

**GATEWAY HEALTH PLAN®
MEDICAL RECORD REVIEW STANDARDS
HOME HEALTH AGENCY**

1. MEMBER ID	Each page in the record contains member name or member ID number.
2. BIOGRAPHICAL DATA	Personal data includes address, telephone numbers, emergency contact, marital status, etc.
3. ENTRY ID	All entries are signed (electronically) or initialed, by the licensed professional.
4. ENTRY DATE	All entries are dated.
5. LEGIBILITY	The record is legible to someone other than the originator.
6. MEDICATION LISTING	Medication listing will be up-to-date reflecting all medications the member receives, including over-the-counter medications and those not administered by the staff.
7. ALLERGIES	Presence/absence of allergies or adverse reactions to medications is prominently noted on each chart.
8. MEDICAL HISTORY	Past medical history, existing conditions and secondary problems are noted in each record.
9. TOBACCO/ALCOHOL/ DRUG USE	Use/non-use of tobacco, alcohol and illicit drugs is documented on members age 14 and older.
10. ASSESSMENTS	The record contains findings of the member's initial assessment and reassessments.
11. DIETARY	There is documentation of any dietary restrictions.
12. CARE AND SERVICES	There is documentation of specific care & services provided to the member & any related functional limitations.
13. CARE PLANS	Documentation of care planning activities related to the member's problems and needs.
14. OTHER CARE GIVERS	There is a notation concerning non-professionals/professionals/organizations involved in member's care, including the ability of non-professionals to provide safe, appropriate care.
15. CONTINUITY & COOR- DINATION OF CARE	There is evidence of timely communication with the PCP/ referring physician i.e. changes in patient status, signed orders, etc., and with other professionals. Information is provided to other agencies if the member transfers care.
16. CONSENT	Consent for care is documented.
17. DISCHARGE SUMMARY	All discharged members must have a discharge summary.
18. LAB/X-RAYS/STUDIES	Record includes all diagnostic procedures done as part of the home health treatment, i.e. blood work, x-rays, etc.
19. CARE MEDICALLY APPROPRIATE	All care must be medically appropriate and necessary, and there is no evidence that the member has been placed at inappropriate risk, including lack of nursing coverage at prescribed times.
20. HOME ENVIRONMENT	Record contains notation regarding the home environment's physical and psychosocial suitability or adaptability for care and services provided, and addresses the need for any safety measures as appropriate.
21. EDUCATION	Member/family training, when appropriate, is documented, as well as post-training assessment of care provided.
22. ADVANCE DIRECTIVE	Notation that information concerning advance directives has been offered to members ages 21 years and older.