

Data-driven Improvement Building Block Two



21 | USING DATA TO DRIVE IMPROVEMENT

[Practice wisdom]: The San Francisco Health Network Hypertension Equity Workgroup

The questions you ask determine what you have the ability to find in your data. When a citywide community health assessment in San Francisco revealed that Black/African American (B/AA) residents have higher premature mortality rates in every disease category as compared to other racial/ethnic groups, the city/county Department of Public Health committed to break down clinical quality measures by race and ethnicity. It was clear from the data that African Americans patients had significantly lower rates of hypertension control.

Health system leadership recognized that disparities created or exacerbated by systemic racism could not be undone without meaningful partnership with affected communities. To that end, they formed the Hypertension Equity Workgroup.

In keeping with Building Block Five (Patient Team Partnership), the Workgroup elected to incorporate patients right from the start. Data from focus groups with patients underscored that there are many non-clinical barriers to keeping hypertension under control in this population. The Workgroup therefore devised a mission that recognizes these barriers while calling out the importance of utilizing data to solve complex health issues. The mission reads in part:

“For our Black/African American patients living with hypertension, controlling blood pressure is complicated by trauma, inadequate housing and jobs, and the societal effects of racism. In order to address this health inequity, we are utilizing data, problem solving, and developing resources together to support our patients to live healthier lives.”

Two of the Workgroups successes are the creation and distribution of Home Blood Pressure Monitoring Toolkits with culturally relevant educational materials and a collaboration with the Food Pharmacy Project to provide culturally appropriate healthy foods and recipes.

Most practices are inundated with both potential sources of data and demands for data reporting. The term “data driven improvement” refers not merely to the production of numbers, but to the art of identifying metrics that can drive meaningful change, sharing and discussing those numbers in open conversation across the practice, and using metrics to hold ourselves accountable.

This module is not intended to be a compendium of all possible measures, to delve into the nuances of electronic health records, or to provide an exhaustive overview of quality improvement methods. What we DO wish to provide in this module is a reflection on the art and science of:

- **Identifying metrics that drive meaningful change**
- **Sharing and discussing those numbers in open conversation**
- **Creating feedback loops that transform data into action.**

COLLECTING DATA FOR QUALITY IMPROVEMENT

Data for quality improvement purposes may be derived from many sources, including:

- Existing quality improvement measures generated for reporting purposes (e.g., HEDIS or MIPS)
- Administrative data (e.g., financial data, number of lab tests ordered, leave requests)
- Data from EHR (e.g., custom data pull, metadata such as time spent after hours)
- Surveys of patients or staff
- Qualitative data (e.g., focus groups, **texting**)
- Structured observations (e.g., cycle times, tallies of calls)

[Practice Wisdom] When your data systems let you down, don't despair!

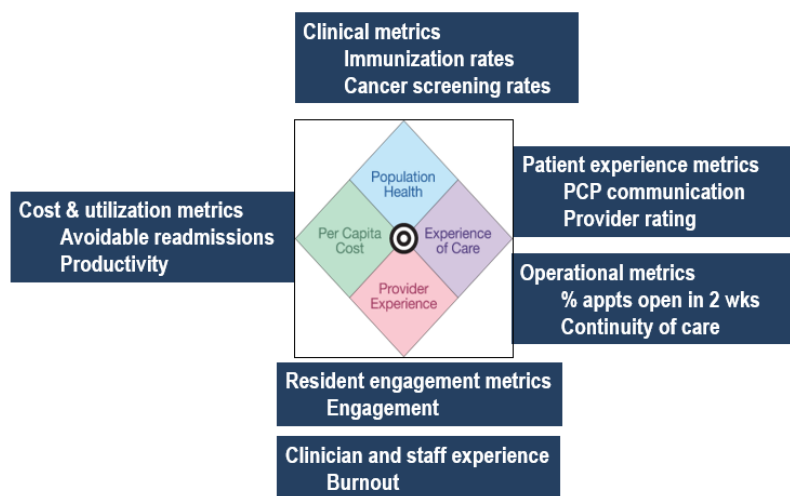
When Dr. Brian Bouchard of Neighborhood Family Practice in Cleveland, Ohio, sought information about childhood lead screenings to guide a quality improvement initiative, he ran into unexpected hurdles pulling that information from the EHR. There were questions about data quality: for example, lists of patients needing care seemed to leave out people who should have been eligible. Local IT was unable to resolve the issue and referred them to system IT, where it was not a priority. Moreover, there were disagreements about what measure was best (Proportion of children screened every year? Proportion of children screen at least once?)

While resolving the reports remains a goal, Dr. Bouchard was able to forge ahead on his practice transformation project by focusing on data that was available: the number of lead tests ordered in the lab. This much simpler and more accessible number provided sufficient information to motivate the practice improvement team.

Clinical and operational metrics and patient experience are some of the most common measures. Ideally, many of these measures are collected at the level of individual teams and clinicians. Drilling down to this level will provide feedback on the performance of individuals and small teams and help to explain variation between groups.

When identifying metrics that may help to measure success and make a case for program support, it can be valuable to consider measures corresponding to all four components of the quadruple aim. For example:

What types of metrics do practices typically collect?

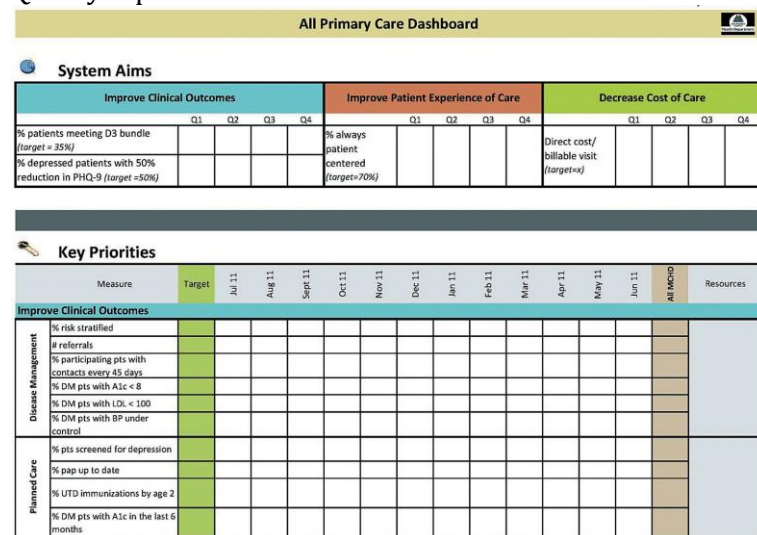


Whenever possible, it can be advantageous to use data from quality or administrative data, both because it is generated for other purposes (and thus doesn't require special requests of IT) and because these metrics are frequently tied to incentives that may help to support the sustainability of your initiatives if successful. A few examples include:

