Milestone: Care Team Assessment and Implementation

Milestone Language: Assess current core and expanded care team roles to identify gaps in functions and roles needed to manage the population of focus. Identify and implement new core and expanded care team model to address identified gaps.

Instructions

The care team is the heart of a practice and is designed to meet most patients' needs. Together, the care team is the primary healthcare partner for patients and families. They provide proactive, planned delivery of in-person and virtual primary care for a defined panel of patients based upon evidence-based clinical judgment, patient needs and preferences, and health equity considerations. Care teams act as the coordinating hub for physical, social and behavioral health needs.

You may find that your care teams are missing key roles, or your practice has known gaps. Please complete the prompts in step 1 and then use Table 1 to inventory your practice's current state of delivering the key functions of primary care and population health management for your population of focus (PoF).

This tool provides an overview of the functions that high-performing primary care practices deliver reliably and proposes a potential array and FTE of team members to do so. Different teams will adjust these roles and FTE to fit their context.

[Population of Focus Displayed Here]

Step 1. Current Care Team Structure & Functions

A. Number of sites that your EPT work encompasses:

B. Core Care Team Structure (Direct Patient Care)

- **List current care team roles (e.g., Primary Care Provider, Nurse, Medical Assistant, Care Coordinator, Behavioral Health Provider, etc.) within your sites that are designing and implementing improvements related to EPT.**
- **If you have multiple sites participating in EPT, pick one site that is most representative for your PoF work.**

- **Please also include additional/expanded care team roles (e.g., Community Health Worker, Pharmacist, Health Coach, Case Manager, Patient Navigator, etc.).**
- **Describe each role's primary responsibilities related to your PoF .**

Table 1. Care Team Roles

Role	# individuals in this role	Combined FTE (Filled/ Total)*	Dedicated or Shared Across Sites (drop-down)	Panel-Assigned to Role (Y/N)	Primary responsibilities related to PoF (if not related to PoF or measures, mark "None")

***Note:**

- Filled FTE: The number of FTE that is currently staffed (positions filled).
- Total FTE: The number of FTEs that are *budgeted* or *needed* for that role.

C. Clarifying Notes:

[As needed, provide additional detail about how roles are distributed across sites, the use of float staff, shared services, or nuances in FTE and panel assignment.]

D. Care Team Functions

Note: As you review care team functions, consider the following prompts to guide your assessment (you will not respond to each prompt but may incorporate these considerations into Table 2). Responses should reflect your current state:

- How are responsibilities distributed across roles?
- Are any roles over- or under-utilized? Could certain functions be more effectively shared?
- Where are the functional gaps (e.g. no clearly assigned role responsible for initiating and ensuring completion of screenings)? Are there tasks that could be shifted to other roles?
- What additional tools, training, or supports would enable your team to perform all functions more effectively?
- Are there other core activities staff are doing related to your PoF that aren't yet captured in this deliverable template?

[ONLY RELEVANT POF TABLE WILL BE DISPLAYED IN THE PORTAL]

Pregnant People: Care Team Function Table

Function	Role that performs this now (title)	Identified Gap (check box)	Role that is best suited to perform this function?
Receives first notification of a pregnant patient			
Maintains list of pregnant patients, gestational age, estimated due date, and disposition of pregnancy (e.g., miscarriage, termination, delivery)			
Schedules prenatal appointments			
Conducts initial pregnancy testing (if required)			
Conducts clinical prenatal assessments (e.g., vitals, fundal height, fetal heart tones)			

Conducts prenatal behavioral health screening (e.g., PHQ-2, PHQ-9, EPDS)			
Screens for intimate partner violence (IPV) and ensures appropriate response or referral (e.g., warm handoff, safety planning, documentation protocols)			
Provides prenatal nutrition counseling			
Provides prenatal health education (e.g., warning signs, breastfeeding basics)			
Orders prenatal lab work			
Follows up on prenatal lab results			
Orders prenatal ultrasounds			
Performs prenatal ultrasounds (if performed on-site)			
Reviews and communicates ultrasound results to patient			
Orders prenatal immunizations			
Administers prenatal immunizations			
Provides options counseling			
Coordinates blood work (on-site or external lab)			
Addresses positive behavioral health screenings (e.g., evaluation, diagnosis, referrals)			
Makes prenatal visit reminder calls			
Prepares for prenatal visits (e.g., chart prep, forms)			

