

AMENDED IN SENATE APRIL 30, 2014

AMENDED IN SENATE APRIL 7, 2014

SENATE BILL

No. 830

Introduced by Senator Galgiani

January 6, 2014

An act to amend 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 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, bill would instead require the office to publish annually, on July 1 of each year, risk-adjusted outcome reports for all coronary artery bypass graft surgeries and heart valve repair and replacement surgeries performed in the state. The 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 *increase the number of individuals appointed to a clinical panel from 9 to 12, including 3 members from a list of names submitted by the California Hospital Association. The 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, whether performed using surgical procedures or using transcatheter interventions,~~ 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.

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

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

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

3 128745. (a) Commencing July 1993, and annually thereafter,
4 the office shall publish risk-adjusted outcome reports in accordance
5 with the following schedule:

			Procedures and
8	Publication	Period	Conditions
9	Date	Covered	Covered
10	July 1993	1988–90	3
11	July 1994	1989–91	6
12	July 1995	1990–92	9

13
14 Reports for subsequent years shall include conditions and
15 procedures and cover periods as appropriate.

16 (b) The procedures and conditions required to be reported under
17 this chapter shall be divided among medical, surgical, and obstetric
18 conditions or procedures and shall be selected by the office. The
19 office shall publish the risk-adjusted outcome reports for surgical
20 procedures by individual hospital and individual surgeon unless
21 the office in consultation with medical specialists in the relevant
22 area of practice determines that it is not appropriate to report by
23 individual surgeon. The office, in consultation with the clinical
24 ~~panel~~ *panels* established by Section 128748 and medical specialists
25 in the relevant area of practice, may decide to report nonsurgical
26 procedures and conditions by individual physician when it is
27 appropriate. The selections shall be in accordance with all of the
28 following criteria:

29 (1) The patient discharge abstract contains sufficient data to
30 undertake a valid risk adjustment. The risk adjustment report shall
31 ensure that public hospitals and other hospitals serving primarily
32 low-income patients are not unfairly discriminated against.

33 (2) The relative importance of the procedure and condition in
34 terms of the cost of cases and the number of cases and the
35 seriousness of the health consequences of the procedure or
36 condition.

37 (3) Ability to measure outcome and the likelihood that care
38 influences outcome.

1 (4) Reliability of the diagnostic and procedure data.

2 (c) (1) In addition to any other established and pending reports,
3 on or before July 1, 2002, the office shall publish a risk-adjusted
4 outcome report for coronary artery bypass graft surgery by hospital
5 for all hospitals opting to participate in the report. This report shall
6 be updated on or before July 1, 2003.

7 (2) In addition to any other established and pending reports,
8 ~~commencing July 1, 2004, and every year thereafter,~~ the office
9 shall publish *annually, on July 1 of each year,* risk-adjusted
10 outcome reports for coronary artery bypass graft surgery *and heart*
11 *valve repair and replacement surgery* for all coronary artery bypass
12 *graft surgeries and heart valve repair and replacement surgeries*
13 performed in the state. In each year, the reports shall compare
14 risk-adjusted outcomes by hospital, and in every other year, by
15 hospital and cardiac surgeon. Upon the recommendation of the
16 clinical panels established by Section 128748 based on statistical
17 and technical considerations, information on individual hospitals
18 and surgeons may be excluded from the reports.

19 ~~(3) In addition to any other established and pending reports,~~
20 ~~commencing July 1, 2015, and every year thereafter,~~ the office
21 shall publish risk-adjusted outcome reports for coronary artery
22 bypass graft surgery and heart valve repair and replacement surgery
23 for all coronary artery bypass graft surgeries and heart valve repair
24 and replacement surgeries performed in the state. In each year, the
25 reports shall compare risk-adjusted outcomes by hospital, and in
26 every other year, by hospital and cardiac surgeon. Upon the
27 recommendation of the clinical panels established pursuant to
28 Section 128748 based on statistical and technical considerations,
29 information on individual hospitals and surgeons may be excluded
30 from the reports.

31 (4)

32 (3) Unless otherwise recommended by the clinical panels
33 established by subdivision (d) of Section 128748, the office shall
34 collect the same data used for the most recent risk-adjusted model
35 developed for the California Coronary Artery Bypass Graft
36 Mortality Reporting Program. Upon recommendation of the clinical
37 panel, the office may add any clinical data elements included in
38 the Society of Thoracic Surgeons' database. Prior to any additions
39 from the Society of Thoracic Surgeons' database, the office shall

1 ~~consider the utilization of sampling to the maximum extent~~
2 ~~possible. following factors shall be considered:~~

3 (A) *Utilization of sampling to the maximum extent possible.*

4 (B) *Exchange of data elements as opposed to the addition of*
5 *data elements.*

6 (4) *Upon recommendation of the clinical panel, the office may*
7 *add, delete, or revise clinical data elements, but shall add no more*
8 *than a net of six elements not included in the Society of Thoracic*
9 *Surgeons' database, to the data set over any five-year period.*

10 *Prior to any additions or deletions, all of the following factors*
11 *shall be considered:*

12 (A) *Utilization of sampling to the maximum extent possible.*

13 (B) *Feasibility of collecting data elements.*

14 (C) *Costs and benefits of collection and submission of data.*

15 (D) *Exchange of data elements as opposed to addition of data*
16 *elements.*

17 (5) The office shall collect the minimum data necessary for
18 purposes of testing or validating a risk-adjusted model for the
19 coronary artery bypass graft and heart valve repair and replacement
20 report.

