Aims and Scope

INTRODUCTION

In the upheaval of today's healthcare system, with its push toward clinical integration, what leadership model will produce stability, even progress? *Dyad Leadership and Clinical Integration* establishes that developing and sustaining dyad leadership is compatible with the growing complexity of the healthcare environment and its many major changes. In fact, the interdisciplinary structure of the dyad aligns well with the drive toward clinical integration.

As you read, you will learn how to use assessment tools to examine the efficacy of the dyad structure and improve hospital management. Further, you will be able to evaluate how well the partners in the dyad complement each other and suggest ways to improve their combined strengths and abilities.

Assessment instruments are designed to help increase self-awareness of one's strengths, weaknesses, thinking patterns, and motivations. Stakeholders (e.g., board members) can use these instruments to identify potential gaps in the skills and competencies of leaders at all levels and make important decisions about investments in leadership development programs. As such, the assessment instruments provided in this book will allow you to contextualize leadership roles and competencies and align them with the goals and strategies of your healthcare system. The framework helps dyads navigate the

hazards of competing values and contradictory interests successfully, making better, more informed decisions. Its central feature is the relationship among strategy, structure, and leadership roles.

PURPOSE OF THE BOOK

This book focuses primarily on complementary forms of leadership and on effective collaboration among physicians, managers, and trustees. We will examine the evolving role of executive dyads in navigating the transition toward value-based systems, laying out a fresh set of collaborative methods that increase leadership effectiveness and accountability. The book highlights the importance of combining clinical competence with administrative skills, mastering leadership and communication competencies, relentlessly pushing to improve the patient experience, and initiating measures to reduce risk and increase safety and reliability.

With leaders drawn solely from management programs, healthcare organizations run the risk of lopsided leadership. Executives who climb the corporate ladder without a deep understanding of the complexity of clinical environments—and of patient flow and cycle time—often fail to recognize how physicians think, decide, and act. Moreover, unlike the usual supervisory structure of management teams in other sectors, which operate through hierarchical reporting, clinical leaders rely on a collegial orientation. In contrast to administrators, clinical leaders focus on patient service. Executives with a management background are sometimes at a loss to understand, let alone improve, the functioning of their own institutions.

What happens when executives and clinical staff work as partners, however? The combination of clinical competence and administrative skills allows the dyad, especially at the executive level, to inform data-driven innovation, pursue wise technology upgrades, and master competitive pressures. This synergy leads to smarter choices in electronic health record implementation, resource allocation, and focused capital investments.

ALIGNMENT OF WORK WITH STRATEGY

An expanded role for physicians in hospital leadership is paramount to the success of clinical integration—a shared vision of a value-based culture in a hospital or healthcare network. However, the question of *how* to involve physicians is difficult to approach; value and integration will likely require structural ambidexterity and leadership skills for managing paradoxes.

In keeping with the maxim "structure follows strategy," health systems benefit when they are configured to be compatible with their strategy—from the creation of divisions and departments to the designation of reporting relationships. In addition, centering the organization's strategic objectives helps achieve the mission and goals of the integrated health system, one in which leadership development programs and skill-building initiatives are aligned with strategic objectives. For example, the strategy of providing health services across the continuum of care through partnerships and alliances at the macro level is supported with interprofessional teamwork at the micro level.

By aligning roles and skills with business objectives, top executives can ensure that the investments they make in leadership development and succession planning are linked with the strategic direction of the organization. Alignment gives organizational members a sense of shared purpose and an understanding of organizational goals and mission. They develop a better sense of ownership, become more committed and accountable, and work collaboratively to achieve aims. Energy and inspiration run high, and both individual and team effectiveness increase.

TRANSFORMATIONS IN THE HEALTHCARE FIELD

Since the advent of the Affordable Care Act (ACA), hospitals have faced enormous pressure to transition from the acute care model. They now work to provide cost-effective health services organizations

with a full range of offerings. Executives work hard to align incentives for providers with quality goals. They seek to integrate care services and delivery, ranging from inpatient and ancillary services (e.g., audiology, clinical lab services) to home health, occupational and physical therapy, pharmacies, and nursing homes.

