

This is the third in a series of Assuring Better Child Health and Development III (ABCD III) issue briefs. ABCD III is a three-year learning collaborative of teams from five states designed to improve care coordination between primary care providers and other providers of community services for children up to age 3 with potential developmental delay.<sup>1</sup> This *State Health Policy Briefing* focuses on the lessons learned in ABCD III about state agency partnerships with physicians and community providers to develop quality improvement projects with a built-in incentive; these projects offer continuing education credit that physicians need to maintain their specialty board certification. The ABCD program is funded by The Commonwealth Fund, administered by the National Academy for State Health Policy (NASHP), and designed to assist states in improving identification of and care coordination for very young children, age 0-3, with or at risk for developmental delay. Since 2000, ABCD has helped 27 states create models of service delivery and financing through a laboratory for program development and innovation.

## Maintenance of Certification: ABCD III State Efforts to Capitalize on an Incentive for Quality Improvement

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The current Assuring Better Child Health and Development learning collaborative (ABCD III) brings together teams lead by Medicaid agencies in five states (Arkansas, Illinois, Minnesota, Oklahoma, and Oregon) to learn from each other as they create systems that improve care coordination and linkages between primary care providers (PCPs) and community resources, including the Early Intervention program, that serve very young children (ages 0-3) with or at risk for developmental delays. ABCD III builds on two prior ABCD learning collaboratives and a Screening Academy, all designed to improve the identification and care of these very young children. The ABCD III state initiatives are in their third year, and a number of early lessons have emerged.<sup>2</sup> This *State Health Policy Briefing* focuses on the opportunities for states to partner with physicians and other stakeholders in quality improvement projects that improve screening and care coordination and that offer an added incentive—“Maintenance of Certification” (MOC) credit incentivizes physician participation and helps them maintain their specialty certification. Physicians, including pediatricians, must engage in quality improvement under Part 4 of their maintenance of certification requirements to achieve and

regularly renew certification by their specialty board. The brief provides background on the MOC Part 4 standards for physicians to maintain board certification in their specialties, and draws on experience with MOC Part 4 programs arising from both the ABCD Screening Academy and ABCD III. These ABCD experiences demonstrate the value of states working closely with professional societies to obtain medical board approval to offer MOC Part 4 credit for quality improvement projects. In addition, the ABCD III experiences also offer lessons for other states interested in improving care coordination about how to structure care coordination quality improvement projects appropriate for MOC Part 4 credit. These lessons include:

- Maintenance of certification credit can be an important motivator for physician practices to engage in structured quality improvement projects. By working collaboratively with professional societies to target topics of joint interest, states can help expand quality improvement in primary care, assure that improvements are evidence-based and spread best practices.
- States can build on existing quality improvement partnerships with providers (such as child health improvement partnerships or medical homes initiatives) to develop and implement MOC Part 4 programs.
- In partnership with physician organizations, state agencies can use maintenance of certification credit to foster the use of data to drive improvement while simultaneously obtaining aggregate data from providers about the effectiveness and reach of quality improvement interventions.
- In managed care states, managed care organizations (MCOs) can be important partners. State partnerships can align quality improvement efforts offering MOC Part 4 credit with federal MCO Medicaid Performance Improvement Project requirements.
- Quality improvement projects designed to offer MOC credit must include some level of foundational training in the quality improvement process (in addition to content-specific information), providing knowledge and skills related to quality improvement that providers may apply more broadly.
- Measurable outcomes should be chosen carefully to include only those that are within the primary care provider's (PCP) control. For initiatives that focus on care coordination, data on frequency of feedback from the referral agency to the PCP must be collected, but PCPs should not be held accountable for outcomes outside their control.
- Care coordination quality improvement projects can effectively improve referral tracking and follow-up if they include participation by both PCPs and referral agencies. Maintenance of certification credit can work well as an incentive as one component of a larger project that includes a parallel effort by the referral agencies.

