

**California Health Policy and Data Advisory Commission**

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Minutes
California Health Policy and Data Advisory Commission
December 7, 2007

The meeting was called to order by Vito Genna, Chair, at approximately 9:34 a.m., at the Crowne Plaza, San Francisco. A quorum of half of the members plus two was in attendance.

Present:

Vito J. Genna, Chairperson
William Brien, MD
Marjorie Fine, MD
Janet Greenfield, RN
Adama Iwu
Corinne Sanchez, Esq.
Jerry Royer, MD, MBA
Josh Valdez, DBA

Absent:

Howard L. Harris, PhD
Kenneth M. Tiratira, MPA
Sol Lizerbram
Sonia Moseley

CHPDAC Staff: Kathleen Maestas, Acting Executive Director; Terrence Nolan, Office Manager

OSHPD Staff: David M. Carlisle, MD, PhD, Director; Elizabeth Wied, Chief Counsel; Michael Rodrian, Deputy Director, Healthcare Information Division; Joseph Parker, PhD, Director, Health Quality and Analysis Division; Jonathan Teague, Manager, Healthcare Information Resources Center;

Approval of Minutes: A motion was made by Commissioner Sanchez and seconded by Commissioner Royer to approve the minutes of the October 12, 2007 meeting. The motion was carried.

Chairperson's Report: Vito Genna, Chair

Chairperson Genna opened the meeting by expressing the support and gratitude of the Commissioners for the exemplary service that Acting Executive Director Kathleen Maestas has provided for the past three years, and continues to provide, both the Commission and the Office. Commissioner Royer echoed the sentiment stating, "For the record, I want to express my appreciation for Kathleen's and Terrence's work."

Chairperson Genna stated that historically, the CHPDAC Executive Director would present the budget numbers for the Commission. In keeping with that tradition,



Chairperson Genna requested an overview of the CHPDAC budget and the various activities that the CHPDAC budget supports, especially in light of the budget shortfall.

Several reports have recently been released which point to the inability of the current healthcare environment to meet the needs of the baby-boomer age wave that is now looming on the horizon. The Centers for Medicare and Medicaid Services (CMS) has released a listing of 54 nursing homes which represented the worst of 1,600 nursing homes in the country and the National Commission for Quality Long-Term Care released a length report stating that the country is not ready to deal with the needs of the increasing number of seniors.

The December issue of the Annals of Internal Medicine reported that a third of all U.S. emergency room visits by seniors were caused by a drug reaction, or not enough of a particular drug. The three drugs the study cited with the greatest impact were: Warfarin, Insulin and Digoxin.

Chairperson Genna asked if OSHPD data was in any way connected to these studies.

Dr. Parker explained that the data used relating to drug interactions would be pharmacy data which is currently not included in the patient discharge data.

Commissioner Fine asked how OSHPD chooses the items for reports, such as the Community-Acquired Pneumonia (CAP) and Coronary Artery Bypass Graft (CABG), "because adverse drug reaction sounds like a topic that should be on the next go-round of State-mandated reports."

Director Carlisle stated that it is a fairly long process and that the selection process would be appropriate for a presentation to the Commission as one of the roles of the Commission is to guide the Office in terms of that selection process.

Briefly, OSHPD prioritizes conditions by their significance, in other words, both their volume and their salience as a mortality or morbidity predictor. And then, "there is the low-hanging fruit side of the equation, can we actually perform an analysis that would be meaningful on the condition."

Commissioner Fine stated that all of this is of particular interest because glucose had been looked at and eliminated from the data collection. "If you are looking for adverse drug reaction, and you are saying that the three drugs that are highest on the list are insulin, Warfarin, and Digoxin, then you have already hampered your ability to collect the data, if you have a pending investigation or reporting status upcoming for those particular, adverse drug reactions.

Director Carlisle pointed out that this is just the first round of our addition of clinical variables. "We certainly will have a second round as part of the process, and we could certainly add glucose back in, as part of the second round."

Deputy Director Rodrian added that staff can also go back and look into how close the ED data can come in answering this specific question. "It may not be as definitive as an

outcome study, but it might shed some light. Another possibility is to see if some other State organization is collecting pharmacy data in its entirety, and we could mine that data, as opposed to being the primary collectors of it.”

Director Carlisle stated that “Our major responsibility is to produce risk-adjusted outcome studies at the hospital, and physician, and other provider level. And one of the questions we would have would be at the hospital level, versus the emergency room level, does this category of drug reaction reach a numeric significance in terms of number of discharges.” OSHPD emergency room data, as suggested by Deputy Director Rodrian may be a starting point to answer that question.

