Medical Aid-in-Dying (MAID) Interim Report

Joint Commission on Health Care

August 22, 2017 Meeting

Michele Chesser, Ph.D., Executive Director

* I would like to thank Meagan D. Sok, JCHC Intern, for her work on this study
Delegate Kaye Kory requested via letter that the JCHC study the issue of Medical Aid-in-Dying (MAID). The delegate asked that the study include a review of states that currently authorize MAID and address the following questions:

- What has been the impact of informing patients about end-of-life options such as hospice care and palliative care?
- In current MAID states, how have the following acted to implement the law?
  - Health care providers
  - Health care systems
  - Health care institutions
- In current MAID states, have people been coerced to ingest end-of-life medication?
  - Have any of the states enacted protections to discourage or prevent coercion?
- Has the implementation of the law impacted any state’s health care costs?
- Using data from states that allow medical aid-in-dying, how many people would likely utilize medical aid-in-dying if it became law in Virginia?

JCHC members approved the study during the Commission’s May 23, 2017 work plan meeting.
A work group was created to discuss Medical Aid-in-Dying and consider components of the statute that will be one of the policy options.

Meeting 1: July 25, 2017
- Overview of issue presented by Dr. Chesser
- Discussion of MAID

Meeting 2: August 25, 2017
- Discussion of policy options and statute components

Meeting 3: TBD
- Discussion of statute components
MAID Study Work Group

- ALS Association
- American Cancer Society
- American Lung Association
- Anthem
- Bon Secours
- Capital Caring
- Carilion
- Compassion and Choices
- DARS
- DBHDS
- DHP
- DisAbility Law Center
- DMAS
- Family Foundation
- HCA Healthcare Virginia
- INOVA
- Mary Washington Healthcare
- Medical Society of Virginia
- NAMI
- Office of the Secretary of Health and Human Resources
- Riverside Health System
- Robert Misbin, MD
- Senior Navigator
- Sentara
- Social Worker, Diane Kane
- Society for Critical Care Medicine
- The Arc of Virginia
- University of Virginia
- Virginia Association of Health Plans
- Virginia Commonwealth University Health System
- VDH
- Virginia Association of Health Plans
- Virginia Association for Hospices and Palliative Care
- Virginia Catholic Conference
- Virginia Centers for Independent Living
- Virginia Health Care Association
- Virginia Hospital and Healthcare Association
- Virginia Nurses Association
- Virginia Public Access Project
- Virginia Society for Human Life
- Virginia Trial Lawyer Association
Definition of Medical Aid-in-Dying

- The ability of a patient to obtain a medication to end their life if they are competent, terminally ill, and over 18 years of age

- The ability of a physician to prescribe a medication that will allow a competent, terminally ill individual over the age of 18 to end their life

- Some individuals/organizations prefer to use terms like assisted suicide
  - However, different legal definition with implications if worded as such in Virginia statute
§ 8.01-622.1. Injunction against assisted suicide; damages; professional sanctions.

A. Any person who knowingly and intentionally, with the purpose of assisting another person to commit or attempt to commit suicide, (i) provides the physical means by which another person commits or attempts to commit suicide or (ii) participates in a physical act by which another person commits or attempts to commit suicide shall be liable for damages as provided in this section and may be enjoined from such acts.

B. A cause of action for injunctive relief against any person who is reasonably expected to assist or attempt to assist a suicide may be maintained by any person who is the spouse, parent, child, sibling or guardian of, or a current or former licensed health care provider of, the person who would commit suicide; by an attorney for the Commonwealth with appropriate jurisdiction; or by the Attorney General. The injunction shall prevent the person from assisting any suicide in the Commonwealth.

C. A spouse, parent, child or sibling of a person who commits or attempts to commit suicide may recover compensatory and punitive damages in a civil action from any person who provided the physical means for the suicide or attempted suicide or who participated in a physical act by which the other person committed or attempted to commit suicide.
D. A licensed health care provider who assists or attempts to assist a suicide shall be considered to have engaged in unprofessional conduct for which his certificate or license to provide health care services in the Commonwealth shall be suspended or revoked by the licensing authority.

