The Passions and Actions of Our Lives: Changing the World Around Us

Jeffrey B. Rich, MD

Sentara Heart Hospital, Norfolk, Virginia

Each of us has experienced this throughout our lives: passions that we have experienced leading to supporting actions that created change. For 50 years The Society of Thoracic Surgeons (STS) has identified the issues of importance to the STS based on the collective wisdom and passions of our leadership and membership. We have identified ourselves as a professional society dedicated to the improvement of care for our patients, the continued education of our residents and our members, and the advancement of cardiothoracic surgery. One of the early actions taken was to create, through the work of Fred Grover and others, a database that allowed us to track our outcomes and use those data to progressively improve care for our patients [1]. We were the first professional society in the United States to do so. We were also the first professional society to create national standards for care in its area of expertise through the National Quality Forum, in this case for coronary artery bypass grafting (CABG) [2]. I was privileged to cochair that committee and have prominent members from the STS on it. We were also the first professional society to enable our members to make those results transparent through our website or consumer reports [3]. The STS has been the national leader as a professional society for clinical accountability, and it is well recognized as such in Washington, DC. The database was and continues to be referenced as the poster child for how it should and could be done. The STS continues to be used as an example of how a professional society should be accountable for its clinical care and how to respond to health care challenges.

The STS also has had a passion for health care policy and created the appropriate infrastructure for involvement. As a result, we have been highly respected in Congress for years. We have been asked to give numerous Congressional testimonies (Fig 1) [4] on measuring performance and redesigning the health care system. We have had and continue to have direct interaction with the Congressional Committees of Jurisdiction and the White House.

We have accomplished much through collaboration with the American College of Cardiology (ACC), the Food and Drug Administration (FDA), and the Centers for Medicare and Medicaid Services (CMS; Fig 2) [5]. First and foremost was the approval of the National Coverage

Jeffrey B. Rich, MD

Determination for Transcatheter Aortic Valve Replacement or TAVR. The importance of this cannot be overstated. It firmly establishes the heart team model for patient care and mandates that cardiac surgeons evaluate the patient preoperatively and that they be involved intraoperatively during the procedure. Second, through the efforts of Mike Mack, David Holmes of the ACC, Bram Zuckermann of the FDA, and Louis Jacques of CMS, the Transcatheter Valve Registry (TVT) was designed for TAVR but is the prototype for databases of the future: it is a true multistakeholder effort and is a blended database with STS, ACC, and CMS data that will serve as a platform for monitoring high-technology devices after commercialization. The TVT registry has rapidly expanded and now includes hundreds of sites and thousands of patient records. Through the use of the registry, the STS and ACC are now sponsors for Investigational Device Exemption Trials with the FDA. This will allow professional societies to help determine the use of this technology using different approaches and in other patient populations. We continue to analyze the results of the ASCERT 1 Trial, which shows benefit of CABG over multivessel percutaneous coronary intervention. It too uses this blended database platform. Finally, I was at a meeting at the White House discussing specialty care and its impact on the health care budget, which was very

Presented at the Forty-ninth Annual Meeting of The Society of Thoracic Surgeons, Los Angeles, CA, Jan 26–30, 2013.

Address correspondence to Dr Rich, 1325 N Bay Shore Dr, Virginia Beach, VA 23451; e-mail: rich1292@cox.net.

© 2014 by The Society of Thoracic Surgeons
Published by Elsevier Inc

Ann Thorac Surg 2014;98:789–98 • 0003-4975/$36.00
http://dx.doi.org/10.1016/j.athoracsur.2014.05.044

Abbreviations and Acronyms

ACA	=	Affordable Care Act
ACC	=	American College of Cardiology
APM	=	alternative payment models
CABG	=	coronary artery bypass grafting
CMMI	=	Center for Medicare and Medicaid Innovation
CMS	=	Centers for Medicare and Medicaid Services
FDA	=	Food and Drug Administration
HHS	=	Department of Health and Human Services
NCD	=	national coverage determination
SGR	=	sustainable growth rate
STS	=	Society of Thoracic Surgeons
TAVR	=	transcatheter aortic valve replacement
TVT	=	Transcatheter Valve Registry
VCSQI	=	Virginia Cardiac Surgery Quality Initiative

revealing. Nearly every specialty in attendance had or had begun to develop registries, with the STS database being held up as the Holy Grail. There also is growing recognition that savings achieved through primary care initiatives are limited and that specialty care may provide more solutions—in general, a move away from the medical home to the concept of the medical neighborhood that brings specialty care into the mix.

A more sobering topic is the state of the health care economy (Fig 3) [6]. Health care spending in the United States has been exponential both in the public and private sector, and most considerate it unsustainable. Recent data show that for the last 3 years health care spending has slowed, increasing annually at 3.9% compared with an average of 7%. Most think this is caused by the recession finally hitting health care and not caused by policy changes (Fig 4) [7]. According to the 34-nation consortium, the Organization of Economic Cooperation and Development, we continue to spend more on health care as a percentage of the gross domestic product than any other nation in the world. In fact, the most recent data from the US Medicare Payment Advisory Commission from June of 2012 [8] show that we spent $2.7 trillion in 2011 on health care, representing 17.9% of gross domestic product, with an estimated 6.1% growth in spending until 2021. Additionally, Medicare beneficiaries will increase from 47.1 million in 2010 to 80.6 million in 2030. So what does this mean? It means we are nearing a fiscal cliff for health care (Fig 5) [9]. This was the state of the Hospital Insurance Trust Fund in 2008 (Fig 5). The graph shows depletion of the fund by 2017 using intermediate-risk modeling. Currently, using the same model, depletion is estimated to occur in 2024. If spending accelerates, depletion will again occur in 2017 (Fig 5).

What is driving excessive spending? It is a combination of many things: expansion of the Medicare population, expensive drugs and technology, waste, complications of care, overuse, and misuse that includes off-label use of drugs and devices. But does the root cause go deeper? Is it that we as providers, like CMS, have difficulty defining what is reasonable and necessary care? A recent *New England Journal of Medicine* article [10], "Medicare's Enduring Struggle to Define 'Reasonable and Necessary' Care," states, "Determining 'reasonableness' has presented even more difficulty. The word implies moderation, suggesting that the resources expended should not be excessive. The issue is not simply whether care is essential, but whether it is advisable given a delicate balance of benefits, risks, and costs." I submit that this is not only Medicare's struggle, but ours as well.

So how do we get from where we are today to a self-sustaining health care system—not doomed to fall off a fiscal cliff? It will require a bimodal approach. A combination of government policy, legislation, and regulation and of providers and professional societies acting responsibly and in the best interest of their patients and as stewards of the health care system. Understanding government's role in health care and the role of the STS in creating a solution is of utmost importance.

First of all, government is good. Politics may be bad, but government is good. As Einstein said, "Politics is more difficult than physics." So how is government structured to create health care policy? There are four power brokers: the White House, the Congress, the Department of Health and Human Services (HHS), and the CMS. Embedded within Congress are the three committees of jurisdiction for health: the Senate Finance Committee, the House Ways and Means Subcommittee on Health, and the House Committee on Energy and Finance.

Change occurs in several ways. Most occurs through the regulatory process and its associated annual updates

Fig 1. Congressional testimony. (SGR = sustainable growth rate.)

Download English Version:

https://daneshyari.com/en/article/2876190

Download Persian Version:

https://daneshyari.com/article/2876190

Daneshyari.com