



The Society for Cardiovascular Angiography and Interventions

SCAI President's Page



The Time Capsule

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I came across two time capsules recently. While they weren't intended to be time capsules, they both gave me snapshots of your professional Society at critical points in its development. Even better, they make for some seriously interesting reading. As the best time capsules do, they tell us both as much about ourselves as about those who created them in the first place. In this column, I'd like to share with you the contents of those time capsules.

The first time capsule was written in 1981, in an article signed by twelve of SCAI's founders, "The Society for Cardiac Angiography: Its Purpose, Efforts, and Goals" [1]. From reading that article, you can tell that the founders had some significant concerns on their mind. They observed, "Because of the obvious relationship between clinical events and coronary anatomy, coronary arteriograms are being performed in increasing numbers so that their cost affects not only the financial resources of an individual patient or institution, but also presents significant socioeconomic implications to society as a whole."

Sounds familiar? Read on: "We share the public concern regarding appropriate use, quality performance, and cost effectiveness of coronary arteriography. However, we are concerned that certain agencies involved in com-

prehensive health planning, in their effort to achieve cost containment, may address the cost but not the benefit of such procedures in modern medical care."

These concerns about the tensions between costs and quality, between caregivers and policymakers, were written twenty-three years ago, but could just as easily have been written today.

In the early days of the Society, the organization's focus was on quality in the lab, quality in imaging, proper technical performance and understanding of radiation—all new concepts to the Cardiologist. The founders focused on diagnostic procedures; in fact, interventional work was only in its infancy. They recognized the importance of the emerging economic issues, but advocacy—efforts to promote the members' viewpoints to elected and appointed policymakers—was not a major focus of the Society. The result was a field awash with

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personal opinions and strong personalities, rather than a unified voice.

As Past President Joseph Babb recently observed, "Even from the beginning, the Society's leadership recognized that the organization needed to voice its opinions to the policymakers. However, the economic pressures on healthcare in recent years have become much more severe. We recognized that it was absolutely vital that the Society become much more aggressive, organized, and united on behalf of invasive/interventional cardiologists. The proof is in the pudding—since we began our formal advocacy program, we've made some progress, but we have a long way to go."

The second time capsule was written a scant three years ago, in the form of a CCI President's Page by Dr. Babb [2]. Although our founding fathers were interested in "certain agencies" and public health policy, the Society did not have a formal advocacy program until 2001. In Joe's President's Page, he challenged us to pursue three advocacy goals: (1) re-energize our Advocacy Committee, (2) set specific advocacy priorities (there were five key areas suggested), and (3) hire an advocacy firm.

In response, we basically started from scratch in 2001. While we worked occasionally with the American College of Cardiology and the American Heart Association, we had no unified voice dedicated solely to invasive/interventional cardiologists. We treat one of the most common ailments in the western world, with some of the most advanced technology and pharmacology ever developed. It was critical that we "get into the game" and have our own voice. As most of you are aware, Joe's diligence resulted in tremendous progress being made relative to all three goals. We have reaped the benefits already. A recap appeared last summer [3]. Some highlights from that report and more recent progress:

Advocacy priority #1: Advocating for fair reimbursement. In the area of Medicare practice expense (PE) reimbursement, we have made significant progress. Previously you paid these expenses but didn't get reimbursed for them. Thanks to your collective efforts, that changed for the better last year when value inputs were approved for your office staff time dedicated to dealing with patients having in-hospital catheterization procedures. Just this January your Society secured valuation for catheterization procedures performed in non-hospital settings. This ensures that these procedures will continue to be paid as CMS revises the payment process over the next few years (they would otherwise have been eliminated). Similarly, after several years of steep declines in overall Medicare reimbursement for your clinical services, we were able to obtain a small increase.

A precursor to adequate reimbursement is appropriate coding. This past fall your Society argued successfully

for establishing separate codes for IVUS (previously IVUS was lumped in with routine transthoracic echo). With unique codes, CMS can now appreciate exactly when this technology is used; ultimately, this will lead to proper reimbursement. We were not as successful with the fractional flow reserve codes, but we will continue to address this inequity and press for appropriate coding and reimbursement. These efforts require professional consultants and many hours of your staff and leadership time. The forums are not glamorous, but they are critical to our collective interests. There is much work ahead, but we are making good progress!

Advocacy priority #2: Dealing with "hot spot" issues. As a recent example, when practice-changing DES were approved, we responded with a position paper and a task force. As a direct result of our visibility, we have developed an ongoing dialogue with the FDA, CMS, and the Office of the Inspector General, thus allowing your voice to be heard at the highest levels of health-related agencies.

Advocacy priority #3: FDA and NRC device approval issues. We have participated in critical committees and regulatory bodies to ensure that our members' interests in diagnostic and therapeutic radiation are represented. As noted above, interventional cardiology is one of the fastest-changing fields in healthcare today. Many of our members advise the FDA or sit on critical committees related to new device approval. Based on concerted efforts by SCAI's advocacy team, we are now viewed as the "go-to" organization by key federal policymakers for impartial and rapid advice.

Advocacy priority #4: Introduce SCAI to Congress and the Executive Branch. SCAI has opened up lines of communication with key Congressional representatives and staffers, and with the Executive Branch. One recent example was the participation of the Federal Government's highest health-related official at our annual meeting in Boston last year, where our respective viewpoints were addressed in a candid, constructive session. We have organized two years of member visits to their representatives on the Hill. Relationships are being formed, and trust built.

We have moved rapidly and have had modest successes, but there is much more to do. Since Dr. Babb's initiative in 2001, many advances have been made in the mechanical and pharmacological treatment of our patients (DES, for example). We are at the crossroads of having the means to arrest atherosclerosis (pharmacologically) and treat the vast majority of patients with coronary artery obstructions (mechanically.) It is, therefore, critical that we continue to have a strong voice and an active role in policymaking beginning at the local level and translating to the national level. I implore you to reconsider the recommendations Dr. Babb made in 2001:

- a) Tell a friend about SCAI and help him or her to apply for membership. There is strength in numbers.
- b) Respond promptly to our email surveys and queries. Data speak more loudly to policymakers than rhetoric.
- c) Become involved with your state SCAI Governor and make issues known to them. Grassroots campaigns work.
- d) Make a personal commitment to get to know at least one policymaker in your state and keep us up to date on your discussions with them.
- e) Keep us informed of your concerns and priorities.

As the authors of both of the “time capsules” discussed above knew very well, together we CAN make a difference!

p.s.: Consider this column the Society’s *next* Time Capsule. Perhaps one of my successors will take a look in several years, and hold us all to account for what we’ve done since those long-ago days of 2004!

REFERENCES

1. Beltane HA, Elliott LP, et al. The Society for Cardiac Angiography: its purpose, efforts, and goals. *Cathet Cardiovasc Diag* 1981;7:217–224
2. Babb JD. SCA&I’s new advocacy program: ensuring that your voice is heard. *Catheter Cardiovasc Interv* 2001;54:539–541.
3. SCAI. SCAI advocacy efforts pay off! *Catheter Cardiovasc Interv* 2003;60:429–431.