## INTRODUCTION

An important area for quality improvement initiatives is improving the identification and coordination of services for children with, or at risk for, developmental delay. Neuro-cognitive research has demonstrated that the early childhood years are a critical time to prevent or minimize developmental delays, making identification and treatment of potential delay in the infant and toddler years important to their life trajectory.<sup>3</sup> In the past, many physicians used informal clinical judgment in assessing infants and toddlers for developmental delay. Yet a standardized assessment has been recommended by the American Academy of Pediatrics since 2001, with more detailed recommendations established in 2006 for using a standardized screening tool at the 9-, 18- and 30-month well-child visits.<sup>4</sup> Although the use of a standardized tool more than doubled between 2002 and 2009, half of pediatricians still do not routinely use a formal developmental screening tool for children less than three years old.<sup>5</sup>

Substantial room for improvement also exists in making referrals and coordinating services for children identified with potential delay. Early Intervention services are provided in federally funded programs in every state, and are intended to provide and coordinate services for children less than three. Yet, although approximately 13 percent of children under age two have developmental delays that would qualify them for Early Intervention services, only 10 percent of those that qualify actually receive services.<sup>6</sup> Evidence also indicates that when a family does receive Early Intervention services, there is a delay of 8.9 months from the time a parent first expresses a concern about a child's development to when the services are received.<sup>7</sup>

One important way to increase the number of children that receive timely early intervention services is to improve the rate of standardized developmental screening by primary care providers, along with appropriate referrals for follow up assessment and services. Research indicates that barriers to physician referral include physicians' lack of understanding of non-medical services in the community such as early intervention, the lack of

feedback when they have referred in the past, the lack of time, discomfort with working with other service providers, and lack of organizational structure to systematically address the needs of children who are at risk or have mild or moderate delay.<sup>8</sup>

To break down these barriers, physicians need training and support to learn about early intervention and other community resources for children with potential developmental delay. They also need to develop office systems for appropriate screening and referral and to receive feedback after a referral is made.

A quality improvement process that engaged the physician with a team of people, including Early Intervention services, provided ABCD III states a structured way of implementing needed change. It also educated team members about the quality improvement process itself, offering practices and community providers a method for testing and implementing other improvements. This effort became the focus of the third learning collaborative of the Assuring Better Child Health and Development (ABCD III). States in ABCD's earlier Screening Academy and in ABCD III have used an important incentive to encourage physicians to participate in a structured quality improvement process: Maintenance of Certification, Part 4 credit.

The ABCD program is a multi-state effort that enjoys a long history of working with Medicaid agencies and broad groups of stakeholders, particularly physicians, who are invested in improving healthy child development. In ABCD I (2000-2003) and ABCD II (2003-2006), eight state teams created models for improving the delivery of child development services. In 2007 and 2008, ABCD teams from 19 states, the District of Columbia and Puerto Rico participated in the ABCD Screening Academy to improve developmental screening of infants and toddlers. Out of this experience arose ABCD III, which is now in its third and final year. ABCD III has brought five state teams (Arkansas, Illinois, Minnesota, Oklahoma, and Oregon) together in a learning collaborative in which each has developed quality improvement projects to improve care coordination for those children identified by a screening as being at risk for developmental delay.

As ABCD teams have explored opportunities to encourage providers to increase screening rates and improve care coordination with other service providers, they have identified credit for Maintenance of Certification (MOC) as a useful incentive for physician participation in quality improvement. This paper describes how MOC Part 4 credit is a mechanism for quality improvement and how ABCD states have structured their ef-

forts to take advantage of it. The lessons from these initiatives will be applicable to similar partnerships to improve developmental screening and care coordination for young children, and may also be useful for other quality improvement efforts in primary care practices.

## BACKGROUND: MAINTENANCE OF CERTIFICATION (MOC) AND QUALITY IMPROVEMENT

Most physicians, including those in family medicine, internal medicine, and pediatrics, are certified as specialists in their fields by a specialty board. They must participate in certain continuing education activities in order to maintain that certification. Credit toward "maintenance of certification," or MOC, is an important motivator for physician participation in quality improvement projects. Although board certification is voluntary, there are high rates of physician participation. For example, in family medicine, eighty-five percent of family physicians are board certified and 91 percent of those eligible to participate are, in fact, participating.<sup>9</sup> In pediatrics 20 percent of physicians are involved at any one time in an improvement effort that involves the patients in their practices.<sup>10</sup> They are required to recertify every five years. Quality improvement projects that have been approved for MOC credit have produced results: improvements in hand hygiene, pediatric catheter-associated blood stream infections and outpatient asthma care, to name a few.<sup>11</sup> Thus, the MOC process offers opportunities for state health policy makers and their physician partners seeking to incentivize quality improvement.