Measurement Body	Target Population	Web Resources
HEDIS	Health Plans; Adults/Peds	https://www.ncqa.org/hedis/
CAHPS	Adults/Peds	https://www.ahrq.gov/cahps/surveys-guidance/index.html
UDS	Federally Qualified Health Centers	https://bphc.hrsa.gov/datareporting/reporting/index.html
Medicare 5 Star	Medicare Advantage Health Plans	https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/CertificationandCompliance/FSQRS
Comprehensive Primary Care Plus (CPC+)	Primary care medical homes	https://innovation.cms.gov/initiatives/comprehensive-primary-care-plus
Oregon Health Authority (OHA)	CCO Incentive Measures for Medicaid population	https://www.oregon.gov/oha/HPA/ANALYTICS/Pages/CCO-Metrics.aspx
Merit-based Incentive Payment System (MIPS) or Advanced Alternative Payment Models	Medicare	https://qpp.cms.gov/

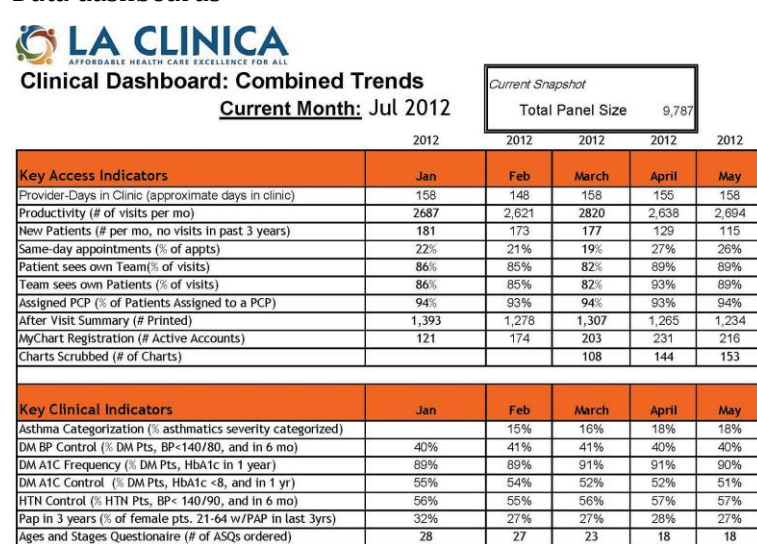
Quality assurance and monitoring data is commonly summarized in a number of ways. Here are a few common examples that can provide resources to identify quality improvement metrics:

Quality report cards



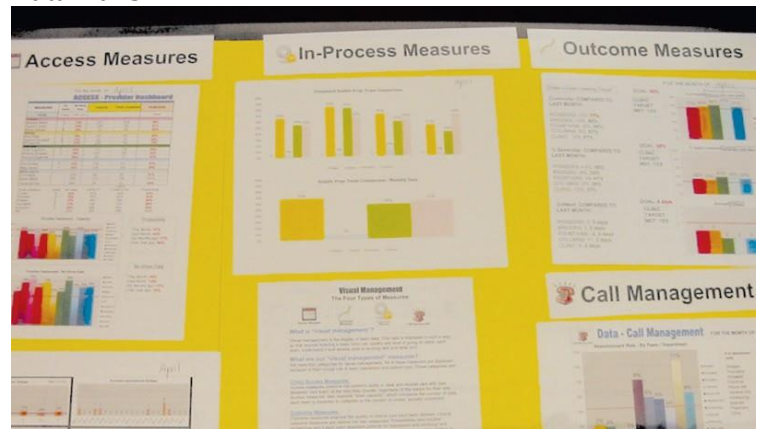
Systematically tracking measures over time to make sure they do not slip, even when the spotlight moves to new metrics. Watching longer term trends.

Data dashboards



Enabling staff to “drill down” to subgroups in interactive web-based platforms.

Data walls

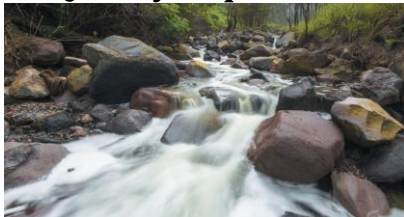


Making data accessible to everyone in the clinic and fostering community ownership. Huddles around the data dashboard can reinforce the feedback loop and send the message that this is something that we own and work on together.

How is data used for quality improvement different from quality assurance and evaluation?

Similar types of metrics might be gathered from a practice for quality assurance, quality improvement, or evaluation. However, the timeframe of the data and how it is presented and used may differ. While quality improvement is the focus of this chapter, all three of these activities are important. It is worth distinguishing their underlying questions and how they shape how data is gathered and presented.

Take for example, the percentage of eligible adolescents with an up-to-date HPV vaccination...

	Quality assurance 	Quality improvement 	Evaluation 
Goal	Ensuring standards are maintained. Change is not necessarily anticipated.	Noticeable change!	Comparison of fixed options
Sample questions	Did we maintain our level of HPV vaccinations? How do we compare to national benchmarks?	Did our work to offer the HPV vaccine at every adolescent visit result in improvement? What can we learn from variation across the team?	Did a decision support tool offered as part of a national study improve HPV vaccination rates compared to the standard of care?
When and How data is shared	Monthly or quarterly report cards, dashboards, data walls (more on this in the next section!)	Rapid cycle data for a few select measures in run charts	Often only at end of program*

* There are increasing schools of thought in evaluation science that try to blend classic evaluation with the rapid cycle evolution of quality improvement

I DESIGNING PERFORMANCE METRICS

What guides your selection of target metrics for improvement? For most health systems, priorities are informed by:

- What payers are incentivizing
- Inequities in care
- Feasibility given existing staffing, resources, etc.
- Ability to measure in a meaningful and timely way

- Ease of securing data (e.g., what an organization is already reporting on)
- Alignment with other efforts
- What staff, clinicians, and patient partners are motivated to work on
- What is a measure that staff can easily understand and can get enthused about

[Practice wisdom] The University of Cincinnati Internal Medicine program holds an annual Defense of the Measures for residents and staff to select their target measures for quality improvement for the coming year. In this event, they can advocate for core metrics for performance, and through the year ahead, they receive monthly reports that drill down to the team and resident panels. Taking part in the selection process contributes to greater buy-in and creativity in moving the measures.

