APPENDIX A: HOSPITAL STATEMENTS

Each hospital included in this report was provided with a preliminary report containing the risk-adjusted models, 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. Four hospitals submitted letters which are included here.

ENLOE
MEDICAL CENTER

August 12, 2009

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

Re: 2007 California CABG Outcomes Reporting Program Report

Dear Dr. Hoegh:

Enloe Medical Center appreciates the opportunity to participate in the California CABG Outcomes Reporting Program.

In review of our hospital's risk-adjusted mortality for 2007, we believe that the California CABG Outcomes Reporting Program Report is misleading. While our risk adjusted mortality for 2007 is "worse than expected", we feel that the reporting does not accurately reflect the quality of care provided by our hospital. Out of the cases in 2007 that resulted in mortalities:

- four had previous cardiac intervention
- six were urgent
- four were emergent coming straight from the Cath Lab

In reviewing these cases, we feel that even though they were an isolated CABG, over half of these patients had a mortality risk of greater than 40 percent.

In 2007, Enloe Medical Center's Heart Program received two designations. It was named as a "Blue Distinction Center for Cardiac Care", based on 2003 to 2004 data, by Blue Shield of California and also was one of 20 hospitals in California to be accepted in the Blue Shield of California's Cardiac Quality Initiative program.

The *Blue Distinction Centers initiative* is a national program designed to create transparency for health care consumers by helping them make more informed decisions and by enabling Blue Cross Blue Shield Association to collaborate with its providers to improve quality outcomes and affordability. Facilities receiving designation met or exceeded specific quality criteria established by expert physician panels and national organizations, demonstrating reliability in delivering cardiac care and better overall outcomes for patients, according to the Blue Cross Blue Shield Association.

The Blue Shield of California Cardiac Quality Initiative is a California statewide program to identify and recognize cardiac programs in the Blue Shield of California network that provide high-quality cardiac care to Blue Shield members. The organization evaluated cardiac program data from 2003 to 2006 against criteria developed by an external clinical advisory committee.

A local, not-for-profit organization • 1531 Esplanade • Chico, CA 95926 • www.enloe.org • (530) 332-7300

Enloe Medical Center is dedicated to continually improving the health and quality of our community which is represented by our successful outcomes for 2008 data and 2009 data year to date.

Sincerely,

Mike Wiltermood
President and Chief Executive Office

Harbor-UCLA
MEDICAL CENTER

Los Angeles County
Board of Supervisors

Gloria Molina
First District

Mark Ridley-Thomas
Second District

Zev Yaroslavsky
Third District

Don Knabe
Fourth District

Michael D. Antonovich
Fifth District

Miguel Ortiz-Marroquin
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August 12, 2009

Holly Hoegh, Ph.D.
Manager, Healthcare Outcomes Center
Clinical Data Programs
Office of Statewide Health Planning and Development
400 R. Street, Room 250
Sacramento, CA 95811-6213

Dear Dr. Hoegh,

Upon receiving the preliminary 2007 CCORP (hospital level) report, we were very concerned about our reported outcomes.

On personal review of the medical records, we discovered many discrepancies in our reported cardiac surgery risk factors. There were many important omissions, and these underreported risk factors significantly and adversely affected our expected mortality and morbidity. Once this was discovered, it was too late to correct the discrepancies.

After careful analysis of the situation, we found that a number of technical terms in the data sheet were not clearly defined and were not captured accurately. This accounts for our risk factors being tabulated far below their true level.

Our County facility has several limitations influencing timely patient discharge. Often it is lack of social support and other resources that lengthen hospital stay independent of post-cardiac surgery medical status. Patients requiring postoperative transfers to a skilled nursing facility face prolonged waiting times. One listed death occurred in a patient following prolonged hospitalization due to gastrointestinal disease. She died six months after the cardiac surgery from complications related to her gastrointestinal disease.

We perform surgery on some Jehovah's Witness patients whose beliefs preclude our ability to provide life saving blood transfusions. We respect their wishes, but this increased our mortality and adversely affected our outcomes.

Our review also noted that various preoperative risk factors, including stroke prior to surgery, were not reported. This gave the erroneous impression that the strokes were related to cardiac surgery. We had two patients whose care was withdrawn per their previously expressed wishes and/or those of their families. Though these patients did suffer significant morbidity, provision of continued aggressive and appropriate care may well have prevented the mortalities.

SHARP Metropolitan Medical Campus

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

Dear Dr Hoegh,

This letter is in response to our receipt of the 2006-2007 California Outcomes Reporting Program (CCORP) report. Sharp Memorial Hospital scored worse than expected on Post-Operative Stroke and we would like to respond to this rating. In 2006 we noted an unusual cluster of 6 strokes. Each case was individually reviewed and no trends or common causes could be identified. Most patients (75%) fully recovered. This unusual cluster strongly influenced our results for the 2 year period. The occurrence of stroke in 2007 was half that of 2006, and in 2008 we had no strokes at all in our isolated CABG patients. In view of this, we feel that the rating, while accurate in number, does not reflect our current performance in this area.

Sharp Memorial Hospital has participated in the California CABG Outcomes Reporting Program since 1998, when it was a voluntary program. The CCORP staff does an excellent job of ensuring accuracy of this data and we wholeheartedly support the program.

