DYADIC

LEADERSHIP MODEL

WHITE PAPER

WHY IT WORKS

PQI PHYSICIAN QUALITY IMPROVEMENT
Specialist Services Committee

Partners in Quality
Interior Health
SSC SPECIALIST SERVICES COMMITTEE

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> The dyadic leadership model addresses the loneliness, competing challenges, and sometimes overwhelming organizational demands of leadership in navigating our complex health systems. They are foundational relationships and partnerships grounded in trust and compassion that are essential in supporting the culture keepers of the organization in improving and sustaining care for our patients, our teams, our families, and our communities. We need to nurture and support these relationships!

DR. HARSH HUNDAL

> Healthcare is provided in teams. High-quality healthcare depends on functional and trusting teams. Improvement and learning are most effective when performed in teams. A shared vision, with quality and patient safety at the centre, provides a collective purpose for our improvement efforts. This foundation of aligned purpose and trust clearly shows in our workplace culture and catalyzes sustained system improvements.

DR. DEVIN HARRIS

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EXECUTIVE SUMMARY

EXECUTIVE SUMMARY

What makes a highly successful healthcare organization? Interior Health Authority (IH) leadership believed in pairing medical and operational leaders as a dyad to foster a culture of learning, trust, and shared vision.

Consequently, it would enhance the culture and success of PQI. Interior Health's experience emulated a successful dyadic partnership model and facilitate the alignment of core values, develop collaborative relationships, demonstrate transparent communication, value their complementary competencies, and model mutual respect.[1] To this end, the IH Physician Quality Improvement (PQI) program implemented a dyadic leadership model in 2018.

Figure 1 – Quadruple Aim for Healthcare [2]

The dyadic leadership model is the foundation for implementing a system-wide culture shift within Interior Health to promote courage and resilience, and to foster learning, connectivity, and innovation. IH-PQI dyadic leadership model has become a core component where the medical and operational leaders are partnered together as a dyad to learn quality improvement through project work. The experience of PQI–IH dyads to date has been very positive, as reflected in an increase in physician engagement, as well as the completion of successful projects. This model has become a fundamental core component of the program, providing valuable linkages between the partners. Ultimately, the goal is to transform the healthcare system into a learning health organization via the Institute for Healthcare Improvement (IHI) [Figure 1].[2]

This paper outlines the value of the dyad leadership model and discusses the characteristics of successful dyad partnerships. Additionally, references to the literature are provided regarding the dyadic leadership model in healthcare delivery as it pertains to the IH-PQI program. Finally, it captures our journey, outlines our current state, and identifies potential opportunities for improvement. The methodology the authors employed for this paper includes a quick process, a data satisfaction process, an ancestry search approach, and an experience survey. Thirty-four medical and operational alumni completed the survey, resulting in a fifty-five percent response.

PART A | OVERVIEW

PART A – OVERVIEW

Background

What is a Dyadic Leadership Model?

Dyads, by definition, are two individuals who work together as co-leaders of a particular system, division, clinical service line, or project.[3] For this paper, a PQI dyadic partnership is two healthcare professionals (e.g., a medical leader [physician] matched with an operational leader) who are committed to the partnership. Moreover, the PQI program's design attracts clinicians who feel passionate about creating positive change in their workplace, have the courage to embark on learning the science of quality improvement and show the impact of their work on the Quadruple Aim. The dyadic partnership, in turn, activates people's agency on an interpersonal level.

The dyadic leadership model is not a new concept in healthcare. Yet, there has been a resurgence in implementing this model in high-performing healthcare organizations worldwide, including in Germany, Canada, and the US.[4–6] These healthcare systems have done so with the vision of breaking down traditional silos to allow operational and medical leaders to work together towards shared goals.[7] The dyadic model has become more common in healthcare.[8–10] However, limited scholarly research explores the lived experience of dyad partnerships and their perception of agency as they develop into a dyadic leadership team.[8]

In British Columbia, the evolution of healthcare delivery continues to shift from a physician and independent operational approach towards an integrated system that focuses on quality. This new approach aims to engage physicians to lead in quality improvement and innovate in a direction that optimizes service experience while improving patient outcomes.[11]

> PQI has made me realize that the days are gone when physicians can make changes on their own-the healthcare system is too complex and dynamic. We are starting to recognize that to make meaningful sustained changes, close working partnerships with operational colleagues is critical. We cannot work in silos. Being part of a dyad has highlighted the importance of relationships in healthcare-people who care about people, coming together to make decisions collaboratively.
>
> **DR. EIKO WAIDA, CO-CHAIR SSC IHI PQI AND SQI STEERING COMMITTEE, CO-CHAIR QI WORKING GROUP, COHORT 2 ALUM**

Why is Dyadic Leadership Important?

There are many reasons why dyadic leadership is important. Some of the reasons include improving patient care and work efficiencies, galvanizing organizational trust, and improving communication and transparency.[3,4,12,13] The dyadic partnership supports a collaborative working relationship to enable each leader to work at the top of their skillset, capabilities and competencies, thus, allowing for a return on each leader's time and effort.[12,13] This, in turn, has a clear benefit of reducing leader burnout due to an understanding of shared responsibility.[4,12] Each partner brings their specific lived experience to the issues at hand, thus allowing the dyad to leverage each other's strengths and learn from one another.[4]

Another reason in support of a dyadic leadership model [Figure 2] within the healthcare setting is to build trust and to improve communication and transparency within the organization.[1] This is about creating a culture of excellence and a supportive environment for patients and care providers. Finally, the dyadic model helps to build physician engagement by strengthening physician leadership capability and accelerating the integration of new physicians.[14] It is a powerful modality by which physicians and the healthcare system can be aligned to benefit the patients they jointly serve.

