TITLE 310. OKLAHOMA STATE DEPARTMENT OF HEALTH
CHAPTER 661. HOSPICE

SUBCHAPTER 1. GENERAL PROVISIONS

310:661-1-2. Definitions

The following words and terms, when used in this Chapter, shall have the following meaning, unless the context clearly indicates otherwise.

"Act" means the Oklahoma Hospice Licensing Act, 63 O.S. 1991, §§ 1-860.1 et seq.

"Alternate Administrative Office" means an approved location from which the hospice provides the same full range of hospice care and services that is required of the hospice issued, stores supplies, and/or is used for documentation and meets the requirements of 310:661-2-1(f)(2). Each location shall meet all of the applicable requirements of Chapter 661. Hospice.

"Attending physician" means a doctor of medicine or osteopathy, identified by the patient or representative at the time the patient or representative elects to receive hospice care, as having the most significant role in the determination and delivery of the patient's medical care.

"Bereavement counseling" means emotional, psychosocial, and spiritual support and services provided before and after the death of the patient to assist with issues related to grief, loss, and adjustment.

"Clinical note" means a notation of a contact with the patient and/or the family that is written and dated by any person providing services and that describes signs and symptoms, treatments and medications administered, including the patient's reaction and/or response, and any changes in physical, emotional, psychosocial or spiritual condition during a given period of time.

"Comprehensive assessment" means an evaluation of the patient's physical, psychosocial, emotional and spiritual status related to the terminal illness and related conditions. This includes an evaluation of the caregiver's and family's willingness and capability to care for the patient.

"Continuous care" means nursing care that is provided by a skilled nurse or a qualified hospice aide for as much as 24-hours a day during periods of medical crisis as necessary to maintain a hospice patient at their place of residence.

"Department" means the Oklahoma State Department of Health.

"Dietary counseling" means education and interventions provided to the patient and family regarding nutritional intake as the patient's condition changes. Dietary counseling is provided by qualified individuals, which may include a registered nurse or dietitian, when identified in the patient's plan of care.

"Employed" means contracting with a person for services, regardless of compensation. This term also includes volunteers.

"Employee" means a person who: (1) Works for the hospice and for whom the hospice is required to issue a W-2 form on his or her behalf; (2) if the hospice is a subdivision of an agency or organization, an employee of the agency or organization who is assigned to the hospice; or (3) is a volunteer under the jurisdiction of the hospice.

"Fast-track" The process where advance approval may be secured for construction starts while design details are completed.

"First-year license" means a license issued for the initial twelve (12) month license period.

"Follow-up inspection" means the inspection by representatives of the Department that shall occur after a hospice has provided hospice services for at least six (6) months.

"Governing body" means a person, persons, or legal entity that is legally responsible for the conduct of the facility as an institution and carries out the functions, ownership, and governance in accordance with these regulations and the laws of this state.

"Initial assessment" means an evaluation of the patient's physical, psychosocial and emotional status related to the terminal illness and related conditions to determine the patient's immediate care and support needs.

"License" means a first-year or permanent hospice license issued pursuant to the Act and these rules.

"Licensed independent practitioner" means any individual permitted by law and by the licensed hospice to provide care and services, without direct supervision, within the scope of the individual's license and consistent with clinical privileges individually granted by the licensed hospice. Licensed independent practitioners may include advanced practice nurses with prescriptive authority, physician assistants, dentists, podiatrists, optometrists, chiropractors, and psychologists.

"**Marriage and Family Counselor"** means an individual who: (1) possesses a master's or doctor's degree which qualifies for licensure or certification as a marriage and family therapist pursuant to State law of the State in which such individual furnishes the services defined as marriage and family therapists; (2) has performed at least 2 years or 3,000 hours of post master's degree clinical supervised experience in marriage and family therapy in an appropriate setting such as a hospital, SNF, private practice, or clinic and: (3) and is licensed or certified as a marriage and family therapist by the Ste in which the services are performed.

"Medical Crisis" means an event or situation in which a registered nurse, through direct assessment of the hospice patient, determines that the patient has entered into a period of crisis which requires a physician's intervention and continuous nursing care to achieve palliation or management of acute medical symptoms. Peaceful symptom controlled death is an expected patient outcome and is not considered a medical crisis. A medical crisis would include, but not be limited to the following: uncontrolled terminal agitation as demonstrated by hallucinations, confusion, and combativeness; uncontrolled pain; uncontrolled respiratory distress; uncontrolled nausea and vomiting; hemorrhaging; uncontrolled seizures; family distress as a result of ongoing symptom management for the patient requiring administration of medications to maintain the patient's comfort; and, any uncontrolled symptom that requires the administration of medications with ongoing assessment of the effectiveness and adjustment of the medication regimen to achieve control of symptoms.

