



DYAD MANAGEMENT AND LEADERSHIP COUNCILS IN AN EMPLOYED NETWORK

PHYSICIAN LEADERSHIP DYAD MANAGEMENT



INTRODUCTION

Physician leadership has long been a recognized entity in health systems, primarily in the construct of formal Medical Staff governance, however, individuals elected to these positions were often undertrained and underdeveloped and the Medical Staff governance structure was traditionally underutilized for strategic and operational planning and execution.

Physician leadership in healthcare organizations is receiving heightened attention – and through a different lens. The journey to value-based care is proving that physician leadership at all levels and in all settings is indispensable to achieving organizational success. Value-based care requires achieving high quality, safe patient care in the most cost-effective manner – and with high patient engagement in and satisfaction with the care provided.

Most of the direct patient care delivered in America is driven by physicians – whether considering inpatient or outpatient settings.[†] Since physicians drive most of the patient care rendered, impacting quality, safety, and patient experience relies on influencing physician behaviors related to the care provided.

Peer-to-peer physician interactions is the most effective mechanism to influence physician behavior. The roots of this concept are the foundation of the formal Medical Staff governance structure. The concept is core to the evolving roles of formal physician leaders, like Chief Medical Officers.⁵ Thus, proficient physician leadership is a core element driving organizational success. While many facets of physician leadership transcend all aspects of healthcare, this white paper will focus on applicability to employed physician networks.

[†] Sheer numbers support this contention with more than 825,000 physicians (MD, DO) in active practice in 2016¹ compared to approximately 205,000 Advanced Practice Registered Nurses (APRNs)² and 115,000 Physician Assistants (PAs).³ These physicians provided more than 990 million office visits in 2015.⁴

PHYSICIAN LEADERSHIP – THE BENEFITS

A major benefit of incorporating physician leadership into the fiber of employed network function is that it drives the employed network forward on its Growth Curve path toward high performance. Achieving this end may require modification of the organizational structure to exploit the power of physician involvement in the operational hierarchy. Instituting a Physician Leadership Council provides a mechanism to improve Quality, generate a Shared Vision⁶ and strategic plan, create a more cohesive culture, and fashion a favorable brand within the market. Integrating physician leaders with administrative leaders in a dyad management team at all levels of the organizational structure ensures synergistic deployment of expertise and influence throughout the network.

The impact on the network, however, exceeds that afforded through the delineated structural elements and includes the following additional benefits:

ENGAGEMENT

Employment of physicians does not guarantee engagement with the organization or its initiatives. Directly involving physicians in the problem-solving and decision-making process engages them in the network's work product and instills a sense of ownership in the outcomes.

ALIGNMENT

Employment of physicians also does not guarantee alignment with organizational objectives. Direct involvement in establishing and collaborating with program, and related project development enhances the likelihood of alignment (and engagement). Creating this level of alignment then permits formal incorporation of associated incentives within the compensation plan, which further cements the interrelationship and propels the network forward.

RETENTION AND RECRUITMENT

As physicians become involved, aligned, and engaged with network strategies and tactics, the work environment favorably evolves to enhance physician job satisfaction – and network reputation as a preferred place in which to practice. Consequently, retention rates and recruitment successes improve.

BURNOUT MITIGATION

Promoting direct physician input into practice and group operations is one of three categories of organizational initiatives that can reduce the risk of physician burnout within the network.⁷ Establishing formal physician leadership positions and, particularly, a Leadership Council with Committee structure represent key initiatives to lessen the risk of physician burnout within employed networks.

The return on investment can be profound. The following outlines the technical path to positioning the network for success.

PHYSICIAN LEADERSHIP

A KEY ELEMENT FOR ORGANIZATIONAL SUCCESS

For the reasons outlined above and its global impact on network function, HSG identifies Physician Leadership as one of the eight key elements that produce employed physician network success.⁸ The other key elements include Strategy, Management Infrastructure, Quality, Culture, Brand/Identity, Aligned Compensation, and Financial Sustainability.

Though listed separately, these key elements are intertwined and interdependent. This is particularly true for Physician Leadership, which has a role in accomplishing initiatives related to each of these areas. The importance of aligned physician leadership cannot be overemphasized as physician passivity, or outright antagonism, makes systemic dysfunction inevitable.

