NEW YORK STATE | Department of Health | Medicaid Redesign Team

The New York State Medicaid Accelerated eXchange (MAX) Series

A state-level approach to effectively turn policy into practice using a Rapid Cycle Continuous Improvement (RCCI) methodology

New York State Department of Health, United States


Identification
Planning
1
Standardized Care Plan
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Cracker Jack Care Planner
3-in house on March 1st
Ground Rules

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Introduction

Turning policy into practice can be challenging and slow, particularly related to large scale change such as healthcare delivery system transformation. While individual approaches and regulatory methods vary, virtually all federal and state healthcare policy focuses on achieving the Triple Aim of better health, better outcomes, and lower cost. Although it is the legislator setting the stage, it is the provider community that must ultimately translate the policies into practice.

While governments develop and issue policy, it has traditionally been the role of the market to find innovative ways to implement and execute on the given direction. Approaches to implementation are also typically not prescribed by the government since change is dependent on, and must be sensitive to, local context. However, by investing in evidence-based tools, frameworks, and methodologies that allow stakeholders to define, own, and implement their desired future state, Medicaid programs across the United States can increase the chances of turning policy into the intended outcomes.

The Rapid Cycle Continuous Improvement (RCCI) methodology is a highly structured and dynamic program which can provide state and local governments with a framework to drive change at the local level and turn policy into practice. It is a data and results-driven approach which facilitates interdisciplinary collaboration around a specific topic, with the goal of generating and testing locally relevant solutions, while leveraging existing budgets, infrastructure, and workforce. The program helps teams of multidisciplinary providers improve their processes in a compressed timeframe of eight to ten months to ultimately reduce cost, improve quality, and increase satisfaction of both patients and workforce. Throughout the program, frontline providers are placed in the lead to make changes at a local level through a series of self-defined action plans that adhere to Plan-Do-Study-Act (PDSA) principles.

As part of the Delivery System Reform Incentive Payment (DSRIP) program, the NYS Department of Health launched its own RCCI approach - the "MAX (Medicaid Accelerated eXchange)" to redesign the way care is delivered for New York State's most vulnerable individuals. The MAX program supports New York's five-year DSRIP effort, which was launched in 2014 and continues until 2020. Major aims of the DSRIP program include reducing avoidable hospital use by 25 percent over the program's duration, stabilizing the state's healthcare safety-net system, improving integration of care across the continuum, and shifting to value-based payment models. To date, the New York State MAX teams have reported reductions in hospitalizations ranging from 20 – 74%[1], decreased wait times, reduced cost and improved quality.

This document serves to transfer knowledge and share lessons learned from the New York State MAX program for those working on process improvement initiatives in the health and human services industries and beyond. We start by briefly outlining the goals of the DSRIP Program. Next we delve into the RCCI methodology and framework for effecting change and discuss how the MAX program is currently being leveraged in New York State as a tool for healthcare professionals to close the gap between policy and practice, and discuss preliminary results. Finally, we end this document with the methodology's key differentiators and outline how it can be deployed to aid governments in supporting their communities in high-paced, high-stakes, transformation projects.

[1] *Decrease does not account for the historical regression to the mean*

The NYS DSRIP program

On April 14, 2014, New York State finalized the terms and conditions with the federal government for a groundbreaking waiver agreement that allowed the state to reinvest $8 billion in accumulated federal savings to address critical healthcare issues and allow for comprehensive reform through a Delivery System Reform Incentive Payment (DSRIP) program. The New York DSRIP program is a multifaceted approach aimed at creating integrated delivery networks of care and significantly improving health outcomes for New York State's 6.4 million Medicaid members and an estimated 1.5 million uninsured citizens. DSRIP specifically targets a 25 percent reduction in avoidable hospital use over five years by improving access to appropriate care and shifting the focus of care to communities, away from costly acute inpatient and emergency department (ED) services. Key themes in the program are integrating behavioral and social services into medical and physical healthcare locations, building up primary care capacity, setting up cross-provider evidence-based protocols, and sharing of real-time data within and between the integrated delivery networks, known as Performing Provider Systems (PPSs). At the time of writing this document, New York State has progressed into the third Demonstration Year (DY3) of the 5-year DSRIP period (DY3 started on 4/1/2017).

How NYS is deploying RCCI through the MAX program

The NYS Department of Health launched its approach to RCCI as the Medicaid Accelerated eXchange (MAX) program to support PPSs in their efforts to redesign the way healthcare is delivered. The key objective of the MAX program is to support the interdisciplinary PPS teams to accelerate their ability to achieve sustainable reductions in hospital admission and emergency department use. Through offering a series of RCCI workshops focused on improving care, the MAX program supports the goal of transforming the system by strengthening care collaborations and getting patients the right care at the right time. By understanding the drivers of high utilization, patients are directed to appropriate community providers and resources while promoting the more efficient use of hospitals for emergent and acute level services.

