

Chapter 5

Examples from the OpiATE Initiative

What kinds of changes can your OAT clinic expect to occur while implementing the OMS? There are many factors that will affect how quickly the quality improvement process takes place at your clinic, such as staff willingness to participate, existing treatment policies, and the clinic's current performance level regarding evidence-based best practices. The first section of this chapter provides graphical data at baseline and after receiving the intervention for six months. Each graph relates to an OAT target practice or associated primary outcome measure. In addition to the graphs are some examples of the different ways in which individual OpiATE Initiative clinics chose to address these practices and outcomes, thus improving the ways in which they provide OAT services to their patients. The second section of this chapter provides a more detailed look at two clinics' experiences over the course of one full year.

SECTION 1: The OpiATE Initiative Experience



Baseline Clinic Characteristics

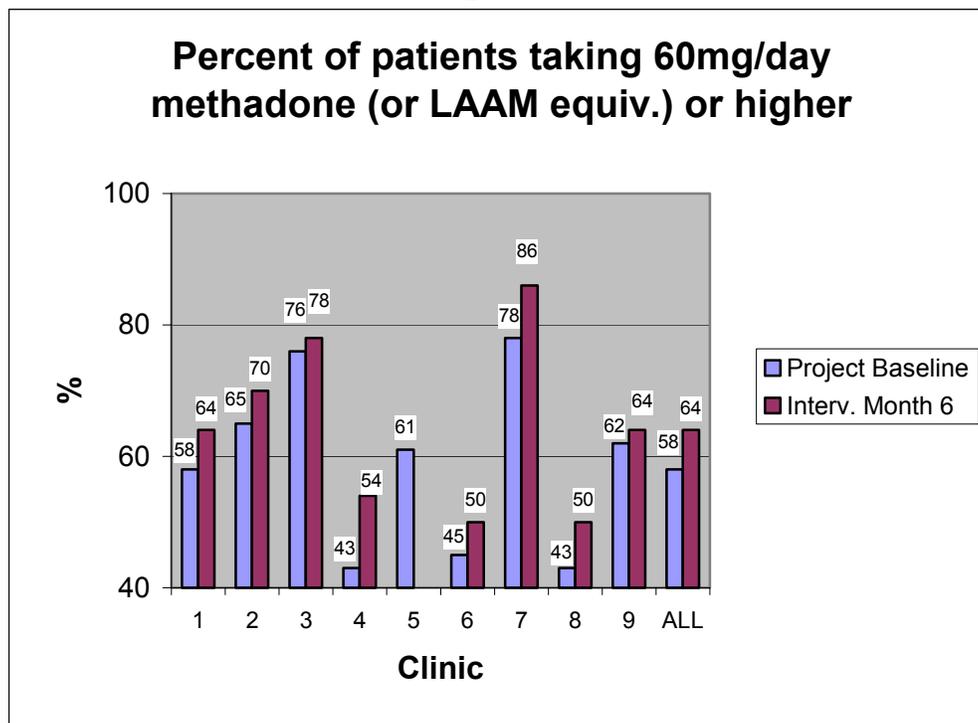
All nine OpiATE Initiative clinics were located in metropolitan areas across the country. The total number of case managers submitting monthly logs at each clinic ranged from 1 to 11 at baseline, representing a total of 44 case managers who participated in the project. Most were full-time employees seeing either methadone patients only, or a combination of methadone patients and patients with other substance use disorders. The total number of patients documented at baseline was 1,167. At six months into the intervention, there were 41 case managers seeing a total of 1,177 patients. Unfortunately, Clinic 5 began the process of closing down a few months into the project, so it is only included in the graphs at baseline and not at six months.



Appropriate methadone (or LAAM equivalent) dosing is a practice all clinics monitor routinely, as it is central to OAT and adjustments are often necessary for any number of reasons (e.g., a patient is experiencing withdrawal symptoms). Throughout this chapter, the term "methadone dose(s)" includes converted LAAM doses. All participating clinics chose to start the FQI process by focusing first on closely reviewing, monitoring, and adjusting methadone doses for all patients. Any patients prescribed less than the OpiATE Initiative benchmark of 60mg/day of methadone were identified and flagged by the Translation Facilitator at the start of the intervention phase. For some clinics, achieving compliance with best-practice recommendations for dose required months of individual and group dose reviews and regular assistance from the Translation Facilitator before dose changes were noticeable. For other clinics, potential dose adjustments were questionable for only a small number of patients and therefore required less scrutiny on the part of both clinicians and the Translation Facilitator. Two clinics were very close to being in compliance with the OpiATE Initiative dosing recommendations at baseline (see Figure 1, Clinics 3 and 7).

Below is a graph displaying the percentage of patients at each of the nine OpiATE Initiative clinics who were taking at least 60mg/day of methadone at baseline and six months after receiving the intervention.

Figure 1.



As can be seen in the figure above, the most substantial dose improvement was made at Clinic 4. This clinic started out with the lowest percentage taking at least 60mg/day of methadone, yet its percentage increase surpassed the two other clinics in the lower range. All clinics conducted thorough dose reviews at the patient level after the Translation Facilitator identified patients with methadone doses less than 60mg/day. Some clinics completed the reviews faster than others, but all clinics made this review a quality improvement priority. These clinics continue to review and adjust doses when appropriate, and Figure 1 shows that meaningful progress had been made over a six-month period at all clinics.

