IN THE SUPREME COURT OF THE STATE OF NEVADA

DARELL L. MOORE; AND CHARLENE A. MOORE, INDIVIDUALLY AND AS HUSBAND AND WIFE, Appellants, vs. JASON LASRY, M.D. INDIVIDUAL; AND TERRY BARTIMUS, RN, APRN, Respondents.	)	 Supreme Court No. 81659

APPEAL

From the Eighth Judicial District Court, Clark County
The Honorable Kathleen E. Delaney, District Judge
District Court Case No.: A-17-766426-C

APPELLANT'S APPENDIX VOLUME IV

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CERTIFICATE OF SERVICE

Pursuant to NRAP 25(b), I certify that I am an employee of the law firm and that on this 21st day of July, 2021, I served a true and correct copy of the foregoing **APPELLANT'S APPENDIX VOLUME IV** as follows:

- ☐ by placing same to be deposited for mailing in the United States Mail, in a sealed envelope upon which first class postage was prepaid in Las Vegas, Nevada; and/or
- ☐ to be sent via facsimile (as a courtesy only); and/or
- ☐ to be hand-delivered to the attorneys at the address listed below:
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DISTRICT COURT

CLARK COUNTY, NEVADA

DARELL L. MOORE and CHARLENE A. MOORE, individually and as husband and wife;

Plaintiffs,

v.

JASON LASRY, M.D., individually; FREMONT EMERGENCY SERVICES (MANDAVIA), LTD.; TERRY BARTMUS, RN, APRN; and DOES I through X, inclusive; and ROE CORPORATIONS I through V, inclusive;

Defendants.

CASE NO.: A-17-766426-C

DEPT. NO.: Dept. 25

PLAINTIFFS' NRCP 59 MOTION FOR NEW TRIAL

HEARING REQUESTED

COME NOW, Plaintiffs, DARELL L. MOORE and CHARLENE A. MOORE, individually and as husband and wife, by and through their attorneys of record, MATTHEW W. HOFFMANN, ESQ., of the law firm of ATKINSON WATKINS & HOFFMANN, LLP, AND E. BREEN ARNTZ, CHTD., and hereby submit their Motion for a New Trial.

I. FACTUAL BACKGROUND

This is a medical malpractice action resulting from an above-the-knee amputation that occurred on or about December 25, 2016. On that date, Plaintiff Darell presented to the emergency department at Dignity Health dba St. Rose Hospital- San Martin (hereafter, "St. Rose") with a one-day history of pain in the calf area of his left leg. He was noted to have a prior history of deep vein thrombosis and a prior femoral and/or popliteal artery bypass surgery on December 11, 2014. The previous procedure of putting a bypass and graft was performed at the same hospital as the visit on December 25, 2016. An ultrasound was ordered to rule out DVT in the left leg, which was negative, but which also showed an occlusion of the left femoral-popliteal arterial bypass graft. No further treatment was recommended in response to the left arterial occlusion and the differential diagnosis did not include arterial occlusion despite Darell's history of a prior femoral-popliteal bypass and despite the fact Darell reported pain increased with walking. Plaintiff Darell was discharged with aftercare instructions for musculoskeletal pain as well as hypertension.

On December 28, 2016, Plaintiff Darell returned to the emergency department at St. Rose. At that time, Darell reported persistent and increasing left leg pain. An arterial duplex ultrasound of the left leg was performed and once again showed occlusion of the left leg graft vasculature with no flow detected in the left posterior tibial anterior tibial or dorsalis pedi arteries. Darell was noted to have an ischemic lower extremity and started on anticoagulants including heparin and tissue plasminogen activator.

Plaintiff Darell was eventually admitted to the Intensive Care Unit in critical condition. On January 2, 2017, Plaintiff Darell underwent an above-the-knee amputation of his left lower extremity under the care of Holman Chan, M.D. He was discharged on January 5, 2017.

II. ARGUMENT

The subject motion is based on two instances of error by this court and the attorney misconduct of Mr. Keith Weaver, counsel for Nurse Practioner Terri Bartmus. First, during the trial Plaintiffs' called Dr. Alexander Marmureanu, a board certified cardiovascular surgeon who was qualified to discuss the standard of care of the Defendants and the causation of the injury of the Plaintiff, the loss of his leg above the knee, due to the malpractice of the Defendants. During the direct examination of Dr. Marmureanu, he was examined on his qualifications, the scope of his opinions and the foundation he possessed as an expert witness to address those issues and form the opinions that he had. Nothing unusual was discussed during the qualifications phase of direct testimony and no objections were made regarding the scope of that questioning. During the cross-

examination of Dr. Marmureanu, over the objection of counsel grounded in a number of different bases, Mr. Weaver was permitted to question Dr. Marmureanu regarding an article in a magazine that related only to his reputation as a cardiovascular surgeon. More specifically, the article didn't even relate to treatment that was the subject of the subject case; rather, it concerned a study from California that tracked the number of deaths in the first thirty days following cardiac bypass surgery. The manner in which Mr. Weaver confronted Dr. Marmureanu was designed to merely impugn the reputation of the Plaintiffs' expert, not to challenge him on the medicine related to the case.

One of the objections made to the cross-examination was that the article that was being used for impeachment was not disclosed pursuant to NRCP 16.1. This court summoned counsel to the bench for a discussion during which this objection and others were made. This court ruled that Mr. Weaver was not required to produce impeachment evidence before trial and ruled that "so long as Mr. Weaver acted in good faith" he was permitted to pursue the line of questioning. Not only does such a ruling contradict the specific language of NRCP 16.1(a)(3) which does require impeachment evidence to be produced, but, Mr. Weaver did not act in good faith as he misrepresented a number of different aspects of the article. The cross-examination should have been disallowed for a number of reasons. First, NRCP 16.1 does require the parties to produce evidence one intends to use for impeachment. Defendants did not produce the article in question. In fact, the rule couldn't be clearer. Second, the evidence presented went only to Dr. Marmureanu's reputation as it concerned information Mr. Weaver suggested demonstrated that Dr. Marmureanu was one of seven worst doctors in California. And, finally, Mr. Weaver misrepresented the substance of the article in a clear attempt to misinform the jury regarding Dr. Marmureanu's reputation as a surgeon. Because this court didn't even require production of the article, it was impossible to afford Plaintiffs the opportunity to rehabilitate their witness.

A second instance of reversible was this court's ruling to exclude Dr. Wiencek as a witness when called by Plaintiffs. Mr. Robert McBride, counsel for Dr. Lasry, had referenced Dr. Wiencek as a potential witness during his introduction to the case, Dr. Wiencek was identified as a witness in all thirteen (13) supplemental disclosures pursuant to NRCP 16.1 with the appropriate description of his anticipated testimony as a treating physician, and, perhaps most critical, the notes and records and treatment by Dr. Wiencek became such a focal point of the evidence at trial that to preclude him from testifying under the circumstances was an abuse of this court's discretion.

A. The Contents of the Article at Issue

On July 17, 2017, Kaiser Health News published an article featured on the website Fierce Health Care entitled "California hits nerve by singling out cardiac surgeons with higher patient death rates". (***https://www.fiercehealthcare.com/practices/calif-hits-nerve-by-singling-out-cardiac-surgeons-higher-patient-death-rates* – *attached hereto as Exhibit 1***). The article's topic was the controversy surrounding a public database which listed California heart surgeons with a higher-than-average death rate for patients who underwent a common bypass procedure. *Id*. "The practice is controversial: Proponents argue transparency improves quality and informs consumers. Critics say it deters surgeons from accepting complex cases and can unfairly tarnish doctors' records". *Id.*

The article uses a report, released in May 2017 by California's Office of Statewide Health Planning and Development, based on surgeries performed in 2013 and 2014. *Id*. Dr. Marmureanu was listed, along with several other veteran cardiac surgeons, as having an above-average death rate for patients undergoing the procedure during that two-year time period. *Id.* While some of the doctors interviewed stated that they supported public reporting, they also criticized the database, pointing out that the calculation of deaths did not fully take the varying complexity of the cases into account and that the results could be easily skewed by only a few bad results depending upon the overall number of surgeries a particular doctor performed. *Id.*

The death rates included those occurring during hospitalization, regardless of how long the stay, or anytime within 30 days after the surgery, regardless of the venue. *Id.* Holly Hoegh, manager of the clinical data unit at the Office of Statewide Health Planning and Development, which issued the report, acknowledged that "a risk model can never capture all the risk", which critics pointed out does not adequately take into account the number of complex and challenging cases a surgeon has accepted. *Id.* The article noted that officials in Massachusetts, who had been reporting bypass outcomes for individual doctors, stopped doing it in 2013 because, while surgeons supported reporting to improve outcomes, they were concerned that they were being identified public as "outliers" when they really were just taking on difficult cases, which could lead to surgeons turning away high-risk patients in order to protect their death rate percentages. *Id.* Dr. Marmureanu, who takes on some of the most difficult cases and the sickest patients, was assigned a mortality rate of 18.04 based on three deaths among 22 cases in the two-year time period covered by the report. *Id*. One of those deaths was due to a traffic accident which occurred within the 30-

day period after the patient had undergone the bypass procedure, illustrating the problematic nature of the report's death rate calculation method. *Id.*

B. The Misleading Line of Questioning at Trial Concerning the Article at Issue and the Court's Response to Plaintiffs' Counsel's Objection

During trial, Mr. Weaver questioned Dr. Marmureanu about the article in a manner that completely misrepresented its contents, making it appear that Dr. Marmureanu had been singled out as one of the "worst" surgeons in the state, in an apparent attempt to undermine his credibility with the jury.

> "Q: In 2017, the State of California declared that you are one of the seven worst cardiovascular surgeons in the entire state out of hundreds; correct?
>
> A: Incorrect, sir. I would like to see that.
>
> Q: So is it your testimony, Dr. Marmureanu, that the office of – the California Office of Statewide Health Planning and Development didn't issue a report that listed you in the top 3 percent of the worst cardiovascular surgeons in California?
>
> A: You're untruthful and incorrect, again, sir.
>
> Q: Okay. So what would you need to be convinced that that report exists?
>
> A: Show it.
>
> Q: Okay. We'll come back to that"
>
> A: Go ahead.
>
> Q: Let me do what's called "lay a little foundation". So do you know what the "California Society of Thoracic Surgeons" is?
>
> A: Very well.
>
> Q: Okay. And you don't believe that the president of the California Society of Thoracic Surgeons supported a report that identified you as one of the top seven worst cardiovascular surgeons in California; correct?
>
> A: Not only do I don't believe, I'm saying you're wrong.
>
> Q: And I would also be wrong if you told a reporter for Kaiser News that, in effect, hospital patients don't care if they're, in your case, nine times more likely to die under your care?
>
> A: That's not what I said. You're not telling the truth again.

Q: Did you say something to that effect, that hospital patients don't care about that report; the only people who care about the data are the journalists?

A: That could be.

Q: But it's in the context of the report that, out of 271 cardiovascular surgeon (sic) in California, found you one of the worst seven?

A: It's absolutely not true. And, I mean, I don't want to judge upset, but I think it's despicable what you're saying.

Q: And would it also be despicable if Hollywood Presbyterian Hospitals got one of the worst rankings as a hospital because of your ranking by the State of California's Office of Statewide Health Planning and Development?

A: That's not true again, sir. You will have to show me.

Q: Okay. We'll come back to that. Sir, you're saying no such report exists; right?

A: Well, not what you said. What you said doesn't exist. You are wrong about the year; you are wrong about the report; you are wrong what the report says, and I'm not sure if you're doing it on purpose or just you don't know enough about it."

(***Reporters Transcript of Proceedings of Jury Trial P.M. Session Testimony of Alexander Marmureanu, M.D. Before the Honorable Kathleen E. Delaney, Friday, January 31, 2020, 29:1-31:10, attached hereto as Exhibit 2***). [1] Mr. Weaver clearly misrepresented the contents of the article during cross examination. When Dr. Marmureanu asked to see the article on two separate occasions, his request was disregarded. Plaintiffs' counsel objected as to foundation, but his objection was overruled and Mr. Weaver was allowed to continue with his line of misleading questioning. (***Id., 31:14-15, 20-21***).

Mr. Weaver repeatedly and incorrectly stated that the article categorized Dr. Marmureanu as one of the "worst" cardiovascular surgeons in California. (***Id., 32:6-13, 22-23; 37:17-19***); ("The state put you in a category that they labeled you as "worst.") (***Id., 32:16-17***); ("Q:…It doesn't say I'm the worst surgeon than the guy who did only three cases and nobody died. A: It

[1] In fact, Hollywood Presbyterian Hospital Medical Center received an "average" (as opposed to "worse", "low" or "acceptable") rating for Isolated CABG Operative Mortality in the 2013, 2014 and 2015 time periods and for CABG + Valve Operative Mortality for 2012-13, 2013-14, 2014-15 time periods. (***California Hospital Performance Ratings for Coronary Artery Bypass Graft (CABG) Surgery by Region, 2013, 2014, 2015, attached hereto as Exhibit 3***).

does.") (***Id., 39:2-5***). The witness again asked to see the article and was told by Mr. Weaver: "I don't have it with me." (***Id., 36:15***).

The Court recapped the bench discussion on the record following Plaintiffs' counsel's objection in pertinent part as follows:

> "The Court: [T]he argument was that Mr. Weaver was not actually confronting the witness with these reports, that he would be required to do so, and that it would not be appropriate; it was not an appropriate line of questioning.
>
> The Court disagreed, respectfully, with that assessment, that when there was testimony obviously by the doctor regarding his qualifications and this information called into question that testimony, that the proper impeachment is to ask certain things – obviously, you have to have your ethical obligations fulfilled that you have a good faith belief to ask the question and that ultimately there was no reason to believe otherwise – certainly Mr. Weaver was able to do so without actually requiring confrontation with documentation, to this Court's opinion, would be akin to impeachment with extrinsic evidence; and that is something that is not allowed, other than in certain circumstances, really more things go towards credibility of testimony, that's not what this would have been.
>
> So the Court indicated that, although the Plaintiffs' counsel may wish to challenge if Mr. Weaver was misrepresenting any such reports and could potentially do so on redirect, that it was not required of Mr. Weaver to confront the witness with actual reports. Although, I do think it was fair for Mr. Arntz to ask to be given a reference to or copy of or citation to what reports he was referring to; and I believe Mr. Weaver agreed, when he lift the bench, to do so. He indicated it was all online and there was a website that could be given. So, again, that inquiry continued."

(***Id., 65:9-66:17***). The Court's response to Mr. Arntz's objection represents reversable error, as discussed, below.

C. Violation of Rules of Civil Procedure - NRCP 16.1

Mr. Weaver misrepresented the substance of the article in an attempt to impeach Dr. Marmureanu. Yet, he never produced the article, either before or during trial. Although the Court found no impropriety, this failure to produce is contrary to the mandate of Rule 16.1, which says just the opposite.

Nevada Rule of Civil Procedure 16.1 states:

> "Except as exempted by Rule 16.1(a)(1)(B) or as otherwise stipulated or ordered by the court, a party ***must***, without awaiting a discovery request, provide to the other parties: …(ii) a copy – or a description by category and location – of ***all documents, electronically stored information***, and tangible things that the disclosing party has in its possession, custody, or control and may use to support its claims or defenses, ***including for impeachment*** or rebuttal, and, unless privileged or protected from disclosure, any

> record, report, or witness statement, in any form, concerning the incident that gives rise to the lawsuit."

NRCP 16.1(a)(1)(A)(ii) (emphasis added).

NRCP 16.1 further states:

> "[A] party must provide to other parties the following information regarding the evidence that it may present at trial, including impeachment and rebuttal evidence:…(C) An appropriate identification of each document or other exhibit, including summaries of other evidence, separately identifying those which the party expects to offer and those which the party may offer if the need arises."

NRCP 16.1(a)(3). The policy underlying NRCP 16.1 "serves to place all parties on an even playing field and to prevent trial by ambush or unfair surprise." *Sanders v. Sears-Page*, 131 Nev. Adv. Op. 50, 354 P.3d 201, 212 (Nev. Ct. App. 2015).

If a party fails to disclose a document or exhibit before trial as so required, the trial court "shall" impose certain sanctions, including prohibiting the use of that document or exhibit. NRCP 16.1(e)(3)(B) permits exclusion of evidence not produced in compliance with disclosure deadlines. Moreover, NRCP 37(c)(1) provides that "[a] party that without substantial justification fails to disclose information required by Rule 16.1…is not, unless such failure is harmless, permitted to use as evidence at a trial…any witness or information not so disclosed." NRCP 37(c)(1).

The rules and their applicability to the instant issue is clear. The Court was in error to rule otherwise. See, e.g. *Cooter & Gell v. Hartmarx Corp.*, 496 U.S. 384, 405 (1990) ("A district court would necessarily abuse its discretion if it based its ruling on …a clearly erroneous assessment of the evidence."), superseded by rule on other grounds, Fed. R. Civ. P. 11; *Finner v. Hurless*, No. 70656, **6-7 (Nev. App. 2018) (unreported) (district court correctly prohibited use of undisclosed deposition transcript for impeachment purposes in cross examination of medical expert).

Sanctions are warranted for failure to comply with discovery obligations unless the delayed disclosures are substantially justified or harmless. *JPMorgan Chase Bank, N.A. v. SR Investments Pool 1, LLC,* No. 76952 (Nev., March 2, 2020), citing NRCP 37(c)(1). A party cannot use at trial any witness or information not disclosed unless one of these terms are met. *Capanna v. Orth*, 134 Nev. 888, 894, 432 P.3d 726, 733 (2018). In *JPMorgan*, the Nevada Supreme Court upheld the district court's decision to strike evidence that was not properly disclosed before trial where such evidence related to a "pivotal and dispositive" issue in the case and the failure to timely disclose was not substantially justified or harmless. *Id*., at *2.

Here, the Court failed in its duty to ensure Plaintiffs' case was not prejudiced by Defendant's failure to abide by the discovery rules. Its failure to do so was prejudicial error, requiring reversal and remand for a new trial. See, i.e. *Wiggins v. State of Mississippi*, 733 So. 2d 872, 874 (Miss. App. 1999) (trial court committed reversible error when it allowed testimony to continue after counsel objected that the opposing party had failed to produce the document at issue).

D. Violation of Rules of Evidence - NRS 50.085

In addition, the Court allowed reputation evidence – which this plainly was, as the topic of the article was not at issue nor was it discussed other than to attempt to wrongfully paint Dr. Marmureanu one of the "worst" surgeons in California – for impeachment purposes, even though NRS 50.085 specifically excludes evidence of reputation to show "truthfulness or untruthfulness". NRS 50.085(2) ("Evidence of the reputation of a witness for truthfulness or untruthfulness is inadmissible.")

Further, NRS 50.085(3) states that "[s]pecific instances of the conduct of a witness, for the purpose of attacking or supporting the witness's credibility, other than conviction of crime, may not be proved by extrinsic evidence". NRS 50.085(3). Such conduct may be inquired into on cross-examination of a witness only if relevant to truthfulness.[2] See, i.e. *Collman v. State*, 116 Nev. 687, 7 P.3d 426, 436 (2000); *McKee v. State*, 112 Nev. 642, 646, 917 P.2d 940, 943 (1996) (it is error to allow impeachment of a witness with extrinsic evidence relating to a collateral matter). "Collateral facts are by nature outside the controversy or are not directly connected with the principal matter or issue in dispute." *Lobato v. State*, 120 Nev. 512, 518, 96 P.3d 765, 770 (2004).

Mr. Weaver's attempt to use the article reporting prior negative surgical outcomes in coronary bypass procedures – which is not the procedure at issue in this case – to attack Dr. Marmureanu's credibility was improper. The article was extrinsic evidence, the matter was collateral and truthfulness/untruthfulness was not the subject of inquiry. Dr. Marmureanu's skill as a coronary bypass surgeon is absolutely irrelevant to his credibility as an expert witness in this matter. This irrelevancy is compounded by the fact that the article's contents were misrepresented

[2] "Specific instances of the conduct of a witness, for the purpose of attacking or supporting the witness's credibility, other than conviction of crime, may not be proved by extrinsic evidence. They may, however, if relevant to truthfulness, be inquired into on cross-examination of the witness or on cross-examination of a witness who testifies to an opinion of his or her character for truthfulness or untruthfulness, subject to the general limitations upon relevant evidence and the limitations upon interrogation and subject to the provisions of NRS 50.090." NRS 50.085(3).

by defense counsel during questioning. This is precisely the type of collateral issue that the rules deem inadmissible.

E. Motion for a New Trial Standard – NRCP 59

Nevada Rule of Civil Procedure 59 states in pertinent part that:

> "The court may, on motion, grant a new trial on all or some of the issues – and to any party – for any of the following causes or grounds materially affecting the substantial rights of the moving party: (A) irregularity in the proceedings of the court, jury, master, or adverse party or in any order of the court or master, or any abuse of discretion by which either party was prevented from having a fair trial; (B) misconduct of the jury or prevailing part; (C) accident or surprise that ordinary prudence could not have guarded against…"

NRCP 59(a)(1)(A)-(C).

Here, Mr. Weaver cross-examined Dr. Marmureanu with an article that had not been produced or made known to Plaintiffs' counsel before the cross-examination occurred. Mr. Weaver misrepresented the contents of the article during his questioning of Dr. Marmureanu in order to diminish the doctor's credibility with the jury. He then failed to produce the article even after Dr. Marmureanu repeatedly asked to see it from the stand. The Court overruled Plaintiffs' counsel's objection and failed to admonish Mr. Weaver or the jury. Instead, the Court allowed Mr. Weaver to continue with the improper line of questioning, declined to order production of the article, and suggested that Plaintiffs' counsel could simply find the article on-line himself at a later time. This was an erroneous response in violation of the rules. The elements of irregularity in proceedings by the court and by the adverse party, misconduct of the prevailing party and unfair surprise have been met in accordance with NRCP 59.

