

Examining the “Dyad” as a Management Model in Integrated Health Systems

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In this article...

Examine a two-pronged approach to the management of physician/hospital integration, including the responsibilities of physician leaders and non-physician leaders.

As market pressures encourage consolidation of the provider side of U.S. health care, integrated health systems are emerging as a response. Integrated health systems align the interests of community hospitals and physicians by a handful of models. A number of systems of care are moving to the employment model with physicians as employees of the unified enterprise.¹

In a growing number of these integrated models of community health care delivery, the “dyadic model” of management is being implemented. In these cases the management “dyad” includes a qualified physician paired with a qualified non-physician manager.

Dyads may oversee an integrated clinical service line (e.g., cardiovascular, orthopaedics, cancer care, etc.); divisions of care providers (e.g., regional primary care networks); or entire community services delivery systems. The genesis of the term dyad as used here most likely stems from its application in sociology; i.e., two persons involved in an ongoing relationship or intervention; the relationship or interaction itself.

Regardless of origin, the philosophy is clear: the nature of the integrated systems of care causes them to be better managed by the application of qualified physicians and non-physician teams.

Rationale and nature of dyads

Frequently asked questions about the dyad model are: “Can’t physicians just practice medicine and let the professional managers run things?” “How do dyads collaborate to divide responsibilities?” and “Who is really in charge?”

The first question is the easiest. By definition, those who apply the model believe that to isolate the talents and experiences of physicians to the “exam room” is an underutilization of the potential of uniquely productive business and clinical models. The more challenging questions follow.

The first of these is “How does the dyad collaborate to divide responsibilities? One would not expect each member to have the same job description. At the end of the day, efforts should be complementary, and certainly not redundant.

Figure 1 provides a visual of the description of a model. Design is as much management art as it is management science. Principal goals are rational divisions of labor and application of skills and experiences to their highest and best uses.

First, it’s useful to describe what the related positions have in common, whether the job is management of a clinical service line, institutional, division, or entire community health system. The commonalities (from Figure 1) are:

- The mission
- The vision
- The values
- The stated clinical, patient service and business goals
- The strategic plan (and related goals)
- The performance scorecard (the methods of monitoring and evaluating clinical as business performance)
- The culture

In other words, each owns the overall performance of the enterprise under them. Neither is permitted to delegate responsibility for these common areas or blame the partner for his or her lack of performance in this regard. The success of each is tied to the other.

But how are distinct and separate responsibilities and accountabilities identified, divided and managed? This is also the art in the design; while each owns areas of performance overall, day-to-day operations distills to distinct and

stated responsibilities and accountabilities.

Let's start with the physician co-leader. The nature of the integrated model presents unique qualities that must be addressed by an equally unique management model. The integrated model is unique in many respects (i.e., it is unlike the traditional community health system delivery model) in that:

1. Physicians are (most likely) employees of the health system. They have no clinical or business interests on the "outside." Their professional and financial success is tied to the health system.
2. Physicians' practice styles directly affect the clinical and operating performance of the organization; any lack of standards of care, or unnecessary process variations, affect operating performance directly.
3. Quality of care is entirely dependent upon the employees of the organization. For the fully integrated models there are no outside (or "independent") physicians.
4. The fixed operating costs (including physician compensation) are typically higher than the traditional models. Consequently, the financial risks related to volumes and payer mix variation can be pronounced. Conversely, the model tends to be more scalable and financially "leverageable" as efficiencies and scalability result from volume management on a relatively fixed cost base.
5. Provider behavior issues are not a problem of the medical staff in the traditional sense; i.e., a problem for independent members of the hospital medical staff. They become an issue for management and should be handled at the lowest levels first (clinical service, department or division). Most often, physicians manage physician behavior issues.

figure 1

The Dyadic Management Model for the Integrated, Community Health System



So, given these conditions, specific responsibilities of the dyad model follow.

Physician leader responsibilities

- **Assuring quality**
Example: Assuring that patient care comes first.
- **Building the medical group practice culture.**
Example: Common values, identity and code of conduct as a unified group practice, for use in physician recruiting and daily practice management.
- **Encouraging teamwork among physicians and multidisciplinary care teams.**

Example: Application of physician extenders as members of a team approach to clinical care, inpatient and outpatient and for specific disease management programs.