During the past twelve years, a physician's process for maintaining board certification in his or her field of specialty changed dramatically from a process of simply demonstrating knowledge and skill to one that actually promotes higher quality care.<sup>12</sup> In 2000, the American Board of Medical Specialties (ABMS) established an MOC process that requires continuous learning in four areas: 1) professionalism, 2) lifelong learning, 3) cognitive expertise, and 4) performance in practice.<sup>13</sup> Periodic recertification in these four areas became a requirement of all 24 of the member boards of the ABMS, including the American Board of Pediatrics (ABP), the American Board of Family Medicine (ABFM), and the American Board of Internal Medicine (ABIM).<sup>14</sup>

The fourth area, performance in practice, requires that physicians engage in a continuous effort to improve a specific

outcome or process in their practice. To meet what is called “Part 4” criteria, physicians must “demonstrate that they can assess the quality of care they provide compared to peers and national benchmarks and then apply the best evidence or consensus recommendations to improve that care using follow-up assessments.”<sup>15</sup> The 24 ABMS member boards vary in how this standard is applied to their particular specialty; however, in common to all is the requirement of engaging in structured quality improvement, including data collection, comparative analysis, and an intervention that results in quality improvement.

These quality improvement activities are typically achieved using standardized quality improvement methods such as “Plan, Do, Study, Act” (PDSA) quality improvement cycles. Under this model, the participants define their objectives and expected outcomes, plan the intervention they hope will result in improvement, and plan how to measure the result (“plan”). They then carry out their plan on a test sample (“do”), analyze their data against benchmarks (“study”), and, adjust the intervention if it needs improvement (“act”).<sup>16</sup> At this point the cycle of planning, modifying the intervention, and measuring and studying the result is repeated until results show that the intervention is ready to be spread system-wide.

With a focus on care for very young children, ABCD state projects have primarily focused on the American Board of Pediatrics (ABP) standards for MOC Part 4. Pediatricians that seek certification have two options for meeting the Part 4 requirements. One option is to participate in internet-based modules approved by the ABP that guide a pediatrician or a group of practitioners through a quality improvement process. The ABP, for example, recently included a Performance Improvement Module on its website for improving developmental screening. The module begins with a brief explanation of the PDSA process, and then walks the pediatrician’s practice through the collection of baseline data and two PDSA change cycles for a small sample of patients. It includes data collection and analysis tools and access to best practice materials.<sup>17</sup> In Oklahoma, the MOC Part 4 credit associated with completing ABP Performance Improvement Module for developmental screening has been identified by staff on the ABCD III team as an important tool for encouraging pediatricians to participate in quality improvement projects to increase routine standardized screening.<sup>18</sup>

The other option for obtaining MOC Part 4 credit is to participate in an established quality improvement project ap-

proved by the ABP.<sup>19</sup> If, as in ABCD, a state Medicaid agency and its partners are encouraging pediatrician participation in a quality improvement project, the project leaders, together with a sponsoring organization, must first obtain ABP approval for participating pediatricians to qualify for MOC credit. The ABP standards for approving quality improvement projects for MOC Part 4 credit require, among other criteria, that the project address:

- One or more quality dimensions identified by the Institutes of Medicine (safety, effectiveness, timeliness, equity, efficiency, and patient-centeredness),
- Care that the pediatrician can influence,
- A defined aim for the project, including the target population, the desired numerical improvement and the timeframe for achieving the improvement, and
- The active participation of the pediatrician that involves care to patients, implementing the change, collection and analysis of data, and participation in at least four project meetings.<sup>20</sup>

As these standards indicate, the maintenance of certification process is more than a process for determining the competency of the physician. It has been designed to be a driver of measurable health quality improvement in physician practices.