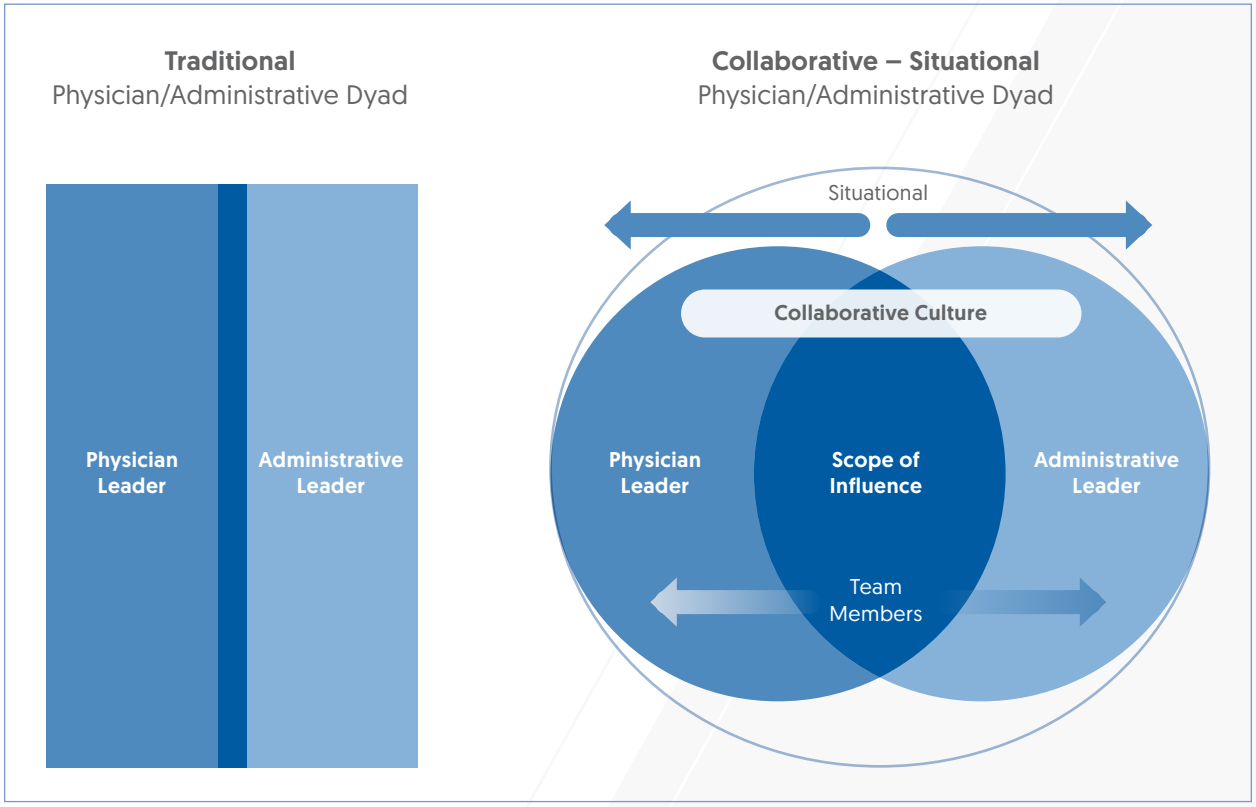


Figure 2 – Adaptation from Dyadic Leadership Combinations: Traditional Versus Collaborative Team.[1]

PART B | REVIEW OF THE LITERATURE AND FINDINGS

PART B – REVIEW OF THE LITERATURE AND FINDINGS

What Makes Dyad Leadership Successful?

Rapid Review Process

Our rapid review used the following databases to capture as many eligible resources as possible: Google Scholar, PubMed, and Medline (EBSCO). Two authors (CH and EW) examined the abstracts of over 150 for relevance and content. Three search strategies were used. Sources from the above databases were retrieved using the following search terms: physician, dyad, dyadic leadership models, and healthcare transformation. Additionally, an ancestry search approach was utilized to broaden the search. The ancestry search approach used included authors' recommendations within the literature and was obtained through the bibliographies of articles meeting the inclusion criteria for this review. Finally, other sources included IHI publications and white papers, grey literature, conference presentations, and documents from regional Health Authorities and universities.

Inclusion and Exclusion Criteria

The inclusion criteria included English sources published between 2000 and 2021 and only those in which a dyad (or dyad relationship) occurred within a leadership model context. Twenty-four sources were found using the above-listed inclusive criteria and were reviewed in depth. Many common terms and influencing factors describe dyad leadership. One author (CH) reviewed eighteen articles and identified (via data satisfaction) thirteen influencing factors (found in APPENDIX A). Using these influencing factors, the authors chose the domains for successful dyad leadership and the survey questions. The authors selected five key influencing factors as overall dyad domains to provide a logical structure throughout the paper. We captured lived experience data by surveying IH-PQI alum (APPENDIX B) from the past three years (Survey Results found in (APPENDIX C).

Historical View - Cultural Values of Physicians and Administrators

Longstanding cultural differences exist between physicians (medical) and administrators (operations). Sandford and Moore coined the phrase "suits versus coats," which describes a historical tension between administrators and physicians.[3] This 'us versus them' idea is attributed to siloed professional training, creating isolated thinking, and precluding collaboration. For example, operations learn to value interdependence and collaboration, yet physicians are trained to be autonomous in medicine.[3,9] The components of these two contrasting mental models can be viewed in Table 1.

PART B – REVIEW OF THE LITERATURE AND FINDINGS

Medical	Differences	Operational
Autonomy	**Values**	Interdependence of bureaucratic structures
Their own patients	**Advocates For**	The hospital as a whole and patients as a group
Finance of own area	**Focuses On**	Finance for the entire organization
Means immediate	**Thinks Timely**	Means response is limited by multiple systems
To the medical profession	**Primarily Loyal**	To the organization
Does not view others (even elected peers) as speaking for the individual physician	**Speaking For**	Believes elected physician leaders can speak for the medical staff as a whole

Table 1: Adaptation from the Very Real Differences between Medical and Operational Cultures. [3]

Many individuals and groups who work in the same area work in parallel to each other and do not cross over to another's domain. Additionally, combining medical and operational partners to work together on a PQI project does not automatically lead to success. If not done in a respectful and supportive manner, it can cause frustration, inefficiency, and inconsistent direction.[15] This leads us to question what influencing factors contribute to the likelihood of dyadic leadership development.[16]

Characteristics of Successful Dyadic Partners

What is success? Mayo and Herwick, in 1908, defined successful dyadic partnerships as those resulting in effective leadership that achieves an integrated healthcare delivery system. Other dyad experts profess that shared accountability contributes to dyad success by allowing for the dyad to leverage individual and combined skills to solve problems and implement solutions more effectively.[6] This implies that a collaboratively shared accountable approach can elevate the level of competence in leadership. This is essential because healthcare systems are complicated and complex, making it unrealistic to expect one person to possess the experience and qualifications to be proficient at everything.[8]

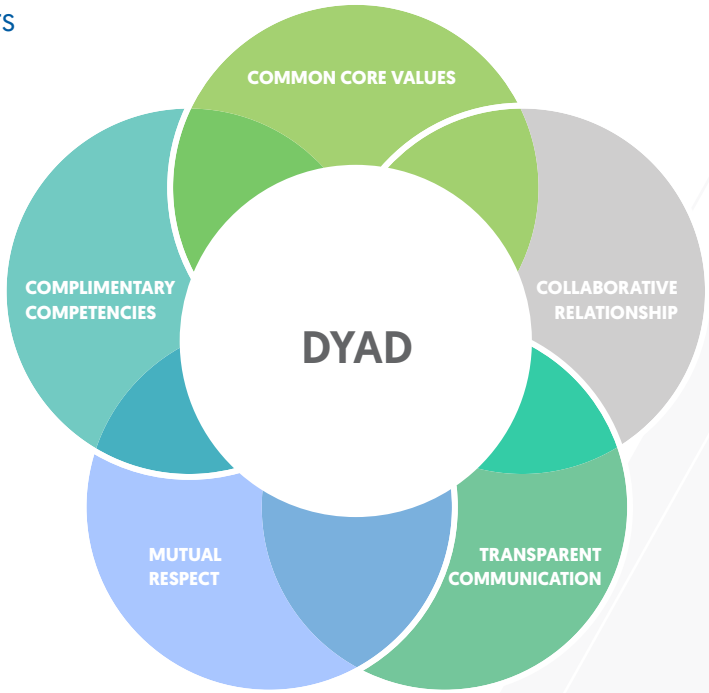
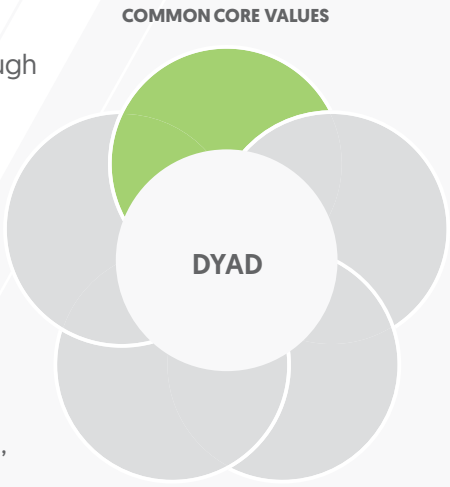


Figure 3 – Adapted from Five Successful Leadership Factors [16]

Although there are numerous leadership factors that create successful dyads, the authors chose Cortese & Smoldt's five leadership factors.[16] These were chosen by the authors as they align with the PQI alum survey results and the inclusion criteria. The five factors are: 1) common core values, 2) collaborative relationships to a common vision and mission, 3) clear and transparent communication, 4) mutual respect, and 5) complementary competencies.

