



Building a Safer System: The Role of Culture, Trigger Tools, and AI Webinar Toolkit

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Welcome to Our Webinar

Building a Safer System: The Role of Culture, Trigger Tools and AI

Featured Presenter



Hayley Burgess, Pharm.D., MBA, BCPP, CPPS

Senior Vice President, Provider Surveillance and Safety, Inovalon

Dr. Burgess provides leadership oversight and strategic vision for Inovalon's Care Management clinical team and supports technology innovations and SaaS product development. Dr. Burgess was the Chief Operating and Clinical Officer for VigiLanz Corporation, a SaaS clinical surveillance workflow solution, and led the team during the acquisition by Inovalon.

Dr. Burgess received her Doctor of Pharmacy degree from Samford University. She completed a post-doctoral residency and clinical science research fellowship in Neurobiology and Psychiatric Pharmacology/Pharmacoeconomics at the University of Texas Health Science Center, and a Healthcare Studies Abroad program in London, England. She holds a Master's in Healthcare Business Administration and is a Board-Certified Psychiatric Pharmacist and a Certified Professional in-Patient Safety.

Agenda

- 1 State of Patient Safety
- 2 Real-World Impact: Rethinking Patient Safety
- 3 Electronic Rule-Based Triggers
- 4 Panel Discussion
- 5 Best Practices & Next Steps

Featured Presenter



Chris Emerson, Pharm.D.

VP, Clinical Quality, Training, Oversight,
and Innovation, Inovalon

Chris has over 15 years of pharmacy and healthcare experience. He joined VigiLanz, now an Inovalon solution, in 2014, and today, he works closely with product management on the design and testing of new products and features.

Prior to Inovalon, Chris completed a PGY-1 Pharmacy Practice Residency at the VA New York Harbor Healthcare System in New York City. After his residency, he was an Assistant Professor of Pharmacy Practice at the Arnold & Marie Schwartz College of Pharmacy and Health Sciences, Long Island University for three years before moving to Lenox Hill Hospital in New York as the Manager of Pharmacy Informatics.

Featured Presenter



James M. Hoffman, Pharm.D., MS, FASHP

Senior Vice President - Quality and Safety, and
Member, Department of Pharmacy and
Pharmaceutical Sciences, St. Jude Children's
Research Hospital, Memphis, TN

James M. Hoffman PharmD, MS, is Senior Vice President-
Quality and Safety and a faculty member in Pharmacy and
Pharmaceutical Sciences at St. Jude Children's Research
Hospital in Memphis, Tennessee. He provides oversight and
leadership for quality and patient safety across St. Jude. He is
devoted to implementing pharmacogenetics as a patient
safety strategy, and he has extensive experience with the
intersection between pharmacogenomics and electronic
health records.

Section 1 

State of Patient Safety

State of Patient Safety

*"Adverse events were identified in nearly one in four admissions, and approximately one fourth of the events were preventable."*¹

*"Patient safety is a relentless, never-ending quest to put patients first."*²



1. Bates DW, Levine DM, Salmasian H, et al. The safety of inpatient healthcare. N Engl J Med 2023;388:142-53.
2. Binder L, President and CEO, The Leapfrog Group (Spring 2025 Hospital Safety Grades report)

Top Patient Safety Risks: ECRI 2025 Highlights

- Diagnostic Errors in Infections & Critical Events
 - Missed or delayed recognition of infections, sepsis, or strokes due to fragmented data, poor communication, and failure to follow up on abnormal results.
- Healthcare-Associated Infection (HAI) Outbreaks
 - Outbreaks persist in long-term care and hospital settings, driven by staffing shortages, IPC practice breakdowns, and slow surveillance response.
- Patient Discharge Coordination Failures
 - Disorganized transitions cause medication errors, readmissions, and patient confusion due to unclear instructions and lack of timely follow-up.
- Dismissing Patient, Family & Caregiver Concerns (Medical Gaslighting)
 - Clinicians unintentionally invalidate patient symptoms, leading to misdiagnoses, delayed care, and loss of trust.



Top 10 Patient Safety Concerns 2025



Top 10 Patient Safety Concerns 2025

This annual report from ECRI and the Institute for Safe Medication Practices (ISMP) highlights the 10 most pressing patient safety challenges facing the healthcare industry in 2025. Leveraging ECRI and ISMP's data-driven research and expert insight, the report discusses critical areas that healthcare leaders should consider as opportunities to minimize preventable harm. Some are emerging issues, while others are persistent yet unresolved. However, all represent areas where impactful change is possible.

This list serves as a strategic guide for implementing proactive, system-wide solutions aimed at reducing risk and improving patient outcomes across the healthcare spectrum.

The List for 2025

1. Risks of Dismissing Patient, Family, and Caregiver Concerns
2. Insufficient Governance of Artificial Intelligence in Healthcare
3. The Wide Availability and Viral Spread of Medical Misinformation: Empowering Patients through Health Literacy
4. Medical Error and Delay in Care Resulting from Cybersecurity Breaches
5. Unique Healthcare Challenges in Caring for Veterans
6. The Growing Threat of Substandard and Falsified Drugs
7. Diagnostic Error: The Big Three—Cancers, Major Vascular Events, and Infections
8. Persistence of Healthcare-Associated Infections in Long-Term Care Facilities
9. Inadequate Communication and Coordination during Discharge
10. Deteriorating Community Pharmacy Working Conditions Contribute to Medication Errors and Compromise Patient and Staff Safety

More Tools for ECRI's Top 10 Patient Safety Concerns 2025

- [Summary](#)
- [Customizable Risk Map](#)

©2025 ECRI. May be downloaded for internal educational purposes only at the following link: <https://www.ecri.org/pressroom/newsroom/2025-top-10-patient-safety-concerns>

ecri@ecri.org | 2

POLL QUESTION 1

What is Your Biggest Barrier to Improving Patient Safety?

