RACGP

RACGP, Office of Chief Executive Officer

Royal Australian College of General Practitioners submission for Options for Revalidation in Australia

The Royal Australian College of General Practitioners

Opening Statement

The Royal Australian College of General Practitioners (RACGP) recognizes the need for ongoing education of the medical workforce in order to continuously improve the quality of everyday clinical practice by promoting the development and maintenance of general practice skills and knowledge.

Whilst responses to individual questions are provided, the RACGP draws attention to several omissions and/or areas of underdevelopment within the paper that should be considered.

Critical to the success of the RACGP QI & CPD program has been a convergence between individual determination and external validation. Whilst the RACGP continues work in balancing these two fundamentals, it appears the *Options for revalidation in Australia – Discussion paper* has not. The extent of external imposition through directed accountability measures is disproportionate to the level of risk and indeed threatens the significant advances that the profession has amassed over many years in evolving personnel rather than regulatory accountability. The lack of any meaningful meta-analysis as to risk cohorts is disappointing. The RACGP considers that macro undiscriminating profiling as suggested in the discussion paper does not lend appropriately to identification of the small percentage of underperforming doctors nor to the determination of specific learning improvement and change strategies. Meta data analysis related to the classification of issues concerning communication, professionalism, ethics, isolation, training, patient servicing, educational participation, scope of practice and the like the RACGP would contend would produce a far more informed intelligence in identifying underperformance and the correlation of underperformance to improvement strategies. What is not adequately represented in the discussion paper is acknowledgement of the actions to be undertaken once underperformance has been signalled. Presumably the identification profiling as suggested in the discussion paper would then analyse the causal actions leading to underperformance. We suggest that those causal actions would be as identified previously in this response and as such should be the criteria for determining risk – a focus on behaviour/performance rather than depiction of gender, age and geography.

The lack of acknowledgement within the document of the role of self-reflection and self-evaluation as quality tools for the review of performance is disappointing. The RACGP contends that considerable evidence exists that supports self-initiated gap and learning needs analysis as a purposeful and long-term effective change strategy.

A serious omission in the paper is informed discussion concerning data exchange, data security, data use cooperation between agencies. The RACGP notes that this exclusion considerable restricts analysis of factors inherent of perceived underperformance in practice thereby directly affecting the selection of potential improvement/remediation strategies. Consideration must be given to ensuring that all pertinent information relating to the issue of underperformance is made available prior to any action being undertaken.

Not addressed within this paper are issues related within a medico-legal context. For instance what safeguards are in play to protect the integrity of material generated through this process? It is possible that data obtained from MSF outcomes or audit activity may be used in matters of legal liability. The RACGP would request that this area is addressed.

The question of mandatory membership of the relevant specialist college has not been canvassed within the paper although the inferred reliance of the specialist colleges as key ‘gatekeepers’ in the process has. It is the RACGP contention that should responsibility for revalidation, at least in the foundational aspects of assessment and compliance, be assigned to the specialist colleges, it must include mandatory membership

of all practitioners working in that discipline with the respective college. In the absence of same it is our contention that serious flaws in the process will emerge severely reducing confidence and utility of the desired outcomes.

The paper does not provide any direction as to an appeals mechanism. Given that revalidation will have profound effects upon a practitioners' vocation the RACGP considers discussion and resolution of this element an integral aspect of any future development.

There appears to be no reference in the document as the countenance or otherwise of different approaches that may be pursued by individual specialist colleges. This despite the diverse environments that each of the specialist colleges operates within. As such the RACGP presents an authoritative case for recognition of its current direction and action as an alternative to a 'one size fits all' revalidation approach.

Further elaboration of the RACGP approach and areas of both confidence and concern in the discussion paper are addressed within the response.

