



*Iowa Healthcare  
Collaborative*

# ***Setting the Stage***

***Medical Error Task Force***

***September 5, 2023***

# ***Agenda 9/5/23***

- ***Introductions***
- ***Context***
- ***Discussion***



# HF 161 Charge

*Review medical error rates of licensed physicians in this state and make recommendations to the general assembly and director of HHS including recommendations address options for:*

- *Reducing Medical Errors*
- *Improvements in Education and Training to minimize errors*
- *Whether applicable penalties for medical errors and physician licensure review measures are sufficient.*

# ***Medical Error Task Force***

## ***Membership***

- Four legislators, D and R from each chamber***
- Director of HHS and staff***
- Director of Inspection, Appeals, and Licensure***
- Executive Director of the Board of Medicine***
- State Ombudsman***
- Iowa Medical Society***
- Board of Regents: UIHC***
- Insurance Commissioner***
- Attorney General***

# ***Medical Error Task Force***

## ***PREWORK***

- ***Wikipedia- Medical Error***
- ***IHI Stories Part 1 and 2***

## ***INTRODUCTIONS***

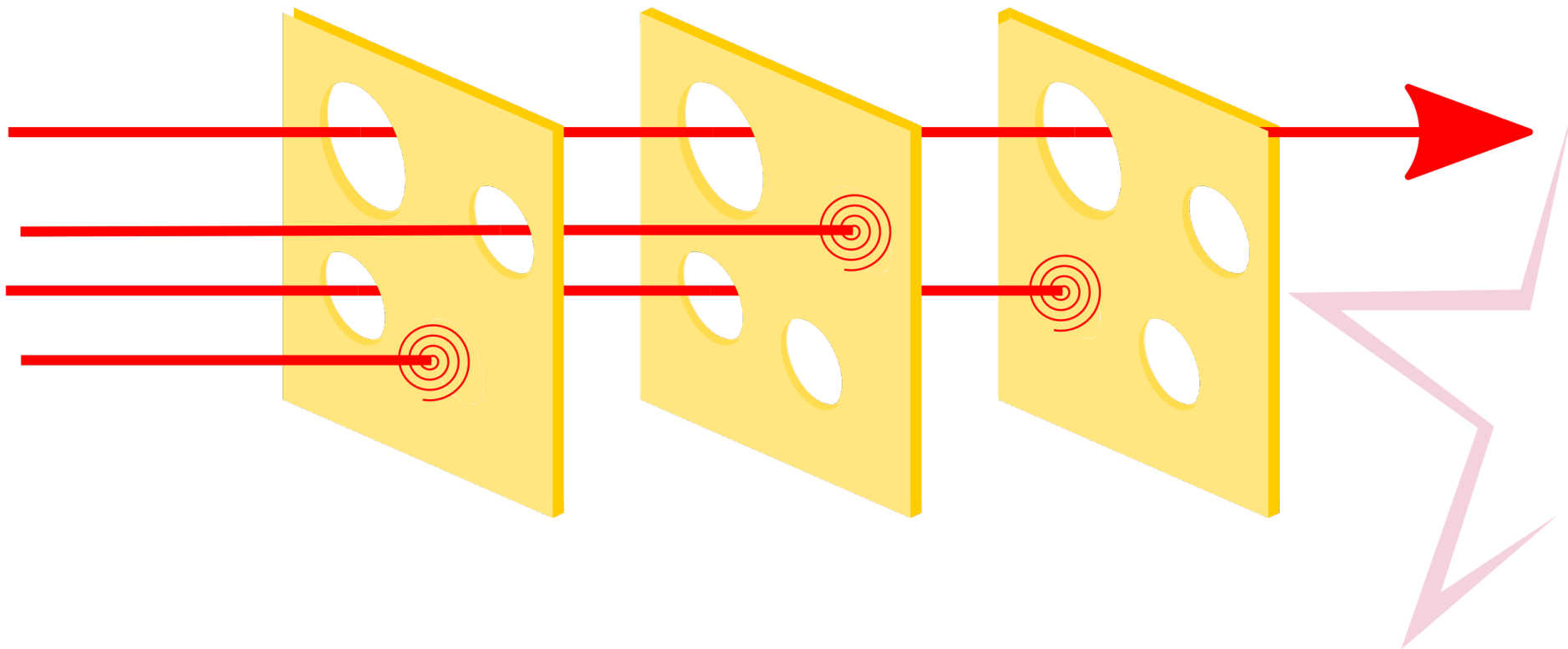
- ***Who are you?***
- ***Have you experienced harm?***

