Call for Comment
Simplifying the Accreditation Requirements and Process

On December 17, 2013, the Accreditation Council for Continuing Medical Education (ACCME®) issued a call for public comment about its proposal to simplify the accreditation requirements and process, in accordance with its Rule-Making Policy. The comment period ended January 31, 2014.

Background

The call for comment continued the ACCME's ongoing process of engagement with the CME and stakeholder community about the simplification and evolution of the accreditation requirements and process. The proposed changes in the call for comment included:

- Simplifying and removing some of the Accreditation Criteria and policy requirements
- Changing terminology from "joint sponsorship" to "joint providership"
- Implementing the policy change prohibiting the use of logos of ACCME-defined commercial interests in commercial support acknowledgments
- Offering providers an abstract as an ACCME-approved tool to use when verifying performance-in-practice
- Simplifying the process for organizations applying for initial accreditation

This call for comment did *not* include the evolution of the criteria for achieving Accreditation with Commendation, which the ACCME has been discussing with stakeholders. The ACCME is in the process of developing a menu of potential new commendation criteria and will share those ideas with the stakeholder community at a later time.

The ACCME decided to separate the simplification proposal from the Accreditation with Commendation proposal in order to expedite the simplification process, in response to stakeholders' requests.

For more background, please see the ACCME Simplification and Evolution Web page.

Summary of Responses

This summary and tables represent the feedback of more than 700 respondents. There were 245 respondents to the December 2013 formal call for comment. There were 458 respondents to the informal online survey that we conducted prior to the call for comment, in the spring of 2013, to gather feedback about the simplification proposal. We explained to stakeholders that if they had already responded to the simplification proposal through the spring online survey, they did not need to repeat their comments through the formal call for comment, as their feedback had been incorporated.

Respondents to the spring survey were asked to provide their feedback about each of the proposed changes using a scale of 1-strongly disagree to 10-strongly agree. In the summary tables below, we included spring survey respondents who chose 1 or 2, categorized as "disagree" and those who chose 9 or 10, categorized as "agree."

In the December 2013 call for comment, respondents were asked if they agreed or disagreed about each of the four sections of proposed changes (Accreditation Criteria, Standards for Commercial Support, policies, and accreditation process). The complete text of all the comments received by the ACCME through the formal call for comment is attached, as well as several letters we received. (We did not include letters from respondents that duplicated the responses they entered through the online call for comment.)

Overall, the responses to the call for comment were consistent with the responses to the spring 2013 survey. Most of the respondents agreed with the ACCME's proposals to simplify the Accreditation Criteria, policies, and process. The comments provided by those who agreed and who disagreed offered important and useful observations, concerns, and questions.

Accreditation Criteria

Accreditation Criteria
C1, C4, C14, C15

		Agree	Disagree
Formal Call for Comment		214	11
Spring 2013 Survey	C1	292	15
	C4	396	7
	C14	367	10
	C15	354	17

This set of changes includes simplifying Criterion 1 and removing Criteria 4, 14, and 15. There were 225 respondents to the formal call for comment and 300 to 400 responses to the spring 2013 survey, which asked individual questions about each criteria change. This group of about 500 showed overall agreement with the changes.

The respondents who **agreed** with the changes to the Accreditation Criteria said that the changes reduce redundancy, enhance clarity, increase flexibility, and will allow providers to focus more on continuous improvement. The respondents who **disagreed** were concerned that providers might need more direction and offered suggestions on how expectations for fulfilling the mission should be even more explicitly emphasized.

Standards for Commercial Support: Commercial Interest Logos

		Standards for Commercial Support SCS 4.3, SCS 6.4, SCS logo policy	
		Agree	Disagree
Formal Call for Comment		142	85
Spring 2013 Survey	SCS 4.3	290	21
	SCS 6.4	291	16
	SCS pol	260	27

This set of changes is about changing the Standards for Commercial Support so as to prevent the use of commercial interest logos in the disclosure of commercial support.

There were 227 responses to the formal call for comment. About 1/3 opposed the change. Approximately 300 had responded in the spring survey to individual questions about each policy change. Most of these supported the changes.

Respondents who agreed with the changes to the Standards for Commercial Support said the changes would minimize any possibility of conflict of interest, eliminate any ambiguity, decrease participants' perception of real or perceived bias, and strengthen the perception of the value of the Standards for Commercial Support. Those opposed to the changes said that the current Standards were sufficient and expressed concerns that prohibiting commercial interest logos would decrease transparency and disclosure, and make it more difficult to distinguish between commercially supported CME and CME that is not commercially supported.

Accreditation Policies

		Accreditation Policies Activity Types, Organization, Joint Providership	
		Agree	Disagree
Formal Call for Comment		183	21
Spring 2013 Survey	EM	264	16
	Internet	269	9
	Journal	277	10
	RSS	273	11
	Organization	286	30
	Providership	223	45

This set of changes removes some of the policy requirements for CME activity types, introduces the term "joint providership" to replace "joint sponsorship," and removes an organizational structure policy that pre-dates the current requirements.

There were 204 responses to the formal call for comment. About 300 respondents had provided feedback in the spring survey to individual questions about each policy change. Overall, this group of about 500 respondents supports the changes.

The respondents who agreed said that the policy changes will simplify the process and accurately reflect the current CME environment and the evolution of technology. They also suggested that the change in terminology should alleviate the misunderstanding created by the use of the word sponsorship and create a more consistent nomenclature. The respondents who disagreed said that the policy requirements were still important for promoting good practices and providing a framework for compliance.

Accreditation Process Abstract, Survey		Agree	Disagree
Formal Call for Comment		185	17
Spring 2013 Feedback	Abstract	265	18
	Survey	245	27

These two changes include eliminating the on-site survey requirement for organizations seeking initial accreditation and introducing an abstract for accredited providers to use when verifying performance-in-practice.

There were 202 responses to the formal call for comment and about 250 responses to the spring survey to individual questions about each process change. This group of about 400 has agreed with the proposals.

The respondents who agreed said the change to the initial applicants' process would provide greater flexibility and reduce cost and burden without degrading the process. Those who disagreed said that the requirement for on-site surveys provided value that other survey formats could not replace. Respondents said the abstract would greatly simplify the process; some who agreed and who disagreed provided important suggestions for improvements.

ACCME Board of Directors Decisions

The ACCME thanks those who submitted comments and feedback during this process.

The ACCME's Board of Directors reviewed and analyzed the responses and **adopted** the changes to the Accreditation Criteria, policies, and accreditation process on February 11, 2014.

