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SPECIAL COMMUNICATION

Comprehensive Primary Care Team Model: Early Insights on Implementation from Care Teams in Family Medicine

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Family medicine faces critical challenges including workforce shortages, limited patient access, and the need for sustainable care models. We implemented a Comprehensive Primary Care Team (CPCT) model pairing physicians with three to four advanced practice clinicians (APCs) in four community-based clinics serving rural Central Texas. This special communication provides insights into early implementation of this model (about 12 months post-implementation). We conducted informal qualitative interviews to understand clinician perspectives on early implementation. This included site visits with the four clinics piloting the CPCT model (n = 19). Interviewees included physicians and APCs. Interviews focused on daily workflows, scheduling, interprofessional communication, patient access, panel-size management, collaborative practices, and perceived barriers. We also conducted an analysis of third next available appointment using administrative data to get a snapshot of our goal to increase access. This analysis compares one CPCT model clinic with a solo-practice clinic. Insights from these informal interviews centered on 4 themes: (1) Teamwork and Collaboration, (2) Access and Scheduling, (3) Panel-Size Management, (4) Clinician Satisfaction. The third next available appointment analysis revealed substantially more appointment availability in the CPCT model clinic across multiple visit types. The CPCT model has potential to be a scalable innovation enabling family medicine practices to safely expand panel sizes, improve access to care, and operationalize physician-led population health management. Ongoing challenges include right-sizing teams, space limitations, and workflow optimization, but early insights support replication in primary care settings seeking to address access gaps and workforce constraints while maintaining quality of care.

Keywords: Access to Care, FMLC 2025, Patient Care Team, Population Health, Primary Health Care

Background

Primary care sits at a crossroads, confronting escalating challenges of access, panel capacity, and workforce sustainability while bearing the responsibility for population health in a rapidly evolving healthcare landscape. The combination of rising chronic disease prevalence, continued population growth, and persistent primary care physician (PCP) shortages, which are projected to reach a deficit of 10,000 PCPs in Texas by 2032, threatens the core of family medicine's ability to deliver timely, comprehensive care to all who need it.[1] Recent estimates show over 100 million Americans, both rural and urban, experience inadequate access to primary care; the average delay for a family medicine appointment now exceeds 20 days, often leading to deferred care and increased reliance on costly emergency services.[2] As patients struggle to obtain routine, preventive, and chronic-disease care due to overburdened practices, clinicians shoulder increasing administrative loads and demands that often far exceed available hours in the workday, contributing to widespread burnout and declining satisfaction.[3,4]

The prevailing model of primary care, typically centered around individual physicians managing panels of 1,500 to 2,500 patients, has become unsustainable.[4] Recent analyses indicate that providing all recommended preventive and chronic services for an average-sized panel would require a physician to work nearly 27 hours per day.[5] The resultant care gaps, reactive rather than proactive approaches, and growing wait times have exposed the limitations of the traditional model. Moreover, the need for cost containment in the face of limited capital and rising utilization, combined with a push for value-based reimbursement, call for meaningful transformation in how care is organized and delivered.[5]

Beyond direct patient care, PCPs are expected to serve as population health managers, combining clinical expertise with data-driven strategies to address health disparities,

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coordinate chronic disease management, and ensure high-value care across patient panels.[6] Evidence shows that primary care–centric leadership within Accountable Care Organizations (ACOs) consistently correlates with improved health outcomes, lower per-capita costs, and higher care quality, particularly when physicians take an active role in preventive and population-level initiatives.[7] Studies indicate that physician-led models that emphasize population health oversight, such as proactive use of chronic-care management, risk stratification, and team coordination, achieve significantly greater continuity and cost efficiency.[6] The National Academy of Medicine and the Robert Graham Center both identify the PCP as the central coordinator of population health integration, responsible for aligning clinical care, technology, and community-based interventions to improve outcomes across populations.[7,8]

In response to these converging challenges, team-based primary care has emerged as a promising strategy to enhance primary care's core functions: access, continuity, coordination, and comprehensiveness.[9,10] The model redistributes care tasks such that physicians oversee complex cases and high-risk patients while advanced practice clinicians (APCs) manage stable chronic and preventive care, all supported by care managers, medical assistants, and other ancillary clinical staff, such as pharmacists and social workers.[11] Team-based care has gained national prominence as a central component of the patient-centered medical home and broader primary care reform efforts.[12] The goal is to maximize the diverse skills of all team members, enabling everyone to operate at the "top of license" and deliver safe, effective, and patient-centered care, while maintaining the essential pillars of family medicine: continuity, comprehensiveness, coordination, and first contact access.[13] Real-time physician consultation and co-visits foster an environment of shared responsibility, deeper patient relationships, and proactive population health management.[14]

Evidence from national demonstration projects and state initiatives suggests that this collaborative approach can meaningfully increase practice capacity, enhance access, and preserve or improve quality and clinician experience.[15,16] For example, registered nurses, medical assistants, community health workers, and other team members have increasingly been tasked with chronic-disease management, preventive care, patient education, and care coordination, freeing up physicians and advanced practice clinicians to focus on complex diagnoses and higher-risk patients.[2] Notably, well-constructed team-based models have been shown to safely support substantially larger patient panels without compromising care, provided roles, workflows, and supervision are thoughtfully designed.[2,16]