What makes data effective?

Consider these common scenarios. What is the problem in each case?

- 1 You are presenting at a clinicians' meeting about trying to improve the rates of colorectal cancer screening. One clinician interrupts you and says, "Look, this report is all wrong! You must have people on the wrong panels or not be counting colonoscopies done off site!"
- 2 You're trying to improve front desk customer service and are using the CAHPS-G measure about front office staff. However, when you share the low scores with the front office, they say, "The reason people are upset with us is that we can't get them appointments when they need them. The schedule is full! Don't blame us for what we can't control!"
- 3 Your clinical teams have been working hard to streamline inbox messages so that they are resolved more quickly. However, there's only one person who knows how to run the numbers on the time to resolution for messages, and she's covering for a practice manager at another site and hasn't had the time to run your numbers. As a result, your project is floundering.

Data that drives improvement has several characteristics:

1. **Timely:** Actionable data has a fast turnaround, ideally within the day or week. In practice, this means that most organizations need to focus on one or two measures that they can produce and share quickly, even daily.
2. **Simple:** Most people need to focus on one to two straightforward measures at a time. A multi-faceted measure relying on a proprietary algorithm is generally hard to use for quality improvement purposes.
3. **Trusted:** Are these diabetic patients with high A1c really my patients? Does a low rate of depression screening reflect practice or just where it was entered in the electronic medical record? When there are doubts about the data, practice change leaders are best served by being transparent about potential data issues and addressing concerns in a timely way that involves the people who express concern.
4. **Viewed through a health equity lens:** To be optimally effective, data should be broken down in a way that examines whether there is a disproportionate impact on groups that frequently experience barriers to access, such as racial or ethnic minorities, people with limited English proficiency, or older individuals. Greater understanding of the groups most effected can help to target efforts, and to ensure that new efforts do not unintentionally widen inequities.
5. **Transparent:** Transparency of data means reporting data in a way that everyone can see. That requires that data is used in a way that is curious rather than punitive. Practice improvement

leadership can help to set the culture by being open about their own failings and modeling a quality improvement approach.

6. **Tied to individual actions:** How can a clinician improve their CAHPS patient ratings of their provider's communication? Effective practice improvement means translating measures into specific expectations about actions.
7. **Celebrated:** One of the best ways to promote both accurate data reporting and sustainability of quality improvement initiatives is to create positive feedback loops in which the team celebrates improvements or positive patient stories.

[Practice coach corner] One of the common pitfalls of quality improvement is a failure to create a feedback loop. Often, practice improvement teams identify a goal and metrics and carry out a project, but they never sit down to look at their results or share those results with other stakeholders. As a result, they don't have a chance to reflect on what went well and what could be improved or to make changes to their project and test those new changes. And when an improvement resulted in the desired change, a failure to share back data with staff and celebrate with them frequently results in lack of momentum and even good projects sputtering to a halt.

DATA THAT IS TRUSTED

When stakeholders do not believe that data reflects reality, it is unlikely to drive action. Understanding and improving data quality is a first step toward improvement.

A Few Common Examples of Sources of Data Error

- PCP field that does not reflect actual primary provider, often because of insurance assignment, policy about residents or APCs as PCPs, or policies that pose barriers to updates
- Failure to enter key data in structured fields in a way that can be searched
- Poorly mapped diagnosis codes between an EHR and a registry
- Race/ethnicity— Non-standard ways to describe; inability to capture multiple fields
- Medications— Multiple names for the same medication

Data Validation Steps

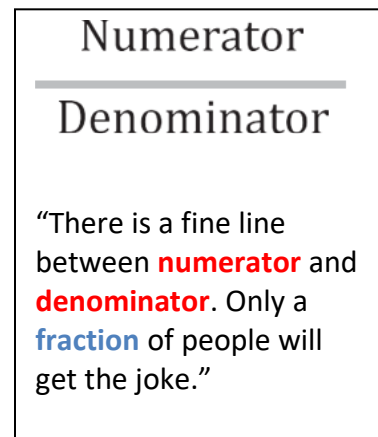
When introducing new measures, anticipate that you will need to spend time introducing the measures, as well as understanding and exploring any concerns that arise. Consider vetting new data with a few key people BEFORE you present it to a large group – ideally, these people are data savvy and will ask you questions that you can research before you go in front of all of the clinicians or staff. Many data quality issues can be flagged through “the inquisitive look,” meaning approaching a set of data with curiosity, and noticing outliers, big changes, or surprising results. In some cases, particularly when changing systems or introducing new reports, creating a data validation team can enable you to be more proactive and inclusive.

Know your data definitions and clearly lay out numerators and denominators in reporting.

[Practice Wisdom]: A primary care system on the West Coast has a Clinical Quality Metrics Team that pulls together a staff representative from different divisions: operations, medical, electronic health records, and quality improvement to form this team to provide support and training around the metrics for leadership and all staff. They also update a centralized intranet page for metrics with information on specifications, latest data results, and a “metric recipe for success guidebook” that details how each role from front desk to medical assistants to providers contribute to successfully meeting a target.

Denominator errors: Many data errors arise because of failing to consider who is in the denominator of a measure. Patients may fail to be counted in a metric if they are not assigned to a clinic or clinician. They may fall out of disease control measures if there is no lab test recorded within a given timeframe. A few common examples:

- Patients with missing demographic data elements
- Patients with no primary care physician documented
- Missing tobacco use assessment on adult patients
- People not up to date for lab work or blood pressure screenings



Numerator errors frequently stem from mapping of EHR fields to metrics. For example, if smoking cessation referrals are recorded as open text rather than in structured fields, they may fail to register in automated metrics relying on the structured fields.

[Practice coach corner]

What do you do when team members do not trust the data? A good starting point is to take their concerns seriously and to co-design tests to address them.

