OREGON

Resolution of Adverse Health Care Incidents, Oregon Laws, 2013, Chapter 5
(text available at https://www.oregonlegislature.gov/bills_laws/lawsstatutes/2013orLaw0005.pdf)

Intention Behind the Legislation: In 2013, the Oregon legislation created the state's Early Discussion and Resolution (EDR) process. EDR conversations are protected by state law and create the opportunity for participants to talk candidly about the harm that occurred, working towards reconciliation outside of the legal system. It is voluntary and is unique in that it allows patient and families, in addition to health care providers and health care facilities, to initiate these important conversations helping to build greater trust in the health care system. The open communication about patient harm events helps to foster a culture where learning and improved patient safety can occur.

Organizations Key to the Legislation: The legislation was the result of a negotiated agreement, directed by Governor John Kitzhaber, between the Oregon Medical Association and the Oregon Trial Lawyers Association. The Oregon Patient Safety Commission (https://oregonpatientsafety.org/) (the "Commission") was tasked with creating the rules necessary to implement the law and to further related quality improvement work.

Summary of Process.

Adverse Health Care Incident: Unanticipated, "usually preventable" serious physical injury/death arising from patient care.

Mandatory versus Optional: A health care provider, their employer, a health care facility, or a patient (or a patient's representative) "may" (optional) choose to file a notice with the Commission about an adverse healthcare incident. The notice (or Request for Conversation) is a request to have a conversation with the other party and initiates the EDR process (which triggers the confidentiality protections for subsequent conversations). Additionally, participation in the process is voluntary for the non-initiating party/parties, and any party can opt out of the process at any time.

Initiation of the Process:

1. Notice of an adverse health care incident is filed with the Commission.
   - A health care facility/employer that files a notice must provide a copy to the patient. They must also alert involved health care providers although the notice should NOT identify them by name.
   - If a patient is the party filing the notice, the Commission must notify all involved health care providers and health care facilities no more than 7 days after receipt of the notice.
2. Health care providers/facilities may notify the Commission of accepted offers of compensation.
3. The initiating party may provide the Commission with a status report within 180 days.

Discussion of an Adverse Health Care Incident: Discussion "may" include **(i)** sharing the steps being taking to prevent similar adverse medical events in the future with the patient and **(ii)** an offer of compensation if warranted (patients without an attorney should receive notice of the right to seek legal counsel in this instance).

Oral versus Written: Any offer of compensation must be in writing. All other discussion related to compensation should remain oral.

Additional Features: Optional mediation in instances where the discussion under this law does not offer resolution.

Statute of Limitations: The statute of limitations is tolled for 180 days (or otherwise by agreement between the parties).