Privileging Issues

Connecting the issues, standards, regulations, and solutions!

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Top Privileging Issues

SEVEN Top Privileging Issues

- Linking privileges to current competence
  - Criteria development
  - New technology
  - Ambulatory privileges
  - Telemedicine
  - ED call & privileges
  - Managing the expanding role of APPs
  - Low Volume & No Volume Practitioners
Top Privileging Issues:
Privilege Criteria Development
New Technology

Do you have a policy for . . .

- Creating privileging criteria?
- Introducing new technology?

Best practice!
The Five P’s:

Our Policy is to follow our Policy.
In the absence of a Policy, our Policy
is to create a Policy.

*The Greeley Company*
Step 1: Burden on the applicant

- Put the burden on the applicant or interested party to provide information (Exhibit A)
  - Specific name of new technology/procedure
  - Clinical conditions for which it will be used
  - Special equipment or staff education needed
  - Operating room setup needed
  - Frequency of use in the next year
  - Names of other hospitals where it is being performed or provided

Step 1: Burden on the applicant

- Put the burden on the applicant or interested party to provide information
  - Outline of qualifications
  - CME
  - Peer-reviewed research concerning the proposed technology/procedure
  - Residency training directors and course materials
  - Manufacturer’s materials
  - FDA approvals (if any)

Step 2: Hospital assessment

- Credentials committee/technology assessment committee
  - Clinical efficacy and effectiveness of the procedure
  - Risk compared to conventional therapy/technique
  - Is it safe and effective, or is it still experimental?
  - Is it appropriate for the scope and complexity of the institution?
Step 2: Hospital assessment

- Senior administration (CEO, CNO, CFO)
  - Community need
  - Sufficient space
  - Appropriately trained personnel
  - Finances/reimbursement issues
  - Appropriate equipment

- Purchasing/materials management department (product evaluation, contracting, delivery)
- Biomedical safety department (safety protocols, testing, procedures for maintenance)
- Nursing manager and OR supervisor (supervision, education, in-service, training)
- MSSD and credentials chair/VPMA (credentialing issues)

- Health information services (coding and abstracting)
- Finance department (reimbursement, coding, and approvals)
- Environmental services (sterilization, disposition, maintenance)
- Performance improvement (monitoring systems, PI systems, regulatory issues)
Step 2: Hospital assessment

- Clinical departments (anesthesiology, radiology, pathology)
- General medical staff input (chief of staff)
- Institutional Review Board (IRB)
- Marketing
- Chief medical officer

Results of hospital assessment

- If procedure or services will not be permitted in the organization, you are done. Notify involved parties as appropriate
- If procedure or services will be permitted in the organization, then determine whether privileging criteria are applicable

The BIG Question:

Is this a new procedure or an extension of my present privileges?
When to develop criteria

- Generally, if the procedure/privilege involves:
  - Different equipment and technique
  - Different skills
  - Further knowledge such that the individual needs additional education (CME) or proctoring

Then a specific privilege should be identified, evaluated, the criteria developed, and approved before the procedure/privilege is requested, granted, and performed.

Step 3: Developing privileging criteria

- If criteria are necessary, identify/summarize:
  - Mechanisms currently used to provide the service (if applicable)
  - Specialty/subspecialties interested in the issue
  - Exclusive contracts
  - Positions of specialty societies or academies, training programs, and specialty boards
  - Findings from similar hospitals

RESEARCH, RESEARCH, RESEARCH, RESEARCH !!!
Step 4: Seek expert advice

- Solicit opinions from subject-matter experts
  - Multispecialty task force
    - One representative from each involved specialty plus at least one member of the credentials committee to chair the task force
  - Individual departments or specialty areas

Step 5: Task force or specialty drafts the criteria

- General requirements
- Education and training
- Board certification
- Experience
- Monitoring
- CME
- Renewal/maintenance of privilege

The Competency Equation

Current competency = 

Evidence you’ve done it recently + 

Evidence that when you did it, you did it well
The numbers game. Are evidence-based criteria really available?

25? 10? 100? 150?