One efficient tool is a chart audit. Not sure if screenings are being entered in a structured field or in the notes? Try pulling a set of 10-20 charts that you fear may be affected to determine whether the concern is really an issue. Sometimes a low error rate during an audit is sufficient to assuage fears. The more you can involve stakeholders in designing or conducting the audit, the more effective it will be.

Don't forget the stories!

When thinking of data for quality improvement, we often focus on quantitative data – numbers such as the proportion of people screened or the number of people reaching a goal. However, many of our stakeholders – including our staff – may actually find storytelling more compelling. Inviting staff or patients to tell their stories, whether formally or informally, and sharing those stories, is a great way to humanize your project.

What should you aim for?

Once you have selected a measure, how do you set a goal? Usually, the goal is a combination of internal considerations (what you think is realistic) and external benchmarks. Some common benchmarks include:

- Use external comparison data
- Medicaid National Average
- Medicaid National Best
- Commercial National Best
- Your local Consortium
(if community health clinic) or Primary Care Association
- HEDIS
- UDS

EXERCISE #2 Identifying target metrics

Discuss with a neighbor...

	What 1-2 numbers do you want to measure?	How will you use this measure to prompt change?
1. You want your staff and provider teams to huddle each morning.		
2. Your clinic is trying to increase colorectal cancer screening rates by having MAs hand out FIT tests to qualifying patients.		
3. You want to increase the attendance at your diabetes support group.		
4. You want to improve the courtesy of front desk staff toward patients.		
Choose your own:		

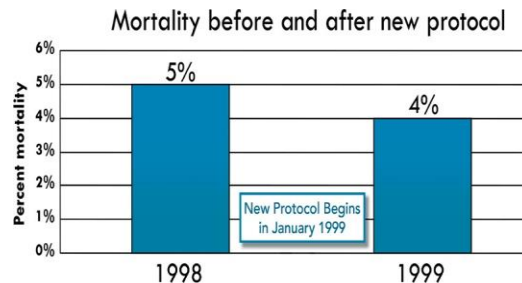
DISPLAYING PERFORMANCE INFORMATION

In contrast to quality assurance, the fundamental question of a quality improvement project is “was there an improvement over time?” How do you show data so as to answer that question?

Let’s take a few examples:

What’s Your Analysis?—Two Views of a Mortality Study

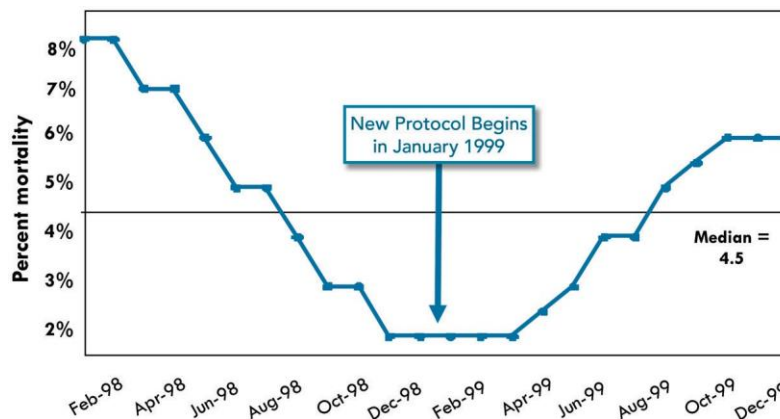
Data View #1:



More Detail– So What’s the Story?

When in doubt plot the dots. You’ll see more!

Data View #2:

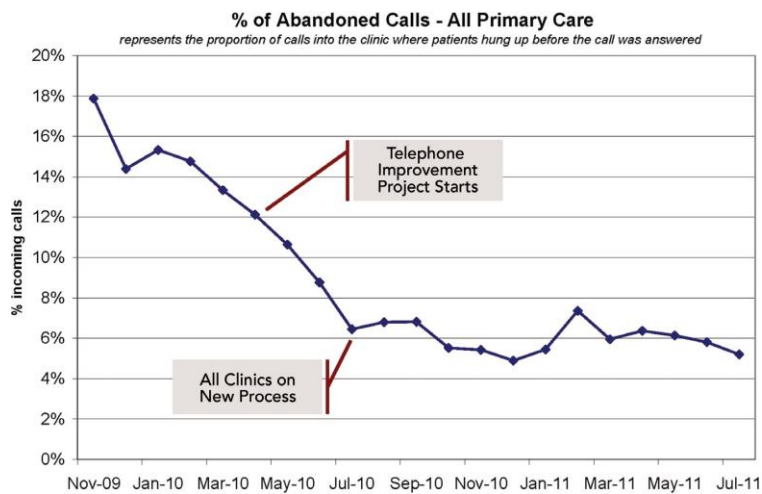


Decreased mortality was not due to the new protocol. Contrary to Data View #1, the visualization in Data View #2 indicates that it may have actually had a negative effect, increasing the mortality rate from approximately 2% to 6% over a six-month period.

Because Run Charts are a crucial tool for quality improvement, it is important that we understand how to interpret them. .

What Run Charts Show

How will we know a change is an improvement? There are a set of techniques for reading run charts and distinguishing common cause variation from special cause variation. Common cause variation may stem from factors such as season, surges in demand (such as demands for appointments to get school physicals in the fall or doctors notes in the winter), or random variation. It does not represent a meaningful change due to an intervention. In contrast, special cause variation results from changes to a process or service (for example, a quality improvement project). To distinguish special cause from common cause variation, we look for patterns such as shifts and trends.