Clinic 1's efforts to increase methadone doses are a good example of how a clinic can examine and revise its existing policies as a basis for quality improvement. Only 58% of Clinic 1's patients were taking 60mg/day or more of methadone at baseline, and during the initial dose review, it was discovered that new patients' doses were being titrated at a slower than recommended rate. The clinic was also quick to utilize administrative discharge to deal with ongoing illicit substance use. Implementing a change in the titration process for new patients by decreasing the time it takes for a patient to receive 60mg/day of methadone, and by reviewing and working with policies regarding discharging patients, Clinic 1 became more guideline concordant and was able to increase their percentage of patients who were prescribed adequate doses. The OpiATE Initiative materials and additional literature and support provided to Clinic 1's clinicians empowered them in their attempts to modify existing practices and policies that would have been difficult to otherwise change.

Achieving optimal dosing practices takes time and effort to achieve. It requires careful attention to clinic practices and policies, and a willingness to modify them in order to make meaningful changes.

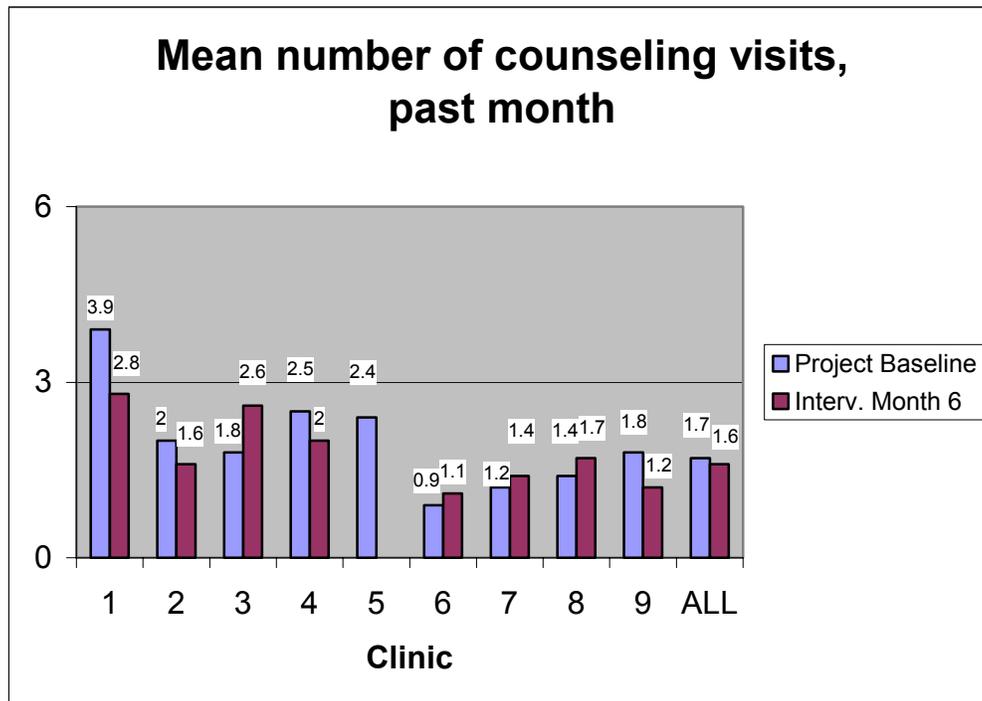


Counseling Frequency

As stated earlier, it is recommended that counseling frequency be higher—at least one counseling visit per week—for patients during their first month of OAT and for patients who continue to use illicit substances, followed by at least one counseling visit per month after the patient is stabilized. OpiATE Initiative staff provides monthly feedback to clinics showing the mean number of counseling visits attended per month at both the case manager and clinic levels. Looking at mean number of visits alone, intervention phase baseline results indicate that all nine OpiATE Initiative clinics were in concordance. However, these means do not allow providers to examine newer/unstable and established patients separately. If an OAT clinic frequently admits new patients and/or has a high number of unstable patients (e.g., high rate of positive urine toxicology screens), it may be most useful for case managers and clinic leaders to highlight and review counseling frequency for new/unstable patients separately from the more established, stable patients.

The graph below shows the mean number of counseling visits attended by patients at all nine OpiATE Initiative clinics at baseline and six months into the intervention phase. Clinic 6 was the only clinic not in compliance with evidence-based best practice recommendations for counseling frequency at baseline. Though this clinic has improved slightly, the clinic was still only seeing patients for an average of 1.1 visits per month at six months.

Figure 2.



Two larger clinics used the counseling frequency evidence summaries and monthly feedback to meet with case managers who were not meeting counseling visit frequency standards. They used the summaries and feedback to educate them about the importance of routine counseling visits and to implement changes in their scheduling practices. Another clinic that was already conforming to counseling visit frequency standards at baseline decided to focus on tracking their “concern status” patients (those who continued to use illicit opioids) to ensure they were attending enough counseling visits. Most importantly, while the average number of counseling visits per month may seem adequate at the clinic level, careful attention to individual counselors with low visit frequency and patients who are new/unstable is perhaps more important.



