

# Health Care Leadership and the Dyad Model

By Kim S. Baldwin, PhD, Nancy Dimunation, RN, BAN, MHA, and Jack Alexander, MD

## In this article...

Study how Fairview Red Wing Health Services in Minnesota developed and implemented a dyad model of health care leadership based on the Institute of Medicine roadmap.

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In health care today, a struggle has emerged between two leadership models—“operations” and “dyad.”

The operations model is the traditional and most-effective model of leadership in most business settings. The management structure is based on a team of supervisors, managers, and directors working together under the leadership of a vice president to coordinate and implement organizational initiatives.

The operations arm of an organization creates the super-highway of information flow. The explicit reporting, structure allows for unambiguous authority and straight-forward decision making. In essence, the supervisor reports to and is evaluated by their manager; the manager reports to and is evaluated by their director or vice president, and so on.

The organizational structure creates the traditional pyramid. Implementation of organizational initiatives is simple because those below on the hierarchy are not typically empowered to reject direction.

In some ways, the simplest and most extreme example of the operations model is a structure with no middle management—the supervisors at the department level report directly to a vice president who has full authority. The “command and control” structure in the military is another obvious example. Orders are accepted unquestioned and then implemented.

One key drawback of the operations model is that, other than the chief medical officer, physicians hold no formal leadership roles. In addition, in most health care organizations, physicians are no longer owners but employees.

In this sense, they should behave as all employees and recognize their relative position within the organizational hierarchy. In the operations model, they would be excluded from positions of legitimate authority and influence unless they held title.

For these reasons, the dyad model makes sense in health care.

The definition of “dyad model” varies across health care organizations. In most health care systems, it appears that the operations model remains intact while the vice presidents are partnered with physician champions, who provided support for their recommendations.

At Fairview Red Wing Health Services (FRWHS), we developed a cross-sectional representation of the ambulatory and hospital service areas and formally partnered an elected physician lead in each with an operations manager.

## Why health care leadership is different

Health care in essence is a sacred act of healing the ill and injured. Health care providers often speak of a calling—a desire to help those in need. The true understanding of this comes only through caring for others.

Unlike business, where individuals enter the organization in leadership positions after completing a bachelor’s degree, the infrastructure in health care relies on the identification of individuals with clinical experience who demonstrate leadership potential. It is essential that leaders in health care bring an understanding of both the clinical world and the organizational world.

Integrated delivery systems require trusting partnerships between caregivers. Because physicians hold a different status than nurses, the need for trust and communication is essential. When trust is engendered, the partnerships allow for alignment and movement toward shared goals, both clinical and organizational.

The dyad model provides physician engagement to build that trust. It opens communication between physician-nurse and physician-administration in a powerful way.

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## Leadership model

In 1997, the physician-owned Interstate Medical Center and the not-for-profit St. John's hospital merged. Fairview Red Wing Health Services' leadership structure was built on a hierarchical operations model with a chief operations officer (COO), a chief financial officer (CFO), and a chief medical officer working together under the authority of a chief executive officer (CEO). The pyramid provided effective representation from all departments/work units. The only physician who held leadership power directly was the chief medical officer, who was appointed by the CEO.

Governance over the medical staff was granted to a medical practice committee (MPC). Because FRWHS also employed its physicians, MPC had both the traditional medical executive role and a management role of physician activities. In essence MPC held two primary functions for the medical staff.

First, it provided guiding leadership to administration and the board as they represented the medical staff in opinion. It was a sounding

board and it offered key feedback and insight regarding the medical staff.

Secondly, it was responsible to ensure a healthy work environment—in this, it held the authority to intervene when necessary regarding problematic physician/provider behavior.

In 2007, when the chief operating officer at FRWHS left the organization, the CEO decided to implement the dyad model. One of his imperatives in the process was “defining how to deepen physician and manager dyads to drive clinical and operational excellence.” Rather than replace the COO, he recruited a chief nursing officer (CNO) to create an “officer dyad.”

Since 2004, each clinical department had elected a physician/provider lead (“department lead”) and the entire organization was represented operationally by managers/supervisors from the operations arm (mainly nursing leads).

The “microsystem” (language from the Institute of Medicine) dyad partnerships were formed between the department leads and the operations leads in all ambulatory departments and hospital service areas.

