Accelerating healthcare policy outcomes

Effectively turning policy into practice using a Rapid Cycle Continuous Improvement program

A white paper for state Medicaid agencies

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Contents

Introduction: Accelerating outcomes and closing the gap between policy and practice

State Medicaid agencies continue to target the common goal of achieving the Triple Aim of better health, better outcomes, and lower cost. The need to accelerate achievement of better Medicaid program performance is now heightened as the potential shift in program structure and funding schema is deliberated in Washington. Turning policy into practice can be challenging and slow; particularly related to large-scale change such as healthcare delivery system transformation. While lessons have been learned from successful and less successful healthcare reform attempts, the focus on implementation at the local level is not always top of mind of those who design the future state, which impacts the intended outcomes. Approaches to implementation are typically not prescribed by policy makers since change is dependent on, and must be sensitive to, local context. Adjusting "the ways things are done" to accommodate policy changes is not an easy task. It is evident that policy makers who are able to support stakeholders by making changes to their practices at the local level will be more successful with policy uptake than those that are not.

This white paper explores how to bridge the gap between policy design and implementation by following a set of guiding principles gained through various case studies that utilize structured Rapid Cycle Continuous Improvement (RCCI) programs targeting process improvements by frontline (healthcare) professionals.[1] Based on our experiences with these programs in various (healthcare) settings, we suggest that policy implementation can be accelerated, thereby supporting the aims of the policy makers, by taking an approach that places frontline professionals in the lead to drive changes at a local level. This approach includes supporting professionals through a series of structured workshops that help them construct self-defined action plans that adhere to Plan-Do-Study-Act (PDSA) principles.

In this white paper, we seek to inspire all parties working on transformation and process improvement initiatives in the health and human services domain and beyond, to accelerate outcomes. The guiding principles in this white paper will help policy makers, payers, and providers build the narrative for change, as well as support measurable results by helping shape the change in a concrete and actionable way using RCCI methods.

[1] We use the term "healthcare professional" to denote the collective group of providers, physicians, nurses and other professionals supporting patient care.

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Regardless of what the outcome is of the federal healthcare policy debate, the approaches described here can help state Medicaid directors more rapidly improve program performance by reducing costs.

Underpinning the case studies described in this document is the KPMG Accelerated Continuous Process Improvement Program (KACI) methodology. This approach identifies and prioritizes high leverage opportunities critical to turning policy in to practice. Interdisciplinary teams of frontline professionals are assembled who understand their local environment and are vital to making on-the-ground changes. By bringing these action teams together in a highly structured and focused environment to design local solutions, over the course of a six month period real change is developed and agreed, and then tested using PDSA cycles.

KACI provides a structure and framework that achieves three things:

- **Breaks large policy goals into high leverage opportunities:** At the outset, policymakers are guided to stay away from attempting too much. Instead policymakers identify high leverage opportunities that can break a policy goal into manageable components and that can have a significant impact. For example, a large goal is a 25 percent reduction in avoidable hospital use, but focusing on all patients across a state would be challenging; so instead a very small group of patients are identified that account for a significant amount of total hospital use and these patients form the focus of our approach.
- **Puts frontline professionals in the lead to design solutions:** Once the focus area is identified, solutions are designed in line with this scope and the team's sphere of influence. A common pitfall in any system transformation is top-down or policy driven innovation where solutions are designed remotely or out of the local context. KACI takes a bottom up approach and assembles teams of mostly frontline individuals that are necessary for driving on-the-ground change and have the insight to know what will and will not work for themselves and their teams. This generally includes individuals from hospitals, primary care, and community based-organizations.
- **Provides a structure and a framework to implement those solutions:** A highly structured approach involves three workshops over a six month period where the action teams come together and design their own solutions that work in their local environment. The teams are then responsible for implementing those solutions immediately after the workshops in action periods which follow PDSA cycles.

