APPENDIX A: HOSPITAL STATEMENTS

Each hospital included in this report was provided with a preliminary report containing the risk-adjustment model, explanatory materials, and results for all hospitals. Hospitals were given a 60-day review period for submitting statements to OSHPD for inclusion in this report. Five hospitals submitted letters which are included here.

Two of the hospitals were concerned with the presentation of the combined hospital-level results for 2005-2006. They argue that the 2006 hospital ratings provide a better picture of their current performance. Recognizing that most readers are interested in the most recent hospital results, the current report highlights the 2006 hospital-level results. However, it also includes the 2005-2006 results since the increased number of patients per hospital over two years provides more stable estimates of hospital performance during that time period.

One hospital noted the significant drop in statewide operative mortality between the 2003-2004 and 2005-2006 report periods and changes in hospital performance ratings between the two reports. This hospital was also concerned with the definition of operative mortality, which includes deaths occurring in the hospital after CABG surgery, regardless of length of stay, but only includes deaths occurring after discharge within 30 days of surgery. OSHPD has adopted the operative mortality definition that the national Society of Thoracic Surgeons (STS) uses for member surgeons to benchmark their own performance. While we recognize that this definition could potentially bias the results of hospitals that do not routinely transfer patients, our analyses to date have not revealed such a bias.

One hospital's primary concern was with their "Low" performance rating for internal mammary artery (IMA) usage, a process measure of surgical quality. This hospital states that IMAs were not used in many cases because of valid reasons, including abnormalities of the IMA or left anterior descending arteries, patient obesity, advanced age, and multiple comorbidities. Because OSHPD's method for calculating IMA usage does not take all these into account, they felt their low score was inappropriate. OSHPD's IMA usage metric takes into consideration most, but not all of the possible reasons for not using the IMA. However, our Clinical Advisory Panel has stated that the remaining valid reasons for non-use should be few and would not by themselves explain very large percentage differences from the statewide hospital IMA rate.

Finally, one hospital commented on their performance over the last 20 years and noted the various measures which have been implemented to improve quality over that time period. They also noted the importance of the human connection between the patient and the surgeon.

USC
UNIVERSITY
HOSPITAL

September 5,2008

Holly Hoegh, Ph.D.
Manager, Clinical Data Programs
Office of Statewide Health Planning and Development
400 R Street, Room 250
Sacramento, CA 95811

Dear Dr. Hoegh,

This letter is in response to the 2006 CCORP Hospital Results for Usage of the Internal Mammary Artery (IMA) Report in which the internal mammary usage rating was designated as low for the USC University Hospital. While we acknowledge that the IMA usage rate is lower than other hospitals, we feel there are several factors that account for this finding.

We reviewed the procedures where the internal mammary artery was not used. In two thirds of the operations, there were abnormalities of the IMA or the left anterior descending (LAD) artery which precluded its use. These abnormalities included a significantly calcified or small LAD and a small internal mammary artery. The remaining third of the patients were morbidly obese, advanced in age, had an arteriovenous fistula or had multiple other medical conditions.

The reasons the internal mammary artery was not used directly correlates with the reasons these patients are referred to an academic center for coronary artery bypass. We continue to use the internal mammary artery whenever the patient's clinical condition and their anatomy is favorable. We continue to care for the critically ill patients with advanced coronary artery disease.

Sincerely,

Vaughn A. Starnes, M.D.
Hastings Distinguished Professor and Chairman
Department of Cardiothoracic Surgery
Keck School of Medicine
University of Southern California

1500 San Pablo Street
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LAC+USC
HEALTHCARE NETWORK

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Stephanie Hall, MD
Chief Medical Officer

Irene Recendez, RN
Chief Nursing Officer

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To improve health through leadership, service and education

August 18, 2008

Holly Hoegh, Ph.D.
Manager, Clinical Data Programs
Office of Statewide Health Planning and Development
400 R Street, Room 250
Sacramento, CA 95811

Dear Dr. Hoegh,

This letter is in response to the report entitled: "The 2005-2006 California CABG Outcomes Reporting Program (CCORP) Preliminary Report", which presents hospitals' risk-adjusted mortality rates for CABG in the calendar years 2005-2006 together and 2006 separately. We find the presentation of the combined 2005-2006 data problematic and arbitrary.

