ECRI's Strategic Insights for Ambulatory Care newsletter is being offered to CAPIC insureds at no cost. If you are interested in visiting any of the links in this edition, please contact Brad Dunkin, Assistant Vice President, at BDunkin@CAPphysicians.com.

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Strategic Insights for Ambulatory Care is a biweekly service provided by ECRI and the Cooperative of American Physicians (CAP). We welcome your comments; please send them to **AmbulatoryCareRM@ecri.org**.

COOPERATIVE OF AMERICAN PHYSICIANS

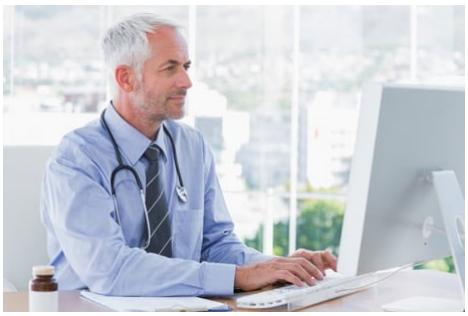
What's New?

- Taking Action: Strategies to Combat the Congenital Syphilis Epidemic **read now**

Spotlight on Cybersecurity

Cybersecurity is an urgent concern in healthcare and aging services organizations. In a **survey of healthcare cybersecurity professionals**, 89% said their organizations experienced at least one cyberattack in the past year. The attacks often had negative effects on patient care, such as poor outcomes from delays in tests and procedures, longer length of stay, more complications from medical procedures, more patient transfers, and even higher mortality in some cases.

- Cybersecurity
- Why Cybersecurity Matters
- The HIPAA Breach Notification and Enforcement Rules
- Essentials: Health Information Technology



Patient Safety & Relations

Patients Worry about Information Sources for Generative AI in Healthcare

What's the news. Patients' biggest concern with generative artificial intelligence (AI) in healthcare is a lack of transparency about source data and validation, cited by 86% of respondents in a **survey by Wolters Kluwer Health**. Nearly half (49%) of respondents were concerned that generative AI might yield false information, and even in a scenario where an AI tool was developed specifically for healthcare applications, 63% of patients continued to express concern.

Why it matters. As new technologies like generative AI are used more widely in physician practices, providers will need to embrace transparency to gain patient trust and use the tools most effectively to aid diagnostic and other processes.

How ECRI can help. The **Resource Collection: Health Information Technology** provides tools and guidance for adoption and management of healthcare technologies, which can provide a useful framework for applying to AI.

WHO Publishes Guidance on Medication Safety for Look-alike, Sound-alike Medications

What's the news. Look-alike, sound-alike medicines are a well-recognized cause of medication errors at any stage of medication use, potentially leading to overdosing, underdosing, or inappropriate dosing of unintended or intended medications; strategies to prevent such errors include educating staff, clearly labeling medications, and utilizing technology-based solutions, according to the World Health Organization's (WHO) recent publication **Medication Safety for Look-alike, Sound-alike Medicines**.

Why it matters. Errors involving look-alike, sound-alike medicines can cause severe harm to patients, including death. It is important that organizations and providers take steps to prevent such errors.

How ECRI can help. The guidance article **Medication Safety** offers strategies to mitigate and prevent medication-related errors and near misses.

GITT-PC Model May Improve Care for Older Adults in Primary Care

What's the news. Implementation of the Geriatric Interdisciplinary Team Training-Primary Care (GITT-PC) model could improve the care of older adults in primary care by emphasizing personal health goals, thereby promoting person-centered care, and by building partnerships between primary care and community-based organizations, according to a **December 1, 2023, article** in the *Journal of the American Geriatrics Society*.

Why it matters. It is important that primary care organizations provide appropriate and effective care to older adults that aligns with patient goals and care preferences.

How ECRI can help. The guidance article **Person-Centered Care** discusses patient-centered care in its broadest sense and provides information and resources that risk managers can use to help their organizations identify and implement person-centered practices.

Worker & Environmental Safety

Nurses Identify Care Environment, Workloads, and Distractions as Challenges to Medication Safety

What's the news. Direct care nurses identified four major themes that impact the medication safety practices of and errors made by nurses: care environment, nurse competency, system influences, and the error paradigm, according to a **study published December 2023** in the *American Journal of Nursing*. Chaotic environments, heavy nursing workloads, and distractions and interruptions increased the risk of medication errors.

