THE JOINT COMMISSION
ON THE STRATEGIC SURVEILLANCE SYSTEM
AUGUST 16, 2007

CATHY BARRY-IPEMA: Welcome to today's telephone conference call with Joint Commission president Dr. Dennis O'Leary; Linda Murphy-Knoll, interim executive vice president for Accreditation and Certification Operations; and Carrie Mayer, associate director of Accreditation Systems Integration. I am Cathy Barry-Ipema, chief communications officer at The Joint Commission.

Dr. O'Leary, Linda Murphy-Knoll, and Carrie Mayer will give an update on the Strategic Surveillance System, which was launched for accredited hospitals on July 30. The goal of the S3 Initiative is to help organizations improve their care processes by focusing their efforts on strategic objectives. When the speakers' comments are concluded, we will take questions from the audience regarding S3.

Because of the large number of participants on today's call, we ask that you please limited yourself to one question and then put yourself back into the queue if you have additional questions. Also, please keep your phones on mute while listening to eliminate any background noise. And now, it is my pleasure to introduce Dr. Dennis O'Leary.

DR. DENNIS O'LEARY: On July 30, The Joint Commission officially launched its Strategic Surveillance System—or S3—for the hospital accreditation program. The goal of this initiative has been to help organizations improve their care processes by focusing on specific identified opportunities for improvement. S3 intends to provide a series of risk assessment and comparative performance measurement reports that can help organizations identify and prioritize these areas for improvement, thereby further enriching the value of Joint Commission accreditation.

This service is provided at no additional cost and its use is purely voluntarily. Probably the best way to look at these reports are as data rich management reports—the kinds of things that an auditor would provide to its customers. That's really what this is. These are management reports that are private and confidential between the auditor and the recipient.

That's simply by way of emphasizing that this is not public information. We do not intend to make this public in any fashion at any time in the future, and we would encourage all of you to treat it in the same fashion. Thank you.

LINDA MURPHY-KNOLL: Thank you, Dr. O'Leary. I'm going to take a moment to step back and review the process we've used to develop the PFP and ultimately S3. The priority focus tool was in development for approximately five years from 1999 through 2003, and ultimately launched in January 2004. At that time, it was simply a tool that the surveyors used to focus the onsite survey and that organizations used in a periodic performance review process.

During 2005 and 2006, we began to analyze the tool for statistical significance and found that the higher an organization’s point total, the greater their risk for receiving a conditional or preliminary denial of accreditation status on a survey. As we continued to verify the tool’s applicability to performance measurement and improvement, we began engagement and development activities for what is now the S3 tool.

We initially worked with 20 organizations to develop the vision, attempting to design a tool that would be useful to multiple types of staff from senior leadership to quality directors and beyond. We worked with organizations that were large, small, community-based, part of a system, and academic in their focus. This initial effort at design took about six months. We spent the next two years in development and testing, and finally the tool went live on July 30, almost three weeks ago .

We launched the tool for our hospital accreditation program customers with the goal of helping organizations to improve their care processes by focusing their efforts on strategic objectives. To that end, S3 provides a series of risk assessment and comparative performance measure reports that can help organizations identify and prioritize areas for improvement.

During the development and testing phase of S3 we worked with over 100 hospitals across the United States, perfecting the tool that you have today. These organizations helped us to assure that the tool, when delivered, would be easy to use and applicable in many types of organizations. We do believe this tool enriches the value of Joint Commission accreditation. We know that The Joint Commission has unique resources and capabilities to assist hospitals and hospital systems and their ability to view performance measurement from a macro and micro perspective with the goals of improving patient safety and the quality of care.

As performance expectations increase, so does the need to know how to use data that drives improvement. We believe S3 can be used to help hospitals improve quality, a demand that has been particularly pressing in recent years as a result of various public and private initiatives. Some of those initiatives include expanded public reporting of hospital performance measurement data and the infusion of a variety of private sector pay-for-performance programs.

Now, I'm going to ask Carrie to discuss the tool itself and some of the feedback we've received to date.

CARRIE MAYER: Thank you, Linda. What I would like to do now is quickly remind you all what S3 is and what it does. The first available tool within S3 is the performance risk assessment tool, and as previously mentioned, this tool does provide a series of risk assessment and comparative reports. It does this by taking various disconnected data sets and bringing them together to turn them into information about systems in clinical areas within a hospital.