KPMG's approach builds a narrative for change with minimal up-front investment and is highly scalable. Being people-orientated, our methodology focuses on collaboration and breaking down traditional silos, leading to policy being made real for the professionals at the frontline who are expected to deliver it.

KPMG Accelerated Continuous Process Improvement

Our approach to packaging Rapid Cycle Continuous Improvement principles

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.[2,3] The less effectively a policy is translated into required practical change at the ground level, the less likely it will meet its objectives, and as a result waste resources and risk a decline of stakeholder buy-in for subsequent efforts.[4] This is true across all industries.

Designed to help local teams adapt care processes and accelerate change to help the overall system or organization meet its policy goals, KACI takes a highly-structured and dynamic approach. While the program benefits regulators, policy makers, and C-suite level executives, it is directly aimed at engaging and inspiring front line professionals, allowing them to champion change in a manner that better suits their own practices and needs.

The program consists of three phases. In Phase I – the assessment and preparation phase – 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 PDSA cycles to optimize and accelerate results. In Phase III – the reporting phase – 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 – Assessment and preparation

The first step in the program is to **clearly articulate the 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? What data do we have at hand to illustrate the urgency and identify focus areas? Once those questions are answered, a potential range of solutions is identified.

Subsequently the key players are identified. The *executive sponsor* role is crucial to the success of the action team as well as the sustainability of the program. Executive sponsors provide overall accountability, sponsorship, and championing of the program. They are often the policy makers, have the vision of the future state in mind, and are able to remove barriers that may prevent the team from being successful. Next, *a multidisciplinary*

[2] Briggs, A.M. et al. Applying a Health Network approach to translate evidence-informed policy into practice: A review and case study on musculoskeletal health. BMC Health Services Research 2012 12:394.

[3] Colquhoun, Heather L. et al. "Methods for Designing Interventions to Change Healthcare Professionals' Behavior: A Systematic Review." Implementation Science : IS 12 (2017): 30. PMC. Web. 9 Mar. 2017.

[4] MacDonald, Marjorie et al. "Supporting Successful Implementation of Public Health Interventions: Protocol for a Realist Synthesis." Systematic Reviews 5 (2016): 54. PMC. Web. 9 Mar. 2017

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action team is assembled, comprised of approximately eight to ten 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 (for example data and IT) 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 front lines of the primary process, are action-driven, open to change, can hold the team accountable, and have decision-making authority. Action team composition may change over the course of the program due to evolving team needs. Depending on the topic at hand as well as the scope of the work, KPMG will typically leverage the knowledge of external or industry *subject matter professionals* (SMP's). These SMP's help to tailor program content to the identified topic, share leading practices and resources from the industry, help monitor progress and outcomes, and provide ongoing program support.

In addition to the above, KPMG conducts an on-site visit to understand the local challenges and current state processes prior to the workshops. Finally, the assessment and preparation phase **establishes an understanding of baseline metrics**, which are used to determine future progress towards goals.

Phase II – Workshops and action periods

The 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 at hand. 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 of what they will be accountable for.

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 in length, 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.

Throughout the program, teams are supported through weekly coaching calls, continuous access to subject matter expertise, performance measurement, periodic virtual shared learning via online collaborative platforms, on-site visits, and webinars.

