PHCNP

Several patient management models but no simple recipe

The practice model for PHCNPs in Quebec, as described in official documents and regulations, is one in which PHCNPs and their physician partners look after patients' needs collectively. However, the specific means by which such patient management is implemented can take various forms.

Source and validity of these recommendations

The information presented here comes from two sources: 1) the results of a systematic review of the scientific literature on advanced nursing practice in primary care, and 2) the results of six case studies of settings that have integrated PHCNPs in three health regions of Quebec. Details of the methodologies used for each of these two research efforts are presented in the Methodology section at www.phcnp.info. The analyses of the data produced in each of these two components were used to inform each other reciprocally. Thus, the data from the scientific literature were analyzed in relation to the various models of integrating PHCNP practice found in Quebec, while the empirical data were interpreted based on themes identified in the literature.

A typology of patient management models

Two broad types of patient management models can be seen in teams that include PHCNPs. The first we call the "joint management model" and the second, the "consultative management model". A model is considered to be *joint* when the PHCNP and the physician partner follow the same group of patients together. In such a model, patients may be seen by both professionals at different points in their treatment. For example, a patient might be seen by both the PHCNP and the physician in one visit, or by the PHCNP in one visit and by the physician in a subsequent visit. Conversely, a model is considered to be *consultative* when the PHCNP and the physician partner each follow a different group of patients and the physician is consulted as needed for support in managing the PHCNP's patients. In the second model, most of the patients followed by the PHCNP never see the physician except for the occasional specific needs.

From our case analyses in the field, three general observations emerged regarding the patient management models implemented. First, the models implemented by the teams were generally not the result of an explicit choice. They seemed rather to have emerged through trial and error. Second, the empirical data showed that, in practice, the models implemented were generally hybrids of the two types presented here. Several regulatory factors, such as procedures for enrolling patients with physicians or clinics, had a determining influence on the patient management model created. Lastly, in the cases analyzed, consultative management figured much more frequently than joint management.

Models must be adapted to teams

Neither the data from the literature review nor the analysis of empirical cases suggest that any one patient management model is, in itself, better than the others. On the other hand, there is convergent evidence to support the notion that it is the overall comprehensiveness of the model that matters. If the patient management model is incompatible either with the types of clientele followed, with the team's composition, or with the PHCNP's level of experience, its operations will be both dysfunctional and frustrating. For this reason, a model that works very well in one setting may turn out to be completely inappropriate in another. There appear to be three determining factors to consider in choosing a patient management model: the characteristics of the clientele, the experience and preferences of the PHCNP, and the number of physician partners.

The most important element to consider in choosing a patient management model is the nature and complexity of the clientele to be followed by the PHCNP. The current definition of the PHCNP's field of practice, the limited range of diagnostic tests and drugs that can be prescribed by PHCNPs, and the procedures for referring their patients to specialists all make it complicated for PHCNPs to follow patients with complex conditions. In practical terms, if PHCNPs follow complex patients in a consultative model, they must constantly consult the physician partner, resulting in duplication and frustration on both sides. Thus, in teams that opt for a consultative patient management model, it is essential to establish parameters regarding the characteristics of patients followed by the PHCNP so that most of those patients' needs can be looked after within the PHCNP's field of practice. It is also important to understand that this implies a potential increase in the average complexity of the patients followed by the physician partner. Clinics receiving new patients primarily from groups of "orphan" or unaffiliated patients should expect that these patients will have complex conditions, and that the autonomous management of these patients by a PHCNP in a consultative practice model will present significant challenges.

The second element to consider is the PHCNP's experience and preferences. There is convincing evidence in the literature that a PHCNP's first year of practice is one of transitioning toward fully occupying the field of practice and developing one's autonomy. Similarly, the data from our case studies showed considerable variability in the complexity of cases that PHCNPs could manage effectively depending on their level of experience. As such, the choice of model should take into account both patient complexity and PHCNP experience, at the same time. It is also important that the patient management model be allowed to evolve over time as the PHCNP gains experience so that the person in this position can eventually assume the full scope of practice. As well, somewhat akin to the great variability seen in general physicians' practice profiles, the preferences and skills of both the PHCNP and the physician partner should both play a role in developing the patient management model. We observed, in the field, that PHCNPs' practices were often defined in conjunction with those of their physician partners or according to their preferences. Here again, it appears to be important to keep these parameters open and to be ready to redefine them over time.

