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Advocacy 101 for Interventional Cardiologists: A Society for Cardiovascular Angiography & Interventions Policy Statement

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ABSTRACT

Advocacy is a core mission of the Society for Cardiovascular Angiography & Interventions (SCAI). SCAI advocates on behalf of interventional cardiologists and our patients. This document provides foundational information and a toolkit for grassroots advocacy by interventional cardiologists. The first half of the document summarizes how health care laws are made, how medical devices are approved, and how procedure reimbursement is determined. The second half of the document is a playbook of advocacy strategies: legislative advocacy, judicial advocacy, advocacy with regulators and payors, advocacy in the media, and participation in SCAI advocacy initiatives, such as the Government Relations Committee and SCAI Political Action Committee. Equipped with this toolbox, interventional cardiologists must increase our advocacy activities with government, payors, and industry.

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Introduction to advocacy

Advocacy is a core mission of the Society for Cardiovascular Angiography & Interventions (SCAI). SCAI advocates on behalf of interventional cardiologists and our patients. Key SCAI advocacy priorities include improving access to care, ensuring fair payment, decreasing health disparities, and supporting clinical research and device innovation. SCAI advocates with local and national governments, payors, industry, and health care systems. SCAI participates in joint advocacy efforts with professional society and industry partners, but SCAI is not an anonymous lobbying entity. SCAI is a member-driven organization. You are SCAI! Therefore, organizing member advocacy is central to SCAI's mission.

Abbreviations: AMA, American Medical Association; CMS, Centers for Medicare & Medicaid Services; CPT, Current Procedural Terminology; FDA, US Food and Drug Administration; GR, Government Relations; HHS, US Department of Health and Human Services; PAC, Political Action Committee; RUC, Relative Value Scale Update Committee; RVU, Relative Value Unit; SCAI, Society for Cardiovascular Angiography & Interventions.

Keywords: Advocacy; approval; government; political; regulation; SCAI.

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This document provides foundational information and a toolkit for grassroots advocacy by interventional cardiologists. First, an understanding of how health care is regulated is fundamental to advocating for changes in health care. The first half of this document summarizes how health care laws are made, how medical devices are approved, and how procedure reimbursement is determined. Second, effective advocacy requires use of a wide variety of techniques and tools. The second half of this document is a playbook of advocacy strategies: legislative advocacy, judicial advocacy, advocacy with regulators and payors, advocacy in the media, and participation in SCAI advocacy initiatives. Equipped with this information, physician-advocates will advocate more effectively for the advancement of the field of interventional cardiology.

Health care regulation

The practice of interventional cardiology is regulated at multiple levels. In the United States, federal, state, and local governments have committees tasked with writing laws to promote equitable access to the spectrum of medical care. The US Food and Drug Administration (FDA) is charged with ensuring that medical devices approved for use in the US have documented evidence of both safety and efficacy.[1] The American Medical Association (AMA), Centers for Medicare & Medicaid Services (CMS), and private payors influence reimbursement for medical services, thereby affecting physicians' practice patterns and the availability of therapies to patients. It is not possible to provide an all-inclusive list of the complex mechanisms by which government regulates health care, but this enormous number of mechanisms creates many potential avenues for advocacy.

How American health care laws are made

Two articles of the US Constitution establish the government's power to pass health care legislation[2]:

Article I, Section I: All legislative Powers herein granted shall be vested in a Congress of the United States, which shall consist of a Senate and House of Representatives.

Article I Section 8: "The Congress shall have Power To lay and collect Taxes…for the common Defence and general Welfare of the United States…"

"[G]eneral Welfare" has been interpreted to include health care. The Social Security Amendments of 1965 expanded the role of government in providing access to and delivery of health care and includes Title V (Maternal and Child Health Services Block Grant), Title XI Part B (Peer Review of the Utilization of Health care Services), Title XVIII (Health Insurance for the Aged and Disabled), and Title XIX (Grants to States for Medical Assistance Programs).[3]