The 2005 CCORP risk-adjusted mortality report for LAC+USC Medical Center shows a "worse than expected" rating, while our risk-adjusted mortality for 2006 is "as expected". The reduction in the observed mortality is the result of a brisk quality improvement program. Regrettably, when the data from 2005 and 2006 are combined, LAC+USC rates "worse than expected" and the noted improvement is obscured. Combining these two years of data does not accurately reflect the performance improvement activity in the program in 2006 and is therefore inequitable and misleading.

It is unclear why CCORP has chosen to group the 2005 and 2006 data together. If the goal is to increase the strength of the statistical analysis, it seems that all four years of data should be grouped together. Alternatively, if the intent is to monitor the year to year activity, then it is reasonable and appropriate to report each year separately. This would more accurately reflect important year to year changes in performance.

The LAC+USC Medical Center is dedicated to excellence in patient care and quality improvement. The publicly reported CCORP data is taken extremely seriously and performance is continuously assessed to identify improvement opportunities. Unfortunately, combining the 2005-2006 data for public reporting masks all improvement efforts, undermines the spirit of quality improvement, is damaging to the organization's reputation and is unfairly misleading to the public.

The 2005-2006 Combined CCORP Report does not accurately reflect the changing performance at LAC+USC. For the reasons outlined here we urge you to publish the 2005 and 2006 data independently and object to reporting the combined the data for 2005-2006.

Thank you for the opportunity to submit our comments and recommendations. We are available at your convenience to discuss this matter and look forward to ongoing collaboration.

Sincerely,

Stephanie L. Hall, MD
Chief Medical Officer
LAC+USC Healthcare Network

Health Services
www.ladhs.org

C: Ismael Nuno, MD, Chief Cardiothoracic Surgery
Nicholas Testa, MD, Associate Medical Director QI
Linda Chan Ph.D., Director Research and Biostatistics

TORRANCE MEMORIAL
MEDICAL CENTER

OFFICE OF THE
MEDICAL STAFF

August 27, 2008

Holly Hoegh, Ph.D.
Manager, Clinical Data Programs
Office of Statewide Health Planning and Development
400 R Street, Room 250
Sacramento, CA 95811

Dear Dr. Hoegh,

Torrance Memorial Medical Center received the 2005 -2006 California CABG Outcomes Reporting Program Preliminary Report and appreciates the opportunity to respond to the results.

In the nine years since OSHPD began reporting CABG mortality rates, Torrance Memorial has experienced one year (2005) of being ranked "worse than expected in mortality for isolated CABG procedures. In every other year, OSHPD has reported a CABG mortality rate of "as expected" for Torrance Memorial.

The unfavorable 2005 results negatively influenced the mortality rate calculation for two reporting cycles: 2005 (last year's report) and 2005 – 2006 (the current release). In 2006 alone OSHPD ranked Torrance Memorial's CABG mortality "as expected."

The year 2005 was clearly an unusual year for Torrance Memorial for outcomes of isolated CABG cases. A multi-disciplinary team of physicians and performance improvement staff analyzed all CABG deaths in 2005. This focused review did not reveal any specific finding or trends which may have impacted mortality. We are committed however to continuing to study and make changes as necessary to improve all cardiovascular patient outcomes.

Torrance Memorial is dedicated to continually improving the care delivered to our patients. Again, thank you for the opportunity to respond to the results of the 2005 - 2006 California CABG Outcomes Reporting Program Report.

