California CABG Outcomes Reporting Program (CCORP)
Clinical Advisory Panel
Minutes of January 15, 2009

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

Clinical Advisory Panel Members in attendance:
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.
Cheryl Damberg, Ph.D.
Keith D. Flachsbart, M.D.
Frederick L. Grover, M.D.
James MacMillan, M.D.

Clinical Advisory Panel Member absent:

Coyness Ennix, Jr., M.D.

OSHPD Staff/Consultants in attendance:

David Carlisle, OSHPD Director
Ron Springarn, Deputy Director Healthcare Information Division
Joseph Parker, Ph.D., HOC
Holly Hoegh, Ph.D., HOC
Robert Springborn, Ph.D., HOC
Denise O'Neill, HOC
Mary Moseley, HOC
Elizabeth Wied, OSHPD Chief Legal Counsel
Beth Herse, OSHPD Legal Counsel
Zhongmin Li, Ph.D., HOC Consultant
Geeta Mahendra, HOC Consultant
Anthony Steimle, M.D., HOC Consultant
James Marcin, M.D., UCD
Richard H. White, M.D., UCD
Beate Danielsen, UCD
Patrick Romano, M.D., UCD
Peters Shorthand staff

Members of the public present:

Kyna Fong

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1. Call to Order and Introductions

Robert Brook, M.D., Chairperson, called the meeting to order at 8:30 a.m. A quorum was not present. Introductions were made by those in attendance and later for attendees who arrived after 8:30 a.m. A quorum was present by 8:40 a.m.

2. Approval of September 3, 2008 Minutes

Dr. Brook asked for comments or corrections to the minutes of the previous meeting. None were offered. The panel approved the minutes of the previous meeting unanimously.

3. OSHPD Director's Report – David Carlisle, M.D.

Dr. Carlisle explained the State's General Fund budget deficit of $41 or $42 billion does not affect OSHPD directly, since the Office operates with special funds; however, OSHPD will participate in employee furloughs, creating a 10% pay cut for staff and a corresponding reduction in work products. The Office may also absorb employees from departments with major funding reductions and layoffs. OSHPD has loaned the State General Fund $10 million.

In response to questions and discussion, Dr. Carlisle stated the Governor's health care reform bill, which would have permitted collection of clinical data for PCI reporting, did not pass the legislature last year; however, PTCA is one of the procedures OSHPD collects and reports from administrative data. The Office plans to publish more reports derived from administrative data in the future. He also stated that Ron Spingarn, the new Deputy Director for the Healthcare Information Division, could direct staff to develop a brief policy paper regarding the State of California's role in CABG reporting as it relates to efforts in public and private reporting nationally and reporting done in other states.

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

Dr. Hoegh reviewed the role of the Clinical Advisory Panel. By state law, the advisory panel's role is to review and approve risk-adjusted models, consult on report materials, recommend data elements, and review physician statements.

The 2005-06 data report is currently under administrative review, and OSHPD hopes for a February release. Dr. Hoegh reviewed the processes required and time line developed for completion of this report.

Also addressed in her presentation were the decrease in isolated CABG volume in states that publicly report; an increase in PCI's in California; and a reduction in CABG in-hospital mortality rates in California.

The medical audits of 2007 hospital charts will begin later in January and will include 1,260 records at 18 hospitals. The audit will target outlier and borderline outlier hospitals, hospitals with poor risk factor coding, and a random selection of remaining hospitals. The audit will focus on complications, elements that have been problematic in previous audits, and salvage cases.

2008 is the first year using the new data elements. The first half of 2008 data has been received and the second half is due in March. Preliminary data indicates a continued decline in CABG volume.

Upcoming CCORP activities include defining a data element for liver disease and continued research regarding the effect of excluding cardiogenic shock cases. Online collection of CABG clinical data is moving forward for implementation later this year.

The panel discussed long-range plans for isolated CABG reporting in California. Several panel members expressed interest in reviewing other topics which could benefit from public reporting in light of the decline of CABG volume, the reduction in CABG mortality, and the decreased reliability of performance assignments with low volume data. Also discussed was the broader issue of individuals who may lack access to appropriate medical care, including CABG surgery. The panel recommended that the office develop a guiding document or strategic plan that addresses OSHPD and California's role in advancing transparency and quality in cardiac care and, given related national efforts, advances in clinical care, and the work of professional societies, provide suggestions for directions that future work include.

