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**Early Discussion and Resolution**
2023 Annual Report

**The Task Force on Resolution of Adverse Healthcare Incidents** ("Task Force") is pleased to present the 2023 annual report on Oregon's Early Discussion and Resolution (EDR) program. The Task Force serves as the evaluative body for EDR, and its governor-appointed members include a patient safety advocate, a hospital industry representative, physicians, trial lawyers, and public members. This report is submitted to the Oregon Legislative Assembly, pursuant to ORS 31.280(2).

# Executive Summary

There has been a marked lack of progress in patient safety over the last 20 years, and preventable harm persists.[1] As a hub for shared learning, the Oregon Patient Safety Commission (OPSC) can support Oregon's collective effort to make our healthcare system safer.

When medical harm occurs, transparency is critical. Oregon's Early Discussion and Resolution (EDR) program promotes transparency by establishing confidentiality protections for the important conversations that need to happen when harm occurs. EDR can also help break down silos of information so that Oregon's healthcare system can make progress together.

In this report, we illustrate:

- Why a **collective approach** is necessary to reduce preventable harm in healthcare.
- How **transparency** is critical to meeting the needs of patients and families, supporting providers, and improving our systems of care.
- What OPSC can do to **increase awareness and use** of EDR, focusing both on equity and provider engagement.
- How implementing a **new data strategy** will strengthen the data OPSC collects to better support shared learning.

OPSC and the Task Force are committed to helping transform Oregon's healthcare system. We have identified priorities for the coming year and look forward to working with OPSC to advance this important effort.

**The Task Force on Resolution of Adverse Healthcare Incidents**

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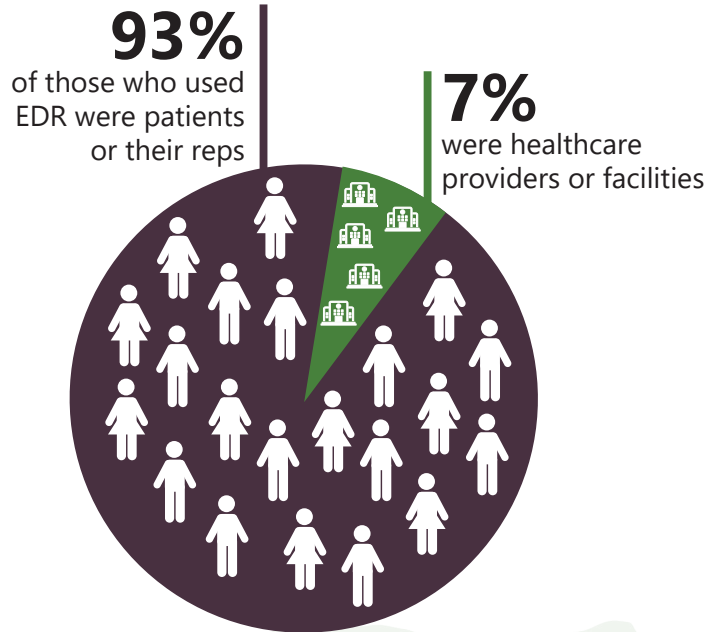- Oregon State Representative Cyrus Javadi, DDS

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# EDR by the Numbers

**Requests for Conversation, July 2014-June 2023**

**338**
**Requests for Conversation were submitted**

**Most common events** mentioned in Requests

- Care delay (43%)
- Surgical/invasive procedure (37%)
- Other event (11%)
- Medication events (9%)
- Healthcare-associated infections (6%)

**42%** of patient Requests were accepted by at least 1 provider or facility

"Yes"

**93%** of those who used EDR were patients or their reps

**7%** were healthcare providers or facilities

**Most common stated reasons** facilities & providers declined to participate in EDR

Using a different process to address this event and will not incorporate EDR

Already addressed this event through another process

Advised against participation by legal counsel or liability insurer

Patient's concerns involve other provider(s), facility only

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# Oregon's Program for Transparency & Learning

The Oregon Patient Safety Commission (OPSC) serves as a hub for shared learning to improve how Oregon's healthcare system responds to patient harm events. OPSC administers **Early Discussion and Resolution (EDR)**, an innovative program that promotes open conversation among patients or their representatives, healthcare providers, and facilities when care results in serious harm or death.

