



A Hospital Guide to the Colorado End-of-Life Options Act

Version 2.0, December 2016

For additional information, contact:

Amber Burkhart

Policy Analyst

amber.burkhart@cha.com

720.330.6028

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A. EXECUTIVE SUMMARY

Version 2.0, December 2016

Background

Proposition 106 – Colorado End-of-Life Options Act (“the Act”) – was approved by voters in November 2016 and went into effect on December 16, 2016. The Act allows Colorado residents with a terminal illness to request and self-administer medical aid-in-dying medication from a physician under certain conditions. To ensure hospitals and hospital employees are in full compliance, CHA advises all Colorado hospital leaders to work quickly to fully understand how the law may impact their hospital, discuss with their respective boards whether the hospital will participate (opt-in) or not participate (opt-out) under the Act, and develop and adopt an emergency policy and procedures.

Participating in activities under the Act is entirely voluntary – for patients, health care professionals and facilities – regardless of whether the decision made by a hospital is to opt-in or opt-out of activities under the Act. However, all health care facilities are strongly advised to develop a policy with regard to the Act and notify patients of the facility’s policy. The absence of hospital-approved policies and procedures could result in individuals seeking medical aid-in-dying medication at the facility, but the facility may lack the Act’s full protections and may also be vulnerable to compliance violations.

In order to ensure CHA members can quickly come into compliance with the new law, the Association developed “A Hospital Guide to the Colorado End-of-Life Options Act,” which includes a detailed overview of the law, a visual tool to help hospitals and their respective boards develop an appropriate policy position, opt-in and opt-out policy templates (which can be easily customized for each facility) as well as a list of optional policy development considerations. CHA made revisions to the hospital guide (Version 2.0) in December 2016, and the updated guide includes revised model policies, among other updates.

Please note that although the guide refers to a hospital choosing to not participate under the Act as “opting-out,” it is not intended to imply that the hospital can opt-out of *all* activities under the Act. A hospital choosing not to participate can prohibit a range of activities under the Act, from a minimal prohibition of on-site self-administration to a much broader scope encompassing staff activities contemplated in the Act.

In light of the ambiguities under the Act, hospitals choosing to opt-out should consult with their legal counsel. For further legal analysis on what a hospital choosing to opt-out can prohibit under the Act, see the Memorandum on “Non-Participating Hospitals” developed by the Association’s legal counsel, available online at <http://www.cha.com/prop106>.

Making a Policy Decision Regarding Medical Aid-in-Dying: Factors to Consider

A facility’s first step should be to make a decision – likely by its governing body – whether to opt-in or opt-out under the Act. There are many factors hospitals should consider regarding their participation under the Act, including the following:

- Whether faith-based standards applicable to the health care facility’s mission and purpose support or preclude adoption of the Act’s procedures.

- Whether support of aid-in-dying procedures is consistent with the health care facility's scope of services (e.g., the facility's scope of services is limited to acute care, precluding non-acute aid-in-dying).
- Whether the health care facility has resources available to ensure implementation of the elements of the Act's required procedures (e.g., medical staff members willing to serve as attending physicians to prescribe medications, consulting physicians to evaluate the patient, available mental health professionals (psychiatrists or psychologists) to evaluate the patient's mental capacity).
- Whether medical staff members support aid-in-dying procedures. Note that although the medical staff may be consulted, the determination of whether to opt-in or opt-out is ultimately a decision for the hospital governing body.
- Although the Act provides immunity for hospitals and staff acting in good faith, the potential risk for litigation and other risk management considerations is a significant concern.

Once a hospital governing body takes a position on aid-in-dying under the Act (opt-in or opt-out), the hospital should adopt a policy that reflects the position as well as the relevant processes. For a health care facility that elects to opt-in, the policy and related procedures should address the process and personnel responsibilities to ensure adequate informed consent, documentation to meet reporting requirements and risk management considerations, and prescribing and self-administering medications (see *"Appendix B: Opt-In Policy,"* page A-2). For a health care facility that elects to opt-out of the Act, the governing body should adopt a policy that expressly reflects this decision, as well as addressing unplanned situations more fully described in the guide (see *"Appendix C: Opt-Out Policy,"* page A-9).

Advance Written Notice to Patients and Physicians

In addition to developing a policy, a health care facility is required to provide advance written notification to patients of its policy regarding medical aid-in-dying, regardless of whether the facility chooses to opt-in or opt-out. In addition, a health care facility is required to provide advance written notification to physicians should the facility choose to opt-out.

The Act does not provide guidance on the means for providing, or content of the advance written notification to patients or physicians. But a health care facility that fails to provide advance notification to its patients and physicians "shall not be entitled to enforce such a policy." A straightforward approach to notify patients could be to provide each patient written notice of the health care facility's policy regarding the Act as part of the admission and consent documents. This information can also be reflected on the health care facility's website and other public locations where patient rights are posted. For physicians, notification could be in the form of the policy that is mailed or emailed to employed and contracted physicians (ideally with mandatory response or confirmation), distributed at meetings (with a sign-in sheet), included in credentialing and re-credentialing packets (for facilities that credential physicians), and posted in locations frequently used by physicians (e.g. physician's lounge).

B. BACKGROUND

Proposition 106 – the Colorado End-of-Life Options Act (“the Act”) – was approved by voters on the 2016 statewide ballot and went into effect on December 16, 2016. The new law amended Colorado statutes and allows Colorado residents with a terminal illness to request and self-administer medical aid-in-dying medication from a physician under certain conditions. This document describes the requirements and options under the law. A full version of the statute – C.R.S § 25-48-101, *et seq.* – is available at:

<https://www.sos.state.co.us/pubs/elections/Initiatives/titleBoard/filings/2015-2016/145Final.pdf>.

Colorado is the sixth state to allow patients to request medical aid-in-dying medication; other states include Oregon, Washington, Vermont, Montana and California. In Oregon between 1998 and 2015, 1,545 individuals received a written prescription for the medication, of which 991 – approximately 64 percent – died from ingesting it. Additionally, 94 percent of individuals administered the medication in their homes, and only one patient administered the medication and subsequently died in a hospital.¹

FIRST STEPS FOR HOSPITALS

Oregon’s experience has shown that the End-of-Life Options Act will likely not be a hospital-focused law (meaning most individuals will choose to not ingest medical aid-in-dying medication on a hospital premises), but Colorado hospital leaders should understand how the law may impact their facilities and employees; discuss with their respective boards whether the hospital will participate in activities under the Act and develop appropriate policies and procedures to ensure the hospital is in full compliance. Participating in activities under the Act is entirely voluntary by all health care providers, including hospitals. However, all hospitals are required – whether opting-in or

opting out – to provide advanced written notice of its policy to patients. In addition, hospitals are required to provide advance written notification to physicians should the facility choose to opt-out.

Please note that although the guide refers to a hospital choosing to not participate under the Act as “opting-out,” it is not intended to imply that the hospital can opt-out of *all* activities under the Act. A hospital choosing not to participate can prohibit a range of activities under the Act, from a minimal prohibition of on-site self-administration to a much broader scope encompassing staff activities contemplated in the Act.

In light of the ambiguities under the Act, hospitals choosing to opt-out should consult with their legal counsel. For further legal analysis on what a hospital choosing to opt-out can prohibit under the Act, see the Memorandum on “Non-Participating Hospitals” developed by the Association’s legal counsel, available online at <http://www.cha.com/prop106>.

DEFINITIONS ²

The following definitions apply to the Colorado End-of-Life Options Act.

“Adult” means an individual who is eighteen years of age or older.

“Attending physician” means a physician who has primary responsibility for the care of a terminally ill individual and the treatment of the individual’s terminal illness.

“Consulting physician” means a physician who is qualified by specialty or experience to make a professional diagnosis and prognosis regarding a terminally ill individual’s illness.

“Health care provider” or “provider” means a person who is licensed, certified, registered, or otherwise authorized or permitted by law to administer health care or dispense medication in the ordinary course of business

¹ Oregon Death with Dignity Act: 2015 Data Summary. Available at: <https://public.health.oregon.gov/ProviderPartnerResources/E>

<valuationResearch/DeathwithDignityAct/Documents/year18.pdf>

² C.R.S. 25-48-102

or practice of a profession. The term includes a health care facility, including a long-term care facility as defined in section 25-3-103.7(1) (f.3) and a continuing care retirement community as described in section 25.5-6-203 (1)(c)(i), C.R.S.