Commissioner Fine stated, “We have multiple mandates. We have the mandate to do effective reporting. We have now identified a potential issue, which could be fruitful. But there is a melding of the data that comes from hospital discharges versus emergency room visit, and how they interplay. So it is very hard to separate what becomes discharge data from a true admission, and what warrants an emergency department visit.”

Commissioner Brien advised caution with regard to “taking an article with these drugs and applying it across the board to hospital admissions, and discharges, and drug toxicity. “I think you have to be very careful before you jump in and take this as something that should be applied as part of the identifiers, because it may or may not be a critical long-term measure of inpatient discharges and the cause of those.”

Director Carlisle stated that this should be considered as an agenda item for a future CHPDAC meeting and Deputy Director Rodrian agreed.

AB 524 Technical Advisory Committee Report: Jerry Royer, MD, Chair

Commissioner Royer gave a detailed report on the most recent TAC meeting highlighting three agenda items: the risk model for Congestive Heart Failure (CHF), the Patient Discharge Data (PDD) Validation Study, and a research design for modeling hospital stroke outcomes.

- The risk model for Congestive Heart Failure (CHF)
 - Clinical rationale:
 - CHF is the second leading cause for hospitalization in California
 - The Agency for Healthcare Research and Quality (AHRQ) include CHF, in hospital death, as one of their quality indicators
 - There is a wide range of outcomes in congestive heart failure in California
 - This study represents a departure from the statistical approach previously used, to a benchmark report employing a quintile approach
 - A parsimonious list of risk factors was compiled because a parsimonious model identifies the variables that are the key statistical predictors and relies on those, producing virtually the same performance that a comprehensive model would

- Diabetes and anemia were found to be protective with regard to CHF and at this point there was not a clear explanation as to why other than the possible indication as to prior medical care being administered
 - The general consensus of the TAC was to go with 30-day mortality rather than inpatient mortality. The rationale being that some hospitals with step down units can easily transfer their patients and shorten their stay thus removing them from their inpatient mortality
- The PDD Validation Study: Preliminary Findings
 - The PDD validation study is an effort to look at the reliability and validity of the coding for condition present at admission, do not resuscitate and external cause of injury or E codes
 - The methodology involved using both health information technologists (HIT) and registered nurses (RN) to verify the hospital coding
 - The study chose eight umbrella conditions and includes forty-eight hospitals representing 23 counties
 - Preliminary findings:
 - HITs coded present on admission, yes, as often as hospitals
 - RNs coded present on admission, yes, as often as hospitals
 - HITs and RNs coded present on admission, yes, with almost the same frequency
 - Next step: Inter-rater reliability examining the differences in coding of the HITs and RNs
 - Final report due June 2008
- Research Design for Modeling Hospital Stroke Outcomes
 - Rational:
 - There are 50,000 plus stroke hospitalizations a year in California compared to 40,000 for AMI.
 - 30-day mortality is 16 percent, compared to congestive heart failure, 3.5 percent.
 - Ischemic stroke has a 12 percent mortality and hemorrhagic stroke has a 30 percent mortality
 - Aims of the study:
 - Establish the validity of diagnosis and procedures in the PDD for stroke
 - Examine the variation of quality measures
 - Examine the use and variation in DNR orders
 - Create analytical models
 - Prepare technical report

OSHPD Director's Report: David M. Carlisle, MD, PhD, Director, OSHPD

OSHPD Director, Dr. Carlisle, reported that the Office has moved to its new location at 400 R Street in Sacramento. The building is owned by Cal-PERS and maintained in keeping with the Cal-PERS standards. The move is occurring in two phases. Phase one is now completed, and that included all of the old Kress building staff and most of the Bateson building staff. The remaining units, Cal-Mortgage and FDD will move into the new building in mid-2008. The Los Angeles office will remain in their current location at the Metropolitan Water District Building.

Maria Giuriato is no longer the Executive Director of the Health Professions Education Foundation. Angela Minniefield will assume the function as Acting Executive Director until such time as the Governor's Appointments Office names a successor.

In terms of healthcare reform, it is still one of the Governor's highest priorities and is the subject of the special session in Sacramento. As part of the ongoing healthcare debate, the Office has received feedback from various organizations including Pacific Business Group on Health, AARP, Consumers Unions, and Health Access, regarding the pace of productivity within the Office, with specific focus on the volume of risk-adjusted outcome reports produced at a hospital level in keeping with the original legislation, AB 524.

