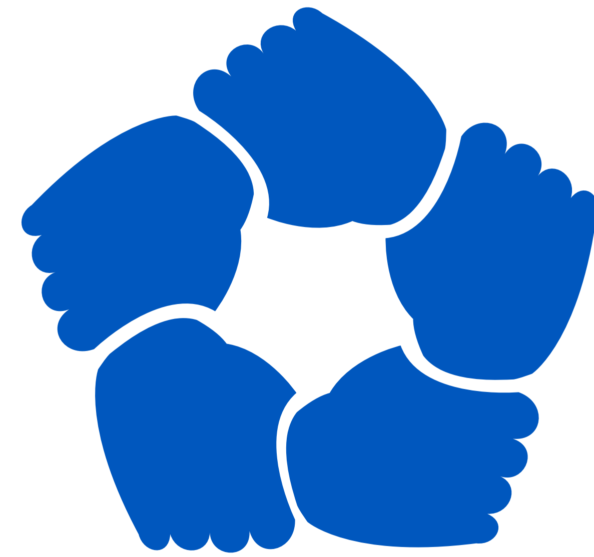


Innovation Support Unit

primary care innovation through collaboration

S314. Team Mapping: A method to support transitions to team-based primary care

Morgan Price, MD, PhD, CCFP, FCFP

Who am I?

Primary Care Provider:
- Cool Aid CHC
- Outreach

UBC Associate Professor:
- Dept of Family Practice (DFP)
- Prev-Interim co-Head Dept (DFP)

UVic Affiliate Faculty:
- Medical Sciences Division
- Software Engineering, Comp Sci
- Health Information Science

Director and (Bald) Talking Head:
- Innovation Support Unit

Today's Goals

- Provide information on Team Mapping
- Highlight how it can be used
- Complete an interactive demo of Team Mapping
- Answer your questions (please interrupt me!)

Faculty/Presenter Disclosure

- **Faculty: Morgan Price**
- **Relationships with financial sponsors:**
  - Grants/Research Support: CIHR, UBC, BC MoH
  - Speakers Bureau/Honoraria: NA
  - Consulting Fees: NA
  - Patents: NA
  - Other: Clinical Practice

