Medical Aid in Dying
Perspectives and Lessons from California

Presented by
Coalition for Compassionate Care of California
Who we are

- Coalition for Compassionate Care of California
- Nonprofit organization founded in 1998
- Promotes high-quality, compassionate care for everyone who is seriously ill or nearing the end of life
Who we are

An interdisciplinary partnership of thought-leaders from:

- healthcare systems and organizations
- government agencies
- consumer organizations
- the general public
Goal

Transform healthcare so that medical care is aligned with individual patient preferences—that people get the care they need and no less, and the care they want and no more.
## What we do

<table>
<thead>
<tr>
<th>Coalition-building</th>
<th>Advocacy</th>
<th>Education</th>
<th>Resource Development</th>
</tr>
</thead>
<tbody>
<tr>
<td>POLST and advance care planning coalitions</td>
<td>Advance care planning</td>
<td>In-person training</td>
<td>For clinicians</td>
</tr>
<tr>
<td>Policy initiatives (e.g., SB 1004 and the California Advanced Illness Collaborative)</td>
<td>Palliative care</td>
<td>Webinars</td>
<td>For consumers</td>
</tr>
<tr>
<td>POLST, end-of-life care</td>
<td>Custom training</td>
<td></td>
<td>Specific populations: Pediatrics, nursing homes, disability community, faith communities</td>
</tr>
</tbody>
</table>
Today’s Webinar

• Introductions & Objectives
• Review of the California legislation with comparison to the Hawaii bill
• Approach to policy development
• Review of data from Washington, Oregon, California
• The Kaiser experience
• Lessons learned
• Q&A
Presenters

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Financial disclosure

CCCC: None
Kaiser Permanente: None
California
End of Life Option Act

Overview
Medical Aid in Dying Statutes:

- MONTANA: No statute / act but no prohibition
- OREGON (Oregon Death with Dignity Act; 1994/1997)
- WASHINGTON (Washington Death with Dignity Act; 2008)
- VERMONT (Patient Choice and Control at the End of Life Act; 2013)
- CALIFORNIA (End of Life Option Act; approved in 2015, in effect from 2016)
- COLORADO (End of Life Option Act; 2016)
- DISTRICT OF COLUMBIA (Death with Dignity Act; 2016/2017)
- **Hawaii** Our Care, Our Choice Act; 2018/2019
End of Life Option Act Key Points

- Detailed complex, legislation
- Patient and provider protections
- Specific eligibility requirements for patients
- Voluntary participation for all providers, healthcare organizations and pharmacies
- Important terms specifically defined
- Forms, Process and Reporting all are detailed
The California End of Life Option Act

The End of Life Option Act permits *terminally ill adult* patients with *capacity to make medical decisions* to be prescribed an aid-in-dying (AID) medication *if certain conditions are met.*
Eligibility

Who Is A “Qualified Individual” Under The Act

• Any adult (18+ years of age)
• California resident
• With capacity to make medical decisions
• Diagnosed with terminal disease by attending physician
  – Incurable & irreversible disease that’s been medically confirmed & will, within reasonable medical judgment, result in death within 6 months
• Voluntarily expresses wish to receive aid-in-dying drug
• Physical & mental ability to self-administer aid-in-dying drug
• Submits signed, dated & witnessed Request Form
Who can make a request for AID medication?

- Request must be made solely and directly by individual diagnosed with terminal disease.
- **Request cannot be made on behalf of patient**; i.e., request cannot be honored if made through:
  - Agent under power of attorney
  - Advance health care directive
  - Conservator
  - Health care agent
  - Surrogate
  - Legally recognized health care decision-maker
  - Parent
  - Spouse
  - Any other person, regardless of relationship to patient
How Does a Patient Make an Aid-in-Dying Request?

- All requests must be given directly to the **attending physician**:
  - 2 oral requests, made at least 15 days apart [Hawaii – 20 days]
  - 1 written request in statutory form
  Law is silent as to when the written request must be made. [Hawaii – No less than 48 hours from receipt of written request to writing of prescription.]
- All 3 requests must be received directly by **attending physician**, not **physician** designee
- Use of interpreter ok if certain requirements met
  - Interpreter declaration required [Hawaii – no discussion of interpreters]
Overview of Process

- 2 oral requests >15 days apart
- 1 witnessed written request
- **Attending** and **Consulting physician** agree and document
  1. Diagnosis
  2. Prognosis
  3. Capacity for informed decision-making
- Either initiate Mental Health referral if indicated
- **Hawaii Counseling** referral is required
- Proper documentation: Forms and Medical Record
- Patient **properly informed & counseled**
- Patient attestation 48 hours prior to ingestion
Documentation & Witness Requirements
For Oral & Written Requests