Health care issues warranting legislative consideration are raised by the members of Congress, individuals, or professional societies, such as SCAI. Congressional staff addresses these issues by crafting bills to propose as laws. Bills involving health care payment (the power of the purse), delivery, and research may fall under the jurisdiction of 3 Committees in the Senate and 5 Committees in the House of Representatives (Table 1). After deliberations and amendments, a committee may advance the bill to floor debate and a vote by the full chamber. Once similar bills are passed by both the Senate and the House of Representatives, a conference committee reconciles any differences between the bills, and both chambers vote on final approval. If approved, within 10 days, the president may either sign the bill into law or veto the bill. A presidential veto can be overridden by a two-thirds vote in both Congressional chambers. If the president does not sign or veto the bill within 10 days and Congress is in session, the bill automatically becomes law. If Congress adjourns before the 10-day period expires and the president has not signed the bill, then the bill does not become law (a "pocket veto").

Table 1. US Congressional committees involved in health care legislation.

Senate	House of Representatives
Finance Committee on Finance Subcommittee on Health care	Committee on Ways and Means Subcommittee on Health
Committee on Health, Education, Labor, and Pensions (HELP)	Committee on Energy and Commerce Subcommittee on Health
Committee on Appropriations Subcommittee on Labor, Health and Human Services, Education, and Related Agencies	Committee on Appropriations Subcommittee on Labor, Health and Human Services, Education, and Related Agencies
	Committee on Education and the Workforce
	Committee on the Budget

Once established by Congress, health care policy is implemented and managed by the US Department of Health and Human Services (HHS), which resides within the executive branch. HHS agencies include CMS, the FDA, and the National Institutes of Health. These agencies manage budgets and oversee policies that directly affect interventional cardiologists. CMS is the largest health care payor in the United States, covering >135 million Americans,[4] and CMS decisions are generally followed by private insurers and the Department of Veterans Affairs, which provides care for >18 million US military veterans.[5] The FDA approves and regulates medical devices and medications. The National Institutes of Health's National Heart, Lung, and Blood Institute is the largest funding source for cardiology research in the world. Beyond adherence to Congressional legislation, these agencies also provide public comment periods for the submission of written commentary on policy implementation. The submission of public comments is an important function of SCAI Government Relations (GR) Committee and SCAI clinical councils.

Beyond the federal government, states further regulate and implement health care policies. State governments provide an important site for advocacy engagement. At the state level, state legislatures, governors, health departments, and social services agencies function similarly to their federal counterparts but on a smaller scale. In addition, states have several other avenues of health care regulation. Thirty-five states plus Washington, DC, have certificate of need legislation, requiring state approval to open major facilities, such as cardiac catheterization laboratories. States regulate where interventional cardiology procedures may be performed, including ambulatory surgical centers and office-based laboratories. Medicaid programs for the indigent are also regulated and paid at the state level.

How medical devices are approved

Over more than a century, US laws have established parameters for governmental device approval. The Pure Food and Drug Act of 1906 prohibited interstate commerce in adulterated and mislabeled food and drugs.[6] Federal regulatory processes governing drug approval were established by the Food, Drug, and Cosmetic Act of 1938 and require substantial evidence of safety and efficacy, often in the form of randomized controlled trials.[7] The Medical Device Amendments of 1976 applied similar regulatory requirements to the approval of medical devices.[8] This law provides the FDA the authority to restrict the sale, distribution, and use of devices if safety and efficacy cannot be reasonably assured. The FDA classifies devices into regulatory categories including class 1 (minimal-to-low risk; FDA issues general controls regulations for device classes), class II (moderate risk; FDA issues general controls and performance standards for specific devices), and class III (high risk; FDA requires general controls and premarket approval of devices). The FDA has several pathways to review and approve devices:

1. The 510(k) pathway was established in 1976 to evaluate low-to-moderate risk devices that are substantially similar to previously approved devices. The 510(k) device applications require an explanation of the similarities and differences between the new and previously approved devices.
2. The de novo pathway applies to low-to-moderate risk devices lacking previously approved similar devices for comparison. Typically, the de novo pathway requires more robust clinical evidence than the 510(k) pathway.
3. The premarket approval pathway applies to class III (high risk) devices. Approval through the premarket approval pathway requires rigorous scientific evidence of both device safety and efficacy.
4. The humanitarian device exemption pathway exempts a device from some of the efficacy data requirements of the FDA. Through this pathway, lifesaving devices with probable benefit for which randomized controlled trials could be unethical may receive Humanitarian Use Device (HUD) designation. HUD status was developed to support the diagnosis or treatment of diseases not affecting >8000 individuals in the United States per year. HUDs must conform to profit and use restrictions. HUD vendors must provide the FDA with documentation of their devices' annual distribution to be eligible to profit from an approved quantity of devices.
5. The Breakthrough Devices Program is a voluntary program designed to expedite patient and clinician access to novel medical devices by accelerating development and assessment while preserving statutory standards for approval. To be eligible for breakthrough device designation, a device must offer the potential for more effective treatment of a life-threatening or irreversibly debilitating disease and represent one of the following: breakthrough technology, no approved alternative, advantage(s) over existing approved alternatives, or availability is in patients' best interest.