Thanks for this opportunity to comment on our results.

Robert Adamson MD
Cardiothoracic Surgeon
Medical Director Cardiac Transplant Program
Sharp Memorial Hospital

St. Joseph's Medical Center
A member of CHW

August 3, 2009

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

To Whom It May Concern:

This letter is in response to correspondence received from the Office of Statewide Health Planning and Development dated June 18, 2009 regarding the **2007 California CABG Outcomes Reporting Program (CCORP) Preliminary Report**. We do not feel the published risk adjusted operative mortality rating accurately reflects the quality of care of our program. We appreciate the opportunity to reply, and our response can be categorized as follows:

- In-hospital versus out-of-hospital mortality
- Continuity of care
- Results in aggregate and over time
- Risk adjustment
- Commitment to quality

First and foremost, for the 2007 calendar year, the metric of risk adjusted operative mortality included 4 deaths that occurred within 30 days, but outside of the hospital. This is an extremely unusual and aberrant finding and represents the totality of the difference in the rating of "worse than" as opposed to "no different than expected."

The 2007 CCORP 30-day (operative) mortality rate for our site sits in stark contrast to our 2007 Society of Thoracic Surgeons (STS) isolated CAB risk adjusted in hospital mortality of 2.9%. This is a result well within expected outcomes and compares to the STS like group rate of 2.3% and the STS national rate of 2.2%. Although the risk methodology varies between the ratings systems, both are scientifically data driven and share similar definitions. We encourage OSHPD to add the distinction of "in" versus "out-of-hospital" 30-day mortality to the CCORP report as a more robust measurement system.

While we understand that reporting 30 day "all cause" mortality encourages hospitals to be accountable for post discharge coordination of care, we cannot ultimately be responsible for all follow up within that time frame. Nevertheless, we have conducted a detailed review of the four out of hospital deaths in an effort to identify and correct potential improvement opportunities. Our review revealed that all cases had evidence of stable vital signs, lab values, diagnostic test results, and physical assessment upon discharge. One case was dismissed to another hospital at the hand of the insurance company, one to a community skilled nursing facility, and the other two to home including arrangements for home heath care and subsequent outpatient treatments including transportation if needed. This is evidence that every effort was made to ensure continuity of care for safe and optimal outcomes for our patients, a priority at the heart of our mission.

Due to natural variation, any hospital can have a singularly exemplary or less favorable performance result. We believe that for all programs, examination of results over time and in aggregate is a more comprehensive reflection of programmatic strength than evaluation of a single year in isolation. Between 1992 and 2006, a time span representing both voluntary and

mandatory public reporting (CCMRP and CCORP), our results have consistently been within the expected performance range. This is true for individual and combined reporting periods.

Continuing the trend of favorable results over time, we must share that during 2008, there were zero isolated CAB deaths outside of the hospital within 30 days which produces an STS risk adjusted operative mortality rate of 0.8% (CCORP results for 2008 not yet available). St. Joseph's has taken care to validate our 2008 data by cross referencing 100% of cases with the public death index database, a practice not required by STS, nor undertaken by many hospitals.

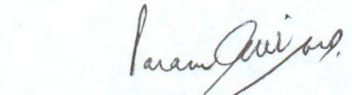
We understand that publishing a single year of data (2007) is an effort to display the most recently available CCORP results and as such is useful. However we assert that to display hospital results in aggregate over a multi-year time frame, including year over year trending in addition to a single year, would be more accurate and helpful to consumers and payers in using the CCORP data. Additionally, we encourage our fellow hospitals to participate in the STS and to validate 30 day STS reportable results as a way to continue to level the playing field for measurement between sites and across measurement systems.

With regard to patient risk, it is common for hospitals and physicians to claim "our patients are sicker". Risk adjustment nullifies this argument in most cases, provided that risk factors are adequately calculated in the predictive modeling. For many California hospitals, including the area in and surrounding Stockton, socioeconomic status (including the potential for undetected underlying chronic conditions) is not a variable accounted for in risk stratification. St. Joseph's philosophy is to provide care to all eligible patients opting for treatment, regardless of payer or socioeconomic factors. For other included risk variables such as peripheral vascular disease and severity of chronic lung disease, we acknowledge that we may have opportunities to more completely document our patients' conditions, such that our predicted risk is more accurately calculated.

Although we consider the most recent ratings to be aberrant, we take the results of this report seriously and remain committed to ongoing measurement and improvement in our cardiovascular services. The provision of excellence in outcomes is accomplished by processes including but not limited to: 1) preoperative risk assessment by a multidisciplinary physician group to ensure optimal planning and coordination of care; 2) a multidisciplinary clinical innovations team dedicated to reducing variation and improving outcomes; 3) robust interdisciplinary peer review including appropriateness screenings; and 4) physician profiles comparing outcomes to peer and national results.

In summary, St. Joseph's Medical Center of Stockton consistently demonstrates favorable isolated CAB mortality results in aggregate, over time, and across a vast array of reporting metrics and agencies. We do not believe the single result displayed in the 2007 California CABG Outcomes Reporting Program report is an accurate reflection of the quality of our program.

Sincerely,



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