## MAINTENANCE OF CERTIFICATION CREDIT INCENTIVIZES SPREAD OF QUALITY IMPROVEMENT IN ABCD

As the MOC requirements were being phased in by the ABP over the past decade, the ABCD learning collaboratives were working to improve screening and care coordination for very young children with or at risk for developmental delay. State teams included the partnerships needed to create effective quality improvement efforts: the Medicaid agency, the local pediatric physician’s organization, community providers and others. Some have taken advantage of the incentive provided by the MOC part 4 credit to help spread their quality improvement efforts.

## USING MAINTENANCE OF CERTIFICATION CREDIT TO EXPAND AND MEASURE IMPROVED DEVELOPMENTAL SCREENING AND REFERRAL: THE OREGON EXAMPLE

In Oregon, approval for MOC Part 4 credit by the ABP of the quality improvement effort to increase rates of developmental

screening and referral helped with expanding pediatrician participation and with the collection of data needed to show the results of the quality improvement effort.

In the fall of 2008, the Oregon Pediatric Society (OPS) initiated the START (Screening Tools and Referral Training) program. This project was an outgrowth of participation in the ABCD Screening Academy, a partnership that included OPS, two of the state's Medicaid managed care contractors, the Oregon Medicaid agency, the Oregon Department of Education's Early Intervention program, and others. Physicians who championed the project were not initially motivated by MOC Part 4 credit. They simply believed that it was right for their patients. In addition, the American Academy of Pediatrics had recently issued new screening and referral guidelines, and the screening had recently become billable under Medicaid.

Together, the team developed a screening and care coordination protocol that the PCPs and Early Intervention offices could be trained to use: a common referral and release form for PCPs to refer families to Early Intervention and for Early Intervention staff to notify the PCP of the results of the referral. Thus, the START training consisted of background on screening, the use of screening tools, community resources where families may be referred, and an exercise to map the workflow in the PCP practice for the new screening and referral protocol.

The Oregon Pediatric Society obtained ABP approval for MOC Part 4 credit for their program in May 2009, and noted that the MOC credit was a "strong incentive" for pediatricians to participate, particularly because it was grant-funded and free to the practice.<sup>21</sup> To receive MOC Part 4 credit, pediatricians in Oregon were required to attend the START Basic Training, implement standardized screening in their practices and submit data to project staff on their screening rates at patients' 9-, 18- and 24-month well-child visits over a nine-month implementation period. Over time, approximately 500 pediatric and family medicine providers participated in the START Basic Training, and most went on to implement a screening tool in their practices. Of those, 54 pediatricians initially sought and obtained MOC credit. They collected and submitted data to inform their quality improvement efforts as part of their MOC Part 4 requirement. The data they submitted was the only data that project partners had that actually linked the improvements in screening and referral rates to the quality improvement projects being conducted. Thus, MOC Part 4 was critical to the data collection needed to develop,

measure and track best practices in screening and referral.

The pediatricians who received MOC Part 4 credit achieved screening rates of over 90 percent of their patients (from a baseline of zero) at each of the 9-, 18- and 24-month well-child checks.<sup>22</sup> In March 2011, START received two years of continued approval from ABP for its quality improvement program for developmental screening. By June 2011, 78 pediatricians received MOC Part 4 credit from the ABP as a result of participating in START.<sup>23</sup> As a result of the entire effort, claims for developmental screening from pediatric practices to the participating managed care organizations increased in the second year by 95 percent. Equally important, the percentage of children identified and referred for Early Intervention services increased by as much as 10 percentage points in the relevant counties, and the appropriateness of referrals improved as well.<sup>24</sup> START continues to expand in Oregon, serving more rural areas of the state and adding new content areas for training, including maternal depression, autism, and social-emotional screening.

START's experience with MOC Part 4 participation is consistent with other efforts to use MOC Part 4 credit to develop and spread particular quality improvement efforts. In North Carolina, for example, the leaders of an effort to improve diabetes and asthma care found that the "early adopters" of the quality improvement program did not need incentives such as MOC Part 4 credit to participate. However, later participants showed much greater interest when MOC part IV credit was possible.<sup>25</sup>

The Oregon START experience benefited from the fact that physician peers and the Oregon Pediatric Society led the effort, thus engendering trust from other pediatricians and providing a strong application to the ABP for MOC Part 4 approval. In addition, the MOC Part 4 process was critical to the data collection process. Indeed, without the MOC Part 4 requirement, pediatricians would not have undertaken the data collection and reporting needed to measure the impact of the project.