Since 1980, the FDA has issued investigational device exemptions (IDEs) for research on high-risk devices based on preclinical data. IDEs enable investigational use of novel devices to generate the necessary safety and efficacy data for a subsequent application for full device approval. In addition to FDA permission, IDE studies also require institutional review board review and approval.

Each of the FDA device approval pathways has mechanisms by which meaningful advocacy can occur. Advocacy is essential to advancing medical science and technology: physicians, professional societies, patients, industry, and the FDA must be involved to define unmet clinical needs, develop novel interventions, and design appropriate trials with meaningful safety and efficacy end points to guide consideration for approval. In addition, all these stakeholders must make certain that patients enrolled in clinical trials adequately represent all members of society, including women and underrepresented minorities. The Safety and Innovation Act of 2012[9] required the FDA to address demographic characteristics, such as sex, age, and race, resulting in 27 FDA recommendations to identify barriers to enrolling members of demographic subgroups and to make study demographic characteristics available to the public. The FDA provided industry guidance documents in 2020 and 2022 to improve clinical trial enrollment from underrepresented racial and ethnic groups.[10,11] Clear advocacy is also needed to make certain that the needs of pediatric patients are addressed because comparatively few devices are developed and studied in pediatric populations, resulting in "off-label" use of devices approved for adults or use through the humanitarian device exemption or breakthrough pathways.

How procedure reimbursement is determined

The procedure reimbursement determination process (Figure 1) begins when a Current Procedural Terminology (CPT) application is submitted to the AMA. Since 1966, the AMA has published a list of standardized CPT codes. In 1983, CMS adopted CPT as the basis for the Health care Common Procedure Coding System. Each CPT application is evaluated by the AMA's CPT Editorial Panel, comprising 21 members: 12 are appointed in rotation by national medical specialty societies; the other 9 include a chair, vice-chair, and insurance and hospital association representatives. The application must justify the introduction or modification of a CPT code based on frequency of a procedure not captured by an existing code and scientific evidence supporting the appropriateness of the procedure. Applications may be submitted by individuals, medical specialty societies, hospitals, payors, and industry. The CPT Editorial Panel meets 3 times per year to discuss and vote on code applications. Panel meetings include official CPT advisors from 96 medical specialty societies, including SCAI. Thus, SCAI-appointed representatives are directly involved in this process, supported by expert SCAI staff. SCAI frequently proposes new CPT codes and comments on codes presented by other parties to the CPT Editorial Panel.

Once a new or updated code is approved, the AMA sends surveys composed in conjunction with the relevant medical specialty societies to a subset of physicians in the specialty. Survey respondents evaluate the code for estimated time and intensity of work, comparing the proposed code to other services as reference points. It is critical that survey respondents evaluate procedures carefully and without bravado because the time and intensity they report help to determine procedural compensation. SCAI and the American College of Cardiology collaborated with the AMA in 2022 to survey codes for percutaneous coronary intervention.

Based on the survey results, the professional societies of physicians performing the surveyed procedure recommend a number of relative value units (RVUs) to be assigned to the procedure. These recommendations are submitted to the Relative Value Scale Update Committee (RUC, pronounced to rhyme with "truck"), which also meets 3 times per year. The 32-member RUC includes rotating members appointed by medical specialty societies. SCAI maintains a rotating RUC membership from among the 121-member RUC Advisory Panel; a SCAI member served a very successful 2-year term as a full member of the RUC from 2020 to 2022. To keep SCAI eligible for RUC membership, 20% of SCAI members must also be AMA members. The RUC refines the societies' RVU recommendations, votes to approve a final slate, and presents its recommendations to CMS.[12] In recent years, CMS has accepted approximately 80% of the RUC's RVU recommendations, but in 20% of the cases, CMS rejects the RUC's recommendations and substitutes RVU numbers of its own calculation, which are almost always lower than the RUC's recommended numbers. CMS codifies accepted CPT codes and new RVU values annually in the Medicare Physician Fee Schedule.