On March 21, 2014, the Board adopted the changes to the Standards for Commercial Support to prohibit the use of ACCME-defined commercial interest logos in the acknowledgment of commercial support.

Call for Comment: ACCME's Simplification Proposal

The Accreditation Council for Continuing Medical Education (ACCME ®) is pleased to issue a call for public comment about its proposal to simplify the accreditation requirements and process, in accordance with its Rule-Making Policy.

This call for comment continues our ongoing process of engagement with the CME community. It includes the changes related to simplifying the requirements and process that were described in the May 2013 Proposal for Simplifying and Evolving the Accreditation Requirements and Process.

This call for comment should take approximately 15 minutes to complete. All viewpoints are welcome, but please make your comments constructive. The ACCME will not consider anonymous submissions. The ACCME considers the comments and the names of those authoring the comments to be public information that may be published on the ACCME's Web site. Comments will be accepted until January 31, 2014.

Only the items with a star are required. Please click the "Begin" button below to complete the call for comment. Thank you for your participation.

Begin

*Name

*Email address

*Organization

*Please tell us which of the following describes you or your organization:

- ACCME-accredited provider
- State-accredited provider (provider accredited by an ACCME Recognized State Medical Society)
- ACCME Recognized State Medical Society
- ACCME-defined commercial interest
- Physician/healthcare professional
- Media
- Member of the public
- ACCME member organization
- Other

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ACCREDITATION CRITERIA

The purpose of the proposed changes to Accreditation Criteria 1–15 is to remove redundancies and streamline the Criteria while maintaining the continuous improvement model and the high standards that are essential for designing and implementing independent, effective, and relevant CME. These changes would reduce the number of criteria required for accreditation from 15 to 12. This would simplify the process for accredited providers, while retaining the Plan-Do-Study-Act cycle, which is integral to the ACCME's expectations.

Proposed Change and Purpose: We propose to simplify Criterion 1 by removing the references to CME purpose, content areas, target audience, and type of activities. We would retain the reference to expected results. We believe this simplification keeps the value of the criterion and supports the focus on learning and change, while removing the references to organizational attributes.

This suggested change is shown below (deletions to the Criterion are shown in ~~strikethrough~~ text).
Criterion 1: "The provider has a CME mission statement that includes ~~all of the basic components (CME purpose, content areas, target audience, types of activities, expected results) with~~ expected results articulated in terms of changes in competence, performance, or patient outcomes that will be the result of the program."

Proposed Change and Purpose: ACCME proposes eliminating Criterion 4. We propose removing Criterion 4 because it is redundant to Criterion 2, which requires providers to design activities based on educational needs that underlie professional practice gaps. If education reflects professional practice gaps it will, in turn, have to match the scope of practice.

The suggested change is shown below (deletions are shown in ~~strikethrough~~ text).
~~**Criterion 4:** "The provider generates activities/educational interventions around content that matches the learners' current or potential scope of professional activities."~~

Proposed Change and Purpose: ACCME proposes eliminating Criteria 14 and 15. These changes will simplify the process for providers, while retaining the Plan-Do-Study-Act cycle.

The suggested change is shown below (deletions are shown in ~~strikethrough~~ text).
~~**Criterion 14:** "The provider demonstrates that identified program changes or improvements, that are required to improve on the provider's ability to meet the CME mission, are underway or completed."~~
~~**Criterion 15:** "The provider demonstrates that the impacts of program improvements, that are required to improve on the provider's ability to meet the CME mission, are measured."~~

Do you agree or disagree with the proposed changes to the Accreditation Criteria?

○ Agree ○ Disagree

Comment
(1000 characters maximum or approximately 125 words)

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STANDARDS FOR COMMERCIAL SUPPORT

In 2011, the ACCME decided to prohibit the use of corporate logos of ACCME-defined commercial interests in commercial support acknowledgment. The ACCME issued a formal call for comment, as required by the ACCME's Rule-making Policy. The Board deferred implementation of the policy change while the ACCME was engaging in discussions with stakeholders regarding simplifying and evolving the accreditation requirements and process. Now that these discussions have progressed, the ACCME is planning to take the necessary steps to ensure that corporate logos, as a form of corporate branding, will not be included in educational materials. With this change, the corporate logos of ACCME-defined commercial interests could not be used in educational materials, disclosure, and acknowledgment of commercial support. In order to fulfill implementation of this change, ACCME has proposed edits to Standard 4.3, Standard 6.4, and the Commercial Support Acknowledgment Policy.

Proposed change: ACCME has proposed changes to **Standard 4.3, Standard 6.4, and the Commercial Support Acknowledgments Policy.** Additions are shown in underlined text and deletions are shown in ~~strikethrough~~ text.

Standard 4.3: Educational materials that are part of a CME activity, such as slides, abstracts and handouts, cannot contain any advertising, corporate logo, trade name or a product-group message of an ACCME-defined commercial interest.

Standard 6.4: 'Disclosure' must never include the use of a corporate logo, trade name or a product-group message of an ACCME-defined commercial interest.

Commercial Support Acknowledgement Policy: The provider's acknowledgment of commercial support as required by SCS 6.3 and 6.4 may state the name, mission, and areas of clinical involvement of ~~the company or institution~~ an ACCME-defined commercial interest ~~and~~ but may not include corporate logos and slogans.~~, if they are not product promotional in nature.~~

Do you agree or disagree with the proposed changes to the Standards for Commercial Support?

○ Agree ○ Disagree

Comment
(1000 characters maximum or approximately 125 words)

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POLICIES

ORGANIZATIONAL FRAMEWORK

Proposed Change and Purpose: ACCME has proposed to remove the Organizational Framework Policy because it pre-dates the current requirements and is no longer necessary in the current CME environment.

The suggested change is shown below (deletions are shown in ~~strikethrough~~ text).

~~The accredited provider must have an organizational framework for the CME unit that provides the necessary resources to support its mission including support by the parent organization, if a parent organization exists.~~

ACTIVITY TYPES

Proposed Change and Purpose: We are proposing to remove some of the special requirements related to activity types. These policies pre-date the current Accreditation Criteria. They were developed over the years to address the evolution in CME activity types. However, as CME and technology have evolved, the special requirements have become incorporated into standard practice and therefore it is no longer necessary to include them in the policies.