1. Common Core Values

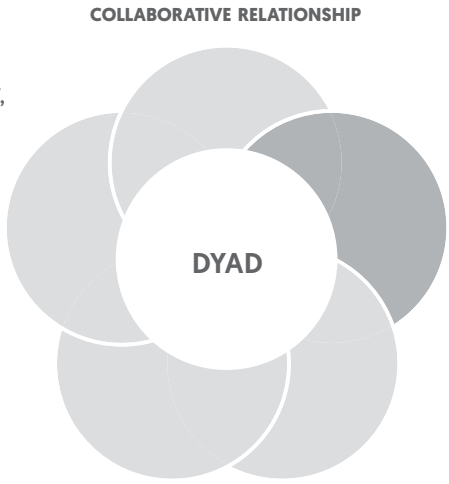
How we live our values is a reflection of our actions and our organizational culture.[1] Dyads, as leaders, influence their culture through their actions. One author (HH) described that working in a dyad empowers agency and builds belonging within the team concept through co-creating a shared vision. When dyads co-create common core values toward a collective vision, it can motivate their behaviour toward a more collaborative problem-solving culture.[9] Therefore, a more conducive culture emerges that fosters innovative ideas and actions towards system improvements from a patient-centered perspective.



Due to the dyad partners' potential differences in education and training, they may have little understanding of the other's values, beliefs, and responsibilities.[17] Therefore, it can make it challenging for the dyads to have a positive approach regarding collaboration. The antidote for this challenge in PQI is two-fold. First, they complete a Strength Deployment Inventory© The intention of the SDI is to learn about each other's strengths

and gain personal insights to help communicate effectively, navigate conflict, and promote collaboration. Second, the dyads complete a "Partnership Agreement." The Agreement challenges them to think about how they will work together, such as decision-making, competencies, values, goals, and accountabilities. The inventory and the agreement prepare IH-PQI dyads for success from the start of their work together. This shared learning approach is intended to help the dyad learn about each other's strengths and gain personal insights to communicate effectively, facilitates conflict and promotes collaboration.

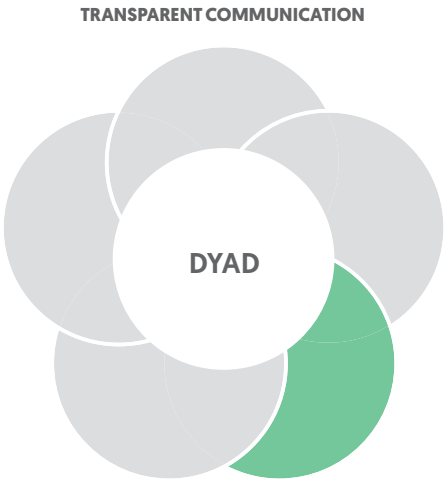
2. Collaborative Relationship – Toward a Common Vision



At a base level, a collaborative relationship can be described as an ongoing process whereby PQI dyads work together effectively and share the responsibility to achieve their project goals.[17] Additionally, the literature suggests that when a medical/operational dyad works together on a shared vision, the greater the likelihood of the project achieving success.[15]

Working together also entails learning together. Peter Senge, a systems scientist in organizational development, describes a learning environment as one in which people begin to employ a common language and meaning that withstand continuous evolution and change.[18] The idea of systems thinking underscores the importance of pooling collective intelligence and developing a shared vision. Insights from systems thinking, and collective intelligence emerge as the dyads collaborate and co-create throughout the experiential learning in PQI.

3. Transparent Communication with Each Other and the Organization



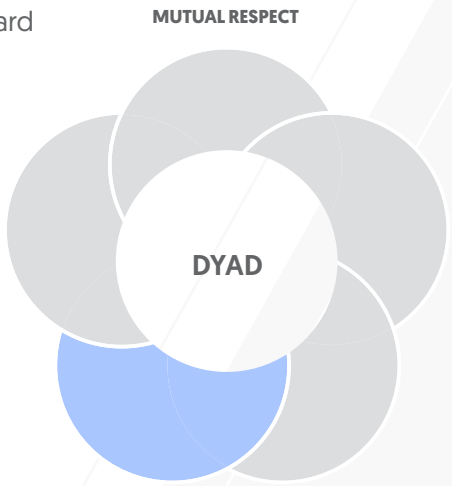
Effective, transparent communication is essential to the success of the PQI dyads as it supports positive learning experiences and successful project development. Dyadic partners who develop transparent communication and an interpersonal relationship are better equipped to create conditions of trust and respect.[8] Engaging in problem solving and improvement projects, and transparently discussing results (both successes and failures) help create leadership authenticity.[9] One could assume that dyadic partners who communicate effectively also possess a cohesive leadership approach to their team.[8]

When dyads bring their unique voices to the dyadic partnership, their collective voice starts to emerge, and their mutual insight improves their joint understanding. Mutual insight is significant because a successful dyad is required to navigate the ambiguity of roles and responsibilities.[8] This is one of the reasons the PQI – IH program encourages a partnership agreement when they begin their project. To conclude, the dyadic leadership model enhances communication, collaboration, culture, and patient care.[14]

> One thing is clear between us: we try to respect our respective expertise. If there is a problem with doctors, I do not intervene directly. Especially if it is related to quality. [My co-leader] will take care of that, but I am informed. Same thing if an administrator in our directorate is more difficult or if we have problems with an employee. We are both informed but we respect each other's expertise.[28]

4. Mutual Respect

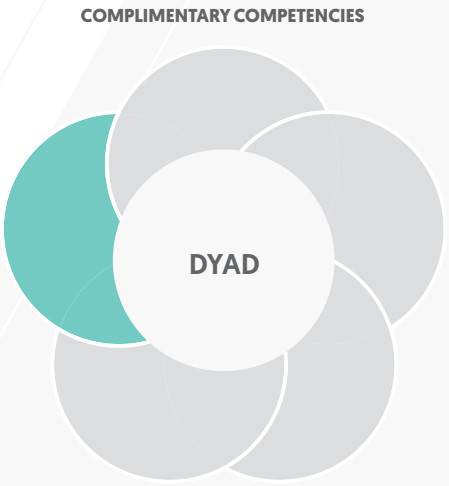
Mutual respect is a positive feeling, specific action, or conduct toward another person.[3] The underlying principle of mutual respect is that each partner is equally valued in their contributions toward their partnership. The dyad leaders' mutual relationship and joint accountability are key characteristics critical to addressing potential conflicts and contradictions, thus achieving success.[19]



For success in transforming healthcare and quality improvement, dyadic leaders must have respect for their team, face failure enthusiastically, and treat it as a learning opportunity.[10] Dyads who are able to approach challenges positively have the ability to build trust and create safe spaces to express themselves freely.[19]

5. Complementary Competencies (Roles)

The dyadic leadership model incorporates complementary competencies and provides the opportunity to amplify the level of expertise and extend the organizational reach for PQI project work. For example, when PQI medical and operational leaders work in a dyad, each at the top of their skill-set, capabilities, and competencies, it can provide a maximum return on their time and effort.[12, 22] Their complementary competencies are necessary because health care is a dynamic and complex system that exceeds the capacity of one organizational leader to be good at all that is required.[15]



The PQI experience provides opportunities for the dyad to learn more about each other's competencies and, as a result, increases their knowledge and experience. Consequently, they become better equipped to co-create solutions that support sustainable changes. Complimentary competencies can also enhance confidence to face team challenges or system barriers, to undertake difficult projects, and implement innovative solutions.[13]

PART C | LEARNINGS

PART C – LEARNINGS

Interior Health PQI Dyadic Leadership Model

Evolution

The IH-PQI program began in 2017/18 and simultaneously introduced the PQI dyadic leadership model. This leadership model was implemented because the former Interior Health Authority Vice President and a physician agreed it aligned with the Health Authority's strategic direction. There has been no formal dyad orientation to PQI – our success is a testimony to the physicians' and non-physicians' courage to support and challenge each other, build trust, and develop mutually supportive relationships.