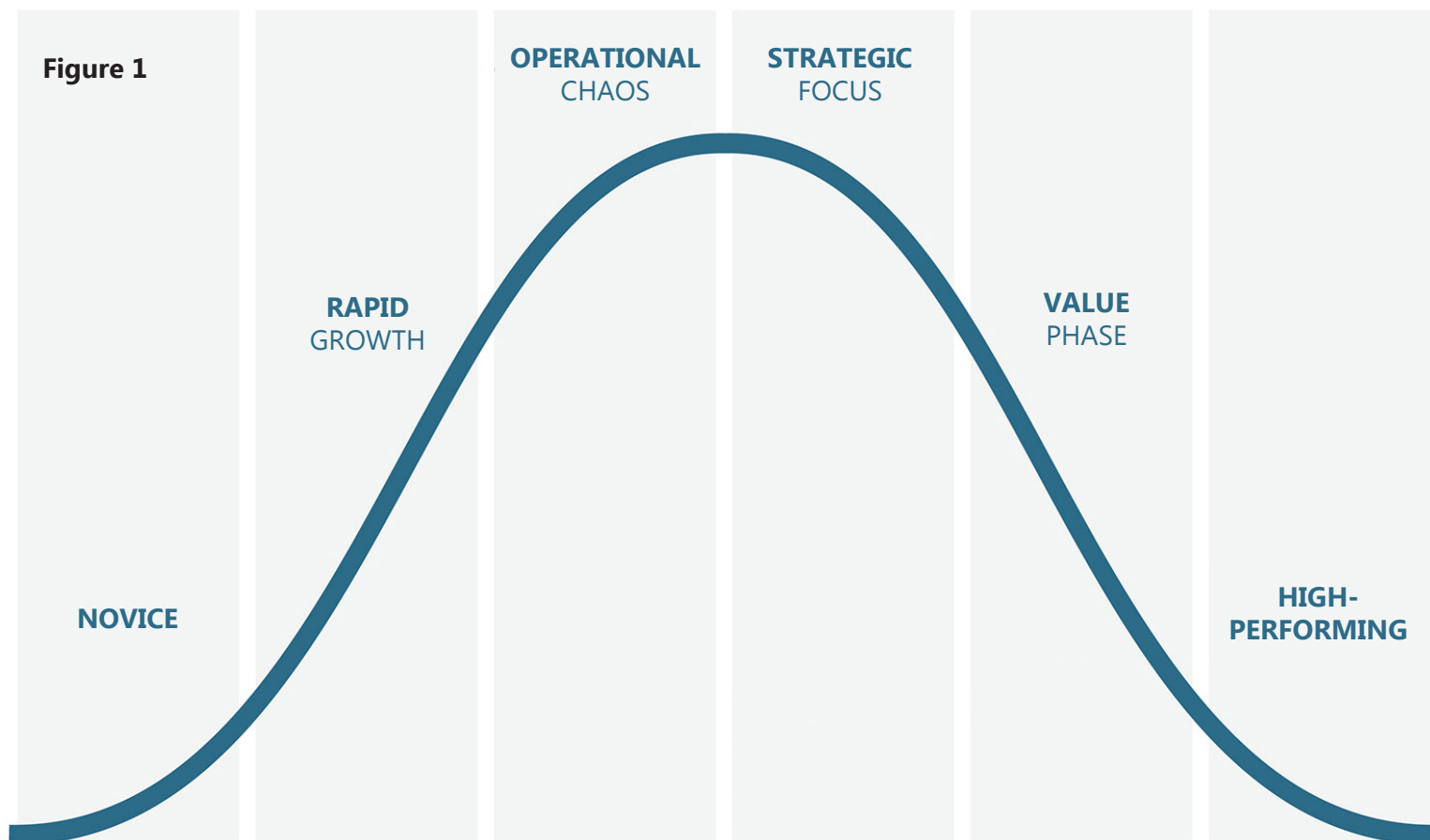
Likewise, Physician Leadership is especially critical to the growth and maturation of employed physician networks. HSG's whitepaper on this topic outlines the growth phases in detail.^{9,10} Physician leadership plays a critical role in accelerating network progress toward the right side of the curve, improving performance, and increasing strategic value. The blue highlighted areas of **Figure 1** depict the key elements that explicitly delineate physician leadership, including management infrastructure, which is expounded upon below. However, most of the elements listed under the right side of the curve, whose application is crucial to progressing through the Strategic Focus, Value Phase, and High Performing phases, rely on physician leadership and active physician involvement to accomplish.