Enduring Materials

Proposed Change: ACCME has proposed that certain requirements for **Enduring Materials CME** activities be deleted as shown below (deletions to the policy are shown in ~~strikethrough~~ text):

~~Because there is no direct interaction between the provider and/or faculty and the learner, the provider must communicate the following information to participants so that they are aware of this information prior to starting the educational activity~~
~~1. Principal faculty and their credentials;~~
~~2. Medium or combination of media used;~~
~~3. Method of physician participation in the learning process;~~
~~4. Estimated time to complete the educational activity (same as number of designated credit hours);~~
~~5. Dates of original release and most recent review or update; and~~
~~6. Termination date (date after which enduring material is no longer certified for credit).~~

Providers that produce enduring materials must review each enduring material at least once every three years or more frequently if indicated by new scientific developments. So, while providers can review and re-release an enduring material every three years (or more frequently), the enduring material cannot be offered as an accredited activity for more than three years without some review on the part of the provider to ensure that the content is still up-to-date and accurate. That review date must be included on the enduring material, along with the original release date and a termination date.

Sometimes providers will create an enduring material from a live CME activity. When this occurs, ACCME considers the provider to have created two separate activities – one live activity and one enduring material activity. Both activities must comply with all ACCME requirements, and the enduring material activity must comply additionally with all ACCME policies that relate specifically to enduring materials.

Internet CME

Proposed Change: ACCME has proposed that certain requirements in the **Internet CME** policy be deleted as shown below (deletions to the policy are shown in ~~strikethrough~~ text):

There are special requirements for Internet CME because of the nature of the activities:

Activity Location: ACCME-accredited providers may not place their CME activities on a Web site owned or controlled by a commercial interest.

Links to Product Web sites: With clear notification that the learner is leaving the educational Web site, links from the Web site of an ACCME accredited provider to pharmaceutical and device manufacturers' product Web sites are permitted before or after the educational content of a CME activity, but shall not be embedded in the educational content of a CME activity.

~~Transmission of information: For CME activities in which the learner participates electronically (e.g., via Internet, CD-ROM, satellite broadcasts), all required ACCME information must be communicated to the learner prior to the learner beginning the CME activity.~~

Advertising: Advertising of any type is prohibited within the educational content of CME activities on the Internet including, but not limited to, banner ads, subliminal ads, and pop-up window ads. For computer based CME activities, advertisements and promotional materials may not be visible on the screen at the same time as the CME content and not interleafed between computer windows or screens of the CME content.

~~Hardware/Software Requirements: The accredited provider must indicate, at the start of each Internet CME activity, the hardware and software required for the learner to participate.~~
~~Provider Contact Information: The accredited provider must have a mechanism in place for the learner to be able to contact the provider if there are questions about the Internet CME activity.~~
~~Policy on Privacy and Confidentiality: The accredited provider must have, adhere to, and inform the learner about its policy on privacy and confidentiality that relates to the CME activities it provides on the Internet.~~
~~Copyright: The accredited provider must be able to document that it owns the copyright for, or has received permissions for use of, or is otherwise permitted to use copyrighted materials within a CME activity on the Internet.~~

Journal CME

Proposed Change: ACCME has proposed that certain requirements in the **Journal CME** policy be deleted as shown below (deletions to the policy are shown in ~~strikethrough~~ text):

A journal-based CME activity includes the reading of an article (or adapted formats for special needs), a provider stipulated/learner directed phase (that may include reflection, discussion, or debate about the material contained in the article(s), and a requirement for the completion by the learner of a pre-determined set of questions or tasks relating to the content of the material as part of the learning process.
~~The ACCME considers information required to be communicated before an activity (e.g., disclosure information, disclosure of commercial support, objectives), CME content (e.g., articles, lectures, handouts, and slide copies), content-specific post-tests, and education evaluation all to be elements of a journal-based CME activity.~~
~~The educational content of journal CME must be within the ACCME's Definition of CME.~~
~~Journal CME activities must comply with all ACCME accreditation requirements. Because of the nature of the activity, there are two additional requirements that journal CME must meet:~~
The ACCME does not consider a journal-based CME activity to have been completed until the learner documents participation in that activity to the provider.
None of the elements of journal-based CME can contain any advertising or product group messages of commercial interests. Disclosure information cannot contain trade names. The learner must not encounter advertising within the pages of the article or within the pages of the related questions or evaluation materials.

Regularly Scheduled Series (RSS)

Proposed Change: ACCME has proposed that certain requirements in the **Regularly Scheduled Series (RSS)** policy be deleted as shown below (deletions to the policy are shown in ~~strikethrough~~ text):

The ACCME defines a regularly scheduled series (RSS) as a course that is planned as a series with multiple, ongoing sessions, e.g., offered weekly, monthly, or quarterly; and is primarily planned by and presented to the accredited organization's professional staff. Examples include grand rounds, tumor boards, and morbidity and mortality conferences. ~~ACCME-accredited providers that offer regularly scheduled series must describe and verify that they have a system in place monitor these activities' compliance with ACCME accreditation requirements. The monitoring system must:~~
~~1. Be based on real performance data and information derived from the RSS's that describes compliance (in support of Accreditation Criteria 2-11), and~~
~~2. Result in improvements when called for by this compliance data (in support of ACCME Criteria 12-15), and~~
~~3. Ensure that appropriate ACCME Letters of Agreement are in place whenever funds are contributed in support of CME (in support of the ACCME Standards for Commercial Support: Standards to Ensure Independence in CME Activities).~~
~~Also, the provider is required to make available and accessible to the learners a system through which data and information on a learner's participation can be recorded and retrieved. The critical data and information elements include: learner identifier, name/topic of activity, date of activity, hours of credit designated or actually claimed. The ACCME limits the provider's responsibility in this regard to "access, availability and retrieval." Learners are free to choose not to use this available and accessible system.~~

TERMINOLOGY CHANGE

Proposed Change and Purpose: In 1998, we stopped using the term sponsor to refer to accredited providers in the ACCME requirements except when using the term **joint sponsorship**. In order to be more consistent with our own terminology and with the terminology used by other accreditors, we propose to modify the wording in our requirements. We have edited the policy below as an example of this proposed change.

JOINT ~~SPONSORSHIP~~ PROVIDERSHIP

The ACCME defines joint **providership** as the sponsorship of a CME activity by one accredited and one nonaccredited organization. Therefore, ACCME accredited providers that plan and present one or more activities with non-ACCME accredited providers are engaging in "joint **providership**." Please note: the ACCME does not intend to imply that a joint **providership** relationship is an actual legal partnership. Therefore, the ACCME does not include the words partnership or partners in its definition of joint **providership** or description of joint **providership** requirements.