# Medical Error Task Force

- **Sept. 5 - Orientation and planning**
  - *Research and prepare materials*
- **Sept. 25 - Education and processing**
  - *Draft 1 and electronic feedback for Draft 2*
- **Oct. 23 - Development**
  - *Draft 3 and electronic feedback for Final Draft*
- **Dec. 1 - Review and final recommendations**

# Swiss Cheese Theory of Patient Safety

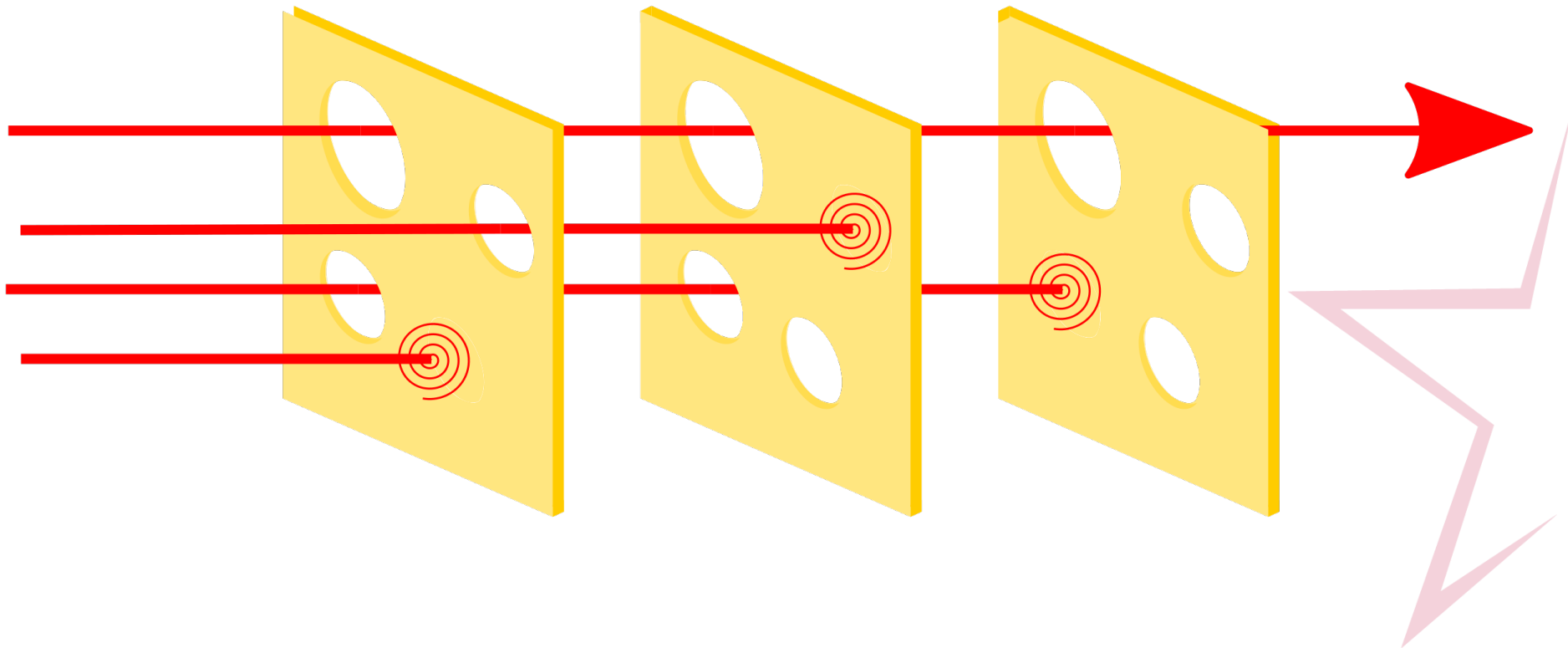
Complex, adaptive, multi-layer healthcare system



