Early Discussion and Resolution

Learning and Recommendations from Three Years of Implementation

July 2014 – June 2017

OREGON
PATIENT SAFETY
COMMISSION

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The Oregon Patient Safety Commission, 2017

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 professional training and intentions of healthcare professional, things can and do go wrong during healthcare. In cases of serious injury or death there is a constructive way forward. An open conversation about what happened can move both patients and healthcare professionals towards resolution. Oregon's Early Discussion and Resolution (EDR) program offers support and legal protections for these important communications. By encouraging transparency and accountability in healthcare, EDR may also promote system improvements that will benefit future patients.

This report provides an overview of three years of EDR activity and offers lessons learned during implementation, as well as recommendations for improvement. The report also summarizes the Oregon Patient Safety Commission's (OSPC) ongoing work to ensure the success of EDR.

OPSC received 33 EDR Requests for Conversation in its third year, bringing the total received during the life of the program to 100 Requests for Conversation. Patients initiated 89% of all requests (89/100). Although less than half of patient EDR Requests for an Conversation were accepted (40/89), three-quarters of patient requests (67/89) resulted in a conversation of some kind, suggesting that the use of the EDR request process may have increased communication between patients and healthcare professionals following adverse events.

OPSC, with oversight from Oregon's governor-appointed Task Force on the Resolution of Adverse Healthcare Incidents, is committed to sharing what is learned from EDR implementation. Key observations include:

- Prompt communication with patients following adverse events may facilitate a more successful resolution process.
- An organizational culture of safety enables implementation of communication and resolution processes.
- Coordination between multiple stakeholders adds complexity.
- EDR creates opportunities for conversation between patients and healthcare professionals even when the formal EDR process is not used.
- Patients may need assistance to advocate for themselves effectively during EDR conversations.
- EDR fills a gap in our legal system, while addressing safety issues.
- Organizations need systems in place to account for the role medical device vendors play in patient care.
- EDR phone calls have reflected the national response to the opioid epidemic.

A full discussion of these observations, as well as recommendations for improvement, can be found in the Lessons Learned section of this report.

Achieving greater transparency and accountability across all settings where Oregonians receive healthcare hinges on long-term culture change by Oregon's healthcare community. OPSC is very encouraged by the level of provider and patient engagement in the first three years of EDR. To accelerate that culture change, OPSC and its partners convened the first cohort of the Oregon Collaborative on Communication and Resolution Programs (OCCRP) in September 2016. Participating organizations learn from national experts and support one other to develop robust Communication and Resolution Programs (CRPs). This work will continue in 2018.

Through the implementation of EDR and the OCCRP, along with involvement in the National Collaborative for Accountability and Improvement (CAI), OPSC is an active participant in the larger national conversation about how to improve patient safety by promoting transparency and accountability. OPSC is proud to advance this important work here in Oregon.

Introduction

While the actual number of errors that occur each year in healthcare may be disputed by some (James 2013; Makary 2016), there is little disagreement that too many patients are harmed during care. EDR exists to provide a constructive way forward when patients are seriously injured or die during healthcare, and to protect future patients from harm by encouraging healthcare professionals to be transparent and accountable. For purposes of this report, healthcare professionals include: healthcare facilities or representatives from healthcare facilities, healthcare providers, and employers of healthcare providers (see Appendix I: Important Terms for this Report).

In 2013, Oregon was one of the first states in the country to pass a law promoting open, transparent communication with patients or their representatives (collectively referred to as "patients" for the purposes of this report) when serious harm or death occurs as a result of care—what is now called EDR.[1] Oregon remains the only state to allow patients to initiate these types of conversations. When conversations between patients and healthcare professionals are initiated using EDR, those conversations are protected, allowing healthcare professionals to talk openly with patients about what happened as they explore the best way to move toward resolution and healing. Open communication can diminish a patient's need to seek legal recourse while also promoting learning for improved patient safety (Boothman et al. 2009).

OPSC administers EDR and is responsible for managing the program infrastructure, creating materials and guidance for participants, connecting patients and providers to have conversations, and promoting shared learning about best practices for resolution of adverse events.

In three years of EDR, OPSC has received 100 Requests for Conversation from patients and healthcare professionals. As many as 75% of patient requests resulted in conversations that may not have otherwise occurred, some using EDR and some using an alternate method. Participants in 21 EDR conversations reported achieving resolution through the EDR process. (Resolution may have been reached in other conversations but not reported.) OPSC is very encouraged by these early signs that EDR may help increase communication and expedite resolution for Oregonians following adverse events. OPSC looks forward to contributing to the national movement promoting greater transparency in healthcare and principled consistent response to patient harm.

> "I hope other states will emulate the thoughtful, inclusive, and patient-centered approach that Oregon is taking to this challenging problem."
>
> **Thomas Gallagher, MD**
> Executive Director, Collaborative for Accountability and Improvement
> Professor, Department of Medicine and Bioethics, University of Washington

[1] Oregon laws 2013, chapter 5. www.oregonlegislature.gov/bills_laws/lawsstatutes/2013orLaw0005.pdf

EDR Overview

Benefits

Despite the best training and intentions of healthcare professionals, things don't always go as planned. When serious injury or death occurs, patients want acknowledgement, answers, and support so they can move forward. The healthcare professionals involved may also need support to move forward, even if they are not at fault. An open conversation about what happened can bring resolution closer for both patients and healthcare professionals.

Used in conjunction with a healthcare professional's own process or independently, EDR can:

Prevent an unfortunate situation from escalating. When patients (or their representative) do not receive an appropriate and timely response after a patient is injured or dies, they may file a complaint or lawsuit. Legal processes can be time-consuming, expensive, and painful for everyone involved. Using EDR to initiate a conversation, and considering fair compensation when appropriate, may avoid litigation and achieve a more positive result.

Maintain the patient-provider relationship. The relationship between the patient and the individual healthcare provider is the keystone of care, and both can feel great unease when it is compromised. An open conversation about what happened and direct steps toward resolution can restore trust and heal a strained or fractured relationship.

Bring greater peace of mind to everyone involved. Healthcare providers can experience fear, guilt, anxiety, and grief if they have been involved in the serious injury or death of a patient, even if they are not at fault. Patients may be in pain, shock, and grief. They want information about what happened, why it happened, whether it was preventable, what impact it may have on their health, and what is being done to improve care for future patients (Gallagher et al. 2003). An open conversation and an acknowledgment of the patient's suffering can help them heal. It can also be beneficial for the healthcare provider by alleviating feelings of personal and professional distress.

Encourage learning from events to improve patient safety. An open conversation creates an opportunity for the healthcare professionals to hear about the event from the patient's perspective. This information may help with the event analysis and new learning from the analysis can be rapidly integrated into the system to improve patient safety. On a broader level, the OPSC analyzes and shares non-identifiable data for statewide learning.

OPSC's Role

OPSC plays multiple roles related to EDR.

On a day-to-day basis, OPSC provide resources to support EDR. OPSC publicizes the EDR program and responds to inquiries about it. OPSC connects patients to involved healthcare professionals when either requests a conversation. Although OPSC staff are not present at conversations, they provide support for constructive conversation through telephone consultations and written materials.

