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Identify the Qualifications, Major Duties, Responsibilities and Expected Outcomes for the Chief Experience Officer among Health Care Systems in the United States

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Scholarly Project Written Proposal

IDENTIFY THE QUALIFICATIONS, MAJOR DUTIES, RESPONSIBILITIES AND EXPECTED OUTCOMES FOR THE CHIEF EXPERIENCE OFFICER AMONG HEALTH CARE SYSTEMS IN THE UNITED STATES

By

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Date of Submission: March 28, 2018

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KATHLEEN D. DAVIS

Abstract

The Chief Experience Officer (CXO) role has emerged in health care in the last five to ten years. There is an absence of role descriptions, qualifications, duties, expected outcomes and reporting structures available in the literature. Most of the available information are reports from private organizations like the Experience Innovation Network, The Beryl Institute (TBI), Catalyst Healthcare Research (CHR) and The Health Care Advisory Board (Boehm, 2015; Boehm & Petty, 2016; Lauing & Woods, 2015; Palmer & Prince, 2013; The State of the Patient Experience, 2015; Wolf, 2015; Wolf & Prince, 2014) who produce information for members and are not generally found in the literature. Trade journals have documented interviews with individuals who are newly appointed to the CXO position (Adamson & Adamson, 2001; Carlson, 2015; Larkin, 2012). This qualitative key informant study seeks to contribute knowledge of the CXO position by identifying the reporting structures and organizational relationships, position qualifications, major job responsibilities, position priorities and focus of the work and expected results and key outcomes for the CXO role. The information will be synthesized to develop a position description for the CXO working in a Health Care system.

Keywords: chief experience officer, patient experience, patient satisfaction

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Chapter 1 Introduction and Background

Creating a positive patient experience has been an identified component of the quality agenda for the United States (U.S.) and is cited in Crossing the Quality Chasm: A New Health System for the 21st Century (Institute of Medicine, 2001). In addition, the topic is listed as one of the six elements of the National Quality Strategy (Agency for Healthcare Research and Quality, 2011). The definition of quality includes six attributes: safe, effective, efficient, timely, patient-centered and equitable (Institute of Medicine, 2001). National attention has recently focused on using patient experience survey results as a component of Centers for Medicare & Medicaid Services (CMS) value based purchasing programs (2016). In 2015 CMS began publishing Hospital Stars that incorporate patient experience survey performance and incorporating patient experience Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) survey results in the CMS Value Based purchasing program where they are subject to penalty (2016). Hospitals and Health Care system are challenged to make patient experience a priority as part of the overall quality agenda and have struggled to improve and sustain patient experience performance results (Clancy & Fraser, 2015).

Hospitals and Health Care systems are increasing their focus on strategies to improve the patient experience as described in proprietary reports (Boehm, 2015; Boehm & Petty, 2016; Lauing & Woods, 2015; Palmer & Prince, 2013; The State of the Patient Experience, 2015; Wolf, 2015; Wolf & Prince, 2014). Merlino (2015) describes the Cleveland Clinic's journey to improve the patient experience. Manary, Staelin, Kosel, Schulman, and Glickman (2015) identifies organizational characterizes of hospitals with higher patient experience performance scores. One strategy that appears to be increasing in health care systems is the

identification of a Chief Experience Officer (CXO) who is responsible for leading and improving the patient experience (Boehm, 2015; Boehm & Petty, 2016; Lauing & Woods, 2015; Merlino, 2015; Palmer & Prince, 2013; The State of the Patient Experience, 2015; Wolf, 2015; Wolf & Prince, 2014). Identifying the dimensions, priorities and measures of success for the CXO position is not well documented in the literature.

Literature Review

The Chief Experience Officer (CXO) role is a new, emerging position in the Health Care Industry focused on improving the patient experience and recently documented in proprietary reports, descriptive interviews and minimal published literature (Boehm, 2015; Boehm and Petty, 2016; Carlson, 2015; Larkin, 2012; Merlino, 2015; Palmer &Prince, 2013; Wolf, 2015; Wolf & Prince, 2014). The quality of the identified material overall is weak; cautiously rating it as expert opinion or less based on the hierarchy of evidence described by Melnyk and Fineout-Overholt (2015). Due to the proprietary nature of most of the identified information in the literature the procedures such as selection of interview candidates, questionnaires, questions, methods used to establish validity, reliability or control for bias and analytical procedures are not disclosed. Articles are not peer reviewed or published in peer reviewed journals; with one exception. Manary et al. (2015) identifies significant organizational characteristics that contribute to higher HCAHPS scores.

Because of the low quality of the available information it is difficult to establish conclusions or have confidence about approaches to structure the CXO role. This knowledge gap confirms the need for more structured and higher quality information about the CXO role in health care.

This study seeks to define the CXO role and contribute to the existing knowledge base. Through key informant interviews of CXO's in Health Care Systems (HCS) the study will identify, define and quantify areas of the role that are consistent and standard, or inconsistent and non-standard in how the CXO role has been formulated. The planned outcomes are the identification of the reporting structure and organizational relationships, position qualifications, major job responsibilities, position priorities and focus of the work, expected results and key outcomes are used to develop a job description for the CXO position in HCSs.

Objectives and Aims

The primary objective of this study is to identify the reporting structure, qualifications, major job responsibilities, position priorities and expected results and key outcomes for the CXO role to use to develop a job description. To meet the primary objectives, key informant interviews were conducted with leaders currently employed in a CXO position in a Health Care System (HCS) will explore the following:

1. Major job responsibilities
2. Expected results and key outcomes
3. Position priorities and focus of the work
4. Reporting structure and organizational relationships
5. Position qualifications
6. Job description for the CXO position

Chapter 2 Review of Literature

The review of literature identified information from three areas. Published interviews in trade and non-peer reviewed journals were identified. Unpublished proprietary reports from private industry networks or membership organizations discussing results from surveys that were conducted by their organizations were identified. Only one research article published in a peer-reviewed journal was identified. PUBMED, CINAHL and Business Source Complete search engines were accessed and online reports were identified from private organizations with expertise in patient experience.

Interviews with Chief Experience Officers

Carlson (2015) interviewed three executives, two Chief Experience Officers (CXO) and one Chief Executive Officer (CEO) documenting the rise of the role at two urban health systems, Cleveland Clinic and University of California Los Angles (UCLA). James Merlino, MD CXO at the Cleveland Clinic and Tony Padilla, MBA UCLA Health CXO's were prompted for opinion and asked three standard questions. The duration of the interview, the method used to record information and use of analysis was not provided. David T. Feinberg, then CEO at UCLA was interviewed where his opinion was solicited and two questions were asked (Carlson, 2015). The publication reports the responses to the interview questions in a question and answer style focused on the rationale for creating the CXO position and the relationship to the Centers for Medicare and Medicaid Services (CMS) initiation of the Value Based Purchasing (VBP) program as one of the motivating factors (Carlson, 2015). It was stated that the first CXO in Health Care was Bridget Duffy, MD named at the Cleveland Clinic in the 2007-2008 timeframe (Carlson, 2015).

Adamson and Adamson (2001) describe the changing Chief Executive Officer role, the impact of personalized technology, the aging baby boomers and the emergence of the CXO role as a response in healthcare. Three large urban and suburban hospitals and a health system CEO responded to a statement about the emerging CXO role and each was quoted in the narrative. The authors offered six fundamentally different ways the CXO must approach the work as intentional, individual, interactive, interpreted, inspirational and instituted as guidance for creating the patient experience; each was described. No data, analysis, or methods of recording the interviews were disclosed (Adamson & Adamson).

Larkin (2012) describes the upheaval in Health Care and suggests that in response organizations are creating new leadership roles, at the c-suite level; identifying the CXO as one such position. The c-suite typically refers to the senior most organizational executives including the Chief Executive Officer (COO), Chief Operating Officer (COO), Chief Medical (CMO)and Chief Nursing Officers (CNO), for example. The author identifies six leaders affiliated multi-hospital health systems identified as urban, suburban and rural and one large urban academic hospital who oversee patient experience activities, with titles ranging from CXO to Vice President, Chief of Patient Experience and/or Marketing and include a range of functions described as service delivery, marketing, customer engagement and performance improvement. In a narrative format five of the six leaders share opinions about the emergence and importance of the CXO role. Specific questions, interview process, data or analysis are not provided. Larkin (2012) lists nine steps to achieving a superior patient experience from Beacon Health System in South Bend Indiana as the source. The Steps are:

1. Hire and retain exceptional staff

2. Create clear expectations for exceptional service.
3. Provide access to materials to help staff understand the science and tools of creating exceptional experience.
4. Recognize and benchmark successful departments.
5. Coach and provide resources to struggling departments
6. Gather customer insights through multiple channels
7. Commit to never walking past an unsafe situation or unsatisfactory patient service.
8. Review policies and procedures to ensure that are patient friendly
9. Learn from industries outside health care. (Larkin, 2012 p.36 referencing the steps.)

Merlino (2015) chronicles the Cleveland Clinics (CC) journey to improve the patient experience and provides a history of the CXO role at CC, the insights and rationale of the CEO who created the position. Merlino (2015) describes evolving from the consultative approach of the initial CXO, Bridget Duffy, MD to one of culture change that required a philosophical shift from command to collaboration, managing day to day experience operations, and addressing resistance and conflict directly. Merlino (2015) references several conversations with leaders as sources of the historical information, in addition to his own experience as the second CXO at CC.

Reports from Private Organizations

Boehm (2015) presents qualitative and quantitative findings from EIN's initial report on this topic titled *The Evolving Role of the Healthcare Chief Experience Officer*. The quantitative component used a convince sample of (N= 96) director and executive level

patient experience leaders who completed an on-line survey. The survey consisted of 14 questions in a structured format prompting the responder to select from a list of answers or from a Likert scale; additional information was not available. The qualitative component included approximately 30 interviews of current CXO's and individuals serving in senior patient experience roles but with the title of Vice President or Executive Director. All survey responders and interviewees were members of the EIN network. A list of individuals is listed and acknowledged; selection criterion was not disclosed. Areas of focus for the CXO in this report were implementation of best practices, technology and innovation to support culture and experience improvement, developing strategy and governance, defining an operating model, data transparency and consumerism.