Step 5: Task force or specialty directive drafts criteria

- Resources:
  - Postgraduate education programs
  - Requirements for specialty boards
  - Position statements from specialty societies
  - Journals/articles/literature search
  - The Credentialing Resource Center’s Clinical Privilege White Papers

Step 5: Task force or specialty directive drafts criteria

- Resources:
  - Privileging software
  - CME programs
  - Equipment manufacturers with physician leadership/consultation
  - Hospitals/ambulatory sites
  - Networking among medical staff leaders and credentialing specialists
Specific examples of criteria

**EGD**
- Gastroenterologists
  - Initially: 130 cases successfully performed during formal training program
  - Demonstrated current competence and evidence of performance of at least ?? in the past 12 months
- General surgeons
  - Initially: Evidence of formal training in upper endoscopy procedures with a minimum of 35 procedures performed or equivalent training/experience obtained outside of a formal program
  - Demonstrated current competence and evidence of performance of at least ?? in the past 12 months

Specific examples of criteria

**C-Sections**
- Obstetrics/gynecology
  - Successful completion of an ACGME/AOA residency
  - Demonstrated current competence and evidence of performance of an adequate volume of C-sections in the past 12 months
- Family medicine
  - Successful completion of an ACGME/AOA residency followed by a one-year fellowship in obstetrics or the equivalent in training/experience
  - Demonstrated current competence and evidence of performance of an adequate volume of C-sections in the past 12 months

Specific examples of criteria - Procedure not included in PGT program

- Stereotactic breast biopsy: Surgeon—successful completion of at least 15 hours of hands-on CME in the past ?? months or the performance of >36 stereotactic breast biopsies in past three years with successful outcomes
Step 5: Task force or specialty
draft the criteria

- Disputes are likely to occur at this step
  - Involve disputing parties
  - Solicit a consensus recommendation regarding education, training, experience
- A recommendation is made to the credentials committee for privileging criteria (which may include one or more minority opinions)

Step 6: Credentials Committee
review & recommendation

- Review recommendations from the subject matter experts/task force:
  - If they agree, you’re done. Recommend the criteria
  - If they disagree, draft a proposed rule and submit for their comment

Step 6: Credentials Committee
review & recommendation

- The credentials committee reviews the proposed criteria (and comments), votes on them, and refers the issue to the MEC
- Members of the credentials committee who practice in any of the specialties involved in a crossover privilege issue should recuse themselves from the vote
Step 7: MEC review & recommendation

- The MEC reviews and votes on the proposed criteria.
- Members of the MEC who practice in any of the specialties involved in the crossover privilege issue should recuse themselves from the vote.

Step 8

- The board approves the criteria and they are applied.

A Tip: Do not simply follow this process

First . . . Create a policy!
Remember . . .

The Five P’s:

Our Policy is to follow our Policy.
In the absence of a Policy, our Policy is to create a Policy.

The Greeley Company
Creating your policy

- Establish a moratorium until adoption of the policy
- Gather information
- Create and recommend the policy/criteria
- Approve the policy/criteria and apply it

Issue:

- Do you have privileging disputes:
  - Among specialties?
  - Among physicians in the same specialty?
  - Among advanced practitioners and physicians?

- Do you have privileging criteria printed on each delineation of privilege form?

The answer is simple

- Create initial criteria and maintenance criteria for your privileging system
- Follow the process outlined in the preceding section
- Once done, only new privileges or new technology will require a revisit to the applicable privilege forms
Top Privileging Issues:
Ambulatory Privileging
When to & when not to ? ? ?

Ambulatory setting: Do you need privileges to work in the clinic?

- **YES** – If the hospital and the ambulatory site(s) have the same CMS Certification Number (CCN), and bill a facility fee for services rendered, CMS applies the same CoP standards to the ambulatory site(s) as the hospital

- CCN is also known as
  - National Provider Identifier
  - Medicare/Medicaid Provider Number
  - Provider Number

Questions?
Ambulatory setting criteria

- Is it really all that different?
  - Identify specialty involved
  - Identify service or care provided or performed
- Define the initial criteria (education, training, experience) to request privileges
- Define criteria to be met for renewal of privileges

The Joint Commission

- Requires privileging of practitioners providing medical level of care at hospital-owned ambulatory site(s)
- TJC indicators for privileging
  - Does the site(s) fall within the hospital organizational chart?
  - Who owns the patients’ records?

Other regulators or accreditors?