Disclosure of Financial Support

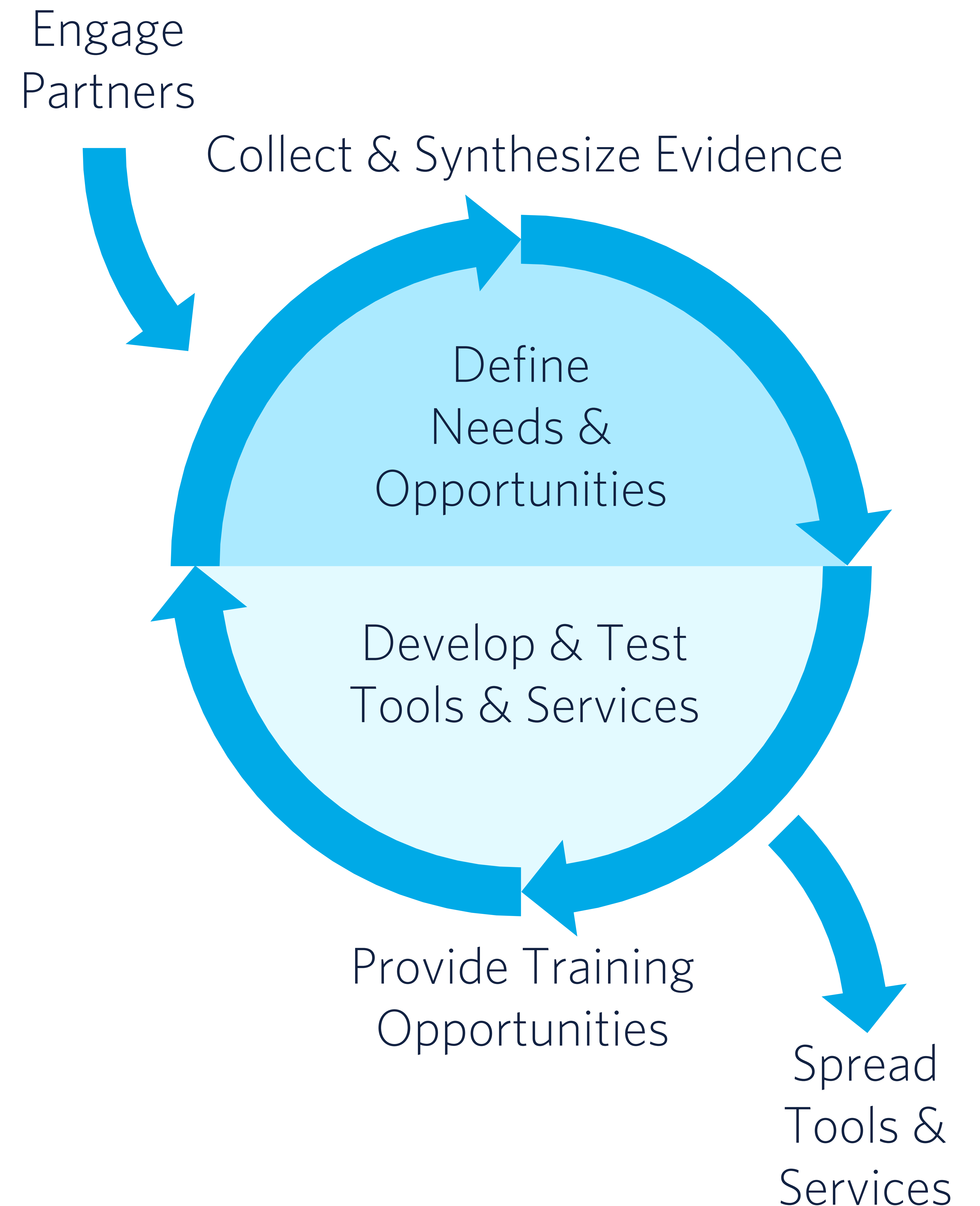
- This program has received financial support from UBC in the form of a SIF Grant and a subsequent grant from the BC Ministry of Health.

- The Team Mapping materials are freely available under open source licences

What is the ISU?

(UBC's Primary Care Innovation Support Unit)

The ISU is a UBC group that collaborates with BC primary care innovators through an action oriented research approach to system challenges.



ISU is focused on team-based care.

Examples of ISU Activities:

Team Mapping

TBC Evaluation Framework

Learning System for TBC

Primary Care Community Mapping

What is Team Mapping?

Rapid, facilitated co-creation workshops to engage *groups* in exploring how they could work together in a primary care *team*.

We use patient personas to explore team structure through paper prototyping circles of care.

We collectively define roles and tasks with teams through the discussion.

We have worked with 13 communities / clinics to do Team Mapping sessions with 200 participants across BC.

We have trained over 100 facilitators in Team Mapping.

Why do Team Mapping?

Team-based care is complex.

It is hard to create an appropriate and effective team.