- A Lack of timely access to safety data
- B Staff burnout and workforce shortages
- C Leadership does not prioritize patient safety
- D Siloed departments and poor collaboration
- E Limited training on safety best practices
- F Outdated or manual reporting systems



Section 2 

Real-World Impact: Rethinking Patient Safety

Rethinking Patient Safety in 2025



Switch to **“safety”**, not just “patient safety”



Safety isn't just avoiding harm—it's **building resilience and adaptive capacity**



Driving change requires a new mindset from quality and safety leaders

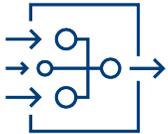
Find the Gaps. Understand the Risks

Identify problems and understanding risk across your health system.



Event detection forms a foundation

Event detection highlights patterns, root causes, and process breakdowns – need both passive and active surveillance



Other proactive methods to understand how work is actually performed

Proactive risk assessment is evolving and technology can support



Bridging the Urgency-Readiness Gap in AI Transformation

98% of surveyed organizations reported an increased urgency to deploy AI, yet only 13% felt fully prepared

Now is the time to:

- Advocate for clear governance and cross-functional alignment
- Pilot safe, transparent AI tools (e.g., rules-based triggers, early warning systems)
- Shift from reactive reporting to proactive risk mitigation
- Position AI as a force multiplier with clinical expertise

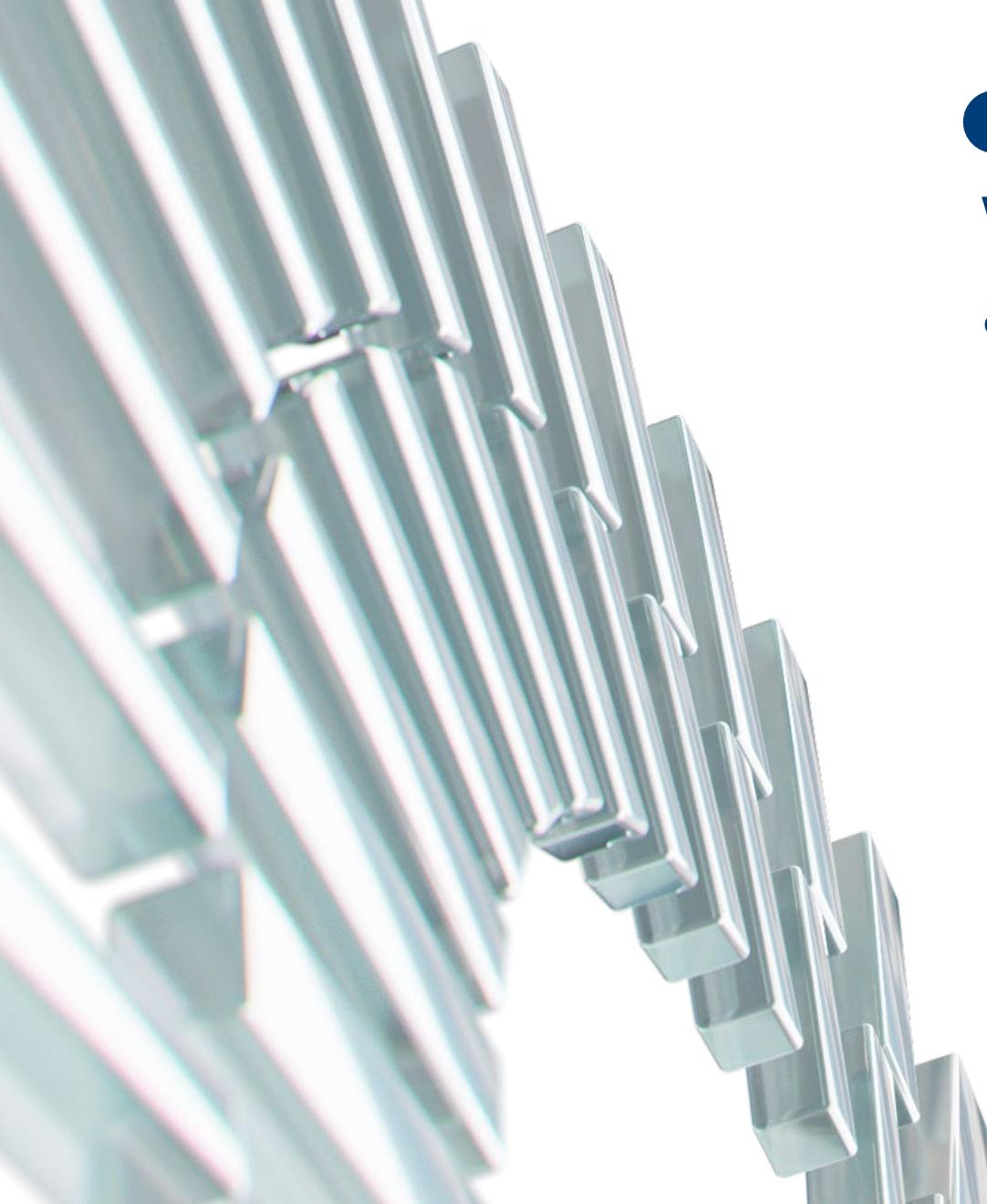
AI isn't the future; it's the now.

Healthcare must clear cultural and operational hurdles to ensure it's safe, scalable, and centered on patient outcomes.

The Role of Technology in Quality and Safety

- Technology is essential for simplifying routine safety and quality efforts.
- AI can be an essential tool for routine quality and safety work.
- AI's impact on routine quality and safety is just beginning.





POLL QUESTION 2

What is the Biggest Opportunity for AI and Safety Event Reporting?