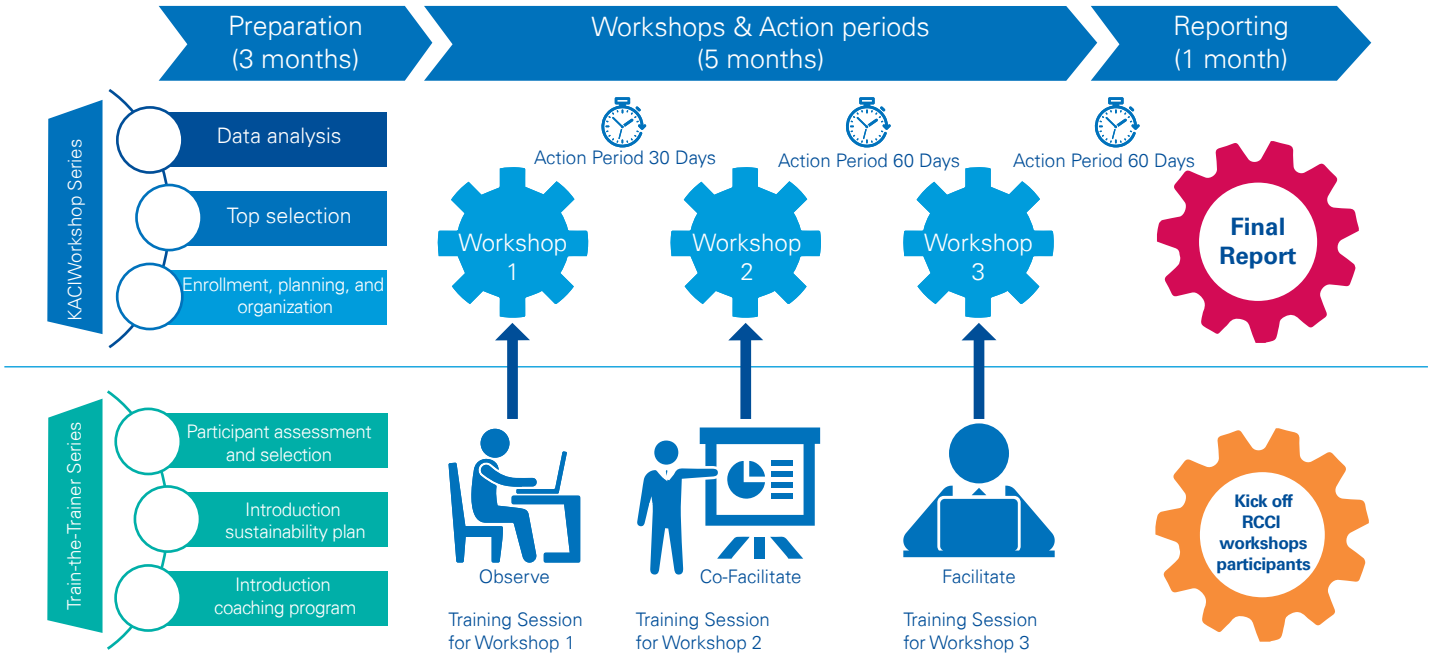

Figure 1: Workshops and train-the-trainer process with 30-60-60 day PDSA-cycles

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 trainees 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, trained in facilitation techniques and RCCI theories delivered in each of the three workshops, and subsequently observe, co-facilitate, and facilitate workshop and action period activities (see Figure 1).

Phase III - Reporting

Reporting on process and outcome measures plays a pivotal role in the 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 internally as well as to identified policy makers and other stakeholders.

KACI programs are run for 1 to 50 action teams at the same time. The group aspect allows action teams to challenge and inspire each other, and share lessons learned. In addition, sharing program progress in the workshops results in healthy competition across the teams.

Case studies: Using Rapid Cycle Continuous Improvement in policy implementation

Case study I: High utilizers in a state Medicaid program

The goal

The United States Medicaid program provides essential health insurance coverage to over 70 million people, including more than 32 million low-income children, over 20 million non-elderly adults (including parents), nearly 7 million elderly adults, and more than 10 million Americans with disabilities.[5] On a population of slightly over 320 million, Medicaid accounts for insurance coverage to one in five Americans. Medicaid expenditures are estimated to have been more than $575 billion in 2016, which accounts for around 17 percent of the total National Health Expenditures.[6] Medicaid is jointly funded by states and the federal government, and administered by states. To a certain degree, states can adjust their Medicaid program design to meet their own state specific needs, and can request waivers from the federal government to make changes.