“Informed decision” means a decision that is:

1. Made by an individual to obtain a prescription for medical aid-in-dying medication that the qualified individual may decide to self-administer to end his or her life in a peaceful manner;
2. Based on an understanding and acknowledgment of the relevant facts; and
3. made after the attending physician fully informs the individual of:
 - a. His or her medical diagnosis and prognosis of six months or less;
 - b. The potential risks associated with taking the medical aid-in dying medication to be prescribed;
 - c. The probable result of taking the medical aid-in-dying medication to be prescribed
 - d. The choices available to an individual that demonstrate his or her self-determination and intent to end his or her life in a peaceful manner, including the ability to choose whether to:
 - i. Request medical aid in dying;
 - ii. Obtain a prescription for medical aid-in-dying medication to end his or her life;
 - iii. Fill the prescription and possess medical aid-in-dying medication to end his or her life; and
 - iv. Ultimately self-administer the medical aid-in-dying medication

to bring about a peaceful death;
and

- e. All feasible alternatives or additional treatment opportunities, including comfort care, palliative care, hospice care, and pain control.

“Licensed mental health professional”

means a psychiatrist licensed under article 36 of title 12, C.R.S., or a psychologist licensed under part 3 of article 43 of title 12, C.R.S.

“Medical aid-in-dying” means the medical practice of a physician prescribing medical aid-in-dying medication to a qualified individual that the individual may choose to self-administer to bring about a peaceful death.

“Medical aid-in-dying medication” means medication prescribed by a physician pursuant to this article to provide medical aid-in-dying to a qualified individual.

“Medically confirmed” means that a consulting physician who has examined the terminally ill individual and the individual’s relevant medical records has confirmed the medical opinion of the attending physician.

“Mental capacity” or **“mentally capable”** means that in the opinion of an individual’s attending physician, consulting physician, psychiatrist or psychologist, the individual has the ability to make and communicate an informed decision to health care providers.

“Physician” means a doctor of medicine or osteopathy licensed to practice medicine by the Colorado Medical Board.

“Prognosis of six months or less” means a prognosis resulting from a terminal illness that the illness will, within reasonable medical judgment, result in death within six months and which has been medically confirmed.

“Qualified individual” means a terminally ill adult with a prognosis of six months or less, who has mental capacity, has made an informed decision, is a resident of the state, and has satisfied the requirements of this

article in order to obtain a prescription for medical aid-in-dying medication to end his or her life in a peaceful manner.

“Resident” means an individual who is able to demonstrate residency in Colorado by providing any of the following documentation to his or her attending physician:

1. A Colorado driver’s license or identification card issued pursuant to article 2 of title 42, C.R.S.;
2. A Colorado voter registration card or other documentation showing the individual is registered to vote in Colorado;
3. Evidence that the individual owns or leases property in Colorado; or
4. A Colorado income tax return for the most recent tax year.

“Self-administer” means a qualified individual’s affirmative, conscious, and physical act of administering the medical aid-in-dying medication to himself or herself to bring about his or her own death.

“Terminal illness” means an incurable and irreversible illness that will, within reasonable medical judgment, result in death.

C. WHO CAN REQUEST MEDICAL AID-IN-DYING MEDICATION? ³

An adult resident of Colorado may make a request to receive a prescription for medical aid-in-dying medication if all of the following conditions are satisfied:

1. The individual’s attending physician has diagnosed the individual with a terminal illness with a prognosis of six months or less;
2. The individual’s attending physician has determined the individual has mental capacity; and

3. The individual has voluntarily expressed the wish to receive a prescription for medical aid-in-dying medication.

The right to request medical aid-in-dying medication does not exist because of age or disability.

D. HOW DOES A PATIENT REQUEST MEDICAL-AID-IN-DYING MEDICATION? ⁴

In order to receive a prescription for medical aid-in-dying medication, an individual must submit to his or her attending physician:

1. Two oral requests that are separated by at least fifteen days; and
2. One valid written request.

ORAL REQUEST

As mentioned above, a person who wants a medical aid-in-dying prescription must make two oral requests – at least fifteen days apart – to his or her attending physician. The attending physician must document in the individual’s medical record the dates of all oral requests.

WRITTEN REQUEST

To be valid, a written request for medical aid-in-dying medication must meet all of the following conditions:

1. Complete the form required by the State of Colorado, titled “Request for Medication to End My Life in a Peaceful Manner.” (See Appendix D, page A-14).⁵
2. Signed and dated by the individual seeking the medical aid-in-dying medication; and
3. Witnessed by at least two individuals who, in the presence of the individual, attest to the best of their knowledge and belief that the individual is:
 - a. Mentally capable;

³ C.R.S. 25-48-103

⁴ C.R.S. 25-48-104

⁵ C.R.S. 25-48-112

- b. Acting voluntarily; and
- c. Not being coerced to sign the request.

E. WHO IS QUALIFIED TO BE A WITNESS? ⁶

Of the two witnesses to the written request, at least one must not be:

1. Related to the individual by blood, marriage, civil union, or adoption;
2. An individual who, at the time the request is signed, is entitled, under a will or by operation of law, to any portion of the individual's estate upon his or her death; or
3. An owner, operator, or employee of a health care facility where the individual is receiving medical treatment or is a resident.

Additionally, neither the individual's attending physician nor a person authorized as the individual's qualified power of attorney or durable medical power of attorney shall serve as a witness to the written request.

F. RESPONSIBILITIES OF THE ATTENDING PHYSICIAN ⁷

The **"attending physician"** is the physician who has primary responsibility for the care of a terminally ill individual and the treatment of the individual's terminal illness.

Prior to prescribing the medical aid-in-dying medication, the attending physician must complete all of the following:

1. Make the initial determination of whether an individual requesting medical aid-in-dying medication is qualified. (See *"Initial Determination,"* page 9).
2. Request that the individual demonstrate Colorado residency. (See *"Confirmation of Residency,"* page 9).
3. Provide care that conforms to established medical standards and accepted medical

guidelines. (See *"Standard of Care Requirements,"* page 12).

4. Refer the individual to a consulting physician. (See *"Referral to a Consulting Physician,"* page 9).
5. Provide full, individual-centered disclosures. (See *"Individual-Centered Disclosures,"* page 9).
6. Refer the individual to a licensed mental health professional if the attending physician believes that the individual may not be mentally capable of making an informed decision.
7. Confirm that the individual's request does not arise from coercion or undue influence. (See *"No Coercion or Undue Influence,"* page 10).
8. Counsel the individual. (See *"Counseling the Patient,"* page 10).
9. Verify, immediately prior to writing the prescription for medical aid-in-dying medication, that the individual is making an informed decision. (See *"Confirmation that the Patient is Making an Informed Decision,"* page 10).
10. Ensure that all appropriate steps are carried out before writing a prescription for medical aid-in-dying medication.

Lastly, the attending physician must also fulfill all documentation requirements. (See *"Physician Reporting Requirements,"* page 12). Specific requirements of these steps are described in more detail below.

INITIAL DETERMINATION

The attending physician is required to make an initial determination of all of the following:

1. The individual has a terminal illness. **"Terminal illness"** means an incurable and irreversible illness that will, within

⁶ C.R.S. 25-48-104

⁷ C.R.S. 25-48-106

reasonable medical judgment, result in death.

2. The individual has a prognosis of six months or less.
3. The individual is mentally capable. **“Mental capacity” or “mentally capable”** means that in the opinion of an individual’s attending physician, consulting physician, psychiatrist or psychologist, the individual has the ability to make and communicate an informed decision to health care providers.
4. The individual is making an informed decision. (See *“Confirmation that the Patient is Making an Informed Decision,”* page 10).
5. The individual has made the request voluntarily.

CONFIRMATION OF RESIDENCY

The attending physician must request that the individual demonstrate Colorado residency by providing any of the following documentation:

1. A Colorado driver’s license or identification card.
2. A Colorado voter registration card or other documentation showing the individual is registered to vote in Colorado.
3. Evidence that the individual owns or leases property in Colorado.
4. A Colorado income tax return for the most recent tax year.