- A** Detecting events that staff may miss
- B** Reducing reporting burden on clinicians
- C** Identify patterns and trends across systems
- D** Driving near-real time interventions, not just documentation
- E** We are still determining how AI fits into our strategy

Section 3 

Electronic Rule-Based Triggers

Auto-detecting safety events using rules to automate workflows and increase reporting

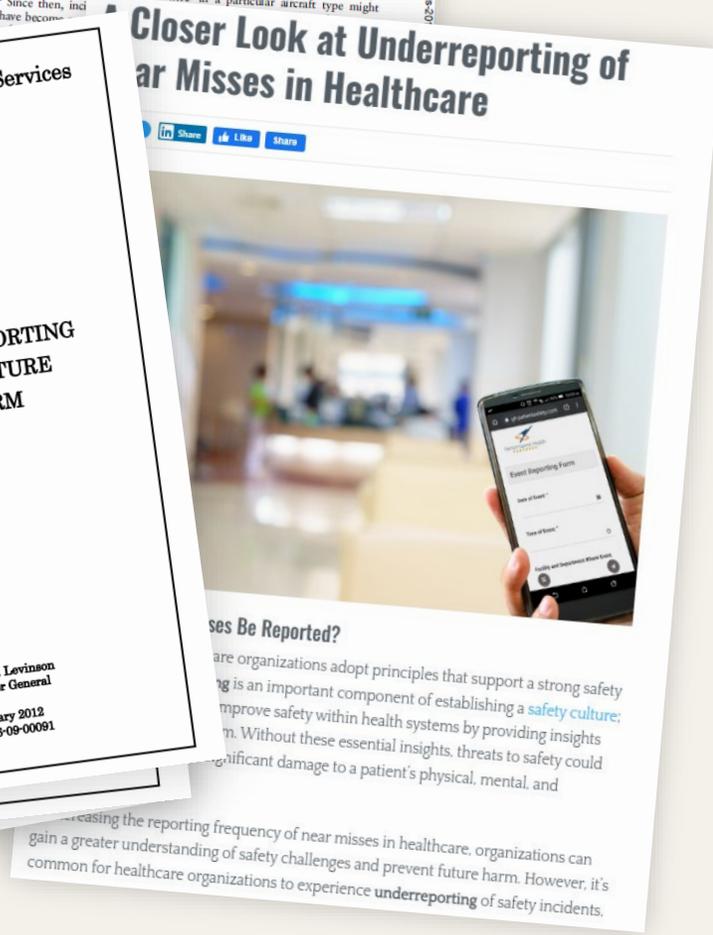
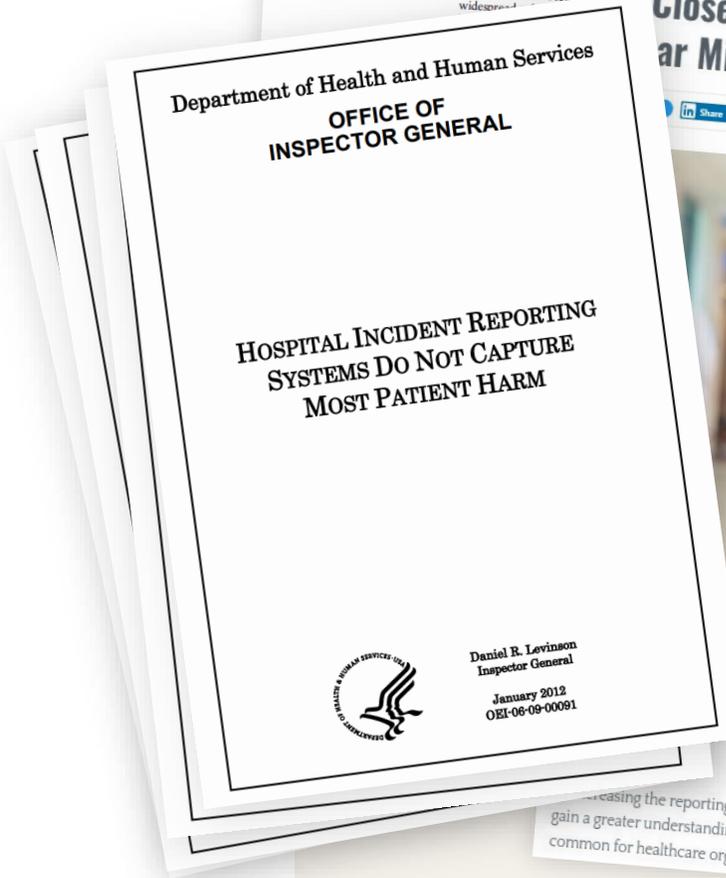
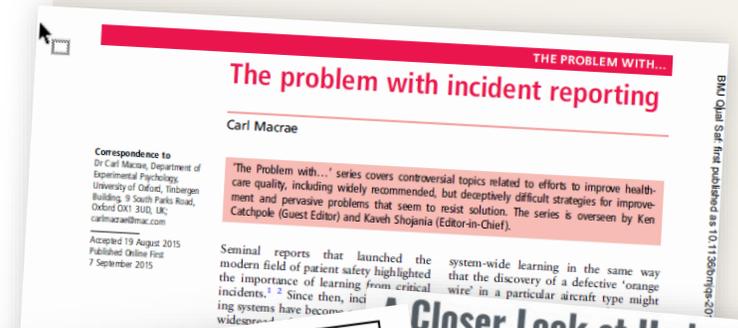
Why It Matters

Approximately 50-80% of medical errors go unreported in the US ^{1,2}

Under-reporting of patient safety incidents reduces healthcare's ability to quantify and accurately measure harm reduction.

The root cause:

Recent studies show the key reason ADEs went unreported was **due to staff lack of understanding about what should be reported.**



1. Noble DJ, Pronovost PJ. Underreporting of patient safety incidents reduces health care's ability to quantify and accurately measure harm reduction. *J Patient Saf* 2010; 6:247-50.
2. Levinson, DR. Hospital Incident Reporting Systems do not capture most patient harm. OIG. <https://oig.hhs.gov/oei/reports/oei-06-09-00091.pdf>

Auto-Detection With Rule-Based Triggers

A review of the process of identifying safety events that have occurred using software algorithms and/or rules engines ...