The RACGP response

The RACGP posits that revalidation as a distinct process will not realize the aspirations of the Medical Board of Australia. Whilst conceptually it provides a direction for accountability, it lacks definitive integration with current processes supported within specialist colleges. For the RACGP the commitment *'to developing a process that supports medical practitioners to maintain and enhance their professional skills and knowledge to remain fit to practice medicine*' does not begin nor end with a focus on revalidation. Revalidation is but one element within a construct that involves:

1. *Evidence based assessment to be selected into the profession - a process unencumbered by conflict of interest of employers or politics.*
2. *Comprehensive supervised training based on achieving an evidence based competency profile and curriculum.*
3. *Fellowship based not only on examinations but on demonstrating professional suitability throughout training.*
4. *QI and CPD underpinned by a rigorous self and peer reflection tool to guide learning and assess competence against identified needs.*
5. *Remediation based on self-reflection and where necessary collegiate involvement.*
6. *Commitment to reviewing clinical governance arrangements across the breadth of the profession and support for models such as the medical home that improve systems based care and connectivity.*

The RACGP has embraced the notion of the life-long learner having developed curriculum and a profession framework that spans pre-general practice to general practice under supervision through to general practice life-long learning http://www.racgp.org.au/education/curriculum/2016-curriculum/ and further underpinned by the competency profile of the general practitioner at the point of fellowship http://www.racgp.org.au/download/Documents/Vocational%20training/Competency-profile.pdf. Inbuilt into this construct is a rethink of general practitioner learning and development underpinned by the principle that quality of service and continued advancement of medical knowledge and skills are paramount.

A reliance only on revalidation for the RACGP is a regressive approach. Revalidation principles have been or are in the process of being integrated with the RACGP learning framework which we contend will be a superior approach as to that outlined by the Medical Board of Australia. We take this opportunity to outline

several major initiatives supporting this strategy and to urge the Board to consider the progress that the RACGP has made in its endeavours.

Our objective is to incorporate the tenets of revalidation within a comprehensive framework. We consider that maintaining and improving the above six levers will obfuscate any direct intervention by the regulatory agencies. Our review of the evidence presented illustrates that there is extremely limited evidence of systemic or widespread risk to patients from underperforming practitioners. We do however acknowledge that there is a small cohort of practitioners who need remediation and/or possible exclusion from working with patients. We remain committed to working with the MBA to identify and manage this cohort.

It is our fervent position that the Medical Board of Australia consider this approach and adopt a position where specialty colleges such as the RACGP delivering the hallmarks of revalidation within existing systems remain free to do so.

Major initiatives supporting the RACGP strategy

QI & CPD

The RACGP contends that the current Quality Improvement and Continuous Professional Development (QI & CPD) approach (as identified by leading international researchers) is at best practice standard having been embedded in a sustained development and improvement process since its inception. For the forthcoming triennium this improvement process continues with the inclusion of a mandatory gap analysis tool (Planning learning and need) aligned to a definitive statement of general practitioner competence (Competency profile of the general practitioner at the point of fellowship). The inclusion of PLAN requires all practitioners to map out and document their learning needs with respect to their practice presentation demographics, community needs and personal aspirations, develop learning priorities and compile evidence of the extent that those learning goals have been achieved. The tool also incorporates opportunity for peer review at various stages along that development and learning process. Self and peer reflection is progressively being implemented in all aspects of the RACGP QI & CPD process.

The QI & CPD remains based on the accumulation of a minimum 130 points with specific inclusions of PLAN, one category 1 activity and CPR.

Selection

The RACGP will shortly enter agreement with the Commonwealth government to undertake responsibility for selection into Australian General Practice Training. This marks the first time in fifteen years that the RACGP will have responsibility for all doctors progressing towards fellowship of the RACGP. The advent of selection enables the RACGP to determine and apply entry level competence and required professional characteristics for all applicants.

The single pathway

The RACGP Practice Based Fellowship Program is an initiative of the RACGP to simplify and strengthen the current multiple pathways to fellowship approach. From a previous arrangement of multiple pathways with single entry points the RACGP Practice Based Fellowship Program moves to a single pathway with multiple entry points underpinned by robust entry appraisal, a high quality curriculum and a purposeful learning program and assessment framework creating a simpler, more efficient and user friendly process. It further aligns with the intent of s19AA legislation that all medical practitioners should have or be working towards recognized vocational standards to ensure that medical services are delivered to a high standard.

The addition of the single pathway is underpinned by the determination of the RACGP Council that in future all FRACGP applicants will be required to have enrolled in either AGPT or RACGP Practice Based Fellowship Program in order to be eligible for FARCGP.

Remediation, return to work and practitioner self-care

The RACGP is in the process of establishing a program supporting remediation, return to work and practitioner self-care. To be led by Dr. George Zaharias the program will offer diagnostic, education and personal services to support general practitioners whom for various reasons are not performing optimally and/or seeking to re-enter general practice. In addition research is currently being pursued from a national and international perspective concerning practitioners that perform sub-optimally and best practice approaches to reinstate safe and effective health care for their patients and to themselves.