CMS further regulates health care expenditures through the annual establishment of a conversion factor (CF), a dollar value assigned per RVU. The annual CF update is based on a complex statutory formula using the previous year's CF with adjustment for the Medical Economic Index, the Update Adjustment Factor, and budget neutrality. The Medical Economic Index is a calculation of the inflation rate for medical services, which is generally higher than inflation in consumer prices overall. The Update Adjustment Factor encompasses growth or decline in the gross domestic product, changes in the number of beneficiaries,

Figure 1.
The 6-step procedure for assigning CMS payments for medical procedures. AMA, American Medical Association; CMS, Centers for Medicare & Medicaid Services; CPT, Current Procedural Terminology; RUC, Relative Value Scale Update Committee; RVU, relative value units.

and regulatory adjustments that may affect the demand for and costs of providing Medicare services. Then, the calculation is subject to budget neutrality, requiring any relative increase in CMS expenditures in one area to be offset by cuts in other areas.

The process of setting the annual CF balances increases in demand for medical services with the finite productive capacity of the economy. The CF must result in a CMS budget that is within $20 million of its inflation-adjusted and demand-adjusted target. If adjustments in RVU values are projected to cause a differential greater than that $20 million or exceeds the target, CMS uses the budget neutrality factor to bring overall payments down to the target level. The CF (dollar amount for each RVU) for 2022 was $34.61 and is $33.89 for 2023. For reference, the CF reached as high as $38.26 in 2001.

Finally, a significant component of physician reimbursement depends on private insurers. Private insurers use multiple payment models, including traditional fee-for-service, such as CMS and fee-for-service discounts negotiated with health systems and capitation models with fixed payments per insured individual.

Advocacy strategies

Advocacy takes many forms, and a successful advocacy campaign generally requires a diverse toolkit of advocacy strategies (Table 2). Advocates may seek to pass laws by garnering support from legislators. In the court system, briefs and lawsuits may provide checks to laws and set legal precedents. Policies from regulatory agencies and payors are important targets for advocacy. Traditional media, professional journals, and social media are important venues for disseminating advocacy information and applying political pressure.

SCAI helps members engage in many of these strategies. This toolkit helps SCAI build a network of member advocates. The GR Committee, representatives to AMA panels, the Industry Relations Committee, and SCAI staff facilitate member advocacy. SCAI works closely with coalitions of like-minded societies, such as the American College of Cardiology and the Society of Thoracic Surgeons in the areas of shared interest. In the contemporary era, when US politics are often driven largely by monetary contributions, SCAI Political Action Committee (PAC) courts and supports legislators whose policies are congruent with SCAI's objectives. Among many wins, SCAI's recent advocacy endeavors include successful development and valuation of new interventional CPT codes, reduction of the burden of prior authorization, and maintenance of appropriate reimbursement for interventional cardiology procedures, preventing the threatened Congressional sequestration of Medicare funds year after year.

Table 2. Health care advocacy strategies.

Legislative advocacy
Writing legislation and finding sponsors to introduce legislation
Garnering support and cosponsors for legislation
Building relationships with legislators
Meeting with legislators and staff
Attending and hosting advocacy events
Advocacy in the courts
Advocacy with regulators
Advocacy with payors
Advocacy in the media
Newspapers, radio, television
Professional journals
Social media
SCAI advocacy infrastructure and endeavors
SCAI PAC

Multiple forms of advocacy are typically necessary to achieve advocacy goals. PAC, Political Action Committee; SCAI, Society for Cardiovascular Angiography & Interventions.

