



# Arizona Chapter ACC

May 2006  
Newsletter

## *Outgoing Chapter President Bids Arizona Chapter of the American College of Cardiology, "Godspeed"*

### **Chapter Officers:**

**President/Governor**  
**James Galloway,**  
**MD**

**Immediate Past President//Governor**  
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**T**hinking primarily about what it will take to educate 6 children, all of whom wish to go to college, and at least several of whom wish to pursue post-graduate education, I have decided to retire from the United States Veterans Affairs Healthcare System, and go into private practice. This decision involves:

- An end to my personal 30-year 'Peace Corps',
- At least a temporary end, to an academic career capped by professorship at 2 excellent State Universities, the University of Colorado, and the University of Arizona,
- My second fare-well to the Tucson community (having lived here from 1980 to 1984; and again from 1999 to 2006),
- A repeat 'hello' to the State of Washington; having done Cardiology Fellowship at the University of Washington from 1978 through 1980, and now joining the Yakima Heart Clinic, which works out of Yakima Regional Hospital and Yakima Memorial Hospital, Yakima, WA, and
- A fond Fare-well to the Arizona ACC chapter, which has allowed me to be its chapter president for nearly a year and a half.

Males who graduated from college between 1965 and 1970 have a particular 'feeling' for the impact the Viet Nam war had on American lives during the period. My ambivalence was heightened by having attended military school (a Naval Academy prep school in Silver Spring, MD) for high school; voluntarily having joined marine ROTC (including begging the naval Dr to overlook my flat feet, spelled 4F); then spending 2 years in the Harvard University Department of Far Eastern Studies, where I learned that the 'domino theory' was less supported by fact, than Iraq's 'weapons of mass destruction'; followed by graduation in 1969, with draft lottery #8, a sure ticket to Viet Nam. Four years of medical school later, and the draft was over, and I was able to pursue residency and fellowships.

Academic medicine provided the opportunity to participate in, and even design, clinical investigation in which I believed strongly. Nevertheless, another major reason I began with the VA, and ultimately stayed 30 years, was the debt I felt I owed to veterans for my freedom, and the ambivalences I have felt about some of the places our government has sent veterans in our names. Whatever else VA service has meant, I have been blessed to care for many extraordinarily deserving and grateful human beings who chose to serve their (our) country. Additionally, by working at 5 University affiliated VA's I have also had the opportunity to interact and mentor some incredible doctors, nurses, pharmacists and technicians in training. Finally, I have been privileged to work with many patriotic and caring staff especially in the cath labs, cardiovascular labs and intensive care units of these facilities.

I have often been asked, 'What did it take to work all of those years in academics?' Two simple answers: continuous psychotherapy and anti-depressant medications. I recommend both for the stress of either academic or private cardiology, as well as potentially complicating conditions such as disc disease or divorce.

One of my good friends likes to joke, "Academic medicine is a dog eat dog world. In private practice, it's the other way around". I will remember both the University of Arizona and Colorado as very excit-

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ing places in which to work and practice medicine. During periods when the practice of cardiology has been revolutionized by multiple forces, such as:

- Acute MI watchful waiting has been replaced with thrombolytic therapy and then percutaneous reperfusion,
- The PVC hypothesis has been abandoned and the iatrogenicity of the pre-CAST days replaced first by abandoning pro-arrhythmic drugs, and then with new anti-arrhythmic devices,
- For heart failure patients, inotropic drugs being replaced by the vasodilator hypothesis, which in turn, made way for the neuro-humoral hypothesis, and from which attention goes forward toward the myocyte,
- Revascularization has evolved from CABG for the anatomically complex and then percutaneous balloons for the anatomically simple, to PCI for acute MI and shock and comorbid, especially as stents and dual antiplatelet, direct thrombins and glycoprotein IIb/IIIa have been added to bare-metal and then drug-eluting stents,

It has been extraordinary to practice and to participate in many of the trials which were spawning the changes going on all around. I know that many of my colleagues in the Tucson, Phoenix and Flagstaff private practice communities, (like the Denver, Colorado Springs, Fort Collins and Grand Junction private practice communities) have shared in many of these efforts. I am merely expressing gratitude for the time (and even requirement) that academic medicine has provided for 'keeping up' or participating in the 'publish or perish' piece of the endeavor.

