

MINUTES

EUPHORIC PROJECT

HELSINKI, 8 OCTOBER 2007

19:00

STAKES

LINTULAHDENKUJA 4

Participants:

- MB: Torre Marina – Istituto Superiore di Sanità (ISS), Rome (Italy)
AB: Häkkinen Unto – Centre for Health Economics at Stakes (STAKES), Helsinki (Finland)
AB: Labek Gerold – EFORT-EAR Innsbruck Medical University (EAR), Innsbruck (Austria)
AB: Fusco Danilo – Department of Epidemiology ASL RM E (DEASL), Rome (Italy)
AB: Psaltopoulou Theodora – National and Kapodistrian University of Athens (NKUA), Athens (Greece)
AB: Marrugat Jaume and Ferrer Yolanda – Institut Municipal d'Investigació Mèdica (IMIM), Barcelona (Spain)

Note: MB: Main Beneficiary, AB: Associated Beneficiary

1. Welcome (Marina Torre)

Marina Torre thanks Unto Häkkinen for hosting the meeting and announces that, on the basis of the information received during the audit held in Rome from October 1-5, the First Interim Report was very appreciated by the EU Commission, and the financing is on its way.

2. Short description of the questionnaires and of both pilots (Gerold Labek and Jaume Marrugat).

CV Pilot:

A two-step approach will be applied:

1st : Data from population-based hospital MI registers will be used to fit predictive models of events at 28 days and perhaps 6 or 12 months only in patients with acute myocardial infarction undergoing the following procedures:

CABG, PTCA and coronary angiography.

This must be done in order to prevent heterogeneity in patient characteristics that could stem from taking all patients who undergo these procedures (since some of them are patients with stable coronary heart disease). The Mascara Study (57 randomly selected Spanish hospitals) meets these characteristics and will be used to determine the role of individual and hospital characteristics on the described outcome.

This will allow the CV pilot to come up with a model with a number of significant variables that will benchmark hospitals.

This information will permit the CV pilot to determine a set of important variables that should be ideally collected from administrative discharge records to achieve a standardized hospital benchmark for these procedures in Europe.

At hospital level, a minimum number of easily collectible characteristics should allow proper classification. Country (simple) characteristics will be taken from existing or completed European projects (EUROCISS, ECHIM, ISARE (?)...).

2nd : The fitted model for 30-day mortality should be validated in other registers from different European countries and the hospital discharge records themselves. If the Beta estimates for each variable are similar among countries, the model could be used to benchmark hospitals. Expected 30-day mortality rate can then be calculated with individual, hospital, and country characteristics if average patient characteristics, together with the country and hospital characteristics, are known. This theoretical rate can thereby be compared to the actual rate and the hospital benchmarked from among remaining available hospitals that were previously benchmarked in Europe. This result could be considered as a basis to develop a web application set up .

Anselm Gitt has not answered the three contact attempts made in the last 3 months: collaboration from the Euro Heart Survey is thereby unlikely.

Unto Häkkinen suggests using the Finnish register of MI patients (project PERFEKT) based on admission records that are complete and contain many individual variables. A meeting or a conference call between Jaume Marrugat (JM) and Unto Häkkinen is necessary to agree on data utilization before March. JM should send what he needs and the steps to follow.

Gerold Labek also proposes contacting Prof. Weidinger who leads the Austrian PCI register and Prof. Pfeiffer who has access to the Austrian discharge records. They seem to be willing to cooperate. Austrian discharge records will also be available for the project as an additional WP.

Danilo Fusco underlines that the final result should be the evaluation of the health system and not of the hospital. In addition, Dora Psaltopoulou suggests including some 300 patients of the EPIC project Greek cohort who developed an MI in different hospitals.

As for including socioeconomic factors, IMIM proposes adding them as a country characteristic and not as individuals that are very difficult to measure routinely.. In order to be representative, the CV pilot elaborations need to include as many countries as possible.

Actions

The preliminary results of the CV pilot (1st step) will be presented tomorrow. They are promising.

Orthopaedics Pilot:

Experts: Theodora Psaltopoulou, Danilo Fusco, Unto Häkkinen, Rino Bellocco (AB Karolinska Institut for statistical matters).

1st : To prepare a general statement from a statistical point of view concerning the preconditions, advantages and disadvantages of the various instruments, models and locations of the prosthesis.