5. Post-Operative Inpatient Stroke as a Risk-Adjusted Outcome for Isolated CABG Patients – Richard White, M.D.

Dr. White presented information about 2006 data quality as related to prevalence of complication measures and hospital variation in prevalence of complications. Complications included Re-Op for Bleed/Tamponade, Re-Op for Graft Occlusion, Deep Sternal Wound Infection, Post-Op Stroke > 72 hours, Prolonged Ventilation > 24 hours, Continuous Coma greater or equal to 24 hours, and Post-Op Renal Failure. Post-Op Stroke and Prolonged Ventilation had moderate to high numbers of events and good Kappa statistics in the audit, so were selected for risk model development.

The panel discussed complication measures in detail and advised OSHPD staff to conduct work on a composite hospital quality measure, answer a variety of questions about possible approaches to be used, and confirm that analysis of 2007 data substantiates the data findings presented to the panel for 2006 data. OSHPD will report back at the May meeting.

The panel discussed the robustness and parsimony of risk models for stroke. Panel suggested OSHPD combine 2006 and 2007 data to create a parsimonious model that may include variables of clinical importance.

Action: The panel approved a two-year risk model for Stroke dependent on analysis of 2007 data that substantiates the 2006 findings presented to the panel.

6. Post-Operative Prolonged Ventilation as a Risk-Adjusted Outcome for isolated CABG Patients – Richard White, M.D.

Dr. White presented the 2006 prolonged ventilation risk model methodology.

The panel had an extensive discussion on the inclusion of prolonged ventilation in the 2007 public report and questioned whether it was an actual independent measure of health care quality or a marker of efficiency/resource use. They determined it should not be reported to the public.

The Panel took no action on a risk model for prolonged ventilation.

7. Preliminary Report on the Impact of Mandatory Public Reporting of CABG Outcomes – Patrick Romano, M.D., M.P.H.

Dr. Romano presented preliminary research regarding public reporting of CABG outcomes on subsequent volume changes, risk-adjusted mortality, and case selection for surgery. He also presented a comparison with other state's CABG reporting.

In the literature review, volume and market share effects appeared insignificant; however, in the State of New York, a study showed larger effects on surgeon volume.

In terms of risk-adjusted mortality, several studies showed reduced mortality to be attributed to public reporting. In New York, the effect appears to result both from lower volume surgeons leaving and focused efforts to improve high-mortality outlier hospitals. Report cards in New Jersey and Pennsylvania indicated similar effects but not the report card in Cleveland.

In New York, no overall effects on severity of illness were shown. New York and Pennsylvania showed a clustering of sicker patients at teaching hospitals with limited evidence of increased selection of low-risk patients after AMI. Increased racial and ethnic disparities occurred in New York, perhaps attributable to surgeons using race and ethnicity as proxy for severity of illness and avoiding these patients.

Dr. Romano first studied the effects of CABG reports in California using data from the 1997 to 2002 voluntary submissions, which included about 2/3 of the hospitals performing CABG surgeries. Beginning in 2003, submission of data was mandatory for all hospitals performing CABG surgeries. The large amount of data over time allows for statistical significance. These data indicate a downward trend in CABG volume with a flattening of the decline in the mandatory reporting era, indicating the decline cannot be attributed to CCORP. The expected mortality, based on the risk model, held constant or declined slightly. There were no apparent trends in case selection; however, patients may be lost on both the low and high ends of the risk distribution, making the overall risk appear to be constant.

Taken as a whole, the lower rated hospitals have managed to improve, the higher rated hospitals have maintained, the better rated surgeons tended to have a little higher volume, the lower rated surgeons had a small decrease in volume, and CABG surgeries diminished across the board. Dr. Romano emphasized these are preliminary findings with more research yet to be done.

8. Definition of Isolated CABG

This agenda item was deferred until the May meeting.

9. Public Comment

No public comment was forthcoming.

The meeting was adjourned at noon. The next meeting will be held in Sacramento on May 6.