MAX is aimed to bridge the gap between policy and practice. While it benefits regulators and policy makers, it is designed to engage, inspire and activate frontline professionals who are working with patients on a daily basis, and allow them to champion change in a manner that best suits their own practice's needs.

The MAX program was launched in the summer of 2015 and since the introduction, has engaged with 45 action teams, including over 450 frontline care and social service providers. To date, New York State has run the MAX program on two topics: "integration of primary care and behavioral health" (10 action teams) and "improving care for High Utilizers" (35 action teams). The latter topic was run several times, first focusing on High Utilizers (HU) in the Emergency Department (ED), and subsequently on HU in the inpatient (IP) setting. This document focuses specifically on the impact of the MAX program on the HU patient group.

- **0.5% of New York State's Medicaid Enrollees are defined as High Utilizers[2].**
- **The High Utilizer population accounts for 20% of inpatient admissions by Medicaid enrollees.**
- **The average spending per High Utilizer recipient over a one-year time frame is approximately 21 times greater than for non-high utilizer recipients.**

These statistics support the need for meaningful transformation. Tackling the High Utilizer challenge, therefore, yields a significant opportunity to move the dial on key DSRIP measures, and should help New York State reach its goal to reduce avoidable hospital use by 25% over five years.

In the following section, we'll describe the MAX methodology, after which we outline early results.

> *The MAX series is providing me with the real stories and evidence of the impact DSRIP is having at the frontline and the benefit it is creating for both patients and staff*
>
> **Dr. Douglas Fish**
> NYS DSRIP
> Medical Director

[2] *Fully enrolled Medicaid members with 3+ IP Admissions and/or 6+ ED Visits within a two year timeframe*

The MAX RCCI methodology

The MAX program consists of three phases: Assessment and preparation (phase I), workshops and action periods (phase II), and reporting (phase III).

In phase I, the focus area (challenge or topic), subject matter professional (SMP), and action teams are identified. Phase II, the core of the program, consists of three workshops and action periods where locally relevant changes are made, tested, and adjusted during short Plan-Do-Study-Act (PDSA) cycles to optimize and accelerate results. The program has a strong, data-driven foundation and draws from tested methodologies, such as business process design, lean, root cause analysis, theory of constraints, and change management. The program concludes with phase III where teams report on results achieved and develop plans to sustain change.

The following section outlines key considerations for each of the three phases.

Phase I – People: The importance of preparation

The first step in setting up an RCCI program is to hone in on a particular challenge or topic. Is the problem identified? Is there a clear goal and view of what success would look like? Is there a sense of urgency? Once those questions are answered, a potential range of solutions are identified, including a target population (if applicable). As part of the RCCI approach, an on-site visit is conducted to understand the local challenges and current state processes prior to the workshops. Finally, the assessment and preparation phase is used to establish an understanding of baseline metrics which are used to determine future progress towards goals.

People are the true key success factor of MAX, below we describe the main roles represented in the program.

The executive sponsor

This role is crucial to the success of the action team, as well as to the sustainability of the program. Executive sponsors provide overall accountability, sponsorship, and championing of the program. They have the vision on what an improved process should look like and can remove barriers that may prevent the team from being successful.

The action team

A multidisciplinary action team is assembled, comprised of 8 – 10 individuals who are well-suited to address the identified challenge and participate in key program activities. Action team members should represent different areas of expertise (such as clinical, administrative, and information technology, for example), as well as the organization's most pertinent key players to the topic identified. It is important to build an action team with the appropriate balance of individuals who are at the frontlines of the primary process, are action-driven, are open to change, can hold the team accountable, and who have decision-making power. Action team composition may change over the course of the program due to evolving team needs.

The program is purposefully designed to be delivered at a rapid pace and be highly engaging. This is what sustains the action plans and decisions which come out of the workshops. Careful consideration in selecting the appropriate people to involve on actions teams is critical to the program's success.

The topic subject matter professional

Depending on the topic at hand, as well as the scope of the work, an external or industry subject matter professional (SMP) is identified. The SMP helps to tailor program content to the identified topic, shares leading practices and resources from the industry, helps monitor progress and outcomes, and provides ongoing program support. For the MAX program, Dr. Amy Boutwell was identified. Since 2008, Dr. Boutwell has been deeply immersed in the clinical, operational, policy, payment and political aspects of approaches to reduce avoidable hospitalizations, and improve care transitions.

Phase II – Process: Highly-structured and dynamic workshop series to drive results

Action teams are challenged to drive change and accelerate results throughout the workshops and "action periods," which are made up of PDSA cycles. They are supported through weekly coaching calls, continuous access to subject matter expertise, performance measurement, and additional touchpoints. These educational opportunities include periodic virtual meetings, shared learning via online collaborative platforms, on-site visits, and webinars.

