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Logic Model and Data System Recommendations

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CORE REPORT – OREGON PATIENT SAFETY COMMISSION

Logic Model and Data System Recommendations

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CORE | Center for Outcomes Research and Education

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Background

Since 2014, Oregon Patient Safety Commission's (OPSC) Early Discussion and Resolution (EDR) program has sought to create confidential and safe spaces for patients and families to have transparent conversations and discussions with providers following incidents of patient harm. In the program's 2022 *Annual Report*, learning from the past and creating a clear plan for moving forward was emphasized as a high priority. The report described four goals for the EDR program in 2022:

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

The Providence Center for Research Outcomes and Education (CORE) and OPSC began a six-month project in October 2022 to help OPSC achieve their data-related goals. The goals for the CORE/OPSC collaboration were:

- Create an informed logic model,
- Review data elements, processes, and structure, and
- Provide data element, process, and structure recommendations.

What follows is a summary of CORE's work to develop the logic model and review data processes and a detailed set of recommendations and next steps.

Logic Model Creation

CORE gathered information for the logic model through a combination of document review, staff interviews, and stakeholder focus groups. CORE reviewed OPSC's annual reports and its previous data and analytics recommendations, as well as regional and national literature on medical harm event Communication and Resolution Programs (CRPs). CORE staff also interviewed four OPSC employees (EDR Program Director, EDR Program Manager, Director of Research and Analytics, and Executive Director) to learn each of their perspectives on OPSC's EDR program and its desired short- and long-term outcomes.

CORE synthesized the documents and interview findings into a draft logic model, which CORE staff presented to the EDR Task Force on the Resolution of Adverse Healthcare Incidents and the OPSC Board of Directors in December 2022. During these meetings, CORE led a discussion designed to seek input on the draft logic model. CORE incorporated stakeholder feedback into the final version of the logic model (See Appendix D for final logic model).

The logic model is based on the overall goal of the EDR program –*to encourage transparency and accountability after medical harm events*– and it drives program activities to work towards the following long-term outcomes:

- Patients and families feel safe and comfortable requesting a conversation, and respected, empowered, and appropriately compensated at the conclusion of the process,

- Providers and facilities feel safe and comfortable requesting a conversation and sharing what they learn with OPSC, and
- Providers and facilities have systems and/or policies that support a culture of safety and transparency.

OPSC and CORE collaborated throughout the project to ensure that equity considerations were prioritized, as both organizations consider equity essential to their mission. The logic model includes callout boxes for equity considerations, which were subsequently addressed in the data recommendations section, to ensure that disparities in conversation requests, acceptance rate, and/or outcomes can be identified and addressed.

Data Elements, Processes, & Structure: Review and Recommendations

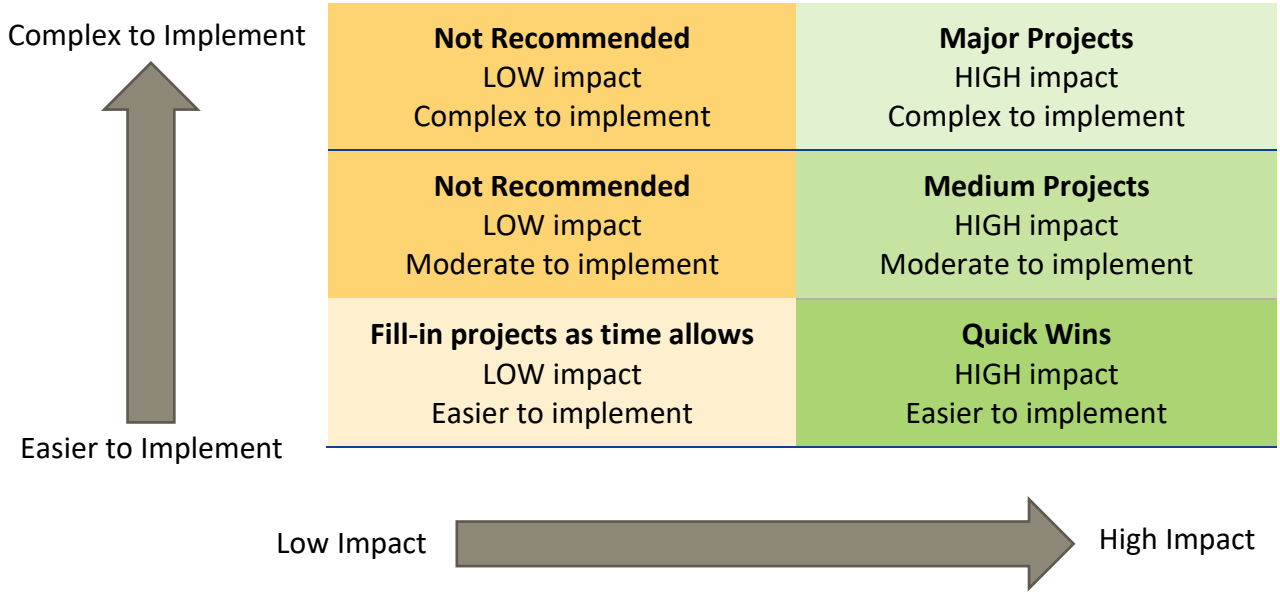
CORE completed a review of all current EDR tools as well as OPSC internal documentation from 2021 about how well the *Resolution Report* was meeting its intent. CORE also conducted an interview with OPSC's Director of Research and Analytics to learn more about the data system and participated in a virtual tool demonstration led by EDR staff. CORE cross-walked all logic model outcome measures with OPSC's current data collection tools, assessed existing data gaps, and developed recommendations to fill those gaps. CORE also reviewed the logic model's equity considerations to ensure that the data recommendations are aligned with those considerations. Finally, CORE reviewed each aspect of the data collection process for ease of use, reliability, and completeness.

CORE found that the current data collection process, structure, and elements are strong in several areas, including their ability to collect information about the conversation status and the fact that providers can log into the system at their convenience. CORE's recommendations build on these strengths and address OPSC's desire to increase their ability to identify disparities and elements of successful conversations. CORE also made data collection recommendations that OPSC can implement as part of program awareness campaigns. CORE's recommendations can be categorized into the following **six themes**:

1) Increase ability to identify disparities within EDR,
2) Gather additional information at the time of conversation request,
3) Increase conversation reporting frequency,
4) Increase *Resolution Report* granularity,
5) Improve the data collection system interface, and
6) Gain insights on program awareness and policy interactions.

CORE took into consideration both impact and ease of implementation when developing recommendations, as depicted in the matrix below. CORE focused on high impact recommendations, which were either classified as quick wins, medium projects, or major projects, depending on their projected ease of implementation. Throughout the report we note several recommendation alternatives and/or potential future recommendations.

Figure 1. Recommendation Impact-Implementation Matrix



How to read this report

Data system, element, and process recommendations are presented by theme. Within each of the six themes, broad process and/or analysis recommendations (e.g., developing a type of analysis) are presented in the narrative section while more specific data collection item recommendations are presented in tables. Changes and question suggestions in the Appendix are examples of questions that would satisfy the recommendations in the body of this report but can be altered or replaced. It is also important to keep the forms as short as possible to reduce participant burden, which should be considered when choosing which examples to include.

