side, however, you know that Carter has excellent clinical instincts. Further, though he may seem to have an air of superiority in interactions with some of his coworkers, his interactions with patients have been consistently outstanding. His ability to help patients manage challenging health issues and take responsibility for their post-discharge care has been noted several times. Your reflections about Carter's possible promotion have left you confused.

Case Questions

1. What is the importance of clinical competence and patient focus relative to one's ability to work as a member of a clinical team in this department?
2. Do you want Carter to be a manager in your department?
3. Regardless of your decision on the possible promotion, what should you tell Carter to help him improve and develop his managerial skills?
4. If you have decided to recommend Carter for the promotion, what do you do now to help him succeed in a managerial role? If you have decided against the recommendation, what do you do to encourage his professional development within New Hope so he does not leave for a different job?

CASE 51

Reimagining Primary Care at Northcoast

Erin Sullivan and Samuel C. Thomas

Deanna Chapman pulled into a parking space and looked around the parking lot, noting that it was probably at 50 percent capacity at 8 a.m. She wondered how full it had been at this hour in the days before COVID-19 arrived and turned the world upside down. For the past three days, Deanna had been in a virtual new-hire orientation and was excited to start her role as a primary care practice manager for one of the largest primary care practices in the Northcoast Health System. COVID-19 had forced the two-physician family practice she had managed for 10 years to close its doors, so she felt fortunate to have landed this new position. As the practice manager, Deanna's new role focused on all aspects of clinic operations, including financial accountability and reporting to the central

administrative office (or "headquarters"). She would manage staff, partner with clinicians, and ensure a smooth patient flow within the clinic.

Staring at the medical office building in front of her, Deanna wondered what new challenges were waiting for her inside. She had interviewed with the practice's medical director and a few staff members as well as the retiring practice manager. Everyone had seemed somewhat stressed by the ongoing tension between in-person and virtual care that most primary care practices were trying to resolve, but Deanna knew that was to be expected. Despite that, everyone seemed competent and well-intentioned and had plenty of ideas and enthusiasm for responding to the health system mandate to "reimagine primary care" in a post-COVID-19 world.

Deanna's conversation with the retiring practice manager, however, still weighed on her when she accepted the job. He warned her that COVID-19 had been the last straw for him and he "couldn't deal with the physicians anymore." He explained that the first two months of the pandemic had been a refreshing change from the normal requests and demands, as everyone worked together to just get through each day, but in spite of the ongoing challenges, the physicians had reverted to their old ways and it was "every physician for themselves," overwhelming the nurses, medical assistants (MAs), and front desk staff on a regular basis. He had fallen into the role of referee and was not willing to negotiate the complexity of this transition to a balance of in-person and virtual care.

Deanna took a deep breath, gathered her things, and headed into the office for her first day on the job.

Two Weeks Later

Deanna's first two weeks on the job had been intense. During her second week, Northcoast headquarters had sent out a memo to all primary care practices accelerating the timeline for the reimagining primary care initiative. Practices had to submit their phase 1 plan in 30 days. Phase 1 plans needed to propose how the practice would use virtual visits while maintaining quality care and high levels of patient satisfaction now that the pandemic was no longer impacting in-person care quite so much. So, Deanna had to learn her new role, build relationships with clinicians and staff, and colead the development of the phase 1 plan with the medical director, who was technically her dyad partner. Northcoast used the dyad model, which paired administrative leaders who had strategic and operational strengths with physician leaders who had clinical expertise to form practice-leading dyads. However, Deanna's boss was the director of ambulatory care in the central administrative office.

Late in her first week, Deanna had spent an entire morning shadowing the patient representative team. She observed the check-in and check-out desks and also spent time in the "phone room" listening to how appointments were scheduled, questions triaged, and referral and insurance requests coordinated. She was impressed with the professionalism and efficiency the staff displayed, but noted the frustration the team was feeling when they were not speaking with patients. She overheard exasperated comments about not being able to keep track of clinician schedules, appointment templates for who was to be seen in person or virtual changing too much, and managing all their technology supporting pre- and post-pandemic operations, but there not being a unified way of operating. She noted a whiteboard in the phone room that tried to codify clinical scheduling updates for quick reference, but it had many strikethroughs and scribbles. Deanna thought the front desk scheduler summed up the group's sentiments best when he said, "We are tired of the chaos of who is in and who is out of the office. Our lives would be much easier and we would be more efficient when talking to patients if the practice could get into a regular rhythm with consistent schedules. The number of times I have to put patients on hold to clarify a schedule is frustrating."

