SENATE BILL No. 830

Introduced by Senator Galgiani

January 6, 2014

An act to amend Section 128745 of the Health and Safety Code, relating to health care.

LEGISLATIVE COUNSEL'S DIGEST

SB 830, as introduced, Galgiani. Health care: health facility data.

Existing law establishes the Office of Statewide Health Planning and Development, which is vested with all the duties, powers, responsibilities, and jurisdiction of the State Department of Public Health relating to health planning and research development. Existing law requires the office to publish certain risk-adjusted outcome reports.

This bill, commencing July 1, 2015, would require the office to publish risk-adjusted outcome reports for percutaneous coronary interventions, including the use of angioplasty or stents, and transcatheter valve procedures.

Vote: majority. Appropriation: no. Fiscal committee: yes. State-mandated local program: no.

The people of the State of California do enact as follows:

SECTION 1. Section 128745 of the Health and Safety Code is amended to read:

128745. (a) Commencing July 1993, and annually thereafter, the office shall publish risk-adjusted outcome reports in accordance with the following schedule:

Publication	Period	Procedures and Conditions

Date	Covered	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) In addition to any other established and pending reports, commencing July 1, 2015, and every year thereafter, the office

shall publish risk-adjusted outcome reports for percutaneous coronary interventions, including, but not limited to, the use of angioplasty or stents, and transcatheter valve procedures.

~~(d)~~

(e) 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)~~

(f) 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.

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(g) 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)~~

(h) 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.

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