Act (42 U.S.C. 1320a–1) and implementing regulations.

(C) Whether the designated planning agency has approved or disapproved the proposed capital expenditure if it was presented to that agency.

(3) *Preparation of plan and budget.* The overall plan and budget is prepared under the direction of the governing body of the HHA by a committee consisting of representatives of the governing body, the administrative staff, and the medical staff (if any) of the HHA.

(4) *Annual review of plan and budget.* The overall plan and budget is reviewed and updated at least annually by the committee referred to in paragraph (i)(3) of this section under the direction of the governing body of the HHA.

§ 484.110 Condition of participation: Clinical records.

The HHA must maintain a clinical record containing past and current information for every patient accepted by the HHA and receiving home health services. Information contained in the clinical record must be accurate, adhere to current clinical record documentation standards of practice, and be available to the physician(s) or allowed practitioner(s) issuing orders for the home health plan of care, and appropriate HHA staff. This information may be maintained electronically.

(a) *Standard: Contents of clinical record.* The record must include:

(1) The patient's current comprehensive assessment, including all of the assessments from the most recent home health admission, clinical notes, plans of care, and physician or allowed practitioner orders;

(2) All interventions, including medication administration, treatments, and services, and responses to those interventions;

(3) Goals in the patient's plans of care and the patient's progress toward achieving them;

(4) Contact information for the patient, the patient's representative (if any), and the patient's primary caregiver(s);

(5) Contact information for the primary care practitioner or other health care professional who will be responsible for providing care and services to the patient after discharge from the HHA; and

(6)(i) A completed discharge summary that is sent to the primary care practitioner or other health care professional who will be responsible for providing care and services to the patient after discharge from the HHA (if any) within 5 business days of the patient's discharge; or

(ii) A completed transfer summary that is sent within 2 business days of a planned transfer, if the patient's care will be immediately continued in a health care facility; or

(iii) A completed transfer summary that is sent within 2 business days of becoming aware of an unplanned transfer, if the patient is still receiving care in a health care facility at the time when the HHA becomes aware of the transfer.

(b) *Standard: Authentication.* All entries must be legible, clear, complete, and appropriately authenticated, dated, and timed. Authentication must include a signature and a title (occupation), or a secured computer entry by a unique identifier, of a primary author who has reviewed and approved the entry.

(c) *Standard: Retention of records.* (1) Clinical records must be retained for 5 years after the discharge of the patient, unless state law stipulates a longer period of time.

(2) The HHA's policies must provide for retention of clinical records even if it discontinues operation. When an HHA discontinues operation, it must inform the state agency where clinical records will be maintained.

(d) *Standard: Protection of records.* The clinical record, its contents, and the information contained therein must be safeguarded against loss or unauthorized use. The HHA must be in compliance with the rules regarding protected health information set out at 45 CFR parts 160 and 164.

(e) *Standard: Retrieval of clinical records.* A patient's clinical record (whether hard copy or electronic form) must be made available to a patient, free of charge, upon request at the next home visit, or within 4 business days (whichever comes first).

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