OREGON
PATIENT SAFETY
COMMISSION

RESPONDING TO PATIENT HARM EVENTS: OREGON'S EARLY DISCUSSION AND RESOLUTION PROCESS

Oregon Society of Physicians' Assistants

October 26, 2019

Our Mission

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

Objectives

1. Review benefits of communication following patient harm
2. Describe Oregon's Early Discussion and Resolution (EDR) process
3. Present key findings from 2018 EDR Report and current review process
4. Q & A

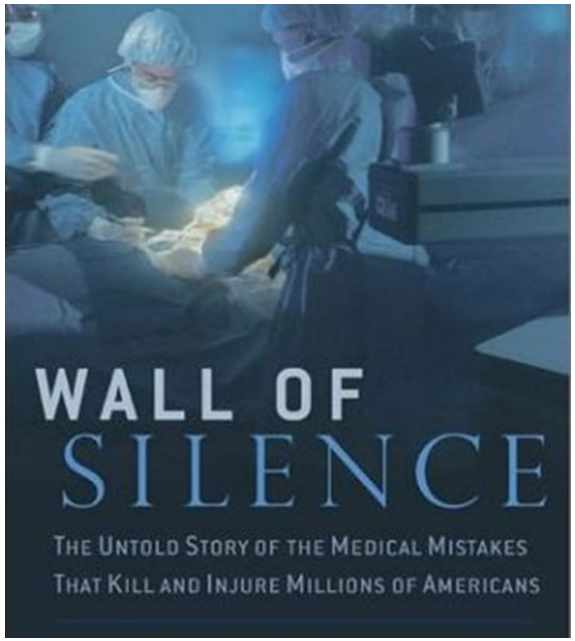
Increasing Transparency About Patient Harm is a Patient Safety Issue

HealthAffairs

February 2012

Survey Shows That At Least Some Physicians Are Not Always Open Or Honest With Patients

Lisa I. Iezzoni[1,*], Sowmya R. Rao[2], Catherine M. DesRoches[3], Christine Vogeli[4] and Eric G. Campbell[5]



Gibson , Rosemary & J. P. Singh, Wall of Silence, 2003.

https://www.ahrq.gov/professionals/quality-patient-safety/patient-safety-resources/resources/candor/introduction.html

Failing to Communicate After Serious Patient Harm

- Compounds suffering of patient and family
- Heightens distress of clinicians
- Increases likelihood of litigation
- Squanders opportunity to improve quality
- Degrades institutional culture and climate
- Reduces public trust in healthcare

May T, Aulisio MP. Kennedy Inst Ethics J. 2001; 11(2):135-146.
CANDOR, Agency for Healthcare Research and Quality

What Patients and Families Want

- An open and direct conversation
- Empathetic communication acknowledging their experience
- Answers to their questions
- Compensation
- To know what is being done to improve patient safety

Moore J, Bismark M, Mello MM. Patients' Experiences With Communication-and-Resolution Programs After Medical Injury. *JAMA Intern Med.* 2017;177(11):1595–1603.

Iedema, Rick, Nadine A. Mallock, Roslyn J. Sorensen, Elizabeth Manias, Anthony G. Tuckett, Allison F. Williams, Bruce E. Perrott, et al. 2008. "The National Open Disclosure Pilot: Evaluation of a Policy Implementation Initiative." Medical Journal of Australia 188 (7): 397–400.

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Oregon Laws 2013, Chapter 5

OREGON'S APPROACH: EARLY DISCUSSION AND RESOLUTION

Role of OPSC

- Neutral administrator of EDR process
- Connector: OPSC connects patients and families to involved healthcare professionals when either requests a conversation
- Educator: OPSC helps healthcare professionals learn about effective strategies for communicating with patients and families after serious adverse events

EDR Criteria

- Event occurred in Oregon
- Event occurred after July 1, 2014
- Event occurred in a healthcare facility or involved healthcare providers
- Event involved serious physical injury or death

EDR Ground Rules

- Discussion communications are protected from disclosure
- Anyone may request a mediator (cost is split 50/50)
- All participants may invite others to participate
- Provider must reasonably accommodate all persons who wish to attend
- No one from OPSC will attend conversations

EDR Ground Rules on Compensation

- Provider can decide whether to offer compensation
- If provider offers compensation, offer must be in writing
- Provider must advise patient (or their representative) of right to consult with an attorney before accepting offer

If You Receive a Request for Conversation

- View the request
- Notify your risk manager or liability insurer
- Seek information and resources when deciding whether to use EDR
- Consider designating someone else in your practice to act on your behalf with respect to EDR

Responding to a Request for Conversation

- Let OPSC know if you will participate

❑**YES.** Follow instructions to set up conversation with Patient or Patient's Rep

NO. OPSC will contact Patient or Patient's Rep

❑**NO** to EDR but **YES** to an internal process. Follow up with Patient or Patient's Rep

- In 180 days, complete Resolution Report

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THE FOUR KEY LESSONS WE HAVE LEARNED FROM FOUR YEARS OF EDR IMPLEMENTATION

I. Culture Change Takes Time

- Few healthcare professionals initiate conversations with patients through EDR.
- All healthcare organizations care about patient safety, but many lack the infrastructure to respond to patient harm.
- Meeting providers' emotional needs is also important.
- Healthcare professionals are reluctant to participate in EDR when patients request conversations.

II. The Complexity of the Healthcare System Creates Challenges for EDR

- Many participants means big coordination challenges.
- Many providers are not employed by facilities where events occur.
- Different philosophies about compensation may affect likelihood of reaching resolution.
- It can be challenging to identify, locate and notify providers in a timely manner.

