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Sustaining Multiple Heart Transplant Programs in One City

Heart transplants are among the most complex procedures in medicine. Without performing transplants on a consistent basis, it is argued that transplant teams may not be able to maintain the utmost level of precision requisite for care. In cities like Chicago, which have 5 transplant centers, are there factors preventing one or more of these hospitals from achieving the highest standard of care.

You are listening to ReachMD, the Channel for Medical 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. MARK NOLAN HILL:

Welcome Dr. Jeevanandam.

DR. VALLUVAN JEEVANANDAM:

Thank you Dr. Hill, it's my pleasure to be here.

DR. MARK NOLAN HILL:

We are discussing the balance of sustaining multiple heart transplant programs in one city. Doctor can you briefly summarize how Chicago has arrived at its current situation.

DR. VALLUVAN JEEVANANDAM:

Well, Chicago has had several programs many years ago, some closed, new programs opened up. Currently, the programs in Chicago are the University of Chicago's program, which has been the largest for the last 7 years, then you have Northwestern, which opened up about 2 years ago. They have had a program in the past, which was essentially dormant and they have now come back with their renewed interest in cardiac care. Loyola was the largest program for probably until about 10 years ago and at one point, they were nationally within the top 4 or 5. One of their cardiologist moved from Loyola and went to Rush. Loyola's program went down, Rush's program went up for a while, then that cardiologist moved out of Rush, then Rush kind of went into disfavor. So, Loyola is reestablishing their program. So, you have Loyola, you have Rush, Northwestern, University of Chicago, and then Christ Hospital which is a community-based hospital that doesn't have any other transplant programs, did develop a mechanical-assist program and has now opened up a cardiac transplant program. So, we now have 5 with Medicare-approved Centers being Loyola, University of Chicago, and Northwestern. I don't know about Rush and I know Christ is not Medicare approved.

DR. MARK NOLAN HILL:

When someone is not Medicare approved, what exactly does that mean?

DR. VALLUVAN JEEVANANDAM:

Well, that means that if they do a Medicare patient, they will not get reimbursed for that patient and usually other insurance companies follow Medicare. So, unless you have Medicare approval, you are not going to be a center of excellence, which generally means you are not going to get reimbursed. So, therefore if you have a fresh program such as the Christ program, before you get Medicare approval, you have to do 10 transplants and show good 2-year survival. So, essentially for the first 18 months or so or probably for at least 2 years, you are not going to get reimbursed for most of your cases unless you can have single negotiated cases with insurance companies. So, that means that the institution needs to put a big investment to get that program off the ground.

DR. MARK NOLAN HILL:

How can an institution survive with not being reimbursed for even in the beginning of their program?

DR. VALLUVAN JEEVANANDAM:

They would basically put aside $150,000 per patient, right? So, you have to do 10 to 12 patients, so they probably put aside about a million and half dollars and they say well that's what they are going to have to invest to get the transplant program up.

DR. MARK NOLAN HILL:

Are there many community hospitals that have viable heart transplant programs in the United States?

DR. VALLUVAN JEEVANANDAM:

A few, but not really many. I mean a transplant program entails a huge infrastructure including pathologists, critical care people, infectious disease, renal. I mean the nice thing about being a transplant surgeon or a transplant physician is that although I am a surgeon, I clearly get exposed to the rest of medicine just by what the transplant patients go through. So, you need to have a large infrastructure and that infrastructure generally exists in academic medical centers over community-based medical centers because the academic centers have, you know, infectious disease people for instance who can spend the time and effort to take care of these transplant patients.

DR. MARK NOLAN HILL:

Is it advantageous in a heart transplant program to have other organ transplant programs as well, in that institution?

DR. VALLUVAN JEEVANANDAM:

In our institution, clearly it is. I mean, we are the world's leader in doing multiple organs with heart, so we do heart-kidney transplants, heart-liver transplants, heart-kidney-liver transplants, heart-pancreas, whatever combination you can dream of.

DR. MARK NOLAN HILL:

And how does that having other organ transplant ability that your institution help you specifically in your heart transplant program?

DR. VALLUVAN JEEVANANDAM:

A lot of patients after a heart failure who are in heart failure for a long period of time may develop kidney issues and then we do know that after we do our transplant and we put them on immunosuppression, some of the side effects of immunosuppression are to make their kidneys worse. So, somebody starts off with a creatinine clearance of only 30 and you give them immunosuppression, then the incidence of dialysis in 5 years after a heart transplant is quite high. So, you want to make sure that their kidneys are okay before you transplant them. Now, some patients just have bad kidneys and then you would not give them a heart transplant because you know that you are going to affect their kidneys. Now, in our institution, we are lucky in that we have the option of giving them a heart and a kidney, so then they are protected both ways. There are some patients who have cirrhosis for instance who also have severe heart problems and we can give them a heart-liver transplant. So, having that flexibility allows us to take care of a lot of patients that otherwise can't be taken care of in other centers.

DR. MARK NOLAN HILL:

If you have just joined us, you are listening to a special segment - Focus On Healthcare Policy on ReachMD. I am your host, Dr. Mark Nolan Hill 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. We are discussing the balance of sustaining multiple heart transplant programs in one city.