To be successful, organizations must cultivate key physician leaders who understand clinical, market, and economic issues; who are committed to improving quality; who are willing to model and drive desired culture; and who are willing and able to hold peers accountable. These individuals must embrace the role of rallying peers and colleagues to accept the challenges associated with the evolving healthcare environment and actively leading positive change.

Physician leaders must represent a philosophy that balances individual autonomy with system expectations; advocates for both the patient and the system; adeptly promotes team participation; and leads by example. They help to establish direction, buoy the vision, and align, motivate, and inspire others to follow. These tenets apply to all levels of physician leadership – from front-line leadership at the point of care to middle management and senior management.

Successful progression along the physician leadership continuum does not happen by chance or magic transformation. It must be cultivated. Formal didactic programs, self-learning adjuncts, and active mentoring all contribute to individual skill enhancement to effectively plan, organize, empower, and problem-solve. These deliberate interventions augment experiential learning – the value of which should not be underestimated. Progress depends on developing and expanding both leadership and management skills.

Figure 1



Physician Alignment Strategy	Management Infrastructure	Network Performance Improvement	Shared Vision	Early Risk Contracting (ACO, Direct Contracting, Bundled Payments)	Leverage Network in Marketplace
Define Compensation Principles	Physician Leadership Development	Revenue Cycle and Productivity Systems	Network Strategic Plan, Integrated with System Plan	Optimize Physician Engagement in Performance Improvement	Full Risk Contracting
Interim Management	Acquisition and FMVs	Physician Advisory Council Enhancement	Clinical Practice Transformation/ Population Health	Quality and Patient Experience Focus Across Continuum	Manage Populations
Executive Search	IT Strategy	Enhance Management Structure	Quality/MACRA/ Patients' Experience	Brand Enhancement	Provider of Choice
		Referral Capture - Network Integrity	Aligned Incentive Compensation		

PHYSICIAN LEADERSHIP DESIGNATION WITHIN THE MANAGEMENT INFRASTRUCTURE

Beyond point-of-care leadership, physician leadership should be formally incorporated within the organization’s management infrastructure and appear on the organizational chart. Two primary mechanisms through which this is accomplished include specifying formally designated physician leadership positions and establishing a physician leadership (or advisory) council – each of which provides direct input into the organization’s strategic planning and operational problem-solving and decision-making processes.

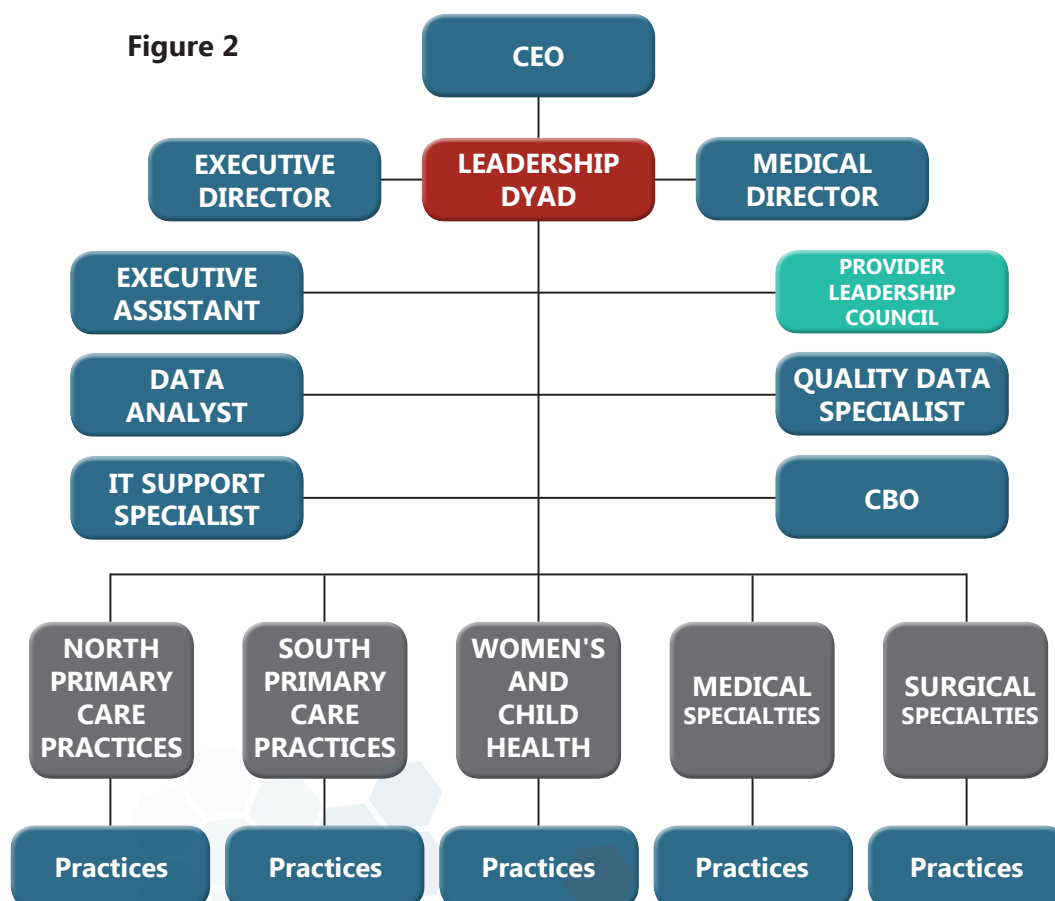
DESIGNATED PHYSICIAN LEADERSHIP POSITIONS