Boehm and Petty (2016) present summary findings from a quantitative and qualitative research report conducted by the Experience Innovation Network (EIN) part of Vocera, Inc. The quantitative component used a convenience sample (N=113) of director and executive level patient experience leaders who completed an on-line survey. The survey consists of 22 questions in a structured format prompting the responder to select from a list of answers or a Likert scale; additional information was not available. The qualitative component included approximately 30 interviews of current CXO's and individuals serving in a senior patient experience role, but with the title of Vice President or Executive Director all members of the EIN network. A list of individuals is listed and acknowledged; selection criterion not disclosed. Six health care systems are highlighted sharing one best practice or perspective; quotes are provided suggesting these were some of the individuals who were interviewed. Interview questions were not disclosed (Boehm & Petty, 2016).

Boehm and Petty (2016) provided details from the survey and interviews including common position titles, reporting structures, qualifications, position scope and budget. The reported priority areas of CXO focus include: achieving desired results, culture development, experience improvement for the workforce, implementing best known practices, systematic inclusion of the patient and family voice, leadership including alignment, systemness and measurement and analytics. CXO interactions with boards and governance, creating linkages to emerging accountable care models, technology integration and cross continuum experience and physician leadership development were discussed as part of the duties. Boehm and Petty report the emergence of increasing involvement of patients and families and a shift in focus to addressing well-being in the workforce.

The 2015 Boehm survey and the 2016 Boehm and Petty survey questions are different with a few exceptions. One question about the position title showed an increase use of the CXO title from n= 21 (22%) to n=49 to (44%) in 2016. An increase in the number of CXOs reporting to the CEO also increased (7%). Both surveys document the major priorities, duties and focus of the CXO. The EIN reports are proprietary and available through membership in the network.

Palmer and Prince (2013) reported results of a survey intended to gather information about tactics United States (U.S.) hospitals are implementing to improve the patient experience. An online survey sent to U.S. hospitals and health systems with 44 questions was fielded between February 8 and March 3, 2013. The total number of surveys fielded was not provided. Total responses (n=1,072) were reported from unique organizations (n = 672). A response rate was not provided. Approximately one half of the responders reported working in a stand-alone hospital and the other half in a health system or hospital group; with

n=364 (34%) from urban, n=311 (29%) suburban and n=375 (35%) rural locations. Of those responding n=268 (25%) reported their current position as CXO. The top three reported priorities for n=750 (70%) of responders was patient experience, for n=675 (63%), quality and patient safety and for n= 396 (37%) cost management. Primary responsibility and accountability for patient experience was identified as assigned to a committee by n=278 (26%) of respondents while n=235 (22%) report that accountability is assigned to a CXO or Director of Patient Experience. Improving customer experience results and leading improvements were noted as key priorities. One obstacle reported by n=664 (62%) of responders was not having strong, visible support from the top.

In a follow-up paper, Wolf and Prince (2014) continue to explore the CXO role. This report summarizes interviews with a sample of leaders (*n*= 15) in CXO or similar roles; all members of The Beryl Institute. Nine reported working at health systems, four at university hospitals, one hospital and one from the National Health Service in London, U.K. Seven topics were addressed in the interviews: reason for professional title, professional background, greatest success, greatest challenge, reflect on what you wish you had known on day one in the role, describe the value of the CXO role and advice to offer other organizations who may be considering the CXO role. Several quotes from interviewees were listed in the report. Recommendations for action were presented as synthesized by the authors: commit to having a CXO, should report to the CEO, diversity of background credentials is acceptable, scope of role can be broad, allocate resources, understand the role in relation to building an organizational culture, and acceptance that the role is new and will develop and change over time.

The Beryl Institute (TBI) and Catalyst Healthcare Research (CHR) (2015) co-produced a report based on an online survey consisting of 60 questions fielded for six weeks from February 7 through March 10, 2015. Wolf (2015) summarized the same survey data in a separate report. Survey questions allow the responder to select yes or no or select from a list of choices; specific questions not disclosed. A total of (n=1,561) responded to the survey including (n=761) from U.S. hospitals, (n=174) from non-U.S. hospitals, (n=116) from long term care and (n=93) from office practices. Patient experience remained a top priority. In U.S. hospitals, the percentage with a CXO role increased from n= 78 (22%) in 2013 to n=149 (42%) in 2015. Also, in U.S. hospitals, the percentage using a committee to manage the patient experience decreased from (n= 92) 22% in 2013 to (n=49) 14% in 2015. Top priorities continue to be quality, patient safety and patient experience. Improving results and achieving better outcomes, direct engagement of the patient voice, developing patient and family advisory committees, culture, purposeful vision and staff development were noted as areas of focus.

Lauing and Woods (2015) report is described as a compilation of information available from other parts of the Health Care Advisory Board practice including references to the literature and surveys of approximately (n=60) CXO's and those with expertise in consumer experience (R. Woods, personal communication, January 4, 2017). Woods (PC) indicated that a questionnaire was not available, questions were not standard and a list of interviewees was not available; she stated that the interviews were 45-60 minutes in length. The report offers best practices from other industries, suggests that the current focus in health care is not sufficient and identifies pitfalls and references technology solutions. Identifies that hiring a CXO is a means and not an end and must be supported for success. It describes

strategies to compete on the consumer experience including transparency in the market, access, reducing critical service flashpoints and building relationships with patients and consumers.

HCAHPS

Manary et al. (2015) fielded a novel survey (n=416) to senior leaders in the VHA (Voluntary Hospital Association) national network of not-for-profit hospitals with 143 (34.4%) leaders responding. The VHA has 1300 community owned hospitals and health systems. The sample size was determined based on geography, hospital size, as well as study resources and a priori sample size calculations. The senior person responsible for oversight of the patient experience at each hospital was identified noting that titles varied widely; for consistency the chief patient experience officer title was used throughout. The survey questions were developed using an iterative approach between study authors and experts. Questions were organized into three domains: senior leader commitment to patient experience, operational activities, culture and perceived barriers. Beginning January 2013, Qualtrics administered the survey via email and web link with an invitation letter, follow-up after two weeks and a phone call at one month to non-responders. The survey results were merged with HCAHP's results available on CMS Hospital Compare's website; using results available September 30, 2012 (CMS, 2016).

Manary et al. (2015) report several characteristics of hospitals with higher HCAHPS performance identifying the board and CEO viewing the patient experience as extremely important. Statistically significant relationships were identified with higher HCAHPS scoring hospitals who reported having an identified chief patient experience leader *(P* = .0403); training for managers, physicians and nurses and staff (*P* =.017); identification of a

collaborative culture had higher scores (*P* = .051) when compared to those who identified culture as hierarchical, competitive or decentralized. No significant difference in HCAPHS scores was identified between hospitals who offered incentives. Statistically significant lower HCAHPS scores identified with hospitals that communicated results at the unit level (P= .005) and with hospitals that identified physician engagement as a barrier (P=.034). Manary et al. (2015) noted that health care was far behind other industries in using patient councils to support improvement despite its importance in other industries.

Berkowitz (2016) discusses the concepts of patient experience and patient satisfaction noting the complexity and challenges for measurement. Berkowitz identifies a lack of consistent terminology and many contributing factors as a result of reviewing a selected sample of literature. Provider communication was identified as a strong predictor of patient satisfaction. Compassionate treatment and timely resolution of requests were noted as factors related to satisfaction scores. Berkowitz (2016) discussed the relationship to adverse clinical outcomes, safety events postulating that increases satisfaction with clinical care results in improved patient experience. The relationship to a positive work environment, Magnet ® designation, nurse burnout and patient satisfaction noting selected published reports that have begun to identify this association.

Job Descriptions

Two sample position descriptions were located as part of this investigation. The Advisory Board Company (2014) provides a role description including duties, reporting structure and identification of priorities. The Experience Innovation Network (2015) provides a sample job description describing major responsibilities and relationships, qualifications and offers candidate selection criteria.

The emergence of the CXO role in the Health Care industry is new, first being documented in 2007-2008 timeframe; this in part explains the dearth in the literature. The topic is ripe for a structured qualitative research scholarly project focused on the CXO role, qualifications, functions and expected results that would build on the information that is being gathered by networks interested in this topic. The opportunity to develop and contribute knowledge to the nursing profession and the Health Care industry would add value as the growth of the role continues in the U.S. and the importance of the patient experience continues as a critical priority.

Chapter 3 Theoretical Model

Deborah C. Small and Robert M. Small (2011) developed a patient centered practice model that was implemented at Cleveland Clinic health system to support the implementation of uniform care methodologies across a large and complex system. The model was intended to enable delivering standardized nursing practice across the system and provide clear direction regarding how nurses were expected to deliver patient and family centered care. Key concepts of the model including alignment with the organizational vision and values were described. Elements in the framework of care includes relationship-based care, thinking in action and serving leader. Domains of nursing practice are defined under broad categories: quality and patient safety, healing environment, professional development and education and research and evidence based practice. Several tools and graphics were developed to aid in communication and implementation of the model. A diagram depicting the nursing practice model can be found in Figure 1