In this particular case study, we focus on a state in which around 25 percent of the state population is on Medicaid, accounting for approximately 40 percent of the state's annual budget. When ranked against other states, despite the relatively high investments in the Medicaid program, the affected state ranked only average in health outcomes, and below average on prevention and avoidable hospital use and cost in 2014. While budget policies had helped to reduce Medicaid cost growth over the past decade, the state (like many of its contemporaries) still struggled with a system largely focused on hospital infrastructure, a lack of investment in primary and community-based care and fragmented care systems.

In order to change this, the state applied for federal funding under the 1115 demonstration waiver to roll out a policy targeting a 25 percent reduction in avoidable hospital use over a five year period by providing incentives to reshape the fragmented healthcare landscape into more integrated networks of care.

[5] Medicaid & CHIP: Strengthening Coverage, Improving Health; Centers for Medicaid and Medicare Services (CMS) United States Department of Health & Human Services, January 2017.

[6] 2016 Actuarial Report on the Financial Outlook for Medicaid; Office of the Actuary Centers for Medicaid and Medicare Services (CMS) United States Department of Health & Human Services, 2016.

The approach

The key mechanism deployed by the state for bringing down avoidable hospital use was by incentivizing networks of healthcare professionals to come together and collectively manage projects targeting specific high utilizer (HU) population groups. Initially, much of the state's attention and dollars were aimed at standing up the "bricks and mortar" of the newly integrated networks of care such as IT-connectivity, data sharing, workforce programs, and legal and administrative structures. Little attention was directed at the frontline healthcare professionals who were expected to change their behavior and processes to help create new seamless care pathways. The state in our case study quickly recognized the need for an intervention that would allow them to support a frontline behavioral change to help accelerate the intended program outcomes at the local level.

As a result, the state launched an RCCI program as part of their reform agenda. The program leveraged a highly structured and dynamic data- and results-driven approach that was built upon bringing together interdisciplinary teams of healthcare professionals around a specific topic. The goal of the program was to generate and test locally relevant solutions, without changing existing budgets, infrastructure, or workforce composition. The program assisted teams of multidisciplinary healthcare professionals to improve their processes in a compressed timeframe of eight to ten months to ultimately reduce cost and improve quality of care for the most vulnerable Medicaid patients. Throughout the program, over 500 frontline healthcare professionals across 45 teams were placed in the lead to make changes at a local level through self-defined action plans that adhered to PDSA principles resulting from three workshop series and 30-60-60 day action periods.

The state focused specifically on high utilizers to accelerate the outcome of a 25 percent reduction in avoidable hospital use over five years, given the significant potential for impact within this one cohort in the Medicaid population.[7]

Key statistics on the high utilizer population include:

— 0.5 percent of the state's Medicaid enrollees were defined as high utilizers.

— The high utilizer population accounted for 20 percent of inpatient admissions by Medicaid enrollees.

— The average spending per high utilizer recipient over a one-year time frame was more than 20 times greater than for non-high utilizer recipients.

The outcome: Early results

1. Quality improvement: Cross-continuum collaboration

The teams that participated in the RCCI program represented a diverse set of hospitals and practitioners from a wide range of communities across the state. Despite this heterogeneity, all participating provider teams reported the establishment of community partnerships as a result of the RCCI program, as well as standardized patient care pathways between these providers. A few of many examples include new collaborations between hospitals and:

— **Food agencies** through implementing a food pantry in the hospital.

— **Managed Care Organizations (MCOs)** by embedding a MCO Care Manager in the Emergency Department (ED).

— **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).

— **School districts** to keep adolescent high utilizers due to behavioral problems out of the hospital.

— **Social service agencies** using shared calendaring and collaborative case conferencing.

— **Health homes** by placing a representative directly in the hospital to build comprehensive transition of care processes.

