Early Discussion and Resolution

Annual Report

July 2014 – June 2015

OREGON
PATIENT SAFETY
COMMISSION
Early Discussion and Resolution

October 2015

The Oregon Patient Safety Commission is a semi-independent state agency that operates multiple programs aimed at reducing the risk of serious adverse events occurring in Oregon's healthcare system and encouraging a culture of patient safety. The Patient Safety Commission's programs include Early Discussion and Resolution, the Patient Safety Reporting Program, and various quality improvement initiatives. To learn more about the Patient Safety Commission, visit oregonpatientsafety.org.

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Executive Summary

Despite the best training and intentions, things can and do go wrong during healthcare. Research shows that, in hospitals alone, the number of patient deaths due to preventable adverse events is 210,000-400,000 a year, making them our nation's third leading cause of death. Serious harm to patients occurs even more frequently (James, 2013). After patient harm or death occurs, healthcare professionals often grapple with feelings of guilt and fear, while patients and families are left without the support and answers they need to move on.

When providers and patients have a conversation about what went wrong, it can bring resolution and closure for both parties. Early Discussion and Resolution (EDR)—launched July 2014—ensures that these conversations are confidential and protected under Oregon law so that more providers and patients can get closure.

Patients and healthcare professionals in Oregon have begun to learn about and take advantage of this unique opportunity. In the first year, 29 patients and healthcare professionals have requested a discussion through EDR by filing a notice. Patients filed 21 notices and healthcare professionals filed eight notices. A majority of the eight notices filed by healthcare professionals were filed by hospital representatives. Some of the filed notices resulted in discussions.

Much of what can be learned about these discussions comes from data reported by participants. With only a small number of resolution reports received to date, limited information about discussions is currently available. In future years, OPSC will be better able to provide information about the impact of EDR on transparency, patient safety, and medical malpractice claims and lawsuits.

Provider and patient engagement in EDR in the first year is encouraging. The success of EDR hinges on long-term culture change among Oregon's healthcare professionals and a significant effort is needed to make that change. Since implementation, the Patient Safety Commission has made the following observations:

- Organizational readiness impacts responsiveness to patients who have been harmed
- Healthcare professionals must work within a culture of safety for EDR to thrive
- Coordination between multiple stakeholders adds complexity to the process
- Some healthcare professionals have expressed uncertainty about using EDR
- Patients lack awareness about EDR or other options for resolution following a negative care experience

This report provides an overview of EDR activity in the first year and lessons learned from early implementation. The report also summarizes the Patient Safety Commission's ongoing work to ensure the success of EDR. For more information about EDR, visit edr.oregonpatientsafety.org.

Introduction

Healthcare professionals work hard to provide patients the best care every day;[1] however, things can and do go wrong in healthcare. Recent research estimates that 210,000-400,000 patients die of preventable harm each year in hospitals alone, making it our nation's third leading cause of death. Serious patient harm occurs much more frequently (James, 2013).

After patient harm, the patient, their family, and the healthcare professional(s) involved can experience lasting effects (see Appendix I for terms and definitions). The patient and their family must cope with the physical, emotional, and financial impact (Duclos et al., 2005; Mazor, Goff, Dodd, & Alper, 2009), which may be exacerbated by a lack of understanding about what happened. The healthcare professional may experience significant emotional distress and job-related stress that may increase if the professional is dissatisfied with disclosure to the patient (Waterman et al., 2007).

Both patients and healthcare professionals can benefit from timely communication and resolution when something goes wrong during care. Oregon is one of the first states in the country to pass a law promoting open, transparent communication with patients and families when serious harm or death occurs as a result of care[2]—what is now called Early Discussion and Resolution (EDR) (for a history of EDR see Appendix II).[3] EDR provides confidentiality that allows healthcare professionals and their patients to talk openly about what happened and to explore the best way to move toward resolution and healing. By talking openly, a patient's need to seek an attorney may be diminished and learning for improved patient safety can occur (Boothman, Blackwell, Campbell, Commiskey, & Anderson, 2009).

Organizations may have communication and resolution processes that encourage open communication and proactive resolution with patients when things go wrong. These processes may vary depending on an organization's size, the types of services provided, or their philosophies regarding apology and compensation (see Appendix III for information on one process model).[4] EDR can enhance an organization's existing communication and resolution process; however, successful integration of EDR requires strong leadership support and a culture of safety.

With the adoption of Early Discussion and Resolution, Oregon continues to take important steps to improve patient safety. As part of a national patient safety movement that promotes the use of proactive communication and resolution processes, EDR can contribute to improved transparency and patient safety beyond Oregon.

Early Discussion and Resolution can enhance an organization's existing communication and resolution process.

EDR Benefits

When things go wrong during care, Early Discussion and Resolution (EDR) encourages transparent conversation and creates the environment necessary for resolution and healing. When used in conjunction with a communication and resolution process, EDR:

[1] Healthcare professionals are healthcare facilities (or representatives from healthcare facilities), healthcare providers, employers of healthcare providers, and liability insurers.

[2] Also referred to as a "serious adverse event"—an unanticipated consequence of patient care that is usually preventable and results in the death of or serious physical injury to a patient.

[3] Oregon laws 2013, chapter 5 became effective July 1, 2014. www.oregonlegislature.gov/bills_laws/lawsstatutes/2013orLaw0005.pdf

[4] One emerging model, called a Communication and Resolution Program (CRP), offers a structured approach for responding to patients who have been harmed, emphasizes patient safety improvements, and aims to meet the needs of both patients and healthcare professionals.

Provides confidentiality to encourage open communication. All communications between a healthcare professional and a patient are protected by law so that healthcare professionals feel comfortable communicating openly. Open and transparent communication fosters an environment of trust and respect. This allows a patient to be heard and a healthcare professional to share important information about what happened. With a better understanding of what happened, the patient and healthcare professional can discuss the best way to move toward resolution and healing.

Offers a path to resolution without lawsuits. When a patient is injured or dies, the outcome can be a long, drawn out legal process that is painful for everyone involved. Lessons from other states suggest that when healthcare professionals communicate openly with patients about harm, all parties are more likely to avoid the pain and expense of lawsuits (Boothman et al., 2009). Proactively working together to resolve patient harm events allows everyone to move toward resolution more quickly.

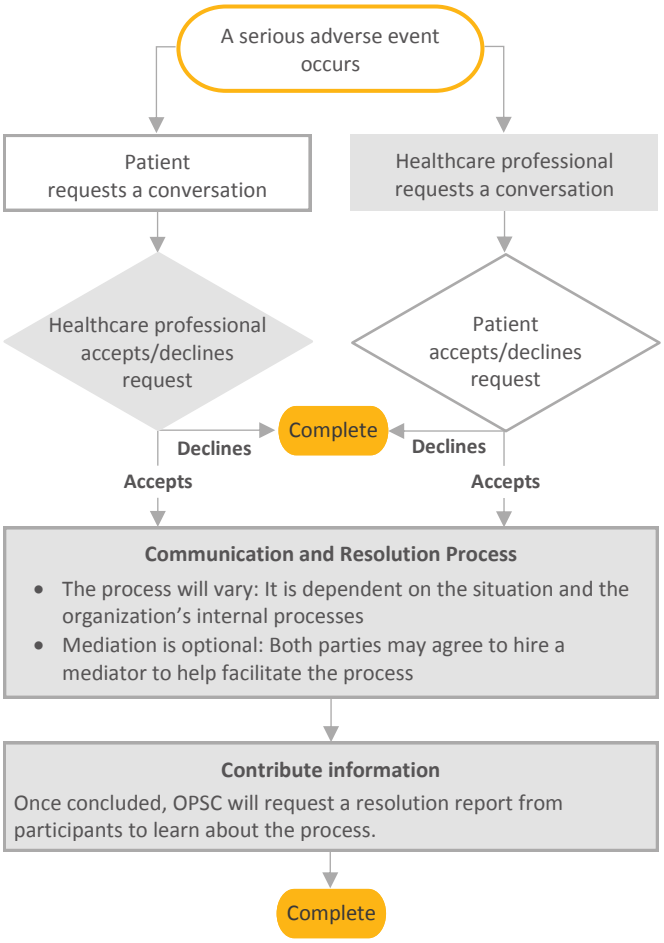
Prevents a bad situation from getting worse. When something devastating happens to a patient and they experience silence, they may be inclined to share their negative experience publicly, file a complaint, or file a lawsuit. A conversation offering a full disclosure of what happened and an acknowledgement of the patient's pain can prevent these actions. Proactive communication can also ensure timely follow up treatment for the patient, if needed.

Fosters learning and improvement. With a communication and resolution process in place, healthcare professionals are empowered to investigate what happened to identify and address safety gaps. In addition, EDR participants share information about their experience with the Patient Safety Commission. Non-identifiable data is analyzed and shared for statewide learning.

