California CABG Outcomes Reporting Program (CCORP)
Clinical Advisory Panel
Minutes of October 1, 2010

The meeting was held at OSHPD Headquarters, 400 R Street, Sacramento, California

Clinical Advisory Panel Members in attendance:

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<th>Robert Brook, M.D., Sc.D, Chair</th>
<th>Cheryl Damberg, Ph.D.</th>
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<td>Timothy Denton, M.D. FACC</td>
<td>Coyness Ennix, Jr., M.D.</td>
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<td>Keith Flachsbart, M.D.</td>
<td>James MacMillan, M.D.</td>
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Clinical Advisory Panel Members absent:

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<th>Andrew Bindman, M.D.</th>
<th>Fredrick Grover, M.D.</th>
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<td>Ralph Brindis, M.D., FACC</td>
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OSHPD Staff/Consultants in attendance:

| David M. Carlisle, M.D., Ph.D., OSHPD Director | Ron Spingarn, Deputy Director, Healthcare Information Division |
| Joseph Parker, Ph.D., Healthcare Outcomes Center Manager | Holly Hoegh, Ph.D., Healthcare Outcomes Center |
| Mary Moseley, M.A., Healthcare Outcomes Center | Denise O’Neill, Healthcare Outcomes Center |
| Robert Springborn, Ph.D., Healthcare Outcomes Center | Merry Holliday-Hanson, Ph.D., Healthcare Outcomes Center |
| Niya Fong, Healthcare Outcomes Center | Sanaa Shabbir, M.P.H, Cal EIS Fellow, Healthcare Outcomes Center Contractor |
| Anna Le, Healthcare Outcomes Center Student Assistant | Daniel Kassis, Healthcare Outcomes Center Student Assistant |
| Beth Herse, OSHPD Sr. Legal Counsel | |
| Zhongmin Li, Ph.D., UCD, Healthcare Outcomes Center Contractor | Geeta Mahendra, UCD, Healthcare Outcomes Center Contractor |
| Dominique Ritley, MPH, UCD, Healthcare Outcomes Center Contractor | Anthony Steimle, M.D., Healthcare Outcomes Center Cardiology Consultant |

Several Members of the Public were also present.

1. Call to Order and Introductions

Robert Brook, M.D., Chairperson, called the meeting to order at 10:30 a.m. A quorum of members was present. Introductions were made.

2. Approval of Minutes of the June 1, 2010 Meeting

The minutes of the June 2010 meeting were approved unanimously.
3. Director’s Report – David Carlisle, M.D., Ph.D., OSHPD Director

Dr. Carlisle noted that state government continues to operate without a budget. OSHPD staff have three unpaid furlough days monthly, which has caused delays in completion of work. Current year contracts are also frozen as is hiring of additional or replacement state employees.

The Governor recently signed legislation to establish a Health Care Exchange in California as a part of national health reform. The exchanges are due to be active in 2014. Dr. Brook noted that not all states will create exchanges.

4. CCORP Program Update – Holly Hoegh, Ph.D., CCORP Manager

Every year the OSHPD produces a hospital level CABG outcomes report and every two years a hospital/surgeon level report. For the hospital/surgeon level report, OSHPD furnishes a preliminary report to every surgeon who shall be included in the upcoming public report. Surgeons have thirty days to provide a statement to OSHPD if they believe their risk-adjusted outcomes are inaccurate. Health and Safety Code, Section 128750 (b) (1), provides surgeons the right to request case reviews by the Clinical Advisory Panel if they do not agree with the OSHPD determination of their statement.

At this meeting the Panel’s primary responsibility was to review surgeon statements regarding case disputes. OSHPD received ten statements for the 2007-2008 report. For OSHPD to uphold a surgeon statement, the surgeon must reveal a flaw in the data or in the risk adjustment model. Five surgeons disagreed with the OSHPD’s determinations and their seven cases were to be reviewed at this meeting. Dr. Hoegh sent Panel members all review cases in advance of the meeting. Public packets were available for audience members, and those packets were collected by OSHPD staff at the end of the meeting.

The Panel could reach three possible conclusions for each statement:

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. The data for this physician shall not be included in the report until the following flaw(s) 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. The report using this risk-adjustment model shall not be issued until the following flaw(s) 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. The preliminary report data for this physician shall be used.

Dr. Brook thanked Holly Hoegh for providing food and beverages for the meeting. The State does not reimburse for food, so individuals provide funding for refreshments.
5. Surgeon Statement Review

Case designated as A-1

The surgeon provided emergency coverage at another hospital and was not given an opportunity to review the data and was never informed by that hospital of the patient’s eventual death. The hospital staff certified that the surgeon was given an opportunity to review the data, but did not complete a surgeon certification form. Some Panel members were concerned about the apparent lack of communication between the hospital and the surgeon. The law does not require hospitals to document attempts to reach surgeons. The surgeon statement did not claim a flaw in the data or the risk adjustment model.