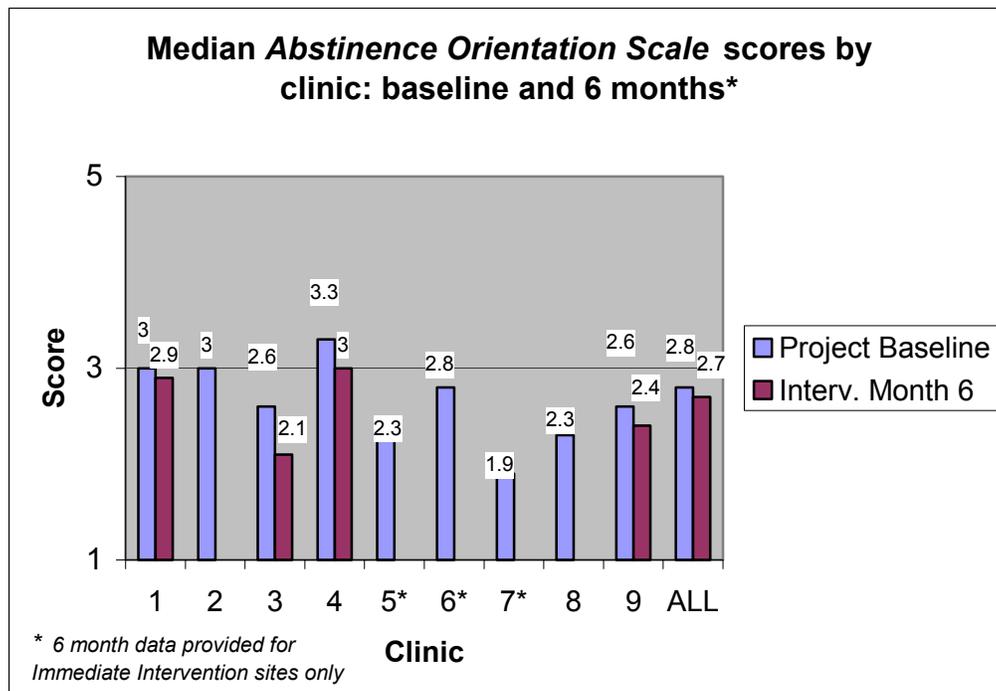
Program Orientation (Abstinence vs. Maintenance)

An OAT clinic’s general treatment orientation shapes the quality of care provided to its patients. Providers’ treatment philosophies regarding OAT are often based on deep-

rooted personal belief systems. Changing such belief systems requires intensive education and clinical evidence. At project start-up, OpiATE Initiative staff asked case managers to indicate on the *Baseline Case Management Log* whether each of their patients was on a maintenance or detoxification treatment regimen. Ninety-five percent of patients project-wide (N=1,085 of 1,147) were reported as being on a maintenance regimen. Nevertheless, based on interviews and observations, it was clear that abstinence oriented attitudes were still prevalent, and that such attitudes coincided with other treatment practices such as lower doses and more punitive responses to continued illicit drug use. Project staff found that a much better tool for measuring the treatment orientation of a clinic is Caplehorn, Lumley, and Irwig's (1998) *Abstinence Orientation Scale (AOS)*, which measures the level of abstinence orientation of individual case managers and other clinical staff (see Chapter 6). The AOS is a 14-item scale with a five-point Likert scale format ranging from Strongly Disagree to Strongly Agree. A provider or clinic with a median score of three or higher was considered abstinence oriented.

As can be seen in Figure 3, there was variation across clinics at intervention baseline and six months later. Neither Clinic 2 nor Clinic 8 returned follow-up scales six months into the intervention phase. For this reason, their 12-month follow-up scores are provided instead in Figure 3. The scores at baseline do not include all case managers who participated in the project, and the scores at six months represent a somewhat different mix of providers than those who initially returned scales (baseline N=58, six-month N=39).

Figure 3.