While the patient representative team was frustrated, Deanna observed that the MA team was riddled with anxiety. Initially, Deanna had thought it was her presence in the pods earlier in the week that made them jumpy. She noticed that the patient flow was chaotic and patients were frequently waiting more than 10 minutes before a clinician greeted them. She also noticed that there was sometimes confusion about whether patients were being seen in person or virtually, and that the MAs did a lot of technical troubleshooting with the virtual platform and getting patients and clinicians connected. Deanna appreciated that the MA team helped each other through the afternoon clinic and were willing to take on new roles navigating patients through virtual rooming, which was different from the typical in-person rooming processes.

Deanna walked to the parking lot that evening with one of the MAs, Sheri, and asked if that day's clinic was typical. Sheri said that it was a typical post-pandemic clinic, and that nothing felt seamless anymore—there was some mishap or confusion during every clinic. Sheri felt bad for the patients, because their experience of the practice was not the same as it was pre-COVID. Deanna asked Sheri if worrying about the patient experience made the MAs anxious, and got a very definitive answer: "No, not really, because we have pretty loyal patients. We all worry about just having a job when the dust settles, when primary care has been reimagined. Our jobs look very different than they used to, and we worry about being obsolete or that Northcoast won't offer to retrain or repurpose us somewhere else in the health system." That the MAs were worried about job security was an important

piece of the puzzle for Deanna. She knew she would need to address that with the MA team, but also factor that into the phase 1 primary care redesign plans. Admittedly, Deanna was not sure what the MA role would look like in a hybrid virtual and in-person world.

The Patient Family Advisory Council Meeting

Deanna reflected on how many constituencies had to be considered in the reimagining of primary care. She had yet to spend any meaningful time with the practice medical director, Dr. Heath, who was allocated at 50 percent administrative and 50 percent clinical. When he was not seeing patients, he was in Northcoast meetings, many of which he attended virtually from home. Deanna had 15 minutes with Dr. Heath prior to last week's patient and family advisory council (PFAC) meeting, and she thought his view on the redesign was very practical, especially given the inefficiencies she had witnessed within the practice. As Dr. Heath explained heading into the meeting, "We need to reimagine primary care. I acknowledge that we will not make everyone happy. There is going to be a mix of care-delivery modalities and we need to alter our systems and structures to make things efficient ASAP."

Dr. Heath and the PFAC cochair, Natalie, had focused the first part of this month's agenda on soliciting the PFAC's input on virtual care during the pandemic and thinking about how patients would like virtual care to be used in the future. Dr. Heath had started the conversation by reminding everyone that pre-pandemic, virtual visits were minimal and used only in unusual situations, such as to see a homebound patient who had a long-standing relationship with one of the clinic's providers. He next shared three months of patient satisfaction data related to virtual visits, and it was largely positive, with 70 percent of respondents saying that they would be willing to have another virtual visit in the future. One of the PFAC members, Al, a 65-year-old patient, found that data shocking because he wanted to go back to in-person care as soon as possible. He explained, "I can't seem to get the technology right for these telehealth visits, and after 5 or 10 minutes of fighting with the computer, Dr. Miller calls me on the phone. I'm not sure what the value is of the phone or computer visit if Dr. Miller can't actually listen to my heart."

While some PFAC members had murmured their agreement with Al, the younger members of the PFAC scrambled to disagree with his comments. Rhonda, a 32-year-old with an infant, said, "I love telehealth. I think with telehealth as an available option, I really only need to see Dr. Heath in person once a year—maybe. It saves me so much time, since I'm juggling work and my five-month-old." The meeting continued for the next 20 minutes

with a point-counterpoint debate about virtual visits. For patients, the positives of virtual visits were convenience, accessibility, and feeling safe during the pandemic; the negatives included trouble with the technology, lack of internet access, and simply preferring to see their provider in person. It was clear to Deanna that patients did not have a good sense of when telehealth was appropriate and when an in-person visit might be necessary. She made a note to herself to ask Dr. Heath about running a patient education campaign about this once the practice had clarified their new appointment structure.

