Medical Error Task Force Minutes
Iowa State Capitol
September 5, 2023

Attendees

- Committee members: Tom Evans, Sarah Reisetter, Robert Kruse, Ed Bull, Rep. Beth Wessell-Kroeschell, Sen. Mark Lofgren, Sen. Nate Boulton, Bernardo Granwher, Andria Seip, Jessica Zuzga-Reed, James Murphy
- Staff and Observers: Natalie Ginty, Doug Struyk, Kelsey Thien, Dylan Keller, Jennifer Harbison, Carrie Malone, Jancy Nielson, Jacob Appel

Welcome

Tom Evans opened the meeting at 11:00 a.m. He discussed the committee prework and described one personal example of medical error. Medical error is a high priority in healthcare and can be very personal to physicians. It will take both providers and patients working together to create an environment to reduce patient harm. He described the objectives for the day were:

- To get to know each other.
- Establish some basic vocabulary.
- Determine the degree on knowledge of committee members on the topic.
- Identify critical questions for the committee to address.

Introductions

Committee members shared their names, backgrounds, and experiences with the topic. Staff and observers were also introduced.

Task Force Organization

The task force charge pursuant to 2023 Iowa Acts, HF 161 is to provide a report to the general assembly and HHS by January 8, 2024 regarding:

- Physician medical error reporting rates in Iowa
- Options for reducing medical errors.
- Improvements in education and training to minimize medical errors.
- Whether applicable penalties for medical errors and physician licensure review measures are sufficient.

The committee is currently scheduled to meet four times. There will be work between meetings.

- 9/5- Introduction and orientation
- 9/25- Education and discussion
- 10/23- Education, discussion, and consideration draft framework.
- 12/1- Final review of draft report.

In discussion, there were questions about how the legislation was drafted. It was noted that medical error a category of patient harm under the broader topic of patient safety. Medical errors often include several factors and system failure. Dr. Evans introduced the “Swiss Cheese Theory” of patient harm and various terms. Three public models used to prevent medical error are:

- licensure (qualifications to practice medicine)
- process improvement and system redesign (structure of the system to deliver care)
- disciplinary action

Critical Questions

The task force discussed potential critical questions to explore:

- Senator Lofgren:
    - What role do hand offs of care between providers play in medical error?
        - There was a discussion of hand offs. What are we doing in Iowa to communicate hand offs?
    - What is the best way to handle disclosure of medical error?
    - Are surgical centers equipped to have residents work at them?
        - There was discussion of the growing role of ASCs and impact on access and cost.
    - What is currently being done to educate physicians on patient safety and medical error?
    - What are the BOM processes regarding licensure, discipline, and communication with those who have complained?
- The Ombudsman's report from 2017 should be included in the prework for the next meeting.
- Dr. Murphy discussed process improvement. We need data to know if improvement is happening. What data do we have and is it getting better?
    - Dr. Evans reported that standardized reporting metrics continue to develop nationally. It's as much about culture change as process change.
- Dr. Reed addressed the Candor law. Iowa is one of the few states with candor law. She noted not all bad outcomes are errors.
    - What role does the Candor law play a role in how things are disclosed?
- Andria Seip
    - Is the peer review process a place where someone can say they made a mistake?
    - What states require medical error reporting, and what are those requirements?
- Rep. Wessell-Kroschell asked what the formal definition of a medical error is, and where does the definition come from?

Next Steps

The next meeting focuses on education.

- Tom Evans will work with Sarah Reisetter and Robert Kruse to organize these critical questions with the charge of the task force.
- Dennis Tibben will present on the various Board of Medicine questions:
    - What is the complaint process?
    - Licensure process?
    - What are the BOM guiding principles (AMA?) and ongoing training of licensees.
    - What data is available about types of complaints they have, if it isn't always medical error.
    - Do you have information on documentation the board is reviewing, for example, density of case files, how does the Board currently determine if public discipline is warranted? Are there progressive steps that happen before someone gets to public discipline? What is the board legally permitted to disclose to complainants.
- James Murphy will organize a Patient Safety 101 presentation to:
    - clarify common vocabulary.
    - consider the science of performance improvement.
    - describe current efforts to educate providers in patient safety.
    - consider the current state of the public reporting.

The meeting adjourned at 1:22 p.m.