Evolution of the C-Suite

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There was a time when physicians seeking to move from the clinical realm could trace a clear path for themselves: medical directorship, chief medical officer (CMO), vice president of medical affairs (VPMA). Now, the track can veer, leading to a completely new destination.

On one hand, that's good news, because physician leaders with an array of skills and abilities can find their niche. On the other hand, the onus is upon them to make certain that niche is the same in practice as in theory. This means digging into the full job prospectus and asking pointed questions to learn the exact scope of responsibility, because in many instances, a rose by another name... may not smell like a rose, after all.

Brian Krehbiel, senior vice president at B.E. Smith, is seeing increased transformation in the C-suite. Roles such as chief patient experience officer, chief of clinical transformation and chief patient rights officer are becoming more common, and Krehbiel consistently receives requests for physician leader candidates. As many of these roles grow directly from intense emphasis on patient satisfaction, he characterizes physicians as "ideal" for these positions.

Historically, these roles reported to the CMO. In today's market, physician leaders can anticipate an exclusive executive role of their own, according to Krehbiel. As indication of the C-suite's state of flux, however, titles do not always align from one organization to another. What is embossed on a business card largely depends on the focus and organizational structure.

Information technology provides an excellent example of this fluidity. Michael Bakerman, MD, chief medical information officer (CMIO) of UMass Memorial Health Care, has seen a number of positions in the market filled by physicians. New thinking is swirling around the CMIO role; the position is becoming increasingly matrixed, embedded in the IT team and doesn't necessarily have direct reports. "Sometimes they're equal to the CIO (chief information officer)," Bakerman said. "They can be responsible for educating, implementing, adopting, but not building and testing."

The CIO spot represents advanced opportunity for physician leaders. Last year, William A. Spooner, chief information officer at Sharp HealthCare in San Diego, commented to *Hospitals and Health Networks* magazine about the benefits of physicians in the CIO role. "Honestly, they have an advantage because they understand patient care better. They have credibility with colleagues and better understand what nurses are talking about."

