

Small Practice Considerations*

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Part One: Building a Strong Conceptual Foundation and CDS Program Introduction

In a small practice, there are fewer hands and resources to get things done. Think about the 'most important things' to accomplish with the CDS program - i.e. how these ideas above apply to your practice. The approach to starting a CDS program and implementing effective CDS interventions will be adapted based on the resources, available personnel, and clinical objectives. Within the framework of the 'Tasks', presented below, are recommendations for success in the small practice setting. These recommendations were suggested by clinicians in small practices successful in their use of CDS or by consultants who help to support small practices in their use of CDS. The recommendations provide specific tasks or highlight concepts that are particularly important for the small practice.

Basic Concepts and Approach: A Shared Broad Understanding of CDS as an Operational Imperative

- Establish a strong/shared foundation around basic concepts (e.g. CDS definition and scope) and approaches for yourself and your team to underpin your efforts to develop successful CDS programs and interventions.
- Each member of the small practice environment should be able to satisfactorily answer the question: "What's in it for me?" Leaders of the initiative should lay out some of the risks and benefits financially and clinically. This will help ensure that they are on board with the creation of the program.
- It is particularly important that CDS become part of the quality improvement initiatives in a practice. In order to be most successful, the program should be "bottom-up" as a "top-down" approach might feel as though it is an enforcement rather than a team initiative.
- In a small practice, the leader of the CDS initiative must be willing to continuously sell and convince all other members of the value of CDS. This is important to creating the right culture for a CDS program.
- Begin outlining, or refining, a set of initial strategic victories to be pursued and claimed
 - Make sure these goals are reasonable and scaled to the resources that the practice has available. Starting with something manageable and useful is important to building confidence. The process requires patience and celebrating small victories.
- Begin building a shared vision among key participants (e.g. physicians, nurses, practice managers, office staff, and patients to the extent that CDS affects their care) about CDS's role in enhancing the practice's clinical and operational performance.

- Likewise, begin building a shared, broad perspective on CDS toolkit – e.g. many potential content and intervention types, recipients, delivery channels, and workflow opportunities (i.e. ‘CDS Five Rights’* approach for improving outcomes with CDS configurations that optimize these dimensions)
 - For small practices, the EHR functionality can be a limiting factor for CDS. It is helpful to ensure that the EHR’s functionality is completely understood.
 - When feasible, attend EHR/Vendor conferences to discover new functionality. Request a demo from the vendor so that you can see how a new product/version or the addition of a new product could improve your workflow.
 - To optimize your CDS capabilities and gain vendor support, it is exceedingly important to develop a good relationship with your vendor.

*The CDS 5 Rights Model suggests that optimally effective and efficient interventions for improving outcomes with CDS require that the right information, be delivered to the right person, in the right intervention format, through the right channel, at the right point in workflow.

Organizing a Successful CDS Program: Documented plan in place and used for CDS-related assessments, decision-making process, oversight and execution

- Why, what , how, who, and when of CDS approach and activities are documented
 - A small practice is also a business. Practices should incorporate the use of CDS into the business plan as a tool to assist in achieving financial, clinical, and operational goals. The entire practice should contribute to the business plan to ensure buy-in and collaboration. The language of the plan should reflect and encourage a “culture of change.” Transparent and communicative leadership are critical aspects of this culture.
 - The documented plan should help to iteratively remind participants of the shared utility of the CDS program. By following the documented plan all participants should be able to find value and agree with its importance.
 - It is important that the CDS program accounts for available time and finances. A member of the team should keep tabs on ROI considerations for new interventions and also ensure that workflow changes are not impeding the normal operation of the practice.
 - Small practices should seek out Software Providers with appropriate expertise and resources to offer them support needed for CDS success, e.g. CDS intervention design, development, implementation and evaluation.
- CDS program appropriately integrated with quality and HIT planning and execution
 - The CDS program, and CDS interventions used within the program, should be approached in the context of the practice’s broader performance improvement efforts. For example, addressing quality-related payment drivers and efforts to improve efficiency compared to baseline data.