Dr. Marmureanu was Plaintiffs' expert witness for purposes of vascular surgery and emergency medicine. He was Plaintiffs' only testifying expert witness in a complex medical malpractice claim. Such cases are dependent upon expert testimony. NRS 41A.100; *Fernandez v. Admirand*, 108 Nev. 963, 969, 843 P.2d 345, 358 (1992) (expert testimony is necessary in a medical malpractice case "unless the propriety of the treatment, or lack of it, is a matter of common

knowledge of laymen"). Plaintiffs' only medical expert which supported their claims was wrongfully discredited on the stand without means for rehabilitation resulting in prejudicial error. See, i.e. *Las Vegas Paving Corp. v. Coleman* (affirming district court's grant of a new trial where admission of improper testimony "almost certainly prejudiced the jury because it was the only evidence that supported (plaintiff's) contention – one that played a significant role in its closing argument to the jury", as but for the error, a different result might reasonably have been expected). As the article was never produced or entered into evidence as an exhibit, it was impossible for the jury to understand the substantial misrepresentations which had occurred. Due to the irregularity in the proceedings occasioned by Mr. Weaver's conduct and the subsequent ruling by the Court, which abused its discretion by overruling Plaintiffs' counsel's objections to such conduct, Plaintiffs' substantial rights were materially affected, which prevented them from having a fair trial and resulted in a defense verdict.

See, i.e. *Lioce v. Cohen*, 124 Nev. 1, 174 P.3d 970, 981 (2008) (where party moving for new trial based on purported attorney misconduct demonstrates that the district court erred by overruling the party's objection and an admonition to the jury would likely have affected the verdict in favor of the moving party, a new trial is warranted). "In this, the court must evaluate the evidence and the parties' and the attorneys' demeanor to determine whether a party's substantial rights were affected by the court's failure to sustain the objection and admonish the jury." *Id.* Where an attorney encourages jurors to look beyond relevant facts in deciding the case, misconduct has occurred. *Id.*, at 6, 973. When an attorney commits misconduct and the opposing party objects, the district court should sustain the objection and admonish the jury and counsel, respectively, by advising the jury about the impropriety of counsel's conduct and reprimanding or cautioning counsel against such misconduct. *Id.*, at 17, 980.

. . .

Error is unfairly prejudice where the aggrieved party demonstrates from the record that but for the error, a different result "might reasonably have been expected". *Hallmark v. Eldridge*, 124 Nev. 492, 505, 189, P.3d 646, 654 (2008). Had Dr. Marmureanu not been unfairly confronted with an unproduced article regarding a collateral issue, the contents of which Mr. Weaver grossly misrepresented before the jury, the outcome may very well have been different. Had the Court sustained Plaintiffs' counsel's objection, prohibited the use of the article in question – or in the alternative, ordered production of the article - and admonished the jury, the outcome may very well have been different. A new trial is warranted.

Moreover, Plaintiffs were unavoidably unfairly surprised to their detriment when Mr. Weaver began cross-examining Dr. Marmureanu about an article which was never disclosed, produced or made available to the witness or Plaintiffs' counsel at trial. In the exercise of ordinary prudence or otherwise, Plaintiffs' counsel could not have guarded against this occurrence beforehand and once his objection was overruled, the harm was complete. The Nevada Supreme Court has explained that surprise materially affects the substantial rights of an aggrieved party where it "result[s] from some fact, circumstance, or situation in which a party is placed unexpectedly, to his injury, without any default or negligence of his own, and which ordinary prudence could not have guarded against. *Havas v. Haupt*, 94 Nev. 591, 593, 583 P.2d 1094, 1095 (1978). This was not a situation where Plaintiffs knew in advance of trial that the article would be used by defense counsel and failed to take action to protect their interests. Its use during Dr. Marmureanu's cross-examination was completely unexpected, the unfairness of which was compounded by Mr. Weaver's refusal to produce the article to the witness or Plaintiffs' counsel during questioning and the Court's refusal to correct the situation. Therefore, a claim of unfair surprise under the rule will lie. *Id.*, at 593, 1095-96.

. . .

III. CONCLUSION

WHEREFORE, Plaintiffs respectfully request that a new trial be ordered due to the aforementioned violations of NRCP 16.1 and NRS 50.085. The requirements of NRCP 59 have been met.

DATED this 7th day of April, 2020.

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CERTIFICATE OF SERVICE

I hereby certify that I am an employee of ATKINSON WATKINS & HOFFMANN, LLP and that on the 7th day of April, 2020, I caused to be served via Odyssey, the Court's mandatory efiling/eservice system a true and correct copy of the document described herein.

Document Served: **PLAINTIFFS' NRCP 59 MOTION FOR NEW TRIAL**

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EXHIBIT 1

Practices

California hits nerve by singling out cardiac surgeons with higher patient death rates

by Anna Gorman, Kaiser Health News | Jul 17, 2017 11:42am

A public database of California heart surgeons identified physicians who had a higher-than-average death rate for patients who underwent a common bypass procedure.

Michael Koumjian, M.D., a heart surgeon for nearly three decades, said he considered treating the sickest patients a badge of honor. The San Diego doctor was frequently called upon to operate on those who had multiple illnesses or who'd undergone CPR before arriving at the hospital.

Recently, however, Koumjian received some unwelcome recognition: He was identified in a public database of California heart surgeons as one of seven with a higher-than-average death rate for patients who underwent a common bypass procedure.

"If you are willing to give people a shot and their only chance is surgery, then you are going to have more deaths and be criticized," said Koumjian, whose risk-adjusted death rate was 7.5 per 100

surgeries in 2014-15. “The surgeons that worry about their stats just don’t take those cases.”

Now, Koumjian said he is reconsidering taking such complicated cases because he can’t afford to continue being labeled a “bad surgeon.”

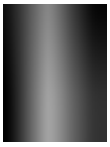
California is one of a handful of states—including New York, Pennsylvania and New Jersey—that publicly reports surgeons’ names and risk-adjusted death rates on a procedure known as the “isolated coronary artery bypass graft.” The practice is controversial: Proponents argue transparency improves quality and informs consumers. Critics say it deters surgeons from accepting complex cases and can unfairly tarnish doctors’ records.

“This is a hotly debated issue,” said Ralph Brindis, M.D., a cardiologist and professor at UC-San Francisco who chairs the advisory panel for the state report. “But to me, the pros of public reporting outweigh the negatives. I think consumers deserve to have a right to that information.”

Prompted by a state law, the Office of Statewide Health Planning and Development began issuing the reports in 2003 and produces them every two years. Outcomes from the bypass procedure had long been used as one of several measures of hospital quality. But that marked the first time physician names were attached—and the bypass is still the only procedure for which such physician-specific reports are released publicly in California.

California’s law was sponsored by consumer advocates, who argued that publicly listing the names of outlier surgeons in New York had appeared to bring about a significant drop in death rates from the bypass procedure. State officials say it has worked here as well: The rate declined from

About the Author



Anna Gorman, Kaiser Health News

Senior correspondent, Kaiser Health News

2.91 to 1.97 deaths per 100 surgeries from 2003 to 2014.

“Providing the results back to the surgeons, facilities and the public overall results in higher quality performance for everybody,” said Holly Hoegh, manager of the clinical data unit at the state’s health planning and development office.

Since the state began issuing the reports, the number of surgeons with significantly higher death rates than the state average has ranged from six to 12, and none has made the list twice. The most recent **report**, released in May, is based on surgeries performed in 2013 and 2014.

In this year’s report, the seven surgeons with above-average death rates—out of 271 surgeons listed—include several veterans in the field. Among them were Daniel Pellegrini, M.D., chief of inpatient quality at Kaiser Permanente San Francisco and John M. Robertson, M.D., director of thoracic and cardiovascular surgery at Providence Saint John’s Health Center in Santa Monica. Most defended their records, arguing that some of the deaths shouldn’t have been counted or that the death rates didn’t represent the totality of their careers. (Kaiser Health News, which produces California Healthline, is not affiliated with Kaiser Permanente.)

“For the lion’s share of my career, my numbers were good and I’m very proud of them,” said Pellegrini. “I don’t think this is reflective of my work overall. I do think that’s reflective that I was willing to take on tough cases.”

During the two years covered in the report, Pellegrini performed 69 surgeries and four patients died. That brought his risk-adjusted rate to 11.48 deaths per 100, above the state average of 2.13 per 100 in that period.

Pellegrini said he supports public reporting, but he argues the calculations don’t fully take the varying complexity of the cases into account and that a couple of bad outcomes can skew the rates.

Robertson said in a written statement that he had three very “complex and challenging” cases involving patients who came to the hospital with “extraordinary complications and additional unrelated conditions.” They were among five deaths out of 71 patients during the reporting period, giving him an adjusted rate of 9.75 per 100 surgeries.

“While I appreciate independent oversight, it’s important for consumers to realize that two years of data do not illustrate overall results,” Robertson said. “Every single patient is different.”

The rates are calculated based on a nationally recognized method that includes deaths occurring during hospitalization, regardless of how long the stay, or anytime within 30 days after the surgery, regardless of the venue. All licensed hospitals must report the data to the state.

State officials said that providing surgeons’ names can help consumers make choices about who they want to operate on them, assuming it’s not an emergency.

“It is important for patients to be involved in their own health care, and we are trying to work more and more on getting this information in an easy-to-use format for the man on the street,” said Hoegh, of the state’s health planning and development office.

No minimum number of surgeries is needed to calculate a rate, but the results must be statistically significant and are risk-adjusted to account for varying levels of illness or frailty among patients, Hoegh said.

She acknowledged that “a risk model can never capture all the risk” and said her office is always trying to improve its approach.

Surgeons sometimes file appeals—arguing, for example, that the risk was improperly calculated or that the death was unrelated to the surgery. The appeals can result in adjustments to a rate, Hoegh said.

Despite the controversy it generates, the public reporting is supported by the California Society of Thoracic Surgeons, the professional association representing the surgeons. No one wants to be on the list, but “transparency is always a good thing,” said Junaid Khan, M.D., president of the society and director of cardiovascular surgery at Alta Bates Summit Medical Center in the Bay Area.

“The purpose of the list is not to be punitive,” said Khan. “It’s not to embarrass anybody. It is to help improve quality.”

Khan added that he believes outcomes of other heart procedures, such as angioplasty, should also be publicly reported.

Consumers Union, which sponsored the bill that led to the cardiac surgeon reports, supports expanding doctor-specific reporting to include a variety of other procedures — for example, birth outcomes, which could be valuable for expectant parents as they look for a doctor.

“Consumers are really hungry for physician-specific information,” said Betsy Imholz, the advocacy group’s special projects director. And, she added, “care that people receive actually improves once the data is made public.”

But efforts to expand reporting by name are likely to hit opposition. Officials in Massachusetts, who had been reporting bypass outcomes for individual doctors, stopped doing it in 2013. Surgeons supported reporting to improve outcomes, but they were concerned that they were being identified publicly as outliers when they really were just taking on difficult cases, said Daniel Engelman, M.D., president of the Massachusetts Society of Thoracic Surgeons.

“Cardiac surgeons said, ‘Enough is enough. We can’t risk being in the papers as outliers,’” Engelman said.

Engelman said the surgeons cited research from New York showing that public reporting may have led surgeons to turn away high-risk patients. Hoegh said research has not uncovered any such evidence in California.

In addition to Koumjian, Robertson and Pellegrini, the physicians in California with higher-than-average rates were Philip Faraci, Eli R. Capouya, Alexander R. Marmureanu, Yousef M. Odeh. Capouya declined to comment.

Faraci, 75, said his rate (8.34 per 100) was based on four deaths out of 33 surgeries, not enough to calculate death rates, he said. Faraci, who is semi-retired, said he wasn’t too worried about the rating, though. “I have been in practice for over 30 years and I have never been published as a below-average surgeon before,” he said.

Odeh, 45, performed 10 surgeries and had two deaths while at Presbyterian Intercommunity Hospital in Whittier, resulting in a mortality rate of 26.17 per 100. “It was my first job out of residency, and I didn’t have much guidance,” Odeh said. “That’s a recipe for disaster.”

Odeh said those two years don't reflect his skills as a surgeon, adding that he has done hundreds of surgeries since then without incident.

Marmureanu, who operates at several Los Angeles-area hospitals, had a mortality rate of 18.04 based on three deaths among 22 cases. "I do the most complicated cases in town," he said, adding that one of the patients died later after being hit by a car.

"Hospital patients don't care" about the report. he said. "Nobody pays attention to this data other than journalists."

***Kaiser Health News**, a nonprofit health newsroom whose stories appear in news outlets nationwide, is an editorially independent part of the Kaiser Family Foundation.*

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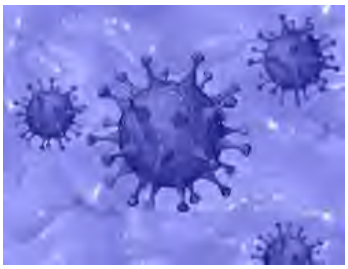
Hospitals & Health Systems



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Apr 7, 2020 2:18pm

Tech

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by Heather Landi
Apr 7, 2020 3:45pm

EXHIBIT 2

IN THE EIGHTH JUDICIAL DISTRICT COURT

CLARK COUNTY, NEVADA

DARELL L. MOORE and CHARLENE A. MOORE, individually and as husband and wife, Plaintiffs, vs. JASON LASRY, M.D., individually; FREMONT EMERGENCY SERVICES (MANDAVIA), LTD.; TERRY BARTMUS, RN, APRN; and DOES I through X, inclusive; and ROE CORPORATIONS I through V, inclusive, Defendants.	)	CASE NO. A-17-766426-C DEPT. NO. 25

REPORTER'S TRANSCRIPT OF PROCEEDINGS OF JURY TRIAL

P.M. SESSION TESTIMONY OF ALEXANDER MARMUREANU, M.D.

BEFORE THE HONORABLE KATHLEEN E. DELANEY

FRIDAY, JANUARY 31, 2020

APPEARANCES:

For the Plaintiffs:

E. BREEN ARNTZ, ESQ.
HANK HYMANSON, ESQ.
PHILIP M. HYMANSON, ESQ.

For the Defendants:

ROBERT C. McBRIDE, ESQ.
KEITH A. WEAVER, ESQ.
ALISSA BESTICK, ESQ.

REPORTED BY: DANA J. TAVAGLIONE, RPR, CCR No. 841

I N D E X

E X H I B I T S

LAS VEGAS, NEVADA, FRIDAY, JANUARY 31, 2020

1:57 P.M.

* * * * *

Thereupon --

ALEXANDER MARMUREANU, M.D.,

having been previously sworn to testify to the truth, was examined and testified as follows:

CROSS-EXAMINATION

BY MR. WEAVER:

Q. Good afternoon, Doctor.

A. Good afternoon, Mr. Weaver.

Q. Welcome to Las Vegas.

A. Thank you, sir. Much appreciated.

Q. I want to start off with a little bit of apology in response to counsel earlier this morning. You had mentioned that you were coming out of the bathroom, I was going in. We shook hands. But I didn't stop and chitchat. I did not mean it as any slight. It's not my style, when I'm in trial, to talk with the other side's expert. Fair enough?

A. Apology accepted.

Q. Thank you. Also, just to clarify something, I'm sure would have got clarified later, but I can just do it quick and easily.

When we were leaving off, before the lunch break, I think you misspoke on the record, and I just wanted to potentially clear it up so that the jury might not get the wrong impression.

You mentioned that, at your deposition, which was taken in my firm's downtown Los Angeles office; correct?

A. I believe so. Yes, you're correct.

Q. And there was an attorney from Mr. McBride's office there, Chelsea Hueth. Do you remember that?

A. That's correct.

Q. And do you remember what Ms. Hueth actually said, which was not --

MR. ARNTZ: Well, hold on. Before you start to ask this question, we need to approach the bench.

THE COURT: Okay.

(Bench conference.)

THE COURT: You didn't get too comfortable, did you, folks? In all seriousness, once a bench conference goes a little bit longer and we're really trying to flesh some things out, it's just much easier to do it without you all present. So if you'll indulge us. You know your admonishment. We'll note it on the record. I'm not going to read

it again. If you could just step outside for a few minutes, we'll have you right back in. Okay?

THE MARSHAL: All rise for the jury.

(Jury exits the courtroom.)

THE COURT: Doctor, can I ask you to please step back to --

THE WITNESS: Of course. Go outside?

THE COURT: Into the alcove. There's a little waiting room.

THE WITNESS: Thank you.

THE COURT: Okay. As is my practice, just indulge me. I would like to, you know, summarize the bench conference.

So what Mr. Arntz' concern expressed, when he asked to approach, was that he believed that Mr. Weaver was going to get into details, but also just identification of potentially that what had come out in the deposition was that Dr. Marmureanu had been represented by Mr. McBride's law firm, not that Mr. McBride's law firm had used him as an expert, and that Mr. Weaver indicated that that clarity was necessary because Dr. Marmureanu had testified that it had come out in the deposition that he had been used as an expert by Mr. McBride's law firm.

I distinctly, from my personal recollection, recall Dr. Marmureanu testifying and going out of his way, in all candor, to testify to your firm and "you've used me" and clearly leaving this jury with the impression that Mr. McBride's law firm had used him as an expert at least once, if not more, in the past.

So my indication at the bench initially, as we were talking but before the conversation got more detailed and concerns expressed about the level in which Mr. Weaver might inquire on this subject, that's when I excused the jury so we could have a better discussion. But Mr. Weaver's response was, you know, the clarity is necessary and that he was not going to inquire into details of the representation, but that he should be able to clarify that there was representation.

Obviously, that's a very fine line to walk if these jurors are connecting to, and I don't know why they wouldn't be, that these attorneys represent doctors in medical malpractice cases and then cast aspersions indirectly that way on this witness.

So we are going to have to figure out how we're going to address this, but my inclination is still, at this moment, to indicate that there must

be some clarity because the doctor did volunteer that information. I don't think it was responsive to an inquiry of Mr. McBride, and he did appear to leave the jury with the impression that his firm had hired him as an expert, and if that's not the case, we need to figure out how to get some clarification. But, Mr. Arntz, let me let you flesh out your argument, and then I'll hear from Mr. Weaver.

MR. ARNTZ: Look, I wasn't -- in fact, at lunch, I cautioned him not to get cute volunteering statements like that. But his statement was not in the context of what was discussed in the deposition. His statement was just a gratuitous, "Oh, and by the way, you guys have hired me too." And this was being discussed when he was talking about how much things cost and so forth.

I don't have any recollection of it being in the context of that being discussed in the deposition. I agree that the only thing that was discussed in the deposition was a disclosure by Ms. Hueth that her firm had represented him before. And she wanted to make sure it wasn't going to be a conflict. But that statement that he made was just a gratuitous statement of "Oh, and by the way, your firm has hired me too."

THE COURT: Right. Gratuitous. Problematic in that way.

MR. ARNTZ: I don't disagree that some clarity brought on by saying "But you represent plaintiffs and/or you testified for plaintiffs, and you've testified for defendants and so forth." I don't see it opening the door to something that happened at deposition where a disclosure was made just so he would be comfortable having one of his attorneys there.

THE COURT: Let's role play here a second. So if I were to limit Mr. Weaver's followup to something along the lines of, you know, "Doctor, you testified earlier that you believed or remembered that Mr. McBride's law firm had hired you as an expert, if I were to indicate to you that there does not appear to be any record of that being the case, would" --

MR. ARNTZ: I don't know if that's true. I don't think that's true.

THE COURT: Have you hired him as an expert?

MR. McBRIDE: Our firm?

THE COURT: I know you said you hadn't met him. Has your firm? I mean, I know your firm is

pretty big.

MR. MCBRIDE: I honestly don't know because we have our firm --

THE COURT: But it never came out in the depo, so.

MR. MCBRIDE: It never came out in the depo, yeah.

MR. ARNTZ: The only thing that came out in the depo was a disclosure.

THE COURT: Mr. Arntz, okay, but I wasn't finished. But, okay, fair enough. I'm trying to figure out a way, because this clarity will occur, how we do it. So I was trying to throw out an option so you can shoot it down, if you want, but then what's your alternative?

MR. ARNTZ: Well, if I had asked Dr. Marmureanu, "Have you ever worked for any of the defense firms" and he said yes, would that require clarity? Because all he did was volunteer a statement that wasn't responsive to a question that still is true.

THE COURT: In Dr. Marmureanu's testimony, I think it's more problematic because it was gratuitous, volunteered, and it appeared to be designed for exactly the effect that counsel is now

concerned about and wants clarity on.

Had you asked, would they be able to clarify? You know, again, I mean, as we sit here today, we can't be certain that he hasn't been used by them as an expert. But, again, it never came up. I would think that we would have that information, if he had, but I guess we can't rule it out. But at this point, you know, what he was talking about appeared to be in the context -- because he said it himself, "In the deposition, it came out."

He's very prone to want to say what he thinks is in there, that he thinks is being kept from the jury. I tried to admonish him, but he's still doing it. And he made it clear that, in the deposition, this is what it says. So maybe that's how we clarify that, you know, "If I were to tell you that there's no statement in the deposition that this firm hired you as an expert, would you have reason to question that at this time?"

MR. ARNTZ: How about striking that from the record and just telling the jury --

THE COURT: They heard it. You can't unring the bell. There needs to be clarity.

MR. ARNTZ: But my point is let's assume for a minute that it's true that he's been hired by

Mr. McBride's firm to act as an expert. How does the fact that, during the deposition, a disclosure was made by Ms. Hueth that her firm had represented him in the past clarify that? It doesn't clarify that. If it's true that he has been retained by them, talking about the fact that he's been represented by that firm doesn't clarify that point.

THE COURT: I don't perceive that to be the issue. I perceive the issue to be that there's no evidence, from what they're telling me, from his deposition which, by all accounts, was lengthy and his C.V. and anything else to indicate that they had hired him as an expert; although, again, we can't completely rule it out, all that came up in the depo was this other issue. He's referring to the depo.

So in the end of the day, you know, he's talking about something that was in the depo that wasn't there. Why is that clarity not appropriate?

MR. ARNTZ: Okay. I don't remember it that way.

THE COURT: You remember which part?

MR. ARNTZ: I don't remember his gratuitous comment being made in the context of this coming up in the depo.

THE COURT: I heard it.

MR. ARNTZ: Okay. I don't remember it that way, but I still don't see how --

THE COURT: Respectfully, I remember it. You don't. We agree to disagree.

MR. ARNTZ: Yeah, no, that's fine. That's not really relevant to the other point, which is I don't see how him asking questions about having been represented by that firm, just because that's what came up in the depo sheds clarity on the statement he made. If he asks that question and then I follow-up by saying, "Well, Dr. Marmureanu, have you been retained by Mr. McBride's firm?" Because then that would clarify even further.

THE COURT: Maybe the better way to do it, go about this, Mr. Arntz, and we need to get to this, but I'm assuming your angst over this is because you don't want it coming out these attorneys who represent doctors in medical malpractices might have represented him.