### **STATE AND COMMUNITY PARTNERSHIPS WITH PHYSICIANS TO CREATE CARE COORDINATION QUALITY IMPROVEMENT PROGRAMS THAT OFFER MAINTENANCE OF CERTIFICATION CREDIT**

State Medicaid or public health agencies can play an important role in bringing together physicians and the other key players physicians must coordinate with to develop and

implement the quality improvement projects offering MOC 4 credit to improve the care coordination for children or for other populations.

In ABCD III, the Medicaid agencies were well situated to serve as the conveners of their ABCD III teams – teams that bring together physicians, Early Intervention agencies, families, and community service providers in an effort to improve care coordination. They also serve as the instigators and conduits for grant funding. However they have been cognizant that physicians must take the lead on the quality improvement processes that affect their practices. In a previous study of state agency partnerships with physician practices, a state official noted that “states should let physicians drive the agenda and then partner with them by providing technical support to enable the work. It helps with buy-in to know that [their] peers are driving the work.”<sup>26</sup>

In Illinois, the state Department of Healthcare and Family Services (HFS), which houses the Medicaid agency, contracted with the Illinois Chapter of the American Academy of Pediatrics (ICAAP) as part of their ABCD III effort to develop and implement quality improvement pilots in the state to improve care coordination. HFS was uniquely positioned to bring together the physician, Early Intervention, and community partners in care coordination that had not worked together frequently. ICAAP took the lead in developing the curriculum and quality improvement protocols that eventually received approval for MOC Part 4 credit. It also supervised the practice coaches to assist practices in implementing their MOC Part 4 projects. ICAAP and HFS also worked closely with Early Intervention and other community service providers to work through quality improvement processes to feed information from referral agencies back to physicians. They learned that to make the feedback process work, Early Intervention offices also required early buy-in and ongoing support to incorporate the new system into their workflow.

Illinois HFS is providing significant support in initiating, spreading and sustaining the care coordination achievements of the providers. The agency is developing secure electronic communications between Early Intervention and primary care providers to automate the referral and faxback system, a function that neither type of provider could have taken on alone. In Illinois, the larger Department of Human Services, in which HFS is housed, also oversees Early Intervention, allowing it to establish policies within that system to assure the referral and feedback processes are spread and sustained.

In developing quality improvement partnerships around screening and care coordination for children, states could first look to see if a Child Health Improvement Partnership is operating in their state. Coached by the Vermont Child Health Improvement Partnership, these partnerships are located in 15 states and include representation from the local chapter of the American Academy of Pediatrics, the state Medicaid agency, the state public health agency, an academic institution, children’s hospital or healthcare delivery institution and an organization with knowledge of quality improvement processes.<sup>27</sup> In two ABCD III states, Oregon and Minnesota, the state child health improvement partnership is a key player in ABCD III as well as in other child health improvement initiatives. A “How To” guide to starting such a partnership, including information on ABP MOC Part 4 credit, is available online.<sup>28</sup>

Medical home initiatives are another potential source of expertise in quality improvement processes, and participating physicians in these efforts would likely also be interested in MOC Part 4 credit. Many medical home initiatives provide support, practice coaching, help with care coordination, and other services to primary care practices seeking to become recognized as patient-centered medical homes.<sup>29</sup>

### **MANAGED CARE ORGANIZATIONS AS PARTNERS IN MAINTENANCE OF CERTIFICATION PROGRAMS: ALIGNING WITH FEDERAL PERFORMANCE IMPROVEMENT PROJECT REQUIREMENTS**

Oregon’s Medicaid population is served by managed care organizations (MCOs). The Oregon ABCD III team is also in the planning phase of submitting an application to provide MOC Part 4 credit for participation in its care coordination quality improvement project. Under federal Medicaid managed care regulations, MCOs are required to have an ongoing program of performance improvement projects (PIPs). The Oregon ABCD III quality improvement projects are being administered by eight participating MCOs as part of this requirement. As a result, the Oregon team is seeking to align their MOC Part 4 standards for their project with the Medicaid PIP criteria. The Medicaid PIP criteria require that the MCO be able to produce data on the success of the projects at least annually. In addition, the PIP project must involve:

- measurement of performance using objective quality indicators;
- implementation of interventions to improve quality;
- an evaluation of the effectiveness of the intervention; and

- planning and initiation of activities for increasing or sustaining the improvement.<sup>30</sup>

These criteria, although written in a different vocabulary, align very well with the MOC Part 4 criteria. This provides an incentive for both the managed care organization and the practices within their network to participate.

