

**California CABG Outcomes Reporting Program (CCORP)
Clinical Advisory Panel
Minutes of August 14, 2012**

The meeting was held at OSHPD headquarters, 400 R Street, Sacramento CA 95811

Clinical Advisory Panel Members present:

James MacMillan, M.D.	Cheryl Damberg, Ph.D.
Coyness Ennix, Jr., M.D.	Andrew Bindman, M.D.
Keith Flachsbart, M.D.	Timothy Denton, M.D.
Robert Brook, M.D.	Fredrick Grover, M.D.

Clinical Advisory Panel Member absent:

Ralph Brindis, M.D.

OSHPD Staff and Consultants present:

Joseph Parker, Ph.D., Healthcare Outcomes Center (HOC) Manager	Beth Herse, Senior Staff Counsel
Holly Hoegh, Ph.D., HOC	Robert Springborn, Ph.D., HOC
Robert David, OSHPD Director	Mary Moseley, M.A., HOC
Ron Spingarn, HID Deputy Director	Elizabeth Wied, Chief Counsel
Denise O'Neill, HOC	Jaspreet Samra, MPH, Cal EIS Fellow, ADP
Justin Reyna, HOC Student Assistant	Anna Le, HOC Student Assistant
Zhongmin Li, Ph.D., UCD Contractor	Geeta Mahendra, M.A., UCD Contractor
Dominique Ritley, MPH, UCD Contractor	

1. Call to Order and Introductions

Robert Brook, M.D., chairperson, called the meeting to order at 10:00 am. Introductions were made. A quorum was present to conduct business.

2. Approval of Minutes of May 1, 2012. The minutes were approved.

3. Approval of Minutes of May 29, 2012. The minutes were approved.

4. Director's Report – Robert David

Director David introduced himself and stated that as a former Chief Deputy Director for OSHPD he has a long-standing knowledge of and support for CCORP. The Director reported that California is ahead of most states creating the Affordable Care Act insurance exchange. OSHPD is also undertaking a once a decade strategic planning process, which shall include input from management, staff, and stakeholders.

Although OSHPD is almost entirely funded by special funds and does not have the dire funding outlook most State government experiences, the department does take reductions to staff and operating costs along with all State departments. On August 31, OSHPD must dismiss nearly all student assistants, which will result in loss of productivity throughout the divisions.

5. Program Director's Report – Holly Hoegh, Ph.D.

Dr. Hoegh explained the statutory duties of the panel to be executed during this meeting: review of surgeon statements and consultation on public report contents.

The law requires OSHPD to publish a hospital-level report yearly and a surgeon-level report every other year. CCORP is drafting the 2010 report, which includes surgeon outcomes. Surgeons were mailed their results in June and had 30 days to submit a statement if they believed the risk-adjusted outcome was based on inaccurate data or the risk-adjustment model was flawed.

Initially, 5 surgeons and 16 cases were submitted for review to CCORP staff. After staff review, 3 surgeons asked for a CAP review of 5 cases. The identity of the surgeons is protected from disclosure. The CAP has the option to uphold or overturn the OSHPD staff (the Office) findings.

6. Panel Review of the Physicians' Statements

Surgeon A: The surgeon requested that the panel review a case believed to be coded incorrectly and requested at a change to non-isolated and/or salvage status. The CAP discussed whether this case should be coded as salvage or non-isolated CABG.

The CAP did not uphold the decision of the Office. They determined that the case be considered a non-isolated CABG (Vote 5-2).

Surgeon B: This surgeon submitted three cases for review.

Case B-2: The surgeon requested that the CAP review a case they felt should not be included in public reporting because the family chose to withdraw care. The CAP reiterated that the reporting process simply discloses outcomes: Death, whatever the cause, is a statistical reality.

The CAP voted unanimously to uphold the decision of the Office.

Case B-7: The surgeon requested that the CAP review a case of a patient with high risk factors. The surgeon felt the case should not be included in public reporting because the death occurred outside the hospital. This case was determined to be an operative death.

The CAP voted unanimously to uphold the decision of the Office.

Case B-8: The surgeon requested that the CAP review a case of a patient who was admitted several times but died outside of the hospital on day 30. The surgeon felt the case should not be included in public reporting because the death occurred outside the hospital. This case was determined to be an operative death.

The CAP voted unanimously to uphold the decision of the Office.

Surgeon C: The surgeon requested that the panel review a case where the patient died after discharge but under unfortunate and extenuating circumstances; however, the death was within 30 days.

The CAP voted unanimously to uphold the decision of the Office.

7. Public Reporting of Results for Surgeons Who have Died During the Reporting Year– Holly Hoegh, Ph.D.

Dr. Hoegh asked for a recommendation regarding how to present in public reports the data for surgeons who have subsequently died. After discussion, the panel unanimously supported the option of removing a surgeon's name from the public report and adding the notation that names of surgeons who have died have been removed.

8. Overview of the Statutory Process for Clinical Panel Appoints – Joseph Parker, Ph.D.

Dr. Parker presented an overview of the history and accomplishments of the CAP along with a timeline of important events. Under this panel's tenure, OSHPD produced 7 outcomes reports with the 8th report discussed at this meeting. OSHPD also completed two reports on program impact and one review of state programs. Additionally, 19 peer-reviewed, subject-related journal articles were published by UCD scholars and others.

The panel reached the 10-year mark with all members serving continually during that time. Some members were also involved in the original voluntary program in the mid-1990's. OSHPD Director Bob David will soon begin a process to open nominations for the panel. The process, outlined in Section 128748 of the Health and Safety Code, requires that nominations are submitted by the California Chapter of the American College of Cardiology, the California Medical Association, and

consumer organizations. Current members may be nominated to serve again. Ideally, the new panel would retain some current members for continuity. Per statute, Director David will make the final appointments. The timeline for the nomination process will take several months.

At this point OSHPD does not know if the current panel members will meet prior to new appointments. OSHPD wanted to release this information to the CAP prior to contacting the nominating organizations and others.

The panel members had a number of questions and concerns many of which focused on the statute offering wide latitude for the types of people appointed. CAP members strongly recommended the retention of 4 cardiac surgeon positions on the panel; OSHPD staff agreed to the importance of this recommendation.

9. Presentations on Issues Raised by the Panel Subcommittee at the May 1, 2012 meeting.

a) Hospital Performance Across Four Quality Measures, 2003-2009 – Holly Hoegh, Ph.D.

b) Applying a Fixed Risk-Adjustment Model to CCORP Data, 2003-2010 – Zhongmin Li, Ph.D.

Dr. Hoegh distributed a chart showing hospitals that were “better than” or “worse than” outliers over time. Dr. Parker noted that the only strong pattern to emerge is one hospital that continues to have low IMA usage.

Dr. Li presented information to answer a CAP question posed at a prior meeting: Could a fixed risk model be applied across the reporting years while retaining data outcome integrity? Using a 2008 study of a fixed risk model applied to CCORP data from 2003 to 2006, Dr. Li expanded the study data to include years 2007 to 2010. Although several potential advantages were identified for using a fixed model, the disadvantages were severe, including the inability to accommodate variable definition changes from STS or add new risk factors. The CAP/Dr. Li concluded that a fixed model is inconsistent with other public quality reporting program standards.

10. Public Comment

There was no public comment. The panel members used this time to encourage OSHPD to communicate with hospitals, surgeons, and the public about the successes of CCORP and improvements in cardiac care during the past ten years.

11. Adjournment

The meeting was adjourned at 12:21 p.m.