The Panel chose to uphold the conclusion of OSHPD that the statement did not reveal a flaw in the data or risk-adjustment model.

Case designated as A-2

The patient was extremely ill with significant comorbidities. The patient was discharged to a skilled nursing facility and died there. The surgeon was unaware of the cause of death and asked that this death not be attributed to them.

Dr. Brook asked if the Panel -- as well as surgeons -- could receive the expected mortalities for individual patient cases. Legal staff stated that, by statute, OSHPD could not provide this information to the Panel, as OSHPD may only provide the statement submitted by the surgeon and OSHPD response. Dr. Hoegh stated that surgeons could run their cases through the risk model themselves, but they do not receive calculated expected mortality information from OSHPD. The letters which surgeons receive from OSHPD do list the risk factors found in each particular case. Dr. Steimle stated that two medical conditions noted in the subject case are not in the risk adjustment model – Alzheimers and occult liver disease. The surgeon did not claim a flaw in the data or the risk adjustment model.

The Panel chose to uphold the conclusion of OSHPD that the statement did not reveal a flaw in the data or risk-adjustment model.

Recommendation: At a future meeting, the Panel would like to discuss how to provide surgeons with information about the credit they receive for their cases.

Case designated as A-3

Patient appeared to have substantial comorbidities. She survived surgery but developed problems four days later and died. Panel members noted that values stated in the case description do not always match the lab values, as in the examples of bowel status, portal vein thrombosis, and evidence that the patient had severe preexisting liver disease. The surgeon did not identify a flaw in the data or in the risk adjustment model.
The Panel chose to uphold the conclusion of OSHPD that the statement did not reveal a flaw in the data or risk-adjustment model.

**Case designated as B**

The surgeon requested the Panel review two cases; however, the surgeon did not supply the required documentation for the Panel to review. No flaw in the data was found or in the risk adjustment model.

The Panel chose to uphold the conclusion of OSHPD that the statement did not reveal a flaw in the data or risk-adjustment model.

**Case designated as C**

The surgeon believed a case does not qualify as an isolated CABG surgery because it should be coded as salvage. The case did not meet the definition for salvage, since CPR was not documented on the way to surgery. No flaws in the data or the risk adjustment model were substantiated.

The Panel chose to uphold the conclusion of OSHPD that the statement did not reveal a flaw in the data or risk-adjustment model.

**Case designated as D**

This patient refused blood products on religious grounds. Postoperatively she was unstable with low blood pressures and cardiac index. The hospital sought family consent and ethics consult to perform ECMO stabilization and emergent catheterization. After consent the procedures were conducted, but the patient did not survive. The surgeon would like the case excluded. Refusal of blood products as a potential exclusionary factor has been discussed at many Panel meetings but has not reached exclusionary status from either STS or CCORP. No flaws in the data or the risk adjustment model were found.

The Panel chose to uphold the conclusion of OSHPD that the statement did not reveal a flaw in the data or risk-adjustment model.

**Case designated as E**

This case also involved a patient who refused blood products on religious grounds. The death of the patient in case “D” was directly related to the surgery, but this case was not. The patient died as a result of severe anemia from a lower GI bleed after being readmitted to the hospital nine days after discharge. No flaws in the data or the risk adjustment model were found.

The Panel chose to uphold the conclusion of OSHPD that the statement did not reveal a flaw in the data or risk-adjustment model.
The Panel discussed refusal of blood products as an exclusionary factor, since the issue arises frequently. National STS has reviewed this issue and the discussion is on-going. The Panel also discussed how surgeons could develop strategies to evaluate and serve these patients. Many patients who refuse blood products are referred to surgeons who specialize in treating them. Also, some studies have indicated no appreciable difference in outcomes for certain patients who refuse blood products for religious reasons.

Dr. Parker suggested that the Panel could request CCORP evaluate a data element for refusal of blood products. In the process, CCORP would review the extent of the problem.

At a future meeting, the Panel would like to revisit— for the surgeon report only — a possible exclusion for refusal of blood products. The group requests CCORP gather and review the data then report back.

For a future meeting, the Panel would like to revisit the possibility of excluding those patients who died within 30 days of surgery when the death was clearly not a result of the surgery, such as airplane crashes and automobile accidents. This exclusion would only be considered for surgeon level reports.

6. Public Comment and Adjournment

No members of the public commented. Dr. Brook adjourned the meeting at 11:37 a.m.

Dr. Hoegh will schedule the next meeting for December or early January. The main agenda items shall be review and approval of new STS data elements and inclusion of possible new data elements for California.