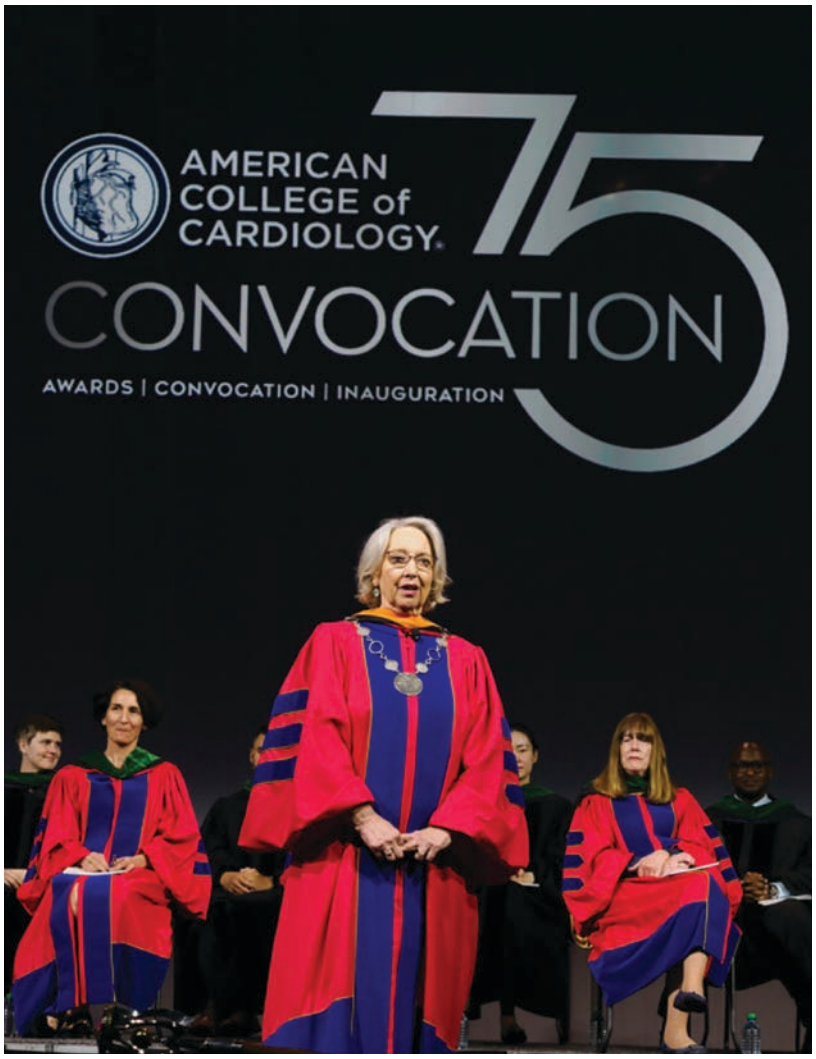
Talking With the American College of Cardiology's New President: Cathie Biga, MSN, FACC

"My heart is still in the cath lab, always and forever," says Cathie Biga, MSN, FACC, the 2024-2025 President of the American College of Cardiology (ACC). "[Even as] VP of a hospital, I used to go to the cath lab just to get my sanity back."

In addition to her current year-long role as ACC President, Biga is also president and CEO of Cardiovascular Management of Illinois, a cardiology physician practice management company. She holds over 40 years of experience in the cardiology field, having worked in both clinical and administrative positions. Biga brings several decades of high-level involvement with the ACC and MedAxiom, and has made history as the ACC's first non-physician president. Read more below from *CLD*'s discussion with Cathie Biga, MSN, FACC.

What do you see as some of the overall challenges in cardiology today?



