AMENDED IN SENATE APRIL 7, 2014

SENATE BILL No. 830

Introduced by Senator Galgiani

January 6, 2014

An act to amend ~~Section~~ *Sections* 128745 *and 128748* of the Health and Safety Code, relating to health care.

LEGISLATIVE COUNSEL'S DIGEST

SB 830, as amended, 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.~~ *reports for specified medical, surgical, or obstetric conditions or procedures, including a coronary artery bypass graft surgery. Existing law requires the office to collect the same data used for the most recent risk-adjusted model, as specified, and authorizes the office to add any clinical data elements included in the Society of Thoracic Surgeons' database. Prior to any additions from the Society of Thoracic Surgeons' database, existing law sets forth factors the office is required to assess. Existing law authorizes the office to add, delete, or revise any clinical data elements not included in the Society of Thoracic Surgeons' database, as specified.*

This bill, commencing July 1, 2015, would additionally require the office to publish risk-adjusted outcome reports for all coronary artery bypass graft and heart valve repair and replacement surgeries, and all percutaneous cardiac interventions and transcatheter valve procedures performed in the state, as specified. The bill would remove the office's

authorization to add, delete, or revise clinical data elements not included in the Society of Thoracic Surgeons' database, would authorize the office to add any clinical data elements included in the National Cardiovascular Data Registry CATH/PCI and TAVR databases with regard to the reports for percutaneous cardiac interventions and transcatheter valve procedures, and would revise the factors to be considered before the office adds clinical data elements.

Existing law requires the Director of the Office of Statewide Planning and Development to appoint, as specified, a 9-member clinical panel for each risk-adjusted outcome report on a medical, surgical, or obstetric condition or procedure that includes reporting data of an individual physician, including coronary artery bypass graft surgery. For the clinical panel authorized for coronary artery bypass graft surgery, existing law requires 3 members to be appointed from a list of names submitted by the California Medical Association.

This bill would instead require the office director to appoint 3 members from a list of 3 or more names submitted by the California Society of Thoracic Surgeons and would additionally require that one appointee be an interventionalist and a member of the Society of Angiography for a clinical panel authorized for coronary artery bypass surgery and heart valve repair and replacement surgery. The bill would additionally require the office director to appoint specified individuals, including, among others, 3 members from a list of names submitted by the California Chapter of the American College of Cardiology, to a clinical panel authorized for percutaneous cardiac interventions and transcatheter valve procedures.

The bill would require all heart valve repair and replacement transcatheter interventions or surgery procedures to be reviewed by a joint subpanel of the coronary artery bypass graft surgery and heart valve repair and replacement surgery, and percutaneous cardiac intervention clinical panels, as provided.

~~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 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~~ *panels* established by Section 128748 based on statistical and technical considerations, information on individual hospitals and surgeons may be excluded from the reports.

(3) 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 coronary artery bypass graft surgery and heart valve repair and replacement surgery for all coronary artery bypass graft surgeries and heart valve repair and replacement 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 panels established pursuant to Section 128748 based on statistical and technical considerations, information on individual hospitals and surgeons may be excluded from the reports.

~~(3)~~

(4) Unless otherwise recommended by the clinical ~~panel~~ *panels* established by *subdivision (d) of* 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:~~ *office shall consider the utilization of sampling to the maximum extent possible.*

~~(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 *and heart valve repair and replacement* 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) 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 cardiac intervention and transcatheter valve procedure for all percutaneous cardiac intervention and transcatheter valve procedures performed in the state. In each year, the reports shall compare risk-adjusted outcomes by hospital, and in every other year, by hospital and physician. Upon the recommendation of the clinical panel established by Section 128748 based on statistical and technical considerations, information on individual hospitals and physicians may be excluded from the reports.

(1) The office shall collect the same data used for the National Cardiovascular Data Registry Cath/PCI and TAVR databases. Upon recommendation of the clinical panel, the office may add any clinical data elements included in the National Cardiovascular Data Registry Cath/PCI and TAVR databases. Prior to any additions from the National Cardiovascular Data Registry Cath/PCI and TAVR databases, the office shall consider the utilization of sampling to the maximum extent possible.

(2) The office shall collect the minimum data necessary for purposes of testing or validating a risk-adjusted model for the percutaneous cardiac intervention and transcatheter valve procedure report.

(3) 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).

(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,~~ *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.

(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.

(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.

(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.

SEC. 2. Section 128748 of the Health and Safety Code is amended to read:

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 *and heart valve repair and replacement 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 *a* list of three or more names submitted by the California ~~Medical Association~~ *Society of Thoracic Surgeons*. 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,~~ *Cardiology* and the California ~~Medical Association~~ *Society of Thoracic Surgeons*, 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*, and one appointee shall be an interventionalist and member of the Society of Angiography and Intervention*. 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) For the clinical panel authorized by subdivision (c) for percutaneous cardiac interventions and transcatheter valve procedures, 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 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 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, and one appointee shall be a cardiovascular surgeon and a member of the California Society of Thoracic Surgery. 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.

(f) All heart valve repair and replacement transcatheter interventions or surgery procedures shall also be reviewed by a joint subpanel of the coronary artery bypass graft surgery and heart valve repair and replacement surgery and percutaneous cardiac intervention panels. The subpanel shall be comprised of three members appointed from the clinical panel established in subdivision (d), three members appointed from the panel established in subdivisions (e), and shall be chaired by one member of the office. The subpanel may make recommendations to the panels established in subdivisions (d) and (e) relating to valve repair and replacement transcatheter interventions or surgery procedures.

~~(e)~~

(g) 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)~~

(h) 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.

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