Implementation of Comprehensive Primary Care Team (CPCT) Model in Central Texas

In 2024, we implemented a CPCT model in the Baylor Scott and White Health (BSWH) Family Medicine department in the Central Texas region (CTX FM). The CTX FM is composed of 15 community-based clinics that are part of the primary care division of the BSWH System, Texas's largest not-for-profit health system. The CTX FM clinics employ 140 clinicians (50% physicians, 50% advanced practice clinicians) serving approximately 130,000 rural patients across a broad geographic region that includes an estimated 1.2 million people living in 31 designated rural counties.

The CTX FM CPCT represents a significant innovation for primary care, enhancing both access and panel size by leveraging a physician-led, multidisciplinary team structure anchored by one physician supervising three to four APCs, which mirrors successful frameworks in leading literature and addresses major challenges confronting family medicine today.[2] We aimed to address the root causes of primary care strain by redistributing work, expanding access points, and fostering closer collaboration among clinicians and support staff.

The model calls for a reduction in direct patient contacts for physicians (to 12–15 patients/day, representing a 30–40% decrease), with greater emphasis on team supervision, complex care management, and availability for real-time consultation and co-visits. APCs manage routine, stable chronic, and well visits, benefitting from frequent physician consultation and targeted support for their continued development as primary care clinicians. Registered nurses, certified medical assistants, patient support staff, and a range of clinical professionals—such as social workers, pharmacists, and dietitians—round out the team, each operating in expanded, meaningful roles. The CTX FM CPCT incorporated protected time for daily team huddles and weekly multidisciplinary panel reviews to ensure continuous communication, proactive patient outreach, and identification of care gaps. Expansion of telehealth and asynchronous modalities was explicitly encouraged to further extend reach and convenience.

To begin to understand internal perspectives of the early implementation of this initiative, we conducted informal interviews and site visits with four family medicine practices piloting the CPCT model. Interviewees included physicians (n = 4) and APCs (n = 15; total n = 19). Interviews focused on daily workflows, scheduling, interprofessional communication, patient access, panel-size management, collaborative practices, and perceived barriers.

This special communication shares the information discovered during those informal interviews to provide insight to clarify operational successes and ongoing challenges. We also conducted an analysis of third next available appointment to get current data (a snapshot of August 8, 2025) on one of our main goals, which is to increase access. This analysis compares one CPCT model clinic with a solo-practice clinic.

Insights

Teamwork and Collaboration

All pilot sites reported substantially improved teamwork and interprofessional collaboration compared to the traditional enhanced care team models they used to work in. Daily or frequent team huddles and close proximity of

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physician and APC workstations fostered ongoing communication, shared decision-making, and smoother care transitions.

Access and Scheduling

The model's lighter physician schedule allowed critical time for urgent high-risk patient visits, hospital discharge follow-ups, and proactive outreach. Teams employed flexible scheduling and pre-visit planning, moving high-need or high-acuity patients between physician and APC schedules. Over time, open slots were expanded for new-patient acute visits and urgent needs.

Panel-Size Management

Clinics successfully expanded patient panel sizes to 3,000–5,000 (from about 1,200) per team while maintaining quality through flexible roles and collaborative planning.

Clinician Satisfaction

Physicians and APCs consistently described increased job satisfaction, reduced burnout, and professional fulfillment, citing more manageable workloads and greater focus on complex, meaningful patient care.

Implementation Barriers

Challenges included clinic space limitations, uncertainties regarding optimal maximum panel size, and continuity during staffing transitions. However, hesitancy among staff during initial implementation typically subsided as team familiarity and trust developed.

Third Next Available Appointment

Table 1 shows the third next available appointment by visit type (new patient, new patient acute, new to provider, wellness visits, physical exams, hospital discharge follow-up, office visits, telemedicine visits, pre-operative, well-child visits). The third next available appointment analysis revealed substantially more appointment availability in the CPCT model clinic across multiple visit types. For acute new-patient visits, the team offered availability on August 8, 2025 (same day), while the solo practice did not accept new patients. For routine office visits, the team offered August 11–August 13, 2025 appointments (APCs) with physician availability on September 6, 2025, compared to September 8, 2025 for the solo practice. For hospital discharge follow-ups (a critical access measure), the team offered August 8–August 21, 2025 appointments, compared to August 14, 2026 (one year later) for the solo practice. Telemedicine appointments were similarly more accessible in the team model, with same-day to next-day availability across team members versus September 2, 2025 for the solo provider.

These early insights from our care teams align with evidence that team-based primary care can support larger, well-managed panels by ensuring capacity for both complex and routine primary care needs.[17] While research highlights that excessively large panel sizes can negatively impact quality, particularly for cancer screening, diabetic care, and continuity, robust team structures with right-sizing are crucial in managing these risks.[9,10] The CPCT model allows for physician supervision, optimized workflows, and regular team communications that are essential to maintaining continuity and mitigating access and quality issues as panel size increases.[11] These insights further reinforce that safe panel expansion requires intentional role definition, daily huddles, and weekly panel reviews to ensure all team members remain aligned on patient priorities and care gaps.