Federal and state legislative advocacy

At both the federal and state levels, health care laws begin as bills that are introduced to committees by senators and representatives their respective chambers and ultimately brought to a vote of both chambers. A bill may have an unlimited number of cosponsors. Advocates seek to obtain legislative support in the form of cosponsorship and commitment to vote for a specific cause on behalf of a specific population. Legislative advocacy involves working with individual lawmakers and lawmaking bodies at each stage of the legislative process. The work of advocacy can involve educating legislators about a cause, working with legislative staff to craft a bill, and demonstrating popular support or opposition by having constituents contact legislative offices and through popular media. Congressional lobbyists (such as several SCAI staff) are professionals trained to conduct legislative advocacy and to support grass roots advocates (such as SCAI members). However, the most effective advocacy efforts involve direct participation by physicians.

An effective interventional cardiology advocacy campaign requires the participation of as many interventional cardiologists as possible and organization of their efforts by experienced advocates, such as SCAI GR staff. First, interventional cardiology advocates must be educated about the bill for which they are conducting advocacy. Second, they must develop a clear and consistent message that can be understood by their nonmedical legislative audience and the general public. Interweaving numeric data and personal experiences provides an especially compelling narrative. Third, these advocates must meet with their legislators to deliver the message. Fourth, the advocates must obtain the support of allies, maximizing support through outreach to like-minded organizations and through popular media. Fifth, a PAC such as SCAI PAC can contribute financially to support legislators whose positions are congruent with that of interventional cardiologists.

Advocates must be aware that advocacy is a lengthy process that may take years: patience and persistence are key to success. Conveying a message is most successful when constituents build a relationship with legislators over time. Personal visits, phone calls, and letters are all appropriate. Data and personal stories from affected constituents are powerful in mobilizing legislators. Multiple bill sponsors and cosponsors, particularly if bipartisan, bolster the likelihood of campaign success. Hence, when conducting advocacy efforts, it is important to work with legislators across the political spectrum; even if there is not agreement on many issues, the legislator may be willing to lend support regarding the issue at hand. One's own political leanings should not restrict working with elected officials from both parties; every elected official represents an entire district or state, not just constituents from one political party. Furthermore, regardless of how a legislator votes on one issue, continued contact and relationship building can help develop allies for other issues.

Building relationships with legislators and staff

Strong personal relationships with legislators and their staff members are one of the most important factors in effective long-term advocacy. These relationships require cultivation with regular contact over time to build familiarity, trust, and understanding.

Legislative staff members are every bit as important as the elected officials themselves. Staff members typically specialize in specific policy areas and will have the time and expertise to devote to health care concerns. No legislator can keep completely current regarding the thousands of issues and bills facing Congress. Legislative staff gather and filter information to provide to the legislators. Staff members write bills for their legislators and read other legislators' bills in their entirety.

Legislators and their staff value trustworthy, expert sources of information and insights. Health care is an extremely complex area of legislation. As a subject matter expert, an interventional cardiologist is well positioned to build meaningful relationships with legislators.

Before meeting with a legislator, advocates should prepare by familiarizing themselves with the legislator's background, committee assignments, and public stances on major issues. The legislator's website is the best resource for this preparation, and supplemental information can be obtained from popular news media. SCAI staff can help to provide much of this information and can also provide detailed summaries of the key issues and bills facing interventional cardiology and talking points to equip the advocate for legislative meetings.

Initial meetings should focus on sharing information and establishing rapport. An interventional cardiologist might educate the legislator and staff about the field and its challenges. Once this connection is established, later meetings with requests to influence their decision making are more likely to be successful.

One way to begin building relationships with legislators and their staffs is to schedule one-on-one in-person meetings with them in their local district offices or in Washington, DC. Legislative offices are eager to meet with their constituents to obtain information about important issues and to earn potential votes and campaign contributions. SCAI advocacy staff can help to arrange these introductory meetings and even accompany interventional cardiologists to these meetings to assist. Other opportunities for connections include town hall meetings and special events in a legislator's district. After each meeting, a handout with key information and a letter, an email, or a follow-up telephone call can help to fortify the relationship and reemphasize what is important to interventional cardiologists.

Another way to build legislative relationships is through campaign support. Financial contributions to campaigns, whether personal or through SCAI PAC, are effective at bringing attention to interventional cardiology issues. Even more valuable, contributing your time will be very well received. Attending campaign events, and in particular, hosting campaign gatherings in your home, rapidly build good will with legislators. These efforts are also critically important to promote election and reelection of legislators that support interventional cardiologists and bring a voice to their issues. SCAI GR staff can help make connections with legislative staff to setup hosting of campaign activities.