- DNV regulations and HFAP standards are silent on the ambulatory setting
  - Interpretation: the same privileging requirements apply as in the acute care setting
- Additionally, individual State regulations may also apply
Which practitioners require ambulatory privileging?

- Licensed independent practitioners
  - Physicians (MD/DO)
  - Dentists (DMD/DDS)
  - Podiatrists
  - Psychologists (Subject to state-specific regulations)
  - Others e.g., chiropractors (Subject to state-specific regulations)

Which practitioners require ambulatory privileging?

- Advanced practice professionals (APP)
  - Physician assistants (PA)
  - Advanced practice nurses
    - Nurse practitioners
    - Clinical nurse midwives
    - Certified nurse anesthetists
    - Clinical nurse specialists

Which practitioners require ambulatory privileging?

- If the practitioner is providing a "medical level of care" in the ambulatory site, privileging is required regardless of their affiliation with the hospital
  - Employed
  - Contracted
  - Independent

*Medical level of care:* Involves making a medical diagnosis and medical treatment decisions (Definition by TJC)
### Which practitioners require ambulatory privileging?

- CMS defines "medical level of care" to include
  - §482.51(a)(4) – Surgical privileges must be delineated for all practitioners performing surgery in accordance with the competencies of each practitioner.
  - CMS relies upon the definition of surgery developed by the American College of Surgeons
  - Surgery is performed for the purpose of structurally altering the human body by the incision or destruction of tissues. Surgery is the diagnostic or therapeutic treatment of conditions or disease processes by any instruments causing localized alteration or transposition of live human tissue which include lasers, ultrasound, ionizing radiation, scalpels, probes, and needles. The tissue can be cut, burned, vaporized, frozen, sutured, probed, or manipulated.

### Examples of service line sites of care that may require privileging

- Outpatient surgery centers
- Birthing centers
- Cancer care centers
- Outpatient testing facilities
- Wound care centers
- Comprehensive pain centers
- Radiology or radiation therapy units
- Rehabilitation, physical, & occupational therapy services
- Urgent care centers
- Dental/Oral surgery clinics
- Complementary &/or alternative care centers

### Examples of clinical office sites that may require privileging

- Single practitioners
  - Primary care / Specialist
- Multiple practitioners / Group practices
  - Family care centers
  - Behavioral health counseling centers
  - Single or multiple specialty group practices
  - Birthing centers
What clinical activity requires privileging?

Scope of privileges at ambulatory site

- Define the clinical services to be provided
  - Examples: Office practice vs. urgent care center
- Define the initial criteria to request privileges
- Define criteria to be met for renewal of privileges

Scope of privileges at ambulatory site

- Design privilege delineation system
- Methods of delineation
  - Create ambulatory site-specific privilege form(s)
Scope of privileges at ambulatory site

- Methods of delineation – *Cont’d*
  - If privileges & criteria for hospital and ambulatory privileges are essentially the same, the current privilege form could be revised to add *either*
    - “Check boxes” indicating sites of care or
    - “Office based practice” as a privilege with a listing of appropriate office-based procedures

  **NOTE**: Avoid duplication whenever possible

How is competency assessed?

Essentially, in the same way as the medical staff evaluates care in the hospital environment!

More examples for the ambulatory setting

- **Medicine**
  - Emergent hospital admissions or readmissions
  - Missed diagnosis or misdiagnosis resulting in patient harm (entire episode of care)
  - Complications of ambulatory care treatment
  - Blood sugar monitoring for diabetic patients
  - Colon cancer screening for patients older than 50

- **Procedural**
  - Procedural complications requiring inpatient admission
Example of physician indicators for performance

<table>
<thead>
<tr>
<th>Competency</th>
<th>Specialty</th>
<th>Indicator</th>
<th>Acceptable Target</th>
<th>Excellence Target</th>
</tr>
</thead>
<tbody>
<tr>
<td>Med/clinical Knowledge</td>
<td>PM, IM, OB/Gyn</td>
<td>Diabetes + DL - C screening prevention</td>
<td>75%</td>
<td>100%</td>
</tr>
<tr>
<td>Patient care</td>
<td>PM&amp;R</td>
<td>Mgmt of osteoporosis</td>
<td>75%</td>
<td>95%</td>
</tr>
<tr>
<td>Systems based</td>
<td>All</td>
<td>NPSG Handwashing</td>
<td>Rule 3</td>
<td>1</td>
</tr>
<tr>
<td>Interpersonal Communication</td>
<td>All</td>
<td>MR compliance – completed within 1 day</td>
<td>Rule 75%</td>
<td>95%</td>
</tr>
<tr>
<td>Professionalism</td>
<td>All</td>
<td>Validated incidents of inappropriate behavior</td>
<td>Rule 2</td>
<td>0</td>
</tr>
</tbody>
</table>

Top Privileging Issues:

Telemedicine:
What is the best approach for your hospital?

