OREGON PATIENT SAFETY COMMISSION

Patient Safety Reporting Program 2020 Annual Report

Evolving Along with Oregon's Healthcare System



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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Executive Summary

During this past year, no industry has been tested like the healthcare delivery system. The COVID-19 pandemic and social movements exposing the systemic racism endemic in American society have shed light on vulnerabilities in our healthcare system. Addressing these deeply-rooted inequities is an immense challenge but also offers countless opportunities to learn, adapt, and improve. The experiences of the last year have increased our sense of urgency at the Oregon Patient Safety Commission (OPSC) to make deliberate and purposeful change. We have an opportunity, and an obligation, to learn and evolve to continue to fulfill our mission—to reduce the risk of serious adverse events occurring in Oregon's healthcare system and encourage a culture of patient safety.

While our mission remains as relevant as ever, healthcare today is not what it was when our first program, the Patient Safety Reporting Program (PSRP), was created back in 2003. Now is an ideal time to dig deeper into what we have learned from PSRP, review relevant patient safety research, and seek to understand how the needs of the healthcare system have changed.

In this report, we take a closer look at the progression of safety culture and how Oregon's PSRP was ahead of its time. By promoting shared learning to enhance quality and safety across the state, PSRP was a lever for culture change in Oregon. We outline a plan to conduct an analysis of PSRP to both keep pace with the rapidly evolving healthcare delivery system and to help raise the bar and continue to drive culture change in Oregon. We also share some of our key lessons that will guide this work.

Summary of Our Continuous Improvement Plan

In the short term, we will analyze our current PSRP legislative mandates for alignment with our mission, current patient safety research, and the needs of the healthcare system. This analysis is to inform potential short-term improvements to PSRP operations that do not require any changes to our mandates. We will also identify opportunities for improvement that may require changes to PSRP mandates.

In the long term, we will move forward with the legislative change process for opportunities identified during the analysis process.

Our Guiding Lessons

We have identified several essential lessons about patient safety, the vital role of culture, and what approaches might lead to widespread progress in patient safety, that we believe must guide our work, our analysis process, and our work going forward:

- Culture of safety requires health equity.
- We must be able to adapt and innovate.
- This work cannot happen in isolation; it must be done together.
- Our mission—to reduce the risk of serious adverse events occurring in Oregon's healthcare system and encourage a culture of patient safety—remains vital.

Learning from the Past to Inform the Future

Over 20 years ago, the Institute of Medicine (IOM) published its seminal work, *To Err is Human*, shining a light on the issue of patient harm and death from medical care in the United States.[1] Since then, some estimates have put medical harm as a leading cause of death in this country.[2–5] While there are varying opinions about just how many patients are harmed or die as a result of medical care each year, we know it is far too many.[2,3,6–10]

To make progress, we must improve how we respond to and learn from medical harm, both within individual healthcare organizations and across the healthcare continuum.

- **Individual healthcare organizations must have a culture of safety:** In our complex and constantly evolving healthcare delivery system, organizations must be able to learn and adapt in response to the wide range of safety issues that will arise, from new research, to a new technology or process, or even a new virus.[11] For any patient safety effort to be successful, organizations must cultivate a culture of safety. Without a culture of safety, patient safety improvement efforts, though well-intentioned, are ineffective and unsustainable.[12,13]
- **We must coordinate efforts and share learning across the healthcare continuum:** In the 2020 report *Safer Together: A National Action Plan to Advance Patient Safety*, the National Steering Committee for Patient Safety (NSC) describes the critical need for a coordinated effort from all stakeholders across the healthcare continuum. In the report, NSC acknowledges a lack of progress in patient safety despite the many evidence-based practices for harm reduction identified by individual organizations, because they are seldom shared beyond the organization or effectively implemented across multiple organizations. NSC concludes, "It has become clear that reducing preventable harm is a complex endeavor that requires a concerted, persistent, coordinated effort by all stakeholders, and a total systems approach to safety."[14(p11)]

This past year has highlighted just how much more work we still must do as a healthcare community to make further progress in patient safety, from the disproportionate impact COVID-19 has had on racial and ethnic minority groups to the exposure of inadequate systems to protect and support healthcare workers in times of crisis. Developing a culture of safety allows organizations to tackle new challenges as they arise, However lasting change takes time and effort to sustain.

The COVID-19 Pandemic Highlights the Need for a Culture of Safety

The ongoing identification and management of risk in healthcare requires a culture that supports learning and improvement, both in times of stability and during periods of intense stress on the healthcare system, like the COVID-19 pandemic.

Risks that already exist can be exacerbated by things like fatigue, burnout, illness, poor psychological safety, and lack of team trust. This increased risk can contribute to adverse events and inhibit the ability of care providers to safely deliver care.[15] Whether the risk is related to the safe administration of medication or having adequate personal protective equipment for staff, an organization with a culture of safety will be better equipped to navigate these situations.

Building organizational capacity to manage risk and address safety issues on an ongoing basis is more important than ever as organizations face the COVID-19 pandemic, and a culture of safety is foundational to these efforts. Leadership must continue to prioritize and resource programs that support culture development to keep both their patients and providers safe.

Guiding Lesson 1: Culture of safety requires health equity.