Workshops

Workshops are fast-paced and planned to the minute

The MAX program consists of three intensive, in-person workshops designed to bring action teams together to rapidly generate plans to improve local processes. Workshops are fast-paced and planned to the minute, alternating between plenary and breakout settings. In the plenary sessions, RCCI theories such as business process design, lean, PDSA, theory of constraints, and change management are covered and tailored to the topic. Immediately following a plenary session, action teams move to breakout groups with their respective facilitators for activities aimed at generating improvement ideas to address gaps and challenges in the local current state. Governing the workshops are "ground rules" outlined at the beginning of each session that encourage action team members to actively participate. The ground rules culminate in the overarching theme for the MAX program – **you must make a change**!

By the end of the day, each action team has generated three concrete and measureable action plans to be implemented immediately following the workshop in the action period. A workshop summary report, which captures key takeaways and outlines the three action plans, is created by the facilitator and shared with the action team following each workshop as a demonstration of the work committed, and as a reminder to the teams as to what they will be held accountable to.

Action periods

Action periods are where policy truly turns into practice

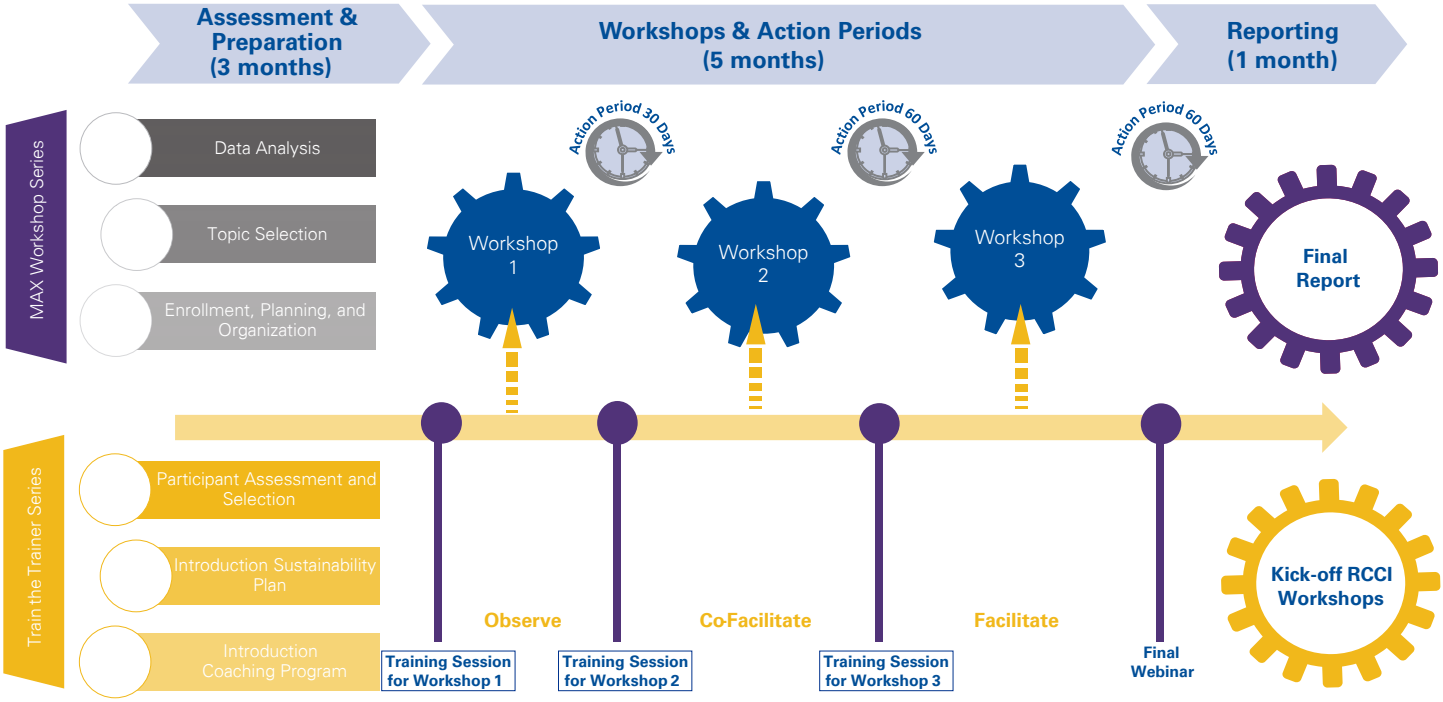
While the action teams and intensive workshops are designed to build consensus and momentum around a solution, the action periods are where policy truly turns into practice.

Each of the three workshops in phase II are followed by a PDSA cycle or action period. During this time, action plans generated during the workshops are implemented by the action team and progress is monitored and measured. Changes to local processes are made, tested, and adjusted over compressed time periods where action period one is 30 days, and action periods two and three are each 60 days (the length may vary based on the selected topic). The first cycle is focused on achieving quick wins. During this time, the expectation is that action teams build confidence in their process improvement capabilities. Action plans in cycle two are typically focused on detailed process redesign. The third and final workshop and action period are designed to build out concrete plans on continuous and sustainable process improvement.