Doctor, if you could be the devil's advocate and you are one of the transplant surgeons at one of the institutions that were not doing as many transplants as they would like, what would you say about your argument?

DR. VALLUVAN JEEVANANDAM:

Well, I would say that you know you want to give patients access to care and so the more centers that are doing the procedure the more access that will be available and more choices that are available for patients and that the more centers you have, the more competition one would encounter and more competition would improve quality.

DR. MARK NOLAN HILL:

Is that true?

DR. VALLUVAN JEEVANANDAM:

I think that in a perverse way is actually the reverse of what happens in reality. I think when you have small programs, they become very conservative and they may have good statistical data on the people they transplant, but what you are going to miss out on are the people that they turn down and do not transplant who could potentially benefit from other centers. For instance, if they have a program that's small, they are not going to be aggressive enough to do a heart-liver transplant. So, the patient who needs a heart-liver transplant is going to be turned down whereas those are things that are available in larger programs like ours.

DR. MARK NOLAN HILL:

As surgeons we know that things always go in cycles, lots of patients, then low numbers of patients and you never can predict, but what would happen if you had a tremendous number of patients and you really needed a backup to deal with the overflow, how would you deal with that?

DR. VALLUVAN JEEVANANDAM:

Well, I mean, you look at programs like Columbia and UCLA. I mean, they do a lot of transplants and

they just create their own backup mechanisms right, where you can always hire new people or have new operating rooms, and I think if you have programs that are that large, you will start getting other programs. I think the n number of 1 is too low for a place like Chicago, but probably 3 programs that are geographically well distributed is probably a good number for a place like Chicago.

DR. MARK NOLAN HILL:

Well, as one of the leaders in this city, what would you suggest is a way to go about solving this problem?

DR. VALLUVAN JEEVANANDAM:

Well, first of all, the problem is going to be somewhat solved once Medicare actually enforces the rules that apply for credentialing. So, in the past, you could apply for Medicare, and once you got Medicare approval, you are never decertified if your volume thresholds decreased. We are now in a stage where Medicare under using JCAHO is actually auditing programs and looking at volumes, and hopefully, they will start decertifying programs that don't meet their volume requirements and that certainly will be intent of what they want to do. So, you know you are going to at least weed out your programs that are doing single digits and perhaps Medicare at some point is then going to look at results of studies like by Dr. Canty that said that you need to have a certain volume and hopefully they will increase that 10 number to 15 or 20 in which case they may have the ability to weed out some programs.

DR. MARK NOLAN HILL:

Well, what's going to happen then to those programs that indeed do have good surgeons, good teams, and just don't have the numbers?

DR. VALLUVAN JEEVANANDAM:

Well, they are going to have to redeploy and do other things.

DR. MARK NOLAN HILL:

Is this something that should be taken over on a more federal level in terms of deciding which institution will be the main institution in the city like Chicago or Philadelphia?

DR. VALLUVAN JEEVANANDAM:

Well, I think there needs to be some kind of regulation. I think as you know every state varies. I mean, Chicago happens to have a very, very loose Certificate of Need, so almost anybody can get a transplant program if they want one as opposed to New York which has a very tight Certificate of Need and you know obviously the programs in New York have much higher volumes than the ones we have in Chicago. So, I do think that it's probably eventually going to come down to Medicare and CMS putting in regulations and controlling everything just by what they are going to be able to reimburse.

DR. MARK NOLAN HILL:

Are the numbers and the percentages really fair? If someone does not have the numbers, does it really mean that the results will be suboptimal?

DR. VALLUVAN JEEVANANDAM:

Again, everything in medicine is statistics, right? So, statistically the lower numbers you have the worst results. Now, does that mean that, you know, you have 1 patient out of 10 who dies and all of a sudden you have a 10% mortality as opposed to if you are doing 50 patients, you know, 5 could die

and you just have 10% mortality. So, you know, some of the mortality numbers you may be looking at may be just because the volumes are down and the problem with transplant I could tell you is, you know, anything can happen to patients. I mean, they can get hit by a truck, which still counts as a mortality and statistically you know you have 10 people and 1 person does something bad, it's going to affect your result. So, I think you have to start at some place and right now it's pretty rigid in terms of what mortality they are looking at and hopefully at some point, we will be able to have graded mortality or looking at better algorithms and developing better algorithms to risk stratify.

DR. MARK NOLAN HILL:

Well, you mentioned before about access to care and certainly in a city as big as Philadelphia or Chicago, it would be a great hardship on the family as well as the patient to travel, lets say 50-60 miles one end of the city to the other or even considering being out of state coming to an institution. Is this hardship being considered at all?

DR. VALLUVAN JEEVANANDAM:

It's perhaps hard for the patient. On the other hand, it is more than made up by the better quality you are going to get in a larger program and the depths of quality you are going to have and the breadth of quality you are going to have.

DR. MARK NOLAN HILL:

I want to thank our guest, Dr. Valluvan Jeevanandam. We have been discussing the balance of sustaining multiple heart transplant programs in one city. I am Dr. Mark Nolan Hill and you have been listening to a special segment - Focus On Healthcare Policy on ReachMD, the Channel for Medical Professionals. Be sure to visit our website at reachmd.com featuring on-demand podcast of our entire library and thank you for listening.