To serve all Oregonians, we must apply an equity lens to everything we do. Patient safety is undeniably linked to health inequity—the differences in health outcomes that are systematic, avoidable, and unjust.[16–18] In the past year, professional organizations across the country have issued policy statements recognizing systemic racism as a public health issue that the healthcare system must address explicitly and urgently.[19–21] Local and state governments have followed suit.[22,23] Structural racism and systemic discrimination based on factors such as race, sex, language, and socioeconomic class are codified in the policies and practices of the U.S. healthcare system.[24] Culture of safety is an organization's shared perceptions, beliefs, values, and attitudes that combine to create a commitment to safety and an effort to minimize harm.[25] When an organization's culture of safety does not address health equity head on, it can deepen the systemic biases and injustices that are already present. For example, one study[17] identified race differences for serious harm events by both type of event and hospital setting for events reported in a voluntary reporting system. Yet, there is limited information about why these differences exist, in part because even basic data on race and ethnicity are either not collected or not included in event reports (Figure 1 and Figure 2). Not until we all take steps to understand the root causes of inequity in patient safety, can we implement targeted strategies and make progress.

Figure 1. Patient Race, 2020

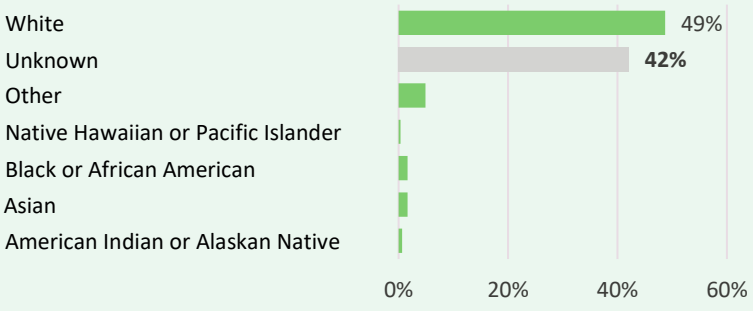
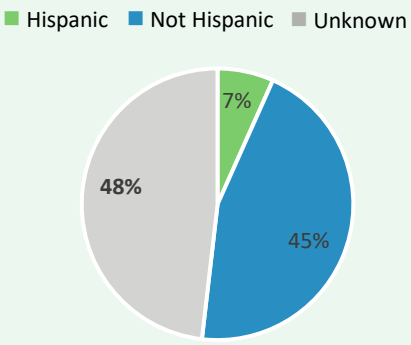


Figure 2. Patient Ethnicity, 2020



See Appendix I. Adverse Events in Oregon for additional PSRP data, including demographic data.

At the Oregon Patient Safety Commission (OPSC) we have the infrastructure in place with the Patient Safety Reporting Program (PSRP) to help organizations develop their culture of safety around key aspects of their comprehensive response to patient harm events, and to serve as a neutral coordinating body to facilitate shared learning across the healthcare continuum. It must be noted, however, that while healthcare has been in a constant state of change since PSRP was created in 2003, its founding legislation has remained largely unchanged.

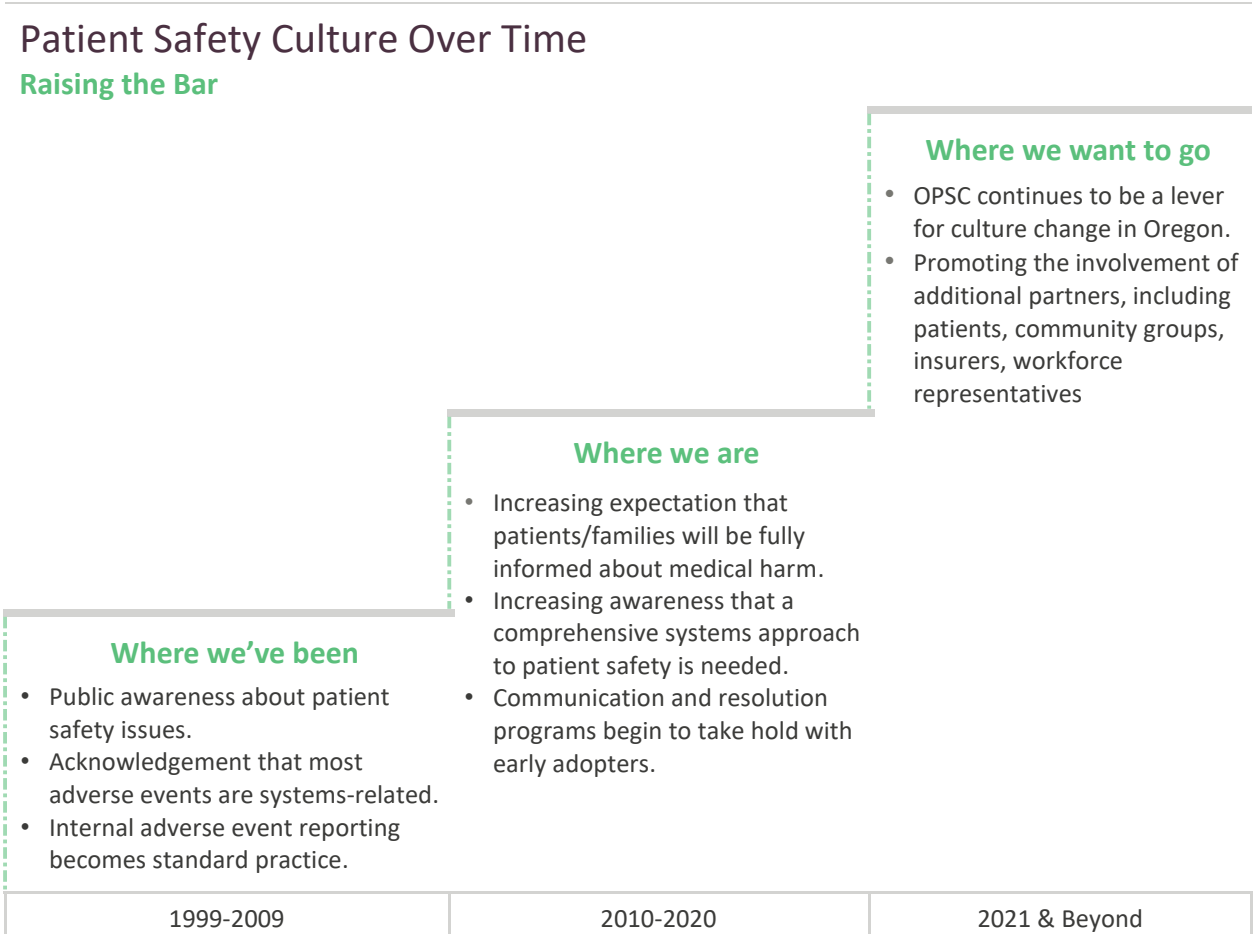
Guiding Lesson 2: We must be able to adapt and innovate.

