enhance the practice of cardiology. In addition, there will be a "CA ACC News" section in every issue of *Reviews in Cardiovascular Medicine,* and we hope to strengthen patient and physician education utilizing this partnership.

We have recently officially inaugurated the twinning program between the CA ACC and the British Cardiovascular Society (BCS). We will have collaborative exchanges between the 2 organizations to further the education of both memberships. Members from California chaired various sessions at the BCS meeting in London on June 1-2, 2009. Leaders from the BCS will be joining us at our Annual Chapter Meeting in October.

I encourage all of you to visit the CA ACC website (www.caacc.org) to view our current educational opportunities and perhaps obtain some ideas for your own state ACC chapter. We encourage you to be an active member of the ACC. ■

American College of Cardiology Health System Reform Summit

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In February 2009, the American College of Cardiology (ACC) sponsored a 2-day conference on Health System Reform in Washington, DC. The issues were complex and difficult, but a number of partial answers seem to be emerging.

The perceptions of the ACC were highlighted by ACC President W. Douglas Weaver, MD, and ACC Chief Executive Officer Jack Lewin, MD. First, we must recognize that medical costs in the United States are currently at $6800 per capita yearly, double those of the mean European Union average. Second, that cost has not resulted in any measurable superiority of health care delivery in this country, as compared with other advanced industrialized countries. In fact, we are far down the list of health care outcomes when compared with our peers in almost every category. Equally disturbing are the great differences within the United States of health care expenditures, along with a complete lack of correlation with any measure of outcomes relative to medical care input. (For example, in the Medicare population, Minneapolis, MN, and Portland, OR, have 60% lower expenditures than Miami, FL, but these cities have similar outcomes.)

The general government point of view is that medical societies have eroded political trust by concentrating solely on reimbursement and less on issues of quality and disparities of care. The response of Dr. Lewin to this view is that we must not be perceived as a trade association, but rather must project some degree of altruism, as well as be recognized as the possessors of special expertise. We should emphasize:

- Data-driven practices.
- Performance improvement.
- Shared best practices.
- Rewards for doing the right thing.

Only by adopting these goals will we achieve meaningful input into the legislative changes that will be coming within the year.

Both Massachusetts and California attempted in the past 2 years to expand medical insurance coverage to nearly all state citizens. Although the plans were quite similar (shared sacrifice, individual and/or business mandates, state subsidy to 300% of the poverty line), one failed and one succeeded. Although business, labor unions, and insurance companies initially supported the initiative put forth by Governor Arnold Schwarzenegger in California, it never left the Senate Health Subcommittee because Democrats refused to vote to require ordinary workers to pay more—in order to subsidize others—for what they already had.

Currently, 97.4% of Massachusetts citizens are covered by insurance, in contrast to 80% of California citizens.

Nonetheless, there now seems to be a widespread consensus that decreasing total costs and disparities of care across the country, and increasing the quality of care and information flow, are even more important goals than near-universal coverage. Although state initiatives may serve as pilot projects to demonstrate successes and failures (note the ignominious and fiscally disastrous failure of TennCare, in Tennessee), there ultimately can only be national solutions to these massive problems.

What were the conclusions of the conference? First, speakers across the political spectrum judge that we will have universal health care by 2011. There is not, however, a practical appetite for a single-payer system. Second, there will be a rapid move in payment mode (driven by the Centers for Medicare and Medicaid Services) away from fee for service, and towards bundled, more comprehensive care. The legislative efforts will be pointed towards a bipartisan consensus, and many of the changes will be consumer-driven (as discussed in Regina Herzlinger's book *Who Killed Health Care?*).[1] There will certainly be some form of capitation, perhaps a bundled payment for long-term care for patients with diagnoses such as congestive heart failure.

I cannot overstate how important it is for all cardiologists to understand the reasons (primarily financial) for these wrenching changes that are currently on the near horizon. To reflexively oppose the changes in health care delivery is to be on the losing side. We must be in a position to shape and guide the changes, to the benefit of our patients and the well-being of our profession. ■

Reference

1. Herzlinger R. *Who Killed Health Care?: America's $2 Trillion Medical Problem—and the Consumer-Driven Cure*. New York, NY: McGraw-Hill; 2007.

AACC: A New Designation

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During the 2009 Annual American College of Cardiology (ACC) Scientific Session, the Board of Trustees unanimously approved a proposal from the Cardiac Care Associates (CCA) for the new designation "AACC," which stands for Associate of the American College of Cardiology. A workgroup comprised of nurses, physician assistants, pharmacists, and physicians planned and implemented a designation that would recognize the strong desire of CCA members to be recognized for attaining national board certification and cardiovascular training. The designation workgroup compiled 25 questions that were answered by 630 members, which was the largest response to any survey conducted by the College. The survey showed that more than 80% of the respondents desired a designation to affirm their certification and training. Following are the opinions of many CCA colleagues:

- Respondents strongly felt that recognition is important and would be improved by a CCA designation.
- Many factors provide recognition in cardiovascular expertise, the strongest of which is years of experience.
- Respondents believed that a CCA designation would, most importantly, "Acknowledge my professional accomplishments" and "Increase recognition of my expertise by physicians, administrators, and non-physician colleagues."
- Among several prominent choices, the most important chosen eligibility criteria was "Active licensure as designated by current licensing state or nation."
- The most popular title for the designation was Associate of the American College of Cardiology (AACC).