IMPLEMENTATION IS A CONTACT SPORT

Interview with: Baptiste Shunatona MD, OMNI Medical Group

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Bat Shunatona MD

... short story... assistant medical director for knowledge management—wears two hats for his organization: full-time office-based family practice and part-time innovator who links operations management with primary care

footprints: Application of the scientific method for primary care operational issues | **key areas of interest & expertise**: lean production and theory of constraints, reliable process, project management

key guides & inspirations: Institute for Healthcare Improvement (IHI)| **motivations & passions**: "Innovate locally and learn nationally," office visit access for primary and specialty care | **what makes it all worthwhile?** when the data and processes help people

Q: Bat, we always love talking with you and learning from you. What one or two issues would you like to address for this interview and why?

A: The Knowing/Doing Gap. What "ought to be" frequently isn't, and it's not always easy to go from "ought to" to "is."

Q: Go ahead and expand on your topic:

Let's assume you know what should change. Making it happen involves all the human stuff. Leaders design changes, but frequently change does not occur. Frequently leaders react by "reminding" their staff about how important things are. When things don't change leaders may conclude the staff is at fault or that they need to re-plan. Most of the time the answer (assuming you are correct about the need to change) is to be very creative about implementation. And frequently an important part of the answer is to provide effective feedback. And the feedback has to be actionable with appropriately short feedback loops.

Let me give you an example. From IHI, we learned about reliable processes. We chose pneumococcal vaccination as our initial project. We have rapidly gone from rates ranging from 20% to 40% to a 96% success for vaccination rates at Omni, and we are sustaining that change. We piloted the process changes in one practice, and then rolled it out. We used standard, formal methods with key points, flow charts, scripting and making sure the medical assistants knew why and how to make the change. We are using the MA's improved skills to improve mammography rates in a similar project. We are also working on a standardized appointment-making process using the same basic approach.

> *"Understand why the system is the problem; not the people…Focus on the process… Reward what you want more of…"*

I should emphasize that each project is unique. For example, improving the process for taking blood pressure is a lot easier than ensuring that BP goals are met. There are many possibilities that could explain differences in clinicians' rates in their BP control. In practices where the physicians recheck and re-record the BP readings after the MA, we know the BP readings will almost always be better. We are not sure about why this is, but this is an important area we are exploring. The behavior could be explained by a focus on ends instead of means. Just imagine the difference between pay-for-performance and pay-for-follow-the-process. Consider that my coronary artery disease patient has tried and failed multiple three anti-hypertensive drug combinations. Is that an acceptable blood pressure outcome instead of just repeating the measure over and over in the clinic until I get the number that I want?

Q: What advice do you have for professionals who are interested in improving work processes.

A: I would advise folks to start by learning some simple principles and methods by reading something like "Quality for Dummies." Learn about quality by design and quality by inspection. Understand why the system is the problem; not the people. Then do projects starting with plans and pilots.

Q: Can you give us some other key points?

A: Sure.
1. Managers and doctors don't want theory.
2. Implementation means dealing with the "messy human stuff."
3. Appointment schedules are extremely personal.
4. Consider making the use of evidence a core value in your group.

Q: If you had one wish for an ideal, what would that be? Or a vision? However you want to answer this...

A: United States would shift from a doctor-centered and specialty-centered system to become a patient- and primary-care based health care system.

Q: What would it take for that to happen?

A: Reward what you want more of.

Q: What do you see as potentially helping medical leaders and others with what you've selected to address?

A: Every day, more care is delivered by office-based primary care doctors than any other setting. Yet the improvement dollars are going to ICU's, ED's, etc. Think upstream.

Q: Do you have favored resources for any groups on the topics you are addressing?

A: IHI website, free to register and constantly updated, including the tantalizing "emerging content."

Q: Do you have other general favored resources? Medical or otherwise?

A: When possible, read the original (Deming, Drucker, etc.).

> ***"Most of the time the answer is to be very creative about implementation … provide effective feedback, which has to be actionable, and use short feedback loops…"***

Q: Any <medical leaders . org> interview candidates that you'd like to hear from?

A: Kim Pittenger (Virginia Mason/Lean), Brent Jaster (Group visits), Mike Davies (primary and specialty care access), David Kendrick (local OU med school faculty, collaboration)

Q: Do you have a favorite story for us?

A: Arthroscopic lavage and debridement for DJD of the knee is a good one. Clinicians started doing it without good evidence and reported observations that it worked well. Orthopedic guidelines recommended it as a useful procedure and cited fatally flawed studies as evidence. Later, a randomized, patient-blinded trial comparing debridement and lavage to sham showed that the procedure does not work. Many physicians continue to favor the flawed studies which reported benefit. This is an example of non-use of reliable science. There is a huge need for physicians to improve their skills in acquiring and using reliable evidence.

Q: And almost lastly, the best medicine is to be happy, yes? What's your favored flavor-of-the-moment to make you or any of us more happy? Toss us a little tidbit from your medicine cabinet, please.

A: Happiness as *summum bonum*…focus on the process not the outcome.

Q: Now tell us something fun about you?

A: I'm an out of work accordion player and was fired from my last band over "artistic and creative differences."