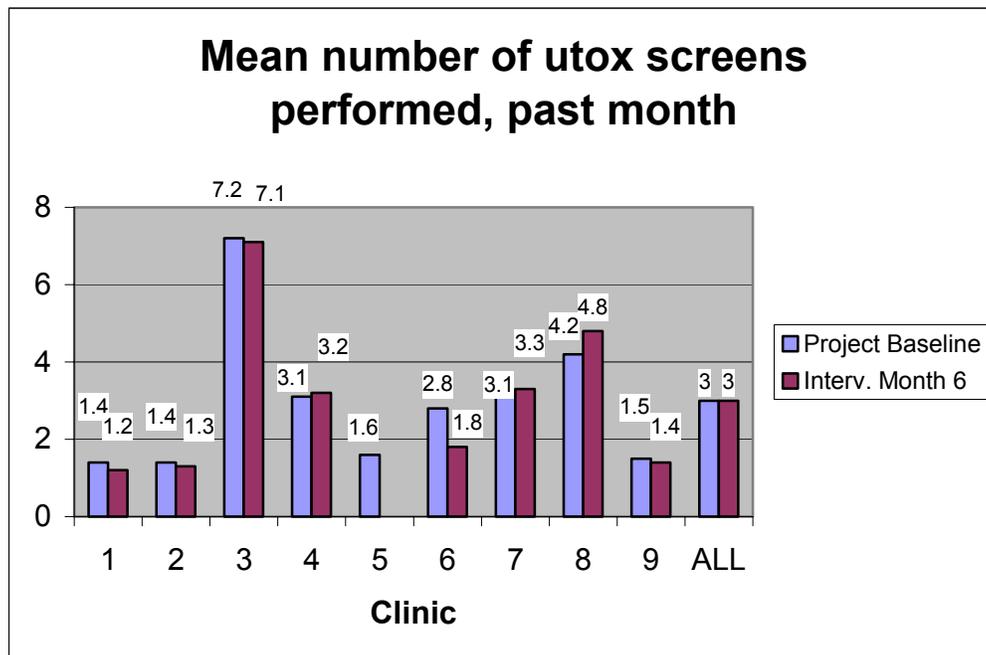


At the clinic level, Clinic 4 had the highest score (3.3) at baseline. After receiving individual and clinic-level baseline scores, Clinic 4’s program leaders worked with staff during team meetings to promote the benefits of a maintenance orientation, working from patients’ existing treatment plans. For example, if a case manager was planning to discharge a newer patient who continued to test positive for illicit opioid use, clinic leaders might initiate discussion regarding the potential benefits of increasing a patient’s dose to an optimal level before deciding to discharge him/her. When asked if any noticeable changes have taken place as a result of receiving OpiATE Initiative information at baseline (e.g., evidence-based summaries), a clinic leader from Clinic 4 stated, “one of the counselors now counsels using the chronic disease model. ... this indicates a real attitude shift on the part of that counselor.” This attitude change will positively affect both patients and staff members. There is still work to be done and ideally clinic-level scores will continue to decrease to closer to 2.0 over time as the clinics continue to work to improve OAT practice and outcomes.

Urine Toxicology Screening Frequency and Tracking Positive Results

The extent to which OpiATE Initiative clinics were in compliance with policies regarding urine toxicology screening frequency varied across clinics at baseline and six months later. It should be noted that a clinic that discharges patients because of continued illicit substance use earlier than is recommended will report fewer positive urine toxicology screen results. Therefore, extremely low positive rates may not necessarily represent a positive outcome. This factor must be taken into consideration when interpreting urine toxicology screening frequency and results.

Figure 4.



Figures 4-6 show OpiATE Initiative clinic variation in average monthly urine screening frequency, the percent of those screens that were positive for illicit opioids, and the percent of screens positive for other illicit substances (excluding cannabinoids).

Figure 5.

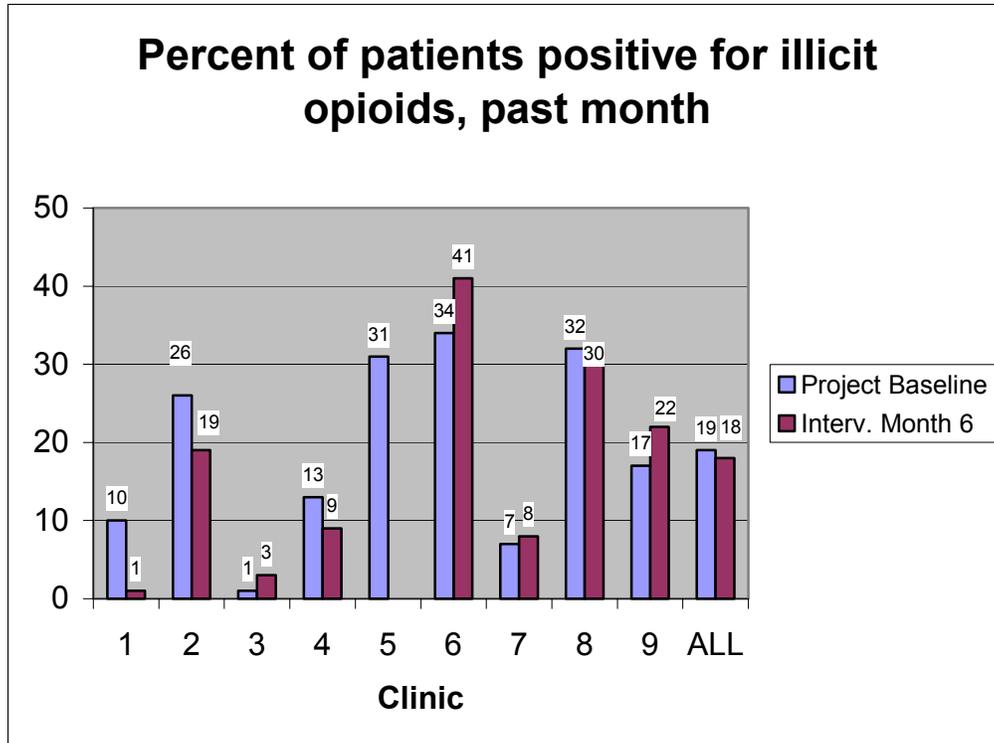
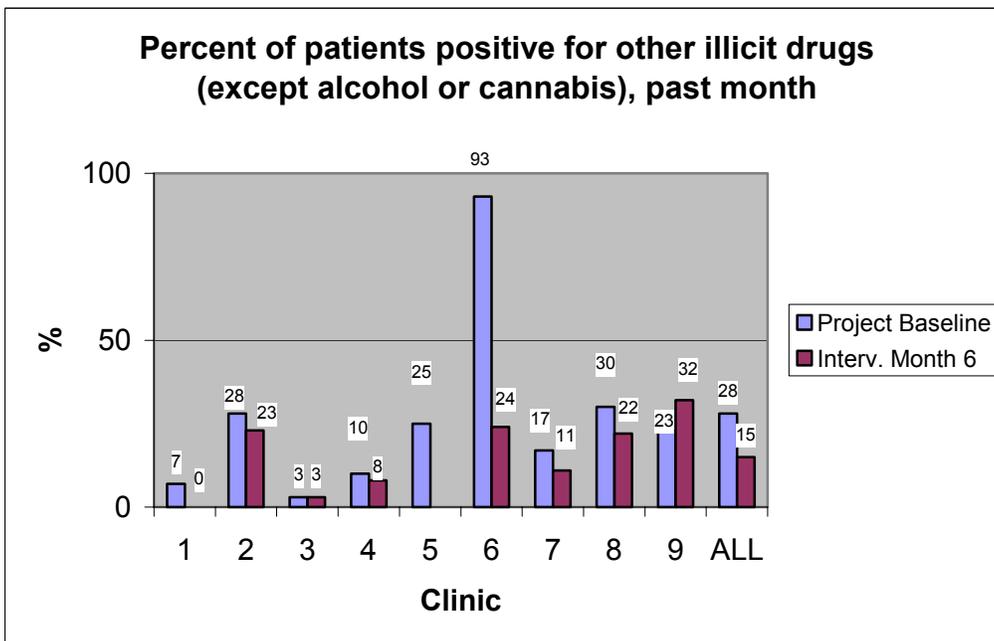