• Particular language not required for oral requests

• Written request must be on statutory form

• Attending physician must document each oral & written request in patient's medical record – no particular language required
Mandatory Statutory Request Form

“Request For An Aid-In-Dying Drug To End My Life In A Humane And Dignified Manner”

- Must be signed & dated by individual seeking aid-in-dying drug
- Must be witnessed by at least 2 adults who, in presence of requesting individual, attest that to best of their knowledge & belief requesting individual:
  - Is personally known to them or has provided proof of identity;
  - Voluntarily signed request in their presence;
  - Is believed to be of sound mind and not under duress, fraud or undue influence; and
  - Is not the attending or consulting physician or mental health specialist
- Only 1 witness may be related to requesting individual by blood, marriage, registered domestic partnership, or adoption or be entitled to portion of requesting individual's estate upon death, or own, operate, or be employed at health care facility where patient is receiving medical treatment or resides.
Additional Documentation Requirements

Attending and Consulting physician both document:
• diagnosis, prognosis, and individual’s capacity to make medical decisions

Attending physician will confirm and document:
• that individual is acting voluntarily
• that individual is making an **informed decision** and received required education and **counseling**
• Report of any mental health assessment
• Required offers to individual of right to withdraw or rescind request
• That all requirements have been met
• Specific steps taken to carry out request
• The aid-in-dying drug prescribed
What Forms Are Needed?

1. Request For An **Aid-In-Dying Drug** To End My Life In A Humane And Dignified Manner *
2. Final Attestation For An **Aid-In-Dying Drug** To End My Life In A Humane And Dignified Manner
3. **Attending Physician Checklist & Compliance Form** *
4. **Consulting Physician** Compliance Form *
5. **Attending Physician** Follow-Up Form **

All forms except Final Attestation must be submitted to Department of Public Health

**Hawaii: forms 3-5 not in text of law, Advisory Board to direct development**

*within 30 days of writing RX for **aid-in-dying drug**
** within 30 days of patient’s death
The prescription

• Very specific methods of getting prescription to pharmacist & dispensing medication to patient

1. Dispensing Medication Directly To Patient
   • Requires **physician** w/ US DEA Certificate, regulatory compliance, etc.)

2. Delivering written prescription to pharmacist (personal, US Mail, electronic) requires written patient consent

3. Delivery of **Aid-in-Dying drug** to patient or appointed designee by US Mail, UPS, or other delivery service is acceptable w/ signature required [HI Law does not address delivery.]

• **Handing patient a written script to take to pharmacy is not an authorized method of delivering an aid-in-dying prescription**
Other requirements and issues

• Unused medication:

“Anyone with custody of unused medication “after death of patient” must return it to qualified facility or otherwise properly dispose of it”

HAWAII

State-specific restrictions apply in Hawaii. There are restrictions on permanent pharmacy-based drug take-back programs, and collections must involve law enforcement presence. See the Product Stewardship Institute web page for National & Local sites https://www.productstewardship.us
The death certificate.

California
There has been debate on this issue.

Hawaii
“The death certificate shall list the terminal disease as the immediate cause of death.”
Hawaii Advisory Board (Section 8)

Composition:
• Designee from Department of Health and no fewer than 5 other members which shall include:
  • Palliative Care, Hospice, medical educator, community member.

Tasks:
• Provide advice to the department to facilitate implementation
• determine data set to be tracked
• prepare forms and checklists
• assist in implementation
Policy Development

A framework for moving forward.
PARTICIPATION

- Provider “Participation” is specifically defined in the legislation.
- Healthcare organizations have certain rights and obligations under the legislation.
- No provider, organization or patient can be required to participate.
- Not all providers can participate.
- All persons involved have right to “Opt Out”
How do healthcare organizations respond to the need for a policy?