21 (6) Patient medical record numbers and any other data elements
22 that the office believes could be used to determine the identity of
23 an individual patient shall be exempt from the disclosure
24 requirements of the California Public Records Act (Chapter 3.5
25 (commencing with Section 6250) of Division 7 of Title 1 of the
26 Government Code).

27 (d) In addition to any other established and pending reports,
28 commencing July 1, 2015, and every year thereafter, the office
29 shall publish risk-adjusted outcome reports for percutaneous
30 cardiac intervention and transcatheter valve procedure for all
31 percutaneous cardiac intervention and transcatheter valve
32 procedures performed in the state. In each year, the reports shall
33 compare risk-adjusted outcomes by hospital, and in every other
34 year, by hospital and physician. Upon the recommendation of the
35 ~~clinical-panel panels~~ established by Section 128748 based on
36 statistical and technical considerations, information on individual
37 hospitals and physicians may be excluded from the reports.

38 (1) The office shall collect the same data used for the National
39 Cardiovascular Data Registry Cath/PCI and ~~TAVR TVT~~ databases.
40 ~~Upon recommendation of the clinical panel, the office may add~~

1 any clinical data elements included in the National Cardiovascular
2 Data Registry Cath/PCI and TAVR databases. Prior to any
3 additions from the National Cardiovascular Data Registry Cath/PCI
4 and TAVR databases, the office shall consider the utilization of
5 sampling to the maximum extent possible.

6 (2) *Upon recommendation of the clinical panel, the office may*
7 *add, delete, or revise clinical data elements, but shall add no more*
8 *than a net of six elements not included in the Cardiovascular Data*
9 *Registry Cath/PCI and TAVR databases, to the data set over any*
10 *five-year period. Prior to any additions or deletions, all of the*
11 *following factors shall be considered:*

12 (A) *Utilization of sampling to the maximum extent possible.*

13 (B) *Feasibility of collecting data elements.*

14 (C) *Costs and benefits of collection and submission of data.*

15 (D) *Exchange of data elements as opposed to addition of data*
16 *elements.*

17 ~~(2)~~

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

22 ~~(3)~~

23 (4) Patient medical record numbers and any other data elements
24 that the office believes could be used to determine the identity of
25 an individual patient shall be exempt from the disclosure
26 requirements of the California Public Records Act (Chapter 3.5
27 (commencing with Section 6250) of Division 7 of Title 1 of the
28 Government Code).

29 (e) The annual reports shall compare the risk-adjusted outcomes
30 experienced by all patients treated for the selected conditions and
31 procedures in each California hospital during the period covered
32 by each report to the outcomes expected. Outcomes shall be
33 reported in the five following groupings for each hospital:

34 (1) "Much higher than average outcomes," for hospitals with
35 risk-adjusted outcomes much higher than the norm.

36 (2) "Higher than average outcomes," for hospitals with
37 risk-adjusted outcomes higher than the norm.

38 (3) "Average outcomes," for hospitals with average risk-adjusted
39 outcomes.

1 (4) “Lower than average outcomes,” for hospitals with
2 risk-adjusted outcomes lower than the norm.

3 (5) “Much lower than average outcomes,” for hospitals with
4 risk-adjusted outcomes much lower than the norm.

5 (f) For coronary artery bypass graft surgery *and heart valve*
6 *repair and replacement surgery* reports and any other outcome
7 reports for which auditing is appropriate, the office shall conduct
8 periodic auditing of data at hospitals.

9 (g) The office shall publish in the annual reports required under
10 this section the risk-adjusted mortality rate for each hospital and
11 for those reports that include physician reporting, for each
12 physician.

13 (h) The office shall either include in the annual reports required
14 under this section, or make separately available at cost to any
15 person requesting it, risk-adjusted outcomes data assessing the
16 statistical significance of hospital or physician data at each of the
17 following three levels: 99-percent confidence level (0.01 p-value),
18 95-percent confidence level (0.05 p-value), and 90-percent
19 confidence level (0.10 p-value). The office shall include any other
20 analysis or comparisons of the data in the annual reports required
21 under this section that the office deems appropriate to further the
22 purposes of this chapter.

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

25 128748. (a) This section shall apply to any risk-adjusted
26 outcome report that includes reporting of data by an individual
27 physician.

28 (b) (1) The office shall obtain data necessary to complete a
29 risk-adjusted outcome report from hospitals. If necessary data for
30 an outcome report is available only from the office of a physician
31 and not the hospital where the patient received treatment, then the
32 hospital shall make a reasonable effort to obtain the data from the
33 physician’s office and provide the data to the office. In the event
34 that the office finds any errors, omissions, discrepancies, or other
35 problems with submitted data, the office shall contact either the
36 hospital or physician’s office that maintains the data to resolve the
37 problems.