REFERRAL TO A CONSULTING PHYSICIAN

The attending physician must refer the patient to a consulting physician for medical confirmation of the following:

1. The diagnosis and prognosis.
2. The determination of whether the individual is mentally capable.

3. The determination of whether the individual is making an informed decision.
4. The determination of whether the individual is acting voluntarily.

A **“consulting physician”** is a physician who is qualified by specialty or experience to make a professional diagnosis and prognosis regarding a terminally ill individual’s illness. (See *“Responsibilities of the Consulting Physician,”* page 11).

INDIVIDUAL-CENTERED DISCLOSURES

The attending physician must provide individual-centered disclosures to ensure that the individual is making an informed decision by discussing with the individual all of the following information:

1. His or her medical diagnosis and prognosis of six months or less.
2. The feasible alternatives or additional treatment opportunities, including comfort care, palliative care, hospice care, and pain control.
3. The potential risks associated with taking the medical aid-in-dying medication to be prescribed.
4. The probable result of taking the medical aid-in-dying medication to be prescribed.
5. The possibility that the individual can obtain the medical aid-in-dying medication but choose not to use it.

NO COERCION OR UNDUE INFLUENCE

The attending physician must confirm that the individual’s request does not arise from coercion or undue influence by another person by discussing with the individual, outside the presence of other persons, whether the individual is feeling coerced or unduly influenced by another person.

COUNSELING THE PATIENT

The attending physician must counsel the individual about the importance of all of the following:

1. Having another person present when the individual self-administers the medical aid-in-dying medication.
2. Not taking the medical aid-in-dying medication in a public place.
3. Safe-keeping and proper disposal of unused medical aid-in-dying medication.
4. Notifying his or her next of kin of the request for medical aid-in-dying medication.
5. The attending physician must also:
 - a. Inform the individual that he or she may rescind the request for medical aid-in-dying medication at any time and in any manner.

CONFIRMATION THAT THE PATIENT IS MAKING AN INFORMED DECISION

A qualified individual cannot receive a prescription for medical aid-in-dying medication unless he or she has made an informed decision and immediately before writing a prescription for medical aid-in-dying medication, the attending physician shall verify that the individual with a terminal illness is making an informed decision.

For purposes of this law, an “**informed decision**” means a decision that is:

1. Made by an individual to obtain a prescription for medical aid-in-dying medication that the qualified individual may decide to self-administer to end his or her life in a peaceful manner.
2. Based on an understanding and acknowledgment of the relevant facts.
3. Made after the attending physician fully informs the individual of all of the following:

- a. His or her medical diagnosis and prognosis of six months or less.
- b. The potential risks associated with taking the medical aid-in-dying medication to be prescribed.
- c. The probable result of taking the medical aid-in-dying medication to be prescribed.
- d. The choices available to an individual that demonstrate his or her self-determination and intent to end his or her life in a peaceful manner, including the ability to choose whether to:
 - i. Request medical aid in dying.
 - ii. Obtain a prescription for medical aid-in-dying medication to end his or her life.
 - iii. Fill the prescription and possess medical aid-in-dying medication to end his or her life.
 - iv. Ultimately self-administer the medical aid-in-dying medication to bring about a peaceful death.
- e. All feasible alternatives or additional treatment opportunities, including comfort care, palliative care, hospice care, and pain control.

G. PRESCRIBING OR DELIVERING THE MEDICAL AID-IN-DYING MEDICATION ⁸

After the attending physician has fulfilled his or her responsibilities described in the “*Responsibilities of the Attending Physician*,” page 8, the attending physician must either:

1. Dispense medical aid-in-dying medications directly to the qualified

⁸ C.R.S. 25-48-106

individual, including ancillary medications intended to minimize the individual's discomfort, if the attending physician meets all of the following criteria:

- a. Has a current drug enforcement administration certificate.
 - b. Complies with any applicable administrative rules.
2. Deliver the written prescription personally, by mail, or through authorized electronic transmission in the manner, to a licensed pharmacist, who shall dispense the medical aid-in-dying medication to the qualified individual, the attending physician, or an individual expressly designated by the qualified individual.

Lastly, an attending physician shall not write a prescription for medical aid-in-dying medication unless the attending physician offers the qualified individual an opportunity to rescind the request for the medical aid-in-dying medication.

H. RESPONSIBILITIES OF THE CONSULTING PHYSICIAN ⁹

Before an individual who is requesting medical aid-in-dying medication may receive a prescription for the medical aid-in-dying medication, a consulting physician must examine the individual. A **"consulting physician"** is a physician who is qualified by specialty or experience to make a professional diagnosis and prognosis regarding a terminally ill individual's illness.

A physician who chooses to act as a consulting physician under the End-of-Life Options Act must complete the following:

1. Examine the individual and his or her relevant medical records.
2. Confirm, in writing, to the attending physician that the individual:

- a. Has a terminal illness.
- b. Has a prognosis of six months or less.
- c. Is making an informed decision.
- d. Is mentally capable, or provide documentation that the consulting physician has referred the individual for further evaluation. (See *"Responsibilities of the Licensed Mental Health Professional,"* page 11).

I. RESPONSIBILITIES OF THE LICENSED MENTAL HEALTH PROFESSIONAL ¹⁰

An attending physician shall not prescribe medical aid-in-dying medication for an individual with a terminal illness until the individual is determined to be mentally capable and making an informed decision, and those determinations are confirmed. If the attending physician or the consulting physician believes that the individual may not be mentally capable of making an informed decision, the attending physician or consulting physician shall refer the individual to a licensed mental health professional for a determination of whether the individual is mentally capable and making an informed decision. A **"licensed mental health professional"** is a psychiatrist or a psychologist.

A psychiatrist or psychologist who chooses to act as a licensed mental health professional under the End-of-Life Options Act must complete the following:

1. Evaluate the individual.
2. Communicate, in writing, to the attending or consulting physician who requested the evaluation, his or her conclusions about whether the individual is mentally capable and making informed decisions.

If the licensed mental health professional determines that the individual is not mentally capable of making informed decisions, the person cannot be deemed a qualified

⁹ C.R.S. 25-48-107

¹⁰ C.R.S. 25-48-108

individual and the attending physician cannot prescribe medical aid-in-dying medication to the individual.

J. STANDARD OF CARE REQUIREMENTS ¹¹

All physicians and health care providers must provide medical services that meet or exceed the standard of care for end-of-life medical care.

Further, if a health care provider is unable or unwilling to carry out an eligible individual's request and the individual transfers care to a new health care provider, the health care provider shall coordinate transfer of the individual's medical records to a new health care provider.

K. OPPORTUNITY FOR PATIENT TO CHANGE HIS OR HER MIND ¹²

At any time, an individual may rescind his or her request for medical aid-in-dying medication without regard to the individual's mental state. In other words, if an individual makes a request for medical aid-in-dying medication while having the capacity to make health care decisions, then loses his or her capacity, the patient can still decide not to take the aid-in-dying medication.

An attending physician shall not write a prescription for medical aid-in-dying medication unless the attending physician offers the qualified individual an opportunity to rescind the request for the medical aid-in-dying medication.

L. DEATH CERTIFICATE ¹³

Unless otherwise prohibited by law, the attending physician or the hospice medical director must sign the death certificate of a qualified individual who obtained and self-administered medical aid-in-dying medication.

In addition, when a death has occurred, the cause of death must be listed as the underlying terminal illness and the death

does not constitute grounds for post-mortem inquiry.

M. PHYSICIAN REPORTING REQUIREMENTS ¹⁴

The attending physician shall document in the individual's medical record, all of the following information:

1. Dates of all oral requests.
2. A valid written request.
3. The attending physician's diagnosis and prognosis, determination of mental capacity and that the individual is making a voluntary request and an informed decision.
4. The consulting physician's confirmation of diagnosis and prognosis, mental capacity and that the individual is making an informed decision.
5. If applicable, written confirmation of mental capacity from a licensed mental health professional.
6. A notation of notification of the right to rescind a request made.
7. A notation by the attending physician that all requirements have been satisfied; indicating steps taken to carry out the request, including a notation of the medical aid-in-dying medications prescribed and when.