- Valuable results from technology implementation, such as achieving meaningful use and otherwise improving care processes and outcomes, depends critically on successful CDS. Therefore, make sure that efforts to implement an EHR and related systems go hand in hand with the CDS program and intervention development activities outlined in this book.
 - Seek to ground the CDS program and interventions in the pertinent evidence base. CDS interventions that lack evidence for the recommended clinical approach may be rejected more easily and considered less useful by clinicians. There should be strong consensus among all those affected in the practice that the right targets have been chosen, and (as discussed in more detail in Part 2), that the CDS approach to these targets are the right ones.
- Oversight for various strategic and tactical decisions (such as initiation and review of interventions of various types) is in place
 - Recognize how outside sources can help the practice to achieve its goals. Vendors, vendor user-groups, CDS collaboratives, Regional Extension Centers, other successful practices similar to your own, and other resources can be of great help. Some EHR systems also permit sharing of CDS “rules” across systems. Don’t reinvent the wheel if you don’t have to.
- All key participants are engaged (or represented) in CDS program decision-making process and oversight, and each recognizes personal advantages from the CDS activities
 - The plan should ensure that all participants are aware of their defined roles regarding CDS and underlying data entry. If there are multiple people within each role (physicians, nurses, office staff) there should be a leader to keep others who share that role on track.
 - Recognize the need for diverse engagement in supporting CDS-related activities. An example is the successful role that nurses can play in facilitating CDS-mediated quality improvement in practices with EHRs. Similarly, front desk personnel can play a key role in supporting CDS. They might be asked to update basic non-clinical data, such as a patient’s preferred pharmacy. This information is particularly important to facilitate efficient e-prescribing. You should think creatively about these models and other approaches to fully engaging all those in the practice in optimizing your efforts.
- CDS approached as shared effort **with** intervention recipients as part of collaborative improvement culture
 - In any practice consisting of more than one person, CDS should be approached as a team sport. CDS success will be related to the extent to which this team is working together toward mutually desirable goals, such as care safety, quality and efficiency. The appearance or reality that one group is ‘doing the CDS interventions’ (especially for strictly selfish purposes) to another undermines the team approach and reduces efficiency and effectiveness. Decision support is not an effective tool for reinforcing ‘command and control’ management in healthcare.

- Primary champions identified, representing “a collection of respected figures in various positions, such that everyone else will listen to at least one of them” – and richly engaged in the process
 - In smaller organizations, especially private practices, it is important to not limit champions to the clinician-owners of the practice. The multiple roles of the clinician-owner may lead to the staff accepting a system that fits the practice poorly because “that’s what the boss wanted.” Successful practices often recruit champions to represent the ancillary staff and other office staff members. Some practices even instruct staff members to voice their thoughts without regards to what the clinician-owners might prefer. (Valdez Family Clinic-Appendix A) (ACDS 3.3)
- Mechanism for ongoing communication identified and begun
 - All members of the practice might not communicate in a timely manner about an important decision related to the CDS program. Members should be notified after decisions have been made and given an avenue for providing feedback. It should not be assumed that silence indicates consent.
- Staff, consultants, and/or vendor personnel are available to fill essential roles needed for CDS program success: design, development, implementation and evaluation
 - Many of the key CDS program and intervention functions will require external support, such as from the REC, consultant and/or EHR vendor. There should be at least one individual within the practice who has ‘ownership’ of the CDS-related activities. This person should oversee and coordinate the external support that’s needed, and ensure that all the activities support the practice’s performance improvement goals.
- Documented plan used for prioritizing CDS-mediated improvement objectives, based on internal/external drivers (e.g. Meaningful Use, PCMH Certification, clinical quality measures)
 - There should be some explicit mechanism and responsibility for determining which improvement imperatives will be addressed with the practice’s CDS capabilities, and the order in which this will happen. Some of this will be driven heavily by external incentives such as clinical quality measures included in the CMS EHR Incentive Programs, but other important improvement drivers should be considered and filtered into the mix. Again, local colleagues and societies, RECs and EHR vendors will be helpful in identifying and prioritizing these objectives.

Other Key CDS Program Building Blocks: Systems, Workflow, and Measurement

- Tools and expertise in workflow analysis
 - Clinical workflow can be complex and nuanced. Documenting workflows before and after CDS interventions can help ensure that all affected staff are fully on board with the new routines and tools and adapt successfully. Keep in mind “upstream” and “downstream” activities that need to happen before and after physician-focused CDS for the intervention to have its intended effect. For example, that ample supplies of flu shots and nurse time are available to handle a desired uptick in flu vaccination rates in response to CDS focused on this target.

