

James C. Blankenship, MD

The newly inducted President of SCAI discusses what's ahead for the society during the next year, challenges with current health care policy, and why he's an enthusiastic radialist.



What goals do you have for your tenure as the Society for Cardiovascular Angiography and Interventions (SCAI) President (2015–2016)?

SCAI has been going through an exciting transition. Over the past year, SCAI hired a new executive director and immediately set to work on a new strategic plan. We started by studying the last strategic plan and found that we achieved almost all of the targets that were set 10 years ago. Over the summer, we will finalize our new strategic plan and will then operationalize it and begin implementation.

We are also excited because, as of January 1 of this year, SCAI opened its membership to cardiovascular professionals other than physicians, including cath lab nurses, technologists, and administrators. We are committed to identifying the educational needs and advocacy issues of the entire cath lab team and providing relevant opportunities for them and for cath lab teams to learn and work together. The excitement and enthusiasm that the cardiovascular professionals bring is energizing because they seem to have been waiting for the opportunity to speak up, get involved, and be engaged—we're particularly looking forward to that!

Finally, in a larger sense, SCAI sees itself as the home and the voice of interventional cardiology. Our goal is to be the best source of education, provide advocacy for all professionals in this field, and allow our members to have a voice at all levels—on the individual, hospital, and health system levels—as well as in geographic areas that extend nationally and even internationally.

Can you reflect on your experience being on the Relative Value Update Committee (RUC)?

The RUC is a committee of the American Medical Association that provides advice to the Centers for Medicare & Medicaid Services (CMS) about the relative values of different physician services and procedures. Most of the procedures and services that doctors provide have been valued by the RUC, and CMS accepts some but not all of them. Most private insurance companies also base their reimbursements on the relative value system.

During the past 10 years, the RUC has gone from obscurity to infamy, as almost all stakeholders feel that the RUC undervalues their services. However, in the years that I have worked on the RUC, I have become convinced that its recommendations are relatively fair. The fact that all specialties believe that their services are undervalued is probably evidence that the RUC's recommendations are fair, or at least equally unfair to all. Further evidence of that is the fact that RUC members often vote against recommendations that would favor their own society when they think the proposed recommendation is inaccurate.

The Affordable Care Act (ACA) requires that CMS hire two consultants to develop an alternative system to the RUC. The initial work by those consultants indicates that they haven't figured out a better way to value physician services.

Do you think that the utility of performance measures, quality initiatives, credentialing, etc. will always outweigh any perceived inconvenience by physicians, or might they eventually become a hindrance to everyday practice?

Depending on which measure, initiatives, or credentialing we're talking about, they can be good or bad. If the measure is one that makes physicians pay attention to a factor that is important to patients, affects patient outcomes, and/or improves the efficiency of health care systems, the benefits may outweigh the additional hassles and time requirements experienced by physicians. On the other hand, some measures may have unanticipated consequences that affect patients. There is evidence that reporting of mortality after percutaneous coronary intervention (PCI) has decreased access to coronary catheterization and intervention for patients who are the sickest and at the highest risk of dying. Thus, innovations that are intended to improve quality can cause adverse consequences.

Furthermore, some metrics seem to be unrelated to what they're trying to measure. An example is 30-day readmission after PCI. Only a small minority of readmissions are related to the PCI procedure, and far more are either totally unrelated to anything cardiac or were related to cardiac problems but unrelated to the initial

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procedure. So, if one is trying to measure the quality of PCI using a metric of 30-day readmissions, I would argue that this is a poor measure of the quality.

Currently, what are your biggest concerns about the direction of health care policy changes and how they might affect physician reimbursement and patient access to treatment?

First, although the ACA has decreased the number of uninsured Americans by 10 million over the past 5 years, it still leaves about 30 million uninsured. So, we have only gone one-quarter of the way toward providing health care insurance, and the access that goes along with it, to previously uninsured people in the United States. The second issue is that the ACA and current policy don't address the huge administrative costs of providing health care. A provision of the ACA requires insurance companies to not spend more than 20% of their income on administration. However, Medicare insures patients for a small fraction of what is spent by third-party payers, and these excess administrative costs represent waste.

