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:**

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**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”)** |
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**\*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:**

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| [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 that 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 2)**

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| **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 2)**

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| **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) |  |  |  |
| **(August 2025 Update)** Conducts behavioral health screening (e.g., depression, substance use) |  |  |  |
| 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 screening (e.g., evaluation, diagnosis, referrals) |  |  |  |
| Documents screenings, assessments, and referrals in EHR |  |  |  |

**Adults with Chronic Conditions (e.g., Diabetes, Hypertension): Care Team Function (Table 2)**

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| **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 |  |  |  |
| **(August 2025 Update)** Conducts behavioral health screening (e.g., depression, substance use) |  |  |  |
| **(August 2025 Update)** Addresses positive behavioral health screenings (e.g., evaluation, diagnosis, referrals) |  |  |  |

**Adults with Preventive Care Needs: Care Team Function (Table 2)**

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| **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 2)**

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| --- | --- | --- | --- |
| **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. Provide more information about how your practice is addressing these gaps in Table 3.*

**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** |
| 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 |
| 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 |
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**3. Evidence of Implementation**

List at least two actions your practice has implemented to improve care team roles or functions for your selected PoF. For each, include the date the action was first implemented (i.e., when it was launched or began being used with patients), how many patients were impacted, how success was measured, and any observed outcomes. Small-scale pilots and PDSA cycles are acceptable. To meet this milestone requirement, practices must implement at least two NEW actions (since the start of EPT) by November 2025.

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 Action Resulted in Improvement | Results Observed |
|  |  |  |  |  |
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**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.