EDR Process Overview

When a serious adverse event occurs, either a healthcare professional or a patient can initiate Early Discussion and Resolution (EDR) by filing a notice with the Oregon Patient Safety Commission (OPSC) (see Figure 1). The notice represents a request from the filer to talk to the other party about what happened and seek resolution. If both parties agree to participate, they will come together for a transparent conversation using the healthcare professional's communication and resolution process. Once complete, participants will share information about their experience in a resolution report. OPSC analyzes non-identifiable data and shares trends and information for statewide learning.

Figure 1. The Early Discussion and Resolution Process*



*See Appendix IV for more detail.

EDR Use

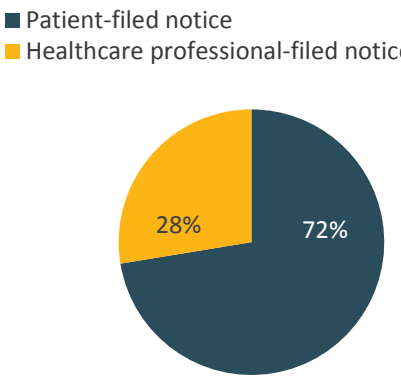
Early Discussion and Resolution (EDR) can be initiated by either a healthcare professional or a patient who files a notice with the Oregon Patient Safety Commission (OPSC).[5] The notice represents a request to have a transparent conversation about what went wrong to bring resolution and closure to all involved.

Data Collection

The EDR Online System is a secure, web-based system where notices can be filed and managed. Data collected through the EDR Online System is confidential and no information about individual events, healthcare professionals, or organizations is made public. Non-identifiable data is analyzed and shared for statewide learning.[6]

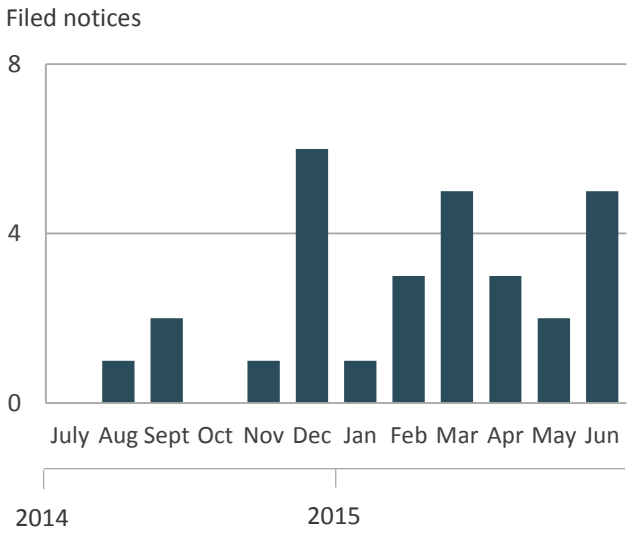
A total of 29 notices were filed by patients and healthcare professionals in the first year of EDR. Patients filed 21 notices (72%) and healthcare professionals filed eight notices (28%) (see Figure 2). A majority of the eight notices filed by healthcare professionals were filed by hospital representatives. No notices were filed by individual healthcare providers.

Figure 2. Filed notices by filer type, July 2014-June 2015 (n=29)



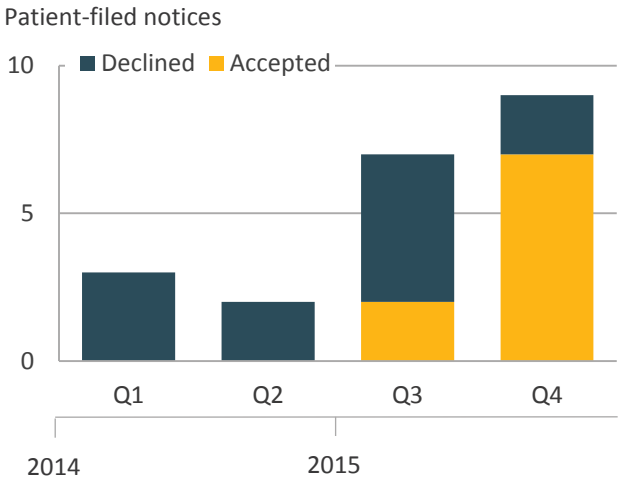
Over the course of the first year, at least one notice was filed each month except in July 2014 and October 2014 (see Figure 3). Patients were the first to file notices (in August 2014). The first notices filed by healthcare professionals were filed in the second quarter (October-December 2014).

Figure 3. Notices filed by month, July 2014-June 2015 (n=29)



Because EDR is voluntary, both parties must agree to participate for EDR to begin and either party can choose to stop participating at any time. For nine of the 21 patient-filed notices (43%), at least one involved healthcare professional accepted the patient's request to participate in EDR (see Figure 4).

Figure 4. Accepted and declined patient-filed notices by quarter, July 2014-June 2015 (n=21)



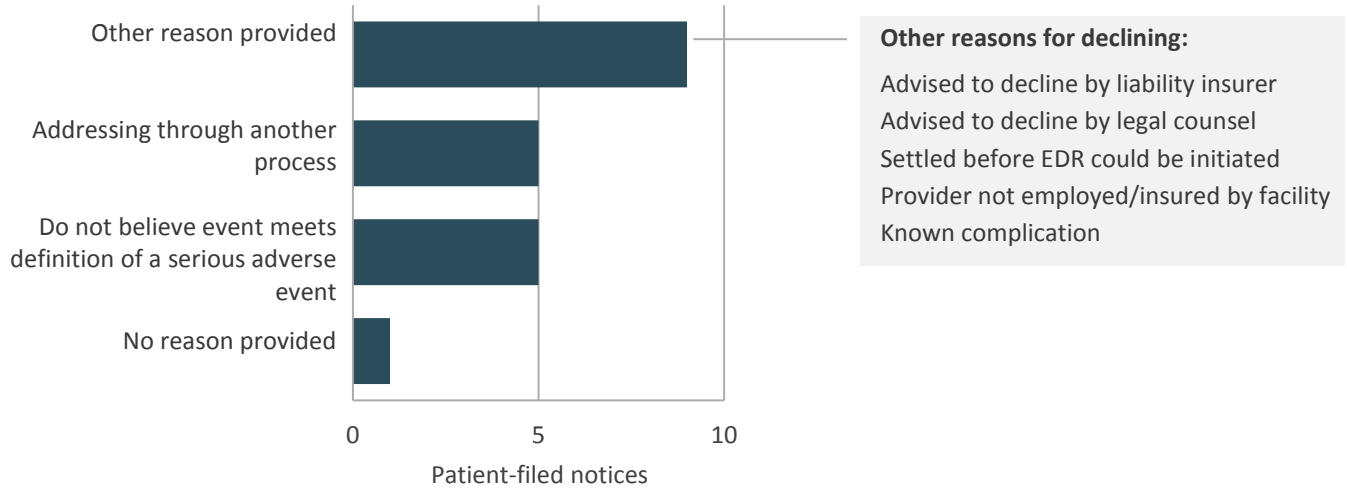
[5] Oregon Laws 2013, chapter 5, section 2 (1)(c) and (2)(c) defines notice filing requirements.

[6] Oregon Laws 2013, chapter 5, section 10 describes the use of data by OPSC.

In the remaining 12 patient-filed notices (57%), the involved healthcare professional(s) chose to decline the request. The most common reasons given for declining EDR were that the event was being addressed through another process (five responses) or that the healthcare professional thought that the event did not meet the definition of a serious adverse event (five responses, see Figure 5).

For healthcare professional-filed notices, information about a patient's decision to participate is collected in a resolution report, which is requested 180 days after the notice is filed. More information will be available in future years as EDR grows and evolves (see Data Limitations on page 6 for additional information).

Figure 5. Reasons healthcare professionals declined patient-filed notices
(n=20)



Note: Some notices named more than one provider. The total number of declined patient notices (12 notices) is different than the total number of decline reasons because in certain circumstances, each named provider may independently make a decision to accept or decline an EDR request (e.g., the named provider is not employed by the facility). Additionally, one notice included more than one reason for declining the EDR request.

