

Maintenance of Certification

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Recommendations include:

1. **Continue discussion with ASN members and other stakeholders regarding the pathway for remaining certified. This discussion involves two unconcluded questions: 1) Should ASN support recertification? and 2) Should ASN support a single recertification entity or process with accountability to nephrologists and kidney professional organizations versus continue to support all options for recertification?**

This recommendation was the most controversial topic among task force members with views ranging from continuing to work with ABIM as the single recertifying entity to establishing a separate recertification entity housed within a professional society, such as ASN. This lack of consensus was driven largely by a loss of confidence in ABIM as an organization that could effectively manage a recertification process. On the other hand, support for ABIM was based on an effort by ABIM to reach out to the community, admit mistakes, and make corrections, such as the suspension of the MOC Part 4 requirements and the recent MOC initiatives, including proposed alternatives to the 10-year examination.

The task force agreed that a need exists for independent research to establish an evidence base that MOC enhances patient outcomes and improves practice. Other considerations include conducting a feasibility study of ASN serving as or supporting an independent recertification entity. At this point, no consensus has been reached among task force members that is consistent with the ASN member survey data (<http://goo.gl/DAPw0V>), particularly the question “Is ABIM the appropriate organization to recertify nephrologists?” to which only 42% of respondents answered yes.

2. **Establish an independent recertification oversight committee comprised of nephrology professional organizations and other key stakeholders to advise and approve ABIM recertification policies and activities**

if ASN were to accept ABIM as the single recertifying entity.

Given the controversies surrounding ABIM and MOC, and the past history of ABIM initiatives that have not been fully vetted by the physician community, the task force felt strongly that there should be an oversight committee comprised of nephrology professional organizations and other stakeholders to advise, and also to approve, any changes in recertification requirements. This oversight committee would be independent of ABIM and the newly established ABIM Nephrology Specialty Board. Oversight would primarily be around process and financial implications of any changes in MOC.

3. **Permanently eliminate Practice Assessment, Patient Voice, and Patient Safety requirements for MOC (Part 4).**

ABIM has suspended the requirement for Practice Assessment, Patient Voice, and Patient Safety in its MOC program through December 31, 2018. Physicians may still choose to earn MOC points for these areas but they are not mandatory. It was the recommendation of the task force that these areas should not be part of the ABIM MOC requirements to avoid redundancy. Quality improvement and patient safety (QI/PS) activities occur within practices, dialysis units, and health systems and will be a component of the clinical practice improvement component of the CMS Merit-Based Incentive Payment System (MIPS) that is part of the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA).

4. **High-quality, relevant educational activities (approved CME and MOC) should be the foundation for obtaining recertification credentials.**

There was general agreement within the task force that recertification should be based on completing accredited CME programs, many of which can now be registered for MOC medical knowledge self-assessment points, if certain conditions are met, including a comprehensive evaluation component. These activities could be combined with low-stakes examinations that could be used as part of self-assessment of knowledge gaps allowing the physician to

target CME activities to their practice needs.

5. **Eliminate the high stakes examination and move to more frequent low-stakes assessments (assessment for learning, not of learning).**

In general, the task force agreed with this recommendation. This position is consistent with the ABIM Assessment 2020 report (<http://transforming.abim.org/assessment-2020-report/>) informing ongoing design of the ABIM MOC program. The ABIM announcement in May 2016 discussed above is also moving in this direction, proposing low-stakes exams and a potential test-out option. The task force felt that the timeline for elimination of the every 10-year examination should be accelerated.

6. **Simplify any web-based information concerning CME/MOC activities for lifelong learning available to nephrologists with more complete information (requirements, cost, other) and transparency.**

The task force agreed, in general, that this recommendation was important to make needed information more accessible to physicians.

7. **Have the task force present at a Recertification Forum at ASN Kidney Week 2016 on Thursday, November 17, 2016, from 10:30 am to 12:30 pm.**

The task force looks forward to discussing MOC, recertification, and the principles and recommendations discussed in this article with Kidney Week participants at this session. Each member of the task force is very interested in more immediate feedback after members have read this article. Together, we will start a conversation about recertification issues on ASN Communities (<http://community.asn-online.org/home>). While ASN continues in these discussions, please forward your comments or concerns related to certification, recertification, ABIM, and related issues to the main ASN email address (email@asn-online.org) and use the subject line “MOC.” ●

Mark Rosenberg, MD, FASN, is affiliated with the University of Minnesota Medical School in Minneapolis and is Chair of the ASN Recertification Task Force. Phillip Kokemueller is Special Advisor to the ASN Executive Vice President.

Findings

Poor Outcomes of Carotid Endarterectomy in Dialysis Patients

For patients on hemodialysis—particularly those with neurologic symptoms—the high risks of carotid endarterectomy (CEA) may outweigh the benefits, according to a study in *JAMA Surgery*.

The retrospective analysis included data on 5142 dialysis-dependent patients undergoing CEA from 2006 to 2011 drawn from the US Renal Data System. Perioperative and long-term outcomes were assessed at a median follow-up of 2.5 years.

Eighty-three percent of patients were

asymptomatic, with no stroke or transient ischemic attack within the previous 6 months. Stroke occurred within 30 days after CEA in 2.7% of the asymptomatic group and 5.2% of the symptomatic group. The myocardial infarction rate was 4.6% versus 5.0%, respectively; mortality was 2.6% versus 2.9%, respectively. Factors associated with a higher perioperative stroke risk were symptomatic status (OR of 2.01), black race (OR of 2.30), and Hispanic ethnicity (OR of 2.28).

From 1 to 5 years, symptomatic patients had higher rates of stroke and death. Five-year overall survival was 33% in asymptomatic patients and 29% in symptomatic patients. Factors associated with higher long-term stroke risk were symptomatic status (HR of 1.67), women (HR of 1.34), and nonambulatory status (HR of 1.81). Risk factors for long-term mortality were older age (OR of 1.02), active smoking (OR of 1.22), history of congestive heart failure (OR of 1.25), and chronic obstructive pul-

monary disease (OR of 1.26).

This large analysis suggests “relatively poor” perioperative and long-term outcomes of CEA in dialysis patients. The authors recommend “optimizing medical management and avoiding CEA” in symptomatic patients and considering CEA only in a “small and carefully selected” group of asymptomatic patients [Cooper M, et al. Perioperative and long-term outcomes after carotid endarterectomy in hemodialysis patients. *JAMA Surg* 2016, in press]. ●