Just prior to the kick-off of SCAI 2014, the Society received official confirmation that the Centers for Medicare & Medicaid Services (CMS) had granted its request for a new physician specialty designation for Interventional Cardiology. This recognition of Interventional Cardiology as a distinct physician specialty is a major achievement, said SCAI 2013–14 President Ted A. Bass, MD, FSCAI, because it will enhance SCAI’s ability to represent the profession and the patients it serves.

“SCAI filed for a dedicated physician specialty code in 2013, upon confirming with government officials and other analysts that Interventional Cardiology has evolved to a point where many of the patients we treat and the treatments that we can offer are significantly different from those of general cardiology and other cardiovascular subspecialties,” said SCAI Secretary and Advocacy Committee Chair Peter L. Duffy, MD, MMM, FSCAI. “Having our own designation will help us to ensure that our concerns and priorities will receive sufficient consideration and will not be lumped in with those of others.”

Having a specialty designation is especially important in today’s healthcare costs. As healthcare costs continue to rise, policymakers and payers are searching for new ways to curb costs. Cardiovascular interventions, like many other procedures, are facing increasing scrutiny. However, when policymakers inappropriately apply cost-cutting measures, SCAI mobilizes its advocacy team to watch for potentially negative impacts on patients’ access to quality care.

That’s what happened in New York when the state’s Department of Health announced that its Medicaid Program would recoup payments for percutaneous coronary interventions (PCIs) deemed inappropriate according to its interpretation of the 2012 appropriate use criteria (AUC) for coronary revascularization. The interventional cardiovascular community went to work, bringing together the expertise of several SCAI members and the reputation of SCAI, ACC and the State ACC Chapter. Working together, they succeeded in educating the Department of Health and convincing policymakers to rethink a policy that ultimately could have reduced access to medically necessary procedures for vulnerable Medicaid patients.

“To our knowledge, the New York case represents the first time a state attempted to apply the AUC to reimbursement, but it may not be the last,” said SCAI 2014–15 Secretary and Advocacy Committee Chair Peter L. Duffy, MD, MMM, FSCAI. “We would not be surprised if policymakers and payers across the United States will seek creative ways to cut costs. New York interventionalists’ advocacy experience in partnership with SCAI provides important lessons for cardiologists everywhere.”

CONTINUED ON PAGE 10
Dear Colleagues,

I’m delighted to announce that SCAI has just held its most successful annual meeting. As you peruse this newsletter, I hope you will enjoy the many photos and stories recapping SCAI 2014. It was a pleasure to be part of such an extraordinary educational event. On behalf of the SCAI Board of Trustees, I thank the SCAI 2014 Program Committee, led by Morton J. Kern MD, MSCAI, and Congenital Heart Disease Program Chair Matthew Gillespie, MD, FSCAI, for their vision, leadership and effort.

To the interventional cardiovascular community, I extend a personal invitation to attend the SCAI 2015 Scientific Sessions, May 6–9, in San Diego. The 2015 Program Committee is already busy, planning a meeting that will continue our favorite traditions while adding new innovations that will excite and inspire us all. Information about abstracts, registration and more is available at www.SCAI.org/SCAI2015.

In addition to the SCAI 2014 highlights in this newsletter, you’ll find information about many new and forthcoming SCAI initiatives. Never have the SCAI committees and staff been so busy or so productive. The opportunities for SCAI members to access new benefits and get involved are plentiful. Please review the SCAI committees at www.SCAI.org/Committees, and choose a committee that interests you. Then email the staff for that committee and join us. One of the most rewarding aspects of my career has been participating as a volunteer in SCAI activities. I hope you will experience the same satisfaction that accompanies partnering with colleagues to advance our specialty on behalf of our patients.

Finally, I’m delighted to share news about SCAI’s latest benefit, launched this summer. The FIT Portal is an innovative online tool that supports the training of tomorrow’s interventional cardiologists. Developed by SCAI’s Program Directors & Training Standards Committee, Education Committee, and Online Education Core Curriculum Subcommittee, as well as many fellows-in-training SCAI members, the FIT Portal will allow fellows to securely document their cases and export them for certification and credentialing, navigate high-quality educational content and access career development opportunities. Program Directors can access the FIT Portal to assign lectures and monitor fellows’ activity. We anticipate that the FIT Portal will soon be the single source for fellows to access the latest information in the field of Interventional Cardiology. Please log on today www.SCAI.org/FIT.

As I write, I am approximately one month into my term as SCAI President. I am both excited and honored to serve the Society and all of you. Throughout the year ahead, I hope you will contact me with your comments on our work and your ideas for the future. Reach me anytime at president@SCAI.org.

Best regards,

Charles Chambers, MD, FSCAI
SCAI 2014–15 President

ACKNOWLEDGMENTS

We thank the following companies for their support of the FIT Portal:

Platinum: The Medicines Company
Gold: Abbott Vascular, Medtronic, Boston Scientific
Silver: AstraZeneca
Bronze: St. Jude Medical

We gratefully acknowledge this support while taking sole responsibility for all content developed and disseminated through this effort.
As a specialty, interventional cardiology is known for leadership in innovation, forging new paths to improved patient care for nearly forty years. So it’s no surprise at the high level of interest and curiosity from SCAI members at SCAI 2014’s session dedicated to Google Glass technology. Members packed the session titled “Applications of Google Glass to Improve Outcomes in Interventional Cardiology,” moderated by Barry Uretsky, MD, MSCAI, to learn what Google Glass is, how it works and how it may improve medical care.

Google Glass is a wearable computer developed by Google with the mission of bringing hands-free technology to the public. Worn as a headset similar to eyeglasses, the Google Glass device displays smartphone-like information and allows users to communicate commands with their voice. Among its current uses: making calls and sending messages, taking pictures, recording video, getting directions and sending messages. Currently unavailable to consumers, Google Glass users are part of its beta-testing program, “Glass Explorers.”

The session, featuring four speakers (Cecelia Abadie, Homero Rivas, MD, Christian Assad-Kottner, MD, and Heather Evans, MD) followed by a Q&A discussion, also covered how the technology is currently being used as a tele-mentoring tool as well as the challenges and opportunities physicians and their teams face as they implement it in practice. Specifically, speakers noted wifi security and HIPAA privacy concerns, battery life of the device, leaded walls in cath labs affecting the device’s 4G signal and patient acceptance as challenges to effectively using Google Glass in practice. Despite these challenges, speakers were optimistic about the opportunities, such as increased access for remote and rural physician training and easy access to patient records and quality improvement tools as a procedure is taking place.