Simultaneously, a significant convergence across healthcare fields is occurring, blurring the lines between payers and providers. Integration takes place clinically or financially, horizontally or vertically. With the rising demand for improved facilities, superior equipment, and new medical technology, and as hospitals look to scale up and improve, mergers are becoming a key growth strategy.

The consolidation of hospitals into integrated healthcare systems, with initiatives ranging from loose affiliations and nonequity agreements to formal partnerships and complete mergers, requires new models of executive leadership. In subsequent chapters, I will demonstrate how dyad leadership aligns well with the strategic initiatives of healthcare systems.

SIZE MATTERS

In the consumer-driven marketplace, achieving economies of scale is a key competitive strategy for large healthcare organizations. Consolidation allows the parties to control costs by reducing or eliminating redundancy, making it possible to reap the benefits of cost advantage and increased efficiencies. Economies of scale are also critical for sustaining the big data analytics that hold considerable promise for effectively managing care delivery.

Recently, a wave of mergers, acquisitions, and partnerships has begun to alter the structure of healthcare systems. In 1975, there were 7,156 hospitals in the United States (National Center for Health Statistics 2017). As exhibit 1.1 shows, however, by 2010 (pre-ACA), the total number of hospitals had dropped by about 1,400. Since then, it has continued to decrease, primarily as a result of closing or consolidation. By 2015, the number of hospitals stood at 5,564,

Exhibit 1.1: Number of US Hospitals

	1975	1980	1990	2000	2005	2010	2012	2013	2014	2015
All hospitals	7,156	6,965	6,649	5,810	5,756	5,754	5,723	5,686	5,627	5,564
Federal	382	359	337	245	226	213	211	213	213	212
Nonfederal	6,774	6,606	6,312	5,565	5,530	5,541	5,512	5,473	5,414	5,352
Community	5,875	5,830	5,384	4,915	4,936	4,985	4,999	4,974	4,926	4,862
Nonprofit	3,339	3,322	3,191	3,003	2,958	2,904	2,894	2,904	2,870	2,845
For profit	775	730	749	749	868	1,013	1,068	1,060	1,053	1,034
State or local government	1,761	1,778	1,444	1,163	1,110	1,068	1,037	1,010	1,003	983

Source: National Center for Health Statistics (2017).

with the majority registered as nongovernment, not-for-profit community hospitals (2,845) and for-profit institutions (1,034), followed by state or local government hospitals (983) (American Hospital Association 2017).

Across the country, megasystems that control an increasing share of the market are changing their business models, consolidating services in regional hubs and creating a competitive edge. Many facilities have become, in effect, outpatient clinics (Ross 2018). Large and financially stable multihospital systems have been racing to form megasystems, in an attempt get ahead of the ACA mandate to improve quality and increase efficiency through coordinated care across the entire care continuum.

Alongside their growth in size and market share, hospital or health system ownership of physician practices grew also by 86 percent from 2012 to 2015. According to Physicians Advocacy Institute (2016) research, 67,000 physician practices nationwide were hospital-owned in 2015, with 38 percent of physicians employed by health systems.

By the end of 2017, a new wave of unprecedented mergers among the largest Catholic-owned hospital systems in the nation took place,

with the aim of further strengthening their brands and health services. Combined, the Dignity Health and Catholic Health integrated system reportedly includes 700 care sites, as well as 139 hospitals staffed by 159,000 employees, including more than 25,000 physicians and other advanced-practice clinicians (Dignity Health 2017). Ascension and Providence St. Joseph Health also plan to create a nonprofit health system giant with nearly 200 hospitals across 27 states (Evans and Mathews 2017). Other Catholic systems have already bought hospitals from for-profit chains.

The pace of consolidation in healthcare has led many independent hospitals to consider joining or affiliating with other organizations. While some hospitals have formed partnerships and collaborations to improve clinical and financial outcomes, others have consolidated long-term and post-acute services and moved discharge planning and transition management across the spectrum of care under common leadership.

