CALIFORNIA CABG OUTCOMES REPORTING PROGRAM (CCORP)
CLINICAL ADVISORY PANEL (CAP)
Sutter Square Galleria
2901 K Street, Room 200 AB
Sacramento, CA 95816

August 31, 2006
9:00 a.m. to 12:30 p.m.

MEETING MINUTES

In Attendance

Clinical Advisory Panel Members:
Robert Brook, M.D., Sc.D.
Andrew Bindman, M.D.
Ralph Brindis, M.D., F.A.C.C.
Timothy Denton, M.D., F.A.C.C.
Coyness Ennix, Jr., M.D.
Keith Flachsbart, M.D.
Frederick Grover, M.D.
James MacMillan, M.D.

OSHPD:
David Carlisle, M.D.
Michael Rodrian
Beth Wied, Chief Counsel
Beth Herse, Staff Counsel
Joseph Parker, Ph.D.
Holly Hoegh, Ph.D.
Denise King
Hilva Chan
Niya Fong

Other Attendees:
Ezra Amsterdam, M.D., UC Davis
Zhongmin Li, Ph.D., Health Services Researcher, UC Davis
Geeta Mahendra, Senior Analyst, UC Davis
Anthony Steimle, M.D., CCORP Consulting Cardiologist

Introduction

Dr. Robert Brook, Chairman, called the meeting to order at 9:00 a.m. and requested the Clinical Advisory Panel (CAP) members to introduce themselves.

Program Director's Report

Dr. David Carlisle welcomed everyone to the meeting. Dr. Joseph Parker began by providing background information on the California CABG Outcome Reporting Program (CCORP). CABG outcomes reporting in California began as a joint collaborative voluntary public reporting program between Office of Statewide Health Planning and Development (OSHPD) and the Pacific Business Group on Health in 1996. This voluntary program used National Society of Thoracic Surgeons data elements, a similar risk model, as well as internal and external data quality monitoring. From this voluntary program three hospital level reports were published between 2001 and 2005 that included an average of 80 to 120 hospitals. These reports were endorsed by CHA Hospital Quality Committee in 2005 (HASC – Jim Barber) and the data has

been used by health plans (Blue Cross centers of cardiac excellence, Leapfrog) as well as quality brokers (Subimo).

The voluntary program ended when Senate Bill 680 passed in 2001 which mandated surgeon and hospital reporting for all hospitals. Data reporting for the mandatory program began in 2003 after the CAP was established, data abstractors training completed and regulations had been approved. The CAP has four main statutory responsibilities: recommending data elements for collection, review and approval of the risk-adjusted model, consultation on report materials and review of physician statements. There have been six CAP meetings since the program inauguration and the membership has not changed. The first mandatory CCORP report was published in February 2006 using 2003 data to rate 120 hospitals. The risk model for this report discriminated mortality better than any other published model for CABG operative mortality.

At the last CAP meeting the risk model for the 2003-2004 report was approved, the surgeon level results were recommended to combine 2003 and 2004 data and no volume cutoff in reporting surgeon risk-adjusted mortality rates or performance ratings was accepted.

Next Dr. Park summarized CCORP's data quality assurance procedures. The data validation process takes about a year to complete. There have been two OSHPD directed hospital abstractor training sessions and a training video has been produced for all hospitals. At the date of submission a signed surgeon and/or CEO/designee certification form attesting to the accuracy and completeness of the data is required. After that, data error warning reports and hospital summary reports are produced and distributed to hospitals. Other analyses and risk factor coding reports are sent to select hospitals that appear to have issues with coding. Next data discrepancy reports are generated, using CCORP data and clinical data linked to the Office's patient discharge data, to find discrepancies that are then sent out to hospitals for correction. The final opportunity for data changes involves sending out to hospitals hospital level and surgeon level data reports, with a 30 day provision to submit any changes. Several months later, an independent medical chart review begins. All potential surgeon and hospital outliers are targeted for audit. The auditor's data replaces what was submitted per CCORP regulations. Results are then prepared for mailing to the surgeons and the hospitals.