The data used in S3 consists of internal Joint Commission data. For example, past survey finding data, ORYX core measure data, data from our Office of Quality Monitoring, which includes complaints and non-self reported sentinel events, and data from your application. We also use external data such as CMS' MedPAR files. So, all of these different data sources get integrated, aggregated and analyzed together to provide you with information.

This information builds upon the priority focus process. Currently, through your PFP, priority focus process, you receive a report that lists your top four priority focus areas and your top four clinical service groups. However, the PRA tool goes into much more detail. For example, you can see performance in all 14 of your priority focus areas, as opposed to just the list of top four. You can also see performance in all 32 of your clinical service groups, as opposed to just your list of top four. You can compare your performance in these areas to national and state benchmark groups, as well as other selected groups such as magnet hospitals or hospitals who have received conditional accreditation.

And you can see all of the underlying data for your hospital as it relates to each priority-focused area and clinical area. For instance, if you drilled down into infection control, which is one of the priority focus areas, you would see at a high level any complaint data that has been related to it. You would also see detailed specific information on any past survey findings that had been related to infection control. You would see ORYX outliers and core measures that were related to infection control. You would see the quarters that you were an outlier and be able to further drill into your control and comparison chart for those. And then you would see any MedPAR data, such as complications as it relates to infection control.

In addition to that, much of that underlying data also provides you with additional comparative information. For example, if you drill down into your MedPAR data, you can find your complication index in a given clinical area and then you can compare where that index falls against all other accredited hospitals by way of a percentile rank.

Now, as with any new tool or technology there will be a learning curve and I understood from some of you already that the tool can be slightly overwhelming at first because there is so much data contained within it. However, I think each time you use it, you'll become a little more comfortable and you'll understand it a little better. But please don’t hesitate to contact us with any questions that you have. We're dedicated to helping you understand the tool and the data and how you can use it.

Within the tool there is an extensive help tab that contains a user guide, web-based tutorial, past *Perspectives* articles, et cetera, and as always, you can contact your account representative, who has been trained on this tool to assist you with any questions.

As Linda mentioned earlier, we launched on July 30th. We've all been pleased with the launch. There has been no reported technical issues and the usage has exceeded our expectations. In the first week, we had close to 2,000 unique users log into the tool, and last week we had over 800 people using it. Now, hopefully some of you are on this call and can provide some comments or feedback or ask any questions when we open up for discussion.

But before we do that, I wanted to speak a little about feedback that I've received to date, the majority of which has been positive. Most people have agreed that the tool does add value to the accreditation process and that it can benefit their hospital to become more proactive in terms of performance improvement. I've received a lot of positive feedback from corporate offices. I think they appreciate the fact that the tool brings together all of this different data across all of their hospitals within their system that we accredit.

I also had a hospital mention that they like this tool better than HealthGrades' because they felt it incorporated more data sources into it and was able to paint a more comprehensive picture of their hospital. However, in addition to the positive feedback, there has been some criticism of the tool, specifically as it relates to usability for specialty hospitals, such as children's hospitals or psychiatric hospitals. This was to be expected. We know that these types of hospitals do not have as much data available, and so their results aren't as comprehensive and they have to be a little more cautious in interpreting their results and utilizing the comparison group.

I just ask that they give us a chance. This is a brand new tool and endeavor for us and it will only get better over time, and one of our future planned enhancements for the tool is to separate out these various groups of specialty hospitals and make them comparison groups to be used within the tool.

So, with that being said, we are committed to continually enhancing and improving the tool. We look to you for your feedback and ideas on how to do this. We will have phased releases spread throughout the year so that we can continuously make it better. One of the ideas I've received is to add some trending reports as future quarters of the tool are released. For instance, you may see from one quarter to the next that you're still a red stop light, but at least you'd be able to see that you're improving over time. Or, you may notice you're still a green stop light, but that your performance has decreased over time. So we'll look to incorporate those ideas in the future.