Formally designated physician leadership positions most often include a Chief Medical Officer or Medical Director for the employed physician network (senior leadership); regional or divisional medical directors (middle management); and lead physicians of larger practices (early middle management with significant front-line leadership).

DYAD MANAGEMENT TEAMS

Pairing a physician leader with an administrative leader in a dyad management team^{11,12,13,14} is a highly productive and efficient leadership tandem in which both individuals have primary and shared responsibilities that exploit personal and professional strengths to result in synergistic function.

A sample organizational chart depicting this concept is shown in **Figure 2**. In the figure, each of the gray boxes would also ideally consist of a dyad team.



Although the exact responsibilities of the dyad members will vary based on the focus, size and complexity of the organization, or subunit thereof, they often consist of those outlined in the following table. The list is obviously not all inclusive but presents an overview.

DYAD MEMBER RESPONSIBILITIES

Shared	Physician Member	Administrative Member
<ul style="list-style-type: none"> Developing or implementing strategy and associated action plans Fostering group culture Promoting, monitoring, and reporting group and individual performances <ul style="list-style-type: none"> Quality of care, patient safety Patient experience Operational efficiency Operating budget Developing internal and external organizational relationships Optimizing clinical informatics and data analytics systems 	<ul style="list-style-type: none"> Providing “medical staff” supervision <ul style="list-style-type: none"> Performance review Discipline Recruiting, on-boarding Creating, implementing, and monitoring clinical practice guidelines Driving population health management initiatives Evaluating clinical outcomes (effectiveness and efficiency) Supporting Administrative Member 	<ul style="list-style-type: none"> Developing operational goals, priorities, responsibilities Monitoring group financial functions – budgeting, accounting, reporting Managing and developing human resources consistent with organizational guidelines, established contracts, and legal requirements Coordinating necessary support functions – marketing, IT, financial Supporting Physician Member

Creating a true dyad management team requires more than just naming individuals to the positions and assuming they will function as desired. The concept represents a paradigm shift from traditional interactions and additional training or coaching is required to achieve the desired level of interactive functionality.

Why would an organization want to pursue such a paradigm shift? Traditional management structures are often strictly operationally focused with clear lines of authority driven by non-clinical administrators. Physicians (and other clinicians) do not have a formal role in the operational leadership hierarchy and risk being disengaged in the process. Decisions would be made within the hierarchy and then physician “buy in” would be sought. Organizational change often progressed slowly – commonly pitted against resistance and characterized by multiple revisions and mounting frustrations.

Instituting a dyad management structure immediately injects physician leadership into the formal management hierarchy and engenders greater physician engagement in group operations. “Buy in” is accomplished as part of normal operational ownership rather than needing to be separately sought and striven toward. Trust in the system is enhanced and the group moves forward more efficiently and effectively.