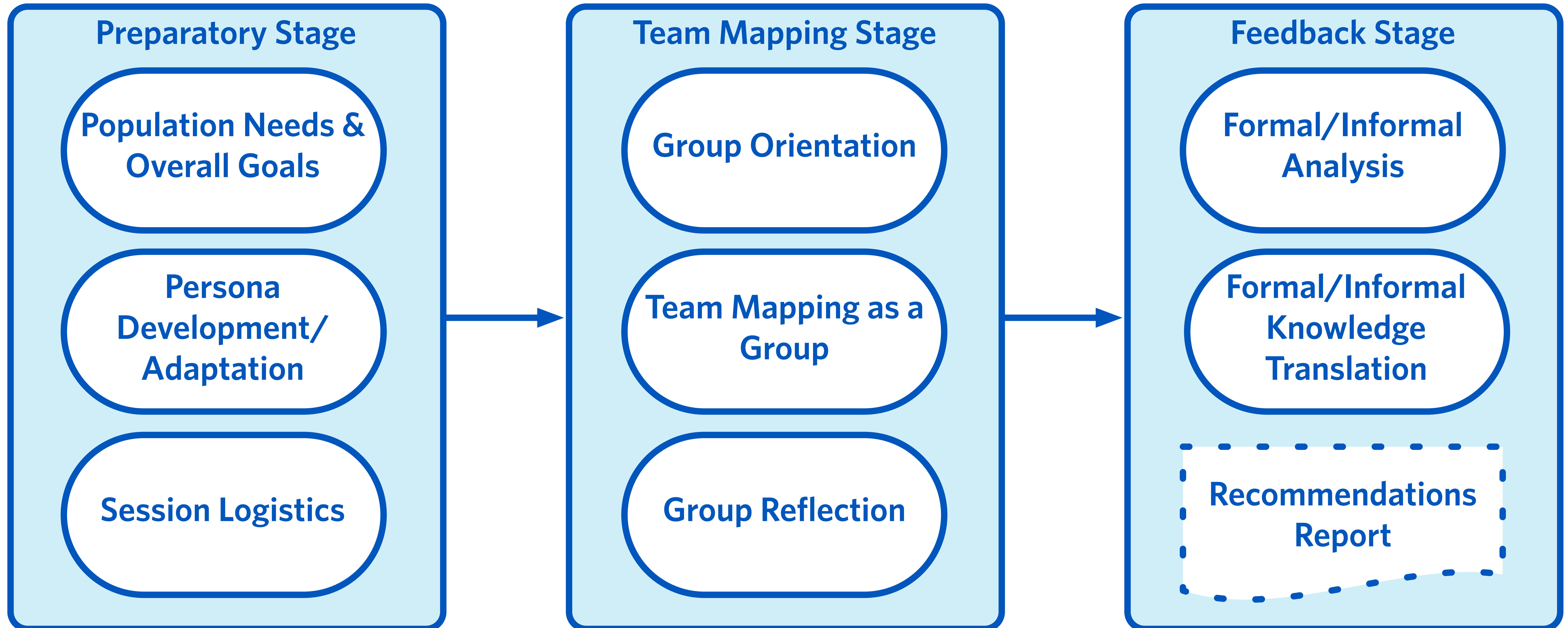
Team Mapping is designed to help primary care teams better understand how they could meet care needs of a population they are serving.

It also gets team-members and stakeholders together on the same page.

Benefits are different, depending on the stage of team development.

(Conceptual, Forming, Established)

Three Stages of Team Mapping



Preparatory Stage
Population Needs & Overall Goals
Persona Development/ Adaptation
Session Logistics
Team Mapping Stage
Group Orientation
Team Mapping as a Group
Group Reflection
Feedback Stage
Formal/Informal Analysis
Formal/Informal Knowledge Translation
Recommendations Report

Preparation Stage

We will develop a specific plan for the Team Mapping session with a community.

Things we want to know

Patient Population(s)

Services Planned/Offered

Already Committed Staffing

Expected Issues/Areas of Focus

Then we design our *Personas* based on the local data and needs.

Persona focus discussions as teams describe TBC and come to common understandings of how the team will work.

