

**Data Collection Form for EMS 10.1 – Adolescent Wellness Visit**

<b>Element</b>	<b>0 Not Met</b>	<b>1 Partially met</b>	<b>2 Mostly met</b>	<b>3 Completely met</b>
<b>Adolescent Resource Toolkit (ART)</b>				
1. Compile and document state laws and policies related to adolescent health care including confidentiality, medical record documentation, consent/assent information				
2. Document Hawaii based case narratives of Bright Futures AWC visits				
3. Develop Hawaii based referral algorithms for behavioral health, substance use, sexual activity, and transition to adulthood				
4. Acquire resource materials (e.g., posters, brochures, video clips, etc.)				
<b>Continuing Education Curriculum Series (Science)</b>				
5. Develop behavioral health training module				
6. Develop substance use training module				
7. Develop sexual activity training module				
8. Develop transition to adulthood training module				
9. Develop homelife module				
10. Develop healthy eating module				
11. Develop transition across settings module				
<b>Outreach and Training</b>				
12. Convene regularly ART & Science Workgroup to conceptualize and refine materials and processes				
13. Establish baseline knowledge and comfort level for addressing adolescent issues with providers				
14. Disseminate ART to 100 primary care providers serving adolescents				
15. Post ART information online				
16. Deploy “Science” series to primary care providers and their staff using a variety of learning methods				
17. Assess for increase in knowledge and comfort level post training				

**Data Collection Form for ESM #12 – Transition to Adult Health Care**

<b>Element</b>	<b>0 Not Met</b>	<b>1 Partially met</b>	<b>2 Mostly met</b>	<b>3 Completely met</b>
<b>Transition policy</b>				
1. Develop a CYSHNS transition policy/statement, with input from youth, families, and providers, that describes the approach to transition, including consent/assent information.				
2. Educate all staff about the approach to transition, the policy/statement, Six Core Elements, and roles of CYSHNS, youth/family, and pediatric/adult health care team in the transition process, taking into account cultural preferences.				
<b>Transition tracking and monitoring</b>				
3. Establish criteria and process for identifying and tracking transitioning youth in the CSHNP database.				
4. Utilize individual flow sheet or database to track youth's transition progress.				
<b>Transition readiness</b>				
5. At least annually assess transition readiness with youth and parent/caregiver, beginning at age 14, to identify needs related to the youth managing his/her health care (self-care).				
6. Jointly develop goals and prioritized actions with youth and parent/caregiver, and document in a plan of care.				
<b>Transition planning</b>				
7. At least annually update the plan of care, in partnership with youth and families, including readiness assessment findings, goals, and prioritized actions.				
8. Prepare youth and parent/caregiver for adult approach to care before age 18, including legal changes in decision-making, privacy, and consent; self-advocacy; access to information; and insurance continuity.				
9. Develop and implement referral procedures to adult service agencies.				
<b>Transition transfer of care</b>				
10. Prepare youth and parent/caregiver for transferring to an adult health care provider and planning for health insurance coverage as an adult.				
<b>Transition completion</b>				
11. Contact youth and parent/caregiver, when CSHNP services end, to confirm having an adult health care provider and health insurance coverage, or provide further transition guidance.				