The accredited provider must take responsibility for a CME activity when it is presented in cooperation with a nonaccredited organization and must use the appropriate accreditation statement.

Do you agree or disagree with the proposed changes to the Accreditation Policies?

◯ Agree ◯ Disagree

Comment
(1000 characters maximum or approximately 125 words)

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83% Complete

ACCREDITATION PROCESS

Application Process for Initial Applicants

Proposed Change and Purpose: We are proposing to eliminate the requirement that organizations seeking to become accredited have their survey interview conducted on-site at their administrative offices. The requirement for on-site survey interviews was necessary in the past to verify that initial applicants met ACCME requirements. However, this requirement adds complexity that is no longer necessary due to advances in technology. The ACCME moved to conference calls as the standard survey interview format for the reaccreditation process in 2010 and our data shows that this format is effective and thorough. Initial applicants and accreditors would continue to have the option of using the other interview formats, on-site, televideo, and face-to-face, if circumstances warrant it.

Performance-In-Practice Review Abstract

Proposed Change and Purpose: In response to requests from the CME community, we will be offering an abstract for accredited providers to use when verifying performance-in-practice. This abstract would take the place of labels and facilitate the process of verifying performance-in-practice. The abstract provides instruction and proposed fields to insert narrative; this narrative would replace the submission of additional documentation from activity files. It also includes proposed specific instructions for submitting attachments that are needed for verification. The purpose of this abstract is to clarify and simplify the performance-in-practice review process. Click here to view a draft abstract.

Do you agree or disagree with the proposed changes to the Accreditation Process?

○ Agree ○ Disagree

Comment
(1000 characters maximum or approximately 125 words)

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SAMPLE ONLY: ACCME Performance-in-Practice Review Abstract

State the **professional practice gap(s)** of your learners on which the activity was based (maximum 25 words). (C2)	
State the educational need that you determined to be the cause of the professional practice gap(s) (maximum 25 words). (C2)	Knowledge need *and/or* Competence need *and/or* Performance need *and/or*
State a justification for your choice of educational format for this activity (maximum 25 words). (C5)	
State the desirable physician attribute(s) this activity addresses (maximum of six attributes). (C6)	**1.** **2.** **3.** **4.** **5.** **6.**
Paste here the ACCME accreditation statement for this activity, as published for learners.	

If the activity was COMMERCIALLY SUPPORTED

List the corporate names of the commercial supporters of this activity and the $ value of any monetary commercial support or indicate in-kind if applicable (C8, SCS 3.4-3.6). For example: 1. Manufacturer Inc., ($80,000) 2. Producer Co., in-kind (durable equipment)	
Paste here the commercial support disclosure information given to learners (C7, SCS 6.3-6.5).	

ATTACHMENTS

Attachment 1: The data or information generated from this activity about changes achieved in learners' competence or performance or patient outcomes (C 11).

Attachment 2: In the form of a MSWORD table using the attached template. (Template to be provided by the ACCME.)

1. A list of all individuals in control of content of the CME activity and specify their role (e.g., planner, faculty, reviewer). (C7)
2. The relevant financial relationships that each individual in a position to control the content of CME disclosed to the provider (C7, SCS 2.1).
3. The disclosure information given to learners about the relevant financial relationships that each individual in a position to control the content of CME disclosed to the provider (C7, SCS 6.1-6.2, 6.4-6.5).

Attachment 3: Verification of the implementation of your mechanism(s) to identify **and** resolve conflicts of interest prior to the start of the activity as described in your self-study report (C7, SCS 2.3).

If the activity was COMMERCIALLY SUPPORTED

Attachment 4: The income and expense statement for this activity that details and accounts for the receipt and expenditure of all of the commercial support (C8, SCS 3.13).

Attachment 5: Each executed commercial support agreement for the activity (C8, SCS 3.4-3.6).

If the activity was an enduring material, journal CME, or Internet CME

If this was an **enduring material:**
Check this box and submit the actual enduring material with the required information, as specified by ACCME policy, flagged for review.

If this was a **journal CME activity**:
Check this box and submit the actual journal with the required information, as specified by ACCME policy, flagged for review.

If this was an **Internet CME activity**:
Check this box, include a URL (if still active) for the activity or a print-out of the activity with the required information, as specified by ACCME policy, flagged for review.