MR. ARNTZ: Right. So I'm giving you an alternative where I'm limiting Mr. Weaver to just asking the witness -- at least for now, we'll see what his answer is -- but just asking the witness, "You testified earlier that you believed it came out in the deposition that Mr. McBride's firm had hired

you as an expert. If I were to tell you that we reviewed this over the break and there doesn't appear to be any indication in the deposition that that is the case or that the dialogue in the deposition was related to not that, you know, would you have any reason to doubt that? Do you have any better recollection of that at this time?"

Something so that it doesn't come up that he was represented, but it comes up that there's nothing in evidence that he was retained by them as an expert. Because he clearly gave testimony to the jury that sounded like he had been retained by them as an expert.

MR. ARNTZ: Right. So I guess maybe the reason I focus on what I have is because that seems to be the focal point, has he been retained by this firm, not whether it came up in the depo. But your solution is fine with me, so long as they don't get into representations.

THE COURT: I think there's a way.

Mr. Weaver, can you tell us, do you think there's a way that you can inquire without --

MR. WEAVER: I think, well, two things. I think that there is a way I can inquire as long as it's clear that it's not just whether he has been

retained as an expert by Mr. McBride's firm, that he has not, but the context of what he said in the deposition is he had it wrong, No. 1.

But, No. 2, the Motion in Limine with regard to lawsuits only applies to defendants. So if I ask him, I'm not intending to ask him questions about Mr. McBride's representation any more than Mr. McBride was obviously, at the end, going to get into his firm's representation. I could get into questions about lawsuits that he's had, and there have been plenty. But I certainly was not intending to get into questions about Mr. McBride's firm representation.

The only thing that I can't live with is he gratuitously offered, implying that it was brought up that he is an expert of Mr. McBride's firm when the only thing that was brought up was not that, but representation.

THE COURT: All right. So, you know, my thought is that we do need to clarify his testimony. The same, whether or not the Motion in Limine was brought by a particular party on behalf of particular parties, it's still the same concept which is, you know, is it relevant and does it, is it substantially outweighed by prejudice -- I

suppose, to some degree -- analysis, and I don't think it should be revealed here that he was represented by Mr. McBride's firm.

But the issue, I think by the way I'm suggesting it be done, I think is resolved because if you say and very clear, you know, "We reviewed this over the break, and we see no indication of that testimony being had or no indication of any, you know, evidence in the deposition of them having, you know, retained you as an expert. So, you know, what you were testifying about does not appear to be accurate in that regard, you know, would you agree with that, or would you have some reason to doubt that?"

Now, the issue is if he says something like "Well, it may have been something different" or "I may have been mistaken" or whatever, we can move on. If he doubles down on it, then where do we go?

MR. ARNTZ: I'll tell him to just take his medicine and we move on.

MR. MCBRIDE: And, Your Honor, just for clarification too, you asked the question if I knew if our firm has retained him, again, I don't know specifically. At least from the deposition list that he provided and trial testimony, I went through

that just now, that he attached from 2009 up to 2019, I don't see any reference to our firm as being, representing him in those depositions or him acting on behalf of our firm or any of the trials or mediations that he's worked on. So just for that --

THE COURT: Right. I mean, it doesn't drive the train.

MR. McBRIDE: Right.

THE COURT: The whole thing boils down to me, and I understand Mr. Arntz and I remember this differently, and maybe the other counsel do as well -- you know, various people in the setting can hear things differently -- is the whole conversation was what was in the depo and what came out in the depo. And I think if we limit it to what's in the depo, we can solve this problem.

I think actually makes it worse, Mr. Arntz, if it's not the case that it was him talking about what's in the depo because then it's a little bit more broad-based about how we can inquire. But I think it can be corrected.

I think it can be corrected by "There's nothing in the depo that would support your recollection of you having a discussion about being retained by Mr. McBride's firm." So, you know, "or

you being retained as an expert by Mr. McBride's firm. So if we indicate that to you, you know, would you stand corrected on that point, or could you have possibly misremembered?" or something along those lines. And, again, if he agrees, yes. If he says "I don't remember" or "maybe I misremembered," then we can move on. But like I said if he doubles down and says "No, I'm quite certain I testified that they represent," then we might have to allow some clarification.

MR. ARNTZ: Like I said, I don't think that the prejudice that Mr. Weaver is talking about is that it came up in the depo. He's talking about whether or not he's been hired by a defense firm, and so I don't know -- I don't know how I see the relevance of the depo. But I'm perfectly happy with your solution, and I will tell him to --

THE COURT: No.

MR. ARNTZ: Because I don't think it's in the depo either. So I'm happy --

THE COURT: We're not going to have that issue again where we've had a dialogue about his testimony. We're, you know, just going to have to live with the answer and go from there.

But, Mr. Weaver, do you think you can make

that line of inquiry?

MR. WEAVER: Sure. I think that's the perfect solution.

THE COURT: I hope. We'll see. Let's get Dr. Marmureanu up in, Dr. "Marmureanu" here first. I don't want to do an outside-the-presence voir dire with him because it's just going to make it worse.

MR. P. HYMANSON: Your Honor, before we go, if I could, Phil Hymanson. Very quickly, Your Honor. So the representation from Mr. McBride's firm is he can't say specifically whether they have or have not, they're just -- at this point, they don't know? Is that the understanding?

THE COURT: I mean, I think that's true.

MR. McBRIDE: Yeah, I think that's true, and I'm just going off also the top of that, what he had listed.

MR. P. HYMANSON: When asking questions, we'll hopefully move through it and move on, but if we don't, then there's Step 2.

THE COURT: I mean, I think we've said that a couple of times, but I appreciate you clarifying, Mr. Hymanson, that we can't be certain, as we sit here today, that he hasn't been retained by his firm as an expert. We know he hasn't been retained by

Mr. McBride as an expert. But by his firm, no.

But what we can also be certain of is that it does not appear to be what was discussed in the depo; and when he testified, from his recollection, that what was in the depo was that fact, that's what we need to clarify.

MR. P. HYMANSON: Thank you.

MR. WEAVER: I'll limit it to that. Thank you.

THE COURT: Ask to approach if it goes south.

(Jury enters the courtroom.)

THE COURT: All right. Thank you, ladies and gentlemen. Have a seat. I'll invite everybody else to have a seat as well. We have resolved the bench conference issue, and everybody in the jury appears to be ready to proceed.

Dr. Marmureanu, could you please also, again, acknowledge you understand you're still under oath.

THE WITNESS: Yes, I do.

THE COURT: Thank you. And, Mr. Weaver, whenever you're ready to resume.

MR. WEAVER: Thank you, Your Honor.

/ / /

BY MR. WEAVER:

Q. Dr. Marmureanu, I think I just want to cut through the chase on something. Over the break, I reviewed the deposition that you and I attended and have refreshed my recollection that I don't believe there's anything in your deposition that indicated Mr. McBride's office has retained you as an expert, which I think you said just before we went on the lunch break.

Would it be fair to say that you just misspoke when you said that and that it didn't come up in the deposition, that that was the case?

A. It is unfair, sir. May I explain?

Q. So let me just stop you there for a minute.

So your recollection of the deposition is there was a discussion about Mr. McBride's firm retaining you as an expert? That's your recollection of the deposition?

A. I don't have much of a recollection of the issue that you brought up. That's not what I referred to when I --

Q. Well, I'm just asking you because the testimony that you volunteered to Mr. McBride was that, in the deposition, it came up that there was something that related to comments on the record

about you being retained by Mr. McBride's firm as an expert. Is it your recollection that that conversation took place or not in the deposition?

A. I don't remember about talking about this during the deposition. May I explain what I was referring to?

MR. WEAVER: No. May we approach.

THE COURT: Yes.

(Bench conference.)

THE COURT: All right. Thank you, Mr. Weaver. You can move on to another line of questioning.

MR. WEAVER: Thank you, Your Honor.

THE COURT: I think we have that clear.

BY MR. WEAVER:

Q. Dr. Marmureanu, I forget whether you said you reviewed the deposition of your co-expert in this case, Dr. Jacobs. Have you or not?

A. I did review it, sir. Yes.

Q. Do you recall seeing in his deposition where he said the exact opposite of you this morning when you said: "The standard of care doesn't require the Five Ps; nobody does that anymore, that the standard of care requires a CT angiogram," and he said the exact opposite?

Do you recall him saying nobody would have done a CT angiogram in this case?

A. I do not recall that, sir. No absolutely not.

Q. Would it shock you?

A. Wouldn't shock me. I just said I don't remember.

Q. Why wouldn't -- if that is his testimony, why wouldn't it shock you that your co-expert in this case says the exact opposite that you do, given that in response to Mr. Arntz' questioning, you said there's one standard of care when it comes to the emergency medicine in this case?

A. Because I truly believe you take it out of context, and I would like you to show us exactly what we're talking about before we make those statements.

Q. Well, it's a statement that you made.

You testified this morning that you're qualified to offer opinions in emergency medicine, even though you haven't been trained in emergency medicine, because there's one standard of care.

So if there's one standard of care for you, if there's one standard of care for Dr. Jacobs, if there's one standard of care for Nurse Practitioner

Bartmus, if there's one standard of care for Dr. Lasry, everybody should be on the same page, or at least you and Dr. Jacobs should be on the same page; correct?

MR. ARNTZ: Your Honor, I have an objection as to this line of questioning regarding Dr. Jacobs' deposition. It's hearsay, and we've had a motion on this before trial started.

THE COURT: Mr. Weaver, do you want to respond?

MR. WEAVER: Yes. What I respond to that is he said he's reviewed that experts are able to rely on anything of a serious matter, and I think that given that the testimony that there's already been, I think it's fair game.

MR. ARNTZ: Okay. He hasn't testified here, and his deposition hasn't been read into the record here.

THE COURT: Maybe you all get to have your exercise. So come on up to the bench.

(Bench conference.)

THE COURT: All right. Thank you. We got right up on that moment of having to start fresh.

But go ahead. Mr. Weaver, I think we have an understanding of how to proceed with this line of

questioning.

MR. WEAVER: Thank you, Your Honor.

BY MR. WEAVER:

Q. Dr. Marmureanu, you said that you reviewed Dr. Jacobs' deposition. When did you last review it?

A. Probably last week.

Q. All right. And you reviewed it obviously in preparation for being here today; correct?

A. That's correct.

Q. And you reviewed it because it was material sent to you by plaintiffs' counsel's office for you to prepare for your deposition -- I'm sorry -- for you to prepare for your trial testimony today; correct?

A. No. Not correct. That was sent to me way before the trial. So I review it because I felt I need to review it.

Q. Why did you feel it would be helpful to review it in preparation for your testimony today?

A. That's who I am. I need to review every piece of document that I can in order to formulate what I believe is the right opinion.

Q. Okay. So you wanted to review all the materials that were provided to you in order to support the opinions for which you're prepared to

testify to today, and that included Dr. Fish's (sic) deposition; correct?

MR. ARNTZ: Not Dr. Fish. Dr. Jacobs.

BY MR. WEAVER:

Q. I'm sorry. Dr. Jacobs' deposition?

A. No, not really. I didn't review it in order to help me support my opinions. I review it in order to basically understand what was his thought on the whole process. So then I decide where it goes from there, but I don't review documents -- I don't know ahead of time what's going to happen with that review. Make sense?

Q. Do you agree with me that Dr. Jacobs' opinions with regard to the violations of the standard of care in this case are different from yours?

A. No. I disagree with you.

Q. Okay. Is it your opinion, based on your review of Dr. Jacobs' deposition, that your opinions fit those of Dr. Jacobs?

A. By and large, yes, that's my opinion.

Q. In what ways don't they, other than that he testified that there did not need to be a CT angiogram? What additional ways don't they match, or would we need to go through them all?

A. We will probably need to go through. If I may explain, I do not believe that he said that there is no need for a CT angiogram. I think you're taking it out of context. What I believe he said, he would follow-up with an arterial duplex immediately after venous duplex, and he will decide from there other ways of discovering if this graft is open or not. In other words, by no means, when we talk about Five Ps, that's historical medicine. That address to physical exam, which is part of the standard of care, but by itself, doesn't represent the standard of care.

Standard of care, it's part of the compilation. It's the physical exam, which you could put the Five Ps in there. There are the studies, and there is the management.

Q. Right. But Dr. Jacobs testified that no reasonable practitioner in the emergency department on December 25th, 2016, would have done a CT angiogram. That's the exact opposite of what you're saying; correct?

A. I do not believe you're truthful, sir. I would like to see that.

Q. Okay. So you don't just think I'm wrong. You think I'm not telling the truth --

A. Either way.
Q. -- about Dr. Jacobs?
A. Yeah, I would like to see that.
Q. So but you don't really need to see it because you're sure I'm just not telling the truth about what he testified to; right?
A. Well, to the best of my recollection, I remember you and him talking about it. I truly believe that he said that perhaps, to the best of my recollection, as an initial step, he wouldn't have ordered it. He would have perhaps ordered it after. It's not about CT angiogram. It's any sort of angiogram. I would like to see that, if possible.
Q. Right. But that's my point. Dr. Jacobs said that in the emergency department, nobody had a duty to order a CT angiogram. This morning, what you testified to to the jury is that: The standard of care isn't to do Five Ps; nobody does that anymore; the standard of care was to do a CT angiogram.
A. Correct. I'm saying the same thing. That's, standard of care, it's Five Ps, forward slash, physical exam and angiograms. MR angiograms, CT angiograms, or real angiogram. And I think, if I recall correct, that's what the E.R. doctor said. I would like --

THE REPORTER: Was that "real" angiogram?

THE WITNESS: Or "regular" angiogram.

BY MR. WEAVER:

Q. Dr. Marmureanu, do you have an opinion of how many cardiovascular surgeons there are in California, roughly?

A. No, sir.

Q. A few hundred?

A. Probably. Could be.

Q. Your understanding?

Okay. And you testified this morning that anytime you're doing heart surgery, it includes vascular. So if you're doing heart surgery, the cardiac part, it also includes vascular. So that it's cardiovascular; correct?

A. That's right. It's -- yes, sir.

Q. And, Dr. Marmureanu, have you heard the term "Pot calling the kettle black"?

A. I'm sorry. What did you say?

Q. Do you know what the term "Pot calling the kettle black" means?

A. No, sir.

Q. How about the term "People who live in glass houses shouldn't throw stones"? Ever heard of that?

A. No, sir.

Q. In 2017, the State of California declared that you are one of the seven worst cardiovascular surgeons in the entire state out of hundreds; correct?

A. Incorrect, sir. I would like to see that.

Q. So is it your testimony, Dr. Marmureanu, that the office of -- the California Office of Statewide Health Planning and Development didn't issue a report that listed you in the top 3 percent of the worst cardiovascular surgeons in California?

A. You're untruthful and incorrect, again, sir.

Q. Okay. So what would you need to be convinced that that report exists?

A. Show it.

Q. Okay. We'll come back to that.

A. Go ahead.

Q. Let me do what's called "lay a little foundation." So do you know what the "California Society of Thoracic Surgeons" is?

A. Very well.

Q. Okay. And you don't believe that the president of the California Society of Thoracic Surgeons supported a report that identified you as one of the top seven worst cardiovascular surgeons in

California; correct?

A. Not only do I don't believe, I'm saying you're wrong.

Q. And I would also be wrong if you told a reporter for Kaiser News that, in effect, hospital patients don't care if they're, in your case, nine times more likely to die under your care?

A. That's not what I said. You're not telling the truth again.

Q. Did you say something to that effect, that hospital patients don't care about that report; the only people who care about the data are the journalists?

A. That could be.

Q. But it's in the context of the report that, out of 271 cardiovascular surgeon in California, found you one of the worst seven?

A. It's absolutely not true. And, I mean, I don't want to judge upset, but I think it's despicable what you're saying.

Q. And would it also be despicable if Hollywood Presbyterian Hospitals got one of the worst rankings as a hospital because of your ranking by the State of California's Office of Statewide Health Planning and Development?

A. That's not true again, sir. You will have to show me.

Q. Okay. We'll come back to that.

Sir, you're saying no such report exists; right?

A. Well, not what you said. What you said doesn't exist. You are wrong about the year; you are wrong about the report; you are wrong what the report says, and I'm not sure if you're doing it on purpose or just you don't know enough about it.

Q. Well, I read the report. What does it say? Well, you're familiar --

A. Allow me to explain. I can explain.

MR. ARNTZ: Your Honor, he's not laying the proper foundation.

THE COURT: Hold on. There's an objection posed, and I'm going to have counsel back at the bench so we can try to resolve it more quickly.

(Bench conference.)

THE COURT: The objection is overruled. You may proceed, Mr. Weaver.

BY MR. WEAVER:

Q. Dr. Marmureanu, you were quoted, weren't you, after the report came out, by a reporter from Kaiser Health News where you were identified in a

news report based on the California Office of Statewide Health Planning and Development where you were asked questions about your ranking in that report; correct?

A. Can you repeat the question.

Q. Sure. Tell me what your understanding is of the report that came out in 2017, from the California Office of Statewide Health Planning and Development, that identified you in the "worst" category.

There were 265 cardiovascular surgeons in one category, and you and six others were in a category that was labeled "worst." A California state document. Are you denying that?

A. Can you, when you say "worst," what are you referring to?

Q. The state put you in a category that they labeled you as "worst." Do you admit that or deny that?

A. I'm asking you when you say "worst," "worst" in which? What kind of "worst"? What category of "worst"?

Q. "Worst" in the context of you having nine times the state average of deaths following CABGs. Tell the jury what a "CABG" is.

A. All right. May I explain, sir?

Q. Sure. Tell the jury what a "CABG" is.

A. So first of all, I truly believe you're totally incorrect, or I'm not sure. Maybe you don't even know what you're saying. We have to look at the report. But here is what he's trying to say. "CABG" means "coronary artery bypass grafting." Most of the people -- people have heart attacks. Instead of having a clotted graft, they have a clotted artery. They get rushed to the hospital. We talk this called "stemi" --

(Reporter request.)

THE WITNESS: It's called a "stemi," S-T-E-M-I.

THE REPORTER: Please begin the sentence again, and speak more slowly. I apologize.

THE WITNESS: Sure. S-T-E-M-I. I don't remember. It's about stemi.

So people whose heart attacks come to the hospital, they're being brought by the ambulance to the hospital; and at that point, we talked about the committees that address the fact that this is an emergency. We have to operate on those patients or do some sort of percutaneous intervention on them within 30 to 90 minutes. The operation that they usually get is called "coronary artery bypass

grafting." Sounds "CABG." It's not a fancy, but that side the way it is.

So the report is from 2013 and not 2017. I've actually had zero mortalities the last seven years. That's a zero. In that year, in 2013, because I cover nine hospital, and most of the busy doctors and the best doctors in town tend to address and to operate on the sickest patients. We don't pick and choose, but we are the first and the last line of defense. We are the one operating on people with chest pain, with the heart being almost dead, with the vessels be blocked with the balloon pumps in them.

The family is there. The cardiologist said "It's nothing that you can do." The easiest thing to do is to deny the case and go and play golf, or you do the case, you spend 18 hours there, and you try to save his life. So in 2013, they decide to look at 30 days mortality. 30 days mortality is, by California, S-T-S, means any patient that died within 30 days for any cause.

I've had a patient that was hit by a bus. I had a patient that had a stroke post update 25 because of anticoagulation. I had a few patients that died before dissection. The whole heart

exploded. The whole aorta exploded, torn apart. So during that procedure, because every I have to reconstruct, I actually put a graft from the aorta to the heart, and suddenly went into this category of CABG. So my mortality that year was in 30 days. No patient ever died on the O.R. table. They were always in 15 days to 30 days.

We had an issue with California Society of Cardiothoracic Surgery, it's plain stupid to blame a surgeon -- and nobody blamed the surgeon. The data is not blaming surgeon. It's that surgeon, in that year, had a higher mortality that his colleagues with they not taking call the way I do in three very busy hospitals. And there was all those sick patients.

So that happens. I gave them an interview. Some of the best cardiac surgeons in Los Angeles, the busiest guy are part of this group, and we're happy because we don't turn patient down. We know they will die if we don't do them. If we do them, they had a chance. Nobody died on the O.R. table, died weeks after. And currently there is a big issue with covering this kind of data because the public has to be informed.

This is not a blame on the surgeons,

otherwise nobody would operate, because misinformed people will take those tables that they don't know what "worst" is about. So it's about, in 2013, I had a few more mortalities, 20 to 30 days postop. Those are patients that are home. One of them got hit by a bus in Vegas, and those death within 30 days. So no, I don't think I'm a bad surgeon, no.

BY MR. WEAVER:

Q. Dr. Marmureanu, the study was not in 2013.

A. 2013.

Q. No, it wasn't. The surgeries were in 2014 and 2015, and the report was in 2017.

A. May I see it?

Q. I don't have it with me. I have the reports. You know why I don't have it with me because it's all online, and it's all online for the world to see, and it's never had to be corrected because this is the first time you've ever claimed that one of your patients is included in that mortality rate by being hit by a bus.

That's not true, is it?

A. It's -- no, it's been -- I actually claimed this before, even during the interview.

Q. You claimed somebody got hit buy a car. Now

you're claiming they got hit by a bus in Las Vegas?

A. It's the same thing. It's car or a bus, yes.

Q. Okay. So the people who compile -- the state employees whose job it is, at the Office of Statewide Health Planning and Development, you agree, don't you, that they didn't just calculate all the deaths from patients by surgeons like you who do the coronary artery bypass surgery. You know that they risk stratified them so that it's apples for apples; correct.

A. More or less, but you can't really re-stratify a death. A death is a death.

Q. Right. But my point is when you're trying to tell the jury that you're actually one of the best cardiovascular surgeons in Los Angeles, but the reason you got tagged as being one of the worst seven in the entire state out of hundreds is because you take harder cases.

The report risk-stratified the cases so that it took into account these extra sick patients that you're talking about you're getting labeled as being in the worst category for.

A. Absolutely incorrect, sir.

Q. Okay. What's incorrect about the report

risk-stratifying and risk-adjusting so it's apples to apples and not just your claim you had more mortalities because of people who got hit by a bus or who were sicker to start?

A. Well, it was restratified, but you cannot restratify mortality. Those are not my mortalities. Those are hospital patients that came in very sick that I've operated on them and within two, three, four weeks, they died from -- not from surgical issues. They have nothing to do with me.

