

NCPS Mission: To continuously improve the safety and quality of healthcare delivery in the region.

NCPS Update: February 2025

A Message from the Patient Safety

Program Director

Carla Snyder, MHA, MT(ASCP), SBB, CPHQ



On January 10, 2025, the U.S. Department of Health and Human Services published their Strategic Plan for the Use of Artificial Intelligence. The plan's stated purpose is "mobilizing an approach to improve the quality, safety, efficiency, accessibility, equitability, and outcomes in health and human services through the innovative, safe, and responsible use of AI." The plan has recently been removed from the HHS website but may be found on at [Healthcare IT News](#). The plan outlined four ways HHS sought to accomplish their goal by focusing on four key goals across public health, care delivery, medical research and other areas:

- Catalyzing health AI innovation and adoption to unlock new ways to improve people's lives.
- Promoting trustworthy AI development and ethical and responsible use to avoid potential harm.
- Democratizing AI technologies and resources to promote access.
- Cultivating AI-empowered workforces and organization cultures to effectively and safely use AI.

With the recent changes in our U.S. presidential administration, it is unclear if their work will continue. Knowing that, I want to bring your attention one of the other groups I am aware of that is working to make the use of AI in healthcare safe. The American Medical Association is convening an Augmented Intelligence Governance Learning Collaborative. They have chosen to use the term "augmented" instead of artificial to emphasize AI's role in assisting and enhancing human intelligence, instead of replacing it. The AI governance learning collaborative will help participants build a framework for the implementation of AI that supports the ethical, equitable, responsible and transparent use of AI in practice. This collaborative is a part of the AMA STEPS Forward Innovation Academy and will run from April 2025 through November 2025. This collaborative supports participants at various stages of AI adoption in learning and sharing best practices for governance development or integration of AI into existing clinical technology governance structures. You may learn more about this collaborative and apply to be a member of the collaborative [here](#).

NCPS Shared Learning Resources

This month's Shared Learning Resource is a Patient Safety Brief reviewing the 2025 Top 10 Technology Hazards as determined by ECRI (an independent, non-profit organization whose purpose is to improve the safety, quality, and cost-effectiveness of care across all healthcare setting). This year's #1 hazard is ***Risks Associated with AI-Enabled Health Technologies***. AI and its potential use in healthcare has been highly researched, debated, and discussed in the past 5-10 years. This Shared Learning highlights important items for any healthcare organization to review as they consider implementing AI into their workflows. The resource may be found on the NCPS website within the members only section of the [Educational Resources tab](#).

Legal Update

AQIPS Litigation Counsel 1st Quarter Meeting

Thursday, March 13, 2025 12noon - 1pm CST

Current administrative actions, court cases and orders, and statutory interpretation will be discussed. Robin Nagele and Beth Ann Jackson of Post & Schnell, P.C. will join in leading the discussion with Peggy Binzer, Executive Director of the Alliance for Quality Improvement and Patient Safety. Join the meeting by pasting this link into your browser:

<https://aqips.my.webex.com/aqips.my/j.php?MTID=m680d6bf45998d159603a80d09ba8d831>

Learning Opportunities for NCPS Members

Staying on Top of Medication Safety 2025 Webinar

Wednesday, February 19, 2025 12noon - 1pm

In this session, Matthew Grissinger, RPh, FISMP, FASCP, Director of Education at the Institute for Safe Medication Practices and PSQH Editor-in-Chief Jay Kumar discuss how healthcare organizations can improve medication safety in 2025. Register [here](#).

The National Action Alliance Safety Culture Webinars

Psychological Safety (Session 1), Feb. 18, 11am - 12noon CST

Teamwork and Patient Safety Norms (Session 2), March 18, 11am - 12 noon CST

Measuring and Responding (Session 3), April 15, 11am –12 noon CST

Register by clicking on the session title.

Patient Safety Resources

"What Else Could It Be?" A Scoping Review of Questions for Patients to Ask Throughout the Diagnostic Process

Over 75% of diagnostic errors in ambulatory care result from breakdowns in patient-clinician communication. Most patient question guides focus on later stages of diagnosis, such as treatment plans and outcomes, rather than the critical early steps when diagnostic errors often

occur. This study funded by AHRQ, underscores the importance of empowering patients to ask relevant questions throughout the process. Doing so early in the process allows for symptoms to be clarified or potential misdiagnoses identified more immediate. This paper from the Journal of Patient Safety may be found [here](#).

Promoting Medication Safety for Older Adults Upon Hospital Discharge: Guiding Principles for a Medication Discharge Plan (MDP)

Older adults are at risk of adverse drug events during transition of care from hospital to community. Optimal communication about medications at discharge is essential. These Canadian researchers sought to create standardized MDP based on consensus-based principles, to create a short-version of MDP, and to generate a practical guide. These all are tools that will assist implementation of MDPs when older adults are discharged from hospital. The paper may be found [here](#).

Surveys Show Mixed Results on Patient and Workplace Safety Culture in Hospitals

New results from AHRQ's Surveys on Patient Safety Culture® (SOPS®) program indicate patient safety culture within hospitals improved in several areas from 2022 to 2024, particularly related to teamwork and among supervisors, managers or clinical leaders. Established in 2001, AHRQ's Surveys on Patient Safety Culture Program conducts activities to understand, measure and improve patient safety culture in healthcare settings. This is also a service offered by NCPS. Please contact Emily Barr at embarr@unmc.edu for information regarding how NCPS can help you conduct such a survey in your organization.

For more information about NCPS and the services we offer, please contact Carla Snyder MT(ASCP)SBB, MHA, Patient Safety Program Director at: carlasnyder@unmc.edu

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