Economies of scale, however, have negative side effects or mitigating factors, called diseconomies of scale. While multihospital networks and merged health systems enjoy increased bargaining power with payers, oversized organizations create economic disadvantages as a result of their new complexity. This complexity also yields additional cost, which outweighs the savings gained from greater scale.

With more hospitals, physician networks, and health systems consolidating under common leadership, achieving a sustainable clinical and operational alignment across specialties and networks is becoming increasingly challenging, both functionally and organizationally.

CHANGES IN LEADERSHIP ROLES

With the expansion of the corporate office in megasystems, local healthcare CEOs experience increased centralization and decreased autonomy. Local boards are becoming advisory in nature. Local cultures are becoming more corporatized, and the focus of the

local CEO is changing from strategic or visionary planning to operational duties. "True" CEOs are far fewer in number. Even the titles are changing—the healthcare sector is now led by presidents, senior vice presidents, and chief administrative officers. One consequence of these changes is a significant increase in CEO turnover rates, which exceeded 20 percent for the first time in 2013 and averaged more than 17 percent over 2012–2017 (American College of Healthcare Executives 2017).

In New York State, the department of health continues to require a local board for each hospital that is generally subservient to a parent board, which in turn has certain reserve power over the local boards. Though the extent to which a local CEO reports to a governing board or corporate officers often reflects her hospital's structure and affiliation, she often reports to a local board and a parent (i.e., integrated system) CEO. You can imagine the complexity of matrix relationships that result.

In virtually every state, and across state lines, the rate of hospital transactions and partnerships is accelerating with direct effects on the local CEO. Each facility, though, continues to need an "officer in charge" or, possibly, a dyad to run the local operations effectively.

SYNERGY AS STRATEGY

With the increase in size and complexity of health systems, it becomes more challenging for a single leader to possess the skills, knowledge, or perspectives necessary for optimal decisions. A supervisory structure with clear lines of authority, driven primarily by nonclinical administrators, is less suited to today's challenges.

Dyads, which pair an administrator with a physician partner, create a powerful synergy that reinforces the new business model. A 2014 survey conducted by the Advisory Board (Trandel 2015) showed that dyad leaders operate in multiple locations within health systems, including the C-suite (e.g., chief medical officer, chief quality officer), divisions of care providers (e.g., regional primary care

network, health centers), and even service lines (e.g., cardiovascular, orthopedics, cancer care). The dyad is congruent with the growth strategy of integrated health systems. The coleaders collaborate to achieve shared goals in their respective positions.

Dyads allow leaders to turn their differences into advantages, cultivating the joint thinking that leads to optimal decisions. Administrators bring the business skills vital to cost-effective, sustainable delivery of care to broad populations. Physicians have the clinical expertise for selecting population health initiatives, caring for patients, and evaluating clinical outcomes. The effective functioning of dyads requires a culture of partnership between administrators and physicians, with a dual focus on flexibility and control, transformational and transactional roles, open communication, and consistency in operations.

Not every physician or executive is well suited for coleadership. According to the Physician Leadership Forum (2014), four characteristics are vital for aspiring physician leaders:

1. The complexity of healthcare organizations requires strong leaders from within the field. Physicians with substantial knowledge of issues such as access, quality, safety improvement, and patient care are more suited to lead health systems than physicians who are not interested in these topics.
2. Physicians with the capacity to embrace a culture of interprofessional collaboration are better positioned to succeed.
3. Physicians who place a high priority on supplementing their functional knowledge and academic skills with leadership development and management skills are prepared for successful leadership.
4. Physicians transitioning into leadership roles must recognize the need for additional skills as they pursue leadership success.

FOCUS

Throughout, *Dyad Leadership and Clinical Integration* maps the dyadic leadership capabilities that extend beyond the traditional roles of hospital executives. The book also offers advice from hospital leaders and other experts about how to achieve an optimal alignment between the dyad management structure and the hospital's strategic priorities. After reading this book, you should be motivated to change your approach to leading and managing healthcare systems. You will also be inspired to pursue a leadership education and development path to achieve your career advancement goal.