My wife and I will miss our many friends in Tucson. We will continue to be drawn back by the fact that sons Shannon and Shane are both completing their second years at the University of Arizona. Both boys love it here and plan on finishing at least undergraduate study here. Whether other siblings will come to the U of A, we do not know, but step-son Chris did one year here before transferring to CU-Denver, and I went to the school of Public Health (PhD 2004); Shannon and Shane hope to graduate in 2008.

We are looking forward to Yakima for numerous reasons. The 14 member group I am joining includes a terrific former fellow, from the University of Colorado (circa 1989); David Kreuger, MD, who, like all of the partners, is a great physician and family man. They all value their spouses and children, as much as they value giving first rate cardiac care. Although private about it, each member has a religious perspective which is an important part of their lives. Philosophically, one of the agreements I have with their practice style is that only 3 of the 14 group members focus on interventional cardiology, and divide that task. I favor sub-specialization rather than the jack-of-all-trades approach to increasingly complex cardiology.

It has been both an honor and a pleasure to work with Peter Maki, MD immediate past-President, and with Patrice Hand, our chapter administrative person in the AZ ACC chapter. I sincerely enjoyed, and hope others also found our last several annual meetings to be valuable. I particularly appreciated the efforts of all of our speakers, and I would like to thank Drs Steve Thomson and Jim Galloway, on both last year's ACC-Diabetes Initiative and this May's ACC Diabetes Initiative in Tucson. It has been a pleasure to begin to get to know, and work with, albeit briefly, Gary Kaufman, Steve Mehta, Steve Cantor, Nathan Laufer, and many other hard-working people who have tried to take some time out for our state ACC. I will miss you and I sincerely wish you all the best.

As I take my leave of the VA, the University of Arizona, Tucson, and the Arizona chapter of the American College of Cardiology, I would like to quote Calvin Coolidge (a framed copy of this quote was presented to me after successful completion of the first 100 PTCA's at the Denver VA in mid 1980's under conditions which might euphemistically be called 'duress').

"Nothing in the World can take the place of persistence.  
Talent will not; nothing is more common than unsuccessful men with talent.  
Genius will not; unrewarded genius is almost a proverb.  
Education will not; the world is full of educated derelicts.  
Persistence and determination are omnipotent.  
The slogan "Press on" has solved and always will solve the problems of the human race."

*With caritas and filia,  
Doug Morrison, MD, PhD  
Former AZ-ACC chapter president*



*Check out our website at [www.acc-az.org](http://www.acc-az.org)*

## President's Message

### James M. Galloway, MD, FACC

Greetings, Friends & Colleagues:

I am humbled at the opportunity to welcome you as the President for the Arizona Chapter of the American College of Cardiology. While this role is new for me, I have had some experiences with the ACC at the national level, including the honor of being selected by the Surgeon General to serve as the Governor for the U.S. Public Health Service and my current service on the ACC International Committee. However, I view the privilege of working with you – my friends, colleagues and role models in Arizona – as one of the greatest honors I have had to date.

My work to date with the American College of Cardiology has been challenging. It has also been extremely rewarding and often quite uplifting. I have had the privilege of watching as Fellows of the American College of Cardiology rise to the issues facing our nation's health care with passion and clarity, on behalf of our patients and the quality of health and health care for the nation, in the face of decreasing access to care with rapidly increasing numbers of uninsured and increasing disparities, decreasing reimbursements, opposition to our profession's ability to provide optimal care and the muted, at times stagnant, national calls for reform.

Indeed, many of the Fellows of this organization, the Cardiovascular Associates and the staff working with them, side by side, are some of the most committed and dedicated individuals I have ever had the pleasure of meeting. These are the individuals that are leading the world in the provision of the highest quality care; dedicated to the latest in research and its translation into practice. These are the individuals with a passion for excellence in medical and patient education. Moreover, these individuals are dedicated broadly to improving the health of the public. It is a great honor for me to serve these selfless individuals.

I would also like to express my appreciation to those individuals currently giving generously of their time and energy in the Arizona Chapter of the American College of Cardiol-

ogy for the benefit of our patients and those of us providing cardiovascular care within Arizona. With the commitment and dedication of many of our members, it is difficult for me to ask for more. Nevertheless, your participation and leadership in our state chapter or in one of its committees are essential as we address the multitudes of issues facing us as cardiologists and more generally as health care providers within the state of Arizona and nationally. We currently have committees on Advocacy (chaired by Mark Stern, MD, FACC), Education (chaired by Peter Maki, MD, FACC), Community Service (chaired by Kris Vijay, MD, FACC) and Quality, which I chair. In an effort to work proactively, I would personally like to see the development of two additional committees, one focused on Imaging Issues and following the developments in the state and the legislature specifically on this issue, and another on the vital issues of disparities in cardiovascular health care across the state. If you would like to get more involved with our organization, please contact me at [galloway@u.arizona.edu](mailto:galloway@u.arizona.edu).