Take-home message--telemedicine

- The requirements by CMS and related accreditation standards are complicated
- Carefully read the CoPs and the accreditors’ standards that apply to your organization and
- Make decisions that are right for your organization
CMS CoPs related to telemedicine

- Effective July 2011
- A written agreement is required with:
  - Distant-site Medicare-participating hospital
  - Distant-site telemedicine entity
    - Provides services that allows the hospital to meet all applicable CoPs to telemedicine, particularly those re: credentialing and privileging

CMS CoPs related to telemedicine - cont’d

- Written agreement also requires the hospital receiving the telemedicine services to grant privileges appropriate to the capabilities of telecommunication systems

CMS CoPs related to telemedicine - cont’d

- The hospital’s governing body has options
  - Fully credential and privilege telemedicine practitioners and require its medical staff to independently assess their credentials and make privileging recommendations

OR
CMS CoPs related to telemedicine - cont’d

- Consider MS recommendations that rely on credentialing and privileging decisions of the distant site
  - The hospital may:
    - Maintain a separate file for all telemedicine practitioners
    - Maintain one file for all telemedicine practitioners with a list of privileges granted to each practitioner on the list

CMS CoPs related to telemedicine - cont’d

- If relying on credentialing and privileging decisions of the distant site, the written agreement additionally requires:
  - Distant site has privileged the practitioner and provides a current list of the practitioner’s privileges
  - The practitioner has a license in the state where the hospital is located
  - AND

CMS CoPs related to telemedicine - cont’d

- The hospital has evidence of an internal review of the individual practitioner’s performance
- At a minimum, adverse events resultant from the services provided and all complaints regarding the practitioner are included
- The information is sent to the distant-site hospital for use in periodic appraisal of the practitioner
- The MS bylaws must include a provision for reliance on the distant site decision
HFAP, DNV, JC : Telemedicine

- Telemedicine standards essentially mirror the CMS requirements
  - A few nuances
  - If your facility is accredited by HFAP, DNV, or JC, review and assure compliance

Let's apply the standards

What credentialing methodology/methodologies would you choose in the following situations?

- Teleradiology
  - Five-hospital system: One large urban facility provides 24-hour interpretations for 4 regional facilities
  - Hospital has a signed contract with a TJC-accredited teleradiology service
  - Hospital is considering contracting with a nearby group of 8 radiologists for night and weekend interpretations

Let's apply the standards

What credentialing methodology/methodologies would you choose in the following situations?

- Telepsychiatry/Telepsychology
  - State-owned penitentiary system creates agreement with hospital for services of employed psychiatrists and psychologists
  - State contracts with individual psychiatrists and psychologists for services
Let’s apply the standards

What credentialing methodology/methodologies would you choose in the following situations?

- Interpretation of pediatric diagnostic studies
  - Community hospital and/or system wants to expand interpretation of EKGs and EEGs studies to include subspecialty of pediatrics. They are considering contracting with:
    - Pediatric hospital
    - Individual pediatric cardiologists and neurologists

In summary

- Determine credentialing and privileging processes for telemedicine practitioners by:
  - Specialty
  - Circumstance
- Create sharing agreements when possible
- Avoid duplicative efforts – Maximize efficiency
- Implement appropriate competence assessment/monitoring processes

So . . . Repeating the previously stated take-home message re: telemedicine

- The requirements of CMS and related accreditation standards are complicated
- Carefully read the CoPs and the accreditors’ standards that apply to your organization
- Make decisions that are right for your organization
Top Privileging Issues:
ED Call and Privileges

What is required?