Sincerely,

David R. Rand, M.D.
Chief of Staff

3330 Lomita Boulevard, Torrance, California 90505-5073 □ 310/325-9110

Tri-City Medical Center
4002 Vista Way, Oceanside, CA 92056-4506 • 760.724.8411

August 12, 2008

Holly Hoegh, Ph.D., Manager
Clinical Data Programs
Office of Statewide Health Planning and Development
818 "K" St., Room 200
Sacramento, CA 95814

Dear Dr. Hoegh:

I am writing in response to the 2005/2006 California CABG Outcomes Reporting Program (CCORP) preliminary report. Tri-City Medical Center has been an original contributor to outcomes reporting agencies such as the Society of Thoracic Surgeons database including required reporting to CCORP. Our fastidious commitment to quality reporting and our use of data to drive clinical care is unwavering.

Tri-City Medical Center's cardiac surgery performance over the last 20 years with the exception of the 2006 year has met and exceeded both state and national benchmarks. Results from the 2006 CCORP report are inconsistent with our on-going commitment to excellence. During our performance improvement process we recognized the aberrancy in our 2006 data and measures have been implemented to improve our quality and performance scores.

Quality Improvement Initiatives:

- Quality oversight of our data occurs on a weekly to monthly basis via our collaborative multidisciplinary cardiology conference including my personal review
- Each case that contributed to our performance rating was reviewed and demonstrated that optimum care was provided
- An outside review, through a third party, evaluated the Cardiothoracic Surgery Program at Tri-City Medical Center
- Two of the three surgeons who impact our data are no longer performing heart surgery at our institution
- Health Grades reporting agency listed Tri-City Medical Center within the top 10 of the 120 cardiac surgery programs in the state for that year and gave it a 5-star rating for the years 2006 and 2007, being the only 5-star rating given to any of the hospitals in San Diego County

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August 12, 2008
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Clearly the CCORP report can be misleading and cause the public to misunderstand the findings. The report brings together two years of data and misrepresents to the community that negative performance was consistent over the two years, when in fact the 2005 year performance exceeded the state norm and only 2006 resulted in a variation below the state performance. Unfortunately, because of the reporting format, the data shows up on two separate reports.

It is important to note that CCORP's compilation of statistics, graphs and charts does not reflect the human connection between the patient and the surgeon. While the data are important and should be kept up-to-date, it should be used to facilitate quality improvement at any particular institution and should not be used to drive a statistical wedge between competitive hospitals. The more the field of medicine is reduced to be similar to industry in general, the less medical care is delivered with the human element of compassion and individual consideration. Clearly, the field of cardiac surgery is one where the patient and the surgeon meet very privately and make a measured judgment as to the risks and benefits of each particular case.

As our population for coronary artery bypass grafting ages, the challenge to provide the same quality of care and achieve the same statistically significant results that previously existed will become more and more difficult. Rest assured we are aware that we had a challenge in our performance rating for 2006. However our improvement plans and quality review process are determined to reflect the excellent care delivered.

Thank you for the opportunity to respond to the 2005-2006 CCORP report.

Sincerely,

T Folkerth

Theodore L. Folkerth, M.D.
Medical Director, Cardiothoracic Surgery
Tri-City Medical Center

cc: Chief of Staff Dr. Richard Burruss

Washington Hospital Healthcare System

2000 Mowry Avenue Fremont California 94538-1716 • (510) 797-1111
www.whhs.com

September 3, 2008

Holly Hoegh, PhD
Manager, Clinical Data Systems
Office of Statewide Health Planning and Development
400 R Street, Room 250
Sacramento, CA 95811

Reference: Washington Hospital - Fremont, CA

Dr. Ms. Hoegh:

This letter is in response to correspondence received from the Office of Statewide Health Planning and Development dated July 7, 2008. It represents our official statement as to why the report does not accurately reflect the quality of care provided at Washington Hospital. We appreciate the opportunity to comment on the data presented.