PHYSICIAN LEADERSHIP DESIGNATION WITHIN THE MANAGEMENT INFRASTRUCTURE (CONTINUED)

Of course, all management structures have inherent pros and cons. In the dyad structure, what is gained in alignment and engagement may be offset by a seemingly less direct decision-making process and potential ambiguity regarding authority. Ensuring dyad management teams function well requires concerted effort. Success can be fostered by focusing on the following elements:

Establish the structure

Before filling positions, ensure that the framework under which the dyad will function is in place. Clearly define the organizational structure, reporting relationships, and expected roles and responsibilities (through well devised position descriptions).

Recruit wisely

Success begins with the selection process. Key selection components go beyond the requisite positional competencies to evaluating the cultural fit within the pair and with the unit they will lead.

Clearly set functional expectations

The pair is expected to work synergistically to execute their well-defined roles and responsibilities. Instill the concept that they are a joint management team who share accountability for the unit's performance and that their roles are complementary rather than duplicative. They are not two people doing the same job nor are they a "team" in which one member (administrator) does all of the work for review by the other (physician).

Train and mentor the physicians selected for these leadership roles

Clinical excellence is not enough. Desirable physicians ideally aspire to the position and a future in medical administration. Formal (specific courses, graduate education) and informal (independent self-study) educational elements should be encouraged and pursued.

Train and mentor the dyad pair in their relationship

Even if individually familiar with dyad concepts, consider formal and informal education combined with individual and paired coaching to promote successful function. If left to their own devices, the pair may devolve into separate worlds, rotating independently while revolving within a common central structure. If this occurs, dysfunction, frustration, and dissonance will likely result.

Educate the organization

When it comes to the dyad's roles and responsibilities, staff reporting relationships, and who should be approached with what issue – or, preferably, whether either member can be approached with any issue and they internally determine who is responsible for taking action. Explicitly defining these elements with staff sets realistic, practical expectations. Reliable execution and reinforcement fulfill the expectations and predict success.

When properly implemented and executed, physician/administrator dyad management teams can have a profoundly positive impact on organizational success.

PHYSICIAN LEADERSHIP COUNCIL

Figure 2 on page 6 also depicts the important positioning of the Physician (Provider) Leadership (Advisory) Council as providing direct input and feedback to the dyad management team. The Physician Leadership Council is a mechanism to incorporate physicians (and APPs – hence, the designation as ‘Provider Leadership Council’ in Figure 3) into network planning, problem-solving, and decision-making processes in a relatively short span of time. Additionally, they promote effective two-way communication within the network.

Physician Leadership Councils should be established through a Charter that defines its composition, leadership, functions, term limits, and reporting requirements. Council functions often include the following broad groupings:

Solicit strategic and tactical input from direct care providers

Early, ongoing physician involvement in the strategic planning process predicts more positive results. By presenting a strategic plan tangentially or after the fact, you’re facing a more difficult, uphill battle. The Plan will not be as well developed, received, or implemented as one developed with active provider input throughout the process. The same principle applies to any other initiative.

Review practice performance

Established operational (financial, productivity, and efficiency), clinical quality, patient safety, and patient satisfaction metrics should be reviewed through a dashboard format on a regularly-scheduled basis. This provides the Council with the opportunity to replicate positive practices and identify potential areas for improvement.

Present potential new initiatives

The Council is an excellent place to vet proposed initiatives arising from management or from the practices.

Promote physician “ownership” of practice function and initiatives

Abdicating, or abrogating, this important responsibility will result in subpar performance.

Establish the desired culture

The Council creates the foundation for a common culture within the network and Council members serve as role models for peers and colleagues.

Educate and groom future leaders

Council membership introduces prospective leaders to the network/hospital/health system’s perspective and promotes a collective rather than individual focus that can differentiate potential leadership candidates and allow early development of leadership characteristics.

The ideal Physician Leadership Council membership composition varies according to the employed physician network’s size and complexity. Provider membership should be relatively inclusive to achieve the broadest input during Council deliberations and effect the greatest acceptance for Council decisions. The membership should be representative of the network’s specialty mix, geographic locations, ages and experience levels, gender, and APP mix. However, the Council’s size must balance inclusiveness with a workable decision-making process.