"**Mental Health Counselor"** means an individual who: (1) possesses a master's or doctor's degree which qualifies for licensure or certification as a mental health counselor, clinical professional counselor, professional counselor under the State law of the State in which such individual furnishes the services as a mental health counselor services; (2) after obtaining such a degree, has performed at least 2 years or 3,000 hours of post master's degree clinical supervised experience in mental health counseling in an appropriate setting such as a hospital, SNF, private practice, or clinic and: (3) is licensed or certified as a mental health counselor, clinical professional counselor, professional counselor by the State in which the services are performed.

"Palliative care" means patient and family-centered care that optimizes quality of life by anticipating, preventing, and treating suffering. Palliative care throughout the continuum of illness involves addressing physical, intellectual, emotional, social, and spiritual needs and to facilitate patient autonomy, access to information, and choice.

"Permanent license" means a license first issued to a hospice program after the first-year license period has been completed and the required follow-up inspection has been conducted.

"Physician designee" means a doctor of medicine or osteopathy designated by the hospice who assumes the same responsibilities and obligations as the medical advisor when the medical advisor is not available.

"Registered nurse" means a person who is currently licensed to practice registered nursing in the State of Oklahoma.

"Representative" or **"Court appointed guardian"** means a person who is authorized in accordance with State law to execute or revoke an election for hospice care or terminate medical care on behalf of the terminally ill individual.

"Skilled nurse" means a person who is currently licensed to practice registered nursing or practical nursing in the State of Oklahoma.

"Social worker" means a person who has a degree from a school accredited or approved by the Council on Social Work Education and conforms to the requirements of the State Licensure Laws of Oklahoma for Social Workers.

310:661-5-2.1. Interdisciplinary group, care planning, and coordination of services

(a) **General.** The hospice must designate an interdisciplinary group or groups which, in consultation with the patient's attending physician, will prepare a written plan of care for each patient. The plan of care will specify the hospice care and services necessary to meet the patient and family-specific needs identified in the comprehensive assessment as such needs relate to the terminal illness and related conditions.

(b) **Approach to service delivery.**

(1) The hospice must designate in writing an interdisciplinary group or groups composed of individuals who work together to meet the physical, medical, psychosocial, emotional, and spiritual needs of the hospice patients and families facing terminal illness and bereavement. Interdisciplinary group members must provide the care and services offered by the hospice, and the group, in its entirety, must supervise the care and services. The hospice will designate a registered nurse that is a member of the interdisciplinary group to provide coordination of care and to ensure continuous assessment of each patient's and family's needs and implementation of the interdisciplinary plan of care. The interdisciplinary group must include individuals who are qualified and competent to practice in the following professional roles:

(A) A doctor of medicine or osteopathy (who is an employee or under contract with the hospice);

(B) A registered nurse;

(C) A social worker~~,~~, marriage and family therapist, or a mental health counselor;

(D) A pastoral or other counselor.

(2) If the hospice has more than one interdisciplinary group, it must identify a specifically designated interdisciplinary group to establish policies governing the day-to-day provision of hospice care and services.

(c) **Plan of care.** All hospice care and services furnished to patients and their families must follow an individualized written plan of care established by the hospice interdisciplinary group in collaboration with the attending physician (if any), the patient or representative, and the primary caregiver in accordance with the patient's needs. The hospice will ensure that each patient and the primary care giver(s) receive education and training provided by the hospice as appropriate to their responsibilities for the care and services identified in the plan of care.

(d) **Content of the plan of care.** The hospice must develop an individualized written plan of care for each patient. The plan of care will reflect patient and family goals and interventions based on the problems identified in the initial, comprehensive, and updated comprehensive assessments. The plan of care must include all services necessary for the palliation and management of the terminal illness and related conditions, including at least the following:

(1) Interventions to manage pain and symptoms;

(2) A detailed statement of the scope and frequency of services necessary to meet the specific patient and family needs;

(3) Measurable outcomes anticipated from implementing and coordinating the plan of care;

(4) Drugs and treatment necessary to meet the needs of the patient;

(5) Medical supplies and appliances necessary to meet the needs of the patient; and

(6) The interdisciplinary group's documentation of the patient's or representative's level of understanding, involvement, and agreement with the plan of care, in accordance with the hospice's own policies, in the clinical record.

(e) **Review of the plan of care.** The hospice interdisciplinary group (in collaboration with the individual's attending physician, if any) must review, revise and document the individualized plan as frequently as the patient's condition requires, but no less frequently than every fifteen (15) calendar days. A revised plan of care must include information from the patient's updated comprehensive assessment and note the patient's progress toward outcomes and goals specified in the plan of care.

(f) **Coordination of services.** The hospice must develop and maintain a system of communication and integration, in accordance with the hospice's own policies and procedures, to:

(1) Ensure that the interdisciplinary group maintains responsibility for directing, coordinating, and supervising the care and services provided;

(2) Ensure that the care and services are provided in accordance with the plan of care;
(3) Ensure that the care and services provided are based on all assessments of the patient and family needs;
(4) Provide for and ensure the ongoing sharing of information between all disciplines providing care and services in all settings, whether the care and services are provided directly or under arrangement; and
(5) Provide for an ongoing sharing of information with other non-hospice healthcare providers furnishing services unrelated to the terminal illness and related conditions.