These organizations specifically told us that the other information products that OSHPD has produced, even voluntary outcome reports, such as the ICU study, were not considered relevant in meeting the level of productivity sought, and they asked the Office to focus specifically on risk-adjusted outcome reports at the hospital and individual physician level. "That is the direction we are being advised about from some of our representatives." These groups represent a part of the stakeholder population and the Office is endeavoring to respond to their specific criticism of the Office.

Finally, in respect to the budget crisis in California, OSHPD and OSHPD programs are somewhat protected from the impact of the deficit because they are fee-supported, special fund programs. The Office has only one significant General Fund program that being the Song-Brown program. If there are budget cuts, the Song-Brown program is probably where the biggest impact will be seen.

Legislative Update: David M. Carlisle, MD, PhD, Director, OSHPD

The Office has been monitoring several significant pieces of legislation.

SB 306, by Senator Ducheny, contains a component that would allow OSHPD to develop a staged review process. OSHPD has discovered in a pilot project that construction moves faster if things are approved one step at a time. This bill speaks to the funding aspect, ensuring that we would receive appropriate funding. The Governor has signed this into law.

SB 139, by Senator Scott, will create a Healthcare Workforce Clearinghouse. The clearinghouse, to be administered by the Office of Statewide Health Planning and Development (OSHPD), will serve as the central source of healthcare workforce data in California. OSHPD will collect, analyze, and distribute information on educational and employment trends for healthcare occupations in the State. This would give

policymakers a better understanding of healthcare professions and education in meeting future needs. Currently this bill is suspended, but the Office expects it to continue to move forward in future sessions.

Commissioner Sanchez asked regarding the Foundation, “Do we know how successful those kinds of programs have been in terms of increasing our diversity?”

Director Carlisle replied that OSHPD has numbers in terms of the diversity and the location of students and healthcare professionals that have received funding through the Foundation. “It is actually, in terms of increasing diversity, something that would require a fairly sophisticated analysis, the relationship between shortage area practice and health professions diversity.”

Director Carlisle suggested that Acting Executive Director Minniefield present to the Commission data on the success of increasing diversity through the Foundation Programs.

Healthcare Information Division (HID): Michael Rodrian, Deputy Director

Deputy Director Rodrian stated that effective in the year 2000, the National Center for Health Statistics shifted to ICD-10 coding but has not made that change yet, principally due to economic issues. The coding system is used in medical billing which means big changes in the billing systems and possibly unexpected changes in revenue streams when this change is implemented.

The adoption of the ICD-10 CM is a very strong move toward additional ability to look at quality issues and better describe hospital care and other care issues. The CMS issued a contract to a private firm to do an assessment of what it will cost facilities to implement, and what it will cost the Federal government to implement the ICD-10. Deputy Director Rodrian stated that he did not expect the ICD-10 to be implemented this year. “Given the magnitude of the change, I am sure that CMS will adopt it and then have an implementation date that is quite a ways down the line.”

Jonathan Teague, HIRC Manager, added that there is legislation pending in Congress with the implementation deadlines of 2010-2011.

Deputy Director Rodrian next presented a Milestone Schedule illustrating the key milestones in the addition of new clinical data elements. The milestones are listed as tasks for which “We have a schedule start, an actual start scheduled, a scheduled finish, and actual finish column. We sorted this by scheduled start, as this would be most relevant to the Commission” with respect to monitoring progress.

Work in Progress:

Completed

- 9/19/07: Conference call with The Pennsylvania Health Care Cost Council (PHC4)

- The Pennsylvania Healthcare Cost Council is one of the most comprehensive data collectors in the nation
- OSHPD staff talked with the Council about what they collect, how they collect it, et cetera
- 11/13/07: Conference call with a licensed clinical laboratory scientist, Dr. Henry Lee, of Hollywood Presbyterian Medical Center
 - Dr. Lee was referred to OSHPD by CHIA
 - Dr. Lee will be looking at OSHPD data collection and providing advice on the specific definitions

In Progress

- Data elements definitions—December 2007
- Hospital on-site survey (HIM, Lab, IT)—January/February 2008
- Clinical Data Elements Survey—February 2008

Stakeholder Input

- Collect the first lab value reported within 24 hours of admission
- Collect the lab values and vital signs on general acute care patients with a type of care “1”
- Collect initial vital sign reading on admission
- Collect patient address in all three data types (IP, ED, AS)

Issues

- Collection of pre-hospitalization lab values/vital signs
- Collection of operating physician ID on all inpatient procedures

Next Report: April 2008

Chairperson Genna stated that “perhaps the most important part of this is data element definitions,” and inquired if this would be ready for presentation to the Health Data and Public Information Committee (HDPIC) on January 15.