- Capabilities and tools for measuring intervention effects on clinical quality & user-satisfaction
 - Capturing the appropriate data in a reportable manner and comparing against quality measures can be time consuming and ultimately a barrier to a successful program. These data and reporting needs should be considered carefully as EHRs and related systems are implemented and maintained. REC's and EHR vendors may be able to help with strategies and tools.
 - In the absence of automated systems to run reports on intervention effects, the practice must create a system (e.g. outlook reminder, excel document, etc.) to make sure reports are run at appropriate intervals.
- Technology and organizational infrastructure catalogued and its implications understood (what you can do easily, what requires a greater or different type of effort)
 - There should be some documentation about deployed information systems and their CDS-related capabilities to serve as a starting point for leveraging these tools for outcome-improving CDS. The number of these tools deployed should be manageable, and the system vendors should be able to help provide the pertinent documentation. RECs can also serve as a resource.
 - Small practices typically lack the clout that larger institutional EHR customers have with their vendors in requesting system modifications to better address workflow and other practice needs and constraints pertinent to CDS. Working with the REC and/or vendor user group can enable the combined voices of many practices to be conveyed to the EHR vendor, and increase the chances that the system will evolve toward increasing value to the practice. When communicating with vendors to request enhancements - it is best to identify the problem that the practice is facing – rather than propose a solution. For example – a patient comes to a physician with a problem (“I have a sore throat”) rather than a solution “please give me Zithromax.” Let the vendor assimilate and understand the problem deeply so that they can work **with** the practice to identify a good solution, just as you would do with your patients.
 - Using an ONC-ATCB certified system [<http://onc-chpl.force.com/ehrcert>] means that functionality related to achieving meaningful use and other quality improvement measures will be more easily implemented. If a system is not ONC-ATCB certified – it has not been tested – and will not qualify for Meaningful Use incentives.
 - Local hospitals can be a source for EHRs and CDS applications, but consider carefully practice workflow, culture and clinical needs, and how these externally supplied tools fit into this mix. There are important synergies between hospitals and practices that sharing CDS and related tools can support, but keep in mind that there may also be important differences in objectives, needs and approach. Exploring these openly with the hospital - bringing in as appropriate support from the EHR/CDS supplier, REC, and local colleagues - can help ensure that potential CDS-related collaborations with the hospital are smooth and valuable for the practice.

Knowledge management for clinical decision support programs: Proactive and systematic process in place for acquiring, validating and updating CDS content

- Knowledge management policies in place, along with tools and processes to enforce policies
 - Although internal resources for this will be limited, it is nonetheless important to have an explicit and proactive plan for how the practice will ensure that its portfolio of CDS interventions and related content remain current, accurate and appropriate. For example, ensuring that alerts, order sets, documentation tools and the like remain consistent with the evolving medical knowledge base, as well as clinical and CDS best practices. EHR and CDS suppliers can handle much of this work, and their policies, procedures and tools can support the practice's knowledge management efforts, but it is important to anticipate the evolution of science – and make sure that the CDS components of your EHR are dynamic – and that you do not make too many “static” local customizations that would require local updating and maintenance. It may seem easy enough to create a template or decision rule today – but updating forty or fifty of them every year will get time consuming.
- Explicit approach (in-house or outsourced to vendor personnel or consultants) for managing the CDS content portfolio's life cycle (scope, currency, consistency)
 - Even though much of the content updating will be handled by EHR and CDS suppliers, clinicians in the practice will likely play some role in monitoring the appropriateness and currency of deployed CDS interventions. Tracking updated guidelines and new literature as part of ongoing professional competency and continuing education requirements can be leveraged for this work, which may include receiving CME credits [link to AMA PRA website]. This knowledge management work should include sharing updates about the medical knowledge base – and corresponding changes to deployed CDS- with other clinicians in the practice.
 - Make the portfolio simple and easy to manage – for example by focusing on interventions to address high priority improvement needs and trying to get the most value from a limited number of suppliers. Monitor key sources for updates to guidelines and other information and interventions pertinent to the practice. This might include the CMS EHR Incentive Programs website [<http://www.cms.gov/EHRIncentivePrograms/>], specific society websites [e.g. links to ADA, NAEP guidelines, etc.]. As the approach for management becomes more effective, begin expanding the number of resources monitored.
 - Determine if your information system and CDS suppliers have an environment for sharing, and communicating with other practices about, CDS content and interventions. This can be helpful in local knowledge management efforts, but care should be taken to ensure that material and experiences are applicable to your practice. Explore whether your REC has tools or approaches that can likewise support your knowledge management needs.