Team Mapping Sessions

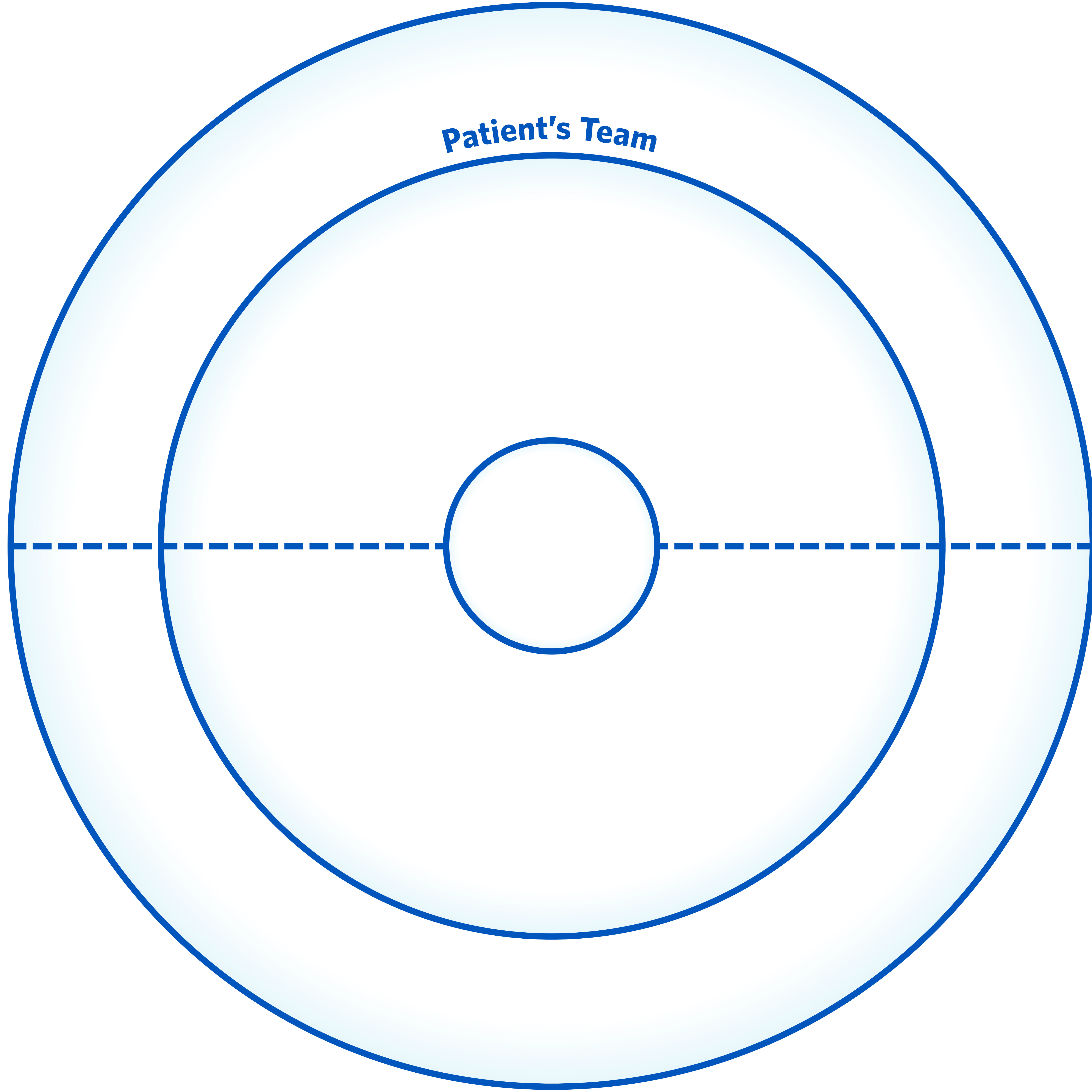
These are highly interactive sessions with a mix of participants where we explore how the new team could support patient care.

