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Roadmap to Reduce Barriers to Medical Aid in Dying for Rural Coloradans: A Health Policy Analysis and Advocacy Campaign

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Table of Contents

Abstract

Background: Medical aid in dying (MAID) is a process by which a terminally ill adult with a prognosis of six months or less can request prescription medications to end their life. Colorado's End-of-Life Options Act requires that two physicians participate in the process to certify terminal illness and prescribe medications. Nearly all rural and frontier counties face shortages of medical professionals. These conditions challenge rural residents who want to access MAID. Advanced practice registered nurses and physician assistants can address gaps in rural and frontier counties; on average, they outnumber physicians in these communities.

Aims: The aims of this health policy project were to increase awareness among state legislators of challenges rural Coloradans encounter when accessing MAID, educate legislators on useful measures for reducing barriers to access, and provide suitable language for amending Colorado's End-of-Life Option Act.

Methods: The design of this project was a governmental policy analysis and a campaign to build legislative awareness. The project employed interactions with stakeholders through in-person and virtual meetings, email, and phone calls.

Results: A total of 50 legislators from both major political parties were provided information on the barriers to patient access. They included rural and frontier legislators, members of the House Health & Insurance Committee, the Senate Health & Insurance Committee, among others. A total of 83 contacts with these legislators occurred over four months, escalating once the legislature was in session. Several legislators volunteered to support the bill if prime sponsorship could be obtained. Two legislators expressed interest in potentially serving as prime sponsors.

Conclusions: Numerous legislators were not familiar with the details of Colorado's End-of-Life Options Act, nor were they aware of access challenges. These legislators shared an appreciation

for constituents' feedback and engagement. Building a statewide coalition will drive ongoing efforts to amend the Colorado End-of-Life Options Act.

Introduction

Medical aid in dying (MAID) has a long and fascinating history in the United States. Over the years it has been called “physician assisted death”, “physician assisted suicide”, “assisted suicide”, and “death with dignity”, but its preferred terminology has evolved to MAID. When one thinks of MAID, they might naturally think of Oregon, which was the first state where MAID became legally accessible in 1997. However, right-to-die legislation was introduced in Florida back in 1967, which ultimately failed, but it was a notable event that started intense debate about rights at end of life in the United States (Compassion & Choices, 2022a). This debate continues to this day as we continue to evaluate MAID laws in relation to health care autonomy, relieving emotional and physical suffering at end-of-life, morality, and religious beliefs.

Although it took nearly three decades for a MAID law to be enacted in the United States after the initial Florida legislation, there has been steady advancement despite passionate debate in protest of such laws. After Oregon voters approved their Death with Dignity via ballot measure in 1994, Washington state became the next state to enact MAID laws via ballot measure in 2008. Montana’s authorized MAID in 2009 after their Supreme Court ruled that physicians could provide MAID to terminally ill individuals. In 2013, Vermont passed legislation to legalize MAID (Compassion and Choices, 2022a).

As of 2014, a number of states enacted MAID laws. This sudden increase in the number of laws being passed is thought to be, in large part, due to the nationwide coverage and subsequent debate in 2014 surrounding the life and death of Brittany Maynard. She was a terminally-ill 29-year-old who shared her story about her desire to utilize MAID and advocated for other terminally ill patient’s rights at end-of-life. After decades of slow progress in enacting

MAID laws, in 2015 there were 25 states that introduced MAID legislation. Over the next 7 years, laws were passed in California, Colorado, Washington, D.C., Hawaii, New Jersey, Maine, and New Mexico that allow terminally-ill individuals to access MAID. The focus of this DNP project is Colorado's End-of-Life Options Act, which passed via ballot measure in 2016 (Compassion & Choices, 2022a).

Background & Significance

MAID is a process by which a terminally ill adult with a prognosis of six months or less can request prescription medications to end their life in a peaceful manner. The individual must be mentally capable of making the decision to participate. Although MAID is legal in Colorado, that does not mean that MAID medications are easily acquired. Obtaining MAID medications in Colorado as outlined by the End-of-Life Options Act (EoLOA) is a multistep process which includes: 1) two verbal requests made to the attending physician; 2) a minimum of 15 days is required between verbal requests; 3) a written request must also be made to the attending physician, witnessed by two qualifying individuals; 4) two separate physicians are required to certify terminal illness and determine medical decision-making capacity; and 5) if there is a question of capacity, then the patient must be referred to a psychiatrist or psychologist for evaluation. All of this, plus additional counseling, must occur prior to a prescription being provided. Health care professionals, pharmacies, and healthcare systems are not required to participate in the EoLOA, either for personal or religious reasons, which reduces the pool of participating resources (State of Colorado, 2016). These conditions can be challenging for those who are debilitated by terminal illness, and even more so to rural residents with limited availability to the resources that are more readily obtainable in urban settings.

For perspective, 77% of Colorado's landmass is considered rural. The rural population has been declining over the past several years, but 12% of Colorado's population resides in rural and frontier counties. Out of a total of 64 counties, 47 are rural or frontier (Colorado Rural Health Center, 2022). Rural counties have no cities with over 50,000 residents. Frontier counties have a population density of "6 or fewer residents per square mile" (Colorado Rural Health Center, 2022). Vital statistics released for 2021 confirmed reduced prescription rates in rural and frontier counties in 2021: approximately 12% of total MAID prescriptions were to residents of these counties, compared to approximately 88% in urban counties. This was a drop of 6% from the previous year, without an identifiable reason, although this was during the Covid-19 pandemic which may have contributed (Colorado Department of Public Health and Environment, 2022). Although the percentage of prescriptions made to rural and frontier residents may appear adequate compared to the total population, we do not know which rural and frontier counties the patients who were prescribed MAID resided in; for example, one could theorize that rural patients to the east of the mountain front range have easier access to the metro Denver area and resources in urban settings than those who must traverse the Rocky Mountains. Moreover, this does not negate concerns regarding access to medical resources for those in rural counties, which is concerning for an unfair burden placed on terminally ill rural residents when trying to access resources to meet the requirements of the law.

Nearly all rural and frontier counties are facing shortages of medical professionals. It is a challenge to recruit and retain physicians, compounded by the ongoing mass retirement of medical professionals. Advanced practice providers (APPs) help bridge the gap. APPs include Advanced Practice Registered Nurses (APRNs), which include Nurse Practitioners (NPs) and Clinical Nurse Specialists (CNSs), and Physician Assistants (PAs). There is an average of 2.65

physicians reportedly servicing each rural health clinic, compared to a total average of 3.09 APPs at these locations (1.74 NPs and 1.35 PAs). An analysis was performed of the number of providers in each county (see Appendix A). When comparing the number of all active physicians (including subspecialities) to APPs, on average, there are more active physicians than APPs serving rural and frontier counties; however, this is not the case for all rural counties as there are two counties without an active full-time physician and 24 counties where APPs outnumber physicians (Health Resources & Services Administration, 2021). Furthermore, a map of Colorado was used to plot rural and frontier counties where the number of APPs is equal to or greater than the number of physicians (See Appendix B). The rural and frontier counties on the eastern half of the state tend to have a higher number of APPs serving those counties than physicians (HRSA, 2021). 36% of rural and frontier counties do not have a psychologist or licensed clinical social worker, which creates a challenge for those patients who may require a referral to a mental health professional. Pharmacy access is also limited in rural counties: nearly 20% of rural counties do not have a pharmacy, while nearly a quarter only have one pharmacy (Colorado Rural Health Center, 2022). Again, it is important to note that under the law, just because a physician, pharmacist, or mental health professional is present within the county does not mean that they can or will participate. With limited physical resources, rural patients are at a disadvantage when it comes to meeting the current requirements mandated to access MAID (State of Colorado, 2016).

Although telehealth is now an expanded option in Colorado that can help address some of the problems associated with medical professional shortages, this does not guarantee access. Frontier counties have the worst broadband coverage in the state, with 25% of frontier counties

having less than 55% broadband coverage. Ouray County only has 38% broadband coverage (Colorado Rural Health Center, 2022).

As we look to solutions to increase accessibility, New Mexico's progressive 2021 EoLOA gives guidance to tailor to the unique needs of a state with a large rural landmass: it allows NPs and PAs to be one of the certifiers of terminal illness in collaboration with a physician, it allows these clinicians to prescribe MAID medications, decreases the wait time between verbal requests down to 48 hours, and has expanded the types of mental health professionals that can perform mental capacity assessments (End of Life Options New Mexico, n.d.).

Needs Assessment

A needs assessment was performed and a SWOT analysis was completed (see Appendix C). The needs assessment revealed that Colorado's current EoLOA has requirements to enact MAID which are easier for urban residents to obtain than rural or frontier county residents. The requirements to participate are intended to protect patients and health care professionals; however, these requirements can also obstruct access to MAID. The law requires that two physicians must participate: however, there are fewer providers servicing a greater number of patients in rural areas, and APPs are more heavily utilized as primary care providers in the rural setting than physicians (State of Colorado, 2016; Colorado Rural Health Center, 2022). This means that patients may have to travel to another county to establish care with a new primary attending physician in order to gain access to MAID. Moreover, individual physicians do not have to participate based on their own convictions or they may be forbidden from participating by their employer, which further limits the pool of physicians in rural counties who may participate (State of Colorado, 2016).

For terminally ill patients who have to travel a great distance to meet the requirements, separating verbal requests by 15 days means that they may have to make 2 separate trips to see their physician, unless telemedicine can be utilized. New Mexico's MAID law offers options for reforming the End-of-Life Options Act to ease access for terminally ill, rural patients in Colorado: allowing advanced practice providers to be one of the certifiers of terminal illness and decreasing the wait times between verbal requests down to 48 hours are two initiatives which could increase accessibility (End of Life Options New Mexico, n.d.).

In discussing the concern for rural residents and the potential for health policy reform in Colorado with leaders from national and local nonprofit advocacy & educational MAID organizations, there is support for this health policy analysis and official recommendations with the intent of increasing access for this population. There is a strong network of health care professionals across a range of specialties, as well as a volunteer network who are currently educating other health care professionals and Colorado residents about the law and access to MAID. Furthermore, three states currently have legislation pending to amend their MAID laws to allow APRNs to participate (Death with Dignity, 2023). However, there will be challenges to expanding access – we should expect repeat opposition from powerful opposers on the 2016 law.

Problem statement

Colorado enacted the EoLOA in 2016, which allows terminally ill Coloradans to seek MAID medications; however, the requirements to seek MAID creates specific challenges to Coloradans residing in rural and frontier counties.

Aim

The aim of this health policy analysis is to provide specific language for a proposed amendment to Colorado's EoLOA in order to increase accessibility to medical aid in dying for rural patients for the 2023 legislative session.

Objectives

- Increase awareness of state legislators on challenges to rural and frontier county Coloradans in accessing MAID
- Identify process variations and measures that could increase accessibility to rural Coloradans
- Provide language to amend Colorado's End-of-Life Option Act

Review of Literature

Research Question

The aim of this literature analysis is to examine the following question: For terminally ill patients residing in rural Colorado counties who wish to participate in medical aid in dying, could an amendment to the Colorado EoLOA which would include modified facilitators to the current law increase access to medical aid in dying?

Search Strategy

A literature review was performed utilizing PubMed, CINAHL, and Cochrane Library (See Appendix D). Search dates included literature published between the years 2012 through 2022. Consultation was sought from a research librarian for assistance with identifying search terms. Research studies surrounding medical aid in dying are extremely limited, especially quantitative studies. Therefore, the search was broadened to focus on the value impacts of nursing in rural locations and palliative medicine in rural locations. The terms used for this

search include: medical aid in dying, aid in dying, voluntary euthanasia, active euthanasia, assisted suicide, nurse practitioners, nursing ethics, nursing, hospice, end-of-life and rural health.

Quantitative studies surrounding medical aid in dying are extremely limited, which could be attributed to the sensitive nature of physician assisted death, practicality of such studies, and concern for both patient and physician privacy. The majority of literature that is available and reviewed that is specifically related to medical aid in dying is non-experimental in nature. Research from the United States is less common than research from Canada and Europe; however, due to the potential for cultural differences and different health care system landscapes, the focus was narrowed to studies performed in the United States. There are also a number of modified facilitators that could be considered in a proposed amendment to Colorado's End-of-Life Options Act, and these modifiers have similar research search limitations (although there is proposed and current legislation that helps guide consideration of realistic proposal options). For this literature review, a primary focus on the potential impact of nursing on medical aid in dying was evaluated, though additional modifiers are being identified through the policy evaluation process and could be explored.

