Senate Bill 229

Modernizing OPSC's Statute to Support Patient Safety Work in Oregon

Oregon's Independent Voice for Patient Safety

ORS 442.820 (2) The mission of the commission is to improve patient safety by reducing the risk of serious adverse events occurring in Oregon's health care system and by encouraging a culture of patient safety in Oregon.

Adverse events happen far too often in healthcare. A recent study in the New England Journal of Medicine found that 24% of hospital admissions had at least one adverse event[1]. In 2003 the Oregon Legislature created the Oregon Patient Safety Commission (OPSC) to reduce the risk of serious adverse events as an independent voice for patient safety. OPSC operates the Patient Safety Reporting Program (PSRP), which grew out of recommendations from a workgroup representing medical providers, insurers, purchasers, and consumers. The workgroup believed that the work of improving patient safety never ends and should not have to be done in isolation. Twenty years later, our founding principles remain relevant; however, some of the elements in our statute are holding us back from being responsive to new knowledge and insights.

OPSC Must Modernize to Keep Pace with the Evolving Healthcare System

While healthcare has been in a constant state of change since PSRP was created, the program and its statute (ORS 442.819 to 442.851) have remained largely unchanged. In 2021, OPSC sought input from members of Oregon's healthcare community to understand their current patient safety priorities and practices. Their input, in conjunction with an analysis of advances in patient safety science, has shaped the revisions proposed in SB 229 that will strengthen PSRP without creating new mandates or additional reporting burden.

Overview of Proposed Revisions

Broaden and revise overly specific or outdated language. Transitioning to broadly applicable terminology will allow the statute to remain relevant over time. For example, replacing the term "root cause analysis" with the broader term "event investigation and analysis," which includes the array of investigation methodologies used by healthcare providers today.

Revise elements of PSRP to support current patient safety knowledge and practice. Proposed revisions align with current patent safety science to focus on the systems organizations have in place to respond to and learn from adverse events, rather than on the specifics of individual adverse events.

Codify health equity as an essential part of PSRP data collection and analysis. Inequitable care cannot be safe care. 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.

Normalize OPSC's board member nomination process to match those of other boards and commissions. It is essential to our agency that OPSC's board reflect the diversity of facilities, providers, insurers, purchasers, and consumers involved in patient safety. The statute requires an extra step that no other board or commission requires—that the OPSC Board nominate a slate of candidates to recommend to the Governor for consideration—causing delays in the appointment process.

SB 229 Will Support the Future of Patient Safety in Oregon

At OPSC, we are uniquely positioned to support learning and collaboration across the healthcare system. 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. SB 229 would ensure that PSRP can continue to support the rapidly changing healthcare environment.

The proposed revisions in SB 229 will:

- ✓ Create agility, allowing PSRP to adapt along with a changing healthcare environment.
- ✓ Inform our understanding of the systems healthcare organizations have in place to respond to and learn from harm events.
- ✓ Build on organizational patient safety efforts without creating an additional reporting burden.
- ✓ Avoid duplicative work for facilities and offer a reporting structure more in line with current practices.
- ✓ Acknowledge that all adverse events are opportunities for learning, regardless of harm.
- ✓ Continue to provide meaningful public accountability.
- ✓ Encourage a collaborative approach because this work cannot happen in isolation.
- ✓ Allow OPSC to use PSRP data purposefully and appropriately to produce meaningful shared learning.
- ✓ Reinforce our commitment to all Oregonians by systematically establishing equity as an essential element in patient safety data collection and analysis.
- ✓ Maintain the diversity of experience necessary for a strong Board of Directors and improve the timeliness of appointments.

Learn more about OPSC's work to advance patient safety in Oregon in our annual reports.

Reference

1. Bates DW, Levine DM, Salmasian H, et al. The Safety of Inpatient Health Care. *N Engl J Med*. 2023;388(2):142-153. doi:10.1056/NEJMsa2206117