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Case of the Month

Deceptive Algorithms: Artificial Intelligence's Troublesome Tale of Inaccuracy and Judicial Rebuke

by Bryan Dildy, MPA, CPHRM, CPPS

Artificial intelligence (AI) platforms use algorithms that extract information from databases to create answers to questions.[1] AI can recognize human language and generate conversational responses, which provides an experience of talking to an actual person.[1] It can also create responses to complex inquiries that would customarily take longer to find in a traditional search engine. Despite these benefits, the serious consequences that can derive from the improper use of AI cannot be ignored. An example of dire consequences was seen in a recent Avianca Airlines lawsuit.

This case involved plaintiff Roberto Mata, who sued Avianca Airlines claiming he was injured in 2019 when a metal cart struck his knee during flight.[2,3] In 2023, Avianca Airlines sought to dismiss the suit based on the statute of limitations expiration.[2,3] Mata's counsel filed a response citing several cases which supported the progression of the suit. However, when Avianca's attorneys reviewed the response, they could not locate any of the cited cases.[2,3] The judge overseeing the trial ordered Mata's lawyers to provide copies of the referenced cases.[2,3] It was later discovered the cases did not exist and were fabricated by ChatGPT.[2,3] On June 8, 2023, Mata's attorney was asked to explain his failure to validate ChatGPT responses.[2,3] Unfortunately, the attorney did not have a valid reason for his lack of diligence besides the assumption ChatGPT was an advanced search engine that yielded accurate results and the context of the information was convincing and authoritative.[2,3]

The Avianca case is an example of AI's use in the legal setting, yet AI's use and influence has not stopped there. The expansiveness of AI is seen across a variety of industries, such as education, military, and healthcare. For example, AI has already been incorporated in clinical decision support systems (CDSS) allowing for the advanced interpretation of clinical data points to help diagnose and treat patients.[4] Though arguments are made that AI has benefits that assist in the diagnosing and treatment of patients, there are specific risks that clinical users of AI should consider. Those risks include accuracy, bias, and protection of data.

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ACCURACY The Avianca Airlines case highlights the unsettling reality of the inaccuracies an AI platform can generate. A recent multi-specialty analysis of 180 clinical questions revealed 57.8% (n=104) of AI answers were rated as not all correct.[5] This study further highlighted ChatGPT's ability to deliver inaccurate conclusions in an authoritative and convincing manner.[5] Like in the Avianca Airlines case, where the attorney relied on the convincing language and tone of ChatGPT, the delivery of false information in a convincing manner to clinical personnel can also lead to reliance on inaccurate information when rendering patient services. This phenomenon has been recognized as AI hallucination, which occurs when AI generates false information.[6] Therefore, it is important that clinicians recognize AI as a supportive tool that should not replace a practitioner's critical thinking and validation of information received.

BIAS The risk of AI bias in healthcare can arise based on the dataset available to the AI system.[7] If the dataset fails to include certain data points related to race, gender, or underrepresented individuals, the information produced can be skewed. For example, if data shows African American patients receive, on average, less treatment for pain than white patients, an AI system could inaccurately learn to suggest lower doses of pain medication to African American patients.[7] As such, recognizing potential data bias is important for any user of AI to consider. To eliminate biased outcomes, the data should be reflective of racial and gender diversity. As such, a clinician should question the AI platform to ensure diversified information is included in the dataset.

PROTECTION OF DATA Federal and state laws require privacy and security of patient identifiable medical information. Artificial intelligence platforms are not considered covered entities and are not subject to the same privacy and security standards required by the Health Insurance Portability Act (HIPAA). Though there are general privacy protections afforded under the California Consumer Privacy Act, it is important that you review privacy policies to understand how inputted information is stored and used. Further, deidentified information should be used, but if not feasible, patient consent must be obtained and documented.

LESSONS LEARNED It is without question that AI has opened the door of endless possibilities related to clinical effectiveness. However, it is important that when considering the use of an AI, you understand the accuracy of the system, system bias, and the protection and security of the AI platform. Consideration should also be given to educating your staff on the limitations of AI and the need to validate the information being presented.