In the first year of the PQI dyadic leadership model, the PQI staff developed a value proposition to encourage physicians and non-physicians to participate. In the first cohort, they yielded three dyads out of sixteen projects. Twelve dyads (physicians and operational leaders) were established in the second cohort. Twenty-two dyadic physicians agreed to or requested a dyad partnership in year three. There has been a palpable shift in dyad responses from "defending and persuading" to "anticipating" the dyadic leadership opportunity.

It is also worth mentioning that the cohort learning sessions were in-person in the first and second years, and these sessions provided the dyads with the opportunity to form relationships. This was particularly noticeable in the second year, with more dyadic partners. In year three, the program pivoted to online learning, which posed a challenge to creating relationships.

PQI–IH Dyads (physicians AND operational leaders) cohort matching

Some of the elements for matching dyad individuals include complimentary yet similar areas of expertise (e.g., a hospitalist with an operational partner in access and flow; a psychiatrist with a mental health director; a surgeon with a Director of Clinical Operations), with each having an elevated level of expertise in their chosen field. Other elements include geography, compatibility and passion for the project, capacity, and a keen interest in quality improvement.

Before PQI Cohort and Applied Learning and Support Sessions (APPENDIX D) - the participants began learning the basics of quality improvement via IHI Open School. [20] All Cohort participants have access to IHI Open School. Throughout the cohort interactive learning sessions (9 days), the participants learn together and apply Quality Improvement (QI) science methodology to their PQI project.

IH-PQI Dyadic Leadership Journey – Lived Experience

IH-PQI Dyad Survey Results

Participants

We invited sixty-one IH-PQI dyad alums who attended the PQI Cohort Learning sessions between Fall 2018 and Fall 2020 to complete an anonymous online survey of Likert-scale and open-ended questions. Excluded from the survey were those who either chose not to have an operational dyad partner or those for whom the dyad option was not fully developed (as in the first cohort year).

PART C – LEARNINGS

Data Collection

The survey was developed iteratively, using knowledge gained from a preliminary review of themes and definitions. Draft questions were created, and dyad individuals (physicians and non-physicians) and the PQI Manager reviewed the questions. Some of the open-ended questions were re-worded, and the order of others was changed. An online platform was used to build the survey. With final approval from the PQI Physician Advisor, Physician Chairs of the PQI Steering Committee and Manager, we administered the survey to sixty-one recipients with an accompanying email.

Participants were invited to self-assess using a Likert scale (1=strongly disagree, 5=strongly agree) in the following categories; dyad communications, trust, shared responsibilities, engagement, project measures, and healthcare quality improvement.

Quantitative Results

Thirty-four of the IH-PQI alum (55%) completed the survey, of which 65% were physicians and 35% were non-physicians/operational partners. Most respondents were Cohort 3 (70%) alum, and the remaining were Cohort 2 (30%) alum.

Dyad Experience – What did Alums Value? (Table 2 and Table 3)

It is noticeably clear from the respondents that being part of a dyad relationship was a key element in the success of their projects; they highlighted effective communication, team-based learning, and shared vision and goal as essential factors driving desired outcomes.

Respondents valued improving the quality of the healthcare system (94%) and applying quality improvement science learning in their regular work (88%). Additionally, 85% of respondents reported that the dyad experience improved physician and non-physician engagement, and similarly, 84% felt that it increased trust.

Categories Valued and Important in Experience	
Improving the quality of the healthcare system	94%
Effective communication	88%
Being part of a team to implement purposeful change	84%
Establishing a goal	84%
Sharing a common vision	78%
Working interdependently	59%
Joint decision-making	53%
Joy in work	50%
Ability to work together to find a solution when there is a disagreement	47%

Table 2: Categories Valued and Important in Experience

Dyad Experience Responses	Agree/Strongly Agree
I have used the quality improvement approach (PDSA, tools) because of what I have learned/experienced throughout my PQI experience.	88%
Communication between dyad partners was timely and intentional (regular / yet flexible).	88%
Our PQI project improved the quality of health care at a local level.	85%
I believe that our dyad partnership has improved overall physician and non-physician engagement.	85%
We (myself and the physician) built trust throughout the project.	84%
Formulating the project measures was an important part of our collaborative decision-making process.	65%
Our dyad partnership shared responsibility (successes and challenges) throughout the PQI project.	64%

Table 3: Dyad Experience Responses

Qualitative Results (APPENDIX C)

Several themes emerged from the rich narratives embedded within the survey (APPENDIX C - Tables 3, 4 and 5).

The first qualitative question in the survey asked, "What was the most important part of participating as a PQI dyad?" The breadth of the responses reflected all five characteristics common to successful dyad partners.

Almost half (48%) of respondents identified their (mutual) ***relationship*** as the most important component of their dyad experience. Details of this partnership included "sharing perspectives, discussing challenges, adding a different lens, shared experiences," and "the ability to work so closely with an operational partner on a shared vision." The term "networking" was used by multiple respondents, as was "collaboration." One respondent explained the value of the dyad as "establishing a team around a common goal which replaces the traditional siloed approach, (which arranges teams according to their designation, and training which obstructs team-based care which is almost always interdepartmental)." Another respondent indicated the value of collaborating with [other] dyads across IH.

The theme of ***communication*** also was prominent (88% strongly agree/agree) among the respondents. Some participants wrote about the ability to "build bridges between management and physicians" and engage in "dialogue, bridging gaps in communication with other healthcare providers, [and] learning about barriers involved in doing so."

Mutual respect was reported as an essential element of their dyad experience. Survey respondents wrote about mutual respect in various ways. Some of their quotes illuminated the recognition of each others differences. For example working in a dyad facilitated "a first-hand glimpse of the other side" and "insight into the operational aspect of medicine." One person wrote about the benefit of "learning the partner's daily function, interests and expertise in more granular detail." Yet others' expressed the joy of "getting support and insight from an operational leader to complete the project" and "hearing another perspective." One respondent wrote, "Can't do this work without a dyad-it's that simple!"

Many of the narratives in the qualitative results highlight that the dyad partners recognized the value of ***complementary competencies***. One participant explained that being in a dyad "amplifies the ability to engage stakeholders in a multidisciplinary project," and another that the power of the dyad is "being able to make change much stronger together."

Finally, having ***common core values*** was identified as an important element of the dyad experience, as it provided an opportunity to work with "other highly motivated staff looking to make positive changes for patient care" and "[to collaborate] with a physician champion for improved the quality of care."

Challenges

In response to the second qualitative question, "What was challenging?" notably, 40% of respondents emphasized that time was a precious commodity. Problematic elements were "finding time amidst competing priorities" and "each partner had other responsibilities, and sometimes those didn't align."

Some alums (***33%***) identified that the ***DYAD RELATIONSHIP*** was challenging. Examples included the "match" being a poor fit, with an imbalance in the perceived level of commitment of the partner and the absence of a shared vision. Other examples included difficulties in consolidating the working relationship due to the virtual nature of the program (Cohort 3) and the ensuing issues of suboptimal communication. One respondent pointed out the challenge of sustaining and spreading gains made during the project when the dyad partner was moved out of their portfolio; "ongoing support provided out of kindness rather than a defined role. This has been disappointing as these relationships become integral to success."

The COVID-19 pandemic was highlighted by 17% of respondents as a special cause variation that interfered with their ability to fully engage in the QI learning environment (overwhelmed/stressed). Some also felt that the pandemic "derailed project timelines," and travel restrictions negatively affected a partner's "ability to support my dyad partner in a meaningful way."

Improvements moving forward

The final qualitative question asked respondents how the dyad experience could be enhanced within the PQI program. Suggested improvements included: 1) more significant opportunity for group work online and face-to-face meetings, 2) emphasis on transitioning beyond PQI, and 3) compensation of operational partners.