Now, in addition to the PRA tool, we are also working on additional new tools for S3, one of which we have previously spoken about, which is called Performance Measure Compare. This tool would allow hospitals to customize comparative analyses on core measure data, as well as other proposed functionality, such as the database with strategies that are known to be effective in improving performance.

The current status is that a field survey will be going out this fall to assess the desirability and perceived value for this tool. And then, based on the results, the team will decide whether or not to move forward with it. So we ask that you stay tuned to your Joint Commission Connect extranet site, as well as *Perspectives* for the latest information on enhancement to the existing tool or developments within new tools.

QUESTION: Is the access to the S3 tool limited?

CARRIE MAYER: Yes. Unlike some of the other tools on your extranet, you can access the tool, we've been a little more restrictive with initial access to S3 and that's due to some of the confidential and sensitive information within the tools. So, what we've done is at the hospital level we've restricted the initial access to the CEO and primary accreditation contact that we have on file in your application. And then at the corporate level we've restricted initial access to whomever is listed as the primary owner contact, secondary owner contact, and corporate contact. Those people receive that initial access. They can open up the tool to whomever else you would like to have it opened up to.

QUESTION: I have a question in regards to the risk index. What is considered a high point total?

CARRIE MAYER: There are all the bar charts within the tool. We know that the average point total for the national group of hospitals that includes hospitals that have all the main data sources is right about 200, I believe. If you look at some of the other comparative groups such as hospitals who had been preliminarily denied accreditation, they're close to, I think, about mid-300. So, we're not making the determination that that's good or bad. We're just separating out these different comparative groups that have been identified by others as being top performers or poor performers and then letting you compare yourself to them and make a determination on how you compare.

QUESTION: I actually have multiple hospitals, and as I look at the pie charts, the different components that make up all of the data sets, the percentage weight in the pie chart varies dramatically by organization. Can you tell me a little bit about the formula that's applied to weight it?

CARRIEY MAYER: For the most part, the data in S3 is not weighted. The way it works is, each piece of data that comes in, be it an outlier on ORYX core measure or a complaint, gets assigned to the priority focus areas that are most applicable. When it gets assigned, those areas get points.

At the end of all of your data being evaluated, you have an overall point total. Then for the pie chart that you're referring to, which shows which data sources contributed which percent to that overall total, all we do is we separate out all of the ORXY data that contributed, add up those points, and then divide it by your total. And then likewise we would separate out all the MedPAR data that contributed, look at the points it assigned, and divide it by your total.

So, what it's doing is showing you for that specific hospital for their point totals what data was contributing most. In some hospitals, we see that for the most part their performance was driven by past survey findings. You may find in another hospital that it was driven more by ORYX data, so it's kind of just an informative report for you.

QUESTION: We are a critical access hospital, but we're surveyed under hospital standards, and we don’t have access to the tool. Does that make a difference or should I contact our account representative to find out why we can't get into it?

CARRIE MAYER: I would contact your account representative. I understand you're surveyed under the hospital standards, but in the technical sense here it probably has to do with what program we have you being accredited under in our system. And if that's a critical access hospital, which we'd have to look at with your account representative, you would not have access.

Not to say that's not coming soon. The problem with critical access hospitals was we didn’t have PFP or priority focus process data for them, but we're actually implementing PFP for critical access hospitals this fall, so I would think it would only be a natural progression to get critical access hospitals up on S3 pretty soon after that.

CALLER: Okay. But we do get priority focus information.

CARRIE MAYER: Okay. If you do get that, then you should have access. My guess on most of the access issues I've heard to date it's been a person trying to get in who is not one of those few initial people that I mentioned had initial access.

CALLER: I'm the key contact person and neither my CEO or I can get in, so I will contact our rep and see.

CARRIE MAYER: We'll definitely help you get access.

QUESTION: I'm wondering how current is the recent or the past survey data, how long does that take? For example, if we had a survey in the first quarter of '07, would that data be reflected already or is there a lag time?

CARRIE MAYER: Well, we go back basically to the most recent survey and pull results from that. However, that survey and the results need to be in what we call the closed or the approved status. So, if you had a survey in the first quarter '07 and you're still working on clarifying any of the findings and that report has not officially been published to your extranet site, then they would not have gotten integrated. But as soon as the results do become published and final, they will get integrated. So if they're not in it right now, the next quarter we run, they probably will get pulled in.