Deputy Director Rodrian stated, “We are not sure. We are very aware of that date and we will try and hit that, if at all possible.”

Commissioner Fine asked, “In terms of the definitions, is there any move to standardize some of the definitions between all these different organizations, be it Leap Frog, OSHPD or Healthgrades? It would seem that from a public reporting stand point, that if there could be some commonality in terms of these definitions, it might allow better comparison of reports from different organizations and less work on the hospitals.”

Deputy Director Rodrian stated that, “In fact, we are challenged by the law on the books for OSHPD to try to do that as much as possible. We are attempting to look at the definitions that other organizations have, and then seek what we think achieves the

objectives of OSHPD and this Commission, as well as incorporates the most salient features from the others. Politically speaking, once government chooses something, often others gravitate to it, because we put it into law, regulation, and that kind of defines the choice. In doing so, we want to make sure that we are choosing wisely.”

Deputy Director Rodrian stated that he was very appreciative of getting the calendar dates for CHPDAC meeting for 2008. “We will now be working with both HDPIC and TAC so we can properly concatenate these. We can take things to the HDPIC, and then have them come here, et cetera, and have a reasonably predictive schedule, so that this works as seamlessly as we can make it.”

Chairperson Genna added as a follow-up, that it was his understanding that part of the process that was unfolding would lead to dividing out, “instead of 15, elements, that maybe if there were six that are easy, that we can just expedite those, and continue to work on the others.”

Commissioner Fine replied that “The problem represents what the hospitals have to invest in software. And if you are giving them a work in progress, you are really hampering their ability to make decisions. If you make a partial decision on three or five new elements, but then ultimately, within a year, make them add ten more, they might need a totally different software system. So you might do better to hold off and get it right the first time.”

Chairperson Genna stated that this is where the HDPIC could really be of value because, “We have hospital representatives that know their systems and what they can handle. And I think that is why the definition side is so important, and I think the HDPIC needs to be there from the get-go.”

Deputy Director Rodrian emphatically agreed. “And it is really a balance of two parts, the HDPIC side on what hospitals have, and the other is how much you have to change your IT system to report it, and what OSHPD has to change. Your comments are well-recognized. Yes.”

Report on National Association of Health Data Organizations (NAHDO): Jonathan Teague, Manger, Healthcare Information Resource Center (HIRC)

Background on NAHDO

- Longstanding OSHPD involvement as a member (state data organization)
- Sponsors meetings featuring the latest developments in the collection and use of health care data
- Goals to improve health care cost, quality, and access
- National meetings on implementation and policy issues to promote the use of health care administrative data

The core constituency of NAHDO are individuals who “really get into the nitty-gritty of administrative data, and how it is collected and how it is used.” The target audience is manifold, including: providers, policy makers, payers, purchasers/employers, health services researchers/academic medicine, nursing, public health and epidemiology,

federal officials and consumer and advocacy groups. OSHPD was heavily represented at the meeting. There were approximately 22 staff managers in attendance and OSHPD also had an exhibit booth.

The pre-conference meeting was focused on technical implementation issues surrounding a variety of matters, such as how do you define admissions, link data, and construct higher value data sets and other topics of interest. There was also a lot of talk about clinical data.

The conference covered a wide variety of topics from pay for performance/value purchasing and reporting health care data for performance to quality improvement and policy evaluation. OSHPD made there major presentations:

- Enhancing Discharge Data for Quality and Public Health—Joseph P. Parker
- Present on Admission Implementation Issues—Starla Ledbetter
- Risk of Mortality and Inpatient Admission for Medical Procedures Performed in Ambulatory Surgery Centers, California, 2005—Mary Tran

Dr. Carlisle was presented with the Elliot Stone Award of Excellence in Health Data Leadership. This award recognizes individuals whose creative efforts have made outstanding contributions to improvements in the collection, application, and/or dissemination of health data.

Director Carlisle added, “As I said during the presentation, the award is really a reflection of the work of the OSHPD staff in advancing the frontier of data collection, especially for the State of California. But what we do in California is an example for NAHDO, other organizations, and for the rest of the country.”

Proposal to Amend Discharge Data Program Regulations concerning Present On Admission Indicators to make California Requirements Compatible with National Reporting Standards– Michael Rodrian, Deputy Director, HID

Deputy Director Rodrian explained that this package proposes replacement of the OSHPD discharge data set's, “whether the Condition was Present on Admission” (CPOA) data element similar to the national standard data element called the “Present on Admission Indicator” (POA). This refers back to the May of 2007 uniform billing form, UB92, which is now being changed by the Federal government to the uniform billing 2004, UB04 form, which includes the present on admission indicator.