N. RESPONSIBILITIES OF THE COLORADO DEPARTMENT OF PUBLIC HEALTH AND ENVIRONMENT ¹⁵

The Colorado Department of Public Health and Environment (the department) is required to annually review a sample of records maintained to ensure compliance. The department also must adopt rules to facilitate the collection of information

¹¹ C.R.S. 25-48-113

¹² C.R.S. 25-48-105

¹³ C.R.S. 25-48-109

¹⁴ C.R.S. 25-48-111

¹⁵ *ibid.*

reported by physicians. (See “Physician Reporting Requirements,” page 12).

Except as otherwise required by law, the information collected by the department is not a public record and is not available for public inspection. However, the department shall generate and make available to the public an annual statistical report of information collected. The department must require any health care provider, upon dispensing a medical aid-in-dying medication, to file a copy of a dispensing record with the department. The dispensing record is also not a public record and is not available for public inspection.

O. DISPOSAL OF MEDICAL AID-IN-DYING MEDICATION ¹⁶

A person who has custody or control of medical aid-in-dying medication dispensed that the terminally ill individual decides not to use or that remains unused after the terminally ill individual’s death shall dispose of the unused medical aid-in-dying medication either by:

1. Returning the unused medical aid-in-dying medication to the attending physician who prescribed the medical aid-in-dying medication, who shall dispose of the unused medical aid-in-dying medication in the manner required by law.
2. Lawful means or any other state or federally approved medication take-back program.

P. VOLUNTARY PARTICIPATION ¹⁷

A health care provider may choose whether to participate in providing medical aid-in-dying medication to an individual. In addition, health care providers – including hospitals – can prohibit physicians employed or under contract from participating in the Act in specific circumstances. (See “Prohibiting Physicians Employed or Under Contract from

Participating in Activities Under the Act,” page 13).

We encourage hospitals choosing to opt-in to carefully review the model policy and additional policy considerations in Appendix B.

Q. DECLINING TO PARTICIPATE ¹⁸

If a health care provider is unable or unwilling to carry out an individual’s request for medical aid-in-dying medication, and the individual transfers his or her care to a new health care provider, the prior health care provider must transfer, upon request, a copy of the individual’s relevant medical records to the new health care provider.

We encourage hospitals choosing to opt-out to carefully review the model policy and additional policy considerations in Appendix C.

R. PROHIBITING PHYSICIANS EMPLOYED OR UNDER CONTRACT FROM PARTICIPATING IN ACTIVITIES UNDER THE ACT ¹⁹

A health care facility may prohibit a physician employed or under contract from writing a prescription for medical aid-in-dying medication for a qualified individual who intends to use the medical aid-in-dying medication on the facility’s premises.

In light of the ambiguities under the Act, hospitals choosing to opt-out should consult with their legal counsel. For further legal analysis on what a hospital choosing to opt-out can prohibit under the Act, see the Memorandum on “Non-Participating Hospitals” developed by the Association’s legal counsel, available online at <http://www.cha.com/prop106>.

NOTICE REQUIRED FOR PHYSICIANS

If the health care chooses to opt-out of activities under the act, the health care facility must notify the physician in writing of its

¹⁶ C.R.S. 25-48-120

¹⁷ C.R.S. 25-48-117

¹⁸ *ibid.*

¹⁹ C.R.S. 25-48-118

policy with regard to prescriptions for medical aid-in-dying medication. A health care facility that fails to provide advance notice to the physician is not entitled to enforce such a policy against the physician.

A health care facility or health care provider cannot subject a physician, nurse, pharmacist, or other person to discipline, suspension, loss of license or privileges, or any other penalty or sanction for actions taken in good-faith reliance on this article or for refusing to act.

NOTICE REQUIRED FOR PATIENTS

A health care facility – whether opting-in or opting-out of activities under the act – must notify patients in writing of its policy with regard to medical aid-in-dying. A health care facility that fails to provide advance notification to patients cannot be entitled to enforce such a policy.

S. INSURER AND HEALTH PLAN PROVISIONS ²⁰

The sale, procurement, or issuance of, or the rate charged for, any life, health, or accident insurance or annuity policy must not be conditioned upon, or affected by, an individual's act of making or rescinding a request for medical aid-in-dying medication in accordance with this article.

A qualified individual's act of self-administering medical aid-in-dying medication does not affect a life, health, or accident insurance or annuity policy.

An insurer shall not deny or otherwise alter health care benefits available under a policy of sickness and accident insurance to an individual with a terminal illness who is covered under the policy, based on whether or not the individual makes a request.

An individual with a terminal illness who is a recipient of medical assistance under the "Colorado medical assistance act," shall not be denied benefits under the medical assistance program or have his or her benefits under the

program otherwise altered based on whether or not the individual makes a request.

T. CONTRACT PROVISIONS ²¹

A provision in a contract, will, or other agreement, whether written or oral, that would affect whether an individual may make or rescind a request for medical aid-in-dying is not valid.

In addition, an obligation owing under any currently existing contract must not be conditioned upon, or affected by, an individual's act of making or rescinding a request for medical aid-in-dying medication.

U. CRIMINAL CONDUCT ²²

A person commits a class 2 felony and is subject to punishment if the person, knowingly or intentionally:

1. Causes an individual's death by any of the following:
 - a. Forging or altering a request for medical aid-in-dying medication to end an individual's life without the individual's authorization.
 - b. Concealing or destroying a rescission of a request for medical aid-in-dying medication.
2. Coerces or exerts undue influence on an individual with a terminal illness to:
 - a. Request medical aid-in-dying medication for the purpose of ending the terminally ill individual's life.
 - b. Destroy a rescission of a request for medical aid-in-dying medication.

Nothing in this article limits further liability for civil damages resulting from other negligent conduct or intentional misconduct by any person.

Additionally, nothing in this law authorizes a physician or any other person to end an

²⁰ C.R.S. 25-48-115

²¹ C.R.S. 25-48-114

²² C.R.S. 25-48-119

individual's life by lethal injection, mercy killing, or euthanasia.

Lastly, nothing in this law authorizes a physician or any other person to end an individual's life by lethal injection, mercy killing, or euthanasia. Actions taken in accordance with this article do not, for any purpose, constitute suicide, assisted suicide, mercy killing, homicide, or elder abuse under the "Colorado Criminal Code."

V. IMMUNITY FROM LIABILITY; PROHIBITION ON SANCTIONS ²³

A person is not subject to civil or criminal liability or professional disciplinary action for acting in good faith under this article, which includes being present when a qualified individual self-administers the prescribed medical aid-in-dying medication.

Additionally, a health care provider or professional organization or association cannot subject an individual to any of the following for participating or refusing to participate in good-faith compliance:

1. Censure;
2. Discipline;
3. Suspension;
4. Loss of license, privileges, or membership; or
5. Any other penalty.

A request by an individual for, or the provision by an attending physician of, medical aid-in-dying medication in good-faith compliance with this article does not:

1. Constitute neglect or elder abuse for any purpose of law; or
2. Provide the basis for the appointment of a guardian or conservator.

This section does not limit civil or criminal liability for negligence, recklessness or intentional misconduct.

W. CLAIMS BY GOVERNMENT ENTITY FOR COSTS ²⁴

A government entity that incurs costs resulting from an individual terminating his or her life under this law in a public place has a claim against the estate of the individual to recover the costs and reasonable attorney fees related to enforcing the claim.

X. NO EFFECT ON ADVANCE MEDICAL DIRECTIVES ²⁵

Nothing in law may change the legal effect of any of the following:

1. A declaration directing that life sustaining procedures be withheld or withdrawn;
2. A cardiopulmonary resuscitation directive;
3. An advance medical directive.