Results

A total of 11 studies were included in this literature review, including one systematic review, four non-experimental studies, one observational study, one qualitative study, one quasi-experimental study, two position statements, and one expert opinion. Each article was evaluated using the evidence of appraisal tools in Dang et al.'s (2021) Johns Hopkins Nursing Evidence-Based Practice for Nurses and Health Care Professionals. All supporting literature was found to be of good or high quality. Seven out of the eight research articles included were Level III research evidence, and the majority were non-experimental studies. There was one quasi-

experimental study included. Two position statements were included as non-research evidence, in addition to an expert opinion piece by Thaddeus Pope, JD.

Discussion

Although MAID is legal in Colorado, that does not mean that there is equitable access to resources to meet the requirements for participation across all demographics. This brings to light the ethical principal of justice: that those with greater means and access to resources have an unfair advantage to meeting the requirements to obtain MAID (Buchbinder, 2018). Buchbinder (2018) interviewed a variety of people which included medical professionals, patients, and stakeholders in Vermont who have had an interest in MAID or who have had experience with Vermont's MAID process. The study revealed that individuals who had a well-developed social network were able to find physicians who were willing to participate more easily, and that those who lived in urban areas near the university health system had less difficulty finding participating physicians. Those who lived in rural areas encountered more challenges with accessing the resources to fulfil MAID requirements (Buchbinder, 2018).

Rural patients have unique health care needs and their own distinct culture. Nurses play an important role in meeting the needs of this population. Nurses who work with rural populations tend to build personal, trusting relationships with their patients. These relationships lend well to delicate conversations about end-of-life topics including advance care planning, and nurses feel confident in leading these discussions to patients living in rural settings (Christensen et al., 2019). Research performed by Holland et al., (2017) in which nurses led an initiative on educating and assisting with advanced directives found that nurses can hold a vital role in successfully assisting patients with completing advanced directives to declare their end-of-life wishes. Specifically in rural settings, nurses are important in providing education on disease

processes, offering psychosocial support, linking patients with resources for end-of-life care, assisting with advance care planning, and they act as a resource for palliative medicine (Pesut et al., 2017).

APRNs are an important part of this equation; they have earned graduate degrees and carry their nursing skills into a different role as providers. There are different types of APRNs with differing specializations, and they include Nurse Practitioners and Clinical Nurse Specialists. Colorado is an independent practice state for APRNs and they fill a considerable need for health care providers working across rural counties (Colorado Rural Health Center, 2022). APRNs cannot participate in MAID in Colorado despite independent practice authority and prescriptive authority (State of Colorado, 2016). Xue et al. (2015) performed a systematic review of quantitative studies and found that allowing NPs to practice to their full scope of practice increases health care utilization and access to primary care services. NPs practicing in rural settings are more likely to practice autonomously. They also are more likely to carry their own patients load, practice independently from physicians, and independently prescribe controlled substances (Neprash, 2021). Primary care NPs are more likely to serve rural communities than primary care physicians. They also spend more time providing education to patients and families (Buerhaus, 2014).

In reviewing position statements from professional nursing organizations, there is a notable shift in acceptance over the past decade related to nurses and MAID. The American Nurses Association's (2019) revised position statement on MAID urges nurses to educate themselves on the facts about the process, to assess how they feel about MAID, and to recognize that it is a terminally ill individual's choice if they wish to seek that option. Nurses are advised to be able to objectively answer questions surrounding the law. Although nurses cannot administer

MAID medications, the statement does not use language to exclude APRNs from prescribing MAID medications. The International Council of Nurses' (2012) position statement goes a step further to empower nurse involvement in legislative and policy issues surrounding death and supports the promotion of nurse participation in a variety of end-of-life issues. Although this position statement does not explicitly name MAID, aid-in-dying is an end-of-life issue that certainly has a place for promotion and amendment of legislation and policy and would benefit from increased nursing involvement.

There is concern that there are not enough participating physicians in rural Colorado to fulfill the requirements of participation for terminally ill patients who want to participate in MAID. Campbell et al. (2021) published a non-experimental study which aimed to evaluate the physician participation in Colorado MAID. An anonymous survey was sent to physicians who would likely have the opportunity to participate in MAID based on their baseline patient population. Out of 300 physician responses, 28% stated that they would be willing to act as the attending physician for MAID. Less than half said that they would be willing to act as a consulting physician. Several barriers were identified to participation including a knowledge deficiency on the subject, ethical concerns, time commitments, and emotional undertaking (Campbell et al., 2021). While some of these barriers could be addressed with further education and support on the subject, additional instruction may not be beneficial for those who report a concern with ethics or the emotional toll associated with participation. Moreover, due to the nature of the study, it cannot be determined where the responses came from and therefore, cannot be discerned how physicians who serve rural communities responded to this survey compared to those who serve urban communities (Campbell et al., 2021). These results do not produce confidence that Colorado physicians alone are able to meet the needs of terminally ill patients

seeking MAID as the law currently stands – especially with consideration of the unique health care landscape for rural Coloradans, where advance practice providers are heavily utilized (Colorado Rural Health Center, 2022).

Although each state determines their own MAID laws and there is variation in the requirements to obtain MAID from state-to-state, in the future one can expect that laws will continue to expand to additional states and that variations will be proposed to both new and current legislation that removes burdensome barriers and increases accessibility. It is likely that APRNs will be allowed to participate in the process by being permitted to serve as the attending or consulting provider and/or being granted prescriptive authority under the law to prescribe MAID medications (Pope, 2020). New Mexico has already adopted such measures into their current End-of-Life Options Act, and we should expect that stakeholders will take notice and similar laws will be adopted in other states (End of Life Options New Mexico, n.d.).

Review of Literature Conclusion

Evidence is found through a variety of qualitative studies and non-experimental studies, position statements for nursing organizations, and expert opinion that collectively create a compelling argument for increased nursing participation in MAID. In particular, APRNs have the skillset to participate in the process. They have established relationships with their own patients, know their patients' health history, and should ultimately be allowed to act as the attending provider to their patients who are seeking MAID. APRNs are capable of identifying terminal illness and providing a prognosis, can educate patients (as required by law) on the MAID process, and can prescribe controlled substances. These skills lend support to allowing APRNs to participate in the process. This literature review displays evidence that the allowance of APRNs could be considered as a facilitator in a proposed amendment to Colorado's End-of-Life Options Act to

increase equitable access for terminally ill rural Coloradans who wish to fulfill requirements to acquire MAID.

Policy Analysis Model

The policy analysis model that was utilized for the project was Bardach's eightfold path. This framework provides the structure that was needed to provide structure for a policy proposal project. The eight steps are (Bardach & Patashnik, 2020):

1) define the problem;

2) assemble evidence;

3) construct alternatives;

4) select the criteria;

5) project the outcomes;

6) confront the trade-offs;

7) decide; and

8) tell your story

Define the problem

Colorado's End-of-Life Options Act has rigid requirements to enact participation in MAID, but these requirements can present unique challenges for terminally ill patients in rural Colorado counties who are interested in participating in the process to obtain MAID.

Assemble evidence

The process for obtaining MAID in Colorado was reviewed extensively in the section, "Background and Significance". As previously noted, the process of obtaining MAID can be particularly challenging for those who are debilitated by terminal illness, and even more so to someone with limited availability to the resources that are more readily obtainable in urban

settings. Nearly all rural and frontier counties are facing shortages of medical professionals, including physicians and mental health professionals. There are also a limited number of pharmacies in rural counties (Colorado Rural Health Center, 2022). With limited medical resources, rural patients are faced with additional challenges to accessing MAID when compared to the resources available to urban residents (State of Colorado, 2016).

Construct the alternatives

New Mexico's progressive 2021 EoLOA gave guidance as to how to modify the law to meet the unique needs of a state with a large rural landmass: it allows advanced practice providers to be one of the certifiers of terminal illness and to prescribe MAID medications, and requires only a 48 hour wait period between the request and filling the prescription (End of Life Options New Mexico, n.d.).

Select the criteria

The course of action was determined based on criteria that impacts access to care for rural Coloradans. This included 1) The type of providers available in rural and frontier communities; 2) The current scope of practice and practice authority of providers in rural and frontier communities; 3) If the proposed action would increase the quality of care provided; and 4) If the proposed action would increase the number of resources available in the MAID process for rural Coloradans.

Project the outcomes

We anticipated that the Colorado Medical Society would reject an effort to expand APP involvement, but in particular, PA participation. This is due to the fact that Colorado requires a supervisory agreement for PAs and Physicians. This is different in New Mexico, where PAs have a collaborative agreement (American Academy of Physician Assistant, 2018). Proposed

legislation to change the PA agreement to a collaborative one is pending in the 2023 session (Colorado General Assembly, 2023a). Based on the current climate, it was felt that promoting APRN involvement would be most successful during this session.

Confront the Tradeoffs

APRNs have full practice authority in Colorado, and they can obtain full prescriptive authority to write prescriptions for controlled substances (Colorado Department of Regulatory Agencies, 2015). APRNs are being utilized in rural medicine, particularly in the eastern and southern portions of the state (HRSA, 2021). Allowing patients to continue medical care with their established provider would improve the quality of care within the continuum of care. Reducing the waiting period to obtain prescription MAID medications could also reduce the burden for those who may have to travel far distances to receive care (i.e., potentially complete process in one trip versus making a second trek 15 days later). Finally, including APRNs in the formal MAID process would increase the number of providers who can participate in rural and frontier counties.

Tell your story

Based on the previous steps completed in Bardach's eightfold path, the recommendations for an amendment included allowing APRNs to formally participate in the MAID process and reducing the waiting period down from 15 days. Further review of this stage will occur later in this paper.

Methods

Design

The design of this project was a governmental policy analysis of the Colorado EoLOA with the intent of producing data and language that could be used to support an amendment to

the current law in order to increase accessibility to medical aid in dying for rural patients. There was no specific organization where this project occurred; rather, the project was built around interactions with stakeholders including a variety of health care professionals, national and local advocacy groups and professional organizations, and state policymakers. Specifically, engagement occurred with legislators by the DNP student to encourage sponsoring a bill to amend Colorado's EoLOA and recommended language was provided for an amendment that could be use by legislators during the 2023 legislative session.

The DNP student engaged with legislators from October 2022 through January 2023. A one-page policy brief, infographic, and specific language from New Mexico's EoLOA was provided to legislators. Expertise on the issue was offered to advocacy and interest groups who are involved in promoting a potential amendment by providing monthly updates to select stakeholders.

The Ohio State's Health Policy Final Project Outline (2019) was used as a guide to determine steps for project completion. The following tasks were completed in the final project:

1) Review Colorado's End-of-Life Options Act
    a. History of the law in Colorado
        i. History of the law in the United States
    b. Identify aspects of the law which impact rural Coloradans
    c. Provide a rationale for an amendment to the current law
2) Literature Review
    a. Provide a formal statement of the problem (PICOT)
    b. Summarize evidence gathered from the literature
    c. Appraise the evidence

d. Establish feasibility of policy change and determine who an amendment will benefit

3) Methods
    a. Provide recommendations for initiating and implementation towards policy change
        i. Present policy briefs to legislators
        ii. Provide expertise to advocacy and interest groups
        iii. Prepare written and oral testimony, as required
    b. Identify steps towards implementation during the project
        i. Oregon Health Authority: Policy Change Process Model
    c. Develop a plan for evaluating amended EoLOA outcomes
4) Findings
    a. Discuss results of project implementation
    b. Develop a plan for dissemination of data

Setting

This project is occurring with stakeholders in Colorado. The primary setting for promotion of legislative change occurred with legislators and stakeholders in their offices, whether in-person or via video conferencing through January 2023.

Population of Interest

Terminally ill Coloradans who reside in rural and frontier counties who wish to participate in MAID will be the group who is impacted the most from policy recommendations, although all terminally ill Coloradans would who wish to participate in MAID would likely experience the benefits if the law was amended.

Recommendations for Implementation of Policy Change

Based on the needs assessment and the review of literature, several recommendations could be made for policy change. One appropriate recommendation is to allow APRNs to participate in the MAID process by allowing them to certify terminal illness and prescribe MAID medications to their patients. Another recommendation is to decrease the waiting time between the first and second request, down to 48 hours. Waiving the 15-day waiting period altogether for those who have a prognosis of less than 15 days (allowing the 1st and 2nd request to occur on the same day) would be an alternate option. Although a thoughtful consideration was made to recommend that PAs be allowed to participate in the process, their limited practice authority in Colorado in conjunction with the General Assembly's rejection of a bill to change physician and PA practice agreements in March 2022 could signal a negative reaction if those providers were included in this amendment recommendation (Goodland, 2022). Similar legislation to change PA practice to require collaborative agreements was introduced in 2023 and has passed the Senate, but has not passed the House in crossover yet (Colorado General Assembly, 2023a).