CALLER: And so as a matter of feedback, and I find the tool very helpful from a system-wide perspective, it would be helpful to see the dates of each of those components that are contributing what date period that they represent, because they're all a little bit different.

CARRIE MAYER: Thank you.

QUESTION: I'm wondering where do we find the user guide and slide presentation on the extranet site?

CARRIE MAYER: The user guide and slide presentation are actually contained within the tool. So you would click on S3 and once you get in the tool, there's various tabs across the top. We do have a help tab and once you go into that there will be the user guide, PowerPoint, and web-based tutorial.

QUESTION: Could you review for us how recent the data will be that's utilized in the displays this offers?

CARRIE MAYER: That is included in the user guide, but I understand a lot of you probably don't like the user guides, they're often intimidating. We do have a chart in there—basically the main data sources we have the ORYX core measure data. And for that we pull in the most recent eight quarters that we have on file here, which coincides with your Joint Commission ORYX performance measure report. However, keep in mind that we're always about six months behind real-time ORYX data.

In terms of the past survey findings, we do go back to your last full survey and we pull in results, any requirements for improvement or supplemental findings from that, as well as if there has been any special for cause or intra-cycle surveys in the meantime. Related to the MedPAR data, we always are looking at the most current file available to us from CMS, but realize that right now what's in production for S3 is still the fiscal year '05 MedPAR data, and that's because the fiscal year '06 MedPAR data hasn't been released by CMS yet. That will be released very soon, and as soon as we get that, we send it onto 3M, they do some analysis, we get it back here. So, hopefully before we run the next quarter we'll have that updated fiscal year '06 MedPAR data.

And then there's the Office of Quality Monitoring data. What we do is, when we run S3, we go back a full three years and we would look for any complaints or non-self reported sentinels events that are in that timeframe.

QUESTION: My question relates actually to the pie chart question that came up earlier. If the hospital has a larger number of points than you would like and you want to try to figure out how you can decrease your points, I'm trying to figure out how those points are distributed among all your data sources?

CARRIE MAYER: I wouldn't use the pie chart to try to figure out any of the underlying data, that's to give you an overall picture. But what you can do in the priority focus area tab, if you click on any of the priority focus areas or the stop lights, that's where you start drilling down and you get at the detailed data. And that's where you can see where were you an outlier on the MedPAR data and that could help you focus in on, for example, high complications in cardiology. That would be displayed there for you. So that would be an area you might want to try to address. It would also show you the ORYX core measure outliers.

So, I would recommend really drilling down to the specific level of data. And those high level bar charts and dashboards give a good overall picture, but to get to the level you want, you need to really start to click in and drill down into everything.

QUESTION: We're a psychiatric hospital, and when we pull up our report, it indicates that there is no ORYX core measure on data on file for the hospital. And I'm not sure why.

CARRIE MAYER: Well, I assume that, as a psychiatric hospital, you do not submit your core measures to The Joint Commission, is that correct?

CALLER: Well, we participate in ORYX database.

CARRIE MAYER: Are those non-core measures?

CALLER: Probably not one of the nine you selected, that's why. So, there's no other ORYX data included in this S3?

CARRIE MAYER: Within the S3 we're only currently looking at the ORYX core measures, and that's because those are more on a national level and we can usually do comparisons better. The non-core measures are not integrated into this tool and that's because those can differ by performance measurement system, and we really have no solid national comparative database for those. So, I'm assuming you submit the non-core measures, which would not be used.

CALLER: Do you see S3 essentially replacing the ORYX system in the future?

CARRIE MAYER: Absolutely not.

DR. DENNIS O'LEARY: No, remember, the ORYX system is publicly reported and the S3 is private and meant for the management level of the hospital.

CALLER: We really are looking forward to something that we can use out of this system, but, for DOD and military organizations, there are some real concerns. We don’t participate with any of the CMS data. We report all sentinel events, so you wouldn't be getting any non-reportable sentinel events. So, that whittles down the data that would be available. And I'm wondering if there's been any consideration by DOD corporate or the separate departments corporately to try and lump us into a separate group like the specialty types.