In an interconnected age where telemedicine and telemonitoring are playing an increasingly important role in education, training and improved patient care, Google Glass offers a new tool for interventionalists to explore as they continue to identify new and better treatment options for patients.

As more testing and development take place and third parties begin to create practical apps for optimal use of Google Glass, SCAI will continue to offer educational opportunities for members to bring the technology to their own practice.

>> Want to learn more about Google Glass? Want to share your ideas about the potential for use of Glass and other new technologies in medical care? Check out the Eye on Intervention blog by Jordan Safirstein, MD, FSCAI, at www.healio.com/EyeonIntervention.
healthcare environment, when CMS and other payers are profiling providers based on the costs of the services they deliver to beneficiaries. SCAI expects that payers will soon be calculating the costs of procedures performed by interventional cardiologists and comparing those costs to those for treatments provided by noninvasive cardiologists, potentially leading to unfair, “apples-to-oranges” comparisons of practice patterns and erroneous reporting of members as outliers.

“During our ongoing analysis of the healthcare landscape, we confirmed that being recognized as a separate and distinct specialty has been an important milestone for many fields,” said Wayne Powell, SCAI’s senior director for Advocacy and Government Relations. It also increases the specialty’s prominence and enhances its credibility.

NEXT STEPS FOR YOU & YOUR BILLING STAFF

What happens now? Soon Medicare’s Administrative Contractors (MACs) will be required to adapt their systems to accept the new interventional cardiology designation code. To be recognized by CMS as interventional cardiologists, physicians will need to re-submit their participating provider form to their MAC. As soon as these forms are available, SCAI will post complete information on www.SCAI.org.

“Please do not be intimidated by the length of the form,” stressed Mr. Powell. “Most members should already have a copy of this form on file and will simply need to change the specialty section.”

To sign up for updates on these developments or for assistance or clarification, contact Mr. Powell at wpowell@SCAI.org or 202.741.9869.

STAY TUNED FOR UPDATES

We invite you to check the SCAI website and read SCAI This Week for regular updates on achievements like this one and the activities of SCAI-PAC. To share your thoughts on advocacy issues, email Dr. Duffy at pld@nc.rr.com or Mr. Powell at wpowell@SCAI.org.

SCAI Rallies House of Cardiology Around MOC Reform

In response to member dissatisfaction with the American Board of Internal Medicine’s (ABIM) Maintenance of Certification (MOC) process, SCAI has formed a physician-led working group to develop an action plan to spur MOC reform.

“We believe that maintaining physician competence is of the highest importance,” explained Alan Yeung, MD, FSCAI, SCAI MOC Working Group chair. “It is the current process and products for facilitating maintenance of board certification that are not acceptable.”

Current ABIM MOC requirements are perceived by many interventional cardiologists as punitive, cumbersome, expensive and of little value to those who participate. SCAI is organizing an effort toward collective action by the House of Cardiology to recommend specific changes to the ABIM for MOC process reform. SCAI will recommend that MOC must be a value-add for those who engage in the process, and must not be a punitive measure. SCAI will also emphasize that professional organizations should play a direct, rather than supplementary, role in the creation and implementation of Part II and Part IV programs and products, especially in specialized areas such as interventional cardiology.

“Professional organizations are best positioned with the expertise to build the tools necessary to assess the knowledge and performance of their members,” said Dr. Yeung. “If the ABIM can efficiently integrate professional organizations into its MOC process, the result would be much more meaningful and successful.”

For more information about SCAI’s activity on this evolving issue, watch for emails from SCAI 2014–15 President Charles Chambers, MD, FSCAI, and read SCAI’s weekly e-brief, SCAI This Week.
SCAI Expands e-Learning Library with New TAVR Center, Transradial Education and More

This spring SCAI added three new CME options to its popular e-Learning Library, offering healthcare providers 24/7 access to high-quality continuing medical education on the hottest topics in invasive/interventional cardiology. The latest additions include –

• **The brand-new TAVR Center**, where members can access case reviews, summaries of key journal articles and a forthcoming CME curriculum for a broad audience of learners.

• **Transradial Interventional Program (TRIP) Online**, the online format for SCAI’s highly regarded live TRIP programs.

  • CME credit now available through Mastering FFR/IVUS Online.

  “There is such a steady stream of new information that all interventional cardiologists must understand and incorporate into our treatment strategies,” said Robert Applegate, MD, FSCAI, immediate past chair of SCAI’s Education Committee. “SCAI is supporting members’ educational needs with a variety of learning formats, including our online offerings, to provide members with the full landscape of any procedural area.”

**TAVR CENTER – ONLINE HOME FOR “ALL THINGS TAVR”**

SCAI’s TAVR Center, led by Editors James Hermiller, MD, FSCAI, and Kretan Mavromatis, MD, FSCAI, is a resource that heart teams will want to return to on a weekly, if not daily, basis, to catch up on the latest news, literature and case discussions in this rapidly expanding therapy.

“We set out with the goal of providing a valuable tool for anyone interested in TAVR, regardless of where you fall on the spectrum of care,” said Dr. Hermiller. “We believe we’ve exceeded our initial goal with a dynamic online home that consolidates all things TAVR.”

The TAVR Center also marks SCAI’s first step in developing a series of clinical interest sections on SCAI.org. The result will be an organized and relevant experience for healthcare providers who want to stay up-to-date on advances in specific areas of interest. SCAI is also creating additional, dedicated clinical interest sections on the larger fields of structural heart disease, coronary interventions, peripheral vascular disease and congenital heart disease.

**LIVE PROGRAMS – TAKE THEM HOME WITH YOU**

SCAI’s live programs – from TAVR sessions at SCAI Scientific Sessions to the regional TRIP series – no longer end when attendees depart for home. Now, thanks to SCAI’s e-Learning Library, live program content is accessible online. The TAVR sessions from the SCAI 2014 Scientific Sessions, for example, were captured and are being repurposed online, integrated into a cohesive online curriculum available through the TAVR Center.

“The end result will be an enduring CME product accessible to those unable to attend the live program,” said Ehtisham Mahmud, MD, FSCAI, chair of the SCAI Education Committee. “We are continuing to develop efficiencies in our educational options, both transferring our live programming content into an online format and filling gaps in information.”