In the complex and rapidly-changing healthcare delivery system, patient safety is not simply a box that can be checked or a task that can be completed. Patient safety work is ongoing. With the introduction of new processes, systems, and technologies in healthcare, new and often unanticipated risks are also introduced. To effectively manage the wide range of safety issues that will arise, healthcare organizations must be able to both anticipate these risks and continually adjust their systems.[26]

We believe that to support healthcare organizations in this shifting landscape, we have an obligation to learn and make deliberate and purposeful change. Embarking on a continuous quality improvement process for PSRP will ensure that the program can adapt to the changing needs of the healthcare delivery system and continue to fulfill our mission, to be a lever for culture change in Oregon.

To start this process, we reflect on where we have been and outline our plan to continue to learn and evolve along with the healthcare system. Figure 3 provides a high-level look at notable progress in safety culture over time.

Figure 3. Timeline of Patient Safety Culture

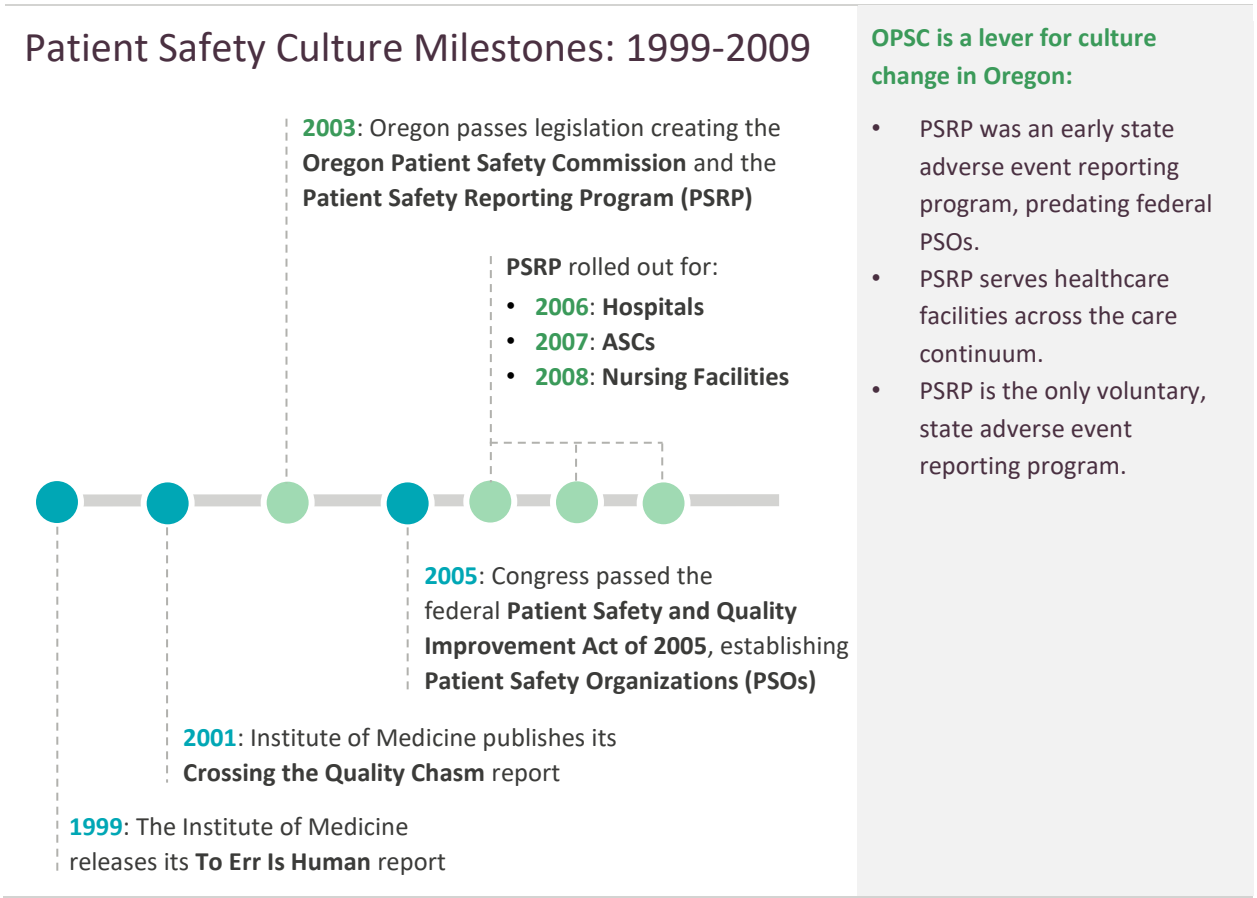


Where We've Been

The release of the Institute of Medicine's report, *To Err is Human,* in 1999 brought public awareness to patient safety, sparking concern over the number of patients harmed by medical care each year.[1] At that time, many people in our state and around the world saw an urgent need for greater collaboration and systemwide insights to address underlying challenges in healthcare that increase the risk of patient harm. In response, the Oregon Legislature created a workgroup representing medical providers, insurers, purchasers, and consumers to offer recommendations about how Oregon could address patient safety. The workgroup believed that the work of improving patient safety never ends and should not be done in isolation. In 2003, based on the workgroup's recommendations, the legislature created the Oregon Patient Safety Commission (OPSC) as an independent voice for patient safety.