Transition Towards Health Policy Change: Development & Implementation

Although MAID receives bipartisan support from voters, it is generally Democrats who have supported Colorado legislation in the past (Compassion & Choices, n.d.a). In 2016, SB 16-025: End of Life Options for Terminally Ill Individuals, was introduced by three democratic state senators. The bill was assigned to the Senate Committee on State, Veterans, & Military Affairs, but was voted down after testimony in a 3-2 vote, with all Republicans voting against and all Democrats on the committee voting in support (Colorado General Assembly, 2016). That same year, voters decided on the issue themselves when Proposition 106 was added as a ballot

initiative, and passed with 65% of voters approving of adoption of the End-of-Life Options Act (Compassion & Choices, n.d.a).

In terms of recruitment for support, the engagement strategy for this project was focused on building a network of support from health care professionals, national and local advocacy groups and professional organizations, and state legislators with the goal of finding prime sponsors that would support an amendment to the current state law. Relationships were built with a variety of other health care clinicians through monthly meetings with the local branch of a national advocacy group. This group includes a diverse group of clinicians including physicians, licensed clinical social workers, death doulas, university researchers, and volunteers. These advocates meet to discuss issues surrounding the EoLOA and discuss ways to improve access in Colorado on a monthly basis. Education was consistently provided to these stakeholders.

Engagement also occurred with the El Paso County Democrats. This group goes to the State Capitol monthly during the regular legislative session to help citizens engage with their legislators. The CEO of Rose Tree Consulting Group, who organizes the visits to the Capitol, was immensely helpful in presenting strategies for engaging with state legislators.

To direct which legislators are a priority, Colorado's 47 rural and frontier counties were identified. There are three counties which are technically urban, but have a large land mass that is considered rural; these have been added to the list of counties totaling 50 counties that are rural, frontier, or urban with significant rural land masses (Colorado Rural Health Center, 2021). All of the state legislators from the Senate and House of Representatives for these counties have been recognized, along with their party affiliation (see Appendix E).

It is expected that if an amendment is brought forth, it is likely to go to the House Health & Insurance committee or the Senate Health & Human Services committee. Therefore,

individuals on these committees were also identified. Research was also gathered on other legislators who have historically taken an interest in MAID or other laws with an emphasis on health care autonomy.

Since Democrats supported the initial end-of-life options bills, the plan was to reach out to Colorado Democrats first (Colorado General Assembly, 2016). It was determined though that meaningful engagement should occur with all rural legislators, regardless of party affiliation, to advocate for the concerns with health care access in these communities.

There were 66 health-related bills that advanced to the House and Senate Health committees during the 2022 legislative session, and 42 health related bills that have advanced in the 2023 legislative session (Colorado General Assembly, n.d.). In 2022, HB22-1279: Reproductive Health Equity Act specifically received much attention. The bill passed along party lines with a Democratic majority and was signed into law by Governor Jared Polis. It guarantees access to abortion in state law, and it does not give personhood rights to an embryo or fetus Senator Sonya Jaquez Lewis was noted as saying, “"It's really what the majority of Coloradans believe: everyone deserves the freedom to make the medical decisions based on their own circumstances. We must protect that right here” (Cooke, 2022). In 2023, several bills that have passed to committee address further protection in access to reproductive health care (Colorado General Assembly, n.d.). If state legislators are ready to pass legislation that guarantees Coloradans rights to medical decision-making freedom, then it is reasonable to think that they would be willing to deliberate on an amendment that would increase accessibility to MAID.

Risks and Benefits

There are a number of risks that have been identified by opponents of MAID, which we must assume could be brought to attention again if a bill is presented to amend the law that

would increase accessibility. Many of these risks appear to be fearmongering, but nevertheless, should be noted and data collected to address these specific concerns presented by the Patient Rights Council (2015):

- The government and profit-driven insurance agencies will deny life extending treatments and encourage MAID to promote cost savings.
- Prescribing to MAID patients who could potentially live for years (miscalculation of estimated life expectancy).
- Vulnerable populations could be susceptible to persuasion into MAID for financial incentive or to ease burden of caregiving.

No evidence has been found in Colorado that suggests that insurance agencies or the government is encouraging people to utilize MAID for cost savings. In fact, it is illegal to do so (Compassion and Choices, 2022b). Currently, two separate physicians must determine that a patient has a terminal diagnosis with a prognosis of 6 months or less (State of Colorado, 2016). If APRNs were involved in the process, one APRN and one physician would make that determination. APRNs have full practice authority in Colorado and are allowed to work independently in providing patient care which includes evaluation, diagnosis, and managing treatments including prescribing medications (Colorado Department of Regulatory Agencies, 2015). It is with the APRN scope to evaluate for terminal illness and prescribe MAID medications, and with their education, experience, and available tools (Palliative Performance Scale, ECOG performance status, diagnostic values, etc.) they have the ability to determine if an individual has a life expectancy of 6 months or less based on disease trends and anticipated trajectory. Finally, it is mandated that at least one witness is an individual who would not receive financial gain from the death of a terminally ill individual (State of Colorado, 2016). This makes

the process safer in ensuring that an individual is not being coerced to enact MAID for financial gain.

The benefit of MAID reform is that it will make the law more accessible to populations who are at an unfair disadvantage to access due to their physical location and resources available in rural settings. It will be important to highlight that, in general, both Democrats and Republican support MAID legislation. Nearly 80% of residents in the Southwest support the option of MAID (Compassion & Choices, n.d.a). It is crucial to make sure that we enact laws that lead to equitable access for all Coloradans, not just urban Coloradans.

Measurement methods

Successfully identifying recommendations to increase accessibility for rural Coloradans who wish to participate in MAID was continuously measured against MAID legislation in other states, as bills in other states either passed or failed the 2022 and 2023 legislative sessions. Current bills which are being actively monitored that allow for APRNs to participate include legislation in Hawaii, Delaware, and Washington state (Death with Dignity, 2023). The recommendations of this policy proposal are similar to New Mexico's Elizabeth Whitefield EoLOA, which allows APRNs to participate, and requires only a 48-hour waiting period between verbal requests (End of Life Options New Mexico, 2022).

Proposed Budget

Financial support for the DNP project was provided by the student alone and included but is not limited to hours invested in the project, travel expenses, stationary and printing, and additional fees estimated at less than $1000.

The original fiscal impact statement from the EoLOA offers guidance on what the state should expect moving forward in terms of expenditures. Since this is an amendment, and not the

creation of an entire new law, it is not expected that there will be a significant change in revenue, expenditures, or the employment requirement by the state to manage data. State revenue has the potential of seeing an increase annually if there are criminal penalties or reimbursements provided to the state by those who die in public locations. Expenditures are estimated at a minimum of approximately $45,000 per year and include the budget of a 0.5 FTE employee for management of data, communication costs with providers, and other indirect costs (Colorado Legislative Council Staff, 2016).

Ethical Behavior

The Office of Legislative Legal Services' (2021) ethics resource brief was reviewed as to have an understanding of the ethics laws and rules for the Colorado General Assembly. As it relates to the DNP student's interactions with legislators, no legislator or member of their family is allowed to receive a gift or item of value worth more than $65 from any one individual annually, without lawful deliberation, although exceptions can be made. Bribery and solicitation of bribery is forbidden between legislators, and though it is not anticipated that this will be witnessed, it is important to note should a situation arise where this is observed. Similarly, those legislators who may have a private interest in a piece of legislation must reveal that information and cannot vote on the measure. If an ethical breach was witnessed by the student, it would be promptly reported to the President of the Senate in a written statement as well as the student's advisors (Office of Legislative Legal Services, 2021).

Evaluation Plan

A driver diagram was utilized in the evaluation plan. A driver diagram helps to visualize components that will advance change towards the overall aim of the project. Primary drivers are first identified, which are actions that directly impacted our aim. Then, secondary drivers are

identified, which are actions that effected the primary driver. Finally, change ideas were identified, which were used to test the secondary driver (Institute for Healthcare Improvement, 2022). The IHI driver diagram toolkit was referenced in order to develop the diagram for this project (see Appendix F).

The driver diagram identifies the aim, which is to provide specific language for a proposed amendment to Colorado's End-of-Life Option Act in order to increase accessibility to medical aid in dying for rural patients for the 2023 legislative session. Primary drivers include: 1) increase awareness to state legislators of the challenges that rural patients face when attempting to access MAID, and 2) offering language for legislators to use in order to amend the current law. Secondary drivers include that 1) legislators may not be aware of the rural health care landscape, 2) legislators may not be knowledgeable in the process to obtain MAID, and 3) that laws vary from state to state, and that current and proposed laws may be helpful. Change ideas that will be used to eventually test these driver theories include 1) providing education to providers through one-page briefs and personal meetings to share my experience in working with this population, and 2) to highlight to legislators less restrictive measures that have been implemented in other states.

Policy Change Process Model

The Oregon Health Authority's (OHA) Policy Change Process Model was used to keep the plan for policy development and implementation on track. OHA's model consists of nine steps, of which, the first 5 were completed during this project (OHA, 2015):

1) Identifying and framing the problem;

2) engaging community and stakeholders;

3) assess readiness for policy change;

4) public education;

5) decision-maker education;

6) draft policy and plan implementation;

7) adopt policy;

8) implement policy and support compliance; and

9) evaluate impact

Data Collection & Analysis

Data collection was performed by the author of the DNP project (see Table 1; Table 2). A number of sources were used to gather data on current and past legislation, current state legislators, and health care statistics in Colorado. Individual state government sites including the Colorado General Assembly provides current and past information on bills, legislators, and voting records (Colorado General Assembly, 2022a). The Colorado Rural Health Center (2022) provides data on healthcare services throughout the state. The Health Resources and Services Administration (2022) also provides data through the Health Professional Shortage Area tool in identifying the number of providers servicing rural counties and the types of services provided. The Colorado Department of Public Health and Environment (2022) provides an annual statistics report on the EoLOA. This data was compiled and stored in Excel spreadsheets for data tracking and comparison. Stakeholders including national and local professional and advocacy groups, and Colorado policymakers were also identified. These contacts and responses were updated and analyzed monthly to help determine where primary efforts for continued engagement should occur.

The data for this health policy analysis was collected using Excel spreadsheets. Data sheets for interactions with stakeholders was divided into months in order to trend encounters. Each

monthly spreadsheet was further divided into days of the month so that interactions with multiple stakeholders that occurred on the same day could be identified. The Team Leader entered the data into Excel in order to analyze:

1. The stakeholders with whom interactions occurred
    a. Advocacy Groups
    b. Professional Organizations
    c. Legislators
        i. Rural
        ii. Colorado Senate Committee: Health & Human Services
        iii. Colorado House Committee: Health & Insurance
        iv. Other Legislators (i.e., El Paso, Pueblo, Metro Denver)
        v. Miscellaneous (i.e., Governor's Office, leadership in local party offices, other elected officials)
        vi. Political party affiliation (if applicable)
2. The date of the encounter
3. The time of the encounter (if applicable)
4. The number of minutes spent in the encounter (if applicable)
5. The type of encounter (in-person, virtual meeting, telephone, and/or email)
6. Current and proposed MAID legislation
    a. Total wait time to obtain MAID prescription
    b. Allowance of advanced practice registered nurses (APRNs) in the process
    c. Bills currently in committee in the 2023 legislative session
7. The quantity of interactions with stakeholders

8. Feedback obtained from legislators on awareness of the MAID law in Colorado (if applicable)

Analysis Plan

The first aim was to increase awareness of state legislators on the challenges for rural and frontier county Coloradans in accessing MAID. The plan was to build stakeholder awareness, engagement, and obtain feedback by identifying advocacy groups and professional organizations who have an interest in medical aid in dying and/or further advancing the responsibilities of APRNs within Colorado, to provide education regarding the practice of MAID in Colorado, the barriers that patients encounter (particularly in rural and frontier communities), and to offer the proposed language which could reduce the impact of these barriers to these groups.

The plan also included the identification of rural legislators who may support an amendment to the law and legislators who sit on the Health Committees in order to provide education regarding the practice of MAID in Colorado, the barriers that patients encounter (particularly in rural and frontier communities), and to propose language to the legislators which could be used in an amendment to reduce the impact of these barriers.

The type of encounter and with whom the encounter occurred was logged into Microsoft Excel. For all encounters, three key pieces of information were provided at minimum: 1) MAID is currently legal in Colorado through the End-of-Life Options Act; 2) Patients are having trouble accessing the resources they need in order to ultimately obtain MAID medications, and 3) we can help address these barriers by considering amending our law to mirror New Mexico's End of Life Options Act.

The second aim was to educate legislators on the process variations and measures that could be used to reduce barriers to accessing MAID for rural Coloradans. The third aim was to

provide language to state legislators that could be used to amend Colorado's End-of-Life Option Act. Recommendations provided to legislators were based on current and proposed laws, including legislation that was introduced in the 2022 and 2023 legislative sessions. An infographic (see Appendix G), a one-page legislative brief (see Appendix H), a document highlighting recommended language directly from New Mexico's Elizabeth Whitefield End-of-Life Options Act (See Appendix I), and a standard email with the key pieces of information were developed for utilization with stakeholders. Additionally, physical folders were created which held the infographic, the one-page legislative brief, a copy of New Mexico's law with an additional document highlighting recommended language from the law, and a business card with contact information for the Team Leader, these were given to legislators during in-person encounters. Data were collected regarding the method of contact with legislators, in which the aforementioned methods of distributing information were utilized.