# *Swiss Cheese Theory of Patient Safety*

Unintended Consequences

Patient Harm





# HF 161 Charge

*Review medical error rates of licensed physicians in this state and make recommendations to the general assembly and director of HHS including recommendations address options for:*

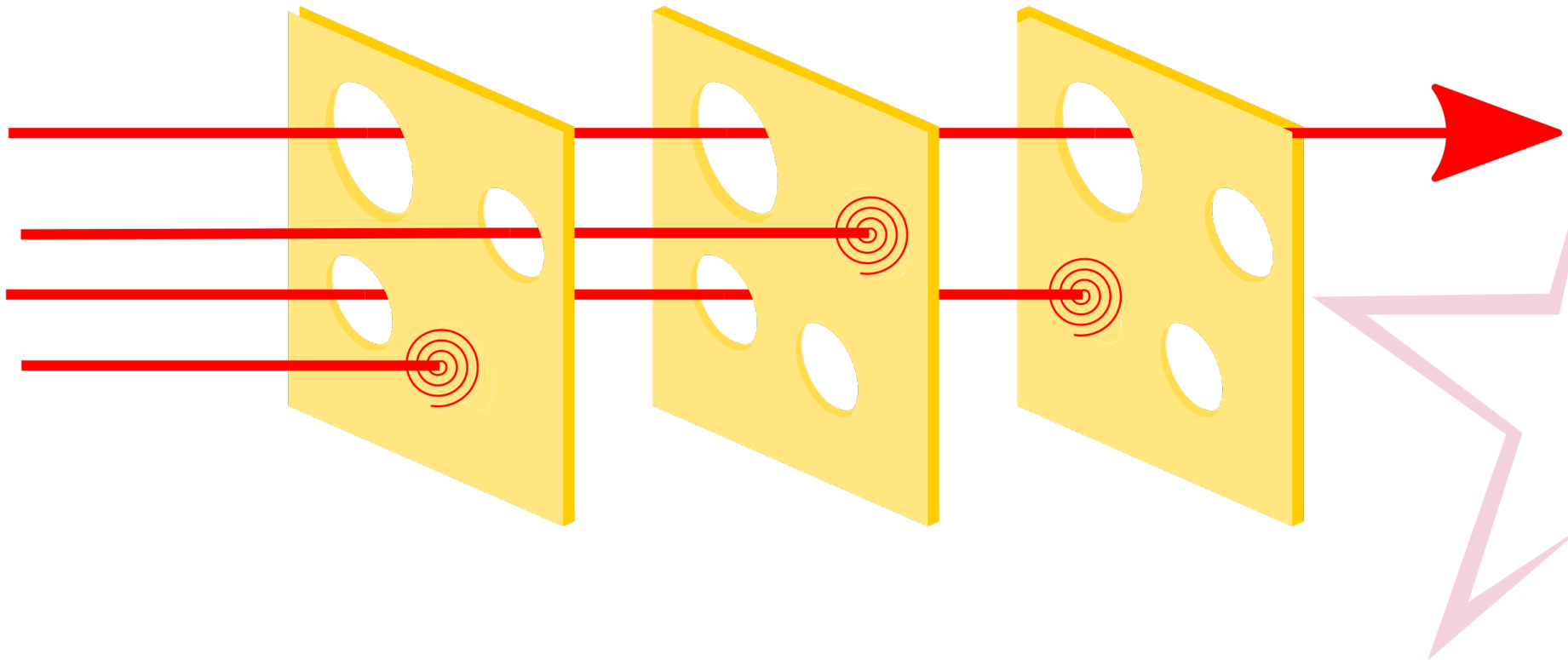
- ***Reducing Medical Errors***
- ***Improvements in Education and Training to minimize errors***
- ***Whether applicable penalties for medical errors and physician licensure review measures are sufficient***

# Preventing Medical Error

**Licensure**

**Process  
Improvement**

**Disciplinary  
Action**



## ***What are the critical questions we need to address at meeting 2?***

1. How do we reduce medical error (improve patient safety and reduce harm)?
2. What improvements are needed in education and training?
3. Are applicable penalties sufficient?