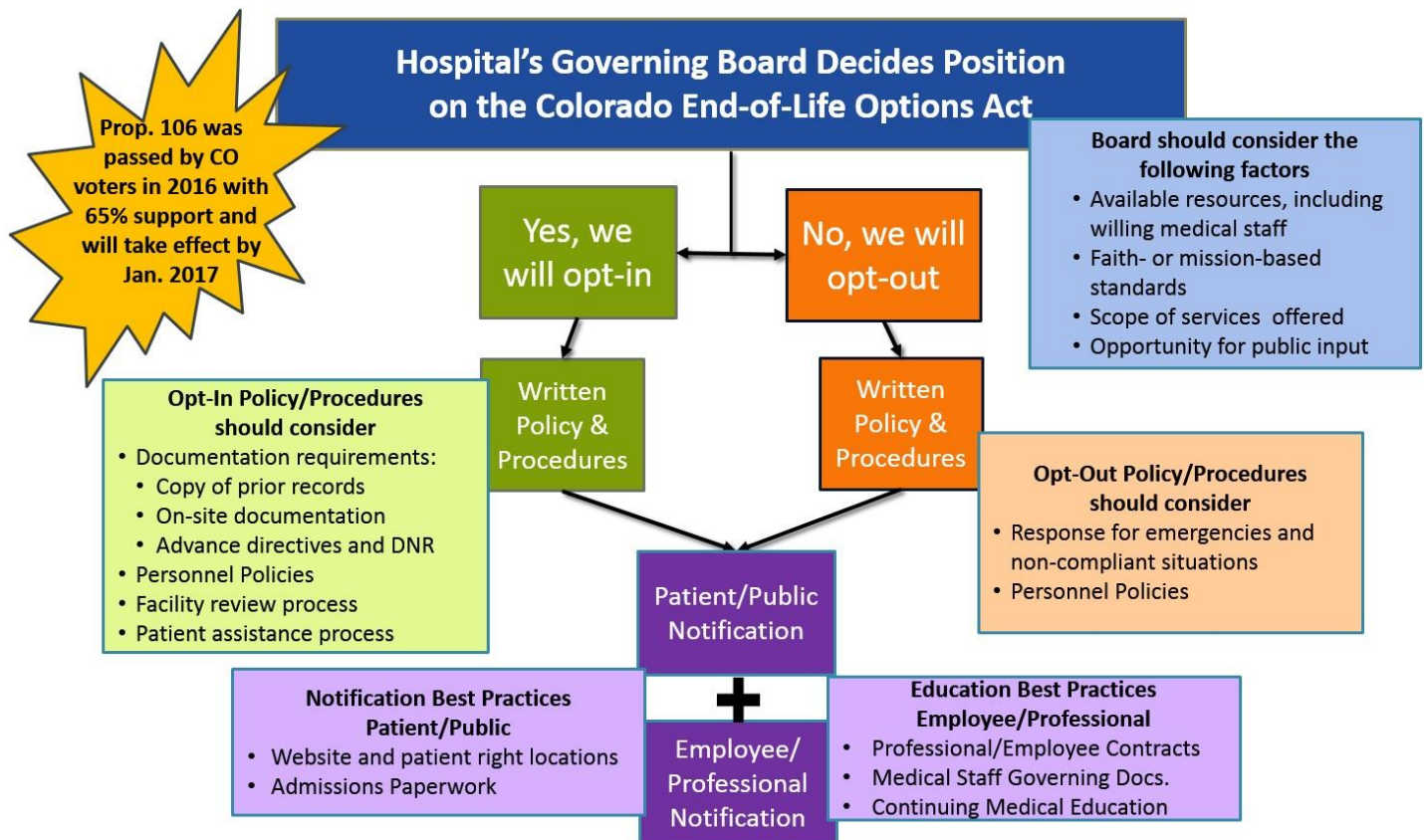
²³ C.R.S. 25-48-116

²⁴ C.R.S. 25-48-122

²⁵ C.R.S. 25-48-123

APPENDIX A: OVERVIEW GRAPHIC

Policy Considerations for Implementing the Colorado End-of-Life Options Act in Colorado Hospitals



APPENDIX B: OPT-IN MODEL POLICY (Version 2.0)

CHA developed an opt-in and opt-out policy, both of which are provided in this guide. Hospitals should select a policy and modify as appropriate for their facilities, review this policy in the context of other policies specific to the facility, and develop procedures to address how the policy will be operationalized. Ensure your hospital's procedures conform to the requirements of the Act as described below in sections I – IV. Also included below are additional policy considerations that facilities may choose to address in their policy and procedures. Although these are optional, a thorough review of these considerations is recommended. A health care facility that elects to opt-out under the Act should consult with legal counsel regarding some of the ambiguities under the Act for opting-out. The governing body should, at a minimum, adopt a policy that expressly reflects this decision.

NOTE: The opt-in policy below has been modified.

- Underlined text indicates updated language.

- Green boxes briefly explain Version 2.0 key modifications.

MODEL POLICY

Policy Title: *The Colorado End-of-Life Options Act (A Patient's Request for Medical Aid in Dying)*

Adoption Date:

Approved Date:

Last Date Revised:

Last Date Reviewed:

Office of Origin: _____

I. PURPOSE

- The Colorado End-of-Life Options Act authorizes medical aid in dying and allows a terminally ill adult with a prognosis of six months or less, who has mental capacity, has made an informed decision, is a resident of Colorado, and has satisfied other requirements, to request and obtain a prescription for medical aid-in-dying medication to end his or her life in a peaceful manner.*
- The purpose of this policy is to describe the requirements and procedures for compliance with The Colorado End-of-Life Options Act and to provide guidelines for responding to patient requests for information about medical aid-in-dying medications in accordance with federal and state laws and regulations and The Joint Commission accreditation standards.*
- The requirements outlined in this policy do not preclude or replace other existing HOSPITAL policies that address advance directives, withholding or foregoing life sustaining treatment, MOST, DNR and other end-of-life care matters.*

II. REFERENCES

- Colorado End-of-Life Options Act (C.R.S § 25-48-101, et seq.)*

- b. Colorado Probate Code (C.R.S § 15-14-503-509 (Medical Durable Power of Attorney); 15-18-101, et seq. (Medical Treatment Decisions Act (Living Will)); 15-18.5-101, et seq. (Proxy Decision-Makers); 15-18.6-101, et seq. (CPR Directives); and 15-18.7-101, et seq.(MOST))
- c. HOSPITAL Policies: [Hospitals should tailor this list to the Hospital's current Policies]
 - 1. Advance Health Care Directives/MOST
 - 2. Patient Rights and Responsibilities
 - 3. Ethics Consultation
 - 4. Withdrawing or Foregoing of Life Sustaining Treatment
 - 5. End-of-Life Care
 - 6. Resuscitation Status (DNR)
 - 7. Pain Management
 - 8. Interpreting and Translation Services
 - 9. Employee Requests to be Excluded from Patient Care
 - 10. Protocols for Self-Administration of Medications

References: CHA included citations for relevant state statutes.

III. DEFINITIONS (for purposes of this policy)

- a. **Adult:** An individual who is eighteen years of age or older.
- b. **Attending Physician:** A physician who has primary responsibility for the care of a terminally ill individual and the treatment of the individual's terminal illness.
- c. **Consulting Physician:** A physician who is qualified by specialty or experience to make a professional diagnosis and prognosis regarding a terminally ill individual's illness.
- d. **Informed Decision:** A decision that is:
 - i. Made by an individual to obtain a prescription for medical aid-in-dying medication that the qualified individual may decide to self-administer to end his or her life in a peaceful manner;
 - ii. Based on an understanding and acknowledgment of the relevant facts; and
 - iii. Made after the attending physician fully informs the individual of:
 - 1. His or her medical diagnosis and prognosis of six months or less;
 - 2. The potential risks associated with taking the medical aid-in dying medication to be prescribed;
 - 3. The probable result of taking the medical aid-in-dying medication to be prescribed
 - 4. The choices available to an individual that demonstrate his or her self-determination and intent to end his or her life in a peaceful manner, including the ability to choose whether to:
 - a. Request medical aid in dying;
 - b. Obtain a prescription for medical aid-in-dying medication to end his or her life;