Train-the-trainer program

A train-the-trainer (TTT) program complements and directly aligns with the three phases of the workshop series. This option is designed to scale and sustain process improvement work by training participants in the RCCI principles used in the workshop series. It provides them with the tools and frameworks to independently lead their own workshops and follows a "See one. Do one. Lead one" approach. Participants are paired with an action team, and subsequently observe, co-facilitate, and ultimately facilitate workshop and action period activities (see Figure 1).

***Figure 1**: MAX workshops and train-the-trainer process with 30-60-60 day PDSA cycles*



Phase III – Outcome: Data, measurability, and accountability

What you cannot measure, you cannot manage. Analytics play a pivotal role in the MAX program, as teams use data to inform change and decision-making, as well as guide testing and implementation. Action teams measure a baseline and over the course of the program, subsequently drive, measure, and analyze informed process improvement initiatives and report on them. Measures are categorized as follows:

- **Structure:** The initial action plans are frequently aimed to create capabilities that successively build out process improvement initiatives. These measures can be simply answered with a "yes" or "no" (is the structure in place?) and are rapidly followed by process and, eventually, outcome measures to drive results.
- **Process:** Measurement of particular volumes, (such as daily HU presented at the ED and the inpatient unit), throughput, and wait times are essential to guiding implementation and identifying opportunities.
- **Outcomes:** These are the ultimate measures which demonstrate impact. These measures can be quantitative (comparison of baseline when program started vs after new process was implemented), as well as qualitative (success stories related to the target population or feedback).

The group aspect allows action teams to challenge and inspire each other, and share lessons learned. In addition, sharing program progress in the MAX workshops results in healthy competition across the teams.

Results to date

The MAX program provides New York State with a standardized methodology to change the way care is delivered for Medicaid's High Utilizers. By putting frontline providers in the lead to design and implement change, the impact of DSRIP policy and its intended outcomes increased, while simultaneously accomplishing higher provider satisfaction, and better patient outcomes in the cohorts observed. While the results presented below are promising, the observed effects represent the short-term benefits of the program. Further roll-out of the program and performance measurement will continue over the course of 2017 and beyond.

Quality improvement: Definitive and timely linkage of patients to appropriate services

The action teams which participated in the MAX program on improving care for High Utilizers represented a diverse set of hospitals and practitioners from a wide range of communities across the State of New York. Despite this heterogeneity, the intensive work to improve care for High Utilizers using the RCCI methodology resulted in a remarkably consistent set of necessary capabilities and feasible actions. All action teams implemented the five steps below and built new patient care pathways:

1. Define, quantify and identify the target population
2. Form an inter-disciplinary, cross-continuum action team
3. View recurrent utilization as a symptom of unmet needs and "do something different"
4. Follow up to help ensure stability
5. Measure to drive implementation and results

One of the most notable concepts of the MAX program to improve quality was the recommendation that action teams systematically pursue the "driver of utilization" (DOU), or root cause, for High Utilizers. The DOU is not the chief complaint, or the complex medical history, but rather the human, individual reason the patient comes to the hospital so frequently. Action teams first considered whether there were opportunities to better identify and address the symptom of recurrent utilization, using the following considerations:

- *Are we looking at the big picture – the patient in context, the patient over time?*
- *Are we accepting responsibility for addressing psycho-social needs?*
- *Are we perpetuating a recurrent pattern of utilization by repeating the same evaluation and the same plan, time and time again?*

Next steps after this root cause analysis were to "do something different" and follow up to help ensure stability, with the ultimate goal to definitively and timely link High Utilizers to appropriate services outside of the hospital setting and improve the quality of care by addressing the patients' social and behavioral needs. **This resulted in more meaningful engagement with interdisciplinary, cross-setting care teams for all participating MAX teams** (see textbox 'New partnerships').

> *MAX is truly changing the trajectory of human lives*
>
> **Jason Helgerson**
> NYS Medicaid Director

New partnerships

All action teams reported establishment of community partnerships through the MAX program. A few of many examples include new collaborations between hospitals and:

1. **Food agencies**, through implementing a food pantry in the hospital.
2. **Managed Care Organizations (MCOs)** by embedding a MCO Care Manager in the ED.
3. **Homeless shelters**, leading to tactical improvements (a nightly bus that picks up homeless people from the ED) and high-level investments (a city-wide homeless initiative).
4. **School districts** to keep adolescent High Utilizers with behavioral problems out of the hospital.
5. **Social service agencies**, using shared calendaring and collaborative case conferencing.
6. **Health homes** by placing a representative directly in the hospital to build comprehensive transition of care processes.

Case Study: Southside Hospital

Intro: Southside Hospital (SSH) is a 341-bed tertiary hospital located in Bay Shore, NY. When SSH joined the MAX program, they did not have any processes in place to specifically identify, assess, and manage their High Utilizer (HU) population. Their initial HU patient population consisted of 144 patients, who accounted for 891 ED Visits and 680 inpatient (IP) admissions in a 12-month period.

