Equity and Practice Transformation (EPT) Payment Program
June 2025 Learning Community Pre-Work
Care Team Assessment

Instructions

The care team is the heart of a practice and is designed to meet most of the needs of most patients. Together, this care team is the primary healthcare partner for patients and families. They provide the 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 of healthcare services, including physical, social and mental health care needs.

You may find that your care teams are missing key roles, or your organization has known gaps. Please use the table below to conduct an inventory of your organization's current state with regard to delivering the key functions of primary care and population health management for your population of focus.

As part of the June 2025 Learning Community, EPT practices will be assessing their care team functions. This work will help them prepare for the Care Teams Assessment and Implementation Milestone: 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. **Please complete the Care Teams Function table below for your population of focus only.**

Pregnant People: Care Team Function Table

Function	Who Performs This Now (Title)	Identified Gap (Check Box)	Who is Best Suited to Perform This Function?
Who receives first notification of a pregnant patient?			
Maintains list of pregnant patients, EDC, GA, EDD, and disposition of pregnancy (e.g., miscarriage, termination, delivery, etc)			
Who schedules prenatal appointments?			
Initial pregnancy testing (if required)			
Provide prenatal care			
Order / administer immunizations			

Provide options counseling			
Orders / completes prenatal ultrasound			
Is blood work done internally at clinic or off site?			
Conducts behavioral health screening (e.g., PHQ 2/9 or EPDS)			
Addresses positive behavioral health screening (including evaluation, diagnosis, referrals, etc)			
Prenatal visit reminder (calls?)			
Prenatal visit prep			
Social needs screening/referrals Ensuring patient is aware of resources such as WIC,			

Black Infant Health, doula programs, visiting/home nursing programs or other population focused support			
Maintains list of resources and how to refer / access (e.g., lactation, WIC)			
Referral coordination for imaging and subspecialty consults (ultrasound, fetal testing, maternal fetal medicine, genetic counseling) Does this person just make referrals or do full closed loop to ensure visit occurs and records back to main prenatal/postpartum care provider Does this person assist with hospital coordination?			
Birth plan discussion & care coordination			

Preregistration with delivery hospital			
Registration for virtual or in person hospital tours and baby showers			
Scheduling induction and cesarean			
Maintain registry of post-partum patients (EDD) and postpartum visit f/u			
Schedules postpartum visit			
Reminder call for postpartum visit			
Postpartum care outreach			
Nutrition counseling/support			
Runs prenatal centering groups			

Children and Youth: Care Team Function Table

Function	Who Performs This Now (Title)	Identified Gap (Check Box)	Who is Best Suited to Perform This Function?
Tracks well-child visits care gaps (maintains list of patients and well-child visit & immunization due dates)			
Conducts outreach to schedule well-child visits			
Well-child no-show/cancelled appointment follow-up (including rescheduling)			
Well child pre-visit planning/prep (e.g., care gaps)			
Obtains newborn / birth history for new newborns to practice			

Pre-visit prep for non WCC visits (e.g., to prompt IZs, scheduling for WCC visit)			
Orders immunizations			
Administers immunizations			
Outreach to patients due for immunizations			
Scheduling immunization visits (or drop-in clinics?)			
Rescheduling immunization visits (if scheduled)			
Addresses abnormal developmental screens (including evaluation, diagnosis, referrals, etc)			
Behavioral health screening			
Addresses positive behavioral health screening			

(including evaluation, diagnosis, referrals, etc)			
Social determinants of health (SDOH) screening (ACES screening?)			
Addresses positive social needs screening (including evaluation, diagnosis, referrals, etc)			

Adults with Chronic Conditions: Care Team Function Table

Function	Who Performs This Now (Title)	Identified Gap (Check Box)	Who is Best Suited to Perform This Function?
Chronic disease management visits			
Lab tracking and care gap outreach			
Health coaching/self-management education			

Medication adherence support			
Remote monitoring coordination			
Initiate new medications for HTN/DM for patients not at goal BP / A1c			
Titrate HTN/DM medications for patients not at goal BP / A1c			
Outreach to patients overdue for lab monitoring			
Outreach to patients overdue for eye exam			
Outreach to patients overdue for a visit (including for foot exam)			

Monitor quality metrics / dashboard related to DM/HTN			
Conducts outreach to candidates for group visits			
Facilitates / runs group visits			

Adults with Preventative Care Needs: Care Team Function Table

Function	Who Performs This Now (Title)	Identified Gap (Check Box)	Who is Best Suited to Perform This Function?
Outreach to patients due for cancer screenings			
pre-visit planning for scheduled patients to identify cancer screening care gaps			
if connected to a health information exchange (HIE) - check if patient has had			

appropriate screening in recent past			
Place routine cancer screening orders			
Provides education re: FIT tests to patients			
Prepares FIT kits			
FIT kit completion reminder calls			
Monitor quality metrics/dashboard for cancer screenings			
Wellness visit outreach / scheduling			
Pre-visit prep for wellness visits to identify care gaps			

Reviews results of cancer screenings			
Communicates normal results to patients			
Follow-up orders / actions for abnormal screens (e.g., colo, diagnostic mammo, repeat pap)			
Communicates abnormal results / follow-up testing plan to patient			
Tracks completion of follow-up testing for abnormal screens			
Checks and flags if patient is due for behavioral health or SDOH screening			
Completes behavioral health screening (depression screening, substance use disorder screening)			

Addresses positive behavioral health screening (including evaluation, diagnosis, referrals, etc)			
Completes SDOH screening			
Addresses positive SDOH screening (including evaluation, diagnosis, referrals, etc)			
Tracks if patients with positive BH / SDOH screens received follow-up (e.g., referrals completed)			

Adults with Behavioral Health Needs: Care Team Function Table

Function	Who Performs This Now (Title)	Identified Gap (Check Box)	Who is Best Suited to Perform This Function?

Checks care gaps to determine if due for BH screening			
Administers behavioral health screening (e.g., PHQ2, PHQ9, AUDIT)			
Addresses positive behavioral health screening (including evaluation, diagnosis, referrals, etc)			
Management of “simple” behavioral health needs			
Management of “complex” behavioral health needs			
Maintains registry of patients with behavioral health needs (depression, MAT) – if any			
Coordination with external MH/SUD services, including closing the loop on referrals, coordinating ROIs			
Medication management and follow-up including medication titration			

Crisis response (e.g, active suicidality, need for hospitalization due to risk of harm to self or others, etc)			
Conducts outreach to patients on MAT or BH registry and schedules follow-up			
Refills medication for opioid use disorder & monitors adherence			