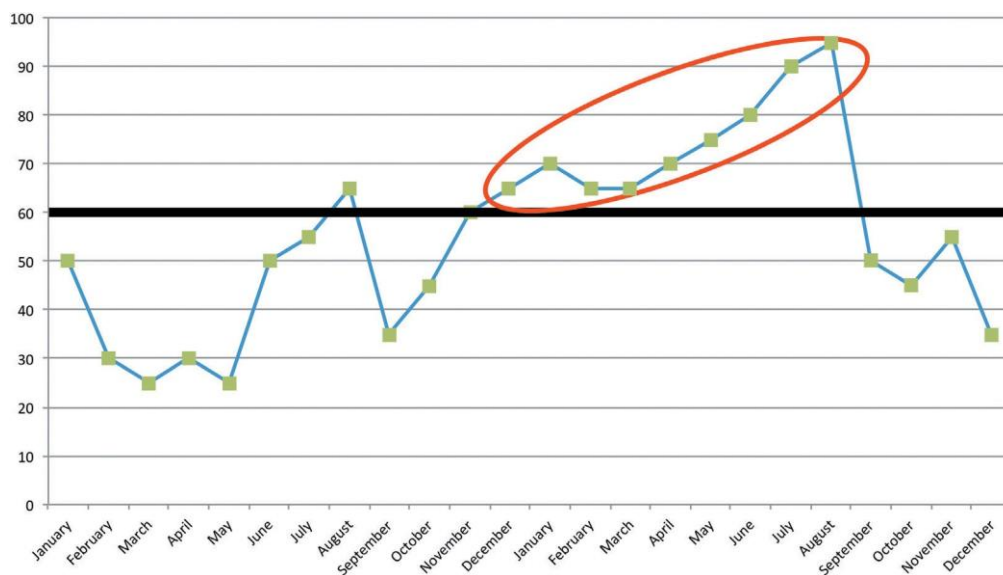


Tests to Determine Special Cause Variation

- **SHIFT:** a run of SIX or more points in a row either all above or all below the median
- **TREND:** FIVE or more points in a row increasing or decreasing (ties between two points in a row don't cancel or add to a trend)
- **Astronomical Data Point:** an unusually high or low value

SHIFT: Special Cause

A run of SIX or more points in a row above (or below) the median (don't count points on the median). A shift usually indicates a meaningful change.



How to calculate a median

Sort all data points from low to high. If you have an uneven number of data points, find the middle number—that is the median. If you have an even number of data points, find the two middle numbers and take the average of those two numbers— that is the median. For example:

3,5,7,9,11,13,17,21,45—

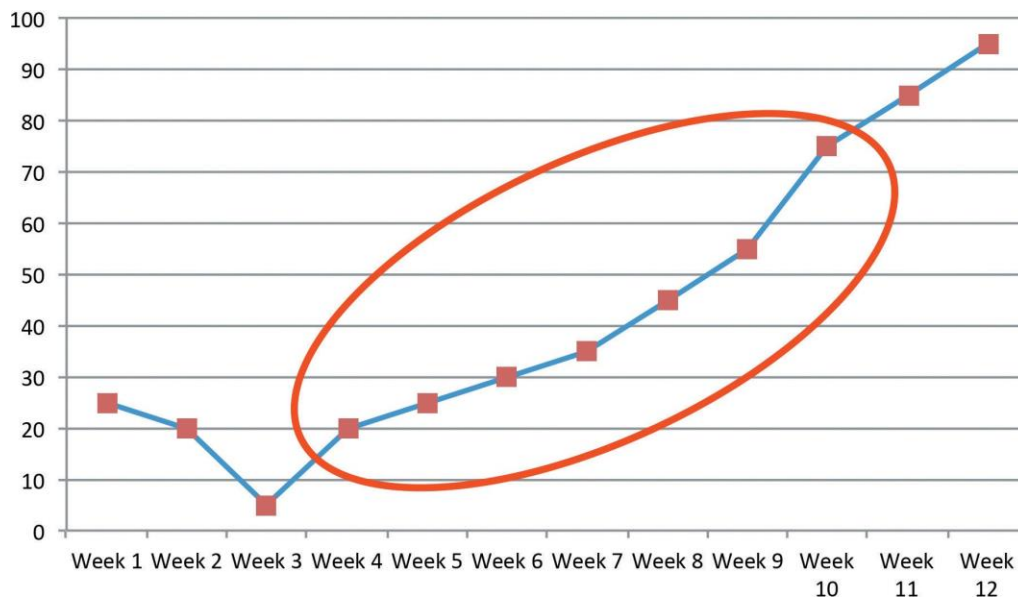
the median is 11

3,5,7, 9, 11, 13, 17, 21,45,52—
the median is 12

TREND: Special Cause

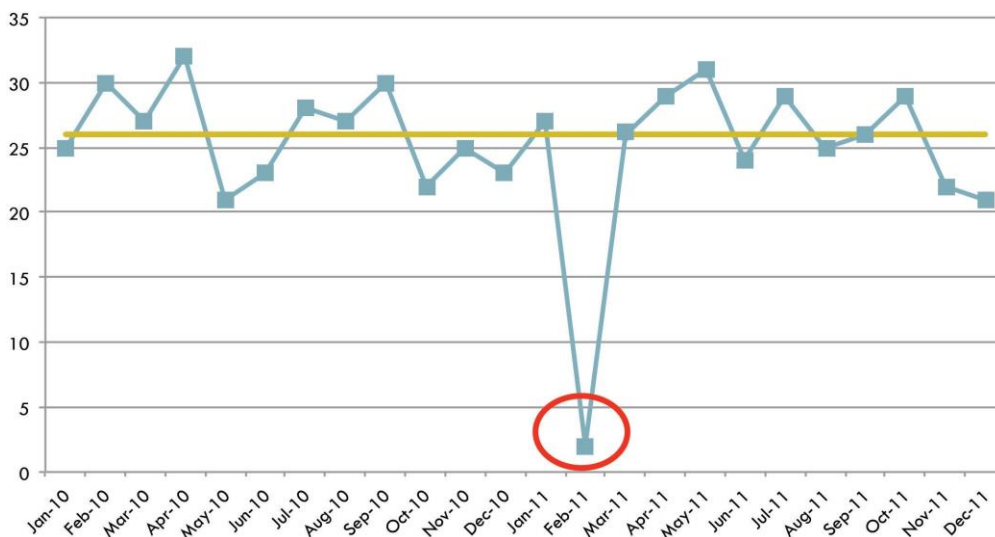
FIVE or more points continuously increasing or decreasing

(when two consecutive points have equal values, the consecutive point doesn't cancel or add to a trend). Like a shift, a trend is likely a meaningful directional change.



Astronomical Data Point: Special Cause

An unusually high or low value. This typically indicates a temporary disruption (e.g., a clinic closure) that does not reflect on the success of the quality improvement effort and – in most cases – should be ignored.



EXERCISE #1 Coaching Run Charts

For this learning activity on airplane-making and the PDSA cycle, please see the materials in the shared folder. To prepare for the activity, provide airplane construction supplies, such as various weights of paper and paperclips. You will need a long hallway or space to fly the airplanes (ideally at least 30 feet). Put down masking or painter's tape along the flight path and mark it for distance. You may also wish to provide each team with a long tape measure.