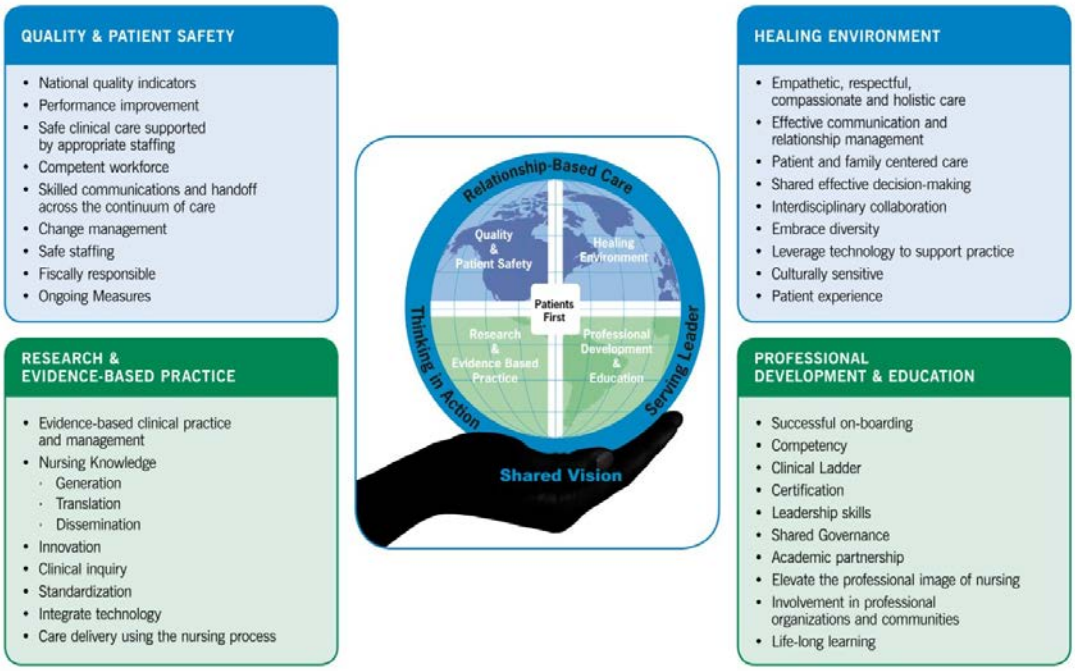

Figure 1. Theoretical Model Diagram

Small and Small's (2011) patient centered practice model will be utilized to develop and organize the foundation of the key informant interview process. The model will be used to categorize core duties and functions of the CXO role in relationship to nursing practice and organizational leadership.

Methods

Qualitative key informant interview study design**.** Because the CXO is a new role in Health Care and has developed organically based on organizational needs, it is important to explore the role in an open-ended manner that allows for individual input. For this study, a qualitative key informant interview research design is used to collect data from a sample of leaders currently serving in the CXO position. The proposed key informant interview questions are shown in Appendix A.

The steps required to gather data for the study were as follows:

1. Institutional Review Board (IRB) approval from the University of New Mexico (UNM) was obtained on May 19, 2017.
2. Key informant general guidelines for questions and prompts was finalized. .
3. Conducted interviews of key informants.
    a. Informed consent was obtained. Participants were provided with the opportunity to decline before meeting is scheduled.
    b. Interviews were scheduled for and lasted approximately one hour. The researcher recorded the interview and took notes during the conversations.

Setting and resources. Use past tense The study took place in the Albuquerque, New Mexico metro area. Study participants were interviewed in the manner of their choosing, providing maximum convenience and respect for their time. Teleconference, Zoom or other

synchronous platforms were utilized for the interview because subjects do not reside in the Albuquerque area.

Resources required included a notepad, writing instrument, two audio recording devices (one to serve as a backup in case the first one fails), extra batteries, a computer, and time. To assist in the coding process, the researcher utilized constant comparative analysis methodology. Collected data was transcribed. Cost associated with this study included transcription and editing. No additional costs were incurred.

Study population. Inclusion criteria: A convenience sample of eleven leaders defined for this study as Chief Experience Officers, senior vice presidents or vice presidents of patient experience or those with comparable title and role who are serving in this capacity in a health system in the United States (U.S.). To gain a national perspective CXO's were selected from different geographical regions of the U.S., will have served in the position two to three years or greater with final selection determined based on those who respond first, second, third, etcetera to the invitation. Exclusion criteria included not being in the role, regardless of title, serving in the position less than two to three years and not working in a Health Care system.

Sources of data. Chief Experience Officer leaders were identified because of their role at various Health Care systems in the U.S. They were directly approached by the researcher in person if possible, via phone and email to invite participation and were provided with informed consent information. Participants were asked a series of open-ended questions that will extract the needed information regarding the CXO role, the reporting structure and organizational relationships, position qualifications, major job responsibilities,

position priorities and focus of the work and expected results and key outcomes. Participants were asked to share their job description via email.

The researcher took notes during the conversation as well as audiotaped the sessions. The study participant's name, the name of the institution, and any other distinguishing information associated with this interview was de-identified and informants were associated by a number in sequence (i.e. number one, two, etc.). Transcripts from the interviews were analyzed for themes that provide context about the CXO role.

Data Analysis

The interviews were audio recorded and transcribed verbatim. The written notes and transcriptions of the interviews were developed in detail immediately after each interview to ensure accuracy. After the transcribed interviews and additional notes were read, a constant comparative and content analysis with preset and emergent labels and categories was derived from the data. The text will be organized into coherent categories with similar content and will be sorted into categories and sub-categories (Gerrish, Lathlean, & Cormack, 2014; Taylor-Powell & Renner, 2003). The researcher developed a simple storage and retrieval system. This allowed relevant parts of interview text to be organized according to the codes and assist in organizing the data so that the patterns and themes became clearer. Descriptive statistics were used to describe demographics of the study population.

A summary of each interview captured information about the key informant's position, reason for inclusion in the list of informants, main points made, needed information regarding the CXO role including the reporting structure and organizational relationships, position qualifications, major job responsibilities, position priorities and focus of the work and expected results and key outcomes. Themes and patterns were summarized.

Notes and transcripts were analyzed using a common set of subheadings for interview texts selected for the major areas being explored. The preset categories included the following: the reporting structure and organizational relationships, position qualifications, major job responsibilities, position priorities and focus of the work and expected results and key outcomes. The responses were further categorized by presence or absence of specific position responsibilities; similarities and differences in the role and any recommendations, outputs, experiences, indicators. Once the categories were identified, focus will move to identifying patterns and connections between categories (Taylor-Powell & Renner, 2003). Consistency and inconsistencies in roles and unique attributes in the CXO role were identified and relative importance determined.

Quality. The key informant interview questions were pre-tested for content with one colleague who has experience in this area to ensure questions are clear and concise. The key informant questions were also be reviewed by my Scholarly Project Committee for cohesiveness and alignment to the overall study objectives. Revisions were made following these reviews.

Ethics and human subject protection. This project was submitted for initial application and has not been previously reviewed by an IRB. There were no data or specimen banking associated with this study. All study participants were volunteers, over the age of eighteen, and did not fall into the category of vulnerable populations. No drugs or devices were used in this study, nor did it utilize any patient data. There were no physical risks associated with this research.

All applicable UNM Information Technology data security requirements were adhered to. The IT Services Manager for the College of Nursing supervised the data security

aspects of the project and ensured that all HSC data security policies were met for the duration. No retrospective data was used in this project. All interview data was stored electronically in a password protected, encrypted computer.

Prior to the interview, the researcher sent a copy of the informational document to the participant with instructions to read and contemplate it before the interview (Appendix B). This provided the participant the opportunity to consider participation in private and to ask questions before the interview began. Participants provided identifying information as part of the key informant interview process. The identifying data was captured and stored separately on a password protected, encrypted computer in a locked office so that the survey itself cannot relate to its completer. Notes from interviews were assigned a study number. The identifying key only exists as a hard copy and was stored in a locked cabinet in a locked office away from any other study data. All notes, recordings, and identifying data will be destroyed two years following after the study.

Interviews with all key informants took place in a private setting of the study participants' choosing. Interviewees will be provided with an informed consent form (Appendix C) at the beginning of the interview and were encouraged to ask questions before signing. Subjects were informed that they could withdraw from the study at any time and could choose not to answer specific questions.

Notes were de-identified and saved in a password protected, encrypted computer in a locked office. Recordings were kept in a locked cabinet in a locked office where only the study investigators had access. Notes from interviews were assigned a study number. The study number key only exists as a hard copy and was stored in a locked cabinet away from any other study data.

Participants may benefit by providing information related to developing the CXO position and contributing to the knowledge. Key informants received a handwritten thank-you note after the interview and will receive a copy of the final research project.

Timeframes or timeline. The project was approved by the College of Nursing and the UNM IRB on May 19, 2017. The key informant interview questions were pre-tested with one colleagues with patient experience background for clarity and possible revision after the IRB approval. Chief Experience Officer interviews took place following IRB approval for three to four months from July through October 2017. Data analysis was completed by February 28, 2018. The scholarly project will be completed and defended by May 1, 2018.

Budget. There were no financial costs to study participants other than their time. Interviews were restricted to one hour to be respectful of their time.

As stated in the resource section of this proposal, the resources required for this project are minimal. They included a notepad, writing instrument, two audio recording devices (one to serve as a backup in case the first one fails), a computer, and time. These items are currently owned by the researcher. Actual expenses were the costs associated with transcription and editing which were paid for by the researcher for this study. Key informants were not compensated.

Chapter 4 Results and Discussion

Eleven Health Care System Chief Experience Officer's (CXO) were interviewed between June and October 2017 for this qualitative key informant study. To improve reliability of the findings, the capstone chair was provided with complete transcripts of each key informant interview organized by interview question, summary data tables and key informant quotes. Data were analyzed using a constant comparative analysis. Each question was evaluated individually and across respondents. Categories naturally emerged based on the interview guide and the predetermined plan to produce a sample CXO job description. Descriptive statistics were developed by question. Through collaborative discussions the codes, themes and categories were further refined.

Table 1

Method for determining Importance, Consistency and Inconsistency

Determining *importance*, *consistency* and *inconsistency*	**Number of key informants where element or duty is present**	**Required achievement to determine level**
Important	9, 10, 11	>80%
Consistent	6,7,8	>50%
Inconsistent	5 or fewer	< 50%

The presence or absence of a specific job duty was identified and categorized as *important*, *consistent* or *inconsistent* using the following approach. *Important* is defined as being present in nine, ten or eleven of the key informant responses, achieving 80% consistency, an accepted standard in education. *Consistent* is defined as 6 or more key

informants affirming the presence of a duty. *Inconsistent* is defined as five or fewer key informants reporting the presence of a duty.