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This moment is a very interesting confluence of a number of events that are challenging to the team. As we focus on the physician-led team as a whole, it is clear we need to transform care—from site-of-service differences to how we care for our patients both pre and post procedure. This transformation needs to occur along the entire continuum of care. The COVID pandemic really highlighted the need to adapt, in an innovative way, how we deliver cardiovascular (CV) care. The cath lab is very indicative of the quagmire we were in, back in 2020, with COVID restrictions. Yet we were able to turn on a dime. A huge number of cath lab patients were treated as outpatient with same-day discharge. We made sure to implement the safety nets and the clinical guidelines necessary to keep patients out of the hospital as much as possible, even though they needed these procedures. We came out of our comfort zone and truly transformed how we delivered CV care, and that transformation continues today. However, now add on top of that, the inability to fully staff our labs. In the last year, staff shortages have improved at many locations, but radiologic technologists, for example, are still very hard to find. The whole CV team is needed for the care of these patients and it is a challenge to make sure that we have that workforce in place. And, of course, as we all know, hospital margins are getting smaller and smaller, which is a direct derivative of all the outpatient care versus our inpatient DRG reimbursement.

How can hospitals best support their physicians and team members?

Our hospital executive teams must include the physicians in all decision-making and governance processes and get back to that governance model where the team is truly physician-led. Physicians know how to care for these patients, and we must understand and embrace having the physician lead. That is a mantra for our administrative colleagues (and I am one of those administrative colleagues!). To do same-day discharge for ablations, most of our diagnostic caths, and even many of our percutaneous coronary interventions (PCIs) means listening to what our physicians need. As one example, we created a dedicated post-interventional recovery area to monitor our patients. It built confidence that when patients were ready for discharge, they were safe for discharge. We did not want to have these patients scattered all over the hospital, but instead we placed them together in a unit where staff is trained to look after and assess these post-procedural patients. Hospital systems are under enormous pressures. Sometimes they forget that in order to practice medicine, we only need two things: we need a physician and we need a patient. Everything needs to circle and support that interaction between that physician and that patient. It is so very important. In the busyness of our worlds, we often forget that.

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What do you think about the rise of cardiovascular ambulatory surgery centers (ASCs)?

If we go all the way back to 2010, which was a remarkable point in time in cardiology, we see the dramatic impact of the 2010 fee schedule and the ongoing impact of the DRA and the PPIS survey, all converging into a major change in cardiovascular care. It changed our employment model for cardiology and obviously we are now sitting at between 80% and 90% of our cardiologists employed. I think site of service is just another piece of that business cycle. The financial and the quality aspects should remain completely entwined. We need to view the Quintuple Aim as our true north, meaning a focus on the best site of service, the best patient outcome, and both patient and provider satisfaction. From a financial perspective, Medicare is struggling, so we must figure out how to do things differently, and aligning site of service is one option the government is looking at closely. We have been looking at office-based labs and ASCs in the cardiology world for a very long time, and probably peripheral vascular procedures were one of the entry points. People are already used to ASCs for ortho and

Cathie Biga, MSN, FACC, during an ACC.24 late-breaking clinical trials session.
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other procedures, but cardiology procedures in ASCs will continue to grow. As that evolutionary process unfolds, the ACC's goal is to ensure quality is never compromised and care of the patient is always at the center of everything we do. The ACC's National Cardiovascular Data Registry (NCDR) for ambulatory surgery centers is a critical element, allowing us to monitor and benchmark quality, and work with our partner societies, the Society for Cardiovascular Angiography and Interventions (SCAI) and Heart Rhythm Society (HRS), as well as our vascular subspecialty societies. It is essential that the 'House of Cardiology' work together as we evolve into these different sites of service. The variation in the ownership models is always interesting to watch from an administrative perspective. Our cardiologists tend to be entrepreneurial in spirit. They want the very best for their patients and so they will, in an appropriate manner, evolve in this world, but we need to be careful with each step that we take.

ACC has a new strategic plan for 2024-2028. Can you tell us more about it?

When creating a strategic plan, you start with the mission, vision, and values. What is exciting to me about the current plan is the addition of two very simple words. As we assess the global nature of cardiovascular care, we added the words 'for all'. We are transforming care *for all*. A critical element of that is equitable access. If the pandemic taught us nothing else, it taught us that we have incredible disparities in how we deliver care globally. Yet heath care deserts exist as equally in the United States as elsewhere in the world. I see it in my day job in Chicago. As we look at the pillars of the strategic plan and embed those elements of equitable access, 'for all' becomes very important.