The Emergency Medical Treatment and Active Labor Act (EMTALA) is a U.S. Act of Congress passed in 1986
EMTALA requires hospitals to:

- Perform a screening exam to determine whether an emergency condition exists
- Stabilize patients with emergency conditions
- Determine disposition
- Post name/date-specific call rosters in the ED
- Ensure that on-call physicians respond in a timely fashion

EMTALA requires on-call physicians to:

- Participate in the care of the patient as needed to:
  - Determine whether an emergency condition exists
  - Provide adequate care to stabilize an emergency condition
  - Determine whether a transfer is appropriate

In other words …

Through EMTALA, the federal government created a hospital obligation that only physicians can fulfill
“Two years ago I wasn’t paying anything for ED call, and my physicians were unhappy. Now I’m paying $2.3 million a year for ED call, and my physicians are more unhappy now than they were two years ago!”

–A hospital CEO

**Conclusion:**
Money doesn’t buy physician happiness!

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**Credentialing solutions for ED call**

- Educate all medical staff leaders on the requirements of EMTALA
- Recognize that all practitioners are permitted emergency privileges as outlined in medical staff governance documents (bylaws, P&Ps, rules/regulations, privilege forms)
- Address ED call obligations and privileges separately

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**Credentialing solutions for ED call**

- Sample language for privilege forms or to include in MEC on-call policy
  - Assess, stabilize, and determine the disposition of patients with emergent conditions consistent with medical staff policy regarding emergency and consultative call services.
  - Continually reassess whether practitioner can meet this minimum expectation or needs to provide alternative coverage
Questions?

Top Privileging Issues:
How to Manage the Expanding Role of APPs

Case Study:
How to manage the expanding role of advanced practice professionals,

OR

How to avoid “scope creep!”
As a reminder, advanced practice professionals (APPs) are

- Psychologists
- APRNs
  - Certified nurse anesthetists
  - Certified nurse-midwives
  - Nurse practitioners
  - Clinical nurse specialists
- Physician assistants

Who else might be considered an APP?

- May include additional healthcare professionals defined by the organization and its accreditor as requiring privileging
  - Other healthcare professionals providing complex care (i.e., advanced-practice level)

Do the regulatory or accreditation bodies provide guidance on how to expand the role of APPs?

No!
To determine if your organization needs to move forward on this issue, answer 3 simple diagnostic questions . . .

- Does your organization adequately address the expanding skills or scope of practice of APPs?
- Are APPs allowed to expand privileges through on-site training?
- Have APPs expanded their scope of privileges without authorization (i.e., “scope creep”)?

Before developing a policy, can you answer “YES” to these questions?

- Does the organization’s current culture support “training up” of APPs?
  - Governing body
  - Medical staff
- Does the hospital’s liability carrier allow “training up”?
- If “training up” is permitted, will patient consent be obtained?

If you answered “YES” to all 3 questions . . .

Develop a policy!
Policy goals

- Protect patients
- Protect hospital
- Protect APP and physician sponsor
- Create process to expand skills of APPs
- Permit physicians to fully utilize APPs’ skills

Policy development . . .
What should be considered?

- What authorization process will be used to allow APPs to expand knowledge and/or skills?
  - Medical staff privileging process to include governing body approval
- What type of privileges should be considered?
  - Privileging under direct supervision—clearly defined

Policy development . . .
What should be considered?

- Will temporary privileges be granted to allow the “train up” process to proceed?
  - Not recommended
**Policy development . . . What should be considered?**

- What criteria must the APP meet prior to applying for permission to expand privileges under direct supervision?
  - Currently meets eligibility criteria for privileges held
  - No issues identified
    - Clinical competence
    - Professional conduct

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**Policy development . . . What should be considered?**

- What if the APP requests privileges that have been previously only been granted to physicians?
  - Establish moratorium
  - Determine through medical staff recommendation to governing body whether privilege will be extended to non-physicians
  - If "yes," create eligibility criteria for APPs
  - Consider the APP request

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**Policy development . . . What should be considered?**

- What will be the procedure to request “train up” privileges?
  - Written request from APP and collaborating/supervising physician
    - Specific procedure(s) requested
    - Name of preceptor(s)
    - Anticipated length of training
    - Competency measurement criteria
    - Patient population (as appropriate)
Policy development . . .
What should be considered?

- Will there be a time limit to complete the training and establish competency?
  - If so, who determines the time limit?
- What methodology will be used to obtain patient consent?

Policy development . . .
What should be considered?