"The RCCI program is truly changing the trajectory of human lives"

— State Medicaid Director

[7] High utilizers were defined as fully enrolled Medicaid members with 3+ IP Admissions and/or 6+ ED Visits within a two year timeframe

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2. Cost reduction: Decrease in avoidable hospital use
The qualitative results of the new patient care pathways went hand-in-hand with quantitative outcomes. 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")?* Subsequently, provider teams measured outcomes and reported an average, aggregated **decrease in monthly ED utilization by 44 percent**.
In measuring the pre vs. post RCCI program intervention utilization of the identified patient cohorts, teams reported a **decrease in overall hospital utilization between 20 percent and 74 percent**.[8]

3. Sustainable and scalable change: Building up RCCI capability
The program was rated an average of 4.8 out of 5 by the participants, and 98 percent of the over 500 participants indicated that they would recommend the program to a colleague. The RCCI workshops were designed to leave provider teams with the skills and tools to continue their process improvement work after the facilitated workshops and action periods concluded. In addition, the state offered a train-the-trainer program with participants who sat outside of the action teams to help scale the change. Many teams have reported using the methodology for different process improvement challenges, **and 100 percent of the action teams convened or planned their RCCI sessions upon conclusion of the program**.

The program provided the state with a standardized methodology to change the way care was delivered for its Medicaid high utilizers. By placing frontline healthcare professionals in the lead to design and implement change, the impact of the policy and its intended outcomes increased, while simultaneously accomplishing better patient outcomes in the cohorts observed.

> **"I use the lessons learned in all my meetings nowadays. We never walk away without concrete action items, deadlines and owners"**
> — RCCI Program Action Team Participant

[8] Decrease does not account for the historical regression to the mean.

Example: Tools to address the opioid epidemic

Policy goal: Improve access to comprehensive substance abuse (SA) treatment

Local provider situation: A critical access teaching hospital had a subpopulation with SA issues consisting of 192 patients who accounted for 1,236 emergency department (ED) visits in a 12-month period.

Complication: A significant portion of the population with SA issues was frequently using the hospital due to chronic pain. Due to the volumes and with little time to truly explore the 'driver of utilization' in the ED setting, these visits were often resulting in the administration and/or prescription of opiates, which reflected a rise of opioid abuse in the area.

Applied solution: Together with local community providers, the hospital set up a multidisciplinary action team and worked through a full cycle of the RCCI program to specifically address issues related to the population in need of substance abuse treatment.

Outcomes:

— **Improved access to community providers:** 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 and the new way of working was actively shared with community providers. Subsequently, workflows between the hospital and community providers were implemented, which improved access for the SA population to appropriate care settings.

— **Reduction of hospital use by population with SA issues:** The new approach resulted in an 80 percent drop in the opioid orders prescribed to the SA patient population in the ED, while patients were taken care of in other, more appropriate care settings.

Building a narrative for change: A patient's story

Implementing policy is not what the frontline healthcare professionals in the program were aiming for. They were motivated by the quick wins and instant success stories they could share with each other and their stakeholders. Simultaneously, it allowed the state to help build its narrative for change using 'real life' examples to roll out the transformation program and accelerate outcomes.

Example: A 50 year old male who had been homeless for 13 years and was chronically using alcohol had 103 ED visits over a 10 month timeframe. He has only been in the ED once in the three months after the RCCI intervention.

"When the patient presented, he was identified as a high utilizer through a flag in his Electronic Medical Record as a result of the RCCI program. In a 10 minute 'driver of utilization' interview, his need for housing was recognized. We connected him with the Homeless Outreach Team, organized transport to the Living Room, and he was assigned a Safe Haven bed."