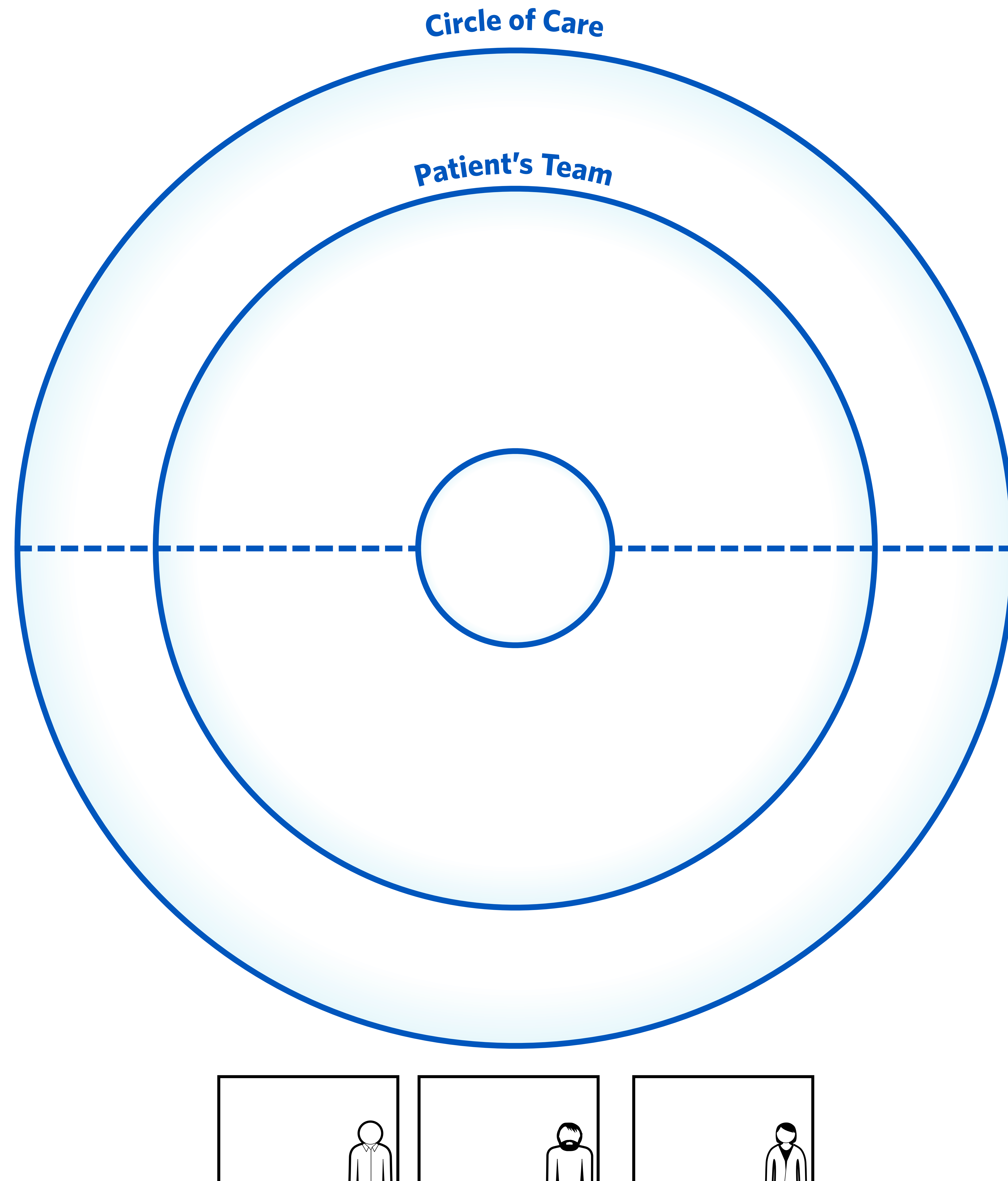
(Patients, MDs, MOAs, RNs, NPs, First Nations, PT, OT, SW, Pharmacists, Care Givers, etc.)

Facilitators guide small groups through the Team Mapping session.

We consider care in a *realistic future* with team-based practice.

Together with teams, we draw a *Circle of Care* for each persona.


Circle of Care
Patient's Team



Circle of Care – the whole map - the patient's own health care system. It changes as the patient's care needs change. It includes all the providers, both formal and informal.

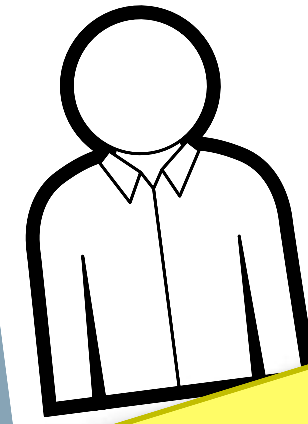
Patient's Circle – The patient, their close family / friends / caregivers.

Patient's Team – the TBC team for the patient that are part of the patient's medical home.

Outer Ring – Other providers that are not part of the collaborative team being imagined but would be care providers (e.g. referred to services, Emergency, Hospitals).

