**CMIO Leadership**

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**Learning Objectives**

Practical tips on leading other physicians and working with C-Suite Executives

Understand the differences in management and leadership

Learn about the skills necessary to thrive in a leadership role

Learn about strategic/tactical versus tactical only thinking

**Leading Clinical End Users**

* It is not just about physicians – while physicians are generally the most difficult group to work with and adopt new methods for patient care and documentation, they are only one of the direct customers you will interact with as a CMIO. Remember that nurses, clerks, EMS and external healthcare teams also need to interact with your systems and information.
* Need allies and clinical champions – in every major department, there will be at least one (and hopefully more) early adopters who will happily adopt new technology as long as there is the potential to improve patient care; however, you also need some very well-respected (and those may be the same person) members of each group to help champion the change management you are trying to implement; without both the early adopters and the clinical champions to be successful
* Be a clinician first – lead by example – this one could be considered controversial, but only because some folks have been successful as CMIO’s without continuing clinical practice, but for most folks, especially those just starting out as CMIO’s, I think this is vitally important. This is also situational. If you are leaving cliwtihl practice after many years, and you are now exclusively dedicated to CI, then that may warrant a different approach. Gauge the culture first (peers and C Suite), then make your decision.
  + There are two parts to this: so-called “street credibility” and the link between the Informatics tools and clinical practice.
    - Street credibility is more important for a new CMIO and for one who comes in from an external system. If you are no longer actively seeing patients, some of the more resistant providers will dismiss you as just another “suit”…unless you have already established that credibility within the organization
    - I consider the second reason, the link between clinical practice and the CI tools you provide (be it an EHR, ancillary systems, business intelligence tools to support PCMH and care coordination, etc), the more important of the two. Everything you provide/support needs to be used in the care setting (except administrative tools). Understanding the effect on patient care/clinical workflow BEFORE you implement is very important to both you and your customers. Unless you are exceptional, this is very difficult to do if you are not actively seeing patients.
* Never lose patience – this is a HUGE challenge at times. Tools (both clinical and administrative) that seem obvious to you would be beneficial to the patients, healthcare team and the hospital/system leadership is not necessarily so obvious to others. You can get lots of push-back all along the continuum, from the CFO to the ward clerk, and that can be very trying on your patience.
  + The minute you lose patience with someone (or lose your temper), you have lost the war. You can be perceived as the pushy geek doctor, bully or worse. Do not put yourself in that position.
  + If necessary, drop the discussion, go get better evidence to support your argument, seek out some allies/champions, then proceed to re-engage in the discussion
* Focus on the patients and clinical outcomes, not productivity – cannot emphasize this enough. It is okay to be a “rebel” as long as you are sincerely focused on quality patient care, patient safety and care coordination, and remembering that the financial/administrative people are also customers.
* You are there to help them use the tools better; never be the enforcer – be the end users’ ally and focus on helping them see patients better, more efficiently and more effectively.
  + The enforcers are to be the C-Suite…and they should be. That is part of the buy-in for the hospital or health system leadership. They need to take on this role.

**Working with the C-Suite**

* Ensure your boss understands your job – this can be much more challenging than one may think. Look at this as an educational opportunity. In most cases, that will help. In some cases, nothing will help.
  + Another strategy is to have your boss go with you to visit your clinical customers and have them talk about what you do (if they know), or at least how critical what you do is to what they do (EHR, PACS, BI Tools (dashboards and reports), etc.). Nothing can sell your job and its importance to the C Suite than satisfied customers.
* Get clear expectations from the C-Suite – no one can ever be successful in his/her job as a CMIO (or anything else, for that matter) without clear expectations from the leadership of their respective organization (at any level). In the CMIO job, that means the C Suite. Get them, especially the CEO and your direct boss (which could be the same person) to let you know what they expect of you and interval updates on how they think you are doing in accomplishing the mission and alignment with the vision.
* Be honest, but never say “no” – organization leaders do not like to be told “no”. What they like is courses of action (called CoA’s), as much concise evidence to support each CoA as is needed to make a solid decision (and they will tell you if it is enough, too little or too much) and your recommendation on which CoA is best for the organization based on the available evidence. They will then make their decision, and you will get to live with it…whether you agree with that decision or not.
* Get the C-Suite to provide priorities – this can be very challenging at times and for multiple reasons. Still, you need to ask (not nag) the C Suite (use your boss as the go between) to provide priorities for you and for Informatics in general.
  + - In most cases, you will have more demands for the tools you can provide than you have the time to provide them. Without C Suite-driven priorities for a global vision and some specifics, you will get overwhelmed and either burn out or potentially make decisions that will not be in alignment with the C Suite.
* Communicate often, but not excessively – need to communicate with your boss as to how often he/she wants to hear from you on a routine basis (we’ll talk about situational communication next). You should also get a read on how often to communicate with the entire C Suite…either via your boss or in direct discussions with the entire C Suite or at least the CEO. What you do not want to be is a pest/nag.
* Identify potential/real problems early – this fits under the heading of “situational communication”, but this is the most important. Do NOT wait to communicate bad news until it becomes a crisis. That is a bad choice. Communicate as soon as you recognize there is a problem and go to the C Suite not with just the problem, but with what actions you have already taken to mitigate the risk and recommendations for what to do (also with CoA’s) from this point forward.
  + Other situational communication – by definition, this will vary based on the situation. Some examples include at the start of a new project, at predetermined stages of a project and at the conclusion. There is also the communication when considering new projects, or when considering terminating current systems or applications.
* Reassess goals and objectives yearly – most functional organizations reassess their goals and objectives yearly. You should do the same to ensure you are in alignment with the organization.
* Focus on patient care and quality – as a physician, this should always be your focus…health, prevention, disease management, care coordination and patient outcomes. As long as those are your focus, you will do the right thing for the organization.