Important questions about the effectiveness of the dyad, covered in this book, include the following:

- What is the context (institutional, organizational, operational) for dyad leadership in a health system?
- How are physicians and administrators paired? How do we optimize the complementary roles and strengths of the partners in a way that makes the dyad more relevant and accountable to organizational goals and needs?
- How can partners sustain trust, mutual respect, and common understanding over time?
- How do we ensure the existence of leadership capacity among physicians with the potential to lead their organizations?

KEY TAKEAWAYS

- Achieving a sustainable clinical and operational alignment across the continuum of care is becoming increasingly complex.
- Cooperative decision-making and interprofessional teamwork are necessary for dealing with complexity.

- New positions have been added to C-suites, roles and responsibilities are evolving, and leadership titles are being redefined.
- The interdisciplinary structure of dyad leadership aligns well with contemporary healthcare goals.
- A successful dyad is built on trust, mutual respect, and complementary skill.
- The combined strength of dyad leadership generates influence and synergy greater than the sum of their parts.
- Using assessment instruments facilitates understanding across administrative levels and functional lines.
- The assessment framework clarifies the relationships among strategy, structure, and leadership roles.
- Aligning roles and skills with healthcare goals and strategies helps to link leadership development to the strategic direction of the health system.
- Economies of scale improve integration of care and reduce duplication; however, diseconomies must be monitored and managed carefully.

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Dyad Leadership: An Integrated Approach

Exhibit 1: Dyad Leadership in Transforming Healthcare Systems
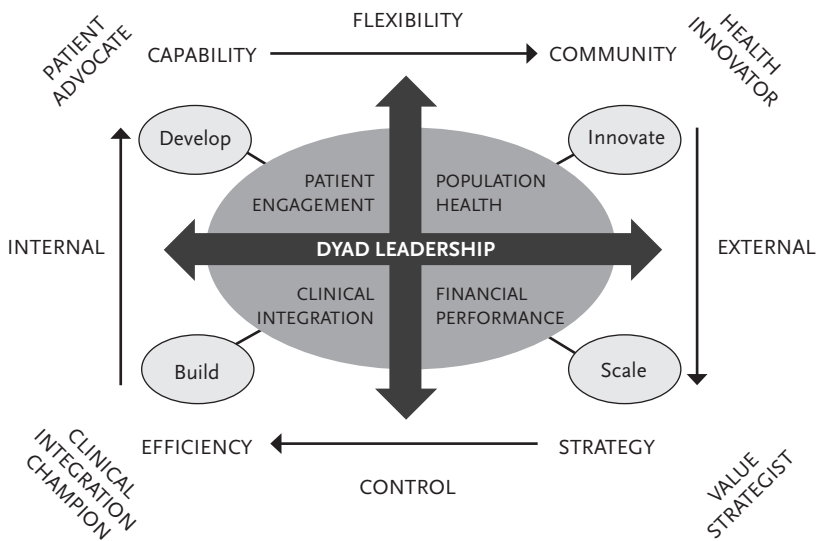
Part I explores a framework, developed specifically for this book, for contextualizing the roles and responsibilities of dyad leaders.

The framework is rooted in organizational effectiveness criteria; therefore, it serves to link leadership roles with organizational goals. Using the ideas explored in this book, dyad leaders can view their health system holistically.

The framework provides a lens for physicians and administrators through which to group and differentiate roles and competencies for optimal outcomes. This tool helps to align complementary leadership roles and competencies with the guiding strategy of the organization. Chapter 2 examines ambidexterity and the dyad management structure as concepts and systems compatible with complex healthcare environments. Chapter 3 presents the integrated framework that serves as an organizing schema for the book. The framework is also used as a road map for contextualizing the dyad leadership roles and domains of operations. Moreover, it provides important anchors for the assessment instruments that were developed specifically for this book. Chapter 4 presents a method for diagnosing and analyzing dyad roles, with examples and interpretations.