OREGON PATIENT SAFETY COMMISSION

Early Discussion and Resolution 2022 Annual Report

Our Opportunity to Strengthen Oregon's Patient Safety Infrastructure

Submitted pursuant to ORS 31.280(2) to the House and Senate Interim Committees on Judiciary and Health Care

OREGON
PATIENT
SAFETY
COMMISSION

The Oregon Patient Safety Commission is a semi-independent state agency that supports healthcare facilities and providers in improving patient safety. We encourage broad information sharing, ongoing education, and open conversations to cultivate a more trusted healthcare system.

Learn more: **oregonpatientsafety.org**

Our Mission

To reduce the risk of serious adverse events occurring in Oregon's healthcare system and encourage a culture of patient safety.

BUILDING A CULTURE OF SAFER CARE—TOGETHER.

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A Message from the Task Force

The Task Force on Resolution of Adverse Healthcare Incidents ("Task Force") serves as an evaluative body for Oregon's Early Discussion and Resolution (EDR) program. The governor-appointed Task Force members include a patient safety advocate, a hospital industry representative, physicians, trial lawyers, and public members. EDR is administered by the Oregon Patient Safety Commission (OPSC).

On behalf of the Task Force, we are pleased to present our annual report on Oregon's EDR program from July 1, 2021, to June 30, 2022. In this year's report, we reflect on what we have learned from a pandemic that has shed light on the fragility of our healthcare delivery system. Despite some important progress in patient safety, we know that preventable harm from healthcare persists. A new approach is needed to strengthen how we respond to and learn from harm events.

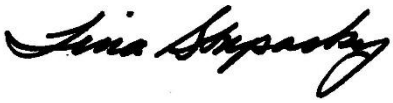
When medical harm occurs, transparency is critical. With EDR, we have an important tool to help advance transparency following harm events. Now, Oregon has an opportunity to leverage EDR to help build statewide capacity to respond to and learn from harm events, both within individual healthcare organizations and across the healthcare continuum. To be successful, a collaborative, statewide approach is needed to develop a strategy for change.

During this program year, we have also supported OPSC in their work to refine and make progress on their 2022 goals, which integrate equity and collaboration as essential elements.

We appreciate the opportunity to submit our evaluation of the EDR program for your consideration.

Respectfully,

John Moorhead, MD
Task Force Co-Chair



Tina Stupasky, JD
Task Force Co-Chair

The Task Force on Resolution of Adverse Healthcare Incidents

- Chandra Basham, trial lawyer
- Jeff Goldenberg, advocate for patient safety
- Anthony Jackson, public member
- Bob Joondeph, public member
- Margaret Mikula, physician
- John Moorhead, physician
- Cameron Padilla, hospital industry
- Tina Stupasky, trial lawyer
- Rep. Ronald H. Noble, House Republican
- Rep. Rachel Prusak, House Democrat

Executive Summary

In their report *Safer Together: A National Action Plan to Advance Patient Safety*, the Institute for Healthcare Improvement (IHI) seeks to address the lack of progress made over the past 20 years to reduce preventable harm in healthcare. The report concludes, "It has become clear that reducing preventable harm is a complex endeavor that requires a concerted, persistent, coordinated effort by all stakeholders"[1(p11)]. Our healthcare system has endured an incredible strain over these past few years as the pandemic has exposed its vulnerabilities and systemic inequities, reinforcing the need for a new approach.

Our pandemic experience has increased our sense of urgency to make deliberate and purposeful change to strengthen patient safety infrastructure throughout our healthcare delivery system. We must build capacity in Oregon's healthcare system to respond to and learn from medical harm, and transparency is central to this effort. With Oregon's Early Discussion and Resolution (EDR) process, we have an important tool to help advance transparency following harm events. However, EDR cannot do these things on its own. For EDR to realize its full potential in Oregon, organizations must have infrastructure in place to respond consistently and effectively to patient harm in a way that prioritizes patient safety, transparency, and learning.

In this report we will describe:

- Oregon's opportunity to leverage EDR to help build statewide capacity to respond to and learn from medical harm events, both within individual healthcare organizations and across the healthcare continuum.
- A transparent, proactive, and systems-based approach for responding to unanticipated harm events that promotes learning to help healthcare organizations improve patient safety.
- The need for a collaborative, statewide approach to develop a strategy for change.
- A starting point for this important and necessary work.

Finally, we will also share a summary of the work OPSC has done in 2022 to make progress on the data process and outreach strategy development goals outlined in last year's report.

During the pandemic, Oregonians came together to keep each other safe. We recognized that these were unprecedented times and that the status quo was insufficient to meet our needs. State leaders made difficult choices in the interest of saving as many lives as possible[2] and Oregonians did their part to try and relieve pressure from our faltering healthcare system. Oregon has, to date, experienced better COVID-19 outcomes than most states[3] and has one of the lowest COVID-19 death rates in the country[4]. As we emerge from the pandemic, it is time to focus on addressing medical harm. *Safer Together* has mapped the way forward: statewide implementation of a proactive and systems-based response to patient harm, and broadly shared learning. We can build on the collaboration and singularity of purpose that we've experienced together over the last two years to make these changes for the benefit of all Oregonians.

How EDR Works

Patient harm or death from medical care

Requests a conversation

A patient, healthcare provider, or facility can submit a request through OPSC*

Patient or their representative

Healthcare provider or facility

For patient requests, OPSC informs involved provider(s) and/or facility of the request and, if they agree, connects them with the patient

Accept or decline Request for Conversation

Have open, confidential conversation(s)

Report to OPSC about how it went

OPSC shares learning

* The Oregon Patient Safety Commission (OPSC) administers Oregon's EDR process.