Q. Okay.

A. Nothing. And that's what the report says. Unfortunately, you interpret the wrong way.

Q. Wait. The report does not say it has nothing to do with you. It says the opposite. It says it's all about you.

A. No, you're incorrect again. Absolutely not. The report deals with 30 days mortality after surgery, and it turns that some -- I had more patients than the average. I do 3 to 500 cases per year, sir. So I do more complicated cases than the average surgeon.

So that's three weeks mortality, somebody dies from a stroke or falls down in the bathroom. This is not attributed to the surgeon. It deals

with the mortality after surgery, and some of those are my patients. But it doesn't say I'm the worst surgeon than the guy who did only three cases and nobody died.

Q. It does.

A. No, it doesn't.

Q. Because it takes the -- it says, out of 100 patients who get surgery, 100 patients who get surgery, you have nine times the rate of patients who die.

A. I will need to see that. But, again, those are not my patients. Sir, those are hospital patients, yes, that I operate on; and then they go back to other facilities, and for whatever reason, they aspirate, they get pulmonary embolus; they get a stroke, or they get hit by a car. I said car or a bus. I think it was a bus actually. So I did say before that. So this has nothing to do with the surgical skill.

MR. WEAVER: Okay. I don't have any additional questions. Thank you, sir.

THE COURT: Thank you. Mr. Arntz.

MR. ARNTZ: Thank you, Your Honor.

What exhibit is that? Is that 104? I don't think it's in. I'd like to move for the

admission of Exhibit 104.

THE COURT: Joint Exhibit 104 is being moved for admission. Any objection?

MR. WEAVER: One moment, Your Honor, please.

THE COURT: That's fine. Can you identify generally what it is, Mr. Arntz.

MR. ARNTZ: I'm only going to use one letter from it.

THE COURT: Whose records they are, what it is so that they can get --

MR. WEAVER: It's Dr. Irwin.

MR. ARNTZ: Dr. Irwin.

THE COURT: Thank you. Any objection?

MR. McBRIDE: No objection.

MR. WEAVER: No objection, Your Honor.

THE COURT: Exhibit, Joint Exhibit 104 is admitted. You may inquire.

(Whereupon Joint Exhibit No. 104 was admitted into evidence.)

REDIRECT EXAMINATION

BY MR. ARNTZ:

Q. Dr. Marmureanu, I'm going to put up a letter here. Have you seen this letter?

A. Yes, sir. I think it's from Dr. Wiencek, yeah.

Q. Okay. And I'll refresh your memory that in December of 2014, Mr. Moore was hospitalized for a blood clot, and so this is probably three or four weeks after that hospitalization, maybe a month. And I'd like to draw your attention specifically to -- it seems as though I was wrong about the DVT, the emphasis I put on that.

But let me ask you something: First of all, what is the importance of the fact that the DVT was the primary differential diagnosis?

A. Well, like I said, DVT should have been part of differential diagnosis, but it should have never been the first thing. A DVT, or a deep vein thrombosis, below the knee, more likely than not will not kill a patient or make him lose a leg. Arterial insufficiency, ischemia, it will do that.

In other words, there is a differential diagnosis. There are things that you have in your mind when you work out a patient. The standard of care in this patient, because of his prior arterial insufficiency history, should have been, the No. 1 should have been leg ischemia. Not only wasn't No. 1, not only wasn't No. 2, wasn't 3, wasn't on

the list.

So even though I don't believe there was a problem ruling out -- actually, I think it's good to rule out the deep vein thrombosis, my issue is that there was nothing done.

Q. And once the ultrasound came back with a blocked arterial graft, what does the standard of care indicate that they should have done at that point?

A. At that point, they need to continue the workup. It's not the Five Ps. It's not the physical exam only. It's something needs to be done. All his symptoms, all his complaints lead toward an arterial problem, not the venous problem. And at that point, you know that basically, again, it's impossible to have normal pulses.

He never had pulses before the bypass. And the bypass is done, according to that ultrasound, he definitely didn't have pulses by Doppler, definitely not palpable. So at that point, you will need to do some sort of an imaging study. You can't -- would be fair to say, you have a venous duplex for the veins. You want to get an arterial duplex for the arteries, which will show it's blocked.

And at that point, you need to get an

angiogram, which will basically be as a roadmap, clearly will show you where the blockage is, what's blocked, how deep, et cetera. And then obviously you have to treat it, start medical management, medication, Heparin. That stops the more clot from being formed versus TPA, which is a clot buster. Call intervention radiology to start those. Call vascular to hopefully try the percutaneous open or do any sort of procedures.

Q. You saw other letters from Dr. Wiencek where he talks about good pulses.

What was significant by what you read in those records about those pulses?

A. It's very interesting because his own surgeon who knows him the best -- he evaluated him, he done the bypasses -- never used the word "palpable." Never. Because the pulses were never palpable. He used "very good pulses," which we're happy to have them, by Doppler. You put it. You find it where you do it, and then you hear (witness makes sound). They're palpable -- well, they're Dopplerable pulses.

So his surgeon is saying that, before the bypass, there were no pulses, Doppler or palpable. After the bypass, we've looked at the report, there

was Dopplerable in one area. And I think in this letter, if I recall correct, he's saying that they're good pulses by Doppler while the graft is open. While the graft is closed -- it's right here -- he had excellent pulses in the foot, current by Doppler. In other words, they're not palpable. Nobody uses the machine if you can feel them.

So it's very difficult for me to understand or actually it's impossible to say that even after the bypass, there were only pulses by Doppler, and before the bypass, there were no pulses at all. Once a bypass is down, and we know from the venous duplex that the bypass is closed, there are no pulses. They can't be.

The blood -- there's no way that you can get blood in that area to have pulses, even by Doppler. So go a step further to have palpable pulses, this patient never had palpable pulses. Obviously it's wrong. It's impossible.

Q. All right. Anything discussed during your cross-examination change any of your opinions?

A. Other than his statements are wrong in regards to study. The study doesn't say that my mortalities is nine times more. That's incorrect. It's not truthful, and everything else, I disagree

with all his statement. I don't have anything else.

Q. In regards to your opinions, have your opinions changed in any way?

A. Absolutely not.

MR. ARNTZ: Okay. That's all I have.

MR. McBRIDE: No questions.

MR. WEAVER: No questions.

THE COURT: May I see, by a show of hands, if there are any jurors who have questions for this witness. I believe that there was a reference made on the lunch break that there might be a question for this witness. Then we'd ask the marshal to make sure that you write it down and have it ready.

If there are questions, please prepare them. I'm just going to remind you to make sure your name and badge number, for the current seat you are in, is on the question and that you use the entire piece of paper.

Can I just see a show of hands right now how many questions we have. Two. Looks like two people have questions. Okay. Finish them up, and whenever you're ready to hand them in, you'll give them to the marshal. She'll bring them forward.

I don't know if you notice, our marshal shrunk a little bit.

MR. McBRIDE: She's probably just as strong though.

THE COURT: Oh, my money is on her.

Did you get the one that --

THE MARSHAL: Yeah, she's still writing.

THE COURT: She's still writing.

You getting close there, Juror No. 8? Thank you. All right. May I have counsel at the bench to read the questions.

(Bench conference.)

THE COURT: All right. Doctor, we do have some questions from the jurors. There are multiple questions on the sheet, and I think that they're sort of standalone. So here's how this process is going to work, if you're not familiar:

I'm going to read the question exactly as written. I'm not at liberty, nor are the jurors, to respond and have a dialogue like the counsel would have. What you do is you answer the question, to the best of your ability, and then the counsel will have an opportunity to follow-up and flesh out those answers, if need be.

Okay. First question: "Are there instances when an occlusion in a graft dissolves or otherwise goes away without medicine or surgery?"

THE WITNESS: Never.
THE COURT: "Will or can blood flow from collaterals demonstrate a pulse in the foot"?
THE WITNESS: No. Not in this case, no.
THE COURT: "In your opinion, does the standard of care mandate the administration of medicine, like Heparin, if a graft appears occluded or possibly has an occlusion?"
THE WITNESS: 100 percent, yes. Very good question. Immediately. There is no downside. It's better safe than sorry.
THE COURT: "Can you clarify what you meant when you stated that it is impossible for PT pulses to have been detected on 12/25/16, due to the 2012 fem-pop."
THE WITNESS: Repeat the question.
THE COURT: Yes. "Can you clarify what you meant when you stated that it is impossible for PT pulses to have been detected on 12/25/16, due to the 2012 fem-pop."
THE WITNESS: I'm sorry I'm having repeating it. 12? Which one was the last date? 12/26? 12/25? 12/28?
THE COURT: I'll read it again, as it's written, and I'll state the date in not number

terms. Okay? "Can you clarify what you meant when you stated that it is impossible for PT pulses to have been detected on December 25th, 2016, due to the 2012 fem-pop."

THE WITNESS: Yes. May I show?

THE COURT: You may.

THE WITNESS: Very good question. Let's look at the facts.

(Reporter request.)

THE WITNESS: Okay. Very good question. Let's look at the facts.

THE COURT: So let me first interrupt, Doctor. You can't illustrate this answer from the sheet that you already have.

THE WITNESS: I cannot do new ones?

THE COURT: Okay. I would like you to return to your seat. I would like you to answer the question, to the best of your ability, if you may; and then, as I mentioned, counsel will have an opportunity to follow-up, and they can determine how they wish to proceed in that regard.

THE WITNESS: Thank you.

The medical documents show that, before the bypass in 2012, there are no pulses. That's what the surgeon said. We looked at it. After the

bypass, he documented he was happy that, by Doppler, he was able to obtain a PT pulse, and he also document in that note that that pulse wasn't present before the bypass. So the bypass that he clearly said he had very good flow brought, allowed him to detect a Doppler, a PT pulse, a foot pulse, with the Doppler, not palpable.

The reason I said it's impossible to have the same PT pulse, on 12/25, is that the bypass is gone. There is no more bypass. It's simple. Before the bypass, he said there was no PT pulse. He did a bypass, and he got a PT pulse.

That bypass in December 25 is gone. And the reason we know it's gone, No. 1, the study show that it's occluded, and we also know he lost his leg three days after. So if the bypass is gone, it's very simple that there was no pulse because only the bypass allows him to bring the flow in there to create the same PT.

So no PT pulse or no foot pulse before the bypass in 2012. If, after the bypass, there is a foot pulse, if you take the bypass away, there is -- you're not going to get that pulse in there, and that's the way it is. 100 percent, you're not going to have a palpable pulse. Impossible because he

never had a palpable pulse. Nowhere in any medical record it says that there is a palpable pulse.

I will actually guarantee you, which we can look in the records, the surgeon says before the bypass, he had no pulses at all. But even in 2012, he had no pulses, mean no palpable pulses, no pulses by Doppler. After a bypass, only by Doppler, for some time. And when the graft goes bad, that Doppler pulse is gone because only the --

If I can show -- can I show the old picture?

THE COURT: That's fine. Just remember the reporter needs to hear you.

THE WITNESS: I'm sorry? I didn't hear you.

THE COURT: Just remember the reporter needs to hear you.

THE WITNESS: This bypass is what brings the blood down to the foot pulses where the PT is. Surgeon says, before he did this, there was nothing here. After he did this, he said he had a PT pulse by Doppler. All what you need to do, if you take this away, this is gone, (indicating). There is no pulse in here by Doppler, and that's what I mean. That's why it was impossible.

THE COURT: Okay. One additional question:

"On February 8, 2016, Dr. Wiencek state the showed good pulses on both lower extremities. Was this only by Doppler?"

If that's what you were just talking about, or can you clarify?

THE WITNESS: Very good question, and I actually looked in the records.

THE COURT: There's a reference, by the way, to Exhibit 109, page 36.

THE WITNESS: I've looked at this. Can we put back the letter?

Surgeons are happy to say "Very good pulses. By Doppler, we can see there are still good pulses, better than no pulses. In his notes -- actually, the two notes that he's talking, he just said "very good pulses." He didn't say "palpable," but he didn't say "by Doppler" either.

In the letter -- first of all, in the O.R., he's describing Doppler. In the letter, he's describing "very good pulses by Doppler." Nowhere he's saying "palpable pulses." The word "palpable" is not being used.

So now what I look at, more likely than not, when the bypass, I know that he never said "palpable." Usually, it's not enough load to create

bounding pulses the way you take your pulse here. That's palpable. He's talking about --

That was good before. Bring it back.

MR. ARNTZ: Oh, you want that letter?

THE WITNESS: Yeah.

MR. ARNTZ: Oh, I'm sorry. I thought you wanted the February letter.

THE WITNESS: No.

"He has excellent pulses in the foot currently by Doppler." In the note, he said, "very good pulses." He didn't say "Doppler"; he didn't say "palpable." So, to me, seems that more likely than not, more often than not, he's talking about pulses, and he adds the word "Doppler."

I can tell you that there were no palpable pulses based on the fact that there was no blood coming on the 25th. This was gone. This is gone. There is no, nothing here. Three days after, he losses his leg. People who has palpable pulses don't lose leg three days. It just doesn't happen. They don't go home and lose their legs.

THE COURT: I'll start with Mr. Arntz.

Do you have any followup questions to the jurors' questions?

/ / /

FURTHER REDIRECT EXAMINATION

BY MR. ARNTZ:

Q. Why do you keep grabbing a pen whenever you're talking about a Doppler?

A. That's how a Doppler probe looks, just like this. There's a transducer in here, and it's got a wire, and it goes to a speaker. And when you do an arterial duplex study, you actually have a screen. You see the flow. It's red and blue, coming towards you and going away from you, and you look.

When the basic one, it just says (witness makes sound). So you actually going to move it around until you find where the flow is, if there is a flow. And when you hear only (witness makes different sound), those are not good pulses by Doppler. Systole and diastole, that's a good pulse by Doppler.

Q. In a person who has a blocked graft, like Mr. Moore, but has collateral source of blood, will that person have a detectable pulse, by any means, Doppler or otherwise?

A. Definitely impossible to have a palpable pulse. The collateral will not give you that. Highly unlikely, because the collaterals are very low here. The collaterals can be here (indicating).

Highly unlikely that you will have a Doppler pulse because the main source is shut down.

Remember, before surgery, there was no pulse here. They did say that. After they put the graft, they found the pulse. They could be some collaterals, and they were collaterals because he lasted three days. So whatever collaterals he had, they were okay. They start clotting right away. But it took a few days for this leg to basically die.

Q. In counsel for Nurse Practitioner Bartmus's opening, he made an analogy --

MR. McBRIDE: Well, again, this goes beyond the question, Your Honor.

MR. ARNTZ: No, it doesn't.

MR. McBRIDE: It does. We're talking about --

THE COURT: Can you make a proffer what you're tying it into, which of the questions, Mr. Arntz, before you ask the --

MR. ARNTZ: The discussion about collaterals.

MR. McBRIDE: That wasn't the question that was read.

THE COURT: There was a question with

regard to collaterals. I'll allow it.

BY MR. ARNTZ:

Q. He made an analogy to being on a freeway and the freeway coming to a stop and having to get off the freeway and you go around to get to where you're going. Is that a good analogy for collaterals, that it's just merely bypassing and finding another route to the foot? Tell the jury how collaterals work.

A. When you have blockages and stenosis, so total blockage and stenosis, just like traffic, the cars tend to go different areas to get down. A lot of time, you're unsuccessful. Like you drive, and there is a cul-de-sac or there are blockages or you can't get that street or it's a one way. That's exactly what happened here.

THE COURT: And, Doctor, I don't mean to interrupt you, but I do want to make sure you put this follow-up question in the context of the question you were asked. The question you were asked was: "Will or can blood flow from collaterals demonstrate a pulse in the foot?"

I believe your answer was no.

THE WITNESS: No. Not in Mr. Moore case.

THE COURT: So can you answer this question in relation to that question. I know the question

from counsel was very broad. But I don't know that we need that broad of a response.

BY MR. ARNTZ:

Q. Yeah, let me narrow it a little bit.

Mainly, what I want to do is I want to take this opportunity, since the question has to do with collaterals, to educate the jury on exactly what it means to have a collateral source of blood flow so they can understand the context of that question.

A. If you have a good source of blood up here (indicating) and it goes here, from the groin, where the femoral artery goes to your foot, which is here, and you have a blockage right in here, the blood tends to avoid this area and then create what's called "collaterals." You see them on the angiogram. Goes around, and then it's called "reconstitutes," and go down here.

That's not the case. He never had a source of blood because the graft was gone, and nothing was coming from above. So you don't have enough collaterals to create enough blood flow and the pulse, definitely not a palpable pulse. The leg died. There was not enough blood in there because there is nothing to create what's called an "inflow." "Inflow and outflow."

There was no inflow in this patient. The graft is gone. Nothing is coming. The iddy-biddy tiny collaterals that I actually explained earlier with my pen here, they're not enough to carry the foot, and that's why this leg died on the 28th.

MR. ARNTZ: Nothing else.

THE COURT: Mr. McBride.

MR. McBRIDE: Sure. Thank you, Your Honor.

CROSS-EXAMINATION

BY MR. McBRIDE:

Q. Doctor, just a couple of follow-up questions. So you looked at that note that was just up on the screen, Dr. Simon's records, for the first time this afternoon while at the lunch break with counsel; right?

A. I don't think so. I remembered it. I remember seeing it at some point.

Q. Okay. And, again, I'm happy to go back through your list of documents that you reviewed that you told me about. You still have that in front of you; right?

A. Well, I have -- the answer is I have a list of documents that I reviewed before the depo, and then I got further records after the depo, just the

way -- so it could have been one of those. I remember the letter actually.

Q. Okay. Doctor, you would agree with me, it's not listed there; right?

A. It's not listed? Well, actually, I'm not sure.

Q. Go ahead and look for it, yeah.

A. I have like 50 things listed.

Q. Sure. Just take a minute to look through it. See if you have Dr. Simon's records there.

A. Well, I didn't write Dr. Simon's records. I mean, I have a lot of records here. I'm not sure if it's listed or not here.

Q. Exactly. I didn't see it, and I can represent to you that in the materials we've been provided from your office that you did review, it's not listed. And neither are the records from Nevada Pain Center. Remember I had asked you about those, where he went to, Mr. Moore went on 12/21/2016, four days before this hospitalization we're talking about? You hadn't seen those records either; right?

A. I think I did. I told you I don't remember. I received two links to medical records in the last few weeks, thousand and thousands of

pages.

Q. You weren't familiar with -- when I asked you those question, Doctor, you weren't familiar with any of that information from that, is it true?

A. I said I don't remember.

MR. McBRIDE: Okay. And that's all the questions I have. Thank you.

THE WITNESS: Thank you.

THE COURT: Mr. Weaver.

FURTHER CROSS-EXAMINATION

BY MR. WEAVER:

Q. Dr. Marmureanu, I'm just going to ask you a question to see if you agree with this.

A. Sure.

Q. Do you agree that this morning, in response to questions from Mr. Arntz, you said, no fewer than five times, that it is impossible that there were pulses in Mr. Moore's foot after 2012. And then after Mr. McBride showed you over and over and over and over in instances of the records, including Wiencek's, where pulses are documented, then after the lunch break, you came back and said, "Well, what I really meant is, okay, there are pulses, they're just not palpable."

Do you agree with that?

A. We're both saying the same thing. I can tell what I referred to, most of it, and the most important part, there were no palpable pulses. Impossible to have palpable pulses on 12/25. In other words, when the patient show up to the E.R., it's absolutely impossible to have palpable pulses.

Q. What I'm talking about is you do agree, don't you -- I'm not talking about 12/25/2016, which is where you keep going to, you told this jury -- over and over and over and over and over, at least my notes say five times -- that after 2012, it was impossible for Mr. Moore to have pulses in his foot. You said that to this jury, didn't you?

A. I did say that, yes.

MR. WEAVER: Thank you.

THE COURT: Anything further? Mr. Weaver? That's it?

MR. WEAVER: Sorry, Your Honor. No more.

THE COURT: Okay. Dr. Marmureanu, you are excused at this time.

THE WITNESS: Thank you very much.

THE COURT: Take your paperwork, if you would.

THE WITNESS: Sure. Thank you very much.

THE COURT: We're going to take a 15 minute -- we're going to take a 15 minute recess, return at 3:30, please.

During this 15 minute recess, you're admonished not to talk or converse among yourselves or with anyone else on any subject connected with this trial or read, watch, or listen to any report of or commentary on the trial or any person connected with the trial by any medium of information including, without limitation, newspapers, television, radio, or Internet. Please don't not attempt to undertake any independent investigations. No independent research, no Internet searches of any kind. Please do not engage in any social media communications, and please do not form or express any opinion on any subject connected with the trial until the case is finally submitted to you. See you back at 3:30.

THE MARSHAL: All rise for the jury.

(Out of the presence of the jury.)

THE COURT: All right. I have a couple of records to make with regards to bench conferences, trying to do this quickly so we can get a little comfort break too.

Bench conference, first, it has not been

yet recorded. In this later part of the testimony was when Mr. Weaver began inquiring of Dr. Marmureanu about having reviewed the Deposition of Dr. Jacobs, Mr. Arntz objected, and then we had a bench conference that ensued that because the bench conference -- I'm sorry -- because the deposition was not in evidence, that there ultimately should not be able to be any inquiry about this, that it was a hearsay concern as well as, again, just that evidence not being in the record.

The response was that, of course, the flow of things with Dr. Jacobs was a later revelation closer to trial that he was not appearing, then a determination or request to perhaps use deposition, and then ultimately because of the stated objection, we already have much record of this in the case already based on the discussion about whether or not opening statements could include references to Dr. Jacobs' deposition.

This is sort of a continuance of that discussion that ultimately it was determined by the Court regarding opening statements, and it was determined again by the Court this time that, yes, the information by Dr. Jacobs or from Dr. Jacobs, to the extent that it was in fact relied on by

Dr. Marmureanu, that that could be inquired about by counsel without otherwise being in evidence.

At the bench conference, Mr. McBride mentioned in references a "Baxter vs. Eighth Judicial District Court" case, I sent a note out to my law clerk to find it, and it turns out actually it's not the "Baxter" case. It's the "Bhatia" case, B-H-A-T-I-A, that was in front of Judge Jones. It is unpublished decision, but it is within the time frame to be able to be cited and considered. And the reference that I believe you made there is what's cited in the case, which is there had been no experts who opined on certain information at the time of trial.

The quote was: "The courts repeatedly observe that once a party has given testimony through deposition or expert reports, those opinions do not belong to one party or another but rather are available for all parties to use at the time of trial." And that was the reference you were making.