SCAI is committed to developing online CME programs efficiently without sacrificing quality, said Dr. Applegate. “Our new processes enable us to build an online program swiftly,” he said. “As we expand and do this across the board, we’ll have extensive resources for all of our audiences, including fellows-in-training, cath lab team members and international members.”

TRIP Online is an example of how well this works. Content captured during live TRIP programs in 2013 have been repurposed online, offering those who did not attend the live program a high-quality online CME resource.

“We will continue to update TRIP Online with new educational content as it becomes available,” said TRIP Program Director Sunil V. Rao, MD, FSCAI. “Additions expected this year include presentations from the TRIP nursing symposium.”

TRIP Online and the TAVR Center join a rapidly expanding set of online educational options in the SCAI e-Learning Library, including Mastering FFR/IVUS Online; High-Risk PCI; Peripheral Vascular Disease and SCAI’s ongoing series of SCAI-Quality Improvement Toolkit webinars.

More information on the SCAI e-Learning Library can be found through www.SCAI.org/elearning.
EDUCATION UPDATE

INNOVATION, INTERACTION & INTERACTIVITY
The SCAI 2014 Program Committee, led by Dr. Morton J. Kern (shown here), combined members’ favorite meeting traditions, especially case-based learning, and incorporated non-stop opportunities for members to explore new innovations such as GoogleGlass (see p. 3), interact with one another and experiment with new modes for interactivity, including the highly praised meeting app and social media channels such as Twitter.

BOOT CAMP: WHERE THE BEST OF THE BEST FOCUS ON LEADERSHIP
SCAI’s inaugural Cath Lab Leadership Boot Camp attracted standing-room-only attendance and won top marks from participants. Attendees praised the meeting’s focus on issues facing the whole cath lab team, including conflict resolution and management strategies. Here, three members of Boot Camp’s steering committee, Drs. Peter Duffy, Ehtisham Mahmud, and Sunil Rao, debriefed after the Thursday session. Not shown are SCAI 2014-15 President Dr. Charles Chambers and Dr. Robert Applegate. At press time, they and other SCAI leaders had already begun planning future Boot Camp offerings. Stay tuned for details!
THE BEST OF THE BEST IN ABSTRACTS
SCAI congratulates the following oral abstract presenters, chosen as the Best of the Best:
FIRST PLACE to Vikas Singh, MD (shown here), for “Corevalve Transcatheter Aortic Valve Implantation Using the Novel Transcaval Approach: First in Man Experience”
SECOND PLACE to Kyung Woo Park, MD, for “1-Year Clinical Outcomes of a Randomized Controlled Trial Comparing Adjunctive Cilostazol versus Double Dose Clopidogrel After Drug-Eluting Stent Implantation: The HOST-ASSURE Trial”
THIRD PLACE to Nileshkumar Patel, MD, for “Impact of Annual Operator Volume on Percutaneous Coronary Intervention Outcomes in High-Risk Subgroups in the United States: A Five-Year Contemporary Experience (2005 to 2009)”

A FAMILY EVENT: DAUGHTER AND DAD LEARN TOGETHER AT SCAI 2014
Drs. Rita Mukerji and her father, Vaskar Mukerji, attended SCAI 2014 together. To the best of their knowledge, they are the only father–daughter interventional cardiologists in the United States.

BEST OF THE BEST IN MEDIA COVERAGE
Approximately 20 reporters from key cardiovascular and medical trade outlets generated significant articles, covering key science and data presented at SCAI 2014. Working from the home base of the SCAI 2014 Newsroom or its online counterpart, reporters attended sessions and interviewed attendees, both on camera and off. The result: dozens of original articles, hundreds of thousands of Twitter accounts reached and millions of impressions.

SALUTING THOSE WHO SERVE
SCAI members were honored to teach and learn alongside leaders in military medicine in two new sessions: Military Medicine: Current State of Interventional Cardiology in the Armed Services and Affiliates (shown here) and VA Interventional Cardiology at SCAI.

ACKNOWLEDGMENTS
SCAI thanks the following industry partners for their generous educational grant support of the SCAI 2014 Scientific Sessions while taking sole responsibility for all content developed and disseminated through this event.
Platinum
Abbott Vascular
Boston Scientific
Silver
AstraZeneca
Medtronic
Bronze
Cook Medical
Cordis, a Johnson & Johnson Company
Covidien
Gilead Sciences
St. Jude Medical, Inc.
Terumo Interventional Systems
The Medicines Company
SCAI also appreciates the educational grant support provided by Spectranetics.
SCAI thanks the following industry partners for their generous support of the SCAI 2014 Interventional Fellows Complex Coronary Complications (C3) Summit:
Abbott Vascular
Cordis, a Johnson & Johnson Company
Medtronic
ZOLL
Innovating in Pediatric Interventional Cardiology: Dr. James E. Lock Outlines Strategies for Success

“Innovation very commonly marries seemingly unrelated topics.”

So began the SCAI 2014 Mullins Lecture by James E. Lock, MD. Highlighting the need for physicians to think creatively to develop effective treatments for congenital heart disease, Dr. Lock explained that despite life-saving advances in cardiology in recent decades, the field of pediatric interventional cardiology faces an uphill battle as it seeks to overcome obstacles to treat congenital heart defects in young patients.

To address the key challenge of clinical trial enrollment thresholds, for example, Dr. Lock emphasized the need for new legislation that expands how the U.S. Food and Drug Administration (FDA) evaluates new devices to include a category of studies that includes fewer patients. Trials for adult treatments can easily include the required 4,000-patient minimum to be studied for safety and efficacy, while trials on pediatric treatments simply cannot achieve such volume. As a result, innovation in pediatric interventional cardiology typically requires evolving and adapting adult treatments and methods for children’s hearts.