Figure 6.



One of Clinic 2's initial concerns after viewing baseline feedback results was its low overall frequency of urine screening (see Figure 4). This concern continued over subsequent months, and during a monthly interview call, a clinic leader stated he used the feedback graphs and an article regarding urine screening frequency to lobby for more frequent urine screens in his clinic. Another clinic began identifying unstable patients early on in the project, requiring them to provide at least one urine toxicology screen per week as part of its new contingency management plans. OpiATE Initiative staff has discovered that it takes many months before noticeable changes in positive urine toxicology rates begin to take place at the clinic and case manager levels. This is because many treatment-related factors (e.g., guideline-concordant dosing, frequency of urine screening) affect the likelihood of continued illicit drug use. Making adjustments to a few individual patients' treatment plans may decrease their illicit drug use, but it takes much longer to clearly see a difference on a larger scale.



Use of Contingency Management

This practice was not directly monitored using the *Baseline and Monthly Case Management Logs* like the practices and outcomes discussed above. Unless a clinic was generally guideline concordant on all other monitored practices at intervention baseline, contingency management did not become a quality improvement focus until later in the intervention phase since it is a more complex practice to monitor at the clinic, case manager, and individual patient level. It requires awareness of, and concordance with, the recommended best practices and outcomes areas above.

Implementing a structured contingency management plan was a goal shared by many of the OpiATE Initiative clinics. Some were much further than others from achieving this goal, even near the end of the project period. Qualitative information obtained during telephone and e-mail communications between project staff and clinic leaders provided the best information about goals and efforts to implement contingency management plans. For example, in a monthly telephone interview, one clinic leader stated that the project materials they received were being used to try out new contingencies. She said, "people [case managers] are trying contingencies, coming to me earlier to try and reinforce lack of drug use. Usually they would wait a longer period of time before they reward clean urines, now they [the patients] get take-homes earlier." Another clinic used the contingency management materials to identify unstable patients and put them on contingency management contracts, which required them to increase urine toxicology screening to at least once per week for these patients.

Another clinic is currently working on increasing the rate at which patients receive take-home doses and the rate they are screened for illicit drug use. In a telephone conversation the clinic coordinator said, "We only collect urines once a month now, so I'd like to increase the urines to more often in the first four weeks so they can get a reward faster." Another clinic's goal is to implement CM policies, but they do not

currently have enough staff available; nor does it have the funding to complete more frequent urine screening. However, the tools provided to them can be used to implement contingency management plans for a smaller number of patients and to push for more resources.

Two other clinics began implementing contingency management plans on a smaller scale. One clinic director decided to develop contingency management plans for some of his patients as a demonstration to his staff that contingency management can improve clinical outcomes. So far the results have been positive. The other clinic began a contract system for patients who were doing poorly so that they could receive a weekend take-home dose of methadone as long as they provided a negative urine toxicology screen the week prior. They were successful in achieving fewer positive urine screen results for this select group of patients. Both of these small-scale examples provide evidence that working with contingencies is feasible, does not necessarily require additional staffing or funding and can result in improved clinical outcomes even if only for a handful of patients. Chapter 2 includes a section with suggestions for implementing contingency management practices in your clinic.

In sum, all OpiATE Initiative clinics are now aware of OAT best-practice recommendations, have made some meaningful improvements, and are continuing to work to improve patient outcomes by improving clinical practice. Some clinics face more barriers (e.g., staff resistance to change, staffing shortages, budget cuts), but all have discovered ways to implement changes for the better, both small and large. Section 2 of this chapter provides examples of quality improvement efforts made by two clinics with the most need for improvement in treatment practices and outcomes at baseline.

SECTION 2: The Quality Improvement Experience at Two Clinics



Clinic A



Baseline clinic description

This immediate intervention site is located in a large urban setting and had nine full-time case managers and 161 patients at baseline. Each case manager was responsible for seeing a combination of both methadone patients and patients with other addictive disorders.

OpiATE Initiative staff identified practices that were not meeting evidence-based standards at baseline. While there was room for improvement in each of the four target practice areas and their associated outcomes, the three areas that required the most immediate attention were:

- 1) dosing,
- 2) overall abstinence orientation, and
- 3) their strict administrative discharge policy.

