

1 AN ACT relating to patient medical records.

2 *Be it enacted by the General Assembly of the Commonwealth of Kentucky:*

3 ➔SECTION 1. A NEW SECTION OF KRS CHAPTER 422 IS CREATED TO
4 READ AS FOLLOWS:

5 *(1) As used in this section, "personal representative" means an individual who has*
6 *authority under state law to make health care decisions for a patient.*

7 *(2) The parent of a patient who is under the age of eighteen (18), or a patient's*
8 *personal representative on behalf of the patient who is under the age of eighteen*
9 *(18), shall have the right to access the patient's health information maintained by*
10 *a health care provider in a medical record unless prohibited under the federal*
11 *Health Insurance Portability and Accountability Act of 1996 or any other federal*
12 *or state law.*

13 ➔Section 2. KRS 311.6225 is amended to read as follows:

14 (1) An adult with decisional capacity, an adult's legal surrogate, or a responsible party
15 may complete a medical order for scope of treatment directing medical
16 interventions. The form shall have the title "*Kentucky* MOST, Medical Orders for
17 Scope of Treatment" and an introductory section containing the patient's name and
18 date of birth~~], the effective date of the form, including the statement "Form must be~~
19 ~~reviewed at least annually"]~~ and the statements:

20 *(a) "The MOST form is voluntary.";*

21 *(b) "A patient is not required to complete a MOST form.";*

22 *(c) "A patient with capacity or their legal representative may void a MOST*
23 *form any time by communicating that intent to the health care provider.";*

24 *(d) "The original form is the personal property of the patient.";*

25 *(e) "A facsimile, paper, or electronic copy is a legally valid form.";*

26 *(f) "HIPAA permits disclosure of MOST to ~~other~~ health care professionals as*
27 *necessary for treatment.";* and

1 (g) "~~[This document is based on this person's medical condition and wishes.]~~Any
2 section not completed **does not invalidate the form and** indicates a preference
3 for full treatment for that section.";

4 (2) The **remainder of the** form shall be in substantially the following order and format
5 and shall have the following contents:

6 (a) Section A of the form shall direct cardiopulmonary resuscitation when a
7 person has no pulse and is not breathing by selection of one (1) of the
8 following:

- 9 1. "Attempt Resuscitation (CPR)"; or
- 10 2. "Do Not Attempt Resuscitation"; and

11 include the statement "When not in cardiopulmonary arrest, follow orders in
12 B, C, and D.";

13 (b) Section B of the form shall direct the **medical interventions**~~[scope of~~
14 ~~treatment]~~ when a person has a pulse or is breathing by selection of one (1) of
15 the following:

- 16 1. Full ~~[scope of]~~treatment, **required if CPR is chosen in Section A,**
17 including **providing appropriate medical and surgical treatments as**
18 **indicated to attempt to prolong life, including intensive care. This**
19 **option shall include the statement "Goal: Attempt to sustain life by all**
20 **medically effective means**~~[the use of intubation, advanced airway~~
21 ~~interventions, mechanical ventilation, defibrillation or cardioversion as~~
22 ~~indicated, medical treatment, intravenous fluids, and comfort measures.~~
23 ~~This option shall include the statement "Transfer to a hospital if~~
24 ~~indicated. Includes intensive care. Treatment Plan: Full treatment,~~
25 ~~including life support measures].";~~

- 26 2. Limited additional intervention, **which may include use of non-invasive**
27 **positive airway pressure, antibiotics, and IV fluids as indicated, and**

1 requires avoidance of intensive care and transfer to a hospital if
 2 treatment needs cannot be met in the current location. This option
 3 shall include the statement "Goal: Attempt to restore function while
 4 avoiding intensive care and resuscitation efforts (ventilator,
 5 defibrillation, and cardioversion)~~[including the use of medical~~
 6 ~~treatment, oral and intravenous medications, intravenous fluids, cardiac~~
 7 ~~monitoring as indicated, noninvasive bi-level positive airway pressure, a~~
 8 ~~bag valve mask, and comfort measures. This option excludes the use of~~
 9 ~~intubation or mechanical ventilation. This option shall include the~~
 10 ~~statement "Transfer to a hospital if indicated. Avoid intensive care.~~
 11 ~~Treatment Plan: Provide basic medical treatments]."; or~~