Event Types

EDR is specifically designed for serious adverse events—unanticipated consequences of patient care that are usually preventable and result in the death of, or serious physical injury to, the patient.[7] Serious physical injury is an injury that:

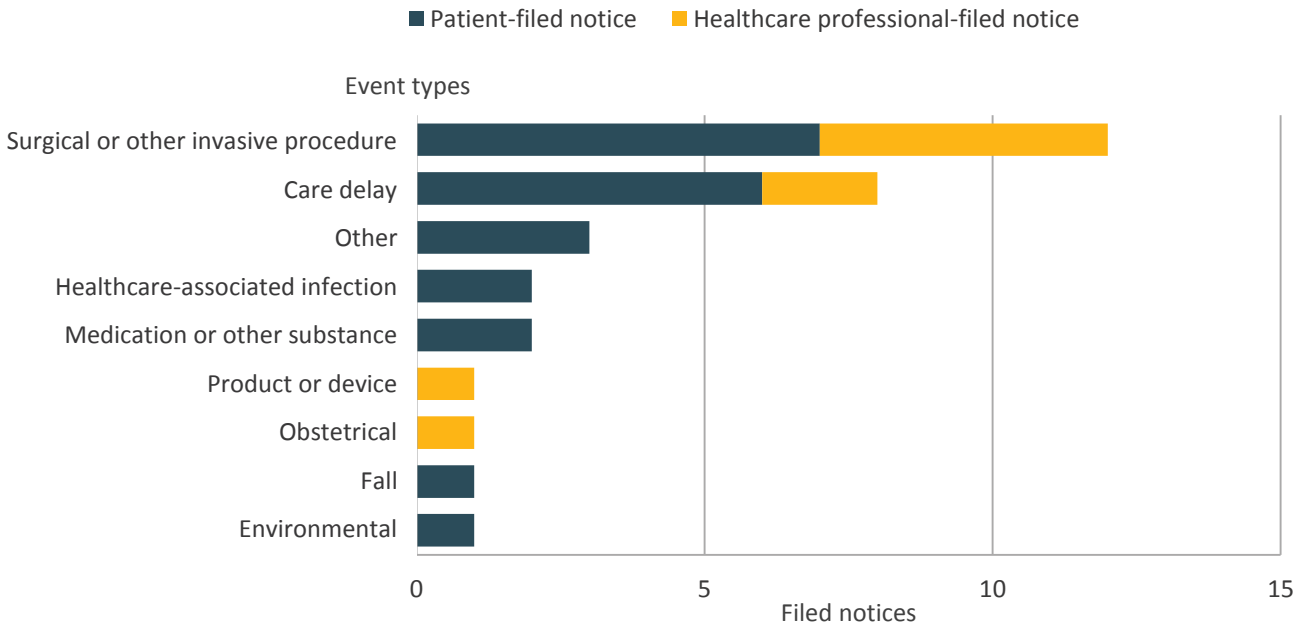
- Is life threatening; or
- Results in significant damage to the body; or
- Requires medical care to prevent or correct significant damage to the body.

The events described in filed notices were categorized by type based on definitions used by OPSC's Patient Safety Reporting Program and informed by the Agency for Healthcare Research and Quality's Common Formats and the National Quality Forum's Serious Reportable Events (see Appendix V).

Categorization was determined by OPSC staff using an independent review process to ensure consistency and inter-rater reliability.

The two most frequently reported event types described in notices filed in the first year of EDR were *Surgical or other invasive procedure* events (39%) and *Care delays* (26%) (see Figure 6).

Figure 6. Types of events described in filed notices by filer type, July 2014-June 2015
(n=31)



Note: The total number of event types does not equal the total number of notices because more than one event type may be included in a notice.

[7] Oregon Laws 2013, chapter 5, section 1(1) defines adverse healthcare incidents which are called serious adverse events for the purposes of this report.

Patient Characteristics

Notices filed by patients include demographic information pertaining to gender and age (see Figures 7 and 8). This information is collected to ensure that the healthcare professional receiving the notice can accurately identify the patient. To ensure timely initiation of the EDR process, only critical information is requested from a notice filed by a healthcare professional. Therefore, patient characteristics from notices filed by healthcare professionals are not yet available (see Data Limitations).

Figure 7. Patient gender in patient-filed notices, July 2014-June 2015
(n=21)

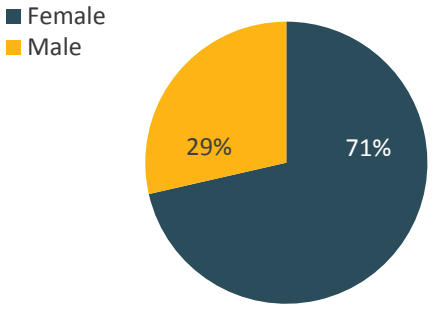
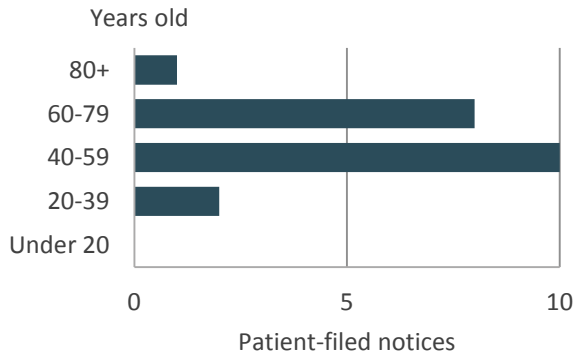


Figure 8. Age group of patient at the time of the event in patient-filed notices, July 2014-June 2015 (n=21)



Data Limitations

Time to reach resolution impacts availability of resolution data: Much of what can be learned about the resolution status and process comes from resolution reports completed by participants. In accordance with the law, resolution reports are voluntary and are requested from participants 180 days after the date the notice was filed unless otherwise indicated. In the first year, only enough time passed to receive a small number of resolution reports. OPSC looks forward to sharing more of this information as it becomes available in the coming years.

Limited patient demographic data: To ensure that paperwork would not be a barrier to participation, the process of filing a notice was simplified as much as possible. As a result, demographic data is primarily collected in resolution reports. With the small number of resolution reports collected during the first year of EDR, limited demographic data is available for analysis.

Lack of baseline or malpractice data: There is currently no mechanism to capture the total number of serious adverse events occurring in Oregon, the number of statewide claims related to events, or the number of statewide medical malpractice cases. Neither the Patient Safety Reporting Program,[8] the National Practitioner Data Bank,[9] nor the Oregon Medical Board collect comprehensive data that can provide a baseline for any of these measures. Oregon is currently transitioning to the eCourt system which will allow tracking of medical malpractice lawsuits in the future,[10] but will not be fully implemented until August 2016. Without a baseline for comparison, data trends will be essential but will take a few years to assess.

[8] OPSC's voluntary program for Oregon healthcare facilities to report adverse event investigation findings and action plans; non-identifiable data is analyzed and shared for statewide learning. oregonpatientsafety.org/reporting-programs/

[9] NPDB is a limited-access, federal repository containing some information on medical malpractice payments and certain adverse actions related to health care practitioners, entities, providers, and suppliers.

[10] Oregon eCourt is a stateside web-based courthouse. courts.oregon.gov/oregonecourt/Pages/About.aspx

Lessons Learned

The first year of Early Discussion and Resolution (EDR) in Oregon was a year of learning and continuous improvement. The Oregon Patient Safety Commission (OPSC) is committed to responding to changing needs as Oregon integrates EDR into the culture of healthcare. The key lessons learned for the first year of EDR implementation and the OPSC's efforts to address identified needs are described in this section.

I. Organizational readiness impacts responsiveness to patients who have been harmed.

Timely communication between a patient and a healthcare professional is essential to resolving patient harm events. Two common factors may impact an organization's responsiveness to a patient following a serious adverse event:

An organizational communication and resolution process. Organizations that consistently use a communication and resolution process already have the infrastructure needed to incorporate EDR. EDR does not replace or independently function as an organization's communication and resolution process; rather, EDR enhances existing processes by providing confidentiality afforded by the law and collecting data for statewide learning.[11]

An EDR plan in place. Organizations can take steps to ensure they are ready to initiate EDR when appropriate or respond to a patient's request to use EDR. Having a plan in place allows for immediate use of EDR and timely responses to patients. Lack of preparedness related to EDR can delay communication with a patient and contribute to unnecessary distress in an already stressful situation.

Targeted Efforts

To support organizational readiness, OPSC is:

Sharing emerging best practices for communication and resolution processes. Lessons from early Communication and Resolution Programs are expected to be released in a toolkit from the Agency for Healthcare Research and Quality.[12] Once released, OPSC will determine the best approach to distribute the tools to healthcare professionals.

Equipping healthcare professionals to quickly respond. OPSC has established a process for healthcare facilities to designate one or more individuals to act on behalf of the facility for purposes of EDR ("EDR Manager"). Having an EDR Manager established in the secure EDR Online System enables a facility to quickly file a notice from any computer with internet access and to be automatically notified if a patient files a notice about an event at their facility. Likewise, any healthcare professional working outside of a defined facility can file a notice, or be granted access to view a notice, from any computer with internet access.

Raising awareness. OSPC is educating healthcare professionals so they can quickly use EDR should the need arise. OPSC has provided education to over 50 healthcare professional associations and developed EDR resource materials that are easily accessed on the website. In the coming year, OPSC is seeking guidance from a communications firm to further develop EDR outreach strategies.