Specifically, several participants suggested the need to "cover content that enhances the dyad partnership," as well as role clarification earlier on in the curriculum. One respondent wrote, "Without the relationships and correct players at the table, [it is] hard to move a project forward." Several people commented on the difficulty of virtual education and the desire for in-person interactions with their dyad partners.

Some respondents mentioned the desire for "support to continue to help sustain and spread change" and "follow-up sessions to maintain momentum." Yet another wrote about the value of "improving the transition from the program to continuing to do subsequent PQI work." Lastly, participants wanted their operational partners to receive financial compensation for their time. One respondent wrote, "Funding for both halves of the dyad."

PART D | INTERIOR HEALTH PQI DYADIC LEADERSHIP MODEL

PART D – INTERIOR HEALTH PQI DYADIC LEADERSHIP MODEL

Moving Forward - Context

In the recently published IHI white paper on Whole System Quality, the authors identify the key elements as building a shared purpose, practicing systems thinking, and engaging in collective learning and dialogue.[21] This, in turn, aids in learning about the interdependencies of the entire system. The dyadic model promotes collective inquiry, leading to an increase in the pool of knowledge.

IH-PQI has established a framework for the dyadic leadership model to do the work of quality improvement within the Interior Health Authority. As this paper and the Driver Diagram (APPENDIX E) outlines, if the dyadic leadership model is an antidote to healthcare fragmentation, developing a comprehensive strategy for PQI dyadic leadership is required to better serve our patients.[22] A comprehensive implementation strategy grounded in QI science requires planning, engagement, time, resources, and capability. The absence of the corresponding components decreases opportunities for success. Although not all the proposed changes may be feasible, there are actions that IH-PQI can take to maximize success and mitigate risks.

Planning for Change

Pivoting for Change

As a QI program, applying scientific QI methodology to the accepted recommendations is implicit. Pivoting for change also involves determining the appropriate scale and creating measures (see Part F). Ensuring adequate resources will increase the likelihood of achieving success, fostering partnerships, supporting our IH-PQI team, and remaining in scope. Transparent engagement and open communication(s) are essential to convey the current state and co-create change.

Co-creating Change

This change can begin by galvanizing our alum and IH-PQI team to undertake the next steps. Coaching, collaborative engagement and planning could involve developing a strategic focus, pooling resources, reviewing processes, and assessing any new skills that may be required. Ideas for consideration to pivot/co-create change could also include mapping a pathway for onboarding new non-physician dyad partners, identifying clear communication and collaboration infrastructure pathways, and carving dedicated time in the Cohort training sessions for building a foundation for relationship building.

Implementing Change

Small and nimble teams would drive rapid action cycles of change – and ensure the team has the depth of knowledge and experience of our dyadic leadership model.

PART E | DESIRED FUTURE IH-PQI RECOMMENDATIONS

PART E – DESIRED FUTURE IH-PQI RECOMMENDATIONS

IH-PQI Dyadic Leadership Component

Our review of the literature, reflection, and analysis of the IH-PQI dyadic program to date and the alum dyad survey results have revealed several opportunities for improvement. It was not the goal of this paper to do a rigorous assessment of the literature; however, conducting an environmental scan and key informant interviews with leaders in SSC, DoBC, and the health authorities provincially and nationally would help to capture the full scope and potential of the impact of dyadic partnerships throughout healthcare systems at large. There is recognition that it is an iterative process (in keeping with the spirit of Quality Improvement). The following are suggested key change ideas generated due to this process.

Common Core Values

The literature and results from our alum survey support the notion that mutually shared core values are a vital element of a successful dyad partnership.

Recommendations

1. To confirm that values are aligned between partners from the project's inception to its completion.
2. To confirm that the voices of the patient, dyad partners and executive sponsor are heard.

Collaborative Relationship

IH-PQI must create a dyad culture, as it takes time to establish trust that ensures the individuals' success as partners.[3] As such, it will be highly valuable to create a clear pathway that outlines the method(s) by which dyads are formed and their ongoing support for success (during their cohort training period and beyond).

Recommendations

3. To create a working group within PQI to co-create a IH dyad strategy. The membership may include a senior PQI consultant, IHA ED, and an experienced dyad.
4. Identify dyad partners based on complementary competencies, expertise, geography, passion, and capacity.
5. To incorporate intentional Cohort teaching sessions on dyadic leadership relationships.

Transparent Communications

The importance of effective communication and collaboration among IH-PQI Alum is instinctively understood; however, the litmus test is how it is practiced. [22] Communication that leads to conversations and creates respect is more likely to develop creative ideas for credible solutions and sharpen each other's communication skills. [23] Transparent and timely communication between partners nurtures trust, effective problem-solving and consolidation of a shared vision key to a successful IH-PQI dyadic leadership team.

PART E – DESIRED FUTURE IH-PQI RECOMMENDATIONS

Recommendation

6. To co-create a Communications and Engagement plan.

Complementary Competencies

Health care is a dynamic and complex system that exceeds the capacity of one organizational leader to be good at everything required. Physicians and non-physicians who learn and work together will improve integration, physician engagement, teamwork, and innovation. Both the complementary and shared competencies will increase the capacity of the organization to achieve the Quadruple Aim.

Recommendations

7. To develop an onboarding process.

8. To consider complementary competencies in the dyad partnership agreement.

Mutual Respect

Mutual respect is a crucial driver of a successful dyadic leadership partnership as it promotes a learning culture and acknowledges each partner's valuable and differing competencies.

Recommendations

9. To foster a psychologically safe learning environment, co-create, and innovate.

10. To support the co-creation of a dyad partnership agreement.

"...the **operational partners provide the physicians with information and abilities that are absolutely key to why Interior Health PQI projects accelerate so rapidly and often spread and become sustainable.** The operational partners have the knowledge of the health authority systems and connections that allow more mature change ideas to be the ones tested in Plan Do Study Act cycles. This means less time and effort spent testing ideas that don't work out and means confidence and momentum are built within the team faster..."

ROSS GIBSON, FORMER PQI MANAGER (2019-2021)

IH-PQI Implementation, Spread, and Sustainability

Physician engagement in quality improvement projects is a measure of success for any PQI program. Their continued involvement as alum supports the sustainability of QI culture in the organization. Additionally, when projects achieve results that align with the HA's strategic direction, there is potential for spread.

Spread is a series of planned efforts to broadly implement a pilot project, practice, product, or process within an organization in all applicable work units.[24] The IH-PQI dyadic model accelerates the transition from a local project to one ready for spread and sustainability. There are two main reasons for this acceleration: 1) the IH-PQI dyadic model embeds senior HA sponsorship from inception, and 2) dyad leaders work, co-create and learn together throughout the PQI project lifecycle to ensure greater operational success. These are necessary elements to sustain the human side of change.[25]

Moreover, alignment for spread and scale has been shown within our HA to have a good Return On Investment (ROI) and helps measure the various components of the Quadruple Aim.[26] The dyad leadership model should be considered a key component of spread and sustainability. Therefore, the following are other change ideas for sustaining the cohort dyad regarding spread and sustainability.

> "...the design of the dyad relationship system appears to be a successful underlying method to aid integration."
>
> **BRUCE HARRIES, 2021. INTERIOR HEALTH AUTHORITY PHYSICIAN QUALITY IMPROVEMENT PROGRAM REVIEW**

IH-PQI Implementation Recommendations

Recommendations

11. To promote operational understanding of the dyadic leadership model for the QI work

12. To ensure ongoing operational support to sustain and spread the work within the HA as appropriate

13. To co-create a crosswalk framework from IH-PQI to Sustainability and Spread Program

14. To improve the relationship between IH-QI and IH-PQI

15. To ensure operational partners are noted in the IH-PQI repository

16. To create a Working Group to support alum to conduct further QI work.

PART F | SUGGESTED DYADIC LEADERSHIP IMPACT

PART F – SUGGESTED DYADIC LEADERSHIP IMPACT

Family of Measures

Why are measures necessary for Quality Improvement? Choosing the right measures can help prioritize opportunities, identify weaknesses, and quantify the desired effects. Measures, methods, and tools are used to determine what works and what does not and show if a change is an improvement.