COMPLETE TEXT OF RESPONSES

Changes to the Accreditation Criteria

Org Description	Vote	Comment
ACCME-accredited provider	Agree	Shortening the mission is an excellent idea. Those five are answered in other parts of the self study.
ACCME-accredited provider	Agree	Please CATEGORIZE the Criterion into FOUR SECTIONS by LINKING together similar sections of: MISSION: Criterion that link together and are related to create the foundation of a CME Mission: Criteria 1, 12, and 13. (Also included would be 14/15, but they will be eliminated). COMPETENCY: Criterion that link together and are related to create the foundation of Competency: Criteria 2, 3, 6, 11 and 16. (Also included would be 4, but it will be eliminated). LEVEL 3: Criterion that link together and are related to create the foundation for Level 3 are: Criteria 5, 17 - 21. (C-16 move to competency section - C-5 move to Level 3). COMMERCIAL: Criterion that link together and are related to create the foundation for Commercial Interests are: 7 - 10, and 22. (MUST Move C-22 from Level 3)
State-accredited provider	Agree	This would definitely reduce redundancy. I would rather see the emphasis on continuous improvement. Reducint hte number of criteria from 15 to 12 definitely allows for more focus on what is important.
State-accredited provider	Agree	We are a small Society (about 240 members) with only one part-time paid staff member. Our Board members and Officers are all volunteer psychiatrists and other psychotherapists, most of whom have busy practices. We believe your accreditation procedures are geared primarily (and properly) for large organizations with substantial paid staff. We have found your re-accreditation requirements quite daunting, and well-nigh impossible for small groups like ours to manage, and wonder if you would consider substantial simplification for groups such as ours. We very much want to continue offering CMEs to our physician and nurse members, and believe we offer excellent continuing education events; our 3-day annual Conference, for example, has been an important part of our activities for several decades, and is highly valued by group therapy professionals in the region.
State-accredited provider	Agree	The proposed changes look and sound very good to make the accreditation process more meaningful and less onerous.
Physician/healthcare professional	Agree	It has required seven years for ACCME to appreciate that the initial promulgation of UAC without posting for comment was a serious omission inducing dissatisfaction and concern among providers. The currently modified criteria are far more acceptable than their predecessors. Appropriately, ACCME should recognize that these criteria are a 'work in progress,' constantly under surveillance and subject to appropriate updates.
State-accredited provider	Agree	thank you!
State-accredited provider	Agree	Streamlining and maximizing efficiency are highly desirable traits when it comes to the criteria - these would definitely be moves in the right direction.
State-accredited provider	Agree	The streamlined criteria will make the daily operation of the CME Program at Winchester Medical Center smoother without affecting the quality of the activities. The streamlined criteria will also make the CME Self Study fresher and we will not need to repeat the same principles using different vocabulary.
ACCME-accredited provider	Agree	The change to the mission statement brings it into line with what a mission statement should be--succinct. Other changes greatly simplify internal efforts
State-accredited provider	Agree	There will have to be additional changes to C13 and maybe 12 if C14 and 15 are completely eliminated as planned or programs will not complete the cycle through to "Act."
Physician/healthcare professional	Agree	Hello ACCME officials: I agree with the proposed changes. It really is not giving up much to make the above deletions of #s 4, 14, 15, and part of 1. I am a member of our CME Advisory Committee, a group of 6-8 dedicated practitioners, and we meet monthly to go over the CME proposals with a fine tooth comb. I am a retired surgeon. I can honestly say over the decades I have never been to a bad CME activity. I think our medical profession is blessed with the built in desire to teach and explain, and those individuals who make CME presentations have the strong sense of responsibility to be thorough, detailed, complete, and current in displaying and presenting their information. Not every CME presentation will win a Nobel Prize. And not every CME presentation will contain information that will produce substantial therapy changes by each attendee, and not every CME presentation will be remembered in its details 3-6 months later. Simplification of the approval process is to be encouraged!
State-accredited provider	Agree	Agree with changes to c1 and c4. Agree with need to keep the PDSA cycle for provider's overall program. I don't see, however, where all the 4 steps are still retained within the proposal. It seems that implementing change (c14) will be added to c13, which is OK with me. But what I'm failing to see is where is the measurement of that change (c15) is going to be in the new proposal? Personally, I'd still like to see it somewhere in the criteria, so as to close the PDSA loop.
ACCME-accredited provider	Agree	Criterion 1: Also delete the words 'that includes' and retain the work 'with' for proper grammar. I thought this criterion was ok as it was, but the change is also ok, just less demanding. Criterion 4, 14, and 15 are covered by other criterion, so are redundant; this is a good change.
State-accredited provider	Agree	Anything that would simplify the onerous record-keeping would help.
Physician/healthcare professional	Agree	Simplification is important for effectiveness, and is a step toward user-centeredness.

Other	Agree	Change to Criterion 1 will support the transition to outcomes based medical education, enhances clarity and reduces redundancy. Elimination of Criterion 4 reduces redundancy, agree. Elimination of Criteria 14 and 15 reduces redundancy considering the changes proposed to Criteria 12 and 13. The key is to retain the Plan-Do-Study-Act cycle.
ACCME-accredited provider	Agree	We concur with these recommendations. The ACCME has appropriately recognized that some of the detailed documentation requirements in the Accreditation Criteria are superseded by demonstrating compliance with overarching program requirements (e.g., establishing professional practice gaps).
State-accredited provider	Agree	Here's how i see some of the proposed criteria in simple terms: c1 -- Have a mission that describes changes in CPPO c3 -- Design activities to change CPPO c11 -- Measure & analyze activities for changes in CPPO c12 -- Summarize how well activities changed CPPO c13 -- Plan and implement improvements to better change CPPO If that's correct, then..... How does c12 differ substantively from c11 ? If providers have other things (besides changes in CPPO) in their mission, will they be required to address them in c12 and c13 ? 5 of 12 criteria focus on changing CPPO -- i understand the emphasis, but are 5 distinct criteria really necessary just to ensure that a provider's activities change CPPO Why not close the PDSA cycle by asking providers to measure or assess the impacts of program changes made, akin to the current c15 ?
ACCME-accredited provider	Agree	My name is Jay Katz. I am CEO of Rockpointe Corporation and Potomac Center for Medical Education an ACCME approved provider with Commendation. I hold the CCMEP certification and have more than 25 years of experience in CME. The proposed changes to criteria 1 - 15 would eliminate some redundancy and streamline the processes and documentation of accredited activities.
Other	Agree	I agree with these proposed changes because they simplify the process and do not negatively impact, through deletion, the defined roles and responsibilities of the provider
State-accredited provider	Agree	Simplification is needed if we are going to continue to have an accredited CME program at our facility.
State-accredited provider	Agree	There is a HUGE need to simply and make this process ELECTRONIC
ACCME-accredited provider	Agree	I would agree with these changes.
ACCME member organization	Agree	We agree with the changes to Criterion 1 but would add the word “knowledge” between “in” and “competence” and agree with eliminating 4, 14 and 15
State-accredited provider	Agree	These changes are acceptable. I would eliminate the RSS component of accreditation criteria as they remain inappropriate and confusing after all of the years of its implementation
ACCME-accredited provider	Agree	The changes simply and make the criteria more consise
ACCME-accredited provider	Agree	I agree that these changes will simplify and clarify the process for providers while maintaining the purpose of the criteria.
ACCME Recognized State Medical Society	Agree	Agree. Many CME providers will include in their mission narrative the CME vision and/or goals - and describe the expected results in terms of learner change and/or patient outcomes.
State-accredited provider	Agree	Your section numbering does not match the survey. there is no section number for Accreditation Critera but there are numbers for the rest. Regarding the accreditation criteria itself, it is unclear, however, how such changes can be articulated in such a global manner. Each training provided would have a different topic specific goal. We obviously want all of our trainings to improve competence, performance, and patient outcomes.
ACCME-accredited provider	Agree	Appreciate combining and removing redundant Criteria and hopefully streamlining the process.
State-accredited provider	Agree	Simplification and avoidance od unnecessary duplication are assets.
State-accredited provider	Agree	I appreciate your thoughtful review of all the criteria and the streamlined changes - thank you!
State-accredited provider	Agree	Could be reduced even more.
ACCME-accredited provider	Agree	Overall, ASTS supports the ACCME’s proposed changes to simplify the accreditation requirements and process by removing redundancies, updating accreditation criteria, and streamlining the application process. However, we were disappointed to discover within the proposal a recommendation to ban corporate logos from CME materials. Due to the limited characters available, please refer to the email from Mina Behari Plante sent to info@accme.org sent today. Thank you.
ACCME-accredited provider	Agree	Deleting Criterion 14 -15 does away with the redundancy esepecially when writing and providing evidence for the self-study. As an accredited provider the outcome of Criterion 13 should be Criterion 14-15
State-accredited provider	Agree	Overall, I agree with the changes, although some of them seem to make becoming an accredited CME provider a bit too easy. Why not have a mission statement that includes, target audience, types of activities, etc? Why wouldn't you want to identify the principal faculty in any enduring materials? Why wouldn't internet CME materials include a way to contact the provider? These seem to be simple efforts on the part of the CME provider that are helpful to the participant, so I'm not sure why they are being eliminated. Thanks!
Other	Disagree	If the only section maintained from the CME mission statement is 'expected results articulated in terms of changes in competence, performance, or patient outcomes that will be the result of the program', how/where are these expected results reported? Is the ACCME suggesting that Criterion 12 covers the total assessment of the CME mission statement? Also, reporting the expected results of the CME mission statement might be easier for providers if they were required to include expected result matrices by which to measure success. Otherwise, I suspect Criteria 1 and 12 will become too diluted to offer much information in terms of evaluating the success of the CME mission statement.