[11] Oregon Laws 2013, chapter 5.

[12] For more information on lessons from early Communication and Resolution Programs, see the Health Affairs publication, "Communication-And-Resolution Programs: The Challenges and Lessons Learned from Six Early Adopters." (Mello et al., 2014)

II. Healthcare professionals must work within a culture of safety for EDR to thrive.

A culture of safety is comprised of three components that are necessary for healthcare professionals to successfully use EDR: a reporting culture, a just culture, and a learning culture. The three components are interconnected and all must be present to achieve a culture of safety. Together, they enable proactive communication with patients when things go wrong.

A reporting culture. A culture that encourages early reporting of adverse events.

A just culture. A culture where staff feel comfortable and are encouraged to provide safety-related information without fear of punishment. Staff is equipped to conduct in-depth investigations to identify root causes of adverse events.

A learning culture. A culture that is open to learning from adverse events and other safety-related information to improve patient care.

For more on a culture of safety, see *Culture of Safety: The Foundation of Patient Safety Improvement* on page 9.

Targeted Efforts

OPSC is committed to supporting healthcare organizations to develop a culture of patient safety through a variety of initiatives. OPSC continuously seeks out best practices and other patient safety innovations to share with healthcare professionals. In 2015, OPSC prioritized raising awareness about support programs for healthcare professionals involved in patient harm events. Because involvement in this type of event can deeply affect both the emotional and professional lives of healthcare professionals, programs to support these individuals are essential. (See Appendix VI for more information on OPSC's efforts to promote safety culture improvement.)

III. Coordination between multiple stakeholders adds complexity to the process.

Participation in EDR may require coordination between the multiple stakeholders associated with a serious adverse event. Coordination is necessary for making a decision to use EDR for a given event, conducting the investigation into what happened and why, and determining how to achieve resolution.

Depending on the unique situation, some of the stakeholders may include:

- A representative from the healthcare organization where the event took place
- The multiple healthcare professionals involved in the event
- The liability insurer representing the healthcare organization
- The liability insurers representing the healthcare professionals
- A representative from the organization that employs the healthcare professional

In cases where multiple stakeholders share responsibility for the event, one party may be reluctant to acknowledge their role. Furthermore, in situations where compensation is appropriate, stakeholders may have differing philosophies about settlement to reach resolution. When stakeholder perspectives do not align, coordinating EDR can be a challenge.

Targeted Efforts

OPSC is engaging healthcare professionals and insurers because these communities may need to collaborate if a patient is harmed. Through increased awareness about EDR, OPSC hopes that healthcare professionals and insurers can thoughtfully plan for situations that may involve communication and resolution strategies and EDR.

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Culture of Safety: The Foundation of Patient Safety Improvement

A culture of safety is comprised of three components: a *learning culture*, a *just culture* and a *reporting culture*. The three components are interconnected—all must be present to achieve a culture of safety—and share common characteristics (e.g., transparency, accountability, committed leadership). Having a culture of safety is foundational to implementing organizational efforts to improve patient safety. Organizational efforts can be enhanced by engaging in supportive patient safety activities, such as the Oregon Patient Safety Commission's (OPSC) programs highlighted below.

Communication and Resolution Process

When something goes wrong during care, the organization has a process to have an open conversation with the patient about what happened and to explore the best way to move toward resolution.

Early Discussion and Resolution (EDR)

When serious physical injury or death occurs, EDR enhances the organization's process by providing confidentiality to encourage open communication creating an environment of trust, diminishing the need for lengthy lawsuits, and fostering learning and improvement.

Adverse Event Investigation Process

When adverse events or safety issues are identified, the organization has a structured process for an in-depth investigation and implements system-level action plans to prevent future occurrences.

Patient Safety Reporting Program

Organizations report their adverse event investigation findings and action plans to OPSC, which are analyzed, de-identified, and shared for statewide learning. Organizations receive consultation and support on adverse event investigation.

Patient Safety Initiatives

The organization is actively working to improve patient safety in targeted areas.

Improvement Collaborative

Through shared learning, teams from different organizations work to rapidly test and implement changes that lead to improvement.

Learning Culture	Just Culture	Reporting Culture
A willingness and competence to learn from safety information systems and the will to implement change as needed.	An atmosphere of trust in which people are encouraged to provide essential safety-related information, while maintaining professional accountability.	An organizational climate which encourages and facilitates the reporting of adverse events and safety issues.

(continued from page 8)

IV. Some healthcare professionals have expressed uncertainty about using EDR.

Some healthcare professionals have expressed concern that using EDR may have inadvertent negative reputational, credentialing, or disciplinary consequences. Specifically, concern was voiced that EDR may increase liability risk or trigger reports to the National Practitioner Databank (NPDB) or state regulators. OPSC is monitoring these concerns.

Other reasons for uncertainty about EDR were less clear. To understand what may contribute to this perspective, OPSC researched communication and resolution process models across the country. OPSC learned that healthcare professionals were often uncomfortable with openly discussing an event with a patient. This discomfort may have stemmed from a lack of training in disclosure and a cultural reluctance to admit involvement in unanticipated patient outcomes (Mello et al., 2014).

Targeted Efforts

OPSC recognizes that fear of change is often an underlying factor in resistance (Gesme & Wiseman, 2010). To address this fear from multiple angles, OPSC has:

- Committed to offering education to healthcare professionals about EDR, its impacts, and how others are using similar programs in other parts of the country
- Presented to over 50 healthcare professional groups and associations about EDR
- Maintained an EDR website so that information about EDR is always available
- Provided individual consultation to healthcare professionals engaged in or considering EDR

Additionally, OPSC is aligning with the best practices of established Communication and Resolution Programs that remind us to "be patient" and expect that the culture shift and returns on investment will take several years (Mello et al., 2014).

V. Patients lack awareness about EDR or other options for resolution following a negative care experience.

Patients (and their families) contact OPSC regularly with patient safety questions and concerns. In situations involving serious harm or death of a patient that may be appropriate for EDR, OPSC offers information to help patients make a decision about using EDR.[13]

In some cases, the events patients describe do not qualify for EDR. Sometimes this is because the event occurred before the EDR effective date of July 1, 2014. While OPSC expects that patient inquiries about events that occurred prior to the effective date will decrease over time, this may only mask the true problem—patients lack awareness of options for resolution following a negative care experience. Ultimately, this knowledge gap may delay or impede the opportunity for resolution and can lead to unnecessary stress and frustration for patients.

Targeted Efforts

Because OPSC believes that open communication can be beneficial regardless of a patient's situation, patients are always encouraged to try resolving their concerns directly with their healthcare professional even if EDR is not appropriate. Most organizations have systems in place to help patients manage healthcare concerns; however, patients are often unaware that these resources exist. When EDR is not appropriate, OPSC connects patients

[13] OSPC provides information to callers to enable them to independently decide if their situation is appropriate for EDR.

with a person or department within a healthcare organization to resolve their concerns.

Sometimes patients want to report a potential standard of care violation but are unaware of the appropriate agency to contact. OPSC has compiled a publicly available list of other resources for resolution.[14]

OPSC Activity

On July 1, 2014, Early Discussion and Resolution (EDR) became effective in Oregon. Oregon is one of the first states in the country to pass a law like this and what we learn may inform how similar laws in other states are designed.

This section of the report describes the Oregon Patient Safety Commission's (OPSC) efforts to develop and implement EDR over the past two years. This includes the development phase (July 2013-June 2014) and the first year of EDR (July 2014-June 2015).[15]

Outreach

The development phase and the first year of EDR involved outreach efforts to ensure that Oregonians were aware of EDR, knew how to participate, and had adequate opportunity to provide input into an effective process.

Soliciting Input

To help shape the design and development of EDR and ensure the clarity of the Oregon Administrative Rules,[16] OPSC sought input in the following ways:

Stakeholder Advisory Group: Members of this advisory group included representatives from healthcare facilities and other key organizations. These committed individuals met monthly to ensure clarity of the administrative rules; share thoughts about potential educational offerings, resources, and support for healthcare professionals; provide input on tools created to support EDR; and share ideas for improvement.

Patient Advisory Group: Members of this advisory group included patients and patient advocates from Oregon and other states who met monthly to ensure that EDR was designed in a way that was easy for patients to use and understand.

Implementation Outreach Sessions: OPSC hosted events for risk managers, medical liability insurers, and other interested healthcare professionals to share early thoughts and provide input into strategies for implementation. OPSC also conducted a series of meetings with the mediation community to better define their role in EDR.