The 7 a.m. All-Team Meeting

Deanna and Dr. Heath agreed that the short submission timeline for the phase 1 reimagined primary care plan required a 45-minute all-team brainstorming meeting. Finding a time for this was no easy feat, but they agreed that it was important to hear ideas and give clinicians and staff the opportunity to weigh in and feel as though they had been consulted on the process. Additionally, it was likely that team members had some good ideas and considerations. Deanna was able to arrange two optional all-team meetings with two and a half weeks until the phase 1 proposal due date. The first all-team was at 7 a.m. (the second was later that day at 5 p.m.), and Deanna organized a catered breakfast from a nearby bakery to sweeten the early meeting time and as an added sign of appreciation for those who could attend.

Dr. Heath kicked off the meeting by providing a five-minute overview of where the practice was in the post-pandemic transition, sharing that clinicians were still conducting virtual visits 40 percent of the time and that in-person visits were at 60 percent. He also noted that, with the introduction of virtual care as an option, the number of patients who failed to keep an appointment was down by 50 percent, with no-show rates nearing 1–2 percent, and same-day cancellations were down 10 percent. He noted that financially, this wasn't adversely affecting the practice's revenue given that the state had mandated parity for virtual visits for the next 18 months while it worked on a more permanent policy. Dr. Heath explained that while the current state of the practice might seem transitional, he didn't envision the practice ever being exactly like it was before COVID-19. And neither did the health system, which was asking for a longer-term reimagining of primary care delivery. At that point, Dr. Heath asked the meeting participants for their thoughts about the future of care at their practice.

Dr. Murphy, a seasoned physician who had been in practice with Northcoast primary care clinics for 25 years, spoke up first, stating that the clinic should prioritize in-person care as much as possible. This was greeted with a spontaneous "Hear, hear!" from Dr. Lopez. Dr. Murphy continued,

saying that his preference was to return to six sessions of in-person care a week and not conduct any virtual sessions. He missed seeing patients in person and talking to the other providers and staff in the team room between appointments. As a preceptor for medical students in the clinic, he was concerned that the medical students were missing out on important physical exam findings. He stated that he was uncomfortable precepting medical students in providing virtual care because this was never part of his training. Dr. Murphy finished by admitted his own surprise that he was able to manage 80 percent of patients' concerns virtually during the pandemic, but noted that he hated sitting alone in a clinic room or his living room on his laptop all day long. Several physicians nodded their heads in agreement.

Dr. Mendes, another physician in the Northcoast clinic with 10 years' experience, followed Dr. Murphy's comments by launching into a description of her own ideal schedule. She wanted to split her clinical schedule, two days in person and two days virtually each week. Similar to Dr. Murphy, Dr. Mendes noted that she was able to manage a majority of patients' concerns virtually during the pandemic, especially when patients were appropriately triaged to either in-person or virtual care based on clinical indication. To improve this process, she had developed a brief triaging guide for the staff members who scheduled patients and hoped the other providers would offer feedback on the guide (see exhibit 51.1 for the triage tool). Dr. Mendes mentioned that refining this triage guide was important because patients didn't always know whether a virtual visit or an in-person appointment was more appropriate. She hoped that this guide would make it easier for schedulers to manage patients who called and asked for virtual visits because they were "too busy to come to the office" or said, "You didn't need to see me in person during the pandemic."

Deanna noticed the two schedulers at the table perk up at the statement about the triage tool. This was something that they had been hoping for. Before ceding the floor to the next provider, Dr. Mendes expressed her gratitude for all of the MAs: "Thanks to all of the MAs for your patience and perseverance in helping my older patients log into the virtual visit. I know that may have made many of your days very frustrating. Beyond becoming 'tech support,' you kept doing many of the things I always relied upon you for, including asking history and screening questions before I entered the room—well, the virtual room."