## STRUCTURING A MAINTENANCE OF CERTIFICATION PROJECT TO FOCUS ON CARE COORDINATION

Designing a quality improvement project to improve care coordination between PCPs and other projects offers the opportunity to support providers in building a foundational knowledge of the quality improvement process, and requires careful crafting of the PCP outcomes that will be measured and analyzed for MOC Part 4 purposes. The following sections describe the experience in ABCD III in designing projects to build this foundation of knowledge and to meet MOC Part 4 criteria.

### Develop Foundational Knowledge Of Quality Improvement

In the process of shaping ABCD III quality improvement projects for approval by the ABP for MOC Part 4 credit, ABCD III state teams are assisting physician practices in developing foundational knowledge in quality improvement processes. Knowledge of quality improvement processes is mixed among physicians. The ABP requires that “QI [quality improvement] projects approved for MOC credit must include training and educational resources on QI methods, as well as hands-on experience implementing QI methods. Such training can take many forms, such as seminars by QI experts, coaching by QI consultants, web-based curriculum, or other approaches.”<sup>31</sup> In Illinois, ICAAP has found that pediatricians early in their careers were exposed to the process in their third year of residency, while those who have been practicing longer did not get this background.

Both the Illinois and Minnesota ABCD III projects require that participants first engage in training in the quality improvement process. In Minnesota, training by a quality improvement expert is provided in person. In Illinois, the participant is required to view an online presentation by the Institute for Healthcare Improvement and then participate in an in-person training about how those principles will be applied in their particular project. In Oregon, in addition to general training about the PDSA cycle, practices must devel-

op their “aim statement” (establishing a clear objective), and then participate in a “map the workflow” exercise to analyze how the change will be implemented in their practices.

### Structuring the MOC Part 4 Portion of the Care Coordination Project: Keeping Outcomes within the PCP’s Control

The Illinois ABCD III team experience indicates that designing a care coordination project for MOC Part 4 approval is more complicated than a project focused just on screening and referral. The MOC Part 4 ABP standards require that the physician be able to influence the outcome being measured. Yet, for care coordination to work, a provider outside the physician’s practice must complete the communication loop. The project could not fairly evaluate the physician on whether the Early Intervention provider communicated back to the physician after a referral was made. To resolve this, ICAAP applied for approval for those elements of the project that were under the physician’s control. Meanwhile, the ABCD III team set up another quality improvement project within the Early Intervention offices to improve and measure the communication back to the PCP.

The Illinois ABP-approved MOC Part 4 program requires pediatricians to participate in PDSA cycles where the practice:

- refers all children identified as at risk for developmental delay to the Early Intervention office by faxing a standardized referral form and sending a copy to the family;
- follows up with all those referred by contacting the family within 36 working hours of the referral to find out if they have questions or concerns and to encourage them to follow through when the Early Intervention program contacts them; and
- follows up with those found ineligible for Early Intervention by referring the family to other appropriate services. (A service provider database is provided.)<sup>32</sup>

These outcome measures are all within the control of the physician’s practice and targeted to be sure that 1) the family that is referred is encouraged to actually follow through with Early Intervention, 2) the practice looks at the feedback from Early Intervention to find out if the family will receive services, and 3) the family obtains services elsewhere if they are not able to obtain Early Intervention services. Meanwhile, the related PDSA cycles were occurring within Early Intervention offices, measuring improvement in these offices’ communication back to the pediatrician. Thus, Illinois’ ABCD III

team has found that an MOC Part 4 program fits well as a component of a larger care coordination quality improvement project.