Preliminary Knowledge and Opinions Survey: OPSC conducted a survey of physicians, physician assistants, medical practice managers, dentists, midwives, nurses, and hospital quality and risk managers to better understand their assumptions and opinions about EDR. While the response rate was small, OPSC was able to learn about perceived benefits, barriers, and EDR-related support needs, which informed OPSC's targeted outreach to healthcare professionals. A follow-up survey will be conducted in the future to understand how knowledge and opinions about EDR may have changed.

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[14] The list of resource for resolution is available on OPSC's website: oregonpatientsafety.org/patients-families/other-resources-for-resolution/

[15] The Task Force on Resolution of Adverse Healthcare Incidents provides oversight and guidance for OPSC's EDR-related activities. Learn more about the Task Force at: edr.oregonpatientsafety.org/reports/content/task-force

[16] Oregon Administrative Rules 325-035-0001 through 325-035-0045. arcweb.sos.state.or.us/pages/rules/oars_300/oar_325/325_035.html

Early Discussion and Resolution

Year in Review

July 2014 – June 2015

29 Notices filed for EDR

8 - Healthcare Professionals

21 - Patients

EDR Online July 1, 2014

EDR Online System Available

The online system is a secure notice filing and management system that can be accessed anywhere with an internet connection.

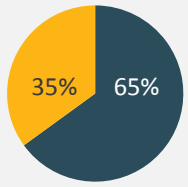
EDR Website Live

The EDR website houses information and resources for patients and healthcare professionals to support EDR.

edr.oregonpatientsafety.org

6,283 Website sessions

Total number of times both new and returning visitors engage with the EDR website



Spreading the Word

EDR impacts anyone receiving healthcare in Oregon, as well as 30 different types of healthcare providers, and five types of healthcare facilities. Sharing information about EDR has been, and will continue to be, a central focus of the Oregon Patient Safety Commission (OPSC).

375	Libraries, community centers, and senior centers received brochures
50	Presentations or exhibits
20	Articles published by newspapers and in newsletters
1	Radio broadcast
1	Podcast

Promoting a Culture of Safety

OPSC facilitated a training to provide healthcare professionals with tools for developing peer support programs. A peer support program connects healthcare professionals with support services following an adverse event or other emotional experience.

100%

Satisfaction

With the content of the Peer Support Training program

56 participants, 54% response rate

Partnerships

Multiple groups partnered with OPSC to help inform the development and implementation of Early Discussion and Resolution in Oregon.

- Stakeholder Advisory Group
- Patient Advisory Group
- Task Force on Resolution of Adverse Healthcare Incidents
- National Collaborative on Accountability and Improvement

(continued from page 11)

Providing Information

Website: The EDR website is the primary source of EDR information, resources, and guidance for members of the public, healthcare professionals, and mediators.[17] The website is also the access point to the EDR Online System which supports functions of EDR. The website went live July 1, 2014 and continues to evolve as additional user needs arise.

Printed materials: To supplement web-based materials, targeted printed materials were distributed to the public and the healthcare professionals. With guidance from a plain language consulting firm, plain language concepts were applied to the materials for the public to improve understanding for all readers. (See Appendix VII for available materials.)

Promoting awareness: OPSC provided educational presentations and exhibited at over 50 conferences and meetings. Additionally, OPSC partnered with medical liability insurers to present for their insureds and provided newsletter and website content to about 15 organizations.

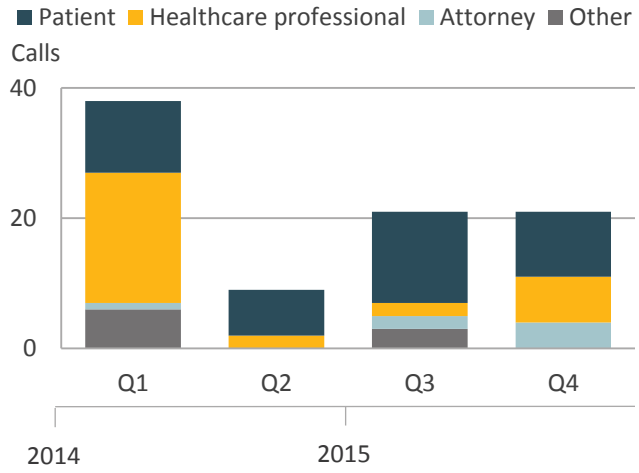
Phone Support

A designated phone line is available to anyone with questions about EDR. Call volume for the first year of EDR was manageable and will be continuously monitored to ensure adequate staff resources are available to support callers (see Figure 9).

Calls included questions about EDR, specific events, how the online system works, and calls related to previously filed notices (see Figure 10). The majority of all calls received (82%) were from patients (or their friends and family) and healthcare professionals.

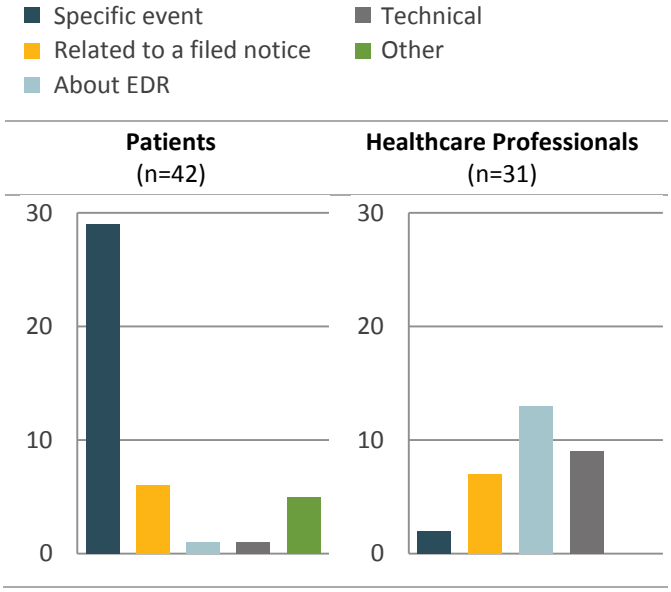
On average, calls from patients were longer (22 minutes) than calls from other caller types (11 minutes). Calls from patients may be longer because patients often desire to tell their story and are less familiar with EDR. A majority of calls from patients (29 of the 42 calls) were about specific events. Calls about specific events were also received from healthcare professionals and attorneys representing patients who had been harmed during healthcare.

Figure 9. Quarterly calls to the EDR phone line by caller type, July 2014-June 2015
(n=89)



Note: Numbers represent total calls and may include multiple calls from a single caller.

Figure 10. Patient and healthcare professional calls to the EDR phone line by subject matter, July 2014-June 2015

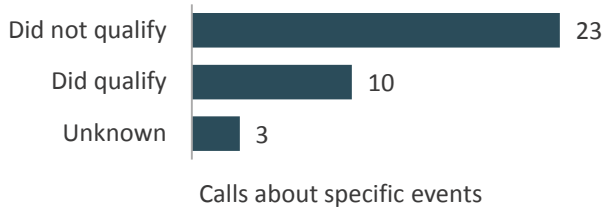


Note: Calls from other caller types (i.e., attorneys and other) are not represented in Figure 10.

[17] edr.oregonpatientsafety.org

Of all calls received by OPSC about specific events (36 calls), 10 were about an event that qualified for EDR (see Figure 11). However, not all calls about events that qualified for EDR resulted in the filing of a notice.

Figure 11. Calls about specific events and whether they qualified for EDR, July 2014-June 2015
(n=36)



Note: Numbers represent total calls and may include multiple calls from a single caller.

Of the calls about specific events that did not qualify for EDR, the majority of the events did not qualify because they occurred prior to July 1, 2014 when EDR became effective (17 calls). Other events did not quality for EDR because serious physical injury or death did not occur (3 calls) or the event did not occur in a healthcare facility or involve a healthcare provider as defined by law (1 call, see Appendix I for terms and definitions). Two callers determined their event did not qualify for EDR but did not indicate to OPSC staff the reason for their determination.

OPSC strives to help all callers, whether EDR is right for them or not. Depending on the caller's needs, OPSC:

- Answers questions about EDR and helps a caller file a notice, if appropriate
- Encourages patients to work directly with the facility or provider involved in the event
- Provides resources such as:
  - Support services (e.g., Medically Induced Trauma Support Services)
  - Oversight and quality of care organizations, if appropriate

Facility Preparation

Beginning in May 2014, OPSC encouraged facilities to designate EDR Managers so they would be immediately notified when a patient filed a notice. An EDR Manager is an individual who can act on behalf of a healthcare facility for purposes of EDR. EDR Managers are empowered to initiate the EDR process by filing a notice or responding to a patient's notice. As of June 30, 2015, 86% of Oregon hospitals had designated an EDR Manager. EDR Managers have also been designated at ambulatory surgery centers, nursing facilities, renal dialysis facilities, and freestanding birthing centers throughout Oregon.