As a tool for transparency, EDR establishes confidentiality protections for these important conversations to encourage participants to talk candidly about the harm that occurred and seek reconciliation outside of the legal system.

## A Collective Effort Is Needed for Progress

The full benefits of EDR can only be realized when healthcare organizations:

- Adopt a systems-based approach to proactively respond to patient harm.
- Contribute what they learn to OPSC as Oregon's hub for shared learning.

The purpose of EDR isn't just to collect data. By gathering information about EDR, and broadly sharing learning and best practices, OPSC can help Oregon's healthcare system adopt a more transparent response to patient harm.

There has been a notable lack of progress in reducing preventable harm in healthcare over the past 20 years.[1] While many evidence-based practices for harm reduction have been identified, they are rarely shared beyond individual organizations or effectively implemented more broadly.[1]

> " *It has become clear that reducing preventable harm is a complex endeavor that requires a concerted, persistent, coordinated effort by all stakeholders.* "
>
> *- Safer Together 2020*[1(p11)]

To make progress, healthcare organizations must break down their silos of information and contribute their knowledge to Oregon's hub for shared learning through EDR. Currently, we have reason to believe that conversations are happening based on responses to the EDR *Follow-Up Survey*. However, providers and facilities often state that, when declining a *Request for Conversation,* they are using a different process to address harm events, perhaps not understanding that EDR complements their established processes.

To support the collective effort toward safer patient care, providers and facilities are encouraged to share what they learn by requesting or accepting a request for a conversation through EDR.



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## Why Transparency Matters

When talking about patient harm, transparency is not optional. Open communication among patients (or their representatives), healthcare providers, and facilities can:

- **Provide** patients with an explanation of what happened and why.

- **Offer** a chance for reconciliation.

- **Give** healthcare providers and facilities a path to continue to care for the patient.

- **Facilitate** learning about (and improvement of) better care delivery systems.

- **Reduce** events that drive medical malpractice claims.

- **Maintain** trust with patients by sharing important information about their care.

A lack of transparency with patients and families about harm events can exacerbate the aftermath of serious medical harm.[2-4] From the perspective of the patient and their family, a response that is not honest and open is a second tragedy[5]. The absence of transparency and accountability also increases the likelihood that patients will take legal action.[3, 6-8]

Our data shows that, when asked, almost 60% of people who contacted OPSC learned about EDR through an attorney. Historically, the only path to resolution after medical harm was through the legal system, *but now we have EDR*. EDR provides an alternative path that more holistically addresses the needs of patients and their families.



### The Four Things Patients Want

After medical harm, patients and their families want four things:[5]

- Information about what happened and why[2,5,7,9–22]

- Information about how the provider or facility will fix the problem[2,5,7,9,10,16–19,21,23,24]

- The provider or facility to take responsibility[2,5,9,10,12,16–22]

- An apology[2,5,9,10,12,16,18–20,22,24,25]

But patient harm events don't only affect patients: providers have described fear, guilt, anxiety, and grief as their common reactions to harm events.[2,6,26,27] An open conversation about patient harm events can help *everyone* move forward, and it promotes learning to help healthcare organizations improve their systems of care, reducing the events that drive medical malpractice claims.

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# Increasing **Awareness & Use** of EDR

## Progress Report: Public Outreach

EDR is available to all Oregonians. *But not all Oregonians know about EDR.* To bridge that gap, OPSC must learn more about Oregonians' unique needs, challenges, and experiences related to medical harm.

Using an equity lens, we asked OPSC to prioritize outreach to historically and structurally underserved communities, specifically patients most likely to experience harm. In 2023, OPSC partnered with an outside firm to conduct statewide market research, wherein OPSC heard directly from Oregonians representing these populations.

### Who Is More Likely to Experience Harm?

The market research[28] identified key populations that are more likely to experience medical harm, including:

- BIPOC individuals
- People with disabilities
- Immigrant, refugee, and non-English-speaking communities
- LGBTQIA2S+ communities (with trans people at the highest risk for discrimination)
- Older adults (65+ years)
- Low-income households, specifically Medicaid recipients
- Rural communities

Informed by this research, OPSC is currently developing an outreach strategy that focuses on reaching populations that are more likely to experience medical harm.