Description of Software

Microsoft Excel was used to store and analyze data. Excel is a software program that allows for the creation of spreadsheets. Within the program, there are formulas and functions which can be used to organize and analyze data. The program has the capability to create graphs, sparklines, and tables to aid in data visualization (Microsoft, 2023). Data was collected and analyzed within Microsoft Excel. Bar and Line charts were utilized to visualize data and to perform an analysis.

Data Entry

Data was entered into Microsoft Excel by the Team Leader on the same day of occurrence. The Microsoft Excel spreadsheet was titled "DNP Monthly Contacts" and was saved to a designated project folder which was titled "DNP Project Folder." Once per week, the Team

Leader would review the weekly events to ensure that all data had been captured and documented appropriately. The type of event that had occurred, day, and time were confirmed through email receipts and previously set calendar alerts for the events. A separate spreadsheet compiling all of the data from September 2022 through January 2023 was created in order to compare with the monthly data. This was used to ensure that the data entry totals from each month matched with the data entry total from the entire DNP project and to try to identify any missing or inaccurate data. This led to the identification of a single event which was documented on the wrong date, and that was subsequently corrected in the record. This change did not affect the outcomes of the project.

Characteristics of Stakeholders

There were two national groups and two state level organizations whose members had experience interacting with stakeholders regarding MAID legislation in Colorado that were identified. There was a total of four local professional organizations/health care entities that were identified who would share an interest in the potential for an amendment. Some of these groups are a part of a national professional organization, but education efforts focused on the local groups.

At the initiation of the DNP project, the 2022 General Assembly members including the rural legislators and health committee members had been identified, and that information guided the initial education efforts. On November 8, 2022, a general election was held, after which, some of the legislators who were initially identified longer served in office. Additionally, Colorado redistricted going into the 2023 legislative session, which meant that some of the legislators who had been identified as serving rural or frontier counties prior to the election were

no longer representing those communities after the election (CNN, 2022). Data was updated to reflect the 2023 legislative session.

Out of a total of 100 legislators in Colorado (65 Representatives and 35 Senators), 28 of the legislators represent rural or frontier counties, or they represent an urban county which has rural areas (Colorado General Assembly, 2023b; Colorado Rural Health Center, 2022). Of the 28 rural legislators, 17 are serving as Republicans and 11 are serving as Democrats. There are no Independents identified as serving currently in the General Assembly (Colorado General Assembly, 2023b).

It is anticipated that if an amendment was introduced, it would likely be assigned to one of the health committees; therefore, characteristics of these committees were identified as well. There are 11 Representatives serving on the House Health & Insurance Committee. Of those 11 members, 8 are serving as Democrats and 3 are serving as Republicans. There are currently 8 Senators serving on the Senate Health & Human Services Committee. Of those 8 members, 6 are serving as Democrats and 2 are serving as Republicans (Colorado General Assembly, 2023b).

In addition to identifying the political party affiliation of the legislators, efforts were made to learn more about them as individuals in order to tailor education efforts by finding areas of commonality. Prior to the election, many of the legislators had live campaign websites which offered more personal insight into their careers, legislative priorities, and rationale for their voting record. Some of these websites included personal phone numbers and personal email addresses and would invite constituents to call, text, or email. After the election, the majority of these sites were taken down; however, the official profile pages for the legislators on the General Assembly website lists the occupation for most members, business contact information, and the

history of legislation that they have introduced, which does provide insight into their professional history and legislative priorities (Colorado General Assembly, 2023b).

Results

The first aim was to increase awareness of state legislators on the challenges for rural and frontier county Coloradans in accessing MAID. A total of 50 legislators including members from both major political parties were provided information on the barriers that patients are encountering and recommendations for policy change (see Table 3; Figure 1). This included 28 current rural legislators, two former rural legislators (2022 legislative session), four members of the House Health & Insurance Committee, four members of the Senate Health & Human Services Committee, and 12 other legislators including local legislators of the Team Leader and urban legislators who expressed interest while at in-person encounters. Information was shared in-person, through email, via virtual meetings, and/or through phone calls. For email correspondence, virtual visits, and in-person visits, an infographic was provided to legislators which highlights the limited resources to rural Coloradans or a PowerPoint presentation was shared that also contained the infographic (see Appendix G). For telephone encounters, this same information was shared verbally over the phone.

Table 3

Data Collection Table: Stakeholders and Quantity of Events per Month

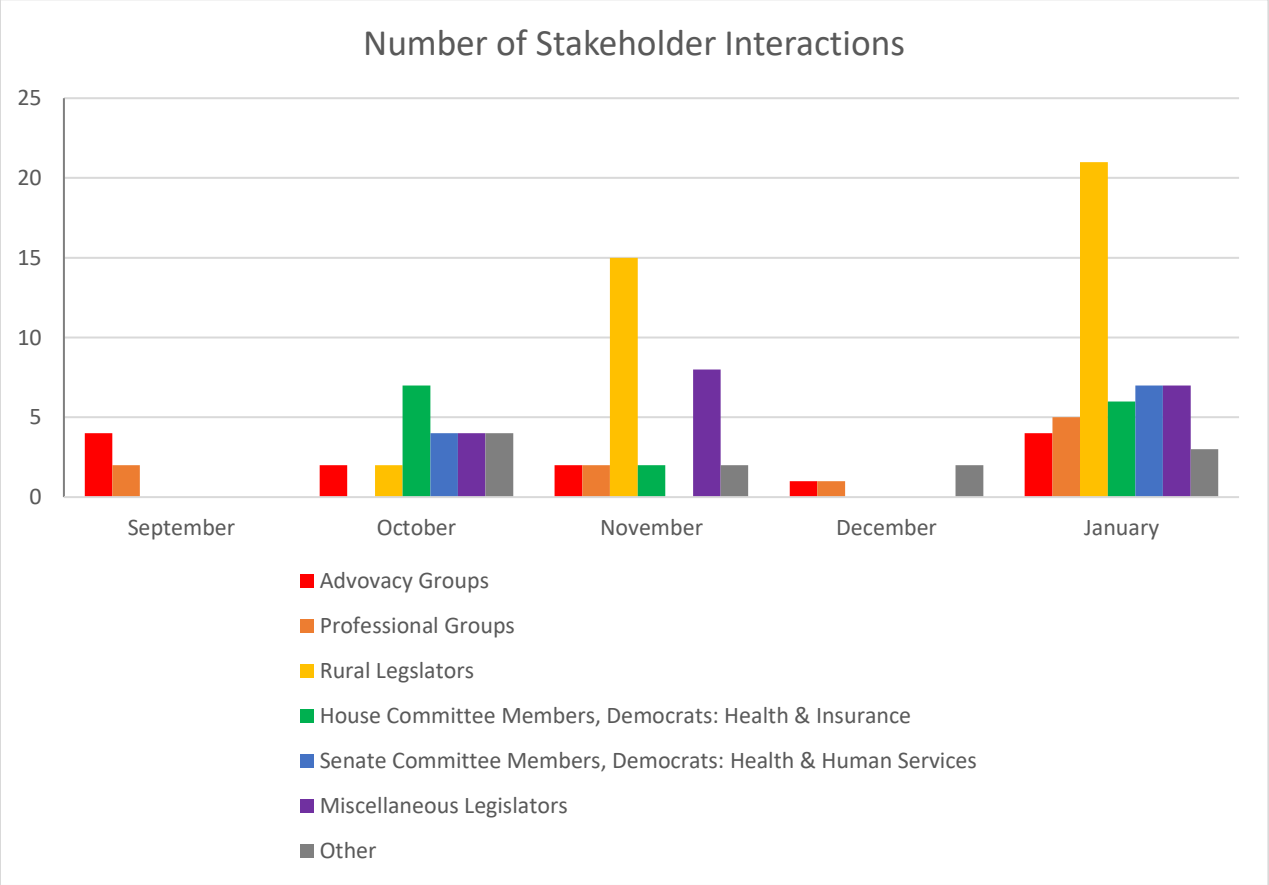
Stakeholder Type	The Quantity of Events	Month
Advocacy Group	4	September
Professional Organization	2	September
Rural Legislator	0	September
House Committee	0	September
Senate Committee	0	September

Stakeholder Type	The Quantity of Events	Month
Miscellaneous Elected Officials	0	September
Other	0	September
Advocacy Group	2	October
Professional Organization	0	October
Rural Legislator	2	October
House Committee	7	October
Senate Committee	4	October
Miscellaneous Elected Officials	4	October
Other	4	October
Advocacy Group	2	November
Professional Organization	2	November
Rural Legislator	15	November
House Committee	2	November
Senate Committee	0	November
Miscellaneous Elected Officials	8	November
Other	2	November
Advocacy Group	1	December
Professional Organization	1	December
Rural Legislator	0	December
House Committee	0	December
Senate Committee	0	December
Miscellaneous Elected Officials	0	December
Other	2	December
Advocacy Group	4	January
Professional Organization	5	January
Rural Legislator	21	January
House Committee	6	January

Stakeholder Type	The Quantity of Events	Month
Senate Committee	7	January
Miscellaneous Elected Officials	7	January
Other	3	January

Figure 1

Monthly Stakeholder Interactions, by type



Email was the most commonly utilized communication method, which was particularly useful when engaging with rural and frontier legislators prior to the start of the 2023 legislative session. Email correspondence remained elevated into January 2023, but with the legislators present at the State Capitol after the start of the 2023 legislative session, engagement in-person became more practical. It is also noted that opportunities to engage in-person with legislators

increased in October and November 2023 as political candidates were out campaigning and were available for conversation at campaign and canvassing events (see Table 4; Figure 2).

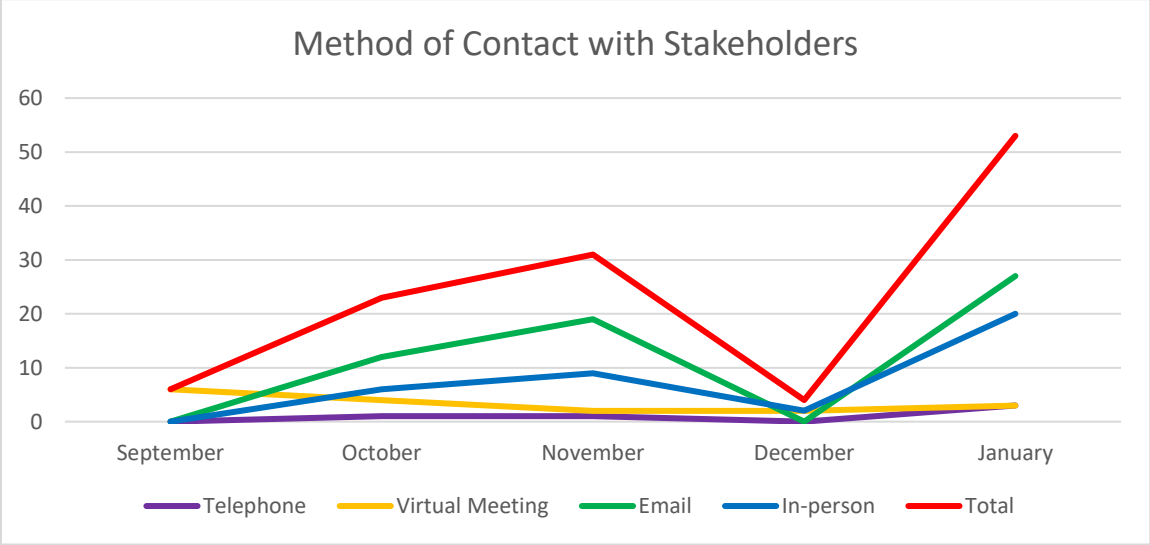
Table 4

Method and Number of Contacts with Stakeholders

Type of Contact Made	Number of Contacts Made	Month
Telephone	0	September
Virtual Meeting	6	September
Email	0	September
In-person	0	September
Telephone	1	October
Virtual Meeting	4	October
Email	12	October
In-person	6	October
Telephone	1	November
Virtual Meeting	2	November
Email	19	November
In-person	9	November
Telephone	0	December
Virtual Meeting	2	December
Email	0	December
In-person	2	December
Telephone	3	January
Virtual Meeting	3	January
Email	27	January
In-person	20	January
Telephone	3	January

Figure 2

Monthly Stakeholder Interactions, number and type



It must be noted that an in-person interaction with a legislator may only allow the opportunity for 1-2 minutes to present information about a topic. Interactions with legislators were not timed, but they were presented by the legislator or their legislative aide as opportunities to talk for as little as 30 seconds and up to 15 minutes, depending on the legislator's schedule. Interest in the topic would often lead to a conversation that lasted several minutes, even if a 30 second amount of time was initially offered. As an example, one scheduled engagement with a Representative was offered as a "walk and talk" upon leaving the House or Senate Floor as they were walking to their Committee meeting, which would allow for 2-3 minutes of conversation. With that said, this environment does not provide the opportunity to collect formal data; however, attempts were made to evaluate if legislators knew about Colorado's End-of-Life Options Act as each situation allowed.