- **Managing provider productivity** (as it is defined within the compensation model).
Example: Specialty-specific work relative value unit (WRVU) productivity expectations and performance oversight.
- **Managing the division of labor** (sub-specialization and provider resource allocations and assignments).
Example: Clinical assignments based upon the performance of

the whole, according to the care model and strategy.

- **Managing physician-driven clinical resource use.**
Example: Task physician leaders with medical device vendor negotiations.
- **Minimizing inappropriate practice style variation across providers**
Example: Create an internal culture of ongoing, open peer review.
- **Maximizing provider-driven patient satisfaction and customer service.**
Example: Share office patient satisfaction scores among physicians.
- **Providing for physician continuing education and skill building.**
Example: Interest in the ongoing development of physician leaders.
- **Encouraging clinical care innovation.**
Example: Promoting clinical model change according to evidence-based standards.

Given this list, the assumption is that, for certain issues, the physician leader is better suited as the manager. In practice, it is far more efficient for physician leaders to deal with such issues (imagine a non-physician confronting a physician over issues of clinical productivity, clinical judgment, practice style or application of specific diagnostic and treatment procedures).

Non-physician leader responsibilities:

- Financial management, accounting and reporting systems and methods
- Operating and financial performance and ratio analysis and management
- Market share performance
- Competitor strategy analysis
- Capital and resource consumption

patterns, comparisons and investment models and management

- Performance scorecard (dashboard management) applications
- Labor relations management
- Strategic planning and plan implementation
- Staff recruiting and staffing plan implementation
- Collaboration on resource and labor use issues across services, sites or divisions
- Supply chain management

Does the dyadic model require two full-time leaders regardless of the size of the enterprise? Often not. Most often (but not always) the physician leader maintains a sizable clinical practice as well (typically from 30 percent to 75 percent time given the size of the co-led and co-managed enterprise). If a clinical practice is maintained, it's important that the physician see the managerial responsibilities as a "real job," not simply tasks performed between patients.

Identifying and selecting physician co-managers

The easiest way to identify and select physician co-managers is by first examining how they're not identified, selected and prepared. They are not a product of:

- A rotational model of selection; i.e. "it's your turn."
- Limited terms assigned; i.e., "you'll do this for two years, then we'll switch."
- "You learn from the person who did it last or by OJT (on the job training).
- "You're winding down your practice (e.g., moving to retirement), so you take the job."

These are real jobs that require individuals who are interested in them as career paths. Physicians in these jobs often have aspirations for expanded leadership roles. It is likely that physicians in co-manager/co-leadership roles will eventually be younger and trained specifically for leadership and management roles. "Administrative medicine" will be a career goal for sure.

Training for these roles will require formal graduate education; including graduate management degrees.²

The psychology of the model

If the dyadic model of community health care management has legs, there is a psychology to its long-term success. The characteristics of this psychology are:

1. Physicians who practice in the integrated models must accept that the autonomy of private practice is relinquished to the team approach. Rarely, however, do physicians in these models report that their ability to exercise professional judgments on behalf of patients is usurped by the dyadic model. On the contrary, many perceive a new type of autonomy; an autonomy that comes with being a valued participant in the whole. Effective dyadic model leaders will encourage a culture and organizational psychology that engages physicians as participants in clinical and business decision making for the system.³
2. Non-physician professional managers must accept that trained practitioners can be successful managers in a partnership model. At times, non-physicians are threatened by the notion that "if physicians can be clinicians and managers, why do organizations need me?"
3. Physicians who elect a professional track of clinical practice and man-

agement are not violating a sacred trust and oath. Their contributions to the health and welfare of patients can be made as a leader and manager too.

4. While some proportions of clinical practice may be psychologically satisfying for the physician manager, at some level of responsibility clinical practice is left behind in favor of organizational leadership. That is to say, at some level of responsibility and accountability, the physician leader can't do both. There is some debate about whether the non-practicing leader has credibility with practicing physicians. Those who support the notion that physician leaders don't need to practice to have the respect of peers, argue that if the physician leader is not qualified or respected as such, no amount of clinical practice time is sufficient. Others argue that some level of practice is required. There is no right answer to the debate; the decision often hinges on personal preference of the physician and the culture of the group.

Performance and payment for the dyad

Some argue that taking a physician "out of production" is a waste of potential; in other words, "let physicians practice medicine and managers manage." If no productivity leverage existed in the model, it wouldn't make sense.