Part Two: Selecting, Developing and Implementing CDS Interventions

Small practices typically rely heavily on vendors and outside experts to successfully design, customize, and implement CDS Interventions. Historically, small practices turn off much of the available basic CDS functionality in their EHR system because it doesn't match with workflow or is not user-friendly. Excessive interruptive alerting is a related problem. This can result from a variety of factors, including too low of a threshold for alerting, over-reliance on alerts as a CDS mechanism, and inadequate clinical data to minimize false positive alerting. In some cases all alerts will be turned off in response, especially if it isn't possible or practical to fine tune individual alerts. The upshot is that practices will likely need some kind of assistance to successfully implement CDS interventions that match the practice's workflow and system capabilities, and achieve desired improvement objectives.

Foundational considerations for effective CDS interventions

- Understand the components of the CDS 5 Rights and how each is applicable to development of effective CDS interventions
 - Small practices should ensure that their EHR and CDS HIT Software Providers collaborate with them to better ensure that the content and delivery channels work smoothly together to meet the practice's deployment needs. Better integration between inter-dependent offerings from CDS content and EHR system providers should be a very high priority for the HIT provider since the joint functionality for small practices is often critical yet problematic.
- There are several major types of CDS interventions that can be delivered via information systems and other channels. Understanding these different types, and their advantages and disadvantages, is critical in selecting and designing optimal interventions to accomplish specific goals.
 - Recognize that achieving outcomes for specific conditions means treating and monitoring a constellation of symptoms. CDS Interventions might often exist in a "cluster" where each intervention might be a piece of puzzle for helping to manage a chronic condition (for example, a pertinent diabetes cluster would include interventions to ensure foot and eye exams, and appropriate monitoring and management of hemoglobin A1c and LDL levels, and providing appropriate patient education on self-management). A combination of intervention types (e.g., alerts, order sets, relevant data display, reference information, documentation tools) can be used to address these targets individually and collectively.

Selecting the Optimal Intervention for the Need: Intervention type is the best choice for the objective

- Intervention(s) are focused on an improvement priority, driven by the CDS decision-making process
 - Ensure that all members of the practice have participated in and approved selection of the improvement target.

- HIT software suppliers and user's groups, RECs, and other colleagues can be helpful to the practice in ensuring that pertinent national drivers are considered. Access to baseline and benchmark performance data for targets of interest can facilitate target selection *appropriate for your practice*, and consensus building around those choices.
- Intervention type is the best choice for the objective; among appropriate intervention types, final choice reflects balance between ease of implementation, acceptability and impact (these may be tuned based on your organization's experience and comfort level).
 - Avoid the trap of assuming that an interruptive alert is the most appropriate approach to every improvement target. Work with your EHR supplier and users groups, REC and other resources to identify the intervention type(s) most useful addressing your goal.
 - Start simple and focus on an "easy win." Build complexity in your interventions as the practice gains more experience applying CDS strategies to improvement goals. The intervention should be easy to implement and outcomes should be easily tracked as well.

Specifying (or Configuring) Interventions: Intervention is optimally designed to fit workflow and clinical objective and vetted by stakeholders

- Intervention content coordinated with related clinical quality/performance measure(s) as appropriate
 - Validate that software suppliers ensure CDS content will adhere to existing national data, quality/performance standards, etc. The data needed to trigger or drive CDS rules should be consistent with emerging standards, and the rules, order sets and other interventions supplied in the system should support improved performance against national targets.
- Intervention is optimized to support workflow and desired outcomes – CDS Five Rights addressed, and unhelpful disruption minimized
 - Seek HIT Software Providers who provide interventions that don't hamper the work of any member of the practice. The HIT provider should create interventions that allow and support for collaboration, such as having corresponding tools and displays for different actors (such as nurse vs. physician).
 - The user interactions with the interventions should align with the clinician role and corresponding workflow. For example, the underlying data driving CDS interventions for nurses and physicians should be the same so that everyone is working from a common source of truth, but the intervention details should be optimized for the different but related actions and decisions that nurses and physicians make. Similarly, the interventions themselves should be tuned to the recipient's role to maximize efficiency and minimize error.
 - Intervention is applied at appropriate stage of workflow, reflecting an understanding of the decision/action process (for example, try to support decisions as they are being made, rather than trying to change sub-optimal choices after they have been made).