Of the 50 legislators who were provided information, the Team Leader felt that 18 legislators provided adequate feedback to subjectively get a sense of if they were familiar with

the law at the time of the initial encounter, prior to providing education. Additionally, a few of the legislators expanded to share what their understanding is of the law and the requirements to obtain MAID medications. Eight legislators indicated that they were aware of the Colorado End of Life Options Act, and shared that this was largely because they remembered it being on ballot in 2016, but they did not expand on their understanding of the actual law. Six of the legislators made statements and/or gestures to indicate that they were somewhat familiar with MAID, but not enough to say that they really understood details to participate in the process. Three legislators said that they had never heard of the Colorado End-of-life Options Act and they were not familiar with MAID; these 3 legislators were representatives of rural and frontier counties. Finally, 2 of the legislators that appeared quite confident in saying that they knew about MAID, shared inaccurate information about the law (One thought that APRNs were already allowed to participate in the process; one thought that there were not safety measures in place for patients).

The second aim was to educate legislators on the process variations and measures that could be used to reduce barriers to accessing MAID for rural Coloradans. The third aim was to provide language to state legislators that could be used to amend Colorado's End-of-Life Option Act. Although the second and third aims are distinct from each other, the information provided to achieve these aims was given on the same one-page brief, PowerPoint presentation, email, through virtual meetings, and in-person; therefore, results of both of these aims will be shared together. Several legislators volunteered to support the bill if prime sponsorship could be obtained. Two legislators expressed interest in potentially serving as prime sponsors, likely in the 2024 legislative session.

There are currently 16 bills active in the 2023 legislative session to create or amend MAID laws. Washington state and Hawaii's proposed amendments would reduce the wait times

between verbal requests to 7 days or 5 days respectively, and both amendments are proposing that APRNs be allowed to participate in the MAID process as prescribers and certifiers of terminal illness. Virginia and Indiana have introduced legislation that would allow APRNs to participate in the MAID process (Death with Dignity, 2023). This information has been shared in discussions with stakeholders as new bills are introduced.

Additional Observations

When able, engagements either in-person or through virtual meetings allowed the best opportunities to thoughtfully dialogue on the topic, to listen to other perspectives, to answer questions, and to share mutually meaningful stories. When providing information strictly through email, the correspondence felt more transactional and was primarily data driven. Legislators seemed genuinely intrigued and open to discussion when the Team Leader would present at in-person events.

In particular at the Colorado State Capitol, legislators would approach the Team Leader to learn more about what was being presented as a citizen-initiated effort. This may due, in part, to the unique name badge that was worn, which identified the Team Leader as a Nurse Practitioner. Comparatively, lobbyists must wear a blue name badge within the Capitol. Lobbyists are not allowed on the House or Senate floors. As a citizen, the Team Leader was welcomed to the House floor and was allowed to perform initial introductions in that location. Additional educational efforts occurred in the halls of the Capitol, in legislator's offices, and in committee meeting rooms.

Handwritten thank you notes were sent to every legislator after each meeting. This appears to be an effective means of creating positive and memorable encounters; the Team Lead

had been stopped at a subsequent Capitol visit by legislators who had received the notes and expressed gratitude for the gesture.

Positive feedback was also received about the physical folders which were provided to legislators that included educational materials. A unique color, teal, was chosen to help make the folders easily identifiable. A current lobbyist in Colorado that formerly worked for a national advocacy group called the Team Leader to provide positive feedback on the folders.

Finally, the time invested in a health policy project is notable. Being present at monthly stakeholder meetings in order to provide updates and obtain feedback is an important step to network, build trust, troubleshoot, and receive insight on next steps. Going to town halls, canvassing events, Capitol days, and campaign events to meet with legislators and their teams ultimately requires time and leads to invitations to additional events. It became clear as the project progressed that the amount of time spent at meetings and events is a consideration of its own for those working on a government level health policy analysis. As the effort to engage with stakeholders intensified, so did the number of hours per month at meetings and events (see Table 5; Figure 3). The time that was tracked does not include the time spent writing and responding to email correspondence. Although aspects of this project were time intensive, being consistently present was beneficial in building relationships, which aided in project outcomes.

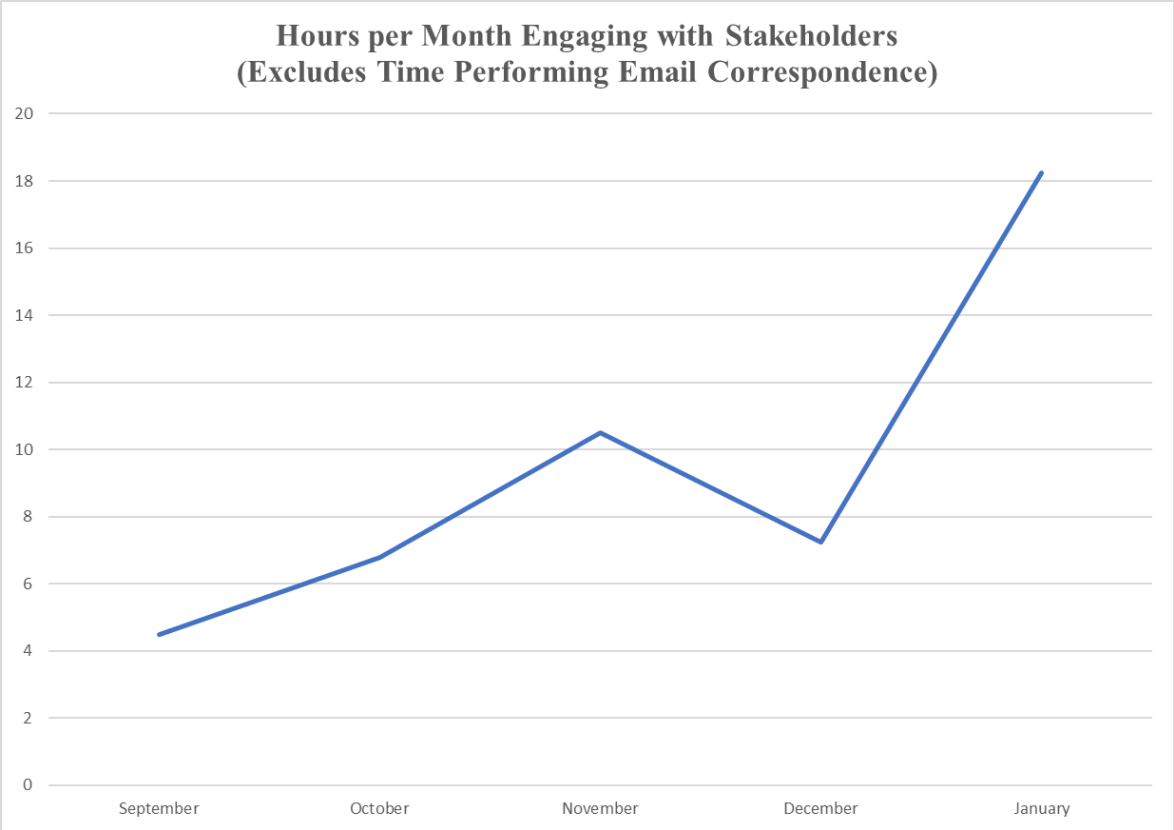
Table 5

Total Hours per Month Engaging with Stakeholders

Month	Minutes	Hours
September	270	4.5
October	410	6.8
November	630	10.5
December	435	7.25
January	1095	18.25

Figure 3

Hours per Month Engaging with Stakeholders



Discussion

Implications for Practice

APRNs in Colorado have full practice and prescriptive authority. They have the education, training, and skills to collaborate with physicians in order to help meet patient needs for access, particularly in rural Colorado. Until an amendment passes, it is critical that APPs educate themselves on the MAID process and assist patients as they are able with coordinating resources required for patients to access MAID, if requested. However, with respect to the conscientious objection clause, APPs can decline to participate in any part of the process.

Implications for Healthcare Policy

It is strongly recommended that other states that are proposing new MAID laws consider APRN practice authority as they are drafting proposed MAID policies. It is also recommended that the APRN role in providing equitable access to resources be taken into consideration. This may prevent the need for later amendments to address concerns with access, particularly in states with substantial rural or frontier land.

Implications for Executive Leadership

Policies related to participating in MAID vary, and it is important that leadership is aware of organizational policies so that factual information is being provided to patients and staff. Larger health care systems have policies that trickle through those organizations to the outpatient clinics. Long-term care, assisted living, and independent living facilities may have policies in place that prohibit the administration of MAID medications on premises. Hospice agencies may have policies in place that limit participation with patients who have acquired MAID. Executive leadership should regularly evaluate their policies, update them as required, and publish their

policies for their patients.

Implications for Quality/Safety

Patients build trusting relationships with their long-term providers, and some of those providers may be APPs. Better quality care will be provided if patients can develop their end-of-life plan of care with their regular providers. In order to promote the best quality of care, the effort must continue to try to allow APPs to participate in the process of obtaining MAID by allowing them to certify the terminal diagnosis and prognosis, and prescribe medications for their own patients, in collaboration with a physician.

Plans for Sustainability and Future Scholarship

The results of this health policy analysis and advocacy campaign will be shared with national and local advocacy groups and professional organizations, including project dissemination at the Social Work Hospice and Palliative Care Network 2023 General Assembly and the Colorado Nurses Association 2023 Annual Assembly.

Stakeholders in Colorado are actively working together to build a coalition to further this effort. The plan is to continue to build awareness and encourage legislative engagement through 2023, with the hope that an amendment to the Colorado EoLOA will be introduced in 2024. The reception to this effort has generally been positive from national MAID advocacy groups.

Conclusion

At the end of this health policy project implementation, 50 legislators from both major political parties were educated on the challenges for rural and frontier county Coloradans in accessing MAID. These same legislators were educated on process variations and measures that could be used to reduce barriers to accessing MAID for rural Coloradans and they were provided language that could be used to amend Colorado's End-of-Life Option Act. Additionally,

members from both local and national advocacy groups and professional organizations were made aware of the same information. Ongoing opportunities remain to work towards introducing legislation by building a coalition based on relationships made by networking throughout this DNP project.

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Additional Tables

Table 1

Data Collection, Evaluation and Analysis Methods Table

Aim 1: Increase awareness of state legislators on challenges to rural and frontier county Coloradans in accessing medical aid in dying

Measure	**Measure Type***	**Data Source**	**Sampling Method**	**Timing/Frequency**
Number of state legislators contacted	Process measure	Excel spreadsheet	Colorado State Legislators (35 Senate; 65 House)	Daily records/Trend Monthly from August 2022-January 2023
Standard Measure?**	No			
Numerator	Contacts (email, phone-call, virtual meeting, in-person) made to legislators			
Denominator or Population***	Total number of legislators			
Exclusions	Strong opponents to initial law			
Calculation/Statistic(s)	Quantity			
Goal/Benchmark	80% of rural legislators; Two committee members from the House and the Senate health committees			

- **Aim 2:** Educate legislators on the process variations and measures that could be used to reduce barriers to accessing MAID for rural Coloradans, and
- **Aim 3:** Provide language to state legislators that could be used to amend Colorado's End-of-Life Option Act

Measure	**Measure Type***	**Data Source**	**Sampling Method**	**Timing/Frequency**
States that allow or are proposing to allow NPs to participate in MAID	Structural Measure	Individual state statute review	All states that currently have or are proposing MAID legislation	After establishing baselines, monitor for new proposed legislation every 60 days
Standard Measure?**	No			
Numerator	States with Laws/Proposed Laws that allow NPs to participate in MAID			
Denominator or Population***	All states with MAID laws or MAID law proposals			
Exclusions	N/A			

Calculation/Statistic(s)	Quantity			
Goal/Benchmark	Identify all current laws and active legislation			
Measure	**Measure Type***	**Data Source**	**Sampling Method**	**Timing/Frequency**
States that have less than a 14-day waiting period between verbal requests	Structural Measure	Individual state statute review	All states that currently have or are proposing MAID legislation	After establishing baselines, monitor for new proposed legislation every 60 days
Standard Measure?**	No			
Numerator	States with Laws/Proposed Laws that have less than a 14-day waiting period between verbal requests			
Denominator or Population***	All states with MAID laws or MAID law proposals			
Exclusions	N/A			
Calculation/Statistic(s)	Percentage/Proportion			
Goal/Benchmark	Identify all current laws and active legislation			