The National Academy of Medicine is currently creating guidelines around the use of AI in healthcare. You can monitor the progression of this three-year project at Health Care Artificial Intelligence Code of Conduct - National Academy of Medicine (nam.edu). In the interim, having your staff sign a code of conduct acknowledgement form is a great way of documenting that AI education was provided. You can access CAP's Code of Conduct template related to the use of AI platforms here.

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Risk Management and Patient Safety News

Keeping Patients Safe in Your Office: Strategies for Fall Prevention

by Rikki Valade, RN, BSN, PHN

Do you recall the television commercial featuring a woman on the floor crying, "I've fallen, and I can't get up"?[1] Those are certainly not words you want to hear from a patient in your office. Patient safety is a high priority in healthcaresettings, including your office.

Most fall prevention programs and statistics are skewed toward hospital falls and focus on the older population. However, falls can and do happen in physicians' offices, and the injuries sustained can be significant. Falls may result in fractures or injuries that affect mobility, daily activities, and quality of life. In 2022, CAP members reported 11 falls within their office settings, with eight of these falls serious enough to require emergency medical treatment. Nine of the 11 falls occurred inside the exam room.

In all medical settings, slips, trips, and falls pose a significant risk to patient safety.[2] Since we know falls are a risk, a fall prevention strategy should be included in the patient safety plan for all medical offices and ambulatory settings.[2] Policies and procedures should include patient monitoring, exam room and general office safety measures, and staff education. "Interventions targeting multiple fall risk factors can reduce fall rates by 30–40%."[3] Staff training should highlight the three most common circumstances leading to falls: transferring to and from wheelchairs; immediately following venipuncture; and while patients are unattended on exam tables.[4]

The Centers for Disease Control (CDC) created *Stopping Elderly Accidents, Deaths, & Injuries* (STEADI), a fall prevention program for outpatient settings focusing on the older adult population. Healthcare providers can implement the three core elements of STEADI in an office setting: screening, assessing, and intervening, to reduce fall risk. STEADI offers these resources:[5]

1. The Coordinated Care Plan to Prevent Older Adult Falls Coordinated Care Plan
2. Evaluation Guide for Older Adult Clinical Fall Prevention Programs Evaluation Guide
3. PowerPoint training presentation for clinic staff on using the STEADI initiative to prevent falls STEADI Our Staff for Fall Prevention

Along with training staff, there are other strategies you can put in place to improve safety in your office. Checking the environment of the office for hazards is a good place to start. ECRI (Emergency Care Research Institute) recommends environmental safety checks and risk reduction strategies for, but not limited to, the following areas:[6]

Exam Room Safety:

- Provide sturdy chairs with armrests. Do not provide chairs with wheels in or outside of the exam room
- Do not sit patients on the exam table while awaiting the physician and avoid high exam tables
- Provide a sturdy stepstool to get onto the exam table
- Allow a family member to accompany a patient to the exam room if identified as a fall risk
- Do not have sharp corners in the exam room

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- Monitor patients after injections or venipuncture
- Remove all clutter from the exam room

Waiting Room, Bathroom, and Hallway Safety:

- Keep free of clutter
- Arrange furniture so it does not interfere with the traffic flow
- Ensure no equipment is blocking the hallways and/or doorway entries
- Provide call bells and safety bars in patient restrooms

Office practices should ensure they follow the Americans with Disabilities Act (ADA) requirements which can be found at this link:[7] **https:///www.ada.gov/resources/medical-care-mobility/**

Laws surrounding injuries sustained from falls in a medical office or surrounding area are intricate and complex. Falls may result in a premises liability claim against the property owner; in other cases, they may result in a medical malpractice case against the physician or practice. After a patient fall, it is imperative to complete a thorough investigation of the incident. The investigations should include the contexts surrounding the fall, witness statements, photos of the areas—including equipment involved, event reports, fall-focused medical exam, and thorough documentation. CAP recommends you notify your general liability carrier and your professional liability carrier if a fall occurs in your practice or the surrounding area. These entities can provide specific guidance on investigations and adverse event management.

