

Making MOC Quality Improvement Participation Meaningful

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Maintenance of Certification (MOC) is intended to ensure the lifelong learning and continued competence of board-certified physicians. The American Board of Pediatrics aligned the MOC process with the core competencies set forth by the American Board of Medical Specialties and the Accreditation Council for Graduate Medical Education (ACGME).¹ The 4 components of MOC, MOC parts I to IV, require that physicians demonstrate (I) good professional standing, (II) lifelong learning and self-assessment, (III) cognitive expertise, and (IV) participation in improving professional practice or in quality improvement (QI). To obtain part IV credit, pediatricians must demonstrate competence in systematic measurement and improvement by participating in 1 approved QI project or by completing 1 Web-based improvement activity during every 5-year MOC cycle.

In this issue of *Pediatrics*, Freed et al² evaluated participation in, motivations for, and attitudes toward QI as well as perceived support for QI activities and self-confidence in the QI skills of >8000 pediatricians enrolling in MOC. The authors compared outcomes across different groups of physicians, including generalists and specialists, academic and nonacademic physicians, and those graduating before or after 2002 (the inaugural year for the ACGME-mandated QI training for pediatric residency programs).

Most (86.6%) pediatricians reported participation in at least 1 QI project over the course of the preceding year. Participation rates were lowest among

nonacademic generalists and highest among academic specialists. Most respondents reported participating in a QI project through their employer or through the American Board of Pediatrics Performance Improvement Modules. Only 28% of respondents reported completing a self-initiated project, with academic specialists being most likely (41.2%) and nonacademic generalists being least likely (19%) to complete a self-initiated project. Extrinsic requirements are particularly important motivators for QI participation; intrinsic motivators, such as the opportunity to identify gaps in practice and implement changes, were ranked as important by fewer than half of the participants. Nearly all respondents agreed that practice improvement was a professional responsibility, and most believed that QI was encouraged in their workplace. Over half of respondents reported adequate information technology support, education, and resources. Although, unsurprisingly, more than half believed they did not have adequate time for QI activities. Furthermore, reported self-confidence in QI skills was uniformly low. Only 46.9% of respondents were confident in their use of data to track changes, and even fewer felt confident in using QI methods and tools to test strategies and inform improvement efforts.

Although this survey provided insight into the types of QI participation among pediatricians enrolling in MOC and into pediatricians' attitudes toward QI, there were several study limitations. Despite a relatively good response rate

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(73.3%), nonrespondents may have differed from respondents in demographics, practice affiliation, and survey outcomes. No data on nonrespondents are presented, so it is not clear how this would have affected the overall outcomes. For example, pediatricians with positive QI experiences may have been more likely to respond to the survey, resulting in an overestimation of intrinsic motivations or self-confidence in QI skills. Although the authors attempted to mitigate recall bias by only asking about participation over the previous year, it is possible that differences in participation rates among groups are less than reported if assessed over a full MOC cycle. Although the analysis used to compare resident respondents graduating before and after 2002 did not reveal meaningful differences, it is likely that meaningful changes in resident exposure to QI lagged behind the ACGME requirements. Finally, although the authors asked about the types of QI participation, they were not able to assess whether certain QI experiences resulted in more positive perceptions of QI participation or in higher self-confidence in QI skills. The authors discuss the need for QI programs that are relevant and

feasible for clinicians in different practice settings and, despite high rates of participation, conclude that there has been limited diffusion of skills to practitioners. Although we agree, it is imperative to evaluate the outcomes of approved QI programs and the benefits to individual participants, such as whether they continue to apply acquired skills in their practice. This study reveals that, although QI participation rates are high, intrinsic factors only modestly influence participation, and outcomes of wide-spread participation (at least in terms of self-confidence in QI skills) are far more modest. For MOC part IV to be meaningful, participation in approved activities should lead to skill acquisition, and application should positively influence health care delivery and patient outcomes. It is highly likely that certain QI experiences are more beneficial than others. Multisite collaboratives may be particularly promising; for example, the Value in Inpatient Pediatrics Network was able to reduce unnecessary bronchodilator use across 17 clinical sites.³ We suspect that concerns regarding time, cost, and lack of true skill attainment after completion of MOC part IV may be influencing many respondents' reports of extrinsic

motivation for completion. By identifying and investing in effective experiences, we anticipate that intrinsic motivation for completion may increase, and thus, the true spirit of MOC part IV will be more attainable.

ABBREVIATIONS

ACGME: Accreditation Council
for Graduate Medical
Education
MOC: Maintenance of
Certification
QI: quality improvement

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