As you know, the values that we share are embodied in the American College of Cardiology. The mission of the ACC is to advocate for quality cardiovascular care-through education, research promotion, development and application of standards and guidelines - and to influence health care policy. The ACC has been and continues to be a prestigious national leader in these areas. Indeed, the leadership and influence of ACC as an organization continues to grow. Our national membership reflects a broad distribution with 64% of the national membership being in solo practice, cardiovascular groups or multi-specialty groups, 20% University faculty, 5% in training and the remainder generally in government. This coalition is reflective of the broad national coalition of cardiovascular specialists with the expertise to address proposed legislative and federal considerations head on. If you have ever felt that you should be more involved in helping to shape the future of health care and its impact on patient care and your profession, now is the opportunity. I invite your participation and leadership.

## Pay for Performance; Fantasy or Reality

by Gary Kauffman, MD, FACC

We are entering a new era in Cardiology with many new challenges ahead of us. We have all heard of pay for performance measures and quality assessment programs, but as I have educated myself in this area, I have found that many of our colleagues are quite naïve and under informed about the impact of these new measures and programs on our practices.

Certainly the concept of quality of care is sound and no one would argue that quality and evidenced based medicine are important. The problem is that the federal government through CMS and the insurance industry are teaming up to develop pay for performance measures and quality assessment programs based on costs and claims data. They tell our medical organizations that their criteria will be based on quality measures and have even involved the ACC in the process of developing guidelines and appropriateness criteria, but the bottom line is that they are trying to save money and cut their costs. Quality is the rouse to engage the public and even us to gain our support for their programs. If we do not become more aware and

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## Mark Your Calendars Now

Please plan to join us on the weekend  
of September 30 -October 1, 2006 for our annual  
Chapter meeting. We are working on an exciting line-  
up of speakers and hope you will be able to attend.

Look for registration information in the  
mail and on our web site soon!

begin to take appropriate action, the end result will likely be an even greater crisis in health care which will further hamper our ability to provide quality care to our patients.

Several insurance carriers including CIGNA, UNITED, and AETNA have already developed new preferred provider networks based on their perception of quality. This has occurred because of pressure from large employers demanding lower health care costs from the insurance companies. To compete for large employers business, the insurance industry has developed their new programs, not to improve quality, but to cut health care costs to compete for business!

These programs are to be fair, partly based on quality measures, including ACC guidelines for management of post MI patients and CHF, but the data is obtained from claims data, not patient's charts. Also, there is a second criterion for inclusion in to the preferred provider network based on costs and claims data based on an episode of care methodology. They call this efficiency. If you meet both quality and efficiency criteria, you are considered a preferred provider for the insurance plan. You can look on a website, as can your patients, and see if you made the grade for these insurance carriers. I think you will be shocked, as was I, when you realize how few of the physicians that you would perceive as high quality physicians that you respect are considered preferred by this obviously flawed methodology.

Most Cardiologists do not even know about these programs. Why not? The insurance carriers and CMS have not really publicized this information although they have been collecting it for almost two years. Currently there are no patients enrolled in these new programs, but there will be soon, likely by 2007. With web access so available to all, the fact that there is currently information on the web stating who is and who is not a preferred provider on insurance plans is frightening, and information in the wrong hands could certainly be misinterpreted and damaging to many practices.

For those that think that this can never happen, like DRGs, pay for performance is coming and is here to stay. These programs will be based on the methodology as discussed above and will also probably start in 2007. Patients will pay a higher copay to see doctors that are not on the preferred list and doctors on the preferred list will get higher reimbursement for their services. Do not get too excited about making more money though. Chances are that this will be budget neutral which means that if Medicare plans a 4% pay cut for 2007, if you are a preferred physician, you will be paid at 2006 Medicare rates, and if you are not a preferred doctor, you will be subject to the 4% pay cut!

We cannot stop these programs from happening, but we can influence the methodology and make sure it is fair and just and based on objective quality measures and not simply on costs. Educate yourselves about these programs. Contact your local Senators and House of Representatives to voice your concerns. Please feel free to contact your local ACC councilor to provide your input. We can make a difference.