The Minnesota ABCD III team has also applied for ABP approval for MOC Part 4 credit for their quality improvement project to systematize and improve the communication loop between PCP practices and Early Intervention. As with Illinois, the team must consider that the physician does not control if information on the child's status is faxed back to the physician's office. They chose as one of the outcome measures whether the PCP incorporated feedback from Early Intervention into the child's medical record. This keeps the measured outcome within the control of the physician practice, allows them to measure the extent of feedback without holding them accountable for another provider's responsibility, and assures that the feedback is available to staff in the physician's practice that are working with the family.

In sum, quality improvement efforts offering MOC Part 4 credit that focus on care coordination must be designed carefully to be sure that physicians are evaluated only on those outcomes that are within their control, while at the same time being sure that the project, as a whole, improves the entire communication loop.

### LESSONS FROM ABCD STATE EXPERIENCE

The ABCD III teams have learned useful lessons about using MOC Part 4 credit, engaging physicians, and structuring quality improvement efforts to improve care coordination between PCPs and other providers.

- Maintenance of certification credit can be an important motivator for physician practices to engage in structured quality improvement projects. By working collaboratively with professional societies to target topics of joint interest, states can help expand quality improvement in primary care, assure that improvements are evidence-based, and spread best practices.
- States can build on existing quality improvement partnerships with providers (such as child health improvement partnerships or medical homes initiatives) to develop and implement MOC Part 4 programs.

- State agencies, in partnership with physician organizations, can use maintenance of certification credit as a means of fostering the use of data to drive improvement while simultaneously obtaining aggregate data from providers about the effectiveness and reach of quality improvement interventions.
- In managed care states, managed care organizations (MCOs) can be important partners. State partnerships can align quality improvement efforts offering MOC Part 4 credit with federal MCO Medicaid Performance Improvement Project requirements.
- Quality improvement projects designed to offer MOC Part 4 credit must include some level of training in the quality improvement process (in addition to content-specific information), providing knowledge and skills related to quality improvement that providers can apply more broadly.
- Measurable outcomes should be chosen carefully to include only those outcomes that are within the primary care provider's (PCP) control. For initiatives that focus on care coordination, data on frequency of feedback from the referral agency to the PCP must be collected, but PCPs should not be held accountable for outcomes outside their control.
- Care coordination quality improvement projects can effectively improve referral tracking and follow-up if they include participation by both PCPs and referral agencies. Maintenance of certification credit can work well as an incentive as one component of a larger project that includes a parallel effort by the referral agencies.

### CONCLUSION

Participating in structured quality improvement projects is now a requirement for physicians to remain board certified. ABCD states have shown that state agencies, working together with physician champions and community providers, have the opportunity to harness this incentive to help spread systematic care coordination practices and to obtain the data necessary to assure the practices are evidence-based.

## ENDNOTES

- 1 For more information about ABCD III please visit the National Academy for State Health Policy's (NASHP), "About ABCD III" page: <http://nashp.org/abcd-history>.
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- 5 Linda Radecki, Nina Sand-Loud, Karen G. O'Conner, et al., "Trends in the Use of Standardized Tools for Developmental Screening in Early Childhood," *Pediatrics*, 2011 128: 14-19
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- 9 Paul V. Miles, "Maintenance of Certification: The Profession's Response to Physician Quality," *Ann. Fam. Med* 2011(9): 196-197. doi:10.1370/afm.1254 [Hereinafter Miles, The Profession's Response]
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- 11 Miles, The Professor's Response, 197.
- 12 Miles, Improving Children's Health Care, S108.
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- 14 American Board of Medical Specialties, About ABMS Member Boards, retrieved February 3, 2012 from [http://www.abms.org/About\\_ABMS/member\\_boards.aspx](http://www.abms.org/About_ABMS/member_boards.aspx).
- 15 ABMS, MOC Competencies.
- 16 For more information on PDSA cycles, see the Institute for Healthcare Improvement, How to Improve, retrieved February 3, 2012 from <http://www.ihl.org/knowledge/Pages/HowtoImprove/default.aspx>.
- 17 American Board of Pediatrics, Developmental Screening Improvement Module, retrieved February 8, 2012 from [http://pim.abp.org/development\\_screening/global/demo.php](http://pim.abp.org/development_screening/global/demo.php).
- 18 Communication from Elaine Stageberg, M.H.A., Oklahoma ABCD III Practice Facilitator (January 30, 2012).
- 19 See Miles, Improving Children's Health Care, S108
- 20 American Board of Pediatrics, "Maintenance of Certification: Quality Improvement Projects for MOC", 8-9 (Version 3.2), retrieved February 8, 2012 from [https://www.abp.org/abpwebsite/moc/performanceinpractice/approvedq1projects/approved/project\\_approval\\_guide.pdf](https://www.abp.org/abpwebsite/moc/performanceinpractice/approvedq1projects/approved/project_approval_guide.pdf) (This document includes other criteria for a quality improvement project, including physician training on quality improvement methods.)
- 21 Oregon Pediatric Society, "Screening Tools and Referral Training Annual Report, July 2009 – June 2010", 7-8, retrieved February 8, 2012 from <http://oregonpediatricsociety.org/programs/ops-programs/start/>. [hereinafter OPS START Annual Report 2009-2010]. Part of the funding was contributed by the Medicaid managed care organizations.