Table 2

Data Dictionary Table

Data Elements	Variable Name	Definition	Data Type*	Data Values & Coding	Restrictions/ Validation
Senator Name	sen_name	Full name of CO Senator	Text	Alphanumeric	Required
House Name	con_name	Full name of CO Congressman	Text	Alphanumeric	Required
Rural Counties	rural_county	Rural county name	Text	Alphanumeric	Required
Party affiliation	party	Democrat, Republican, Independent	Categorical	1, Democrat 2, Republican	Required
Health Committee Member	health_committee	Member of either the House or Senate Health Committees	Categorical	1, Yes 2, No	Required
Level of awareness of Colorado MAID law	level_awareness	Response to initial question regarding awareness of Colorado MAID law	Categorical	Level_Awareness 1, Yes 2, No 3, Indicated somewhat aware 4, Provided inaccurate Details	If applicable
Current MAID states	active_maid	Name of State with current MAID laws	Text	Alphanumeric	Required
Proposed MAID states	proposed_maid	Name of State with proposed MAID laws	Text	Alphanumeric	Required
NP MAID participation: current states	active_APRN	State has current law allowing NPs to participate in MAID	Categorical	1, Yes 2, No	Required

Data Elements	Variable Name	Definition	Data Type*	Data Values & Coding	Restrictions/ Validation
NP MAID participation: proposed states	proposed_APRN	State has proposed law allowing NPs to participate in MAID	Categorical	1, Yes 2, No	Required
Total days required to wait to receive medications	current_wait	Current wait time in days per active state statute	Text	Alphanumeric	Required
Proposed days required to wait to receive medications	proposed_wait	Proposed wait time in days per an active bill or amendment	Text	Alphanumeric	Required
Current Legislation 2023	2023_legislation	Current bill in the 2023 general assembly	Categorical	1, Yes 2, No	Required
Date of Contact	contact_date	Date that contact was made (letter, phone-call, or in-person)	Categorical	Date (D-M-Y) 08-01-2022 to 01-31-2023	Required Date (M-D-Y)
Date of event/interaction	event_date	Date of a prolonged event or interaction with stakeholder	Categorical	Date (D-M-Y): 08-01-2022 to 01-31-2023	Required
Time of interaction	time_log	Time of the prolonged encounter with stakeholder	Text	Time: 00:00-23:59	Required
Total minutes of interaction	total_minutes	Total minutes spent in the prolonged encounter	Text	Alphanumeric	Required
Individual contacts made with stakeholders	unique_event	Each contact with a stakeholder	Text	Alphanumeric	Required

Appendix A

Rural Colorado counties, population and provider data

County	Population	Active M.D./D.O.	*ALL M.D./D.O**	Nurse Practitioner & Clinical Nurse Specialist	Physician Assistants
Alamosa	16,180	40	47	31	15
Archuleta	14,196	26	36	11	5
Baca	3,555	3	5	3	1
Bent	3,356	1	2	5	0
Chaffee	20,661	57	80	18	7
Cheyenne	1,795	1	1	2	0
Conejos	8,143	5	8	4	2
Costilla	3,921	0	2	1	0
Crowley	5,696	1	1	2	2
Custer	5,183	5	9	8	0
Delta	31,067	50	69	28	9
Dolores	2,096	1	3	0	1
Eagle	54,929	183	251	36	45
Fremont	47,867	47	62	43	19
Garfield	60,366	146	192	44	24
Grand	15,794	15	25	8	3
Gunnison	17,593	39	50	11	12
Hindsdale	808	2	6	0	0
Huerfano	6,883	12	17	10	3
Jackson	1,389	2	2	1	0
Kiowa	1,458	0	1	2	0
Kit Carson	7,121	4	4	9	3
La Plata	56,564	260	334	60	48
Las Animas	14,420	24	31	6	0
Lake	7,987	5	8	4	10
Lincoln	5,680	3	3	9	5
Logan	21,974	27	32	16	9
Mineral	773	1	3	0	2
Moffatt	13,144	9	12	6	12
Montezuma	26,408	55	67	28	15
Montrose	43,322	94	125	46	25
Morgan	28,941	33	38	18	8
Otero	18,201	18	26	22	5
Ouray	5,001	22	30	1	0
Phillips	4,367	6	6	7	0
Pitkin	17,894	66	96	12	7
Prowers	12,106	7	13	14	6

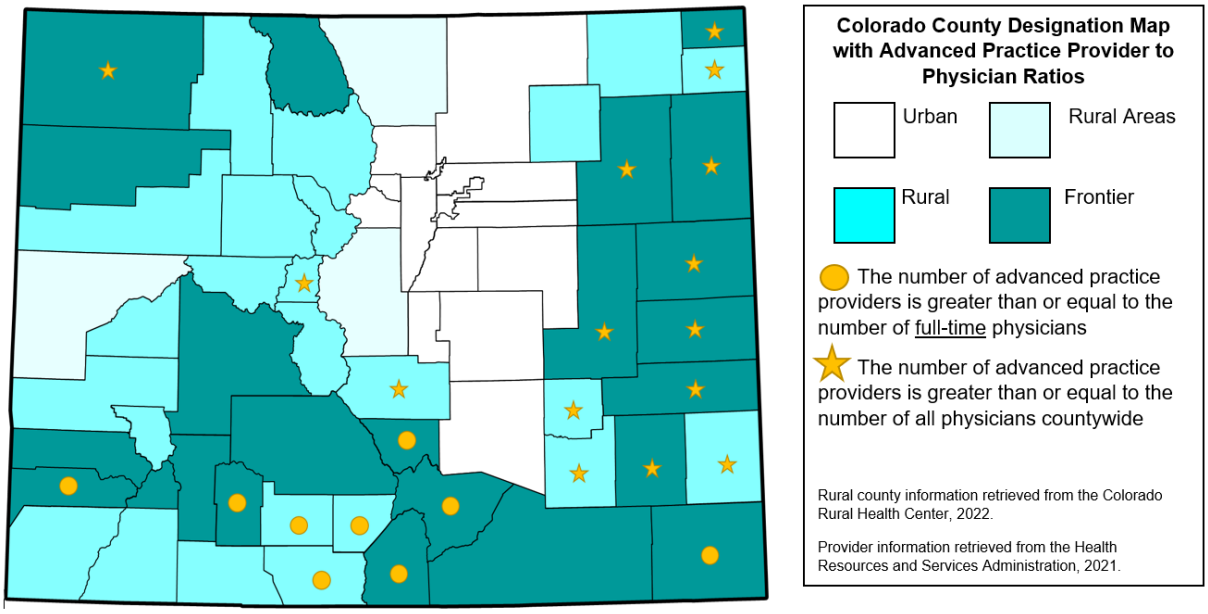
County	Population	Active M.D./D.O.	*ALL M.D./D.O**	Nurse Practitioner & Clinical Nurse Specialist	Physician Assistants
Rio Blanco	6,342	13	15	3	4
Rio Grande	11,296	14	19	8	6
Routt	25,560	101	140	21	17
Saguache	6,938	5	8	1	1
San Juan	748	2	2	0	0
San Miguel	8,105	14	22	3	3
Sedgwick	2,260	1	1	2	2
Summit	30,631	76	122	19	18
Washington	4,875	3	3	4	1
Yuma	10,047	7	9	6	6

*All M.D./D.O. includes retired, semi-retired, part-time, work less than 20 hours/week, or currently not practicing

Data obtained from HRSA, 2021.

Appendix B

Colorado county designations, Advanced practice provider to physician comparison



Appendix C

SWOT analysis figure	***Helpful*** To achieving the objective	***Harmful*** To achieving the objective

Internal Origin
{Attributes of the current policy}
	Strengths
	• Linear process for obtaining MAID medications
	• Safeguards to help protect vulnerable populations
	  ○ Mental Capacity
	  ○ Witnesses
	  ○ Self-administration
	• Providers, pharmacists, and health care systems are not required to participate
	  • Citizen-initiated ballot measure made into law
		Weaknesses
		• Providers, pharmacists, and health care systems are not required or may be forbidden from participating
		• Decreased number of physicians servicing rural areas. APPs are heavily utilized in rural areas and cannot participate in MAID.
		• There is potential to ease access to CO EoLOA based on laws passed in other states
		  ○ Allow APPs to participate
		  ○ Reduce wait times between requests
		  ○ Require health care agencies to post information about MAID participation

External Origin
{Attributes of current policy}
	Opportunities
	• Legislators are open to discussing health care related topics
	• Looking at other state laws reveals opportunities for increasing access
	  ○ Decreasing wait times between verbal requests
	  ○ Allowing advanced practice providers to participate
	  ○ Requiring transparency in participation from organizations
	• Washington, Oregon, and Hawaii have current legislation to amend their laws to increase access.
	  •
		Threats
		• Lack of support from physicians for expanding APP role in MAID
		• Repeal of the current law or adding unfavorable language
		• Monetary support and campaign opposition from powerful organizations

Appendix D

Evidence table

Article #	Author, Date & Title	Type of Evidence	Population, Size, Setting	Intervention	Findings that help answer the EBP Question	Measures Used	Limitations	Evidence Level & Quality	Notes
1	American Nurses Association. (2019).	Position statement	N/A	N/A	Nurses must understand the difference between euthanasia and MAID – they cannot administer MAID medications "with the sole intent to end life"; the position statement does not preclude APRNs from prescribing MAID medications.	N/A	N/A	IV, B	Although this is a position statement for nurses, it does not specifically address the APRNs potential role in MAID.
2	Buchbinder, M. (2018)	Qualitative Study	144 interviews over 2 years in Vermont. Includes: a mix of medical professionals, patients, caregivers, activists, and legislators.	Semi-structured interview process over a 2-year period. Questions included ideas about a good death, views on physician	Although MAID may be legal, that does not guarantee access. The ethical principal of justice is noted – that those with greater means and access to networking are able to obtain MAID more easily. Those in rural areas have a more difficult time finding	N/A	Those who supported MAID laws were over-represented in the study.	III, B	

Article #	Author, Date & Title	Type of Evidence	Population, Size, Setting	Intervention	Findings that help answer the EBP Question	Measures Used	Limitations	Evidence Level & Quality	Notes
				position on MAID, attitudes on the subject, and exchanges with patients about MAID.	participating physicians rather than those who live closer to the largest city in Vermont.				
3	Buerhaus, P.I., DesRoches, C.M., Dittus, R., & Donelan, K. (2014).	Non-experimental study	Primary care providers; 467 NPs and 505 MD; providers who provide direct patient care in primary care.	2012 National Survey of Primary Care Nurse Practitioners and Physicians.	PCNPs are significantly more likely to work in urban and rural settings, compared to PCMDs, who are more likely to work in suburban settings. PCNPs spend more time providing education to patients and families.	N/A	Sampling/non-sampling error; respondent bias; did not include PAs; did not survey all primary care NPs and PAs	III, A	
4	Campbell, E.G., Kini, V., Ressalam, J., Mosley, B.S., Bolcic-Jankovic, D., Lum, H.D., Kessler,	Non-experimental study	Colorado Physicians selected through a sampling strategy of identifying physicians who had the	A completely anonymous survey was sent out with a postage paid return envelope. There was	The researchers note that physicians that were contacted had probably had the chance to participate in MAID based on their patient population. Only 28% of those physicians	Response categories presented to questions gave options of "very unprepared", "generally unprepared",	Results applicable to physicians within Colorado that care for patients who are likely to ask for MAID;	III, B	

Article #	Author, Date & Title	Type of Evidence	Population, Size, Setting	Intervention	Findings that help answer the EBP Question	Measures Used	Limitations	Evidence Level & Quality	Notes
	E.R., & DeCamp, M. (2021).		opportunity to participate in MAID. There were 300 physician responses.	also a cash incentive. Thes Survey evaluated preparedness of physicians to discuss MAID, how likely there were to participate, and barriers to participation.	stated that they would act as the attending for MAID. The physicians largely felt unprepared that act as a MAID physician. Those who responded that they had already acted as an attending has done so for 3-4 patients, on average.	"generally prepared" or "very prepared"; or "definitely not", probably not", "probably yes" or "definitely yes". Responses were rated as a 1 if positive, or 0 if negative.	not outside of Colorado. Due to anonymity, cannot determine how various demographics may apply to results.		
5	Christensen, K.L., Winters, C.A., Colclough, Y., Oley E., & Luparell, S. (2019).	Non-experimental study	Nurses working in rural home health, palliative care, and community, 22 respondents.	Copies of the Knowledge, Attitudinal, and Experimental Survey on Advance Directives were mailed to rural nurses identified in rural counties of	Due to the relationship that rural nurses build with their patients, they have a unique opportunity to assist with advance care planning. Knowledge about advance directives is moderate though, although the nurses felt confident leading the discussions. Rural	The Knowledge, Attitudinal, and Experimental Survey on Advance Directives	Small study size; rural area with higher population was primary practice area; not every participant filled out each question.	III, B	