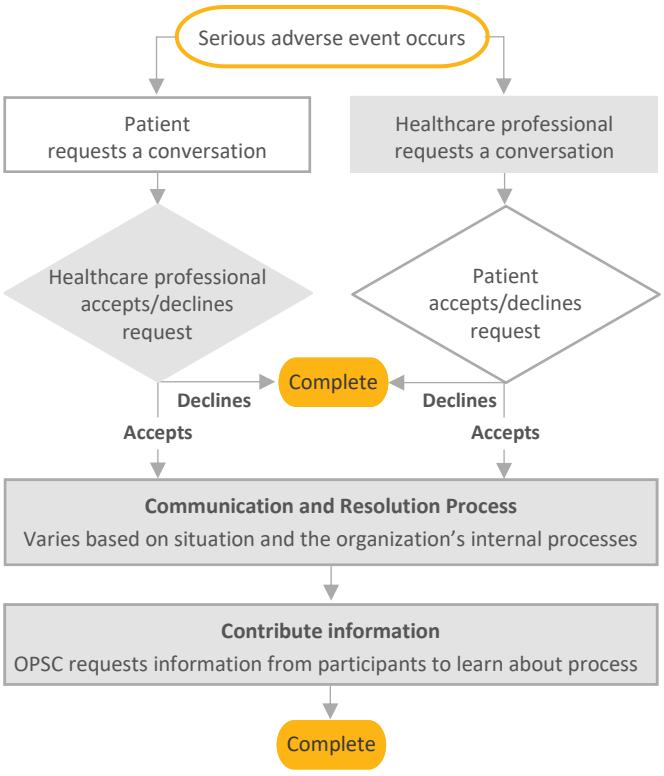
OPSC maintains a secure online system to protect the privacy of both patients and the healthcare professionals in the EDR process. OPSC also maintains a qualified mediator list. Each mediator on the list meets rigorous standards for education and experience developed by members of the Oregon Mediation Association and the Alternative Dispute Resolution section of the Oregon Bar Association. While this resource is available, EDR participants are free to choose mediators who are not on this list.

OPSC is committed to promoting shared learning and asks patients and healthcare professionals to complete a voluntary questionnaire after EDR conversations have concluded (i.e., a Resolution Report). OPSC expects the data from Resolution Repots to grow over time and will use it to provide guidance on how to more effectively address and resolve adverse healthcare events across Oregon.

EDR Process

When a serious adverse event occurs, either a patient or a healthcare professional can initiate EDR by requesting a conversation through OPSC (see Figure 1). The conversation is an opportunity for the patient and the healthcare professional(s) to talk about what happened and seek resolution. If both parties agree to participate, they come together for a conversation, coordinated by the healthcare professional. OPSC invites participants to share information about their experience in a Resolution Report within 180 days after the initial Request for Conversation is made. OPSC analyzes non-identifiable data and shares trends and information for statewide learning.

Figure 1. The Early Discussion and Resolution Process*



*See Appendix II for more detail.

EDR Use

Much of what OPSC knows about the impact of EDR comes from our informal communication with patients and healthcare professionals. On the other hand, most of what we can more definitively say about EDR comes from structured data collection tools. When someone completes a Request for Conversation or a voluntary Resolution Report in the EDR Online System, that information is stored in our secure system for future analysis.

Data Limitations

Limited Resolution Report data. Much of what can be learned about the resolution status and process comes from Resolution Reports. In accordance with the law, Resolution Reports are voluntary and are not always submitted by EDR participants. Additionally, those that are submitted may be incomplete.

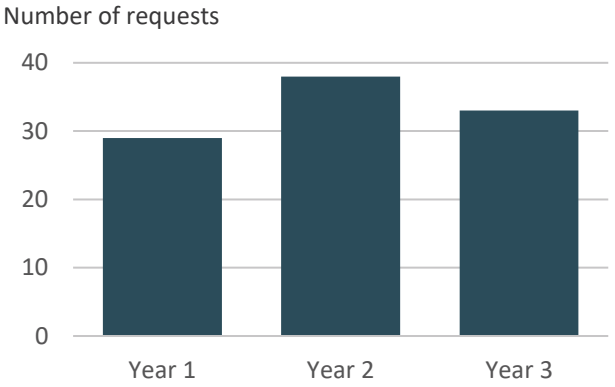
Limited patient demographic data. Patient demographic data is primarily collected in Resolution Reports and these fields are only available to respondents when they indicate that a conversation occurred.

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,[2] the National Practitioner Data Bank,[3] nor the Oregon Medical Board collect comprehensive data that can provide a baseline for any of these measures. Oregon has newly transitioned to the eCourt system which may allow tracking of medical malpractice lawsuits in the future.[4]

Requests for Conversation

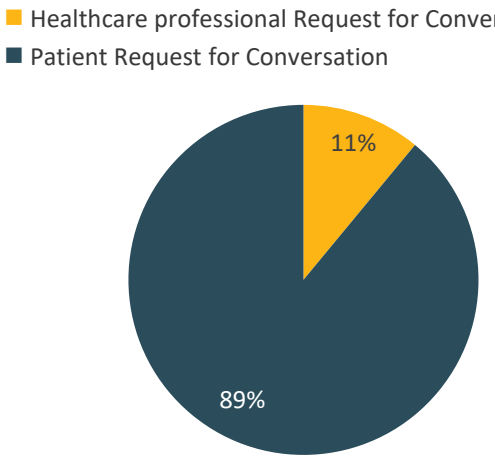
In the first year of the program, EDR saw a total of 29 Requests for Conversation. In the second year, there was a 31% increase. Growth plateaued in the third year, with 33 requests (see Figure 2), bringing the total to 100 over the three-year period.

Figure 2. Number of Requests for Conversation by year, July 2014-June 2017
(n=100)



The majority of Requests for Conversation (89%) have come from patients (see Figure 3). In the coming years, we hope to see more healthcare professionals proactively initiating conversations .

Figure 3. Requests for Conversation by requester type, July 2014-June 2017
(n=100)



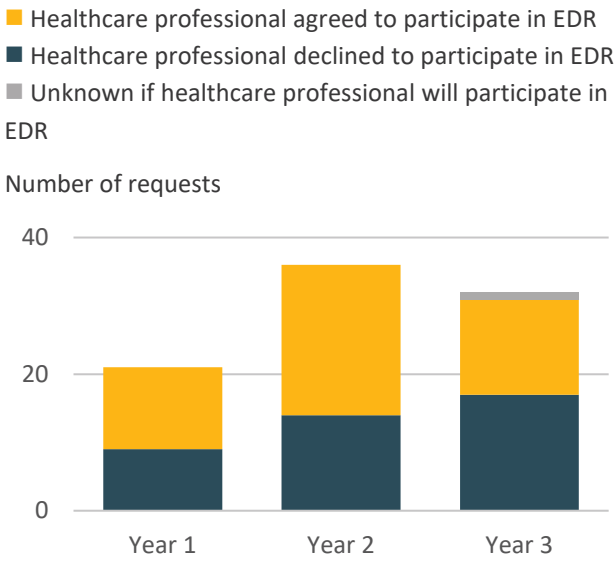
[2] The Patient Safety Reporting Program is OPSC's voluntary statewide adverse event reporting program. Learn more at oregonpatientsafety.org.

[3] 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.

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

Because EDR is voluntary, all participants must agree to engage in EDR and any participant can withdraw at any time. At least one involved healthcare professional accepted a patient's request to participate in EDR in 40 out of 89 patient Requests for Conversation (45%) (see Figure 4).

Figure 4. Accepted and declined patient Requests for Conversation by year, July 2014-June 2017
(n=89)



A Request for Conversation submitted by a patient may include multiple healthcare facilities and/or providers (collectively referred to as healthcare professionals in this report); each has the option to accept of or decline the request. The acceptance rate for patient Requests for Conversation has remained stable, ranging from 42% to 45% during the three years.