EDR Use in Oregon

July 2014-June 2022

309 **Requests for Conversation submitted**

92% **of Requests for Conversation were made by patients (or their representatives)**

Most common event types mentioned in Requests for Conversation

- **43%** Care delay
- **38%** Surgical or other invasive procedure
- **11%** Other event type
- **9%** Medication event
- **6%** Healthcare-associated infections

Most common locations where those events occurred

- **66%** Hospitals
- **24%** Other locations (including doctor's office)
- **6%** Ambulatory Surgical Centers
- **2%** Hospital Satellites

45% **of patient Requests for Conversation were accepted by at least one involved healthcare provider or facility**

Main reasons patient Requests for Conversation were not accepted by an involved healthcare provider or facility

- **42%** Intend to use a different process and will not incorporate EDR
- **19%** Have already addressed this event through another process
- **16%** Patient's concerns involve other provider(s)/facility only
- **16%** Other decline reasons
- **11%** Don't believe this meets the definition of an adverse event
- **9%** Advised against participation by legal counsel
- **8%** Advised against participation by liability insurer

OPSC OREGON PATIENT SAFETY COMMISSION

Introduction

The Institute for Healthcare Improvement's (IHI) 2020 report, *Safer Together: A National Action Plan to Advance Patient Safety*, seeks to address the lack of progress made over the past 20 years to reduce preventable harm in healthcare. The report concludes, "It has become clear that reducing preventable harm is a complex endeavor that requires a concerted, persistent, coordinated effort by all stakeholders"[1(p11)]. To make progress, *Safer Together* recommends that:

- Individual healthcare organizations adopt a systems-based approach to proactively respond to and learn from unanticipated medical harm.
- We coordinate efforts and share learning across the healthcare continuum.

Since the publication of *Safer Together*, the healthcare system has endured tremendous strain, further exposing the fragility of our healthcare delivery system and reinforcing the need for a new approach. For example, the pandemic highlighted the inadequacy of systems to protect and support healthcare workers in times of crisis[5–7] and exacerbated existing structural health inequities[8–10]. Healthcare system resilience was put to the test as staff shortages, redeployments, and burnout resulted in a widespread disruption of healthcare worker team structures[11–13]. These challenges directly affected patients, who experienced an increase in infection rates[14], more frequent diagnostic error[15], and other harms[12].

When medical errors occur, transparency is critical. Transparency allows patients to receive an explanation about what happened and allows healthcare providers and facilities to continue to care for patients, to learn, and to improve their care delivery systems, reducing the events that drive medical malpractice claims. A lack of transparency with patients and families about harm events can exacerbate the situation[16–18]. From the perspective of the patient and family, a response that is not honest and transparent is a second tragedy[19]. The absence of transparency and accountability increases the likelihood that patients will take legal action[17,20–22].

> "Transparency—the free, uninhibited sharing of information—is probably the most important single attribute of a culture of safety. In complex, tightly coupled systems like healthcare, transparency is a precondition to safety. Its absence inhibits learning from mistakes, distorts collegiality and erodes patient trust."
>
> —Leape et al. 2009[23(p425)]

A Tool for Transparency in Oregon

In 2013, the Oregon Legislature passed what is now called Early Discussion and Resolution (EDR)[i] into law as part of a larger strategy to help address medical liability in the state. EDR is an innovative program that promotes open conversation between patients (or their representatives), healthcare providers, and facilities[ii] when care resulted in serious harm or death. EDR establishes confidentiality protections[iii] for these important conversations to encourage participants to talk candidly about the harm that occurred and seek reconciliation outside of the legal system. The Oregon Patient Safety Commission (OPSC)[iv] administers EDR, collecting information about EDR use, and broadly sharing

[i] See Appendix I for a definition or *Early Discussion and Resolution*.
[ii] See Appendix I for definitions of *patient representative*, *healthcare provider*, and *healthcare facility*.
[iii] EDR creates confidentiality protections for written and oral discussion communications. EDR protections do not change other protections afforded by state or federal law. See Appendix I for a definition of *protections*.
[iv] See Appendix II for more information on OPSC's role.

learning and best practices to help Oregon's healthcare system adopt a more transparent response to patient harm.[v]

Transparency is key to preventing future harm events, and EDR is an important tool to help advance transparency following harm events. However, EDR cannot do these things on its own. For EDR to realize its full potential in Oregon, organizations must have infrastructure in place to respond consistently and effectively to patient harm that prioritizes patient safety, transparency, and learning. Oregon has an opportunity to leverage EDR to help build statewide capacity for responding to and learning from harm events, and we will need a collaborative, statewide approach to develop a strategy for change.

We feel a sense of urgency to make deliberate and purposeful change to strengthen patient safety infrastructure throughout our healthcare delivery system. We have learned from our pandemic experience that the healthcare system can no longer maintain the status quo. We must cultivate resiliency in our healthcare system by developing our capacity to respond to and learn from medical harm, and transparency is central to this effort.

[v] See Appendix IV. The Early Discussion and Resolution Process for more information on the EDR process.

The Opportunity

When the legislature enacted the EDR law in 2013[vi], it took an important step to encourage transparency following medical harm. The confidentiality protections in the law were intended to make everyone involved more comfortable communicating openly and directly following harm events. Now, Oregon has an opportunity to leverage EDR to help build statewide capacity to respond to and learn from medical harm, as recommended in *Safer Together*, both within individual healthcare organizations and across the healthcare continuum.

> "Total systems safety requires a shift from reactive, piecemeal interventions to a proactive strategy in which risks are anticipated and system-wide safety processes are established and applied across the entire health care continuum."
>
> —*Safer Together* (2020)[1(p11)]

Healthcare Organizations Must Adopt a System-based Approach

In our complex and constantly evolving healthcare delivery framework, organizations must have capacity to learn and adapt in response to the wide range of safety issues that will arise. From risks posed by a new technology or process, or even a new virus, to more routine issues including over-crowding, staffing shortages, equipment failures, and human error, safety issues are present in all aspects of healthcare. Additionally, because patient safety is undeniably linked to health inequity—the differences in health outcomes that are systematic, avoidable, and unjust[24–28]—equity must be integrated into all systems of care. Taking a systems-based approach to harm can help ensure that the organization's response to medical harm prioritizes patient safety, transparency, and learning.

The communication and resolution program (CRP) model provides a best practice, systems-based approach to proactively respond to and learn from unanticipated harm. In a 2020 *BMJ Quality & Safety* editorial, national CRP experts wrote, "CRPs appear to improve patient and provider experiences, patient safety, and in many settings lower defense and liability costs in the short term and improve peer review and stimulate quality and safety over time."[29(p876)] CRPs emphasize a comprehensive, consistent, and systematic response to every patient harm event, including an inquiry into what happened, on-going communication with the patient and family, support for involved healthcare providers, and restitution when the standard of care was not met. CRPs also promote learning to help healthcare organizations improve their systems of care.