Dr. Lock faces these challenges daily as cardiology chairman at Children’s Hospital Boston and the Alexander S. Nadas Professor of Pediatrics at Harvard Medical School. He developed a step-by-step innovation process for “safe and successful firsts,” or first-time use of treatments:

- **Review all the available literature.** Don’t discount the older data as it often offers the best insights.
- **Use animal models judiciously.** Be sure the models are as relevant as possible to the patients needing treatment.
- **Consult widely with other providers,** both to hear varying perspectives and to spread the word about your efforts.
- **Make a list of possible uses for the innovations you are considering.** Determine the best uses cautiously.
- **Use extreme care when choosing your first patient.** Patients who have other treatment options are typically not the best choice for first-time use of an innovative treatment.
- **Seek and identify peer review for approval of your treatment choice** based on the individual patient. Patient-generic peer review does not work in extremely complex pediatric cases.
- **Conduct a thorough mock drill** to identify the hurdles your team may face during the procedure and determine solutions.
- **Succeed.** Do everything you can to ensure the first procedure goes well. When first-time treatments go awry, the likelihood of second tries is slim.
“Because Children Are Not Just Small Adults,” SCAI Unveils Pediatric SCAI-QIT

During SCAI 2014, the Society’s Congenital Heart Disease Council launched Pediatric SCAI-QIT, a new quality improvement toolkit designed to meet the needs of structural/congenital interventional cardiology teams and their patients.

Pediatric SCAI-QIT Chairs Henry Justino, MD, FSCAI, and Kalyani Trivedi, MD, FSCAI, encouraged members to use the toolkit’s modules to address their own quality concerns. Each module provides a specific and detailed bibliography of resources on pediatric care, numerous web links for easy access to online resources, information on and access to registries, and benchmarking information.

“Children are not simply small adults,” said Dr. Justino. “Just as pediatric care requires a dedicated approach, pediatric quality improvement requires specific tools and resources tailored to the unique medical needs of children.”

Pediatric SCAI-QIT can be accessed at www.SCAI.org/PEDQIT. For more coverage on Pediatric SCAI-QIT, including tips for using its modules, don’t miss the next issue of SCAI News & Highlights.

PEDIATRIC SCAI-QIT AT A GLANCE

Pediatric SCAI-QIT currently includes four modules, available for download one at a time or all at once, depending on the needs and goals of cath lab teams.

1. Procedural Quality
2. Catheterization Conferences
3. Procedural Checklists
4. Radiation Safety

The toolkit will be updated by a team of physician authors to ensure the latest quality standards are included, with additional modules expected to reflect growth in the field.

SCAI’s publications pipeline continues to yield a steady stream of documents that define the standards for patient care and physician training.

Published during SCAI 2014:
The first in series of four consensus documents on interventional procedure for treatment of peripheral artery disease, spearheaded by the Society’s Peripheral Vascular Disease Committee. Watch the video, featuring Committee Chair Michael Jaff, DO, FSCAI, and Christopher J. White, MD, MSCAI, here: http://bit.ly/1ifvGxK

A new expert consensus statement on advanced training for interventional cardiologists who wish to perform pediatric and congenital heart disease interventions. Watch senior author Robert N. Vincent, MD, FSCAI, on video here: http://bit.ly/1yrZzj4

For more SCAI 2014 video highlights, visit SCAI TV: http://bit.ly.1kHXryL.
LESSON 1: BUILD UNDERSTANDING

New York’s Medicaid policymakers misunderstood the purpose of the AUC, said SCAI Past President Gregory J. Dehmer, MD, MSCAI, who has served on multiple AUC-writing committees. “The 2012 Update states AUC are not to be used as a method to determine payment. The AUC are intended as a quality improvement tool.”

Unfortunately, the AUC that are currently in place for revascularization still use the term inappropriate to describe a minority of procedures and will be replaced in future versions by the term rarely appropriate, said Dr. Dehmer. Non-clinicians and those unfamiliar with the AUC process have misunderstood what the term inappropriate means within the context of the AUC process. For that reason the new term, rarely appropriate, is a better characterization of the clinical situation. Most policymakers don’t understand that six clinical domains guide the AUC; that these six domains couldn’t possibly take into account all of the clinical factors, including age, comorbidities and patient preference; and that physicians examine each patient’s entire clinical situation.

“A procedure that appears inappropriate according to the AUC can be appropriate when the entire clinical picture is considered,” said Dr. Duffy. “Similarly, a case that appears to be appropriate by the AUC may be inappropriate for a given patient. The challenge, in New York and elsewhere, is conveying that information to policymakers and payers.”

LESSON 2: COMMUNICATE AND COORDINATE

“If proposed policies in your state appear detrimental, share your concerns with SCAI,” said Srihari S. Naidu, MD, FSCAI, who was among a group of SCAI members and staff who traveled to Albany to meet in person with the state’s Medicaid team. “National associations may not hear about proposals in every state, so members need to share the information to garner support.”

When SCAI requested a face-to-face meeting between New York officials and SCAI and ACC representatives, the State’s policymakers recognized that the organizations represent thousands of cardiologists. “National organizations have the clout to schedule a meeting with state officials,” said Dr. Naidu. “The State realized that SCAI and ACC are at the forefront of developing quality improvement tools, which makes the associations powerful allies.”

When it comes to advocacy issues, especially situations like the one in New York, where the policy was already being enacted, mobilizing swiftly is key. “The sooner you contact SCAI, the better,” said Dr. Duffy. “Knowing the whole story and being able to promptly notify state and local policymakers about concerns gives SCAI time to understand the situation.”

LESSON 3: STAY EDUCATED AND ALERT

In SCAI, members have a partner to work with, but local physicians are the Society’s eyes and ears, added Dr. Duffy. “Educate yourself about what’s going on nationally and at the state level. We need the on-the-ground experience and insights of local members and their input on how to approach the situation at the local level.”

Members are the Society’s legs, too, added Dr. Naidu. “There’s
nulling more powerful than a busy physician who represents a large number of other physicians traveling to meet policymakers on their own turf to discuss their concerns,” he stressed.

LESSON 4: DETAIL CARDIOLOGISTS’ CONCERNS AND STRIVE FOR A POSITIVE MESSAGE

“Advocacy is a balancing act,” said Wayne Powell, SCAI’s senior director for Advocacy and Government Relations. “Recognizing that policymakers and cardiologists both want to deliver appropriate care for all patients is key to an effective relationship.”

The New York proposal was frustrating, said Dmitriy N. Feldman, MD, FSCAI. “When we traveled to Albany, we focused on educating, rather than battling, policymakers and started by outlining several concerns about the state’s proposal:

- Patients could be denied medically necessary care and ultimately harmed by implementation of the policy. While the committee’s goal was to curtail overuse, they hadn’t thought through how their policy could lead to underuse of PCI among underserved patients.
- The state had not developed a collaborative process to help physicians understand the proposal prior to its planned implementation.
- The state had not developed an appeals process, and it appeared that they planned to take back money before any appeal could be considered, let alone a process that would draw on the expertise of practicing interventional cardiologists.