Professional behaviour

The RACGP Council has approved alterations to the college policy framework specifically directed at addressing professional behaviour for the vocation. Specific policies are either in place or in the process of drafting that recognize professionalism, ethics and ongoing participation in learning and development.

Advocacy and policy development

The RACGP understands systemic errors rather than personnel errors account for most poor patient outcomes. The medical home, work with Primary Health Networks, continued engagement with government and regulatory bodies and other mechanisms are being developed to deliver safer high quality clinical health care across the primary health care sector.

Response to questions for discussion

1. *Is the proposed integrated approach a reasonable way to improve the performance of all medical practitioners, reduce risk to the public, proactively identify and then support remediation of individual medical practitioners back for safe practice?*

   Whilst it is accepted that improvement is best effected through a quality QI & CPD system, it is highly contentious to assume that such a system does not have the propensity to also identify underperformance. The development of separate approaches all seeking to in part identify poor or under performance is not one of integration but more of complementary or parallel approaches that have a strong likelihood of yielding conflicting outcomes.

   Strengthening QI and CPD approaches through access to a greater range of data sources, i.e. billing and prescribing) compulsory participation in the RACGP QI & CPD program (for all doctors working in general practice) and mandatory participation in remediation (condition of provider number retention) are all elements that can be utilized that do not involve significant additional cost nor change to an existing resource base. Identification of underperforming doctors can be pursued through CPD participation activity, billing and prescribing algorithms, access to a register of complaints and feedback from other practitioners and patients without the imposed requirement/need for a parallel system.

2. *Are there other approaches that could feasibly achieve these aims?*
   See above

3. *What are the barriers for implementation and gaps that will need to be addressed for the proposed approach?*

   Data access remains a significant impediment for a properly configured system. Identification of potential underperformance cannot be assumed on the basis of gender, age, ethnicity or geography instead requiring a much broader matrice which currently is not available due to the limitations of data access.

   Additionally assignment of responsibility should be afforded to a single agency as coordination and identification functions are severely disrupted through a multi-agency process.

   As a condition of medical provider status it is recommended that all practitioners must fully participate in the relevant colleges QI & CPD program. External mirroring organizations should not be accepted as viable alternatives to enrolment and participation in a college CPD program.

   Consistency of approach and action should be implemented particularly with respect to non-compliance and / or underperformance regardless of circumstance (health and personal tragedy excluded). This has not been a hallmark of recent systems.

4. *Do you agree with the guiding principles? Are there other guiding principles that should be added? Are there guiding principles that are not relevant?*

   The guiding principles as written are appropriate. As revalidation is essentially an assessment process should guiding principles associated with fairness, validity, reliability and the like be included? This is particularly important given the potential consequence of underperformance.

5. *How can evidence based strengthen CPD be achieve?*

   The RACGP for the 2017-2019 triennium has introduced a compulsory analysis tool – Planning Learning and Need (PLAN) requiring all practitioners to self-evaluate their professional skills in comparison to community needs through a process of critical thinking and examination. Participants by undertaking PLAN are then provided with a consolidated determination of the learning and skill areas to be considered for the 2017-2019 triennium. The inclusion of a foundation analysis tool provides significant rigor and direction to learning objectives and a method for evaluating levels of improvement attuned to individual requirements.

6. *Who should be involved in strengthening CPD and what are their roles?*

   The professional college – determination of requirements, performance benchmarks, support, records management and reporting.

Regulatory bodies (AHPRA, MBA) overall policy structure, audit and compliance.

Individual practitioner – determination of areas of improved performance based on professional standards, community needs and personal aspirations.

The RACGP contends that increased fragmentation of responsible entities such as the addition of third party QI & CPD recording agencies will only weaken the process. For the program to retain and improve rigor, applicability and compliance, a tripartite arrangement encompassing the individual practitioner, the professional college and relevant regulatory authority, should be mandated.

7. *Are there any unintended consequences of this approach?*

A purposeful and strategic approach for QI & CPD will yield positive gains for the community and the practitioner. Introducing and/or countenancing variation in provider services and multiple regulatory authorities will adversely affect aspirations of continued improvement. Minimizing the potential role of disparate agencies, clearly specifying roles, responsibilities and accountabilities and maintaining a systems approach for QI & CPD will yield continued improvement.