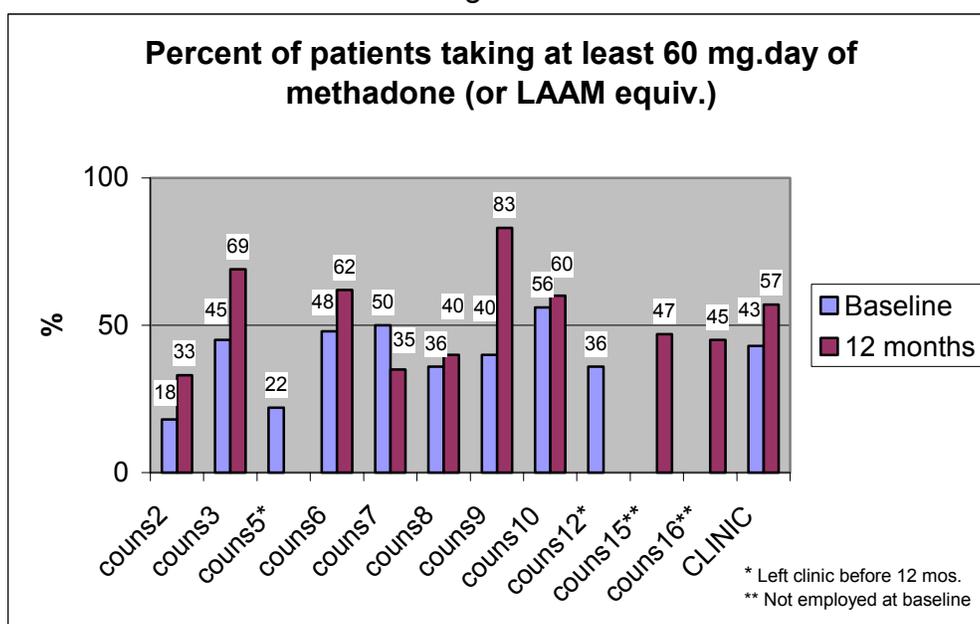
Monthly log data and information gathered during telephone conversations between project staff and clinic leaders provided evidence that improvements in each of these three areas were made. The following section describes Clinic A's focus on these three primary areas of concern in their attempts to improve the quality of care they provide.

Dosing

All OpiATE Initiative clinics chose to begin the quality improvement process by examining methadone doses for all of their patients. The process of identifying unstable (e.g., testing positive for illicit opioids) patients with methadone doses below 60mg/day,

and adjusting their doses accordingly, results in more immediate, noticeable, positive patient outcomes than the other target practice areas. In addition, the dose review results in staff paying more attention to urine toxicology screening practices and outcomes. To begin the quality improvement process, project staff collected Clinic A's dosing policies at baseline, along with baseline methadone doses for each patient in the *Baseline Case Management Logs*. Clinic leaders indicated that their policy for dosing newly enrolled patients was to increase their doses to 40mg/day of methadone and to hold them at that dose for monitoring. Log data supported this policy information showing that only 43% of patients were taking at least 60mg/day of methadone (see Figure 7). The average patient methadone dose for the entire clinic was 55mg/day, among the three lowest of the nine participating clinics.

Figure 7.



To begin the quality improvement process, the Translation Facilitator extracted all patients from the *Baseline Case Management Log* with methadone doses under the recommended 60mg/day and asked case managers to indicate on a *Dose Review Form* (see Chapter 6) why these patients were receiving low doses and whether or not they might benefit from a dose increase. In some cases patients were reported as being stable on lower doses (i.e. they were established patients and were not providing opioid-positive urine toxicology screen results), while a few patients required lower doses due to medical reasons (e.g., metabolic disorder). While these are legitimate reasons for not prescribing doses of 60mg/day or higher, the Translation Facilitator asked case managers and clinic leaders to formally consider dose increases (e.g., discuss dose increases at weekly team meetings) for all other patients receiving less than 60mg/day of methadone. In subsequent months, the Translation Facilitator continued to monitor patients for whom doses had still not been increased but for whom increases might be beneficial. Clinic leaders were asked to complete a separate dose review form for these patients and were asked to discuss their doses with the OAT

team. During the dose review process, the team agreed to change their dosing policies for new patients so that their doses are routinely increased to 60mg/day at a faster rate (rather than 40mg/day).

According to one clinic leader, the process of reviewing doses on an ongoing basis made OAT staff more aware of the potential for, and benefits of, increasing dose to appropriate levels. More specifically, she commented that this systematic dose review forced case managers to recognize the association between positive urine toxicology screens and low doses—a connection that was not being made prior to the formal review. In general, they are now more aware of this association when making clinical decisions, and low doses must be justified when making dosing decisions for individual patients. As a result, Clinic A experienced an increase in methadone doses at the clinic level.

Of the seven case managers who were treating patients at baseline and 12 months later, only one case manager did not experience an increase in percentage of patients taking at least 60mg/day of methadone (see Figure 7). One case manager increased the percentage of his caseload taking at least 60mg/day by 43% (40% at baseline to 83% 12 months later). As shown in Figure 7, the percentage of patients at the clinic level taking 60mg/day or more increased by 14% over 12 months. This increase surpasses the dose percentage increases made at the other two clinics with the lowest clinic-level methadone doses at baseline.