CARRIE MAYER: I think that's great feedback. Yes, I actually have worked with some of the executives within the DOD. Because you don’t submit the CMS MedPAR data, like you said, you're missing a key source. But I understand that the Department of Defense has their own separate database that they maintain, which is very similar. If you would be willing to share that with us, we could get that integrated into the tool at some point.

I understand your concern about sentinel event data. Since you self-report all sentinel events they don’t get included. It's kind of a balancing act there. If we use self-reported sentinel events, people get upset because the point of self-reporting is it's a non-punitive process. However, then other people say well if you don’t use them, we're missing out on this data, so it's a delicate balancing act.

Certainly, we can work with the DOD to kind of modify or customize S3. We could work with any types of facilities to do that. Just remember this was the first iteration of the tool, and we'll work with you to make it better for your facility. Just be careful, especially being the DOD or anyone who gets the asterisk that says you don’t have MedPAR data. Make sure when you compare yourself, you're using that comparison group that also does not have MedPAR data, otherwise your comparisons can get a little skewed.

CALLER: The second part of it also is that for some of us the priority focus area is still something that we're struggling to understand how to use and use them adequately, and the clinical service groups also bother us. This specific hospital is very large in labor and delivery, and yet, labor and delivery is not one of our Clinical Service Group. The application process that it doesn’t contain comprehensive enough data to pick up the fact that we do that.

CARRIE MAYER: Right. On the application we use to collect volume and then that was seen as being very cumbersome, so we stopped collecting it. Now, as a result, we know what services you offer, however, we don’t necessarily know what your high volume services are. Again, it's a delicate balancing act. You have the people who say, well, high volume equals high risk. You have the people who say, well, low volume equals high risk. And so I get people calling me saying this is all we do, why isn't it a priority Clinical Service Group? Or, then, you get the people saying, why is this a priority CSG, we only do a few cases of these a year? So, what we try to do, is take the low volume, high risk and high volume, high risk approach, but certainly, we don’t capture all of it in every situation.

QUESTION: We're one of the specialty hospitals, long-term acute care. We also do the non-core measures. So, I guess I wanted to clarify if we're doing the non-core measures, is it suggested that we not complete this or it would not apply to us, being that it's based off of the core measures?

CARRIE MAYER: I would not suggest that. There's nothing to complete, but in terms of utilizing the tool, I wouldn't suggest that you don’t use it. Because what we've done is we've separated out all of the hospitals that don’t submit ORYX core measures or all of the hospitals that do not submit the CMS MedPAR, or some hospitals do not submit either. So, we've formed comparison groups for those types, so at least you can use it to compare yourself to hospitals at that level.

Now, I would like in the future to separate out, like you said, specialty long-term care acute hospitals. If we could separate out all those hospitals that we accredit into their own group and provide more value to you in doing that, we certainly will.

CALLER: Okay great. So, that's in the future plans?

CARRIE MAYER: Yes. And at this time, it's a good time for me to encourage you all. Within that help tab there is also a ”take our survey” link. So, for any of the specialty type hospitals, because this is not my area of expertise, I'd like to know how we can make the tool better for you. So, what would the comparative groups be or what would a report look like, or what would be additional data we could use for you.

QUESTION: We're an eight-hospital network. I'm wondering if there are any plans to explore the ability for S3 to actually allow a system of hospitals to connect the data to get an overview of how you're doing on a higher level and then the ability to also drill down into individual organizations. Is that something that is on the horizon?

CARRIE MAYER: Yes, it's definitely feasible and technically possible. But we'd have to have some type of disclosure or a disclaimer form where all eight of those hospitals would have to agree and accept or confirm that they're okay with being lumped together into a group where you all could see each other's data.

CALLER: Right now we have a centralized accreditation department that manages all of the hospitals. So, I was just wondering if in the future we would be able to connect the information.

CARRIE MAYER: Yes, I think that it's definitely possible for the future. In the meantime, what you can do, though, is you can take those people at that central office and you can have them added to each of the eight hospitals tool, I know you don't need more work, but then that person could kind of, at least for now, manually aggregate those eight hospitals' data.

QUESTION: We've kind of been tossing around what MedPAR data you're using, what elements are you taking from MedPAR, and since you're back in '05 fiscal year, you won't be getting to the other data for awhile. So what elements are you using from the MedPAR file?