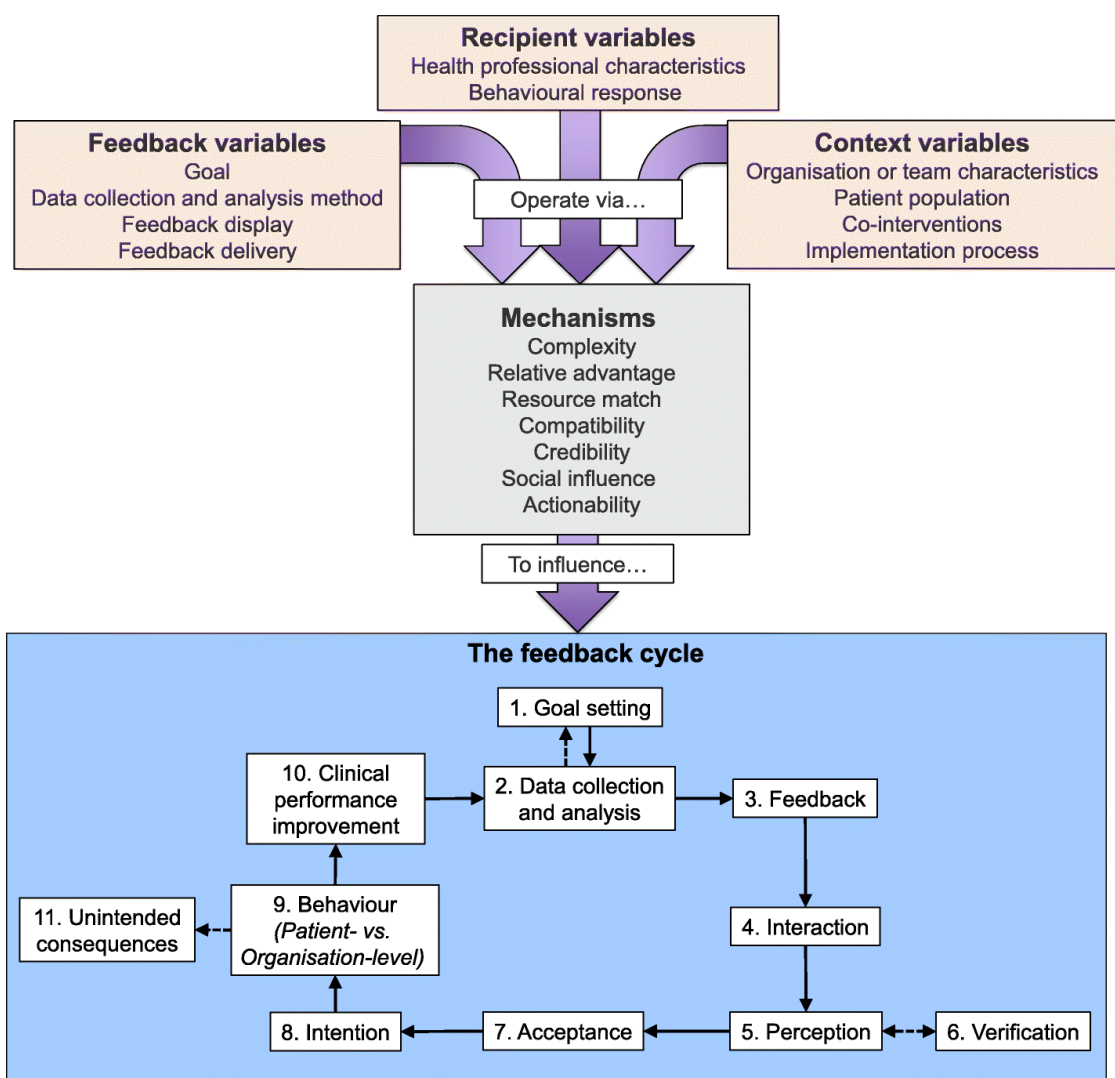
Divide into teams of about 4-6 people. Each team will identify a pilot, a recorder, and a measurer. Each team will construct a paper airplane and then fly it 6 times, recording the distance flown on their chart. Then they will huddle to identify one (and only one!) change they wish to make to their airplane. After making the change, they will fly it another 6 times and record the distance for each flight. Then make one more change (Encourage teams to consult with each other! Quality improvement requires cross-team collaboration!) and make another 6 flights.

Use the run charts just created to look for shifts, trends, and astronomical data. Did groups see an improvement?



Clinical Performance Feedback Intervention Theory (CP-FIT)

New research has culminated to create a comprehensive health care-specific feedback theory that can be used to design, implement and evaluate feedback. Four specific feedback variables influence progress round the feedback cycle and drives improvement: feedback variables, recipient variables, context variables, mechanisms.



A common struggle for clinics is they implement data driven improvement strategies that result in a wide range of impact. Without understanding the how and why feedback works many times the strategy is abandoned.