OPSC's founding legislation also created the Oregon Patient Safety Reporting Program (PSRP), one of the earliest state adverse event reporting programs focused on culture of safety in the nation. Through PSRP, healthcare facilities voluntarily provide information about serious patient harm—or near misses—and their strategies for preventing future events. We analyze these details to better understand how and why the harm occurred, and then share the broader lessons learned to support healthcare facilities statewide in improving patient safety. PSRP focuses on building greater trust in the healthcare system and strengthening its culture of patient safety.

Figure 4. Past Patient Safety Culture Milestones



Oregon was an early leader in developing programs that support a culture of safety. Shortly after Oregon created OPSC and PSRP, Congress passed the Patient Safety and Quality Improvement Act of 2005, creating federal Patient Safety Organizations (PSOs). Like OPSC, federal PSOs were intended to promote shared learning to enhance quality and safety nationally. While other states also developed adverse event reporting programs, Oregon's program was unique in that it was the only voluntary state program and the only program that included reporting for pharmacies. PSRP was designed to support system-wide collaboration, including hospitals, ambulatory surgery centers, nursing facilities, and pharmacies.

Guiding Lesson 3: This work cannot happen in isolation; it must be done together.

At OPSC, we are uniquely positioned to support learning and coordination across the healthcare continuum, free from industry interests. As Oregon's patient safety organization, we can offer insight into the efficacy of organizations' processes and systems for learning from patient harm events to make care safer. Individual healthcare organizations have the internal expertise to best investigate and understand the vast breadth of clinical and technical issues that comprise patient safety work. For example, in 2020 alone PSRP received 299 reports across 21 different event types (Table 3, page 15). Individual healthcare organizations will always be in the best position to determine what solutions are likely to be successful in their facilities.

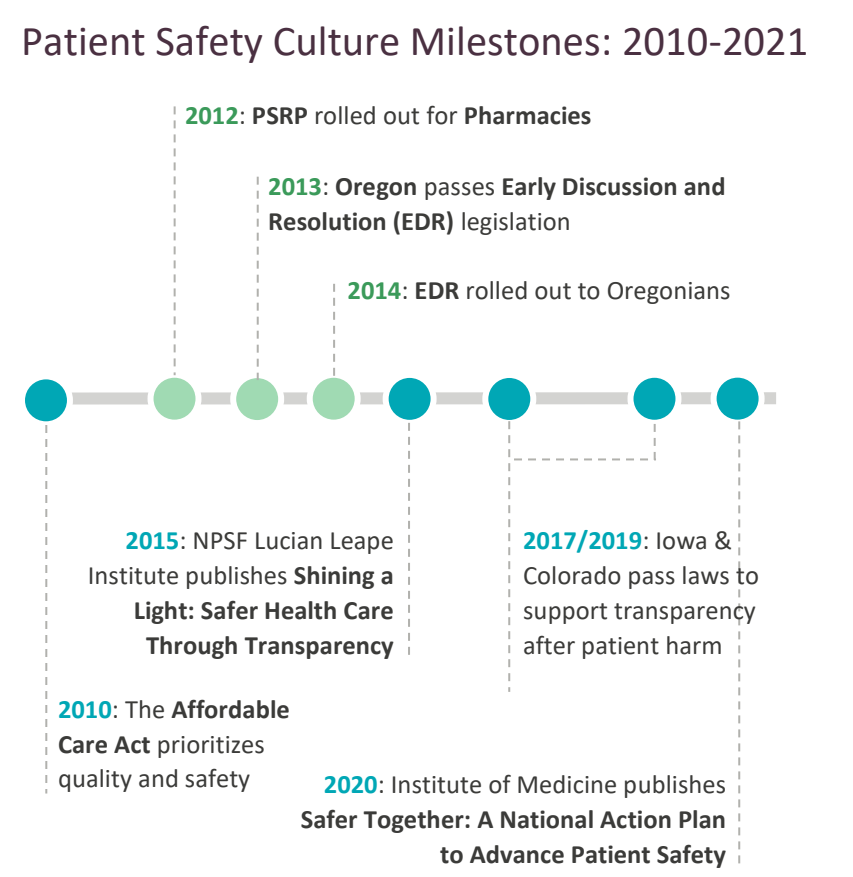
Where We Are

Over the past decade, there has been a shift in the expectations of patients and their loved ones. They expect to be more involved in their care, to have access to their health information,[27] and to be fully informed when medical harm occurs.[28] During this time, we have also seen increasing awareness that, to make progress, organizations must have comprehensive systems in place to consistently and effectively respond to patient harm.

Several leading healthcare organizations across the country recognized that their current infrastructure did not support full transparency with patients and families following a harm event, and they would need to overhaul their existing systems. These organizations began to develop and fine-tune communication and resolution programs (CRPs), comprehensive systems for responding to patient harm that prioritized patient safety, transparency, and learning.

In 2013, Oregon found itself leading the way with policy to support the development of further culture change. The law that created Early Discussion and Resolution (EDR) was one of the first in the country to promote open communication between patients (or their representatives), healthcare providers, and facilities when serious harm or death occurred as a result of care, and it remains the only law that allows patients to initiate the conversation. EDR establishes confidentiality protections for these important conversations to encourage organizations to adopt a new approach for responding to patient harm, and to create and sustain systems to support a transparent communication process.