The Line - Self Access (above) vs Referral (below)

Primary Care Provider



Assess Patient

Prescribe Meds

Primary Care RN

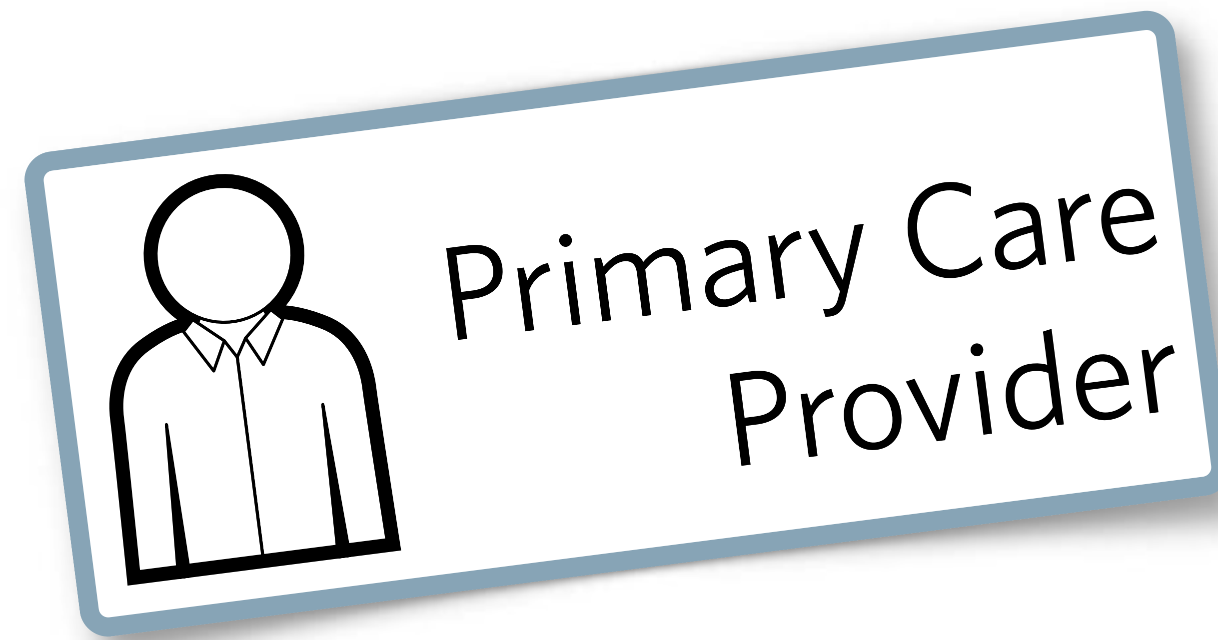
Triage

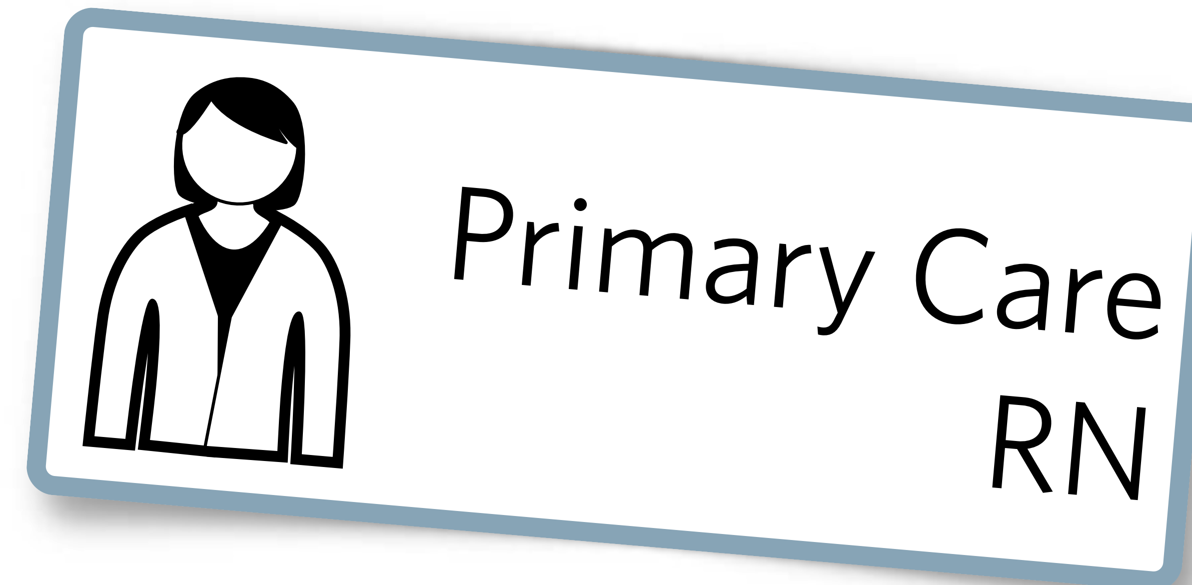
Manage Chronic Illness

On Call MD

Dan

ROLES ARE NOUNS





TASKS ARE VERBS

Triage

Assess Patient

Prescribe Meds

Manage Chronic Illness

If there are multiple teams at a session, teams review and amend each other's Circle of Care Maps.

(i.e., Design Charrette approach)

Circle of Care

Patient's Team

Self Access

Referral

Hank

Friends

MOA
- phone calls-follow up
- set up monthly connect to team

scheduling

Pharmacist
- Med Review

GP
- assessment TO/Ro referrals coordination
- order labs
- assessment
- referral to ER
- review admissions

Dispensing pharmacist

Paramedical

hospital PT
- home assessment

Hospital
- plan + schedule family meet
- refers to home support

Notification in EMR re. admission

Team meetings (1x/m) w everyone
- could be f2f or teleconference

Primary Care Assistant
- coordinate paperwork
- Scheduling
- communication + updates (encounter notes to GP)
- create a new e-process

DIABETIC NURSE
- Education
- Monitoring

PT
- follow up
- home safety assessment

/OT
- home assessment

Family Meeting - involves whole team + family (discharges)
- Review current state + discharge plan

SW
- Advanced care planning
- Finances + medical costs
- housing

Teamlead
- Communication

Primary care nurse
- connect to hospital for discharge planning
- RAI Assessments
- PCN assessments (intake assessment)
- (re-do assessments every 6 months)
- waitlist for LTC (wait of 6-12 months)

All Team roles connect back to GP to update
- Fax or call!

Monthly meeting