- Organizations may develop policies and provide direction to staff and employees.
- Policies can reflect mission and values of the institution.
- Providers and employees need to be aware of policies.
In healthcare organizations

• The legislation includes protections for employers and providers who Opt Out
• Healthcare employers may limit or prohibit participation of employees
• The following can NOT be prohibited:
  • Informing patient of terminal illness or medical prognosis
  • Determining capacity to make medical decisions
  • Providing information about aid in dying
  • Providing referral to a participating provider
Steps for policy development

Convene stakeholders
• Experts
• Ethics
• Administration
• Patient advocates, others

Determine level of participation or opt-out status

Draft policy

Finalize and share with staff/providers

Revise as needed
California 2016 the first six months
June-December

- 191 prescriptions written
- 111 ingestions
- 21 died other causes
- 59 undetermined outcomes
California 2017

Figure 1: Summary of EOLA Prescriptions Written in 2017

577 Prescriptions in 2017

374 deaths from ingestion
Characteristics of individuals who died following ingestion of aid-in-dying drug

Age

- Under 60 (36)
- 60-69 (88)
- 70-79 (93)
- 80-89 (107)
- 90 and over (50)

Series 1 ▪ ▪ ▪ ▪ ▪
Series 2 ▪ ▪ ▪ ▪ ▪
Series 3 ▪ ▪ ▪ ▪ ▪
Gender

- Female (190)
- Male (176)

Level of Education

- No HS diploma 13
- Some college 67
- Doctorate or professional degree 22
- HS diploma or GED 80
- Assoc. Bachelor or Master Degree 183
- Unknown 9
Disease Categories

Chart Title

- Malignant Neoplasm 256 (68.5%)
- Neurological Diseases 35 (9.4%)
- Cardiovascular diseases 30 (8%)
- Other 22 (5.9%)
- Chronic respiratory diseases 17 (4.5%)
- Cerebrovascular diseases 14 (3.7%)

CALIFORNIA END OF LIFE OPTION ACT 2017 DATA REPORT

https://www.cdph.ca.gov/Programs/CHSI/Pages/End-of-Life-Option-Act-.aspx

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Malignant Neoplasm by Type

- Brain: 5.9%
- Colon: 5.5%
- Lung and Bronchus: 17.2%
- Ovary: 7.0%
- Blood: 7.0%
- Prostate: 8.2%
- Pancreas: 9.8%
- Head and Neck: 10.9%
- Breast: 11.3%
- Other: 17.2%

CALIFORNIA END OF LIFE OPTION ACT 2017 DATA REPORT
https://www.cdph.ca.gov/Programs/CHSI/Pages/End-of-Life-Option-Act.aspx
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End of Life Care Choices

- Enrolled Hospice or Palliative Care: 312
- Not enrolled: 42
- Unknown: 20

Ethnicity

- Caucasian: 356
- Asian/Native American/Pacific Islander: 20
- Hispanic: 15
- Unknown: 8
- Black: 0

CALIFORNIA END OF LIFE OPTION ACT 2017 DATA REPORT

https://www.cdph.ca.gov/Programs/CHSI/Pages/End-of-Life-Option-Act.aspx

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Other States’ Experiences
## Oregon, Washington & California

<table>
<thead>
<tr>
<th>STATE</th>
<th>Population</th>
<th>YEAR</th>
<th>Prescriptions</th>
<th>Deaths due to Ingestion</th>
</tr>
</thead>
<tbody>
<tr>
<td>WA</td>
<td></td>
<td>2017</td>
<td>212</td>
<td>164</td>
</tr>
<tr>
<td>OR</td>
<td></td>
<td>2017</td>
<td>218</td>
<td>144 (incl. 14 from previous year)</td>
</tr>
<tr>
<td>CA</td>
<td></td>
<td>2016 (1st 6 months)</td>
<td>191</td>
<td>111</td>
</tr>
<tr>
<td>CA</td>
<td></td>
<td>2017</td>
<td>577</td>
<td>374 (incl. 11 Rx from 2016)</td>
</tr>
</tbody>
</table>
Oregon DWDA: Prescription Recipients vs. Ingestion

Source: Oregon Public Health Authority
https://public.health.oregon.gov/ProviderPartnerResources/EvaluationResearch/DeathwithDignityAct/Pages/ar-index.aspx

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## Data from the Oregon Death With Dignity Act 1998-2017