Another key pillar of the strategic plan is establishing the pathway for continuous cardiovascular competency with new boards, a highlight that we hope to complete this year. The chance to have our own cardiology boards is a welcome component of the new strategic plan.

We are also making sure that clinical guidance is usable at the point of care. As we continue to learn the appropriate use of artificial intelligence (AI), which continues to not only expand but explode, we want to ensure that our clinicians have the tools to harness AI, including using it to reduce administrative burdens and using it at the point of care for patients, so that it is an assistant to what clinicians do on a day-to-day basis.

The last pillar, and one that as a non-physician president of the College I find very exciting, is creating a best practice framework for care delivery. We will be focusing on the implementation of healthcare strategies as we transform care. We can look back to 2020 to see how quickly many of us changed how we delivered care — and then how fast we reverted back in late 2020 and 2021. One example is the use of telehealth to deliver care differently, something we need to further explore, because we are not doing it well.

Through the strategic plan over the next five years, my goal is to deliver actionable knowledge, transform care, and utilize the continuous learning pathway for our physicians. The key is to make sure ACC is the professional home for everyone. A large part of that is embracing our CV team. One thing at ACC.24 that was so heartwarming was seeing so many of our team members present, such as our pharmacists and our dieticians, as well as seeing some of the late-breaking trials that incorporate the CV team. This aspect is what I find the most exciting for the next five years of the strategic plan.

Can you share more about your work outside your role as ACC president?

I am president and CEO of Cardiovascular Management of Illinois, which includes 14 acute care hospitals and a little over 100 cardiologists across the Chicagoland area. We started the company in 1998, and from day one, it has been physician-led and professionally managed. I think the key to our success has been our governance model. We have built an outstanding service line. Our challenge at the moment, just like everywhere else, is looking at different ways of doing things. Right now, we are continuing to implement subspecialty clinics because a personalized approach to their care is what our patients need. Today in cardiology overall, you are no longer simply an "interventionist," but are structural, complex PCI, chronic total occlusions (CTOs). "Noninvasive" has become advanced imaging, structural imaging, and so on. Yet we need to be sure we don't get too segmented and keep that continuum of care.

Do you have a message for professionals who might not be involved with the ACC, but who are team members in the cath lab?

When Jim Dove (ACC president from 2007-2008) first opened the college to non-physician CV team members, it was logical to include advanced practice providers and nurses, because with the team approach, we were always tied at the hip with our physicians. As this pathway evolved, we started looking at that whole care team component. Heart failure was the next stepping stone, as we knew full well that we also needed pharmacists, dietitians, etc., on board. For noninvasive and interventional cardiology, we needed our radiologic technologists and exercise physiologists, all as part of the team.

One of my favorite talks I love to give is about delivering the continuum of care after the guidelines are published. Our clinicians do phenomenal work with the guidelines, but then we need the team to help us implement these guidelines. We need our team to help us get blood pressures to optimal levels, get statins on board for targeted cholesterol levels, and make sure that patients are aware of and can make necessary lifestyle changes. As we look at the social determinants of health, it is so obvious that we have to meet patients where they are. We have missed this element for many years. We need to have a care team that looks like our patients and that understands their culture. That is true in the cath lab, too.

I know the team has many options, but I hope they will see both the educational and the professional goals of the College as welcoming to all. Having radiologic technologists and nurses, and everyone who is involved with cardiovascular patients as part of the College keeps the message consistent. Honestly, when I went to my first ACC meeting so many years ago, I felt like, oh, here I am, a nurse surrounded by physicians. It has been so gratifying to watch that environment evolve, and see physicians who are at ACC's Scientific Sessions with their allied health partners. They are learning together and bringing all that knowledge back home so it can be implemented on a day-to-day basis. As a nurse, I am forever grateful to Jim Dove. I still have his letter inviting us to the College, and I thank the College for their willingness to be so diverse and inclusive in so many different areas.

Any final thoughts for readers?

What can ACC do to help you get involved? Sometimes people think they have to come all the way to Washington, D.C., in order to be involved. I encourage everyone to become involved at their local level – find your local Chapter and get involved in the education and networking. It is easy for team members to find their state chapters online. I think you will find it professionally valuable and satisfying. ■

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