Item wording recommendations can be found in Appendix A. The appendices also include a list of definitions for key elements (Appendix B), sample survey questions that could be used in an environmental scan around EDR awareness (Appendix C), the final logic model (Appendix D), and a version of the logic model that is mapped to recommendation themes (Appendix E).

THEME 1: Increase ability to identify disparities within EDR.

Sivashanker et. al. (2020) offer a four-tier model for establishing 'meaningful measurements that will advance equity for patients and for staff of the organization.'[1] While these tiers are grounded in clinical care, there are analogous steps in the context of EDR: 1) access to/awareness of EDR, 2) acceptance of conversation requests, 3) conversation outcomes, and 4) the larger socioeconomic/environmental impact of successful resolutions. A critical start in measuring access to/awareness of EDR is understanding the demographics of patients/families who request conversations. With more complete demographic data, OPSC staff can begin identifying disparities in conversation acceptance and outcomes, which will be meaningful measurements for the second and third tiers of the equity model. OPSC can work towards stratifying data by other demographic factors, such as gender identity or geography, but we feel that leading with race/ethnicity and language is imperative due to the systematic racism historically and currently present in the health system.[2,3] This theme has two recommendations for additions to the patient *Request for Conversation*, which are both classified as quick wins. See Appendix A for specific item suggestions.

Figure 2. Equity Framework to Apply to EDR

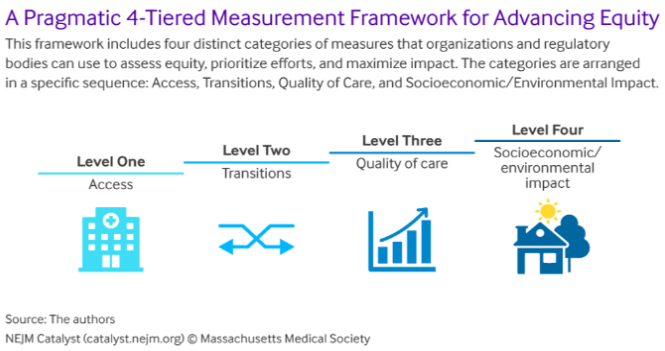


Table 1. Equity theme item recommendations for the patient *Request for Conversation*

Recommendation	Rationale	Type
1a. Add item collecting patient race/ethnicity to the *Request for Conversation*.	Important equity measurement to move towards measuring disparities in conversation outcomes. It is currently collected in the voluntary *Resolution Report* at the end of the process (resulting in incomplete data); collecting this information at the beginning of the process will provide a more complete picture.	Quick Win
1b. Add item collecting patient language to the *Request for Conversation*.	Important equity measurement to move towards measuring disparities in conversation outcomes. It is currently collected in the voluntary *Resolution Report* at the end of the process (resulting in incomplete data); collecting this information at the beginning will provide a more complete picture.	Quick Win

CORE recommends that, after these changes are implemented, OPSC begin monitoring conversation acceptance rate and outcomes by race/ethnicity and language. Over time OPSC can plan to implement and/or adjust outreach and education strategies to address any identified disparities.

[1] Health Care Equity: From Fragmentation to Transformation | (nejm.org)

[2] Austin, J. Matthew, et al., 2021. "Health System Leaders' Role in Addressing Racism: Time to Prioritize Eliminating Health Care Disparities." Joint Commission Journal on Quality and Patient Safety 47 (4): 265–67.

[3] Benda, Natalie C., Deliya B. Wesley, Matthew Nare, Allan Fong, Raj M. Ratwani, and Kathryn M. Kellogg. 2022. "Social Determinants of Health and Patient Safety: An Analysis of Patient Safety Event Reports Related to Limited English-Proficient Patients." Journal of Patient Safety 18 (1): e1–9.

THEME 2: Gather additional information at the time of conversation request.

The *Request for Conversation* is the most reliable place to collect information because one is required for each EDR. The information collected in the *Request for Conversation* and the *EDR Participation Decision Screen* (the online system questions about facility and provider participation decisions) allow for baseline data for later comparison. Collecting additional information at the start of the process will enable OPSC to complete more nuanced analyses of successful conversations. This theme has four specific item recommendations, all of which are classified as quick wins. See Appendix A for specific item suggestions.

Table 2. *Request for Conversation* and *EDR Participation Decision Screen* recommendations

Recommendation	Rationale	Type
2a. Add item on how the requestor learned about EDR to the *Request for Conversation*.	Collecting this information will allow OPSC to understand where people learn about EDR. This data is currently collected during an optional telephone intake process if the requestor calls OPSC prior to or while submitting their *Request for Conversation* and is therefore not a reliable data source for all requestors.	Quick Win
2b. Add item on the requestor's steps previous to EDR (e.g., have they already contacted the legal system) to the *Request for Conversation*.	Learning what processes requestors have tried to get the information and resolution they need prior to EDR (for example, asking for a conversation outside of EDR, using a facility's grievance process, contacting a lawyer, etc.) will allow OPSC to better characterize and understand conversation processes and outcomes. It will also provide OPSC with more knowledge of the system gaps between patient/family needs and what they get.	Quick Win
2c. Add item collecting conversation goals to the *Request for Conversation*. (Note, these goals would not be passed along to other parties)	Allowing requestors to detail 3-5 goals for the resolution process will establish a personal baseline that they can return to in the *Resolution Report*. Over time this will allow OPSC to categorize the most frequent types of goals and how often they are achieved.	Quick Win
2d. Replace the 'another process that does not include EDR' option within the reasons that providers/facilities can use to decline the conversation on the ***EDR Participation Decision Screen*** with a clearer option**.**	This option implies that EDR is separate from a hospital/clinic's process, so we recommend its deletion. If there is a desire to ask about the process that will happen, consider a separate question (separate from the decline reasons) that asks if a clinic or facility based medical harm event process will or has occurred.	Quick win

Note, in addition to the recommendations in Themes 1 and 2, OPSC could consider adding sexual orientation and/or gender identity questions to the *Request for Conversation* to further advance its ability to identify disparities in outcomes. Sample sexual orientation and gender identity questions can be found OHA SOGI questions.

THEME 3: Increase conversation reporting frequency.

Currently, the *Resolution Report* is sent to conversation participants 90 days after the conversation request, which may not be timely enough to allow people to recall specifics about the conversation(s) that occur during the resolution process. In addition, the *Resolution Report* format only allows respondents to answer one question before it potentially puts them into a 'pending' status, triggering another 90-day time period before the next contact.

We recommend pilot testing a subset of '*Check-in Questions'* to conversation participants every 60 days after conversation request. These questions focus on the conversations that have occurred since the last time the respondent answered them. We believe that more frequent touchpoints will allow for better reliability and recall of conversations. These questions allow respondents to provide information about conversations before they answer a question about current status, which would then shuttle them either into the *Resolution Report* or a 60-day time period before the next check-in.

