HIGHMARK WHOLECARE

MEDICAL RECORD REVIEW STANDARDS
HOME HEALTH AGENCY

1. MEMBER ID*	Each page in the record contains member name of member ID number.
2. BIOGRAPHICAL DATA*	Personal data includes address, employer, telephone numbers, emergency contact, marital status, etc.
3. ENTRY ID*	All entries, including dictation, are signed (electronically) or initialed by the licensed professional (as appropriate). NA notes are to be cosigned by the supervising professional. All verbal orders are cosigned by the physician.
4. ENTRY DATA*	All entries are dated.
5. LEGIBILITY*	The record is legible to someone other than the originator.
6. MEDICATION LIST*	Prescribed medications including dosage and frequency, and over-the counter medications that the members take on a regular basis are documented on a separate medication list.
7. MEDICATION REVIEW*	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.
8. ALLERGIES*	Presence/absence of allergies or adverse reactions to medications are prominently noted on each member chart after one year of age.
9. MEDICAL HISTORY*	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.
10. TOBACCO USE	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.
11. ALCOHOL/DRUG USE	Use/nonuse of alcohol and illicit drugs is documented on members age 11 and older.
12. INITIAL ASSESSMENT AND REASSESSMENT	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 the need arises.
13. DIETARY RESTRICTIONS	Documentation of nutritional assessment is required.
14. SPECIFIC CARE AND SERVICES	Documentation includes skilled observations/assessment, intervention, treatments, interdisciplinary team communication, and updated orders.
15. FUNCTIONAL ASSESSMENT	Documentation of a baseline functional assessment.

16. SPECIFIC PLAN OF CARE	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.
17. INDIVIDUALS INVOLVED IN CARE	There is notation of other individuals or agencies involved in the members' care and, if indicated, an assessment of the ability of nonprofessionals to provide safe, appropriate care.
18. CONTINUITY / COORDINATION OF CARE*	If the members' care is being transferred to another agency or a facility, there is documentation the information was shared.
19. COMMUNICATION WITH PCP*	There is documentation of relevant information to the PCP/ordering physician on a regular basis.
20. DISCHARGE SUMMARY*	There is documentation of relevant information to the PCP/ordering physician/facility that includes members' conditions and follow-up care needs.
21. CONSENT FOR TREATMENT*	There is a consent for treatment signed by the member/guardian/parent.
22. OB MEMBERS	Documentation includes a notation of a scheduled postpartum visit and/or offer of assistance in scheduling appointment.
23. CONSULTS/XRAYS/LABS/IMAGING STUDIES	Documentation of all reports is current and present in the record.
24. ABNORMAL STUDY RESULTS	All abnormal reports are called/emailed/faxed to the ordering physician, and the physician has signed and dated the reports.
25. APPROPRIATE TREATMENT*	There will be no evidence that the member was placed at inappropriate risk by a diagnostic or therapeutic modality.
26. HOME ENVIRONMENT	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).
27. EDUCATION	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.
28. ADVANCE DIRECTIVE	There is annual documentation of whether the member has executed an advance directive (ages 21 and older). If "yes," a copy must be included in the medical record. Advance care plans include advance directive, actionable medical orders, DNR status, living wills and surrogate decision maker.

***Indicates Critical Factors**