8. *How can we collaborate with employers and other agencies involved in systems which support and assure safe practice to minimize duplication of effort?*

As previously outlined fragmentation of responsibility will diminish quality outcomes. Whilst secondary agencies and the evidence/guidance they produce are important and should be considered, they are subordinate to the determination made by the professional colleges, the individual practitioner and the regulatory agencies. That tripartite group has the responsibility to ensure that relevant data/information is considered and infused where appropriate. Hence demonstration of awareness and consideration of application is the critical component and not compulsory introduction of other fragmented or disparate information services.

9. *Is each of these principles relevant and appropriate?*

The RACGP supports the guiding principles as outlined.

10. *Are there other guiding principles for CPD that should be added?*

We would emphasize that programs reflect community needs, professional requirements and personal aspirations. The latter element (personal aspirations) lacks visibility in the described principles.

11. *What is your view on the proposed model for strengthening CPD that includes a combination of performance review, outcome measurement and validated education activities?*

The RACGP would propose that personal reflection and evaluation are key learning and assessment processes that are not given visibility (i.e. Figure 2 Types of CPD). For instance self-recording and reflection of patient encounters are excellent educational tools and approaches for review of performance and direction for further development. The list relating to Undertaking educational activities could include case study analysis, personal performance review, action research etc. Reviewing performance should identify and promote self-reflection and analysis as a primary tool. Measuring outcomes should include prescribing approaches for specific morbidities, referral patterns and the like.

12. *What are the implications for specialist college programs if medical practitioners were required to undertake CPD that is a combination of performance review, outcome measurement and validated educational activities?*

The RACGP QI & CPD program does embrace these qualities however the approach is centred around self-reflection/determination and not specifically on third party judgement. The critical factor in this question is not the methodology but the level of imposition and third party intervention. The RACGP contends that QI & CPD assessment processes must retain a high degree of personal reflection with third party input to be used largely as a critical reference point rather than as an absolute driver for change or as a primary assessment instrument.

13. *What a the implications for medical practitioners undertaking self-directed programs if medical practitioners were required to undertake CPD that is a combination of performance review, outcome measurement and validated educational activities?*

As outlined the RACGP QI & CPD program requires practitioners to undertake professional development activities within a prescribed framework incorporating these elements. Our experience is that externally enforced actions rarely result in proposed outcomes being realized. Increasing personal control and accountability has for us, realized significantly improved outcomes compared to that of externally mandated positions.

14. *Is it a reasonable approach to work to better understand the factors that increase medical practitioners' risk of performing poorly so that effort can be focused on this group of doctors?*

It is of considerable concern that profiling and/or MSF will identify and confirm at risk practitioners with validity, reliability, affordability and practicality. This is complicated by a lack of definition of what is considered an 'at risk' practitioner, particularly if we concentrate only upon reporting. The

consumer who simply 'walks away' from a practice without report will not be uncovered in the proposed approach although arguably a recipient of serious underperformance.

The RACGP contends that blunt analysis mechanisms do little in identifying underperformance and often alienate the profession. From our observations there appears to be little by way of meta-analysis of the risk factors and while it is noted that age and gender may be disproportionally presented, a focus on these two discriminators as primary agents is not appropriate. From the evidence presented the RACGP contends that the data is at best correlational and not causal and hence factoring profiling actions on such undiscriminating data will, we believe, alienate practitioner support for the concepts espoused in revalidation.

The RACGP believes that behaviourally undiscriminating criteria does not lend appropriately for the determination of specific learning improvement and change strategies. Meta data analysis related to communication, professionalism, ethics, isolation, training, bullying practices, complaints, prescribing, patient servicing patterns, scope of practice, late/incomplete/low level CPD compliance and the like produce a more informed analysis of underperformance. This is accepted by the professional where gender and age discrimination are not.

It is also somewhat incongruous that risk level is not scaled to perceived underperformance. For practitioners the identification methodology proposed is inconsistent to the nature of general practice and level of risk. An improved risk analysis would better identify underperformance, reduce cost and empower the profession.

15. *Do you have any feedback on these risk factors identified in the evidence? Do you know of other risk factors that are relevant? Are you aware of combinations of risk factors that can identify medical practitioners at risk of performing poorly?*
    See above.

