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President's page

Advocate for Our Patients, Advocate for Our Profession

James C. Blankenship, MD, MHCM, FSCAI
2015–2016 President of SCAI,
Geisinger Medical Center, Danville, PA

Peter L. Duffy, MD, MMM, FSCAI
2015–2016 Vice-President of SCAI Chair, SCAI Advocacy and Government Relations Committee,
Reid Heart Center, FirstHealth of the Carolinas,
Pinehurst, NC

James C. Blankenship

Peter L. Duffy

Imagine yourself as a young interventional cardiologist, a year or two out of fellowship, just appointed to the Economics of Health Care Delivery Committee of a major medical Society. It is the young cardiologist's first committee meeting. Members are arguing about how the Society should cope with rapid changes in the health care system. Suddenly a senior member of the Society proclaims "Remember our patients. We need to focus on how to improve care of our patients". The young cardiologist is very impressed and decides that here is a cause worthy of his time and energy.

The year was 1989, the society was the American College of Cardiology (ACC), the elder statesman was Adolph Hutter Jr MD (then president-elect of the ACC), and the young cardiologist was one of the authors (JCB). That incident inspired my view of advocacy throughout his career, and Dr Hutter's words continue to remind my of why we should all be advocates.

Advocacy is a major activity and goal of SCAI, and SCAI devotes enormous resources to advocacy. But what does advocacy mean in healthcare, and specifically for SCAI?

The word "advocacy" comes from Medieval Latin *ad* ("to") + *vocare* ("to call"). The literal meaning is "to summon to one's aid", and a common definition is "to **support** or urge by argument; recommend publicly". The natural next question is "When used in the medical profession, what is advocacy supporting, and to what purpose?"

THE THREE TYPES OF ADVOCACY

The medical literature on advocacy describes 3 general types of advocacy. The first is advocacy for

*Address for correspondence: James C. Blankenship, MD, MHCM, FSCAI Department of Cardiology 27–75 100 N Academy Avenue Geisinger Medical Center Danville PA 17821 Phone 570-214-1991 Fax 570-271-8056 jblankenship@geisinger.edu

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specific patients or groups of patients [1,2]. Examples are patients who lack insurance or the resources to obtain medical care, such as children or the elderly. Patients with diseases that are perceived as needing additional resources, such as AIDS or breast cancer, are included here. The medical literature robustly debates the ethical obligation of individual physicians to advocate for their patients and whether such advocacy skills should be taught during medical school and post-graduate training [3–5].

A second type of healthcare advocacy, also for patients, is for making high quality services available to patients. Examples in this category include patient-centered decision making (promoting autonomy of patients), efforts to ensure appropriate availability and use of services, and efforts to improve the quality of care provided to all patients. All physicians have an ethical responsibility to advocate for patients in this way. Many would purport that physicians and other cardiovascular professionals are uniquely qualified to provide this type of advocacy, given our knowledge of clinical issues and the healthcare system, and our direct interactions with patients and families.

The third type of healthcare advocacy is not for patients, but for other stakeholders, such as medical professionals. This type of advocacy typically falls to professional medical societies rather than individual physicians. While medical societies have been accused of "differing from trade unions only in their sanctimoniousness" [6], professional societies generally balance advocating for patients and advocating for members [7–13].

Advocacy for physicians and other medical professionals can be viewed as indirect advocacy for patients, since challenges that healthcare providers face may translate into poorer care for patients [12]. This perspective has become more common, or at least more often verbalized, as the medical profession and its practitioners undergo rapid transitions that severely stress clinicians [10,14]. In this context, the need for advocacy for medical professionals, and perhaps for their patients, has become more apparent [14].

A TRADITION OF SCAI ADVOCACY

SCAI has a long tradition of advocacy for members. In 2001 SCAI, under the leadership of Dr. Joe Babb, formed the Advocacy and Government Relations Committee, initially chaired by a past president, Dr. Carl Tommaso [15]. The challenges identified then were strikingly similar to those we face today. SCAI's first advocacy committee focused on regulators in Wisconsin and Massachusetts with no medical knowledge writing policies that would dictate how interventional care was provided, a 23% decrease in Medicare-allowed charges for interventional procedures over the previous 4 years, and federal regulation of cardiac cath labs. Advocacy goals in 2001 were fair reimbursement for cardiologists, influencing federal and state regulation of interventional cardiology practice, facilitating FDA approval of new drugs and devices, and improving relations with legislators.

