Collaborative Care Model:
Nurse-Physician Partnerships in Primary Care

Christine A. Sinsky, MD FACP
Thomas A. Sinsky, MD FACP

BACKGROUND: Medical Associates Clinic (MAC) is a physician-owned, 115-physician, multi-specialty clinic in Dubuque, IA (pop 60,000.) In 2008 MAC was one of the first 13 clinics nationwide recognized as a level three Patient Centered Medical Home. Medical Associates Health Plan, covering about 30% of the MAC patient population, is a Medicare five-star plan, making it one of the top thirteen in the nation. In addition, Dubuque has the lowest costs of care for Medicare hospitalized patients in last two years of life (Dartmouth Atlas 2008), the second lowest global costs for the commercial population (Thomsen-Reuters 2009) and is ranked 2nd in the nation for overall health system performance (Commonwealth Fund 2012.) Primary care physician satisfaction at MAC is three times American Medical Group Association national benchmarks. Our primary care physicians, like others throughout the U.S., face the challenges of an increased workload of clinical, administrative and clerical work.

OBJECTIVE: To improve the quality of care provided to patients, more fully leverage the training of the nurses and physicians, and improve the work-life satisfaction for the team.

STRATEGY: In the Collaborative Care Model the nurse stays with the patient from the beginning to the end of their appointment, acting as the patient's advocate, guide and health coach. During the first component the nurse obtains vitals, performs medication reconciliation, gathers information relevant to the appointment, helps the patient set the agenda and begins to record the history. The physician then joins the appointment, builds on the history, performs the exam, and together with the patient and nurse, helps to craft a plan. It is a three way conversation, with the nurse also recording much of the visit in real time. One explicit goal is to increase the percentage of the visit during which the physician provides undivided attention to the patient. After the physician component, the nurse stays with the patient, operationalizing the plan and reinforcing instructions. For select patients the nurse will make between visit calls.

RESULTS: Our preliminary qualitative data suggests improved patient, nursing and physician satisfaction. Patients have a more thorough understanding of instructions and plan, nurses are better able to respond to between visit calls and physicians report feeling less harried, and able to provide more attention to the patients' concerns, as they spend less of the visit on administrative tasks.

We have also learned important lessons in team building and organizational change management. We believe our model is currently working at only about 20% of its full power and have identified technology, administrative and regulatory changes that would facilitate further improvements in efficiency, quality and satisfaction.

CONCLUSIONS: Nurse-physician partnerships in a core team model have the potential to improve patient care and health professionals' work life satisfaction.

NEXT STEPS: For further dissemination we recommend 1. Increasing the primary care RN workforce, especially through an expansion of the Associates Degree RN workforce; 2. Developing EHRs with better team-based functionality; 3. Creating institutional and regulatory frameworks that acknowledge the authority and competency of the nursing members of the team. 4. Formal research analysis of clinical, financial and satisfaction metrics of nurse-physician partnerships in a collaborative care model.