Many of SSH's High Utilizers faced challenges within the community, including a lack of housing, barriers to transportation, low health education, and poor connectivity to mental health and substance use services. As a result, High Utilizers were frequently left to navigate the healthcare system on their own, leading to high rates of hospital utilization, readmissions and non-adherence to hospital discharge plans.

Quality improvement: The MAX program enabled the SSH action team to create new processes that resulted in more effective cross-continuum collaboration between key individuals and organizations working on behalf of the patients. Within the hospital, the action team increased communication and joint problem-solving between multiple departments through daily huddles where plans were developed to engage and address the needs of High Utilizers who were currently admitted. Outside of the hospital, the action team established a shared calendaring system with the Family Service League, a social service organization that provides connection to social and mental health services. The integration between entities led to a "culture change," where the hospital acknowledged and addressed the patients' social and behavioral issues, in addition to their medical issues.

"This program helped us break down silos and work together in new ways to meet patient needs."

Reduction of avoidable hospital use: Over the course of eight months, SSH saw a **60% drop in the IP admissions** among a representative sample of its HU patient population.

Cost reduction: Decrease in avoidable hospital use

The qualitative results of the new patient care pathways go hand-in-hand with quantitative outcomes. The MAX program measurement strategy has developed and standardized overtime since the participation of the first action teams. To understand baseline and volumes, it was essential to bring visibility to the full group of patients who presented to the facility. In the initial series, the threshold for High Utilizers was set as patients who had been hospitalized four or more times in the past 12 months prior to the MAX program and/or visited the Emergency Department (ED) 10 or more times in the past 12 months. In subsequent series, this threshold was shifted solely to the inpatient setting, to accommodate the focus of the program where intervention was more likely to take place.

Process measures were registered and analyzed on a monthly basis to answer key questions such as: *How many patients presented? How many admissions did they have? And did the patients receive a specific intervention (did the provider "do something different"?).*

Action teams in the first 2016 MAX program (6 teams) reported an average, aggregated **decrease in monthly ED utilization by 44%**. In measuring the pre vs. post-MAX intervention outcome utilization in the subsequent 2016 series (7 teams), action teams reported a **decrease in overall hospital utilization between 20% and 74%**[3].

In addition, for the 2017 program (22 teams), 30-day all-cause readmission rates and pre vs. post utilization outcomes will be measured.

[3] *Decrease does not account for the historical regression to the mean*

Case Study: Champlain Valley Physicians Hospital (CVPH)

Intro: Champlain Valley Physicians Hospital (CVPH), located in Plattsburgh, NY, is the largest healthcare provider and employer in New York's North Country. Due to significant primary care access issues and care delivery network disconnection, High Utilizer patients in the North Country were frequently left to navigate the healthcare system on their own, contributing to high rates of hospital utilization, readmissions, and non-adherence to hospital discharge plans. CVPH's initial High Utilizer patient population consisted of 91 patients, who accounted for 1,245 ED Visits and 243 IP Admissions over a 12-month period.

Quality improvement: From the start of the MAX program, the CVPH action team established a unique team structure that included several community-based organizations and representatives from local government. The action team then developed highly integrated workflows between the hospital and its community-based partners. This included a real-time alert notifying both the in-hospital care team and relevant community-based partners when a High Utilizer presented to the ED. The enhanced integration between entities paved the way for an unprecedented level of care coordination shifting the culture of care from visit-based services to holistic, community-based care planning.

Patient Feedback: Several of CVPH's High Utilizer patients have provided feedback to the team that the persistence and hard work of the case workers and the care team have improved their quality of life. In some patient cases, decreases in hospital utilization were only seen after prolonged and repeated attempts to engage the patient. Several of these patients conveyed a deep sense of gratitude for the members of the action team whose willingness to help made a difference in a difficult period of the patient's life.

"If it wasn't for you coming into my home and making me feel normal, I would have never started this journey." – High Utilizer patient

Reduction of avoidable hospital use: CVPH found that there was no single solution to reducing hospital use for the High Utilizer population. Instead the action team needed to take an individualized approach to each patient and build a trusting relationship based on mutual respect and understanding. Through a variety of strategies, CVPH **reduced hospital utilization by 74%** for a representative sample of their High Utilizer patient population.

Sustainable change: RCCI capability

In New York State, MAX was positioned as a "program," not a "project." It was designed to leave teams with the skills and tools to continue their process improvement work after the facilitated workshops and action periods concluded.

As part of the requirements for participation in the MAX program, all action teams committed to continuing process improvement work beyond their involvement in the current program. To that end, each action team created an action plan in the final workshop to hold a "Continuous Improvement Workshop." Many teams have reported using the methodology for different process improvement challenges, and **100% of the action teams convened or planned their own RCCI workshops upon conclusion of the program**.