The two new case managers (see Figure 7, Month 12) were hired after improvements in dosing practices began, and though they were assigned newer patients when they started, these new patients' doses should increase to 60mg/day at a faster rate than they would have before the clinic participated in the OpiATE Initiative. This will hopefully result in these patients stabilizing earlier in their course of treatment. Clinic A will continue to work with their evidence-based dosing tools and maintain their updated dosing practices for new patients. Though there is still room for improvement, Clinic A's efforts to improve its dosing policies have resulted in noticeable dose increases at both the case manager and clinic levels. While increasing patient doses was the most tangible, immediate improvement clinics could make, improvements in other practice areas were necessary in order to sustain their improved dosing practices.

Treatment philosophy (abstinence vs. maintenance)

While continuing to work on dosing practices, Clinic A received feedback regarding its overall OAT treatment orientation score based on the AOS (see Chapter 3), which all case managers and other clinic staff were asked to complete at baseline. Before the intervention began, clinic leaders acknowledged that the clinic was an abstinence-based program and that a few case managers were strongly abstinence oriented. The median clinic score was 3.3, the highest (or most abstinence oriented) score across all nine clinics. There were two case managers whose scores were considerably high, which was not surprising to clinic leaders. In addition, the chief case manager endorsed an

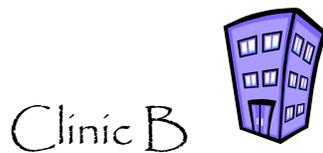
abstinence-based approach to OAT, along with one of the psychiatrists who was resistant to prescribing higher doses. Finally, the number of patients being administratively discharged at the clinic level was high compared to other clinics.

With support from the Translation Facilitator, clinic leaders used the AOS scores as a basis for discussion with the two abstinence oriented case managers about the ineffectiveness of abstinence-based OAT. This was necessary early on in the intervention because a continued resistance to providing maintenance treatment would slow progress in making quality improvements in other target practice areas. At 12 months into the intervention, there is still some open resistance to supporting a maintenance philosophy, but meaningful changes have been made. Changing clinicians' attitudes about their treatment beliefs is a difficult and time-consuming process and, unlike changing a patient's dose, it requires a detailed examination of a clinician's long-held beliefs and that person's willingness to make adjustments to their daily treatment routine.

While both OpiATE Initiative staff and clinic leaders at Clinic A have worked to educate individual case managers who were abstinence oriented at baseline, 12 months is not likely enough time for clinic-level changes in attitude to occur as evidenced by AOS scores. This was true for all participating clinics. At the same time, follow-up interviews with clinic leaders at Clinic A indicated that case managers have become more aware of the advantages of maintenance-based OAT, and that this awareness has been demonstrated in recent months in clinical treatment decisions. One clinic leader said that she has noticed a shift among some staff to viewing methadone maintenance as a chronic disease model, using diabetes as an example. One of these staff members was the chief case manager. Interestingly, after a few months of participation in the OpiATE Initiative, he began interviewing candidates for case manager positions and decided to ask candidates about their attitudes toward maintenance oriented OAT, providing education about the benefits of maintenance therapy if they were supportive of an abstinence-based approach to OAT. In addition, clinic leaders noted that some case managers were much more likely to utilize administrative discharge to deal with continued substance use. Clinic leaders now require the team coordinator to sign off on all administrative discharge orders to reduce the variability across case managers. Lastly, the psychiatrist who was resistant to prescribing higher levels of methadone is now open to prescribing higher doses after being provided with educational materials and training.

Six months into the intervention, a follow-up scale was administered in an attempt to qualitatively assess progress made to date. The clinic-level score shows a slight shift toward endorsement of a maintenance philosophy. The median clinic-level AOS score decreased by 0.3 points to 3.0. While this score is an improvement since baseline, it is still not indicative of an overall maintenance orientation. Meaningful changes are being made at Clinic A, but they are still actively working to overcome some major barriers to becoming a more maintenance-based program. There is still room to improve the number of administrative discharges that continue to occur. Clinic leaders are hoping this will change now that policies have been modified in recent months. By continuing to

work toward becoming a maintenance oriented program, associated maintenance oriented best-practices (e.g., guideline-concordant dosing) will be easier to implement and maintain over time.



Baseline Clinic Description

This immediate intervention site is located in a large urban setting with seven case managers (FTE=5) and 210 patients at baseline.

Like Clinic A, baseline data collection at Clinic B revealed multiple practices and associated outcomes with potential for improvement. The three primary areas of focus for quality improvement were:

- 1) dosing practices,
- 2) counseling frequency, and
- 3) contingency management.

Dosing

Clinic leaders claimed they were a “high dose” clinic before the project started, but log data at baseline indicated otherwise. Specifically, only 43% of patients were actually prescribed methadone doses of 60mg/day or higher. Along with Clinic A, this represents the lowest percentage across all nine clinics. The average dose at baseline was 56mg/day at Clinic B, among the three lowest clinic averages.