PHYSICIAN LEADERSHIP COUNCIL (CONTINUED)

Most Councils are jointly led by the administrative and medical director dyad. Other administrative team members (e.g., CEO, CIO) are usually involved on a regular or ad hoc basis. The intended membership should be outlined in the Charter.

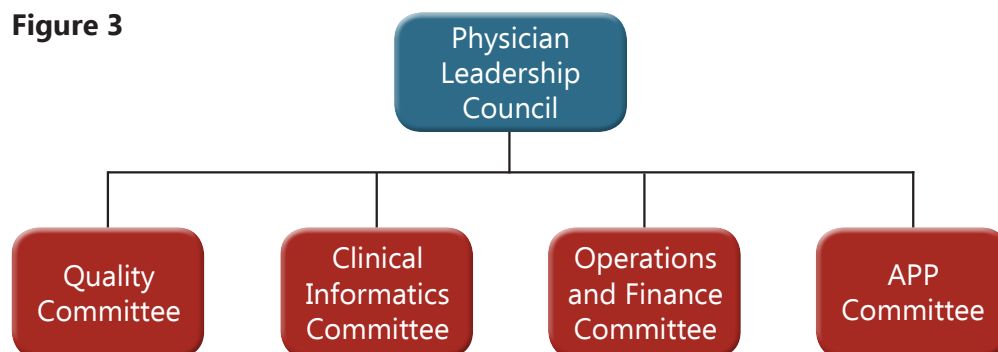
It is important to establish expectations of Council members from the outset and include discussion and adoption of these expectations in the first meeting's agenda. Common expectations include the following:

- Assume a fiduciary duty to the system and to peers. Membership does not represent an opportunity to advocate or pursue private agendas, but an opportunity to work for the common good of the network.
- Exhibit respect for all those involved (directly or indirectly) in the process.
- Faithfully attend all meetings.
- Actively prepare for and participate in meetings.
- Become an information conduit to and from peers.
- Openly discuss opinions during meetings but rallying behind and championing the decisions made.
 - Members must not convey internal disagreements outside of the meeting unless the discussion is pertinent to moving an initiative forward with others in the network or system. Discussing internal disagreements with others in the network tends to undermine Council effectiveness. External solidarity is key.

Most Physician Leadership Council Charters permit creation of a Committee structure to allow it to effectively and efficiently accomplish its designated responsibilities and functions. The multidisciplinary Committees perform the detailed work related to a defined area of responsibility on behalf of the Leadership Council. The Leadership Council remains the ultimate "decision-making" body and the Committee provides regular reports to and recommendations for Council action. A secondary benefit of the Committee structure is that it affords additional opportunities to actively involve more group members in network operations, promoting greater engagement and "ownership" within the group.

Committees should be established in a manner similar to the parent Council – with a defined charter or charge. As demonstrated in **Figure 3**, common functional areas guiding Committee formation include Quality, Clinical Informatics, Operations, and Finance – each with its own charter or charge. Committee function should be linked with the corresponding hospital/health system program(s) to avoid siloed functions. The linkage is usually accomplished through a combination of membership designation and process development.

Figure 3



The **Quality Committee** is usually tasked with developing, implementing, and monitoring an employed network quality plan that addresses clinical quality (including office-based peer review), patient safety, customer service, operational efficiencies, and other areas pertinent to delivering high quality care in a cost-effective manner that promotes patient and provider engagement and satisfaction. The employed network focus should complement and augment system initiatives while comprehensively addressing issues associated with office operations.

The **Clinical Informatics Committee** is usually tasked with comprehensively addressing clinical informatics issues pertinent to the employed network practices and operations. These often include optimizing the current EHR platform (or participating in the selection, build, and implementation of the next EHR platform); pursuing uniform IT (and operational) processes across the system; identifying data analytic solutions that can drive decision-support and manage population health; and other IT initiatives.

The **Operations and Finance Committee** is usually tasked with providing input to the employed network's administration to achieve or improve employed network financial sustainability, streamline clinical operations, and promote highly effective yet cost efficient practices. The Committee focuses equally on operational policy and procedure and financial performance while prioritizing strategic initiatives, developing specific action plans for Leadership Council approval, overseeing the implementation and execution of approved pertinent action plans, and developing and monitoring measures of success.