In the 2017 MAX program, the **train-the-trainer program** component was added to scale and sustain process improvement work across New York State. Participants who sit outside of the action teams are educated in the RCCI methodology using the "See one. Do one. Lead one" approach to workshops and action period activities, while also being provided with the tools and framework to lead their own independent RCCI workshops upon completion of the program.

I use the MAX TTT lessons learned in all my meetings nowadays. We never walk away without concrete action items, deadlines and owners.

Case Study: Ellenville Regional Hospital

Intro: Ellenville Regional Hospital (ERH) is a 25-bed, critical-access teaching hospital located in Ulster county, a rural area of the Mid-Hudson Region. ERH is physically adjoined to a satellite location of The Institute for Family Health (IFH), a Federally Qualified Health Center (FQHC). A significant portion of ERH's High Utilizer population was frequently using the hospital due to chronic pain. These visits were often resulting in the administration and/or prescription of opiates, which reflected a rise of opioid abuse in Ulster and adjacent counties. ERH's High Utilizer patient population consisted of 64 patients who accounted for 418 ED visits in a 6 month period.

Quality improvement: To reduce the number of patients presenting to the ED for the management of chronic pain, the ED staff and hospital administration implemented a standardized, chronic pain policy. The new policy avoided the dispensing of opioid-based medications for patients presenting to the ED for chronic pain. The policy was approved unanimously by ERH's medical staff and then disseminated to the community providers. The standardized practice guidelines helped deter the administration of opioids in the ED and allowed providers to leverage a standard policy for opioid decisions. The policy was applied to all chronic pain patients (the population) and the cohort is a proxy for the impact on the entire population.

Another key element of the action team's success was the integration of workflows between ERH and the IFH. Following the chronic pain policy change, ERH implemented a workflow that resulted in the deployment of an IFH Care Navigator to support the coordination of follow-up appointments for the High Utilizer patient population. The participants believe the project could be easily replicated in other hospital emergency departments in collaboration with local primary care providers.

Community impact: ERH's efforts in the MAX program have impacted both the High Utilizer patient population as well as the surrounding community. The team's efforts increased provider awareness of the HU population and provided a forum to communicate leading practices, increased provider and community collaboration, and boosted staff morale.

Outcomes: The implementation of a standardized chronic pain policy resulted in an **80% drop in the opioid orders prescribed to ERH's High Utilizer patient population in the ED**.

MAX key-differentiators

Policy into practice through tested methodologies

Systematic review of available literature shows that interventions deployed to change processes and behavior in the healthcare setting are often poorly designed or inadequately specified (1,2). The less a policy is effectively translated into required practical change at the ground level, the less likely it will meet its objectives, thus wasting resources and risking a decline of stakeholder buy-in for subsequent efforts (3). This is true across all industries.

The MAX program, of combining elements of widely accepted methodologies in process improvement, brings policy into practice, while simultaneously giving the NYS Department of Health insight into the impact of transformation efforts and the ability to draw from examples and lessons learned throughout the process. In this way, the program creates a "two-way street" for successful reform implementation.

Minimal frontline investment

In an ideal world, time and money would be set aside and teams would start with a blank sheet of paper to design the perfect process. But that is not the world we live in, nor the playing field the MAX action teams face. However, "we've always done it this way" or "we're doing everything you're suggesting already" are common refrains, yet staff continue to experience frustration in their roles and in processes as there remains ample room for improvement.

Teams achieve more in 8 months than they would ever imagine at the start of the program. MAX is providing them with that first step to change

Peggy Chan
NYS DSRIP Program Director

The MAX program re-channels efforts in current processes to actions that streamline and optimize those processes. Upfront, the boundaries of the solution are defined with the executive sponsor. Generally, the MAX workshops assume no ability to change existing budgets, infrastructure, or workforce. Action teams are guided throughout the workshops to create action plans within their "sphere of influence." Longer term solutions, or initiatives that require significant resources, are set aside or escalated outside the program. The focus of the program is not on developing perfect plans, but rather short- and medium-term benefits, building momentum, and getting started "with what you have."

Quantifiable impact and waste reduction

Taking frontline providers out of their day jobs, away from their patients, can only be justified if results and impact are significant. Implementing reform is too frequently approached in an uncoordinated, fragmented manner resulting in additional workload for all involved. When new processes are implemented, previous practices are more often kept in place, which not only creates waste, but immediately defeats the purpose of "process improvement." Change requires significant effort, and should therefore build upon a clear vision and understanding of the expected impact.

Before the start of the MAX program, a realistic target is defined with the action teams. Action plans and overall goals are always translated into quantifiable aims. Additionally, the question "What will you stop doing?" is asked as a prerequisite for sustainable, workshop outcomes. Finally, the participants in the MAX and train-the-trainer programs and their organizations benefit from the investment in their own capability to lead and implement change. This allows the impact to excel beyond the immediate, specific action period and influences how participants perform in their daily roles.

People and data-driven change management

Measure what is important. What you cannot measure, you cannot manage. Motivation and inspiration are critical to effective management.