CARRIE MAYER: Well, what we do for the MedPAR data is, we purchase the raw files from CMS and they actually go directly to 3M. They're our custodian of that data, and they use their methodology for determining complications and mortality, so I don't know the specific fields from the MedPAR files. But what 3M does is they parse through those MedPAR files and they pull out he DRG codes, the ICD-9 codes that they can lump together across 32 clinical areas.

What they do is, they give us the mortality rates and then the complication rates using their complication methodologies. They give us your actual values and then they calculate expected values for each of those as well, utilizing their risk adjustment, which takes into account the severity of illness and risk of mortality. So, what we actually get back here is at a hospital level across 32 different clinical areas. We get data on complications, on mortality and average length of stay.

QUESTION: Do you incorporate our annual self-assessment in the data?

CARRIE MAYER: No, we do not. The self-assessment is really a completely separate process. And, as you know, even the account representatives and none of us here really have access to that data. We made a conscious decision to keep that out of priority focus process the same way we keep the self-reported sentinel events out and that it's a non punitive process and we don't want to use that data in any way where you would perceive that it was penalizing you.

Now all that being said, of course there are the people who would like to incorporate it into this to make the tool more robust and better for them, and I think one of the future goals of S3 is eventually to be able to allow you to enter some of that data or integrate some of your own data. So, it's not used now, but possibly in the future.

QUESTION: My question is, if the clinical service group point totals do not factor into the overall priority focus process point totals because it is driven by service and/or volume data, how come the same color codes and symbols are used, suggesting negative or positive direction? And how can we use the CSG point totals to identify our risk points and benefit from it?

CARRY MAYER: That's a great question. Let me clarify a couple of things. The clinical service groups currently receive points from all of the data. But in addition to the other data sources that I mentioned like the past survey findings, ORYX, et cetera, we also integrate application service data into your clinical service group point total because we need to know who you are and what you do.

Now, for the overall point total, which is really kind of the risk index, which is a separate report within the tool, we do not incorporate the clinical service group point totals because those points are calculated based on data that is undesirable or negative and by virtue of the fact that you offer a service, that's not undesirable or negative.

So, in those overall point totals we do not incorporate them, but the point totals on your clinical service group dashboard still do mean something and still do have value because it shows you the clinical areas for which there is some undesirable data. So, I think it's just looking at the different reports and understanding the differences, not to mention that the stoplights on the dashboard reports are calculated differently than stoplights on a different report. I think that's part of it the education and learning curve.

QUESTION: When I run my PFA report for my hospital, we have a red stop sign for organizational structure. When I drill down, I see no contributing data except for length of stays lower than the tenth percentile in a lot of categories where we have very low volume cases, in some cases one case. So, that just doesn't seem like a true measure that should be comparable to others.

CARRIE MAYER: There are two things you're kind of hitting on there. One is that when we look at length of stay we look at very high lengths of stay, and we also look at very low lengths of stay. Now, most people would say, well, isn't a very low length of stay a good thing, and in the majority of cases it probably is. But, we have these rules that tie low lengths of stay to organizational structure and that's based on some expert literature that talks about possibly some organizations putting bed care decisions or care decisions not really in the nursing staff's hands, but in maybe more of the organizational or business hands. Is there a risk of moving patients out of the hospital too fast? Is there pressure from upper management to move them through the system too quickly? So, we've got some literature that would suggest take a look at the organizational structure and philosophy if you've got a lot of extremely low average lengths of stay.

Now, in terms of the second part of the question that talks about the number of cases, you're absolutely correct. We don’t filter out any data based on number of cases, but we do display that for you so that you can use that detail to determine whether or not you think you need to do anything to address the situation. Some people will say, well, I don’t care if we have two patients or 200, if our complications are high, I'm interested in that, and I want to look into that area. But that's why we provide the number of cases for you so you can decide.

QUESTION: We're wondering if we will ever be provided with our specific hospital formula for that detailed algorithm for arriving at this specific point total for each PFA and Clinical Service Groups?

CARRY MAYER: Well, currently that is proprietary information. It's what makes this tool valuable to you and valuable for us and enhances the value of our accreditation. I don’t see, in the future, us making those specific algorithms available publicly.