Article #	Author, Date & Title	Type of Evidence	Population, Size, Setting	Intervention	Findings that help answer the EBP Question	Measures Used	Limitations	Evidence Level & Quality	Notes
				Montana. Nurses had two weeks to respond.	patients have a unique culture. Less than half of nurses reported they had received any training on cultural awareness of the population.				
6	Holland, D.E., Vanderboom, C.E, Dose, A.M., Ingram, C.J., Delgado, A., Austin, C.M., Green, M.J., & Levi, B. (2017).	Quasi-experimental study	Primary care clinic in the Midwest; 40 adult patients enrolled, 38 completed the study. Adults enrolled had not competed advanced directives within the past 10 years, did not have documented evidence of moderate to severe cognitive impairment, and did not have a severe	Two visits with a nurse care navigator to discuss and assist with advanced care planning using one of four decision aids.	Nurses are capable of holding meaningful conversations with patients about end-of-life planning, and to assist with the completion of advance directives in primary care settings.	The advance care planning survey; The advance care planning engagement survey	Small study size; patients were primarily white and had at least a high school education; patients that chose to enroll may have been wanting to complete advance care planning; use of online decision aides may be less accessible to certain populations.	II, A	

Article #	Author, Date & Title	Type of Evidence	Population, Size, Setting	Intervention	Findings that help answer the EBP Question	Measures Used	Limitations	Evidence Level & Quality	Notes
			psychiatric diagnosis.						
7	International Council of Nurses (ICN). (2012).	Position Statement	N/A	N/A	The ICN supports nursing associations in actions to promote nurse participation in end-of-life issues, promoting nurse involvement in legislative and policy issues surrounding death, and state that nurses must respect patient's decisions as it relates to patients end-of-life wishes.	N/A	N/A	IV, B.	
8	Neprash, H.T., Smith, L.B., Sheridan, B., Moscovice, I., Prasad, Shailendra, & Kozhimannil. (2021).	Non-experimental study	Billing and EHR data from Athenahealth, Inc. Evaluation of primary care practices in urban (2,115) and rural (475) setting. Compared NP	N/A	NPs in rural settings are significantly more likely to practice autonomously, including prescribing controlled substances, to carry an independent patient load, and to work independently from physicians.	NP autonomy was measured by identifying patients who were only treated by NPs. Physician supervision was measured by calculating the number of	Only applied to primary care settings for which Athenahealth supplied technology services; only evaluated settings that included both NPs and	III, A	NPs act as primary care providers in rural settings, and are likely to work independently from physicians – as independent practice

Article #	Author, Date & Title	Type of Evidence	Population, Size, Setting	Intervention	Findings that help answer the EBP Question	Measures Used	Limitations	Evidence Level & Quality	Notes
			independence and complexity in care in rural and urban settings.			NP visits performed without a MD in the office, and the number of visits that were billed directly to the NPs NPI number Prescribing authority was calculated by identifying NPs who prescribed controlled substances.	physicians; evaluated autonomy and complexity based on face-to-face interactions per RVUs; quality was not evaluated; this study only notes an association between NP and rural practice autonomy, and does not suggest cause.		providers in Colorado carrying their own patient load, allowing NPs to participate in medical aid in dying could increase the number of participating providers.
9	Pesut, B., Hooper, B., Jacobsen, M., Nielsen, B., Falk, M., & O'Conner, B.P. (2017)	Observational study	Older adults and a family member (if applicable). 25 older adults and 11 family members. Two rural communities	Bi-weekly home visits to provide palliative support by a nurse. Study was completed over a two-year period	In rural settings, nurses can lead discussions on palliative topics including advance care planning and linking patients with resources for end-of-life care. They also provide psychosocial support, help link	McGill Quality of Life Questionnaire; Caregiver Support Needs Survey; evaluation of health care services since prior visit; and	Cost prohibitive; lack of integration with primary care services	III, B	Not specifically related to NPs, but shows value of nurses in rural palliative medicine interventions

Article #	Author, Date & Title	Type of Evidence	Population, Size, Setting	Intervention	Findings that help answer the EBP Question	Measures Used	Limitations	Evidence Level & Quality	Notes
			(populations < 10,000).		patients to resources, and provide education related to chronic disease processes. Nurses can be an impactful resource for palliative care in rural settings.	qualitative interviewing			
10	Pope, T. (2020).	Expert opinion	N/A	This is a review of different variations in state laws and expected upcoming variations which include allowing APRNs to participate and redefining the timeframe to define terminal illness prognosis from 6	Thaddeus Pope is a lawyer with expertise in medical laws and clinical ethics. He describes the future of medical aid in dying, and a likely inevitable allowance of APRNs to participate, based on their scope of practice. As a medical law and clinical ethics expert, his opinion is meaningful from a legal standpoint.	Review of state statues and research studies are appropriately used as support throughout the document.	N/A	V, A	Thaddeus Pope is a renowned expert within MAID circles on medical law and clinical ethics. He is the Director and Professor at the Health Law Institute at the Mitchell Hamline School of Law. He has over 200 publications in a variety of

Article #	Author, Date & Title	Type of Evidence	Population, Size, Setting	Intervention	Findings that help answer the EBP Question	Measures Used	Limitations	Evidence Level & Quality	Notes
				months to 12 months.					medical and law journals.
11	Xue, Y., Zhiqiu, Y., Brewer, C., & Spetz, J. (2015).	Systematic review of quantitative studies and synthesis	15 articles published between 1997 and 2015: eight studies examined scope of practice on NPs; one study looked at NP growth related to scope; four studies found higher rates of NPs in states with greater practice independence; two studies evaluated effect of state regulations on distribution of NPs.	N/A	Allowing NPs to practice to their full scope increases health care utilization and access to primary care services.	N/A	Did not evaluate NP specialties; limited number of qualitative studies	III, A	NPs have full practice authority in Colorado, and yet, are not allowed to certify terminal illness nor are they allowed to prescribe medical aid in dying medications. In allowing NPs to practice to practice to their full scope with medical aid in dying, we could see increased utilization of

Article #	Author, Date & Title	Type of Evidence	Population, Size, Setting	Intervention	Findings that help answer the EBP Question	Measures Used	Limitations	Evidence Level & Quality	Notes
									this health care service.

This assignment is used during the DNP Project Planning Course to evaluate the Table of Evidence. It is adapted from Dang, D., Dearholt, S., Bissett, K., Ascenzi, J., & Whalen, M. (2021). *Johns Hopkins Nursing Evidence-Based Practice Model and Guidelines*. Indianapolis, IN: Sigma Theta Tau International.