Figure 5. Recent Patient Safety Culture Milestones



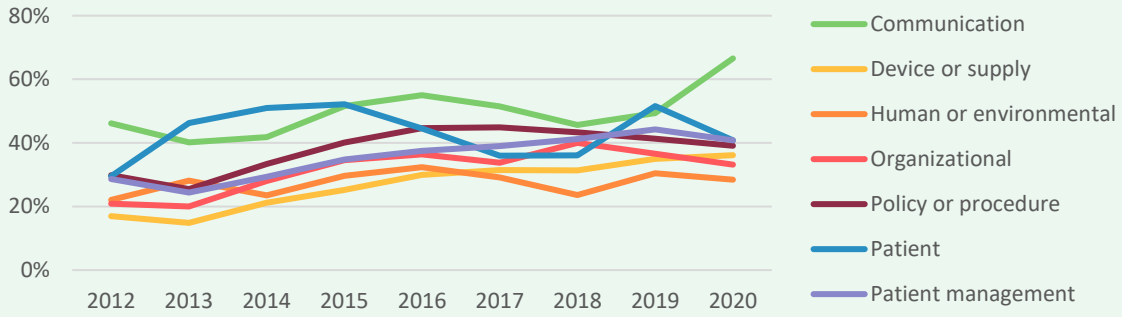
OPSC is a lever for culture change in Oregon:

- OPSC implemented one of the first laws in the country, EDR, to promote open conversation following patient harm.
- EDR remains the only program that allows patients to initiate the conversation.
- OPSC is contributing to the national conversation about transparency following patient harm and is a model for other states.

Guiding Lesson 4: Our mission remains vital.

Since its creation in 2003, OPSC's mission—to reduce the risk of serious adverse events occurring in Oregon's healthcare system and encourage a culture of patient safety—has remained relevant. Serious adverse events continue to occur, and the reports we have received throughout the history of PSRP show little change in the system-level causes of adverse events in Oregon. Research has identified the same pattern in reporting systems around the world and suggests that this may be due, in large part, to the slow pace of culture change. As the Agency for Healthcare Research and Quality put it, "Improving the culture of safety within health care is an essential component of preventing or reducing errors and improving overall health care quality… Improved culture is not the means to an end but an end itself."[29]

Figure 6. All Segments Contributing Factor Categories Over Time (2012-2020)



Where We Want to Go

We have been a national leader in patient safety, supporting innovative programs to encourage a culture of patient safety. We administer the only voluntary, state adverse event reporting program in the country—PSRP. We also implemented one of the first laws in the country to promote open conversation between patients who have been harmed by their medical care, healthcare providers, and facilities. However, we know that more must be done to move the needle on patient safety. OPSC is uniquely positioned to share information and best practices to help Oregon's healthcare system move forward together. We have an opportunity to continue to support the culture development necessary to make progress. To do this we must:

- **Learn and evolve along with the healthcare system.** We can look to emerging research to advance patient safety and adapt together with the healthcare system.
- **Leverage our unique role to support system-wide learning.** We have the infrastructure in place to serve as a neutral, coordinating body for Oregon, supporting various aspects of an organization's response to patient harm events and facilitating learning across the healthcare continuum.
- **Reinforce our state's commitment to patients who have been harmed by medical care, their families, and healthcare providers involved in harm events.** The number one thing that patients want when they experience harm is to know that the facility is doing something to prevent future harm. The reporting program is designed to capture what facilities learn when they investigate adverse events so that it can be shared more broadly. We have an opportunity to support collaboration to make our care delivery system safer for patients and providers alike, and to encourage patient and family engagement in these efforts in keeping with the recommendations in *Safer Together: A National Action Plan to Advance Patient Safety*.[14]

Figure 7. Future Patient Safety Culture Milestones

Patient Safety Culture Milestones: 2021 and Beyond

2023: OPSC pursues PSRP legislative changes to align our mandates with our mission, current patient safety research, and the needs of the healthcare system

2024 and beyond: OPSC operationalizes updates to PSRP, in collaboration with representatives across Oregon's healthcare continuum

OPSC can continue to be a lever for culture change in Oregon:

- We can align our PSRP legislative mandates and processes with:
  - Our mission
  - Current patient safety research
  - Needs of the healthcare system
- To build on our opportunities, we will likely need to update our legislation.
- We know legislative change is a multi-year process that is followed by implementation, so we must start now.

How We Get There

PSRP has a strong foundation that is rooted in OPSC's mission—to encourage a culture of safety and help make care safer for all Oregonians. However, healthcare today is not what it was in 2003 when OPSC was created. As a learning organization, OPSC must be responsive to new knowledge and insights. Analyzing the program to identify opportunities for improvement will ensure it can continue to support the rapidly changing healthcare environment. OPSC will embark on a phased analysis process to inform programmatic changes.

Short-term Plan

In the coming one to two years, we will analyze our current PSRP legislative mandates for alignment with:

- **Our mission.** OPSC's mission provides a clear and focused goal for PSRP. Establishing a clear connection between each mandate and our mission will help ensure the program continues to serve Oregonians.
- **Current patient safety research.** PSRP was a groundbreaking program when it was created. Now, emerging research is focusing on the systems and infrastructure organizations have in place to learn from adverse events or other system weaknesses, rather than specific solutions to individual problems. In other words, there is a shift from focusing on what organizations learn to how they learn. The focus on patient safety infrastructure is not limited to adverse event reporting and investigation, but extends to policies on health equity and patient and family involvement in patient safety work (see Appendix II).
- **Needs of the healthcare system.** Since PSRP was designed, the healthcare system has been constantly changing. We are uniquely positioned to support collaboration and learning across Oregon through PSRP; but the best way to do that may have changed. Understanding the current needs of the healthcare system will be essential to shaping what future support looks like.