- What will be the process when an APP and supervising physician are approved for “train up” privileges?
  - Clear communication including expectations
    - APP applicant
    - Supervising physician
    - Nursing and ancillary services staff

Policy development . . .
What should be considered?

- How does the APP request privileges without direct supervision?
  - Complete the training period
  - Collaborating physician confirms competence
  - Eligibility criteria met for requested privilege
Policy development . . .
What should be considered?

- How does the APP request privileges without direct supervision? Cont’d
  - Request submitted through normal medical staff channels
    - Medical staff recommends
    - Governing body approves
    - FPPE begins (TJC requirement only)

Questions?

Top Privileging Issues:
Low Volume & No Volume Practitioners:
What is the solution for your organization?
Low volume/No volume practitioners

Growing issue due to:
- Rapid growth of hospitalist programs
- Outpatient settings offering better practitioner productivity with fewer hassles
- Physicians seeking enhanced revenues from provider-owned outpatient facilities
- Technological advances allowing minimally invasive procedures to be performed in the outpatient setting
- Practitioners seeking better life balance
- Active efforts to reduce or avoid ED call

Types of low volume/ no volume practitioners

- Practitioners with adequate quality data elsewhere
- Practitioners with inadequate quality data anywhere looking to return to professional activity and/or clinical practice after an extended period of absence

So, what’s the problem –

- Insufficient clinical activity at your organization and limited to no access to clinical outcomes
- Inability to matching requested privileges with demonstrated current competency

Leaving your organization unable to answer …
The Competency Equation

Current competency =

Evidence you’ve done it recently
+
Evidence that when you did it, you did it well

Is this a 5 P’s moment?

Our Policy is to follow our Policy. In the absence of a Policy, our Policy is to create a Policy.

Policy goals

- Protect patients
- Grant privileges only when there is evidence of demonstrated current competency
- Meet regulatory requirements
- Protect hospital reputation
Policy development... What should be considered?

- All practitioners are only granted privileges for which they have demonstrated current competence.
- Build and maintain strategic relationships between the hospital and practitioners who rarely or never practice with the organization.

Policy development... What should be considered?

- Do not create new membership categories when it's only privileges that are different.
- Allow non-clinically active practitioners to be able to visit their patient, order outpatient tests, etc., and include this language in the appropriate MS category.
- Separate membership from privileges.

Policy development... What should be considered?

- Membership = political rights
  - Vote on bylaws amendments
  - Elect officers
  - Hold office
  - Serve in leadership roles
  - Serve on committees
  - Receive due process (hearing & appeal)
- Privileges = what practitioners are authorized to do.
Policy development... What should be considered?

- Accurately delineate clinical privileges
  - None
  - Independent with limited scope (e.g., general surgeon who only first assists)
  - Co-management (Caution: may be problematic)
  - “Refer and follow”

Sample language for “Refer & Follow” privileges

- Order outpatient diagnostic tests and services
- Visit patient in hospital
- Review medical records for patients referred for admission/services
- Consult with attending physician
- Observe diagnostic or surgical procedures with the approval of the attending physician/surgeon

Types of low volume/no volume practitioners

- Practitioners with adequate quality data elsewhere
- Practitioners with inadequate quality data anywhere
Create an approach based on the individual

- Active practice and adequate quality data elsewhere
  - Provides a needed clinical service to your organization
  - Provides a ‘win-win’ relationship
  - Relationship offers little ROI

Active practice elsewhere

- Evidence of competency
  - NPDB
  - Professional liability actions
  - Sanctions
  - Clinical interview
  - Peer references
  - Peer review and performance monitoring results
    - External chart review
    - Health plan quality profiles

The clinical interview: A tool for assessing competence

- Build rapport
- Practice content/experience
- Strengths and weaknesses
- Gap questions
- Clinical knowledge questions
- Clinical judgment questions
Improve quality of information from references at the time of reappointment

- Policy-driven references for each clinical specialty
- Address broad quality framework (technical, service, professionalism, etc.)
- Open- and closed-ended content
- Validated through physician-to-physician dialogue
- Place the burden on the applicant for incomplete information (form letters, refusal to speak, etc.)

The bottom line

- There is not one simple answer or solution to low volume/no volume practitioners
- Remember that one size does not fit all
- The development of a well-thought-out strategy applied to individual practitioners is key

Questions?