<table>
<thead>
<tr>
<th></th>
<th>1998-2016</th>
<th>2017</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Gender</strong></td>
<td>51% male / 49% female</td>
<td>58% male / 42% female</td>
</tr>
<tr>
<td><strong>Age at death</strong></td>
<td>68% &gt;65, median 71</td>
<td>80% over 65, median 74</td>
</tr>
<tr>
<td><strong>Race</strong></td>
<td>96%</td>
<td>94% Caucasian</td>
</tr>
<tr>
<td><strong>Married or Domestic Partner</strong></td>
<td>45%</td>
<td>52%</td>
</tr>
<tr>
<td><strong>Widowed</strong></td>
<td>23%</td>
<td>23%</td>
</tr>
<tr>
<td><strong>Enrolled in hospice</strong></td>
<td>90.5%</td>
<td>90%</td>
</tr>
<tr>
<td><strong>Insured</strong></td>
<td>98.6%</td>
<td>98%</td>
</tr>
<tr>
<td><strong>Cancer</strong></td>
<td>77.1%</td>
<td>77%</td>
</tr>
<tr>
<td><strong>Neurologic diseases</strong></td>
<td>8%</td>
<td>14% (7% ALS, 7% other)</td>
</tr>
<tr>
<td><strong>Lower respiratory disease</strong></td>
<td>4.5%</td>
<td>4.5%</td>
</tr>
<tr>
<td><strong>Heart /circulatory</strong></td>
<td>2.6%</td>
<td>6.3%</td>
</tr>
</tbody>
</table>

**Source:** Oregon Public Health Authority
[https://public.health.oregon.gov/ProviderPartnerResources/EvaluationResearch/DeathwithDignityAct/Pages/ar-index.aspx](https://public.health.oregon.gov/ProviderPartnerResources/EvaluationResearch/DeathwithDignityAct/Pages/ar-index.aspx)
Oregon DWDA: Patient diagnosis

Source: Oregon Public Health Authority
https://public.health.oregon.gov/ProviderPartnerResources/EvaluationResearch/DeathwithDignityAct/Pages/ar-index.aspx
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<table>
<thead>
<tr>
<th>Patient Concern</th>
<th>OR</th>
<th>WA</th>
</tr>
</thead>
<tbody>
<tr>
<td>Losing autonomy</td>
<td>91.6%</td>
<td>86%</td>
</tr>
<tr>
<td>Less able to engage in enjoyable activities</td>
<td>89.7%</td>
<td>86%</td>
</tr>
<tr>
<td>Loss of dignity</td>
<td>78.7%</td>
<td>69%</td>
</tr>
<tr>
<td>Losing control of bodily functions</td>
<td>48.2%</td>
<td>49%</td>
</tr>
<tr>
<td>Burden on family/friends/caregivers</td>
<td>41.1%</td>
<td>52%</td>
</tr>
<tr>
<td>Inadequate pain control or fear of it</td>
<td>25.2%</td>
<td>35%</td>
</tr>
<tr>
<td>Financial implications of treatment</td>
<td>3.1%</td>
<td>13%</td>
</tr>
</tbody>
</table>

Source: Oregon Public Health Authority
https://public.health.oregon.gov/ProviderPartnerResources/EvaluationResearch/DeathwithDignityAct/Pages/ar-index.aspx
## Washington: End of Life Concerns

Table 2. End of life concerns of participants of the Death with Dignity Act who have died.

<table>
<thead>
<tr>
<th>End of Life Concerns</th>
<th>2017 Number</th>
<th>2017 %</th>
<th>2016 Number</th>
<th>2016 %</th>
<th>2015¹ Number</th>
<th>2015¹ %</th>
</tr>
</thead>
<tbody>
<tr>
<td>Losing autonomy</td>
<td>167</td>
<td>90</td>
<td>208</td>
<td>87</td>
<td>170</td>
<td>84</td>
</tr>
<tr>
<td>Less able to engage in activities making life enjoyable</td>
<td>162</td>
<td>87</td>
<td>201</td>
<td>84</td>
<td>170</td>
<td>84</td>
</tr>
<tr>
<td>Loss of dignity</td>
<td>135</td>
<td>73</td>
<td>157</td>
<td>65</td>
<td>135</td>
<td>67</td>
</tr>
<tr>
<td>Burden on family, friends/caregivers</td>
<td>105</td>
<td>56</td>
<td>122</td>
<td>51</td>
<td>96</td>
<td>48</td>
</tr>
<tr>
<td>Losing control of bodily functions</td>
<td>86</td>
<td>46</td>
<td>102</td>
<td>43</td>
<td>102</td>
<td>51</td>
</tr>
<tr>
<td>Inadequate pain control or concern about it</td>
<td>70</td>
<td>38</td>
<td>97</td>
<td>40</td>
<td>71</td>
<td>35</td>
</tr>
<tr>
<td>Financial implications of treatment</td>
<td>19</td>
<td>10</td>
<td>18</td>
<td>8</td>
<td>25</td>
<td>12</td>
</tr>
</tbody>
</table>