The Agency for Healthcare Research and Quality issued a model CRP toolkit—Communication and Optimal Resolution (CANDOR)[30]—in 2016. The CANDOR toolkit is publicly available and provides a roadmap for implementation and sustainability.

> "Elementally, CANDOR is a deliberate strategy intent on normalizing *honesty, transparency, and accountability*."
>
> — Boothman (2016)[31(p2488)]

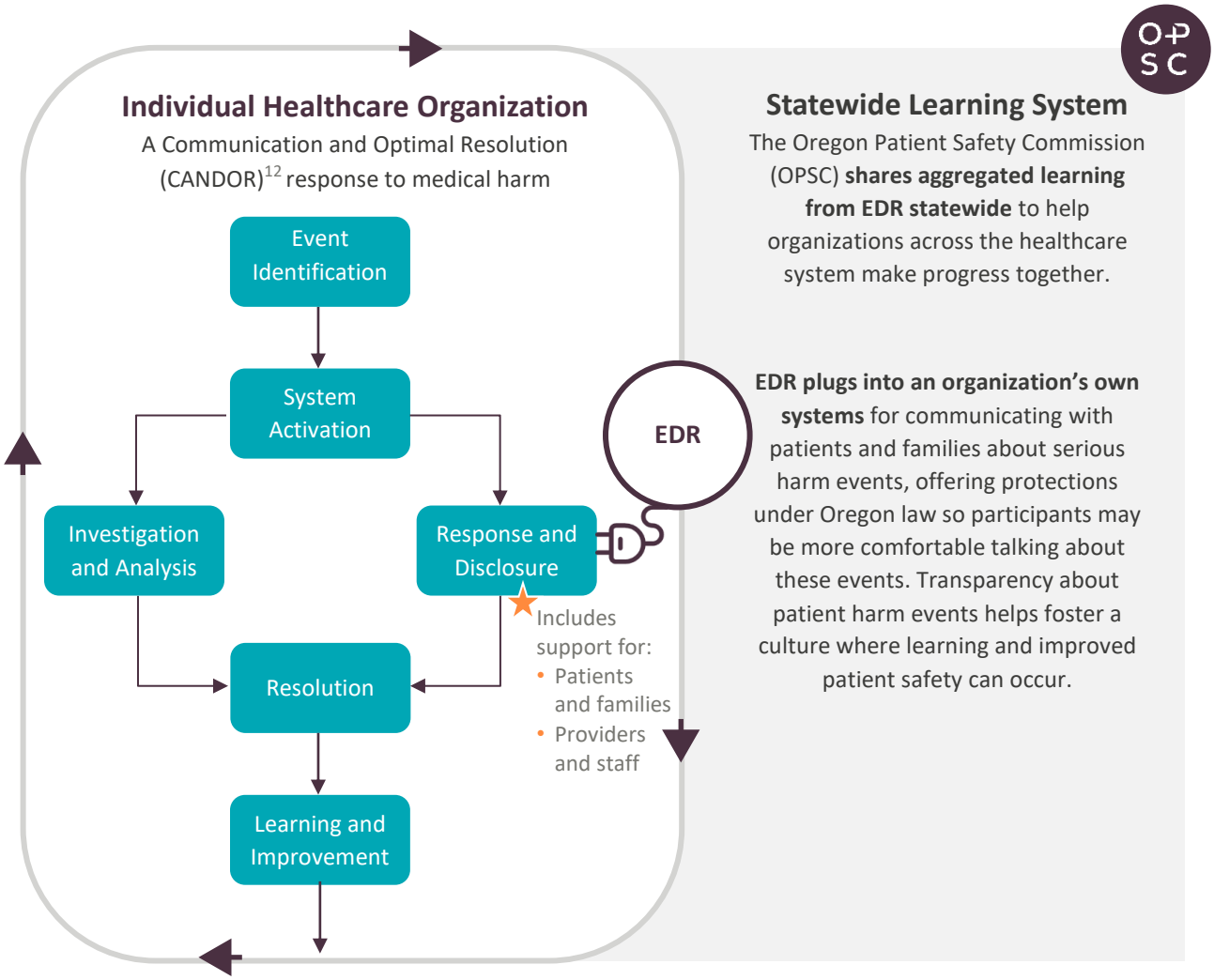
[vi] In 2013, the Oregon Legislature passed Senate Bill 483, creating Oregon's Early Discussion and Resolution (EDR) program (Oregon Laws 2013, Chapter 5). In the 2021 Legislative session, Senate Bill 110 passed, removing the sunset provision originally established for Sections 1 to 10 and 17 to 19 of the 2013 Act. Now, EDR is now established in ORS 31.260 to 31.280.

We Must Coordinate Efforts and Share Learning Across the Healthcare Continuum

There is a critical need for a coordinated effort from all stakeholders across the healthcare continuum. *Safer Together* observes that a primary reason for our lack of progress in patient safety is that the many evidence-based practices for harm reduction that have been identified by individual organizations are seldom shared beyond the organization or effectively implemented across multiple organizations[1]. Oregon can leverage EDR to support shared learning to collectively improve our response to harm events. The EDR law establishes OPSC as a hub for collecting and disseminating shared learning. When healthcare organizations use a system-based approach to respond to and learn from unanticipated medical harm, incorporating EDR to support their response, they also contribute to Oregon's collective statewide learning system (Figure 1).

Figure 1. Oregon's EDR Process Supports an Organization's Systems for Responding to Medical Harm and Contributes to Statewide Learning

A Coordinated, System-based Approach for Responding to and Learning from Medical Harm



What We Need to do to Get There

To build statewide capacity for responding to and learning from patient harm, we need to both assess Oregon's readiness to implement CRPs and build a statewide strategy for progress.