Key Informant Sample Characteristics and Position Qualifications

The sample consisted of six (54.4%) women and five (45.5%) men. Four (36.3%) reported having the medical doctor (MD) credential. It was noted as being the requirement for this position at their institution. None reported that they had the registered nurse (RN) credential, nor was it required. Four (36.3%) reported having a master's degree noting it was a position requirement; two (18.1%) of the four disclosed having a master's in business administration. One (9%) reported having a bachelor's degree and being a certified public accountant. Two (18,1%) key informants did not disclose specific required educational preparation despite prompting; instead stating they had extensive experience in marketing, communications and Health Care administration.

Health System Characteristics

The key informants were asked to describe their Health Care System (HCS) to include number of hospitals, type of hospital system, employees and providers. The HCS key informants are geographically distributed across seven states; representing 167 hospitals and over 500,000 employees and providers. There was no overlap of key informants in competitive market areas. Five (45.4%) key informants categorized their system as academic, one (9%) as academic and children's and one (9%) as academic and community based hospitals. Four (36.3%) categorized their systems as community based, one (9%) as county owned and one (9%) as a federal health system.

All of the key informants indicated that their system owned and operated large numbers of ambulatory clinics. All also indicated having other services along the continuum

of care such as homecare. The number of hospitals in the eleven HCS sample ranged from one to 53 with a mean of 15.

The employee population was estimated with information from eight (72.7%) key informants; two (18.1%) informants did not know the number of employees and one outlier organization reported 360,000 employees. This outlier was removed from the sample. The number of reported employees ranged from16,000 to 25,000.

The provider population was more difficult to estimate due to complexities such as employment status, legal limitations on employment options in several institutions such as employing only physician residents or physicians remaining independent on the medical staff. Overall key informants reported a rough estimate range of 400-8000 providers employed in each of the HCS. Despite variations in the nature of the employment relationship with providers; all discussed provider involvement and engagement as a priority.

Table 2

Health System Categorized by Type (Interview question 11)

Health System Characteristics	**Hospitals in HCS**	**Employees**	**Estimate of Number of Providers**
Academic	9	Several thousand	>1200
Community	5	15,000	1000
Community	15	25,000	1400
Academic Children's	2	3000	900
County	1	unknown	400
Community	48	48,000	8000
Academic	1	16,000	3300

Health System Characteristics	Hospitals in HCS	Employees	Estimate of Number of Providers
Academic	10	35,000	5000 residents
Academic Community	15	28,000	Unknown
Community	8	14,000	700
Federal Veterans	53	360,000	In the employee count, estimate thousands

Results of Key Informant Interviews

Dimensions of the CXO role. The initial set of questions focused on the dimensions of the position, the title and the genesis of the Chief Experience Officer (CXO) role including how long the organization had the role in place. Three (27.2%) key informants indicated having the Chief Experience Officer title. Three (27.2%) key informants reported having the Chief Patient Experience Officer (CPEO) title. Three (27.2%) had Patient Experience Officer (PEO) in their title, although preceded by Vice President, Administrative Officer and Chief Quality making the PEO component the most common element of the title, reported by six (54.5%) key informants. The descriptor Experience Officer was present in nine (81.8%) of the key informant titles, making it the most common component of the title.

Ten (90.9%) informants reported being the first executive in the position. The range of time the organizations have had the CXO role ranged from one month to 12 years with the M= 3.7 years having the position established. Key informants reported the time served in their current positon as M= 3.25 years.

Seven (63.6%) of the executives were promoted from within to a newly created position, or their role evolved into the CXO position. Four CXOs were external hires

(36.3%) and all reported that they had previous experience as a CXO in Health Care. One (9%) reflected upon prior experience in innovative patient care design. One (9%) external hire was recruited back to an organization as a CXO after a five-year stint as a CXO at another organization.

Table 3

Dimensions of the CXO role (Interview question 1)

Position Title	**Years HCS has had CXO role**	**Key informants time in the CXO role**	**Path to the current position**
Chief Experience Officer (CXO)	1.5 years	1.5 years, created role	Promoted from within, was Pt. Safety Officer
CXO	1 month	1 month	Promoted from within
Vice President (VP) Patient (Pt.) Experience Officer (PEO)	12 years	12 years, created role	Position evolved over many years
Administrative Officer, Patient Experience (Px)	5 years	5 years, created role	Promoted from within
Chief Quality & PEO	4 years	4 years	Promoted from within
Chief PEO	5 years	1 month, 3rd person in role	External hire, +10 years prior position as CXO
Chief PEO	1 year	8 months, first in role	External hire; 15 years prior position as CXO
Senior VP, CXO	2 years	2 years, first in role;	External hire; recruited back to current org after 5 years as CXO elsewhere
Executive VP, Human Experience Officer	1 year	1 year, post- merger at merged org.	Promoted from within; had 25 years as Human Resource Executive
Senior VP, Chief PEO	3.5 years	3.5 years, first in role, at same org	Promoted from within; had been CFO and COO
Executive Director, National Office on Patient Centered Care	6 years	6 years, first in role	External hire

Rationale for establishing the role. The key informants described the genesis and rationale for establishing the position with several recurrent themes, reporting three dominant reasons. Concerns about declining or stagnant patient experience performance results was expressed as a driver by seven informants (63.6 %). Five (45%) noted the loss of millions in the CMS value based purchasing program. Two (18.1%) noted post-merger and reorganization situations where the assessment of patient experience indicated no plan or strategy and readiness for placement of a new position with an internal executive with proven track records. All of the key informants described an organic evolution to the CXO role to develop and implement a strategic approach and plan. The desire to place patient experience front and center and drive cohesive and internally aligned improvement. All key informants mentioned that there is a lot of pressure on their organizations, several realizing they were behind.

Table 4

What was the rationale for establishing the role? (Interview question 1)

Category	**Theme**	**Quotes**
Performance	Inadequate	*"not performing at desired levels"* *"not happy with performance"* *"scores declining"*
Financial penalties	Value based payment penalties are growing in size	*"losing 2 million per year & it escalated"* *"realized they were behind"* *"not happy with performance, very payment related"*
Strategic focus	Absence of sufficient focus	*"Absence of a cohesive approach, no strategy"* *"ever increasing strategic focus of healthcare on patient experience and to consumerism, models not working"* *"post-merger, functions decentralized, no strategy, no plans"* *"organization assessed itself to be behind"*

Reporting structure and organizational relationships. The next set of key informant questions focused on the organizational hierarchy, reporting relationships, key relationships, peers and influence at strategic planning and leadership meetings. Five (45%) key informants reported to the Chief Operating Officer, making it the most prevalent reporting relationship. Three (27%) reported to the CEO or equivalent as in the case of the U.S. Secretary of Health. Other reporting relationships included the Chief Medical Officer, Chief Quality Officer and the Senior VP of Human Resources.

The number of employees reporting to the CXO ranged from (n= 0- 55). The distribution appears to be bimodal with four organizations having one to four staff reporting

and five reporting 11-36 staff reporting. The organizations with larger numbers of staff reporting to the CXO indicated responsibility for areas like patient advocates, service training, survey management and complaint management. Several key informants mentioned that it was preferred to be unencumbered by experience operations and have fewer direct reports.

Key informants were quick to verbalize that they enjoyed personal credibility within their organization based on historical successful performance and this facilitated their access and ability to influence patient experience priorities. Even those who were new to their respective organization pointed out their rapidly increasing organizational credibility that enabled increasing influence. The size of the organization appears to influence the position placement and reporting in the organizational hierarchy; whether it was at the corporate, network or the campus/facility level. Key informants noted that while not reporting to the CEO access to the CEO and strategy development was critical.

Eight (72.7%) informants reported attending most senior level strategic planning meetings while three (27.2%) stated they did not attend. Six (54.5%) reported attending highest level executive operations meetings even when reporting to the COO. Three (27.2%) reported not having sufficient influence or not being sure of level of influence.

Table 5

Describe position peers and key influence relationships? Does the CXO attend senior most leadership and strategic planning meetings? (Interview questions 2,3,7)

Category	**Theme**	**Quotes**
Key Relationships	Peers	*"partner with Admin leader who reports to CNO"* *"CNO, CMO, Chief of Quality"* *"regional presidents"* *"campus COO's"*
Key Relationships	Executive influence	*"CNO, CMO, Senior HR Executive"* *"CMO wasn't onboard with this experience stuff so it was put under HR"* *"network level"*
Strategic planning, influencing priorities and access to executive leadership	Adequacy of influence over priorities, participation, planning	*"position has sufficient influence"* *"yes, position well placed, attends all necessary meetings and has sufficient influence"* *"No, influencing through boss the CQO, need to blaze a trail here"* *"yes, part of CEO Executive team and directly influence the strategic plan"* *"regular participant on the CEO Leadership Team even though I report to the COO"*

Major job responsibilities, position priorities and focus of the work. In this section key informants were asked to describe major job duties and accountabilities and to describe the top one to five position priorities over the next one to three years. The Small and Small (2011) theoretical model was utilized to organize and categorize job responsibilities.

Determining *importance*, *consistency* and *inconsistency*. The presence or absence of a specific job duty was identified and categorized as *important, consistent* or *inconsistent* using the following approach (see Table 1, page 21). *Important* is defined as being present in nine, ten or eleven of the key informant responses, achieving 80% consistency, an accepted standard in education. *Consistent* is defined as six or more key informants affirming the presence of a duty. *Inconsistent* is defined as five or fewer key informants reporting the presence of a duty. This is depicted in Table 1 and utilized to sort, categorize and capture the frequency of key informants responding affirmatively to the presence of a particular job duty. Table 6 categorizes each job responsibility using this approach.

