

EXECUTIVE SUMMARY

# Designing the Interprofessional Team to Deliver Comprehensive Primary Care

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Primary care has expanded well beyond diagnosing and treating acute illness. Today's practices are expected to provide preventive care, manage chronic disease, integrate behavioral health, coordinate care across settings, address social needs, improve population health, and build long-term relationships with patients and families. Practices are expected to deliver increasingly comprehensive care, yet payment policies have not supported the full range of capabilities required to provide it.[1]

In our report, we identify interprofessional capacity – the people and staff time required to manage the volume and range of work – and the capabilities – the knowledge, skills, expertise, and competencies required – to perform the functions expected of primary care. We translate these findings into staffing recommendations and cost estimates for practices serving different populations.

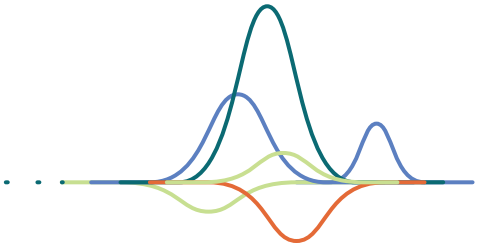
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# Study Overview

A broad body of evidence shows that the demands on primary care practices have changed.[2-7] These changes have increased both the volume and the range of work required to deliver primary care, raising fundamental questions about how practices should organize and staff that work.[5, 8-11] Team-based care is central to most contemporary strategies for improving primary care.[12] Yet few studies have identified the staffing configurations that primary care practices need to care for their patients.[13] One notable exception is the Agency for Healthcare Research and Quality (AHRQ) workforce study conducted a decade ago,[14] which attempted to empirically enumerate primary care team personnel and associated costs.

We conducted an in-depth mixed-methods study of twelve United States (U.S.)-based primary care practices selected by national leaders for their approaches to comprehensive primary care. Practices varied in size, ownership, geography, organizational structure, and patient population, allowing us to examine multiple approaches to interprofessional team design. We intentionally selected a small portion of our sample to represent practices with an integrative approach to medicine and to understand the staffing implications. Across practices, we documented staffing, interviewed clinicians and staff, and analyzed how practices organized care. We developed staffing recommendations based on cross-case analyses and estimated the Per Member Per Month (PMPM) cost for a practice of 10,000 active patients to support those recommendations. We selected 10,000 patients as a standard reporting denominator—consistent with the AHRQ workforce study noted above—to allow comparison across practices and settings. The underlying staffing ratios, however, are not specific to a practice of this size: they scale to smaller practices.

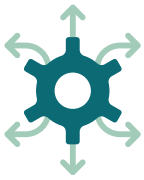


**Staffing recommendations will continue to evolve as patient needs, technologies, and models of care change. This report offers a framework for designing primary care around the functions it must perform, and the capacity and capabilities required to perform them.**

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# Key Findings



## Primary care practices perform a core set of functions.

Despite considerable variation in staffing and organizational structure, practices perform the same core set of primary care functions. These functions—including direct patient care, self-management support, care coordination and referral management, population management, complex care management and care transitions, administrative support, practice leadership, medication management, behavioral health integration, and community linkages—represent the work primary care must accomplish regardless of who performs it.



## Practice leaders have blind spots.

Practice leaders don't know what they don't know about staffing their teams. For example, most of the practices we studied did not employ registered nurses, and those with little or no experience working with a registered nurse rarely listed this capability as something they needed when we asked. This wasn't because they didn't need registered nurses. They had never seen what a registered nurse could do for their team and their patients, so they couldn't picture the gap. Practices that already had a strong registered nurse were asking for more because they understood firsthand how much value this capability added. This pattern also emerged for other health care workers. This means the staffing recommendations in this report needed to be a cross-practice composite of the best we observed.



## Staff capabilities matter.

One pattern observed across practices was consistent alignment between primary care functions and interprofessional team capabilities. Registered nurses, behavioral health clinicians, pharmacists, clinicians, community health workers, and other health care workers each contributed distinct capabilities. Practices must match tasks to the level of clinical judgment, technical expertise, relationship-building, and community knowledge each function requires. The staffing configurations that follow illustrate one way to align staff for two representative patient populations.