A particularly effective relationship-building methodology is to bring legislators to visit the hospital or clinic. In this way, an interventional cardiologist can obtain undivided attention for a substantial period. The experience of being in a medical setting helps to reinforce the message being delivered. Many advocates who have hosted legislators subsequently become the go-to health care experts for the legislators and will receive calls from the office seeking their opinions when new health care legislative issues arise.

Advocacy in the courts

Throughout US history, the judicial branch of government has been instrumental in interpreting the Constitution and legislation to determine the limits of legislative and regulatory policies on health care. The role of the judiciary is not to enact laws but rather to interpret them. However, laws may be complex, ambiguous, and even conflicting. The court system determines jurisdiction and applicability of laws.

The interpretation of laws allows for wide latitude by judges, and hence, there is a significant role for education and advocacy in the courts. There is a longstanding precedent of courts' giving great deference to the role of physicians in determining standards of care. Although the initial premise for this deference arises from tort law and malpractice law, this deference to physician professionalism has led to a widespread openness to the expert opinions of physicians and medical specialty societies, such as SCAI.

In the court system, physician participation may take the form of *amicus curiae* briefs. Literally meaning "friend of the court," an *amicus curiae* brief provides the judge with expert professional information to support a particular decision. More directly, interventional cardiologists may also serve as expert witnesses in cases involving health care policy. Working in the court system, physician-advocates can parlay their excellent patient care judgment to apply beyond the hospital walls to ensure the best professional care for patients across their districts, states, and country.

Advocacy with regulators and payers

HHS, and in particular, CMS and the FDA, implement and oversee the regulations that govern physician practice and payments, making them an important target for physician advocacy. HHS is responsible for approximately one-quarter of the entire annual federal budget. Falling under the executive branch, HHS works closely with the president's staff and the Office of Management and Budget.[13] By statute, pending rules and regulations must follow the Administrative Procedures Act. The Administrative Procedures Act requires that all government agencies issuing new regulations comply with its notice and comment period requirements to ensure that the process is open to interested parties such as the public and published in the Federal Register.

Policy issues related to coding, reimbursement, and coverage may be influenced by advocacy input from interventional cardiologists. When relevant issues arise, public comment requirements allow interventional cardiologists to write or testify on policy decisions. SCAI closely monitors and reviews HHS activities and frequently seeks expertise, letter writing, and testimony from SCAI members. Volunteering to serve the society and the field in this manner is a highly effective method of advocacy.

Commercial health care payors develop their own policies, providing another avenue for physician advocacy. Many private sector health insurance programs closely follow Medicare's lead in coverage and payment policies, although there are notable exceptions, particularly in the realm of novel procedures and structural heart disease interventions. As users of payer's services, interventional cardiologists can provide valuable insights to guide development of appropriate payer policies. SCAI monitors payers' policies closely and frequently receives requests to comment as policies are developed and revised. SCAI members play a pivotal role in drafting, evaluating, and commenting on these policies.

Advocacy in the media

Media advocacy refers to the strategic use of mass media to influence public opinion in support of community goals and policies. Media outlets include newspapers, radio, television, websites, and social media. Media advocacy for interventional cardiology involves a combination of science, fiscal policy, politics, and messaging to advance the field and promote the best interests of patients and physicians.

Media communications are designed to educate and influence the public about specific issues. These issues may include public health measures, access to health care, and payment for health care. By spreading a message among the general public, media advocacy also targets policymakers by motivating their constituents to compel them toward a specific course of action. Media advocacy harnesses the democratic process to affect policy.

Media advocacy begins with agenda setting and framing. Media advocates must set an agenda of topics to make visible to the public and, therefore, to policymakers. Framing is the process by which information is delivered in a way that identifies problems, implicates causes, and proposes solutions. How information is framed determines how individuals reconcile new information with their previous understanding.