— Health System Senior Vice President

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Case Study II: Providing hospital-based care to patients with diabetes

Worldwide, the number of people with diabetes has risen from 108 million in 1980 to 422 million in 2014. As the absolute number of patients with diabetes has risen, so has the global prevalence in the same period, rising from 4.7 percent in 1980 to 8.5 percent in 2014 among adults over 18 years of age.[9] In the United States, 9.1 million people or 9.3 percent of the population have diabetes.[10] Diabetes is associated with a myriad of serious complications, such as heart disease, stroke, blindness, and kidney failure. Many of the complications mentioned above, especially those related to microvascular (e.g., eye, kidney, and nerve) disease, can be avoided with good blood glucose level control.

Blood glucose levels are typically measured through the levels of glycated hemoglobin (HbA1c). By tracking HbA1c levels, clinicians can obtain an overall picture of what average blood glucose levels have been over a period of weeks/months. For patients without diabetes, a 'normal' range for HbA1c levels is between 4 percent and 5.6 percent.[11] For patients who have diabetes, average HbA1c levels of 6.5 percent to 7.5 percent are considered a target range. The hospital in this case study faced the issue that a sizeable percentage of its patients with diabetes were consistently tracking above-target HbA1c levels, resulting in suboptimal patient outcomes and subpar hospital quality benchmark ratings. In order to address the issue, the hospital set itself the goal **to lower the average HbA1c levels for its population of patients with diabetes, and reduce avoidable complications by improving the level of support**.

The approach

Similar to the case study on high utilizers in the Medicaid program, the hospital set up a workshop to bring together an 'action team' of individuals who were well suited to address the identified challenge. Action team members were pulled from the full spectrum of disciplines from the patient care team (nurses, endocrinologists and psychologists) as well as IT and administrative support personnel. Similar to the RCCI program deployed in the state case study, the action team in the hospital worked through two days of facilitated workshops. During a series of process improvement cycles, they were challenged to design concrete, defined action plans for change. As part of the continuity aspect of the program, action team members were asked to reconvene 30 days later in a similar setting, to report back, modify existing plans, and create new action plans.

The outcome

Taking frontline healthcare professionals out of their day jobs and away from their patients can only be justified if results and impacts are significant. Implementing reform is too frequently approached in an uncoordinated, fragmented manner resulting in additional workload for all involved and a lack of tangible results. By implementing a structured Rapid Cycle Continuous Improvement approach, this hospital team was able to reach its goal, and reported a 0.5 percent HbA1c level reduction in a representative cohort over a six month timeframe by:

- Expressing a shared vision
- Designing a diabetes care pathway including:
  - Standardized individual and group education
  - Reducing the 'no-show' rate by introducing a system of automatic reminders
  - Reducing wait times by pre-planning the full series of appointments for patients
  - Streamlining paperwork resulting in higher provider satisfaction and reduced patient visits
- Group 'huddles' to discuss ongoing improvements to the diabetes care management pathway
- Continuous process and outcome measurement

[9] Global report on diabetes, World Health Organization, Geneva 2016

[10] Estimates of Diabetes and Its Burden in the United States; National Diabetes Statistics Report, 2014

[11] These ranges may vary based on the age, duration of diabetes and overall health status of the patient

Case Study III: Supporting college enrollment in a school district

The RCCI approach can be applied across any setting where agencies work in silos and people fail to receive the support they need as a result. This case study describes the application of the methodology in an education setting, evidencing the adaptability of the approach and the variety of challenges where RCCI thinking can be utilized.

The goal

The 21st-century knowledge economy demands a highly trained and skilled workforce for the jobs of tomorrow. Sixty-five percent of US jobs will require a college education by 2020, with 35 percent requiring a bachelor's degree or higher.

This third case study focuses on improving enrollment rates into college following high school in a single geographical area. For students in this case study, enrollment rates into college were not standard across the different demographic groups of graduates from high schools in the geographical area, who were classified by ethnicity as White, Black, Asian or Hispanic. In the fall of 2015, 78 percent of White graduates and 77 percent of Asian graduates were enrolled in college, while only 53 percent of Black graduates and 62 percent of Hispanic graduates were enrolled. Despite being the largest sub-population of high school graduates, students identifying as Black or African American enrolled in college at the lowest rates compared to their peers. And while many of these students identifying as Black or African American had college-going plans, 22 percent of high school graduates from this cohort who had college-going plans (measured by a senior exit survey conducted by guidance counselors) did not end up enrolling in college.