E. Nothing in this section shall be construed to limit or conflict with § 54.1-2971.01 or the Health Care Decisions Act (§ 54.1-2981 et seq.). This section shall not apply to a licensed health care provider who (i) administers, prescribes or dispenses medications or procedures to relieve another person's pain or discomfort and without intent to cause death, even if the medication or procedure may hasten or increase the risk of death, or (ii) withholds or withdraws life-prolonging procedures as defined in § 54.1-2982. This section shall not apply to any person who properly administers a legally prescribed medication without intent to cause death, even if the medication may hasten or increase the risk of death.

F. For purposes of this section:

"Licensed health care provider" means a physician, surgeon, podiatrist, osteopath, osteopathic physician and surgeon, physician assistant, nurse, dentist or pharmacist licensed under the laws of this Commonwealth.

"Suicide" means the act or instance of taking one's own life voluntarily and intentionally.

1998, c. 624; 2015, c. 710.
Existing Medical Aid-in-Dying Statutes
States with MAID Laws:
Oregon (1998)
Washington (2008)
Vermont (2013)
California (2016)
Colorado (2016)

*By Judicial Review, legal in Montana (2009):
Nothing in the state law prohibits MAID. Physicians cannot be prosecuted so long as the patient is competent, terminally ill, at least 18 years of age and acting voluntarily.

https://www.deathwithdignity.org/news/2016/03/state-progress/
Status of bills and court cases as of July 2017. Source: https://www.nytimes.com/2017/08/05/opinion/sunday/dying-doctors-palliative-medicine.html
Generally, Existing MAID Statutes Include:

Eligibility Criteria:
- Adult, 18 years of age and older
- Resident of the state
- Suffer from a terminal illness
- Able to self-administer the medication

Process:
- Attending and consulting physicians determine and agree that the patient suffers from a terminal disease with less than six months to live.
- Patient must provide 2 voluntary oral requests no less than 15 days apart.
- Patient must provide a signed written request (form provided) for the medication, co-signed by 2 witnesses.
- Physician to provide prescription at least 15 days after the initial oral request and at least 48 hours after the signed request.
- Before providing the prescription, the physician must confirm the patient has not rescinded the request and remind the patient that the patient is not required to ingest the medication.
- If either physician believe the patient is suffering from depression or any behavioral health condition that may be impacting their choice, they are to refer the patient to a psychiatrist before proceeding.
- For prescription: After obtaining patient approval, attending physician calls pharmacy to alert pharmacist of the prescription to be filled and sends the written prescription through specified means.
- When ingesting, patient must self-administer the medication.

Requires physician provide the following to the patient:
1. Diagnosis with prognosis
2. Range of options including palliative care and hospice care
3. Risks and probable death from prescription
Oregon (1998 Statute)

- **Eligibility**: Oregon resident, determined by attending and consulting physician to have a terminal disease, and voluntarily expressed wish to die

- **Consulting physician** shall examine the patient and relevant medical records and confirm, in writing, the attending physician’s diagnosis that the patient is suffering from a terminal disease, and verify that the patient is capable, is acting voluntarily and has made an informed decision.

- **Counseling**: If either physician believes the patient may have a mental health disorder (including depression) causing impaired judgement, the physician may refer the patient for counseling. Medication can only be prescribed if the counselor determines that the patient does not have impaired judgement resulting from a mental health condition.

- **Patient Request**: Patient must provide two oral requests no less than 15 days apart, and a written request witnessed by two people
  - Prescription cannot be provided less than 15 days from initial oral request and less than 48 hours after written request
Witnesses: Must attest that to the best of their knowledge the patient is capable, acting voluntarily, and is not being coerced to sign the request. One of the witnesses shall be a person who is not:

- A relative of the patient by blood, marriage or adoption;
- A person who at the time the request is signed would be entitled to any portion of the estate of the qualified patient upon death under any will or by operation of law; or
- An owner, operator or employee of a health care facility where the qualified patient is receiving medical treatment or is a resident.