Once advocates define the problem, causes, and solutions, they develop media strategies to reach their intended audience. Local advocacy can be accomplished by offering interviews to local radio and

television stations and by writing letters to local newspapers. National advocacy may work with national television stations and websites. In particular, press releases may be distributed broadly to maximize uptake of a message. Unlike politicians, regulators, and industry representatives, interventional cardiologists have a unique authority and authenticity to speak about health care matters concerning their field. SCAI can help by providing reference materials and templates for these media endeavors and by identifying potential media targets.

Media engagement frequently requires very concise presentations or "sound bites." These concise presentations should be developed a priori and ready for use. The characteristics of effective presentations include[14]:

1. Succinct, straightforward statement of the problem;
2. An analogy that emphasizes the nature and scale of the problem;
3. Evoking strong, shared values;
4. Avoidance of negative trigger words and presenting the opposing viewpoint;
5. Use of "social math" by presenting statistics in a local context or with an analogy; and
6. Use of compelling visuals.

Recently, social media has become a major advocacy tool used by interventional cardiologists.[15] Social media has more than 2 billion users worldwide, such as >70% of Americans and every member of the US Congress. Although traditional media may gravitate toward well-known or high-ranking individuals, social media provides a mouthpiece for every interventional cardiologist to be heard and amplified by like-minded individuals. Social media advocacy campaigns should develop hashtags (#) to unite their messaging. SCAI regularly provides social media advocacy materials. By following SCAI on Twitter, Facebook, and LinkedIn, advocates can access, share, and comment on these materials.

SCAI advocacy

SCAI advocacy activities fall under the purview of the GR Committee. One-third of Committee members, such as the chair and cochair, are appointed to 3-year terms by the incoming SCAI president before each year's annual meeting. SCAI GR staff, such as lobbyists and reimbursement specialists, support the work of the Committee and provide consistency as membership changes.

The scope of the GR Committee is broad and consistent with enhancing SCAI strategic initiatives including patient access to care, health equity, reimbursement issues, and regulatory issues. As described in this document, SCAI GR activities include CPT, RUC, CMS, legislative, judicial, and media advocacy. SCAI leverages the expertise of interventional cardiologists to give them a powerful collective voice in processes that establishes payment and regulation for the work that they do. SCAI collaborates with other specialty societies to amplify physicians' voices.

Beyond governmental advocacy, SCAI GR works with industry and payors to ensure physicians and patients have access to the tools they need for optimal care. Such collaborations have led to new CPT codes, expert testimony in FDA hearings, postmarketing study of novel technologies, and elimination of burdensome previous authorization requirements. In such endeavors, SCAI is very careful to avoid conflicts of interest: financial support from industry and payors for these activities is strictly forbidden, and individuals with relevant financial conflicts are excluded.

SCAI does not provide legal counsel but does engage counsel whether issues supported by scientific evidence and SCAI policy documents may be affected. SCAI policy documents have been referenced in numerous legal cases, affecting the interventional cardiology community. The GR Committee works with other committees and councils to ensure that SCAI documents are prepared with sensitivity to this possibility.

At the time of writing, SCAI GR Committee has not directly engaged a hospital or health care system. However, a recent publication[16] directly addressed many of the issues that may arise between hospitals and interventional cardiologists. It is likely that SCAI GR will become more engaged in issues relevant to practice in health care systems with the expansion of Accountable Care Organizations and other alternative payment models.

In addition, within the mission of advocacy, SCAI GR Committee is charged with facilitating advocacy by interventional cardiologists, the rationale behind the present document. The GR Committee works to educate SCAI members and the greater community on issues affecting that profession and patients. SCAI GR Committee webpage (https://scai.org/government-relations) is regularly updated with information about current issues and Committee activities. Society email communications keep members informed about evolving issues and frequently include links to email legislators' prewritten advocacy messages. Educational talks at national meetings are frequently given by GR Committee members with the goal of increasing the general understanding of advocacy issues within the interventional cardiology community. Before and during the 2022 RUC survey to revalue percutaneous coronary intervention codes, SCAI GR Committee led a major campaign to educate the interventional cardiology community about the significance of the survey and importance of participation by those receiving surveys from the AMA. Whenever the interests of interventional cardiologists and their patients need representation, SCAI GR Committee has a mission to act.

