(Amended by Stats. 2011, Ch. 32, Sec. 29. Effective June 29, 2011. Operative January 1, 2012, by Sec. 73 of Stats. 2011, Ch. 32.)

128745.

(a) Commencing July 1993, and annually thereafter, the office shall publish risk-adjusted outcome reports in accordance with the following schedule:

Publication Date	Period Covered	Procedures and Conditions Covered
July 1993	1988–90	3
July 1994	1989–91	6
July 1995	1990–92	9

Reports for subsequent years shall include conditions and procedures and cover periods as appropriate.

(b) The procedures and conditions required to be reported under this chapter shall be divided among medical, surgical, and obstetric conditions or procedures and shall be selected by the office. The office shall publish the risk-adjusted outcome reports for surgical procedures by individual hospital and individual surgeon unless the office in consultation with medical specialists in the relevant area of practice determines that it is not appropriate to report by individual surgeon. The office, in consultation with the clinical panel established by Section 128748 and medical specialists in the relevant area of practice, may decide to report nonsurgical procedures and conditions by individual physician when it is appropriate. The selections shall be in accordance with all of the following criteria:

(1) The patient discharge abstract contains sufficient data to undertake a valid risk adjustment. The risk adjustment report shall ensure that public hospitals and other hospitals serving primarily low-income patients are not unfairly discriminated against.

(2) The relative importance of the procedure and condition in terms of the cost of cases and the number of cases and the seriousness of the health consequences of the procedure or condition.

(3) Ability to measure outcome and the likelihood that care influences outcome.

(4) Reliability of the diagnostic and procedure data.

(c) (1) In addition to any other established and pending reports, on or before July 1, 2002, the office shall publish a risk-adjusted outcome report for coronary artery bypass graft surgery by hospital for all hospitals opting to participate in the report. This report shall be updated on or before July 1, 2003.

(2) In addition to any other established and pending reports, commencing July 1, 2004, and every year thereafter, the office shall publish risk-adjusted outcome reports for coronary artery bypass graft surgery for all coronary artery bypass graft surgeries performed in the state. In each year, the reports shall compare risk-adjusted outcomes by hospital, and in every other year, by hospital and cardiac

surgeon. Upon the recommendation of the clinical panel established by Section 128748 based on statistical and technical considerations, information on individual hospitals and surgeons may be excluded from the reports.
(3) Unless otherwise recommended by the clinical panel established by Section 128748, the office shall collect the same data used for the most recent risk-adjusted model developed for the California Coronary Artery Bypass Graft Mortality Reporting Program. Upon recommendation of the clinical panel, the office may add any clinical data elements included in the Society of Thoracic Surgeons' database. Prior to any additions from the Society of Thoracic Surgeons' database, the following factors shall be considered:
(A) Utilization of sampling to the maximum extent possible.
(B) Exchange of data elements as opposed to addition of data elements.
(4) Upon recommendation of the clinical panel, the office may add, delete, or revise clinical data elements, but shall add no more than a net of six elements not included in the Society of Thoracic Surgeons' database, to the data set over any five-year period. Prior to any additions or deletions, all of the following factors shall be considered:
(A) Utilization of sampling to the maximum extent possible.
(B) Feasibility of collecting data elements.
(C) Costs and benefits of collection and submission of data.
(D) Exchange of data elements as opposed to addition of data elements.
(5) The office shall collect the minimum data necessary for purposes of testing or validating a risk-adjusted model for the coronary artery bypass graft report.
(6) Patient medical record numbers and any other data elements that the office believes could be used to determine the identity of an individual patient shall be exempt from the disclosure requirements of the California Public Records Act (Chapter 3.5 (commencing with Section 6250) of Division 7 of Title 1 of the Government Code).
(d) The annual reports shall compare the risk-adjusted outcomes experienced by all patients treated for the selected conditions and procedures in each California hospital during the period covered by each report, to the outcomes expected. Outcomes shall be reported in the five following groupings for each hospital:
(1) "Much higher than average outcomes," for hospitals with risk-adjusted outcomes much higher than the norm.
(2) "Higher than average outcomes," for hospitals with risk-adjusted outcomes higher than the norm.
(3) "Average outcomes," for hospitals with average risk-adjusted outcomes.
(4) "Lower than average outcomes," for hospitals with risk-adjusted outcomes lower than the norm.
(5) "Much lower than average outcomes," for hospitals with risk-adjusted outcomes much lower than the norm.
(e) For coronary artery bypass graft surgery reports and any other outcome reports for which auditing is appropriate, the office shall conduct periodic auditing of data at hospitals.
(f) The office shall publish in the annual reports required under this section the risk-adjusted mortality rate for each hospital and for those reports that include physician reporting, for each physician.

