

# Managing Data for Cardiac Outcomes Reporting

CCORP Data Abstractor Training  
February 1, 2012



# Agenda

- Welcome
- About CCORP
- Risk Adjustment for CABG Surgery Outcomes – The Basics
- Data Element Definitions (Version 5.1 – starting July 1 2011)
- Q and A
- Vignettes



# Training Objectives

- To define CCORP and its data submission and correction process
- To understand how the CCORP public reports are produced and used
- To understand how the basics of risk adjustment
- To understand CCORP data element definitions
- To understand why proper and consistent coding are critically important to generating accurate quality-of-care analyses
- To understand how to review hospital records and documentation to accurately code cases



# History of CCORP

- 1996-2002 voluntary program started. Over 75 hospitals participated.
- 2001 Senate Bill 680 passed. Mandated public reporting of risk-adjusted outcomes for all California non-federal hospitals that perform CABG surgery.
- Public reports:
  - 2003 hospital report: February 2006
  - 2003-2004 hospital/surgeon report: July 2007
  - 2005 hospital report: January 2008
  - 2005-2006 hospital/surgeon report: April 2009
  - 2007 hospital report: October 2010
  - 2007-2008 hospital/surgeon report: June 2011
  - 2009 hospital report: soon!



# History of CCORP

## ■ Milestones

- 2003-2004 Report included finding for Internal Mammary Usage.
- 2007 Report included hospital level outcomes for post-operative stroke (2006-2007 combined).
- 2009 Report will include hospital level outcomes for readmissions.
- 2009 was the first year of on-line data submission.

## ■ Successes

- Operative mortality rate has dropped from 3.91% in 2003 to 1.90% in 2009.
- IMA utilization has increased from 89.6% in 2003 to 96.2% in 2009 (note: this increase is partially due to exclusions that have been added overtime).
- Three successful surgeon statement (appeals) processes.