The **APP Committee** noted in **Figure 3** is a type of constituency committee and affords opportunities for its members to cultivate professional interactions that are usually nonexistent otherwise. As a rule, APPs tend to feel disenfranchised and relatively isolated. They frequently comment that the network physicians at least have the Medical Staff structure in which to relate professionally with peers but the APPs do not have a similar structure and are often not included in the traditional Medical Staff model. In addition, APP issues can be communicated directly to the Council (i.e., possess a larger voice) and the Council can utilize the Committee as a ready-made focus group to vet queries or concerns. The APP Committee construct has been uniformly well received.

The membership of each Committee should first be determined by the roles required to accomplish its multidisciplinary functions. The defined roles are usually contained in the charter or charge, with specific individual members subsequently identified based on position, expertise, and wherewithal to contribute. As mentioned above, the membership should include linkages to hospital or health system programs as appropriate. Some individual positions may be crucial to all functional areas and may need to be represented on each committee, such as Information Technology.

HSG additionally recommends that a downlink (liaison) from the Leadership Council to each Committee be separately named to ensure direct, first person knowledge of both Leadership Council and Committee workings, deliberations, and processes. We also recommend that the network dyad leaders be members of each Committee to ensure that a common direction is maintained across all functional areas.

PHYSICIAN LEADERSHIP COUNCIL (CONTINUED)

When considering the position of Committee Chair, most organizations allow the Committee to determine (elect) its Chair from its membership. Note that the Council downlink (liaison) does not need to serve as the Committee Chair, especially in situations for which a leader with subject matter expertise might be better suited. The latter situation is conducive to creating a dyad leadership structure for the Committee consisting of a subject matter expert co-leader pairing with a clinician co-leader declaring interest in the subject matter. This co-chair approach is very effective for facilitating Committee activity while sharing the burden of Committee leadership.

Just as it is important for Council function, each Committee should define expectations for all members during the first meeting and sustain those expectations as the Committee evolves.

Committee agenda items come directly from charter/ charge fulfillment, from Leadership Council taskings, from the Committee's work (which tends to spawn other issues to address), and from the network at large (such as feedback elicited during All-Provider meetings).

As noted above, the Committee works under the guise of the Leadership Council and provides regular reports to the Council – often through both written (minutes or meeting summaries) and verbal reports during meetings. Verbal reports can be provided by the Chair or the downlink, depending on individual circumstances.

CONCLUSION

Investing in developing and involving physician leadership at all levels and aspects of the organization will reap broad benefits, including more closely aligning physicians with the organization.

Physician leadership should be formally incorporated within the organization's management infrastructure by specifying formally designated physician leadership positions and establishing a physician leadership council to provide direct input into the organization's strategic planning and operational problem-solving and decision-making processes. Doing so will lead to more efficient and effective organizational function, enhanced positioning for value-based care delivery, and accelerated progress toward becoming a high performing network.

HSG can assist with incorporating physician leadership within employed provider networks – particularly with creating, optimizing, or re-organizing Provider Leadership Councils. We possess extensive experience in this area and maintain a wealth of customizable documents and processes to effectively facilitate and catalyze the process to achieve tangible results in a compressed time frame. To begin a conversation about how your health system can take advantage of these tools, contact Dr. Terry McWilliams.



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About The Author

Before joining HSG's consulting team in November, 2013, Dr. Terrence R. McWilliams, a Family Physician, spent a decade as the Vice President of Medical Affairs and Chief Medical Officer at Newport Hospital, an acute care community hospital in Rhode Island. During his tenure as CMO, he supervised the Medical Staff Services Office; was responsible for quality of care/patient safety/risk management, clinical information systems, medical staff services, physician recruitment and clinical service line development. He was intimately involved in numerous system-wide initiatives, including creating system-wide Medical Staff Bylaws, spearheading various clinical IT projects, and contributing to broad-based performance improvement efforts.

A University of Pittsburgh School of Medicine graduate, he retired from the US Navy after a career spanning more than 20 years working as a family physician and clinical administrator in a variety of practice environments, including leading multi-specialty clinical operations and physician-hospital alignment. Dr. McWilliams completed a Master of Science in Jurisprudence (MSJ) focused on Hospital and Health Law from Seton Hall University School of Law in August 2015.

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