Transcript Details

This is a transcript of an educational program accessible on the ReachMD network. Details about the program and additional media formats for the program are accessible by visiting: https://reachmd.com/programs/focus-on-public-health-policy/potential-pitfalls-of-many-heart-transplant-programs-in-one-city/3604/

ReachMD

www.reachmd.com
info@reachmd.com
(866) 423-7849

Potential Pitfalls of Many Heart Transplant Programs in One City

POTENTIAL PITFALLS OF MAINTAINING SEVERAL HEART TRANSPLANT CENTERS

Our presidential election is only days away. Forty eight million people in America are uninsured and healthcare costs are rising 2 to 3 times faster than our nation's GDP. Where will America's healthcare system be in 5 years?

Welcome to ReachMD's monthly series - focus on Public Health Policy. This month we explore the many questions facing healthcare today.

The Chicago metropolitan area is home to 5 Adult Heart Transplant Centers equal to Philadelphia for the most in one city in the United States. Some say it's a tribute to the determination of Chicago's Hospitals to collectively become a national leader in heart transplantation, but others believe it's a serious strategic mistake. What are the key policy questions at hand here. You are listening to ReachMD XM 157, The Channel for Medical

 © 2019 ReachMD

Professionals.

Welcome to a special segment focus on healthcare policy. I am your host, Dr. Mark Nolan Hill, Professor of Surgery and practicing general surgeon and our guest is Dr. Valluvan Jeevanandam, Professor of Surgery at University of Chicago Pritzker School of Medicine and Chief of Cardiothoracic Surgery at the University of Chicago Medical Center.

DR. HILL

Welcome Dr. Jeevanandam.

DR. JEEVANANDAM

Well, thank you very much Dr. Hill. It's my pleasure to be here on your program.

DR. HILL

We are discussing the potential pitfalls of maintaining several Heart Transplant Centers in one city. Why is this a pitfall?

DR. JEEVANANDAM

There have been many studies. The latest one that's come out of Johns Hopkins that shows that with most surgical programs, volume really does matter. You know size matters in terms of getting better results. So, the data suggest that programs that do about 20 transplants and above have better results than programs that do 10 transplants and less and therefore I think programs should be only opened if they can do a certain amount of transplants to give the best patient care.

© 2019 ReachMD

DR. HILL

Are there regulations that guide this?

DR. JEEVANANDAM

Well, there are Medicare regulations. Now, Medicare originally too would credential centers and to credential a center you have to do 12 transplants over a 2-year period and have 2-year results. So, it took 3 years to get Medicare certification. Now, that was in the past, and after much lobbying from many other programs, those requirements decreased to doing 10 transplants per year with 1-year results. Now, the problem is that many programs would get Medicare certification and then let their programs decrease in terms of volume and Medicare would never come back and audit them and remove programs. So, once you got Medicare credentialing, you never got de-credentialed. I think that there have been several transplant programs in the country that have been caught with bad publicity in situations where they were not doing transplants that they should have been doing and therefore Medicare is now joining up forces with JCAHO, are auditing programs and going over their results every couple of years, and if they do less than 10 transplants per year, they are now decertifying programs, and under that threat, programs are voluntarily taking themselves off transplant certification because they rather do that as opposed to being audited.

DR. HILL

Let's talk about the results. In general surgery, we are always told that if you don't do a certain number of Whipple's a year or certain number of abdominoperineal resections a year you lose the technical ability to get good results. When you talk about the less than optimal results in centers that do not do a lot of transplants, are we talking about specifically with regard to the surgical team or the overall transplant team?

 © 2019 ReachMD

DR. JEEVANANDAM

I think transplant is a technical operation, but it's much more of an intellectual operation. One needs to decide what is a good donor, what is a good recipient, and in addition to the surgeon, there is an entire team that needs to be passed out with transplant. That team would include cardiologists, pathologists to read the biopsy, infectious disease experts, critical care experts, nephrologists or renal experts. So, there need to be a large infrastructure that is established to make a good heart transplant team or any transplant team.

DR. HILL

But how did Chicago and Philadelphia get so many heart transplant programs to begin with?

DR. JEEVANANDAM

When I was in Philadelphia, I was Director of the Temple program. We did about 100 transplants a year. We were the largest program in the country, and in the city of Philadelphia, the year before I left; we did 180 transplants just in the city of Philadelphia. That’s a tremendous amount of transplants. There was a lot of enthusiasm and a lot of focus on transplants, and after I left, you know Temple's program has decreased their volumes significantly, and even though they have 5 programs now, they don't do nearly the volume that we used to do many years ago.

DR. HILL

Why do you think that is? Are we treating these patients medically more efficiently?

 © 2019 ReachMD

DR. JEEVANANDAM

Yeah, I think again since the 90s or the late 90s when I was there, we now have beta-blockers that are being used more for patients, we have biventricular pacing, but I also think that there are other policy decisions that have made transplant lot less of an option. In the 90s, we did not have ventricular assist devices, and so if the patient didn't get transplanted, you know their only other choice was death, and so we were very aggressive by transplanting patients. Now, you have mechanical assist devices, some of which can actually be placed in, and for patients who are not great transplant candidates, you can put a device in and not get them transplanted. I think the other policy decision though is that Medicare is auditing all these programs, and because you now get audited, unless you have a 1-year survival of greater than 85%, you are at risk of losing your accreditation.

DR. HILL

Well doctor, do the transplant centers in the city like Chicago where you are or Philadelphia, do they talk to each other?

DR. JEEVANANDAM

Probably more at national meetings than we do on a regular basis within the city that we are all based in. So, we don't really talk to each other on an ongoing basis, and honestly, it is pretty competitive.

DR. HILL

Why would the hospitals who do not do a great number of heart transplants want to continue their program?

DR. JEEVANANDAM

Because transplant is a major draw to get patients to come in, who in heart failure and heart failure can be potentially profitable for institutions especially people need to have diagnostic tests performed, perhaps a correctable lesion can be discovered and the patient will end up getting catheterization or stent or may be even surgery, and also because there are so many regular heart surgery programs, programs need to distinguish themselves and take care of the heart failure patients and certainly a way to do that.

DR. HILL

Dr. John Conte, Director of Heart Transplantation at Johns Hopkins Chicago may have the finest group of transplant surgeons of any city in the world. With this in mind, where is the hold up?

DR. JEEVANANDAM

When I was talking to you earlier, it wasn't just the surgeons, right, it's the whole team and it's the policies of Medicare looking at mortality. So, let's say you have a program that does less than 10 transplants or does 10 transplants and is on the cusp. If they lose 1 patient in the first year, that's a 90% survival and they are okay. If they lose 2 people, that's an 80% survival, but they are now going to be at the cusp of not getting Medicare approval. So, they are going to be very, very selective on what they do, and being selective means that you are not going to take a patient, who may be at slightly higher risk, and I will give you an example, let's say you have a patient, who is almost certainly going to die without transplant, so for him the chance of death is you know 100%. Now let's say you can operate on him and transplant him and the chance of survival is 60%, okay. So from his point of view that's a positive 60% in terms of survival; however, if Medicare mandates that you have..

DICTATION ENDS ABRUPTLY

© 2019 ReachMD