ACCME Recognized State Medical Society	Disagree	Regarding changes to Criterion 1, the statement 'Our mission is to change competence' would demonstrate compliance with changes proposed for C1. It is suggested that C1 requires identification of target audience, types of activities to be provided and expected results articulated in terms of changes in competence, performance, or patient outcomes that will be he results of the program. To emphasize expected results, C 12 might be changed to refer to '....analysis on the degree to which the expected results of the CME program have been met' and C 13 might be changed to state '.....required to improve on ability to meet the expected results of the CME program.'
Other	Disagree	I am 100% in favor of continuing to provide the option to use corporate supporters' logos on all CME materials
ACCME-accredited provider	Disagree	I don't agree that eliminating the items in Criterion 1 is useful. Agree with changes to 4, 14, 15.
State-accredited provider	Disagree	As a CME surveyor and CME committee chairman I believe clarification is needed as follows: Cr 1: Does this change mean that all a program has say in its mission statement is that "We expect improvement in competence, performance and/or patient outcomes? Cr 4: In a hospital setting, will a program need to indicate who, of all possible participants, the practice gap refers to? If they do not, will CR2 be considered non compliant? Cr 11-13. With the strikethroughs and the elimination of all but expected results from the mission statement, it seems compliance is based solely on a plan, if needed, to improve expected results. If expected results are attained in CR 11, as this now reads, this appears to negate the need to respond to CR12-13. Where will "-Study-Act" be implemented?
ACCME-accredited provider	Disagree	The Potomac Center for Continuing Medical Education (PCME), an ACCME provider, is dedicated to providing health care practitioners and professionals with the highest quality of continuing education (CE) and continuing medical education (CME). Standard 6 of the ACCME Standards for Commercial Support™, states that providers must disclose to learners the sources of commercial support. Transparency in accredited CME programs is of paramount importance and the audiences at accredited CME programs are well aware of the source of commercial funding. To our knowledge, there has not been objective evidence suggesting that logos creates bias in the mind of learner. Without evidence, adopting more restrictive policies will have potentially negative consequences on CME stakeholders, including decreased funding. PCME recommends that ACCME not adopt this change.
ACCME-accredited provider	Disagree	The important component of C4 was clarifying that gaps could be relevant even when applying to 'the learners'... potential scope of professional activities.' This was very important when the current criterion were released and caused a great deal of discussion at the time. Deleting this criterion could cause confusion around this subject unless C2 was modified to include similar language.
ACCME-accredited provider	Disagree	a) Comments: i) Internally contradictory – need to be able to identify the appropriate learner in order to identify educational needs underlying professional performance gaps, etc. ii) Recommend that the list of basic CME components being removed from Criterion 1 are incorporated into either Criterion 2 or 3 to ensure they are incorporated into CME activities. iii) Also, if not in the CME mission statement, details regarding 'purpose, content areas, targeted learners , type of activity, and expected results' need to be provided for each proposed activity; otherwise, how can the provider know if the activity has been effective?
State-accredited provider	Disagree	I believe there is value to an organization deciding clearly what it's purpose for the CME program, areas of concentration of content, and who its target audience
Physician/healthcare professional		30 Jan 2014 Hello ACCME, I completed this survey a few weeks ago and since then I got to thinking. The CME accreditation process is SO time consuming. Our Department secretary told me she will have to come in weekends to do all the CME evaluations completed by attendees going back to September 2013. For decades our Department Chair has participated in assigning topics for the CME accredited Grand Rounds, and they always are topics appropriate to our resident-faculty patient care, teaching, and research activities. In 44 years I have never been to a bad Grand Rounds. Not all of my practice has been covered by Grand Rounds, and not all of our Grand Rounds topics are areas in my practice. I don't always pick up something I am going to change in my practice, and expecting that of every attendee is not realistic. I urge you to drop the bureaucracy and simplify the CME process. Thank you.
ACCME-defined commercial interest		Professional journals genrerally require that technical manuscripts include the manufacturer's name, headquarters city and state. This policy ensures that research can be linked to specific equipment used to achieve results reported. When results of technology-focused research are presented at ACCME events, notification of product source isstrictly prohibited. This policy, intended to protect the audience from (the appearnace of) commercial bias, defeats the learner's goal of applying positive research outcomes to their own practices or avoiding negative outcomes in a similar way. FDA-regulated medical products are approved on the basis of safety and efficacy but products approved for the same indication are rarely equally safe or effective. Restricting information to generic descriptions prevents the practitioner from scrupulously applying ACCME-compliant content to the care of their patients. ACCME shoud insist on detailed reference to make and model in all presentations.