- The patient’s attending physician at the time the request is signed shall not be a witness
- If the patient is in a long term care facility at the time the written request is made, one of the witnesses shall be an individual designated by the facility and having the qualifications specified by the Department of Human Services
Informed Decision: The attending physician, to ensure that the patient is making an informed decision, shall inform the patient of:

- His or her medical diagnosis and prognosis
- The potential risks associated with taking the medication to be prescribed
- The probable result of taking the medication to be prescribed
- The feasible alternatives, including, but not limited to, comfort care, hospice care and pain control
- Immediately prior to writing the prescription for medication, the attending physician must verify that the patient is making an informed decision

The attending physician also shall:

- Recommend the patient notify next of kin
- Counsel the patient about the importance of having another person present when the patient takes the medication and of not taking the medication in a public place (e.g. a hotel room, park)
- Inform the patient that he or she has an opportunity to rescind the request at any time and in any manner, and offer the patient an opportunity to rescind at the end of the 15 day waiting period
- Document all steps of the MAID process in the patient’s medical record
• Dispensing of Medication: The physician shall dispense medications directly if he/she is registered as a dispensing physician or, with the patient’s consent, contact a pharmacist and inform the pharmacist of the prescription and deliver the written prescription personally or by mail to the pharmacist, who will dispense the medications to either the patient, the attending physician or an expressly identified agent of the patient.

• Reporting Requirements: The physician shall fill-out and submit to the Center for Health Statistics required forms when medicine was prescribed (including the dispensing record) and after death. The Department of Human Services shall generate and make publically available an annual statistical report of de-identified, aggregate information.

• Liabilities: Fraud and coercion are a Class A Felony.

• Effect on Construction of Wills, Contracts or Statutes:
  • No provision in a contract that would effect whether a person engages in MAID shall be valid.
  • The sale, procurement, issuance or rate of life, health, or accident insurance shall not be effected by MAID. In addition, ending one’s life utilizing MAID shall not have an effect upon a life, health, or accident insurance or annuity policy.
  • Nothing in this statute shall be construed to authorize a physician or any other person to end a patient’s life by lethal injection, mercy killing or active euthanasia. Actions taken in accordance with this statute shall not, for any purpose, constitute suicide, assisted suicide, mercy killing or homicide, under the law.
• **Immunities and Opting-Out:** No one shall be punished for choosing to participate or not participate in MAID. Participation in MAID shall be voluntary. If a health care provider is unable or unwilling to carry out a patient’s request the physician can transfer the patient to a new provider (which includes a new physician or new facility)

  • However, a provider (facility/health care system) may prohibit another provider (physician) from participating in MAID on the premises of the prohibiting provider if the prohibiting provider has notified the health care provider of the prohibiting provider’s policy regarding participating in MAID. If the provider engages in MAID, he/she can receive sanctions within the context of the facility/health care system.

    • Suspension or termination of staff membership or privileges due to prohibited participation in MAID is not reportable under ORS 441.820 and shall not be the sole basis for a report of unprofessional or dishonorable conduct under ORS 677.415 (2) or (3)

  • A health care provider can participate in MAID while acting outside the course and scope of the provider’s capacity as an employee or independent contractor; and a patient can contract with his or her attending physician and consulting physician to act outside the course and scope of the provider’s capacity as an employee or independent contractor of the sanctioning health care provider.


• Cause of death on death certificate is the terminal illness

• A request by a qualified individual to an attending physician to provide an aid-in-dying drug shall not provide the sole basis for the appointment of a guardian or conservator.

• Claims by governmental entity for costs incurred: Any governmental entity that incurs costs resulting from a person terminating his or her life in a public place shall have a claim against the estate of the person to recover such costs and reasonable attorney fees related to enforcing the claim.
Statutes: What Other States Have Done Differently

- **Most states and D.C. used the Oregon statute as a blueprint**
- **CA**: The attending physician, consulting physician, or mental health specialist shall not be related to the individual by blood, marriage, registered domestic partnership, or adoption, or be entitled to a portion of the individual’s estate upon death
- **VT**: Physician must inform the patient, *in writing*, of their diagnosis, prognosis, and range of treatment options including hospice and palliative care
- **DC**: Inform the patient of the availability of supportive counseling to address the range of possible psychological and emotional stress involved with the end stages of life
- **CO**: Attending physician must confirm no coercion or undue influence by having a private conversation with the patient
- **CA, CO**: As part of informed decision, physician must state the possibility that the patient may choose to obtain the medication but not take it.
- **VT, CA, CO**: Statute does NOT include the following: If the patient is in a long term care facility at the time the written request is made, one of the witnesses shall be an individual designated by the facility and having the qualifications specified by the Department of Human Services
Statutes: What Other States Have Done Differently

- **CA**: Attending physician shall give the patient the final attestation form, with the instruction that the form be filled out and executed by the patient within 48 hours prior to taking the medication.