Those who have applied the model successfully point to opportunities for productivity performance improvement that were certainly not available in the more traditional "non-integrated" models and are less available in the integrated models where physicians are "producing clinicians" only.⁴ Specifically, they cite examples such as:

- Efficiency through sub-specialization and division of labor; i.e., physicians managing the allocation



Case Study 1

Insights from Experts on the Dyad Management Model

"The dyad leadership model of shared accountability for clinical quality, service excellence and financial performance allows us to leverage our skills toward more effective problem-solving and execution.

Making the dyad model work requires trust; significant, regular communication; and true respect of the other partner. When this happens, no matter in what forum, when one person in the dyad speaks, everyone knows that he/she speaks for both."

Carl E. Heltne, MD
Chief medical officer
Essentia Health

Daniel McGinty
President
Essentia Community Hospitals and Clinics

"The dyadic model must effectively manage the tension of two cultures:

- Hospitals are based on a culture of collectivism serving groups through: standards, policies and uniformities.
- Physicians work within a profession that favors expert knowledge applied in service to individuals.

The delivery of medical care is a business, caring for patients is not. A principal goal of the dyad is the effective management of this tension for the good of the patient and the organization"

James G Anderson, MHA, FACHE
Administrator, Collaborative Affairs
Mayo Clinic

"The best interest of the patient is the only interest to be considered and in order that the sick may have the benefit of advancing knowledge, union of forces is necessary....it has become necessary to develop medicine as a cooperative science."

W.J. Mayo, 1910

continued...

Insights from Experts on the Dyad Management Model

What value does the dyad/co-management leadership model add to your organization and to your ability to run an integrated CV health system?

“It enhances communication and raises the level of engagement throughout the organization. A co-management leadership model ultimately provides us the best opportunity to transform health care, transitioning from rescue care with crisis management to greater longitudinal care with coordinated management.”

Thomas A. Malasto

Chief executive officer

Community Heart & Vascular & the Indiana Heart Hospital

“Having a co-management leadership model is integration. It does not add to, but is the keystone to successful integration. Physician engagement through leadership integration is the only way to empower team thinking focused on improving customer, patient-centric care while accountable for cost restructuring and financial performance improvement.”

Ramarao Yeleti, MD

President

Community Heart & Vascular & the Indiana Heart Hospital

What does it take to make the co-management model work for the two of you and for your organization?

“It takes willingness from both physicians and administrators to think and perform differently than we have previously in health care. It takes a mindset of managing the business in its entirety, effectively engaging all stakeholders and not managing components in isolation.”

Thomas A. Malasto

“It requires highly-motivated leaders—physicians, clinical directors and administrative champions—with a strong organizational infrastructure, well-defined goals and metrics, and timely verifiable data. It requires individuals to understand that the relationship is akin to a marriage; that it will only succeed with an open, trusting relationship. That is not commonly found between physicians and non-physicians.

Ramarao Yeleti, MD

of physician skills and effort across sub-specialized clinical services and program needs

- Development of evidence-based best practices and more standardized clinical pathways
- Improved fixed asset turnover (efficiency) rates, especially for capital-intensive areas for specialized clinical services
- Design and management of geographic outreach strategies
- Effective balance of the medical staff numbers (FTEs) within and across specialties
- Use of physician extenders
- Narrowing variations on pharmaceuticals and devices

While some might argue that paying physicians to do the above isn't necessary, others argue to achieve success with the above requires physicians in compensated co-management roles.

Who is ultimately in charge?

Every integrated health system has a chief executive officer. Every CEO is ultimately responsible for the performance of the organization as a whole. The CEO is also responsible for the organizational design and function of management models applied, including the dyad models. The CEO is the final arbiter of the dyadic model of management.

It's important to note that no management model is 100 percent reliable or infallible. The unique nature of the integrated models of care does encourage leaders toward the dyadic model, however.

Long-term success with the dyad model does require an organizational commitment to the design, supported by a commitment to invest in the development of physicians as co-leaders and co-managers. For successful

users of the model, the dyad becomes a part of the cultural fabric of the organization; “it is how we do it here.”

Members of successful dyads often refer to the relationship as a marriage. “We don’t always agree, but we know we need to make the relationships work for the good of the organization and those we serve.”



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