Changes to the Standards for Commercial Support

Org Description	Vote	Comment
ACCME-accredited provider	Agree	We agree due to the significant variability in the size and presentation of different corporate logos. Especially with the growth of multi-supporter certified activities, we believe it important to communicate to learners – in a clear and uniform way – the identity of these commercial interests. These provisions within the Standards for Commercial Support should continue to emphasize transparency with respect to commercial support (what entities have provided commercial support should be immediately obvious to learners).
ACCME member organization	Agree	We agree with the changes
ACCME-accredited provider	Agree	CMDA does not accept commercial support, however I agree with these changes
ACCME-accredited provider	Agree	Please CATEGORIZE the Criterion into FOUR SECTIONS by LINKING together similar sections of: MISSION: Criterion that link together and are related to create the foundation of a CME Mission: Criteria 1, 12, and 13. (Also included would be 14/15, but they will be eliminated). COMPETENCY: Criterion that link together and are related to create the foundation of Competency: Criteria 2, 3, 6, 11 and 16. (Also included would be 4, but it will be eliminated). LEVEL 3: Criterion that link together and are related to create the foundation for Level 3 are: Criteria 5, 17 - 21. (C-16 move to competency section - C-5 move to Level 3). COMMERCIAL: Criterion that link together and are related to create the foundation for Commercial Interests are: 7 - 10, and 22. (MUST Move C-22 from Level 3)
State-accredited provider	Agree	I think this will help reduce confusion about potential bias.
State-accredited provider	Agree	Our events do not have commercial support of any kind.
Physician/healthcare professional	Agree	All q.e.d. and have been practice among edified providers despite their specific absence.
State-accredited provider	Agree	more specific and easier to understand (and explain to others)
State-accredited provider	Agree	Changes are very explicit and eliminate any ambiguity.
ACCME-accredited provider	Agree	The prohibition of corporate logos is a needed addition.
State-accredited provider	Agree	These changes take the 'discouraging of commercial support' one step further - leaves no room for loose interpretation - again, moves things in the right direction.
Physician/healthcare professional	Agree	Thank you for the opportunity to comment. I agree, but I do think the rule might be a little excessive. If one attends a conference and the stated commercial support is from Bayer Aspirin, for example, the attendees are all well aware of that company's products as relative to the subject of the CME. And in Bayer's defense, they are paying dollar support for the conference, and deserve something in return. Also the attendees will not be expected to rush headlong in to the nearest Bayer Shop to buy up all the Bayer product. Give the attendees credit for the ability to analyze the information they are being given in the scientific presentations to be able to decide if they can beneficially utilize the sponsors' products. Similarly, exposure to a corporate logo, slogan, trade name, or product group message will not 'poison' the mind of the attendees to where they cannot make a rational judgment about the sponsor's product.
State-accredited provider	Agree	Agree wholeheartedly with eliminating use of logos in these areas!
ACCME-accredited provider	Agree	good job!
State-accredited provider	Agree	We haven't used commercial support for years….this change wouldn't effect us.
State-accredited provider	Agree	There should be no evidence of "branding" in education. Listing sponsors or commercial supporters is necessary, but they should be listed with similar fonts and not convey any branded marketing, which a corporate logo could be perceived to do.
State-accredited provider	Agree	It has not been the practice of the organizations I have worked at to use commercial interests' logos because we felt it was advertisement of their brand as brand identity is a recognized form of advertisement... On another note, people in the business of selling health insurance, being non-profit or for profit have brand identity logos to promote their companies or health insurance. I think it is inappropriate for presenters from health insurance at national or state CME meetings to use the brand identity of their insurance companies in presentations for continuing medical education… The ACCME might want to consider eliminating any promotion from CME so CME is void of any organizational promotion or influence otherwise the education will become a promotion of that insurance company. Instead of coming to present about CME it becomes a promotion for that organization. It will come a time that the FDA will zero in on this issue too and the ACCME should be pro-active and prepared.
ACCME-accredited provider	Agree	Agree and Disagree: I agree that corporate logos should never been seen within the educational content (slides, handouts, etc.), and never seen within the disclosure information for those who impact content. However, I disagree with not allowing corporate logos within the acknowledgement of commercial support. When commercial support is acknowledged to the participants the inclusion of corporate logos will support transparency. As long as the corporate logos are shown with restraint (may not be large and bold), it should not be a violation to show them only in the support acknowledgement section of the handout materials.
ACCME-accredited provider	Agree	We support adding "corporate logo." We do not support restricting to ACCME-defined commercial interests. All educational materials should be free of all advertising, trade names, or product-group messages.

ACCME Recognized State Medical Society	Agree	I agree, with one exception. I am not sure that the use of non-promotional corporate logos is an issue in the acknowledgement process. Do we have clear evidence that this use creates an issue of conflict and confusion for the learner and/or provider? This change is a major change in the fundamental understanding that providers have of the policy, and may result in a prolonged period of non-compliance for many providers on both the ACCME and SMS provider levels. Without some really clear evidence that the current policy is problematic, I cannot support this change.
State-accredited provider	Agree	Since my facility doesn't accept any commercial support, and we already have a stringent disclosure policy, these changes don't really have much effect on us.
ACCME-accredited provider	Agree	Thank you for the opportunity to participate in the evolution of the accreditation criteria and provide comment on specific changes. AAHPM believes the proposed changes enhance the accreditation criteria and the self-study process. Prior redundancies that created confusion for providers have been addressed.
State-accredited provider	Agree	However, not sure that there is any value of noting areas of clinical involvement as this still smacks of commercial advertisement
ACCME-accredited provider	Agree	The American College of Chest Physicians has already removed the use of logos when providing disclosure of financial and in-kind support.
Other	Agree	This is very reasonable and avoids perceived or other promotion.
State-accredited provider	Agree	We had a program lately which had a (different local) hospital's logo on it and we asked them to remove it. So this coincides with our feelings about this.
ACCME-accredited provider	Agree	Agree with the caveat that Institutional/Academic logos may remain in presentations as long as they are NOT an ACCME defined commercial interest.
ACCME-accredited provider	Agree	These are in alignment with our organization's standards.
ACCME-accredited provider	Agree	A corporate logo equates to advertising or branding. If advertising is prohibited, the use of logos should be prohibited. Prohibiting the use of a logo could also decrease the participants perception of real or perceived bias regarding said ACCME-defined commercial interest, resulting in more trust in the validity of the educational content being delivered.
Other	Disagree	As a medical education provider, we fail to see the value in prohibiting the use of corporate logos. The ACCME and its members have gone to great lengths to ensure full disclosure and transparency. The proposed changes to eliminating logos counter the very spirit of transparency in CME and healthcare overall. Additionally, it is our belief that should commercial support go unrecognized, or buried in a 'sea of text', we could put future educational dollars at risk which would negatively impact patient outcomes. The current use of corporate logos has never, in our experience of having executed hundreds of activities, impacted the value of the educational intervention. Therefore, the proposed change only offers a potentially significant downside while providing no benefit whatsoever to the most important stakeholder in continuing medical education: patients that need and deserve better care.
Other	Disagree	I believe that banning the use of corporate logos on all educational material violates the full disclosure policies that the ACCME has in place. The logo serves as a indicator as to which for-profit company is providing support for the educational activity and without it participants must extensively search for this information.
ACCME-accredited provider	Disagree	The American College of Rheumatology thanks the ACCME for requesting comment from stakeholders on The Proposal for Simplifying and Evolving the Accreditation Requirements and Process. We support the proposed simplification with the exception of proposed change in the Standards for Commercial Support (4.3) which we believe contradicts the intention of the standard which is to promote full disclosure and transparency. We are not aware of any evidence that suggests that the inclusion of corporate logos influences learners' perception of an activity. Moreover we do not perceive a company logo as branding in the sense of advertising, but rather as the mark of a commercial interest's identity. We believe current practice respects the sprit of the standard. However if clarification is sought, the ACR would propose a provider independence tag line be included near recognition/acknowledgement of commercial support such as: The ACR, an ACCME-accredited provider has developed this activity independent of commercial interests and maintains control via policies and procedures that foster independence.
Other	Disagree	As a part of a medical education company collaborating with multiple providers, I believe that banning the use of corporate logos in all educational material is contrary to the full disclosure that ACCME has been advocating in the recent years. As it currently stands, the grant support is being acknowledged amidst a large volume of text in the CME page. Having the corporate logo in the midst of these texts makes it clearly visible to the participants which for-profit pharmaceutical and/or device manufacturers are providing support for the educational activity. If this logo is removed, then the acknowledgement becomes buried in the middle of all the text and the participants have to really fish out this information.
Other	Disagree	PhRMA remains concerned that a prohibition on the use of corporate logos will disserve the public interest by diminishing transparency and the goal of the disclosure requirements. A corporate logo is easily recognizable, is not product specific, and quickly identifies the source of the commercial support. Disclosures in text format may become lost or buried in other information in electronic or print format. In addition, the proposal is more extensive than necessary to achieve ACCME's stated purpose. Alternatively, ACCME could require providers to maintain appropriate standards for the size and use of logos to ensure a reasonable balance between and among CME providers and commercial supporter(s). To clarify that CME activities are independent and free from commercial influence, providers could state: "Corporate supporters have had no influence over content, faculty, methods, or audience for this activity." Thank you for the opportunity to submit these comments.
State-accredited provider	Disagree	Better the way it was before...allow logos/slogans but no product information..