The Court ultimately did rule that further inquiry regarding -- and that we asked Mr. Weaver to make sure he laid a foundation -- but that further inquiry of the doctor of his review of Dr. Jacobs' reports and whether he agreed or disagreed with

those opinions could be had, and there was.

Mr. Arntz, anything further you want to state as far as this bench conference record?

MR. ARNTZ: No. Although I will state, for the record, that I am having to reconsider whether I read Dr. Jacobs' deposition because it's been referenced so much, I might as well get the context of it all in.

THE COURT: And that's still an option, and the Court indicated earlier and certainly respects your decision, one way or the other, whether or not you wish to do that; and whether or not it's the whole depo or whether or not you have experts, as long as the parties communicate about that and whether they can agree or not on what to read, if there's some dispute, the Court has a reasonable opportunity to resolve that dispute, that's still your choice.

But anything further to that bench conference, Mr. McBride?

MR. McBRIDE: No, Your Honor.

THE COURT: Mr. Weaver.

MR. WEAVER: No, Your Honor.

THE COURT: Okay. The second bench conference arose when Mr. Weaver was inquiring of

Dr. Marmureanu about reports that would indicate or question his abilities as a surgeon or his rankings related to his practice. I'll sort of, for just purposes of discussion, give it the title of, you know, "bad press," so to speak.

And he was denying these things, and Mr. Weaver was referencing them. Then Mr. Arntz objected at some point during that inquiry, and when we came to the bench conference, the argument was that Mr. Weaver was not actually confronting the witness with these reports, that he would be required to do so, and that it would not be appropriate; it was not an appropriate line of questioning.

The Court disagreed, respectfully, with that assessment, that when there was testimony obviously by the doctor regarding his qualifications and this information called into question that testimony, that the proper impeachment is to ask certain things -- obviously, you have to have your ethical obligations fulfilled that you have a good faith belief to ask the question and that ultimately there was no reason to believe otherwise -- certainly Mr. Weaver was able to do so without actually requiring confrontation with documentation,

to this Court's opinion, would be akin to impeachment with extrinsic evidence; and that is something that is not allowed, other than in certain circumstances, really more things that go towards credibility of testimony, that's not what this would have been.

So the Court indicated that, although the plaintiffs' counsel may wish to challenge if Mr. Weaver was misrepresenting any such reports and could potentially do so on redirect, that it was not required of Mr. Weaver to confront the witness with actual reports. Although, I do think it was fair for Mr. Arntz to ask to be given a reference to or copy of or citation to what reports he was referring to; and I believe Mr. Weaver agreed, when he left the bench, to do so. He indicated it was all online and there was a website that could be given. So, again, that inquiry continued.

Mr. Arntz, do you have anything you want to add to this bench conference?

MR. ARNTZ: No, Your Honor.

THE COURT: Mr. McBride?

MR. MCBRIDE: Nothing, Your Honor.

THE COURT: Mr. Weaver, this was more your inquiry.

MR. WEAVER: No, Your Honor.

THE COURT: No. All right. Thank you. We get a little more time. Just whenever you all are ready, come on back, but I'd like to aim for 3:30. I guess I should ask scheduling question now too while we're at it. Who's the second witness tonight, today?

MR. ARNTZ: Dr. Fish.

(The proceedings concluded at 3:23 p.m.)

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C E R T I F I C A T E

STATE OF NEVADA)
)SS:
COUNTY OF CLARK)

I, Dana J. Tavaglione, RPR, CCR 841, do hereby certify that I reported the foregoing proceedings; that the same is true and correct as reflected by my original machine shorthand notes taken at said time and place, and prepared in daily copy, before the Hon. Kathleen E. Delaney, District Court Judge, presiding.

Dated at Las Vegas, Nevada, this 27th day of February 2020.

/S/Dana J. Tavaglione
_____
Dana J. Tavaglione, RPR, CCR NO. 841
Certified Court Reporter
Las Vegas, Nevada

EXHIBIT 3

California Hospital Performance Ratings for Coronary Artery Bypass Graft (CABG) Surgery by Region, 2013

Region	Hospital	Isolated CABG Operative Mortality – 2013			CABG + Valve Operative Mortality[1] – 2012-2013			Post-Operative Stroke[2] 2012-2013			30-Day Readmission[3] – 2013			Internal Mammary Artery Use[4] – 2012	
		Cases (Deaths)	Risk-Adjusted Rate	Performance Rating[5]	Cases (Deaths)	Risk-Adjusted Rate	Performance Rating[5]	Cases (Strokes)	Risk-Adjusted Rate	Performance Rating[5]	Cases (Readmissions)	Risk-Adjusted Rate	Performance Rating[5]	Cases (%)	Performance Rating[5]
Statewide		11,940 (273)	2.29		5,150 (309)	6.00		23,660 (352)	1.49		10,740 (1,252)	11.65		10,767 (95.6)	
Sacramento Valley & Northern California Region	Enloe Medical Center – Esplanade Campus	121 (4)	3.66	Average	36 (1)	4.87	Average	253 (2)	0.88	Average	116 (11)	10.97	Average	110 (99.09)	Acceptable
	Mercy General Hospital	436 (9)	1.39	Average	333 (14)	3.87	Average	887 (16)	1.77	Average	393 (53)	8.49	Average	408 (99.75)	Acceptable
	Mercy Medical Center – Redding	100 (2)	1.49	Average	40 (2)	3.45	Average	204 (2)	1.01	Average	83 (6)	5.71	Average	71 (100)	Acceptable
	Mercy San Juan Hospital	80 (2)	2.41	Average	59 (4)	5.32	Average	154 (1)	0.58	Average	74 (11)	14.35	Average	71 (100)	Acceptable
	Ridgecrest Regional Hospital	74 (5)	5.50	Average	31 (4)	11.06	Average	170 (10)	5.31	Worse	68 (14)	20.37	Average	64 (98.88)	Acceptable
	Saint Joseph Hospital – Eureka	23 (0)	0.00	Average	11 (1)	9.00	Average	38 (0)	0.00	Average	20 (1)	6.29	Average	18 (94.44)	Acceptable
	Shasta Regional Medical Center	81 (4)	4.77	Average	17 (0)	0.00	Average	160 (3)	2.69	Average	73 (14)	22.45	Worse	64 (89.06)	Acceptable
	Sutter Memorial Hospital	301 (4)	1.28	Average	136 (12)	9.52	Average	668 (4)	0.67	Average	297 (27)	9.24	Average	296 (97.97)	Acceptable
	UC Davis Medical Center	116 (4)	3.90	Average	51 (4)	8.50	Average	221 (5)	2.65	Average	101 (8)	8.35	Average	109 (100)	Acceptable
San Francisco Bay Area & San Jose	Alta Bates Summit Medical Center – Summit Campus – Hawthorne	121 (2)	1.76	Average	65 (4)	5.21	Average	233 (2)	0.76	Average	107 (17)	15.59	Average	118 (99.15)	Acceptable
	California Pacific Medical Center – Pacific Campus	69 (2)	3.97	Average	33 (2)	5.27	Average	133 (1)	0.83	Average	52 (7)	14.15	Average	67 (97.01)	Acceptable
	Community Hospital of the Monterey Peninsula	72 (0)	0.00	Average	41 (0)	0.00	Average	141 (3)	2.73	Average	64 (7)	12.50	Average	56 (100)	Acceptable
	Dominican Hospital – Santa Cruz/Soquel	64 (0)	0.00	Average	26 (3)	14.66	Average	122 (0)	0.00	Average	53 (6)	11.01	Average	56 (96.55)	Acceptable
	El Camino Hospital	85 (2)	2.43	Average	40 (4)	9.26	Average	125 (0)	0.00	Average	55 (4)	8.38	Average	59 (100)	Acceptable
	Good Samaritan Hospital – San Jose	87 (3)	3.41	Average	34 (2)	6.52	Average	143 (3)	1.78	Average	68 (5)	10.40	Average	56 (100)	Acceptable
	John Muir Medical Center – Concord Campus	207 (1)	0.52	Average	66 (5)	9.21	Average	425 (3)	0.82	Average	189 (17)	9.38	Average	97 (97.94)	Acceptable
	John Muir Medical Center – Walnut Creek Campus	0 (-)	N/A	N/A	0 (-)	N/A	N/A	0 (-)	N/A	N/A	0 (-)	N/A	N/A	0(-)	N/A
	Kaiser Foundation Hospital – San Francisco	338 (9)	3.02	Average	161 (9)	6.09	Average	654 (16)	2.84	Worse	329 (33)	11.26	Average	327 (95.53)	Acceptable
	Kaiser Foundation Hospital – Santa Clara	249 (2)	0.89	Average	161 (7)	5.88	Average	463 (5)	1.06	Average	244 (20)	7.88	Average	222 (100)	Acceptable
	Marin General Hospital	32 (0)	0.00	Average	9 (0)	0.00	Average	72 (1)	1.91	Average	28 (5)	24.77	Average	30 (93.3)	Acceptable
	North Bay Medical Center	49 (1)	1.87	Average	8 (2)	29.85	Average	105 (2)	1.80	Average	43 (6)	12.65	Average	46 (100)	Acceptable
	O'Connor Hospital – San Jose	30 (3)	5.17	Average	17 (1)	5.82	Average	85 (1)	0.96	Average	24 (2)	9.00	Average	25 (100)	Acceptable
	Peninsula Medical Center	39 (1)	3.46	Average	21 (1)	5.82	Average	83 (0)	0.00	Average	34 (6)	18.44	Average	38 (97.37)	Acceptable
	Queen of the Valley Hospital – Napa	51 (4)	8.66	Average	19 (3)	16.32	Average	107 (3)	2.79	Average	37 (1)	2.84	Average	43 (100)	Acceptable
	Regional Medical of San Jose	77 (2)	1.23	Average	28 (2)	8.18	Average	132 (2)	0.96	Average	66 (13)	19.28	Average	53 (98.38)	Acceptable
	Saint Helena Hospital	69 (4)	4.86	Average	26 (4)	13.83	Average	124 (0)	0.00	Average	61 (8)	12.72	Average	N/A (N/A)	N/A
	Saint Mary's Medical Center, San Francisco	47 (0)	0.00	Average	8 (3)	39.15	Worse	39 (1)	2.03	Average	15 (1)	7.20	Average	15 (100)	Acceptable
	Salinas Valley Memorial Hospital	85 (4)	4.36	Average	22 (1)	6.91	Average	160 (5)	3.19	Average	75 (4)	4.82	Average	79 (94.94)	Acceptable

California Hospital Performance Ratings for Coronary Artery Bypass Graft (CABG) Surgery by Region, 2013

Region	Hospital	Isolated CABG Operative Mortality[1] 2013			CABG + Valve Operative Mortality[2] 2012-2013			Post-Operative Stroke[3] 2012-2013			30-Day Readmissions[4] 2013			Internal Mammary Artery Use[5] 2013	
		Cases (Deaths)	Risk-Adjusted Rate	Performance Rating[6]	Cases (Deaths)	Risk-Adjusted Rate	Performance Rating[6]	Cases (Strokes)	Risk-Adjusted Rate	Performance Rating[6]	Cases (Readmissions)	Risk-Adjusted Rate	Performance Rating[6]	Cases (Uses)	Performance Rating[6]
Statewide		11,940 (273)	2.29		5,150 (309)	6.66		23,660 (382)	1.49		10,740 (1,252)	11.66		10,767 (96.6)	
San Francisco Bay Area & San Jose	San Ramon Regional Medical Center	19 (0)	0.00	Average	6 (1)	28.08	Average	52 (0)	0.00	Average	17 (1)	9.74	Average	16 (100)	Acceptable
	Santa Clara Valley Medical Center	68 (0)	0.00	Average	23 (2)	12.96	Average	155 (0)	0.00	Average	63 (6)	17.68	Average	58 (98.53)	Acceptable
	Santa Rosa Memorial Hospital – Montgomery	73 (2)	2.07	Average	24 (1)	4.92	Average	134 (0)	0.00	Average	69 (2)	3.51	Average	58 (85.41)	Acceptable
	Sequoia Hospital	45 (2)	2.89	Average	62 (1)	1.33	Average	97 (1)	1.64	Average	42 (4)	8.52	Average	38 (97.44)	Acceptable
	Seton Medical Center	57 (2)	2.52	Average	9 (0)	0.00	Average	95 (5)	4.15	Average	49 (5)	9.26	Average	50 (84.00)	Acceptable
	Stanford Hospital	97 (1)	1.74	Average	60 (5)	9.34	Average	168 (5)	4.24	Average	74 (0)	0.00	Better	53 (87.69)	Acceptable
	Sutter Medical Center of Santa Rosa	64 (2)	3.25	Average	32 (1)	3.83	Average	120 (2)	2.66	Average	50 (5)	13.22	Average	44 (75.00)	Low
	UC San Francisco Medical Center	78 (1)	1.92	Average	29 (3)	10.10	Average	138 (3)	3.17	Average	65 (7)	12.05	Average	75 (100)	Acceptable
	Valleycare Medical Center	23 (0)	0.00	Average	13 (1)	5.78	Average	67 (0)	0.00	Average	18 (2)	9.43	Average	20 (100)	Acceptable
	Washington Hospital – Fremont	112 (3)	2.30	Average	51 (3)	22.93	Average	189 (5)	2.28	Average	93 (12)	11.96	Average	101 (95.00)	Acceptable
Central California	Bakersfield Heart Hospital	78 (3)	4.11	Average	27 (1)	4.26	Average	159 (5)	3.40	Average	70 (8)	11.62	Average	75 (94.67)	Acceptable
	Bakersfield Memorial Hospital	128 (2)	1.24	Average	45 (3)	5.44	Average	251 (2)	0.72	Average	124 (16)	11.14	Average	111 (94.59)	Acceptable
	Community Regional Medical Center – Fresno	213 (4)	1.75	Average	43 (6)	14.95	Average	447 (3)	0.65	Average	194 (24)	12.00	Average	187 (98.47)	Acceptable
	Delano Regional	44 (2)	4.30	Average	9 (1)	7.30	Average	97 (1)	0.78	Average	38 (4)	10.42	Average	40 (97.50)	Acceptable
	Doctors Medical Center	190 (7)	2.72	Average	61 (4)	3.57	Average	412 (9)	1.27	Average	165 (24)	12.67	Average	165 (95.15)	Acceptable
	Emanuel Medical Center	47 (0)	0.00	Average	4 (1)	18.59	Average	82 (0)	0.00	Average	46 (6)	17.40	Average	41 (95.12)	Acceptable
	Fresno Heart and Surgical Hospital	135 (5)	2.99	Average	51 (4)	7.30	Average	322 (3)	0.98	Average	129 (10)	7.98	Average	120 (95.83)	Acceptable
	Kaweah Delta Medical Center	162 (3)	2.13	Average	33 (4)	11.37	Average	303 (5)	2.03	Average	150 (16)	10.70	Average	154 (89.05)	Acceptable
	Marian Regional Medical Center	62 (0)	0.00	Average	23 (0)	0.00	Average	114 (2)	1.60	Average	49 (1)	1.92	Better	49 (100)	Acceptable
	Memorial Hospital Medical Center – Modesto	156 (4)	2.28	Average	69 (7)	9.11	Average	289 (4)	1.40	Average	146 (17)	12.01	Average	140 (87.86)	Low
	Saint Agnes Medical Center	217 (2)	1.08	Average	81 (7)	9.55	Average	457 (4)	0.89	Average	177 (14)	8.26	Average	201 (99.00)	Acceptable
	Saint Joseph's Medical Center of Stockton	190 (7)	3.10	Average	85 (7)	8.61	Average	368 (3)	0.81	Average	178 (22)	10.82	Average	173 (96.84)	Acceptable
	San Joaquin Community Hospital	69 (1)	1.43	Average	41 (1)	7.58	Average	127 (2)	1.40	Average	61 (5)	9.23	Average	59 (93.22)	Acceptable
San Fernando Valley, Antelope Valley, Ventura and Santa Barbara	Antelope Valley Hospital	20 (2)	5.93	Average	6 (-)	-	Better	40 (1)	2.47	Average	18 (4)	25.35	Average	17 (82.35)	Low
	Community Memorial Hospital – San Buenaventura	70 (1)	1.08	Average	31 (2)	4.78	Average	155 (1)	0.61	Average	65 (7)	10.56	Average	51 (100)	Acceptable
	French Hospital Medical Center	88 (1)	1.33	Average	62 (3)	3.78	Average	153 (4)	2.42	Average	80 (12)	17.25	Average	78 (98.72)	Acceptable
	Glendale Adventist Medical Center – Wilson Terrace	127 (5)	5.09	Average	23 (2)	9.51	Average	242 (4)	2.1	Average	110 (17)	18.72	Average	117 (94.87)	Acceptable
	Glendale Memorial Hospital and Medical Center	108 (3)	2.64	Average	33 (2)	7.40	Average	225 (3)	2.28	Average	95 (16)	17.14	Average	103 (100)	Acceptable

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California Hospital Performance Ratings for Coronary Artery Bypass Graft (CABG) Surgery by Region, 2013

Region	Hospital	Isolated CABG Operative Mortality[1] 2013			CABG + Valve Operative Mortality[2] 2012-2013			Post-Operative Stroke[3] 2012-2013			30-Day Readmission[4] 2013			Internal Mammary Artery Use[5] 2013	
		Cases (Deaths)	Risk-Adjusted Rate	Performance Rating[7]	Cases (Deaths)	Risk-Adjusted Rate	Performance Rating[7]	Cases (Strokes)	Risk-Adjusted Rate	Performance Rating[7]	Cases (Readmissions)	Risk-Adjusted Rate	Performance Rating[7]	Cases (%)	Performance Rating[7]
Statewide		**11,940 (273)**	**2.26**		**5,150 (309)**	**6.00**		**23,660 (352)**	**1.49**		**18,740 (1,252)**	**11.66**		**10,787 (98.6)**	
San Fernando Valley, Antelope Valley, Ventura and Santa Barbara	Los Robles Hospital and Medical Center	74 (3)	3.06	Average	36 (3)	7.55	Average	125 (4)	3.18	Average	68 (10)	15.11	Average	62 (98.39)	Acceptable
	Northridge Hospital Medical Center	83 (2)	2.89	Average	18 (2)	11.76	Average	122 (5)	3.56	Average	55 (10)	18.87	Average	56 (100)	Acceptable
	Palmdale Regional Medical Center	10 (3)	0.00	Average	1 (0)	0.00	Average	21 (0)	0.00	Average	9 (2)	0.00	Average	10 (80.00)	Low
	Providence Holy Cross Medical Center	40 (1)	2.23	Average	15 (2)	19.94	Average	102 (2)	1.88	Average	33 (6)	24.02	Average	37 (100)	Acceptable
	Providence Saint Joseph Medical Center	48 (3)	6.00	Average	16 (1)	9.40	Average	96 (1)	1.39	Average	46 (5)	13.18	Average	46 (100)	Acceptable
	Providence Tarzana Medical Center	52 (1)	1.61	Average	24 (3)	0.00	Average	91 (1)	1.29	Average	47 (3)	7.24	Average	47 (100)	Acceptable
	Saint John's Regional Medical Center	56 (1)	1.66	Average	32 (2)	4.11	Average	120 (4)	2.82	Average	50 (6)	11.16	Average	54 (93.10)	Acceptable
	Santa Barbara Cottage Hospital	77 (3)	0.00	Average	30 (1)	4.24	Average	169 (3)	1.83	Average	78 (8)	9.39	Average	71 (92.36)	Acceptable
	Valley Presbyterian Hospital	41 (2)	6.35	Average	8 (0)	0.00	Average	90 (2)	2.37	Average	34 (5)	13.11	Average	35 (100)	Acceptable
	West Hills Hospital and Medical Center	44 (3)	0.00	Average	15 (0)	0.00	Average	85 (0)	0.00	Average	41 (4)	9.83	Average	33 (95.87)	Acceptable
Greater Los Angeles	Beverly Hospital	28 (1)	3.43	Average	4 (0)	0.00	Average	48 (1)	1.60	Average	26 (3)	9.49	Average	26 (95.15)	Acceptable
	California Hospital Medical Center – Los Angeles	52 (3)	0.00	Average	(.)	.	N/A	40 (1)	1.64	Average	27 (2)	5.61	Average	29 (93.55)	Acceptable
	Cedars Sinai Medical Center	130 (1)	1.03	Average	98 (7)	5.13	Average	241 (1)	0.57	Average	116 (18)	13.9	Average	116 (99.14)	Acceptable
	Centinela Hospital Medical Center	26 (3)	10.42	Average	5 (0)	0.00	Average	51 (1)	1.48	Average	19 (4)	11.11	Average	21 (95.24)	Acceptable
	Citrus Valley Medical Center – Inter Community Campus	90 (2)	1.99	Average	33 (2)	6.06	Average	202 (7)	2.83	Average	84 (11)	17.05	Average	90 (95.00)	Acceptable
	Downey Regional Medical Center	50 (1)	1.99	Average	5 (0)	0.00	Average	102 (3)	0.00	Average	53 (7)	11.42	Average	56 (94.83)	Acceptable
	Garfield Medical Center	107 (1)	1.93	Average	35 (0)	0.00	Average	243 (4)	1.38	Average	70 (11)	15.7	Average	101 (87.60)	Low
	Good Samaritan Hospital – Los Angeles	58 (2)	2.27	Average	35 (1)	2.80	Average	173 (3)	1.53	Average	64 (9)	13.67	Average	75 (94.67)	Acceptable
	Henry Mayo Newhall Memorial Hospital	18 (0)	0.00	Average	8 (1)	10.05	Average	16 (1)	9.54	Average	12 (5)	39.29	Worse	11 (100)	Acceptable
	Hollywood Presbyterian Medical Center	47 (2)	3.03	Average	2 (0)	0.00	Average	89 (0)	0.00	Average	43 (10)	21.79	Average	36 (92.31)	Acceptable
	Huntington Memorial Hospital	86 (3)	0.00	Average	48 (1)	2.05	Average	191 (1)	0.74	Average	64 (10)	16.36	Average	64 (100)	Acceptable
	Kaiser Foundation Hospital – Bellflower	532 (9)	2.33	Average	252 (12)	5.17	Average	1014 (11)	1.13	Average	466 (47)	9.89	Average	470 (96.95)	Acceptable
	Keck Hospital of University of Southern California	82 (3)	5.70	Average	87 (4)	5.19	Average	217 (1)	0.99	Average	83 (7)	12.05	Average	93 (94.94)	Acceptable
	Lakewood Regional Medical Center	79 (4)	3.93	Average	19 (4)	13.73	Average	180 (1)	0.48	Average	70 (11)	12.76	Average	71 (88.73)	Acceptable
	Long Beach Memorial Medical Center	157 (7)	3.86	Average	38 (3)	7.26	Average	311 (4)	1.16	Average	137 (13)	8.87	Average	144 (95.14)	Acceptable
	Los Angeles County/Harbor - UCLA Medical Center	82 (4)	7.80	Average	19 (0)	0.00	Average	180 (4)	2.56	Average	67 (15)	22.56	Worse	60 (100)	Acceptable
	Los Angeles County/ University of Southern California Medical Center	97 (7)	0.00	Average	31 (1)	4.82	Average	209 (2)	1.24	Average	79 (15)	22.21	Worse	92 (94.57)	Unacceptable
	Methodist Hospital of Southern California	46 (3)	0.00	Average	17 (1)	9.17	Average	93 (0)	0.00	Average	43 (4)	9.99	Average	42 (97.62)	Acceptable