We will use this analysis to:

- Inform potential changes to PSRP operations that do not require legislative mandate changes. We have some flexibilities in how we operationalize PSRP that may offer opportunities to make improvements in the short term.
- Identify opportunities for long-term, PSRP legislative mandate changes.

Long-term Plan

Information from our analysis process will help shape our long-term plan, and we will fill in the details as we learn more. What we know now is that we expect to:

- Move forward with the legislative change process for opportunities identified during the legislative mandate analysis. We will work with the OPSC Board of Directors (See Appendix III) and members of the healthcare community to thoughtfully consider any change to PSRP legislation.
- Develop plans for and operationalize any legislative mandate changes. Just as OPSC did in the initial roll out of PSRP, we will collaborate with representatives of relevant healthcare segments on any changes to the program.

Guiding Lessons for Our Continuous Quality Improvement Process

Through our work, we have learned many important lessons about patient safety, the vital role of culture, and what approaches might lead to widespread progress in patient safety. We believe some of these lessons are crucial to our work going forward and must guide our analysis process:

Culture of safety requires health equity. To serve all Oregonians, we must apply an equity lens to everything we do. As we do our analysis, we will explicitly look at how our decisions can advance health equity and take special care to make sure they do not perpetuate systemic inequities.

We must be able to adapt and innovate. To effectively support an industry that is constantly evolving, often in unpredictable ways, we must constantly incorporate new knowledge and insights to meet changing needs. Being responsive to the events of this past year is our only option.

This work cannot happen in isolation; it must be done together. We will look for opportunities to focus on how we can support collaboration and learning across the healthcare system so that we can make progress together.

Our mission—to reduce the risk of serious adverse events occurring in Oregon's healthcare system and encourage a culture of patient safety—remains vital. Supporting patient safety culture development is essential to making our healthcare system safer. We will ensure our mission drives our analysis of PSRP, as it drives everything we do.

Conclusion

OPSC was built on the idea that progress happens when we come together to work on our shared goal of safer care for all Oregonians. The events of this past year have highlighted just how much more work we still must do as a healthcare community. The COVID-19 pandemic exposed vulnerabilities and pervasive inequities in our healthcare system. We believe that we have an opportunity, and an obligation, to learn and make deliberate and purposeful change.

It is more important than ever that we proactively plan for a future that allows us to continue to fulfill our mission, and our unique role as an independent voice for patient safety in Oregon and a central hub for shared learning across the healthcare system. We will undertake a phased analysis process of PSRP to identify opportunities for improvement to ensure it can continue to support the rapidly changing healthcare environment. We look forward to engaging with members of Oregon's healthcare community as we work together on the shared goal of improving the safety of our healthcare system.

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Appendix I. Adverse Events in Oregon

Additional Demographics

Data on race and ethnicity can be found on page 2.

Figure 8. Patient Age Groups, 2020

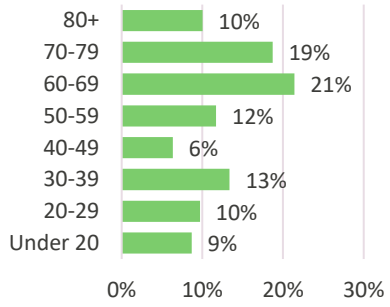
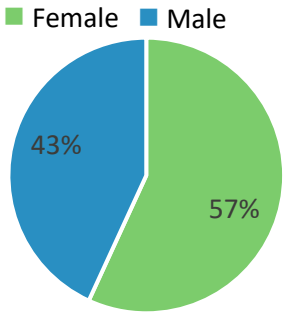


Figure 9. Patient Gender, 2020



Participation and Engagement

Four healthcare segments—ASCs, hospitals, nursing facilities, and pharmacies—are eligible to participate in the Patient Safety Reporting Program (PSRP). All eligible hospitals are enrolled in PSRP, while some ASCs, nursing facilities and pharmacies have not yet enrolled. Not all enrolled facilities submit reports every year.

Table 1. Percent of Eligible Facilities Enrolled and Percent of Enrolled Facilities that Submitted, by Segment, 2020

Segment	Enrolled	Eligible	% of Eligible That Are Enrolled	Number of Enrolled That Submitted	% of Enrolled That Submitted
ASC	66	93	71%	15	23%
Hospital	59	59	100%	28	47%
Nursing Facility	106	129	82%	0	--
Pharmacy	119	695	17%	4	3%
Grand Total	350	976	36%	47	13%

Oregon facilities submitted 299 adverse event reports in 2020 (Table 2).

Table 2. Total Submissions by Segment, 2020

Segment	Number
ASC	64
Hospital	222
Nursing Facility	0
Pharmacy	13
Total	299

Event Type

In 2020, Oregon healthcare organizations voluntarily contributed 299 adverse event reports to PSRP for learning: 64 reports were from ASCs, 222 were from hospitals, and 13 were from pharmacies. Nursing facilities did not report in 2020. Table 3 provides a list of the types of adverse events that Oregon healthcare facilities contributed to PSRP.