I. Assess Oregon's readiness to implement CRPs that integrate EDR to help prioritize efforts.

Widespread CRP implementation and use of EDR in Oregon will require a clear understanding of the distance between where we are and where we want to go. Oregon does not currently track how many healthcare organizations use a CRP approach or which elements they have adopted and use consistently. Variable use of CRP practices has been identified as a challenge in some CRP demonstration projects[32–34]. For example, an organization may not use a CRP response if they do not anticipate a patient will seek legal action, or an organization may choose to use some but not all elements of their CRP.[34(p1846)] An assessment would help inform a statewide strategy to support and enable CRP adoption in Oregon. Elements that could be considered in a readiness assessment include:

- Awareness of EDR and the CRP approach
- Current organizational systems and practices, including:
    - Response to patient harm
    - Programs to support patients and families, as well as healthcare providers and other staff following patient harm
    - Degree of CRP implementation
    - Integration of equity throughout an organization's response to patient harm
- Potential policies or incentives, in addition to EDR, to encourage CRP adoption
- Willingness to share data and information for systemwide learning
- Support and resource needs for CRP implementation and sustainability

II. Collaboratively develop a statewide strategy for progress.

Any process for strategy development should be collaborative. Patients and families, CRP experts, the numerous stakeholders affected by CRPs (e.g., physicians and other healthcare providers, organizational leadership, patient safety personnel, medical liability insurers, quality and risk management departments, and attorneys), and policy leaders must all have a voice in the conversation.

Oregon will not need to reinvent the wheel as it considers how to move forward. Leading healthcare organizations across the U.S. have used various methods to implement CRPs, ranging from multi-system learning collaboratives to private consultants. Oregon will have the benefit of their experience. Some notable examples include:

- **The Pathway to Accountability, Compassion, and Transparency (PACT)** learning community supports organizations across the U.S. with implementation of highly reliable CRPs that prioritize patient safety and learning. PACT was established by three leading healthcare organizations—Ariadne Labs[vii], the Collaborative for Accountability and Improvement[viii], and the Institute for

[vii] **Ariadne Labs** is a joint center for health systems innovation at Brigham and Women's Hospital and Harvard T.H. Chan School of Public Health. Visit ariadnelabs.org for more information.

[viii] **The Collaborative for Accountability and Improvement** (CAI) is a program of the University of Washington. CAI serves to advance highly reliable communication-and-resolution programs that meet the needs of patients, families, and providers for accountability, compassion, transparency, and improvement after patient harm. Visit communicationandresolution.org for more information.

Healthcare Improvement[ix]. The PACT support model includes offerings for organizations at varying stages of CRP adoption readiness.

- **MedStar Health**, a large regional health system, initiated CANDOR implementation in 2015 as an Agency for Healthcare Research and Quality (AHRQ) demonstration project, with support from its captive insurance company. The MedStar Risk and Safety leadership team worked closely with hired consultants[35]. They saw a doubling of internally reported adverse events after program implementation, and a decrease in the number of events that started as a claim or lawsuit.
- **The Massachusetts Alliance for Communication and Resolution Following Medical Injury (MACRMI)** was established as a body to create and house resources for facilities that opted to use a CRP approach, including leadership and risk management teams from involved hospitals, liability insurers, the Massachusetts Medical Society, the Massachusetts Hospital Association, the Massachusetts Bar Association, and leaders of patient-focused organizations. MACRMI provided "at the elbow" support for CRP implementors and also collected data for shared learning[32]. The collaborative approach used in Massachusetts has proven successful. Comparisons of before-CRP and after-CRP trends showed improvements in the rate of new claims and legal defense costs at some hospitals, and no worsening liability trends[36]. These findings suggest that when the CRP model is followed with high fidelity, "transparency, apology, and proactive compensation can be pursued without adverse financial consequences"[36(p1836)].

Oregon will also benefit from the support of its unique state patient safety organization, OPSC. In addition to providing a safe table to encourage collaboration among stakeholder groups, OPSC will harness its statewide learning system through EDR to facilitate data collection and shared learning.

> "Communication and Resolution Programs help provide for the many different needs of individuals after harm. In the past, patients experienced only silence and abandonment after a medical error. CRPs and their participants now realize the importance of talking with the patient and family immediately after harm and continuing those conversations until all of their questions have been addressed and answered."
>
> — Hemmelgarn (2017)[19(p6)]

[ix] **The Institute for Healthcare Improvement** (IHI) is an independent not-for-profit organization that has used improvement science to advance and sustain better outcomes in health and health systems across the world. Visit ihi.org for more information.

Our Progress so Far and Next Steps

In our 2021 report, we identified some key lessons and corresponding high-level goals to help give direction to the EDR program in 2022.

EDR 2022 Program Goals

- Prioritize health equity in all EDR program related activities.
- Collaborate with interested parties to revisit assumptions based on what we've learned.
- Revisit and revise our priorities and process for data collection.
- Develop a strategic communication plan to increase awareness about EDR that prioritizes equitable information dissemination.

Over the past year, OPSC has worked to refine and build upon on its 2022 goals. Prioritizing health equity and collaborating with interested parties, once stand-alone goals, have been integrated as essential elements in all EDR work. OPSC is currently focused on two core bodies of work to move these goals forward:

- Data Process Strategy Development
- Outreach Strategy Development

Data Process Strategy Development

Revised Goal: By May 2023, update the EDR data process strategy to ensure a cohesive set of data practices that will support effective program operations as well as the learning and program evaluation needs of OPSC's staff, board of directors, and the Task Force.

As a goal for 2022, OPSC committed to undergo a data collection process evaluation to identify opportunities to improve what, when, and how information is collected during the EDR process. The evaluation would inform changes to the EDR data collection process and other improvements to program operations. A key element of the process was to identify equity issues related to EDR.

In 2022, OPSC went through a request for proposal process to engage a contractor to support this work. The data strategy development work will run from September 2022 through March 2023, and will include a set of key activities:

- **Create an informed program logic model** to map program activities to desired short- and long-term outcomes. Include stakeholder engagement to understand goals, key questions, and constraints.
- **Review data elements, processes, and structures.** One important consideration will be how equity is incorporated in data collection, analysis, and reporting.
- **Provide recommendations and next steps** for improving EDR data collection, analysis, and reporting.

Next Steps

With the data strategy recommendations and guidance for how to move forward, OPSC will develop an implementation plan to update its processes and systems accordingly.