38 (2) The office shall collect the minimum data necessary for
39 purposes of testing or validating a risk-adjusted model. Except for
40 data collected for purposes of testing or validating a risk-adjusted

1 model, the office shall not collect data for an outcome report nor
2 issue an outcome report until the clinical panel established pursuant
3 to this section has approved the risk-adjusted model.

4 (c) For each risk-adjusted outcome report on a medical, surgical,
5 or obstetric condition or procedure that includes reporting of data
6 by an individual physician, the office director shall appoint a
7 clinical panel, which shall have ~~nine~~ 12 members. Three members
8 shall be appointed from a list of three or more names submitted
9 by the physician specialty society that most represents physicians
10 performing the medical, surgical, and obstetric procedure for which
11 data is collected. Three members shall be appointed from a list of
12 three or more names submitted by the California Medical
13 Association. *Three members shall be appointed from a list of names*
14 *submitted by the California Hospital Association.* Three members
15 shall be appointed from lists of names submitted by consumer
16 organizations. At least one-half of the appointees from the lists
17 submitted by the physician specialty society and the California
18 Medical Association, and at least one appointee from the lists
19 submitted by consumer organizations, shall be experts in collecting
20 and reporting outcome measurements for physicians or hospitals.
21 The panel may include physicians from another state. The panel
22 shall review and approve the development of the risk-adjustment
23 model to be used in preparation of the outcome report.

24 (d) For the clinical panel authorized by subdivision (c) for
25 coronary artery bypass graft surgery and heart valve repair and
26 replacement surgery, three members shall be appointed from a list
27 of three or more names submitted by the California Chapter of the
28 American College of Cardiology. Three members shall be
29 appointed from a list of three or more names submitted by the
30 California Society of Thoracic Surgeons. *Three members shall be*
31 *appointed from a list of names submitted by the California Hospital*
32 *Association.* Three members shall be appointed from lists of names
33 submitted by consumer organizations. At least one-half of the
34 appointees from the lists submitted by the California Chapter of
35 the American College of Cardiology and the California Society of
36 Thoracic Surgeons, and at least one appointee from the lists
37 submitted by consumer organizations, shall be experts in collecting
38 and reporting outcome measurements for physicians and surgeons
39 or hospitals, and one appointee shall be an interventionalist and
40 member of the Society of Angiography and Intervention. The panel

1 may include physicians from another state. The panel shall review
2 and approve the development of the risk-adjustment model to be
3 used in preparation of the outcome report.

4 (e) For the clinical panel authorized by subdivision (c) for
5 percutaneous cardiac interventions and transcatheter valve
6 procedures, three members shall be appointed from a list of three
7 or more names submitted by the California Chapter of the
8 American College of Cardiology. Three members shall be
9 appointed from a list of three or more names submitted by the
10 California Medical Association. *Three members shall be appointed*
11 *from a list of names submitted by the California Hospital*
12 *Association.* Three members shall be appointed from lists of names
13 submitted by consumer organizations. At least one-half of the
14 appointees from the lists submitted by the California Chapter of
15 the American College of Cardiology and the California Medical
16 Association, and at least one appointee from the lists submitted
17 by consumer organizations, shall be experts in collecting and
18 reporting outcome measurements for physicians and surgeons or
19 hospitals, and one appointee shall be a cardiovascular surgeon and
20 a member of the California Society of Thoracic ~~Surgery.~~ *Surgeons.*
21 The panel may include physicians from another state. The panel
22 shall review and approve the development of the risk-adjustment
23 model to be used in preparation of the outcome report.

24 (f) All heart valve repair and replacement ~~transcatheter~~
25 ~~interventions or surgery~~ procedures, *whether performed using*
26 *surgical procedures or using transcatheter interventions,* shall
27 also be reviewed by a joint subpanel of the coronary artery bypass
28 graft surgery and heart valve repair and replacement surgery and
29 percutaneous cardiac intervention panels. The subpanel shall be
30 comprised of ~~three~~ *four* members appointed from the clinical panel
31 established in subdivision (d), ~~three~~ *four* members appointed from
32 the panel established in ~~subdivisions~~ *subdivision* (e), and shall be
33 chaired by one member of the office. The subpanel may make
34 recommendations to the panels established in subdivisions (d) and
35 (e) relating to valve repair and replacement *surgeries or*
36 ~~transcatheter interventions or surgery procedures.~~ *intervention*
37 *procedures.*

38 (g) Any report that includes reporting by an individual physician
39 shall include, at a minimum, the risk-adjusted outcome data for
40 each physician. The office may also include in the report, after

1 consultation with the clinical panel, any explanatory material,
2 comparisons, groupings, and other information to facilitate
3 consumer comprehension of the data.

4 (h) Members of a clinical panel shall serve without
5 compensation, but shall be reimbursed for any actual and necessary
6 expenses incurred in connection with their duties as members of
7 the clinical panel.