Why it matters. Understanding the challenges to medication safety can help organizations implement effective strategies, including addressing environmental barriers to safe medication practices, ensuring medication-management education and training, and revising policies and procedures with nurse input.

How ECRI can help. The guidance article **Medication Safety** discusses strategies to help ensure safe medication administration and prevent medication-related errors.

Legal & Regulatory

Disclosure of Adverse Events to Historically Marginalized Patients

What's the news. Challenges in disclosing errors and adverse events to historically marginalized patients include fragmentation of care, lack of standardized protocols, and patients' mistrust; study participants noted that culturally appropriate toolkits, disclosure training, and including multidisciplinary healthcare team members would help meet the needs of these patients, according to a **December 2023 article** in the *Journal of Patient Safety*.

Why it matters. Understanding the challenges of disclosing adverse events can help organizations create and implement customized tools and resources to support culturally appropriate disclosure conversations and improve health equity.

How ECRI can help. The guidance article **Disclosing Unanticipated Adverse Outcomes** discusses challenges and strategies to address provider and patient attitudes regarding disclosure as well as legal and regulatory concerns, and provides action recommendations for building and maintaining robust policies and procedures on disclosure.

Massachusetts Latest State to Remove "Stigmatizing" Questions from Credentialing Process

What's the news. Joining a growing national movement, Massachusetts healthcare organizations will eliminate questions related to prior drug use and mental health from their credentialing processes, according to an announcement from the **Massachusetts Health & Hospital Association**. The association will work with organizations throughout the state to update their policies and procedures to reflect the new standards.

Why it matters. The move, which was endorsed by hospitals, health systems, and health plans statewide, is intended to reduce barriers that are perceived to prevent providers from seeking care for fear that it will impede their future employment or credentials.

How ECRI can help. Use **Resource Collection: Credentialing and Privileging** to develop and implement a robust credentialing and privileging process, ensuring that all providers have the requisite education, skills, and experience to offer high-quality care.

Physician, Nurse Practitioner Did Not Inform Patient of Worsening Thyroid Condition

A Pennsylvania jury returned a verdict of more than $1.4 million against a primary care physician and nurse practitioner for failing to diagnose and treat a patient's hyperthyroidism, ultimately resulting in the patient's death, according to an article in the September 2023 *Medical Malpractice Verdicts, Settlements & Experts*.

The 30-year-old patient went to his primary care office for an asthma checkup and was seen by both a physician and a nurse practitioner. During the visit, they noticed a

swollen spot on the patient's neck. The nurse practitioner prescribed thyroid medication and ordered blood tests; at a return visit four days later, the patient was told he had hyperthyroidism and instructed to continue the medication. Over the next several months, two additional visits occurred and additional tests were run, revealing worsening thyroid levels which were allegedly not shared with the patient.

Six months after the initial visit, the patient saw a different physician, who deemed the patient's condition emergent, increasing the patient's medication, recommending an ultrasound, and referring him to an endocrinologist. The patient died about 10 days later after arriving at a hospital by ambulance because he was experiencing nausea, vomiting, and weakness.

The patient's estate sued, alleging that the defendant physician and nurse practitioner saw the patient's condition worsening over multiple visits but neither informed the patient of this fact nor altered the course of treatment. Despite the defense's denial of any wrongdoing, the jury awarded the plaintiff $1,431,000.

ECRI Resources:

- **Safety Break: Provider Cognitive Bias: Impact on Diagnosis**
- **Infographic: The Road to the Correct Diagnosis**

ECRI Commentary: Organizations should have processes in place to ensure that test results and interpretations are timely reported to patients, along with recommendations for follow-up. Even if test results do not indicate any need for a change in treatment, this fact should be communicated to patients. Failure to respond to new, actionable information that should change a course of treatment is a form of diagnostic error. Adopting a shared decision-making model facilitates person-centered care by creating a collaborative process in which members of the patient's care team provide personalized and evidence-based information about the individual's diagnosis(es), treatment options, and potential outcomes, including any uncertainties. Ideally, the patient shares what is important to them in light of their values and care goals, considers the risks and benefits of the treatment options and possible outcomes, and makes a decision in collaboration with their care team.

This abstract is a summary of a recent court decision, verdict, settlement, or other action affecting healthcare organizations and their risk management programs. When reviewing this abstract, keep in mind that laws and court decisions vary among jurisdictions and that decisions of lower courts may be overturned on appeal. For specific legal guidance regarding the significance or applicability of this decision, contact legal counsel.

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