Table 3. Event Types by Segment, 2020

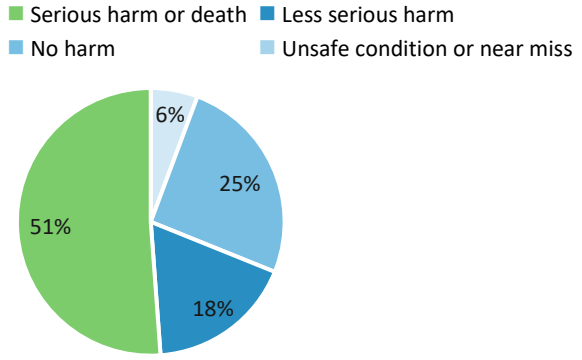
	ASC		Hospital		Pharmacy		Total	
Event Type	Number	Percent	Number	Percent	Number	Percent	Number	Percent
Surgical or other invasive procedure	33	52%	15	7%			48	16%
Medication or other substance	5	8%	18	8%	13	100%	36	12%
Healthcare-associated infection (HAI)	11	17%	23	10%			34	11%
Fall	6	9%	24	11%			30	10%
Pressure ulcer			27	12%			27	9%
Care delay			24	11%			24	8%
Device or supply	1	2%	19	9%			20	7%
Retained object			18	8%			18	6%
Other	4	6%	12	5%			16	5%
Maternal			12	5%			12	4%
Suicide or attempted suicide			8	4%			8	3%
Perinatal			5	2%			5	2%
Failure to follow up test results			5	2%			5	2%
Aspiration			4	2%			4	1%
Anesthesia	2	3%	1	0%			3	1%
Contaminated drugs, devices or biologics	1	2%	1	0%			2	1%
Radiologic			2	1%			2	1%
Irretrievable loss of irreplaceable specimen	1	2%	1	0%			2	1%
Contaminated, wrong or no gas given to a patient			1	0%			1	0%
Blood or blood product			1	0%			1	0%
Elopement			1	0%			1	0%
Total Reports	64		222		13		299	

Event types that are unavailable to a particular segment are denoted with gray cells.

Harm Level

OPSC has adapted the National Coordinating Council for Medication Error Reporting and Prevention's (NCC MERP) Medication Error Index (2001) to classify adverse events reported to PSRP according to the severity of the outcome. PSRP participants are required to report serious adverse events. Participants are also encouraged to report less serious harm events, no harm events, and near misses, because all events, regardless of harm, are prime opportunities to learn and improve systems of care. As expected from the program's emphasis on serious adverse events, more than half of the reports submitted to PSRP in 2020 (51%) resulted in serious harm or death (Figure 10).

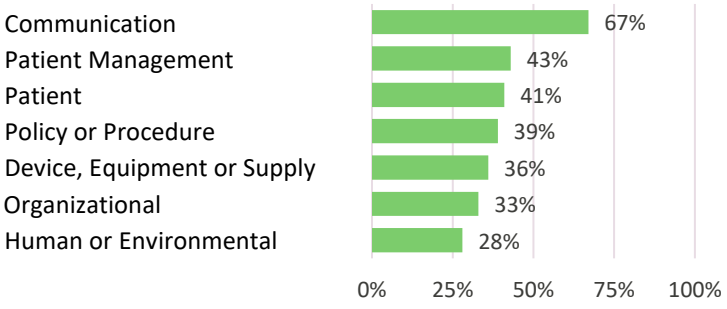
Figure 10. Harm Categories for All Segments, 2020



Contributing Factors

Contributing factors shed light on the circumstances or conditions that increased the likelihood of an event. By identifying system-level factors, such as communication and patient management factors, organizations have a solid starting point to uncover deeper system-level causes (or root causes) that can be addressed to prevent the event from recurring. PSRP reporters selected 62 individual contributing factors across seven categories (Figure 11).

Figure 11. Contributing Factor Categories, 2020

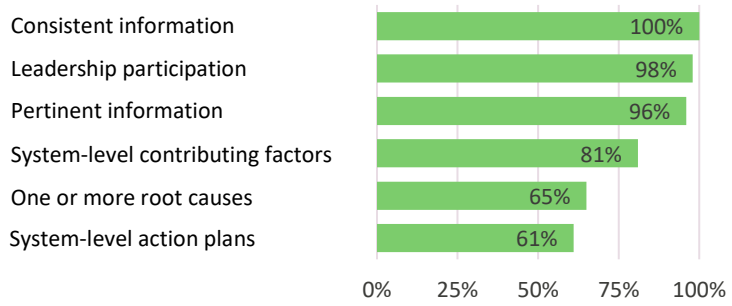


Quality

Event reports submitted to PSRP provide a window into an organization's event review and analysis process. OPSC reviews reports based on a set of quality components, which serve as indicators of a strong event review and analysis process that can prevent future events. The two most frequently missing quality components were:

1. One or more system-level action plans designed to minimize risk
2. One or more root causes

Figure 12. Percent of Reports Receiving Each Quality Component, 2020



Just over half of submitted reports included all six elements necessary for acceptable quality. Less than 20% of ASC reports and no Pharmacy reports were acceptable quality (Table 4).

Table 4. Acceptable Quality by Segment (2020)

Segment	Number	Percent
ASC (n=66)	12	19%
Hospital (n=222)	145	65%
Pharmacy (n=13)	0	0%
All Segments (n=299)	157	53%

Appendix II. Foundational Reading

A selection of resources we are looking at to inform our Patient Safety Reporting Program analysis.

Safer Together: A National Action Plan to Advance Patient Safety
Institute for Healthcare Improvement (IHI), 2020 | National Steering Committee for Patient Safety

Key takeaways: *Safer Together* addresses a key issue hindering patient safety progress over the past 20 years: everyone is approaching patient safety independently and learning is siloed within organizations. Effective implementation of evidence-based best practices at a national level requires a shared framework. *Safer Together* is a national action plan to give everyone the same framework for patient safety improvement. It focuses on infrastructure and culture, and it includes a self-assessment tool for organizations and an implementation resource guide. This national action plan focuses on the systems and infrastructure organizations have in place rather than specific solutions to individual problems. OPSC is uniquely positioned to support collaboration and learning across Oregon, so that we can make progress as a state.