Reasons Healthcare Facilities Decline Requests

Healthcare facilities decline participation primarily because they have elected to use their own internal approach to resolution and have not integrated EDR into their approach. Healthcare facilities also decline participation when they determine the event resulted from actions of a healthcare provider they did not employ (see Table 1 on page 6). Many Oregon facilities are staffed, in part, by employees of private practices that have contracted with the facility to provide care.

Reasons Healthcare Providers Decline Requests

The individual healthcare providers who decline are most likely to do so because they are using a resolution process that does not incorporate EDR or because their liability insurers have recommended that they decline (see Table 1 on page 6).

There are many reasons providers decline participation included in the *other* category, each occurring fewer than three times. The *other* reasons include the fact that the authority of an individual to serve as a patient's representative could not be confirmed (see Appendix I. for a description of who can serve as a patient representative), that a healthcare provider had left practice and no longer has access to medical records, or that a provider learned that a facility would not be participating and elected not to participate either.

Despite early concerns that healthcare providers would decline EDR due to fear of reporting to the Oregon Medical Board or the National Practitioner Data Bank, no one has cited either as a reason for declining to participate.

Table 1. Reasons facilities and providers declined patient Requests for Conversation, July 2014-June 2017

Decline reasons	Number of facilities declining patient requests (n=45)	Number of providers declining patient requests (n=39)
I intend to use a different process to address this event, and will not incorporate EDR	16 (36%)	10 (26%)
Patient's concerns are exclusive to provider(s)/facility	10 (22%)	1 (3%)
I have already addressed this event through another process	7 (16%)	6 (15%)
Other	6 (13%)	7 (18%)
I do not believe event meets definition of adverse healthcare event	5 (11%)	4 (10%)
Advised against participation by liability insurer	1 (2%)	7 (18%)
Advised against participation by legal counsel	0 (0%)	4 (10%)

Note: Patients can name more than one provider on a Request for Conversation. When the event took place at a healthcare facility, a patient must name the healthcare facility, but naming one or more providers is optional. When the event took place outside a healthcare facility, a patient must name one of more providers. Each facility and provider named in a Request for Conversation can accept or decline the request.

Event Types

The 100 Requests for Conversation received included 109 distinct events event types (see Appendix III for a list of event types); nine requests included two distinct event types. Almost half of the Requests for Conversation were related to *surgical or other invasive procedure* events (43%). The second most common event type was *care delay* (30%), which includes both delays in diagnosis and delays in treatment (see Table 2).

Table 2. Types of events described in Requests for Conversation, July 2014-June 2017

Event Type	Patient Requests (n=89)	Healthcare Professional Requests (n=11)	Total (n=100)
Surgical or other invasive procedure	35 (39%)	8 (73%)	43 (43%)
Care delay	28 (31%)	2 (18%)	30 (30%)
Healthcare-associated infection	5 (6%)	0 (0%)	5 (5%)
Medication or other substance	6 (7%)	0 (0%)	6 (6%)
Other	10 (11%)	0 (0%)	10 (10%)
Patient protection	3 (3%)	0 (0%)	3 (3%)
Product or device	5 (6%)	2 (18%)	7 (7%)
Radiologic	1 (1%)	0 (0%)	1 (1%)
Fall	1 (1%)	0 (0%)	1 (1%)
Environmental	1 (1%)	0 (0%)	1 (1%)
Blood or blood product	1 (1%)	0 (0%)	1 (1%)
Obstetrical	0 (0%)	1 (9%)	1 (1%)

Note: percentages may total more than 100 as two requests involved more than one event type.

Resolution Information

The Resolution Reports completed by EDR participants serve as OPSCs primary window into the conversations that have taken place between patients and healthcare professionals. Because not all participants choose to submit a Resolution Report, and about one third were missing at least one field, OSPC is cautious about basing broad generalizations on this incomplete dataset. However, there are some pearls of knowledge contained in the data.

These Reports include questions about whether an event has been resolved and if so how, the number of conversations and who participated in them, the topics included in the conversation, the overall satisfaction with the process, and whether a respondent wants to volunteer additional information.

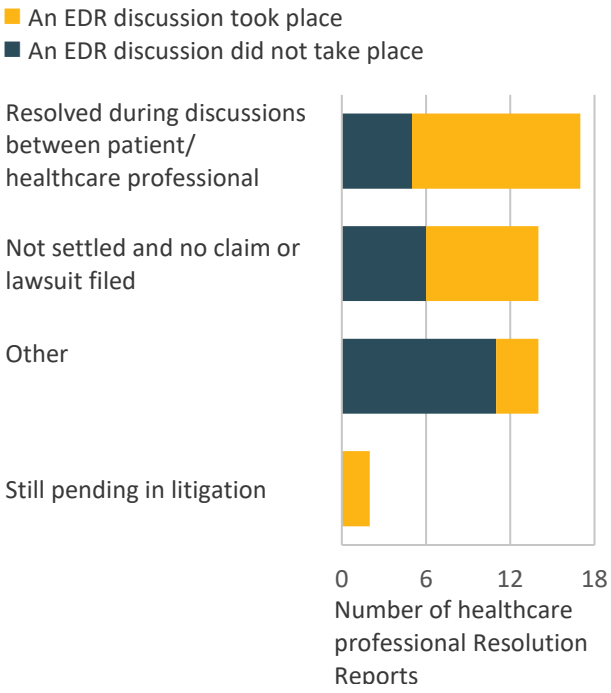
One or more Resolution Reports were completed for 64 of the 100 Requests for Conversation that were submitted in the three years of the program. In 15 cases, both the patient and one involved healthcare professional completed a Resolution Report, and in one case, a Resolution Report was completed by the patient, a facility, and a provider not employed by the facility, resulting in a total of 79 Resolution Reports related to 62 original Requests for Conversation. A comparison of Resolution Report information from events where multiple reports were received can be found in the discussion of Differences in Perception on page 10.

Status of the EDR Process

Patients and healthcare professionals can complete Resolution Reports even if no conversation occurred. The Resolution Report asks the status of the EDR process at the point in time the Report is made. Half of the Resolution Reports submitted by providers followed a discussion. Almost half (48%) of the provider Resolution Reports following a discussion indicated that the discussion resulted in resolution,

compared to nearly a third (27%) of those where a discussion did not take place (see Figure 5).

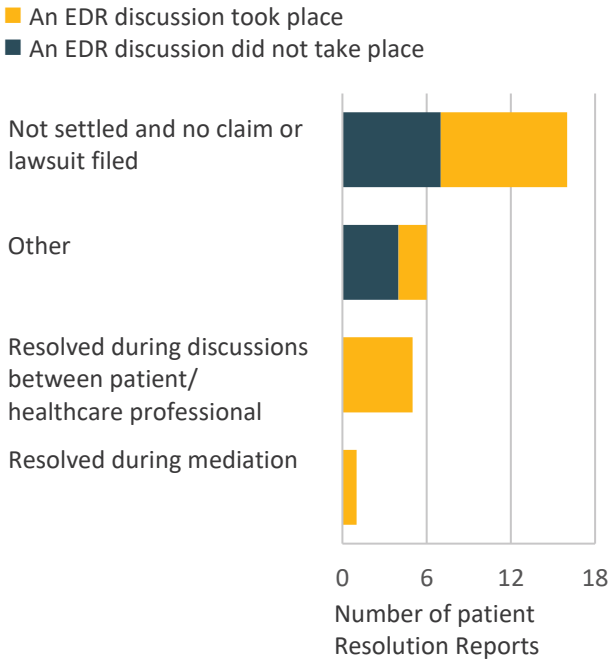
Figure 5. Healthcare professional Resolution Report statuses, July 2014-June 2017
(n=49)



Note: One *other* was *resolved with liability insurer*.