The IHI Model for Improvement Framework (Figure 3)[2] is commonly used to accelerate improvement in healthcare. The Framework has two parts; the first step involves answering three questions, and the second consists of implementing Plan-Do-Study-Act (PDSA) cycles of rapid change. The three questions in the Model for Improvement are

i. What are we trying to accomplish?

ii. How will we know that a change is an improvement?

iii. What change can we make that will result in improvement?

The outcome, balancing and process measures are necessary to assess if a change is an improvement. Therefore, we offer the following as measures for IH-PQI dyadic leadership. The driver diagram (APPENDIX E) is an iterative platform to identify and prioritize change ideas to advance dyadic leadership.

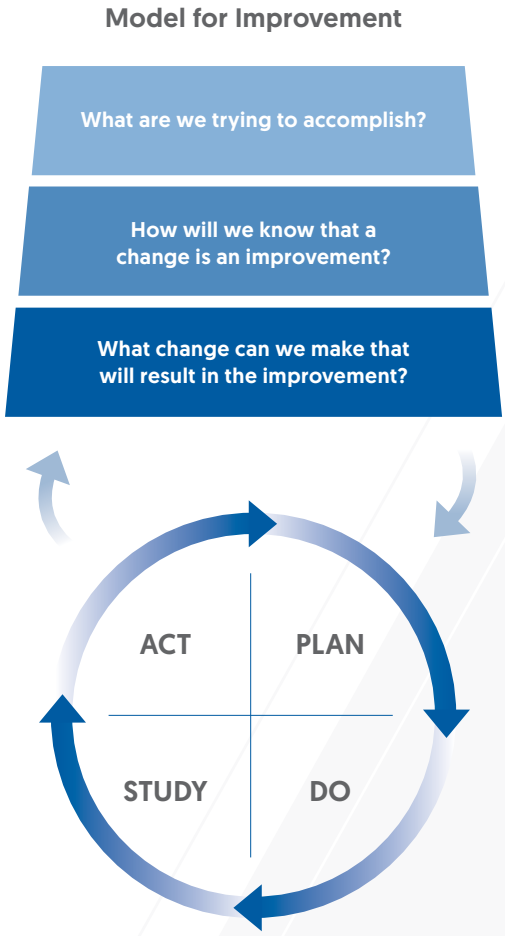


Figure 3 – Model for Improvement[28]

Suggested Outcome Measures

- ***Average dyadic experience/engagement scores each year.***
  - Measuring our culture of quality and value-based healthcare
- ***The number of PQI program-generated co-led presentations locally, regionally, provincially, and internationally.***
  - Supporting the spread of our quality improvement projects
- ***Number of storyboard presentations of dyad projects' accepted at IHI National Forum each year.***
  - Supporting SSC longitudinal culture

PART F – SUGGESTED DYADIC LEADERSHIP IMPACT

Suggested Balancing Measures

- ***Number of successfully matched engaged IH-PQI dyadic partners***
  - Could be intentionally or unintentionally matched complementary skills
- ***Number of actively disengaged PQI dyadic partners measured by a survey***
  - Could be unforeseen conditions (staff transitioning to other positions or moving) or miss-matched expectations

Suggested Process Measures

Transparent and Effective Communications

- ***Percentage Cohort 4 participants familiar with dyadic model***
  - Enhancing cohort's ability to communicate (e.g., elevator pitch) about the dyadic model
- ***Number of operational partners in IH-PQI Cohorts***
  - A simple measure of dyad involvement in IH-PQI
- ***Number of IHI and Health Quality BC Quality Forum presentations that include dyadic partners***
  - Measuring dyadic collaboration
- ***The number of publications submitted with dyad partners (BCMJ, etc.)***
  - Recognizing and celebrating the IH-PQI dyadic achievements
- ***Number of articles IH - In the Loop***
  - Recognizing and celebrating the IH-PQI dyadic achievements

Collaborative relationship

- ***Effectiveness of a partnership agreement guide***
  - Building relationships to improve dyadic leadership culture in IH
- ***Number of projects transitioned to spread and scale***
  - Enhancing dyadic partners' ability to seamlessly transition beyond PQI Cohort
- ***Number of IH-PQI presentations by dyadic partners (e.g., PQI-Spread SC, Exec, SET)***
  - Measuring alignment with Interior Health (and our partner's) Values

PART G | SUMMARY

PART G – SUMMARY

The IH-PQI program, with the support of SSC, has been instrumental in advancing the science of quality improvement throughout our health authority in a relatively brief period. It has provided a framework by which physicians who are passionate about engaging in their health care system and the quality of their patients' care can effect positive changes.

The dyadic leadership model, introduced as a change idea at the program's inception, has now become an expectation of new participants. Feedback from cohort alums has clearly expressed the value, importance, and necessity of the physician/administrator partnership in achieving success in many projects. Additionally, having senior sponsorship for every project has accelerated the ability to scale, spread, and sustain the acquired innovations.

This opportunity to reflect on the dyadic model within IH-PQI has highlighted several exciting opportunities for improvement, many of which center around creating an explicit framework for the dyad partnership to optimize learning, joy in work, and project success. It is the foundation on which Interior Health Authority can evolve as a learning organization. This dyadic model activates people's agency on an interpersonal level, with the hope and anticipation to increase connectivity, trust, and innovation throughout the organization.

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APPENDIX

APPENDIX A

Data Display of References and Thirteen Influencing Factors of Dyadic Leadership

References	Relationship	Trust	Vision	Common Goal	Values	Communication	Respect	Joint Decision Making	Shared Roles / Responsibilities	Competencies /Skills	Interdependence	Team work/ (development)	Physician Engagement/ Collaboration
Cortese DA, Smoldt RK. 5 success factors for physician administrator partnerships. Published 2015. Available at: https://www.mgma.com/resources/business-strategy/5-success-factors-for-physician-administrator-part	X		X	X	X	X	X		X	X	X	X	
Clouser JM. Vundi NL. Cowley AM., Cook C., Williams MV, McIntosh, M, Li J. [2020]. Evaluating the clinical dyad leadership model: a narrative review. Journal of Health Organization and Management Vol. 34[7] 2020, 725-741. C Emerald Publishing Limited 1477-7266 DOI 10.1108/JHOM-06-2020-0212	X	X	X	X	X	X	X	X	X	X		X	X
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Buell JM. The Dyad Leadership Model – Four Case Studies. Health Executive. Sept/Oct. 2017.	X	X	X	X	X	X	X	X	X	X	X	X	X
Campanelli, SM, "The Lived Experience Of Healthcare Leadership Dyads: Perceptions Of Agency" 2019. All Theses and Dissertations. 218. https://dune.une.edu/theses/218	X	X	X	X	X	X	X	X	X	X	X	X	X