- **CA**: Not liable if a person assisted the patient by preparing the medication so long as the person did not assist with the ingestion of the drug.

- **CA**: Instructs patient to keep the medication in a safe and secure location until the time that the qualified individual will ingest it.

- **CA, WA, VT, CO**: Rules for safe disposal of unused medications.

- **CA**: Actions taken in compliance with MAID statute shall not constitute neglect or elder abuse for any purpose of law.

- **CO**: An individual utilizing MAID and on Medicaid shall not have their benefits denied or altered.

- **CA**: Patient level data shall not be disclosed, discoverable, or compelled to be produced in any civil, criminal, administrative, or other proceeding.

- **VT**: Does not require statistics to be collected for public use.
Statutes: What Other States Have Done Differently

• **CA:** Prohibits an insurance carrier from providing any information in communications made to an individual about the availability of an aid-in-dying drug absent a request by the individual or his or her attending physician at the behest of the individual. The bill would also prohibit any communication from containing both the denial of treatment and information as to the availability of aid-in-dying drug coverage.

• **DC:** Death certificate states terminal disease as cause of death, but the Office of the Chief Medical Examiner shall review each death involving a qualified patient who ingests a covered medication and, if warranted by the review, may conduct an investigation.

• **DC:** Mayor shall issue rules to specify the recommended methods by which a patient may notify first responders of his or her intent to ingest a medication; and establish training opportunities for the medical community to learn about the use of covered medications by patients, including best practices for prescribing the medication.
Oregon, Washington and California statutes require that data be collected annually (as does D.C. and Colorado, but no data are available at this point)
Figure 1: DWDA prescription recipients and deaths*, by year, Oregon, 1998–2016

Oregon MAID Utilization Rates


*As of January 23, 2017
Summary of MAID Outcomes: Oregon, 2016

204 people had prescriptions written during 2016

114 ingested medication

36 did not ingest medication and subsequently died from other causes

54 ingestion status unknown

19 people with prescriptions written in previous years ingested medication during 2016

133 died from ingesting medication

10 died, ingestion status unknown

44 death and ingestion status pending

Source: Oregon DWDA 2016 Data Summary
Washington MAID Utility Rates

Data compiled from Washington's annual DWDA data reports, 2009-2016

248 participants with medication dispensed

- 240 participants have died
  - 236 After Death Reports received
    - 192 ingested lethal medication
      - 1 participant with death certificate pending
    - 8 unknown if ingested
    - 36 did not ingest lethal medication
      - 0 participants with death certificate pending
  - 8 unknown if ingested

- 8 with status pending
  - 4 participants without After Death Report
    - 4 unknown if ingested
    - 0 death certificates received

Source:
Summary of MAID Outcomes: California, 2016

258 individuals made a request for MAID to their physician

Note: California enacted MAID statute in 2016. As a result, all data is for 6 months, from June to December of 2016

Source: California EOLO Act 2016 Data Report
2016 MAID Demographics

Oregon: N=133     Washington: N=239     California: N=111 (In 6 months)

SEX (Male)
- Oregon: 72 (54.1%)     Washington: 120 (50%)     California: 51 (45.9%)