Seventeen of the 28 Resolution Reports completed by patients followed an EDR discussion. A third of the patient Resolution Reports completed following an EDR discussion indicated that the discussion resulted in resolution. In patient Resolution Reports where no EDR discussion took place, no resolution was reached (see Figure 6).

Figure 6. Patient Resolution Report statuses, July 2014-June 2017
(n=28)



Overall, 18 of the 45 Resolution Reports from healthcare professionals (40%) and six of the 28 Resolution Reports from patients (21%) indicated that the parties reached resolution.

Conversation Elements

Resolution Report respondents were asked to indicate the elements included in any conversations that took place from a list of nine discussion elements. The most common elements selected by the 39 patients and healthcare professionals that responded to the question were *information about the event* (33/39; 85%) and *information about why the event happened* (27/ 39; 69%) (see Table 3 on page 9).

Table 3. Conversation elements in early discussions, July 2014-June 2017

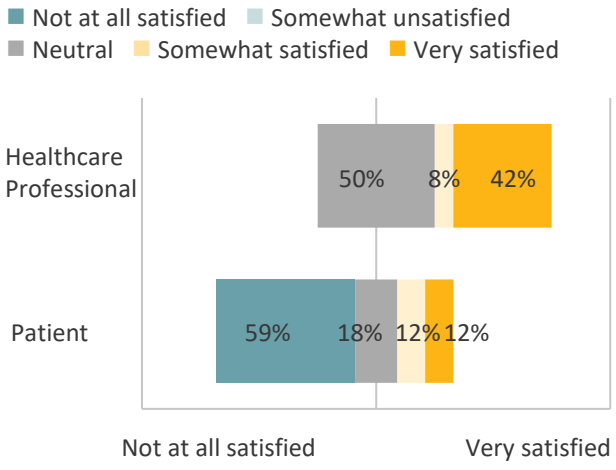
Conversation Element	Patient Resolution Reports (n=15)	Healthcare Professional Resolution Reports (n=23)	Total Resolution Reports (n=38)
Information about the event	14 (93%)	20 (87%)	34 (89%)
Information about why the event happened	10 (67%)	18 (78%)	28 (74%)
The possible impact of the event on the patient's health, treatment, and follow-up	6 (40%)	15 (65%)	21 (55%)
Explanation that an error occurred	4 (27%)	16 (70%)	20 (53%)
Explanation that an error did not occur	6 (40%)	6 (26%)	12 (32%)
What actions will be taken to prevent recurrence	2 (13%)	9 (39%)	11 (29%)
How additional information will be shared with the patient in the future	0 (0%)	11 (48%)	11 (29%)
An offer of compensation (other than waiver of medical bills)	6 (40%)	4 (17%)	10 (26%)
An offer to waive medical bills	1 (7%)	7 (30%)	8 (21%)

Note: Percentages may add up to more than 100% because users can mark multiple conversation elements in one Resolution Report

Satisfaction Ratings and Apologies

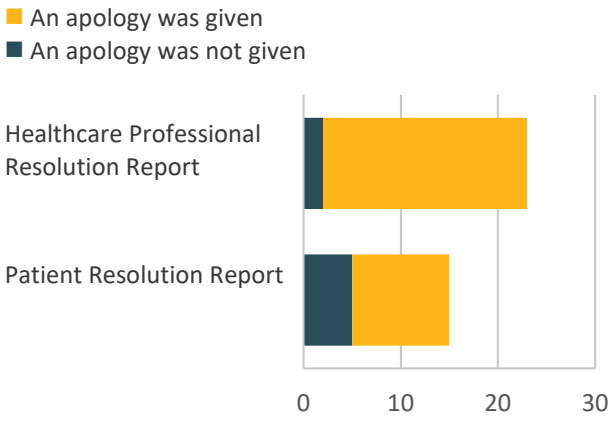
Healthcare professionals and patients often enter conversations about an event with differing expectations and knowledge. When they report their satisfaction with the resolution process, this variation remains evident. Respondents indicated their satisfaction using a 5-point scale: *very satisfied*, *somewhat satisfied*, *neutral*, *somewhat unsatisfied*, *not at all satisfied*. Of the 25 healthcare professionals and 17 patients that received this question, all but one responded. All 24 healthcare professionals who responded to this question indicated that they were *very satisfied*, *somewhat satisfied*, or *neutral*. Patient experiences, on the other hand, varied widely, from *very satisfied* to *not at all satisfied* (see Figure 7).

Figure 7. Respondent satisfaction with the resolution process, July 2014-June 2017
(n=41)



Resolution Report respondents also indicate whether the patient or patient's representative received an apology (see Figure 8 on page 10).

Figure 8. Resolution Report type, was an apology given (n=38)



Thirty-one of 38 Resolution Report respondents who answered this question (82%) indicated that an apology was given. A comparison of the perceptions of patients and healthcare professionals as to whether an apology was made can be found on page 11. Receiving an apology was not correlated with the resolution of the Request for Conversation (see Table 4) or either party's satisfaction with the process (see Table 5).

Table 4. Resolution Report type by Resolution Report status, was an apology given

	An apology was given	An apology was NOT given
Patient Resolution Reports (n=15)		
Issue was resolved in discussion	4 (27%)	1 (7%)
Issue was unresolved	5 (33%)	4 (27%)
Other Resolution Report status	1 (7%)	0 (0%)
Healthcare Professional Resolution Reports (n=23)		
Issue was resolved in discussion	9 (39%)	2 (9%)
Issue was unresolved	7 (30%)	0 (0%)
Other Resolution Report status	5 (22%)	0 (0%)

Table 5. Resolution Report type by Resolution Report status, satisfaction with the process

	An apology was given	An apology was NOT given
Patient Resolution Reports (n=15)		
Very or somewhat satisfied	3 (20%)	1 (7%)
Neutral	1 (7%)	1 (7%)
Somewhat unsatisfied or not at all satisfied	6 (40%)	3 (20%)
Healthcare Professional Resolution Reports (n=23)		
Very or somewhat satisfied	10 (43%)	2 (9%)
Neutral	11 (48%)	0 (0%)
Somewhat unsatisfied or not at all satisfied	0 (0%)	0 (0%)

The Resolution Reports also show that resolution may be reached during a conversation even when no apology is made.

Differences in Perception

Resolution Report status. There were three situations in which the healthcare professional indicated that resolution had been reached during the discussion but the patient reported that no resolution had been reached. All of these situations involved a facility and a contracted healthcare provider, not employed by the facility. In each, the patient perceived that the individual provider had shown an insufficient degree of accountability or respect.

Conversation elements. Nine Requests for Conversation had an associated Resolution Report from both a patient and a healthcare professional, that also included a response to the question about what elements were included in a conversation. (This question is only offered when a conversation took place and was not asked on all Resolution Reports.). Although in every case, patients and healthcare professionals agreed on at least one

reported conversation element, there was only one situation in which all identified conversational elements matched (1/9; 11%). The most commonly shared element was *information about the event* (9/9; 100%). The conversation elements most frequently reported by the healthcare professional only were *the possible impact of the event on the patient's health, treatment, and follow-up* and *explanation that an error occurred* (each 5/9; 56%).

By contrast, the conversation element most frequently reported by the patient only was *an explanation that error did not occur* (4/9; 44%). In fact, in two of those four cases, the provider reported contradictory information (*explanation that an error occurred*).

Apologies. There are eight cases where both a patient and a healthcare professional responded to the question regarding the offer of an apology. In every case but one, the healthcare professional reported offering an apology, but only four of the patients reported receiving an apology.