To address the demographic disparity in college enrollment rates, an "education partnership" consisting of representatives from local government, corporate organizations, and various schools, colleges, and educational institutes joined forces and formed a project team.

They defined a policy target to ultimately bring enrollment rates into college up to 100 percent of those Black and African American students graduating from high-school who indicated that they had college-going plans.

The approach

After defining the enrollment goals, the project team came together to work through a series of steps in a Rapid Cycle Continuous Improvement program. One of the first steps was mapping out the process and identifying key drivers of the problem. The project team quickly identified "summer melt" as a key driver for preventing college enrollment within six months after high school graduation. Students 'melted away' because there was no structured transfer between the high schools and colleges. Since enrollment can be a financial and administrative challenge, students dropped out. In using PDSA principles, the project team identified concrete action items. As a result, they proposed offering 1:1 coaching sessions for the target population (and their families) to assist them with various aspects of the college enrollment process. All participating high schools administered a senior exit survey to identify which students were most at-risk for melting. These students were specifically targeted in outreach efforts and additional support was provided to help ensure they attended the 'summer melt' coaching sessions.

The outcome

The project team reported that a total of 35 students, all identifying as part of the target population, participated in the coaching sessions. Following coaching, 100 percent of these participating students successfully enrolled in college six months after high school graduation. Additionally, students were overwhelmingly satisfied with the help they received.

— 100 percent of their questions were answered.

— 91 percent would recommend the session to others.

In addition, as a result of the KPMG train-the-trainer capacity building program, the summer melt project has scaled to include 18 high schools and 10 colleges, and will reach over 2,000 students in the summer of 2017.

Guiding principles of Rapid Cycle Continuous Improvement

The common theme binding together the three case studies in the previous section is that in all cases, policy or decision makers deployed a form of Rapid Cycle Continuous Improvement programs in order to help professionals target, kick-start, and sustain improvement efforts. Based on our experiences with the case studies combined with our understanding of RCCI methodologies, we have outlined a series of principles that can help guide the practical implementation of policy through high intervention programs aimed at the local level.

Start with a clear vision and measurable goal

Implementing reform is too frequently approached in an uncoordinated, fragmented manner resulting in additional workload for all involved. Change requires significant effort, and should therefore go hand-in-hand with a clear vision of the future state and a quantifiable target. Policy implementation is often accepted to be a difficult and lengthy process. However, setting a clear goal within a reasonable timeframe can help various stakeholders to understand the task at hand, and will help to hold different parties accountable. **Data is crucial: what you cannot measure, you cannot manage**. This principle should not only be applied to the overarching goal but to all locally designed action plans. Data should be collected and measured to understand the impact of interventions (and adjusted where necessary during PDSA cycles), as well as to follow progress on consolidated program measures.

Restrict process improvement to a controllable sphere of influence

In an ideal world, time and money would be set aside and local teams would start with a blank sheet of paper and design the perfect process in alignment with the policy goal. However, that is not the world we live in, nor the playing field frontline professionals face on a daily basis. A crucial factor for successful reform implementation through a RCCI program is to set the boundaries upfront in which solutions and new processes must be designed. Generally speaking, the program **assumes no ability to change existing budgets, infrastructure, or workforce**. Action teams should be guided throughout the RCCI program to create action plans within their "sphere of influence", and longer term solutions, or initiatives that require significant resources, are set aside or escalated elsewhere. The focus, therefore, is not to develop perfect future plans, but rather targets for short- and medium-term benefit, building momentum and getting started with 'what there is'.