16. *Who can play a part in the identification of at risk and poorly performing doctors to strengthen early identification? How would this occur?*

The RACGP contends that fragmentation of responsibilities, lack of data interchange, inconsistent regulatory compliance and application are major inhibitors to early identification of underperformance. Enhanced collaboration and sharing approaches coupled with changed responsibilities would promote superior co-ordination and focus resulting in improved identification. If this change was linked to quality remediation and education rather than a punitive regime of action, further improved outcomes and disclosure would be achieved. The RACGP proposes that this would best be achieved through expanded collaboration between the regulatory authorities and the colleges paralleled with an increased level of responsibility afforded to the colleges. Necessarily this would involve all practitioners being affiliated with the college in their area of practice and as a consequence, reduce the capacity for practitioners to pursue QI & CPD regimes outside of college jurisdiction. This is not to limit provider delivery but to ensure a purposeful and robust QA process is in place.

17. *What do you think about the proposed options for a tiered assessment?*

Modern practice in determining and scaling risk is seldom if at all focused on large undiscriminating data sets. Through purposeful criteria and specific algorithms risk levels and cost imposts are better balanced. The proposed options in terms of escalating levels of intervention are sound. The initial screening process however is too wide and not cost-efficient in the outcomes seeking to be met. The resources required, the sample size to be considered, the cost of undertaking and duration of process would prohibit a streamlined and effective method.

The RACGP contends that improved identification of the target group must be undertaken. The risk matrix therefore is a critical factor and must go further than the macro determinants cited in the paper. Meta-analysis of current previous underperformance must be distilled to inform more precise risk indicators thereby achieving an improved balance between level of risk and resource deployment.

18. *Can you provide feedback on the proposal that MSF be used as a low cost, effective tool to assess medical practitioners identified as being at risk of poor performance? Are there other cost effective approaches that could effectively assess medical practitioners?*

The utility of MSF varies considerably with respect to context. Whilst its applicability within tertiary facilities is somewhat uniform, the scope and applicability to remote and rural environments in primary health will vary in terms of comprehensiveness and accuracy. Parameters relating to choice of feedback provider, knowledge of practice, responsiveness, areas of focus and the like will impact upon the integrity of the outcome. Consideration should be given to MSF as but one secondary and not primary data source thereby enabling scalability to cost and resource allocation. The primary source of identification, as previously outlined, would focus on more precise risk indicators and improve data points.

19. *If MSF is to be used, how can Australian benchmarks be developed? What are appropriate sources of comparative data?*

There are considerable variations in discipline and context around Australia rendering comparison data problematic. There similarly exists no standard benchmark of performance and under performance in general practice. If benchmarks are to be developed that are cogent, it is probable that they will be several years in collection and ratification. At best MSF data in the nascent years will have utility in individual comparisons only. The RACGP reiterates that primary source data analysis as previously cited, would provide strong comparative data with reduced cost.

20. *Which Stakeholders have a role in identifying, assessing and supporting remediation of poorly performing medical practitioners or those at risk of poor performance?*

Interim determination of poor performance within general practice will predominantly come through data distillation and then qualified through additional information sources such as MSF. Whilst these processes may identify general practitioners requiring remediation, the decision as to participation in any such process rests with the individual and may be thwart if that practitioner declines to participate. Employer relationships vary significantly in general practice to that of tertiary health care providers hence employer compulsion is not generally an empowering strategy for participation. This leads to a determination that access to support structures must be made more readily available and that supportive rather than punitive approaches will yield improved outcomes.

If the participation in remediation is to have legitimacy, it may be necessary for the registration bodies to effect compulsory participation. This may include sanctions such as restriction to practice if practitioners choose not to appropriately participate.

Colleges should be the primary agent to remediate under and poorly performing practitioners. In addition to a wealth of expertise in education and training they are importantly impartial in their deliberations thereby not subject to conflicts of interest as per the array of fee for service providers. The RACGP from the next QI & CPD triennium will be able to review/audit practitioner self-review, educational activities and completion rates.