Patient Characteristics

Patients who either requested a conversation or were engaged in a conversation by a healthcare professional were more likely to be female than male (see Figure 9) and were most likely to be between the ages of 50 and 69 (58%, see Figure 10).

Figure 9. Patient gender
(n=100)

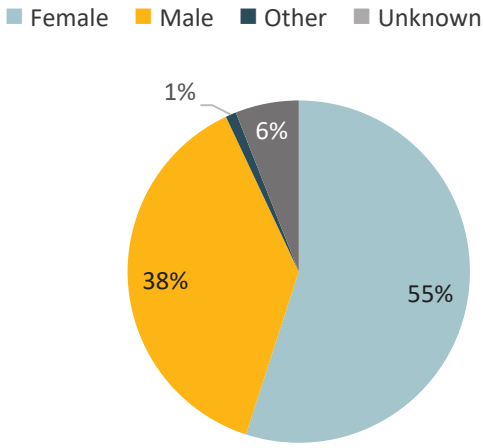
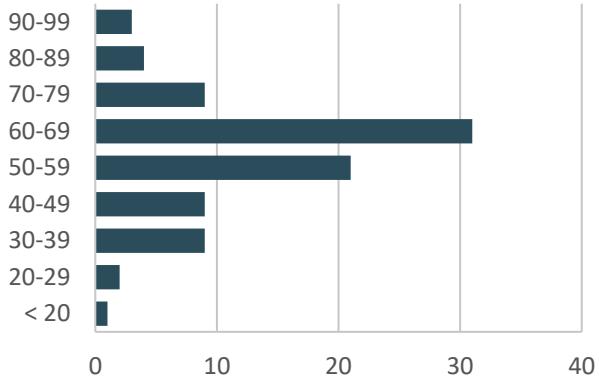


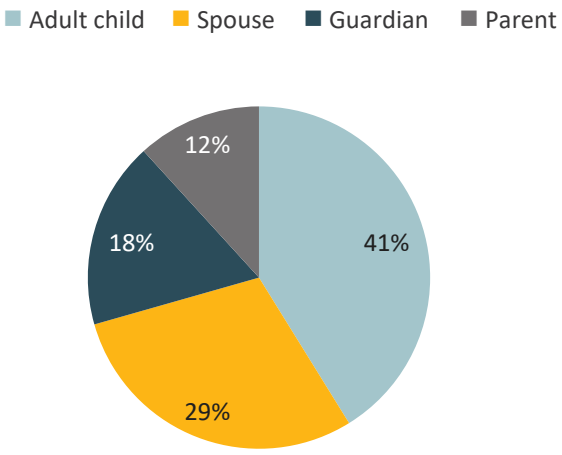
Figure 10. Patient age by age groups
(n=89)



Patient Representative Characteristics

Seventeen Requests for Conversation were submitted by patient representatives (see Appendix I for a description who can serve as a patient representative). Seventy percent were the adult child or spouse of the patient (see Figure 11). All but four of the patient representatives were so authorized because the patient had died. In one of the other cases, the representative was the parent of a child under the age of 18. In the other three, the patient's doctor determined that the patient was incapable of making decisions related to EDR.

Figure 11. Type of patient representative
(n=17)



Lessons Learned

OSPC is committed to sharing what is learned through the administration of EDR to improve communication and resolution practices in the wake of serious adverse events. The key lessons from three years administering this program, as well as OPSC's efforts to respond to identified needs, are described in this section.

I. Prompt communication with patients and families following adverse events may facilitate a more successful resolution process.

After a patient's serious injury or death, timely and appropriate communication between the patient (or patient representative) and the healthcare professional can have a significant impact on the patient's experience. No response or a delayed response from a healthcare professional may compound the injury for the patient, while proactive communication may help preserve the relationship and better position everyone for a productive resolution discussion.

When healthcare professionals do not reach out quickly, patients may lose trust that a resolution process will either occur or be beneficial. For example, in cases where a patient requests an EDR conversation and must wait several weeks for a response, the patients may suspect that an organization is hiding something. During this time, they may consider a lawsuit and may become wary of heading into conversations in the future.

Recommendation for healthcare professionals: Healthcare professionals should engage with patients as quickly as possible, ideally within 72 hours of learning about an adverse event. An initial conversation may simply include an acknowledgement that this was not the desired outcome and a commitment to learn more and share new information. At the end of the initial conversation, healthcare professionals should schedule a follow-up conversation, as appropriate.

Recommendation for healthcare facilities: Healthcare facilities should designate EDR Managers—individuals who can quickly submit an EDR Request for Conversation in the EDR online system or be automatically notified if a patient submits a request about an event that happened at the facility. EDR Managers are currently designated in 81% of hospitals, 25% of ASCs, 13% of freestanding birthing centers, and lower percentages of dialysis facilities and nursing facilities.

Note: Healthcare professionals working in other healthcare settings, outside of the previously listed healthcare facilities, are currently not able to designate an EDR Manager but can submit or view a Request from any computer with internet access.

OPSC Targeted Efforts

Infrastructure support. To support success with EDR, OPSC offers on-going consultation and support to help organizations develop their EDR infrastructure, including policies, timelines, and protocols, that will ensure consistent responses to patients following adverse events.

Organizations that are better prepared to initiate or respond to EDR requests may be perceived by patients as being more communicative and responsive.

Convening the Oregon Collaborative on Communication and Resolution Programs (OCCRP). From September 2016 through September 2017, OPSC provided intensive support to a cohort of six organizations (Cohort One) as they developed a principled, comprehensive, and systematic approach for responding to patients who have been harmed during healthcare—called a Communication and Resolution Program (CRP). The OCCRP was convened by OPSC in partnership with the

Oregon Medical Association, the Osteopathic Physicians and Surgeons of Oregon, and the Oregon Association of Hospitals and Health Systems.

The Communication and Optimal Resolution (CANDOR) Toolkit published by the Agency for Healthcare Research and Quality was used as the base curriculum, with the addition of original material pertinent to Oregon.

In 2017, the OCCRP developed a model policy for communicating with patients following adverse events. While the policy was initially created for OCCRP cohort participants, it can be implemented by any healthcare organization in Oregon.

In January of 2018, we will begin Cohort Two of the OCCRP cohort, with at least six healthcare organizations and/or systems participating. Cohort Two will include an assessment of each participant's readiness to implement a CRP approach to adverse events (Gap Analysis), a focus on developing a peer support program, and support to integrate EDR into existing processes.

EDR Notification Workgroup. To address the unique needs of large group practices or medical clinics, OPSC convened the EDR Notification Workgroup. These large practices frequently centralize risk management, claims, quality improvement, and patient safety functions, much like facilities do. The Workgroup is developing a set of recommendations for review by the State of Oregon's Attorney General that would allow a practice to enter into an agreement with OPSC whereby the practice designates an EDR Representative for all its employed providers. This EDR Representative would be able to support employed providers and manage the EDR process for the practice, much as facility EDR Managers do now.

II. An organizational culture of safety enables implementation of communication and resolution processes.

A strong organizational culture of safety is needed to support and sustain open communication with patients following serious adverse events. A culture of safety is one in which healthcare professionals are encouraged to report safety events and near misses, where everyone knows how to report such events and can do so without fear of reprisal, and where the organization commits to learning from events by sharing the results of its event analysis and improving care for future patients.

An organization that holds these values will find that adopting a policy of using EDR to communicate with patients consistently and openly following an adverse event will fit naturally into its existing culture.