Mediator List Maintenance

Sometimes reaching resolution can be challenging. The patient and the healthcare professional may choose to hire a mediator to help facilitate the communication and resolution process. Although there is no formal license or certification for a mediator in Oregon, OPSC worked with the Oregon Mediation Association, representatives from the Alternative Dispute Resolution section of the Oregon Bar Association, and the Task Force on Resolution of Adverse Healthcare Incidents to establish the qualifications required for inclusion on the Qualified Mediator List. OPSC maintains this list on the EDR website as a resource for patients and healthcare professionals. If both parties agree, any mediator can be selected to support EDR even if they are not on the Qualified Mediator List. As of June 30, 2015, 22 mediators were on the list. Each county in Oregon is served by at least one mediator on the list.

Conclusion

With Early Discussion and Resolution (EDR) underway in Oregon, healthcare professionals and patients have used EDR after patient harm to have conversations and seek resolution and closure. Organizations that have already used EDR have made a significant commitment to transparency and shared vital insights to shape and strengthen EDR. In

addition, many medical liability insurers, attorneys, and other stakeholders impacted by EDR have played an active role in moving EDR forward.

The Oregon Patient Safety Commission (OPSC) recognizes that organizations must have strong leadership support and a culture of patient safety to successfully implement processes for open, transparent communication with patients. With this in mind, OPSC has established recommendations that organizations can take to move open, transparent communication and EDR forward. OPSC will continue to support organizations' efforts and will respond to emerging needs to support EDR into the future.

I. **Recommendation:** Consistently use a communication and resolution process approach to engage with patients who have been harmed by their care,[18] and integrate a plan for using EDR when serious physical injury or death occurs.

   OPSC will provide best-practice resources for communication and resolution process development and promote awareness and encourage engagement in EDR when serious patient harm or death occurs.

II. **Recommendation:** Strive to maintain and improve organizational culture of safety.

   OPSC will integrate culture of safety concepts into materials for healthcare professionals and offer guidance for peer support program development.

III. **Recommendation:** Proactively plan for situations that may involve multiple stakeholders in a discussion and resolution process (e.g., insurers and contracted healthcare professionals).

   OPSC will continue to work with medical liability insurers and healthcare professionals to encourage collaboration for participating in EDR.

IV. **Recommendation:** Ensure patients and families have easy access to the organization's services for addressing negative care experiences.

   OPSC will encourage patients and families to work directly with the organization or healthcare professional involved in the event when EDR is not appropriate.

The Patient Safety Commission is honored to support Early Discussion and Resolution. We are committed to continuously learning about how healthcare professionals and patients use EDR to support transparent communication when things go wrong, and to making ongoing improvements to the EDR infrastructure and support services. We look forward to continued, and new, collaborations as we work to foster a culture of patient safety in Oregon. We are optimistic that with increased participation, Early Discussion and Resolution will improve patient safety and transparency in healthcare and strengthen the relationship between the Oregon healthcare community and the population it serves.

Acknowledgements

The Oregon Patient Safety Commission is grateful for the dedicated stakeholders and community leaders who contributed to the design and implementation of EDR. The hard work of so many highlights the growing desire for a new and better approach to resolving serious adverse events. These include, but are not limited to:

- The Task Force on Resolution of Adverse Healthcare Incidents
- The Stakeholder Advisory Group
- The Patient Advisory Group
- The Oregon Patient Safety Commission Board of Directors
- Members of the healthcare community
- The many individuals who have come forward to share their ideas and tell their stories

[18] See Appendix III for information on a communication and resolution process model.

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Appendix I. Important Terms for this Report

Term	Definition
Serious adverse event (also called adverse healthcare incident*)	Unanticipated consequence of patient care that is usually preventable and results in the death of or serious physical injury to a patient. Serious physical injury is an injury that: • Is life threatening; or • Results in significant damage to the body; or • Requires medical care to prevent or correct significant damage to the body.
Confidentiality	Confidentiality applies to discussion communications for Early Discussion and Resolution (Oregon Laws 2013, chapter 5, section 4). All written and oral communication is confidential, may not be disclosed, and is not admissible as evidence in any subsequent adjudicatory proceeding. However, if a statement is material to the case and contradicts a statement made in a subsequent adjudicatory proceeding, the court may allow it to be admitted.
Communication and resolution process	A process used by healthcare professionals to communicate with patients who have been harmed by their healthcare. The goal is to seek resolution and address the quality and safety gaps that contribute to events.
Healthcare professionals	Includes *healthcare facilities (*or representatives from *healthcare facilities*), *healthcare providers*, employers of *healthcare providers*, and liability insurers
Healthcare facility*	A licensed healthcare facility as listed in Oregon Laws 2013, chapter 5. Healthcare facilities are: • Ambulatory surgery centers • Freestanding birthing centers • Hospitals (including any licensed satellite facility) • Nursing facilities • Outpatient renal dialysis centers
Healthcare provider*	A licensed healthcare provider as listed in Oregon Laws 2013, chapter 5. Healthcare providers are: • Audiologists • Chiropractors • Dental hygienists • Dentists • Denturists • Direct entry midwives • Emergency medical service providers • Marriage and family therapists • Massage therapists • Medical imaging licensees • Naturopathic physicians • Nurse practitioners • Occupational therapists • Optometrists • Pharmacists • Physical therapists • Physicians • Physician assistants • Podiatric physicians • Podiatric surgeons • Professional counselors • Psychologists • Registered nurses • Speech-language pathologists
Patient	A patient or a patient's representative
Patient's representative*	A patient may have a representative for the purposes of Early Discussion and Resolution if a patient is under the age of 18, has died, or has been confirmed to be incapable of making decisions by their doctor. This following list names, in order, the

	people who can serve as a patient's representative. Only the first person in this list, who is both willing and able, may represent the patient: 1. Guardian (who is authorized for healthcare decisions) 2. Spouse 3. Parent 4. Child (who represents a majority of the patient's adult children) 5. Sibling (who represents a majority of the patient's adult siblings) 6. Adult friend 7. A person, other than a healthcare provider who files or is named in a notice, who is appointed by a hospital
Notice*	A Notice of Adverse Healthcare Incident is a brief form that includes information about a specific physical injury or death (serious adverse event). A notice can be filed by a patient, a patient's representative (in certain circumstances), a healthcare facility representative, or a healthcare provider. Filing a notice starts the Early Discussion and Resolution process. The notice lets the other party know that the filer would like to talk to them about what happened.

*Term defined in Oregon Administrative Rules 325-035-0001 through 325-035-0045.

Appendix II. History of Early Discussion and Resolution

July 2012
Original workgroup formed

The governor formed the Patient Safety and Defensive Medicine Workgroup with the goal of recommending a legislative concept for medical liability reform. The Workgroup's efforts were guided by the following principles: improving patient safety, effectively compensating injured individuals, and reducing medical liability system costs.

March 2013
Law signed

The legislation was signed into law March 18, 2013 with overwhelming bipartisan support,[19] and established the Early Discussion and Resolution (EDR) process.

The law charged the Oregon Patient Safety Commission (OPSC) with administration of the EDR process. OPSC was a natural fit to administer the process because of its mission to improve patient safety in Oregon and its substantial experience with sharing learning statewide for patient safety improvement.

October 2013
1st Task Force meeting

The law established the Task Force on Resolution of Adverse Health Care Incidents to provide oversight for the EDR process. The Task Force meets quarterly with OPSC to provide input on the EDR process and related activities, and reports annually to the Legislative Assembly on the progress of EDR.

June 2014
Rules approved

OPSC developed EDR administrative rules with feedback from OPSC's Board of Directors, the Task Force, the EDR Patient Advisory Group, the EDR Stakeholder Advisory Group, and a month-long public comment period.

July 2014
Law in effect

The administrative rules and the EDR process went into effect on July 1, 2014.[20]

[19] Oregon Laws 2013, chapter 5. www.oregonlegislature.gov/bills_laws/lawsstatutes/2013orLaw0005.pdf
[20] Oregon Administrative Rules 325-035-0001- 325-035-0045. arcweb.sos.state.or.us/pages/rules/oars_300/oar_325/325_035.html

Appendix III. Overview of a CRP

Collaborative FOR ACCOUNTABILITY AND IMPROVEMENT
Reaching resolution after patient harm

Communication and Resolution Programs (CRPs):

What Are They and What Do They Require?

Communication and Resolution Programs (CRPs) are a principled, comprehensive, and systematic approach to responding to patients who have been harmed by their healthcare.

They are an integral component of a larger commitment to patient quality and safety, and are implemented for the benefit of both patients and the professionals who deliver care. CRPs seek to meet the needs of a patient and their family when something goes wrong during their care. They also address the quality and safety gaps responsible for the event. While implementation may vary slightly by institution, all CRPs are based on a common set of essential commitments, elements, and steps, which are outlined in this document.

