



The Society for Cardiovascular Angiography and Interventions

SCAI President's Page

Moving Forward: Results of the Strategic Planning Session

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I am delighted to report to you the results of the Society's strategic planning session held this summer. The meeting's purpose was to chart a course for the Society for the next few years. In preparation for this meeting of the Society's leadership and representative members, nine work groups were organized to develop formal written proposals to present at the meeting. Each work group was asked to formulate three concrete goals achievable over the next three years. These reports were presented to the assembly of nearly 50 participants, who then were asked to prioritize the eight most important goals. The final "white paper" was approved by the Society's Board of Trustees on October 20, 2005. The rest of this President's Page is the text of the Executive Summary of this document. It would be of great value to the Society if, after reading this summary, you would share with me any comments you have by e-mailing president@scai.org.

EXECUTIVE SUMMARY

Background

Founded by a core group of invasive cardiologists in 1978, the Society for Cardiovascular Angiography and

Interventions (SCAI; the Society) was originally dedicated to fostering quality in the cardiac catheterization laboratory. Since that time, the expansion of interventional cardiology has provided the opportunity for the Society to expand both its membership and its mission.

To ensure proper growth and direction, SCAI has organized formal efforts devoted to strategically planning the Society's future. The last such effort occurred in 1997. Since that time, the Society has evolved rapidly as an organization, doubling its membership, significantly expanding its CME offerings, and developing an advocacy function, among other major advances. By 2005, the time was ripe for a reappraisal of the Society's mission and goals to create a path for continued growth and achievement over the next 3–5 years.

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The strategic planning process developed to accomplish this task was divided into three phases:

Phase I: From January to June, the development of a set of “vision” documents by eight working groups, each convened virtually to discuss a major area of involvement by the Society:

- Advocacy
- Education — the Annual Meeting
- Education — All Activities except Annual Meeting
- Communications and Publications
- Society Growth, Globalization, and Membership
- Quality Standards, Guidelines, and Ethics
- Society Business Planning and Infrastructure
- Congenital/Pediatric Interventional Cardiology

Each group was asked to propose three major strategic initiatives within their topic area.

During the working group deliberations, it became apparent that one area was not being addressed. Therefore, a ninth topic area was added to the above list — to envision the Society's role in data registries and as an accreditation body.

Phase II: On July 29–30, a strategic planning summit was held in Bethesda, Maryland, as an in-person planning session for discussion and prioritization of all the working group vision documents and initiatives. At this meeting, the top eight proposed initiatives were selected. (Two initiatives were eventually combined to yield seven top initiatives.) This number was arbitrary and reflected the reality of limitations in personnel, money and time that might be devoted to such efforts over the next several months. The initiatives that received the highest priority will be initiated first, with concomitant knowledge that work will occur on the other initiatives at a later date.

Phase III: Development of final strategic plan with approval by the Board of Trustees (October 2005.)

The following section of the Executive Summary, titled “General Goals and Strategies,” offers statements that underlie the specific recommendations from each of the working groups. These were the consensus views reached at the strategic summit. “General Goals and Strategies” explicitly articulates the assumptions under which the specific strategic initiatives have been recommended.

General Goals and Strategies

- **SCAI Mission** — Reaffirm the original mission, but reinterpret it to apply to current practice:
“To promote excellence in invasive and interventional cardiovascular medicine through physician

education and representation and the advancement of quality standards to enhance patient care.”

- **Advocacy** — Pursue a proactive stance. This relatively new endeavor by the Society (only hinted at in the last strategic plan) began its work in a “reactive” posture. The current stance of the Society is to be proactive and lead, identifying regulatory and legislative issues that require Society input and action before they enter into the “crisis” mode or are shaped by other groups.
- **Congenital Heart Disease** — Pursue methods of solidifying the Society's position as the premier organization for interventional congenital heart disease (pediatric) cardiologists.
- **Annual Scientific Sessions** — Strengthening our national meeting is a high priority. The meeting represents the “face” of the Society. Efforts should be made to continue enhancement of the quality and attractiveness of the meeting in the face of increased competition.
- **CME Activity** — Educating the interventional cardiologist is a major priority of the Society and offers great potential for growth. Clarity of purpose and procedure as well as adherence to the Society's mission and to sound business principles are crucial elements in this growth process.
- **Society Growth, Globalization, and Membership** — The Society should primarily target growth to physicians, and not expand at this time to include other health care providers. The Society is viewed in most quarters as predominantly an American organization, but the opportunity exists to become a truly global society. In such a scenario, the terms “domestic” and “international” lose their meaning. SCAI should expand its efforts to create a global society with member interventionists in all countries, notwithstanding the practical and feasible issues of running a global organization.
- **Quality Standards, Guidelines, and Ethics** — The Society should lead the way in all three of these areas, each of which is central to the Society's mission. However, the specific path to achievement in each area is a subject of debate. At the Executive Committee level, leadership has stressed the importance of the Society participating in guidelines development related to interventional cardiology, even if generated by other organizations such as AHA or ACC. The working group on this topic recommended leading the way by developing “orphan guidelines,” or those guidelines related to interventional cardiology that are often overlooked by the larger organizations. It appears that the consensus of the Society is to be involved in the development of all guidelines

that are in some way related to interventional cardiology. Involvement might be in leading development efforts (e.g., orphan guidelines), co-writing guidelines (e.g., as it has with the revision of the PCI guidelines), or endorsing guidelines that, in part, relate to interventional activities (e.g., valvuloplasty and indications for coronary arteriography as part of the recent revision of the ACC/AHA guidelines on valvular disease.)

- **Registries and Accreditation** — The Society believes acquiring high-quality data on interventional procedures provides the basis for education and good patient care. SCAI wants to participate substantively in or lead development of data registries for various interventional procedures. Carotid stenting represents the reasonable next platform for involvement.

Patient outcomes in the performance of interventional procedures may be enhanced by the accreditation of facilities and individual operators. It seems reasonable that a physician-led effort, if properly undertaken, is an acceptable approach to accreditation. As CMS has mandated that institutions performing interventional procedures such as carotid

stenting be accredited, the Society believes that its involvement in accreditation of labs performing carotid stenting represents an important, relevant attempt in this area.

CONCLUSIONS

The 2005 strategic planning process accomplished two major goals. First, it provided a valuable framework for the Society's priorities over the next three years. Based on the planning process in 1999, it is likely that unforeseen events may shift the priorities of the above items, thrusting new priorities into the forefront, which the leadership must then address. However, the current blueprint is a reasonable starting point for the SCAI's next efforts. Second, and probably of equal importance to the first goal, the planning effort was very broad-based and participatory, bringing together a consensus building team comprised of senior physicians, current leaders (Committee Chairs, Society officers, Board members), and active members (who will likely be our future leaders).