As mentioned, throughout the workshop and action periods, data are collected and measured to understand the impact of action plans (and adjust where necessary during the PDSA cycle), as well as to follow progress on consolidated program measures. A crucial element of the MAX program is not to just measure and perform data analysis for the action teams, but to offer it as an integral educational module within the series to help teams continue the work with control charts, run charts, and additional data and analytical techniques after the program has concluded. In addition, qualitative data are collected to facilitate the translation of policy into practice. These real-life stories are often the most powerful aspects to the program and are what brings policy to "life." This dual approach provides sound insight into change, as well as ongoing inspiration for those asked to implement it. To reflect the importance of the balance between data and people, one of the MAX ground rules is: "When you've reached your target, you must celebrate!"

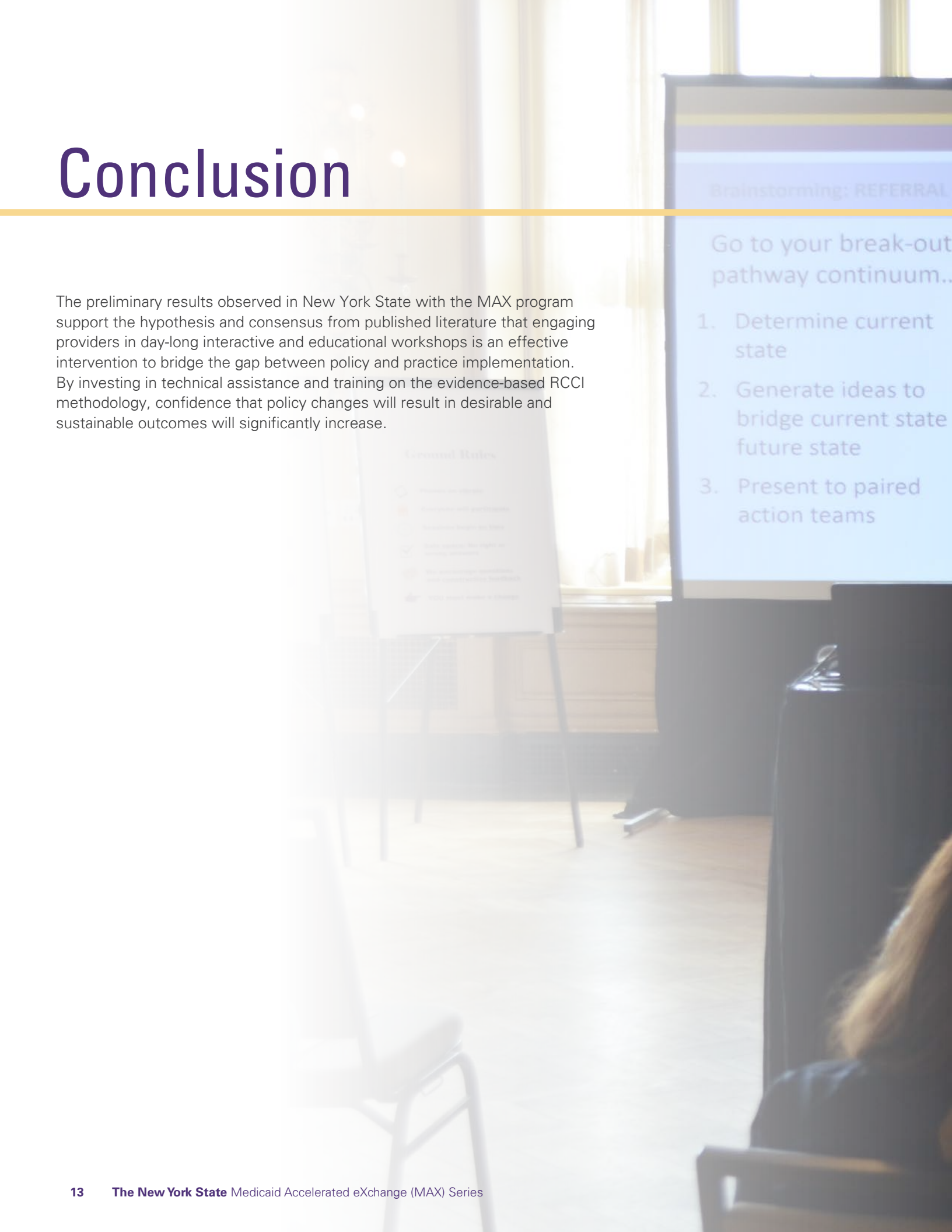
Focus on sustainability and scalability

The consensus from published literature shows that engaging providers in interactive and educational workshops is an effective intervention to close the gap between policy and practice (4). However, the more intense the intervention, the more effort it takes to scale and sustain change.