Outreach Strategy Development

Revised Goal: In 2023, develop an outreach strategy that incorporates key EDR stakeholder groups and prioritizes equitable information dissemination to increase awareness about and use of EDR.

Because EDR is available to all Oregonians, increasing awareness of EDR through outreach efforts was identified as a key program goal for 2022. OPSC's primary focus has been on short-term initiatives to increase awareness about EDR among two key audiences: patients and their families, and physicians. This work has centered on two strategies.

- **Strategy:** Provide actionable information about EDR to sources patients and families look to for help following a harm event, so they can offer EDR as a resource.

  OPSC has identified sources with broad reach that Oregonians frequently look to for information about available services. For example, EDR is now listed as a resource with 211info[x] and with the Oregon Health Authority Ombuds Program[xi]. OPSC has also worked to optimize the program in internet searches for those searching online for resources following a harm event.

  Through this process, it has become clear that any strategy aimed at reaching patients and families in communities that have been historically and structurally underserved must be informed by members of those communities. OPSC will integrate this element into the development of a strategic outreach plan in 2023.

- **Strategy**: Leverage existing relationships within the medical community to increase physician awareness of EDR.

In June 2022, OPSC also began planning for the development of a long-term outreach plan to increase EDR awareness and use. Equity will be a central element of this work.

- **Strategy:** Develop and implement a strategic outreach plan, in consultation with a communications expert, to increase EDR awareness across Oregon.

OPSC has been working to identify potential contractors among consulting firms with relevant experience in public health or healthcare, and a strong track record of effective outreach to historically or structurally underserved communities.

Next Steps

Through this process, it has become increasingly clear that outreach and awareness, in the traditional sense, are just one aspect of engagement in EDR. We recognize that there are many stakeholders who are involved in and influence how an organization or provider responds to medical harm[37–39], including how willing they are to use EDR. We hope that collaborative conversations about how to move the CRP work forward will consider Oregon's readiness to implement CRPs using EDR as the statewide learning system. In the coming year, we will partner with OPSC on next steps.

[x] 211info helps people in Oregon and southwest Washington identify, navigate, and connect with the local resources. Learn more at 211info.org.

[xi] Oregon Health Authority Ombuds Program is a team that helps Oregon Health Plan members get quality health care. Learn more at https://www.oregon.gov/oha/ERD/Pages/Ombuds-Program.aspx.

Conclusion

With EDR, Oregon's Legislature took an important step to encourage transparency following medical harm. For EDR to realize its full potential in Oregon, organizations must have infrastructure in place to respond consistently and effectively to patient harm in a way that prioritizes patient safety, transparency, and learning.

Now, Oregon has an opportunity to leverage EDR to help build statewide capacity to respond to and learn from medical harm, as recommended in *Safer Together*, both within individual healthcare organizations and across the healthcare continuum. To move forward effectively will require thoughtful planning and a collaborative approach. We must first:

- Assess Oregon's readiness to implement CRPs that integrate EDR.
- Collaborate with stakeholder groups to develop a statewide strategy for progress.

The pandemic has highlighted just how much more work we must do to strengthen our healthcare delivery system for patients, their families, and healthcare providers, and to address its systemic inequities. Now, more than ever, we feel a sense of urgency to make deliberate and purposeful change. We look forward to partnering with OPSC on their continued efforts to use EDR to support and inform Oregon's response to medical harm.

Acknowledgements

We are grateful for the dedicated stakeholders and community leaders who contributed to the implementation of EDR this year and helped to ensure its continued availability for Oregonians. The hard work of so many highlights the growing desire for a better approach to resolving patient harm events.

These include, but are not limited to:

- The Oregon State Legislature
- The Oregon Patient Safety Commission Board of Directors
- The Oregon Patient Safety Commission staff
- The Collaborative for Accountability and Improvement
- Members of the healthcare community
- The people of Oregon, and those patients and family members who have sought EDR following medical harm
- The Oregon healthcare organizations and providers who have participated in EDR conversations

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Appendix I. Important Terms for this Report

Term	Definition
Communication and Resolution Program (CRP)	A comprehensive, systematic program for reporting and responding to medical harm events. Some of the key elements of CRPs are continuous communication with patients and families throughout the process, event analysis, system improvements, emotional support for caregivers, and compensation when appropriate.[19]
Early Discussion and Resolution (EDR)	Early Discussion and Resolution (EDR) provides a constructive way forward after medical harm (i.e., serious physical injury or death) and promotes learning for improved patient safety (ORS 31.260-31.280). Either a patient (or their representative), a healthcare provider, or facility can initiate EDR by requesting a conversation through the Oregon Patient Safety Commission (OPSC). When these conversations are initiated using EDR, they have confidentiality protections, encouraging healthcare providers and facilities to talk openly with patients about what happened as they explore the best way to reach resolution. When OPSC receives a Request for Conversation, it plays a dual role in EDR administration: • **Connector:** OPSC connects patients (or their representatives) to involved healthcare providers when patients request a conversation through EDR. • **Educator:** Using research and information collected through EDR administration, OPSC helps healthcare professionals learn about effective strategies for communicating with patients and families after medical harm events. OPSC also disseminates best practices for resolving these events.
Healthcare facility*	A licensed healthcare facility as described in ORS 31.260 (2). Healthcare facilities are: • Ambulatory surgery centers • Freestanding birthing centers • Hospitals (including any licensed satellite facility) • Nursing facilities • Outpatient renal dialysis centers

Term	Definition
Healthcare provider*	A licensed healthcare provider as listed in ORS 31.260 (3). 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'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: • Guardian (who is authorized for healthcare decisions) • Spouse • Parent • Child (who represents a majority of the patient's adult children) • Sibling (who represents a majority of the patient's adult siblings) • Adult friend • A person, other than a healthcare provider who files or is named in a notice, who is appointed by a hospital
Protections	Initiating EDR by submitting a Request for Conversation through OPSC establishes confidentiality protections. These confidentiality protections apply to discussion communications for EDR (ORS 31.266). All written and oral communication is confidential, may not be disclosed, and is not discoverable or 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. EDR protections do not change other protections that are afforded by state and/or federal law. For example, Health Insurance Portability and Accountability Act (HIPPA) protections for a patient's medical records and other personal health information remain unchanged with the use of EDR.