SCAI PAC

SCAI PAC is a federally registered organization developed to support advocacy efforts on issues related to interventional cardiology by engaging with US senators and Congressional representatives and candidates for those positions. SCAI PAC is a separate entity from SCAI GR Committee, with its own chair, cochair, and leadership committee. SCAI PAC identifies opportunities to advance the agenda developed by the GR Committee; however, it is important that SCAI PAC decisions regarding the distribution of funds remain independent because SCAI PAC is financially and legally separate from the society itself. SCAI PAC receives no funds from SCAI, only from contributions directly to the PAC. To donate legally to SCAI PAC, one must be a dues-paying SCAI member or SCAI staff, aged 18 years, and a citizen of the United States.

SCAI PAC selects candidates for donations based on criteria developed by its leadership committee. Consistent with the legal separation of SCAI and SCAI PAC, these criteria (Table 3) were developed independently and align with SCAI strategic goals. Balance

Table 3. Criteria used by SCAI PAC to select candidates to receive SCAI PAC funding.

1. Is the candidate on a key health care committees and/or subcommittees?
2. Is the candidate a current member of Congress and likely to maintain a seat?
3. Does the candidate have an established relationship with a SCAI member or staff?
4. Has the candidate sponsored or co-sponsored legislation that SCAI supports?
5. Has the candidate supported SCAI's positions with regulatory agencies?
6. Is the candidate a physician and/or supported by the Medical and Dental PAC (MADPAC)?
7. a. Equal dollar value contributions to Democratic and Republican candidates
   b. Candidate for US Senate or House of Representatives (not state or local, not presidential)

PAC, Political Action Committee; SCAI, Society for Cardiovascular Angiography & Interventions.

Table 4. The top 10 ways for interventional cardiologists to get involved in advocacy.

1. Call or email a legislator about key issues
2. Meet with a legislator in-person
3. Volunteer for and support a legislator's election campaign
4. Testify in court
5. Complete an RUC survey
6. Review and comment on regulators' and payers' policies
7. Write to and speak with newspaper, radio, and television media and professional journals
8. Post and repost on social media about health care issues and tag colleagues and legislators
9. Apply to join SCAI Government Relations Committee
10. Contribute to SCAI PAC and attend SCAI PAC events

SCAI staff can provide talking points, make contact, and facilitate meetings. Visit https://scai.org/government-relations to get involved.
PAC, Political Action Committee; RUC, Relative Value Scale Update Committee; SCAI, Society for Cardiovascular Angiography & Interventions.

between the Democratic and Republican parties is mandatory, and a running total of donations awarded to each political party is presented to SCAI PAC Committee before voting on each subsequent contribution. SCAI PAC does not consider a candidate's positions on issues that are not directly relevant to interventional cardiology.

These criteria are used by SCAI PAC staff and PAC Committee members to identify potential candidates. Alternatively, SCAI members may have connections to their local representatives and recommend them to the Committee. Once a potential candidate has been identified, the rationale to consider support is presented to the members of the Committee, and a simple majority is required to decide whether SCAI PAC should support the candidate and with what amount.

Contributions to SCAI PAC are an important way that SCAI members can engage in advocacy. Contributors to SCAI PAC have the opportunity to meet with the selected US senators, representatives, and candidates. Through these meetings, the society can educate the legislator on key issues and positions while building important relationships for future collaboration.

Getting involved

With an understanding of the health care regulatory landscape, interventional cardiologists must increase our advocacy activities of all types, as described. The field of interventional cardiology depends on all of us to help, and SCAI is well poised to facilitate. Table 4 provides the top 10 ways for interventional cardiologists to get involved in advocacy.

Conclusion

Advocacy is the medium by which interventional cardiologists can direct the future of our field. Equipped with an understanding of health care legislation, device approval, and procedure reimbursement, physician-advocates can affect change through legislative, judicial, regulatory, payor, and media engagement.

The future of interventional cardiology depends on a nationwide team of physician-advocates. SCAI is building this team through advocacy education, SCAI-led advocacy initiatives, and SCAI PAC. To optimize the practice of interventional cardiology and to provide optimal care for our patients, interventional cardiologists must increase our involvement in our professional society, SCAI, and advocate effectively with government, payors, and industry.

Peer review statement

Given his role as associate editor, Andrew M. Goldsweig had no involvement in the peer review of this article and has no access to information regarding its peer review.

Declaration of competing interest

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