APPENDIX A CONTINUED

References	Relationship	Trust	Vision	Common Goal	Values	Communication	Respect	Joint Decision Making	Shared Roles / Responsibilities	Competencies /Skills	Interdependent	Team (work/ (development)	Physician Engagement/ Collaboration
Swensen S, Pugh M, McMullan C, Kabcenell A. High-Impact Leadership: Improve Care, Improve the Health of Populations, and Reduce Costs. IHI White Paper. Cambridge, Massachusetts: Institute for Healthcare Improvement; 2013. (Available at ihi.org)	X	X	X	X	X	X	X	X	X		X	X	X
Swensen S, Mohta NS. Leadership Survey Ability to Lead Does Not Come from a Degree. NEJM Catalyst. Massachusetts Medical Society. Insights Report August 2017.		X						X	X	X	X	X	
Vremes C. A Tale of Two Leaders: Dyad Leadership Model in Healthcare Organizations. Degree EdD (Doctor of Education), Copyright: Thesis/Dissertation© Cornelia Vremes, 2018.	X	X	X	X	X	X	X	X	X	X	X	X	X
Oostra RD. 2016), Physician leadership: a central strategy to transforming healthcare. 2016 Frontiers of Health Services Management, Vol. 32(3) 15. doi: 10.1097/01974520-201601000-00003.	X	X	X	X	X	X		X	X	X	X	X	X
Baldwin KS, Dimunation N, Alexander J. (2011). Health Care Leadership and the Dyad Model. Physician Executive Journal; July/ August 2011. (accessed Dec 29, 2020).		X	X	X		X	X	X	X	X	X	X	X
Robbins RA. Beware the Obsequious Physician Executive (OPIE) but Embrace Dyad Leadership. Southwest Journal of Pulmonary and Critical Care Vol 15:2017.			X	X	X	X	X	X	X	X	X	X	
Hemker RA, Solomon LA. Building a Physician Culture for Healthcare Transformation: A Hospital's Leadership Challenge, Frontiers of Health Services Management: Spring 2016 – Vol 32(3) 3-14.	X	X		X	X	X	X	X	X	X	X	X	X

References	Relationship	Trust	Vision	Common Goal	Values	Communication	Respect	Joint Decision Making	Shared Roles / Responsibilities	Competencies /Skills	Interdependent	Team (work/ (development)	Physician Engagement/ Collaboration
Saxena A., Challenges and success strategies for dyad leadership model in healthcare. Healthcare Management Forum 2021, Vol. 34(3) 137-148. 2020. The Canadian College of Health Leaders. Article reuse guidelines: sagepub.com/journals-permissions' DOI: 10.1177/0840470420961522 journals.sagepub.com/home/hmf	X	X	X	X	X	X	X	X	X	X	X	X	X
Clark RC, Greenawald M. Nurse-Physician Leadership Insights into Interprofessional Collaboration. JONA: Dec 2013 Vol 43(12) 653-659. doi: 10.1097/NNA.0000000000000007	X		X	X	X	X	X	X	X	X	X	X	X
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Van Aerde J, Dickson G. Accepting our responsibility, A blueprint for physician leadership in transforming Canada's health care system. 2017. Canadian Society of Physician Leaders White Paper, available at: https://physicianleaders.ca/assets/whitepapercspl0210.pdf	X	X	X	X	X	X		X	X	X	X	X	X
Young R. It takes two: Can dyad leadership provide a durable pathway in healthcare's brave new world? Practice Management. Jan 30, 2017. https://www.cardiovascularbusiness.com/topics/practice-management/it-takes-two-can-dyad-leadership-provide-durable-pathway-healthcares	X		X	X	X	X	X	X	X	X		X	X
Total %	**83**	**89**	**89**	**89**	**89**	**94**	**83**	**83**	**94**	**83**	**83**	**100**	**83**

APPENDIX B

IH-PQI Dyad Partners Experience Survey 2021

Preamble:

Thank you for participating in this survey. We are capturing your dyad partnership experiences in PQI Cohorts 1, 2, and 3.

This is an anonymous survey. Highlights will be included in dyad IH-PQI white paper.

This survey aims to learn about your dyad experience - what has worked well and what can be improved in the future.

For this survey, a dyad partnership is defined as follows: two healthcare professionals (a physician matched with a non-physician operational/administrative leader) who are committed to the partnership share a passion and incorporate the quadruple aim vision.

This survey aims to engage you in our learning, celebrate successes, and identify opportunities for strategic steps forward in IH-PQI. We value your input and look forward to informing you of our progress.

1. I was/am a dyad partner:

☐ Medical ☐ Operational

2. I was/am a dyad partner in:

☐ Cohort 1 ☐ Cohort 2 ☐ Cohort 3

Likert Scale Questions (Strongly disagree, Disagree, Neural, Agree, Strongly agree, Not Applicable)

1. I have used the quality improvement approach (PDSA, tools, etc.) in my regular work because of what I have learned/experienced throughout my PQI experience.
2. Communication between dyad partners was timely and intentional (regular / yet flexible).
3. We believe (myself and the physician) that we built trust throughout the project.
4. Formulating the project measures was an important part of our collaborative decision-making process.
5. Our dyad partnership has improved overall physician and non-physician engagement.
6. Our dyad partnership shared responsibility (successes and challenges) throughout the PQI project.
7. Our PQI project improved healthcare quality at a local level.

The following components of my experience were important to me. Please check all that apply.

- ☐ Sharing a common vision
- ☐ Establishing a common goal
- ☐ Joint decision-making
- ☐ Effective communication
- ☐ Working interdependently
- ☐ Joy in work
- ☐ Each partner being highly skilled in the area of subject expertise
- ☐ Improving the quality of the healthcare system
- ☐ Being part of a team to implement purposeful change
- ☐ Ability to work together to find a solution when there is a disagreement

Open-ended questions:

What was the most important part of participating as a dyad partner in Interior Health PQI?

What was challenging?

What are your ideas to improve the PQI program?

APPENDIX C

Qualitative Survey Results

Table 3 Question: What was challenging?

Comments/Quotes = 30

Theme	# and % Responses	Quotes
Time	12 | 40%	"Needing more time" "Time; both of us have busy clinical schedules" "Finding the time" "Each partner had other responsibilities, and sometimes those didn't align re: timing of when work could get done." "Finding time to work on the project" "Finding time to meet; no funding for operational dyad half-she was working overtime" "Maintaining our timeline as legislative changes came in the midst of our project, which delayed our implementation by several weeks. But, we had to surrender to that and shift our timeframes and expectations." "Finding time to dedicate to project and meetings" "Finding time amidst competing priorities" "Finding time" "Finding time/scheduling/working around system constraints" "Scheduling occasionally"
Relationships	10 | 33%	"Losing touch and not being able to connect with dyad partner 1/2 way through the project. Still do not know where they are or if they are still working for IH" "Understanding the expectations of the dyad partner" "Dyad not owning the project as much as I did". "Very little involvement of dyad partner in the project often felt was more supported by QI consultant" "Change is challenging. Sustaining it and spreading an ongoing challenge. Dyad's partner now moved out of the role. Ongoing support is provided out of kindness rather than a defined role. This has been disappointing as these relationships become integral to success" "Virtual format. More challenging to get to know my partner only on the phone". "Finding a partner with a similar degree of investment in the identified issue" "My dyad partner was too busy to get involved" "Effective communication with my dyad partner" "Dyad partnership was not really in the same domain as where I work. I felt the commitment was less"
Covid	5 | 17%	"Covid and time felt not proper timing for proper engagement (all are feeling overwhelmed and stressed)" "COVID, not connecting in person, timelines of the project dependent on variables out of our control (procurement of new equipment)" "Living in different communities limited the amount of face-to-face time COVID" "COVID derailing project timelines" "Travel restrictions and ability to support my dyad partner in a meaningful way".
Outliers	3 | 1%	"Remembering to take baby steps" "THE SLOW PROCESS where things take FOREVER" "Physician partner paid, operational partner came in on days off (ex: Saturdays) and received no compensation"

Table 4 Themes: What was the most important part of participating as a PQI Dyad?