“We identified the main concerns relevant to this issue in a constructive, respectful way that represented the wish of the state to practice value-driven medicine,” recalled Ajay Kirtane, MD, FSCAI, who initially brought the issue to SCAI’s attention.

In other words, advocacy is best approached as a bi-partisan effort, where everyone is focused on a shared goal of improving patient care. In New York, the advocacy group focused on common ground with the state Medicaid program, namely that neither physicians nor policymakers want inappropriate procedures being performed.

“It’s incumbent on us to be the trusted organization – by being strong advocates for our patients and our members, always in support of our colleagues’ efforts to provide exemplary care in cardiovascular medicine,” added Dr. Duffy.

LESSON 5: THINK BROADLY AND ENGAGE

“We aren’t sure how widespread the desire is to create regulations like these,” said Dr. Duffy. Although the New York proposal was limited to Medicaid patients, SCAI is concerned that implementation of such a policy could lead to similar proposals affecting Medicare patients and those covered by third-party payers.

“There could be a domino effect,” Dr. Duffy continued, as he urged cardiologists to become involved.

For more information about this issue and how to get involved with SCAI’s advocacy program, visit www.SCAI.org/Advocacy or email Wayne Powell at wpowell@SCAI.org.
SCAI’s Quality Improvement Apps Boost AUC Scores, Support Discussion About Risk

Since coronary revascularization appropriate use criteria (AUC) were released, hospitals across the country have worked to improve their AUC scores. Now two busy cath labs have achieved real-world success using SCAI’s quality improvement tools. One of the most helpful: SCAI’s easy-to-use software app that transforms the 25-page AUC document into simple dropdown menus and, with just a few mouse clicks, provides real-time information to help interventional cardiologists determine whether a PCI would be considered appropriate.

“The key to success for Baptist Health was the SCAI online AUC app is great,” said Nanette Jackson, director of cardiovascular services for Baptist Health in Lexington, Ky., who reported on the AUC project at the SCAI 2014 Scientific Sessions. “You get immediate feedback and can decide where you need to go from there.”

The coronary revascularization AUC app is part of SCAI’s Quality Improvement Toolkit (QIT), which also includes two new PCI risk assessment tools and a forthcoming app for the diagnostic cardiac catheterization AUC.

“The goal of all of these apps is to allow clinicians to assess the appropriateness and risks associated with a procedure. Doing that more accurately and consistently not only improves the quality of the care we deliver, it allows us to have a more informed discussion with the patient,” said Kalon Ho, MD, FSCAI, director for quality assurance in the Cardiovascular Division at Beth Israel Deaconess Medical Center in Boston, vice-chair of SCAI’s Quality Improvement Committee and the architect of several of SCAI’s quality improvement tools.

NEW APP-ROACH TO AUC YIELDS REAL-WORLD SUCCESS

In 2011, Baptist Health took a look at its initial AUC scores and realized that—like many health systems—it had a big problem. Only about one in four PCI procedures was deemed appropriate. So they got to work, and over about a two-year period, more than doubled that number.

The key to success for Baptist Health was coming up with new cath-lab processes that seamlessly incorporate the revascularization AUC app and the information it provides, Ms. Jackson said. Today physician assistants in the patient prep area fill out a data form with all of the clinical information needed for the online AUC calculator. That form goes to the cath lab, where staff input the information into the AUC calculator using a hyperlink that Baptist Health incorporated directly into the cath lab’s structured reporting system. They then print out a chart-ready Revascularization AUC Data Reporting Sheet, which lists AUC rankings individualized for each patient.

AUC results are monitored weekly, and immediate feedback is sent to interventional cardiologists by email. Physicians also receive scorecards with information on their performance and that of the department overall. By early 2014, this program resulted in 62.1 percent of PCI cases being rated appropriate, more than double the 2011 starting point of 27.7 percent.

Beth Israel Deaconess Medical Center in Boston instituted a similar procedure, with cardiology fellows entering each patient’s clinical information in the online AUC calculator before the cardiac catheterization procedure and posting the print-out in the cath lab. After PCI, the fellows enter the angiographic findings to come up with a final AUC rating. SCAI 2014 featured an abstract by cardiology fellow Stuart Chen, MD, who reported on Beth Israel Deaconess’s use of the AUC calculator in 308 consecutive elective PCI procedures. The result: 63.6 percent of cases were rated appropriate; 25.6 percent, uncertain; and 0.6 percent, inappropriate. Another 10.1 percent of cases were not rated, because the AUC did not include a suitable clinical scenario.

STAYING AHEAD OF LEGISLATION: NEW MANDATES FOR AUC, CLINICAL DECISION SUPPORT TOOLS

Recent legislation may offer additional reasons for interventional cardiologists to incorporate AUC apps into everyday practice. In March, Congress passed the latest “patch” to the sustainable growth rate (SGR) formula, which would have otherwise mandated a significant cut in Medicare physician payments. Woven into the patch were provisions requiring the use of AUC and clinical decision support tools for advanced diagnostic imaging studies.

Beginning in 2017, Medicare claims for advanced imaging studies will not be paid unless such tools are used. AUC must be developed or endorsed by professional medical societies, and clinical decision support software must be available free of charge, according to the new legislation.

For now, diagnostic cardiac catheterization does not fall within the legislative definition of advanced imaging, said Dr. Ho. However, invasive imaging studies could be subject to this type of mandate in the future, or assessment of appropriateness may be required by some private payers.

“The concept is out there, and it’s embedded in law,” Dr. Ho said. “SCAI is getting ahead of the game. We’re providing AUC and other decision-support tools that comply with the letter and spirit of healthcare reform. We want to help members to do the right thing.”
NEW RISK ASSESSMENT APP-TITUDE

SCAI’s new PCI risk assessment apps draw on different data sources, both allowing physicians to enter pre-procedural clinical information and receive an estimate of PCI-related risks. They can be accessed at www.SCAI.org/QIT and are available in formats compatible with smartphones, tablets, laptops and PCs.