Rule **created in background**
to ID potential event



Rule **populates** safety
event reporting platform



Clinician auto-assigned
for investigation

Comparative Analysis of ADEs

Auto-Detection vs. Manual Reporting

19

Hospitals across 4 regions

21

Electronic trigger scenarios

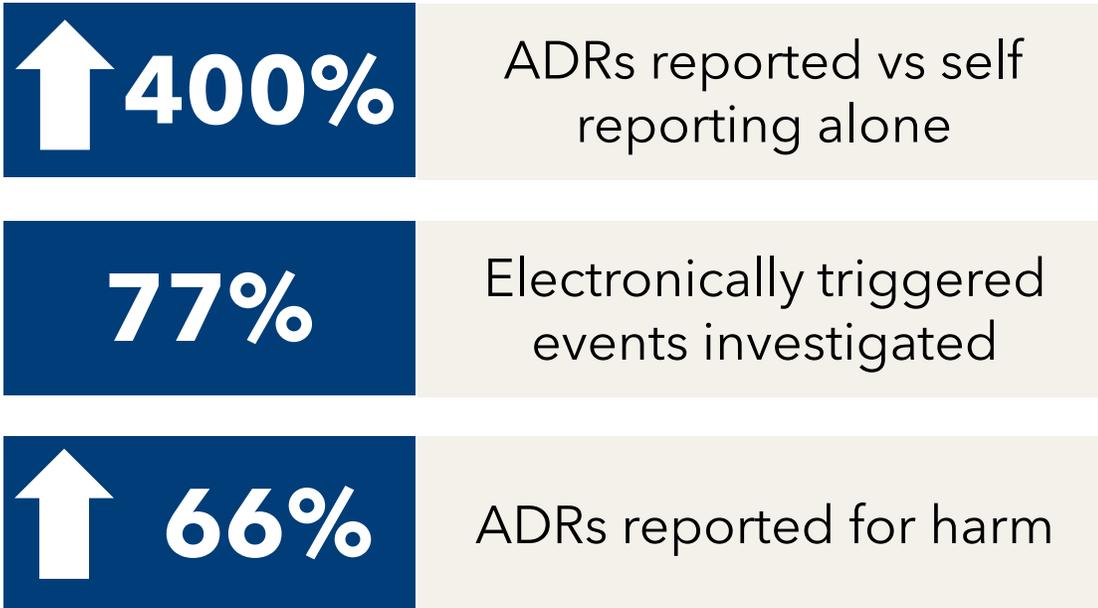
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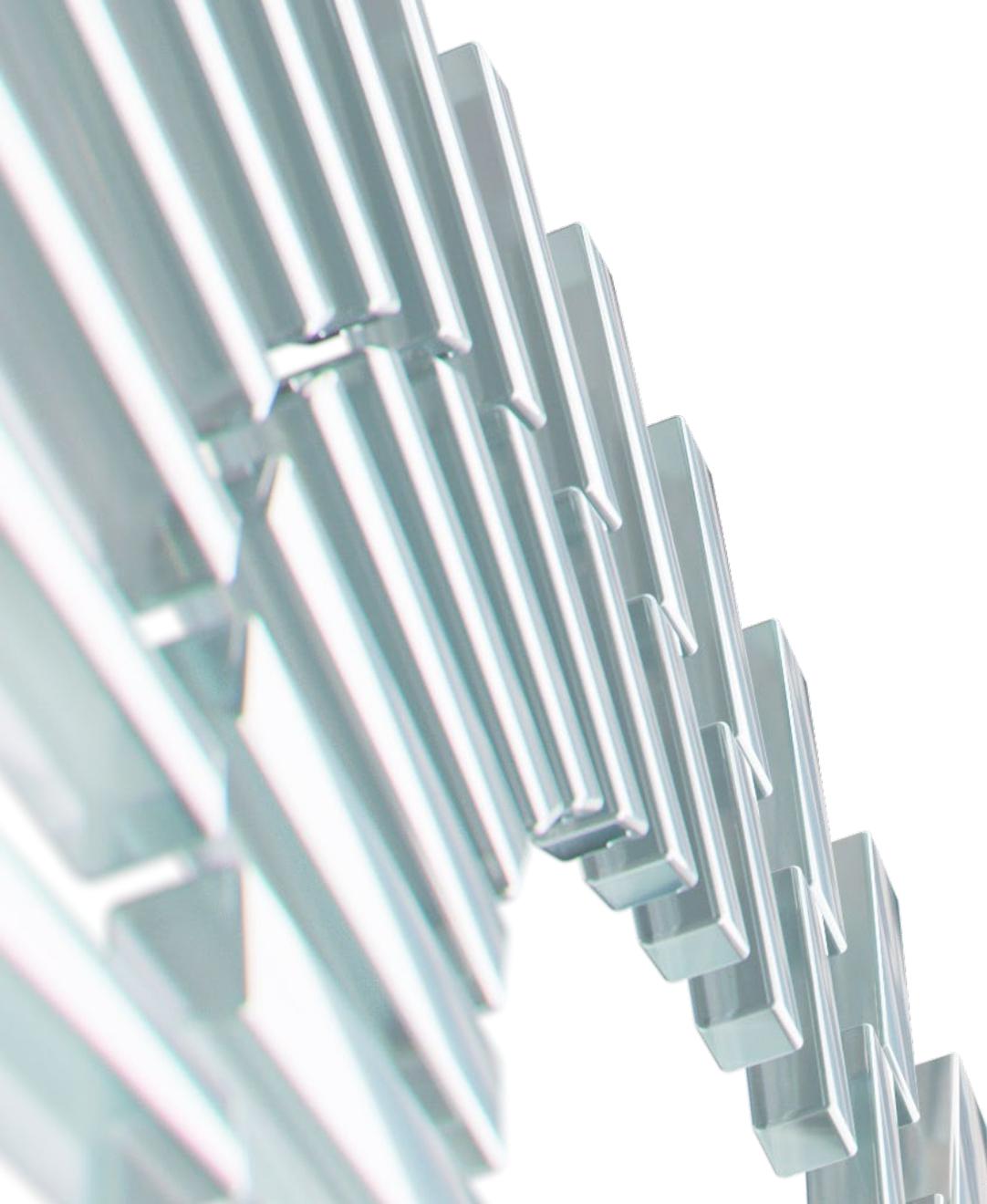
Events per month auto-routed per site for investigation



Awareness

Auto-Detection Results





POLL QUESTION 3

Does Your Organization Use Electronic Triggers for Safety Events?

