engage this population in future care. More research is needed to determine the gaps within the healthcare delivery system for young adults and the associated missed opportunities for this specific population.

The above issues are complex and challenging. However, nurse practitioners offer a solution to the problem of fragmented and inadequate healthcare service delivery. Nurse practitioners are trained to work with vulnerable populations in a primary care setting and have been doing so for decades (Van Zandt, Sloand, & Wilkins, 2008). Over 60% of nurse practitioners are trained in the area of family care (American Association of Nurse Practitioners [AANP], 2018), meaning they specialize in providing healthcare throughout the life continuum.

As a result, they are uniquely positioned to bridge the transition from adolescence into young adulthood and beyond. Furthermore, the scope of practice for a nurse practitioner aligns with the needs of young adults. Nurse practitioners can assess, diagnose, prescribe, and treat all while underscoring health promotion and disease prevention (AANP, 2013). With a foundation rooted in nursing principles, screenings, counseling, and health promotion education are of primary concern to the nurse practitioner as he or she values the whole person and emphasizes patient-centered care delivery (AANP, 2015). Moreover, five decades of research have shown that nurse practitioners provide as effective, if not better, care to patients when compared to their physician counterparts (AANP, 2015). This is evidenced by better health outcomes and patient satisfaction rates (AANP, 2015). With their armamentarium, nurse practitioners are well equipped to deliver high quality, evidence-based, patient-centered care to the young adult population.

Conclusion

Societal changes over the last several decades have differentiated young adulthood as a distinct transitional period between adolescence and middle-aged adulthood. During this timeframe, it is known that the young adult will experience further psychological, cognitive, and emotional development, which allows the young adult to form an identity, participate in meaning making, and gain independence. The young adult is then able to more successfully navigate the changes required to enter into adulthood.

Along with the developmental challenges associated with this timeframe, young adults also have increased rates of preventable morbidity and mortality due to engagement in risky behaviors and unhealthy lifestyle choices. It is imperative for the health and wellbeing of young adults that healthcare providers are familiar with young adult risk factors, know how to properly identify issues, and can successfully communicate to help prevent sequalae or offer treatment for

existing conditions. As the field of young adult medicine continues to develop, nurse practitioners will be instrumental leaders in providing care to young adulthoods, and in turn, improving their health outcomes.

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