Efficiently structuring team roles allows practices to safely increase panel size while maintaining quality outcomes. Current targets within CTX FM are panels of 1,800 for solo physicians and up to 4,500 for physician-APC teams. Long term, we expect to expand panel sizes to 6,000 per care team using a formula that assumes an average of 2.3 visits per patient annually, with 18 visits per 1.0 FTE APC and 15 visits per 1.0 FTE physician per day, all within a 46-week year. Using this formula, a team of one PCP and three APCs could expand their panel up to 6,860 patients.

Evolution of the Physician's Role as Population Health Manager

The CTX FM CPCT represents an evolution of the primary care physician's role, moving from traditional sole provider to operational leader of multidisciplinary population care teams.[6] In this model, the physician functions as a clinical strategist, managing patient stratification, supporting APCs in chronic and preventive care, and leading proactive outreach for high-risk populations. The proportion of physician visits in the team model demonstrates this shift: physicians focus on complex, high-acuity care while APCs handle stable chronic and preventive visits.

This design positions the physician as the population health manager within a high-capacity system that leverages data analytics, daily team huddles, and multidisciplinary collaboration to manage thousands of patients safely and effectively. Unlike earlier team-based models that primarily redistributed clinical tasks, the CPCT explicitly centers the physician's leadership in coordinating and improving population-level outcomes through shared accountability, data-informed workflows, and adaptive care processes.[7] Our qualitative findings show that physicians in the pilot sites consistently described greater professional fulfillment through meaningful focus on complex cases and team leadership (rather than focusing on visit volume).

Implications for Family Medicine

The implementation of the CTX FM CPCT advances the mission of family medicine by improving access, expanding capacity, and supporting sustainable practice models amid clinician shortages and increasing patient demand. Physician-led teams foster greater clinician and patient satisfaction, promote high-quality care, and allow practices to be resilient in the face of healthcare system pressures—criti-

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Table 1. **Third Next Available Appointment: Snapshot as of August 8, 2025**

Appointment Type	Team-Based Model	Solo MD			
	Physician	NP 1	NP 2	NP 3	Physician
New Patient	1/30/2026	N/A	N/A	11/24/2025	No new patients
New Patient Acute	8/21/2025	N/A	N/A	8/8/2025	No new patients
New to Provider	9/2/2025	N/A	N/A	12/15/2025	No new patients
Medicare Wellness	9/6/2025	10/8/2025	9/12/2025	8/18/2025	10/7/2025*
Physical Exam	9/6/2025	9/4/2025	9/5/2025	8/19/2025	10/7/2025
Hospital Discharge	8/21/2025	8/21/2025	8/11/2025	8/8/2025	8/14/2026
Office Visit	9/6/2025	8/13/2025	8/11/2025	8/11/2025	9/8/2025
Telemedicine Visit	8/20/2025	8/13/2025	8/11/2025	8/9/2025	9/2/2025
Pre-Operative	9/6/2025	8/21/2025	8/8/2025	8/11/2025	9/8/2025
Well Child	9/6/2025	8/22/2025	8/11/2025	8/12/2025	10/7/2025

*Note: Solo practice will exceed session limits at this appointment availability.

cal benefits as family medicine confronts workforce, access, and cost challenges.[10,12,17]

The CPCT model is a scalable innovation grounded in evidence and designed to maximize the strengths of multidisciplinary teams. It enhances access, supports larger panels, sustains physician well-being, and delivers more comprehensive, continuous, and coordinated care—fulfilling the core promises of family medicine in a changing healthcare landscape.[14,18] This model operationalizes physician-led population health, transforming the family physician's role from sole provider to architect of community health stewardship.[6]

Future Directions and Conclusions

Next steps for our team will be to monitor and collect prospective data on patient satisfaction, provider-burnout scores, financial outcomes, and clinical quality across a broader set of practices and geographic regions, including those that are practicing CPCT and those that are not. Comparative effectiveness research examining different team configurations, optimal panel sizes, and staffing ratios would inform best practices. Investigation of implementation strategies, barriers, and facilitators will support wider dissemination of the model.

While clinical quality metrics require ongoing attention as panels expand and patient populations shift, we expect to demonstrate that team-based primary care, when implemented with attention to workflow, supervision, and continuous improvement, can simultaneously enhance access, expand capacity, and improve the practice environment for clinicians and patients alike. The CPCT model offers family medicine a path forward in an era of workforce constraints, rising demand, and the imperative for sustainable, high-quality, accessible primary care.

The CPCT model shows early promise among the care teams as a scalable innovation to address persistent challenges in family medicine. The insights reinforce that thoughtfully designed teams with clear role definitions, frequent communication, and physician leadership foster improved clinician satisfaction and collaborative care.

Conflicts of Interest

None.

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None.

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