With respect to physician reimbursement, many independent cardiologists have become hospital employees. Overall, I am concerned that this trend will lead to decreased physician reimbursement.

Once we figure out which types of payment systems will actually improve the quality of care and the patient experience, I think we will see improvement in the quality of care we deliver and a decrease in the amount of waste in the system. I'm optimistic that it will be beneficial for physicians as well.

Do you think that payment reimbursement for cardiovascular imaging has improved or will improve based on the Medicare Access and CHIP Reauthorization Act or other regulatory changes, or is this still under threat of decrease due to value-based purchasing models or other challenges?

The overall number of imaging procedures has decreased about 30% over the past decade. I think that bundling initiatives (which are part of the alternative payment systems encouraged by the ACA) and value-based purchasing models will tend to discourage imaging, as it

represents an increased cost and the value is subject to question.

It's also worth noting that more advanced cardiac imaging modalities, such as coronary CT angiography and magnetic resonance imaging, are limited in their uptake by the perception of practitioners that they are not equitably reimbursed. Of course, insurance companies also discourage imaging studies because of their costs. This will probably cause further downward pressures on cardiovascular imaging.

Based on the data we have seen thus far, as well as on your own clinical experience, where do you stand on the radial versus femoral debate for PCI? Is one simply better than the other as a first-line approach, or is the decision more situational?

I've been cath lab director for 18 years, and for 14 of those years, femoral access complications were the bane of my existence. We tried everything to reduce them, and despite that, we were always in the worst quartile of labs according to the National Cardiovascular Data Registry (NCDR). About 4 years ago, as a lab, we transitioned to routinely performing radial access, including for ST-elevation myocardial infarction patients. Since then, we've been in the best quartile of institutions with respect to bleeding and vascular access complications, and our door-to-balloon times remain in the top 10% of labs reporting to the NCDR.

We now perform more than 80% of PCIs radially (I'm at 92%). According to the recently released fourth-quarter 2014 NCDR data, the use of radial access for PCI now stands at 25% in the United States, up from 7% just a few years ago. I think the proportion of cases performed via radial access in the United States will rise to 80% in the next decade.

Honestly, I would be happy to never perform another case using femoral access.

Why do you think there is a lack of adherence to optimal medical therapy for patients with complex coronary artery disease who undergo PCI, and especially coronary artery bypass grafting, as shown in the recent SYNTAX trial findings? Are there any ways to help improve adherence?

The answer can be broken down into two general categories. One is problems with adherence in general, and the second is particular problems with adherence in patients who undergo bypass surgery. SCAI recently participated in developing an article that examines strategies to improve adherence to dual-antiplatelet therapy

after PCI, which can be found at: http://www.healio.com/cardiology/education-lab/2015/04_april/spotlight/spotlight.

Medication adherence has been extensively studied, and it is well documented that patients don't like to think of themselves as patients. They equate taking medicine with being unhealthy, and if they don't take medicines, it is easier to believe they are healthy. Other factors leading to nonadherence include medication side effects, the cost of copays, the hassle of going to the pharmacy every month, and simply forgetting to take their medications or not knowing what they are.

Bypass surgery patients fill their initial prescriptions and refills less often compared to PCI patients. These patients may have a sense that they have had the "big fix" and perhaps do not need medicines any longer because they have been cured. Surgeons may be less focused on medical therapy compared to cardiologists, who have their training in internal medicine. The consequences of nonadherence after bypass surgery, such as graft occlusion, may be less dramatic than the consequences of nonadherence after PCI, such as stent thrombosis.

In an effort to improve compliance, our institution and many others have implemented programs to help patients transition from inpatient to outpatient. That includes a pharmacist talking with each person who starts on warfarin or an antiplatelet medication and providing extra education about why it's important. Studies show that many prescriptions are never initially filled, so our pharmacists bring the first month of these medications to the bedside, decreasing the risk that patients will never fill the prescription in the first place.

Good medication adherence improves outcomes, and it is in everybody's interest to help these patients to do better in terms of adherence. This is especially true for providers, who are increasingly going to be judged not only on how patients do in the hospital, but also how they do after discharge. ■

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