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California Hospital Performance Ratings for Coronary Artery Bypass Graft (CABG) Surgery by Region, 2013

Region	Hospital	Isolated CABG Operative Mortality 2013			CABG + Valve Operative Mortality[1] 2012-2013			Post-Operative Stroke[1] 2012-2013			30 Day Readmission[2] 2013			Internal Mammary Artery Use[3] 2013	
		Deaths (Denials)	Risk-Adjusted Rate	Performance Rating[4]	Cases (Deaths)	Risk-Adjusted Rate	Performance Rating[4]	Cases (Strokes)	Risk-Adjusted Rate	Performance Rating[4]	Cases (Readmissions)	Risk-Adjusted Rate	Performance Rating[4]	Cases (Rate)	Performance Rating[4]
Statewide		11,940 (273)	2.29		5,150 (309)	3.00		23,660 (352)	1.48		10,740 (1,252)	11.66		10,767 (96.6)	
Greater Los Angeles	Presbyterian Intercommunity Hospital	67 (0)	0.00	Average	110 (6)	3.67	Average	141 (2)	1.57	Average	63 (3)	4.23	Average	54 (95.91)	Acceptable
	Providence Little Company of Mary Medical Center – Torrance	79 (2)	2.39	Average	43 (5)	13.92	Average	135 (0)	0.00	Average	76 (15)	18.62	Average	67 (89.55)	Acceptable
	Ronald Reagan UCLA Medical Center	109 (1)	0.94	Average	112 (4)	3.23	Average	211 (4)	1.83	Average	103 (20)	17.72	Average	78 (100)	Acceptable
	Saint Francis Medical Center	36 (1)	5.75	Average	7 (0)	0.00	Average	52 (0)	0.00	Average	23 (3)	13.28	Average	24 (79.17)	Low
	Saint John's Health Center	41 (2)	5.69	Average	28 (3)	13.40	Average	72 (1)	1.55	Average	34 (2)	6.92	Average	37 (97.30)	Acceptable
	Saint Mary Medical Center	82 (1)	1.25	Average	43 (2)	4.13	Average	85 (2)	1.76	Average	60 (6)	9.84	Average	40 (85.00)	Acceptable
	Saint Vincent Medical Center	86 (4)	5.80	Average	13 (1)	8.50	Average	138 (3)	2.00	Average	80 (11)	16.01	Average	69 (91.53)	Acceptable
	Torrance Memorial Medical Center	38 (1)	2.94	Average	41 (8)	12.80	Average	74 (1)	1.26	Average	33 (0)	0.00	Average	37 (97.30)	Acceptable
	White Memorial Medical Center	47 (0)	0.00	Average	7 (0)	0.00	Average	107 (5)	4.29	Average	42 (2)	4.15	Average	45 (100)	Acceptable
Inland Empire, Riverside & San Bernardino	Desert Regional Medical Center	103 (2)	2.15	Average	40 (3)	7.89	Average	201 (1)	0.56	Average	95 (13)	14.07	Average	81 (97.80)	Acceptable
	Desert Valley Hospital	31 (1)	2.46	Average	5 (1)	18.29	Average	36 (3)	7.18	Average	25 (7)	30.64	Average	29 (93.55)	Acceptable
	Eisenhower Medical Center	182 (3)	1.61	Average	44 (1)	1.99	Average	277 (5)	1.35	Average	119 (19)	12.14	Average	116 (100)	Acceptable
	Loma Linda University Medical Center	179 (4)	1.83	Average	71 (7)	7.94	Average	366 (5)	1.56	Average	149 (26)	14.58	Average	158 (94.10)	Acceptable
	Loma Linda University Medical Center – Murrieta	55 (1)	0.76	Average	12 (0)	0.00	Average	139 (3)	0.00	Average	73 (3)	8.57	Average	84 (95.24)	Acceptable
	Pomona Valley Hospital Medical Center	103 (2)	1.68	Average	23 (1)	5.53	Average	211 (6)	1.59	Average	94 (16)	17.20	Average	89 (96.88)	Acceptable
	Riverside Community Hospital	180 (7)	3.02	Average	55 (3)	0.00	Average	359 (4)	1.15	Average	142 (20)	15.56	Average	136 (99.40)	Acceptable
	Saint Bernardine Medical Center	437 (14)	3.09	Average	55 (1)	13.55	Average	965 (9)	1.30	Average	404 (38)	10.56	Average	426 (98.35)	Acceptable
	Saint Mary Regional Medical Center	114 (4)	3.57	Average	27 (1)	5.57	Average	282 (4)	2.23	Average	99 (10)	10.39	Average	100 (94.00)	Acceptable
	San Antonio Community Hospital	139 (1)	0.73	Average	52 (3)	6.35	Average	266 (2)	0.78	Average	126 (7)	6.83	Average	116 (98.32)	Acceptable
Orange County	AHMC Anaheim Regional Medical Center	116 (2)	1.42	Average	49 (2)	5.21	Average	216 (5)	2.38	Average	95 (13)	12.87	Average	110 (95.45)	Acceptable
	Fountain Valley Regional Hospital and Medical Center – Euclid	97 (2)	1.77	Average	17 (1)	4.87	Average	193 (3)	2.17	Average	89 (9)	8.84	Average	94 (93.62)	Acceptable
	Hoag Memorial Hospital Presbyterian	152 (3)	1.78	Average	106 (3)	4.63	Average	268 (1)	0.38	Average	146 (14)	9.76	Average	130 (93.08)	Acceptable
	Vission Hospital Regional Medical Center	108 (1)	0.87	Average	40 (1)	2.14	Average	224 (2)	0.94	Average	98 (12)	13.01	Average	94 (95.94)	Acceptable
	Orange Coast Memorial Medical Center	74 (0)	0.00	Average	27 (1)	4.67	Average	139 (2)	1.92	Average	72 (13)	22.24	Worse	68 (97.09)	Acceptable
	Saddleback Memorial Medical Center	82 (0)	0.00	Average	26 (2)	7.80	Average	154 (5)	4.03	Average	76 (8)	11.20	Average	76 (97.87)	Acceptable
	Saint Joseph Hospital – Orange	98 (3)	3.84	Average	50 (4)	7.65	Average	180 (4)	2.77	Average	79 (4)	5.60	Average	81 (97.53)	Acceptable
	Saint Jude Medical Center	77 (0)	0.00	Average	15 (0)	0.00	Average	184 (4)	2.17	Average	89 (7)	9.62	Average	64 (98.44)	Acceptable
	UC Irvine Medical Center	46 (1)	2.48	Average	13 (0)	0.00	Average	100 (0)	0.00	Average	41 (7)	19.78	Average	44 (97.73)	Acceptable

California Hospital Performance Ratings for Coronary Artery Bypass Graft (CABG) Surgery by Region, 2013

Region	Hospital	Isolated CABG Operative Mortality[1] 2013			CABG + Valve Operative Mortality[2] 2012-2013			Post-Operative Stroke[3] 2012-2013			30-Day Readmissions[4] 2013			Internal Mammary Artery Use[5] 2013	
		Cases (Deaths)	Risk-Adjusted Rate	Performance Rating[6]	Cases (Deaths)	Risk-Adjusted Rate	Performance Rating[6]	Cases (Strokes)	Risk-adjusted Rate	Performance Rating[6]	Cases (Readmissions)	Risk-adjusted Rate	Performance Rating[6]	Cases (%)	Performance Rating[6]
Statewide		11,940 (273)	2.29		8,150 (399)	6.80		23,650 (382)	1.49		10,740 (1,252)	11.66		10,767 (96.6)	
Orange County	West Anaheim Medical Center	28 (2)	8.35	Average	<11		N/A	47 (0)	0.00	Average	18 (5)	22.16	Average	24 (91.67)	Acceptable
	Western Medical Center – Anaheim	56 (1)	2.19	Average	18 (1)	5.13	Average	112 (0)	0.00	Average	51 (4)	8.08	Average	48 (100)	Acceptable
	Western Medical Center – Santa Ana	75 (1)	1.47	Average	16 (0)	0.00	Average	120 (0)	0.00	Average	66 (10)	15.33	Average	37 (100)	Acceptable
Greater San Diego	Alvarado Hospital	37 (2)	5.50	Average	13 (2)	17.24	Average	69 (1)	1.33	Average	29 (3)	10.76	Average	34 (100)	Acceptable
	Grossmont Hospital	123 (6)	4.11	Average	56 (5)	7.33	Average	261 (10)	2.73	Average	96 (22)	18.95	Worse	112 (100)	Acceptable
	Palomar Health Downtown Campus	44 (1)	2.12	Average	17 (1)	7.69	Average	91 (2)	2.16	Average	42 (4)	8.36	Average	39 (100)	Acceptable
	Scripps Green Hospital	37 (0)	0.00	Average	46 (2)	6.00	Average	82 (2)	4.38	Average	22 (2)	10.25	Average	22 (100)	Acceptable
	Scripps Memorial Hospital – La Jolla	203 (1)	0.45	Average	150 (1)	0.86	Better	436 (5)	1.28	Average	226 (20)	9.68	Average	216 (99.07)	Acceptable
	Scripps Mercy Hospital	124 (1)	1.06	Average	44 (5)	11.94	Average	258 (5)	2.37	Average	116 (19)	17.31	Average	116 (100)	Acceptable
	Sharp Chula Vista Medical Center	79 (4)	5.53	Average	58 (3)	5.67	Average	164 (5)	2.24	Average	38 (12)	18.32	Average	73 (100)	Acceptable
	Sharp Memorial Hospital	169 (2)	2.45	Average	89 (2)	2.25	Average	195 (3)	1.54	Average	110 (13)	13.18	Average	109 (94.50)	Acceptable
	Tri-City Medical Center – Oceanside	60 (3)	6.65	Average	32 (4)	14.42	Average	109 (1)	0.71	Average	64 (1)	2.08	Better	52 (98.08)	Acceptable
	UC San Diego Health – Sulpizio Cardiovascular Center	81 (2)	3.33	Average	46 (2)	5.02	Average	150 (3)	0.00	Average	71 (9)	12.35	Average	75 (97.33)	Acceptable

[1] Isolated CABG Operative Mortality is defined as patient death occurring in the hospital after isolated CABG surgery, regardless of length of stay, or death occurring anywhere after hospital discharge but within 30 days after the isolated CABG surgery. Hospital ratings are risk-adjusted using a statistical technique that allows for fair comparison of hospital outcomes even though some hospitals have sicker patients than average.

[2] CABG + Valve Operative Mortality is defined as patient death occurring in the hospital after CABG with Valve surgery (Aortic Valve Replacement, Mitral Valve Replacement or Repair or a combination of both), regardless of length of stay, or death occurring anywhere after hospital discharge but within 30 days after the surgery. Hospital ratings are risk-adjusted using a statistical technique that allows for fair comparison of hospital outcomes even though some hospitals have sicker patients than average.

[3] Post-Operative Stroke is defined as a post-operative, central neurologic deficit persisting for more than 24 hours after isolated CABG surgery while in the following hospital.

[4] 30-Day Readmission is defined as an isolated CABG surgery patient being readmitted to an acute care hospital within 30 days of being discharged to home or a non-acute care setting with a principal diagnosis indicating a heart-related condition, or an infection or a complication that was likely related to the CABG surgery.

[5] Internal Mammary Artery (IMA) Usage in CABG surgery is an evidence-based indicator of surgery quality. Most first-time CABG surgery patients are eligible to receive an IMA bypass. Clinical research shows that IMA grafts used in CABG surgery stay open longer and increase patients' survival. Very low hospital utilization rates may be associated with poorer care. These hospitals with IMA usage rates below 85.1% (two standard deviations below the state average [98.8%]) are labeled as "Low"; those with rates above 98.1% are labeled as "Acceptable." Hospitals are not assessed for very high IMA usage rates because there is no consensus on what constitutes an optimal rate.

[6] The performance rating is based on a comparison of each provider's risk-adjusted mortality/stroke/readmission rate to the California observed mortality/stroke/readmission rate. A provider is classified as "Better" if the upper 95% confidence limit of its risk-adjusted mortality/stroke/readmission rate falls below California observed mortality/stroke/readmission rate. A provider is classified as "Worse" if the lower 95% confidence limit of its risk-adjusted mortality/stroke/readmission rate is higher than the California observed mortality/stroke/readmission rate. A provider is classified as "Average" if the California mortality/stroke/readmission rate falls within the confidence interval of the provider's risk-adjusted mortality/stroke/readmission rate.

† Hospital submitted letter in response to the 2013 CABG surgery performance ratings. Click on hospital name to view the letter.

N/A-Not Applicable: Hospital results are not shown for one of the following reasons: 1) data necessary to confirm deaths or IMA use were not available, 2) CABG case(s) performed did not meet the criteria for a specific measure.

California Hospital Performance Ratings for Coronary Artery Bypass Graft (CABG) Surgery by Region, 2014

Region	Hospital	Isolated CABG Operative Mortality[1] 2014			CABG + Valve Operative Mortality[2] 2013-2014			Post-Operative Stroke[3] 2013-2014			Internal Mammary Artery Use[4] 2014	
		Cases (Deaths)	*Risk-Adjusted Rate*	*Performance Rating[5]*	*Cases (Deaths)*	*Risk-Adjusted Rate*	*Performance Rating[5]*	*Cases (Stroke)*	*Risk-Adjusted Rate*	*Performance Rating[5]*	*Cases (Rate)*	*Performance Rating[5]*
Statewide		**12,152 (239)**	**1.97**		**5,239 (293)**	**5.56**		**24,092 (308)**	**1.28**		**11,043 (97.1)**	
Sacramento Valley & Northern California Region	Enloe Medical Center – Esplanade Campus	130 (2)	1.30	Average	35 (2)	10.50	Average	251 (4)	1.71	Average	112 (96.43)	Acceptable
	Mercy General Hospital	413 (3)	0.80	Average	373 (13)	2.93	Better	849 (10)	1.21	Average	396 (99.75)	Acceptable
	Mercy Medical Center – Redding	128 (4)	2.04	Average	33 (4)	18.88	Average	228 (1)	0.40	Average	91 (100)	Acceptable
	Mercy San Juan Hospital	85 (1)	1.33	Average	51 (2)	4.18	Average	165 (2)	1.37	Average	79 (100)	Acceptable
	Ridecut Memorial Hospital	91 (4)	3.57	Average	28 (2)	8.37	Average	165 (6)	3.19	Average	78 (100)	Acceptable
	Shasta Regional Medical Center	55 (1)	1.76	Average	17 (0)	0.00	Average	138 (5)	4.36	Worse	52 (80.77)	Low
	St. Joseph Hospital – Eureka	17 (1)	4.73	Average	15 (1)	10.67	Average	37 (0)	0.00	Average	15 (100)	Acceptable
	Sutter Memorial Hospital	315 (2)	0.64	Average	198 (13)	5.86	Average	646 (7)	1.17	Average	290 (98.28)	Acceptable
	UC Davis Medical Center	80 (2)	3.84	Average	65 (7)	10.59	Average	196 (5)	3.02	Average	78 (100)	Acceptable
	Alta Bates Summit Medical Center – Summit Campus – Hawthorne	115 (0)	0.00	Average	56 (6)	9.86	Average	233 (0)	0.00	Average	114 (100)	Acceptable
	California Pacific Medical Center – Pacific Campus	57 (1)	1.19	Average	28 (1)	3.51	Average	125 (2)	1.47	Average	53 (95.23)	Acceptable
	Community Hospital of the Monterey Peninsula	89 (2)	2.04	Average	50 (0)	0.00	Average	161 (2)	1.74	Average	81 (100)	Acceptable
	Dominican Hospital – Santa Cruz/Soquel	63 (0)	0.00	Average	36 (5)	18.68	Worse	127 (1)	0.84	Average	62 (100)	Acceptable
	El Camino Hospital	85 (1)	0.98	Average	45 (2)	4.92	Average	151 (0)	0.00	Average	79 (96.2)	Acceptable
	Good Samaritan Hospital – San Jose	71 (3)	3.63	Average	37 (2)	6.30	Average	138 (5)	3.45	Average	66 (100)	Acceptable
	John Muir Medical Center – Concord Campus	206 (1)	0.46	Average	60 (5)	8.72	Average	413 (2)	0.48	Average	188 (100)	Acceptable

San Francisco Bay Area & San Jose

John Muir Medical Center – Walnut Creek Campus	0 (0)	N/A	N/A	0 (0)	N/A	N/A	0 (0)	N/A	N/A	0 (0)	N/A
Kaiser Foundation Hospital – San Francisco	305 (3)	1.51	Average	130 (0)	0.00	Better	643 (12)	2.16	Average	287 (96.61)	Acceptable
Kaiser Foundation Hospital – Santa Clara	283 (6)	2.12	Average	147 (5)	5.34	Average	512 (5)	0.85	Average	245 (99.59)	Acceptable
Marin General Hospital	32 (0)	0.00	Average	11 (0)	0.00	Average	84 (1)	2.50	Average	30 (96.67)	Acceptable
North Bay Medical Center	35 (1)	2.31	Average	6 (2)	31.87	Average	84 (0)	0.00	Average	34 (100)	Acceptable
O'Connor Hospital – San Jose	40 (1)	1.96	Average	12 (1)	6.67	Average	70 (1)	1.08	Average	32 (100)	Acceptable
Peninsula Medical Center	45 (0)	0.00	Average	21 (1)	5.92	Average	84 (0)	0.00	Average	45 (97.78)	Acceptable
Queen of the Valley Hospital – Napa	36 (1)	2.65	Average	14 (2)	12.10	Average	87 (2)	2.33	Average	31 (100)	Acceptable
Regional Medical of San Jose	66 (0)	0.00	Average	25 (0)	0.00	Average	137 (2)	1.09	Average	62 (98.39)	Acceptable
Salinas Valley Memorial Hospital	103 (0)	0.00	Average	20 (1)	5.82	Average	188 (5)	2.43	Average	92 (98.91)	Acceptable
San Ramon Regional Medical Center	24 (0)	0.00	Average	8 (2)	26.57	Average	43 (0)	0.00	Average	21 (100)	Acceptable
Santa Clara Valley Medical Center	69 (1)	1.84	Average	26 (3)	11.45	Average	137 (0)	0.00	Average	57 (100)	Acceptable
Santa Rosa Memorial Hospital – Montgomery	71 (0)	0.00	Average	21 (1)	4.23	Average	144 (1)	0.69	Average	57 (96.49)	Acceptable
Sequoia Hospital	55 (2)	2.86	Average	57 (0)	0.00	Better	100 (2)	1.61	Average	50 (96)	Acceptable
Seton Medical Center	51 (2)	2.87	Average	12 (1)	6.02	Average	108 (5)	3.89	Average	46 (91.3)	Acceptable
St. Helena Hospital	82 (0)	0.00	Average	30 (4)	13.24	Average	151 (0)	0.00	Average	75 (96)	Acceptable
St. Mary's Medical Center, San Francisco	22 (0)	0.00	Average	6 (1)	14.21	Average	39 (1)	2.39	Average	18 (100)	Acceptable
Stanford Hospital	97 (1)	0.86	Average	61 (4)	7.14	Average	184 (4)	2.40	Average	89 (96.63)	Acceptable
Sutter Santa Rosa Regional Hospital	52 (0)	0.00	Average	22 (1)	5.77	Average	106 (2)	2.67	Average	46 (95.65)	Acceptable
UC San Francisco Medical Center	66 (0)	0.00	Average	29 (3)	9.81	Average	142 (3)	2.61	Average	53 (100)	Acceptable
Valleycare Medical Center	25 (0)	0.00	Average	13 (1)	6.31	Average	48 (0)	0.00	Average	20 (100)	Acceptable

