**ALLEGHENY COUNTY DEPARTMENT OF HUMAN SERVICES √ if item is complete**

 **OFFICE OF COMMUNITY SERVICES ─ if missing information**

**Prevention Synergy Data Review**

 **IMT common area: Policy/Procedure**

**Program/Site:** (Family Center / Home Visiting / Hybrid)  **Date: ­­­­­­­­­­­­­­­­ Monitor:**

DIRECTIONS FOR USING THIS FORM: Randomly choose individuals in Synergy to check if their data is complete for required fields. We assume that names are being collected for all head of household members. All families should indicate if pregnant, primary language, family’s interests and referral information if provided. Enrolled families should have the rest of the data listed in this form as fits their status (e.g., no pregnancy data if they are not pregnant). Fill in the case number in the top of the column. Put checks in boxes to indicate that the data is complete in a data field in Synergy.



| CASE ID | 1:  | 2:  | 3: | 4:  | 5: | 6: | 7: | 8: | 9: | 10: |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Drop-In (DI), Enrolled (E), Home Visiting (HV) |  |  |   |  |  |  |  |  |  |  |
| REQUIRED (for all) |  |  |  |  |  |  |  |  |  |  |
| Legal Sex |  |  |  |  |  |  |  |  |  |  |
| Birthdate |  |  |  |  |  |  |  |  |  |  |
| Phone Number |  |  |  |  |  |  |  |  |  |  |
| Contacts (approx. 1 ENGAGED contact per month enrolled; approx. 1 per quarter drop-in) |  |  |  |  |  |  |  |  |  |  |
| Contacts: Referral Category, Referral to, Referral Details (if applicable) |  |  |  |  |  |  |  |  |  |  |
| HIGHLY ENCOURAGED (for all) |  |  |  |  |  |  |  |  |  |  |
| Family Interests (updated yearly – required for HV) |  |  |  |  |  |  |  |  |  |  |
| Race (required for HV) |  |  |  |  |  |  |  |  |  |  |
| Ethnicity (required for HV) |  |  |  |  |  |  |  |  |  |  |
| Service Involvement (required for HV) |  |  |  |  |  |  |  |  |  |  |
| Pregnant (required for HV) |  |  |  |  |  |  |  |  |  |  |
| **# RELEVANT DATA FIELDS** |  |  |  |  |  |  |  |  |  |  |
| **# DATA FIELDS COMPLETE** |  |  |  |  |  |  |  |  |  |  |
| **Green –** 7 or more participants have at least 7 data fields complete**Yellow** – 5-6 participants have at least 7 data fields complete**Red** – 4 or less participants have at least 7 data fields complete |
| HOME VISITING ENROLLEES ONLY |  |  |  |  |  |  |  |  |  |  |
| Address |  |  |  |  |  |  |  |  |  |  |
| Household Members |  |  |  |  |  |  |  |  |  |  |
| Pregnant |  |  |  |  |  |  |  |  |  |  |
| Primary Language |  |  |  |  |  |  |  |  |  |  |
| CI: Address (HoH) |  |  |  |  |  |  |  |  |  |  |
| CI: Phone (HoH) |  |  |  |  |  |  |  |  |  |  |
| CI: Emergency Contact (at least one recorded) |  |  |  |  |  |  |  |  |  |  |
| D: Income Source (HoH) |  |  |  |  |  |  |  |  |  |  |
| D: Income Frequency (HoH) |  |  |  |  |  |  |  |  |  |  |
| D: Insurance Type (children) |  |  |  |  |  |  |  |  |  |  |
| D: Housing Status (HoH) |  |  |  |  |  |  |  |  |  |  |
| D: Housing Type (HoH) |  |  |  |  |  |  |  |  |  |  |
| D: Moved in Last Year (HoH) |  |  |  |  |  |  |  |  |  |  |
| HPREG: Father’s Name |  |  |  |  |  |  |  |  |  |  |
| HPREG: Approx. Due Date |  |  |  |  |  |  |  |  |  |  |
| HPREG: Begun Receiving Prenatal Care |  |  |  |  |  |  |  |  |  |  |
| HPREG: Did Staff Member Assist |  |  |  |  |  |  |  |  |  |  |
| HPREG: Pregnancy Outcome |  |  |  |  |  |  |  |  |  |  |
| HCHILD: Immunizations Current? |  |  |  |  |  |  |  |  |  |  |
| HCHILD: Lead Screening? |  |  |  |  |  |  |  |  |  |  |
| HCHILD: Receives Well Child Visits? |  |  |  |  |  |  |  |  |  |  |
| HCHILD: See Dentist? |  |  |  |  |  |  |  |  |  |  |
| HCHILD: Birthweight (if born after family enrolled) |  |  |  |  |  |  |  |  |  |  |
| A: Child Name |  |  |  |  |  |  |  |  |  |  |
| A: ASQ Type |  |  |  |  |  |  |  |  |  |  |
| A: ASQ Age |  |  |  |  |  |  |  |  |  |  |
| A: ASQ Screening Date |  |  |  |  |  |  |  |  |  |  |
| A: All Scores and Cutoff Scores |  |  |  |  |  |  |  |  |  |  |
| A: Referral Recommended |  |  |  |  |  |  |  |  |  |  |
| A: Referral Made (If recommended) |  |  |  |  |  |  |  |  |  |  |
| A: Child Eligible |  |  |  |  |  |  |  |  |  |  |
| A: Accepted EI Services |  |  |  |  |  |  |  |  |  |  |
| A: EI Start Date (If accepted) |  |  |  |  |  |  |  |  |  |  |
| Contact: Referral Category |  |  |  |  |  |  |  |  |  |  |
| Contact: Referral to |  |  |  |  |  |  |  |  |  |  |
| Contact: Referral Details |  |  |  |  |  |  |  |  |  |  |
| P: Plan Summary |  |  |  |  |  |  |  |  |  |  |
| **# RELEVANT DATA FIELDS** |  |  |  |  |  |  |  |  |  |  |
| **# DATA FIELDS COMPLETE** |  |  |  |  |  |  |  |  |  |  |
| **Green –** 7 or more participants have >80% of relevant data fields complete**Yellow** – 5-6 participants have >80% of relevant data fields complete**Red** – 4 or less participants have >80% relevant data fields complete |

Recommendations:

Click or tap here to enter text.