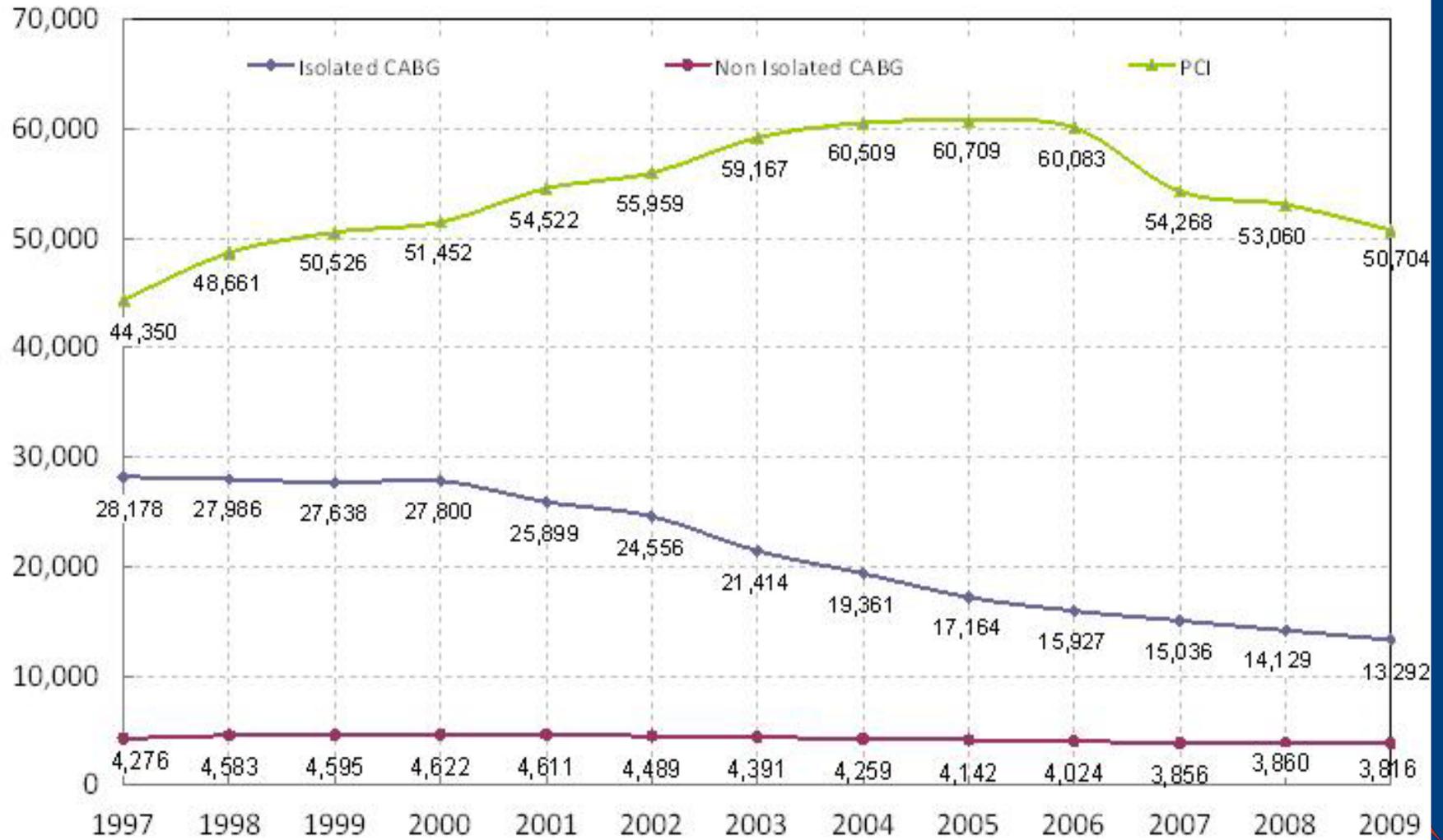


# Clinical Advisory Panel

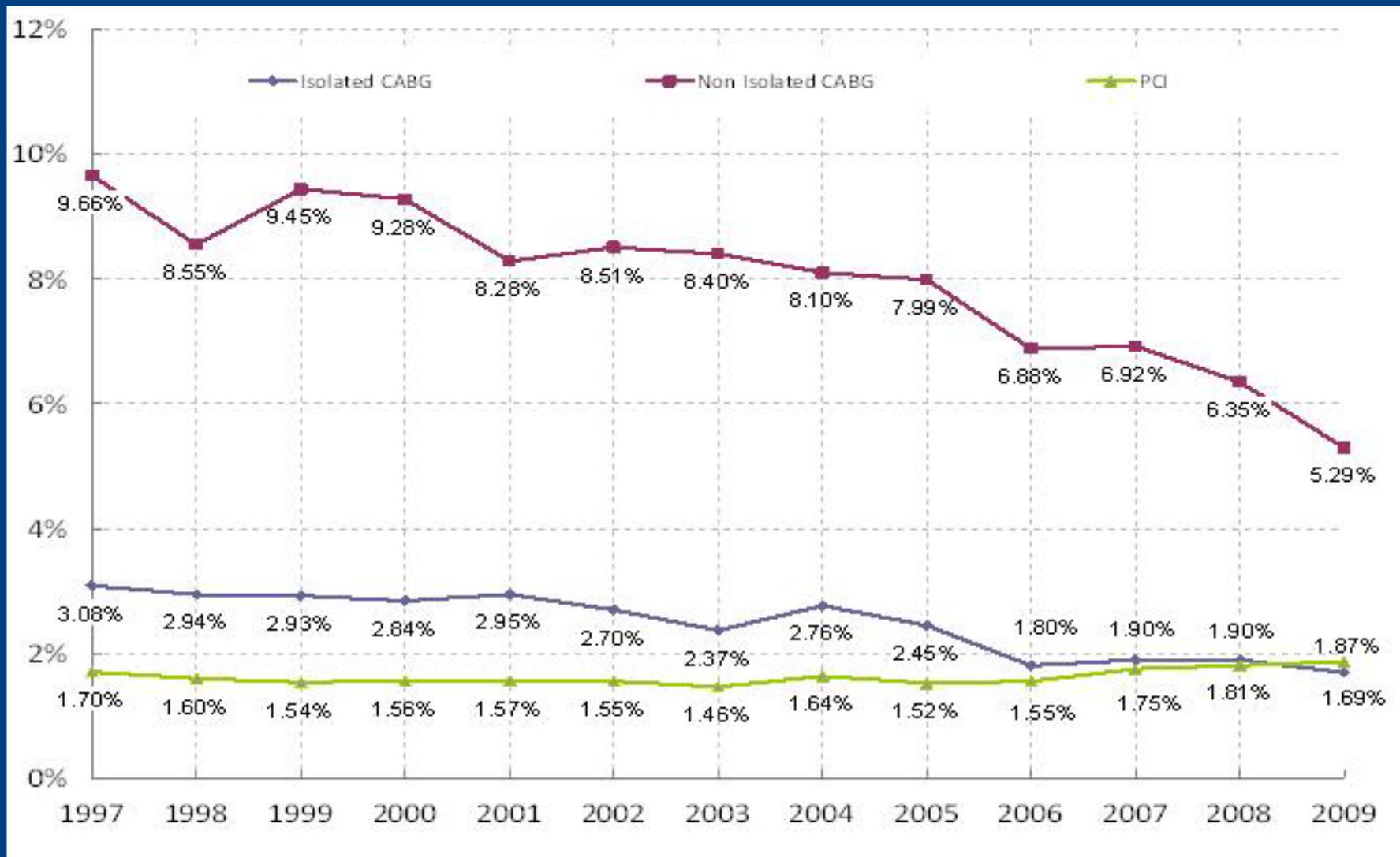
- Senate Bill 680 also established a Clinical Advisory Panel. The panel's role is to:
  - Recommend data elements
  - Review and approve risk-adjustment models
  - Review physician statements
  - Consult on report materials
- Public meetings are held once to twice a year
- Next meeting: May 1, 2012