AGE

<table>
<thead>
<tr>
<th></th>
<th>Oregon</th>
<th>Washington</th>
<th>California</th>
</tr>
</thead>
<tbody>
<tr>
<td>18-54</td>
<td>8 (6.1%)</td>
<td>18-44</td>
<td>6 (3%)</td>
</tr>
<tr>
<td>55-64</td>
<td>18 (13.5%)</td>
<td>45-64</td>
<td>65 (27%)</td>
</tr>
<tr>
<td>65-84</td>
<td>83 (62.4%)</td>
<td>65-84</td>
<td>126 (53%)</td>
</tr>
<tr>
<td>85</td>
<td>24 (18%)</td>
<td>85</td>
<td>42 (18%)</td>
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<table>
<thead>
<tr>
<th></th>
<th>Oregon</th>
<th>Washington</th>
<th>California</th>
</tr>
</thead>
<tbody>
<tr>
<td>85 or &gt;</td>
<td>13 (11.7%)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

RACE / ETHNICITY

<table>
<thead>
<tr>
<th></th>
<th>Oregon</th>
<th>Washington</th>
<th>California</th>
</tr>
</thead>
<tbody>
<tr>
<td>White</td>
<td>127 (96.2%)</td>
<td>232 (97%)</td>
<td>102 (89.5%)</td>
</tr>
<tr>
<td>Black</td>
<td>0</td>
<td>.</td>
<td>3 (2.6%)</td>
</tr>
<tr>
<td>Hispanic</td>
<td>2 (1.5%)</td>
<td>.</td>
<td>3 (2.6%)</td>
</tr>
<tr>
<td>Asian</td>
<td>2 (1.5%)</td>
<td>.</td>
<td>6 (5.3%)</td>
</tr>
</tbody>
</table>

Note: Age categories differ for each state

Source: Each state’s 2016 Data Summary/Report
# 2016 MAID Demographics

<table>
<thead>
<tr>
<th>Education</th>
<th>OR</th>
<th>WA</th>
<th>CA</th>
</tr>
</thead>
<tbody>
<tr>
<td>Less Than High School</td>
<td>3.8%</td>
<td>4%</td>
<td></td>
</tr>
<tr>
<td>High School Graduate</td>
<td>17.4%</td>
<td>27%</td>
<td></td>
</tr>
<tr>
<td>Some College</td>
<td>28.8%</td>
<td>35%</td>
<td></td>
</tr>
<tr>
<td>Baccalaureate or Higher</td>
<td>50.0%</td>
<td>32%</td>
<td></td>
</tr>
<tr>
<td>No High School Diploma</td>
<td></td>
<td></td>
<td>5.4%</td>
</tr>
<tr>
<td>High School Diploma or GED</td>
<td></td>
<td></td>
<td>22.5%</td>
</tr>
<tr>
<td>Some College, No Degree</td>
<td>14.4%</td>
<td></td>
<td>14.4%</td>
</tr>
<tr>
<td>Associate, Bachelor or Master Degree</td>
<td>45.9%</td>
<td></td>
<td>45.9%</td>
</tr>
<tr>
<td>Doctorate or Professional Degree</td>
<td>11.7%</td>
<td></td>
<td></td>
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</table>

<table>
<thead>
<tr>
<th>Marital Status</th>
<th>OR</th>
<th>WA</th>
<th></th>
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</thead>
<tbody>
<tr>
<td>Married</td>
<td>47.0%</td>
<td>43%</td>
<td></td>
</tr>
<tr>
<td>Widowed</td>
<td>19.7%</td>
<td>20%</td>
<td></td>
</tr>
<tr>
<td>Divorced</td>
<td>27.3%</td>
<td>27%</td>
<td></td>
</tr>
<tr>
<td>Domestic Partner</td>
<td>.</td>
<td>1%</td>
<td></td>
</tr>
<tr>
<td>Never Married/Single</td>
<td>6.1%</td>
<td>7%</td>
<td></td>
</tr>
</tbody>
</table>