Susan, the nurse care manager in the clinic, was next to join the conversation, saying, "I find virtual care very frustrating. I'm ready to go back to my pre-pandemic schedule with all in-person appointments. I'm losing too much through the computer screen and always running behind because I can't ever enter a virtual room without a tech problem." Susan explained that in the two years until she retires she wants to connect in person with the

patients she has known for more than 20 years. She also said she thought that the quality of her chronic care visits and patient education is not up to par via virtual care. She mentioned that maybe one of the other nurses in the practice would like to go mostly virtual because, while it doesn't work for her, she was surprised that many of the patients who frequently missed in-person appointments seemed more than happy to attend a video visit. She said, "I very rarely have patients 'no-show' my appointments anymore." Deanna looked to see if there were other nurses in the room to validate or respond to what Susan had said, but noticed there were no other nurses in the room.

There seemed to be a lull in conversation and Deanna noticed that Jackson, the clinic social worker, was poised to say something. She invited him to share his thoughts. Jackson ran the social determinants of health (SDOH) initiative in the clinic and explained that his work was dramatically disrupted by the pandemic. He noted feeling that his work was getting back on track as in-person appointments increased. In particular, he found screening patients for SDOH nearly impossible with virtual care since the process for screening involved the front desk staff handing patients a paper screening form. Jackson explained, "I am worried that because of our outdated paper process, we failed to meet many needs during the pandemic, and if we don't develop a way to do this screening virtually, many patients will continue to fall through the cracks."

At that point, Dr. Miller chimed in, "Jackson, I believe what you are saying is spot on. We need a more inclusive screening process that works with virtual care. In fact, shouldn't most of our processes be as inclusive as possible moving forward, so that they work in person and virtually? Didn't the pandemic give us a good head start on having in-person and virtual systems? I'm sitting here listening and there seem to be a lot of personal preferences being shared, and I'm hearing some resistance to change among the clinicians, but what about our patients? How do we provide excellent care going forward?"

As soon as Dr. Miller finished asking that question, everyone started talking at once. Deanna had no idea what anyone was saying, but noticed that the MAs and front desk staff, who were seated near each other on the far side of the conference room, looked very animated as they started talking among themselves. Deanna noticed that Dr. Murphy, Dr. Lopez, and Susan had their heads huddled together while Dr. Mendes approached the whiteboard to draw a weekly schedule template on the board. Dr. Heath raised his eyebrows at Deanna and said, "It seems like it's every person for themselves here." He got up and attempted to restore order to the meeting.

While Dr. Heath tried to bring everyone back into one conversation, Deanna's mind was racing. She thought to herself, *This phase 1 plan might be a bigger challenge than I thought, and what I've witnessed in this meeting so far is probably an example of the behavior that wore out the last practice manager.*

Deanna was determined to use the remaining minutes in the meeting to bring the group together around a shared vision and mission of the clinic.

She had taken notes on preferences, questions, and concerns from each of the stakeholders at this meeting and had gathered her notes from the numerous observations in clinic and other meetings, including her notes about the patient perspective from the PFAC meeting. Dr. Heath asked her to share her thoughts with the group. She started by emphasizing the unique timing of this opportunity to reshape care delivery so the clinic could be more equitable. She also pointed out that the team could be more focused on the quadruple aim, which is an approach to optimizing health system performance by focusing on four dimensions: improving the health of populations through improved quality of care, enhancing the patient experience of care, reducing the per capita cost of healthcare, and enhancing the provider experience of care.

Deanna knew that what she had heard in the most recent PFAC meeting about creating a more patient-centered approach and from Jackson about health equity and screening for the SDOH must not be lost in the discussion of provider and staff preferences and their degree of comfort (or discomfort) with change. As part of the clinic's phase 1 plan, Deanna proposed that the clinic pursue a model of care called the patient-centered medical home (PCMH), which puts patients at the forefront of care. Deanna had done her research and confirmed that PCMHs improve quality of healthcare, the patient experience, and increase staff satisfaction—while reducing healthcare costs. The PCMH model emphasizes team-based care, communication, and coordination, which was needed now more than ever as patients sought to have a hybrid in-person and virtual model of care delivery.