# Volume of Isolated CABG, Non-Isolated CABG, and PCI Surgery in California 1997-2009



# In-Hospital Mortality Rates for Iso CABG, Non-Iso CABG, and PCI Surgery in California 1997-2009



# CCORP Overview

- Approximately 120 hospitals in California perform CABG surgery.
- Hospital data submissions include both isolated and non-isolated CABG cases, currently only isolated outcomes publicly reported, but we expect to report CABG + valve in the future.
- Submissions DO NOT include non-CABG open heart cases.



# Data Submission and Correction Process

- Each six months of data (Jan-Jun and Jul-Dec) is due 90 days after report period.
- Cardiac Online Reporting for California (CORC) is used for file upload or online data entry.
- Test submission function available.
- Data passes or fails submission and immediate feedback is displayed.
- A notice is sent to the primary data contact if documentation is needed for cardiogenic shock and/or salvage cases.
- A Data Quality Report is automatically created when data is accepted.
- A 30-day extension period is available through CORC.



# Data Submission and Correction Process (cont.)

- After clean submissions are in from all hospitals, CORC is opened for a 20-day data correction period.
- After CCORP has reviewed all data, CORC is open for the final 30-day data correction period. Hospitals receive a Data Discrepancy Report. After hospitals finalize data, surgeon certification forms are generated.
- Each surgeon must attest to the accuracy of the data for his or her CABG surgeries AND hospitals should fax all completed and signed Surgeon Certification Forms **within** the final 30-day correction period.



# Producing the Public Reports

- CCORP data is linked to state death records to determine deaths that occurred after discharge but with-in 30-days.
- A subset of hospitals are audited.
- The Clinical Advisory Panel approves risk-adjustment models and report contents.
- Preliminary Results are sent to hospitals (every year) and surgeons (every other year).
- The mortality and post-op stroke cases are sent to each hospital for review.



# Producing the Public Reports

- Hospitals have 60 days to submit a statement if they believe the risk-adjusted outcomes do not accurately reflect the quality of care provided. Statements will be included in the public report.
- Surgeons have 30 days to submit a statement if they believe the risk-adjusted outcome does not accurately reflect the quality of care provided.
  - OSHPD reviews statements and makes determinations.
  - If a surgeon is not satisfied with the OSHPD determination they may forward the statement to the Clinical Advisory Panel (CAP) for review.
  - The CAP's determination is considered final.
- CCORP prepares public report.
- Approved at Department and Agency level.



# How Public Reports Are Used (cont.)

- Allows consumers to make informed healthcare decisions for themselves, family or friends.
- Allows payers and employers with information to help them spend their healthcare dollars more effectively.
- Provides benchmarks so hospitals and surgeons can:  
Measure their own performance, Review patient care practices, Improve their quality outcomes



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CORC is OSHPD's secure internet Coronary Artery Bypass Graft (CABG) data collection system. CORC was developed to assist

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## Healthcare Information Division Coronary Artery Bypass Graft (CABG) Surgery in California

CABG surgery is the most common surgical procedure for treating coronary artery disease. In this surgery, a vein or artery from another part of the body is used to create a new path for blood to flow to the heart, bypassing the blocked artery. Coronary artery disease is the leading cause of all adult non-maternal admissions to California hospitals, representing nearly 9% of all admissions. It is a chronic condition in which cholesterol and fat solidify to form plaque along the linings of the coronary arteries. If plaque continues to build up, blood vessels can be restricted or blocked leading to chest pain or a heart attack.

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