ENCOMPASS FAMILY HEALTH HOME

CHILDREN'S RECORD AUDIT TOOL

Date of Audit:	**Netsmart ID #:**	**Date of enrollment:**
Agency:	**Auditor:**	**Score:**

STANDARD	**Yes**	**No**	**NA**	**Located In:**		**Recommendations**	**Additional Comments**
ELIGIBILITY *Recent claims and clinical data document the following:*				**Chart**	**EHR**		
Current Medicaid Recipient							
Copy of Medicaid Card							
One or more of the following: *Check all that apply.* ☐ Two or more qualifying chronic health conditions. ***AND/OR*** ☐ Single qualifying chronic condition (SMI or SED), ***AND/OR*** ☐ History of Complex Trauma ***(includes supporting forms and documentation completed by licensed professional as necessary);*** ***AND/OR*** ☐ HIV/AIDS							
Documentation Supporting Appropriateness Criteria							
Eligibility confirmed prior to enrollment							
ENROLLMENT/ CONSENTS							
Outreach activities provided are documented, active and progressive.							
Assessment process was initiated with enrolled Child/Family through an interview process at 1st meeting							
Initial Needs/Eligibility Assessment completed							
Initial Needs/Eligibility Assessment Signed by Child/Guardian, Care Manager & Supervisor							

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Standard	Yes	No	NA	Chart	EHR	Recommendations	Additional Comments
Documentation of Consent to Refer *(on referral form or note documenting source)*							
Completed DOH-5200 Enrollment Consent Form *(For Children under age 18 who are not pregnant, parents or legally married)*							
Review of FAQ form documented prior to completion of DOH-5200							
Completed DOH-5055 *(for children 18 or older who can self-consent, or for children under 18 and a parent, pregnant or legally married)* ☐Includes the Child's dated signature next to each provider.							
Section 1 of the DOH-5201 Data Sharing Consent *(for children under 18)* completed by Child's Parent/ Guardian/Legally authorized representative							
Section 2 of the DOH-5201 Data Sharing Consent Form completed by the Child with the Care Manager *(or documentation of attempt to complete the section)*							
Annual update of DOH-5055 ***OR*** DOH-5201 ☐ Includes initials and dates next to each provider change							
Documentation of referral source notification within 48 hours of assignment.							
Completed PSYCKES Consent Form							

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Standard	Yes	No	NA	Chart	EHR	Recommendations	Additional Comments
Appropriate PSYCKES identification obtained: ☐Copies of legal documentation of identity ***OR*** ☐Documented relationship with CMA							
Completed Agency Releases of Information if applicable ☐Signed and dated by Child/ Guardian ☐Witnessed ☐Purpose Selected							
Health Home Consent Information Sharing Release of Educational Records Form (DOH-5203) completed if needed.							
Health Home Rights and Responsibilities Completed at Admission							
Health Home Rights and Responsibilities signed by Child/Guardian/ Consenter and printed name of staff							
Health Home Rights and Responsibilities renewed annually							
2 Consents to RHIO Access							
Consents/Releases are added /updated to reflect change *(i.e. guardianship or consent status)*							
All Withdrawal of Consents completed as appropriate							
All Consent and Withdrawal of Consent forms are uploaded to Netsmart.							
ASSESSMENT/ REASSESSMENT				**Chart**	**EHR**		
Interdisciplinary Team meeting planning documented at first visit.							

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Interdisciplinary Team meeting facilitated within 30 days of enrollment.							
Interdisciplinary Team meeting inclusive of all individuals identified on the consent and of identified family supports.							
DOH-5230 Functional Assessment Consent Form completed							
DOH-5230 Functional Assessment Consent Form completed prior to assessment							
CANS-NY Assessment Completed							
CANS-NY Assessment Completed within 30 Days of enrollment.							
CANS-NY Re-assessment conducted: □every 6 months (from 1st day of the month it was completed), **OR** □within 30 days of significant changes/events.							
Supporting Documentation for CANS-NY attached in Netsmart							
Comprehensive Assessment Process (CAP) completed within 60 days of enrollment in conjunction with the completion of the CANS-NY.							
CAP completed with input from the Care Team							
Brief Assessment completed in conjunction with the CANS-NY as needed based on significant events. □ Supervisor sign-off							
Case review held after significant events □ Includes supervisor							
Annual Comprehensive Reassessment completed							