- A** We use electronic triggers routinely and have integrated them into workflows
- B** We're in the early stages of exploring or piloting electronic trigger tools
- C** We rely mostly on manual reporting and are not yet using electronic triggers
- D** We are new to this topic
- E** Not sure

Section 4 

Panel Discussion

Making the Case for Quality: ROI-Q Findings from NAHQ

NAHQ report quantifies the return on investment in quality (ROI-Q), demonstrating measurable financial and clinical outcomes.

- 50% reduction in serious safety events (CHRISTUS Health)
- \$6.5M in cost avoidance over 2 years (Kaiser Permanente NCAL)
- ROI-Q validates that reducing preventable harm is not just clinically vital, but financially rewarding
- Trigger tools and AI-powered surveillance solutions, like those featured today, are essential components of a modern quality infrastructure

****The takeaway:** Clinical surveillance, advanced analytics, and focused dashboards paired with workforce competency enhancement is a proven path to better outcomes, safer care, and measurable ROI.



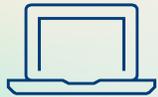
ROI-Q REPORT

New report quantifies the return on investment for quality (ROI-Q) demonstrating that investing in workforce development drives improved clinical and financial outcomes

Thank you



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WHITE PAPER

Enhancing Patient Safety with **Electronic Trigger Tools**

The Hospital's Guide



Executive Summary

The current state of patient safety in the United States is reflective of both incredible progress and significant challenges. While advancements have been made in recent years, studies continue to highlight the prevalence of adverse events and medical errors in hospitals, indicating that preventable harm still occurs far too frequently. The importance of improving patient safety is a growing priority for health system leaders — and effective safety event reporting systems can help.

Event reporting systems are crucial for health systems aiming to establish and cultivate a robust culture of safety. By helping to track, collect, manage, and analyze safety events as well as to understand the root causes of harm, these systems can significantly improve patient safety and decrease risks. They also can identify safety gaps within the hospital and across the organization.

Most event reporting systems require manual event documentation by staff members, but the most effective solutions use electronic trigger tools to automatically identify potential adverse events and errors. Also known as automatic event detection, or “autodetection,” this groundbreaking technology expands on human reporting activities by using data from the electronic health record (EHR) to automatically identify safety incidents that may otherwise have been missed. Not only does this improve the accuracy and completeness of documented events, but it overcomes common event reporting barriers and empowers health systems to capture more events, learn from them, and reduce risk.

[VigiLanz Safety Management](#), an Inovalon solution, is the only offering on the market currently leveraging automated event detection. This guide further explores its benefits, discusses why every hospital should deploy it, and shares how one innovative health system is using this software to enhance patient safety.

What are safety event reporting systems?

Safety event reporting systems are used by forward-thinking inpatient and outpatient healthcare facilities to capture adverse events, near misses, medical errors, and other incidents that compromise patient, staff, or visitor safety. By collecting and analyzing this data, hospitals can implement targeted interventions, enhance patient safety protocols, and proactively prevent future occurrences of harm.

Traditionally, these systems rely on manual detection and reporting processes that require healthcare staff to personally input safety incidents into the system for review.

What are electronic trigger tools?

Electronic trigger tools are advanced features of effective safety event reporting systems, defined as the automatic identification of potential adverse events that may otherwise have gone unnoticed or unreported. These events are then automatically documented in the safety event reporting system for staff to review.

When used in combination with manual event reporting, electronic trigger tools provide an additional layer of protection for both patients and clinicians by ensuring that more events are captured. As a result, health systems have a more accurate understanding of their overall safety performance, and can put better strategies in place to prevent future harm.

Why are these tools so important?

In many hospitals, the only method used to capture and report safety events is manual reporting. However, because of common barriers — such as forgetting to report or fear of negative consequences — only 10-20% of safety events are ever reported, resulting in alarming hospital safety gaps.

Other common drawbacks of relying solely on a manual approach for event reporting include:

- Less information captured when rushed staff members document events
- Delayed reporting, due to lack of urgency if staff members considered the event to be minor
- Lack of documentation due to confusion over reporting responsibilities or misunderstandings about what events should be reported

Electronic trigger tools help address all of these problems. They ensure more events are documented sooner and more thoroughly.

How do electronic trigger tools work?

By continuously monitoring real-time patient information inside the EHR, automated event detection software searches this data for concerning patterns, trends, and anomalies that may indicate a safety event has occurred. Inovalon works with clinical leaders to create customized safety event triggers, often referred to as rules, that are tailored to the organization's preferences. As a result, each event that is automatically detected and documented is highly relevant and meaningful to the health system.



Automated event detection can be extremely helpful in terms of finding more events. The better sense you have of how many events there actually are, the better you can do in terms of managing safety going forward.”

David Westfall Bates, M.D.

Medical Director of Clinical and Quality Analysis, Mass General Brigham and Chief of General Internal Medicine, Brigham and Women's Hospital

Automated Event Detection in Action: A CHRISTUS Health Case Study

About CHRISTUS Health

[CHRISTUS Health](#) is an international Catholic, not-for-profit health system comprising more than 600 centers, including community hospitals, urgent care centers, health insurance companies, and physician clinics in Texas, Louisiana, New Mexico, and Latin America. With more than 45,000 team members and more than 15,000 physicians providing individualized care, CHRISTUS aims to deliver a complete healing experience that respects every individual.

Challenge

Adverse drug events (ADEs) represent a significant, and often avoidable, problem in United States healthcare. ADEs cause approximately 1.5 million emergency department visits annually, and about 500,000 of those patients need to be hospitalized for further treatment¹ – yet it's estimated that half of ADEs in the U.S. are preventable.²

Often, when these events do occur, they are either unreported or lack critical details and context. This makes it difficult for quality, safety, risk management, and other teams to document, analyze, and prevent similar events from occurring in the future.

While many hospitals have patient safety event reporting processes and procedures in place, many lack automated event detection capabilities to make the event reporting faster, easier, and more accurate.

Solution

CHRISTUS implemented VigiLanz Safety Management, which automates the management, reporting, and detection of safety events. This patient safety software integrates clinical data from multiple sources with comprehensive detection and investigation tools. For example, the software monitors EHR data — including data related to patient demographics, medication orders, medication administrations, lab results, radiology notes, and vital signs — and documents triggered events based on CHRISTUS-defined safety event criteria. This makes it easier for CHRISTUS to quickly identify, manage, address, and prevent adverse drug events.

