

VIEWPOINT

Maintenance of Certification—A Prescription for Improved Child Health

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When parents seek care for their children, they typically turn to general pediatricians and pediatric subspecialists for this care, recognizing that pediatricians have received specialized training tailored to children and adolescents. Parents generally trust pediatricians inherently and expect that these physicians will provide outstanding, state-of-the-art care on every encounter, keeping pace with the constantly evolving practice of pediatrics. To demonstrate to parents, hospitals, credentialing bodies, and payors evidence of the necessary background and expertise to provide state-of-the-art care, most pediatricians obtain board certification, a voluntary process that goes above and beyond state licensing requirements for practicing medicine and indicates an additional level of accomplishment and expertise. Hospitals increasingly require board certification for medical staff privileges, and credentialing bodies and payors often require board certification for participation in provider networks and for reimbursement.

The process of board certification for general pediatricians and most pediatric subspecialists is administered by the American Board of Pediatrics (ABP) and requires completion of training in an accredited program, verification by the training program director of competence in 6 core competencies (patient care, medical knowledge, practice-based learning and improvement, professionalism, interpersonal and communication skills, and systems-based practice), and satisfactory performance on the ABP certifying examination in general pediatrics or the relevant pediatric subspecialty. For individuals who obtained initial certification in 1988 or afterward to remain certified, the ABP requires participation in Maintenance of Certification (MOC), a program that currently focuses on 3 of the core competencies, specifically professionalism, medical knowledge, and practice-based learning and improvement. Maintenance of certification is intended to demonstrate for the public those pediatricians who meet the highest standards of professionalism (part 1), lifelong learning and self-assessment (part 2), ongoing knowledge assessment (part 3), and improving professional practice (part 4).

The process of MOC has received considerable attention in recent years,¹ raising questions among members of the pediatric community (and other medical specialties) about the objectives, format, time commitment, and impact relative to the cost to the diplomate. In response to feedback from pediatricians, the ABP has implemented major changes in the MOC program over the past few years, allowing MOC to continue to evolve. In particular, the ABP has attempted to clarify the goals of MOC, expand the range of options to satisfy MOC requirements, create options more applicable to a practi-

tioner's daily practice and achievable during a routine day, simplify and shorten the process for gaining credit, and, most importantly, demonstrate improvement in pediatric care.

In an effort to address concerns that options for ongoing learning and self-assessment exclude many continuing medical education offerings and are too limited, the ABP is partnering with the Accreditation Council of Continuing Medical Education to ensure that continuing medical education activities associated with assessment result in automatic credit for part 2. In response to feedback that the closed-book MOC examination assessing knowledge once every 10 years does not reflect practice and is not conducive to sustained knowledge, the ABP has initiated a pilot called MOCAPeds (Maintenance of Certification Assessment—Pediatrics), patterned after an approach that was recently implemented in anesthesiology for part 3 credit. In this pilot, diplomates will receive 20 independent online questions per quarter and will have 5 minutes to answer each question, accessing reference material as time allows. The questions are associated with learning objectives, feedback, and references, aiming to stimulate learning and assess knowledge simultaneously and resulting in both part 2 and part 3 credit. To determine whether the new format achieves the desired goals and is as reliable as the secure examination, the ABP will be studying this format during the pilot period.

Of the 4 parts of MOC, perhaps most controversial is part 4, improving professional practice. As a consequence of recent changes, options for improving professional practice are now plentiful and are much more advanced than some of the early performance improvement modules, some of which generated significant cynicism. Examples of current options include participating in any of a long list of national quality improvement (QI) collaborative networks, participating in projects that are developed and managed locally by an institution (institutional portfolios), gaining recognition for being certified as a "patient-centered medical home" or a "patient-centered specialty practice," completing QI projects that are initiated in the practice workplace, and even facilitating improvements in residency and fellowship training programs. All of these options supplement the longstanding performance improvement modules and the many newer performance improvement modules.