Total responses = 28

Theme	# and % Responses	Quotes
Communication	2 | 7%	"Dialogue, bridging gaps in communication with other healthcare providers, learning about barriers involved in doing so" "Being partners, communication, and building the vision"
Relationship Networking Connecting Spending time Shared Experiences Engaged	13 | 48%	"Relationship" "Building a relationship to get and give a firsthand glimpse of the other "side" "Expanding relationships and sharing a common goal to improve patient care." "Networking/Learning." "Networking/Building Supports." "Connecting with operational partners." "Dedicated time spent with my physician dyad partner" "Shared Experiences" "Great experience alongside a physician that is well respected and easy to work with. Physicians too value all of the other disciplines' feedback and want to work with that". "Sharing perspectives, discussing challenges, adding a different lens, shared experiences." "The ability to work so closely with an operational partner on a shared vision" "Getting support and insight from an operational leader to complete the project." "Amplifies the ability to engage stakeholders in a multi-disciplinary project."
Collaboration Building team	5 | 17%	"Collaboration with difference dyads across IH." "Collaborating with a physician champion for improved quality of care" "Establishing a team around a common goal which replaces the traditional siloed approach which arranges teams according to their designation and training which obstructs team-based care which is almost always interdepartmental". "Building bridges between management and physicians" "Being able to make change much stronger together"
Learning/ training, measurable	3 | 11%	"Learning in more granular detail partners daily function, interests and expertise. Also, access to fantastic coaching resources" "Training, having second opinions from another perspective" "Supporting a physician to take her idea of improving an area of health care delivery and turn it into a tangible project and measurable outcomes. aka change-much stronger together"
Outliers	5 | 17%	"Staying motivated and on track with the project" "Seeing other highly motivated staff looking to make positive changes for patient care" "Can't do this work without a dyad – it's that simple!" "Hearing another perspective" "Insight into the admin aspect of medicine"

APPENDIX C

Table 5 Themes: What are your ideas to improve the PQI program?

Total responses = 24

Theme	# and % Responses	Quotes
Operational partners	6 | 25%	"Nonmedical dyad partners should be compensated financially for their time" "Fund both halves of dyad" "Maintain and or mandate dyad partners. Supports to continue to help sustain and spread change." "Have more dedicated time for operational partners to focus on PQI" "Highlighting non-physician areas of expertise" "Continue to involve operational dyad partners and cover content that enhances the dyad partnership"
In-person **Online learning** **Session blocks more time – less didactic** **More interaction**	6 | 25%	"In my case, the in-person formula would have given us the opportunity to at least connect significantly during the three-day sessions, which hasn't been the case." "When we can travel again, have more in-person time" "Face to face time would have been much better. Sessions were sometimes long and distracting, i.e., Locating visuals, reading chat, participation glitches, breakouts, and some too short. Before sessions, provide power points to make notes on just in time. All in all, adapting to online learning was a challenge." "More work time during session blocks, less didactic time" "Subgroup work during the series of 3-day sessions were excellent… potentially have more time dedicated to these… I'm stretching, trying to find things, as the program is excellent already!" "I feel privileged to be part of the PQI program, and I look forward to continuing work on our project. The program did very well to adjust to online delivery due to COVID-19. The content of the sessions was excellent and highly valuable, but I did feel a bit overwhelmed with the volume of content at times and wished for more interaction. I really enjoyed hearing about the different projects and loved the organic nature of the networking and system linkages. The whole team provides excellent leadership, and I wish to acknowledge the profound insights provided by Drs. Harris and Hundal. Thank you!"
Working well	5 | 21%	"Excellent team with responsive leads--great experience overall" "Love the PQI program" "The virtual, it improved as we went along!" "No BIG idea" "Difficult as I found things laid out very simplistic, encourage starting small and growing, I think this would also be very valuable for other leaders to be offered these courses…etc."
Dyad	4 | 17%	"Expectations of the dyad partners" "Role clarification early on" "Regularly scheduled meetings with dyads and consultant to keep everyone on track and in the loop to hit deadlines" "I would suggest doing some of the relationship-building talks in the first three-day session, not the last. Without the relationships and correct players at the table, hard to move a project forward. Need to ensure have thought about all players!"
Transitioning beyond PQI	3 | 13%	"I think there needs to be a better closure to the PQI project. Our project hit some challenges, and now there isn't a great way of circling back to address issues. Also, the dyad partnership was not the one I might have chosen if I had been able to choose". "Follow-up sessions to maintain momentum for a somewhat sustained amount of time would be helpful" "Improving the transition from the program to continuing to do subsequent PQI work"

APPENDIX D

IH-PQI Training Levels

APPENDIX E

Driver Diagram: IH-PQI Dyad Leadership Model

AIM

Through PQI – SSC/IH, achieve a sustainable co-leadership dyadic model, led by physicians and operational partner(s) with patients & PQI team toward Quadruple AIM outcomes within the IH healthcare system.

Outcome Measures

1. Dyad experience
2. Number of PQI dyad presentations locally, regionally, provincially, internationally (check WP for duplication)
3. # of co-authored publications
4. # of projects selected for Spread and Scale where operational partners are included

PRIMARY DRIVERS

- Common Core Values
- Clear Communication
- Collaborative Relationship
- Complimentary Competencies
- Mutual Respect
- Leadership Development
- PQI - Improvement Science

Balancing Measures

1. Increased IH-PQI understanding about dyad leadership
2. Health Authority ability to provide opportunities for operational partners.

SECONDARY DRIVERS

- Clear vision
- IH and PQI SC senior leadership endorsement
- Dyads engage in decision-making and sustainable change.

- Communication infrastructure
- Collaboration with partners

- Relationship with dyad partner
- Relationship with inter-professional teams
- Patient partners
- PQI consultants/leads

- PQI dyad – medical/and Operations are highly skilled in area of expertise
- Sphere of influence
- Interdependently self governing
- High functioning Healthcare system

- Safety
- Collaborative/dynamic team

- Meaningful work as part of leadership development

- PQI experiential learning and educational Opportunities
- Alignment with strategic direction (e.g., SSC/PQI/HA's)

CHANGE IDEAS	PROCESS MEASURES
#1 Communicate history of dyad partners in PQI program **#2** Develop a pathway of onboarding dyad partners **#3** Collaboratively develop clear communication pathways between physician, HA PQI process, dyad partner, manager, PQIC **#4** Assemble an alumni dyad/physician/PQI working group to develop a PQI dyad brief (to accompany the dyad white paper) for the initiative.	• # of communication submissions about PQI dyad partners • # of presentations to introduce dyadic leadership model and PQI dyads (e.g., Alliances, PQI SC, Exec; SET)
#5 Define role of dyad partnership **#6** Expand the pool of dyad partners **#7** Promote collaborations with dyad partners in co-presenting **#8** Develop more curriculum based on dyad partnerships **#9** Develop communications about dyads to be included in PQI application **#10** Capture lessons learned during the cohort sessions	• Draft dyad model elevator pitch and PDSA with cohorts • # of dyad agreements completed • % of dyads in PQI cohorts
#11 Collaborate with partners to develop partnership agreements to outline best practices that would frame future dyad/physician PQI model. **#12** Engage in discussion PQI executive and SC regarding model and PDSA agreements	• # of draft dyad partnership agreements
#13 Share the dyad leadership model concept at all levels of the organization (IH) **#14** Develop outline and agreement of partner's roles in the dyad	• Provide dyad communications in cohort Level 3 orientation package
#15 Socialize dyad framework and integrate with IH-PQI strategic direction and PQI SSC Culture	• Collaborate with SSC PQI to ensure clear communications re: WP
#16 Develop linkages with NAVIG8 **#17** Create & Implement leadership curriculum into the PQI cohort Level 3 **#18** Link with dyad alumni strategy	• # of dyad orientations provided prior to start of cohort Level 3
#19 Collaborate and align with the curriculum harmonization efforts focusing on meaningful engagement with dyad partners **#21** Develop dyad orientation (including elevator pitch) session prior to upcoming PQI cohorts **#22** Create intentional time for dyad relationship building (SDI and cohort corner)	• # of dyad orientations completed prior to cohort

PQI PHYSICIAN QUALITY IMPROVEMENT
Specialist Services Committee

Partners in Quality
Interior Health SSC SPECIALIST SERVICES COMMITTEE