DR. DENNIS O'LEARY: That's right. We're not going to do that.

QUESTION: I just wanted to clarify, being a free standing pediatric facility, are you saying that at present the tool will not be able to give comparison data from other pediatric hospitals or is there a way to choose that to make it a little bit more valuable to us?

CARRIE MAYER: Currently, pediatric hospitals are not lumped together in their own comparative group. Based on the different data sources you contribute, as a pediatric hospital you likely don't have MedPAR, and you likely don't have ORYX core measures. Now, most of the other hospitals in that group that also do not have those two data sources are probably pediatric hospitals, though there will be other type specialty types as well. So, for now you can use that group to get a good baseline, and in the future we will separate out all the pediatric hospitals.

QUESTION: How often do you update the data?

CARRIE MAYER: It will update quarterly, but keep in mind that every quarter we run we go back up to three years. So, you might see some old data fall off and some new data get pulled in. So, it's not a quarterly time period that's represented by the data, but it is updated quarterly.

QUESTION: I was wondering how this tool will be used at survey time.

CARRIE MAYER: The tool will not be used at survey time. This tool really is intended for your use only. And as such, the S3 tool is not shared with our surveyors. They will still receive that priority focus process report, so they'll get that list of top four areas and they'll use that to focus the survey, but they have no access to the S3 tool, and we've actually taught them that if you try to give them your S3 data and ask them to look at it or use it, that they should not, and then they direct you to contact us here.

QUESTION: We're also a specialty long-term care hospital and I was wondering about the comparison with other facilities like us?

CARRIE MAYER: That would be another one of those groups like the children's, the military, the long-term acute care facilities. What we'll do is we'll look at all the different types of specialty hospitals and analyze them. We do have to be a little careful because the more specific we get in the specialty groups, the less number of hospitals included, and then the results might not be statistically significant or different. So, we'll definitely work to analyze that, and get it out as soon as possible.

QUESTION: The other question is, I've been using the program, I just found it yesterday, but it's very, very slow. Is this a function perhaps of my computer or is it the program?

CARRIE MAYER: Well, it could be either. If you continue to experience that, contact your account representative. It could also do with the time you're using it. Sometimes here we do schedule reboots of systems. We typically do those on a Sunday morning or at a time period that we would expect low activity, but I really don’t know. But like I said, if you continue to experience that, contact us here and we could look into it.

QUESTION: Our question was, could you explain more about how you assigned an association or causality to the priority focus area? As we look at our data on equipment use and see some outliers related to some of the ORYX core measure data, we don’t understand the causality, for instance, time to PCI being associated with equipment use.

CARRIE MAYER: I can't really speak to a specific example, but the process we've used in making the association between each data source and the priority focus areas is we do a thorough expert literature review. We have guidelines in place typically where we have to review at least five articles. For instance, say we’re looking at the ORYX core measure on smoking cessation. What we do is, we browse through all of the expert literature and so when we find that organizations are not doing smoking cessation or not performing it, we review what expert literature and studies have linked that to. So, we go through that whole process. As you can imagine, a lot of the data could really relate to any of the 14 or all of the 14. So, after we do that first initial browse through of the literature, we look for those priority focus areas which are repeated within the expert literature. So, if in all five articles they linked smoking cessation to assessment and care then we make that link. So, we go through that process and we did it initially in 2004 for priority focus processes being implemented. And then just last year we reviewed all the rules we have that would assign the points. We reviewed all those rules based on updated expert literature review, and we've got about 1,500 of those rules.

I understand that sometimes it's hard to see the correlation. A good example is, I had a question on how medication management was related to increased lengths of stay. And when I looked at the expert literature that we reviewed that supported it, it referenced a couple of studies that had found that inappropriate drug prescribing was often linked to higher lengths of stay.

So, there's all of that detailed data underneath, which unfortunately isn't being shown to you or shared with you right now, which could be helpful to you because it could give you ideas of where to look or how to fix it. I'll have to follow-up here in terms of do we have licenses or copyrights to display that literature. I know there's a lot of legal and issues surrounding that. But, I hope to get to the point that we can kind of display some of that to you so that you know where it came from.