3-4 Huddles a week
- Reviewing new referrals
- every 2nd week collaborative for complex clients

1/2 days in clinic 1x a week
- (OT + PT not[illegible])

Gaps Discussed

- Challenge of turnover + how to share information
- Idea of team meeting 1x month
- Communication btw. team + SPs → EMRs don't communicate

Participants (list roles)

GP x2
SW
PT
Admin
PCRN

Home Support Rapid Mobilizator

We aim to do up to 6 maps in an evening.

(Photographing them for analysis)

We wrap up the sessions by getting feedback - both on the team map and our process.

(So we can get better.)

Analysis and Recommendations Report

From a session we capture:

Roles / Tasks

Gaps

Recommendations

After, we synthesize the findings (from the created maps) and bring in evidence and recommendations into a short report.

Team Mapping Demo

Let's try Team Mapping together so you get a sense of how it works.

NewClin is a brand new clinic. You are on the team.

On the team there will be

- 2 Family Physicians
- 1 Nurse Practitioner
- 2 RNs
- 5 MOAs
- 1 Allied health professional (TBD)

Dorothy

70-year-old female with a history of COPD, osteoarthritis in her knees, and sciatica. Dorothy is a retired instructor and now volunteers on several local boards.

She is a patient in the Patient Medical Home.

Dorothy’s health is fairly stable.

- **Who would be on her care team?**
- **Are there any tasks that you already see for these roles?**
- **How is her chronic disease management handled across the team?**

Scenario: It is flu season. Over the last week and a half, Dorothy has developed a worsening cough, which has become productive of green sputum with fever/ chills at night. This is a COPD exacerbation.