CORE offers these recommendations for pilot testing *Check-in Questions:*

- Initiate *Check-in Questions* 60 days after the conversation request.
- Tailor *Check-in Questions* to the time since the respondent's last response.
- If a respondent indicates on the *Check-in Questions* that no future conversations are planned, automatically route them to the *Resolution Report*.
- If a respondent indicates that future conversations are planned, or they are not sure, continue to send an email linking to the *Check-in Questions* every 60 days.
- At 12 months after the request, send all participants who have not completed the *Check-in Questions* and/or the *Resolution Report* a link to answer the *Check-in Questions* and *Resolution Report*.

CORE has classified this as a **medium project**, knowing that it will take a degree of planning, data system modifications, and workflow adjustments to implement. If OPSC is unable to make these changes, we offer two modified recommendations:

- Send the *Check-in Questions* to the conversation participants until they indicate that no future conversations are planned, then send a combined *Check-in Questions/Resolution Report* to all other parties.
- Continue with the current timing but add the Check-in Questions to the *Resolution Report* (the ones that are not already in the *Resolution Report*.)

The following two figures detail the current process and the process with CORE's recommendations.

Figure 3. Current process (RR=Resolution Report). Note that OPSC currently places a reminder call around 7 days after each reminder with no response. CORE recommends continuing this practice.

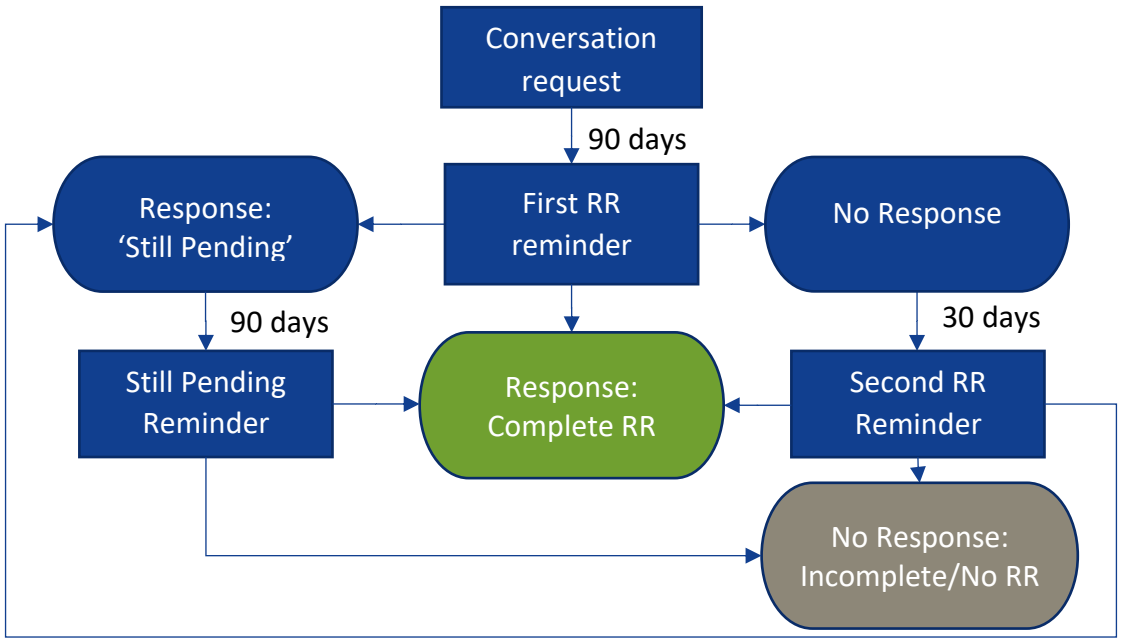


Figure 4. Process with CORE recommendations (note that process ends after 12 months after request) (CIQ=Check-in Questions)

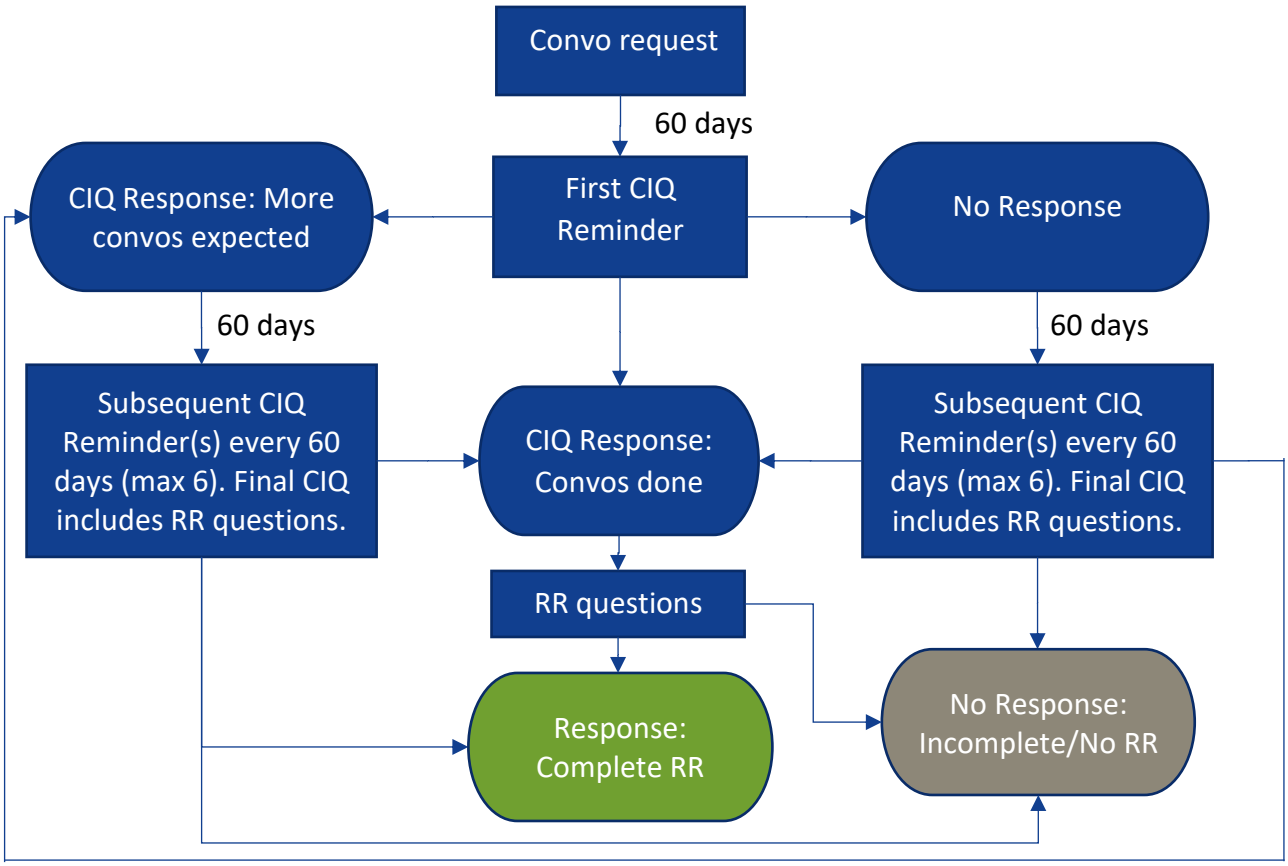


Table 3 includes the recommended items for the *Check-in Questions*. Appendix A details CORE's recommendations for item wording.