Surgeon results for 2003-2004 were mailed on July 3, 2006. These included results of all the surgeon- unblinded, a guide to interpretation, the risk model and a description of the physician statement process. CCORP was required to promptly review all physician statements and respond with one of three decisions: the statement revealed a flaw in the data or the model or failed to reveal any flaw in the accuracy of the reported data and/or the risk model. 30 surgeon statements and supporting documentation was reviewed and the following responses were determined: eight statements were found to reveal flaws in the data and some or all flaws were corrected; in 22 statements no flaws were revealed in the data. In no instance did a statement reveal a flaw in the risk model. After verified data flaws were corrected by staff, surgeon results were recalculated and mailed with response letters to surgeons. Nine physicians unsatisfied with the administration's decision requested their statements be reviewed by the CAP to either uphold or change the final conclusion set forth by the law. The law states that for any surgeon statement found to reveal a flaw in their data, that has not been corrected by CCORP and materially diminishes the validity of the report, the data must be corrected for the report or data for that surgeon must be excluded. Any surgeon statements found to reveal a flaw in the risk model will result in the report not being issued until the model is corrected. Any surgeon statements that do not reveal a flaw in the data or the model will not change the public report process. The CAP's decision is the final determination regarding the physician statement.

Dr. Brook then reviewed the order of the meeting and commended the OSHPD staff for doing such and efficient job in handling the data. Dr. Ralph Brindis moved to approve the minutes for the last meeting and Dr. Timothy Denton seconded the motion. All were in favor.

Dr. Denton gave a summary of physician statement "A" that was essentially concerned about the accuracy of the data due to inappropriate coding from the hospital's staff. OSHPD responded by correcting some errors but the angina variable which was of particular concern had been excluded from the model and after recalculation of the risk-adjusted mortality rate the physician's performance rating did not change. Dr. Denton agreed with OSHPD's decision and Dr. James MacMillan concurred that no supportive documentation had been supplied. Physician "A" argued an emergency case had not been submitted that he felt would change his performance rating. After lengthy discussion Dr. Denton and Dr. MacMillan withdrew their motions to accept OSHPD's decision. The CAP voted to not uphold the conclusion of the Office because the physician's statement revealed a potential flaw in the accuracy of the data. Therefore once documentation had been submitted, the Office needed to rerun the model to included the emergency case and then report the findings for the surgeon.

Dr. Frederick Grover highlighted the details of physician statement "C-1" which addressed concerns that there were certain risk factors that were not captured in a number of patients. Physician statement "C-2" was regarding unusual circumstances for several patient deaths, the issue of operating at a referral center which inherently takes on more high-risk cases and personal illness which combined led to a poorer performance rating. OSHPD responded that many of the proposed risk factors were not in the risk model due to evidence of poor coding and reliability but did make some changes where documentation had been provided. Dr. Grover moved to uphold the Office's decision and all were in favor.

Dr. Keith Flachsbart discussed physician statement "D" that felt the expected mortality for their patients was low based on the severity of the patients. OSHPD responded that the noted risk factors were not in the risk model and when recalculating the risk model to included the data involved did not change the surgeon's performance rating. A discussion ensued on the accuracy of case coding and the later effects on performance rating for hospitals and surgeons. Dr. Flachsbart moved to not uphold the Office's decision due to potential flaws in the data and to recalculate the relative risk using the in-house data then report the resulting performance rating for that surgeon. Dr. Grover seconded and all were in favor.