Key Takeaways

- Establish fall prevention strategies and patient safety plans and incorporate them into your policies and procedures
- Identify factors in your office that pose a risk to your patients
- Educate/train staff on fall prevention, risk identification, and fall management
- Establish clear procedures for fall investigations

In summary, to reduce the risk of a fall in your practice, be sure a component of your practice management plan includes a fall prevention strategy to ensure patient safety.

Your CAP Senior Risk and Patient Safety Specialist can be reached at CAP's Risk Management Hotline (800)252-0555 to answer any questions and provide resources to help with preventing falls in your practice.

Rikki Valade is a Senior Risk & Patient Safety Specialist. Questions or comments related to this article should be directed to RValade@CAPphysicians.com.

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UPDATE: DEA Extends Telehealth Waiver to 12/31/2024

by Andie Tena

On October 6, 2023, the United States Drug Enforcement Administration (DEA) announced that the telehealth flexibility waiver, which allows healthcare providers to prescribe controlled substances via telemedicine without an in-person patient visit, would be extended through December 31, 2024. The telehealth waiver was initially issued in March 2020 during the COVID-19 public health emergency (PHE) and was set to expire on November 11, 2023. The DEA anticipates releasing a final rule by the Fall of 2024.

The DEA's decision to further extend telehealth capabilities comes in response to the evolving needs of patients, healthcare providers, and the healthcare system at large. The COVID-19 pandemic highlighted the importance of telehealth to provide continuous medical care while minimizing the risk of viral transmission. The DEA extension follows an earlier temporary rule issued in May 2023, which authorized all DEA-registered practitioners to prescribe schedule II-V controlled medications via telemedicine until November 11, 2024, without a previous in-person visit if the patient had an established relationship with the provider prior to November 11, 2023. The new extension allows providers to prescribe schedule II-V medications via telemedicine regardless of when the practitioner-patient relationship was established.

The in-person regulation was originally established in 2008 through the Ryan Haight Act, which required a telemedicine provider to evaluate and examine a patient in person prior to prescribing a controlled substance. The controlled substance prescribing flexibilities were enacted in March 2020 in response to the PHE, which allowed for prescribing of controlled substances without a required in-person evaluation and visit.

One of the most significant advantages of the DEA's telehealth flexibility is improved patient access to care, especially for those in remote or underserved areas. Patients who were previously unable to access certain treatments and medications due to geographic or logistical constraints can now benefit from telehealth services. This shift is expected to reduce healthcare disparities and ensure that all patients receive the care they need.

Andie Tena is CAP's Assistant Vice President of Practice Management Services. Questions or comments related to this column should be directed to ATena@CAPphysicians.com.

Important CAP Member Notice: Effective January 1, 2024: A 3% Fee Will Be Charged on All Credit Card Transactions. Debit Cards Will No Longer Be Accepted.

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Don't wait until January! To avoid the fee, set up one-time or automatic monthly ACH payments when you log in to your account

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2. Once logged in, make sure to go paperless if you have not already by selecting the green "Set Up Paperless Billing" button.

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For assistance with your account, or if you have questions about your membership or the new credit card fee, please call 800-610-6642 or email MS@CAPphysicians.com.

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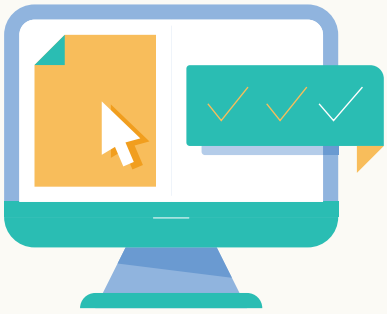

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Last Chance to Update Your Membership Information for Year-End Planning

If you are considering a change in your practice this year or in 2024, please notify CAP as soon as possible so our Membership Services Department can work with you to ensure that any necessary coverage transitions are implemented smoothly. Changes include, but are not limited to:

- Retirement from practice at age 55+
- Part-time practice (e.g., 20 or fewer hours per week or 16 hours for anesthesiologists)
- Reduction or any change in the scope of your practice
- Employment with a government agency or non-private practice setting
- Employment with an HMO or other self-insured organization
- Joining a practice insured by another carrier
- Moving out of state
- Termination of membership

The Mutual Protection Trust (MPT) Board of Trustees will levy an assessment in November 2023. To allow ample processing time, we strongly recommend that you complete your Coverage Update Form (CUF) immediately if you have not already to be evaluated for reductions or proration of the 2024 assessment.