The third element to consider is the number of physician partners. While the literature is not specific on the optimal number of physician partners per PHCNP, our case analyses suggest the optimal number is probably between 2 and 4. Having only one physician partner results in logistical challenges when that person is absent. Conversely, the more physician partners there are, the more adaptation is required from the PHCNP, as the bonds of trust are built up slowly and differently from one person to another. Our case analyses indicated that the time required from physicians to respond to the PHCNPs' questions decreased steadily as the level of trust between them increased and as the PHCNP gained experience. It may also be that the joint patient management model entails closer PHCNP–physician collaboration and that the optimal number of physicians should be limited accordingly. Lastly, it is essential that the procedures for communication between PHCLPs and their physician partners be compatible with the patient management model in place.

Symptoms of dysfunctional models

In our case analyses, we observed that certain characteristics of the patient management models implemented produced dysfunctional practices. These problems were symptoms that the models needed to be reviewed and adapted. For example, in a consultative model, if the PHCNP cannot see patients when the physician with whom they are enrolled is not present, this complicates appointment scheduling and can severely limit the model's efficiency. In some of the settings we analyzed, it was difficult to assemble a sufficient patient caseload for the PHCNPs, despite their availability. This was a serious indication that the patient management model was suboptimal. Likewise, in some cases studied, an overly stringent interpretation of procedures for the PHCNPs' practice made the consultative model's daily functioning very heavy and transformed it into a model in which the physician became the de facto supervisor of the PHCNP's practice. Such a supervision model, in which a lot of patient management is duplicated, is not desirable.

The characteristics of effective models

The suitability of any patient management model can be assessed in terms of three desirable characteristics of professional practice: *group* practice, *interdisciplinary* practice, and *collaborative* practice. What we refer to as *group* practice is characterized by team members' sharing of resources and responsibilities. We use the term *interdisciplinary* to describe the fact that the patient management model is based on pooling the complementary expertises of the various professionals (see the Role Definition information sheet at www.phcnp.info). Lastly, we describe as *collaborative* the communication and task-sharing processes that optimize efficiency and quality of care (see the Collaboration information sheet at www.phcnp.info).

When thinking about the patient management model, it is therefore important to keep in mind a collegial concept of the team that transcends professional boundaries. If only a certain portion of

a clinic's physicians work with PHCNPs, what kinds of relationships do those PHCNPs have with the other physicians? Can they turn to them if necessary? If so, what procedures do they follow? What are the collaboration mechanisms between PHCNPs and nurse clinicians or other professionals? The cases analyzed suggested that the links between PHCNPs and nurse clinicians or other professionals are not always clear. Some PHCNPs refer patients to nurse clinicians, while others do not. Some nurse clinicians might seek advice from PHCNPs to broaden the scope of their own practice, and inversely, some PHCNPs, especially those still in training, are also able to learn from nurse clinicians who are specialized. All of this helps improve the complementarity of patient care.

The importance of defining the patient management model

The process of identifying and implementing a patient management model should always remain focused on the two ultimate objectives of the exercise: quality of care and treatment, and service accessibility. There is, however, a certain amount of tension between these two objectives. Devoting many resources to a small number of patients may improve quality but reduce accessibility, whereas providing services to a large patient pool with few resources will have the opposite effect. The selected patient management model should focus on maximizing both quality and accessibility in a balanced way.

Data from analyses of success factors for nurse practitioner implementation all agree on the importance of clarifying the broad outlines of the patient management model. As a general rule, it is important for the teams to be reflective and attentive to the fit between the implemented model and any practical constraints and to optimize practices as required. Likewise, there needs to be consensus in the team on these broad orientations, and a good fit between individual practices and the patient management model selected. A coherent definition of the practice model is a crucial determinant of the quality of interprofessional collaboration and of the capacity to establish operational definitions of each team member's role. There is also credible evidence to suggest that the coherent definition of a patient management model is an important determinant of job satisfaction in primary care interdisciplinary teams.

For more information

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