## Interprofessional teams reflect patient complexity.

Practices caring for patients with greater medical, behavioral, and social complexity consistently require larger, more diverse interprofessional teams than those serving less complex populations. Practices need additional investment in registered nurses, behavioral health clinicians, pharmacists, peers, community health workers, and other health care workers responsible for care coordination and addressing social needs. These findings support interprofessional teams that explicitly account for patient complexity rather than applying uniform staffing recommendations across all primary care settings.

## Recommendations

Based on these and other findings, we identify five principles for designing the primary care interprofessional team.

**01**

### Design around primary care functions.

Start by designing and staffing interprofessional primary care teams around essential primary care functions.



**02**

### Build interprofessional teams with complementary capabilities.

Practices relied on physicians, nurse practitioners (NPs), physician associate (PAs) registered nurses (RNs), behavioral health clinicians (BHCs), clinical pharmacists, community health workers (CHWs), and other health care workers whose expertise complemented one another.



**03**

### Match staffing to patient complexity.

Practices serving populations with greater medical and social needs require larger and more diverse interprofessional teams.



**04**

### Preserve local leadership while strategically sharing services.

Practices need to retain control over clinical care, operations, and leadership decisions, even as they share or centralize certain services, such as specialized expertise, to improve access. This includes decisions about empanelment, scheduling flexibility, and priorities, with an emphasis on maximizing continuity of relationships.



**05**

### Align payment with staffing needs.

Rather than limiting funding to a narrow set of billable professional services, payment policy should support the number and mix of health care workers needed to deliver comprehensive primary care.



The staffing recommendations below reflect these principles and present a single reference configuration for two representative patient populations: the **Base Model** and the **High Social Need Model**. Base Model practices serve a typical mix of patients across the lifespan. High Social Need Model practices serve populations with greater medical and social needs. Practices with different ownership structures, geographies, or organizational models may combine the same capabilities in different ways. These ratios are reported for a practice with 10,000 active lives to allow direct comparison across practice types and with prior research. These recommendations can be scaled to a smaller practice.

TABLE 1

## Staffing Recommendations for 10,000 Active Lives

| | BASE MODEL | HIGH SOCIAL NEED MODEL |
|---|---|---|
| **Physician panel** | ~1,300 patients | ~1,100 patients |
| **NP/PA panel** | ~1,000 patients | ~900 patients |
| **Clinician Total FTE** | 9.3 FTE | 10.5 FTE |
| ***Physician*** | *3.6 FTE* | *4.1 FTE* |
| ***Medical Director*** | *0.3 FTE* | *0.3 FTE* |
| ***NP/PA*** | *5.4 FTE* | *6.1 FTE* |
| **RN** | 1 per 3 clinician FTEs | 1 per 2 clinician FTEs |
| **Medical Assistant/Licensed Practical Nurse/Layperson** | 1.5 per clinician FTE | 2.5 per clinician FTE |
| **Clerk/Front Desk Administration** | 1 per clinician FTE | 1 per clinician FTE |
| **Practice Manager** | 1 FTE per 10,000 Active Lives | 1 FTE per 10,000 Active Lives |
| **Behavioral Health Clinician** | 1 per 2–3 clinician FTEs (minimum of two per practice) | Approximately 1 per 1 clinician FTE |
| **Psychiatry NP** | -- | 0.8–2.5 FTE per 10,000 Active Lives |
| **Clinical Pharmacist** | 1 per 5–6 clinician FTEs | 1 per 5–6 clinician FTEs |
| **Community Health Worker/ Peer** | 1 to 2 | 6 to 7 |
| **Dietician/Nutritionist/ Health Coach** | 2 FTE per 10,000 Active Lives | 2 FTE per 10,000 Active Lives |
| **Dentistry** | -- | 1 FTE per 10,000 Active Lives |
| **Total FTE** | **~45-47** | **~76-78** |

Notes: To calculate total FTE, we used the higher end of the recommended range when one was provided. For example, for psychiatric NPs in the High Social Need Model, we used 2.5 FTE. We excluded the 0.30 FTE for the Medical Director when calculating per-clinician ratios. The RN and Medical Assistant/Licensed Practical Nurse/Layperson (MA/LPN/Layperson) levels shown here reflect a practice still building RN capacity; see the section on MA/LPN/Layperson staffing for how these may change as RN staffing matures.

