



Pennsylvania's Guide to Coronary Artery Bypass Graft (CABG) Surgery 2003 - Key Findings

- ⊕ Patient in-hospital mortality and thirty-day mortality following coronary artery bypass graft (CABG) surgery in Pennsylvania hospitals remained steady between 2002 and 2003.
- ⊕ Readmission rates within seven days following bypass surgery decreased 4.7 percent between 2002 and 2003. Thirty-day readmission rates increased by 5 percent during the same period.
- ⊕ The top two reasons for patient readmission within 30 days of bypass surgery were infection and heart failure. Readmissions within 30 days for infections amounted to over \$16.7 million in hospital charges and over 3,400 hospital days. Readmissions within 30 days for heart failure amounted to over \$7.6 million in hospital charges and over 1,700 hospital days.
- ⊕ Patients with longer post-surgical lengths of stay were more likely to be readmitted within 30 days of CABG surgery.
- ⊕ The average hospital charge for all CABG surgeries increased by 43 percent from 2000 to 2003, while the average charge for all inpatient discharges increased by 45 percent during the same time period.
- ⊕ Overall, the number of CABG surgeries decreased by 17 percent from 2000 to 2003, while the number of balloon angioplasty procedures increased by 26 percent during the same time period.
- ⊕ When examining all open-heart surgeries, the average number of cases per hospital decreased from 408 in 2002 to 390 in 2003 (a decline of 4.4 percent). The average number per surgeon remained relatively the same - about 130 cases per surgeon.
- ⊕ The risk for CABG patients increased about 4.4 percent from 2000 to 2003 due to the presence of such comorbid conditions as diabetes, obesity, chronic obstructive pulmonary disease, complicated hypertension, etc. The percentage of patients 80 years old and over increased by 12 percent from 2000 to 2003. The in-hospital mortality rate for this age group increased 22 percent during the same time period.
- ⊕ Surgeons who performed higher numbers of procedures (200-250 procedures) tended to have better results; i.e. lower patient mortality rates. Patients treated by surgeons who performed 200 to 250 surgeries were twice as likely to survive after bypass surgery as patients of surgeons with less than 100 procedures per year.
- ⊕ In general, patients treated by surgeons with higher volume had shorter post-surgical lengths of stay.

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