(g) The office shall either include in the annual reports required under this section, or make separately available at cost to any person requesting it, risk-adjusted outcomes data assessing the statistical significance of hospital or physician data at each of the following three levels: 99-percent confidence level (0.01 p-value), 95-percent confidence level (0.05 p-value), and 90-percent confidence level (0.10 p-value). The office shall include any other analysis or comparisons of the data in the annual reports required under this section that the office deems appropriate to further the purposes of this chapter.
(Amended by Stats. 2011, Ch. 32, Sec. 30. Effective June 29, 2011. Operative January 1, 2012, by Sec. 73 of Stats. 2011, Ch. 32.)

128747.

Commencing July 1, 2002, and biennially thereafter, the office shall evaluate the impact of the office's published risk-adjusted outcome reports required by Sections 128745 and 128746 on mortality rates in California and on any other measure of quality the office deems appropriate. The office shall also coordinate with other state agencies in promoting prevention and educational initiatives on those reported procedures and conditions.
(Added by Stats. 2001, Ch. 898, Sec. 7. Effective January 1, 2002.)

128748.

(a) This section shall apply to any risk-adjusted outcome report that includes reporting of data by an individual physician.
(b) (1) The office shall obtain data necessary to complete a risk-adjusted outcome report from hospitals. If necessary data for an outcome report is available only from the office of a physician and not the hospital where the patient received treatment, then the hospital shall make a reasonable effort to obtain the data from the physician's office and provide the data to the office. In the event that the office finds any errors, omissions, discrepancies, or other problems with submitted data, the office shall contact either the hospital or physician's office that maintains the data to resolve the problems.
(2) The office shall collect the minimum data necessary for purposes of testing or validating a risk-adjusted model. Except for data collected for purposes of testing or validating a risk-adjusted model, the office shall not collect data for an outcome report nor issue an outcome report until the clinical panel established pursuant to this section has approved the risk-adjusted model.
(c) For each risk-adjusted outcome report on a medical, surgical, or obstetric condition or procedure that includes reporting of data by an individual physician, the office director shall appoint a clinical panel, which shall have nine members. Three members shall be appointed from a list of three or more names submitted by the physician specialty society that most represents physicians performing the medical, surgical, and obstetric procedure for which data is collected. Three members shall be appointed from a list of three or more names submitted by the California Medical Association. Three members shall be appointed from lists of names submitted by consumer organizations. At least one-half of the appointees

from the lists submitted by the physician specialty society and the California Medical Association, and at least one appointee from the lists submitted by consumer organizations, shall be experts in collecting and reporting outcome measurements for physicians or hospitals. The panel may include physicians from another state. The panel shall review and approve the development of the risk-adjustment model to be used in preparation of the outcome report.
(d) For the clinical panel authorized by subdivision (c) for coronary artery bypass graft surgery, three members shall be appointed from a list of three or more names submitted by the California Chapter of the American College of Cardiology. Three members shall be appointed from list of three or more names submitted by the California Medical Association. Three members shall be appointed from lists of names submitted by consumer organizations. At least one-half of the appointees from the lists submitted by the California Chapter of the American College of Cardiology, and the California Medical Association, and at least one appointee from the lists submitted by consumer organizations, shall be experts in collecting and reporting outcome measurements for physicians and surgeons or hospitals. The panel may include physicians from another state. The panel shall review and approve the development of the risk-adjustment model to be used in preparation of the outcome report.
(e) Any report that includes reporting by an individual physician shall include, at a minimum, the risk-adjusted outcome data for each physician. The office may also include in the report, after consultation with the clinical panel, any explanatory material, comparisons, groupings, and other information to facilitate consumer comprehension of the data.
(f) Members of a clinical panel shall serve without compensation, but shall be reimbursed for any actual and necessary expenses incurred in connection with their duties as members of the clinical panel.
(Added by Stats. 2001, Ch. 898, Sec. 8. Effective January 1, 2002.)