Appendix E

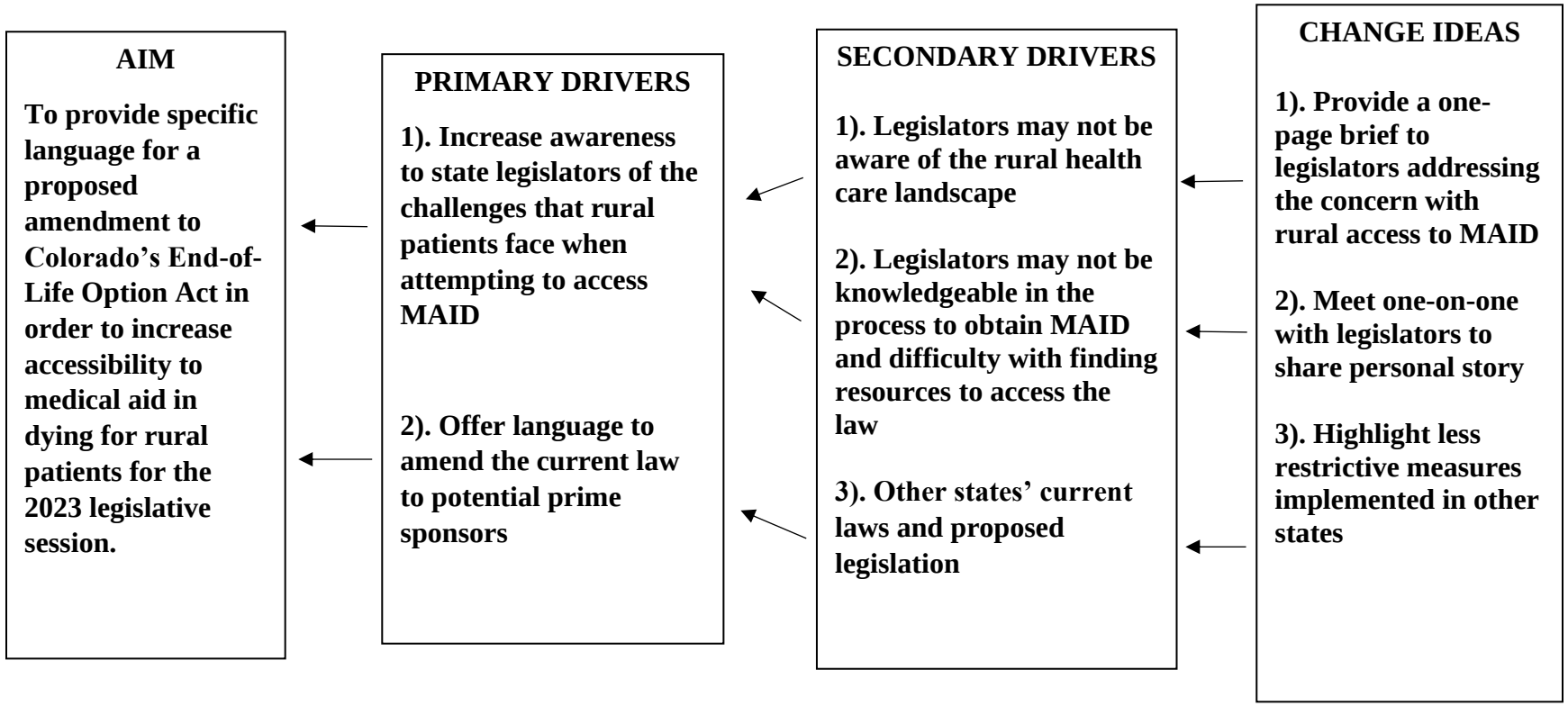
Rural Colorado legislators

County	Senator	Senator	Senator	Congressperson	Congressperson	Congressperson	Congressperson		
Alamosa	Cleave Simpson (6)			*Matthew Martinez (62)*					
Archuleta	*Cleave Simpson (6)*			Barbara McLachlan (59)					
Baca	*Rod Pelton (35)*			*Ty Winter(47)*					
Bent	*Rod Pelton (35)*			*Ty Winter(47)*					
Chaffee	*Mark Baisley (4)*			*Julie McCluskie (13)*	*Stephanie Luck (60)*				
Cheyenne	*Rod Pelton (35)*			*Rod Bockenfeld (56)*					
Conejos	Cleave Simpson (6)			*Matthew Martinez (62)*					
Costilla	Cleave Simpson (6)			*Matthew Martinez (62)*					
Crowley	*Rod Pelton (35)*			*Ty Winter(47)*					
Custer	*Mark Baisley (4)*			*Stephanie Luck (60)*					
Delta	*Janice Rich (7)*	Perry Will (5)		*Marc Catlin (58)*	Matt Soper (54)				
Dolores	*Don Coram (6)*	Cleave Simpson (6)		*Marc Catlin (58)*					
Eagle	*Dylan Roberts (8)*	Perry Will (5)		*Meghan Lukens (26)*	*Elizabeth Velasco (57)*				
Fremont	*Mark Baisley (4)*			Stephanie Luck (60)					
Garfield	*Dylan Roberts (8)*	Perry Will (5)		*Elizabeth Velasco (57)*					
Grand	*Dylan Roberts (8)*			*Julie McCluskie (13)*					
Gunnison	Perry Will (5)			*Marc Catlin (58)*					
Hindsdale	Perry Will (5)			*Marc Catlin (58)*					
Huerfano	*Rod Pelton (35)*			*Ty Winter(47)*	*Matthew Martinez (62)*				
Jackson	*Dylan Roberts (8)*			*Julie McCluskie (13)*					
Kiowa	*Rod Pelton (35)*			*Ty Winter(47)*					
Kit Carson	*Rod Pelton (35)*			*Rod Bockenfeld (56)*					
La Plata	*Don Coram (6)*	Cleave Simpson (6)		Barbara McLachlan (59)					
Lake	*Mark Baisley (4)*			*Julie McCluskie (13)*					
Larimer	Joann Ginal (D)	*Janice Marchman(15)*		Andrew Boesenecker (53)	Cathy Kipp (52)	*Ryan Armagost (64)*	Hugh McKean (49)	*Judy Amabile(49)*	*Mike Lynch (65)*
Las Animas	*Rod Pelton (35)*			*Ty Winter(47)*					
Lincoln	*Rod Pelton (35)*			*Rod Bockenfeld (56)*					
Logan	*Byron Pelton*			Richard Holtorf (63)					
Mesa	*Janice Rich (7)*			*Rick Tagart (55)*	Matt Soper (54)				
Mineral	Cleave Simpson (6)			*Matthew Martinez (62)*					
Moffatt	*Dylan Roberts (8)*			*Meghan Lukens (26)*					
Montezuma	*Don Coram (6)*	Cleave Simpson (6)		*Marc Catlin (58)*	*Barbara McLachlan (59)*				
Montrose	*Don Coram (6)*	Cleave Simpson (6)	Perry Will (5)	Marc Catlin (58)					
Morgan	*Byron Pelton (1)*			Richard Holtorf (63)					
Otero	*Rod Pelton (35)*			*Ty Winter(47)*					
Ouray	*Don Coram (6)*	Cleave Simpson (6)		*Marc Catlin (58)*					
Park	*Mark Baisley (4)*			*Julie McCluskie (13)*					
Phillips	*Byron Pelton (1)*			*Richard Holtorf (63)*					
Pitkin	Perry Will (5)			*Elizabeth Velasco (57)*					
Prowers	*Rod Pelton (35)*			*Ty Winter(47)*					
Rio Blanco	*Dylan Roberts (8)*			*Meghan Lukens (26)*					
Rio Grande	Cleave Simpson (6)			*Matthew Martinez (62)*					
Routt	*Dylan Roberts (8)*			*Meghan Lukens (26)*					
Saguache	Cleave Simpson (6)			*Matthew Martinez (62)*					
San Juan	*Don Coram (6)*	Cleave Simpson (6)		Barbara McLachlan (59)					
San Miguel	*Don Coram (6)*	Cleave Simpson (6)		*Marc Catlin (58)*					
Sedgwick	*Byron Pelton (1)*			*Richard Holtorf (63)*					
Summit	*Dylan Roberts (8)*			*Julie McCluskie (13)*					
Washington	*Byron Pelton (1)*			Richard Holtorf (63)					
Yuma	*Byron Pelton (1)*			*Richard Holtorf (63)*					

Data obtained from Colorado General Assembly, 2023b

Appendix F

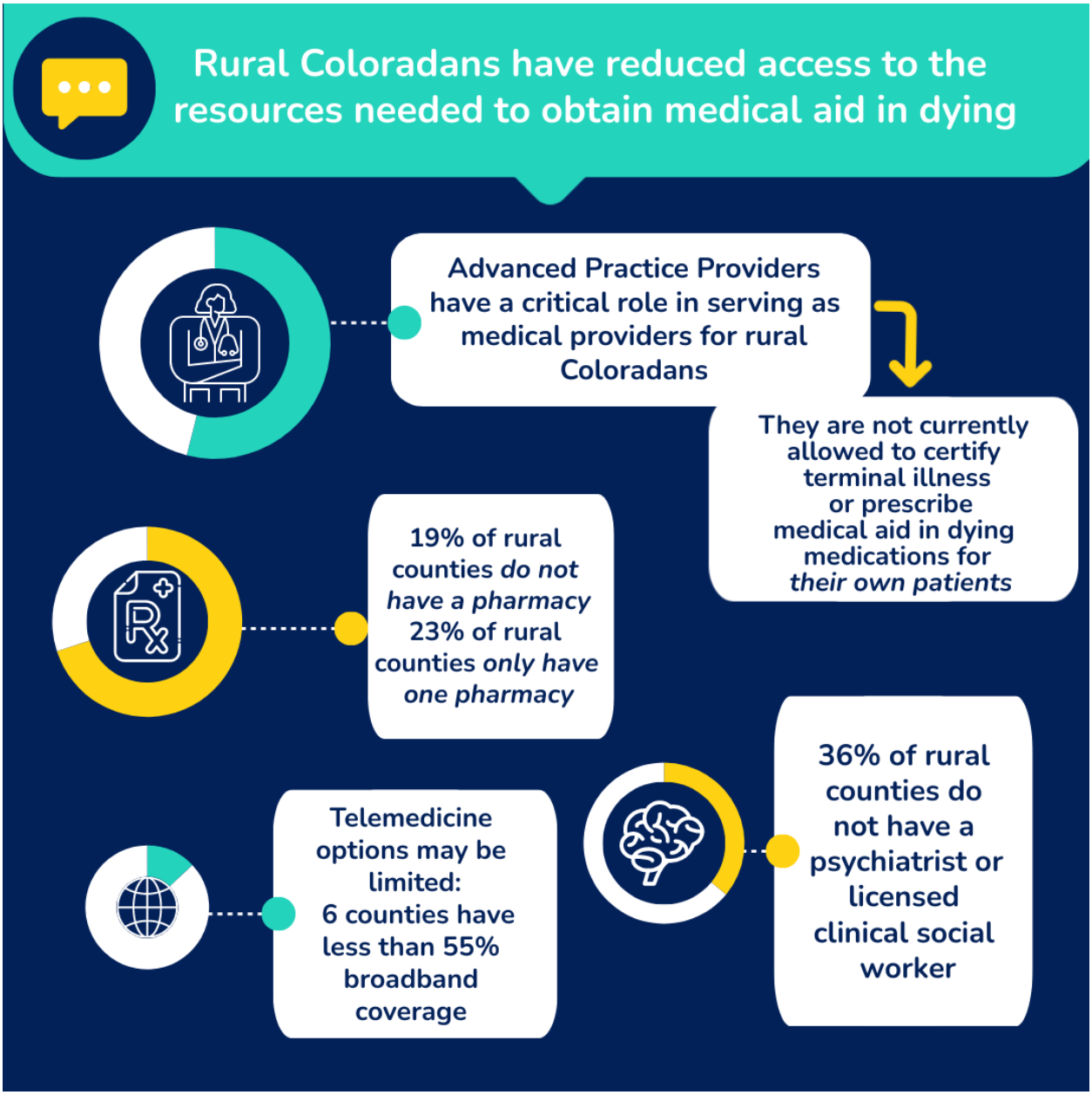
MAID Driver Diagram



Adapted from Institute for Healthcare Improvement. (2022). *QI essentials toolkit: Driver diagram.* http://www.ihi.org/resources/Pages/Tools/DriverDiagram.aspx?PostAuthRed=/resources/_layouts/download.aspx?SourceURL=/resources/Knowledge%20Center%20Assets/Tools%20-%20DriverDiagram_095088a2-98ac-48d2-ab97 dd6c899193ae/QIToolkit_DriverDiagram.pdf

Appendix G

Infographic



Data retrieved from Colorado Rural Health Center, 2022

Appendix H

One-page legislative brief

Reducing Barriers to Accessing Medical Aid in Dying: Improving the Colorado End of Life Options Act

Why an amendment is necessary:

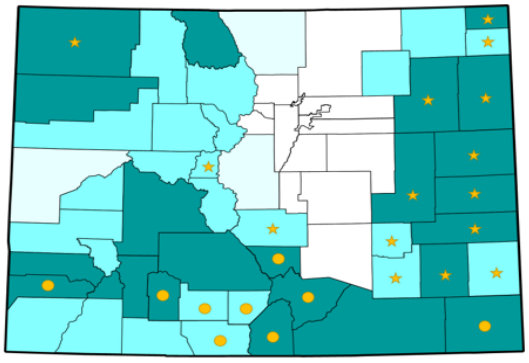
Medical aid in dying (MAID) is a process by which a terminally ill, competent adult with a prognosis of 6 months or less can choose to obtain prescribed medication to end their life peacefully. The Colorado End-of Life Options Act (EOLOA) currently requires that two physicians certify terminal illness. Physicians are not required to participate, either due to conscientious objection or as forbidden by their employer (i.e., religiously affiliated health systems), which limits the pool of participating physicians.[1] Once an individual is able to find two physicians who are willing and able to participate (which can take months), the law then requires that the individual make two verbal requests 15 days apart to their attending physician. Obtaining MAID can be a difficult, time-intensive process – especially for residents living in rural and frontier areas.

Nearly all rural and frontier counties are facing shortages of medical professionals.[2] Advanced practice providers (including nurse practitioners and physician assistants) help to bridge the gap, but these providers are not currently allowed to certify terminal illness or prescribe MAID medications in Colorado.[3] Particularly in the eastern and southern portions of the state, advanced practice providers outnumber physicians.[4] There are two counties where no active physicians are identified and six counties where there is only one active physician identified[4] *Terminally ill, debilitated rural patients may have to travel a significant distance to find two physicians willing to participate in order to obtain medical aid in dying.*

Policy Recommendation:

An amendment to the EOLOA could help reduce burden for terminally ill individuals seeking MAID. New Mexico's Elizabeth Whitefield End of Life Options Act of 2021 provides guidance:

- **Allow advanced practice provider to participate as a certifier of terminal illness and *prescriber in collaboration with a physician.*[5]**
- **Reduce waiting period from 15 days down (48 or 72 hours are options).[6][7]**
- Waive the waiting period if the individual is not expected to survive 15 days and all other requirements are met.[8]
    - Since law was amended in Oregon in 2020, 20% of MAID recipients were granted this exception annually[9]
- Enrollees in hospice have already been certified to have a terminal diagnosis with a prognosis of 6 months or less – hospice medical director can make determination on their own to certify and prescribe MAID.[5]



Colorado Rural County Designation Map with Advanced Practice Provider to Physician Ratio

Urban | Rural areas

Rural | Frontier

Number of Advanced Practice Providers is greater than or equal to the number of full-time physicians countywide

Number of Advanced Practice Providers is greater than or equal to the number of all physicians countywide

Map adapted from: Colorado Rural Health Center, 2022.

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[1] State of Colorado, Article 48, Title 25, C.R.S. (2016). https://www.sos.state.co.us/pubs/ elections/Initiatives/titleBoard/filings/2015-2016/145Final.pdf

[2] Colorado Rural Health Center. (2022). *Snapshot of rural health in Colorado: 2022.* https://coruralhealth.org /wp-content/uploads/2022/01/2022-Snapshot-of-Rural-Health-FINAL-Final.pdf

[3] State of Colorado, Article 48, Title 25, C.R.S. (2016). https://www.sos.state.co.us/pubs/ elections/Initiatives/titleBoard/filings/2015-2016/145Final.pdf

[4] Health Resources & Services Administration. (2021). *Area health resources files.* https://data.hrsa.gov/topics/health-workforce/ahrf

[5] End of Life Options New Mexico. (n.d.). *Steps for using the end-of-life options act.* https://endoflifeoptionsnm .org/end-of-life-options-act/steps-for-using-the-eolo-act/

[6] Compassion and Choices. (n.d.b). *California.* https://compassionandchoices.org/in-your-state/california

[7] Compassion and Choices. (n.d.c). *Washington.* https://compassionandchoices.org/in-your-state/washington

[8] Compassion and Choices. (n.d.d). *Oregon.* https://compassionandchoices.org/in-your-state/oregon

[8] Oregon Health Authority. (2022). Death with Dignity Act. https://www.oregon.gov/oha/ph/providerpartne rresources/evaluationresearch/deathwithdignityact/pages/ar-index.aspx

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Ashley Fry is an inpatient palliative medicine nurse practitioner in Colorado Springs. She has over 15 years of nursing experience, including work in inpatient and outpatient palliative medicine settings and hospice. She is certified as an advanced hospice and palliative care nurse and is a symptom management specialist for those living with chronic, progressive, and terminal illness.

Appendix I

Highlighted recommendations, Elizabeth Whitefield End-of-Life Options Act

HB47/a, page 2, lines 6-18. Section 2- Definitions, subsection D: "health care provider" means any of the following individuals authorized pursuant to the New Mexico drug, device, and cosmetics act to prescribe a medication to be used in medical aid and dying: 1) a physician licensed pursuant to the Medical Practice Act; 2) an osteopathic physician licensed pursuant to the Osteopathic Medicine Act; 3) a nurse licensed in advance practice pursuant to the Nurse Practice Act; 4) physician assistant license pursuant to the Physician Assistant Act or the Osteopathic Medicine Act

HB47/a, page 5, lines 2-25. Section 4 – Medical Aid in Dying- Prescribing health care provider determination form, subsection G: …Affirmed that the individual is (1) enrolled Medicare-certified hospice program; or (2) eligible to receive medical even dying after the prescribing health care provider has referred the individual to a consulting health care provider, who has experience with the underlying condition rendering the qualified individual terminally ill, and the consulting health care provider has […]

State of New Mexico, Chapter 132, House Bill 24. (2021).