Source: Washington State Department of Health
https://www.doh.wa.gov/YouandYourFamily/IllnessandDisease/DeathwithDignityAct/DeathwithDignityData
Specific findings from California

EoLOA convening & research
Lessons from California Experience

Image is one-on-one doctor-patient relationship
- Process has many steps
- Need willing pharmacist
- Healthcare delivery today is complex

Two settings where it works
- Fully integrated system
- Specialty boutique

Non-participating providers
- Still need to be prepared to respond
- And to provide supportive services
## Lessons from California Experience

### Best practice
- Clear policy
- Buy in from leadership
- Commitment or resources to make policy a reality

### Participating physicians
- Want to help but don’t know patient well
- Comfort with competencies required
- Fear of being ostracized

### Variable access
- Geography
- Integrated Health System
- Insurance Coverage of Cost
- Disease / Ability to prognosticate last six months
- Impact on survivors
- Stress on day of ingestion
- Disenfranchised grief
Lessons from California Experience

All providers benefit from preparation
  Know how to respond
    Acknowledge request
  Get to reason / motivation for request
  Come back to request

Interrelations with palliative care
  PC ambivalent about role with EOLOA
    Acknowledge requesting patient should have access to PC
  PC familiar with this time in life and larger issues

How to move EoL forward more generally--Build off what exists
Lessons from California Experience

Vulnerable populations

- Concept of “better off dead”
- “Choice” is culturally biased

Is this a civil right / entitlement

- Framing helped get law passed

List of participating doctors

- List of organizations with policies that allow doctors to participate

Data

- What needs to be collected
- Release of data – Research interests
Data collection current issues

• To understand the implications of medical aid-in-dying we will need research based on good data

• States vary in the data that they collect and not all collected data is reported
Examples of data variation by states

<table>
<thead>
<tr>
<th></th>
<th>Oregon</th>
<th>Washington</th>
<th>Vermont</th>
<th>California</th>
<th>Colorado</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient race, ethnicity</td>
<td>Yes</td>
<td>Yes</td>
<td>No</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Physician report of patient end of life concerns</td>
<td>Yes</td>
<td>Yes</td>
<td>No</td>
<td>No*</td>
<td>No</td>
</tr>
<tr>
<td>Duration of physician/patient relationship</td>
<td>Yes</td>
<td>Yes</td>
<td>No</td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td>Referral for mental health evaluation</td>
<td>Yes</td>
<td>Yes</td>
<td>No</td>
<td>No*</td>
<td>No</td>
</tr>
<tr>
<td>Which drug was used</td>
<td>Yes</td>
<td>Yes</td>
<td>No</td>
<td>No*</td>
<td>Yes</td>
</tr>
<tr>
<td>Complications of ingestion</td>
<td>Yes</td>
<td>Yes</td>
<td>No</td>
<td>No*</td>
<td>No</td>
</tr>
<tr>
<td>Physician compliance with legal requirements</td>
<td>Yes</td>
<td>Yes</td>
<td>No</td>
<td>No*</td>
<td>Yes</td>
</tr>
</tbody>
</table>

*California is collecting these items but not reporting them
Ongoing research shows

Significant variation in institutional responses
- Many still figuring it out

Patients face difficulty in finding willing providers
- Low rates of physician participation
- Exceptions in institutions that have prioritized giving patients access

Developing policies and responding to requests takes a village
- Clinicians and team members experience a range of reactions to the practice
Kaiser Permanente Experience
Details from a Health System

Kaiser Permanente
1. Decision to Opt In
Kaiser Foundation Health Plan
• Can excellent palliative care reduce or eliminate all types of suffering?

Southern California Permanente Medical Group
• How can a diverse physician partnership work together in a spirit of “One KP,” yet respect differing values.

2. How to operationalize
Support robust decision making
• LCSW Coordinators
  • Hired at all SoCal service areas
  • Duties expected
• Palliative Care Referrals (if not on hospice)
  • Patient’s can opt-out
  • Specialty level terminal illness assessments/interventions and elucidation of a patient’s goals and values.
• Pharmacist support
Kaiser Permanente Experience

Executive EOLOA Task Force

- Bioethics (x2)
- Quality
- Palliative care
- Physician Education
- Pharmacy
- Nursing
- Legal
- Psychiatry
- Operations