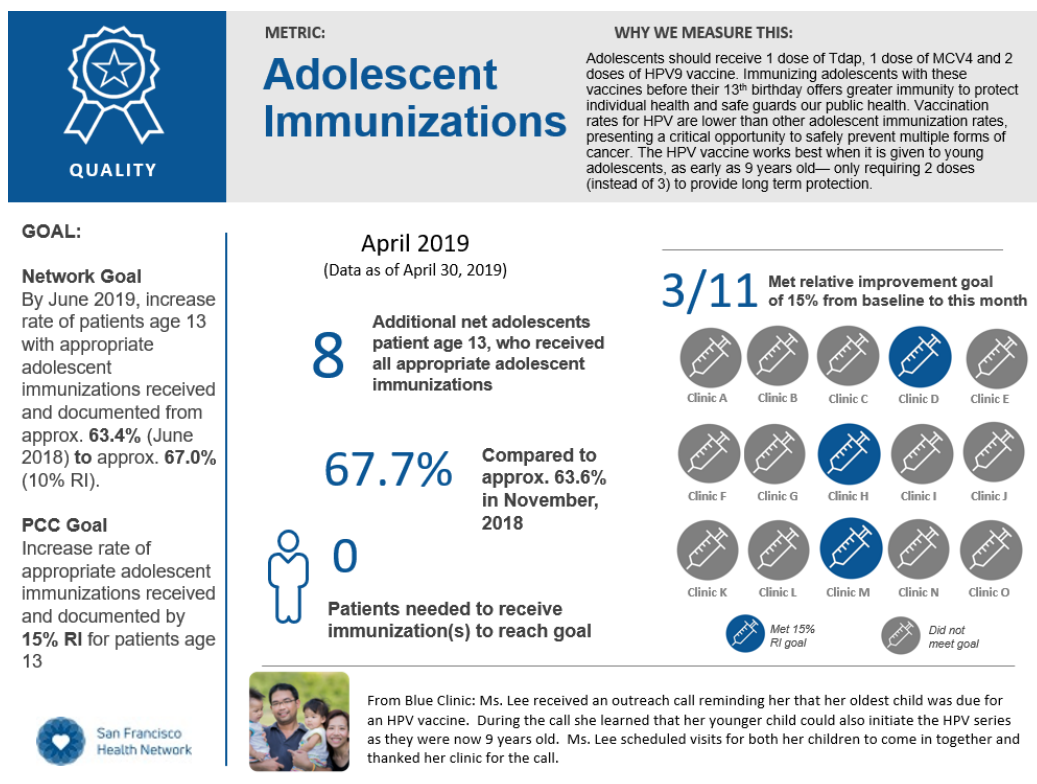
NURTURING A CULTURE OF QUALITY

So you have a great goal, you've chosen your measure, and everyone trusts your data. Now how do you create a culture of openness and excitement around your data? How do you avoid the feeling that data is being used in a punitive way?

Here are some of the approaches that we have observed that are effective at data-driven improvement:

1. **Be transparent with failings:** At multiple clinics, we've seen a medical director openly acknowledge being at the bottom of rankings on metrics such as access. Admitting imperfection and asking for advice can help set the tone for others.
2. **Translate percentages into patients:** A movement from 65% to 68% for up to date mammography may not be exciting, but what about saying that we ensured that 17 more patients completed their mammograms? Is there a specific patient story to be proud of?

One health system used this template for their quality measures, always tying percentages to number of people and their stories.



3. **Express curiosity and appreciation:** Engage the team as experts in patient care who can help to unravel a puzzle (What are some of the reasons that our diabetic retinopathy screening rate is low? What are you hearing from patients?) and come up with new ideas (Wow! Blue team got 25 people up to date on colorectal cancer screening this month! What are you doing?)

Helpful questions begin with...	Avoid questions that begin with...
• What are...? • How can we ...? • Tell me about... • What do you do if ...?	• Why didn't you...? • Shouldn't we...? • Why haven't you...? • If it were me, I'd just ... • Why can't we just...?

EXERCISE #3

Case Study Clinic #1

Clinic 1 has been focused on improving the screening rate of pap smears and mammograms. They have been emailing clinician-level data for the last 3 months. They are getting significant pushback from some providers who don't understand why they are being given this "Report Card." They are asking if they will be penalized on their performance incentives based on this data and question the validity of the data and the targets. It is unclear if several clinicians in the practice have been receiving the reports, as the quality improvement team hasn't heard anything back. There are four teams in the clinic, each comprised of 2 providers, 3 support staff, and an RN. Teams meet monthly.

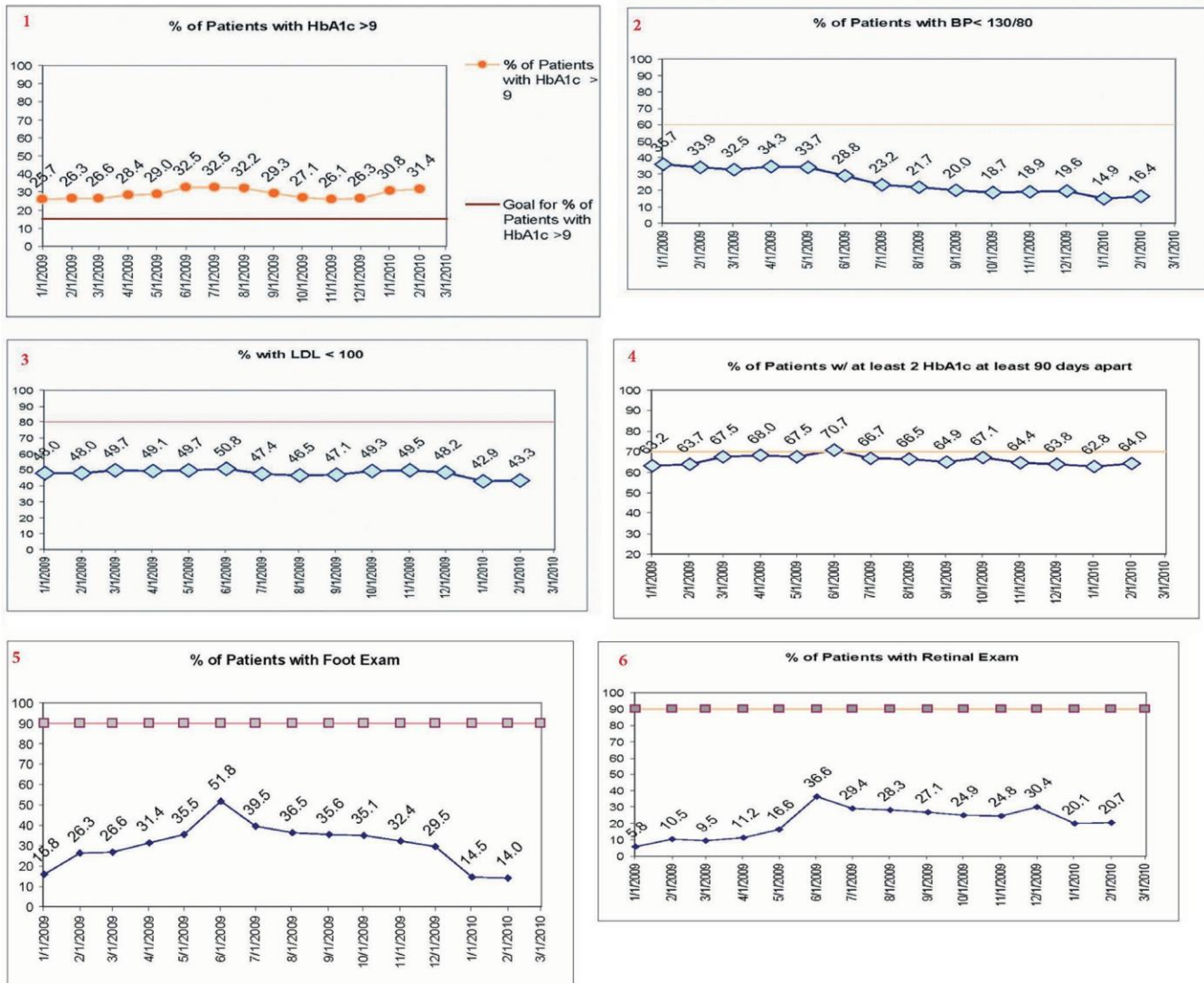
What advice would you give the Leadership Team of Clinic 1 for:

- ***How to address the concerns of the vocal providers in the clinic?***
- ***How to make sure all staff who need access to the data are getting it?***

Case Study Clinic #2

Clinic 2 has been tracking several metrics for their patients with diabetes and displaying it on a data wall for the clinic to see. They are asking for help interpreting the data and giving them an idea of where to focus their improvement efforts for this sub-population in the clinic.

For Clinic #2, take a look at the following measures:



- *What is the run chart telling you?*
- *After reviewing all charts, where would you recommend the leadership team focus?*

Case Study Clinic #3

Clinic 3 conducted a quality improvement project designed to improve pediatric immunization rates. The conducted outreach calls to families whose kids were overdue for immunizations and invited them in for well-child visits. They mentioned the project a few times at staff meetings and the leadership team looked at quality data at their monthly meeting and noticed promising improvements in immunization trends. After a few months, they started a new project about improving foot screenings and retinopathy screening for patients with diabetes, and the immunization project was largely forgotten.

What advice would you give the Leadership Team of Clinic 3 for:

- ***Why do you think this project faded out?***
- ***How might the practice improvement have used the data to drive and maintain improvements?***

Answer keys

Exercise 2: Some sample answers include...

	What 1-2 numbers do you want to measure?	How will you use this measure to prompt change?
1. You want your staff and provider teams to huddle each morning.	Number of days in a week the team huddled	Put up board with name of each team and mark with green dots when they huddle, red when they don't. Huddles every day get you bagels and coffee the next Monday.
2. Your clinic is trying to increase colorectal cancer screening rates by having MAs hand out FIT tests to qualifying patients.	Proportion of people who needed a FIT test each day who received one	Provide a prize (gift card, or even just a goofy trophy) each week to the MA reaching the greatest proportion of people needing FIT tests. Share patient stories at staff meetings about patients who decided to take care of their testing because of interaction with MA.
3. You want to increase the attendance at your diabetes support group.	Number of first time attendees Number of return attendees	Engage core group of patients & staff in identifying the needs of patients (e.g., through waiting room survey) so as to tailor the content. Involve them in inviting others and in monitoring changes to attendance.
4. You want to improve the courtesy of front desk staff toward patients.	Average score on patient survey question: "I feel the front desk staff treats me with respect"	Mini-retreat with front desk staff and patient advisors. Ask patient advisors to speak about one good and one bad experience with front desk (doesn't have to be at this clinic) and how it impacted them and their relationship with the clinic. Invite staff to share their own experiences, as well as what barriers they face (e.g.,

	What 1-2 numbers do you want to measure?	How will you use this measure to prompt change?
		supervisors or back office staff who don't support them in resolving problems). Develop shared way of greeting and responding to patients and support needed from practice leadership. Review scores during weekly huddles at the data dashboard.
Choose your own:		

Exercise 3

Some Answers...

You will come up with even more!

What advice would you give the Leadership Team of Clinic 1 for:

- How to address the concerns of the vocal providers in the clinic?
 - Distribute patient lists along with metric performance data so that all teams know which patients are driving the measure.
 - Share the specifications early and often. Make sure everyone has access to the knowledge of where each data element comes from in EHR and how the metrics are calculated. Consider attaching this to dashboards when they are distributed.
 - Have Medical Director go 1:1 or to small provider meetings to answer questions
 - Allow providers/team members to audit reports and get back to them about why different patients are included/excluded.
 - Be patient and answer these questions as often as they come up.
- How to make sure all staff who need access to the data are getting it?
 - Consider printing out copies and leaving it on team members chairs
 - Distribute hard copies during monthly meeting. Leaders can be present to answer questions.
 - Create data wall to display all data so that it's easy to see

For Clinic #2, take a look at the following measures:

- What is the run chart telling you?
 - There has been no change in the % of diabetic patients whose A1C is out of control
 - The % of patients with their blood pressure under control has steadily decreased; the performance is going down
 - The % of patients with LDL < 100 hasn't changed over the time period measured
 - The frequency of A1c measurements hasn't changed
 - There was an improvement in the early part of the year on foot exams but that has also decreased
 - There was some improvement in the % of patients with eye exams in June that has held relatively steady
- After reviewing all charts, where would you recommend the leadership team focus?
 - Overall, performance is stagnant or decreasing – if diabetics are a key part of the clinic population, they are right to focus here.
 - Ensure that the clinic leadership team has the ability to print out patient registries by each teamlet to identify all the diabetic patients on each panel.
 - Start with a volunteer pilot team to focus on improving these measures.
 - Give each team member a role but start focus where improvement can be seen easily (ie. Allow RNs/providers to pick 5 patients to coach/care manage but focus heavily on recall efforts to get the panel patients back in for their lab tests)

What advice would you give the Leadership Team of Clinic 3 for:

- Why do you think this project faded out?
 - There was no feedback loop in which staff asked to make outreach calls saw the results of their efforts or had an opportunity to celebrate their successes
- How might the practice improvement have used the data to drive and maintain improvements?
 - Providing regular reports on how many children were brought up to date on immunizations or sharing stories from family would have connected people making the outreach calls to the results of their work and given them an opportunity to make improvements over time.
 - Telling success stories from the project and publicly thanking the staff involved might have elevated their work.
 - This would be a great project in which to celebrate successes! Bringing bagels and coffee or sharing a thank

you card would be small tokens of appreciation that might be meaningful.

- Institutionalizing this work would have entailed integrating it into standard workflows and monitoring.