Table 6

Describe your major job duties and accountabilities (Interview question 5)

Presence of Job responsibilities, organized by *important, consistent, inconsistent*	**Job Responsibilities- frequency (n) of identification by key informant**	**Presence of Job responsibility in the Small and Small (2011) model**
Important	Culture development (11)	Absent from Model
	Px Performance improvement projects (11)	Performance improvement
	Drive results and set goals for patient experience (10)	National quality indicators, performance improvement
	Employee Engagement (9)	Effective communication & relationship management, Leadership skills
	Provider Engagement (9)	Effective communication & relationship management, Leadership skills
	Data and survey management (9)	Absent from Model
	Patient facing technology (9)	Integrate technology
Consistent	Establishing healing environment (8)	Healing environment
	Professional development and education focused on patient experience (7)	Professional development and Education
	Transparency and consumerism (6)	Absent from Model
	Patient and family advisory councils (6)	Patient and family centered care
	Patient centered care model (6)	Patient and family centered care
	Research and evidence based practice (6)	Research and evidence based practice
	Structure jobs and roles at various organizational levels (6)	Absent from Model

Table 6 Continued

Presence of Job responsibilities, organized by *important, consistent, inconsistent*	**Job Responsibilities- frequency (n) of identification by key informant**	**Presence of Job responsibility in the Small and Small (2011) model**
Inconsistent	Leadership development (5)	Leadership development
	Digital strategy (5)	Absent from Model
	Access to care focus in ED and other key areas (5)	Performance improvement
	Complaint, advocacy and service recovery (4)	Absent from Model
	Quality and patient safety (3)	Quality and Patient Safety
	Spiritual Care (2)	Absent from Model
	Experience design/journey mapping (3)	Patient Experience
	Innovation of experience, digital innovation (2)	Innovation
	Contact (call) center design (1)	Absent from Model
	Shared Decision making with patients (1)	Shared Decision Making
	Marketing customer service model (1)	Absent from Model
	Social media listening center (1)	Absent from Model
	Digital innovation- virtual care (1)	Absent from Model
	Discharge Call Center (1)	Absent from Model
	Customer Service model – mentions of coaching, rounding, leader/large group rounds, service standards, recognition	Absent from Model
	Unique roles identified by KI : Ethnographer (1), Data visualization expert (1), Director of Resiliency(1)	Absent from Model

Small and Small Theoretical model (2011). Key informants were asked to identify major job duties and accountabilities using the Small and Small (2011) model domains (see Figure 1). Small and Small (2011) offer seven to ten items in each domain as examples of

what is included under the category header. Thirty duties were identified by key informants and 16 (53.3%) are present in Small and Small (2011). The alignment of the sixteen key informant identified duties with the 40 items in Small and Small (2011) is approximately 40%.

Alignment of key informant reported duties to the model for *important* job duties is five of seven (71.4%) and for *consistent* job duties, also five of seven (71.4%). Further analysis by domain depicts this level of alignment with the model: four of 14 (28.5%) align with the quality and patient safety domain, seven (50%) with the healing environment domain, three (21.4%) with research and evidence based practice domain and two (14.2%) with professional development and education domain. Twenty four elements in the Small and Small (2011) model describe the nurse professional requirements, such as safe staffing, and shared governance that supports the RN delivery of an exceptional experience; they do not describe the role of a nurse executive in leading the patient experience in a health system.

Use of the Small and Small (2011) appears to be most helpful in identifying the *important* and *consistent* job duties with 71.4 % alignment. Two (18.1%) *important* elements, culture development and data and survey management are absent from the model. Two (18.1%) *consistent* elements, transparency and consumerism and structuring organizational roles were also absent. Use of the model to identify *inconsistent* job duties is limited. Four of 16 (25%) job duties aligned to those identified by key informants. The four (36.3%) *inconsistent* job duties that are in the model and reported by key informants are: leadership development, access issues aligned with performance improvement, quality and patient safety and experience and design/journey mapping.

***Important* major job duties.** One hundred per cent of key informants identified culture development as a job duty and linked leadership, engagement and improvement activities as mechanisms to develop culture. Improving patient experience through improvement projects was described by 100% of key informants; a notable example was the Nurse Blueprint project, intended to redesign RN work. Establishing organizational goals for patient experience and driving results was voiced by ten (90.9%) key informants and nine (81.8%) discussed management of data and patient experience surveys as a key duty. Nine key informants described provider (81.8%) and employee (81.8%) engagement as an *important* accountability; the key informant physicians noted that having a physician in the CXO role was intentional and part the engagement approach. Driving decisions about patient facing technology was also an *important* duty with nine (81.8%) informants having this duty; several informants referenced a patient portal and one mentioned patient room design for a new hospital wing in this context.

***Consistent* major job duties**. Eight (72.7%) informants highlighted their role in establishing a healing environment to include journey mapping, organizing and facilitating focus groups for facility design, contributing to developing prototypes for care areas and creating virtual tours of care spaces to share with patients. Seven informants (63.6%) described a variety of professional development and education activities focused on patient experience including curriculum design, communication training, and creating focus through leader meetings; one noted Patient Centered Friday sessions. Transparency and consumerism was noted by six (54.5%) informants with publicly posting provider experience results with all six providing this as the example of transparency. Consumerism was discussed in terms of meeting patient needs using web sites, and other communication methods consumers

value. Patient and family advisory council oversight was identified by six (54.5%) informants as a job duty noting the creation of on-line advisors and the most mature councils are in the pediatric areas. Patient centered care models and research and evidence based practice was noted as a duty by six (54.5%) informants and described as care design with patient involvement to improve the experience. Six key informants (54.5%) described structuring jobs and roles at various organizational levels to carry out the patient experience work.

***Inconsistent* major job duties.** This category captures job duties identified five or fewer times by informants. There is an interesting variety of duties including, five informants who mentioned leadership development (45%), digital strategy (45%), overseeing access in EDs and key areas (45%) as duties. Four (36%) informants identified complaint management and service recovery as a duty. The remaining duties are present infrequently and unique to the key informants background and organizational needs like the contact center design identified by one (9%) and oversight of spiritual care identified by two (18%).

Position priorities and focus of the work. Key informants were asked to describe their top one to five position priorities over the next one to three years. All of the key informants verbalized culture development and influence as a top position priority. This was expressed in a variety of ways including a common understanding and definition of patient experience and strategic focus on patient experience. Ten (90.9%) key informants described improving patient experience scores and patient experience performance improvement projects and programs as a top position priority. Redesign of work and work processes for nurses, call centers, ambulatory access and for the processes facing the patient and family were repeatedly expressed.

The evolution of planning and strategy development to a human experience mindset was expressed by all (100%) key informants. The integration of the employee and provider experience and the affirmation that employee and provider engagement was essential to achieve desired levels of patient experience performance was verbalized as *important*. Key informants mentioned defining the employee culture, rebuilding trust, focus on resiliency and burnout, embedding a human philosophy, a strategic focus on burnout, resiliency, evolving the organizational culture and the management systems to support human experience. The focus on human experience, and person centered and team well-being emerged as dominant strategic theme and key informant priority.

Table 7

Describe your top one to five position priorities over the next one to three years (Interview question 6)

Category	**Theme**	**Quotes**
Top position priories	Cultural influence, transformation	"*shared mental model"* *"big bucket- strategic focus on patient, employee and provider experience; consumerism"* *"embedding the human philosophy into the mission, vision and operational projects"* *"develop an integrated strategy for patient, family and caregiver experience- quality, safety, leadership training and development"*
	Performance improvement	*"get patient experience scores to the 50th percentile, accelerate improvement, clarify accountability"* *"access, re-design the contact/call center, bringing together digital health"* *"patient satisfaction rated declining and raising them is a top priority"*
	Human Experience	*"Team engagement: People Credo, define employee culture, rebuild trust"* *"transforming to a future state of implementing a whole health system- person centered approach to health and well being"* **"***big bucket: resiliency, burnout; evolving the organizational culture and the management system to support"*

Table 7 Continued

Category	Theme	Quotes
Responsibility for employee and provider experience	Overlap of duties and accountabilities	*"train teams in patient experience and provider coaching"* *"yes, all integrated"* *"influences content, develops curriculum"* *"no, very high RN and provider engagement"*

Incentives to support goals and performance. Key informants were asked about monetary incentives for executives, providers and employees related to achievement of patient experience goals. Nine (82%) informants reported that monetary incentives have been available at their organization, tied to achievement of patient experience, quality, safety and financial goals. When in place they are consistently available for executives and physician leaders. There was more variability related to front line providers as many worked via a contracted arrangement or were prohibited by compensation regulations. One (9%) organization reported a separate staff RN incentive designed to reward staff RNs for achieving patient experience results at a department level. Another reported that employees could earn up to six additional days of paid time off for achieving organizational goals, of which patient experience is always a goal. Seven (63.3%) talked about goal achievement driving merit pay increases for director and managers and achievement of system or network level goals driving incentive pay for executives. Two (18%) key informants reported that no incentive pay was available or planned, reasons included being prohibited by organizational structure and hesitant to tie incentive pay to achievement of patient experience scores. Some

skepticism voiced as to the effectiveness of incentive. Variability exists in how incentives are structured across key informant organizations.

Table 8

Are incentives available for achievement of goals? Patient experience results? (Interview question 9)

Category	**Theme**	**Quotes**
Incentives	Monetary for executives and MD's	*"yes, at all levels"* *"no, hesitant to tie to scores"* *"MDs in leadership roles"*
	Director and manager level	*"have not had for several years"* *"patient experience is always a component"* *"bonus ties to experience"*
	Employees	"*employees can earn up to 6 additional PTO days"* *"considering a gain sharing program"* *"Managers can award $100 ICARE recognition awards to staff"*
	RN's	*"a separate RN incentive program that includes the Px"*

Reflections on the CXO position: gaps, expansion, future insights. Seven (63.6%) key informants articulated alignment and buy-in and five (45.5%) noted patient experience infrastructure as areas where closing gaps could improve effectiveness. The alignment and buy-in theme was expressed as a high level mindset and focused largely on physicians, CEO and c-suite executives. Key informants reflected on the need for physician leaders to step forward and administrative leaders to integrate patient experience into priorities and actions; not enough to just state that patient experience is *important*. The effectiveness of

collaboration between executives was mentioned by six (54.5%) key informants with the alignment and capability of human resources, strategy, marketing, physician groups and business analytics as gaps that limit the effectiveness of the CXO role and achieving desired performance results. Six (54.5%) key informants described the patient experience infrastructure as separate from the overall operational infrastructure and identified this lack of integration as a problem. One (9%) key informant indicated that he enjoyed high levels of collaboration and without this he would be advocating to have more departments and functions reporting to him. Shared accountability of the physician and nurse leaders for patient experience would improve alignment of priorities and ultimately results, was voiced by another key informant.