Washington Hospital has participated in the State reporting of coronary artery surgery mortality since its inception in 1999. Only a subset of all California cardiac surgery programs reported on a voluntary basis at that time. In the three voluntary public reports issued by CCMRP from 1999 through 2002, and in the four annual public reports issued by CCORP from 2003 through 2006, Washington Hospital has scored "as expected". In the 2003-2004 California CABG Outcomes Reporting Program combined report, Washington Hospital scored "as expected". In the 2005-2006 California CABG Outcomes Reporting Program combined preliminary report, Washington Hospital is listed as "worse than expected". We have a number of concerns regarding this combined preliminary 2005-2006 CCORP Report. They include:

1. We are surprised at the lack of comment in your report regarding the drop in observed CABG mortality rates in the State of California between 2003-2004 and 2005-2006 (the mortality rate for 2003-2004 was 3.08% and the mortality rate for 2005-2006 was 2.65%). The drop in observed CABG mortality rates is statistically significant. It means "the bar has been raised" for all hospitals in the State, and all hospitals in the report are held to a more rigorous standard than in any other comparison report from the Office of Statewide Health Planning and Development.

Nancy Farber, Chief Executive Officer
Washington Township Health Care District • Washington Hospital • Washington Clinics
Washington-Stanford Radiation Oncology Center • Washington Outpatient Surgery Center
Washington Heart Program • Washington Outpatient Rehabilitation Center • Washington Center for Joint Replacement
Institute for Minimally Invasive and Robotic Surgery

2. We believe the impact of this statistically significant drop in mortality on CCORP's regression model and resulting performance ratings should be addressed in the report.

3. Clearly, the 2005-2006 CCORP Report performance ratings are different from all previous reports and contain anomalies. In the two year combined period of time in which the cardiac surgery mortality rate for all California hospitals improved by over 14%, no one hospital performed "better than expected". Eight individually listed hospitals performed "better than expected" in years 2005 and 2006 but when those results are combined in the 2005-2006 CCORP Report, no hospital performed "better" than expected. The 2005-2006 CCORP Report does not recognize individually or collectively the superior results of California hospitals and California cardiac surgeons. On the other hand, five individually listed hospitals were rated "worse than expected" in years 2005 and 2006, and, when those reports are combined in the 2005-2006 CCORP Report, six hospitals were rated "worse than expected" This combined report included Washington Hospital despite the fact that Washington Hospital did not appear in either individual report. The results of all previous CCORP reports (whether annual or combined) have followed a distribution pattern that has approximated a normal curve. Performance ratings had an equivalent number of hospitals rated as "better than expected" and "worse than expected". The fact that the CCORP 2005-2006 Report results are not distributed normally makes them "different" from all previous reports and apparently biased. Perhaps consideration should be given to only evaluating and making public single year results.

4. We would like to point out that the CCORP database includes the mortality of patients who have been in the hospital for extended lengths of stay. Washington Hospital is a District Hospital that takes care of all residents within its District borders, regardless of their socioeconomic status. Washington Hospital also accepts transfers and admission of patients from surrounding hospitals who do not provide cardiac surgery service. Many of our patients will not or cannot be accepted to the next level of care in neighboring facilities due to their socioeconomic status. This means that we regularly can and do have cardiac surgery patients presented to the hospital with multiple co-morbid conditions who often stay in excess of thirty days. We believe that CABG patients who expire after a prolonged length of stay from conditions not related to their cardiac surgery should not be included in a state-mandated, publicly reported database. Inclusion of this data unfairly penalizes both the hospitals and the surgeons involved.

Finally, we would like to point out that the observed mortality rate of CABG patients at Washington Hospital has declined between 2005 and 2006, has declined again between 2006 and 2007, and, so far, has declined again between 2007 and 2008. This is a clear indication that Washington Hospital is firmly committed to continuously improving the quality of care provided to cardiac surgery patients and to the "patient first" ethic.

Should you have any questions or wish to discuss these matters further, please feel free to contact me at (510) 745-6513.

Sincerely,

Edward J. Fayen
Associate Administrator
System Operations and Management Support
Washington Hospital Healthcare System

Sang Lee, M.D.
Medical Director
Cardiovascular Operative Services
Washington Hospital Healthcare System

EF/mlc