One aspect of a culture of safety that has been receiving greater national attention of late is the need to create a supportive environment for healthcare workers, particularly following adverse events. While many healthcare organizations have an Employee Assistance Program or make referrals to mental health professionals when deemed necessary, few are equipped to proactively offer peer support to an affected provider immediately following an event. The lack of emotional support is a leading contributor to provider burnout (Sanchez-Reilly et al. 2013). National leaders in communications and resolution such as Tim McDonald, MD, JD have observed that an affected provider is not always in a condition to initiate and manage communications about the adverse event with their patient.

Recommendation for healthcare professionals: Healthcare professionals interested in implementing a CRP should cultivate a culture of safety that will support and sustain it. To obtain a baseline measure of patient safety culture and track progress, an organization may conduct a

patient safety culture survey and repeat it at regular intervals (e.g., every two years). The Agency for Healthcare Research and Quality (AHRQ) is a resource for surveys of this type.

A Gap Analysis process can also be used to assess safety culture. The CANDOR Toolkit includes a Gap Analysis that involves structured interviews with multiple focus groups representing various cohorts within an organization. While the CANDOR Gap Analysis emphasizes readiness to implement CRPs, it has significant overlap with the AHRQ Patient Safety Culture survey. In 2018, OPSC staff will assist OCCRP participants with an assessment of their organization's safety culture using this method.

OPSC Targeted Efforts

Providing education to support culture of safety development. OPSC is committed to supporting healthcare organizations to develop a culture of patient safety through a variety of initiatives. Over the past year, OPSC has worked to provide the healthcare professionals in Oregon with education to support culture of safety development through publications, conference exhibits and presentations, and a variety of OPSC sponsored trainings (Appendix IV. OPSC Sponsored Trainings, 2016-2017).

OPSC has also encouraged Oregon healthcare organizations to attend the national and regional conferences on communications and resolution programs sponsored by our national partner, the Collaborative for Accountability and Improvement (CAI). OPSC, through its representation on the CAI Board of Directors and participation in national and regional gatherings, puts Oregon at the table of the nationwide movement for CRPs.

OPSC will continue to seek out best practices and other patient safety innovations to share with healthcare professionals to strengthen the culture of safety within their organizations.

Building capacity to support healthcare providers following adverse events. OPSC, upon recommendation from OCCRP Cohort One, decided to make peer support the primary focus for Cohort Two. The connection between EDR and peer support is that when providers' responses and emotions are attended to with compassion and respect, they will be in a better position to respond to their patients' needs following medical harm.

III. Coordination between multiple stakeholders adds complexity.

When multiple stakeholders are associated with a serious adverse event, EDR may require additional preparation and coordination.

Depending on the unique situation, the stakeholders may include:

- The healthcare facility where the event occurred
- The involved healthcare provider(s)
- The organization that employs the healthcare provider(s)
- The liability insurer representing the facility
- The liability insurer(s) representing the healthcare provider(s)

Lack of coordination among stakeholders may delay the initial communication with a patient or delay a prompt response to a patient's Request for Conversation. It may also further complicate the event investigation and analysis.

If it appears that care was not reasonable or did not meet institutional standards, stakeholders' differing philosophies about compensation may affect the likelihood of reaching resolution.

Recommendation for healthcare professionals and their liability insurers: Healthcare professionals and liability insurers should proactively coordinate with potential stakeholders before an event ever occurs. Healthcare professionals should anticipate that

their positions may not align and consider how to resolve these differences without delaying compensation to the patient. Having plans and protocols in place for a coordinated stakeholder response, should an event occur, may create a better experience for the patient who was harmed and may lead to more successful resolution for everyone involved.

OPSC Targeted Efforts

OPSC continues to engage healthcare professionals and insurers, encouraging them to work through potential obstacles to develop an aligned response in advance of a specific adverse events. In the context of OCCRP Cohort One, OPSC supported participants to develop relationships with their counterparts in the organizations with whom they most frequently partner. OCCRP participants developed a model letter that a healthcare organization could send to potential insurers to assess their comfort and experience with a CRP approach. OPSC is monitoring how stakeholders coordinate with one another and will continue to explore ways to bring stakeholders together to respond to patients following adverse events.

IV. EDR creates opportunities for conversation between patients and their healthcare professionals even when the formal EDR process is not used.

OPSC believes that direct, open communication is important for both patients and healthcare professionals after adverse events. The EDR program has features that may enhance the likelihood of a constructive conversation, such as legal protection for conversation communications, the right to bring a support person to the conversation, conversation guidance materials, and the availability of mediation. However, there are cases when EDR was not used that still resulted in direct communication between the patient and healthcare professional.

When patients do use EDR to request conversations, healthcare professionals may choose not to engage in discussions. Of 89 patient requests, 40 (45%) were both accepted by a healthcare professional and moved forward with EDR discussions. An additional 27 EDR requests (30%) were declined, but the healthcare professional indicated that they had already used or planned to use their organization's existing processes to communicate with patients. Thus, as many as 75% of patient Requests for Conversation resulted in direct communication between patients and healthcare professionals. OPSC believes many of these conversations would not have taken place had EDR not been available.

Recommendation for healthcare professionals. While having a conversation with the patient and family in the wake of an adverse event is important, the success of the conversation may hinge on who carries the message.

Healthcare professionals have varying levels of skill and confidence communicating with patients in these situations. A weaker communicator should always be paired with someone with greater skill. OPSC can suggest tools and methods to assess a healthcare professional's communication skills before an adverse event ever occurs.

OPSC Targeted Efforts

Seeking more comprehensive resolution information. Beginning in 2017, OPSC has requested Resolution Reports following all Requests for Conversation that resulted in a conversation, without regard to whether the conversation took place under the auspices of EDR or an organization's internal process.

Equipping healthcare professionals with communication tools. Research suggests that healthcare professionals are often uncomfortable openly discussing an adverse event with a patient. This discomfort may stem

from a lack of training in disclosure, and/or a cultural reluctance to admit involvement in unanticipated patient outcomes (Mello et al. 2014).

In year three of EDR, we sent each provider named in a Request our Conversation a conversation guidance tool—a simple, evidence-based guide to what patients are likely to want from a conversation, how to prepare for the initial and subsequent conversations, and what to cover during each stage of the conversation.

Offering communication training. Participants in the OCCRP Cohort One received interactive communication training from two national leaders in the field, Bruce Lambert and Rick Boothman. Both training programs used patient actors to provide a realistic situation for practicing communication.

V. Patients may need assistance to advocate for themselves effectively during EDR conversations.

At present, most patients who submit Requests for Conversation do so an average of five and a half months after an adverse event has occurred. They find EDR through internet searches, lawyer referrals, or newspaper articles. In some cases, the patient has already attempted to speak to a healthcare professional, but more frequently they did not know who to talk to or how to get assistance.

Many of those who had talked to a healthcare professional were not satisfied. They may not have known what questions to ask, or they may not have understood the healthcare professional's process. They left feeling that their concerns had not been addressed.

OPSC wants EDR to offer patients a better experience, but there are some inherent challenges. Patients may find conversations difficult—most have never been in a situation like this before and typically have limited medical knowledge. They are often speaking with experienced healthcare professionals who know exactly how the process should work and have many resources at their disposal.

Mediators may be a potential resource during the process, helping to ensure that common patient questions are addressed, such as what happened and whether it was preventable; however, the cost of a mediator remains a barrier. EDR provides that either party can request a mediator, and that the parties must split the cost unless they make another agreement. Further, a patient's request for a mediator may be mistaken for a signal that the patient intends to litigate.