Key Benefits



Improved efficiency, accuracy, and completeness of events reported



Ability for patient safety teams and claims managers to intervene quickly



Safety events recorded in near real-time



More comprehensive capture of safety events

CHRISTUS team members can also use the solution to quickly document and self-report safety events through customizable forms, mobile access, mandatory fields, and anonymous reporting. The solution includes:

- Patient safety event reporting analytics and investigative tools that can be used within specific departments, sites, and across the organization.
- Customizable and automated email notifications and automated escalations to ensure timely reviews and management.

Results snapshot:

400%

increase in ADRs reported with auto-detection compared to manual reporting

7X

more ADRs identified in facilities with auto-detection than facilities that identified ADRs via voluntary reporting

<77%

of auto-detected ADEs leading to investigation and analysis

66%

overall increase in ADRs reported for harm categories with auto-detection compared to manual reporting



Automated event detection saves us a significant amount of time, and gives us more peace of mind that more events are captured. As a result, we can now spend more time analyzing events and identifying improvement opportunities.”

Tina Collins, PharmD

Corporate Director of Medication Safety at the Division of Clinical Excellence and CHRISTUS Health

Outcomes

Over an 18-month period, CHRISTUS deployed 21 surveillance rules to auto-detect ADEs. This led to a 400% increase in ADRs reported compared to manual reporting.

CHRISTUS facilities with VigiLanz Safety Management identified 8.7 times more ADRs than facilities that relied on voluntary reporting. In addition, more than 77% of the auto-detected ADEs led to an investigation – a testament to the accuracy of the software’s rules.

CHRISTUS saw a 66% overall increase in ADRs reported for harm categories (including mild harm, moderate harm, severe harm, and death) with auto-detection compared to manual reporting. Auto-detection also identified 4.8 times more near-miss ADRs, 2.3 times more moderate-harm ADRs, and 1.6 times more mild-harm ADRs as compared to manual reporting.

“Our number of reported events is increasing due to automated event detection and reporting,” said Collins. “The technology, which is now used across all of our hospitals, ensures we’re capturing more events and gathering more insights.”

Sources

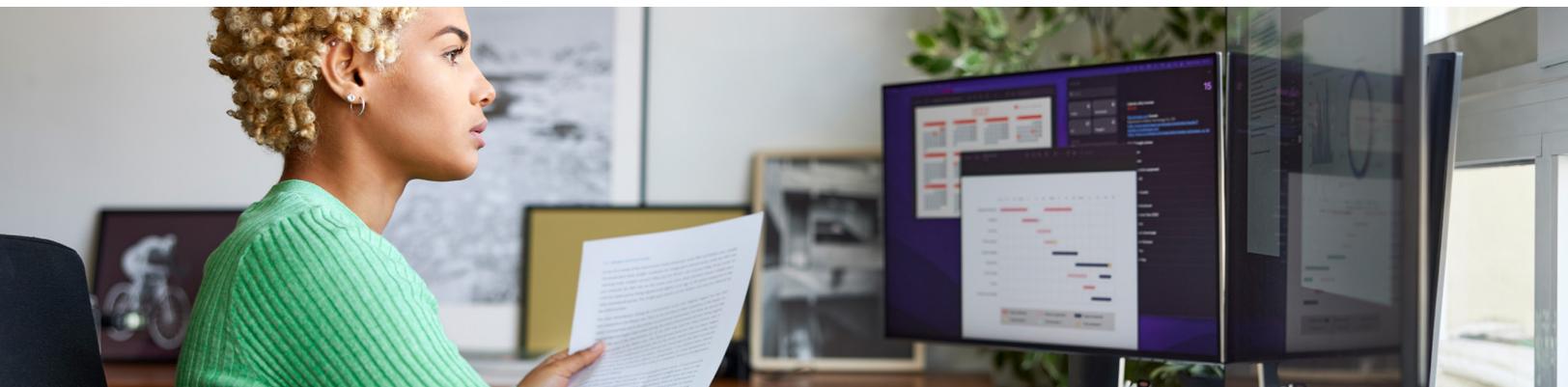
1. FastStats: Medication Safety Data, U.S. Centers for Disease Control and Prevention, April 17, 2024, <https://www.cdc.gov/medication-safety/data-research/facts-stats/index.html>.
2. Medication Errors and Adverse Drug Events, Patient Safety Network, September 7, 2019, <https://psnet.ahrq.gov/primer/medication-errors-and-adverse-drug-events>.

What other capabilities should hospitals look for when evaluating safety event reporting systems?

While automated event detection is crucial to effective safety event reporting, health systems should watch for other key capabilities when evaluating event reporting solution partners.

Two of the most important functionalities to seek out in a solution include event form auto-population in addition to advanced analytics and reporting tools. While many safety event reporting solutions might claim to have these capabilities, it's very important during evaluations to assess the depth of functionality that is truly built into the tool.

- 1. Form auto-population.** As noted, automated event reporting systems use various data feeds to detect safety events. A similar approach can be used to streamline documentation for staff members when they are manually reporting events. With form auto-population, standardized and normalized data are pulled in real-time from data feeds while staff members are documenting events. This significantly reduces staff time spent filling out forms and enhances reporting accuracy.
- 2. Advanced analysis and reporting tools.** While automated event detection and form auto-population are critical to ensuring safety events are identified quickly and documented properly, these capabilities are also key to enabling quick and thorough investigation and analysis of safety events. Since organizations without automated detection and auto-population tend to capture fewer events and fewer details related to events, their reporting and analytics platforms are working with incomplete data. That means these organizations are missing key safety trends and improvement opportunities. When automated event detection is used in tandem with a robust set of reporting and analysis tools — such as timelines, cause mapping, solution maps, and fishbone diagrams — hospitals can identify more safety events and safety trends quickly. This helps them intervene faster to prevent future problems.