2nd : Set up datasets for registers and surveys. Basic data from existing datasets should be taken into consideration. These datasets will be used to calculate the impact of the levels of confounders on the validity of results.

The most important variables have to be clarified for these analyses. It is common sense to focus on a maximum of 10 variables.

The orthopaedic variables will be extracted from the Finnish and Swedish registers. Theodora Psaltopoulou suggests doing the same as in the CV pilot with individuals, hospitals and country variables.

Unto Häkkinen comments that different diseases do not follow the same pattern.

In any case, the orthopaedics pilot will have to rely on existing data sets and there is a minimum data set that is standardized for all the registers.

A discussion on arthroplasty is derived from the necessity of determining the procedures, the outcomes to be considered, the variables that may be candidates as potential confounders as well as the number of registers/patients required to assess the effect of all the potential confounding factors.

Actions

A recommendation is suggested for the arthroplasty pilot to define the procedures, the outcomes and the potential confounding variables (the type of first step in the CV pilot) for a preliminary analysis so as to determine which are the most important and feasible within the EUPHORIC project.

Theodora Psaltopoulou will prepare a document within 20 days describing variables (such as a nomenclature) that could be included in the dummy dataset.

3. Final proposal: results and aims of the WP 5.3 (Gerold Labek and Jaume Marrugat)

It became obvious in the past evaluations, that standardized procedures in statistics and risk adjustment are major issues in the EUPHORIC project. For this reason and due to the fact that the organization will be done in specialized subgroups, it seemed rational to gather the activities in a special WP (5.3) as a joint activity between the two pilots. Since the number of requested partners involved is higher than the orthopaedic pilot's, GL will be in charge of its coordination.

Two reports shall be produced as a final result:

- A report on basic statistics concerning the various instruments for outcome measurement that will lead to a standardized ranking system for dataset quality led by NKUA.
- A report concerning advanced procedures for risk adjustment with special consideration of the instruments under investigation led by DEASL.

4. Work packages for the individual partners (Gerold Labek and Jaume Marrugat)

From the CV pilot point of view, each partner should take responsibility for:

1. Providing their hospital MI registry databases for the first step analysis.
2. Preparing and providing the discharge or admission systematic records for the CV step II (verification of betas in the models).
3. Implementing the model on the website with translation into all languages.
4. Disseminating the recommendations that stem from the CV pilot's final results.

For the orthopaedics pilot:

1. Theodora Psaltopoulou (Partner NKUA) is in charge of organizing and setting up the basic statistics WP, as described above.
2. Danilo Fusco (Partner DEASL) is in charge of organizing and setting up the WP concerning risk adjustment.

5. Inclusion of non-beneficiary partners (Gerold Labek)

Emanuela Taioli, the Associated Beneficiary GRI (Milan), will officially resign to make the funds that she is receiving from the EU available to the rest of the partnership. A contract amendment will be necessary. E Taioli was supposed to prepare a pilot on cancer. Since there is no possibility of organizing it with another partner, we planned to use her funding to subcontract other tasks to non-members of EUPHORIC. These tasks can be related to the cardiovascular pilot or the arthroplasty pilot. Among others, we could discuss the possibility of including the outcome for MI admission, which was not considered initially in the CV pilot.

Kerstin Pankewitsch from Halle/Saale has completed a very interesting PhD thesis concerning risk adjustment and offered to make it available for the EUPHORIC project. It would be a good idea to consider it in detail through personal meetings between Danilo Fusco and Ms Pankewitsch.

Prof. Pfeiffer (Head of the Dept for Biostatistics and Health Economics at the Med. Univ. Innsbruck) has access to discharge records in Austria, wide experience in evaluations, including outcome, and is already cooperating with Austrian cardiovascular registers. Cooperation would create added value for both pilots.

Actions

All the partners agree on initiating the necessary steps to achieve the objectives of recycling this partner's funds.

6. Project management and reporting procedures (Gerold Labek and Jaume Marrugat)

Since the orthopaedics pilot requires a higher number of partners to be involved in the WP 5.3 (NKUA, DEASL, KAR, STAKES), Gerold Labek (GL) will be in charge of the coordination of WP 5.3.

GL requires a monthly report from every partner in the orthopaedics pilot to be able to achieve proper project management.