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Supportive Documentation for the CAP and all reassessments obtained and uploaded							
Additional assessments completed as needed based on needs identified in the CANS-NY and CAP.							
CAP identifies needed referrals and interventions							
Referrals and interventions put in place as identified in the CAP							
All assessments are uploaded into Netsmart.							
PLAN OF CARE (POC)							
Approved POC completed 60 days from enrollment (or documentation present describing circumstances for delay)							
POC developed based on CANS-NY Assessment and Comprehensive Assessment Process							
POC signed by Child/Guardian/Consenter							
POC signed by Care Manager							
POC signed by Care Management Supervisor							
POC developed with the Interdisciplinary team input.							
POC addresses History and Risk Factors							
Strengths and preferences identified							
Barriers identified							
Functional Needs Identified							
Services & Key Providers/Support Identified as a part of the care team							
Key Informal Community Supports identified							
Emergency/Disaster Plan (Assessment) completed							

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Standard	Yes	No	NA	Chart	EHR	Recommendations	Additional Comments
Crisis/Relapse plan completed							
Interventions have Appropriate Timeframes							
Needed Transitional Plans are present							
The Child's/ Medical Consenters Signatures							
Objectives are measurable.							
Objectives are strengths-based							
POC is updated at least **quarterly** or as needed to reflect transition or changes							
POC updated after brief and/or comprehensive reassessment							
Quarterly review form completed							
Ongoing Supportive Documentation provided							
Consent of Family/Legal Guardian/Medical Consenter given for all POC revisions.							
Signed POC is uploaded into Netsmart.							
POC identifies involvement and role of all Care Team members							
POC identifies involvement and role of MCO							
CARE NOTES							
Care notes correspond to the POC and identify the HH Core Services provided monthly. ☐ At least 1 for Low acuity Children ☐ 2 or more for Medium & High acuity Children (on 2 separate dates)							
Care Notes document active and progressive movement towards objective and goal obtainment.							

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Standard	Yes	No	NA	Chart	EHR	Recommendations	Additional Comments
Care Notes document provision of care coordination to meet needs directly related to the Child's diagnosis/ chronic condition							
Care Notes document coordination of preventative services							
Care Notes document coordination of medication management if appropriate							
Documentation of Interdisciplinary Team meeting at least every 6 months/during CANS-NY re-assessment or as needed ☐If no meeting took place, is there documentation of the effort to facilitate such a meeting?							
Documentation of follow-up after appointments/ treatments within 2 days.							
Documentation of outreach/follow-up within 24 hours of: ☐Missed appointments ☐Use of Emergency Services							
Care Notes identify efforts to provide necessary transitional care.							
Documentation of follow-up within 48 hours of transition or discharge.							
Care Notes identify ongoing communication with identified community supports*(i.e. family, schools, spiritual support)*							
Care notes contain type of contact.							
Care notes contain location of contact.							
Care notes are documented by the person who provided the service.							

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Care notes document provision of appropriate services based on the outcomes of the CANS-NY and Comprehensive Assessment Process							
Care notes document provision of appropriate services based on reassessments.							
MANAGED LONG-TERM CARE (MLTC)							
MLTC/Health Home Care Coordination Agreement Form completed outlining services needed and provided by each entity							
Care Planning and Coordination for MLTC and Health Homes Form completed and Uploaded to Netsmart ☐Completed at each reassessment							
Notes document ongoing collaboration							
DISCHARGE							
Signed Withdrawal of Consent Form (DOH-5052 or 5058)							
Supportive documentation for discharge within care notes							
Quarterly Review Form reflects discharge process and readiness.							
Pre-discharge note containing: ☐Date of Lost-To-Service if known ☐Reason for discharge planning process							
Completed discharge note with the following: ☐Explanation of why the Child is being discharged ☐Efforts made to connect Child to services to meet ongoing needs							

☐Summary of all care coordination activities during the discharge process including transitional services and referrals							

SCORING.

The score for each section may be calculated by dividing the number of "yes" responses by the sum of both "yes" and "no" responses (Responses of N/A do not contribute to the score in any way.) Multiply your answer by 100 to calculate the percent.

The score for the entire chart audit may be calculated by adding the scores from each section completed, dividing by number of sections completed and multiplying by 100.

SECTION	SCORE(%)	COMMENTS
ELIGIBILITY		
ENROLLMENT/CONSENTS		
ASSESSMENT/RE-ASSESSMENT		
PLAN OF CARE		
CARE NOTES		
MANAGED LONG-TERM CARE		
DISCHARGE		