III. Asymmetry between Patients and Healthcare Professionals Affects EDR Process

- Patients often need assistance from OPSC to engage in the EDR process.
- Patients want OPSC to help them advocate effectively during EDR conversations, a role we cannot fill.

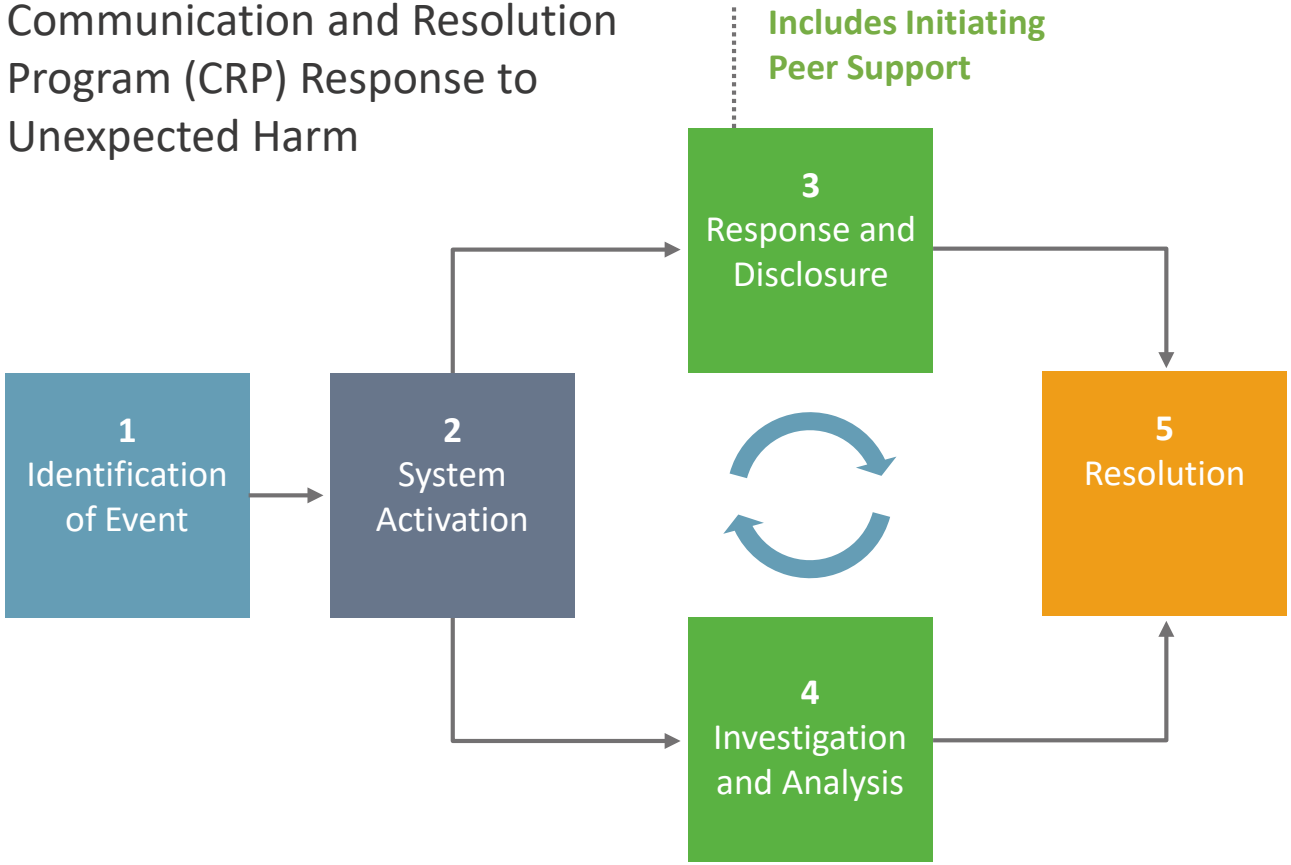
IV. Impacts of EDR Are Difficult to Measure at the State Level

- Oregon lacks data on:
  - the total number of serious adverse events here
  - the number of insurance claims filed
  - the number of medical malpractice cases filed
- OPSC unable to quantify patient harm events prevented because of improvements made in response to an EDR request.

Mandated Mid-point Review and Report to the Legislature

- EDR law created the Task Force
- The Task Force's charge:
  - Evaluate the implementation and effects of EDR, including whether improvements to the process are necessary.
  - Report to Legislature on implementation and effects of EDR.
- The Task Force **may** also recommend legislation "to improve resolution of adverse healthcare incidents."

Communication and Resolution Program (CRP) Response to Unexpected Harm



The Benefits of the CRP Response

	Traditional Response	CRP Response
Incident reporting by clinicians and staff	Delayed, often absent	Immediate
Communication with resident, family	Delay, deny, defend	Transparent, ongoing
Event analysis	Physician, nurse are root cause	Focus on Just Culture, system, human factors
Quality improvement	Provider training	Drive value through system solutions, disseminated learning
Financial resolution	Only if family prevails on a malpractice claim	Proactively address resident, family needs
Care for the caregivers	None	Offered immediately
Resident, family involvement	Little to none	Extensive and ongoing

Collaborative FOR ACCOUNTABILITY AND IMPROVEMENT

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Resources

Oregon Patient Safety Commission

- oregonpatientsafety.org
- Beth Kaye: 503.227.2632 or beth.kaye@oregonpatientsafety.org
- Linda Lancaster: 503.224.9227 or linda.lancaster@oregonpatientsafety.org

Communication and Optimal Resolution (CANDOR) Toolkit

- https://www.ahrq.gov/professionals/quality-patient-safety/patient-safety-resources/resources/candor/introduction.html

Collaborative for Accountability and Improvement

- communicationandresolution.org


Questions?
Who?
What?
Where?
When?
Why?
How?