**Leadership**

* Healthcare leadership more complex – not sure you need any information on this…it is what it is, and you are likely living this every day.
* CMIO’s cross over leadership groups – as a CMIO, you will deal with the C Suite (organization leadership), department leadership (family medicine, pediatrics, etc.), service line leadership (inpatient, ambulatory, maternity care, ED, etc.), group leadership (physicians, nurses, EMS, clerks, PAD, etc.) and external groups. Each of them comes with a set of desires, biases, politics, etc.
  + Try to learn what are the most important focus areas for each group, find common ground if possible, then address them in light of the overall organizational vision, mission, goals and objectives to give each a win…even if it is a small win.
* Several responsibilities as a leader
  + Serve as cross-cutting matrix resource
  + Must partner with others
  + Must provide vision and strategy while executing tactically
  + Must provide innovation, while focusing on safety, security, outcomes, income and balance

**Management**

* Normally focuses on work and tasks – managers are generally goal oriented, and that is not to be minimized in its importance. However, as a CMIO, you now have moved beyond a primary management role into a leadership and strategic role. Don’t forget the importance of these, but now think beyond them.
* Helps organization produce products and services as promised
* Most CMIO’s have management experience
* Good management is very important to quality, safety and consistency
* Management ≠ Leadership

**What is the difference?**

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| --- | --- |
| * Management focus   + Stability   + Decision-making   + Plans around constraints   + Short-term vision   + Reactive   + Minimizes risk   + Keeps status quo   + Values results | * Leadership focus   + Change   + Facilitates decisions   + Sets/leads direction   + Long-term vision   + Proactive   + Takes risk   + Challenges status quo   + Values achievement |

**Skills for Leadership**

* Build relationships, understand the culture – this is pretty easy if you “grew up” in the organization, but it can be very challenging if you are new to the organization. How do you overcome the latter?
  + Visit with your customers…internal and external…to learn their needs, desires, pain points and biases
  + Treat everyone with respect (see below)
  + Take the opportunity to let everyone know what you do, where you come from and that you are focused on the patients and the folks who take care of them
  + Sit back and watch…and learn
* Always follow, “Do unto others….”
* Remember that respect is earned, but give it freely – even though you are now a leader, a physician or other healthcare professional, are very smart and probably very successful in your career, always treat others with respect. That is the best way to earn others respect, learn the culture and build the relationships you will need to be successful in this job
* Apply the style for the situation – this goes to Situational Leadership (see below)
* Be sincere, honest and patient focused
* Try to never have a “bad day” – if you are having a bad day, do not take it out on others, at work or at home. Find your stress release and go do it.

**Situational Leadership**

* Situational leadership series of books – Paul Hersey and Ken Blanchard 🡪 Ken Blanchard
* <http://en.wikipedia.org/wiki/Situational_leadership_theory>
* The fundamental underpinning of the situational leadership theory is that there is no single "best" style of leadership.
  + Effective leadership is task-relevant, and the most successful leaders are those that adapt their leadership style to the maturity ("the capacity to set high but attainable goals, willingness and ability to take responsibility for the task, and relevant education and/or experience of an individual or a group for the task") of the individual or group they are attempting to lead or influence.
* Four behavior types, named S1 to S4:
* **S1: Telling** - characterized by one-way communication in which the leader defines the roles of the individual or group and provides the what, how, why, when and where to do the task;
* **S2: Selling** - still providing direction, but the leader is now using two-way communication and providing the socio-emotional support that will allow the individual or group being influenced to buy into the process;
* **S3: Participating** - shared decision-making about aspects of how the task is accomplished and the leader is providing less task behaviors while maintaining high relationship behavior;
* **S4: Delegating** - leader still involved in decisions; however, the process and responsibility has been passed to the individual or group. The leader stays involved to monitor progress.
* Four levels of Maturity M1 through M4:
* **M1** - lack the specific skills required for the job in hand and are unable and unwilling to do or to take responsibility for this job or task. (According to Ken Blanchard "The honeymoon is over")
* **M2** - unable to take on responsibility for the task being done; however, they are willing to work at the task. They are novice but enthusiastic.
* **M3** - experienced and able to do the task but lack the confidence or the willingness to take on responsibility.
* **M4** - experienced at the task, and comfortable with their own ability to do it well. They are able and willing to not only do the task, but to take responsibility for the task.
* Maturity Levels are task-specific.
  + A person might be generally skilled, confident and motivated in their job, but would still have a maturity level M1 when asked to perform a task requiring skills they don't possess.