Table 3. Recommendations for *Check-in Questions*

Recommendation	Rationale	Type
3a. Ask EDR participants the number and date of conversations occurring since their last response on the *Check-in Questions*.	Gathering this additional information will provide a sense of scale and length of the EDR process. OPSC can determine how the number of conversations and/or the presence of certain parties impacts conversation outcomes.	Medium Project
3b. Ask EDR participants which major parties were involved in the conversation(s) on the *Check-in Questions*.		
3c. Ask EDR participants which elements were present in the conversation(s) on the *Check-in Questions*, including if conversations integrated EDR's confidentiality protections.		
3d. Ask EDR participants if future conversations are planned on the *Check-in Questions*.	This question can be used to determine if a participant should receive the *Resolution Report*. If no more conversations are planned participants can receive the *Resolution Report.*	Medium Project

Note, CORE considered multiple timing and respondent scenarios for asking *Check-in Questions.* OPSC may want to consider testing 30 or 45 days if respondents note difficulty recalling conversations after 60 days.

THEME 4: Increase *Resolution Report* granularity.

While the current *Resolution Report* collects data on many aspects of the conversation, most items refer to the whole process, which does not allow OPSC to pull out specific aspects of conversation success or participant satisfaction. With the recommendation that questions relating to the number and nature of conversations move to the *Check-in Questions*, the *Resolution Report* can be a place for OPSC to gain insights into the final status of the process and the conversation requestor's level of satisfaction with each party. This theme's recommendations are designed to support OPSC's goal of being able to gain more specific insights on successful conversations. These recommendations are all classified as quick wins. Additional details and wording for each item can be found in Appendix A.

Once these changes are implemented, **CORE recommends that OPSC use the additional data fields to develop definition(s) of what a successful conversation looks like** and to use the information to inform collective solutions in the wider healthcare community. OPSC will likely need to define multiple measures of conversation outcomes, such as the requestor's feelings of satisfaction with the resolution, and the requestor's level of satisfaction with the way they were treated by each party. OPSC can assess the current state of each outcome measure and potentially set targets for their improvement, as warranted. We have classified **the development of these benchmarks and targets as a medium project**.

Table 4. *Resolution Report* item recommendations

Recommendation	Rationale	Type
4a. Ask all EDR participants their level of satisfaction with the major parties (including OPSC staff) involved in conversations on the *Resolution Report*.	The current *Resolution Report* does not give the respondent the opportunity to distinguish satisfaction between conversation parties and/or OPSC staff. Increased granularity will offer OPSC the chance to analyze satisfaction rates with different stakeholders.	Quick Win
4b. Ask patients/families about what kinds of support they were offered, as well as their level of satisfaction with that support, on the *Resolution Report*.	This will measure the kinds of support (including financial compensation) that patients/families are receiving. It will also give insight into whether OPSC's goal of patients and families feeling appropriately supported is being met or is improving over time. CORE's item recommendations are focused on the patient/family perspective.	Quick Win
4c. Ask patients/families whether they were able to speak with all the parties they wanted to on the *Resolution Report.*	This information will provide insight into reasons underlying whether patients/families felt respected or listened to during the conversations and their satisfaction with the conversation process.	Quick Win

Recommendation	Rationale	Type
4d. Ask patients/families about the legal and/or other next step(s) they plan to take on the *Resolution Report*.	This will give information as to whether patients/families look for additional information or redress after the conversations and processes using EDR protections are concluded. It is possible that this question will inform whether the legislature's general goal of avoiding litigation is being accomplished or affected over time, although the number of patients/families being referred to the process after not being able to pursue legal remedies should also be considered in that assessment.	Quick Win
4e. Ask patients/families about their level of feeling respected and listened to during the process, by major party, on the *Resolution Report*.	Adding questions regarding whether patients/families felt respected and listened to will give insight into whether the long-term OPSC goal of patient/family empowerment is being met or is improving over time. It can also be connected to the questions about patient/family next steps, to examine whether feeling respected during the process affects plans, including the possibility of litigation.	Quick Win
4f. Follow up with conversation requestors' specific initial goals to assess how well they were met on the *Resolution Report*.	This will be a chance for EDR requestors to assess how well their goals were met. Over time this will allow OPSC to analyze which types of goals are most likely to be met or unmet, and which goals emerge during the process. Individual goals will need to be matched with survey respondents.	Quick Win
4g. Ask patients/families if they felt prepared and informed during the conversation process, and ask what information would have been helpful on the *Resolution Report*.	This will help OPSC identify where there are gaps in understanding for patient and family participants about the conversation process. Using this information, OPSC can focus on the intended outcomes around increasing knowledge of EDR and CRP best practices.	Quick Win
4h. Ask providers/facilities if they felt prepared and informed before the conversation process on the *Resolution Report*.	This will be a chance for OPSC to learn whether providers/facilities are comfortable with the process, and/or whether that changes over time if OPSC engages in outreach.	Quick Win

Note, CORE also considered asking satisfaction and respect questions about each conversation, but we did not hear a use case for this level of disaggregation. If this use case arises, for example if there is a desire to analyze the difference between the second and third conversation, or to assess the impact of the presence of different parties within different conversations, OPSC may want to consider further separation. Additionally, an item(s) could be added to the *Resolution Report* to ask more specifically about accommodations such as materials provided in another language and/or translators during the conversations. The current item simply asks an open-ended question "Please describe how you addressed any barriers."

THEME 5: Improve the data system interface.

The current data collection process is generally streamlined and accessible, with a system of multiple reminders and opportunities for assistance. However, while providers and facilities receive a unique login, allowing them to update data whenever is convenient for them, patients and families do not currently have that option. In addition, there is some language that could be defined to ensure more standard responses.

The following recommendations focus on how to increase usability and process streamlining for all data system users, especially patients and families.