A commitment to patient-centered quality and safety is a prerequisite for CRP implementation.

CRPs are most successful when quality and safety are prioritized within an organization, and leadership and staff work to align internal processes and incentives with those priorities. Organizations that communicate this, and set clear expectations that management and staff act consistently with these priorities, are best prepared to implement CRPs. CRPs, in turn, can reinforce a culture that values honesty and transparency and is just and accountable.

CRP CORE COMMITMENTS

A CRP requires that healthcare organizations and their clinicians commit to the following:

- Being transparent with patients around risks and adverse events, including sharing information about what happened, whether the adverse event was preventable, why the event happened, and how recurrences will be prevented in whatever detail the patient desires.
- Analyzing adverse events using human factors principles, and developing and implementing action plans designed to prevent recurrences of adverse events caused by system failure or human error.
- Supporting the emotional needs of the patient, family, and care team affected by the event.
- Proactively and promptly offering financial and non-financial resolution to patients when adverse events were caused by unreasonable care.
- Educating patients or their families about their right to seek legal representation at any time.
- Working collaboratively with other healthcare organizations and professional liability insurers to respond to adverse events involving multiple parties.
- Assessing continuously the effectiveness of the CRP program using accepted, validated metrics.

KEY STEPS IN THE CRP PROCESS

Initial Response

Following recognition of an unsafe condition/practice or an adverse event, the following key steps in the CRP process should be carried out:

1) Immediately report the adverse event to the institution or organization (within 30 minutes of the event's discovery).
2) Ensure the patient's immediate clinical needs related to the risk or adverse event are addressed.
3) Ensure the immediate needs of the involved clinicians are addressed, as it is common for clinicians involved in an event that harmed a patient to experience acute distress.
4) Engage the patient and family as soon as possible after the event's discovery in establishing priorities and expectations. This includes listening to and communicating with the patient and family about what happened, how the patient's immediate needs are being addressed, what the patient should expect from the CRP process going forward, and unqualified expressions of empathy.
5) Monitor and respond to the patient's and family's needs, questions and concerns and share factual (as differentiated from speculative) information about the event as it becomes available.
6) Hold the patient's bills, pending outcome of the event analysis.

Patient Safety and Quality Improvement Activities

1) Undertake a rigorous, human-factors-based event analysis that incorporates information and perspectives from the patient and family.
2) Develop and implement plans for preventing recurrences of the event, based on human factors and Just Culture principles.

Continued Patient Engagement and Movement Toward Resolution

1) Hold a resolution discussion with the patient and family and share the final results of the event analysis and prevention plans.
2) Proactively offer fair financial or non-financial compensation to the patient and family for adverse events determined to be caused by unreasonable care, rather than waiting for the patient and family to request compensation.
3) Educate patients or their families about their right to seek legal representation at any time.

Post-Event Dissemination of Patient Safety and Quality Improvement Lessons Learned

1) Summarize the lessons learned with identifying information removed and disseminate throughout the organization.
2) Take steps to ensure wide distribution of lessons learned so other clinicians and institutions can prevent the same kinds of mistakes. Share with other healthcare institutions, professional associations, and stakeholder groups.

LAUNCHING A CRP

Institutions and organizations preparing to handle adverse events using a CRP will need to:

Obtain commitment from leadership.

- The board and other senior leaders formally adopt a CRP as a corporate priority.
- Senior leaders provide the necessary financial, personnel, and other resources to support the CRP.

Put into place a number of operational elements supporting successful CRP implementation.

- Review and revise existing policies and procedures to align with the CRP Core Commitments and Key Steps as outlined in this document.
- Develop new policies and procedures to clearly distinguish roles and delineate the activities involved in a successful CRP response to an adverse event.
- Integrate the functions of patient relations and risk management—effective communication and coordination across these functions is essential to a patient's and family's concerns being addressed in a timely manner.
- Integrate core CRP activities and tracking functions into the existing IT or other systems for adverse event reporting, risk management, and claims.
- Ensure adverse event analysis programs use human-factors-based best practices, and can complete the analyses and develop prevention plans optimally within 3 weeks of the event.
- Create a cadre of experts throughout the organization who are trained in communication and the CRP to provide just-in-time coaching and peer support to clinicians and staff following adverse events.
- Create and publicize channels for reporting safety and quality concerns and adverse clinical events. As part of this, establish a safe and accountable adverse-event reporting system with the following attributes:
  - Allows anonymous and/or confidential reporting
  - Provides immediate and ongoing feedback to the individual reporting the event
  - Is available to all health care workers and professions within the organizations
  - Optimizes legal protections for quality improvement and peer review information
- Create means for secure internal communications about clinical risks and adverse events to encourage communication, identify safety and quality risks elsewhere, and further the overall development of a safety/quality culture.

Communicate and set clear expectations.

- Communicate to all clinical staff the goals and core functions of the CRP, and clarify their roles and responsibilities within the CRP.
- Communicate the expectation to all clinical staff that adverse events be reported as soon as they become aware of an adverse event or critical safety concern, and continually reinforce the value of early reporting.
- Communicate the institution's commitment to Just Culture and emphasize that retribution or punishment for reporting is prohibited.
- Communicate the institutional expectations for addressing adverse events with patients and their families, including when to seek support, coaching, or referral to other professionals.

- Communicate the expectation to all relevant internal and external stakeholders, including medical professional liability insurers and re-insurers, risk and claims managers, and defense attorneys, that their response to patient injury be consistent with the Core Commitments and Key Steps of the CRP outlined in this document. This includes holding patient bills following all adverse events pending completion of the event analysis and, where warranted, making fast and fair offers of financial and non-financial compensation to patients.

About the Collaborative for Accountability and Improvement

The Collaborative for Accountability and Improvement brings together leading experts to support the growth and spread of Communication and Resolution Programs (CRPs), advocate on behalf of these programs with a shared voice, and exchange ideas. CRPs drive quality improvement, enhance patient safety, and facilitate patient-centered accountability. The Collaborative, which is currently based at the University of Washington, is poised to bring these programs to scale in the US and beyond.

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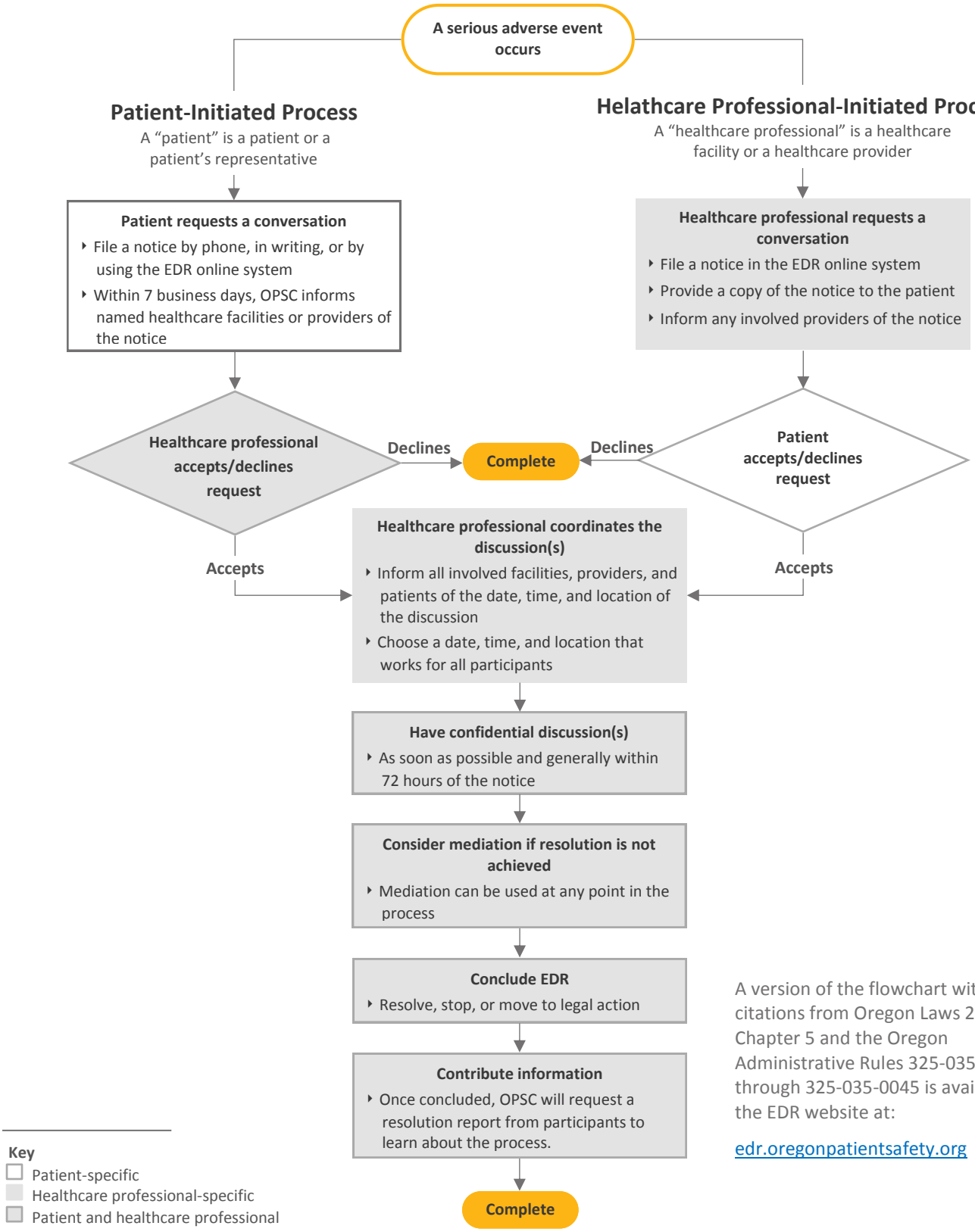
To learn more about the Collaborative for Accountability and Improvement or CRPs, please contact us at TheCAI@uw.edu.