To ensure that all Oregonians can access, understand, and use EDR, OPSC is assessing all communications tools and systems, as well as branding and messaging, to identify opportunities for improvement, especially when it comes to accessibility.

## Progress Report: Facility & Provider Awareness & Buy-In

No one goes it alone when reducing patient harm.

A coordinated effort from all stakeholders across the healthcare continuum is critical to making progress and building capacity for responding to harm events. We all have a role to play.

Organizations must adopt a systems-based approach in order to respond to patient harm consistently and effectively while prioritizing patient safety, transparency, and learning. This requires healthcare leadership to overhaul their existing processes and systems for responding to medical harm.

OPSC is partnering with Pathway to Accountability, Compassion, and Transparency (PACT) to support the efforts of healthcare organizations to adopt this systems-based approach. PACT is a learning community dedicated to improving the way healthcare responds to harm. The goal of PACT is to spread the adoption of best practice, systems-based models like Communication and Resolution Program (CRP) and Communication and Optimal Resolution (CANDOR).

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# Strengthening the EDR Data Strategy

## Progress Report: Evaluation & Recommendations

Over the last year, OPSC worked with the Center for Outcomes Research and Education (CORE) to conduct an evaluation of EDR data collection processes. This effort was key to strengthening the data OPSC collects to better support its role as Oregon's hub for shared learning. A key element of this process was also to identify equity issues related to EDR. OPSC and CORE collaborated throughout the project to ensure that equity considerations were prioritized. CORE's final recommendations include changes to improve OPSC's ability to identify disparities in conversation requests, acceptance rates, and outcomes.

Following the evaluation, CORE recommended a comprehensive data strategy that included improvements grouped into six themes:

- Increase ability to identify disparities within EDR
- Gather additional information at the time of the conversation request
- Increase conversation reporting frequency
- Expand *Follow-Up Survey* granularity
- Improve the data collection system interface
- Gain insights on program awareness and related policy interactions

**(Read the full CORE report)**

## Progress Report: Implementing the Recommendations

OPSC prioritized an initial set of CORE's recommendations to address in 2023. The organization is focusing first on those recommendations that center on increasing usability and streamlining processes for all data system users, especially patients and families.

These changes will help OPSC:

- Learn more about the patient experience with conversations after harm.
- Collect better demographic data to support our equity goals.
- Improve the consistency with which OPSC asks how patients and patient representatives learned about EDR to inform outreach efforts.
- Give patients real-time access to information about their *Request*.
- Improve program accessibility by clarifying and simplifying complex language.

### Completing the Picture with a Focus on Equity

CORE identified that OPSC's practice of collecting patient race and ethnicity data in the voluntary *Follow-Up Survey* did not provide a complete picture of who is using EDR. Of the *Follow-up Surveys* OPSC has received, respondents either chose "unknown" or did not answer the question 37% of the time for patient race and 51% of the time for patient ethnicity. Given this recommendation, OPSC will modify its system to collect race and ethnicity data earlier in the process.

Throughout the 2023/2024 program year, OPSC will continue to make progress on both a comprehensive implementation plan and subsequent execution of the recommendations.

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## Looking to the Future: OPSC Goals for 2024

As the evaluative body for EDR, we will work closely with OPSC to inform the organization's EDR-related priorities for the coming year. We consider the following revised goals to be a key part of OPSC's strategic planning process:

- Use market research to develop and begin implementing a public outreach strategy that focuses on reaching populations that are more likely to experience medical harm

- Work with key partners to review and revise our approach to the Pathway to Accountability, Compassion, and Transparency (PACT) strategy to better support the healthcare ecosystem through alignment and collaboration

- Implement the data process strategy recommendations from the Center for Outcomes Research and Education (CORE)

### Acknowledgments

We are grateful to the ongoing commitment of the dedicated stakeholders and community leaders who continue to support this important program for Oregonians. Thank you to:

- The Oregon State Legislature

- The Oregon Patient Safety Commission Board of Directors

- The Collaborative for Accountability and Improvement

- Members of the healthcare community

- The people of Oregon and those patients and family members who have used EDR following medical harm

- The Oregon healthcare organizations and providers who have participated in EDR conversations



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**The Oregon Patient Safety Commission (OPSC)** 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.

oregonpatientsafety.org