Term	Definition
Request for Conversation	A Request for Conversation is a brief form that includes information about a specific physical injury or death event from medical care. A request can be submitted by a patient, a patient's representative (in certain circumstances), a healthcare facility representative, or a healthcare provider. Submitting a Request for Conversation starts the Early Discussion and Resolution process. The request lets the other party know that the requestor would like to talk to them about what happened.
Serious adverse event *(Referred to as "patient harm" or "medical harm" in this report)*	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. Early Discussion and Resolution is for serious adverse events.

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

Appendix II. OPSC's Role in EDR

The Oregon Patient Safety Commission (OPSC) is responsible for the implementation of Early Discussion and Resolution (EDR).

When serious harm from medical care occurs (i.e., serious physical injury or death), either a patient (or their representative), a healthcare provider, or facility can initiate EDR by requesting a conversation through OPSC. OPSC plays a dual role in EDR administration:

- **Connector:** OPSC connects patients (or their representatives) to involved healthcare providers when patients request a conversation through EDR.
- **Educator:** Using research and information collected through EDR administration, OPSC helps healthcare professionals learn about effective strategies for communicating with patients and families after medical harm events. OPSC also disseminates best practices for resolving these events.

OPSC serves in a neutral capacity, offering information that can help both patients and healthcare professionals use the process effectively. OPSC does not provide advice to or advocate for either patients or healthcare professionals. Once a request is made and the involved parties agree to have a conversation, the healthcare professional coordinates the conversation(s). OPSC is not present for any conversation.

After the conversation(s) have concluded, OPSC asks participants to share information about their experience in a voluntary questionnaire. OPSC shares trends and other deidentified and aggregated information for statewide learning.

In addition to its role implementing EDR, OPSC also provides staff support for the Task Force on Resolution of Adverse Healthcare Incidents and maintains a qualified mediator list as an optional resource for EDR participants. Each mediator on the list meets standards for education and experience developed by members of the Oregon Mediation Association and the Alternative Dispute Resolution section of the Oregon Bar Association. EDR participants are free to choose mediators who are not on this list.

Appendix III. Additional Data

EDR Use in Oregon, July 2014-June 2022

309

Requests for Conversation

Figure 2. Requests for Conversation by EDR Year

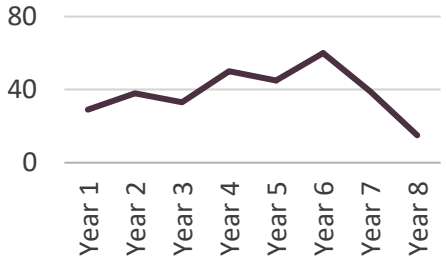


Table 1. Event Types Mentioned in Requests for Conversation
n=309

Event Type	Percent
Care delay	43%
Surgical or other invasive procedure and anesthesia	38%
Other	11%
Medication event	9%
Healthcare-associated infection	6%
Product or device event	5%
Patient protection	1%
Environmental event	1%
Fall	1%
Obstetrical event	1%
Blood	0.3%
Radiologic	0.3%

Table 2. Serious Harm Event Location
n=309

Location	Percentage
Hospital	66%
Other location (including doctor's office)	24%
Ambulatory surgery center	6%
Hospital satellite facility	2%
Nursing facility	2%
Freestanding birthing center	0.6%
Outpatient renal dialysis center	0.3%

Who Requests Conversations through EDR

Figure 3. Requests for Conversation by Requester
n=309

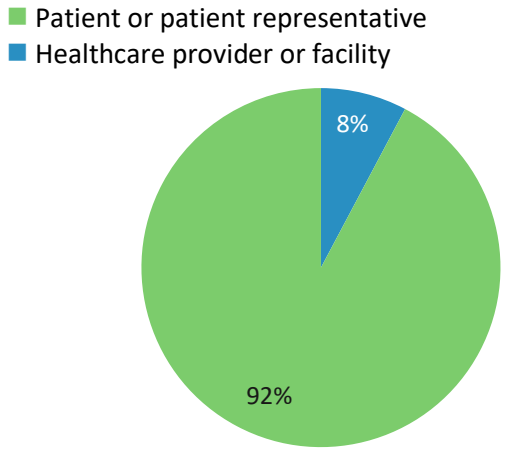
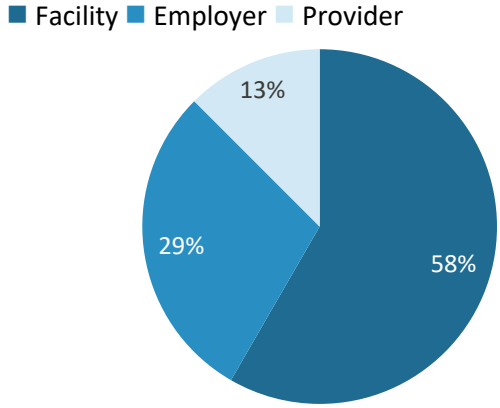


Figure 4. Healthcare Professional-Initiated Requests by Provider Type
n=24



Facility Type (n=14)
- Hospital (100%)

Employer Type (n=3)
- Employer of physicians (67%)
- Employer of Emergency Medical Services Providers (33%)

Provider Type (n=3)
- Physician (100%)

Figure 5. Patient or Patient Representative Requester Type
n=285

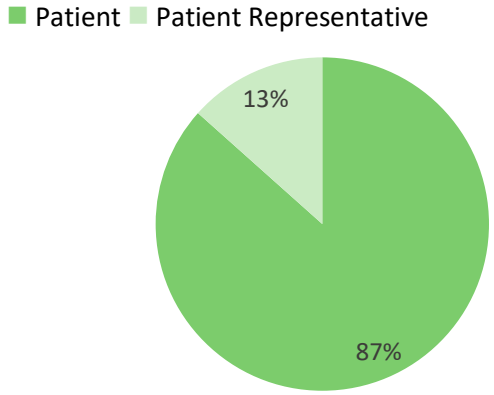
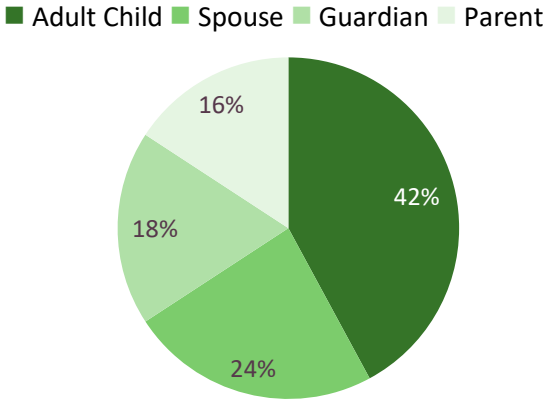