The leader in data-driven patient care

For more than 20 years, VigiLanz solutions have helped hundreds of healthcare institutions dig deeper into their data to streamline their operations, prevent adverse events, and optimize patient safety. Now part of Inovalon, our safety management software is the only solution on the market currently utilizing both voluntarily reported and automatically detected safety incidents to help health systems gain visibility into the true state of patient safety inside their institutions. Our auto-populating forms, comprehensive reports, and detailed analysis tools additionally give leaders the information they need to effectively improve safety, reduce costs, and optimize care.

To learn more about how Inovalon can help your health system automatically identify and capture more safety incidents to build a robust culture of safety, [contact us](#) to request a demo today.

About us

Inovalon is a leading provider of cloud-based SaaS solutions empowering data-driven healthcare. The Inovalon ONE® Platform brings together national-scale connectivity, real-time primary source data access, and advanced analytics into a sophisticated cloud-based platform empowering improved outcomes and economics across the healthcare ecosystem. The company's analytics and capabilities are used by nearly 20,000 customers supporting more than 53,000 sites of care. For more information, visit www.inovalon.com.

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BUYER'S GUIDE

2025 Safety Event Reporting

How to Choose the Right Safety Event Reporting System

Your guide to enhancing care and reducing risks in healthcare facilities

Implementing an effective safety event reporting system is a vital strategy for inpatient and outpatient facilities seeking to enhance care and decrease risks. These systems help quality, safety, and other teams maintain compliance with regulatory requirements through the efficient documentation and management of safety events. They also support a culture of continuous improvement by helping staff, clinicians, and leadership identify gaps within key departments

and across the organization, so that better strategies can be put in place to prevent future harm and improve patient outcomes. However, not every safety event reporting system is equally effective. This guide is designed to help your healthcare facility evaluate solutions and find an innovative system that empowers your staff and protects your patients. Here, you'll find the critical features and functions that make up a strong safety event reporting system.



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Integration, Implementation, and Training

Your facility's safety event reporting system should never become a burden for employees or IT staff. Seamless integration, easy implementation, comprehensive training, and timely support are key.

1 Integration

The system should integrate with your electronic health record (EHR), and it should be able to leverage multiple types of data — including patient demographics, medication orders, pharmacy orders, and lab results.

2 Configurability

The system should adapt to your processes and workflows, providing tailored event forms and enabling automated notifications and communication processes that align with your desired workflows.

3 Security

The system should adhere to current industry security standards, including data encryption in transit and at rest, role-specific privileges, compliance with third-party security attestations, and providing security audit reports. It should also undergo vulnerability and penetration testing multiple times per year from a reputable outside firm.

4 Accessibility

The system should be accessible via approved mobile devices, and it should support mobile viewing without requiring an app download. That way, staff can easily document and review events when they are connected to the network.

5 Training

The system's training program should include free live and on-demand training modules to ensure optimal use by existing staff and new staff. Role-based training should be provided to administrators (who manage and oversee the event reporting process) and investigators (who investigate events). Training materials should also be available to reporters (staff who report safety events), so everyone can report events appropriately.

6 Support

The system should provide a healthcare-experienced service and support team, including a main point of contact who rapidly responds to inquiries and requests. This contact should answer questions; assist with building custom forms, charts, and reports; and help explore additional capabilities when new needs arise.



Electronic Triggers for Safety Events

Also known as automatic event detection, electronic triggers reduce the likelihood of missed safety events, ensure a faster response, and decrease time spent entering data.

1 Automated identification

The system should leverage automatic safety event detection to provide a comprehensive capture of safety events that are occurring, potentially increasing capture of those events healthcare workers are most resistant to reporting. Automated detection results in fewer missed or unreported events for reasons such as staff forgetting to report, staff not reporting due to fear of punitive action, or staff failing to report in a timely manner. To enable this functionality, the system must be able to monitor EHR data — including data related to patient demographics, medication orders, medication administrations, lab results, radiology notes, and vital signs — and trigger events based on defined criteria.

2 Automated alerts

The system should enable the implementation of automated event routing or notifications when certain events are detected, providing opportunities for real-time conversations between safety team members and front-line workers.

Automated Event Detection In Action

The event reporting platform should use several criteria for automatic detection. For example, if the following criteria are met for Narcan, it should document a safety event automatically:

1. Narcan is administered to a patient who recently received morphine.
2. The patient has evidence of respiratory depression via a decrease in respiratory rate or oxygen saturation.
3. The patient is not currently located in a procedural area where the use of Narcan is more routine.





Health systems increasingly recognize that they must find ways to intervene more quickly when safety events occur. The longer the delay in intervention, the more likely it is a similar event will occur again. **Automated event detection and alerts keep patients safer because interventions can be made faster.”**

—Karen Biesack,
Senior Application Support Analyst,
Inovalon



Event Reporting

Configurable reporting forms, pre-populated data, and intelligent fields minimize time spent capturing events and enhance reporting accuracy.

1 Configurable forms

The system should provide forms tailored to your organization upon implementation with the ability to make adjustments as needed. This ensures it can quickly meet evolving needs and requirements.

2 Mandatory form fields

The system should enable easy configuration of mandatory fields within reporting forms, ensuring no critical information is missed.

3 Anonymous reporting

The system should have the option to enable anonymous reporting for all events or for specific types of events. This reduces the risk of undocumented events due to concerns among staff about punitive action.

4 Auto-populated demographic data

The system should automatically populate form fields with relevant patient and staff data to streamline reporting and enhance accuracy. Forms should take no more than five minutes to complete.

5 Intelligent field population

The system should dynamically adjust which fields are visible in the form as reporters enter information — creating a more intuitive, streamlined process to enter event details. For example, the “Name of Provider Notified” field should only appear after the user indicates that “Yes,” a provider was notified.

6 Smart logic

The system should use smart logic and analytics for keyword recognition to detect words and phrases and then associate them with a standardized table of risk terms. This enhances accuracy and grants visibility to key risk factors within the organization.

7 Attachments

The system should enable reporters to attach files — such as photos, videos, pdfs, audio, and more — to forms. This ensures all supporting information can be included with the event, and makes it easy for administrators to access it when needed.