- c. *Fill the prescription and possess medical aid-in-dying medication to end his or her life; and*
 - d. *Ultimately self-administer the medical aid-in-dying medication to bring about a peaceful death; and*
 - iv. *All feasible alternatives or additional treatment opportunities, including comfort care, palliative care, hospice care, and pain control.*
- e. **Licensed Mental Health Professional:** *A psychiatrist licensed under article 36 of title 12, C.R.S., or a psychologist licensed under part 3 of article 43 of title 12, C.R.S.*
- f. **Medical Aid-in-Dying:** *The medical practice of a physician prescribing medical aid-in-dying medication to a qualified individual that the individual may choose to self-administer to bring about a peaceful death.*
- g. **Medical Aid-in-Dying Medication:** *Medication prescribed by a physician to provide medical aid-in- dying to a qualified individual.*
- h. **Mental Capacity or Mentally Capable:** *In the opinion of an individual's attending physician, consulting physician, psychiatrist or psychologist, the individual has the ability to make and communicate an informed decision to health care providers.*
- i. **Prognosis of Six Months or Less:** *A prognosis resulting from a terminal illness that the illness will, within reasonable medical judgment, result in death within six months and which has been medically confirmed.*
- j. **Qualified Individual:** *A terminally ill adult with a prognosis of six months or less, who has mental capacity, has made an informed decision, is a resident of the state of Colorado, and has satisfied the requirements of the Act in order to obtain a prescription for medical aid-in-dying medication to end his or her life in a peaceful manner.*
- k. **Resident:** *An individual who is able to demonstrate residency in Colorado by providing any of the following documentation to his or her attending physician:*
 - i. *A Colorado driver's license or identification card issued pursuant to Article 2 of Title 42, C.R.S.;*
 - ii. *A Colorado voter registration card or other documentation showing the individual is registered to vote in Colorado;*
 - iii. *Evidence that the individual owns or leases property in Colorado; or*
 - iv. *A Colorado income tax return for the most recent tax year.*
- l. **Terminal Illness:** *An incurable and irreversible disease that has been medically confirmed and will, within reasonable medical judgment, result in death.*
- m. **Self-administer:** *A qualified individual's affirmative, conscious, and physical act of administering the medical aid-in-dying medication to himself or herself to bring about his or her own death.*

Definitions: CHA alphabetized the list and included two new definitions: "Qualified Individual" and "Resident".

IV. POLICY

- a. *The Colorado End-of-Life Options Act (herein after the "Act") allows certain terminally ill adult patients with a prognosis of six months or less, who have mental capacity, have made*

- an informed decision, are Colorado residents and have satisfied other requirements (the “qualified individuals”) to request and obtain a prescription for medical aid-in-dying medication from an attending physician to end the patient’s life in a peaceful manner.*
- b. Patients requesting medical aid-in-dying medication must be “qualified individuals” and satisfy all requirements of the Act in order to obtain the prescription for medical aid-in-dying medication.*
 - c. A request for medical aid-in-dying medication must be initiated by the patient. Medical aid-in-dying medications cannot be requested by the patient’s personal representative (e.g., guardian, proxy decision-maker or the person designated under a medical durable power of attorney).*
 - d. HOSPITAL (“HOSPITAL”) allows its physicians and other health care providers who are permitted under the Act to participate in activities authorized by the Act, if they so choose. HOSPITAL physicians and other health care providers may, as applicable and as defined in the Act and herein:*
 - i. Perform the duties of an attending physician.*
 - ii. Perform the duties of a consulting physician.*
 - iii. Perform the duties of a licensed mental health professional.*
 - iv. For attending physicians, prescribe medical aid-in-dying medications under this Act.*
 - v. For HOSPITAL’S pharmacy and pharmacists, fill a prescription for medical aid-in-dying medication under this Act.*
 - vi. Be present when the qualified patient self-administers the medical aid-in-dying medication [provided that the physician or other health care provide shall not assist the patient in self-administering the aid-in-dying medications].*
 - vii. Participate in patient or provider support related to the Act.*
 - e. The request for medical aid-in-dying medications may not be made to or ordered by a nurse practitioner or physician assistant. Nurse practitioners and physician assistants must notify the patient’s attending physician about any patient request for medical aid-in-dying medication.*
 - f. HOSPITAL neither encourages nor discourages individual health care provider participation in the Act; participation is entirely voluntary. Only those providers who are willing and desire to participate should do so. Those providers who do choose to participate are reminded that the overall goal is to provide patient-centered care and support the patient’s end-of-life wishes, and that participation may not necessarily result in aid-in-dying medications being prescribed if the patient’s needs can be met in other ways (e.g. pain control, comfort, hospice and palliative care).*
 - g. Participation in activities authorized under the Act is completely voluntary. Any physician employed by or under contract with HOSPITAL may choose not to participate in providing medical aid-in-dying medications to a patient. However, if the physician transfers care to a new health care provider, the physician will, upon request, provide a copy of the patient’s relevant medical records to the new health care provider.*
 - h. Under the Act, if the attending or consulting physician believes that a patient may not be mentally capable of making an informed decision, the individual shall be referred to a*

licensed mental health professional for a determination of whether the individual is mentally capable and making an informed decision before a prescription for medical aid-in-dying medication may be written.

- i. While participating in the Act, the HOSPITAL and any individual health care provider at HOSPITAL must ensure the appropriate standard of care is followed.*
- j. HOSPITAL may provide oversight and may review records to the extent necessary to ensure all requirements of the Act have been followed by the attending physician and the correct documentation completed and submitted to the Colorado Department of Public Health and Environment (CDPHE).*
- k. HOSPITAL will notify patients of this Policy in the admission packet and other means intended to provide advance written notification.*

Policy: CHA made a number of wording changes to clarify who is eligible to receive medication, who can prescribe and fill a prescription, as well as a physician's duty to transfer a patient's medical record if the physician chooses not to participate in the Act. Additionally, CHA added two new sections, including clarification that a request for medical aid-in-dying medication cannot be made or ordered by a nurse practitioner or physician assistant (*section e*) and a hospital's requirement to notify patients in writing of the hospital's policy (*section f*).

V. PROCEDURE [Hospital should develop a procedure and a checklist that includes all of the documentation elements under the Act, including forthcoming reporting requirements from CDPHE.]

ADDITIONAL POLICY CONSIDERATIONS

- **Informed Consent and Documentation**

For a health care facility that elects to opt-in under the Act, the policy and/or procedures should address the process for medical aid-in-dying medications, including the pertinent documentation requirements and an informed decision process that carefully tracks the elements of the Act.

- Rules on documentation and rulemaking are forthcoming from CDPHE. As such, these considerations may change in the coming months, and hospitals may wish to locate these requirements in procedures or other documents that can be easily and expeditiously amended.
 - The hospital's procedure should require documentation of each of the elements for the request and verification of an informed decision for medical aid-in-dying medications under the Act (*e.g.*, attending physician documentation of oral requests, written request, diagnosis, prognosis, mental capacity, consulting physician concurrence, licensed mental health professional evaluation, if applicable, and appropriately executed and witnessed written request by the patient).
 - In consideration of the vulnerabilities of particular patient populations, including but not limited to patients who lack social support or patients with disabilities, hospitals should consider whether to require a thorough assessment for consent and capacity determination beyond what is required by the Act.

- Since the documentation of the initial oral requests, diagnosis, prognosis, consulting physician and mental health evaluation may occur outside of the health care facility, the health care facility's procedure could require a copy of the attending physician's documentation and the written request, and have a process to review this documentation.
- The health care facility should verify the patient's advance directives, including a CPR directive or living will. The Act does not change the legal effect of advance directives under Colorado law. *See* C.R.S. § 25-48-123; C.R.S. § 15-18-101, et seq.; C.R.S. § 15-18.6-101, *et seq.*; and C.R.S. § 15-18.7-101, *et seq.*
- To honor the patient's wishes, it would be helpful if the patient who self-administers the medical aid-in-dying medication, regardless of location, has a CPR directive and/or living will under Colorado law. If the patient self-administers the medical aid-in-dying medications within an opt-in health care facility, a CPR directive and living will can guide the health care providers. The hospital should consider requiring the attending physician to write a DNR order as well.
- If the hospital has a Graduate Medical Education program, the hospital can consider whether residents or fellows may serve as the "attending physicians" or "consulting physicians" under the Act.

Informed Consent and Documentation: CHA included the citation for the Colorado Medical Treatment Decision Act (C.R.S. § 15-18-101) as well as an additional policy consideration for hospitals that have a Graduate Education Medical program.

- **Self-Administered Medication Policy**

The health care facility should also review its protocol for self-administered medications to allow for the self-administration of medical aid-in-dying medications on the health care facility premises. For hospitals, relevant standards are under the Medicare Conditions of Participation, 42 CFR § 482.23, and the Colorado General Hospital regulations, 6 CCR 1011-1, Ch. 4, Sec. 13.102. The attending physician's order would be required for the self-administered medications. If the health care facility does not have a protocol for self-administration of medications, it should consider this protocol as a necessary element of implementing the Act.