- **Give patients/family members a unique login** so they can check and update information over time. This would allow them the option to update information when it is convenient, instead of just when they receive the intermittent form reminders. Depending on technology considerations, this could either be a **medium or major project**. Once the login is implemented, we recommend that each communication to patients/families reminds them that they can update conversation information at any point during the process.
- **Add standard definitions** to the *Request for Conversation*, *Check-in Questions*, and *Resolution Report*. One way to accomplish this could be with information circles that hover over terms, although there may be accessibility issues with this option. Appendix B has a list of recommended words to define and definition options. We have classified this as a **quick win**.
- **Change date formats** to allow for month/year of conversation if respondents do not know the exact date. We have classified this as a **quick win**.
- **Consider piloting process changes designed to improve data completeness**, for example, reminders of different types and/or at different points in the process or testing question completeness with an option to address more in-depth questions via interview. During the interviews, staff mentioned that *Resolution Reports* can have data completion issues. Given this existing issue and the fact that we are recommending new/additional items, we recommend piloting process changes designed to increase completeness. Depending on the pilot testing method, this could either be a **medium or major project.**
- **Leverage the communication log** to complete the *Request for Conversation* as much as possible, and consider ways to make them connected, or ways that the communication log could auto-populate the *Request for Conversation*. This may not always be possible since the intake calls could cover more than one eligible event or providers who are not involved in the harm event itself. However, in some cases, there may be opportunities to consolidate either contact and/or event information between the two data sources. We have classified this as a **medium project**.

THEME 6: Gain insights on program awareness and related policy interactions.

Demonstrating program impact is also measured by general program awareness: what are the current outreach strategies deployed by OPSC staff, how are those strategies received, etc. Also understanding how EDR fits into the larger healthcare ecosystem's efforts related to communication and resolution can help to strengthen program awareness. Finally, tracking policy interactions can help to demonstrate the program's impact on policy.

- **Develop and track EDR outreach campaign metrics** (e.g., total # of campaigns, # of people called, etc.) to the broader community, such as the OHA Health Transformation Center (hub for CCO information), the OHA Ombudsman program, hospital/facility/clinic risk managers, and senior centers. Tracking the scope and intensity of campaigns could include the length of effort, number of modalities to reach people, the number of people reached, etc. Results can be shared in the annual report, as well as in EDR staff and task force meetings. We have classified this as a **medium project.**
- **Consistently ask where callers learned about EDR** during the initial phone conversation between EDR staff and patients/families. During this phone call, staff ask callers how they heard about OPSC/EDR; there is also an opportunity to ask if the caller had received any of the outreach from campaigns tracked above. Collecting this information consistently can potentially show the impact of the outreach campaign efforts in the previous recommendation. We have classified this as a **quick win**.
- **Consider conducting a survey** to further track program awareness. Staff or a contractor can design a short, electronic (online) survey of OPSC's current mailing list, a group of clinic risk managers, or even a random sample of the general population (the latter would likely need to be done in partnership with a communications partner). The survey can ask about general awareness of the program, as well as receipt or knowledge of previous/current outreach campaigns, and preferred communication modes to inform further outreach campaigns. Collecting this information can potentially show the impact of the outreach campaign efforts in the first recommendation. We have classified this as a **medium project**.
- **Consider an environmental scan** of Oregon health systems' current communication and resolution programs, and track changes over time. Understanding the ecosystem in which EDR exists may help to better inform outreach campaigns and program communication. EDR staff can document Oregon health systems' current communication and resolution programs and practices: which systems have programs, which do not, who has used EDR in the past, etc. EDR staff can also explore surveying regional associations of risk managers about use/awareness of EDR. See Appendix C for sample survey questions. This will help OPSC to understand where there are gaps and opportunities to improve awareness (and use) of EDR. We have classified this as a **major project**.
- **Conduct and disseminate a literature review** of other states' practices and how the practices have changed over time. OPSC's EDR program was designed and implemented in 2014 and there may be emergent practices that would be worthwhile to track and potentially implement. While OPSC currently conducts these types of reviews, there may be value in systematizing and disseminating the results more broadly to stakeholders such as the Board, the Task Force, and statewide policy makers. We have classified this as a **medium project**.

Next Steps

CORE recommends that OPSC takes the following next steps starting in July 2023.

Short-term next steps: (months 1-3)

- Review and finalize the **Quick Win** item recommendations.
- Implement the **Quick Wins** within the electronic data collection system, starting with the race/ethnicity and language additions.
- Develop a plan to implement structural changes within the data system, such as the ability to match users to their unique goals and expectations, provide patients/families with a unique login, and an accessible way to display definitions.
- Develop a plan to pilot test the *Check-in Questions*.
- Begin to track outreach efforts and related policy.

Medium-term next steps: (months 3-6)

- Implement structural changes within the data system, such as the ability to match users to their unique goals and expectations, provide patients/families with a unique login, and an accessible way to display definitions.
- Pilot test the *Check-in Questions*.
- Disaggregate the number of conversation requests, conversation acceptance rates, level of satisfaction, and conversation outcomes by race/ethnicity and language.

Long-term next steps: (months 6-12)

- Disaggregate level of satisfaction and conversation outcomes by the elements that occurred within the conversation process and conversation participants, to begin understanding correlations between process elements and conversation outcomes.
- Analyze the newly collected fields and use the results to develop measures for conversation outcomes and potential improvement targets as warranted.
- Conduct an awareness survey with OPSC mailing list or other identified stakeholder group.
- Investigate surveying risk managers, potentially through the risk management association or other avenues.
- Identify resource needs to conduct an environmental scan of current health system. Note that implementing the environmental scan will likely extend beyond 12 months.

Summary

Medical harm events are frightening and unpredictable for everyone involved. OPSC is working to create a space for open communication after medical harm through its EDR program and has made great strides in developing a data system that captures information about the conversation process. CORE's recommendations focus on advancing EDR's ability to understand potential disparities, to begin to understand and analyze more granular EDR outcomes, provide a seamless user experience, and gain insights about the communication and resolution model across healthcare settings.

Appendices

Appendix A: Item Examples and Language Recommendations

Request for Conversation

1a. Add race/ethnicity item to patient *Request for Conversation*. Subcategories listed as a single bullet in the question below should be separate answer options. The third question references circling an item from the second question, this wording may need to be adjusted to fit within the OPSC system.

How do you identify your **race, ethnicity, tribal affiliation, country of origin, or ancestry**?

- Open-ended

Which of the following describes your **racial or ethnic identity**? *Please check ALL that apply.*

- American Indian and/or Alaska Native
  - American Indian; Alaska Native; Canadian Inuit, Metis, or First Nation; Indigenous Mexican, Central American, or South American
- Asian
  - Asian Indian; Cambodian; Chinese; Communities of Myanmar; Filipino/a; Hmong; Japanese; Korean; Laotian; South Asian; Vietnamese; Other Asian
- Black and African American
  - African American; Afro-Caribbean; Ethiopian; Somali; Other African (Black); Other Black
- Hispanic or Latino/a/x
  - Central American; Mexican; South American; other Hispanic or Latino/a/x
- Middle Eastern and/or North African
  - Middle Eastern; North African
- Native Hawaiian and Pacific Islander
  - Chamoru (Chamorro); Marshallese; Communities of the Micronesian Region; Native Hawaiian; Samoan; Other Pacific Islander
- White
  - Eastern European; Slavic; Western European; Other White
- Other categories
  - Other (please list); Don't know; Don't want to answer

If you checked **more than one** category above, is there **<u>one</u>** you think of as your **primary** racial or ethnic identity?