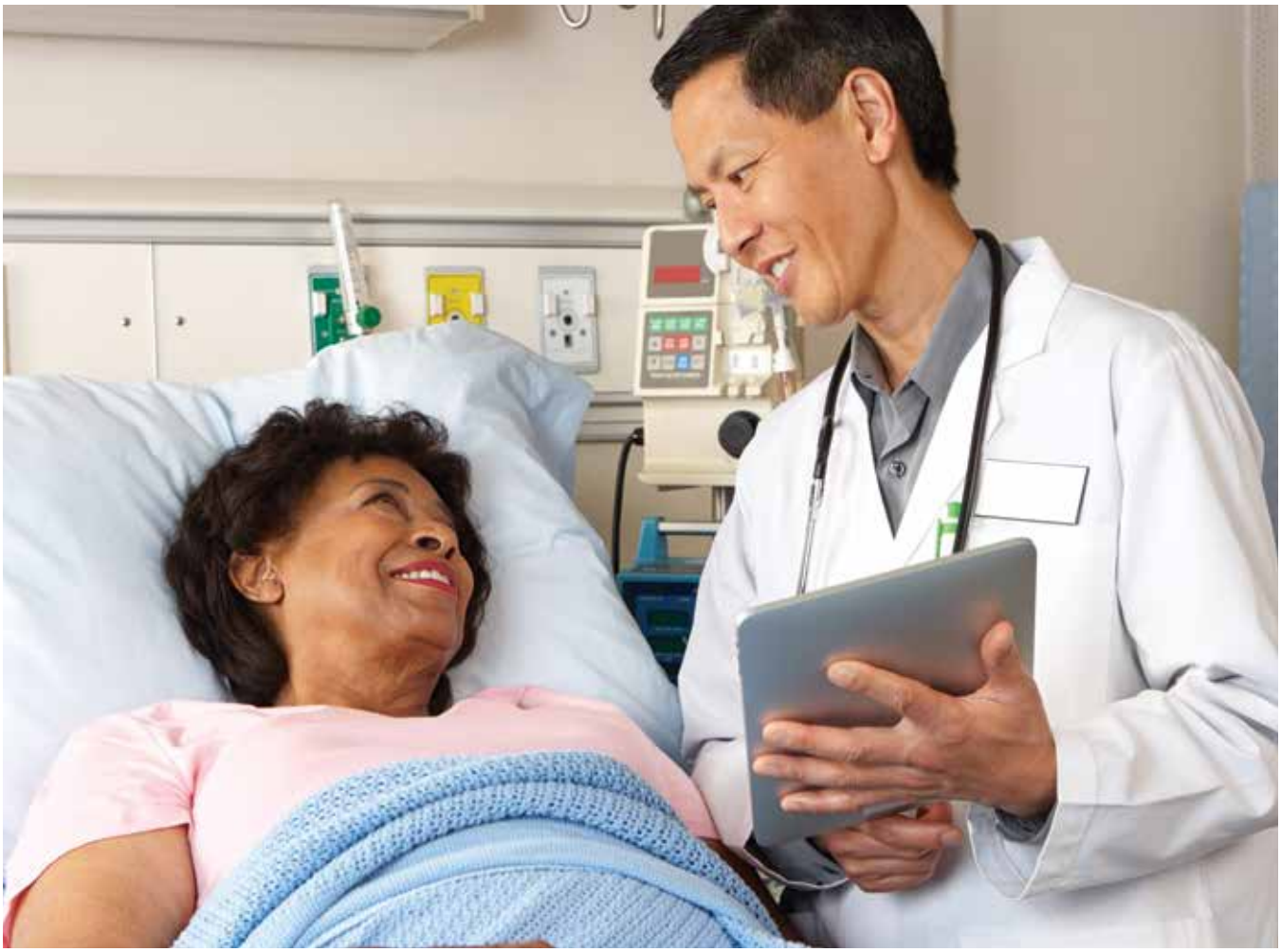
In the know

But there's a wrinkle: the CIO role is sometimes called chief knowledge officer (CKO), while other experts parse out responsibilities between the two. An article in *Health Data Management* stated, "The CIO acquires and implements information technology, while the chief knowledge officer shows the organization how to use the information. ... Information becomes knowledge when shared, when it is understood how data is used, when the data is acted on and applied in new ways."

When applying for either position, physician leaders should take an honest inventory of their skill set and experience. Many organizations expect CKOs to herald the benefits of a risky project, and, according to the *Hospitals and Health Networks* article, "create a culture of trust and sharing."

Bakerman feels the prioritization of projects falls within the CKO's realm of responsibility. He notes that many organizations struggle when trying to determine how to "best achieve IT project completion when they are strategic, such as data management, security and privacy."

The differentiation between CMIO, CIO and CKO roles can be instrumental in addressing and managing these issues effectively, and physician leaders should possess the acumen during an interview to explain why. The downfall of such delineation, of course, is the potential for silos and skewing of priorities.



There is a growing demand for chief patient experience officers.

Transforming or innovating?

Industry journals often refer to "innovation" and "transformation," and these concepts can seem nebulous. Divya Shroff, MD, chief clinical transformation officer (CCTO) and vice president of clinical services group for HCA, says she "didn't necessarily know she was being transformational" while immersed in projects. "Paths collided because I was already doing things," she says. "I was doing it without knowing it."

For Shroff, the concept of transformation has a personal component. She recommends physicians examine the kinds of decisions they'll be required to make in such a role. "Is the organization really looking for transformation? And if so, what kind?"

There are numerous capacities in clinical information technology where CCTOs serve; Shroff focuses on the nexus of physicians and technology and mobility's transformation in health care delivery. She created a website within HCA that is accessed by 11,000 clinicians and also oversees methods to improve the physician experience with patient care.

"I've seen health care organizations benefit from appropriate leveraging of technology as a tool for effectiveness and safety," she said. Industry trends largely influence her position's roadmap.

Shroff recommends physicians interested in transformation roles become involved in process and quality improvement projects. Exploring the fundamentals in an informal way allows leaders to test their aptitude and demonstrate worth.

It is also integral to determine who the team players are, and take advantage of current infrastructure to move initiatives along. Krehbiel offers a similar view: Organizations want to recruit physician leaders who have the ability to influence other physicians.

Patient experience

Krehbiel also reports a growing demand for chief patient experience officers. "Patient experience management is extremely important in today's

transitioning market," he said.

The Clinician-Patient Communication Research Initiative, sponsored by the Garfield Memorial Fund, published results of a study in the *Permanente Journal* in 2002. "Patient perceptions of quality tend to focus on interpersonal aspects of care. The top correlates of patient satisfaction ... are the provider's interest and attention, shared decision-making, listening and ability to explain." Eleven years later, these sentiments have become a cornerstone within value-based purchasing.

The Cleveland Clinic was one of the first systems to create a C-suite spot dedicated to patient experience. Their goal was to concentrate on the emotional aspect of health care, and it worked. In 2009, out of the 17 largest health systems, Cleveland Clinic was at the bottom in patient satisfaction. That same year they created the chief patient experience officer position and, by 2012, they were reportedly at the top in all but two areas.

Hospitals and health systems are looking for physicians with innovative ideas to create that level of change. These executives must be able to view the care delivery process not only through the eyes of the provider, but also of the patient, and they must be able to communicate the importance of change in an objective, nonpunitive way.

When considering career shifts, the inevitable question of compensation must be broached. Krehbiel says that some organizations are basing compensation decisions on the experience of the physician under consideration. "For example, compensation might be increased for an individual who was previously a radiologist or surgeon as opposed to family practice."

A growing number of organizations pay physician leaders for their actual scope of responsibility, as opposed to title alone; executives in these new roles can expect compensation to align with the value they potentially provide. This can make for a challenging negotiation, and candidates must be prepared to clearly articulate their side of the proposition.

As the C-suite population grows heavier, opportunities and competition grow for physician leaders. Those interested in moving into less traditional roles should do several things:

1. Spend time speaking with others who are already doing the jobs. As Shroff notes, "Don't be afraid to reach out and ask people how they got where they are."
2. Take stock of current capabilities and past experience, and compare to job descriptions of interest, to identify competencies and gaps.
3. Be prepared to discuss the distinctive value they offer.