The impact that MOC has had on child health outcomes has been substantial, with potential for even greater impact in the future. Among the many QI projects that pediatricians are currently pursuing, some were stimulated directly by the ABP MOC program and others were influenced indirectly by the ABP yet qualify for MOC credit. As examples, the ImproveCareNow collab-

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orative (the prototype pediatric subspecialty learning collaborative for MOC, created jointly by the ABP and the North American Society for Pediatric Gastroenterology, Hepatology, and Nutrition) has increased remission rates for patients with inflammatory bowel disease by 47%,²⁻⁴ and the National Pediatric Cardiology QI Collaborative (aided by ABP leadership and by MOC as an incentive for participation) has decreased mortality among patients with hypoplastic left heart syndrome by 46%.^{5,6} Similarly, QI projects in our own departments that have been motivated by MOC credit and increasingly by the institutional culture stimulated by MOC have resulted in marked improvements in care and outcomes across many patient groups.

To address the controversies surrounding MOC and the challenges in ensuring that certified general pediatricians and pediatric subspecialists are aware of the recent changes in MOC, the Federation of Pediatric Organizations organized a convening in February 2016 that included leaders from the 7 Federation of Pediatric Organizations member organizations (the Academic Pediatric Association, the American Academy of Pediatrics, the ABP, the American Pediatric Society, the Association of Medical School Pediatric Department Chairs, the Association of Pediatric Program Directors, and the Society for Pediatric Research) and representatives from the Council of Pediatric Subspecialties, the Children's Hospital Association, and a parent organization called Family Voices. The discussion

concluded with the pledge that the Federation of Pediatric Organizations member organizations are committed to working collaboratively with the ABP to improve MOC, aiming ultimately to achieve the ABP mission of maintaining standards of excellence that lead to high-quality health care for children.

As we reflect on MOC, we are struck by the significant evolution that has occurred since the program was first rolled out less than a decade ago and by the progress that has occurred in improving how pediatricians deliver care to pediatric patients and in improving child health outcomes. The ABP is listening to pediatricians and is implementing changes based on this input and on the principles of continuous QI, both internally and in collaboration with other pediatric organizations, recognizing the need to balance the time constraints of daily practice and the value of QI. In addition, the ABP is actively evaluating the impact of MOC on patient outcomes, assisted by the ABP Research Advisory Committee, which includes a number of experienced pediatric clinical investigators. In our minds, it is difficult to argue with the emphasis of the ABP MOC program, namely, increased focus on professionalism, lifelong learning and self-assessment, knowledge assessment, and improving professional practice, in particular when we consider the interests of patients and the expectations of parents and families. We are very strong proponents of MOC, and we believe that MOC is a prescription for state-of-the-art pediatric care and for improved child health.

ARTICLE INFORMATION

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Conflict of Interest Disclosures: Dr First is the chair of the department of pediatrics at the University of Vermont, chair of the Association of Medical School Pediatric Department Chairs (AMSPDC) Education Committee, member of the American Board of Pediatrics (ABP) Research Advisory Committee, member of the AMSPDC Planning Committee, editor of *Pediatrics*, and past chair of the National Board of Medical Examiners. Dr Gremse is chair of the department of pediatrics at South Alabama University, chair-elect of the ABP, member of the AMSPDC Planning Committee, and past member of the AMSPDC Board of Directors. Dr St Geme is chair of the department of pediatrics at the Children's Hospital of Philadelphia and the University of Pennsylvania, associate chair of the AMSPDC Research Committee, and immediate past chair of the ABP.

Disclaimer: We wrote this Viewpoint as chairs of departments of pediatrics and as individuals who have been involved with the APB in recent years, allowing us to gain insights into the past, present, and future versions of the ABP Maintenance of Certification Program. Our comments reflect our own views and do not represent the official views of the ABP, the AMSPDC, or any other pediatric organization.

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