- Yes. Please circle your primary racial or ethnic identity above.
- I do not have just one primary racial or ethnic identity.
- No. I identify as Biracial or Multiracial.
- N/A. I only checked one category above.
- Don't know
- Don't want to answer

1b: Add language item to the patient *Request for Conversation*. Note, consider revising the current interpreter question to match the OHA READ format.

What language or languages do you **use at home**?

- Open ended

[Skip coded questions if response in addition to or other than English is chosen]
In what language do you want us to communicate **in person, on the phone, or virtually** with you?

- Open ended

In what language do you want us to **write** to you?

- Open ended

2a. Add how the requestor learned about EDR to the *Request for Conversation*.

How did you hear about EDR? Check all that apply.

- Provider or someone at the facility where the harm occurred
- Provider or someone at a different hospital, clinic, other healthcare facility
- Friend or family
- Support group
- Attorney
- Other (please specify)

2b. Add item about what other steps/conversations/processes have occurred since the event to the patient *Request for Conversation*. Note, if OPSC is interested in more detailed information about the outcomes of the conversations, they can pilot a version with open-ended options at the end of each response choice to determine its effect on completion rate and the usefulness of the information received.

After medical harm, there are many ways patients and families can try to get what they need, like information or additional support. Please tell us about anything you've tried before EDR. Check all that apply.

- Reached out to the provider to talk about the harm event.
- Reached out to administrators or other representatives of the facility where the harm occurred to talk about the harm event.
- Contacted your health insurance plan to talk about the harm event.
- Contacted an attorney about options to address your medical harm.
- Filed a grievance or complaint with the hospital/clinic/facility where the harm occurred.
- Filed a grievance or complaint with the Oregon Medical Board or other agency.
- Another action(s). Tell us: _____
- None of the above, I'm trying EDR first.

Is there anything you would like to share about the result of any of those steps?

- Open ended

2c. Add item about conversation requestor's conversation goals to the *Request for Conversation*.

What are your goals for engaging in the EDR process? *Please list up to three goals you have for the conversations.* A goal can be anything that you hope to get out of the EDR process, such as an apology, help with financial hardship the harm event has caused, an explanation of what happened, or information on what the facility is doing to prevent similar harm from occurring to others in the future.

- Open-ended

2d. Revise some of the conversation decline reasons on the *EDR Participation Decision Screens* to remove first option and replace it with another.

Revise option "Using a different process to address this event and will not incorporate EDR" and replace with

- Intend to address this event and will not incorporate EDR's confidentiality protections

Revise option "Already addressed this event through another process" and replace with:

- Already addressed this event without EDR's confidentiality protections

Check-in Questions

3a. Ask participants about the number and date of conversations on the *Check-in Question*s. Tailor the question depending on the participant being sent the questions (i.e., ask providers and facilities about patients/families and ask patients/families about providers).

How many conversations did you have with [providers and/or facilities, or patient/family] since [insert last date of check-in question completion]. (A conversation includes a discussion with either the provider or a representative of the facility where you had opportunities to ask questions and receive information. The conversation might include information about the medical harm event, actions to make sure the harm will not happen again, apologies or explanations, offers of compensation, etc. Please do not include short communications like scheduling a conversation or declining a longer conversation.)

- Fill in the blank on the number
- For the date, allow for month/year instead of just day.

3b. Ask participants which major parties were involved in each conversation on the *Check-in Question*s.

Use question from *Resolution Report*. Ask for each conversation.

3c. Ask participants which elements were present in each conversation on the *Check-in Question*s.

Use question from *Resolution Report*. Ask for each conversation. Add another response option to the current question:

- Explicit mention of EDR confidentiality protections

3d. Ask participants if future conversations are planned on the *Check-in Questions.*

Will there be any more conversations with the [provider/facility or patient/family] about this event? (A conversation includes a discussion with either the provider or a representative of the facility where you had opportunities to ask questions and receive information. The conversation might include information about the medical harm event, actions to make sure the harm will not happen again, apologies or explanations, offers of compensation, etc. Please do not include short communications like scheduling a conversation or declining a longer conversation.)

- Yes
- No → Send *Resolution Report*
- Not sure

Resolution Report

4a. Ask all participants items that indicate general level of satisfaction with each major party involved in the conversations on the *Resolution Report*. These should be asked separately about all major parties involved (e.g., EDR staff, provider(s), facility representative(s), patients/family depending on requestor) involved in each conversation on the *Resolution Report*. For satisfaction with OPSC staff, the same questions could be relevant, but the introductory language might be amended to refer to the "conversations I had with OPSC staff" rather than referencing any conversations that occurred once EDR confidentiality was requested.

Thinking about the conversations you had with [major party] after EDR protections were requested, how much do you agree or disagree with the following statements?

- I was satisfied with the way that [insert major party] treated me during the conversations
- I felt that [insert major party] was truthful and not trying to hide anything
- I felt like [insert major party] cared about me and what happened
- I had as many conversations with [major party] that I wanted
- I was given a chance to describe to [major party] what happened from my point of view

Response options: Strongly disagree, somewhat disagree, neither agree nor disagree, somewhat agree, strongly agree, not applicable

4b. Ask patient/families about types of support (financial compensation, etc.) and satisfaction with the support on the *Resolution Report*.

Did the hospital/clinic/facility offer to support the needs you experienced as a result of this harm event, such as:

- Money to cover things such as lost wages, extra childcare, or other expenses caused by the harm event?
- Other support? (For example, ongoing medical monitoring or mental health support)
- A promise to do something acknowledging what happened? (For example, using the story of what happened to teach physicians or planting a memorial garden)

Response options: Yes, no, not applicable. *Include a text box allowing an explanation.*

Were you satisfied with what the hospital/clinic/facility offered you?

- Yes
- No
- Not applicable
- *Include a text box allowing an explanation*

4c. Ask patients/families whether they were able to have a conversation with all parties they wanted to speak to on the *Resolution Report.*

Were you able to have a conversation with everyone that you wanted to?

- Yes
- No

- Not sure

Who did you want to have a conversation with but were not able to? *[Skip-coded question if 'no']*

- Use party choices from current question on the *Resolution Report*

4d. Ask patients/families about any next steps in the resolution process on the *Resolution Report.*

Are there any next steps you plan to take? Check all that apply.

- Considering, planning, or engaged in mediation
- Considering, planning, or engaged in legal action
- No next steps planned
- Not sure
- Other
- *[Allow text box for further explanation]*

4e. Ask patients/families about their level of respect and empowerment during the process, by major party, on the *Resolution Report*. This could include multiple questions or a matrix question with the response options listed at the bottom.

Did the people you spoke with listen to your concerns?

- Yes
- No
- Not sure

Overall, did the hospital/clinic/facility treat you with dignity and respect during the conversations?

- Yes
- No
- Not sure

4f. Ask conversation requestor if each individual goal was met on the *Resolution Report.*

When you asked for a conversation, you listed what you were hoping to accomplish by engaging in the EDR process. For each, let us know whether your goals were met and give any additional explanation about how the goal was or was not met. *(Individual goals would be piped into survey).*

- This goal was met over the course of the conversation[s]. Please tell us more.
- This goal was not met over the course of the conversation[s]. Please tell us more.
- This is no longer a goal. Please tell us more.