	Washington Hospital – Fremont	86 (0)	0.00	Average	13 (3)	15.97	Average	198 (4)	1.98	Average	81 (100)	Acceptable
Central California	Bakersfield Heart Hospital	50 (1)	2.13	Average	13 (1)	20.90	Average	129 (3)	2.91	Average	46 (89.13)	Acceptable
	Bakersfield Memorial Hospital	118 (2)	1.80	Average	50 (4)	13.49	Average	247 (6)	2.30	Average	113 (95.58)	Acceptable
	Community Regional Medical Center – Fresno	220 (13)	4.91	Worse	51 (2)	3.46	Average	433 (4)	0.83	Average	196 (98.98)	Acceptable
	Dameron Hospital	57 (3)	4.97	Average	9 (0)	0.00	Average	101 (0)	0.00	Average	47 (95.74)	Acceptable
	Doctors Medical Center	244 (6)	1.81	Average	89 (5)	6.66	Average	434 (4)	0.76	Average	215 (98.14)	Acceptable
	Emanuel Medical Center	73 (2)	2.56	Average	5 (0)	0.00	Average	120 (1)	0.72	Average	67 (98.51)	Acceptable
	Fresno Heart and Surgical Hospital	139 (1)	0.62	Average	45 (3)	5.99	Average	274 (2)	0.66	Average	119 (99.16)	Acceptable
	Kaweah Delta Medical Center	166 (3)	1.72	Average	39 (5)	13.08	Average	328 (1)	0.30	Average	152 (99.34)	Acceptable
	Marian Regional Medical Center	59 (2)	2.60	Average	27 (1)	2.88	Average	111 (1)	0.75	Average	50 (100)	Acceptable
	Memorial Hospital Medical Center – Modesto	151 (3)	1.57	Average	62 (3)	10.06	Average	337 (5)	1.41	Average	135 (91.11)	Acceptable
	Saint Agnes Medical Center	235 (4)	1.75	Average	92 (4)	4.38	Average	452 (4)	0.94	Average	193 (100)	Acceptable
	San Joaquin Community Hospital	74 (3)	3.30	Average	23 (1)	3.67	Average	143 (4)	2.51	Average	63 (96.59)	Acceptable
	St. Joseph's Medical Center of Stockton	225 (7)	2.23	Average	71 (4)	4.47	Average	415 (4)	0.78	Average	200 (98.5)	Acceptable
Valley,Ventura & Santa Barbara	Antelope Valley Hospital	17 (1)	5.55	Average	2 (0)	0.00	Average	37 (1)	2.87	Average	16 (73.33)	Low
	Community Memorial Hospital – San Buenaventura	75 (1)	1.60	Average	37 (2)	6.06	Average	145 (0)	0.00	Average	67 (100)	Acceptable
	French Hospital Medical Center	77 (1)	2.04	Average	62 (2)	3.58	Average	165 (2)	1.38	Average	74 (97.3)	Acceptable
	Glendale Adventist Medical Center – Wilson Terrace	96 (5)	5.96	Average	35 (1)	4.01	Average	223 (4)	2.19	Average	89 (98.88)	Acceptable
	Glendale Memorial Hospital and Medical Center	120 (0)	0.00	Average	35 (3)	10.34	Average	228 (4)	1.74	Average	114 (99.12)	Acceptable
	Los Robles Hospital and Medical Center	65 (6)	4.07	Average	39 (5)	13.25	Average	139 (4)	2.52	Average	64 (100)	Acceptable
	Northridge Hospital Medical Center	85 (2)	2.23	Average	14 (2)	12.49	Average	148 (5)	3.15	Average	77 (98.7)	Acceptable

San Fernando Valley, Antelope Va	Palmdale Regional Medical Center	8 (1)	16.88	Average	0	N/A	N/A	18 (0)	0.00	Average	8 (37.5)	Low
	Providence Holy Cross Medical Center	39 (2)	5.85	Average	18 (0)	0.00	Average	79 (1)	1.27	Average	34 (100)	Acceptable
	Providence Saint Joseph Medical Center	46 (0)	0.00	Average	21 (1)	7.35	Average	94 (1)	1.48	Average	45 (97.78)	Acceptable
	Providence Tarzana Medical Center	62 (3)	4.45	Average	21 (2)	7.60	Average	114 (2)	1.94	Average	50 (98)	Acceptable
	Santa Barbara Cottage Hospita	99 (3)	3.89	Average	32 (0)	0.00	Average	167 (2)	1.32	Average	83 (100)	Acceptable
	St. John's Regional Medical Center	83 (2)	2.20	Average	27 (5)	9.95	Average	139 (5)	5.15	Average	80 (97.5)	Acceptable
	Valley Presbyterian Hospital	42 (0)	0.00	Average	3 (0)	0.00	Average	83 (1)	1.35	Average	40 (100)	Acceptable
	West Hills Hospital and Medical Center	51 (2)	2.46	Average	12 (0)	0.00	Average	95 (2)	1.39	Average	43 (100)	Acceptable
Angeles	Beverly Hospital	13 (0)	0.00	Average	1 (0)	0.00	Average	41 (0)	0.00	Average	11 (100)	Acceptable
	California Hospital Medical Center – Los Angeles	19 (0)	0.00	Average	3 (0)	0.00	Average	51 (3)	3.36	Average	19 (94.74)	Acceptable
	Cedars Sinai Medical Center	129 (0)	0.00	Average	93 (3)	4.04	Average	259 (2)	1.08	Average	117 (98.29)	Acceptable
	Centinela Hospital Medical Center	28 (3)	8.98	Average	7 (1)	9.15	Average	53 (0)	0.00	Average	27 (96.3)	Acceptable
	Citrus Valley Medical Center – Inter Community Campus	110 (3)	1.96	Average	25 (2)	7.69	Average	198 (2)	0.82	Average	103 (96.12)	Acceptable
	Downey Regional Medical Center	46 (0)	0.00	Average	3 (0)	0.00	Average	109 (0)	0.00	Average	45 (88.89)	Acceptable
	Garfield Medical Center	102 (1)	0.95	Average	33 (0)	0.00	Average	209 (1)	0.49	Average	96 (95.83)	Acceptable
	Good Samaritan Hospital – Los Angeles	87 (2)	2.22	Average	32 (2)	5.80	Average	175 (3)	1.77	Average	77 (100)	Acceptable
	Henry Mayo Newhall Memorial Hospital	35 (1)	2.14	Average	12 (1)	7.81	Average	48 (1)	1.93	Average	31 (93.55)	Acceptable
	Hollywood Presbyterian Medical Center	42 (1)	2.78	Average	3 (1)	41.65	Average	89 (1)	1.15	Average	41 (97.56)	Acceptable
	Huntington Memorial Hospital	65 (0)	0.00	Average	44 (2)	5.26	Average	131 (1)	0.79	Average	61 (98.35)	Acceptable
	Kaiser Foundation Hospital – Sunset	583 (7)	1.21	Average	272 (11)	3.91	Average	1086 (10)	0.91	Average	539 (99.07)	Acceptable
	Keck Hospital of University of Southern California	73 (4)	4.76	Average	94 (5)	5.48	Average	135 (1)	0.71	Average	61 (98.36)	Acceptable

Greater Los	Los Angeles County/Harbor – UCLA Medical Center	54 (0)	0.00	Average	15 (1)	5.98	Average	146 (3)	2.14	Average	34 (88.44)	Acceptable
	Los Angeles County/University of Southern California Medical Center	80 (1)	2.64	Average	23 (1)	4.64	Average	177 (1)	0.81	Average	78 (98.72)	Acceptable
	Lakewood Regional Medical Center	89 (3)	2.22	Average	28 (3)	8.44	Average	169 (0)	0.00	Average	81 (91.36)	Acceptable
	Long Beach Memorial Medical Center	159 (4)	2.18	Average	42 (3)	5.25	Average	315 (6)	1.83	Average	146 (95.21)	Acceptable
	Methodist Hospital of Southern California	54 (4)	5.84	Average	17 (0)	0.00	Average	99 (3)	3.00	Average	48 (93.88)	Acceptable
	Presbyterian Intercommunity Hospital	51 (2)	4.29	Average	111 (2)	1.20	Better	118 (1)	0.77	Average	49 (97.96)	Acceptable
	Providence Little Company of Mary Medical Center – Torrance	92 (3)	2.29	Average	59 (6)	11.66	Average	171 (1)	0.53	Average	86 (94.19)	Acceptable
	Ronald Reagan UCLA Medical Center	137 (6)	4.48	Average	39 (7)	7.45	Average	246 (1)	0.51	Average	96 (95.83)	Acceptable
	Saint John's Health Center	41 (2)	5.14	Average	23 (1)	4.09	Average	82 (2)	2.51	Average	37 (97.3)	Acceptable
	St. Francis Medical Center	28 (1)	5.46	Average	9 (0)	0.00	Average	53 (0)	0.00	Average	23 (86.96)	Acceptable
	St. Mary Medical Center – Long Beach	36 (0)	0.00	Average	13 (0)	0.00	Average	88 (3)	2.64	Average	32 (96.88)	Acceptable
	St. Vincent Medical Center	48 (1)	2.41	Average	13 (0)	0.00	Average	113 (2)	1.86	Average	48 (100)	Acceptable
	Torrance Memorial Medical Center	47 (0)	0.00	Average	38 (3)	10.59	Average	86 (0)	0.00	Average	46 (100)	Acceptable
	White Memorial Medical Center	39 (2)	6.93	Average	8 (0)	0.00	Average	96 (3)	3.45	Average	37 (100)	Acceptable
Riverside & San Bernardino	Desert Regional Medical Center	112 (7)	7.72	Worse	39 (3)	8.94	Average	216 (0)	0.00	Average	104 (96.15)	Acceptable
	Desert Valley Hospital	34 (3)	9.14	Average	10 (1)	15.15	Average	66 (3)	4.19	Average	33 (100)	Acceptable
	Eisenhower Medical Center	122 (0)	0.00	Average	49 (0)	0.00	Better	254 (3)	1.13	Average	111 (100)	Acceptable
	Kaiser Foundation Hospital – Fontana	51 (0)	0.00	Average	10 (0)	0.00	Average	51 (0)	0.00	Average	49 (97.96)	Acceptable
	Loma Linda University Medical Center	161 (8)	3.47	Average	83 (6)	7.12	Average	340 (1)	0.25	Average	145 (93.52)	Acceptable
	Loma Linda University Medical Center – Murrieta	115 (1)	0.77	Average	12 (0)	0.00	Average	210 (2)	0.87	Average	95 (95.79)	Acceptable
	Pomona Valley Hospital Medical Center	131 (0)	0.00	Average	31 (1)	4.63	Average	234 (6)	2.51	Average	118 (98.31)	Acceptable

Inland Empire, E	Riverside Community Hospital	152 (2)	1.30	Average	66 (1)	1.72	Average	322 (5)	1.58	Average	142 (97.16)	Acceptable
	San Antonio Community Hospital	130 (6)	4.40	Average	58 (5)	6.95	Average	269 (3)	1.08	Average	110 (97.27)	Acceptable
	St. Bernardine Medical Center	428 (3)	0.77	Average	47 (4)	7.32	Average	886 (3)	0.37	Better	412 (99.03)	Acceptable
	St. Mary Medical Center – Apple Valley	80 (0)	0.00	Average	37 (2)	6.22	Average	194 (3)	1.79	Average	68 (100)	Acceptable
	Temecula Valley Hospital	15 (0)	0.00	Average	0	N/A	N/A	15 (0)	0.00	Average	15 (93.33)	Acceptable
Orange County	AHMC Anaheim Regional Medical Center	128 (0)	0.00	Average	49 (2)	4.23	Average	245 (4)	1.69	Average	123 (97.56)	Acceptable
	Fountain Valley Regional Hospital and Medical Center – Euclid	118 (5)	0.49	Average	14 (3)	26.05	Average	215 (7)	3.00	Average	110 (89.09)	Acceptable
	Hoag Memorial Hospital Presbyterian	135 (0)	0.00	Average	103 (6)	5.66	Average	287 (0)	0.00	Average	122 (100)	Acceptable
	Mission Hospital Regional Medical Center	113 (2)	1.42	Average	44 (3)	9.37	Average	221 (4)	1.75	Average	104 (99.04)	Acceptable
	Orange Coast Memorial Medical Center	59 (0)	0.00	Average	18 (1)	7.84	Average	133 (0)	0.00	Average	57 (100)	Acceptable
	Saddleback Memorial Medical Center	67 (0)	0.00	Average	27 (2)	6.27	Average	149 (4)	3.22	Average	85 (100)	Acceptable
	St. Joseph Hospital – Orange	61 (3)	4.31	Average	52 (6)	9.93	Average	147 (3)	2.30	Average	22 (100)	Acceptable
	St. Jude Medical Center	79 (0)	0.00	Average	28 (0)	0.00	Average	158 (4)	2.33	Average	72 (100)	Acceptable
	UC Irvine Medical Center	71 (4)	4.36	Average	11 (0)	0.00	Average	117 (1)	0.79	Average	68 (97.06)	Acceptable
	West Anaheim Medical Center	22 (0)	0.00	Average	1 (1)	92.28	Average	48 (0)	0.00	Average	19 (100)	Acceptable
	Western Medical Center – Anaheim	30 (2)	5.52	Average	9 (0)	0.00	Average	56 (1)	0.96	Average	30 (100)	Acceptable
	Western Medical Center – Santa Ana	82 (1)	0.91	Average	18 (0)	0.00	Average	167 (1)	0.60	Average	82 (100)	Acceptable
Diego	Alvarado Hospital	28 (1)	3.14	Average	13 (2)	19.78	Average	66 (0)	0.00	Average	24 (100)	Acceptable
	Grossmont Hospital	115 (3)	2.18	Average	43 (1)	2.30	Average	238 (4)	1.32	Average	103 (100)	Acceptable
	Palomar Health Downtown Campus	44 (0)	0.00	Average	21 (2)	7.71	Average	86 (1)	1.18	Average	41 (90.24)	Acceptable
	Scripps Green Hospital	49 (0)	0.00	Average	42 (1)	3.02	Average	80 (1)	2.11	Average	44 (100)	Acceptable

Greater San D	Scripps Memorial Hospital – La Jolla	249 (3)	1.16	Average	175 (1)	0.65	Better	482 (2)	0.48	Average	235 (100)	Acceptable
	Scripps Mercy Hospital	99 (4)	3.42	Average	27 (4)	16.58	Average	223 (4)	1.76	Average	92 (100)	Acceptable
	Sharp Chula Vista Medical Center	84 (0)	0.00	Average	54 (3)	8.48	Average	182 (3)	1.80	Average	79 (100)	Acceptable
	Sharp Memorial Hospital†	107 (2)	2.52	Average	101 (4)	5.38	Average	226 (8)	4.27	Worse	97 (97.94)	Acceptable
	Tri-City Medical Center – Oceanside	89 (2)	1.84	Average	25 (3)	12.37	Average	149 (1)	0.66	Average	74 (97.3)	Acceptable
	UC San Diego Health – Sulpizio Cardiovascular Center	89 (1)	1.37	Average	61 (1)	2.03	Average	170 (0)	0.00	Average	93 (100)	Acceptable

[1] Isolated CABG Operative Mortality is defined as patient death occurring in the hospital after an isolated CABG surgery, regardless of length of stay, or death occurring anywhere after hospital discharge but within 30 days after the isolated CABG surgery. Hospital ratings are risk-adjusted using a statistical technique that allows for fair comparison of hospital outcomes even though some hospitals have sicker patients than average.

[2] CABG + Valve Operative Mortality is defined as patient death occurring in the hospital after CABG with Valve surgery (Aortic Valve Replacement, Mitral Valve Replacement or Repair or a combination of these), regardless of length of stay, or death occurring anywhere after hospital discharge but within 30 days after the surgery. Hospital ratings are risk-adjusted using a statistical technique that allows for fair comparison of hospital outcomes even though some hospitals have sicker patients than average.

[3] Post-Operative Stroke is defined as a post-operative, central neurologic deficit persisting for more than 24 hours after isolated CABG surgery while in the operating hospital.

[4] Internal Mammary Artery (IMA) Usage in CABG surgery is an evidence-based indicator of surgery quality. Most first-time CABG surgery patients are eligible to receive an IMA bypass. Clinical research shows that IMA grafts used in CABG surgery stay open longer and increase patients' survival. Very low hospital utilization rates may be associated with poorer care. Those hospitals with IMA usage rates below 84.21% (two standard deviations below the state average [97.1%]) are labeled as "Low"; those with rates above 84.21% are labeled as "Acceptable." Hospitals are not assessed for very high IMA usage rates because there is no consensus on what constitutes an optimal rate.

[5] The performance rating is based on a comparison of each provider's risk-adjusted mortality/stroke/readmission rate to the California observed mortality/stroke/readmission rate. Providers are classified as "Better" if the upper 95% confidence limit of their risk-adjusted mortality/stroke/readmission rates fall below the California observed mortality/stroke/readmission rate. Providers are classified as "Worse" if the lower 95% confidence limit of their risk-adjusted mortality/stroke/readmission rates are higher than the California observed mortality/stroke/readmission rate. A provider is classified as "Average" if the California mortality/stroke/readmission rate falls within the confidence interval of the provider's risk adjusted mortality/stroke/readmission rate.

† Hospital submitted letter in response to the 2014 CABG surgery performance ratings. Click on hospital name to view the letter.

N/A-Not Applicable: Hospital results are not shown for one of the following reasons: 1) data necessary to confirm deaths or IMA use were not available, 2) CABG cases performed did not meet the criteria for a specific measure.

California Hospital Performance Ratings for Coronary Artery Bypass Graft (CABG) Surgery by Region, 2015

Region	Hospital	Isolated CABG Operative Mortality[1] 2013			CABG + Valve Operative Mortality[2] 2013-2015			Post-Operative Stroke[3] 2013-2015			30-Day Readmission[4] 2013-2015			Internal Mammary Artery Use[5] 2015		
		Cases (Deaths)	Risk-Adjusted Rate	Performance Rating[6]	Cases (Deaths)	Risk-Adjusted Rate	Performance Rating[6]	Cases (Strokes)	Risk-Adjusted Rate	Performance Rating[6]	Cases (Readmissions)	Risk-Adjusted Rate	Performance Rating[6]	Cases	Percentage Use	Performance Rating[6]
Statewide		**12,486 (313)**	**2.50**		**5,058 (274)**	**5.42**		**24,727 (333)**	**1.31**		**21,680 (2,494)**	**11.50**		**11,664**	**97.49%**	
Sacramento Valley & Northern California Region	Enloe Medical Center - Esplanade Campus	148 (3)	4.00	Average	32 (4)	12.04	Average	276 (5)	1.68	Average	257 (32)	12.58	Average	135	96.66%	Acceptable
	Mercy General Hospital	457 (5)	0.89	Better	308 (10)	3.76	Average	870 (14)	1.67	Average	780 (82)	8.54	Better	424	98.35%	Acceptable
	Mercy Medical Center - Redding	117 (4)	2.97	Average	48 (3)	11.36	Average	245 (2)	0.75	Average	225 (22)	10.19	Average	100	98.00%	Acceptable
	Mercy San Juan Hospital	72 (0)	0.00	Average	42 (0)	0.00	Average	157 (2)	1.43	Average	146 (18)	13.30	Average	89	98.65%	Acceptable
	Redbluff Memorial Hospital	111 (5)	6.33	Worse	28 (5)	19.74	Average	202 (2)	0.90	Average	189 (26)	13.71	Average	99	100.00%	Acceptable
	Shasta Regional Medical Center	70 (0)	0.00	Average	19 (0)	0.00	Average	128 (2)	1.39	Average	117 (12)	10.18	Average	84	98.44%	Acceptable
	St. Joseph Hospital - Eureka	20 (0)	0.00	Average	9 (1)	9.54	Average	37 (0)	0.00	Average	34 (2)	5.24	Average	17	100.00%	Acceptable
	Sutter Memorial Hospitals	235 (5)	1.36	Average	201 (8)	3.36	Average	610 (7)	1.16	Average	540 (64)	10.50	Average	285	99.63%	Acceptable
	UC Davis Medical Center	97 (3)	3.30	Average	54 (3)	13.99	Average	177 (5)	3.45	Average	164 (17)	11.71	Average	94	98.94%	Acceptable
San Francisco Bay Area & San Jose	Alta Bates Summit Medical Center - Summit Campus	105 (3)	2.23	Average	39 (2)	3.61	Average	228 (0)	0.00	Average	199 (23)	11.66	Average	108	100.00%	Acceptable
	California Pacific Medical Center - Pacific Campus	68 (2)	2.22	Average	26 (1)	5.21	Average	125 (2)	1.49	Average	107 (17)	15.41	Average	61	98.36%	Acceptable
	Community Hospital Monterey Peninsula	93 (0)	0.00	Average	46 (0)	0.00	Average	182 (1)	0.62	Average	165 (14)	8.98	Average	84	100.00%	Acceptable
	Dominican Hospital - Santa Cruz/Soquel	75 (3)	3.61	Average	65 (7)	11.28	Average	138 (1)	0.74	Average	113 (9)	8.41	Average	67	100.00%	Acceptable
	El Camino Hospital	85 (3)	2.34	Average	44 (1)	1.59	Average	170 (1)	0.63	Average	133 (15)	11.43	Average	77	100.00%	Acceptable
	Good Samaritan Hospital - San Jose	75 (3)	3.02	Average	29 (2)	6.93	Average	147 (6)	2.99	Average	134 (22)	16.95	Average	80	100.00%	Acceptable
	John Muir Medical Center - Concord Campus	189 (3)	1.61	Average	65 (1)	1.77	Average	392 (7)	1.93	Average	345 (39)	11.37	Average	170	94.24%	Acceptable
	Kaiser Foundation Hospital - San Francisco	373 (3)	1.11	Average	123 (2)	2.57	Average	678 (6)	0.97	Average	683 (41)	7.62	Better	383	99.77%	Acceptable
	Kaiser Foundation Hospital - Santa Clara	283 (6)	2.01	Average	161 (10)	6.95	Average	546 (6)	1.09	Average	518 (41)	7.76	Better	283	100.00%	Acceptable
	Marin General Hospital	28 (1)	2.78	Average	15 (0)	0.00	Average	60 (1)	1.76	Average	52 (5)	11.64	Average	27	100.00%	Acceptable
	Marin Bay Medical Center	53 (2)	5.16	Average	8 (2)	53.00	Worse	89 (0)	0.00	Average	83 (14)	18.92	Average	53	100.00%	Acceptable
	O'Connor Hospital - San Jose	35 (0)	0.00	Average	9 (0)	0.00	Average	73 (1)	1.21	Average	50 (7)	11.90	Average	34	100.00%	Acceptable
	Peninsula Medical Center	58 (0)	0.00	Average	18 (0)	0.00	Average	104 (1)	1.18	Average	91 (11)	13.62	Average	55	100.00%	Acceptable
	Queen of the Valley Hospital - Napa	43 (0)	0.00	Average	11 (3)	17.47	Average	79 (3)	3.95	Average	53 (5)	8.34	Average	41	100.00%	Acceptable
	Regional Medical of San Jose	77 (2)	3.64	Average	21 (0)	0.00	Average	113 (0)	0.00	Average	126 (24)	17.11	Average	75	100.00%	Acceptable
	Salinas Valley Memorial Hospital	90 (3)	4.67	Average	21 (1)	4.14	Average	193 (7)	3.83	Worse	176 (19)	11.47	Average	86	95.84%	Acceptable
	San Ramon Regional Medical Center	23 (0)	0.00	Average	5 (1)	19.19	Average	47 (0)	0.00	Average	44 (7)	17.47	Average	18	100.00%	Acceptable
	Santa Clara Valley Medical Center	72 (0)	0.00	Average	26 (2)	10.95	Average	141 (2)	1.76	Average	121 (11)	8.00	Average	72	95.83%	Acceptable
	Santa Rosa Memorial Hospital - Montgomery	90 (0)	0.00	Average	22 (1)	3.84	Average	181 (1)	0.62	Average	141 (16)	7.23	Average	86	94.18%	Acceptable
	Sequoia Hospital	45 (1)	3.17	Average	30 (0)	0.00	Better	100 (1)	1.12	Average	92 (4)	5.29	Better	41	100.00%	Acceptable
	Seton Medical Center	45 (1)	1.67	Average	8 (1)	12.00	Average	96 (5)	4.70	Worse	83 (6)	8.64	Average	35	100.00%	Acceptable