“Director dyads” were created with a partnership between a physician director and a nursing director. The director dyads represented primary care, emergency department/urgent care, surgery/operating room, and inpatient areas. The physician directors were appointed by the CMO and the team was completed with a psychologist director, forming “medical leadership.”

Unlike MPC, medical leadership sat outside of the medical staff structure. It was an administrative/operations team reporting to the CMO and, thus, to the CEO. The primary work was around implementation and follow up of initiatives from MPC with a particular focus on standardization and accountability within the medical staff. The nursing directors had a similar structure—they reported to the CNO who reported to the CEO and focused on the nursing staff.

In truth, most of the work organizationally has occurred through the director dyads—this structure has allowed the organization to engage physicians effectively around quality, service and physician behavior (a Joint Commission point of emphasis).

**Table 1**

Criteria of Effective Leadership		Operations	Dyad
1.	Speed of decision making	Quick	Moderate to slow
2.	Implementation of change	Moderate to slow	Quick
3.	Executive Power	Centralized	Shared
4.	Trust of Administration	Weak	Strong
5.	Stakeholder engagement (physician, nurse, clinical staff)	Poor	Good
6.	Culture of consensus and other bottlenecks	Low risk	High risk
7.	Ability to accelerate decisions in crisis	Quicker	Slower
8.	Ability to make tough decisions to contain costs/take out extra costs	Quicker	Unclear
9.	Role clarity	Clear	Mixed
10.	Ambiguity regarding decision making	Low	Medium
11.	Communication and coordination of decisions: who, when, how	Good	Good
12.	Rapid cycle/point of care innovation	Poor	Good
13.	Organizational alignment	Low	High
14.	Physician understanding and support in the delivery of care	Low	High

The structured partnership of physicians and nursing leads has been seen very positively internally, particularly by the nursing leadership.

The microsystem dyads themselves recently evaluated the 2010 department lead job description. The physicians rated the job description as a B+ and the nursing supervisors and managers rated the job description as an A+. The nursing leads expressed intense satisfaction at having clear, explicit expectations with their physician partner.

The remaining piece in the leadership structure at FRWHS is “leadership council” (LC). Leadership council holds primary operational responsibility for the organization. The members are vice presidents, selected by and accountable to the CEO. Their work is both strategic and operational.

Leadership council is expected to support the mission, vision, and promise of the organization and carry out the directives of the board. The only practicing member of LC is the CMO, who allocates 30 percent of

his time to clinical practice (internal medicine) although the CNO has a long history of clinical experience as a nurse in multiple settings.

## Challenges

The most important issue around leadership isn’t necessarily what model, but how well does a model succeed. On the surface, this question may appear simple, but, in reality, there is little objective criteria to measure leadership model effectiveness in health care. Table 1 provides a comparison of the two models.

In most business settings the preferred model is an operational one—a pyramid structure with clear lines of authority and accountability. This structure is efficient and straightforward. Authority increases as one moves upward and falls ultimately on one individual’s shoulders. The strength of this structure is the clear lines of accountability—the supervisor reports to the manager who both directs them and evaluates their success.

Health care, however, has unique differences and a new model, the dyad model, has taken root. In this model at FRWSH, the operations arm is partnered at every level with physician leads.

There are many benefits of this model. Foremost, the dyad model partnership of operations and physician reduces the “us-them” perspective that plagues many health care organizations. This problem is so significant that many physician groups continue to maintain their independence from the health care setting that they practice in.

A classic example of the gulf appears in the hospital setting where administrators strive to engage physicians in standardized workflows, especially those that do not immediately improve safety or patient experience but are based on the need

to comply with a governmental or accreditation body.

Without physician engagement, the organization struggles to successfully implement standardized workflows or, perhaps more importantly, to rollout new workflows or innovations. In the dyad model, the time invested up front ensures that the physicians understand the change and have voiced their opinions regarding a potential change. With physician leads that are respected by their colleagues, mistrust is reduced and compliance can be swift.

A second benefit is obvious from the perspective of the supervisor or manager. In the operations model these individuals are often instructed that changes x, y, and z need to occur by a certain date. They are left with the challenge of changing the practice of the physicians in their work area—physicians who are not informed around the reasons for the

change and may well be mistrustful of administration.