- 12 3. Comfort measures, including use of oxygen, suction, and manual
 13 treatment of airway obstruction as needed for comfort, avoidance of
 14 treatments listed in full or limited additional interventions and transfer
 15 to a hospital only if comfort cannot be achieved in the current setting.
 16 This option shall include the statement "Goal: Maximize comfort
 17 through symptom management; allow natural death~~[keeping the~~
 18 ~~patient clean, warm, and dry; use of medication by any route;~~
 19 ~~positioning, wound care, and other measures to relieve pain and~~
 20 ~~suffering; and the use of oxygen, suction, and manual treatment of~~
 21 ~~airway obstruction as needed for comfort. This option shall include the~~
 22 ~~statement "Do not transfer to a hospital unless comfort needs cannot be~~
 23 ~~met in the patient's current location (e.g. hip fracture)]."~~

24 ~~— These options shall be followed by a space for other instructions];~~

- 25 (c) Section C of the form shall direct the use of artificially administered fluids
 26 and nutrition, including always offering food and fluids by mouth as
 27 tolerated, and shall include a statement that medically assisted nutrition and

hydration when it cannot reasonably be expected to prolong life, would be more burdensome than beneficial, or would cause significant physical discomfort. The following options shall be provided:

- 1. No artificial nutrition by tube;
- 2. Trial period of artificial nutrition by tube. This option shall be followed by: "Goal....."; or
- 3. Long-term artificial nutrition and hydration by tube~~[oral and intravenous antibiotics by selection of one (1) of the following:~~

- ~~1. Antibiotics if indicated for the purpose of maintaining life;~~
- ~~2. Determine use or limitation of antibiotics when infection occurs;~~
- ~~3. Use of antibiotics to relieve pain and discomfort; or~~
- ~~4. No antibiotics, use other measures to relieve symptoms.~~
- ~~— This option shall include a space for other instructions];~~

(d) Section D of the form shall direct the use of antibiotics. The following options shall be provided:

- 1. Use of antibiotics as medically indicated; or
- 2. No antibiotics;

(e) A section of the form shall provide space to include any additional treatment preferences;

(f) A section of the form shall be titled "Attestation by a Licensed Health Care Professional" and shall include:

- 1. Space for the printed name and the signature of the licensed health care professional and the date of completion; and
- 2. A statement that in completing the form the licensed health care professional is attesting that:

a. He or she has reviewed the patient's pre-existing advance directive and found it in accordance with the selections on the

1 MOST form; or

2 b. The patient does not have a pre-existing advance directive;

3 (g) A section of the form shall be titled "Signature: Patient or Patient
4 Representative (E-Signed Documents Are Valid)" and shall include:

5 1. The printed name, signature, and contact telephone number of the
6 patient, surrogate, or responsible party;

7 2. An indication that the signing party is the:

8 a. Adult patient with decisional capacity;

9 b. Surrogate decision maker per advance directive; or

10 c. Responsible party in accordance with KRS 311.631; and

11 3. The following statements:

12 a. "I agree that adequate information has been provided and
13 significant thought has been given to decisions outlined in this
14 form. Treatment preferences have been expressed to the
15 physician. This document reflects those treatment preferences
16 and indicates informed consent. If signed by a surrogate or
17 responsible party, the preferences expressed reflect the patient's
18 wishes as best understood by that surrogate or responsible
19 party."; and

20 b. "Your signature is not required on this form to receive
21 treatment.";

22 (h) A section of the form shall be titled "Physician Signature (E-Signed
23 Documents Are Valid)" and shall include:

24 1. Space for the physician's printed name, signature, contact telephone
25 number, and the effective date; and

26 2. The following statement: "My signature below indicates that I or my
27 designee have discussed with the patient, the patient's surrogate, or

1 the responsible party, the patient's goals and available treatment
2 options based on the patient's medical conditions. My signature below
3 indicates to the best of my knowledge, that these orders indicated on
4 this form are consistent with the patient's current medical condition
5 and preferences.";