- **Click on “PCI Risk Calculator App”** for a tool developed in collaboration with the Blue Cross and Blue Shield of Michigan Percutaneous Coronary Intervention Quality Improvement Initiative (BMC2 PCI). This app estimates the risk of mortality, contrast-induced nephropathy and transfusion.
- **Click on “PCI Risk Assessment Tool”** for models developed using data from the National Cardiovascular Data Registry (NCDR) CathPCI Registry, the Massachusetts Data Analysis Center (Mass-DAC) and the DELTA Network. It predicts the risk of in-hospital mortality, significant bleeding, vascular injury, kidney injury, need for dialysis, repeat revascularization, and 30-day hospital readmission. In addition to web-based formats, it is available as an Excel spreadsheet, which can be used to create graphs that may help patients understand their risks.

Dr. Ho said he foresees cardiologists using the new apps at the bedside, in the cath lab and in the office before sending patients for procedures.

“The goal is to facilitate discussions with patients and improve shared decision-making,” he said. “Until now, cardiologists have not had tools for predicting risk in an easy way. Now they do.”

ACKNOWLEDGMENTS The SCAI-Quality Improvement Toolkit was developed with founding support from Daiichi-Sankyo, Inc. and Lilly, USA, LLC, and support from AstraZeneca. The PCI Risk Calculator App was supported by The Medicines Company. The Society gratefully acknowledges this support while taking sole responsibility for all content developed and disseminated through these efforts.
You've finished your interventional fellowship year(s). You may have been the rock star of your class, but now you are the small fish in a big pond. How will you succeed? How will you get through that all-important first case? Here are some suggestions compiled from the experiences of SCAI's Interventional Career Development Committee:

1. **CHOOSE AN EASY CASE.**
   Make sure that the patient is “Appropriate” on all counts (diagnostic and therapeutic). Avoid an ad hoc procedure. The SCAI website has many tools to help you. No matter how green you are, if you pick a low-risk case, you are more likely to have a great outcome. Don’t set yourself up for failure.

2. **KNOW YOUR PATIENT, AND MAKE SURE YOUR PATIENT KNOWS YOU.**
   This recommendation cannot be overemphasized. Having a good, established relationship with the patient is a huge confidence-booster. Your patient’s apprehension is terrible for confidence levels in the room. Talk to the family, explain the procedure and be candid. If a patient looks uncertain or asks for another cardiologist or opinion, let him or her go. There will be many more. The majority of patients would rather have you – the physician who knows them – than someone else.

3. **PLAN YOUR CASE.**
   Set up your case well in advance. Make sure you have all of the equipment you need. Meet with your cath lab manager to review requirements. Schedule it to avoid administrative or clinical conflicts. Stress caused by delays hurts confidence. Remember, everyone will be fine with you being slow as long as your patient does well and the case goes smoothly. Make sure you set aside time to talk with the patient and the family, both before and after the procedure.

4. **WHO NEEDS A MENTOR?**
   Everyone needs a mentor. Never hesitate to call upon a colleague to assist or advise you when you struggle. If you call a colleague for help or mentoring, it is courteous to offer the RVUs or the billing on the case, because your colleague is giving up the time to be with you. Many will decline, but the offer will be appreciated.

5. **TAKE CONTROL.**
   As a fellow, you hated the “hands-on” attending who wouldn’t let you touch anything. Nevertheless, most would agree that for
your first 20–50 cases you must control every aspect of the case. At the end of the day, it doesn’t matter who makes the mistake(s), the patient is YOURS. Physician assistants and technicians are often more understanding and usually will let you take control. They are a useful resource with helpful hints and ideas in tough situations.

6. ACCESS, ACCESS, ACCESS.

Everything we do in interventional cardiology and endovascular medicine is predicated on vascular access. Even though it is only the gateway, vascular complications are irritating, frequently dangerous and usually avoidable. Be careful and meticulous with access management: site selection, access technique, procedural access monitoring and post-procedure hemostasis.

7. IF EVERYTHING IS GOING DOWNHILL … FAST!

So you’re doing everything by the book, but things are looking bad. The patient is unstable. You are not sure what to do, and everyone is looking at you for answers. First, calm down and take a breath. Call for help! There is no shame in getting help from a colleague. Make sure your vascular access is stable. Do not pull back any guidewires. Go over the ABCs. If resuscitation is needed, start ACLS. If not, start corrective measures, stabilize the airway, get venous access for pressors, IABP, pacemaker, etc. If you think a surgeon might help, get vascular/cardiac surgery. In many instances, additional imaging – echo and vascular ultrasound – can be lifesavers. Despite how bad things might seem, in the vast majority of cases, you and your patient will pull through – just keep your cool.

8. SHARE SUCCESS.

You are ecstatic that your first case was a resounding success. Be humble, and thank your team.

9. DEAL WITH FAILURE.

Occasionally, despite everything, you will not be successful. Accept responsibility. Thank the team for their help. Be open to suggestions and criticism. Speak directly to the patient and family about the outcome and why things did not work out as planned. Do not delegate or postpone this responsibility.

10. REMEMBER – IT’S ALL ABOUT THE PATIENT.

As long as you have the patient’s best interests at heart and have performed the case to the best of your ability, you will be at peace. Approach each patient the same way you would want the cardiologist to treat someone you love.

No matter how talented you are, the outcome of your case will depend on the confidence levels of your patient, your team and, most importantly, you. Confident people make better decisions. Over- and under-confidence are often precursors of aggressive or desperate decisions and poor outcomes. Ensuring that safe, appropriate procedures are performed with integrity will ensure that your first case (and every subsequent one) will be a success. We wish you the best of luck as you join us as interventional cardiologists.

Dr. Mitul Kadakia
Receives 2014 Braden Fellow of the Year Award

At the SCAI 2014 Annual Reception, Mitul Kadakia, MD, an interventional cardiology fellow at the Hospital of the University of Pennsylvania, received the 2014 Gregory Braden Memorial Fellow of the Year Award.

Dr. Kadakia received his undergraduate and medical degrees from Harvard University and completed his residency at Brigham & Women’s Hospital and cardiology fellowship at the University of Pennsylvania. Already well-published, he has performed more than 350 coronary interventions and 100 structural procedures as a fellow, and is recognized among colleagues for his skill, sound judgment and quality patient care. Following his fellowship he will join Cardiovascular Consultant Medical Group/Stanford University Health Alliance in San Francisco.

The Gregory Braden Memorial Fellow of the Year Award is given annually to one outstanding interventional cardiology fellow-in-training. Candidates are evaluated based on their interventional cardiology skills, contributions to cardiovascular research, published articles and promising future in interventional cardiology.