4g. Ask patients/families if they felt prepared and informed during the conversation process on the *Resolution Report.* This could include multiple questions or a matrix question with the response options listed at the bottom.

How much do you agree with the following statements about the conversation process?

- I understood how many opportunities I would have to ask questions.
- I knew what questions to ask the provider or facility.

- I understood the role of each person in the conversation and how they were connected to the harm.
- I felt comfortable asking for any accommodations (e.g., rescheduling the conversation, getting an interpreter, asking for breaks, etc.).
- The hospital/clinic/facility provided me with information that helped me understand what would occur during the conversations.
- I had enough information to feel prepared.

Response options: Strongly disagree, somewhat disagree, neither agree nor disagree, somewhat agree, strongly agree, n/a

What information would it have been helpful to know in order to feel prepared for the conversation?

- Open-ended

4h. Ask providers/facilities if they felt prepared and informed before the conversation process on the *Resolution Report*. This could include multiple questions or a matrix question with the response options listed at the bottom. These questions could also be included in the provider *Request for Conversation* in the instances where a provider initiates the process.

These questions refer to your knowledge and familiarity with communication and resolution processes before engaging in the process. Please indicate how much you agree or disagree.

- I was familiar with communication and resolution processes prior to engaging in conversations with the patient/family.
- I received training from my facility/organization on how to talk with a patient/family about a harm event.
- I knew where to access tools and other resources to help me in talking with the patient/family about what happened.
- I was confident that I would be able to conduct an effective conversation with the patient/family about what happened.

Response options: Strongly disagree, somewhat disagree, neither agree nor disagree, somewhat agree, strongly agree, n/a

Appendix B: Definitions

The following definitions in this Appendix are intended to be plain language suggestions for describing some of the terms in the *Request for Conversation* and the *Resolution Report*.

Ambulatory surgery center: A facility that provides surgical care and other procedures on an outpatient basis, meaning that patients do not need to stay overnight.

Apology: A statement of apology or regret offered to a patient/family in the initial communication after a harm event, as well as subsequent conversations. This is not a statement of wrongdoing or explanation of deviation from standards of care but is a critical expression of empathy.

Compensation: Compensation can include paying for medical bills, other out-of-pocket expenses, or money to account for possible future injuries and/or other damages.

Conversation/Discussion: A conversation includes a discussion with either the provider or a representative of the facility where the patient/rep has opportunities to ask questions and receive information. The conversation might include an explanation of what occurred, an explanation of the causes of the medical harm, an apology or expression of regret, actions the facility or provider will take to prevent the harm from occurring again, offers of compensation, etc. These do not include short communications scheduling a conversation or declining a longer conversation.

Conversation Requestor: The party that submits a *Request for Conversation*. Currently, this is usually the patient or family, but can include providers or facilities.

Facility: A facility can include an outpatient surgery center, birthing center, hospital, nursing facility (i.e., skilled nursing, rehabilitation, or long-term care), or outpatient dialysis center.

Mediation: A process where a mediator assists and facilitates two or more parties to reach a mutually acceptable resolution.

Goal: Any expectation or outcome that a patient or family hopes to get out of the EDR process, such as an apology, help with financial hardship the harm event has caused, an explanation of what happened, or information on what the facility is doing to prevent similar harm from occurring to others in the future.

Participant: Anyone who participates in the EDR protected conversations, including patients or families, providers, facility representatives, etc.

Provider: In this report, provider refers to a person licensed to provide medical care or treatment.

Request for Conversation: A form that may be completed by a patient, patient representative, healthcare provider, employer of healthcare providers, or facility that creates confidentiality for

conversations between patient/family and provider/facility about an adverse event that caused the patient serious physical harm. The *Request* lets the other party know that the requestor would like to talk to them about what happened.

Resolution Report: A voluntary follow-up survey of parties that either submitted a *Request for Conversation* or were named in one.

EDR Participation Decision Screens: Questions presented in the online system about whether the provider or facility will accept the conversation request and integrate EDR into their conversation process.

Appendix C: Potential Survey Questions

EDR staff can explore regional and national associations of risk managers and surveying those associations about use/awareness of EDR. The survey could be used to assess three primary aspects of EDR or general CRP processes: (1) General familiarity with EDR/CRP, (2) Which CRP elements the participants' associated facilities have, and (3) Experiences with using EDR or CRP processes. Below are some potential survey questions that could be used.

Familiarity with Oregon's EDR process

How familiar are you with Oregon's Early Discussion and Resolution process?

- Very familiar
- Somewhat familiar
- Slightly familiar
- Not at all familiar

How familiar are you with communication and resolution programs (CRP)?

- Very familiar
- Somewhat familiar
- Slightly familiar
- Not at all familiar

In your opinion, how important is it that the hospital/clinic/facility you work at has a formal CRP process?

- Very important
- Somewhat important
- Somewhat unimportant
- Very unimportant

How interested would you be in receiving more information on EDR and CRP processes?

- Very interested
- Somewhat interested
- Slightly interested
- Not at all interested

Existing CRP processes

Does the facility you work at have a formal CRP process?

- Yes
- No
- Not sure

Please indicate how much you agree with the following statements:

- Leadership at my facility supports engagement with CRP processes
- Providers at my facility receive training around immediate disclosure of medical harm
- Providers at my facility receive training around communication after harm

Response options: Strongly disagree, somewhat disagree, neither agree nor disagree, somewhat agree, strongly agree, n/a)

How frequently does your facility engage in the following?

- Reporting incidents of harm immediately
- Conducting investigations into incidents of harm rapidly
- Sharing full and complete explanations about the incident with the patient and family
- Offering psychosocial support to the patient and family
- Offering psychosocial support to the provider
- Offering apologies to the patient or family from the facility
- Offering apologies to the patient or family from the provider
- Offering compensation for care proactively
- Engaging in learning to prevent recurrences

Response options: Very frequently, frequently, occasionally, rarely, very rarely, never

Participation in the EDR process

Have you ever participated in conversations initiated through an EDR process?

- Yes
- No
- Unsure

How many times? *[Skip-coded if 'yes']*

- 1
- 2
- 3 or more

Have you ever received a request for conversation through the EDR process on behalf of your facility, or been part of the decision to accept or refuse a request for conversation?

- Yes
- No
- Unsure

Have you ever refused a request for conversation through the EDR process or been part of that decision? *[Skip-coded if 'yes']*

- Yes

- No
- Unsure

Have you ever recommended that a provider refuse a request for conversation? *[Skip-coded if 'yes' to question about receiving a request]*

- Yes
- No
- Unsure
- Not applicable

Why did you choose not to engage in the conversations? Select all that apply. *[Skip-coded if 'yes' to question about refusing a request]*

- Advised against participation by legal counsel
- Advised against participation by liability insurer
- Advised against participation by another person at the facility
- My organization advises against participating in all EDR requests
- Concerns that the conversations would be combative or unpleasant
- Did not believe the event was serious enough to warrant a conversation
- Other, please explain:

For those who engaged in EDR-related conversations:
Did the relevant provider(s) attend the conversation?

