Fortunately, the ACC is committed to helping members navigate the new changes. An update has been published in *Journal of the American College of Cardiology*[2] and there is an online resource center on CardioSource. The ACC's new online Lifelong Learning Porfolio is designed to help members achieve MOC requirements whereas minimizing the discomforts of doing so. ACC leaders are committed to working with the ABIM to make MOC a relevant, efficient, and effective means of improving patient care. ■

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Who Should Be at the Helm? A Discussion on Team-based Care

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Team-based care (TBC) has been gaining momentum in the medical community although many health care professionals have been practicing in TBC practice settings for many years. Many changes are already occurring due to the Patient Protection and Affordable Care Act (ACA). TBC is more important now than ever to provide safe, cost-effective, and timely patient care. This discussion will highlight how TBC is best utilized in different clinical settings and how teams are led by situational leaders based on the acuity and needs of the patient.

Much debate has occurred over what encompasses a team and who should be the team leader. In 2013, many heated discussions focused on TBC including an article by John Iglehart published by the *New England Journal of Medicine* that highlighted nurse practitioner practice in the United States.[1] The article discussed the Institute of Medicine (IOM) report on the future of nursing and implementation and barriers to nurses' increasing autonomy. Iglehart described the physician as the captain and discussed a traditional hierarchical approach to TBC. In order to have effective teams, health care leaders and law makers will need to modify the patriarchal, hierarchical approach to caring for patients. Evolution is required in health care culture to shift the focus back to patients being at the center of care, embraced by a care team. This would be better accomplished by the utilization of the situational leader, who could be a registered nurse, physician, nurse practitioner, dietitian, physician assistant, or pharmacist, depending on acuity, the needs of the patient, and the resources available.[2] A Letter to the Editor in response to a series of letters triggered by Iglehart suggested a similar theme presented here. R. Scott Braithwaite suggested classifying services according to relevance based on evidence-based protocols.[3] This idea lends itself to the situational leader.

The IOM report is clear that nurses should practice to the full extent of their education and training and should, therefore, achieve higher levels of education and training.[4] Advanced practice nurses have excellent outcome data showing safety and quality in many

delivery-of-care settings.[5] TBC has flourished in inpatient acute-care settings and in outpatient specialty settings in addition to primary care. Transaortic valve replacement and heart transplant teams consist of surgeons, cardiologists, nurses, technologists, pharmacists, and researchers. The surgeon or interventional cardiologist will likely play the role of situational leader. In the outpatient interventional clinic setting, the physician assistant or nurse practitioner may play the role of situational leader, seeing patients in the outpatient clinic while the interventional cardiologist remains in the catheterization laboratory performing procedures. Nurse practitioners and physician assistants can see patients and bill for outpatient services while other team members remain in their area of expertise. If needed, the interventional cardiologist is available for consultation by phone.

Nurse practitioner–led heart failure clinics and lipid clinics are great examples of optimal utilization of nurse practitioners in the chronic disease setting. As Medicare reimbursement is reduced and the number of elderly increase, these cost-effective, quality-care clinics will play an integral role in keeping patients out of the emergency department. There are other settings where the entire team may not need to be present. These examples are generally in the primary care setting and examples are a flu shot or primary care clinic or well-baby check-up. In fact, many primary care situations can be handled solely by the primary care physician or the primary care nurse practitioner.

Professional societies, including physician and nurse organizations, need to work together to place the patient's interest first and secondary motives last. The American College of Cardiology (ACC) has done an excellent job placing patients first. A physician's guild at its inception, it is now a professional organization that has welcomed all care-team members, including nurses, pharmacists, practice administrators, physician assistants, and nurse practitioners. To recognize the expertise of their team members, a designation specifically for nonphysician members who demonstrated expert cardiovascular care was developed: the Associate of the American College of Cardiology.[6] In addition to professionally supporting all cardiovascular ACC members, a TBC organizational approach has supported important national legislation and lobbies each year as a team on Capitol Hill. However, much more needs to be accomplished at the grassroots level. It is important for specialty societies to support their primary care colleagues who are also important team players and can also be situational leaders. TBC is the wave of the future; make sure your practice doesn't miss the boat. ■

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