The operations person (often a nurse) needs to create change in physician behavior but holds no legitimate authority over physicians. Sadly, the rollout can take an extensive amount of time and generally the organization creates multiple workarounds to create compliance when a physician refuses to change (either overtly or covertly).

The dyad model does create financial demands. The organization needs to invest time and money in the education and training of the physician leads. This takes them away from their clinical practices and, therefore, income earning activities.

In our organization, we kept the department leads in practice and compensated them outside of their clinical time at an hourly rate. The medical directors had time carved out of their practices due to the

complexity and time demands of the work.

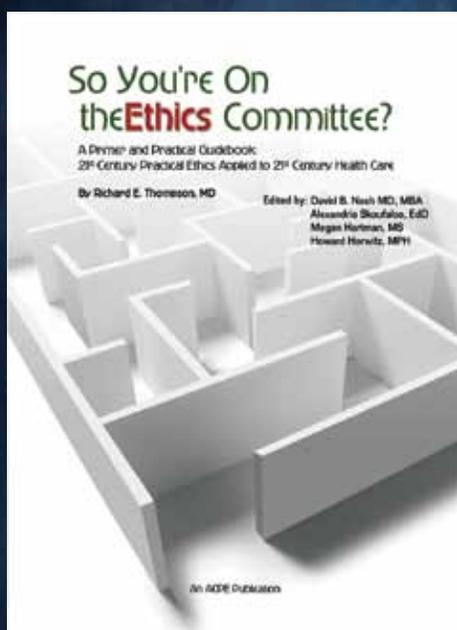
A key challenge in the dyad model is to harness the leadership potential of the MBA who brings essential perspective and knowledge around the larger sphere of business and effectively partner them with the MD who lives intimately in the clinical realm.

If the dyad model is to succeed, the organization must invest resources in increasing the physician's knowledge and skills around leadership. This model can create frustration for the MBA who is accustomed to autonomous decision making.

The process of partnered decision making is slower up front and physicians are trained to be autonomous decision makers themselves.

In the end, any successful management innovation needs to be an improvement in delivering value to patients. This means better financ-

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ing, quality and service. If it fails to deliver on this value proposition, the new model will likely fail.



**Kim S. Baldwin, PhD**, is a licensed psychologist and director of professional engagement at Fairview Red Wing Medical Center in Minnesota.

Kbaldwi1@redwing.fairview.org



**Jack W. Alexander, MD**, is chief medical officer at Fairview Red Wing Medical Center in Minnesota.

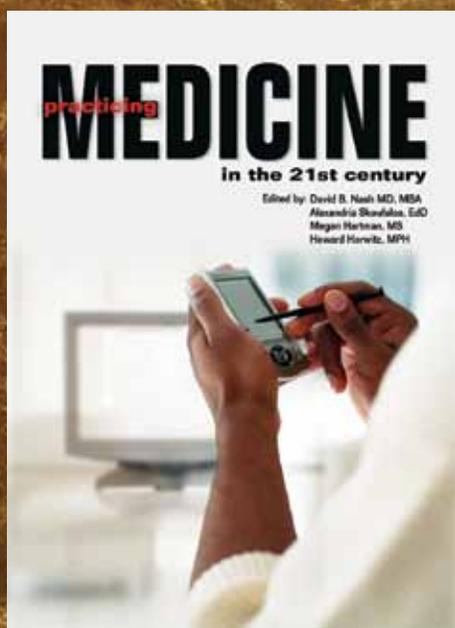


**Nancy Dimunation, RN, BAN, MHA**, is vice president and chief nursing officer at Fairview Red Wing Medical Center in Minnesota.

### Resources

1. Zimmer, DK., Brueggemann, JG. Examining the Dyad as a Management Model in Integrated Health Systems. *The Physician Executive Journal*, 36(1): 14-19, Jan/ Feb 2010.
2. Institute of Medicine, *To Err is Human* Washington, DC: National Act Press, 1999.
3. Institute of Medicine, *Committee on Quality of Care in America Crossing the Quality Chasm : A Now Health System for teh 21st Century*, Washington, DC: National Academ Press, 2001.

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