Method 1: Patient-centred Measurement Team Mapping

Example: Patient with Chronic Obstructive Pulmonary Disease (COPD) recently released from the hospital.

Patient and Family: Rob is a 60-year-old man living with COPD. His most recent hospitalization has left him with many worries about recurrent bronchitis and he is feeling rather depressed. His spouse is extremely worried as he doesn't seem himself. The PHQ-9 completed today at the office visit shows moderate depression. His bronchitis episode has resolved but he is confused about his medications and has not been monitoring his airflow with his spirometer. He is using his CPAP machine for sleep apnea but is not sure it is working.

> **What new activities are introduced with PCM**? Monitoring his lung capacity will be important, as will be monitoring his depression.
>
> **Alternate ways to collect PCM**: Rob has a computer and seems interested in recording both his spirometer readings and tracking his depression with PHQ-9. He could also keep a physical log of both.
>
> **Priority areas and how addressed:** For now, it seems best to have him log his entries into a spreadsheet and forward them by email to the clinic. Once the patient portal is ready, Rob and his spouse can be enrolled and sent reminders or PHQ-9 forms to complete. A home visit by a respiratory therapist would be optimal to check his ability to do spirometry and determine if his CPAP machine is working. A session with the local pharmacist to review his medications would also be helpful.

Clinic and Healthcare services: The clinic personnel available to form a team around Rob include an office social worker, RN trained to monitor his spirometry readings, and Medical Office Assistant who does outreach as well as scheduling. The hospital has a respiratory therapist who makes home visits and there is a local community pharmacist.

Technology: You have a secure email and phone line. Your practice has a new patient portal that is not yet up and running.

Peers and Local Community: The social worker identified a COPD support group that meets weekly via zoom. The pharmacist is willing to meet with Rob to review his medications and help he and his spouse keep track of his pills using a pill organizer.

Putting it all together in team-based care: Roles and Responsibilities: The team has formed to assist Rob going forward. The office social worker has room on her schedule to do virtual counseling with Rob or with he and his spouse and will reach out to schedule. The RN can monitor his spirometry readings, when available, and alert the healthcare provider about concerning numbers. The Medical Office Assistant will call him weekly for the next two weeks and will monitor the email line and forward his email log and completed PHQ-9 form to the

nurse and social worker, respectively. The hospital respiratory therapist does make home visits and can complete one in the next few weeks.