The online Membership Information Update form is available in the Member's Area of the CAP website at **https://member.CAPphysicians.com**.

If you have not yet registered for the Member's Area, please register for an account at **https://member.CAPphysicians.com/register**. You will need your member number and the last four digits of your Social Security number.

For assistance, please call Membership Services at **800-610-6642** or email **MS@CAPphysicians.com**.

NOVEMBER 2023

Legislation Impacting Healthcare Costs in 2024

by Gabriela Villanueva

On September 14, 2023, the California legislature adjourned the first session of its two-year legislative cycle. October 14, 2023, was the signing deadline for the 1,046 bills that made it to Governor Newsom's desk. Of that total, the governor vetoed 156 bills, a higher number that may be attributed to concerns over increased spending and higher employer costs.

Here is a summary of three signed bills that are most likely to impact healthcare policy going forward:

- **AB 119-MCO Tax:** This bill reinstates the Managed Care Organization (MCO) tax. After passing unanimously in both the Senate and Assembly, AB 119 was signed into law by Governor Newsom on June 29, 2023. The tax applies retroactively to April 1, 2023, through December 2026 and is projected to bring in $19.4 billion in funding over its lifetime. AB 119 requires managed care plans operating in California to pay up to $192.50 per enrollee per month of enrollment.

- **AB 118-Provider Payment Reserve Fund:** This bill is a companion bill to the MCO tax that allocates $11.1 billion for the fund, which will be used to increase Medi-Cal reimbursement rates. Specifically, Medi-Cal reimbursement rates will increase for primary care, obstetric care, doula services, and non-specialty outpatient mental health services that must be at least 87.5% of the lowest maximum allowance set by the Medicare Program. The rate increases will go into effect on January 1, 2024.

- **SB 525-Increase Minimum Wage for Healthcare Workers:** Introduced by Senator Maria Elena Durazo (D-Los Angeles), this bill will raise the minimum wage for those considered California's lowest paid health workers such as nursing assistants, medical techs and janitorial workers to $25 an hour over the next several years based on a tiered system and type of healthcare facility.

A contentious bill from the start, last minute amendments to strike a deal between the state's largest labor union and bill sponsor, Service Employees International Union (SEIU), and the hospitals and dialysis centers resulted in the following parameters:

- Dialysis clinics and large health systems with more than 10,000 workers would pay a minimum wage of $23 an hour in 2024, $24 in 2025, and $25 in 2026.
- Hospitals with a high mix of Medi-Cal and Medicare patients, as well as rural independent hospitals would have to pay workers $18 an hour in 2024. That rate would increase 3.5% annually until it reaches $25 in 2033.
- Community clinics would start the pay increase at $21 per hour in 2024, rising to $22 in 2026 and $25 in 2027.
- Other health care employers would increase their minimum wage to $21 per hour in 2024, $23 in 2026 and $25 by 2028.
- The union agreed to a 10-year moratorium on local measures that aim to increase compensation for medical workers. Also, for four years, the union will not take any dialysis-related measures to the ballot.

It is important to note that the bill author put out a letter clarifying the intent of the bill. Basically, this is confirmation that "individual practices" with less than 25 employees are not in the scope of this bill. Will they be impacted by it? Absolutely. But that's a topic for another column.

More details on SB 525: **https://calmatters.org/health/2023/09/california-minimum-wage-health-care-workers/**

Gabriela Villanueva is CAP's Government and External Affairs Analyst. Questions or comments related to this article should be directed to GVillanueva@CAPphysicians.com.

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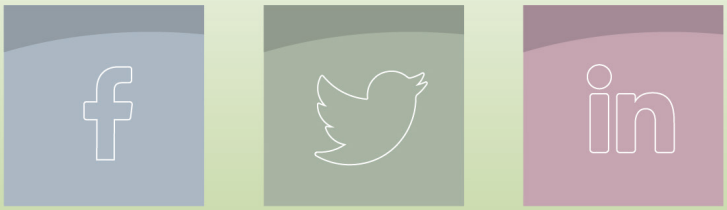

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