8 Location- and facility - specific tags

The system should include a searchable location feature that makes it easy for reporters to associate events with specific facilities and locations. This streamlines reporting and enhances accuracy.

“ My mantra throughout this process has been that it only takes 30 to 60 seconds to enter a risk event — it all depends on how fast you type.

— Kerrie Griffin
Director of Ambulatory Quality Management,
CHRISTUS Health



Event Communication

Strong safety event communication ensures gaps are identified and addressed as quickly as possible — and that no information slips through the cracks.

1 Automated event routing

The system should automatically assign safety events to pre-defined investigators based on location, event type, and severity, as well as issue automated email notifications. This streamlines workflows and supports timely investigations.

2 Automated email confirmation

The system should send automated email confirmations to users who complete reports so they know the event is being handled and investigated.

3 Automated event escalation

The system should automatically escalate events based on customized alert thresholds and protocols to ensure your investigation guidelines are consistently followed. Automated event escalation should also inform safety investigators when the time frame for investigating a case has expired or is nearing expiration. Escalations should also be sent to reporters and managers when cases are saved but not submitted or when serious event classifications are entered.

4 Communication templates

The system should provide predefined email templates for notifying relevant team members about events. This streamlines and automates workflows.

5 Automated delivery of scheduled reports

The system should have the capability of automating scheduled report delivery for authorized users, creating efficiencies and saving time.

“ It’s been said that if you can’t measure it, you can’t manage it. [...] I think without knowing how much harm you have that’s caused by the various types of events, you can’t effectively do a good job in addressing the things that are most important at your institution.

— Dr. David Westfall Bates
Medical Director of Clinical and Quality Analysis, Mass General Brigham; Chief of General Internal Medicine, Brigham and Women’s Hospital



Event Analysis and Investigation

In order to foster continuous safety improvements, the system should make it easy to analyze and investigate safety event data.

- 1 Analysis tools**

The system should use event analysis tools to convert health data into intelligence that provides greater visibility into trends and gaps – helping leaders prioritize safety and quality initiatives and drive change. Tools should include timelines, cause mapping, solution maps, fishbone diagrams, the five whys, and gaps analysis. Additional review features should include options to create sentinel event reports, root cause analysis, and Joint Commission reporting forms.
- 2 Action plans and results**

The system should enable users to define event action plans and assign tasks to others, as well as the ability to measure the effectiveness of the action.
- 3 Report tracking**

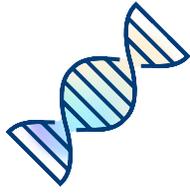
The system should enable certain users to review reported events, including current status and any details surrounding action plans.
- 4 Personalized dashboards**

The system should enable certain users to create personalized dashboards based on their needs (i.e., the data and charts most meaningful to them), and provide comprehensive graphical executive dashboards with presentation-ready visualizations. This makes it easy to share information with relevant individuals, departments, and leadership.
- 5 Enterprise-level reports**

The system should enable users to create and export tables, pivots, and charts to analyze data across the organization and at the location level.
- 6 Search features**

The system should enable quick searches for relevant information, including by name, MRN, Patient ID, event type, dates, keywords, locations, and open incidents. This improves efficiency for investigators and administrators.
- 7 Automated record documentation**

The system should automatically document activity associated with event records (including information related to event views, record opens, patient searches, and record changes). This ensures a proper chain of custody, including providing insight into when and why changes are made.



Scalability and Collaboration

The most effective safety event systems work with healthcare facilities as an extension of their clinical teams — adapting to meet expanding needs, delivering on new initiatives, and helping instill a culture of continuous improvement.

1 Expansive capabilities

The system should be designed to scale and adapt to evolving needs. For example, a system integrated into a larger platform of solutions provided by the same vendor — such as those that reduce organizational risk, manage compliance concerns and legal claims, improve patient relations and service recovery, and streamline audit processes — provides workflow and cost advantages to healthcare facilities.

2 Proven expertise

The vendor partner should provide references, case studies, and proof points that attest to their ability to support safety and quality objectives, such as those related to antimicrobial stewardship, sepsis, and medication errors. Industry recognition from organizations such as KLAS also help differentiate reputable and experienced vendors from the rest.

3 Comprehensive protection

The patient safety solution should integrate seamlessly with the EHR and work together with clinical surveillance software to protect both clinicians and patients. This integrated approach ensures organizations are well-informed about a wide range of events through data tracking, trend analysis, and insights into close calls or serious harm incidents — all without solely relying on frontline staff for reporting.

4 Collaboration

The vendor should explore new ideas and embark on new projects with their customers, and a wide range of references should attest to this attribute. The most effective vendors are nimble and dedicated to continually improving features and functionality, expanding the value they deliver.

“ Investing in synergistic technology in conjunction with EHRs to help clinicians prioritize their workflow by providing the right information to them at the right time prevents harm, improves safety, and is simply a good return on investment.

— Dr. Hayley Burgess
SVP, Provider Surveillance and Safety,
Inovalon

Get Ahead of Harm with Inovalon

VigiLanz Safety Management, part of Inovalon's suite of award-winning clinical surveillance tools ranked #1 by KLAS Research, is an innovative cloud software application that supports patient safety initiatives. The software provides a modern, configurable platform for identifying, reporting, managing, and communicating patient safety events.

By incorporating all of the features and functions listed in this guide, VigiLanz Safety Management enables inpatient and outpatient organizations to rapidly identify and analyze safety incidents, minimize time spent capturing and managing them, and promote a culture of safety while reducing adverse events.

Contact us to learn how partnering with Inovalon can help your institution get ahead of harm and make a difference in patient care.

Connect with our clinical experts today at [inovalon.com](https://www.inovalon.com).





About Us

Inovalon is a leading provider of cloud-based SaaS solutions empowering data-driven healthcare. The Inovalon ONE® Platform brings together national-scale connectivity, real-time primary source data access, and advanced analytics into a sophisticated cloud-based platform empowering improved outcomes and economics across the healthcare ecosystem. The company's analytics and capabilities are used by nearly 20,000 customers supporting more than 53,000 sites of care. For more information, visit www.inovalon.com.

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