KP Northwest Consulting

Response to Staff Moral Experience

Policy Creation

Video Creation

Research on Physician Attitudes

Staff Survey

Pharmacy Operations

EMR
Kaiser Permanente Data

- Initial Inquiries: 379
  - 1st Request with Attending: 176
    - Consulting physician visits: 140
    - 2nd Request with Attending: 120
    - EOLOA Prescriptions written: 108
      - EOLOA Drugs dispensed: 92
        - Ingested & died: 68
        - Did not ingest & died: 8
        - Undetermined outcome: 16
  - Excluded: 203
    - 1st Request with Attending: 36
      - Consulting physician visits: 20
        - 2nd Request with Attending: 12
          - EOLOA Prescriptions written: 16
            - EOLOA Drugs dispensed: 12
              - Ingested & died: 71
                - too ill: 8
                - changed mind: 14
                - Info only: 25
                  - Excluded: 61
                    - not eligible: 4
                    - pending: 12
                    - other: 8
                    - missing: 14
                    - too ill: 8
                    - changed mind: 3
                      - not eligible: 1
                      - lack of family support: 1
                    - not eligible: 5
                      - other: 1
                      - missing: 8
                    - died: 11
                      - too ill: 4
                      - changed mind: 1
                        - not eligible: 3
                        - other: 1
                        - missing: 7
                  - too ill: 1
                    - not eligible: 1
                    - died: 10
                      - condition improved: 1
                      - missing: 1
                      - too ill: 1
                        - not eligible: 1
                        - died: 5
                          - too ill: 2
                            - Rx not picked up: 7
                              - Ingested & died: 1
                                - too ill: 7
                                  - Other: 1
                                  - missing: 1
                                - changed mind: 2
                                  - not eligible: 1
                                  - too ill: 1
                                  - condition improved: 1
                                  - missing: 1
                                - undetermined outcome: 16

Kaiser Permanente Experience

Characteristics of patients who ingested medications (n=68)

<table>
<thead>
<tr>
<th>Characteristic</th>
<th>Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age (yrs, median)</td>
<td>69</td>
</tr>
<tr>
<td>Male</td>
<td>57%</td>
</tr>
<tr>
<td>White</td>
<td>76%</td>
</tr>
<tr>
<td>High school graduate</td>
<td>51%</td>
</tr>
<tr>
<td>&gt; $75,000 income level</td>
<td>47%</td>
</tr>
<tr>
<td>Cancer Diagnosis</td>
<td>76%</td>
</tr>
<tr>
<td>Palliative Care Support</td>
<td>63% (50% pre-inquiry)</td>
</tr>
<tr>
<td>Hospice Support</td>
<td>87% (56% pre-inquiry)</td>
</tr>
<tr>
<td>Reason: to avoid suffering</td>
<td>66%</td>
</tr>
<tr>
<td>Timing from inquiry to second request</td>
<td>24 days</td>
</tr>
</tbody>
</table>

Non-participating PC physicians

Patients assume that in a palliative care clinic they can get the Rx, but then find out that our clinic’s physicians have opted out. Yet knowing that they can talk openly about the option with us has helped.

They have reported valuing having both their palliative team and end-of-life team.

It’s been hard and has effected us. We are always questioning our decision. These are my patients and I’m very attached to them. I want them to know that I still care for them.
Participating PC physicians

I have prescribed 6 Rxs, all have researched prior to calling us. All were glad that someone understood them.

Patients shared with me that they respected and understood the reasons why their own doctors had opted out.
Participating social workers

Our team feels like we are part of a bigger cause. **We thought we were over-communicating** at first with the coordinating social worker, physicians, pharmacists, and nurses. But in the end the family said it all seemed seamless to them.

A patient shared with me that they finally have **power over the disease** that had initially left them powerless.
I spent years on the bioethics committee and was the most seasoned clinician on the team, yet this was very difficult for me. I had to train my brain to think 180 degrees then what we do.

...It was surreal the first time I provided this education. It was weird saying that you’ll slip into a coma and then you’ll die after your lungs stop and then your heart stops. In fact, the first time it was freakin’ weird.

I also felt out of place. My whole career was spent educating patients at the pharmacy, now I was in a patient’s home.
What we’ve learned

• Physician participation is limited and evolving
• Contracting for external opinions is challenging
• Individuals have switched to KP to access medical aid-in-dying (MAID)
• KP patients in external hospice agencies have had to be repatriated
• Medication coverage and pricing is variable and affects utilization
• Moral experiences have been profound
• Coordinating support for staff is challenging
• Education and ongoing communication is crucial

• California as social experiment
• Ongoing monitoring of usage and safeguards
Other Issues
Just Ahead
Discussion/Questions
Thank you for joining us for today’s webinar.

If you have additional questions, please see the contact information below.