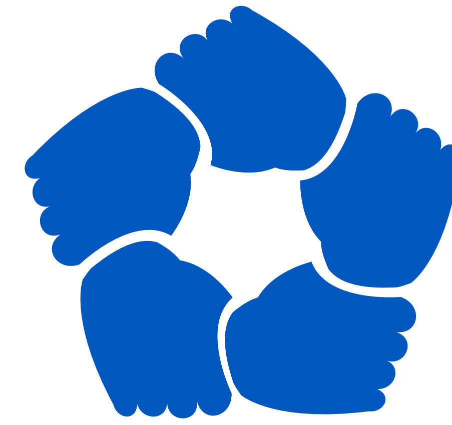
Dorothy is brought to the PMH by her daughter without calling.

- **Who does Dorothy see first?**
- **What happens?**
- **Who follows up with Dorothy?**

That is your first step into Team Mapping

(congrats team!)

Happy to answer your questions



Innovation Support Unit

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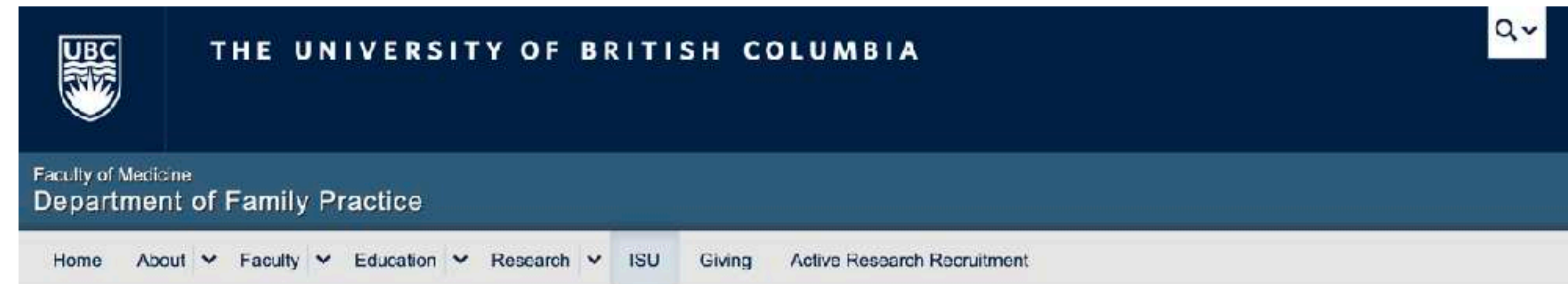
More questions?

isu@familymed.ubc.ca

www.familymed.ubc.ca/isu



» Faculty of Medicine » Home » The ISU » Team Mapping Facilitator Materials

Team Mapping Facilitator Materials

UPDATED: 2019-July-19

Hello Team Mapping Facilitator! This page has links to all the materials you need for Team Mapping. If you have been to the facilitator training, you will know how to use each of these. If you have not been to the training, we suggest you contact us and come to one of the sessions. (isu@familymed.ubc.ca)

We have organized the resources below into sections based on which of the three stages of Team Mapping you are at in the process.

Learning About Team Mapping (general materials)

- **Team Mapping Facilitator Training Workbook**: This PDF workbook walks facilitators through the three stages of the Team Mapping method in detail. It maps to the Team Mapping Facilitator Training workshop activities.
- **Team Mapping Circle of Care Template**: This PDF document is the large map that we use in the sessions on the tables. You will have one as a part of your workshop participation. This is provided in case you want / need to print more. This document is set to be printed in 36"x48". (This can easily be done at Staples- engineering prints are $7.99. We also recommend getting large maps laminated so they can be re-used.)

Preparation Stage Materials:

- **Community Prep Worksheet Template**: This Word document provides a set of preparatory activities facilitators can complete as they prepare for a Team Mapping session.
- **Community Stakeholder Interview Guide**: This PDF document contains sample questions to be used in preparation for a Team Mapping session with a community or clinic.
- Persona Materials:
  - **ISU Persona Library V1-01**: **(19-July-2019)** This Word document provides a ready reference of personas available for selection, adaptation, and use in a Team Mapping session. It

Please fill out your session evaluation now!

Complete a session evaluation one of two ways:

- FMF app
- Fmf.cfpc.ca

Session #: S314

Session Name: Team Mapping: A method to support transitions to team-based primary care

YOUR FEEDBACK IS IMPORTANT TO US!