The Society of Thoracic Surgeons

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COPY SENT VIA EMAIL

Ms. Wendi Roberts
Executive Director, Certification Programs
The Joint Commission
One Renaissance Blvd.
Oakbrook Terrace, IL 60181

Dear Ms. Roberts:

On behalf of The Society of Thoracic Surgeons (STS), I write in response to the Joint Commission's request for feedback on a proposed comprehensive Cardiac Center Certification Program (CCCP). We regret that the Joint Commission did not involve STS or the other relevant medical specialties and patient organizations earlier because there are a number of flaws and oversights in the current CCCP document and survey instrument. We encourage the Joint Commission to temporarily halt further action on this project, thereby providing time to meet with the appropriate interested experts and stakeholders.

Founded in 1964, STS is an international not-for-profit organization representing more than 7,000 cardiothoracic surgeons, researchers, and allied health care professionals in 90 countries who are dedicated to ensuring the best surgical care for patients with diseases of the heart, lungs, and other organs in the chest. The mission of the Society is to enhance the ability of cardiothoracic surgeons to provide the highest quality patient care through education, research, and advocacy.

Although we are not aware of the impetus for this project, the potential adverse consequences of this program could be quite substantial including limiting patient access to care and misappropriation of critical health care resources. STS would be willing to work with the Joint Commission and representatives of other specialties to provide information on the resources that should be used in any effort to create a CCCP and identify the potential impacts of such a program on the health care infrastructure.

One such resource is the STS National Database - established by cardiothoracic surgeons in 1989 as an initiative for quality assessment, improvement, and patient safety. The Database has three components—Adult Cardiac, General Thoracic, and Congenital Heart Surgery. About 95% of the adult cardiac surgical procedures performed in the United States are captured in the Adult Cardiac component. The fundamental principle underlying the

STS National Database initiative is that surgeon engagement in the process of collecting detailed clinical information on every case, robust risk-adjusted outcomes assessment based on pooled national data, and feedback of these risk-adjusted results to individual practices and institutions, will provide the most powerful mechanism to change and improve the practice of cardiothoracic surgery for the benefit of patients. In fact, published studies indicate that the quality of care has improved substantially as a result of efforts directly related to the STS National Database.

In preparing these comments, we queried data submissions to the STS National Database from 2014 to see how many cardiac surgery programs that submitted data for the full 12 months would meet the volume requirements articulated in the CCCP proposal. In doing so, we encountered our first problem with the proposal. The CCCP includes volume thresholds for CABG and valve procedures, but does not define whether these criteria would apply to isolated CABG (only a CABG surgery is performed without any other procedure), isolated valve procedures (only a valve surgery is performed without any other procedure), or alternatively any procedures that included these components. Subsequent iterations of CCCP criteria should be precise in defining these inclusion/exclusion criteria. Based on all-payer data from the STS National Database, only about 15% of participants in the Adult Cardiac Surgery Database would meet the CABG or valve volume criteria if these were defined as isolated procedures, and only 60% would meet these thresholds if ANY combined procedures that included these components were permitted. Exclusion of such a large percentage of programs from potential CCCP certification could have several unintended negative consequences. First, if such criteria were applied by governmental or commercial payers in a restrictive fashion, it would hamper access to care for certain populations, especially those in rural areas. Second, these volume criteria could be a perverse incentive to perform marginally indicated procedures, a phenomenon which our data suggests is extremely rare today.

Further, we would encourage the Joint Commission to consider the intended impact of this program on the health care infrastructure. Using the CCCP as currently outlined, hospitals could spend billions of dollars trying to meet program requirements and not have a meaningful impact on care quality and patient outcomes. Many of the recommendations for advanced services contained within the CCCP criteria have intuitive appeal, but lack empirical evidence that they result in better outcomes. In addition, this proposal does not demonstrate how certified programs will measure and report on their excellence. Will the program be able to measure patient outcomes and compared risk-adjusted outcomes at CCCP certified and non-certified centers? It is also not clear that the Joint Commission has considered how such a program would affect access to emergent care, availability of cardiac services in rural areas, and geographic disbursement of resources.

Finally, the survey tool that accompanies the CCCP proposal is complex and unnecessarily tedious. Insurance companies have been using – and refining – similar tools for years. These surveys are designed to be efficient and useful in insurers' decision-making and, in many cases, the surveys use data reported to the STS National Database. Numerous STS surgeon leaders, all of whom are deeply interested in optimizing the quality of cardiovascular services and quite familiar with the subject matter of the CCCP proposal, have expressed frustration with the CCCP

survey tool. It is our belief that the survey instrument is unlikely to be completed by most practitioners, which will reduce its value in helping to shape future iterations of this proposal.

If the Joint Commission is intent on proceeding with the CCCP, STS stands ready to provide insight into how best to measure, improve, and report on quality of care in cardiac surgery. We and our cardiology colleagues have been measuring and reporting on quality for over 20 years, and we are confident that our collective experience in this arena would prove invaluable to the Joint Commission's efforts. For example, whenever possible, we prioritize outcomes measures above structural and procedural measures, something we find lacking in the CCCP proposal. We can also use the STS National Database to help with analyses of the downstream consequences of this effort, both clinical and financial. We would caution against implementing the CCCP without conducting a meaningful impact analysis using data that are already available.

We encourage the Joint Commission to temporarily halt the current CCCP project, and to engage the broader stakeholder community, including the medical specialties and patients that will be impacted. I hope you will contact Courtney Yohe, STS Director of Government Relations at 202-787-1222 or cyohe@sts.org to begin this conversation.

Sincerely,

Mark S. Allen, MD
President

cc: Joyce Marshall, Senior Research Associate, Division of Standards and Survey Methods