SCAI's advocacy efforts over the past decade have reflected the evolving need for a society focused on interventional cardiology to advocate for both patients and professionals [16,17]. Patient advocacy has been directed towards supporting the needs of individual patient groups (e.g., pediatric patients who often have no or limited insurance coverage, or patients who would benefit from new technologies such as TAVR) and ensuring that policies do not restrict patients' access to medically necessary care. Even greater advocacy efforts, often unrecognized as advocacy, have been directed toward improving outcomes and delivery of care for patients [18]. This concept produced the "real value equation" proposed by Duffy in which the value of a medical service is defined in part by the perceived value of the service to the patient [19].

SCAI'S CURRENT ADVOCACY

At present, SCAI's Advocacy and Government Relations Committee is chaired by Dr. Peter Duffy, assisted by co-chair Dr. Osvaldo "Steve" Gigliotti, SCAI Senior Director Wayne Powell and 26 SCAI members. The committee's mission is "to educate members, ourselves, and key stakeholders (legislators and their staff, government agencies, patients, and the general public) about policies and positions that directly and indirectly affect all aspects of interventional cardiology and to advocate for those positions as directed by the Executive Committee of SCAI." The committee meets by telephone monthly and face-to-face at the annual SCAI scientific sessions.

The pervasiveness of patient advocacy throughout SCAI is represented by the fact that at least 15 of SCAI's 30 committees work to improve the quality of patient care. For example, Drs Mike Jaff and Kenny Rosenfield of the SCAI Peripheral Vascular Disease (PVD) Committee recently led a coalition of societies that convinced CMS's coverage advisory committee to recommend coverage of PVD procedures. The Structural Heart Disease Committee is leading SCAI's advocacy efforts for appropriate approval of, payment for, and training in new structural heart procedures. SCAI's Quality Improvement Committee is evaluating and influencing the development of new quality measures for evaluating and compensating SCAI members. The

SecondsCount Editorial Board manages the SecondsCount.org website that provides information about cardiac diseases and treatment to over a million people each year.

RECENT SCAI ADVOCACY SUCCESSES

SCAI's advocacy efforts for interventional professionals have been too numerous to relate here, but include the following:

1. **Development of codes for new interventional procedures,** along with the best possible Medicare reimbursement and appropriate coverage policies. SCAI efforts have influenced the revision and revaluation of codes, when required by Medicare, that best preserve the ability of interventionists to deliver these services. This includes providing advisors to the American Medical Association (AMA) Current Procedural Terminology (CPT) Editorial Panel (Dr. Art Lee) and the AMA Relative Value Update Committee (RUC) (Dr. Cliff Kavinsky).
2. **Recognition of Interventional Cardiology as a unique medical specialty by CMS,** allowing payment for documented interventional cardiology consultations, and representation in the AMA House of Delegates by Dr. Joe Babb.
3. **Formation of a political action committee (PAC),** currently chaired by Dr. Tom Tu. Total contributions from members have topped $110,000. The PAC has dramatically increased SCAI's visibility on Capitol Hill and its ability to participate directly in federal policymaking. SCAI now routinely receives invitations from legislators and other advocacy groups, providing SCAI a seat at many tables in Washington where policies and legislation are discussed. Because Congressional Representatives now send drafts of legislation to SCAI for comment, we have been able to influence legislation before it is formally introduced to Congress. This level of influence has proved critical on key issues affecting SCAI members' ability to serve patients and optimize care. For example, in the recently enacted SGR repeal law, SCAI convinced Congress to reward physicians for participation in existing registries, rather than requiring enrollment in new registries (as had been required in drafts of the bill.).
4. **Advocacy for patients and interventionists at the state level,** most notably in California (Dr. Art Lee), Maryland (Drs. Mark Turco, Greg Dehmer and Charlie Chambers), New York (Drs. Dmitriy Feldman and Srihari S. Naidu), Oregon (Drs. Ed Toggart, Saurabh Gupta, David Lee, and Charles Cannan), and Washington (Drs Larry Dean and Steve Goldberg). SCAI has successfully advocated for changes in laws and regulations, preventing onerous restrictions on availability of interventional services to patients in these states.
5. **Advocacy for patients with private payers,** including Aetna, WellPoint and Blue Cross/Blue Shield to ensure patients have appropriate access to interventional procedures.
6. **In-person meetings with Members of Congress on Capitol Hill,** such as during annual Fly-Ins.
7. **Encouraging FDA approval of new interventional devices** (most recently with presentations to FDA panels by Drs. Art Lee, Zoltan Turi and George Vetrovec)
8. **Collaboration with other medical organization** to finally get the sustainable growth rate (SGR) regulations repealed and move Medicare toward fair payment for performance measures.
9. **Changes in the ABIM Maintenance of Certification Program** favorable for interventional cardiologists. SCAI played a major role in ABIM's decision to not require interventional cardiologists to also take general cardiology board exams.