The award is sponsored through a fund established at the Forsythe Medical Center in Winston-Salem, N.C.
Why Be Anywhere Else?
Dr. Ted Bass Unveils New Video on Value of Interventional Cardiology

SCAI 2013–14 President Ted A. Bass, MD, FSCAI, kicked off SCAI 2014 with a new video highlighting SCAI’s ongoing commitment to quality improvement. Featuring a number of SCAI members and their patients, the video set the foundation for the meeting and showcased SCAI’s core values, rooted for nearly 30 years in education, advocacy and, of course, quality.

“If you haven’t seen the SCAI video, log on to SCAI.org today.”

“The video demonstrates who we are as a profession and as a Society,” said Dr. Bass. “It’s a testament to the work we do and our commitment to our patients. And it is an invitation to get involved as SCAI tackles the challenges of today’s rapidly evolving healthcare environment.”

SCAI WELCOMES NEW TRUSTEES
SCAI is pleased to welcome the following Fellows to the Board of Trustees.

SCAI thanks the following Fellows whose terms as Trustees or Executive Committee members ended in May 2014. Their service to the Society is gratefully acknowledged.

SCAI Honors Dr. Christopher J. White for Distinguished Service

At SCAI 2014 in Las Vegas, the Society thanked Christopher J. White, MD, MScAI (right), for distinguished service to the Society and Invasive/Interventional Cardiology. Dr. White served two terms as editor-in-chief of SCAI’s journal, Catheterization & Cardiovascular Interventions, overseeing a period of tremendous growth marked by its rising impact factor, expanding subscriptions and appreciation by readers and societies both in the United States and internationally. Dr. White served as 2010–11 President of SCAI. During his tenure, the SCAI Quality Improvement Toolkit (SCAI-QIT) was launched. Here, SCAI 2013–14 President Ted A. Bass, MD, FSCAI (left), presents Dr. White with the Society’s highest honor, the F. Mason Sones, MD, Distinguished Service Award.
On Friday, May 30, the inaugural class of Master Interventionalists of SCAI (MSCAI) was announced as part of SCAI 2014 activities.

The new designation, MSCAI, recognizes outstanding members of SCAI who are nominated by their peers for having demonstrated excellence over the course of their careers and for their commitment to the highest levels of clinical care, innovation, publication and teaching. Up to 20 new Master Fellows will be recognized each year. Please join us in recognizing the 2014 Master Interventionists of SCAI:

Joseph D. Babb, MD, MSCAI
Steven R. Bailey, MD, MSCAI
Peter L. Block, MD, MSCAI
Antonio Colombo, MD, MSCAI
Michael J. Cowley, MD, MSCAI
Larry S. Dean, MD, MSCAI
Gregory J. Dehmer, MD, MSCAI
Ted E. Feldman, MD, MSCAI
Ziyad M. Hijazi, MD, MPH, MSCAI
Morton J. Kern, MD, MSCAI
Charles E. Mullins, MD, MSCAI
Carlos E. Ruiz, MD, PhD, MSCAI
Carl L. Tommaso, MD, MSCAI
Zoltan G. Turi, MD, MPH, MSCAI
Barry F. Uretsky, MD, MSCAI
George W. Vetrovec, MD, MSCAI
Bonnie H. Weiner, MD, MSEC, MBA, MSCAI
Christopher J. White, MD, MSCAI

Do You Think Your Colleague Deserves to Be an MSCAI?
Nominate Your Colleague TODAY!
For more information, please visit www.SCAI.org/MSCAIAplication
Nomination Deadline: October 31, 2014

SCAI congratulates the first class of Master Interventionists of SCAI.

Inaugural Class of MSCAI Inducted

SCAI 2014 Tweets

Dennis Kim @DennisWKim
Tom Forbes leading a band of musketeers to improve congenital heart disease therapies. All for one and one for all #CCISC #scai2014

lyndon box @BoxLyndon
Loving SCAI 2014. It’s like being at Spacecamp for an interventional cardiologist at #SCAI2014

Christian Assad, MD @ChristianAssad
#Scai2014 using Twitter is easy if you follow one simple rule. Don’t tweet anything u would not say in front of 1k people

Patrick Hoier @patrickhoier
TAVR therapy: Cardiology vs. Surgery...Who is your gate keeper for patient selection? Question most programs still struggle with #Scai2014

Jeffrey Cavendish @JCavendishmd
#Scai2014 DES for everyone? Nobody ever gets a BMS? I am not sure about that...

Pradeep Natarajan @pnatarajendmd
The PRAMI trial continues to challenge widely-held views re: non-culprit PCI dlvr.it/5qYwdd by @ShellyWood2 @theheartorg #scai2014

Chase Wasson @Chase_Wasson
“@CardiologyToday: Smokers more vulnerable to arterial plaque ruptures goo.gl/Xgvhph #scai2014” #NIRS scan of arteries beneficial?

Cardiology Today @Cardiology Today
Earlier today: Radial access for PCI after STEMI lowered risk for bleeding, transfusion goo.gl/a3tifs

MedPage Today @medpagetoday
Long list of potential Google Glass applications counterbalanced by long list of implementation obstacles #Scai2014 bit.ly/1tU3z8X
AUGUST 2014

– AMPUTATION PREVENTION SYMPOSIUM (AMP)
  Date: Aug. 14–16, 2014
  Location: Chicago, IL
  Director: Jihad A. Mustapha, MD, FSCAI
  For more info: www.amptheclimeeting.com

– ACCF/SCAI PREMIER INTERVENTIONAL CARDIOLOGY OVERVIEW AND BOARD PREPARATORY COURSE
  Date: Aug. 22–24, 2014
  Location: Amelia Island, FL
  Directors: Larry S. Dean, MD, MSCAI, FACC, and Frederick G.P. Welt, MD, MSC, FACC, FSCAI
  For more info: www.CardioSource.org/intvboard2014

SEPTEMBER 2014

– SCAI CHRONIC TOTAL OCCLUSION REGIONAL TRAINING PROGRAM—MIAMI
  Date: Sept. 26, 2014
  Location: Miami, FL
  Directors: David Kandzari, MD, FSCAI, and William Lombardi, MD, FSCAI
  For more info: www.SCAI.org/CTOMiami

– SCAI TRANSRADIAL INTERVENTIONAL PROGRAM (TRIP)—MIAMI
  Date: Sept. 27, 2014
  Location: Miami, FL
  Directors: Samir Pancholy, MD, FSCAI, and Sunil V. Rao, MD, FSCAI
  For more info: www.SCAI.org/TRIP