The MAX program is designed to accommodate multiple action teams working simultaneously across the state. Working at scale has the additional benefits of generating cross-learning, more rapid and consolidated policy implementation, and healthy competition. Additionally, the TTT program allows participants to scale the program for widespread impact beyond the life of the initial RCCI series. It establishes local system leaders as RCCI knowledge professionals, equipped with the tools and experience needed to continue transformation efforts independently and to maximize the legacy benefits of the MAX program.

Conclusion

The preliminary results observed in New York State with the MAX program support the hypothesis and consensus from published literature that engaging providers in day-long interactive and educational workshops is an effective intervention to bridge the gap between policy and practice implementation. By investing in technical assistance and training on the evidence-based RCCI methodology, confidence that policy changes will result in desirable and sustainable outcomes will significantly increase.

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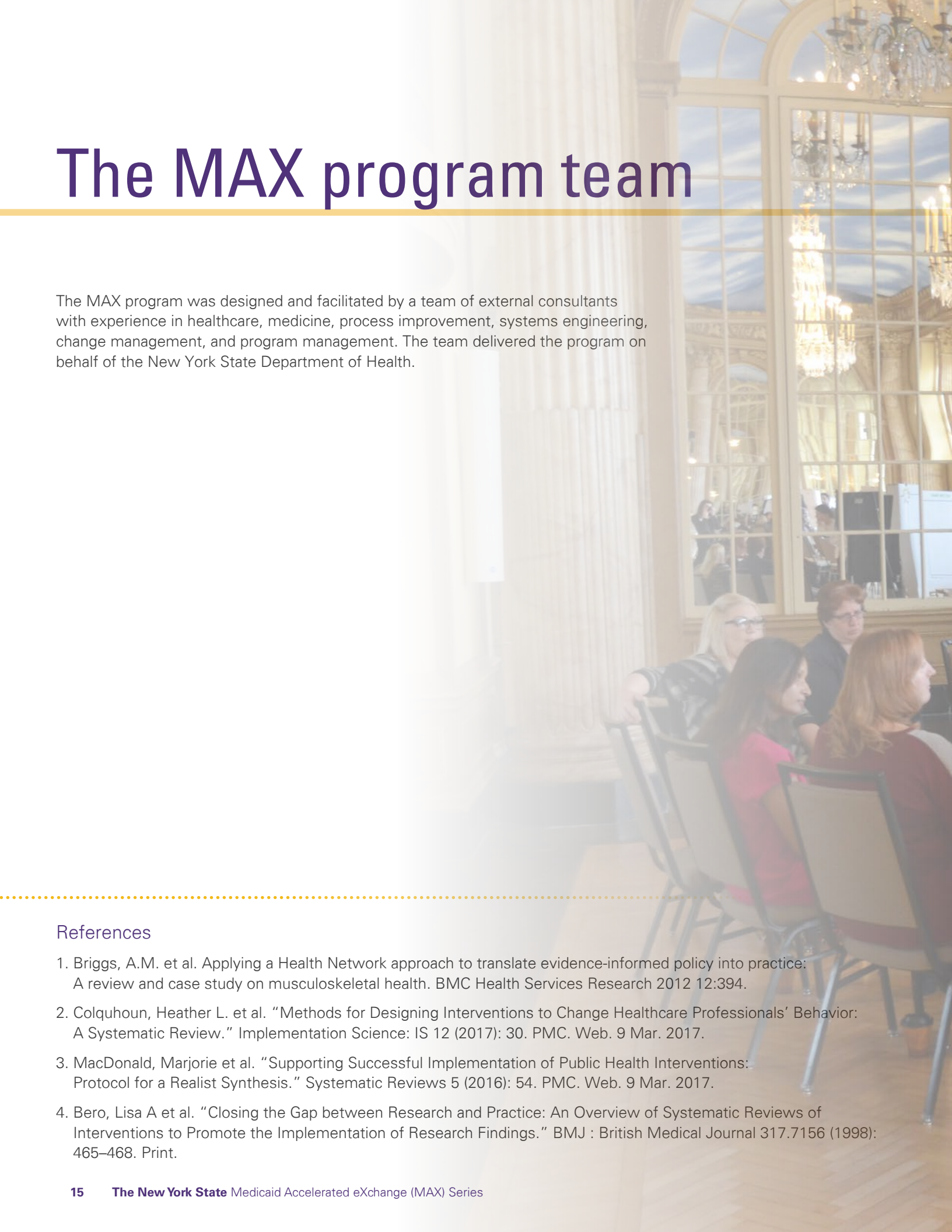
PATHWAYS
groups and using the referral
Non-Definitive, Linkage to Services
Definitive, Timely Linkage to Services
Current State
Referral Pathways Activity
Non-Definitive, Linkage to Services
Definitive, Timely Linkage to Services
Current State

The MAX program team

The MAX program was designed and facilitated by a team of external consultants with experience in healthcare, medicine, process improvement, systems engineering, change management, and program management. The team delivered the program on behalf of the New York State Department of Health.



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PARKING LOT
Referral Pathways

Contact for more information:
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