

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

<b>1. MEMBER ID*</b>	Each page in the record contains member name or member ID number
<b>2. BIOGRAPHICAL DATA*</b>	Personal data includes address, employer, telephone numbers, emergency contact, marital status, etc.
<b>3. ENTRY ID*</b>	All entries including dictation are signed (electronically) or initialed by the licensed professional, as appropriate. NA notes are to be cosigned by supervising professional. All verbal orders are cosigned by the physician.
<b>4. ENTRY DATA*</b>	All entries are dated.
<b>5. LEGIBILITY*</b>	The record is legible to someone other than the originator.
<b>6. MEDICATION LIST*</b>	Prescribed medications including dosage and frequency, and over the counter medications that the member takes on a regular basis are documented on a separate medication list.
<b>7. MEDICATION REVIEW</b>	Documentation that medication names, doses, timing and method of administration are reviewed with the member/guardian/parent. Documentation must be signed and dated by the member/guardian/parent.
<b>8. ALLERGIES*</b>	Presence/absence of allergies or adverse reactions to medications are prominently noted on each member chart after one year of age.
<b>9. MEDICAL HISTORY</b>	Includes serious injuries, operations and illnesses, and secondary conditions and any other disorders that impact on the member's care. Documentation must include why the member is being treated by the home health agency.
<b>10. TOBACCO USE*</b>	Use/nonuse of tobacco products is documented on members age 11 and older. This includes tobacco, chew, pipe and/or snuff. If a smoker, documentation that smoking cessation strategies were discussed.
<b>11. ALCOHOL/DRUG USE</b>	Use/nonuse of alcohol and illicit drugs is documented on members age 11 and older.
<b>12. INITIAL ASSESSMENT AND REASSESSMENT</b>	A complete initial assessment is in the record including physical, psychosocial/mental health history, as well as complete pain assessment. Reassessment every 6 months in collaboration with the member minimally and/or when need arises.
<b>13. DIETARY RESTRICTIONS</b>	Documentation of nutritional assessment is required.
<b>14. SPECIFIC CARE AND SERVICES</b>	Documentation includes skilled observation/assessment, intervention and treatments, interdisciplinary team communication, and updated orders.
<b>15. FUNCTIONAL ASSESSMENT</b>	Documentation of a baseline functional assessment.
<b>16. SPECIFIC PLAN OF CARE</b>	Physician orders must be in writing and present in the record. Documentation of a completed medical plan developed in collaboration with the member is present in the record.
<b>17. INDIVIDUALS INVOLVED IN CARE</b>	There is a notation of other individuals or agencies involved in the members' care and if indicated an assessment of the ability of the non-professionals to provide safe appropriate care.
<b>18. CONTINUITY/COORDINATION OF CARE *</b>	If the members' care is being transferred to another agency or a facility, there is documentation the information was shared concerning care.
<b>19. COMMUNICATION WITH PCP *</b>	There is documentation of relevant information to the PCP/ordering physician on a regular basis.
<b>20. DISCHARGE SUMMARY*</b>	There is a discharge summary sent to the PCP/ordering physician/facility that includes members' condition and follow-up care needs.
<b>21. CONSENT FOR TREATMENT *</b>	There is a consent for treatment signed by the member/guardian/patient.
<b>22. OB MEMBERS</b>	Documentation includes a notation of a scheduled postpartum visit and/or offer of assistance in scheduling appointment.
<b>23. CONSULTS/X-RAYS/LABS/IMAGING STUDIES</b>	Documentation of all reports is current and present in the record.

\*Indicates Critical Factors

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<b>24. ABNORMAL STUDY RESULTS</b>	All abnormal reports are called/e-mailed/ faced to the ordering physician, and the physician has signed and dated the reports.
<b>25. MEDICALLY APPROPRIATE CARE</b>	There will be no evidence that the member was placed at inappropriate risk by a diagnostic or therapeutic modality
<b>26. HOME ENVIRONMENT</b>	The medical record contains a notation regarding home environment's physical suitability (condition, cleanliness, crowding) or adaptability (adequate space for necessary equipment/stairs for care and services that are being provided.
<b>27. EDUCATION</b>	Members should be educated about their specific health care needs and encouraged to initiate appropriate self-care measures to promote their own health. Notation also includes members' ability to perform needed care.
<b>28. ADVANCED DIRECTIVE</b>	There is annual documentation of whether the member has executed an advance directive (ages 21 and older), and if "yes" a copy must be included in the medical record. Advance care plans include advance directive, actionable medical orders, living wills, surrogate decision maker