No surprise, one hundred percent of key informants expressed the perspective that the CXO role is important and anticipate the importance of the position increasing in the future, seeing it mature and evolve. Three (27%) specifically stated that expansion of the CXO role to include the broader human experience is necessary referencing joy in work, the quadruple aim and needing a resilient and healthy workforce. Two (18%) anticipate increased focus on consumerism and transparency and two (18%) mentioned the need to reinvent or redesign Health Care, reflecting on the mess. One (9%) indicated the need for increased focus on capturing the return on investment and benefits of the work. One (9%) envisioned patient experience becoming a specific discipline in Health Care with a defined knowledge and evidence base.

Table 9

Gaps in the CXO scope and defined work that if part of the CXO role would increase effectiveness. What additional comments or insights would you offer? Future of CXO role, view of new or expanding duties, what else would you share? (Interview questions 8 and 10)

Category	**Theme**	**Quote**
Alignment and buy-in	Medical group	*"MDs need to step up"*
	Physicians	*"MDs have a history of being very production oriented"* *"shared accountability of MD and RN leader"*
	CEO and C-Suite	*"mindset focused on short term results and not redesigning the experience"* *"pushing a boulder uphill, they say it but not reflected in priorities or actions"* *"connection to marketing and strategy"* *"mindset and culture"*
Patient experience infrastructure	Current state	*"analytics and business intelligence"* *"Px value equation, not just look at results, have to change how we do stuff"* *"re-engineering the system with linkages to operations and design"* *"focus on core product- safety and quality and then the "cream" hospitality"*
Human Experience	Evolution towards	*"Migration to team member engagement"* *"role expansion anticipate…resiliency, burnout, quadruple aim focus"* *"need to define human experience and include employees"*

Table 9 Continued

Category	Theme	Quote
Insights for the future	Insights for the future	*"roles are critical moving forward, expect to see growth. Need a national conversation about the Px and Hx"* *"Joy in work, integration to the quadruple aim"* *"Consumerism, transparency, things are really broken"* *"role will mature and evolve, success has been enabled by collaboration between roles"* *"Patient experience becoming a discipline, developing a knowledge and evidence base- a specific skill set"* "*articulating the return on investment*"

Findings

Themes. Dominant position characteristics and qualifications among the key informants emerged for degree held, types of HSC's, and job titles. The dominant level of education was having a master's degree or above. The Chief Experience Officer (CXO) position is distributed across academic and community HCSs. There were several other types of HCSs identified, but had only one informant in each. Key informant job titles varied, however, *experience offic*er words are the most prevalent theme with different preceding words like chief, patient, vice president and administrative officer.

Time in position, personal characteristics and reporting. The dominant theme for mean time position established emerged 3.7 years. Nearly all key informants reported being the first person in the position. Key informants reported the mean time serving in the

position as 3.25; validating the newness of the position. Being promoted from within was the dominant theme followed by the key informants position evolving to a CXO role. Personal credibility and previous organizational success was noted as a theme for personal characteristics. For the reporting structure, the dominant themes were reporting to the COO, followed by the CEO.

Establishing the CXO position. Three dominant themes emerged as rationale for establishing the CXO position. Declining or stagnant patient experience performance results emerged as the most frequent reason, followed by reported loss of millions of dollars in value based purchasing programs as rationale. The final dominant theme described an organic evolution to the CXO role to develop and implement a strategic approach.

Success factors. Collaboration, influence and key relationships are critical to the success of the CXO role, as was having sufficient organizational influence. The two dominant themes enabling success were having a seat at the most senior level strategic planning meetings and at the highest executive operations meetings. The dominant success factors are depicted in the word cloud (see Figure 2 – Success factors).

Figure 2. Success factors

***Important* and *consistent* job duties.** The frequency of the repeated themes for important and consistent job duties is illustrated in Figure 3 as a word cloud. The two most reported themes for i*mportant* duties was culture development and patient experience improvement projects. The most reported theme for *consistent* duties was creating a healing environment.

***Important* job duties**. The researcher defined *important* as the duty being present for 80% or more of the informants. The dominant themes that emerged for *important* and *consistent* job duties are illustrated in Figure 3 as a word cloud.

Figure 3. *Important* and *Consistent* Job Duties

The following job duties emerged as themes that met these criteria: culture development, patient experience performance improvement projects, establishing goals and driving patient experience results, provider and employee engagement patient experience survey and data management and identifying patient facing technology.

***Consistent* and *inconsistent* job duties**. The themes for *consistent* duties includes: establishing a healing environment, patient experience communication training and development, transparency and consumerism, patient and family council oversight, patient centered care models, evidence based practice and structuring jobs to carry out patient experience work.

Inconsistent duties that emerged as themes includes: leadership development, digital strategy, access and ED experience and complaint management. Over a dozen duties were identified, but not classified as themes as these additional duties were unique to only one or two informants.

Top position priorities. The themes identified for top position priorities for the next three to five years included: culture development and influence, improving patient experience scores and patient experience improvement projects. The evolution of planning and strategy development to a human experience mindset was expressed as a developing priority. The increasing overlap of provider, employee and patient experience improvement was described as evolutionary and the need to integrate this work emerged as a theme. Monetary incentives were available in their organizations and are intended to drive achievement of patient experience and other goals. Top themes identified as position priorities are depicted in the following word cloud (see Figure 4).

Figure 4. Top position priority themes

Small and Small Model (2011). Thirty discrete duties that were identified by key informants and were present in the Small and Small model (2011). This is approximately 40%. The theme of alignment of reported duties to the model is equally strong for *important* job duties and *consistent* job duties.

Effectiveness. Key informants were asked to identify what would increase the effectiveness of the CXO role. Eleven discrete themes emerged. These are illustrated in Figure 5 as a word cloud.

Figure 5. Increasing CXO role effectiveness

Anticipating the CXO role growing and maturing in the future was the most dominant theme, followed by the need for alignment and buy-in at various organizational levels emerged as a *consistent* theme when informants were asked about increasing the effectiveness of the CXO role. The effectiveness of collaboration between executives is also critical to success and a *consistent* theme. The current state, level of integration and connectedness of the patient experience infrastructure was a theme identified as a gap to overcome.

Discussion

Through the key informant interviews and constant comparative qualitative analysis, the following observations and conclusions are offered.

The Chief Experience Officer (CXO) position has evolved organically primarily driven by patient experience results that need improvement and the Centers for Medicare and Medicaid Services (CMS) Value Based Purchasing (VBP) hospital program that carry large financial penalties and reputational risk. The individuals placed in the role have credibility resulting from a history of getting projects accomplished and demonstrating the capability to improve performance results. This credibility suggests that the CEO and COO have confidence in the CXO capabilities and recommendations, this confidence enables influence over organizational priorities.

The CMS VBP hospital program coincides with the accelerated emergence of the CXO role. The 3.25 year, average time in the role aligns with the onset of penalties that arise from the VBP program. One might speculate that health care executive attention was not focused on patient experience until there was sufficient external attention and pressure; especially related to financial payment.

Executives with a clinical background, especially physicians are increasingly placed in CXO roles. The physician CXO often has a nurse or administrative partner. The lack of alignment of physicians overall with improving the patient experience may be a driver of identification and placement of physician CXO's. The physician CXO key informants reported credibility with their physician colleagues, which may have been a critical selection criterion. The physicians in this sample had variable formal general leadership and management experience.

The absence of the RN executive in the CXO key informant sample is a curious and interesting finding in this analysis. Two possible conclusions are that this is a limitation of the sample or that it is an emerging trend. In *The Rise of the Healthcare Chief Experience Officer* report (Boehm, L. & Petty, K., 2016) that seven percent of the CXOs reported to the CNO; although this was not a reporting relationship identified in this research analysis. In Boehm, L., (2015) report 23% of CXO's reported having a nursing degree followed by the Boehm, L. & Petty, K. (2016) report where 33% of CXO's reported having a nursing degree, reflecting an increasingly observed qualification. Also in this report 12% reported having a medical degree.

Further consideration of whether individuals with a nursing degree may or may not serve in a CXO role could be an area of future exploration and learning. This research identified study participants by title and not qualification. If fewer nurse executives are in the CXO role nationally, a possible reason could be lack of nurse executive interest. The HCS internal history and political environment could be another source of influence. If the level of nurse engagement is high and the provider engagement is low, a physician may be

preferred. Another reason could be that incumbents in the CNO role are not perceived as able to influence performance results making them weak contenders for the CXO position.

The CNO's position may be placed at an organizational level in these large systems that the CNO's work doesn't have visibility to the CEO or COO. The CNO may not have access to the CEO or COO and limited ability to build the needed relationship to be considered for a CXO position. There may also be a question of whether the skills and capabilities between the CNO and the CXO roles match. This area is ripe for further exploration.

The CXO role includes a blend of strategic duties, operational duties and translating strategy into operations. Broad capabilities in building a patient experience strategic approach, influencing the organizational strategic plans and priorities and understanding complex HCS's represent some of the strategic duties. The capacity to influence and develop a culture to ensure excellent patient experience performance is a prominent strategic duty. Operational duties include the capability to design and lead performance improvement projects in areas where performance gaps exist. These high visibility areas, like emergency departments, ambulatory access, call centers and hospital throughput have proven to be some of the most difficult challenges for HCS's. Other duties like oversight of patient advocates and complaint management are examples of operational duties. One example of translating strategy into operations is the development and structuring of jobs at various organizational levels to implement the work.

There appears to be relationship to the size of the organization and the focus of the CXO role. The larger the HCS the fewer number of specific duties included in the CXO role. The CXO's in smaller organizations were responsible for more functions like quality and

operational areas. In larger organizations the CXO's reported more focus on cultural development and alignment, and strategic work.

Independent of HCS size, capabilities and skills in collaboration seem critical for the success of the CXO role. The key relationships are broad, including other senior executives, hospital presidents, system CMO and CNO's and those responsible for marketing, digital and consumer facing services. The CXO's ability to make linkages visible and relate them to the patient experience is powerful and likely necessary in systems with department and functional silos. This suggests a need for emotional intelligence and awareness to develop and sustain many key relationships that are needed to advance the patient experience.