Advancing Racial Equity in America
National Academies of Sciences, Engineering and Medicine, 2021 | Molly Galvin and Sara Frueh

Key takeaways: This statement from the National Academies of Sciences, Engineering and Medicine articulates the urgency with which we must act to address racial inequity. *Advancing Racial Equity in America* describes the problems created by systemic racism in the domains of healthcare, criminal justice and the fields of science, engineering, and medicine, as well as the work the National Academies are doing to inform meaningful change. The Academies recognize that these are complex, structural problems that require coordinated efforts across multiple domains. OPSC's mission to encourage a culture of safety is not achievable if our efforts do not explicitly acknowledge and address systemic racism.

Health Care Equity: From Fragmentation to Transformation
NEJM Catalyst, 2020 | Karthik Sivashanker, Tam Duong, Andrew Resnick, Sunil Eappen

Key takeaways: The authors provide a four-tier framework for evaluating and improving quality measurement to support the advancement of health equity. Healthcare organizations cannot provide high quality care if they do not first provide equitable care. *Safer Together* outlines a coordinated, system-focused plan to advance patient safety that incorporates equity as a core principle and cross-cutting theme for all of its recommendations. *Health Care Equity* outlines the practical application of that principle which OPSC can use in support of our mission. The first tier of the framework is access, which "refers to whether patients can even gain entry to the health care system." As OPSC gathers information to inform the future of the reporting program, we will pay special attention to providing equitable access to participate in our process.

Safety Analysis over Time: Seven Major Changes to Adverse Event Investigation
Implementation Science, 2017 | Vincent, Charles A., Jane Carthey, Carl Macrae, and Rene Amalberti

Key takeaways: The authors reassess adverse event investigation methods used in healthcare and find that they are no longer meeting our needs. They make seven recommendations aimed at improving the efficacy of investigations. Some of their recommendations, like working together across organizational boundaries, could be facilitated by organizations like OPSC.

Patient Safety Incident Reporting: A Qualitative Study of Thoughts and Perceptions of Experts 15 Years after 'To Err Is Human'
BMJ Quality & Safety, 2016 |Imogen Mitchell, Anne Schuster, Katherine Smith, Peter Pronovost, and Albert W. Wu

Key takeaways: The authors interviewed 11 patient safety experts to understand what had changed about our understanding of incident reporting since the publication of *To Err is Human*. The experts identified five key challenges to explain why incident reporting doesn't seem to be associated with safer care. All five challenges (and their associated recommendations) are about the systems facilities have in place to do the work that results from incident reporting rather than the content of the reports themselves. Currently, OPSC's evaluation of PSRP adverse event reports focuses on the report content without information to understand the systems that facilities have in place to analyze incident reports and implement proposed solutions.

Learning from Incidents in Healthcare: The Journey, Not the Arrival, Matters
BMJ Quality & Safety, 2017 | Ian Leistikow, Sandra Mulder, Jan Vesseur, and Paul Robben

Key takeaways: Based on evolving patient safety science, the Netherlands Healthcare Inspectorate changed how they evaluate adverse event reports submitted to their national reporting program. They stopped evaluating the specific events and their associated solutions ("what hospitals learn") and focused instead on facilities' learning processes ("how hospitals learn"). The article concludes that, while more research is needed, "shifting the goal of incident reporting systems from solving specific safety issues to improving the process of learning seems a promising strategy." Currently, OPSC's evaluation of PSRP adverse event reports focuses on the report content without information to understand the systems that facilities have in place to analyze incident reports and implement proposed solutions.

Appendix III. OPSC's Board of Directors

The Oregon Patient Safety Commission (OPSC) Board of Directors is made up of 17 volunteer members, reflecting the diversity of facilities, providers, insurers, purchasers, and consumers that are involved in patient safety. The board serves as the governing body for OPSC to further OPSC's mission.

Amy Baker PHARMD
Rogue Community Health
Position: Pharmacist

Amanda Bemetz BSN, RN-BC, PCCN-K
Bay Area Hospital
Position: Nurse

Smitha Chadaga MD, FHM, FACP
Legacy Health
Position: Physician

Bob Dannenhoffer MD
Douglas County Public Health
Position: Physician

Lisa Bui MBA
Oregon Health Authority
Position: Public Purchaser

Mary Engrav MD, FACEP
Care Oregon
Position: Health Insurer

Gayle Evans MS, SPHR VICE CHAIR
Unitus Community Credit Union
Position: Private Purchaser

Heather Hurst MSN, RN, CCRN-SCRN-CNRN
Kaiser Permanente
Position: Labor Representative

Vacant
Position: Healthcare Consumer

Leah Mitchell MSN, BS, RN TREASURER
Salem Health
Position: Hospital Administrator

Kristi Ketchum RN, MBA, HACP, CPHQ
Surgical Care Affiliates
Position: Ambulatory Surgery Center Representative

Linda Kirschbaum
Oregon Health Care Association
Position: Nursing Facility Representative

Judy Marvin MD CHAIR
Providence Health and Services
Position: Health Insurer

Jessica Morris
Meals on Wheels People
Position: Healthcare Consumer

Juancho Ramirez PHARM.D.
OSU/OHSU College of Pharmacy
Position: Faculty Member

Regina Rose MSN
Bay Area Hospital
Position: Hospital Administrator

Dana Selover MD, MPH
Oregon Health Authority
Position: Public Health Officer