21. *What is each stakeholder's responsibility to act on the results of that assessment to address medical practitioners' performance?*

The report highlights several case studies and whilst they are far from conclusive, highlight known issues associated with the identification of risk. Most notably is that risk varies with the type of specialty, the level of activity, the complexity of the presentation and that the number of previous complaints and the time span between those complaints is particularly significant. The difficulty with such data is that it is retrospective in nature i.e. Complaints must firstly occur and be authenticated to identify pattern. The focus of a risk analysis should be as much as possible on the early identification of the risk. Hence increased attention should be directed to the practitioners self-assessment of risk and any proposal and action to correct same (the first authoritative point of analysis) , the professional colleges analysis of the outcomes (assuming access to all appropriate data points) of the individual's assessment and action resulting from that assessment, and ultimately for the regulators to (a) empower the professional colleges to oversight the rectification actions undertaken by the individual practitioner, and (b) implement sanctions should practitioners fail to participate in appropriate personal or college directed action or fail to meet the standard of performance deemed appropriate by the specialty college.

An underlying inference in the revalidation paper appears to be that poor and underperformance is recognised by all stakeholders. The RACGP considers this to be particularly flawed and as such has worked strongly upon raising practitioner awareness of knowledge and skill gaps aligned to the professions standards. Practitioners that do not have objective and referenced assessment criteria are particularly vulnerable in this respect.

If poor and under performance is to be detected as early as possible, it is the practitioners that must be given the tools to recognise same. Awareness and subsequent action to address deficits illustrates a concerned and responsive practitioner, similarly a failure to act on such data would tend to indicate potential risk. Hence for the RACGP, participation in a compulsory planning

learning and need (PLAN) activity provides significant insight to not only a practitioners' awareness of knowledge and skill gaps but also the manner and purpose in which it is addressed.

This process places primary emphasis upon the practitioner (with access to range of available appropriate tools) with secondary identification and support through the specialty colleges. Failure to proceed or achieve desired outcomes through primary and secondary action then becomes the province of the regulators to determine continued status as a practitioner.

22. *What barriers are there for stakeholders to share information about the performance of medical practitioners? How can these be overcome?*

The sharing of information is limited by personal and organizational reticence, information technology capture and connectivity systems, legislation, data size and configuration and security of intended and non-intended use of that data.

The RACGP considers that the sharing of information can only proceed with the development of a properly configured and controlled framework that balances informed and evidence based data aligned with practitioner support and community protection. It cannot be purely a punitive approach but instead a pro-active method for identifying risk (primarily through the determination of the practitioner), and the outlining of corrective action and/or support from enabling agencies. Current approaches are both retrospective and punitive. This needs to alter to refocus on prospective identification and availability of support and remediation structures.

23. *What are your views about the threshold for reporting poorly performing medical practitioners to the Medical Board?*

Specialty colleges should have a responsibility for advising the Medical Board of poorly performing medical practitioners, however in the vast majority of cases, such reporting should be preceded by purposeful remediation and support programs. Underpinning those programs must be college access to all relevant data and information enabling a comprehensive analysis of the practitioner to be developed that will inform, in conjunction with practitioner input, the most likely successful intervention.

Only after proposed options for remediation have been undertaken and found ineffectual should those identified practitioners be reviewed by the Medical Board for alternate action. This is not to obfuscate the advising of the Medical Board where remediation is being undertaken. It is however of paramount importance that the specialty colleges and the individual practitioner are afforded the status to undertake identification, assessment and potential remediation of potential poor performance without intervention. The specialty colleges are best placed to determine competence against professional standards and to make recommendations to the Medical Board concerning the outcomes of any assessment and/or remediation program which then may be used by the Medical Board with respect to any potential future action. Major infractions would be directly reported to the Medical Board.

24. *Who should be responsible for supporting remediation of identified under-performers who do not meet the threshold for referral to the Medical Board?*
    See question 23

25. *Who should be responsible for identifying, assessing and supporting remediation of poorly performing medical practitioners who are not associated with specialist colleges or organisations with robust clinical governance structures?*

    The RACGP contends that no medical practitioner should be outside the jurisdiction of the relevant medical college. Entry and continued registration as a practicing medical professional should be contingent upon membership and active participation within the relevant colleges CPD structures. Failure to do so dilutes quality and safety for patients and the community and additionally places the medical practitioner at risk.

    As represented consistently in this response, the specialty colleges are the only viable organisations that can effect necessary change within the system. Fragmentation of this approach (as evidenced currently) will only serve to weaken patient safety and quality.