Source: Each state’s 2016 Data Summary/Report
### 2016 MAID Demographics

#### Insurance

<table>
<thead>
<tr>
<th>Oregon</th>
<th>Washington</th>
<th>California</th>
</tr>
</thead>
<tbody>
<tr>
<td>Private</td>
<td>Private Only</td>
<td>Private</td>
</tr>
<tr>
<td>26.3%</td>
<td>18%</td>
<td>18.9%</td>
</tr>
<tr>
<td>Medicare, Medicaid or Other Gov’t</td>
<td>Medicare, Medicaid Only</td>
<td>Medicare</td>
</tr>
<tr>
<td>61.7%</td>
<td>46%</td>
<td>44.2%</td>
</tr>
<tr>
<td>None</td>
<td>Combo of Private &amp; Medicare/Medicaid</td>
<td>Medicaid</td>
</tr>
<tr>
<td>0.01%</td>
<td>17%</td>
<td>3.6%</td>
</tr>
<tr>
<td>Unknown</td>
<td>None</td>
<td>Medicare/Medicaid (Dual Eligible)</td>
</tr>
<tr>
<td>11.3%</td>
<td>&lt;1%</td>
<td>9.0%</td>
</tr>
<tr>
<td></td>
<td>Unknown</td>
<td>Medicare/Medicaid &amp; Private Supplemental Insurance</td>
</tr>
<tr>
<td></td>
<td>6%</td>
<td>11.7%</td>
</tr>
<tr>
<td></td>
<td>Other (Including VA)</td>
<td>Has Insurance, but Type Unknown</td>
</tr>
<tr>
<td></td>
<td>11%</td>
<td>9.0%</td>
</tr>
<tr>
<td></td>
<td></td>
<td>None</td>
</tr>
<tr>
<td></td>
<td></td>
<td>3.6%</td>
</tr>
</tbody>
</table>

Most private insurance pays for MAID medication and the physician visit. By law, federal funds cannot be used for MAID medication; therefore, Medicare and the VA cannot pay for MAID medication.

Medicare enrollees may use their private supplemental insurance. Medicaid can pay for MAID medication out of a pot of state-only funds.

Source: Each state’s 2016 Data Summary/Report

Oregon: N=133     Washington: N=239     California: N=111 (In 6 months)
## Underlying Illness, 2016

<table>
<thead>
<tr>
<th>Oregon</th>
<th>Washington</th>
<th>California</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Cancer</strong></td>
<td>78.9%</td>
<td>77%</td>
</tr>
<tr>
<td>ALS</td>
<td>6.8%</td>
<td>Neuromuscular: 18%</td>
</tr>
<tr>
<td>Chronic Lower Respiratory Disease</td>
<td>1.5%</td>
<td>Respiratory Disease (including COPD): 8%</td>
</tr>
<tr>
<td>Heart Disease</td>
<td>6.8%</td>
<td>Heart Disease: 6%</td>
</tr>
<tr>
<td>Other</td>
<td>6.0%</td>
<td>Other: 2%</td>
</tr>
</tbody>
</table>

Source: Each state’s 2016 Data Summary/Report
Oregon: Underlying Illnesses (1998-2016)

Source: Oregon DWDA 2016 Data Summary
## Circumstances When Medication Ingested or at Death, 2016

<table>
<thead>
<tr>
<th>Location</th>
<th>OR</th>
<th>WA</th>
<th>CA</th>
</tr>
</thead>
<tbody>
<tr>
<td>Home</td>
<td>88.6%</td>
<td>88%</td>
<td>.</td>
</tr>
<tr>
<td>LTC/ALF/ Adult Foster Care</td>
<td>6.8%</td>
<td>7%</td>
<td>.</td>
</tr>
<tr>
<td>Hospital</td>
<td>2.3%</td>
<td>0</td>
<td>.</td>
</tr>
<tr>
<td>Other</td>
<td>2.3%</td>
<td>2%</td>
<td>.</td>
</tr>
</tbody>
</table>

### Hospice

<table>
<thead>
<tr>
<th>Hospice</th>
<th>OR</th>
<th>WA</th>
<th>CA</th>
</tr>
</thead>
<tbody>
<tr>
<td>Enrolled</td>
<td>88.7%</td>
<td>77%</td>
<td>83.8%</td>
</tr>
<tr>
<td>Unknown</td>
<td>0</td>
<td>9%</td>
<td>4.5%</td>
</tr>
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</table>

### Health Care Provider Present at Death (Oregon)

<table>
<thead>
<tr>
<th>Provider Type</th>
<th>Count</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prescribing physician</td>
<td>13</td>
<td>9.8%</td>
</tr>
<tr>
<td>Other provider</td>
<td>14</td>
<td>10.5%</td>
</tr>
<tr>
<td>No provider</td>
<td>102</td>
<td>76.7%</td>
</tr>
<tr>
<td>Unknown</td>
<td>4</td>
<td>3.0%</td>
</tr>
</tbody>
</table>