OCTOBER 2014

– SCAI-FORTIS FELLOWS COURSE
  Date: Oct. 2, 2014
  Location: New Delhi, India
  Directors: Ashok Seth, MD, FSCAI, and Michael J. Cowley, MD, MSCAI

– THE VEINS 2015
  Date: Oct. 9–12
  Location: Chicago, IL
  Directors: Raghur Kolluri, MD, FSCAI, and Gregory Mishkel, MD, FSCAI
  For more info: www.theveins.org

NOVEMBER 2014

– SCAI TRANSRADIAL INTERVENTIONAL PROGRAM (TRIP)—LOS ANGELES
  Date: Nov. 15, 2014
  Location: Los Angeles, CA
  Directors: Rajiv Gulati, MD, PhD, FSCAI, and Samir Pancholy, MD, FSCAI
  For more info: www.SCAI.org/TRIP

– SCAI CHRONIC TOTAL OCCLUSION REGIONAL TRAINING PROGRAM—LOS ANGELES
  Date: Nov. 16, 2014
  Location: Los Angeles, CA
  Directors: David Kandzari, MD, FSCAI, and William Lombardi, MD, FSCAI
  For more info: www.SCAI.org/CTOLosAngeles

DECEMBER 2014

– SCAI 2014 FALL FELLOWS COURSES
  Date: Dec. 7–10, 2014
  Location: Las Vegas, NV
  Directors: Zoltan G. Turi, MD, MSCAI, Jonathan M. Tobis, MD, FSCAI, John Lasala, MD, FSCAI, John P. Cheatham, MD, FSCAI, and Matthew Gillespie, MD, FSCAI
  For more info: www.SCAI.org/FallFellows

MAY 2015

– SCAI 2015 SCIENTIFIC SESSIONS
  Date: May 6–9, 2015
  Location: San Diego, FL
  Directors: Michael R. Jaff, DO, FSCAI, Roxana Mehran, MD, FSCAI, Robert Applegate, MD, FSCAI, Doff McElhinney, MD, FSCAI, and Jacqueline Kreuzer, MD, FSCAI
  For more info: www.SCAI.org/SCAI2015
Coarctation of Aorta: Coding Strategy for Congenital Case

Q: Which codes are applicable for repair of coarctation of aorta?
A: The short answer to this question is that this case would be reported with codes 33881, 93531, and 75957. To understand why, it is necessary to review a procedure description and summary of the angiography performed. Readers should note that, due to publication space limitations, only the basics from the real-world procedure report are presented. References to product names have been removed as appropriate. While accurate coding requires review of all procedure reports in their entirety, we have highlighted keywords that support the coding decisions discussed here.

BASIC PROCEDURE DESCRIPTION
1. Bilateral groins and the left radial artery area were prepped and draped in the usual sterile fashion.
2. Lidocaine 1% was used for local anesthesia. General anesthesia was administered by the anesthesia service.
3. Following use of micropuncture sets, a 6-French sheath was placed under fluoroscopic guidance in the right femoral artery, a 7-French sheath was placed in the left femoral vein, and we attempted access in the left radial artery; however, this was atretic.
4. Right heart catheterization was performed using a 7-French inside-out catheter. Left heart catheterization was performed using 5-French marker pigtail.
5. Temporary pacing was performed using a 5-French balloon-tipped pacing wire placed from the left femoral venous access site.
6. Rotational angiography of the aortic arch and descending aorta were performed using the 6-French catheter placed in the aortic root with simultaneous rapid ventricular pacing. 3D reconstruction was performed demonstrating an excellent view of the moderate severely coarcted segment in the descending aorta.
7. For stent delivery, the 6-French sheath in the right femoral artery was up-sized to a 12-French sheath.
8. A 36-mm endograft stent was placed using a 16 mm balloon-in-balloon system in the coarcted segment. Post-stent dilation was performed using an 18 mm balloon at low pressures.
9. The right femoral arterial access site was subsequently closed using 2 ProGlide systems. The 7-French femoral venous access sheath was removed under manual hemostasis.
10. At the end of the case, the patient was extubated for hemostasis.

SUMMARY OF ANGIOGRAPHY PERFORMED
Radial angiography, abdominal aortography, angiography in support of placement of the endograft

CODING INSIGHTS
The major therapeutic intervention performed is the placement of an endograft for repair of coarctation of aorta, which should be reported using code 33881.

33881 Endovascular repair of descending thoracic aorta (eg, aneurysm, pseudoaneurysm, dissection, penetrating ulcer, intramural hematoma, or traumatic disruption); not involving coverage of left subclavian artery origin, initial endoprosthesis plus descending thoracic aortic extension(s), if required, to level of celiac artery origin

(For radiological supervision and interpretation, use 75957 in conjunction with 33881)

Code 33881 is considered a “component-coded” service with catheterization, imaging, and most concomitant procedures separately reportable. Coarctation of the Aorta is considered a congenital defect; therefore, the congenital heart catheterization codes would be used to report the catheterization performed in conjunction with the endograft placement. Both a right and a left heart catheterization were performed, which would be reported using code 93531. If the catheterizations had not been advanced into the heart, the applicable peripheral catheterization codes (36140, 36200-36218) would be implicated.

93531 Combined right heart catheterization and retrograde left heart catheterization, for congenital cardiac anomalies

The patient’s condition and planned intervention were known prior to beginning the procedure. Based on the information available, it does not appear that any of the angiography described was for diagnostic purposes. Rather, all of the angiography reported appears to be associated with advancement and placement of the endograft. This work is captured by reporting the endograft-associated radiological supervision and interpretation (RS&I) code, 75957.

75957 Endovascular repair of descending thoracic aorta (eg, aneurysm, pseudoaneurysm, dissection, penetrating ulcer, intramural hematoma, or traumatic disruption); not involving coverage of left subclavian artery origin, initial endoprosthesis plus descending thoracic aortic extension(s), if required, to level of celiac artery origin, radiological supervision and interpretation

In summary, accurate coding for this case would use codes 33881, 93531, and 75957.

Do you have an interesting case you would like to have reviewed by SCAI’s coding experts? If so, remove all patient identifiers and submit a copy of the report to dhopkins@SCAI.org.
See You in Sunny San Diego!

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