Screens for social needs and makes referrals (e.g., WIC, doula programs, Black Infant Health)			
Maintains list of referral resources and how to access them (e.g., lactation, WIC)			
Coordinates referrals for imaging and specialty consults (e.g., MFM, genetic counseling), including closed-loop tracking and hospital coordination			
Discusses birth plan and coordinates related care			
Completes preregistration with the delivery hospital			
Schedules hospital tours (virtual or in-person)			
Schedules inductions and/or cesarean procedures			
Documents prenatal care activities in EHR (e.g., screenings, education, referrals)			
Identifies and monitors high-risk pregnancies (e.g., comorbidities, social risks)			
Provides interpretation services or coordinates language access			
Schedules postpartum visits			
Makes reminder calls for postpartum visits			
Conducts postpartum care outreach			
Maintains registry of postpartum patients and follow-up status			
Facilitates centering group visits			

Children and Youth: Care Team Function Table

Function	Role that performs this now (title)	Identified Gap (check box)	Role that is best suited to perform this function?
Tracks well-child visit care gaps (e.g., maintains list of patients and well-child care (WCC)/immunization due dates)			
Conducts outreach to schedule well-child visits			
Conducts follow-up for no-show or canceled well-child appointments (including rescheduling)			
Prepares for well-child visits (e.g., identifies care gaps)			
Obtains newborn/birth history for new patients			
Prompts for immunizations during non-well-child visits			
Schedules well-child visits during non-well-child visits			
Orders immunizations			
Administers immunizations			
Conducts outreach to schedule immunization visits			
Schedules immunization visits (including drop-in clinics)			
Reschedules immunization visits			
Addresses abnormal developmental screening results			

(e.g., evaluation, diagnosis, referrals)			
Conducts behavioral health screening			
Addresses positive behavioral health screening results (e.g., evaluation, diagnosis, referrals)			
Conducts social determinants of health (SDOH) screening, including Adverse Childhood Experiences (ACEs)			
Addresses positive SDOH or ACE screenings (e.g., evaluation, diagnosis, referrals)			
Documents screenings, assessments, and referrals in EHR			

Adults with Chronic Conditions (e.g., Diabetes, Hypertension): Care Team Function Table

Function	Role that performs this now (title)	Identified Gap (check box)	Role that is best suited to perform this function?
Provides health coaching and self-management education			
Provides medication adherence support			
Coordinates remote monitoring with patients (e.g., blood pressure (BP) or hemoglobin A1c (A1c) tracking at home)			
Initiates new medications for hypertension or diabetes for patients not at goal blood pressure or A1c			
Titrates hypertension or diabetes medications for patients not at goal blood pressure or A1c			

Orders or pends labs for diabetes or hypertension monitoring (e.g., A1c, metabolic panel, microalbumin)			
Orders or pends retinopathy screening for patients with diabetes			
Performs diabetic foot monofilament testing			
Conducts outreach to patients overdue for lab monitoring			
Conducts outreach to patients overdue for diabetic eye exam or retinopathy screening			
Conducts outreach to hypertension or diabetes patients overdue for a follow-up visit			
Monitors diabetes and hypertension quality metrics or dashboards			
Conducts outreach to candidates for group visits			
Facilitates group visits for chronic disease management			
Documents chronic care interventions and outcomes in EHR			

Adults with Preventive Care Needs: Care Team Function Table

Function	Role that performs this now (title)	Identified Gap (check box)	Role that is best suited to perform this function?
Conducts outreach to patients due for cancer screenings			

