Models of Practice

Strumpf (1994) describes three practice models commonly used in primary care. They are:

The Parallel Model:

The non-physician provider sees stable patients, and the physician sees more medically complex patients.

The Sequential Model:

The NP or PA performs an initial history & physical exam while the physician assumes responsibility for differential diagnosis and management; alternatively the physician may see patients initially to screen for complexity, with the less complex patients being assigned to the non-physician.

The Shared Model:

All providers on an alternating basis see patients.

The Collaborative Model:

Archangelo et. al (1996) propose a fourth model which they term the collaborative model. In this model, patients choose their provider as desired regardless of the complexity of their problems. All providers collaborate as needed to provide safe, high quality care (p.108) yet each practices autonomously.

Collaboration can be defined as a joint communication and decision-making process with the goal of satisfying the health care needs of a target population. The basis of collaboration is the belief that quality patient care is achieved by the contribution of all care providers. A true collaborative practice has no hierarchy. It is assumed that the contribution of each participant is based on knowledge or expertise brought to the practice rather than the traditional employer/employee relationship (Archangelo, et al; p.106).

Components of Collaborative Practice:

- A common group of patients
- Common goals for patient outcome and a shared commitment to meeting these goals
- Member functions are appropriate to an individual's education and expertise
- Team members understand each other's role
- A mechanism for communication
- A mechanism for monitoring patient outcome
- Trust among all parties establishes a quality working relationship that develops over times as the parties become more acquainted.
- Knowledge is a necessary component for the development of trust. Knowledge and trust remove the need for supervision.
- Shared responsibility suggests joint decision making for patient care and outcomes and practice issues within the organization.

- Mutual respect for the expertise of all members of the team is the norm. This respect is communicated to the patients.
- Communication that is not hierarchic but rather two-way, facilitating sharing of patient information and knowledge. Questioning of the approach to care of either partner cannot be delivered in a manner that is construed as criticism but as a method to enhance knowledge and improve patient care.
- Cooperation and coordination promote the use of the skills of all team members, prevent duplication, and enhance productivity of the practice.
- Optimism that this is the most effective method of delivery of quality care to promote success.

*Adapted from Grant, (1995) pgs. 45-46.

Collaborative Practice

Collaborative Practice as a Preferred Model—Team Members

There are numerous members of a successful collaborative team, besides physicians, physician assistants, and nurse practitioners. It is useful to consider both a core team, consisting of those members who are involved in patient relations on a continuous basis, and an extended team consisting of members with critical skills, such as physical therapists, who assist with patient care as needed. These other individuals may include social workers, nutritionists, psychologists and specialty providers. A community clinic team also may include translators, volunteers, and health educators. Health administrators also are an important part of the patient care environment.