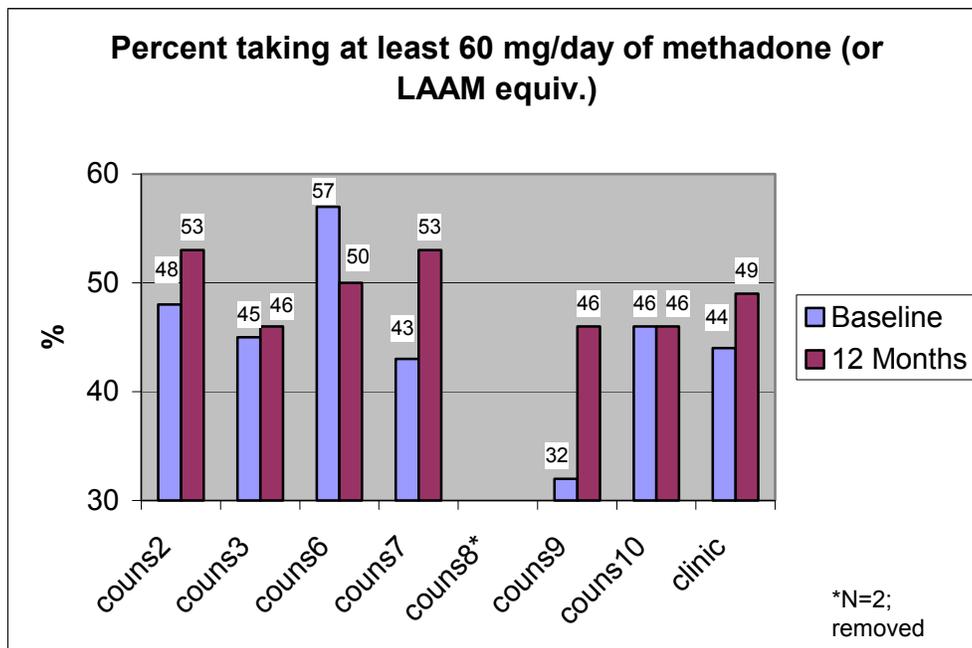
In some cases participating clinics or individual case managers assumed they were in concordance with one or more evidence-based best practices, and were surprised to learn that the *Baseline Case Management Log* data they submitted indicated otherwise. Dosing practice at Clinic B provides a good example of the importance of carefully examining current treatment practices rather than assuming that minimum standards are being met. As mentioned above, *Baseline Case Management Logs* revealed that only 43% of patients were receiving methadone equivalent doses of 60mg/day or higher. Clinic leaders were very surprised to hear this after assuming they were a “high dose” clinic.

In an attempt to improve the quality of dosing practices at Clinic B, the Translation Facilitator worked with clinic leaders to identify which factors were contributing to lower

patient doses. The two factors identified through conversations with clinic leaders were that positive urine toxicology screens were not being flagged routinely, and that patients who refused recommended dose increases were documented but then no further intervention took place.

The Translation Facilitator asked case managers to complete the *Dose Review Form* and to use this information to address dose issues for individual patients during team meetings. Seeing the number of positive urine toxicology screens next to dose on paper forced case managers to make the association between low dose and increased positive urine screen frequency. One clinic leader reported that she now requires case managers to routinely review both dose and number of positive urine screens for all patients. This scrutiny has resulted in staff members feeling as if they are treating patients on a more individual level as opposed to applying a “blanket course” treatment plan to all patients. As mentioned above, some patients were reportedly refusing dose increases that were recommended by staff. Recognizing that there was lack of follow-up with these patients after they refused, the medical director decided to start meeting individually with patients to explain the importance of compliance with recommendations. Though there are still improvements to be made, Clinic B has been successful so far in identifying and addressing critical factors that were preventing guideline-concordant dosing practices. As can be seen in Figure 8, Clinic B’s dose improved over a 12-month period from 43% to 49%, taking at least 60mg/day or more of methadone. The average dose increased from 56mg/day to 58mg/day over 12 months.

Figure 8



Counseling Frequency and Contingency Management

There were a few case managers who were not following evidence-based best-practice guidelines for counseling frequency. To address this problem, the medical director decided to meet individually with these case managers to educate them about the importance of providing at least the minimum recommended number of counseling visits each month. Since then these case managers have complied with recommendations. OpiATE Initiative materials (e.g. counseling frequency evidence summary) and support provided the medical director with the necessary tools to approach and work with these case managers.

The third focus of Clinic B's quality improvement efforts was to refine their existing contingency management policies and start implementing them routinely. After discussing their existing contingency management policies with the Translation Facilitator and components that required modification, staff members at Clinic B worked together during team meetings to draft new contingency management policies. One practice that was inconsistent with evidence-based best practice guidelines was their system for awarding and removing take-home doses. Staff members recognized that while they were consistently removing take-home doses for patients testing positive for illicit drugs, they were not consistent in awarding take-homes to stable patients. Patients were responsible for requesting a change in take-home schedule when they believed they had met the requirement. To resolve this, they developed a schedule for awarding take-homes to qualified patients that made the process of recommending take-home doses for individual patients a clear process for all case managers. The second area Clinic B staff focused on in order to improve their contingency management practices involved their LAAM patients who were chronic illicit drug users. Unlike unstable methadone patients who are required to come to the clinic for dosing 6 times per week, unstable LAAM patients were only required to come to the clinic for dosing 3 times per week. Clinic staff decided to switch these LAAM patients to methadone and require them to come to the clinic 6 times per week for dosing. In addition, they were placed on new contracts allowing them to earn one additional take-home if they are abstinent for 30 consecutive days, followed by an additional take-home if they are abstinent for 60 consecutive days. Clinic B is adjusting to these new changes and is still working to develop a solid contingency management plan.

Summary

The previous case studies are just two examples of how implementing the OMS in your clinic may assist in documenting quality improvements, support consistency in program policies, and foster dialogue between staff members. The OMS is a toolkit provided to assist clinic managers in this endeavor. Because clinics differ in their strengths and needs, the OMS allows for flexible implementation. This toolkit provides materials to assist in staff education of OAT best practices, as well as tools to measure and implement these practices.