The trend toward human experience and having roles that integrate patient, provider and employee experience appears to be an evolving trend. Focus on the human experience driven by the impact of high employee and provider burnout, low resiliency and compassion fatigue and the negative effect on patient experience was noted by key informants. As data from patient and employee/provider surveys becomes more highly correlated, key informants suggest that health care leaders will need to place more focus on employee and provider engagement to achieve patient experience goals. A question remains regarding whether the CXO will lead this work, if other executives will, or if additional new roles will emerge.

The Small and Small theoretical model (2011) is useful in identifying *important* and *consistent* elements of the CXO duties. The model has additional benefit in identifying elements of the nursing professional practice that need to be considered and in place for the RN to deliver a consistent patient experience. The model is limited in defining a consumer view of the patient experience and contextually is focused on when the patient is receiving

care. Much of the CXO work relates to patients in ambulatory settings and accessing care on-line who may not see themselves in the patient role, rather in a customer role.

Implications for Health Care Systems

The Chief Experience Officer (CXO) role has emerged in HCS to increase the senior executive level focus on the patient experience. The key informants identify a lack of senior executive alignment, physician alignment, strategic focus and resultant inadequate performance as reasons for the evolution of the CXO role. The CXO role is new and maturing. The duties assigned to the CXO may initially be specific to the unique issues within the specific organization and will likely develop over time.

According to key informants, CXO's need sufficient organizational influence, an important consideration for CEO's who are considering this investment. Decisions regarding the reporting relationship of the CXO and what senior level meetings the CXO will contribute to are important to set up for success. To solve the challenges of the patient experience the CXO will need to influence the organizational culture; a sensitive area in many organizations and typically seen as CEO territory. Other HCS executives will need to collaborate with the CXO, an area where the CEO can establish expectations. CEO's awareness of the interrelationship of patient experience and provider and employee engagement is an area needing continued CEO attention. The need to focus on the consumer aspects of the patient experience will require CEO support as CXO's work to influence marketing and digital strategy and experience.

Limitations and Strengths

Limitations. The researcher has identified the following limitations of this study:

1. Although a convenience sample of eleven key informant CXO's in HCS was identified and the sample has gender, geographic and organizational diversity, it does not have any CXO's with a nursing degree.
2. Key informant CXO's were identified by title and role. This research did not capture the perspective of the CXO's supervisor and CXO interview information was not validated, potentially introducing bias.
3. The Small and Small model (2011) is not a consumer model it is a patient care model and did not capture many of the consumer needs of the patient experience identified by key informant CXO's.
4. The qualitative key informant interviews introduce a potential for bias due to the researcher designed questions and the researchers interest in the outcomes.
5. Qualitative research is difficulty to replicate. To mitigate this inherent challenge, the researcher kept the interview to the script and interview questions, restated interview responses to ensure understanding and limited the discussion to the interview questions.

Strengths. The researcher identified the following strengths of this study:

1. Ethical and quality standards were strictly followed.
2. The key informant sample had gender, geographic and organizational diversity.
3. Key informant confidentiality was safeguarded and key informants spoke openly and candidly.
4. Key informants were eager to participate and enthusiastic about the interview and indicated interest in the study outcomes.

5. Interviews allowed for key informant reflection and offering opinion and perspective.
6. The study identifies *important and consistent* CXO duties from a national perspective and will be useful in developing CXO job descriptions. The study results also identify i*nconsisten*t duties for consideration and exploration as leaders are developing the CXO role for their HCS's.

Suggestions for Future Research

The Chief Experience Officer (CXO) role is an emerging position in Health Care. The job duties and qualifications are not well documented the published literature. Research on the fundamental CXO duties and impact on the patient experience are needed to demonstrate the impact of the CXO role and the return on investment. Further exploration of the qualifications for the role, particularly the nurse executive and whether the skills and competencies of the nurse executive are aligned. Research focused on nurse CXO's would contribute to the body of knowledge.

The identification of a patient consumer model would benefit the Health Care industry and the patient experience. Research in this area could focus on the alignment and overlap of patient care models and consumer models. Patient care design and experience design could be examined to better articulate and understand patient needs from a consumer view.

Research on the impact of provider and nurse engagement on the patient experience is needed to identify highly correlated strategies and tactics to enable and support investment in these areas. Validating that integrated strategies and tactics have benefit could accelerate improvement in the patient experience as organizations make difficult financial decisions.

Clarity in these areas could influence focus on an integrated human experience approach; another area of exploration.

Research on the key informant reported lack of alignment among and between senior executives, physicians, nurses and other leaders would be beneficial to understand how this lack of alignment impacts the patient experience. Determining the areas of alignment could accelerate improvement. Understanding more fully the areas where there is an absence of alignment and agreement has the potential to focus the CXO role and accelerate improvement.

Research that identifies strategies and tactics that improve the patient experience is needed. Today, the landscape offers many best practices but scant peer reviewed literature that demonstrates tactics that have a high probability to improve the patient experience. Getting to a core set of proven strategies and tactics could improve executive alignment and accelerate patient experience improvement.

Concluding Remarks

This qualitative research is useful because it offers a greater confidence about the structure of the Chief Experience Officer (CXO) role. Specifically, this research provides information about the common titles, qualifications, reporting structures and key relationships. This research also isolates major job responsibilities and categorizes them as *important*, *consistent* and *inconsistent* job duties for use in developing the CXO role. The Small and Small (2011) theoretical model is applied and insights are gained about the models usefulness and level of alignment with the key informants identified job duties in the research. Also useful are the insights regarding position priorities and focus of future work which provide additional information about the knowledge, skills and attitudes needed for the

CXO position. Taken together, this research produced a job description (see Appendix D) that is useful for Health Care leaders to develop a CXO position and to compare existing CXO positions to it for modification.

As described, this is a new, emerging role in the Health Care industry (Boehm, 2015; Boehm & Petty, 2016; Carlson, 2015; Larkin, 2012; Merlino, 2015; Palmer & Prince, 2013; Wolf, 2015; Wolf & Prince, 2104). Because of the new nature of the CXO role it is likely that the job responsibilities and key accountabilities will continue to develop and evolve. Refreshing the *important, consistent* and *inconsistent* job duties may be useful over time and to document further evolution of key accountabilities.

Two thoughts are offered regarding the potential to spread this method and qualitative approach to other contexts. One is to replicate this approach using the same methods and questions, but to alter the selection of the sample and only include RNs who are in CXO roles; to determine if the job duties are similar when a RN is in the CXO role. This would potentially add knowledge to the nursing profession. The second possibility it to use this approach and method for other emerging Health Care leadership roles, to assist with examining the dimensions of the job and the key accountabilities.

As identified in the literature review, there is an absence of published and peer reviewed literature on this topic. The researcher plans on disseminating these findings through submission of a manuscript to the Journal of Nursing Administration (JONA). As JONA is designed for nurse executives there may be limited interest in this research because of the absence of RNs in the study sample. The Journal of Patient Experience, a SAGE publication is also recommended for evaluation for submission; this journal has a broad audience and accepts a wide range of manuscript topics. The Online Journal of Issues in

Nursing is also an option for further consideration. More general health care publications that target CEO and COO's are also a consideration to reach this audience; publications aligned with the American Hospital Association may be worthy of evaluation.

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Appendix A: Key Informant Interview Questions

Dimensions of the Chief Experience Officer role:

1. What is your job title, general information about the position, and job qualifications?
    a. Prompt: time in position?
    b. Prompt: Is this a new position? When established?
    c. Prompt: What was the rationale for establishing the role?
    d. Prompt: Describe required qualifications
    e. Prompt: Describe your professional credentials
2. To whom do you report to in your health system?
    a. Prompt: Describe the hierarchy?
    b. Prompt: Do you attend senior most leadership meetings, strategic planning activities?
    c. Prompt: How do you influence the patient experience priorities?
3. Describe key organizational leadership relationships to support you as an CXO?
    a. Prompt: Are you a peer to the CMO, CNO?
    b. Prompt: Level of interaction with VP of HR? VP of Strategy?
    c. Prompt: others
4. Scope of responsibility: experience improvement activities? Who reports to you? Departments? Fte?
    a. Prompt: clinical services? Relationship to nursing?
    b. Prompt: quality and patient safety?
    c. Prompt: patient experience functions like complaint management, experience design, coaching, etc.
    d. Prompt: organizational development, employee experience?
    e. Prompt: number of direct reports and fte, budget
    f. Prompt: total fte reporting to your area

Position major responsibilities and accountabilities and priorities…..

5. Describe your major job duties and accountabilities. (Small and Small, 2011 model domains a-d)
    a. Prompt: Quality and Patient Safety
    b. Prompt: Research and evidence based practice
    c. Prompt: Healing environment
    d. Prompt: Professional development and education
    e. Prompt: Provider engagement
    f. Prompt: Culture development
    g. Prompt: patient facing technology
6. Describe your top 1-5 position priorities over the next 1-3 years
    a. Prompt: How are your priorities derived ? negotiated ?
    b. Prompt: What data and information are used?

   c. Prompt: How do you align with organizational priorities?
   d. Prompt: listen for improve patient experience /improve physician/staff well-being; experience culture; implement best practices; create/improve experience strategy; improve measurement system; embed patient/family voice; area/service line focus; design care models
   e. Prompt: Patient engagement; patient and family centered care
   f. Prompt: consumer digital strategy, transparency of results
7. Discuss areas of essential collaboration and influence with other leaders/departments to accomplish your priorities
   a. Prompt: Clinical Leadership, HR, OD, Strategy?
   b. Prompt: describe role in developing organizational strategy and priorities
   c. Prompt: describe your role in developing experience strategy and priorities
8. Describe gaps in CXO scope and defined work that if part of the CXO role scope would increase effectiveness

Measures of Success

9. How do you define goals for your role? measures of success?
   a. Prompt: Incentives?
   b. Prompt: alignment with other leaders?
   c. Prompt: targets for patient experience results?
   d. Prompt: targets for employee and provider experience results?
   e. Prompt: complaints and compliments
   f. Prompt: social media
   g. Prompt: patient quality and safety results
10. What additional comments or insights would you offer ?
   a. Prompt: future of CXO role
   b. Prompt: view of new or expanding duties
   c. Prompt: what else would you share ?
11. Health System description
   a. Prompt: total revenues and FTEs'
   b. Prompt: employees and employed providers
   c. Prompt: number of hospitals, academic medical center
   d. Prompt : geographic region of U.S.