- Sample Policy Language: *An attending physician may prescribe medical aid-in-dying medication for self-administration on HOSPITAL premises. The medications will be ordered, dispensed and stored in accordance with HOSPITAL's self-administered medication policy.*

- **Personnel Policies**

A health care facility that has elected to opt-in cannot subject any physician, nurse, pharmacist or other person to discipline or other penalties for actions in "good faith reliance" on the Act, or for refusing to act under the Act.

- Sample Policy Language: *If any HOSPITAL-affiliated attending physician or other health care provider participates in the Act with a patient of this HOSPITAL, that provider must immediately notify [HOSPITAL ADMINISTRATION POSITION]. It is the attending physician's responsibility to ensure the correct procedures are followed and the correct documentation is completed in accordance with the Act and HOSPITAL policy and procedure. The steps included in the attached checklist should be followed*

carefully and documented appropriately. [Hospital should develop a checklist based on the Act and forthcoming CDPHE language.]

All providers at HOSPITAL are expected to respond to any patient's query about medical aid-in-dying medication with openness and compassion. HOSPITAL believes our providers have an obligation to openly discuss the patient's concerns, unmet needs, feelings, and desires about the dying process. Providers should seek to learn the meaning behind the patient's questions and help the patient understand the range of available options, including but not limited to comfort care, hospice care, and pain control. Ultimately, HOSPITAL's goal is to help patients make informed decisions about end-of-life care.

The Act requires the involvement of two physicians; an attending physician and a consulting physician as defined in the Act. HOSPITAL requires that at least one of these physicians be privileged pursuant to criteria set forth by the HOSPITAL Medical Staff for participation.

HOSPITAL employees who experience moral or spiritual distress related to patient request to access the Act may utilize supportive services such as_____.

Notwithstanding any limitations or rules pertaining to physicians employed or contractors of HOSPITAL, nothing in this policy prohibits a physician who is employed by or who is a contractor of HOSPITAL from participating under the Act when not functioning within the scope of his or her capacity as an employee or independent contractor of HOSPITAL.

- **Patient Services**

A health care facility may wish to address any assistance provided to patients, either within the facility or through community partners.

- Sample Policy Language: *When a patient makes an inquiry about or requests access to activities under the Act, the patient will initially be referred to patient's attending physician and HOSPITAL [Social Services Department or Patient Navigator Program]. [Social Workers or Patient Navigators], who are well versed in the requirements of the Act and will assist patient understanding of the Act, inform them about the process and provide educational material related to the patient's end-of-life options. This activity will augment, but not substitute for, the obligations of the attending and consulting physicians' roles described herein. If the patient's attending physician chooses not to participate in the Act, which is his or her right under the Act, a social worker will assist in the identification of a HOSPITAL physician who will participate, if available.*

Patient Services: After further legal analysis, CHA removed the sample policy language stating a hospital would not accept a new patient solely for the purposes of accessing the Act.

APPENDIX C: OPT-OUT MODEL POLICY (Version 2.0)

CHA developed an opt-in and opt-out model policy, both of which are provided in this guide. Hospitals should select a policy and modify as appropriate for their facilities, review this policy in the context of other policies specific to the facility, and develop procedures to address how the policy will be operationalized. Ensure your hospital's procedures conform to the requirements of the Act as described below in sections I – III. Also included below are additional policy considerations that facilities may choose to address in their policy and procedures. Although these are optional, a thorough review of these considerations is recommended. A health care facility that elects to opt-out under the Act should consult with legal counsel regarding some of the ambiguities under the Act for opting-out. The governing body should, at a minimum, adopt a policy that expressly reflects this decision.

Please note that although the guide refers to a hospital choosing to not participate under the Act as “opting-out,” it is not intended to imply that the hospital can opt-out of *all* activities under the Act. A hospital choosing not to participate can prohibit a range of activities under the Act, from a minimal prohibition of on-site self-administration to a much broader scope encompassing staff activities contemplated in the Act.

In light of the ambiguities under the Act, hospitals choosing to opt-out should consult with their legal counsel. For further legal analysis on what a hospital choosing to opt-out can prohibit under the Act, see the Memorandum on “Non-Participating Hospitals” developed by the Association's legal counsel, available online at <http://www.cha.com/prop106>.

NOTE: The opt-out policy below has been modified.

- Underlined text indicates updated language.

- Green boxes briefly explain Version 2.0 key modifications.

MODEL POLICY

Policy Title: *The Colorado End-of-Life Options Act (Patient's Request for Medical Aid in Dying)*

Adoption Date:

Approved Date: **Date Revised:**

Last Date Reviewed:

Office of Origin: _____

I. PURPOSE

- The Colorado End-of-Life Options Act (C.R.S § 25-48-101, et seq.) authorizes medical-aid-in-dying and allows a terminally ill adult with a prognosis of six months or less, who has mental capacity, has made an informed decision, is a resident of Colorado, and has satisfied other requirements, to request and obtain a prescription for medical aid-in-dying medication to end his or her life in a peaceful manner.*
- The purpose of this policy is to describe the position of HOSPITAL regarding the Colorado End-of-Life Options Act, including participation of physicians employed or under contract and to provide guidelines for responding to patient requests for information about medical*

aid-in-dying medications in accordance with federal and state laws and regulations and The Joint Commission accreditation standards.

II. DEFINITIONS (for purposes of this policy)

- a. **Adult:** *An individual who is eighteen years of age or older.*
- b. **Medical Aid-in-Dying:** *The medical practice of a physician prescribing medical aid-in-dying medication to a qualified individual that the individual may choose to self-administer to bring about a peaceful death.*
- c. **Medical Aid-in-Dying Medication:** *Medication prescribed by a physician to provide medical aid-in-dying to a qualified individual.*
- d. **Prognosis of Six Months or Less:** *A prognosis resulting from a terminal illness that the illness will, within reasonable medical judgment, result in death within six months and which has been medically confirmed.*
- e. **Qualified Individual:** *A terminally ill adult with a prognosis of six months or less, who has mental capacity, has made an informed decision, is a resident of the state of Colorado, and has satisfied the requirements of the Act in order to obtain a prescription for medical aid-in-dying medication to end his or her life in a peaceful manner.*
- f. **Terminal Illness:** *An incurable and irreversible disease that has been medically confirmed and will, within reasonable medical judgment, result in death.*
- g. **Self-administer:** *A qualified individual's affirmative, conscious, and physical act of administering the medical aid-in-dying medication to himself or herself to bring about his or her own death.*

Definitions: CHA alphabetized the list, included the definition of "Qualified Individual", and removed unnecessary definitions. The full scope of definitions is not required for an opt-out facility, because the facility will not be overseeing informed consent, the consulting physician role, mental capacity determination, etc.

III. POLICY

- a. *Colorado law recognizes certain rights and responsibilities of qualified individuals and health care providers under the Colorado End-of-Life Options Act (herein after the "Act"). Under the Act, a health care provider, including HOSPITAL is not required to participate in providing medical aid-in-dying medication to any patient under the Act.*
- b. *HOSPITAL has chosen to not participate under the Act.*
- c. *Physicians employed by or under contract with the HOSPITAL may not write a prescription for medical aid-in-dying medication for a patient who intends to self-administer the medication on the HOSPITAL premises.*
- d. *When a patient expresses intent to request medical aid-in-dying medication, the patient will be informed that HOSPITAL and its physicians employed or under contract will not participate in providing medical aid-in-dying medication for self-administration on HOSPITAL premises.*

- e. *HOSPITAL caregivers will still provide all other requested end-of-life and palliative care and other services to patients and families.*
- f. *Consistent with this policy, HOSPITAL will continue to provide care to patients who qualify for and request services, regardless of their stated interest in seeking medical aid-in-dying medication.*
- g. *Upon request, HOSPITAL will transfer a copy of the patient's medical record to the new health care provider/facility.*
- h. *HOSPITAL will notify patients in writing of this policy in the admission packet and other means intended to provide advance written notification.*
- i. *HOSPITAL will notify employed and contracted physicians in writing of this policy by [mail, email, through meetings and postings].*

Policy: CHA simplified the language to clarify what a opt-out hospital can prohibit under the Act, including what elements of the Act a hospital opting-out can prohibit employed and contracted physicians, and other staff (employed and contracted) from performing. A hospital choosing not to participate can prohibit a range of activities under the Act, from a minimal prohibition of on-site self-administration to a much broader scope encompassing staff activities contemplated in the Act.