6 ~~(i)1. Have the heading "Medically Administered Fluids and Nutrition: The~~
7 ~~provision of nutrition and fluids, even if medically administered, is a basic~~
8 ~~human right and authorization to deny or withdraw shall be limited to the~~
9 ~~patient, the surrogate in accordance with KRS 311.629, or the responsible~~
10 ~~party in accordance with KRS 311.631.";~~

11 ~~2. Direct the administration of fluids if physically possible as determined by the~~
12 ~~patient's physician in accordance with reasonable medical judgment and in~~
13 ~~consultation with the patient, surrogate, or responsible party by selecting one~~
14 ~~(1) of the following:~~

- 15 a. ~~Long term intravenous fluids if indicated;~~
- 16 b. ~~Intravenous fluids for a defined trial period. This option shall be followed by~~
17 ~~"Goal:....."; or~~
- 18 c. ~~No intravenous fluids, provide other measures to ensure comfort; and~~

19 ~~3. Direct the administration of nutrition if physically possible as determined by~~
20 ~~the patient's physician in accordance with reasonable medical judgment and in~~
21 ~~consultation with the patient, surrogate, or responsible party by selecting one~~
22 ~~(1) of the following:~~

- 23 a. ~~Long term feeding tube if indicated;~~
- 24 b. ~~Feeding tube for a defined trial period. This option shall be followed by~~
25 ~~"Goal:....."; or~~
- 26 c. ~~No feeding tube. This option shall be followed by a space for special~~
27 ~~instructions;~~

- 1 ~~(e) Section E of the form shall:~~
- 2 ~~1. Have the heading "Patient Preferences as a Basis for this MOST Form" and~~
- 3 ~~shall include the language "Basis for order must be documented in medical~~
- 4 ~~record";~~
- 5 ~~2. Provide direction to indicate whether or not the patient has an advance~~
- 6 ~~medical directive such as a health care power of attorney or living will and, if~~
- 7 ~~so, a place for the printed name, position, and signature of the individual~~
- 8 ~~certifying that the MOST is in accordance with the advance directive; and~~
- 9 ~~3. Indicate whether oral or written directions were given and, if so, by which one~~
- 10 ~~(1) or more of the following:~~
- 11 ~~a. Patient;~~
- 12 ~~b. Parent or guardian if patient is a minor;~~
- 13 ~~c. Surrogate appointed by the patient's advance directive;~~
- 14 ~~d. The judicially appointed guardian of the patient, if the guardian has been~~
- 15 ~~appointed and if medical decisions are within the scope of the guardianship;~~
- 16 ~~e. The attorney in fact named in a durable power of attorney, if the durable~~
- 17 ~~power of attorney specifically includes authority for health care decisions;~~
- 18 ~~f. The spouse of the patient;~~
- 19 ~~g. An adult child of the patient or, if the patient has more than one (1) child, the~~
- 20 ~~majority of the adult children who are reasonably available for consultation;~~
- 21 ~~h. The parents of the patient; and~~
- 22 ~~i. The nearest living relative of the patient or, if more than one (1) relative of the~~
- 23 ~~same relation is reasonably available for consultation, a majority of the~~
- 24 ~~nearest living relatives;~~
- 25 ~~(f) A signature portion of the form shall include spaces for the printed name,~~
- 26 ~~signature, and date of signing for:~~
- 27 ~~1. The patient's physician;~~

1 ~~2. The patient, parent of minor, guardian, health care agent, surrogate, spouse, or~~
 2 ~~other responsible party, with a description of the relationship to the patient~~
 3 ~~and contact information, unless based solely on advance directive; and~~

4 ~~3. The health care professional preparing the form, with contact information;~~

5 (g) A section of the form shall be titled "Information for patient, surrogate, or
 6 responsible party named on this form" with the following language:

7 1. "The MOST form is always voluntary and is usually for persons with
 8 advanced illness. MOST records your wishes for medical treatment in
 9 your current state of health. The provision of nutrition and fluids, even if
 10 medically administered, is a basic human right and authorization to deny
 11 or withdraw shall be limited to the patient, the surrogate in accordance
 12 with KRS 311.629, or the responsible party in accordance with KRS
 13 311.631.";