Appendix B: Script for Email Recruitment and Consent for Leaders

Hello. This is Kathy Davis, Senior VP and CXO with Presbyterian Healthcare Services based in Albuquerque New Mexico. Today I am emailing you as a University of New Mexico Doctor of Nursing Practice (DNP) student. I am conducting a series of key informant interviews with CXO leaders presently employed in the CXO position for my DNP Scholarly Project study. This study is designed to identify your perspectives to further define the CXO role and contribute the existing knowledge base. The planned outcomes are the identification of the reporting structure, qualifications, major responsibilities, goals and expected key results for quality and the patient experience; to develop a job description for the CXO position in Health Care Systems.

You are being invited to voluntarily participate in this study because you are identified as a CXO leader working in a health system. Your involvement in the study will include participating in a key informant interview with me, the student researcher, lasting approximately 60 minutes. In addition, you will be asked several demographic questions that will be used to describe the sample. The interviews will be audiotaped and I will take notes during the interview to help clarify data. Your name, the name of your institution, and any other distinguishing information associated with this interview will be de-identified. Transcripts from the interviews will be analyzed for themes that provide context about current attributes of the CXO role.

Interview questions are generally open-ended. You may choose at any time to not to participate. You may choose not to answer any question and you may terminate the interview at any time. Further, you may also choose to have your interview removed from the study, including after the interview is completed. While it is always a possibility of loss of privacy and confidentiality with a research study, we are taking every possible step to protect your information. Only the investigator will have access to your interview questions, notes, and e-mails. Electronic data will be de-identified, coded, and stored on a password protected computer in a locked office. All transcripts and audio tapes will be kept in a locked file cabinet in a locked office. E-mails, electronic demographic data, tapes, notes and transcribed surveys will be destroyed at the end of the survey.

In the future, the student investigator will use these data for Scholarly Project final paper and a poster presentation. The final projects will then be submitted for publication. You may ask questions about the study at any time and your questions will be answered. There are no costs associated with the study except the time spent being interviewed.

By sending a return email back to me that you have read and understand the study and the consent form and are willing to schedule a Key-Informant interview as described above, you will be agreeing to participate in the above described research study. Thank you for your consideration and help with this study.

Kathy Davis RN, MBA, NEA-BC

If you have any questions about this research project, please feel free to call me at (505) 220.1482 or P.J. Woods, PhD, MBA, RN who is the Principle Investigator of the study at (505) 272.4258. If you have questions regarding your legal rights as a research subject, you may call the UNM Office of the IRB at (505) 277-2644.

Appendix C: Information Sheet / Consent Form

Identify the Qualifications, Major Duties, Responsibilities and Expected Outcomes for the Chief Experience Officer among Health Care Systems in the United States

INVITATION TO PARTICIPATE

Kathleen Davis, RN, MBA is a doctorate of nursing practice student in the University of New Mexico College of Nursing (CON) in the Nurse Executive/Organizational Leadership track. She is under the supervision and guidance of P.J. Woods, PhD., MBA, RN, Associate Professor at CON and Carolyn Montoya, PhD, CPNP, Interim Dean of CON. You are being invited to voluntarily participate in this key informant interview because you are identified as a Chief Experience Officer in your health care system.. Please read this document and ask questions about anything you do not understand before deciding whether to participate.

1. PURPOSE OF THE STUDY

The primary objective of this study is to identify the reporting structure, qualifications, major responsibilities, goals and expected key results for the CXO role. To meet the primary objectives, key informant interviews conducted with leaders currently employed in a CXO position in a Health Care system will explore the following:

- Major job responsibilities
- Expected results and key outcomes
- Position priorities and focus of the work
- Reporting structure and organizational relationships
- Position qualifications
- Job description for the CXO position

2. PROCEDURES, PRIVACY AND CONFIDENTIALITY

The interviews will last approximately 60 minutes and will be audio taped to ensure the accuracy of statements made by participants. During the session, you will be asked about your experience and opinions related the Chief Experience Officer position. Also, we will not use your name during the interview so that your name will not be recorded in any documentation related to your comments today. The audio tapes and this consent form will be kept in separate locked cabinets to which only study personnel will have keys. No identifying information will be kept in the file containing the audiotapes from this interview. This helps ensure your name will not be used in any reports and you will not be contacted again as a result of participating in this interview. However, we cannot guarantee that the information discussed today will be kept private. This interview is being

undertaken for research purposes only. You will receive no financial compensation for your time, but you will have the deepest thanks of the investigators.

3. POTENTIAL RISKS AND DISCOMFORTS AND RIGHT TO REFUSE

The conversation might include discussion of specific costs and problems that may be considered proprietary. Participating in this interview is completely voluntary. You can decide not to answer individual questions or to stop the interview at any time.

4. ANTICIPATED BENEFITS

Your answers in this study are important and will help the investigators learn more the Chief Experience Officer role and how this relatively new position is being implemented in health systems in the U.S. This information may be used to design a sample job description.

5. IDENTIFICATION OF INVESTIGATORS

If you have any questions about this project, please contact Pamela Woods, PhD, MBA, RN, Principal Investigator, at pjwoods@salud.unm.edu or by phone at (505) 272-4258. You may also contact Kathy Davis, RN, MBA at kadavis54@unm.edu or by phone at (505) 220.1482.

6. RIGHTS OF RESEARCH SUBJECTS

If you have questions regarding your legal rights as a research subject, you may call the UNM Office of the IRB at (505) 277-2644.

7. PARTICIPATION AND WITHDRAWAL

Your participation in this research is entirely voluntary. You have the right to stop participating at any time, even after the interview is concluded. Refusal to participate will involve no penalty.

INITIALS OF RESEARCH SUBJECT OR LEGAL REPRESENTATIVE

I have read the information provided in this consent/authorization form. I have been given an opportunity to ask questions and all of my questions have been answered to my satisfaction. If I have questions later, I understand I can contact the investigators or the UNM College of Nursing.

BY INITIALING THIS FORM, I WILLINGLY AGREE TO PARTICIPATE IN THE RESEARCH IT DESCRIBES.

Subject's Full Name _____ Date _____

Subjects Printed Name

Researchers Signature

Appendix D: Chief Experience Officer Sample Job Description

Job Summary

The Chief Experience Officer (CXO) will serve as the senior executive responsible for leading the Health Care System's efforts to create and consistently deliver an exceptional patient experience. The CXO will develop and lead the organizational culture transformation needed to achieve and sustain excellent results at all levels of the system. The CXO will serve as a member of the senior leadership team. The CXO will develop and articulate an organizational patient experience strategy. The CXO will translate the strategy into an aligned patient experience infrastructure capable of delivering excellent results. The CXO will demonstrate extensive systems experience in order to lead, collaborate, influence, align and inspire system wide. The CXO will collaborate and partner closely with senior executives and stakeholder's enterprise wide to ensure cultural alignment, buy-in and smooth implementation.

Major Job Responsibilities

- Develop and align culture to support patient experience strategies.
- Ensure that priority patient experience performance improvement projects are identified and positioned to achieve results
- Drive performance results as measured by the voice of the patient and family in surveys, focus groups, and other sources. Skilled in benchmarking and interpreting external reports.
- Using national benchmarks, establish goals for patient experience performance results by organizational departments, functions, business units and regions. Articulate gaps to senior leadership. Develops and implements internal and external methods to share results and create transparency.
- Ensures provider and employee engagement is aligned with patient experience and collaborates with Human Resource Executives to develop shared strategies and tactics. Understand provider and staff levels of resiliency and capability to deliver on the patient experience strategy. you have some periods, some comma's and some with no punctuation. Pick one and stick with it
- Develops and oversees patient experience survey strategy to include data management, identification of adequacy of capturing the voice of the patient, benchmarking and internal reporting
- Participates and provides subject matter expertise into the development of healing environments to deliver services
- Expertise in analyzing and identifying patient centered technologies that enhance the patient experience
- Contributes to the development of professional training and development to ensure that the content reinforces the patient experience processes and best practices, and cultural content that reinforces the cultural transformation
- As part of developing the organizational strategy, assess and evaluate the patient interactions that occur via the electronic medical record and web site. Provide

recommendations to Marketing to ensure these technologies optimize the patient experience.
- Develop a patient centered model for the organization that includes patient and family advisory councils, e-patient advisors and other approaches using best practices.
- Assess executive, provider and staff incentives to determine alignment with patient experience and recommend modifications.

Position priorities and initial focus of the work:

- Develop and articulate a cohesive organizational patient experience strategy.
- Assess current performance. Develop and implement national best practice strategies and tactics to improve patient experience performance and position for success in value based purchasing programs.
- Assess the maturity and alignment of the patient experience and workforce experience strategy to determine readiness to evolve to an integrated human experience approach.

Key organizational relationships:

Reports to: CEO or COO

Key Colleagues: CMO, CNO, Chief Quality Officer, Senior Human Resources Executive, Strategy Officer, Marketing and Communications Executives

Departments Reporting:

Provides day to day management of Patient Experience Strategic Plan Manager, Patient Experience Improvement Advisors, Coaches and Patient Survey Analytics Team.

Position qualifications:

- Ten years of related Health Care leadership experience with progressive levels of accountability
- Experience at a senior executive level preferred
- Advanced degree in health care administration, nursing, medicine, public health, customer engagement or related field
- Experience developing strategic plans and creating a vision and approach to successful implementation to drive cultural transformation
- Proven track record of excellent performance to establish credibility with internal leaders, external constituents, providers, staff and patients
- Advanced knowledge of various survey tools, survey analytics, performance benchmarks and national best practices in the patient experience domain
- Advanced communication and presentation experience, to senior executives, boards, etc.