Smaller practices, particularly those with independent ownership, can cross-train staff, combine several functions into one full-time position, or share that position across locations. Practices still need access to the same range of capabilities. Many small practices currently lack access to the full range of capabilities they need under prevailing payment arrangements, though this constraint is not unique to small practices.

## Cost of the Interprofessional Team

Using this study's staffing recommendations, we estimate the cost to support these two primary care models, using wage data from the Bureau of Labor Statistics[15] and operational costs from the Medical Group Management Association[16] to calculate PMPM estimates. We use the higher end of the recommended FTE range when applicable. PMPM costs include benefits (30% of wages) and operational costs (30% of total costs). PMPM estimates reflect the cost to staff and operate the team; they do not include operating margin, reserves, or costs due to vacancy or turnover. They also do not include clinician hospital and obstetrics work or transformation time.

Staffing recommendations and costs are estimates and will vary based on community needs and patient preferences. These may include integrative modalities (e.g., acupuncture) that we found were not available in most practices. Moreover, applying current labor prices to these models may fit the current context but may not be sufficient to attract staff to primary care careers given competing options.

### Recommended Staffing Cost

| BASE MODEL PRACTICES | HIGH SOCIAL NEEDS MODEL PRACTICES |
|---|---|
| ~$80 PMPM | ~$130 PMPM |

FIGURE 1
Estimated Interprofessional Team Investment (using 75th percentile salaries)

The recommended Base Model costs approximately $80 PMPM for a practice of 10,000 active patients, and the High Social Need Model approximately $130 PMPM. Current primary care spending is roughly $35 to $50 PMPM, depending on the payer, so our estimates suggest these teams would require about 1.7 to 2.2 times current spending in the Base Model and about three times current Medicaid primary care spending in high social need settings.[17,18] Since our report's PMPM spending amounts are per active patient, they include members who never visit. The spending increases are likely to be upper bounds. Nevertheless, because most primary care dollars currently accrue visit by visit rather than being budgeted against the functions a team performs, our report offers one such budget, built role by role, so that payers, states, and practices can see what a given level of primary care investment would buy.

To help practices, payers, and policymakers apply these findings to their own contexts, we built an interactive staffing cost estimator. For practices of other sizes, the estimator allows fully customized estimates. Users can adjust panel size, wage level, benefits, and operations costs as a percentage of benefits, as well as the local cost of living, to generate a customized PMPM and annual cost estimate, broken down by health care worker, rather than relying solely on the national averages presented here. The tool reflects the same Base and High Social Need Models described above, so the recommendations serve as a starting point that can be adapted to a specific market rather than a fixed benchmark.

## Why This Matters Now

A growing number of states have begun setting explicit targets for the share of total health care spending directed to primary care, on the premise that primary care in the U.S. has been chronically underfunded relative to its value.[1] These targets represent a significant, and in some cases mandated, redirection of health care spending. Yet they are being set largely without empirical answers to the questions this study addresses. **Without this evidence, purchasers, payers, policymakers, and patients have no reliable way to judge whether a given spending target is sufficient to fund comprehensive, high-value primary care.** Purchasers and payers need to know what they are buying when they pay for primary care and what they should hold systems and practices accountable for staffing, functions, and outcomes. Policymakers need an empirical basis to set and adjust value-based spending targets. Patients and the practices that serve them need a clear standard against which to expect, develop, and advocate for the staffing that high-value primary care requires. This study aims to provide that empirical foundation.

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