In light of the ambiguities under the Act, hospitals choosing to opt-out should consult with their legal counsel. For further legal analysis on what a hospital choosing to opt-out can prohibit under the Act, see the Memorandum on "Non-Participating Hospitals" developed by the Association's legal counsel, available online at <http://www.cha.com/prop106>.

Additionally, CHA added three new sections, including the appropriate transfer of a copy of a patient's medical record (*section g*), notifying patients in writing of the hospital's policy (*section h*) and notifying employed and contracted physicians in writing of the hospital's policy (*section i*).

ADDITIONAL POLICY CONSIDERATIONS

○ Patient Requests

Even if a health care facility elects to opt-out of activities under the Act, the facility should nonetheless consider how to address a patient who is an inpatient or resident and desires to request and obtain medical aid-in-dying medications. If the patient requests transfer to another health care provider, the health care facility must coordinate transfer of the patient's medical records to the new health care provider. The health care facility is not expressly required to arrange for the patient's physical transportation to another location, but this may become a likely outcome.

- *Sample Policy Language: If a HOSPITAL patient wishes to request medical aid-in-dying-medication, HOSPITAL may assist the patient in transfer to another facility of the patient's choice. The transfer will promote continuity of care.*

○ Emergency & Non-Compliant Situations

A health care facility that elects to opt-out of activities under the Act should also be aware of the possibility that a patient might self-administer aid-in-dying medications on its premises in violation of its policy. There could be a time gap of weeks or months between the time an attending physician prescribes the medical aid-in-dying medications and the time the patient presents to and is admitted to the health care facility. The health care facility should

develop a protocol to address the possibility of self-administered medical aid-in-dying medications on its premises, consistent with health care facility's policies and the patient's advance directives.

- **Personnel Policies**

A health care facility that opts-out of activities under the Act may restrict some, but likely not all, involvement of employed and contracted personnel.

- A facility that opts out “may prohibit a physician employed or under contract” from writing a prescription for medical aid-in-dying medications for use on the health care facility's premises. The health care facility must notify the physicians “in writing” of its policy to opt-out of activities under the Act. The Act doesn't address the timing or content of the written notice. For health care facilities that opt-out of activities under the Act, this notification could be in the form of the policy that is mailed or emailed to employed and contracted physicians (ideally with mandatory response or confirmation), distributed at meetings (with a sign-in sheet), included in credentialing and re-credentialing packets (for facilities that credential physicians), and posted in locations frequently used by physicians (*e.g.*, physician's lounge).
- The Act does not address a health care facility employer's ability to restrict employed physician's participation in medical aid-in-dying in the course and scope of employment, for example, prescribing medical aid-in-dying medications for self-administration in the patient's home or other location. A health care facility that employs physicians may consider adopting policies that impose such restrictions on the course and scope of a physician's employment (at any location), subject to advice of legal counsel.
- The Act also does not expressly address the ability of an employer that is not a health care facility (such as a hospital subsidiary or affiliated corporate entity) to restrict employed physician's participation in medical aid-in-dying in the course and scope of employment. A health care facility that employs physicians and a health care facility that owns or controls a subsidiary or affiliate that employs physicians may consider adopting policies that impose such restrictions on the course and scope of a physician's employment (at any location), subject to advice of legal counsel.
- Nothing in the Act specifically addresses the ability of health care facilities that opts-out of activities under the Act to prohibit members of the health care facility's medical staff (who are not otherwise employed by or contracted with the health care facility) from prescribing aid-in-dying medications for self-administration on the health care facility's premises. While Colorado law is not entirely settled on this point, some hospitals' Medical Staff Bylaws provide that the Medical Staff Bylaws themselves constitute a contract between the hospital and the medical staff members. A health care facility that elects to opt-out of activities under the Act could consider adopting a policy that prevents medical staff members and other staff from prescribing, dispensing or writing orders for self-administration of medical aid-in-dying medications for use on the health care facility premises, subject to advice of legal counsel. The medical staff members would likely be obligated to comply with the health care facility's policy in their capacity as medical staff members.

- A health care facility cannot restrict its employed or contracted physicians from participating under the Act outside the scope of employment or when the physician is not performing services for the hospital.
 - Sample Policy Language: Notwithstanding any limitations or rules pertaining to physicians employed or contractors of HOSPITAL, nothing in this policy prohibits a physician who is employed by or who is a contractor of HOSPITAL from participating under the Act when not functioning within the scope of his or her capacity as an employee or independent contractor of HOSPITAL.

APPENDIX D: STATUTORY FORM – REQUEST FOR AID IN DYING

REQUEST FOR MEDICATION TO END MY LIFE IN A PEACEFUL MANNER

I, _____ AM AN ADULT OF SOUND MIND. I AM SUFFERING FROM _____, WHICH MY ATTENDING PHYSICIAN HAS DETERMINED IS A TERMINAL ILLNESS AND WHICH HAS BEEN MEDICALLY CONFIRMED. I HAVE BEEN FULLY INFORMED OF MY DIAGNOSIS AND PROGNOSIS OF SIX MONTHS OR LESS, THE NATURE OF THE MEDICAL AID-IN-DYING MEDICATION TO BE PRESCRIBED AND POTENTIAL ASSOCIATED RISKS, THE EXPECTED RESULT, AND THE FEASIBLE ALTERNATIVES OR ADDITIONAL TREATMENT OPPORTUNITIES, INCLUDING COMFORT CARE, PALLIATIVE CARE, HOSPICE CARE, AND PAIN CONTROL.

I REQUEST THAT MY ATTENDING PHYSICIAN PRESCRIBE MEDICAL AID-IN-DYING MEDICATION THAT WILL END MY LIFE IN A PEACEFUL MANNER IF I CHOOSE TO TAKE IT, AND I AUTHORIZE MY ATTENDING PHYSICIAN TO CONTACT ANY PHARMACIST ABOUT MY REQUEST.

I UNDERSTAND THAT I HAVE THE RIGHT TO RESCIND THIS REQUEST AT ANY TIME.

I UNDERSTAND THE SERIOUSNESS OF THIS REQUEST, AND I EXPECT TO DIE IF I TAKE THE AID-IN-DYING MEDICATION PRESCRIBED.

I FURTHER UNDERSTAND THAT ALTHOUGH MOST DEATHS OCCUR WITHIN THREE HOURS, MY DEATH MAY TAKE LONGER, AND MY ATTENDING PHYSICIAN HAS COUNSELED ME ABOUT THIS POSSIBILITY. I MAKE THIS REQUEST VOLUNTARILY, WITHOUT RESERVATION, AND WITHOUT BEING COERCED, AND I ACCEPT FULL RESPONSIBILITY FOR MY ACTIONS.

SIGNED: _____

DATED: _____

DECLARATION OF WITNESSES

WE DECLARE THAT THE INDIVIDUAL SIGNING THIS REQUEST:

IS PERSONALLY KNOWN TO US OR HAS PROVIDED PROOF OF IDENTITY;
SIGNED THIS REQUEST IN OUR PRESENCE;

APPEARS TO BE OF SOUND MIND AND NOT UNDER DURESS, COERCION, OR UNDUE INFLUENCE; AND

I AM NOT THE ATTENDING PHYSICIAN FOR THE INDIVIDUAL.

_____ WITNESS 1/DATE

_____ WITNESS 2/DATE

NOTE: OF THE TWO WITNESSES TO THE WRITTEN REQUEST, AT LEAST ONE MUST NOT:
BE A RELATIVE (BY BLOOD, MARRIAGE, CIVIL UNION, OR ADOPTION) OF THE INDIVIDUAL SIGNING THIS REQUEST; BE ENTITLED TO ANY PORTION OF THE INDIVIDUAL'S ESTATE UPON DEATH; OR OWN, OPERATE, OR BE EMPLOYED AT A HEALTH CARE FACILITY WHERE THE INDIVIDUAL IS A PATIENT OR RESIDENT.

AND NEITHER THE INDIVIDUAL'S ATTENDING PHYSICIAN NOR A PERSON AUTHORIZED AS THE INDIVIDUAL'S QUALIFIED POWER OF ATTORNEY OR DURABLE MEDICAL POWER OF ATTORNEY SHALL SERVE AS A WITNESS TO THE WRITTEN REQUEST.