128750.

(a) Prior to the public release of the annual outcome reports, the office shall furnish a preliminary report to each hospital that is included in the report. The office shall allow the hospital and chief of staff 60 days to review the outcome scores and compare the scores to other California hospitals. A hospital or its chief of staff that believes that the risk-adjusted outcomes do not accurately reflect the quality of care provided by the hospital may submit a statement to the office, within the 60 days, explaining why the outcomes do not accurately reflect the quality of care provided by the hospital. The statement shall be included in an appendix to the public report, and a notation that the hospital or its chief of staff has submitted a statement shall be displayed wherever the report presents outcome scores for the hospital.
(b) (1) Prior to the public release of any outcome report that includes data by a physician, the office shall furnish a preliminary report to each physician that is included in the report. The office shall allow the physician 30 days from the date the office sends the report to the physician to review the outcome scores and compare the scores to other California physicians. A physician who believes that the

risk-adjusted outcome does not accurately reflect the quality of care provided by the physician may submit a statement to the office within the 30 days, explaining why the outcomes do not accurately reflect the quality of care provided by the physician.
(2) The office shall promptly review the physician's statement and shall respond to the physician with one of the following conclusions:
(A) The physician's statement reveals a flaw in the accuracy of the reported data relating to the physician that materially diminishes the validity of the report. If this finding is made, the data for that physician shall not be included in the report until the flaw in the physician's data is corrected.
(B) The physician's statement reveals a flaw in the risk-adjustment model that materially diminishes the value of the report for all physicians. If this finding is made, the report using that risk-adjustment model shall not be issued until the flaw is corrected.
(C) The physician's statement does not reveal a flaw in either the accuracy of the reported data relating to the physician or the risk-adjustment model in which case the report shall be used, unless the physician chooses to use the procedure set forth in paragraph (3).
(3) If a physician is not satisfied with the conclusion reached by the office, the physician shall notify the office of that fact. Upon receipt of the notice, the office shall forward the physician's statement to the appropriate clinical panel appointed pursuant to Section 128748. The office shall forward the physician's statement with any information identifying the physician or the physician's hospital redacted, or shall adopt other means to ensure the physician's identity is not revealed to the panel. The clinical panel shall promptly review the physician statement and the conclusion of the office and shall respond by either upholding the conclusion or reaching one of the other conclusions set forth in this subdivision. The panel decision shall be the final determination regarding the physician's statement. The process set forth in this subdivision shall be completed within 60 days from the date the office sends the report to each physician included in the report. If a decision by either the office or the clinical panel cannot be reached within the 60-day period, then the outcome report may be issued but shall not include data for the physician submitting the statement.
(c) The office shall, in addition to public reports, provide hospitals and the chiefs of staff of the medical staffs with a report containing additional detailed information derived from data summarized in the public outcome reports as an aid to internal quality assurance.
(d) If, pursuant to the recommendations of the office, the Legislature subsequently amends Section 128735 to authorize the collection of additional discharge data elements, then the outcome reports for conditions and procedures for which sufficient data is not available from the current abstract record will be produced following the collection and analysis of the additional data elements.
(e) The recommendations of the office for the addition of data elements to the discharge abstract should take into consideration the technical feasibility of developing reliable risk-adjustment factors for additional procedures and conditions as determined by the office with the advice of the research community, physicians and surgeons, hospitals, consumer or patient advocacy groups, and medical records personnel.

(f) The office at a minimum shall identify a limited set of core clinical data elements to be collected for all of the added procedures and conditions and unique clinical variables necessary for risk adjustment of specific conditions and procedures selected for the outcomes report program. In addition, the committee should give careful consideration to the costs associated with the additional data collection and the value of the specific information to be collected.

(g) The office shall also engage in a continuing process of data development and refinement applicable to both current and prospective outcome studies.

(Amended by Stats. 2011, Ch. 32, Sec. 31. Effective June 29, 2011. Operative January 1, 2012, by Sec. 73 of Stats. 2011, Ch. 32.)