14 2. *"KRS 311.631: Responsible parties authorized to make health care*
 15 *decisions: (1) The judicially appointed guardian of the patient; (2) The*
 16 *health care power of attorney; (3) The spouse of the patient; (4) An*
 17 *adult child of the patient, or if the patient has more than one child, the*
 18 *majority of the adult children who are reasonably available for*
 19 *consultation; (5) The parents of the patient; (6) The nearest living*
 20 *relative of the patient, or if more than one relative of the same relation*
 21 *is reasonably available for consultation, a majority of the nearest*
 22 *living relatives.";* and

23 3. "Once initial medical treatment is begun and the risks and benefits of
 24 further therapy are clear, your treatment wishes may change. Your
 25 medical care and this form can be changed to reflect your new wishes at
 26 any time. However, no form can address all the medical treatment
 27 decisions that may need to be made. An advance directive, such as the

1 Kentucky Health Care Power of Attorney, is recommended for all
 2 capable adults, regardless of their health status. An advance directive
 3 allows you to document in detail your future health care instructions or
 4 name a surrogate to speak for you if you are unable to speak for
 5 yourself, or both. If there are conflicting directions between an
 6 enforceable living will and a MOST form, the provisions of the living
 7 will shall prevail.";

8 ~~(j)(4)~~ A section of the form shall be titled "Directions for Completing and
 9 Implementing Form" with these four (4) subdivisions:

- 10 1. The first subdivision shall be titled "Completing MOST" and shall have
 11 the following language:

12 "MOST must be reviewed~~[, prepared,]~~ and signed by the patient's
 13 physician~~[in personal communication with the patient, the patient's~~
 14 ~~surrogate, or responsible party].~~

15 MOST must be reviewed and contain the original ~~[or electronic]~~
 16 signature of the patient's physician to be valid. Be sure to document the
 17 basis in the progress notes of the medical record. Mode of
 18 communication (e.g., in person, by telephone, etc.) should also be
 19 documented.

20 The signature of the patient, surrogate, or a responsible party is required;
 21 however, if the patient's surrogate or a responsible party is not
 22 reasonably available to sign the original form, a copy of the completed
 23 form with the signature or electronic signature of the patient's surrogate
 24 or a responsible party must be signed by the patient's physician and
 25 placed in the medical record.

26 ~~[Use of original form is required. Be sure to send the original form with~~
 27 ~~the patient.]~~

1 **Copies of the original form are equally as valid as the original form.**

2 There is no requirement that a patient have a MOST.";

3 2. The second subdivision shall be titled "Implementing MOST" and shall
4 have the following language: "If a health care provider or facility cannot
5 comply with the orders due to policy or personal ethics, the provider or
6 facility must arrange for transfer of the patient to another provider or
7 facility.";

8 3. The third subdivision shall be titled "Reviewing MOST" and shall have
9 the following language:

10 "This MOST must be reviewed at least annually, **at any time the patient**
11 **or patient's representative requests, and when**~~[- or earlier if]:~~

12 The patient is admitted and/or discharged from a health care facility;

13 There is a substantial change in the patient's health status; or

14 The patient's treatment preferences change.

15 If MOST is revised or becomes invalid, draw a line through Sections A-
16 ~~D~~~~E~~ and write "VOID" in large letters."; and

17 4. The fourth subdivision shall be titled "Revocation of MOST" and shall
18 have the following language: "This MOST may be revoked by the
19 patient~~[-, the surrogate,]~~ or the responsible party."; and

20 ~~(k)~~~~(i)~~ A section of the form shall be titled "Review of MOST" and shall have
21 the following columns and a number of rows as determined by the Kentucky
22 Board of Medical Licensure:

23 1. "Review Date";

24 2. "Reviewer (**print**)~~[- and Location of Review]~~";

25 3. "**Physician**~~[- MD/DO]~~ Signature~~[- (Required)]~~";

26 4. "Signature of Patient, Surrogate, or Responsible Party~~[- (Required)]~~";

27 and

- 1 5. "Outcome of Review, describing the outcome in each row by selecting
2 one (1) of the following:
3 a. No Change; or
4 b. FORM VOIDED~~[, new form completed; or~~
5 c. ~~FORM VOIDED, no new form]~~".