Some CRP models include legal representation for patients, not in anticipation of legal action, but because a lawyer may be able to help a patient understand the process and provide guidance regarding next steps. The Massachusetts Alliance for Communication and Resolution following Medical Injury (MACRMI) strongly recommends that patients be represented and provides guidance for lawyers participating in the resolution process.[5]

EDR rules allow a patient to bring anyone, including a lawyer, to an EDR conversation for support. However, healthcare professionals may be less willing to participate if the patient is represented. EDR rules currently require that a patient be advised of their legal right to consult an attorney only when an offer of compensation is made.

Recommendations for healthcare professionals: Healthcare professionals should be mindful of the power imbalance a patient may feel coming

[5] Guidance for lawyers from MACRMI is available at http://www.macrmi.info/attorneys/#sthash.J9yQ6Ej5.mTNJZecG.dpbs.

into an EDR conversation. Healthcare professionals should set expectations up front about who will be attending the conversation on their behalf and the role each person will play. Healthcare professionals should also encourage the patient to bring a support person to the conversation. These considerations may help demonstrate that the healthcare professionals have the patients best interest in mind. Additionally, healthcare professionals can consider bringing in a neutral third party—i.e., a mediator—to help facilitate conversations and ensure everyone's voice is heard.

OPSC Targeted Efforts

OPSC provides patients with information about what they might expect during the process; however, as the neutral administrative entity of EDR, OPSC's ability to provide support for patients is limited. This year, OPSC began to explore how Oregon's Office of the Long-Term Care Ombudsman provides support to patients and families. It may serve as a potential model.

OPSC also began to actively engage the legal community to increase the number of plaintiff lawyers who are familiar with a lawyer's potential role in the EDR process and might be willing to represent patients in EDR. However, the cost of retaining a lawyer may be a barrier for some patients. One outcome of this outreach has been an increase in referrals to EDR from plaintiff lawyers.

OPSC also intends to begin to explore what other resources for patient advocacy might be available through healthcare organizations, non-profits, and other entities.

VI. EDR fills a gap in our legal system, while addressing safety issues.

When highly successful malpractice defense attorney Richard Boothman approached his client, the University of Michigan Health System (UMHS), with a proposal to implement one of the nation's first CRPs, he noted that his successful representation of UMHS in medical negligence claims had had the unintended effect of allowing unsafe practices at UMHS to persist. Mr. Boothman reasoned that litigation was not an effective way to address system-level issues that lead to medical error, while a robust CRP would encourage prompt identification and correction of these issues. He also predicted that UMHS would save money by reducing defense and appeal costs. Under Mr. Boothman's leadership, UMHS's proactive strategy has been successful at diverting cases headed for litigation into the CRP process. Among the benefits UMHS has realized: system weaknesses have been pinpointed and addressed, patient care has improved, and litigation expenses have declined. Other systems with CRPs have shown similar results (Lambert et al. 2016).

EDR is similarly equipped to handle cases that might otherwise have resulted in litigation. However, based on the phone inquiries to OPSC about EDR, many of the patients who used EDR in 2016 and 2017 may not have had recourse to the legal system. A few of these were unable to pursue a lawsuit because the statute of limitations had run out. Most were patients who had approached numerous plaintiff lawyers but were informed that the potential recovery from their cases, although strong, was insufficient to justify filing a legal action.

Information OPSC has received suggests that a medical negligence case must have potential damages in excess of $200,000 to be economically viable. A patient's advanced age (over 55), lack of dependents, affliction with other serious health conditions, and low earning potential are some of the factors that may diminish potential recovery, even if there has been a clear breach of the standard of care. Plaintiff lawyers often refer these patients to EDR.

For these older, sicker, and/or low-income patients, EDR may provide an opportunity to get

information about what happened, to receive compensation if the provider agrees that the standard of care was not met, and to bring attention to system issues that, if addressed, may improve safety for future patients.

VII. Organizations need systems in place to account for the role medical device vendors play in patient care.

Currently, medical device manufacturers' representatives and other vendors are not covered providers in the EDR statute. However, these individuals are often present in the surgical suite or other patient-care areas, and their recommendations of adjustments to devices or products may affect a patient's care.

Multiple patient calls to OPSC and one EDR Request for Conversation were related to actions of a medical device manufacturer's representative that affected patient care.

Recommendation for healthcare professionals: In their organizations, healthcare professionals should ensure their policies and processes related to vendors are consistently implemented, monitored, and enforced. This includes vesting oversight responsibility within the organization's leadership, establishing what vendors can do and where, and obtaining informed consent from patients before a vendor plays a role in patient care (e.g., services a medical device).

VIII. EDR calls have reflected the national response to the opioid epidemic.

OPSC has seen an increase in calls to the EDR phone line from patients who have been affected by government and private efforts to address the opioid epidemic. There is confusion from healthcare professionals and patients alike about what new opioid reduction-related federal guidelines mean, and how much discretion healthcare professionals retain in prescribing this category of medication.

Some patients who describe themselves as long-time, high-dose users to treat chronic pain have expressed fear about what a dramatic reduction will mean for their quality of life, particularly when no alternative treatment options and transition plan have been discussed. Other patients have described challenges getting even small doses of pain medication for acute pain after having been labeled as "drug-seeking" in their medical record.

OPSC Targeted Efforts

Because these situations have not involved serious physical harm, EDR was not available to these patients. OPSC has identified a number of resources for patients in these situations. OPSC also intends to reach out to Governor Brown's new statewide Opioid Task Force, convened in September 2017 to combat opioid abuse and dependency, to inform them of the concerns patients have raised in their calls to OPSC. OPSC will continue to monitor opioid-related calls in coming years and share any new learning.

Conclusion

EDR, while still in its infancy here in Oregon, is gaining visibility and acceptance by a growing number of patients and healthcare professionals in our state. OPSC is encouraged by the numbers of people who have used EDR to seek open communication toward resolution of adverse events.

EDR is the first statewide program of its kind in the country, and the only one to support initiation by patients as well as healthcare professionals. What OPSC learns through EDR implementation will contribute to the national conversation about communication and resolution processes.

In the interests of transparency and continuous learning, OPSC offers these key recommendations from three years of administering EDR:

- Proactive communication with patients after adverse events should be prompt, even when investigations are not yet complete. This may help preserve the patient-provider relationships and better positions everyone for a productive resolution discussion.
- A culture of patient safety is essential for healthcare organizations to implement communication and resolution processes. The culture should be regularly monitored and actively promoted.
- Having plans and protocols in place for a coordinated stakeholder response, should an event occur, may create a better experience for the patient who was harmed, and may lead to more successful resolution for everyone involved.
- Direct, open communication is important for both patients and healthcare professionals after adverse events. EDR creates opportunities for conversation between patients and their healthcare professionals even when the formal EDR process is not used.
- Patients need assistance to advocate for their needs and to productively participate in conversations with healthcare professionals. Additional resources should be made available to them, whether through healthcare professionals or through referrals.
- Because medical device vendors are often present in patient-care areas, organizations should ensure they have appropriate policies and processes in place, and that they are consistently implemented, monitored, and enforced.
- With a new focus on the opioid epidemic nationally and locally, individuals who have been long-time opioid users to treat chronic conditions are now facing challenges getting needed pain care.

The governor-appointed Task Force on Resolution of Adverse Healthcare Incidents provides key input into the ongoing development of this program and will continue to consider improvements and new directions.

OSPC is honored to support EDR and is committed to continuously learning about how patients and healthcare professionals use EDR to support transparent communication following adverse events. OPSC is also committed to making ongoing improvements to the EDR infrastructure and support services.

OPSC looks forward to continued, and new, collaborations to foster a culture of patient safety in Oregon. OPSC is optimistic that EDR has the potential to help to improve patient safety and transparency in healthcare and strengthen the relationship between the Oregon healthcare community and the people it serves.

