"It's not my data. It's my patients' data."

By James Furbush | July 5, 2016

When an organization makes a major change, getting buy-in from staff is a critical step — and a leadership challenge.

athenaInsight spoke with Bryan Hinch, M.D., chief medical information officer at the University of Toledo Medical Center, to learn how an academic medical center leader can encourage busy physicians to embrace data transparency and new technology — while fostering a culture of learning and safety.

Q How would you describe the culture at University of Toledo Medical Center?

A The frontline staff — whether it's the physicians, the nurses, whoever — understand that one of our main missions is our culture of safety. Second is going to be our academic mission.

Our residents drive a significant amount of the care that is delivered in our system, and we are very proud of that. There is significant oversight, but in order to become a full-fledged attending, the residents really need to be able to spread their wings. We have built systems to allow the residents to do that in a very structured, safe way for the patients. In our continuity clinics, our residents are seen as the primary care provider, and we ensure that the patient/doctor relationship develops that way, and we're kind of proud of that.

Q Can you give an example of how you foster that culture of safety?

A Over the past few years, our hospital leadership has really pushed the idea of transparency about patient safety events. The goal is to make our folks feel comfortable reporting events in such a way where they understand that it's not about blame. It's about identifying the event so that we can properly investigate through a systems-based approach — as opposed to an individual approach — to solving whatever led to the safety event.

Q How do you use data to measure and improve performance across the organization?

A Before you start asking what the metrics are, one of the questions you're going to have to

ask is how transparent you want to be with the data. At most institutions that I have been at, and UT is no different, there is hesitancy with the physicians and others to have complete transparency. Our senior leadership has made some commitments and decisions that more transparency is going to be better.

So now we have gone through the process of educating our docs how to access their own quality data, but it also means they may have access to their colleagues' data. In an organization that is trying to foster collaborative care, that is critical. Because in my mind, it's not my data. It's my patients' data, and I need the specialists to move the mark on some of these metrics. We're in the process now of really engaging our physicians so they understand how to access that data.

I am a big believer that you need the right information at the right time, [delivered] to the right person and in the right format, to be able to make the right decision.

Q How do you get physicians to buy in when there's a transition of this magnitude? Does buy-in matter?

A I think it matters very much. Without physician engagement, we're not going to be successful in almost any endeavor. The physicians are our thought leaders, and people look up to them. It's a challenge, not because the physicians don't want to be engaged, but because they are just so busy.

At an academic medical center, you're not just tasked with providing direct patient care. You're tasked with teaching. You may have a significant amount of time doing research. And on top of that, you've got a guy like me coming along saying, "I want more of your time."

The challenge is: How do you approach physicians in such a way where they understand the value of devoting time that is very tough for them to carve out? We have tried to do it a number of ways, and we have been successful and we have failed. We reach out through emails, which is usually not the best way to go, but sometimes the best way to reach a large number of folks. I have reached out personally, where I make phone calls or have face to face meetings and have discussions. And we'll have meetings where we just invite anyone that wants to show up to give their input. I think you need each of those modalities, because you're going to reach the providers in a way they want to be reached.

The other thing you have to be cognizant of, with physician engagement, is that you have to close the loop with them and follow through on something that you say you're going to do to the best of your ability. If a provider reaches out for help, we do the best we can to circle back and either complete the task or explain to them why it can't be done.

There are just some things that we have to say "no" to, because of resource constraints, or the technology is not available, or it's too expensive. But I think making sure that they understand why you're saying "no" is critical.

Q How would others in the organization describe your leadership style?

A What I hope they would say is that I listen and that I have a shared decision-making model. In describing how I do things, I always come back to Star Trek. For those who know the show, you could either be Kirk or you could be Picard. My model for decision-making is more the Picard model, where you come across a problem, you gather the senior folks who are the stakeholders and knowledge content experts, you have a discussion, and oftentimes the solutions become self-evident.

That doesn't mean that you never need Kirk. Sometimes you have to make a decision either quickly or imminently. However, most of the time you really do need to take an approach where you gather the information from the folks who know the best. And it's not just, say, senior leadership. Oftentimes it's the frontline

staff whose input you need in some way to shape, or form, or inform your decision-making. So, my hope is that I am more of a Picard.

Q **Speaking of boldly going where no one has before, UT's new cloud-based inpatient initiative is quite bold. Can you give us insight into how it came about?**

A We took about eight months to evaluate the decision — and it was not unanimous, because there were concerns about risk in change management. The feeling was that maybe we should take the easy way out, so to speak. We did our best due diligence in evaluating timelines, budgets, and our own goals as to what we wanted to achieve with swapping out the inpatient system. Patient safety and our learners were topmost in our thought process, but the flow of information, the accessibility of information across the inpatient and outpatient space, was also critical.

What won the day was the significant enough satisfaction that the product that we would get on the inpatient side would also be enough to satisfy our physicians' needs, and probably exceed their expectations.

It's something that the entire institution is incredibly excited about. We are basically implementing an EHR, physician order entry, physician documentation, nursing workflows, as well as looking at our pharmacy system and the surgical management system being replaced and implemented within the next year and a half, if not a little bit longer. We're excited about this and we understand that there is a little bit of risk, but we feel that that risk is worth it because of the advantages.

Q **Are there any companies or industries that inspire you, or that healthcare can emulate?**

A One company we can learn from is Disney, because of their focus on a quality experience for their end user. For Disney, the customer drives their decision-making. At UT College of Medicine, if our end users are our patients and our learners, we have to make sure that we keep the focus on them.

Interview was condensed and edited. James Furbush is managing editor of athenaInsight.

Photo courtesy of the University of Toledo Medical Center.