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).

This new designation will assist the ACC in meeting cardiovascular care team members' strong desire to be recognized for their completion of appropriate training and achievement of national certification. With the primary focus on national board certification, and members' interests in advanced learning, skill building, and professional recognition, the Cardiovascular Team Council has compiled a list of boards whose certifications would be required for AACC designation. Following are the requirements and criteria for the designation.

- State licensure.
- Nationally recognized board certification.
- Majority of professional activities must be devoted to the field of cardiovascular disease.
- Three sponsorship letters from current Fellows of the ACC. Letters of sponsorship cannot all come from the same institution. Your ACC State Governor is a good example of a sponsor.
- Employment in a practice that is focused primarily on cardiovascular patients (at least 75%).
- Commitment to cardiovascular practice for 5 years or more prior to applying for the designation.
- CCA member for 2 years prior to applying for the designation.
- At least 12 hours of cardiovascular-related continuing education/ continuing medical education/ continuing education units each year.
- Membership in the ACC's Cardiovascular Team Section.

We hope you will share this information with nurses, physician assistants, and other members of your cardiovascular care team. CCA members who meet the above criteria can apply when the application is available this summer. Please visit www.acc.org for further details, or contact Kelli Bohannon at kbohanno@acc.org or Margo Minissian at MinissianM@cshs.org. ■