Acknowledgements

OPSC 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 Advisory Committee to the Oregon Collaborative on Communication and Resolution Programs
- 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
- The people of Oregon, and those patients and family members who have sought early discussion and resolution following serious adverse events

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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.
Apology	In the book *Healing Words: The Power of Apology in Medicine*, Michael Woods describes an effective apology, acknowledging that the "requirements for an effective apology will vary from case to case, depend on the injured person's hopes, needs, and fears, and the relationship between the two parties…broadly speaking an authentic apology is likely to include the following five elements: 1. Recognition of the event that caused harm 2. An expression of regret and sympathy (the partial apology) 3. An acknowledgement of responsibility—where appropriate—once the facts are fully understood (the full apology) 4. Effective reparation 5. One or more opportunities to meet again after a period of reflection" [6]
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*, and employers of *healthcare providers*
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

[6] Woods, M. S., & Star, J. I. (2004). *Healing words: The power of apology in medicine*. Doctors in Touch.

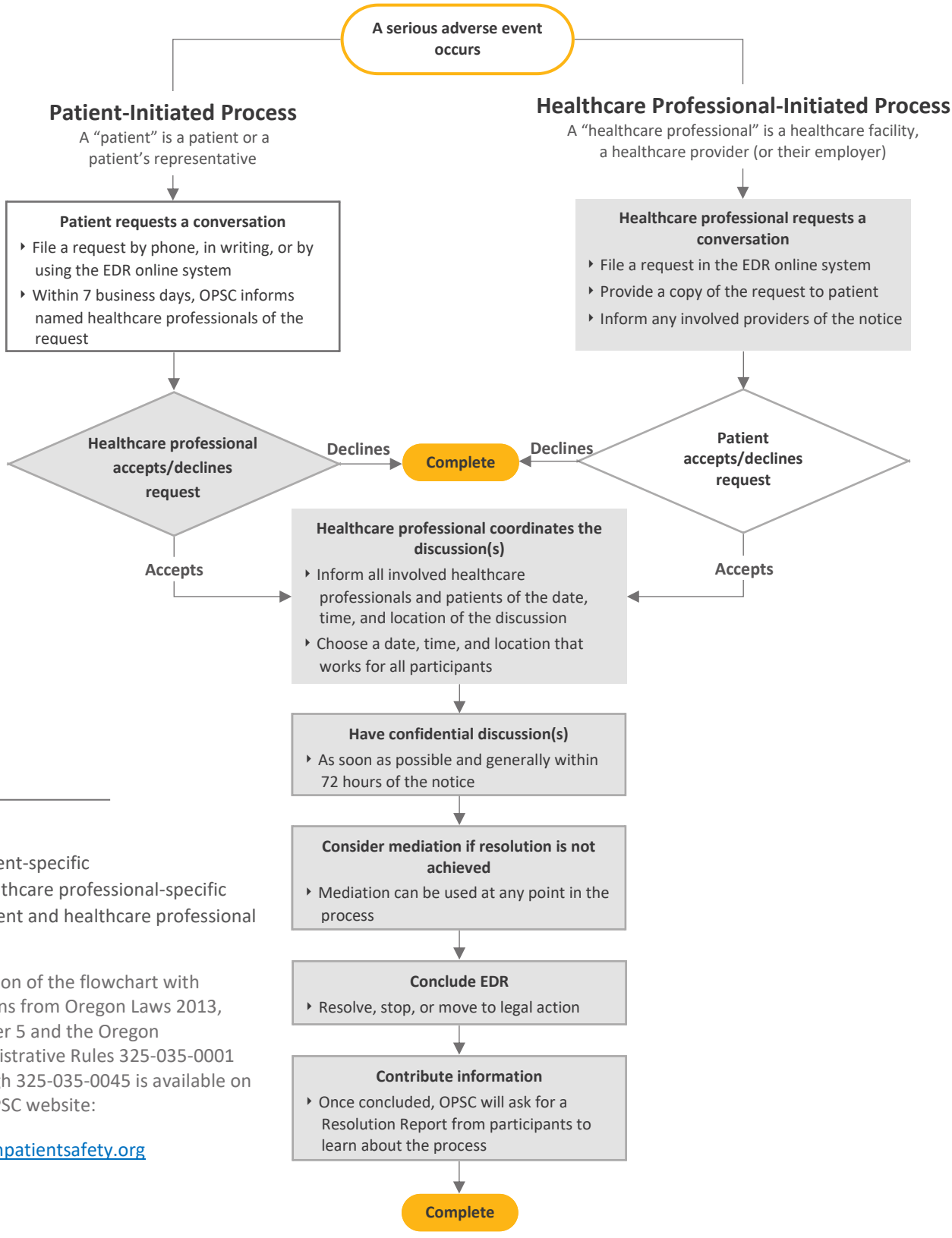
Healthcare provider*	A licensed healthcare provider as listed in Oregon Laws 2013, chapter 5. Healthcare providers are: • Audiologists • Chiropractors • Dental hygienists • Dentists • Denturists • Direct entry midwives • Emergency medical service providers • Marriage and family therapists • Massage therapists • 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 advocate	A person whose role is to support the patient and family in a healthcare setting, and to ensure that their voices are heard. Patient advocates may work for the organizations that are directly responsible for the patient's care, for an outside organization, or may be independent. Most are laypeople but some are trained medical professionals. Responsibilities may include: • Personalizing and humanizing the healthcare experience • Explaining policies, procedures and services • Acting as a liaison between patients and medical providers • Ensuring that care is culturally appropriate and accessible • Providing access to resources for individual needs and questions • Providing access to information regarding sensitive healthcare questions • Supporting the exercise of autonomy on medical decision-making • Serving as the point of contact for concerns, complaints, and grievances Patient advocates with specialized training may also provide medical guidance, insurance or financial guidance, and legal or ethical advocacy.
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
Request for Conversation	A Request for Conversation 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. Submitting a Request for Conversation

	starts the Early Discussion and Resolution process. The request lets the other party know that the filer would like to talk to them about what happened. (Termed "Notice of Adverse Healthcare Incident" in Oregon Administrative Rule 325-035-0001 through 325-035-0045)

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

Appendix II. The Early Discussion & Resolution Process

When a serious adverse event occurs, either a patient or a healthcare professional can initiate EDR by completing a Request for Conversation, through 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 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 OPSC website:

oregonpatientsafety.org

Appendix III. Event Type Categories

Event type categories are based on definitions used by the 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.[7, 8]

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.

[7] 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.

[8] 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 IV. OPSC Sponsored Trainings, 2016-2017

OPSC is committed to supporting healthcare professionals to develop a culture of patient safety through a variety of initiatives. Over the past year, OPSC has worked to provide education to support safety culture development, which included the following:

- Avoid Band-Aid Solutions: Strengthening Adverse Event Investigations
- Speak Up for Patient Safety: Communicating Before, During, and After and Adverse Event
- Fundamentals of Communication and Resolution Programs
- Walking the Talk: Healing, Learning, and Safer Healthcare through Open Communication
- OCCRP Learning Session: Just Culture
- OCCRP Learning Session: Peer Support Program Development
- OCCRP Webinar: Adverse Event Reporting
- OCCRP Learning Session: Adverse Event Analysis
- OCCRP Learning Session: Communication with Patients and Families in the Wake of an Adverse Event
- OCCRP Webinar: Professional Liability and Resolution: Collaborative Relationships with Internal and External Stakeholders
- OCCRP Learning Session: Communicating with Patients and Families Towards Resolution
- OCCRP Learning Session: The Role of Mediators, Attorneys, and Insurers in the Resolution Process