# Patient safety, health IT and getting to the bottom of all-cause harm

## 10 articles at the intersection of patient care and technology

BECKER'S HOSPITAL REVIEW

HealthCatalyst
ignite outcomes improvement

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# Health Catalyst launches patient safety surveillance application and its federally-certified patient safety organization

BY STAFF

The Health Catalyst Patient Safety Monitor™ Suite: Surveillance Module solves the challenges confronting today's patient safety experts. Unlike the standard post-event reporting process, theSurveillance Module is a trigger-based surveillance system, enabled by the unique industry-first technological capabilities of the Health Catalyst® Data Operating System (DOS™) platform including predictive analytic models and AI.

The Surveillance Module quickly identifies patterns of harm and proposes strategies to eliminate patient safety risks and hazards for current and future patients. This potent combination of predictive analytics, text analytics and near real-time data from multiple sources enables thePatient Safety Monitor Suite to predict harm events and trigger a response while the patient is still in the hospital.

To further support hospitals' patient safety initiatives, the Health Catalyst Patient Safety Organization (PSO) creates a secure and safe environment where clients can collect and analyze patient safety events to learn and improve, free from fear of litigation. The patient safety suite, along with quality-improvement services and the PSO (which is listed with the Agency for Healthcare Research and Quality), turns the current paradigm on its head. Unlike other approaches to using analytics within a PSO to identify and address episodes of patient harm, the suite monitors triggers in near real-time to reveal whether a patient is currently at risk for a safety event, so clinicians can intervene to prevent it. It provides constant vigilance; no patient encounter goes unnoticed.

# The harm hospitals can't see: 6 questions with Health Catalyst's Valere Lemon

BY STAFF

Precision is integral to patient safety, yet hospitals' standard manual approach of reporting patient safety events has been shown to paint a less-than-accurate picture of the harm patients experience on a regular basis.

When hospitals rely on manual reporting of safety events, they are made aware of less than 5 percent of all-cause harm.

Before delving further into how hospitals' current reporting falls short, it is first helpful to understand the difference between medical errors and all-cause harm.

To distinguish the two concepts, Becker's Healthcare caught up with Valere Lemon, RN, MBA, a senior subject matter expert for Salt Lake City-based Health Catalyst who has also worked as a pediatric hematology/oncology nurse at two children's hospitals.

*Note: Responses have been edited lightly for length and clarity.*

**Question: What is the best way to distinguish medical errors from harm?**

**Valere Lemon:** Errors are still harm; they really aren't ...