**Oregon:** N=133  
**Washington:** N=239  
**California:** N=111 (In 6 months)

Source: Each state’s 2016 Data Summary Report
MAID Patient Concerns

Oregon & Washington 2016

<table>
<thead>
<tr>
<th>Reason Provided</th>
<th>OR %</th>
<th>WA %</th>
</tr>
</thead>
<tbody>
<tr>
<td>Losing Autonomy</td>
<td>89.5</td>
<td>87</td>
</tr>
<tr>
<td>Unable to engage in enjoyable activities</td>
<td>89.5</td>
<td>84</td>
</tr>
<tr>
<td>Loss of dignity</td>
<td>65.4</td>
<td>66</td>
</tr>
<tr>
<td>Loss of bodily control</td>
<td>36.8</td>
<td>43</td>
</tr>
<tr>
<td>Burden on family</td>
<td>48.9</td>
<td>51</td>
</tr>
<tr>
<td>Concern about pain control</td>
<td>35.3</td>
<td>41</td>
</tr>
<tr>
<td>Financial implications of treatment</td>
<td>5.3</td>
<td>8</td>
</tr>
</tbody>
</table>

Source: Oregon’s and Washington’s 2016 Data Summary/Report

Oregon 1998-2015

- Losing autonomy (%)
- Less able to engage in activities making life enjoyable (%)
- Loss of dignity (%)
- Losing control of bodily functions (%)
- Burden on family, friends/caregivers (%)
- Inadequate pain control or concern about it (%)
- Financial implications of treatment (%)

Source: Oregon’s and Washington’s 2016 Data Summary/Report
What has been the impact of informing patients about end-of-life options such as hospice care and palliative care?

- In the states with available data (OR, WA, CA), the great majority of MAID users already were enrolled in hospice and had access to palliative care
  - Oregon: 88.7% (2016); 90.4% (1998-2015)
  - Washington: 77% (2016); 81% (2015); 69% (2014)
  - California: 83.8% (2016)

- All MAID statutes require that both the attending and consulting physician inform the patient about end-of-life options, including hospice and palliative care

- Hospice utilization has increased in Oregon since MAID was passed, but hospice utilization in Oregon has been among the highest in the nation since at least 1992

- In Oregon, palliative care services spending and patient satisfaction have risen since 1998, when MAID became legal
  - The request for information on MAID can lead to conversations between patients and their physicians about a range of end-of-life options

Coercion and Fraud

• Penalties for coercion and fraud included in statute:
  • Oregon: Class A felony
  • Washington: Class A felony
  • Vermont: Unable to find section on coercion/fraud
  • California: A felony
  • Colorado: Class 2 felony
  • D.C.: Class A felony

• Research on instances of coercion and/or fraud is ongoing and will be presented during the final presentation
Estimating MAID Utilization in Virginia

Oregon: Number of MAID Deaths per 10,000 Total Deaths

Data compiled from Oregon’s annual DWDA data summaries, 1998-2016
Estimating MAID Utilization in Virginia

• In Oregon, there were 37.2 MAID deaths per 10,000 total deaths in 2016
  • Less than 1 percent of all deaths

• In California the death rate was 6.06 per 10,000 total deaths for the first six months after enactment (June-December, 2016)
  • Out of 191 prescriptions written, the outcome for 59 patients is still unknown

• For Oregon and Washington (states for which there is trend data), the number of people who died due to MAID medication has remained below 200 individuals

• Estimate for Virginia: Like Oregon and Washington, it is likely that the number of people requesting MAID would be quite small for the first few years, gradually increasing to approximately 242 individuals dying from MAID medications
  • Oregon: 37.2 / 10,000 = .00372 percent of all deaths
  • Virginia: .00372 x 65,000 (total deaths in 2015*) = 241.8

*Most recent data. Sources: Oregon, Washington and California data summaries/reports; and for Virginia death data: http://vaperforms.virginia.gov/indicators/healthfamily/mortalityLongevity.php
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