Figure 6. Patient Representative Requester Type
n=38



Characteristics of Oregon Patients in EDR Requests for Conversation

Figure 7. Patient Ethnicity
n=104

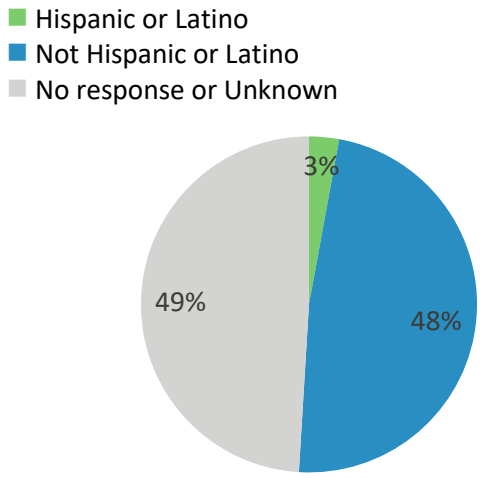


Table 3. Patient Race
n=104

Race	Number	Percent
American Indian or Alaskan Native	1	1%
Asian	3	3%
Black or African American	3	3%
White	61	59%
Other	1	1%
No response or Unknown	36	35%

Note: Respondents may select more than one race so percentages may not total 100%.

Figure 8. Patient Age
n=285

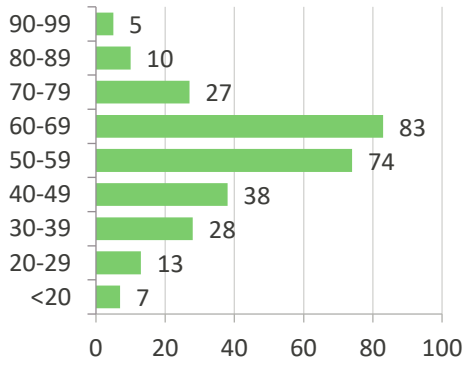


Figure 9. Patient Gender
n=309

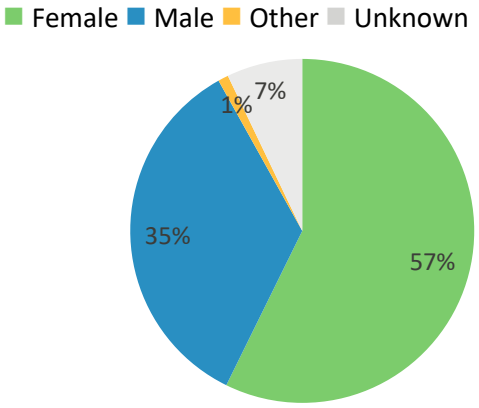


Figure 10. Patient language
n=104

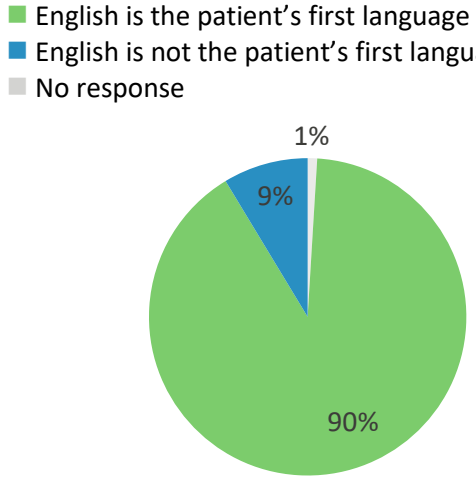
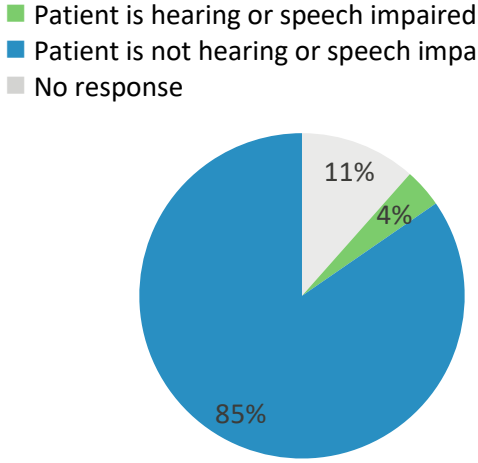
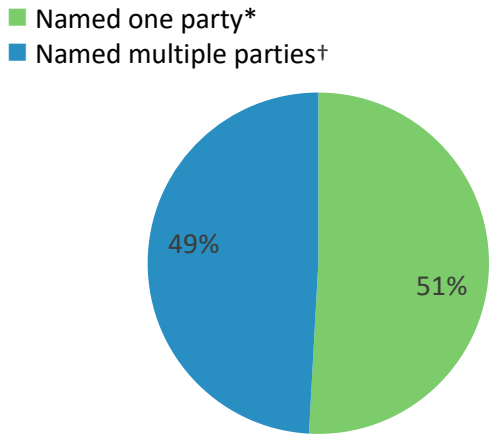


Figure 11. Patient Hearing or Speech Impairment
n=104



EDR Participation

Figure 12. Proportion of Requests for Conversation Naming One or Multiple Parties
n=285



*A request naming one party may have named a facility alone, a facility and one or more employed providers, or a single provider at a doctor's office or "other" location.

†A request naming multiple parties may have named multiple non-employed providers or a facility and one or more non-employed providers.