Build the narrative for change through high impact stories

Data measurement is only meaningful if it is translated to **return on investment (ROI)**. This ROI can be considered from multiple dimensions depending on the underlying challenge. The solutions designed within the RCCI program always either result in cost reduction or quality improvement. Results can subsequently be communicated in a comprehensive story; 'we saved x million dollars, which we will reinvest in x, y or z", or "we linked x patients to social and behavior healthcare services", et cetera. Simultaneously, qualitative data should be collected to humanize the translation of policy into practice. **These real life, individual stories are often the most powerful aspects to the program, and they are what brings policy 'to life'**. This dual approach provides a strong basis to help build and communicate the narrative for change, since it serves as ongoing inspiration for those asked to implement the transformation agenda, and on a broader scale speaks to the 'recipients' of the policy goals such as patients or students.

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Engage in continuous support from external subject matter professionals

Taking frontline professionals out of their day jobs away from their patients, students or other work can only be justified if results and impact are substantial. A crucial element in the preparation phase of a RCCI program is getting commitment from the various parties. They'll have to agree to the vision, goals and time investment the program will take and be willing to hold themselves and each other accountable. In addition it can be effective to assign an external party; someone who doesn't work with the team on a daily basis, from inside or outside the organization to function as a subject matter professional, who can **challenge the group and provide industry best practices**. 'We've always done it this way' or 'we're doing everything you're suggesting already' are common statements heard while teams continue to experience frustration in their roles or in processes where there is ample room for improvement. An external view can help accelerate the process as well as take care of the logistics an RCCI program requires.

Focus on sustainability and scalability

Throughout this white paper we have consequently positioned the application of the RCCI methodology as a program, not a project. The techniques and structures offered in the program should be positioned as **'a new way of working' to sustain the transformation efforts and help the team in their future (continuous!) improvement efforts**. An example is to not just measure and perform data analysis for the action teams, but to offer it as an integral educational module within the program to help the team continue the work with control charts, run charts, and additional data and analytics techniques after the program has concluded. Finally, the general consensus from published literature shows that engaging professionals in interactive and educational programs is an effective form of intervention to close the gap between policy and practice.[12] However, the more intense the intervention, the more effort it takes to scale change. Investing in highly structured and dynamic interventions can accelerate policy outcomes, as we have illustrated in the various case studies. Working at scale, has the additional benefit of generating cross-learning, more rapid and consolidated implementation of policy, and it adds a component of healthy competition.

[12] Bero, Lisa A et al. "Closing the Gap between Research and Practice: An Overview of Systematic Reviews of Interventions to Promote the Implementation of Research Findings." BMJ : British Medical Journal 317.7156 (1998): 465–468. Print.

Final thoughts

By leveraging RCCI principles policy makers can truly transform the landscape of their jurisdiction or organization to be more effective and aligned with policy goals. Through KACI programs, policy is brought into practice by placing frontline professionals in the lead. Cross collaboration and integration are facilitated through people and data driven change management with a clear return on investment and minimal frontline investment, to help build the narrative for change in a scalable and sustainable way.

Our experience in working with states and other policy makers on this journey, shows that by following the approach in this white paper, the time needed to achieve results on policy implementation activities, is significantly reduced. In a fast pace world, where those at the top are given less and less time to show their value and quick results are required, investment in implementation should be incorporated in all policy making activities. KACI can help those who want their vision to become reality.

About KPMG

KPMG leverages a global network of highly experienced health and human services professionals from across a wide range of functional and technical service areas to deliver tailored and practical approaches to our firm's clients. Our teams have strong skills and deep knowledge in business transformation, harnessing data analytics, and implementing solutions to improve program outcomes. KPMG's tools include the KPMG Enterprise Reference Architecture for Health and Human Services, KPMG Resource Integration Suite, KPMG Analytics Driving Insights, and KPMG Accelerated Continuous Process Improvement Program.

For more insights, visit www.kpmg.com/us/hhs-insights.

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