With the advent of new payment models that reward value over volume, hospitals and health systems across the United States are increasingly taking a hard look at innovative opportunities to improve their service lines. Dyad management is 1 model gaining prominence as a way to address operational excellence and reduce costs, while at the same time further improve the quality of patient care and enhance the patient experience.

Dyad, put simply, means “a pair”—2 people in an interactional situation, for example, patient and therapist, husband and wife (1). Over the last several years, many hospitals and health systems, my own included, have adopted the dyad concept to create management teams consisting of a clinical member paired with an administrative member. Each dyad partner brings specific expertise in clinical and/or business operations to the team with the goal of leveraging each other’s strengths to advance organizational performance and ultimately save lives.

At Lee Health in Fort Myers, Florida, the cardiovascular comanagement agreement (which we know as the Heart and Vascular Institute) spans across the system and is managed by a board composed of elected physician leaders and appointed system administrators. Multiple committees and work groups are run by dyad partners made up of 1 physician and 1 administrative leader. We rely on data, such as that from the American College of Cardiology’s (ACC’s) National Cardiovascular Data Registries, to compare our performance to national benchmarks, identify areas for improvement, and help us develop goals that will increase value to patients, physicians, and the Lee Health System as a whole.

A typical example of such a dyad exists in the Lee Health System’s cardiac catheterization laboratories, where a physician medical director works in close cooperation with the catheterization laboratory administrative director to identify and address process and programmatic issues related to best practices. The clinical and scientific insights provided by the expert interventionalist are complemented by the knowledge of resources and management provided by the administrator. Similar fixed dyads exist in noninvasive and electrophysiology areas, as well as in workgroups devoted to specific topics or areas of need.

We have found the dyad model to be valuable in creating a collaborative culture that is built around shared goals and takes into account administrative and clinical needs, all while striving to keep quality of patient care central to all discussions. In a 2010 paper in the Physician Executive Journal, Zismer et al. (2) summarized both the individual and shared responsibilities of clinician and nonclinician leaders. On the clinical side, the physician leader is responsible for ensuring quality, evidence-based care; minimizing variations and gaps in care; encouraging teamwork; maximizing the productivity of the clinical team; and overseeing clinician-driven resource use and staffing. Meanwhile, financial and supply-chain management, market-share analysis, and capital planning and deployment are among the responsibilities of the administrative lead (2). We have found these responsibilities generally apply in our own dyad relationships, recognizing varying degrees of application dependent on maturity of the area of management. Increasingly, most would also add compliance and maintaining professionalism to the responsibilities of clinician leaders, whereas performance reporting is a
growing responsibility for administrative leads. Innovation is a buzz word that is being added to the list of responsibilities that are shared across both leaders in forward-leaning institutions.

The dyad model also helps to drive alignment and incentivize performance—increasingly important benefits given the current focus of hospitals and physicians on preparing for the Quality Payment Program (QPP) under the Medicare and CHIP Reauthorization Act (MACRA) of 2015. According to the American Hospital Association, “MACRA will have a significant impact not only on physicians, but also on the hospitals and health systems with whom they partner” (3). Physicians that are employed by hospitals will still need to meet the new physician performance reporting requirements under the QPP, and hospitals will bear some risk for any payment adjustments as a result of noncompliance. Hospitals can also help their physicians qualify for incentives by participating in advanced alternative payment models. Having a dyad system in place can help ensure that the administrative structure is in place so that clinicians can most effectively (and successfully) measure performance and outcomes and participate in the QPP.

A paper published in ACC’s CardioSource World-News in 2014 cautions that “optimal service-line decision making cannot occur in administrative bubbles” (4). It goes on to say: “Forming a governing body around an inclusive structure—consisting of physician leaders (both hospital-employed and those in private practice) and administrators—gives everyone a seat at the table and allows for decisions that address the interests and goals of all stakeholders” (4). Speaking at the ACC’s recent Cardiovascular Summit in January 2017, Peter Angood, MD, president and chief executive officer of the American Association for Physician Leadership in Tampa, echoed this statement, saying that dyad models will fail if the business side and the clinical side of the relationship stay in their silos and don’t collaborate.

A dyad model may also fail if physician/clinician involvement does not occur from the very start. Buy-in from the top tier of hospital and health system management is also key. Speaking at ACC’s 2017 Cardiovascular Summit, Kevin C. “Casey” Nolan told attendees that “culture starts at the top and you have to live it every day.” Nolan, MBA managing director for Navigant Consulting, Inc., in Washington, DC, also noted that those hospitals and health systems that “realize healthcare is a team sport are going to do very well.”

A 2012 white paper from the ACC’s Council on Clinical Practice provides several important tips to help foster collaborative and collegial cultures (5). Cathleen Biga, RN, and colleagues recommend thoughtful discussions around data results and analysis. They write that discussing data as a team “produces optimal patient outcomes, financial stability and growth and high levels of satisfaction” (5). They also stress the need for hospital and health system leadership to “demonstrate appreciation of the value of physician leadership and expertise by appropriating time and money for the education and training of physician leaders, as well as compensating them for leadership time” in this expanded role (5). Development of agreed-upon leadership competencies that can then be measured is also an important element for success. As systems of care continue to evolve, strong engagement by practicing clinicians is essential for maintaining focus on quality of patient care. Identifying competencies, providing protected time for such endeavors, and compensating physicians appropriately for the loss of clinical time are critical to success.

As noted in the white paper: “solid dyad leadership can be dynamic, generating a common vision that can become a powerful, strategic force, driving high quality care and exceptional patient outcomes” (5). As we head into a new era of health care, our experience suggests this to be true. Recognizing the skill sets of others and working collegially toward the common goal of improved outcomes is a path likely to improve success.

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REFERENCES