***SITUATIONAL LEADERSHIP IS NOT***

***SOMETHING YOU DO TO PEOPLE***

***BUT***

***SOMETHING YOU DO WITH PEOPLE***

**Strategic/Tactical Thinking**

* Strategic thinking critical for long term organizational success – if you cannot think strategically, you will eventually fail in a leadership position…and so will the organization. Of course, you cannot be the ONLY strategic thinker in the organization or the C Suite.
* Strategic thinking is for ALL leaders
* As a CMIO, you must think BOTH tactically and strategically – as above, you have to accomplish tasks, and there are externally imposed “emergencies”, but the goal is to be able to focus on the now and near future (1-12 months), but you also have to think beyond that and what the effects of what you are doing/planning to do will have on your systems and the organization as a whole within the next 3-5-10 years.
* Thinking 🡪 Planning and Execution – the thinking that you do should lead right into the planning and execution phase; that is why the dual thinking process is so valuable
* Should be evidence-based – often, you will not find incontrovertible evidence to support your thinking (especially strategic thinking); however, you should look for and use the best evidence you can find…and reassess the evidence annually. Just think about how beta-blockers and HTN/CAD have changed over the years. Health IT is even more dynamic.
* Avoid “magical” thinking – xxx/fill in

**Tactical-only Thinking**

* Focused on the short term
* Task-oriented…how do I get the job done?
* Rarely thinks beyond the fiscal year
* Often deals with “mission criticals”
* Exclusive tactical-thinking will not consider the long term effects of decisions

**CMIO Thinking**

* Should incorporate both tactical and strategic thinking
* ROI hard to estimate at times, but need to try with strategic thinking – there are tools out there to help with this…xxxx/fill in
* Need to consider decisions made now with effects 3-5 years from now – need to align this with the organization strategic plan, which may be 3-5-10 years. Discuss with your CEO, CMO and CIO (and the C Suite in general) to understand their perspectives and get their feedback.
* All Health IT decisions should be based on strategic thinking – even the most tactical situations, once managed, will have effects beyond the here and now. That should help to drive the tactical choices. There are always options. Choose the one that gives you and the organization the best balance of short and long term outcomes.

**Data Focus vs Clinical Focus**

* Do not become enamored of and blinded by the data – the data informs the decision, but it cannot make the decision for you. There are so many other factors, tangible and intangible, that have to be taken into account to make the RIGHT decision. Use data, but use it wisely. It is more important to have “information” than it is to have “data”.
* Data is only as important as its ability to improve patient care and outcomes – this gets back to information and knowledge. Data (especially raw data) is not really actionable unless it is placed in context, integrity is verified (data integrity, that is), and external factors weighed. You should not have to do this yourself, but you often do. As such, it is good to know your data sources and possess the tools and skills to create the knowledge or information from it. Then, it will be useful to you and your customers.
* Give people the type and amount of data to achieve their goals – see above. People do not always know exactly what they need to do their jobs. They often have an ideal about what they want to accomplish (hopefully). One of our jobs is to take that information and work through what information they need to accomplish it. That starts with the data, but it certainly does not end there.
* Focus both on internal, clinical/fiscal goals and external reporting requirements – collect the data from the various sources needed to create these reports or feed pre-made reporting tools. Ensure the reports are what people need/want and that they are usable by the customer to accomplish the intended goals. Adjust as needed. Again, reassess annually.

**Making Decisions**

* Many factors and influences involved – some are internal. Some are external. Some you can control. Some you cannot. Know the difference. If you feel a decision will be controversial or risky, run it by someone you trust first. If it is at odds with the mainstream, make sure you have solid evidence to support the decision. Be prepared to “undo” the decision if the organization leadership disagrees with it. Never get into a “pissing contest” with the C Suite or your boss…unless you are actively seeking new employment.
* Remember…tactical/strategic thinking
* Use the available evidence
* Estimate short-/long-term ROI – again, there are tools to help with this. Find them and use them whenever possible.
* Remember the clinical goals…improved clinical outcomes usually means improved fiscal outcomes
* Collaboration and consultation helpful

**Closing Thoughts**

* You are now a leader, but you still have to manage projects/tasks
* Think tactically and strategically…at the same time
* Clinical focus, data & evidence driven
* Know the culture; collaborate
* Earn respect by respecting others
* Common sense is not that common

Please let me know if you have any questions: fpnet@msn.com