- Yes
- No
- Unsure
- Not applicable

Was the patient or family offered an apology?

- Yes
- No
- Unsure

Was the patient or family offered compensation?

- Yes
- No
- Unsure

How satisfied were you with the process?

- Very satisfied
- Somewhat satisfied
- Somewhat dissatisfied
- Very dissatisfied

Appendix D: Final Logic Model

GOAL: A culture of safety in healthcare systems that includes transparency and accountability after medical harm events.

<table>
<tr><th>Inputs</th><th>Activities</th><th>Short term Outcomes</th><th>Intermediate Outcomes</th><th>Long term Outcomes</th></tr>
<tr><td rowspan="2">OPSC program:
Staff, Taskforce, and Board activities</td><td>Public Facing:

CONDUCT OUTREACH to the community. Determine best outreach strategies to connect with and engage patients and families.</td><td>• Increase program awareness for patients and families

• Increase number of conversations</td><td>• Increase diversity in referral/reporting sources

• Increase number of patients and families who choose EDR processes as a first resolution option

• Increase referral demographic diversity

Equity considerations: Reduce disparities in who asks for a conversation.</td><td rowspan="2">• Patients and families feel respected, empowered, and appropriately compensated

• Providers and facilities feel safe and comfortable requesting a conversation and sharing what they learn

• Providers and facilities have systems and/or policies that support a culture of safety and transparency

Equity considerations: Consider data by demographics, such as race/ethnicity and language, to measure disparities in feelings of respect, empowerment, and satisfaction.</td></tr>
<tr><td>Program Facing:

HAVE CONVERSATIONS with program participants.</td><td>• Increase program participant[4] knowledge of best practices in EDR</td><td>• Increase successful conversations (apology, transparency/information, accountability, compensation)

Equity considerations: Consider conversation success data by demographics, such as race/ethnicity and language, to measure any disparities.</td></tr>
</table>

[4] Program participant includes patients, families, providers, and facilities.

<table>
<tr><th>Inputs</th><th>Activities</th><th>Short term Outcomes</th><th>Intermediate Outcomes</th><th>Long term Outcomes</th></tr>
<tr><td rowspan="2">OPSC program: Staff, Taskforce, and Board activities</td><td>Provider and System Facing:

ENGAGE providers, facilities, and other participants in the process (e.g., attorneys, insurers, etc.).

SHARE information around best practices among health providers, facilities, and other participants.

WRITE Annual Report and share findings with Task Force, Board, etc.</td><td>• Increase EDR awareness among providers, facilities, and other participants

• Increase provider and facility requests of EDR conversations

• Increase provider and facility acceptance of conversations

Equity considerations: Collect data to understand if patient and family requests are accepted at equal rates.</td><td>• Increase successful conversations (apology, transparency/information, accountability, compensation)

• Increase number of health systems that have elements of a communication and resolution program</td><td rowspan="2">• Patients and families feel respected, empowered, and properly compensated.

• Providers and facilities feel safe and comfortable requesting a conversation and sharing what they learn.

• Providers and facilities have systems and/or policies that support a culture of safety and transparency.

Equity considerations: Consider data by demographics, such as race/ethnicity and language, to measure disparities in feelings of respect, empowerment, and satisfaction.</td></tr>
<tr><td>Insights:

COLLECT, ANALYZE AND SHARE DATA from patients, families, providers, and facilities participating in the process.

ALIGN data collection, analysis, and utilization with logic model.</td><td>• Increase OPSC knowledge of program strengths and gaps</td><td>• Increase use of data-driven targets and benchmarks

• Increase program monitoring and reporting

• Increase stakeholder awareness and knowledge of program</td></tr>
</table>

Appendix E: Final Logic Model with Recommendation Mapping

GOAL: A culture of safety in healthcare systems that includes transparency and accountability after medical harm events.

<table>
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Staff, Taskforce, and Board activities</td>
<td>Public Facing:

CONDUCT OUTREACH to the community. Determine best outreach strategies to connect with and engage patients and families.</td>
<td>• Increase program awareness for patients and families

★ Theme 6: Gain insights

• Increase number of conversations</td>
<td>• Increase diversity in referral/reporting sources
★ Theme 2: Addnl request info
• Increase number of patients and families who choose EDR processes as a first resolution option
• Increase referral demographic diversity

Equity considerations: Reduce disparities in who asks for a conversation.
★ Theme 1: Ability to assess equity</td>
<td>• Patients and families feel respected, empowered, and appropriately compensated
• Providers and facilities feel safe and comfortable requesting a conversation and sharing what they learn
★ Theme 4: Resolution report

• Providers and facilities have systems and/or policies that support a culture of safety and transparency</td>
</tr>
<tr>
<td>Program Facing:

HAVE CONVERSATIONS with program participants.</td>
<td>• Increase program participant[5] knowledge of best practices in EDR

★ Theme 3/4: Check-in and resolution report</td>
<td>• Increase successful conversations (apology, transparency/information, accountability, compensation)

Equity considerations: Consider conversation success data by demographics, such as race/ethnicity and language, to measure any disparities.
★ Theme 1: Ability to assess equity</td>
<td>★ Theme 6: Gain insights

Equity considerations: Consider data by demographics, such as race/ethnicity and language, to measure disparities in feelings of respect, empowerment, and satisfaction.

★ Theme 1: Ability to assess equity</td>
</tr>
</table>

[5] Program participant includes patients, families, providers, and facilities.

<table>
<tr><th>Inputs</th><th>Activities</th><th>Short term Outcomes</th><th>Intermediate Outcomes</th><th>Long term Outcomes</th></tr>
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ENGAGE providers, facilities, and other participants in the process (e.g., attorneys, insurers, etc.).
SHARE information around best practices among health providers, facilities, and other participants.
WRITE Annual Report and share findings with Task Force, Board, etc.</td><td>• Increase EDR awareness among providers, facilities, and other participants
Theme 6: Gain insights
• Increase provider and facility requests of EDR conversations
• Increase provider and facility acceptance of conversations
Equity considerations: Collect data to understand if patient and family requests are accepted at equal rates.
Theme 1: Ability to assess equity</td><td>• Increase successful conversations (apology, transparency/information, accountability, compensation
Theme 4: Resolution report
• Increase number of health systems that have elements of a communication and resolution program
Theme 6: Gain insights</td><td rowspan="2">• Patients and families feel respected, empowered, and properly compensated.
Theme 4: Resolution report
• Providers and facilities feel safe and comfortable requesting a conversation and sharing what they learn.
Theme 4: Resolution report
• Providers and facilities have systems and/or policies that support a culture of safety and transparency.
Theme 6: Gain insights
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Theme 6: Gain insights</td><td>• Increase use of data-driven targets and benchmarks
• Increase program monitoring and reporting
• Increase stakeholder awareness and knowledge of program
Theme 6: Gain insights</td></tr>
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