22 OPS START Annual Report 2009-2010.

23 The number of pediatricians seeking MOC Part 4 credit was likely lower in these early years than it will be in the future because pediatricians did not have to meet the new requirement until the end of their seven year (now 5 year) renewal cycle. Thus, most had yet to approach their deadline to obtain the credit in order to maintain certification.

24 Oregon Pediatric Society, "Screening Tools and Referral Training Annual Report, July 2010 – June 2011", Figures 11, 12 and pp. 11, 17, retrieved February 8, 2012 from <http://oregonpediatricsociety.org/programs/ops-programs/start/>. Information about the appropriateness of referrals was obtained in a communication from Dr. R.J. Gillespie, Medical Director. Oregon Pediatric Improvement Partnership (March 27, 2012).

25 Warren P. Newton, Ann Lefebvre, Katrina E. Donahue, et al, "Infrastructure for Large-Scale Quality-Improvement Projects: Early Lessons from North Carolina Improving Performance in Practice," *Journal of Continuing Education in the Health Professions*, 2010 30(2):106-113.

26 Helen Pelletier, "How States are Working with Physicians to Improve the Quality of Children's Health Care", 5 (Portland, ME: National Academy for State Health Policy and The Commonwealth Fund April 2006), retrieved April 5, 2012 from [http://www.nashp.org/sites/default/files/states\\_working\\_with\\_physicians.pdf](http://www.nashp.org/sites/default/files/states_working_with_physicians.pdf).

27 For more information on these partnerships, see the website of the University of Vermont College of Medicine, National Improvement Partnership Network, <http://www.med.uvm.edu/vchip/improvementpartnerships/HP-DEPT.ASP?SiteAreaID=513>.

28 Vermont Child Health Improvement Program, *Establishing a Child Health Improvement Partnership: A How-to Guide*, (2<sup>nd</sup> Ed., October 2009), retrieved March 12, 2012 from <http://www.med.uvm.edu/vchip/improvementpartnerships/HP-DEPT.ASP?SiteAreaID=513>.

29 For a state-by-state description of practice supports among medical home initiatives, see National Academy for State Health Policy, Supporting Practices, <http://nashp.org/med-home-strategies/supporting-practices>.

30 42 C.F.R. § 438.240(d), retrieved February 10, 2012 from <http://www.law.cornell.edu/cfr/text/42/438/240>.

31 American Board of Pediatrics, "Maintenance of Certification: Quality Improvement Projects for MOC," 11 (Version 3.2), retrieved February 8, 2012 from [https://www.abp.org/abpwebsite/moc/performanceinpractice/approvedq1projects/approved/project\\_approval\\_guide.pdf](https://www.abp.org/abpwebsite/moc/performanceinpractice/approvedq1projects/approved/project_approval_guide.pdf)

32 Illinois Chapter of the American Academy of Pediatrics, "Illinois Healthy Beginnings II Maintenance of Certification Part 4", retrieved February 9, 2012 from <http://illinoisAAP.com/>; Illinois ABCD III Report to the National Academy for State Health Policy, October 2011, 5-6.

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