	St. Helena Hospital	64 (6)	4.08	Average	37 (4)	11.65	Average	176 (2)	0.00	Average	157 (16)	9.37	Average	84	98.43%	Acceptable
	St. Mary's Medical Center, San Francisco	22 (1)	3.54	Average	4 (0)	0.00	Average	46 (1)	2.11	Average	37 (5)	15.82	Average	18	100.00%	Acceptable
	Stanford Hospital	56 (1)	1.12	Average	76 (4)	6.47	Average	183 (5)	2.76	Average	158 (20)	12.69	Average	84	98.81%	Acceptable
	Sutter Santa Rosa Regional Hospital	40 (2)	5.28	Average	23 (2)	11.82	Average	101 (1)	1.38	Average	90 (3)	4.39	Average	43	90.70%	Acceptable
	UC San Francisco Medical Center	69 (3)	5.00	Average	21 (0)	0.00	Average	135 (2)	1.56	Average	124 (13)	11.15	Average	85	98.82%	Acceptable
	Valleycare Medical Center	17 (1)	5.79	Average	2 (0)	0.00	Average	42 (1)	2.56	Average	39 (5)	13.12	Average	17	100.00%	Acceptable
	Washington Hospital - Fremont	79 (2)	3.00	Average	15 (1)	5.74	Average	165 (0)	0.00	Average	141 (18)	12.01	Average	76	97.37%	Acceptable
Central California	Bakersfield Heart Hospital	48 (6)	17.56	Worse	0 (1)	20.83	Average	68 (3)	3.60	Average	62 (12)	25.63	Worse	47	85.11%	Low
	Bakersfield Memorial Hospital	87 (1)	1.05	Average	34 (2)	7.62	Average	206 (5)	2.68	Average	191 (25)	12.97	Average	77	100.00%	Acceptable
	Community Regional Medical Center - Fresno	184 (2)	1.13	Average	45 (4)	6.38	Average	404 (6)	1.19	Average	370 (72)	17.07	Worse	155	98.73%	Acceptable
	Dameron Hospital	54 (0)	0.00	Average	6 (0)	0.00	Average	111 (1)	0.72	Average	79 (10)	10.59	Average	42	90.48%	Acceptable
	Doctors Medical Center	231 (7)	1.65	Average	95 (11)	9.42	Average	475 (7)	1.26	Average	420 (43)	8.47	Average	209	96.65%	Acceptable
	Emanuel Medical Center	58 (4)	5.64	Average	5 (0)	0.00	Average	131 (2)	1.28	Average	101 (14)	11.69	Average	57	100.00%	Acceptable
	Fresno Heart and Surgical Hospital	81 (2)	2.23	Average	47 (1)	1.69	Average	287 (1)	0.33	Average	217 (23)	9.26	Average	143	97.90%	Acceptable
	Kaweah Delta Medical Center	191 (2)	1.01	Average	39 (2)	5.23	Average	357 (3)	0.80	Average	333 (36)	10.76	Average	191	98.95%	Acceptable
	Marlon Regional Medical Center	70 (1)	1.57	Average	27 (1)	4.09	Average	129 (2)	1.37	Average	120 (13)	9.82	Average	60	100.00%	Acceptable
	Memorial Hospital Medical Center - Modesto	136 (4)	2.54	Average	65 (4)	5.59	Average	286 (4)	1.32	Average	277 (31)	10.44	Average	123	95.24%	Acceptable
	Saint Agnes Medical Center	221 (3)	1.41	Average	92 (4)	4.10	Average	466 (3)	0.70	Average	403 (35)	8.84	Average	201	99.00%	Acceptable
	San Joaquin Community Hospital	81 (1)	1.67	Average	24 (2)	8.34	Average	165 (3)	2.13	Average	129 (16)	12.08	Average	74	97.30%	Acceptable
	St. Joseph's Medical Center of Stockton	215 (9)	2.49	Average	75 (6)	8.25	Average	440 (6)	1.42	Average	375 (46)	10.91	Average	191	99.48%	Acceptable
San Fernando Valley, Antelope Valley, Ventura & Santa Barbara	Antelope Valley Hospital	13 (1)	10.80	Average	2 (0)	0.00	Average	30 (1)	3.64	Average	26 (6)	24.87	Average	13	69.23%	Low
	Community Memorial Hospital - San Buenaventura	79 (4)	3.79	Average	35 (2)	6.70	Average	154 (2)	1.31	Average	129 (13)	11.34	Average	79	98.63%	Acceptable
	French Hospital Medical Center	82 (5)	5.37	Average	39 (1)	3.28	Average	159 (2)	1.34	Average	146 (9)	6.68	Average	69	98.55%	Acceptable
	Glendale Adventist Medical Center - Wilson Terrace	129 (5)	6.33	Average	31 (2)	8.42	Average	226 (2)	0.97	Average	180 (32)	18.44	Worse	121	99.17%	Acceptable
	Glendale Memorial Hospital and Health Center	95 (2)	1.97	Average	35 (3)	7.39	Average	216 (4)	2.06	Average	182 (27)	14.18	Average	91	97.80%	Acceptable
	Los Robles Hospital and Medical Center	56 (4)	4.82	Average	35 (1)	3.67	Average	121 (3)	1.72	Average	99 (14)	11.79	Average	51	94.44%	Acceptable
	Northridge Hospital Medical Center	67 (3)	3.41	Average	12 (2)	16.03	Average	162 (6)	3.56	Average	127 (19)	13.60	Average	60	95.37%	Acceptable
	Palmdale Regional Medical Center	8 (0)	0.00	Average	0 (-)	N/A	N/A	18 (0)	0.00	Average	13 (1)	9.67	Average	8	62.50%	Low
	Providence Holy Cross Medical Center	42 (2)	4.25	Average	15 (0)	0.00	Average	82 (0)	0.00	Average	69 (5)	7.30	Average	36	100.00%	Acceptable
	Providence Saint Joseph Medical Center	50 (3)	6.39	Average	21 (1)	6.56	Average	66 (1)	1.24	Average	57 (9)	11.46	Average	46	95.65%	Acceptable
	Providence Tarzana Medical Center	51 (1)	1.79	Average	4 (2)	15.04	Average	113 (2)	1.74	Average	99 (14)	14.08	Average	44	95.45%	Acceptable
	Santa Barbara Cottage Hospital	81 (0)	0.00	Average	36 (1)	3.78	Average	171 (1)	0.67	Average	164 (7)	4.61	Better	75	86.73%	Acceptable
	St. John's Regional Medical Center	84 (1)	1.23	Average	30 (10)	25.95	Worse	147 (7)	4.34	Worse	128 (14)	10.51	Average	61	95.72%	Acceptable
	Valley Presbyterian Hospital	20 (0)	0.00	Average	1 (1)	61.46	Average	62 (0)	0.00	Average	54 (15)	27.64	Worse	13	100.00%	Acceptable
	West Hills Regional Medical Center	45 (1)	1.65	Average	15 (1)	6.21	Average	98 (3)	2.31	Average	76 (11)	13.51	Average	41	97.36%	Acceptable
	Beverly Hospital	28 (0)	0.00	Average	4 (0)	0.00	Average	41 (1)	2.12	Average	36 (6)	15.31	Average	28	100.00%	Acceptable

Greater Los Angeles	California Hospital Medical Center - Los Angeles	23 (0)	0.00	Average	6 (1)	13.37	Average	42 (3)	4.33	Average	29 (-5)	24.27	Worse	25	80.00%	Acceptable
	Cedars Sinai Medical Center	161 (4)	3.42	Average	62 (4)	8.05	Average	290 (3)	1.25	Average	228 (25)	15.06	Average	118	100.00%	Acceptable
	Centinela Hospital Medical Center	35 (3)	8.36	Average	6 (1)	12.89	Average	62 (0)	0.00	Average	43 (-3)	13.66	Average	38	100.00%	Acceptable
	Citrus Valley Medical Center Inner Community Campus	21 (2)	1.40	Average	24 (1)	5.37	Average	231 (3)	1.29	Average	185 (23)	11.47	Average	113	94.68%	Acceptable
	Downey Regional Medical Center	28 (0)	0.00	Average	5 (0)	0.00	Average	74 (1)	1.37	Average	70 (8)	9.52	Average	28	96.00%	Acceptable
	Garfield Medical Center	124 (6)	4.70	Average	32 (0)	0.00	Average	226 (3)	1.41	Average	147 (12)	12.33	Average	114	95.61%	Acceptable
	Good Samaritan Hospital - Los Angeles	67 (4)	5.31	Average	20 (1)	3.17	Average	154 (3)	1.85	Average	81 (9)	9.05	Average	55	98.28%	Acceptable
	Henry Mayo Newhall Memorial Hospital	29 (0)	0.00	Average	13 (2)	17.74	Average	84 (0)	0.00	Average	55 (7)	11.76	Average	25	96.00%	Acceptable
	Hollywood Presbyterian Medical Center	51 (3)	3.95	Average	2 (1)	103.02	Average	93 (2)	1.74	Average	68 (-7)	20.01	Worse	45	95.56%	Acceptable
	Huntington Memorial Hospital	84 (1)	1.47	Average	35 (1)	9.36	Average	149 (3)	2.30	Average	139 (19)	13.87	Average	83	97.59%	Acceptable
	Kaiser Foundation Hospital - Sunset	587 (7)	1.39	Average	297 (5)	2.95	Average	1170 (16)	1.69	Average	1134 (126)	10.82	Average	559	99.82%	Acceptable
	Keck Hospital of University of Southern California	65 (0)	0.00	Average	55 (2)	2.66	Average	138 (1)	0.65	Average	102 (-5)	9.13	Average	57	98.25%	Acceptable
	Lakewood Regional Medical Center	76 (3)	2.78	Average	30 (3)	12.13	Average	165 (1)	0.50	Average	140 (-3)	7.30	Average	75	98.67%	Acceptable
	Long Beach Memorial Medical Center	165 (7)	2.97	Average	38 (2)	5.37	Average	324 (8)	1.84	Average	262 (43)	14.96	Average	148	98.96%	Acceptable
	Los Angeles County/Harbor UCLA Medical Center	69 (1)	2.06	Average	11 (1)	6.50	Average	123 (1)	0.67	Average	91 (17)	17.42	Average	54	95.15%	Acceptable
	Los Angeles County/University of Southern California Medical Center	55 (0)	0.00	Average	26 (1)	6.06	Average	135 (0)	0.00	Average	104 (-0)	12.12	Average	55	100.00%	Acceptable
	Methodist Hospital of Southern California	52 (0)	0.00	Average	10 (0)	0.00	Average	107 (3)	2.77	Average	101 (-5)	16.00	Average	52	96.15%	Acceptable
	Presbyterian Intercommunity Hospital	55 (1)	1.20	Average	31 (5)	4.00	Average	107 (0)	0.00	Average	96 (9)	8.65	Average	50	96.00%	Acceptable
	Providence Little Company of Mary Medical Center - Torrance	112 (3)	4.86	Average	39 (7)	10.43	Average	204 (1)	0.49	Average	180 (30)	15.23	Average	110	93.64%	Acceptable
	Ronald Reagan UCLA Medical Center	168 (1)	0.61	Average	90 (3)	0.59	Average	293 (5)	1.86	Average	250 (40)	16.23	Worse	135	100.00%	Acceptable
	Saint John's Health Center	21 (0)	0.00	Average	12 (0)	0.00	Average	52 (1)	1.83	Average	59 (11)	22.39	Average	19	100.00%	Acceptable
	St. Francis Medical Center	26 (1)	7.38	Average	9 (0)	0.00	Average	54 (0)	0.00	Average	43 (11)	25.25	Worse	25	84.00%	Unacceptable
	St. Mary Medical Center - Long Beach	59 (3)	3.68	Average	14 (0)	0.00	Average	35 (1)	0.82	Average	83 (15)	16.83	Average	55	96.36%	Acceptable
	St. Vincent Medical Center	38 (1)	3.30	Average	7 (1)	25.44	Average	98 (0)	0.00	Average	73 (4)	5.69	Average	36	97.37%	Acceptable
	Torrance Memorial Medical Center	63 (1)	1.67	Average	43 (1)	3.38	Average	130 (1)	0.83	Average	113 (10)	9.42	Average	82	100.00%	Acceptable
	White Memorial Medical Center	66 (2)	2.38	Average	14 (0)	0.00	Average	105 (4)	3.82	Average	87 (6)	6.20	Average	64	96.84%	Acceptable
Inland Empire, Riverside & San Bernardino	Desert Regional Medical Center	123 (10)	5.00	Worse	26 (5)	15.06	Worse	236 (1)	0.42	Average	205 (16)	8.40	Average	110	93.18%	Acceptable
	Desert Valley Hospital	26 (1)	3.62	Average	4 (0)	0.00	Average	60 (0)	0.00	Average	58 (7)	10.84	Average	25	96.00%	Acceptable
	Eisenhower Medical Center	187 (5)	2.18	Average	27 (0)	0.00	Average	309 (4)	1.10	Average	272 (35)	12.24	Average	176	98.86%	Acceptable
	Kaiser Foundation Hospital - Fontana	253 (2)	0.83	Average	56 (1)	2.55	Average	304 (0)	0.00	Average	292 (23)	7.39	Average	248	98.79%	Acceptable
	Loma Linda University Medical Center	188 (7)	2.87	Average	66 (4)	4.14	Average	349 (6)	1.36	Average	306 (24)	7.74	Average	176	97.73%	Acceptable
	Loma Linda University Medical Center - Murrieta	125 (4)	2.99	Average	20 (0)	0.00	Average	240 (4)	1.64	Average	216 (22)	10.13	Average	112	99.11%	Acceptable
	Pomona Valley Hospital Medical Center	135 (0)	0.00	Average	39 (0)	0.00	Average	230 (2)	0.76	Average	241 (27)	11.61	Average	128	95.44%	Acceptable
	Riverside Community Hospital	156 (2)	1.23	Average	44 (1)	2.63	Average	318 (2)	0.62	Average	276 (39)	14.37	Average	141	98.29%	Acceptable
	San Antonio Community Hospital	132 (4)	1.89	Average	54 (4)	8.11	Average	262 (4)	1.54	Average	216 (28)	12.75	Average	116	100.00%	Acceptable
	St. Bernardine Medical Center	272 (17)	4.67	Worse	90 (6)	7.68	Average	701 (8)	1.15	Average	553 (75)	13.81	Average	284	98.43%	Acceptable

	St. Mary Medical Center - Apple Valley	65 (1)	0.93	Average	35 (2)	5.06	Average	166 (1)	0.65	Average	156 (24)	16.22	Average	78	97.37%	Acceptable
	Temecula Valley Hospital	50 (2)	4.38	Average	5 (1)	25.83	Average	65 (0)	0.00	Average	67 (11)	18.57	Average	47	100.00%	Acceptable
Orange County	AHMC Anaheim Regional Medical Center	120 (2)	2.08	Average	57 (0)	0.00	Average	249 (3)	1.26	Average	203 (17)	8.09	Average	114	95.45%	Acceptable
	Fountain Valley Regional Hospital and Medical Center - Euclid	115 (1)	0.78	Average	11 (3)	36.82	Worse	233 (4)	1.42	Average	195 (22)	10.28	Average	110	92.73%	Acceptable
	Hoag Memorial Hospital Presbyterian	181 (3)	1.96	Average	90 (5)	6.60	Average	366 (1)	0.40	Average	244 (15)	7.58	Average	115	100.00%	Acceptable
	Mission Hospital Regional Medical Center	97 (1)	1.40	Average	37 (3)	9.00	Average	210 (5)	2.75	Average	184 (19)	11.26	Average	93	100.00%	Acceptable
	Orange Coast Memorial Medical Center	75 (3)	4.95	Average	19 (1)	6.73	Average	134 (2)	1.71	Average	123 (14)	12.69	Average	89	100.00%	Acceptable
	Saddleback Memorial Medical Center	86 (4)	4.16	Average	22 (1)	4.00	Average	182 (3)	2.80	Average	140 (14)	11.26	Average	77	97.40%	Acceptable
	St. Joseph Hospital - Orange	92 (1)	1.20	Average	46 (5)	8.26	Average	153 (3)	2.06	Average	139 (22)	15.88	Average	88	96.66%	Acceptable
	St. Jude Medical Center	81 (1)	1.12	Average	29 (0)	0.00	Average	160 (2)	1.84	Average	148 (9)	6.15	Average	75	93.67%	Acceptable
	UC Irvine Medical Center	55 (3)	5.43	Average	12 (3)	21.71	Average	130 (1)	0.72	Average	103 (11)	9.57	Average	57	98.25%	Acceptable
	West Anaheim Medical Center	31 (2)	6.01	Average	3 (1)	49.80	Average	53 (1)	1.88	Average	58 (6)	16.38	Average	31	93.52%	Acceptable
	Western Medical Center - Anaheim	15 (1)	5.04	Average	6 (0)	0.00	Average	45 (1)	1.87	Average	37 (2)	4.70	Average	15	100.00%	Acceptable
	Western Medical Center - Santa Ana	51 (1)	1.30	Average	15 (0)	0.00	Average	132 (2)	1.92	Average	107 (13)	11.83	Average	48	95.83%	Acceptable
Greater San Diego	Alvarado Hospital	26 (0)	0.00	Average	13 (2)	8.73	Average	51 (0)	0.00	Average	25 (9)	18.10	Average	25	100.00%	Acceptable
	Grossmont Hospital	106 (4)	2.66	Average	54 (3)	3.97	Average	221 (3)	1.11	Average	193 (29)	13.44	Average	94	100.00%	Acceptable
	Palomar Health Downtown Campus	46 (2)	4.83	Average	21 (1)	5.46	Average	90 (3)	0.00	Average	84 (9)	10.41	Average	42	95.24%	Acceptable
	Scripps Green Hospital	52 (0)	0.00	Average	48 (1)	2.54	Average	101 (3)	0.00	Average	94 (8)	11.39	Average	50	100.00%	Acceptable
	Scripps Memorial Hospital - La Jolla	278 (5)	1.72	Average	165 (3)	1.75	Better	527 (1)	0.20	Better	480 (47)	10.65	Average	285	99.62%	Acceptable
	Scripps Mercy Hospital	104 (4)	3.93	Average	26 (1)	3.46	Average	208 (2)	1.01	Average	178 (23)	14.71	Average	99	93.99%	Acceptable
	Sharp Chula Vista Medical Center	64 (6)	4.87	Average	35 (2)	6.39	Average	178 (2)	1.12	Average	161 (21)	12.17	Average	90	100.00%	Acceptable
	Sharp Memorial Hospital	97 (3)	4.07	Average	38 (1)	6.51	Average	264 (6)	3.49	Average	192 (30)	11.14	Average	97	96.83%	Acceptable
	Tri-City Medical Center - Oceanside	55 (2)	3.61	Average	23 (2)	8.43	Average	146 (2)	1.32	Average	131 (16)	12.62	Average	53	100.00%	Acceptable
	UC San Diego Health - Sulpizio Cardiovascular Center	149 (2)	1.48	Average	53 (1)	2.29	Average	256 (2)	0.87	Average	222 (15)	6.80	Better	146	95.63%	Acceptable

Isolated CABG Operative Mortality is defined as patient death occurring in the hospital after isolated CABG surgery, up to 90 days, death occurring anywhere after hospital discharge but within 30 days after the isolated CABG surgery or all deaths after transfer to another acute care center up to 90 days. Hospital ratings are risk-adjusted using a statistical technique that allows for fair comparison of hospital outcomes even though some hospitals have sicker patients than average.

[2] CABG + Valve Operative Mortality is defined as patient death occurring in the hospital after CABG with Valve surgery (Aortic Valve Replacement, Mitral Valve Replacement or Repair or a combination of these), up to 90 days, or death occurring anywhere after hospital discharge but within 30 days after the surgery, or all deaths after transfer to another acute care center up to 90 days. Hospital ratings are risk-adjusted using a statistical technique that allows for fair comparison of hospital outcomes even though some hospitals have sicker patients than average.

[3] Post-Operative Stroke is defined as a post-operative, central neurologic deficit persisting for more than 24 hours after isolated CABG surgery while in the operating hospital.

[4] Bleeding Readmission is defined as an isolated CABG surgery patient being readmitted to an acute care hospital within 30 days of being discharged to home or a non-acute setting with a principle diagnosis indicating a heart-related condition, or an infection or a complication that was likely related to CABG surgery. Study population includes patients discharged alive that could be followed-up via hospital patient discharge data.

[5] Internal Mammary Artery (IMA) Usage in CABG surgery is an evidence-based indicator of surgery quality. Most first-time CABG surgery patients are eligible to receive an IMA bypass. Clinical research shows that IMA grafts used in CABG surgery stay open longer and increase patients' survival. Very low hospital utilization rates may be associated with poorer care. Those hospitals with IMA usage rates below 86.69% (i.e. two standard deviations below the statewide average [87.40%]) are labeled as "Low"; those with rates above 87.89% are labeled as "Acceptable." Hospitals are not assessed for very high IMA usage rates because there is no consensus on what constitutes an optimal rate.

The performance rating is based on a comparison of each provider's risk-adjusted mortality rate and the California observed mortality rate. This is a test of statistical significance. A provider is classified as "Better" if the upper 95% confidence limit of its RAMR is below the California observed mortality rate. A provider is classified as "Worse" if the lower 95% confidence limit of its RAMR is higher than the California observed mortality rate. A provider is classified as "Average" if the California mortality rate falls within the confidence interval of the provider's risk-adjusted mortality rate.

* Hospital submitted letter in response to the 2014-2015 CABG surgery performance ratings. Click on hospital name to view the letter.

Data: Isolated CABG Operative Mortality: Hospital report for Isolated CABG Operative Mortality is based on cases from January to July of 2015 and for CABG+VALVE Hospital Operative Mortality and 30-Day Readmission is based on cases from January to December 2014 and January to July of 2015. Post-operative Stroke is based on cases from January to December 2014 and January to December of 2015.

N/A or Applicable: Hospital results are not shown for one of the following reasons: 1) data necessary to confirm cardiac or IMA use were not available, 2) CABG case(s) performed did not meet the criteria for a specific measure.