Dr. Andrew Bindman reviewed physician statement "D-1" that mentioned incorporating other risks into the model and questioned the number of coded deaths for this surgeon. OSHPD provided clarification on the deaths in question. Dr. Bindman moved to uphold OSHPD's decision, Dr. Flachsbart seconded and all were in favor. Physician statement "D-2" pertained to an issue about a Jehovah's Witness patient who died that should not be viewed as an isolated CABG due to their unwillingness to accept blood transfusions and that not incorporating these types of patients into the risk factor could deter surgeons from operating on patients who express these personal preferences. OSHPD acknowledged that this patient's preference was not incorporated into the risk model but that the case still satisfied the definition of an isolated CABG. Physician "D-2" provided more detailed information on the case. After a lengthy discussion the CAP voted to uphold the Office's decision. Next physician statement "D-4" was examined that wanted a liver transplant patient that died after a successful CABG surgery excluded as an isolated CABG because it was felt that the risk model did not adequately capture

the degree of illness in such a patient. OSHPD concluded that hepatic disease is incorporated into the risk model. Dr. Coyness Ennix moved to not uphold the Office's decision and to exclude this case and recalculate the surgeon's performance rating. Dr. Brindis seconded the motion and all were in favor. Dr. Brook felt reevaluating the definition of a salvage case was an important topic for future discussions by the CAP once evidence, reports and data was available.

Physician statement "D-5" felt the risk-adjusted model did not adequately capture the risk of a patient that had undergone two previous CABG surgeries and a stent procedure. The Office's response was that, in fact, there is a data element for prior cardiac surgery and prior PCI procedures that is incorporated in the model and therefore assumes the risk of the patient appropriately. Dr. Bindman recommended to uphold the OSHPD's decision. All were in favor.

Dr. Ennix summarized physician statement "H" which due to a high turnover in abstractors at their institution led to erroneous data collection and interpretation primarily in the area of angina type. OSHPD responded that most of the data in question involved the risk factor angina which was not currently included in the model, so no flaw was found in the data or risk model. Dr. Ennix and Dr. Brindis both agreed with the Office's decision and noted no supporting documentation was provided with the statement. All were in favor.

Dr. Grover motioned to uphold the Office's findings that there was no flaw found in the data or risk adjusted model with regards to physician statement "B" who classified themselves as a low volume surgeon and objected to being reported with medium and high volume surgeons. All were in favor.

Physician statement "R" was discussed next which disputed the risk model's ability to capture the severity to their patients. The Office responded that in most of the cases the risk factors were correctly assessed by the model and no flaw was found by the statement. Dr. Grover moved to accept the Office's decision and Dr. Ennix seconded. All were in favor.

Dr. Brindis reviewed physician statement "T" which addressed under-coding issues at their institution that still had no affect on their performance rating therefore Dr. Brindis motion to accept OSHPD's report. All were in favor.

Dr. MacMillan discussed physician statement "U" that requested use of re-audited data. Some of the submitted changes were accepted that had documentation included but the Office found it still did not change the performance rating. Dr. MacMillian agreed with the OSHPD's decision. However after further discussion the committee agreed to rescind the motion to accept the Office's decision for physician statement "C", "T" and "U" and Dr. Flachsbart moved to allow re-submission of documenting evidence to support any disagreement of data submitted in the original physician's statement. Dr. Brindis seconded and all were in favor. Dr. Brook would like an agenda item for the next meeting about providing suggestions to staff on the specificity of the physician statement letters that tells them exactly what is required for them to submit in the form of documenting evidence.

Physician statement "U-2"s contention was the patient's death was a complication of the orthopedic operation and shouldn't have been considered an isolated CABG. OSHPD responded the case fit the definition of an isolated CABG. After a lengthy discussion Dr. Brindis moved to accept the Office's decision to include the case and Dr. MacMillan seconded the motion. All were in favor.

The committee agreed to rescind the motion for physician statement “A” and “H” and allow re-submission of documenting evidence to support any disagreement of data submitted in the original physician’s statement. All were in favor.

The last physician statement “W” was discussed that explained the initial abstraction was done by a resident without a clear understanding of the data definitions resulting in errors. Dr. Grover motion to allow re-submission of documenting evidence to support any disagreement of data submitted in the original physician’s statement. Dr. Ennix seconded. All were in favor.

After public comments the meeting was adjourned at 12:30 pm.