“The goal is to have these changes in place by the time the Federal changes take place, and to make them congruent with the Federal changes, to lessen the burden on reporting and improve quality.

Deputy Director Rodrian asked of the Commission, “If it is your pleasure, we would like a recommendation to go forward with this package.”

Commissioner Brien made a motion that OSHPD go forward with the package presented.

Commissioner Sanchez seconded the motion. The motion was carried.

Healthcare Outcomes Center Report: Joseph Parker, PhD, Director

Report on Research Activities

- California Coronary Artery Bypass Graft Surgery Reporting Program (CCORP)
 - The 2005 CCORP is under administrative review with a target release of December 2007
 - In addition to hospital mortality rates, the report contains two new sections: one features the rates of hospitals over time, in a graphical format, and the second that shows ratings of hospitals by their use of an important process measure, use of IMA, internal mammary artery graft, on patients that are eligible
 - Eligible patients include first-time CABG patients, and those that are non-emergent, non-salvage cases
 - The next CCORP, Clinical Advisory Panel meeting is on January 22nd, 2008, to discuss adding additional data elements to the CCORP data, so that OSHPD can perform risk-adjusted mortality analyses on non-isolated CABG patients
 - Non-isolated CABG patients are patients that might be having a valve surgery at the same time
- Community-Acquired Pneumonia report
 - The new Community-Acquired Pneumonia report is being reviewed internally
 - The mandatory 60-day hospital review ends on December 17th, 2007
 - No hospital comment letters have been received as of this status report which contrasts with past reports some receiving up to 30 hospital comment letters
 - The target release is February 2008
- Maternal Outcomes report
 - The Maternal Outcome report with 2004-2006 data which includes linkage of patient discharge data with the birth files from Vital Statistics has a target release of late summer 2008
 - OSHPD has a rough draft of the public report which is being reviewed, and OSHPD has the contractor for final revisions
- Agency for Healthcare Research and Quality (AHRQ) Volume and Utilization Indicators and Patient Safety Indicators

- OSHPD has added the AHRQ Volume and Utilization Indicators and Patient Safety Indicators to the OSHPD website
- These include VBAC rate, uncomplicated C-section, complicated C-section, along with actual Caesarean rates and other indicators such as volume of PCI
- California Patient Profile report
 - The California Patient Profile report will probably take the form of a fact book
 - There needs to be further internal review involving Dr. Carlisle and staff with a possible target of February, 2008

Director Carlisle added that with regard to the AHRQ Volume and Utilization Indicators, “this represents a landmark product for the Office. We have posted those to our website and we have press release that is coming out to describe those shortly. The reason we are attaching significance to this is that they include 2006 data. We are presenting information; the recent is no more than two years old.”

“There are some landmark finding in the utilization data. For instance, Caesarean section rates are highly variable across California hospitals. We have posted rates that are adjusted for age. So the predilection of older mothers to have a Caesarean section is controlled for. Even then, we see C-section rates as high as 50 percent in one case, in one particular hospital. And so those results are very dramatic.”

Dr. Parker agreed, stating that with measures such as the VBAC rates, “you can identify hospitals where virtually none of those are being done, despite fairly high volume of births, and you can identify places where a lot of those are being done and they have also a high number of births.”

“I think that for some of the surgeries, like abdominal aortic resection, and others, where there is an established relationship, a pretty clearly defined one in the literature, higher volume and better outcomes, the public can also use that information until the time when OSHPD produces their own risk-adjusted mortality rate study for AAA.”

Dr. Parker concluded by stating that the AAA risk-adjusted model had been presented to the TAC about six months earlier and that the intention is to present some volume and outcomes analyses, along with a refinement of the risk-adjustment model for producing hospital level reporting to the TAC at the next meeting scheduled for March 7, 2008.

Next Meeting: The next meeting will be held on February 15, 2008 in Southern California.

Adjournment: The meeting adjourned at 12:15 p.m.

Pending Items:

1. Presentation on the relationship between additional patient discharge data elements being considered for PDD and the list of the procedures and conditions from which future outcomes reports might issue.
2. Presentation on exploration of OSHPD ED data and the possibility of mining other State Organizations' pharmacy data with respect to answering Dr. Fine's question as to whether excluding glucose may hamper future investigation and reporting.
3. Deputy Director, Angela Minniefield present to the Commission data on the success of increasing diversity through the Foundation Programs.