6 ~~(3)~~~~(2)~~ The Kentucky Board of Medical Licensure shall promulgate administrative
7 regulations in accordance with KRS Chapter 13A to develop:

8 (a) The format for a standardized medical order for scope of treatment form to be
9 approved by the board, including spacing, size, borders, fill and location of
10 boxes, type of fonts used and their size, and placement of boxes on the front
11 or back of the form so as to fit on a single sheet. The board shall create an
12 electronically fillable version of the MOST form that can be accessed on the
13 board's website~~[Web site]~~. The board may not alter the wording or order of
14 wording provided in subsection (1) or (2)~~[subsection (1)]~~ of this section,
15 except to provide translated versions of the MOST form or add identifying
16 data such as form number and date of promulgation or revision and
17 instructions for completing, reviewing, and revoking the election of the form;
18 and

19 (b) A guide to advance care planning that describes the following three (3)
20 options for advance care planning:

21 1. An advance directive as defined in KRS 311.621;

22 2. A power of attorney including advance health care instructions; and

23 3. A medical order for scope of treatment.

24 (4) The board shall:

25 (a) Provide a translation of the MOST form in print and in an electronically
26 fillable version into Spanish, and other languages as needed;

27 (b) Provide a translation of the guide to advance care planning into Spanish,

1 and other languages as needed; and
 2 (c) Make the MOST form and the guide to advance care planning accessible on
 3 its website.

4 (5) The board shall consult with appropriate professional organizations to develop the
 5 format for the medical order for scope of treatment form and the guide to advance
 6 care planning, including:

- 7 (a) The Kentucky Association of Hospice and Palliative Care;
- 8 (b) The Kentucky Board of Emergency Medical Services;
- 9 (c) The Kentucky Hospital Association;
- 10 (d) The Kentucky Association of Health Care Facilities;
- 11 (e) LeadingAge Kentucky;
- 12 (f) The Kentucky Right to Life Association; and
- 13 (g) Other groups interested in end-of-life care.

14 ~~[(3) The medical order for scope of treatment form developed under subsection (2) of~~
 15 ~~this section shall include but not be limited to:~~

- 16 ~~(a) An advisory that completing the medical order for scope of treatment form is~~
 17 ~~voluntary and not required for treatment;~~
- 18 ~~(b) Identification of the person who discussed and agreed to the options for~~
 19 ~~medical intervention that are selected;~~
- 20 ~~(c) All necessary information necessary to comply with subsection (1) of this~~
 21 ~~section;~~
- 22 ~~(d) The effective date of the form;~~
- 23 ~~(e) The expiration or review date of the form, which shall be no more than one~~
 24 ~~(1) calendar year from the effective date of the form;~~
- 25 ~~(f) Indication of whether the patient has a living will directive or health care~~
 26 ~~power of attorney, a copy of which shall be attached to the form if available;~~
- 27 ~~(g) An advisory that the medical order for scope of treatment may be revoked by~~

1 the patient, the surrogate, or a responsible party at any time; and

2 ~~(h) A statement written in boldface type directly above the signature line for the~~
 3 ~~patient that states "You are not required to sign this form to receive~~
 4 ~~treatment."~~

5 ~~(4) A physician shall document the medical basis for completing a medical order for~~
 6 ~~scope of treatment in the patient's medical record.~~

7 ~~(5) The patient, the surrogate, or a responsible party shall sign the medical order for~~
 8 ~~scope of treatment form; however, if it is not practicable for the patient's surrogate~~
 9 ~~or a responsible party to sign the original form, the surrogate or a responsible party~~
 10 ~~shall sign a copy of the completed form and return it to the health care provider~~
 11 ~~completing the form. The copy of the form with the signature of the surrogate or a~~
 12 ~~responsible party, whether in electronic or paper form, shall be signed by the~~
 13 ~~physician and shall be placed in the patient's medical record. When the signature of~~
 14 ~~the surrogate or a responsible party is on a separate copy of the form, the original~~
 15 ~~form shall indicate in the appropriate signature field that the signature is attached.]~~

16 (6) The MOST form may be electronic or printed on any color of paper and the form
 17 shall be honored on any color of paper.

18 (7) *Health care professionals are encouraged to provide a copy of the guide to*
 19 *advance care planning to the patient, surrogate, or responsible party at the time a*
 20 *MOST form is being completed.*