Although much of the work lay ahead, Deanna emphasized that their current way of operating was okay for the short term, but was not sustainable over the long term. She urged the providers and staff to join her in reimagining primary care in a way that puts the patient first, emphasizes equity of care, and meets patients where they are. For the first time in the meeting, there appeared to be general agreement and consensus on a shared mission, one that was greater than any individual goal and something that everyone could support.

Case Questions

1. Deanna and Dr. Heath have a chance to run another all-team meeting this evening at 5 p.m. What might you suggest they do differently in that meeting, and why?

2. Can you identify the fundamental challenges within the Northcoast practice that are obstacles to getting the phase 1 plan developed?
3. Can you identify all the stakeholders and their different perspectives? Are there any missing stakeholders? How might Deanna navigate the various stakeholders in drafting a phase 1 plan?

EXHIBIT 51.1
Triage Tool for In-Person Visit vs. Video Visit

In-Person Visit vs. Video Visit for Primary Care Table		
VISIT TYPE	**In Person**	**Video**
SYMPTOMATIC		
Back pain	No	**Yes**
Breast lump or pain	**Yes**	No
Dizziness, vertigo	No	**Yes**
Diabetes mellitus: follow-up	No	**Yes**
Ear issues (ear pain, hearing problems)	**Yes**	No
Eye (red eye with no pain, no vision changes)	No	**Yes**
Headache (mild)	No	**Yes**
Joint pain or bone pain with trauma	**Yes**	No
Joint pain or bone pain without trauma	No	**Yes**
Mass (new, palpable lesion/bump)	**Yes**	No
Pelvic pain	No	**Yes**
Procedural needs (e.g., splinter removal, abscess incision and drainage, Pap smear, IUD insertion)	**Yes**	No
Rectal pain or bleeding	**Yes**	No
Respiratory symptoms (mild)	No	**Yes**
Testicular pain, penile pain, UTI in a male patient	**Yes**	No
Vaginal discharge, vaginal pain, vaginal bleeding (not related to pregnancy)	**Yes**	No
FOLLOW-UP CARE		
Complete physical exam/well child check	**Yes**	No
Follow-up: Behavioral health (anxiety, depression, insomnia)	No	**Yes**
Follow-up: Emergency department/hospital discharge	No	**Yes**
Follow-up: Diabetes mellitus	**Yes**	No

Follow-up: Dizziness/vertigo	**Yes**	No
Follow-up: Hypertension	**Yes**	No
Follow-up: Sexually transmitted illness with fever and without pelvic pain	No	**Yes**
Follow-up: Sexually transmitted illness with fever and pelvic pain	**Yes**	No
Follow-up: For any other problem not listed in the follow-up section	No	**Yes**
Immunizations	**Yes**	No
Lab or imaging follow-up	No	**Yes**
Travel advice	No	**Yes**

EXHIBIT 51.1 Triage Tool for In-Person Visit vs. Video Visit *(continued)*

CASE 52

Matrix or Mess? The Matrix Management Challenge

Ann Scheck McAlearney

Carol is excited about her newest job change. After serving as a quality improvement (QI) manager at Valley Community Hospital for the past two years, she will finally be able to put to use her expertise in both nursing and informatics by taking a new role as a clinical informaticist for the hospital. Though she felt like she had been in school forever, her experience as a nurse, her undergraduate degree in informatics, and her on-the-job training in QI have given her a broad perspective about how information technology can be usefully implemented to improve the quality of care provided at the hospital.

This new job, though, while seemingly a great fit on paper, also makes Carol a bit nervous. In her prior role in QI, she had reported to a single director. Her new position has given her a second boss, the director of information systems (IS) for the hospital. In a so-called matrix design, Carol reports to both directors and is responsible for satisfying them both.

In fact, the IS department as a whole is a matrixed department within the hospital. This organizational design for IS had been introduced because of the combination of functional and project responsibilities involved in each IS initiative. The functional areas of the department—such as budgeting, hiring, and training—are consistent regardless of project, but IS project