- For CDS interventions that depend on complete and accurate data (such as patient weight, smoking status, current medications or other clinical details), make sure there are workflows in place that ensure this information is entered appropriately and reliable. Vendors may provide multiple pathways for providing data (free text, drop-down etc), but an efficient, standardized approach will ensure that CDS interventions draw from appropriately structured data.
- Intervention behaves as expected, providing useful and appropriate information needed to support desired decisions, actions and outcomes; consider implications of possible future care process or data changes
 - Since small practices typically must rely on their system suppliers to provide largely pre-configured interventions, it is particularly important that the practice lead on adopting the intervention validates that it is clinically appropriate and helpful before further vetting with others in the practice.
 - Think ahead about possible changes to care processes in the office - such as new staff or different staff roles, new services offered by the practice, and the like – that might affect the planned intervention. Likewise, anticipate changes in key data related to the intervention, such as new or different codes from your laboratory data provider. With appropriate data and system suppliers and others, develop a proactive approach to sensing and responding to these changes.
- Intervention contains ability to measure user response and process change
 - Make sure that for each CDS intervention, the intervention itself, or related functionality in the system, enables you to measure the intervention use and impact, and generate data needed to continuously improve its value. In a small practice, this capability typically must be provided by the system supplier(s).
- All parties key to intervention success engaged at appropriate stage; an early shared vision is developed among end-users and other participants about needs, goals, strategies related to interventions; interventions are done **with** end-users, not **to** them
 - Everyone in the office affected by an intervention has a say in its development. These individuals should have been involved to at least some degree from the earliest stages of target selection, through intervention configuration
 - If interventions are being deployed in a network of small practices, clinician champions should meet one-on-one with physicians in the local settings. These champions should be users of the CDS interventions to they understand clinician questions and concerns. They should be capable of addressing these, including providing practical steps to taking optimal advantage of the forthcoming interventions to improve personal efficiencies (such as saving time) and patient outcomes.
- Intervention content thoroughly tested for usability and safety before deployment in live environment; explicit responsibility for owner to approve final version of intervention before deployment; backup and failsafe measures in place as appropriate.
 - Anticipate that upgrades and modifications to the EHR and other systems – including addition of new CDS functionality - might have unexpected effects on key features such as usability, workflow and system response times. Evaluating and

addressing these issues with end users prior to launch is important to avoid glitches that might frustrate or alienate these users.

- New or enhanced interventions will likely be tested within the 'live' system, so make sure with the vendor that there are backup and failsafe measures in place to ensure that the new intervention testing and subsequent release do not disrupt the system or other clinical processes. The implementers should anticipate possible necessary changes to the intervention arising during testing (such as adjusting the threshold or display properties of an alert) and prepare for them prior to implementation. If users in the practice have been engaged throughout the intervention configuration processes, there shouldn't be any major surprises or rework.
- Although the technical details will fall to your information system supplier, consider the workflow implications for the practice of having the CDS intervention(s) unavailable in the event that the intervention itself, or broader system, is down for some reason. If the intervention is critical for patient safety or efficiency, develop a backup plan.

Putting interventions into action

- Deployment plan is in place
 - Although it doesn't need to be elaborate, it is ideal to at least sketch out an explicit deployment plan for the intervention [refer to pertinent worksheet]. In any practice with more than one person, this documentation can be used to help ensure that everyone knows what's happening, when and how. This documentation not only helps everyone in the practice participate optimally in getting the intervention off the ground, it also provides a more solid base for further refining intervention launches in subsequent deployment rounds.
- All users prepared for intervention launch - e.g. via communication, training, user support
 - Make sure everyone in the practice as appropriate understands the intervention details – why, when, how, who, where, etc. Fully leverage the communication channels – such as bulletin boards, formal meetings, informal gatherings, and the like to get out the word and make sure everyone is 'on board.'
 - Check with your HIT Provider to see what training resources and other types of support they offer for successful CDS intervention rollout. In addition to technical rollout, clinical training is essential. Cultural and clinical workflow changes are to be expected, particularly when major new CDS interventions are launched, such as new clinical documentation tools or order set functionality. HIT providers and RECs may be able to provide materials and other support to ensure that members of the practice know what is expected with these new interventions, how workflows will change and how to get the most out of the system. This is especially valuable in smaller practices where internal training resources beyond ad hoc peer-to-peer support may be quite limited.
- Capability to address altered workflows and care delivery needs (e.g. providing more procedures, testing or medications that may result from successful CDS intervention)

