Title: **Hospice Policy 707**
Section: **HOSPICE SERVICE COORDINATION**
Subject: **Clinical Records**
Reference: **ARM 37.40.805, 42 CFR 418.104**
Supersedes: **Policy 707, JULY 2017**

CLINICAL RECORDS

A clinical record containing past and current findings is maintained for each hospice member. The clinical record must contain correct clinical information that is available to the member's attending physician and hospice staff. The clinical record may be maintained electronically.

CONTENT

Each member's record must include the following:

1. The initial plan of care, updated plans of care, initial assessment, comprehensive assessment, updated comprehensive assessments, and clinical notes;
2. Signed copies of the notice of member's rights and election statement;
3. Responses to medications, symptom management, treatments, and services;
4. Outcome measure data elements;
5. Physician certification and recertification of terminal illness;
6. Any advance directives; and
7. Physician orders.

AUTHENTICATION

All entries must be legible, clear, complete, and appropriately authenticated and dated in accordance with hospice policy and currently accepted standards of practice.

PROTECTION OF INFORMATION

The clinical record, its contents and the information contained therein must be safeguarded against loss or unauthorized use.

The hospice must be in compliance with the Department's rules regarding protection of personal health information.

RETENTION OF RECORDS

Member clinical records must be retained for six years after the death or discharge of the member, unless State law stipulates a longer period of time. If the hospice discontinues operation, hospice policies must provide for retention and storage of clinical records. The hospice must inform its State agency and its CMS Regional office where such clinical records will be stored and how they may be accessed.

DISCHARGE OR TRANSFER OF CARE

If the care of a member is transferred to another Medicare/Medicaid-certified facility, the hospice must forward to the receiving facility, a copy of:

1. The hospice discharge summary; and
2. The member's clinical record, if requested.

If a member revokes the election of hospice care, or is discharged from hospice in accordance with Hospice Policy 406, the hospice must forward to the member's attending physician, a copy of:

1. The hospice discharge summary; and
2. The member's clinical record, if requested.

The hospice discharge summary must include:

1. A summary of the member's stay including treatments, symptoms and pain management;
2. The member's current plan of care;
3. The member's latest physician orders; and
4. Any other documentation that will assist in post-discharge continuity of care or that is requested by the attending physician or receiving facility.

RETRIEVAL OF CLINICAL RECORDS

The clinical record, whether hard copy or in electronic form, must be made readily available on request by an appropriate authority.