QUESTION: I have a question on the symbols. On one of our priority focused areas we have a less point total than the comparison group, but we still came up with a yellow stoplight. Could you explain how this works because I know I'll be asked by upper management and I want to be able to explain how that happens?

CARRIE MAYER: Basically, we took a more liberal approach in assigning the yellow stoplights. And that's because when we were pilot testing S3 we found that when you're reviewing a dashboard, what do you do? You immediately skim over the green, and you focus on those yellow and red stoplights.

So, the point of you being at or around average and still having the yellow means that you're not significantly different from average, however, there is still some underlying data that contributed to the area, and we don’t want you to gloss over it and ignore it. We want to draw your eye to it, to look into the data and determine if there's any additional analysis that needs to be done, as opposed to the red stoplight, which really is reserved for where you are statistically different.

QUESTION: All of the questions have been valuable and I haven't really got into the tool, so I can't ask any specifics, so I'm sure my account rep will be hearing from me when I finally get in. But, I'm just wondering, since this is a voluntary process, which seems very valuable, why the opt out?

DR. DENNIS O'LEARY: Well, I'm just going to tell you. If you have information, there is an expectation that you will do something with it. We have this in some of our relationships with government agencies that have not been anxious for us to share information with them that they are entitled to, because then they would have to do something with it.

CALLER: I still might mention it to my CEO, because I wanted to make sure that everybody knew what that actually meant. That we were going to go in and we were going to use the information and that we weren't playing around with it.

DR. DENNIS O'LEARY: It gives everybody full flexibility. The issue was raised actually by the field, and we're just trying to accommodate people's needs.

QUESTION: Right now I understand it's the CEO and our designated coordinator has access to this. Do we just go through the account representative to get additional access?

CARRIE MAYER: Actually, your CEO and primary accreditation contact, which was formerly the survey coordinator, have special rights on your extranet that allow them to grant additional access to those people. Certainly, if they can't figure it out or have a question they can contact their account representative for help, but those people have those rights to grant that access.

QUESTION: If I'm looking at a priority focus area like our quality improvement, and I drill down to expand all of the areas that tells me where there might be a problem, and I look at the undesirable trends under the MedPAR, when I click on that little graph over there it tells me that I have a green stoplight, but yet it's coming up under the undesirable trends. Why would that be happening?

CARRIE MAYER: That's kind of what I hit on earlier where, depending on the view you're in and the report you're in, it could have different methodologies. But what that's saying is, the green stoplight is there because likely all three areas of your data was at, or above the goal line, so you're performing well. However, within the last three years you're probably also increasing. So, even though it's still overall good, if your mortality has increased over the past three years, we still want to alert you that, you're still good comparatively, but within your own organization it has increased and you might want to take a look to see what's going on.

QUESTION: I have a question about the clinical service groups. I think I understand how you're getting information into some of these groups, but how do you get neonatology and OB information if you have a low Medicaid population that's not Medicare? Where does that information come from?

CARRIE MAYER: The MedPAR data will not factor into OB/GYN or neonatology like you said. However, we do have the pregnancy core measures, so if you did submit that data set and your outliers and any of those measures that could factor in. If we received a complaint from someone who said that while they were there for procedures related to OB/GYN or for their baby in neonatology that complaint could be tagged to that area and displayed under there. And then if you had any past survey findings, say the surveyor was going through the NICU and found some issues, they could have assigned that to those areas also. So, really all of the other data sources could theoretically contribute to it.

QUESTION: My question is related to the emergency department and why they are not part of our clinical service group?

CARRIE MAYER: The emergency department actually gets grouped into the trauma clinical service group.

CATHY BARRY-IPEMA: I'd like to thank everyone who participated in today's call. We hope it was of value to you. Please remember to visit The Joint Commission website at www.jointcommision.org or your secure extranet site for more information on this topic.

You will also receive an e-mail with a toll free number that you can call to hear a playback of today's call and a written transcript will be posted to the website and the extranet within the next few weeks. A list of upcoming telephone conference calls is posted on your extranet site. The next call will be in September and will be on National Patient Safety Goals. Registration information for telephone conference calls that are applicable to your accreditation program will be e-mailed to you one week prior to each call. Again, thank you all for joining us.