Figure 13. Breakdown of Requests for Conversation Naming One or Multiple Parties
n=285

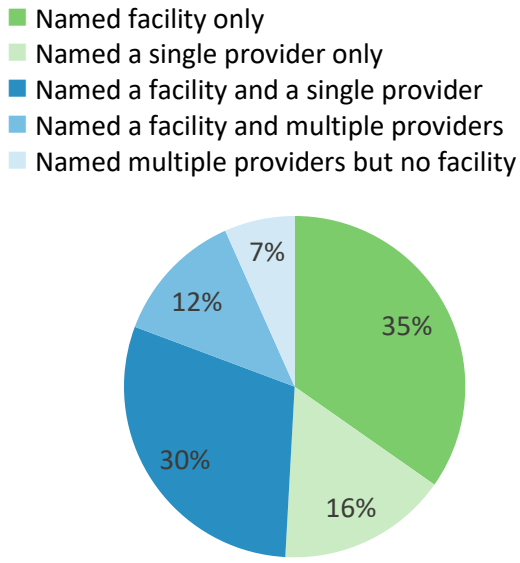


Figure 14. Will anyone participate in EDR, July 2014-June 2021
n=308

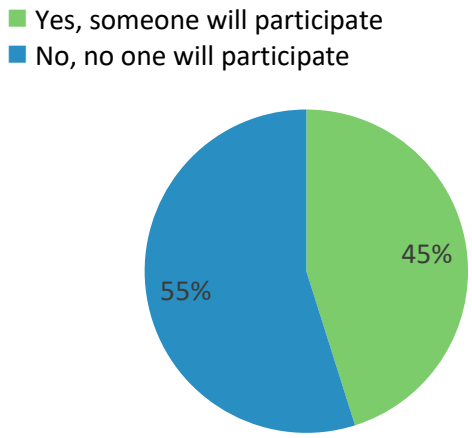


Figure 15. Percent of Requests for Conversation with at Least One Acceptance, by EDR Year
n=308

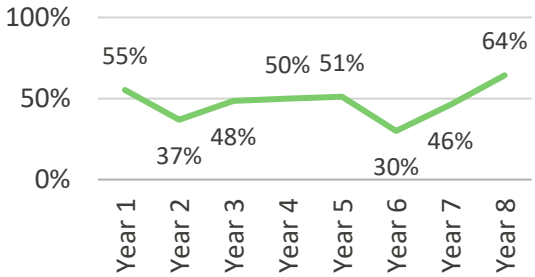


Table 4. Reasons Facilities and Providers Declined to Participate in EDR
n=270 facilities and providers that declined EDR

Decline Reason	Percent of Named Facilities and Providers That Used This Decline Reason
Intend to use a different process to address this event and will not incorporate EDR	42%
Have already addressed this event through another process	19%
Patient's concerns involve other provider(s), facility only	16%
Other	16%
Don't believe this meets the definition of an adverse event	11%
Advised against participation by legal counsel	9%
Advised against participation by liability insurer	8%
Patient abandoned/discontinued process	2%
Unclear patient representative authority	1%
Have never seen this patient	0.4%

Note: facilities and providers may select more than one decline reason, so percentages will not total 100%

Figure 16. Did a conversation occur?
n=226 Requests for Conversation associated with one or more Resolution Reports

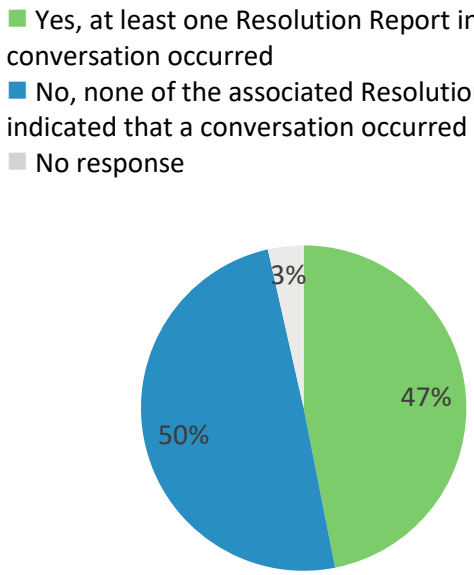


Figure 17. Was there more than one conversation?
n=106 Requests for Conversation associated with one or more Resolution Reports wherein at least one Resolution Report indicated a conversation occurred

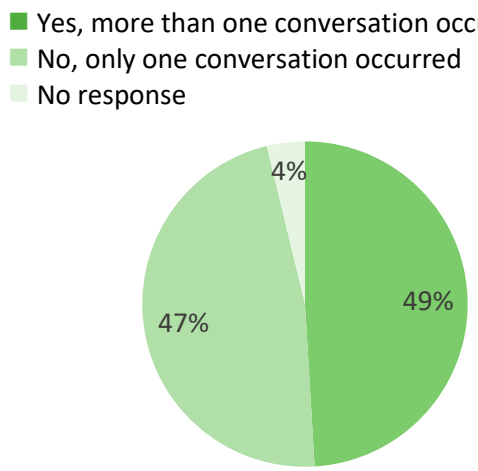


Figure 18. Resolution Report Status by Respondent Type

RR Status	Patient n=135	Facility n=136	Provider n=76	Total n=347
Resolved	18 (13%)	53 (39%)	30 (39%)	101 (29%)
Not resolved	81 (60%)	51 (38%)	29 (38%)	161 (46%)
Other	17 (13%)	17 (13%)	8 (11%)	42 (12%)
Still pending	19 (14%)	14 (10%)	9 (12%)	42 (12%)
Dismissed by court	0 (0%)	1 (1%)	0 (0%)	1 (0.3%)

Note: each party involved in a Request for Conversation (patient or patient rep, facility, provider that isn't employed by the facility) is invited to submit their own Resolution Report, meaning that a single Request for Conversation can result in several Resolution Reports. Completing a Resolution Report is not required to participate in the process.

Appendix IV. The Early Discussion and Resolution Process

When a patient is harmed by medical care (i.e., serious physical injury or death), either a patient (or a patient's representative), a healthcare provider, or a facility can initiate Early Discussion and Resolution (EDR) by completing a Request for Conversation, through the Oregon Patient Safety Commission (OPSC), to talk to the other party about what happened and move toward resolution. If both parties agree to participate, they will come together for an open conversation coordinated by the healthcare provider or facility.

☐ Patient (or patient's representative)
Healthcare provider and/or facility
☐ Patient and healthcare provider and/or facility