Conducts pre-visit planning to identify cancer screening care gaps for scheduled patients			
Reviews health information exchange (HIE) data for recent cancer screening results			
Places routine cancer screening orders			
Provides education to patients about fecal immunochemical tests (FIT)			
Prepares FIT kits for distribution			
Conducts reminder calls to patients with outstanding FIT kits			
Monitors quality metrics or dashboards related to cancer screenings			
Conducts outreach and scheduling for wellness visits			
Conducts pre-visit preparation for wellness visits to identify preventive care gaps			
Reviews cancer screening results			
Communicates normal cancer screening results to patients			
Communicates abnormal cancer screening results and follow-up plan to patients			
Places follow-up orders or actions for abnormal cancer screening results (e.g., colonoscopy, diagnostic imaging)			
Tracks completion of follow-up testing for abnormal cancer screening results			
Flags patients due for behavioral health or social determinants of health (SDOH) screening			

Conducts behavioral health screening (e.g., depression, substance use)			
Addresses positive behavioral health screenings (e.g., evaluation, diagnosis, referrals)			
Conducts SDOH screening			
Addresses positive SDOH screenings (e.g., evaluation, diagnosis, referrals)			
Tracks follow-up completion for patients with positive behavioral health or SDOH screenings (e.g., referrals completed)			
Documents preventive care activities and follow-up in the EHR			

Adults with Behavioral Health Needs (noting that screening is for all adults – not just adults with BH needs): Care Team Function Table

Function	Role That Performs This Now (Title)	Identified Gap (Check Box)	Role That is Best Suited to Perform This Function?
Reviews care gaps to determine if the patient is due for depression screening			
Administers standardized depression screening tool (e.g., PHQ-2, PHQ-9)			
Follows up on positive depression screens with documented evaluation, diagnosis, referral, or treatment plan			

Manages nonspecialty mental health needs (e.g., mild to moderate depression or anxiety)			
Coordinates referral for specialty mental health services (e.g., severe mental illness, complex comorbidities)			
Maintains registry or tracking list of patients with behavioral health needs (e.g., depression, medications for addiction treatment [MAT])			
Coordinates with external mental health or substance use disorder services (e.g., closes loop on referrals, manages Releases of Information [ROIs])			
Manages behavioral health medications, including initiation, titration, and follow-up			
Provides crisis response (e.g., suicidality, hospitalization for safety concerns)			
Conducts outreach to patients on behavioral health registry or receiving medications for addiction treatment (MAT) to schedule follow-up visits or check adherence			
Manages refills and adherence for medications for opioid use disorder			

Step 2: Implementation Plan – Action Items to Optimize Care Team Model

To meet this milestone requirement, practices must implement **at least two NEW actions** (since the start of EPT) by **November 2025**.

Select a minimum of two action items to implement or highlight based on the gaps identified in Table 2. You may include actions implemented at any time during your participation in the EPT program.

Table 3

Gap Identified in Table 2	**Action Taken or Planned**	**Team Role(s) Added or Changed**	**Training or Support Needed**	**Implementation Status (since start of EPT) ☐ Previously Implemented ☐ In Progress ☐ Planned**
e.g., No BH support for screening follow-up	Implement BH consult workflow and train MA to use PHQ-9 screen	Added LCSW consult & MA screening role	LCSW training; MA refresher on screening protocols	☐ Previously Implemented ☐ In Progress ☐ Planned
e.g., Manual tracking of care gap follow-up by RN	Develop automated EHR alert/tool to flag and track follow-up needs	Shifted tracking from RN to automated workflow	EHR tool development ; training for RN and IT support	☐ Previously Implemented ☐ In Progress ☐ Planned

3. Evidence of Implementation

For each implemented action, please complete the table 4:

Table 4

Implemented Action	Date of Implementation	# of Patients Impacted	Metrics Used to Evaluate Whether the	Results Observed

			Action Resulted in Improvement	

Notes:

- Results may be qualitative (e.g., staff or patient feedback) or quantitative (e.g., care gap closure rates).
- Small-scale pilots or PDSA cycles are acceptable as evidence.