- A successful CDS intervention requires that responsibility for its success is shared. Nurses or office staff should take on tasks appropriate to their levels of expertise such as entering vital signs or information where possible.
- It is important to address how an intervention may alter the interaction with the patient. Giving clinicians a script to use when explaining the intervention to a patient may help to ease tensions.
- Capacity in place to obtain user feedback and to deal rapidly with immediate concerns
 - It's important to proactively develop plans for documenting, triaging and addressing issues that arise with CDS interventions – especially around the critical launch period [see worksheet]. If a practice has multiple clinicians or locations, then an explicit plan for proactively and reactively gathering user feedback will be important.
 - In some cases concerns might be addressed with policy or workflow changes, but in many cases, tweaks to the intervention – perhaps requiring support from the vendor will be needed. Plans for these should be developed in advance.

Measure Results & Continuously Refine the Program

- Plan is in place for identifying, tracking and addressing intended and unintended intervention behavior and effects
 - You will hopefully have worked with your CIS/CDS HIT Software Providers to assess their system capabilities collect, store, and make available the data required to measure and monitor these four different aspects of specific CDS interventions.
 - whether the CDS system is functioning as expected (e.g., if the alert fires in the correct situations);
 - the effect of the interventions on clinician behavior (e.g., whether they change the order);
 - the effect of these interventions on one, or more, intermediate process of care measures (e.g., whether the patient receives the medication that was contraindicated in the alert within a specified period); and
 - the effect of these interventions on patient outcome (e.g., whether the patients who receive the contraindicated medication despite an alert have more adverse events and/or higher costs).
- Plan is in place for reporting intervention effects to pertinent stakeholders and supporting continuous monitoring and improvement
 - Internal discussion about the intervention results will be valuable. You should make and use an intervention effects communication plan that addresses who will gather and share the results, to whom will they be communicated and how often, and how decisions will be made about next steps. This communication and planning should be scaled to the intervention – that is, it should be robust for major new CDS intervention configurations tied to central practice drivers (such as pay for performance targets), but much less involved for more minor CDS enhancements such as a specific new problem-specific documentation form.

- Victories and exceptional efforts are tracked, frequently communicated and leveraged to sustain performance and set up enthusiasm for future CDS interventions
 - Various communication channels should be used to share and celebrate successes from each round of applying CDS to achieving practice improvement goals. A growing sense of shared potency within the practice around leveraging CDS will provide the foundation needed to tackle increasingly challenging and important improvement goals.
- Owners or responsible parties are identified for CDS interventions and their content; processes in place to maintain and update intervention, periodically and as needs arise
 - Although the EHR/CDS providers may need to support the actual content update, a person in the practice should be identified as being responsible for monitoring the intervention currency and appropriate. Paper, or better electronic (e.g. in spreadsheet form) version of [worksheet] can help with this.
 - Informal e-mail communication can stand-in for formal knowledge management procedures. For example, an asynchronous conversation via e-mail about a non-controversial change to an intervention parameter might be adequate to achieve consensus about the change, rather than a more formal meeting and decision process.

The practice's EHR supplier – and associated CDS knowledge-based content providers (e.g., drug-drug interaction checking, drug-allergy checking, reminders, order sets and templates) should make it as easy as possible for the practice to incorporate, validate updates, monitor, and ensure critical changes as needed to the CDS interventions. Determine with your system providers whether, when and how trained personnel in the practice (e.g. CDS Super user, physician champion, practice manager) can and should customize CDS logic and/or content. Make sure that the EHR and any related CDS content suppliers have processes in place to ensure that your interventions are evidence-based and current. Ideally, you should be able to engage in detailed discussions about their editorial process, ongoing training of editors, literature surveillance and analysis, content update methodologies and tools, and ensure that these are in sync with your practice needs and expectations.