THE FUTURE OF SCAI ADVOCACY

SCAI is updating its Strategic Plan [20]. Advocacy for both patients and professionals will play a prominent role. With the addition of non-physician cardiovascular professionals to SCAI, we are learning about a new set of concerns and challenges they face. SCAI will be adding these issues to our portfolio of advocacy issues as we move forward.

As SCAI anticipates the future, we see many advocacy issues on the near horizon:

1. **Continued emphasis on quality as a value that guides all aspects of SCAI's planning**. SCAI will continue to provide educational resources and support to help members provide the best possible patient care yielding the best possible outcomes.
2. **Continuing SCAI's patient education initiatives,** such as provided on SecondsCount.org under the guidance of the Editor-in-Chief Dr. Dennis Kim and Associate Editors Dr. John P. Reilly and Rena Silver.
3. **Refinement of current appropriate use criteria (AUC) for invasive/interventional procedures.** Development of AUC for new procedures is needed but should be contingent on appropriate use of AUC by all stakeholders. SCAI will continue to lobby against their use by regulators and insurers to determine coverage.

4. **Refinement of current guidelines that affect interventional cardiology services**. Revision of existing guidelines will be an ongoing process as guidelines become "living documents."
5. **Continued testimony to the FDA and other regulatory bodies** to influence approval of technologies that advance the field of interventional cardiology.
6. **Continued engagement at the state level** in regulatory and insurance issues.
7. **Identification of, and advocacy for, issues important to other cardiovascular professional members** of the interventional cardiology community. For example, SCAI is advocating for Registered Invasive Cardiovascular Professionals to preserve their roles in catheterization laboratories.

OPPORTUNITIES FOR MEMBER INVOLVEMENT IN SCAI ADVOCACY

SCAI welcomes participation by members in a broad array of advocacy opportunities. While SCAI's advocacy platform provides opportunities for all members to have a large and meaningful impact on the healthcare environment and on Interventional Cardiology policy in particular, some have suggested that it is especially appealing for early-career SCAI members, both physicians and other cardiovascular professionals. In contrast to most other areas of interventional cardiology, no one has formal training in advocacy, so the only requirements to participate in SCAI advocacy are enthusiasm and willingness to learn. Specific ways to get involved include the following:

1. Volunteer for the SCAI Advocacy and Government Relations Committee or the SCAI PAC Committee.
2. Notify SCAI staff (Wayne Powell at wpowell@scai.org)mailto: if you learn of problems with local/state laws or regulations affecting interventional care. (These can arise with little publicity or announcement, so it takes alert SCAI members to recognize an emerging problem.)
3. Develop personal relationships with local, state or national legislators. Learn how to do this by contacting PAC members or staff. Remember – these decision-makers really do want to hear from you!
4. Volunteer to participate in SCAI's CPT Panel Advisory or RUC Advisory groups.

If you have other ideas or want to volunteer, contact Wayne Powell (wpowell@scai.org)mailto: or Jim Blankenship (570-854-3712, cell) or President.SCAI@SCAI.org.

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