Appendix IV. The Early Discussion and Resolution Process

When a serious adverse event occurs, either a healthcare professional or a patient can initiate Early Discussion and Resolution (EDR) by filing a notice with the Oregon Patient Safety Commission (OPSC). The notice represents a request from the filer to talk to the other party about what happened to reach resolution. If both parties agree to participate, they will come together for an open conversation using the healthcare professional's communication and resolution process.



A version of the flowchart with citations from Oregon Laws 2013, Chapter 5 and the Oregon Administrative Rules 325-035-0001 through 325-035-0045 is available on the EDR website at:

edr.oregonpatientsafety.org

Appendix V. Event Type Categories

Event type categories are based on definitions used by the Oregon Patient Safety Commission's Patient Safety Reporting Program and informed by the Agency for Healthcare Research and Quality's Common Formats and the National Quality Forum's Serious Reportable Events.[21, 22]

Event Type Category	Description
Blood product	Serious physical injury or death of a patient associated with unsafe administration of blood products (e.g., hemolytic reaction, mislabeled blood, incorrect type, incorrect blood product, expired blood product).
Care delay	Serious physical injury or death associated with a delay in care, treatment, or diagnosis.
Environmental	Serious physical injury or death of a patient associated with electric shock, oxygen or other gas related event, burns, restraint or bed rail related events.
Fall	Serious physical injury or death of a patient associated with a patient fall.
Healthcare-Associated Infection	Serious physical injury or death of a patient associated with an infection acquired while being cared for in a healthcare setting.
Medication	Serious physical injury or death of a patient associated with the administration of a medication; includes medication omissions.
Obstetrical	Serious physical injury or death of a patient associated with childbirth and the processes associated with it.
Patient protection	Serious physical injury or death of a patient associated with elopement, suicide, attempted suicide, or self-harm.
Pressure ulcer	Serious physical injury or death of a patient associated with a pressure ulcer.
Product or device	Serious physical injury or death of a patient associated with contaminated drugs devices or biologics, use or function related events, or intravascular air embolisms.
Radiologic	Serious physical injury or death of a patient associated with the introduction of a metallic object in the MRI area.
Surgical or other invasive procedure	Serious physical injury or death of a patient associated with a surgical or other invasive procedure (including anesthesia).
Other	Serious physical injury or death of a patient associated with any other event type that does not fit into one of the defined event type categories.

[21] Agency for Healthcare Research and Quality's Common Formats (common definitions and reporting formats) support healthcare professionals to uniformly report patient safety events and prevent future harm.

[22] The National Quality Forum's Serious Reportable Events list is a compilation of serious, largely preventable, and harmful clinical events, designed to help healthcare professionals assess, measure, and report performance in providing safe care.

Appendix VI. Targeted Efforts to Promote a Culture of Safety

To serve its mission, the Oregon Patient Safety Commission's (OPSC) work aims to reduce the risk of serious adverse events occurring in Oregon's healthcare system and to encourage a culture of patient safety. Through the promotion of targeted best practices, OPSC supports healthcare professionals to build the infrastructure and cultivate the skills needed to strengthen the safety of healthcare in Oregon. Each year, OPSC highlights a specific patient safety focus area related to the use of Early Discussion and Resolution.

2015 Patient Safety Focus—Provider Support after Serious Adverse Events

After a serious adverse event, the patient and their family are always considered the principal victims. However, involvement in adverse events can deeply affect both the emotional and professional lives of healthcare providers, increasing the risk of additional harm to patients during care.

Patient safety expert Albert Wu, M.D., M.P.H., coined the term "second victims" to describe "the burden that healthcare providers feel after a patient is harmed, manifesting in anxiety, depression, and shame, weighs so heavily on providers that they themselves are wounded by the event." Additionally, research suggests that "involvement in error seems to considerably increase the risk for burn-out and depression and the evidence suggests a reciprocal cycle of these symptoms and future suboptimal patient care and error" (Schwappach & Boluarte, 2009). Acknowledging that providers seldom use traditional support services, innovative healthcare organizations are developing peer support programs that make available a trained network of peers who can reach out and provide one-on-one support to a provider experiencing stress.

In 2015, OPSC made raising awareness about provider peer support a priority. Peer support was the theme for OPSC's annual patient safety event. National experts shared strategies for implementing peer support programs with Oregon providers. OPSC assembled a collection of peer support program resources that is available on the EDR website and shared additional educational opportunities with Oregon healthcare professionals.

2016 Patient Safety Focus—Disclosure Skills Development

In a 2014 OPSC survey of clinicians, "support for the development of disclosure skills" was one of the most frequently identified needs for Early Discussion and Resolution. To assess the current state of disclosure education in the state, OPSC convened a small group of organizations with subject matter expertise. The group consisted of representatives from the Oregon Medical Association and the medical malpractice insurance companies representing the majority of healthcare providers in Oregon: The Doctors Company, Physicians Insurance, and CNA. With advice and insights from the group, OPSC has slated disclosure-focused efforts for 2016 to align with the release of the tools and materials that comprise the CandOR—Communication and Optimal Resolution—toolkit, an Agency for Healthcare Research and Quality initiative. The premise of CandOR is that more open communication between patients and their providers will strengthen the patient-provider relationship, improve patient safety, reduce malpractice lawsuits, and expedite resolution.

Reference

Schwappach, D.L. & Boluarte, T.A. (2009). The emotional impact of medical error involvement on physicians: a call for leadership and organizational accountability. *Swiss Medical Weekly*, 10(139), 9-15. doi: /aop/smw-aop12417.

Appendix VII. Resources to Support Early Discussion and Resolution

Resource	Audience	Description	Where to Access
General Brochure	Members of the public	A high-level introduction to EDR	Available on request
Brochure with Notice	Members of the public	An overview of EDR including the *EDR Decision Guide for Patients* and a copy the notice that can be completed and mailed to the Oregon Patient Safety Commission (OPSC)	Available on request
EDR Info Sheet	Healthcare professionals	An overview of Early Discussion and Resolution (EDR), benefits, and potential participants	EDR Website
EDR Process Flowchart for Patients	Members of the public	A flowchart of the EDR process with explanations of the law and administrative rules	EDR Website
EDR Process Flowchart for Providers	Healthcare professionals	A flowchart of the EDR process with references to the law and administrative rules	EDR Website
What You Need to Know If You File a Notice	Healthcare professionals	Guidance for healthcare professionals who file a notice, which includes next steps and information for having a successful discussion	EDR Website
What You Need to Know If You are Named in a Notice	Healthcare professionals	Guidance for healthcare professionals named in a notice, which includes next steps and information for having a successful discussion (provided to healthcare providers named in a notice)	EDR Website
EDR Decision Guide for Patients	Members of the public	Guide to help a patient determine whether their event meets the criteria for participation in EDR	EDR Website
EDR Decision Guide for Providers	Healthcare professionals	Guide to help healthcare professionals determine whether an event meets the criteria for participation in EDR	EDR Website
Guidance for a Successful Discussion	Healthcare professionals	Guidance for having a successful discussion (also included in the What You Need to Know documents)	EDR Website
Notice of Adverse Healthcare Incident (Paper)	Members of the public	A hard-copy of the notice that can be completed and mailed to OPSC	EDR Website or available on request
Resolution Report (Paper)	Members of the public	A hard-copy of the Resolution Report that can be completed and mailed to OPSC	Sent to patients 180 days after they file a notice
Starting a Peer Support Program	Healthcare professionals	A summary of tips, tools, and resources for starting a peer support program in an organization	EDR Website