ACCME-accredited provider	Disagree	ASTS is disappointed to discover a recommendation to ban corporate logos from CME materials.Consistent with our 6/2011 submission regarding the Call for Comment Disclosure of Commercial Support, we continue to oppose this proposal to prohibit the use of corporate logos. Due to the limited characters available to insert our full comments, please refer to the email sent to info@accme.org which was sent today from Mina Behari Plante. Thank you.
ACCME-accredited provider	Disagree	I do not see the harm in having a supporter poster outside of an exhibit room (not within an educational session) that would include the logos of the supporters.
Other	Disagree	It seems to me that if commercial interests provide grants to support educational activities, the least we could do is publicly recognize them for their faith in the CME community...particularly since advertising is prohibited. A corporate logo is NOT a product logo and would fit logically before or after a commercial support statement, such as This educational activity is supported through an educational grant provided by <insert the name of the commercial supporter.><insert corporate logo>. Also, the Coalition has created some guidelines for use of corporate logos. These guidelines were recently published in the November issue of Medical Meetings. I support these guidelines and the logic offered by the Coalition.
ACCME-accredited provider	Disagree	Standard 6.4 is untenable. One cannot make a disclosure in many cases without listing a company or a product. Agree that taglines should NOT be allowed in disclosures however.
State-accredited provider	Disagree	Appears as though you are grasping for something to change just like a member of Congress.
State-accredited provider	Disagree	Many of the presenters use powerpoint templates from their own institutions. I believe this would be a hardship for either the presenter or the CME Coordinator if they had to remove all corporate logo references.
ACCME-accredited provider	Disagree	Agree with changes to Standards 4.3 and 6.4 With CME providers already being burdened with adapting processes in light of the Sunshine Act, I would hate to add what might be perceived as an additional disincentive to providing commercial support in prohibiting the use of logos in commercial support acknowledgments.
ACCME-accredited provider	Disagree	The corporate logo of a commercial interest should not be eliminated but it also cannot be larger than that of an ACCME provider. I see no need to eliminate the use of logos.
ACCME Recognized State Medical Society	Disagree	In our experience accrediting state medical society providers, most have self-selected to withhold the use of corporate logos on event materials. We do not see the need to restrict the use of logos as proposed.
Other	Disagree	I do not, for a variety of reasons, support the elimination of corporate logos, but will only focus on one for your consideration. Grantor logos actually aid transparency and thank them for providing an independent grant. They are much more visible than small text and, is identical to the demand made on us by USAID and PEPFAR, two very important Federal agencies, as an educational company producing educational and training programs in Africa that is certified, in our instance by Witwatersrand University, South Africa. They demand that we follow very clear rules about showing their logos on programs that are funded by them, to insure that everyone understands and APPRECIATES who has funded these training and educational programs. Bottom line here is that the physician community should appreciate the independent medical education grants provided that have made such important and needed, free of commercial bias, educational programs available to help them to provide optimal care.
ACCME-accredited provider	Disagree	AACE would like to strongly reaffirm comments submitted on the proposed policy to modify SCS 6.4 in 2011 and to reemphasize the crucial need to enhance, not further emasculate, continuing medical education. In 2009, the AACE Board of Directors adopted a position statement affirming that relationships between physicians & industry, including the important conduct of continuing medical education activities for both physicians and allied health professionals, have overwhelmingly met ethical standards. AACE feels that standards and criteria set by ACCME for the disclosure of commercial support are already equal to or exceed those applied to other segments of our society, including legislative and regulatory bodies. A corporate logo is a visual portrayal of the company's name like AACE, ACCME, and other organizations˜an appropriate symbol of organizational identity, functioning as a prefix or suffix to the name. Disclosing the logo to learners aligns with the CME spirit of transparency.
State-accredited provider	Disagree	use of logos in acknowledgements does not interfere with CME events or create conflict. If logos are allowed to remain in acknowledgements, the logos should all be of equal size and be inclusive of all finaccial support (all or none mentality - use logo for all commerical supporters for an event or none at all). I do agree that they do not belong in education materials however.
State-accredited provider	Disagree	I agree with all aspects but not corporate logos. Many speakers have indicated that their organization logo are a requirement, and therefore, keep them on their slides. Thankfully, there is no reference to their organization other than name, title, and organization noted on the first slide. I think as long as there is no discussion or reference to the logo during the presentation, I don't see what harm it would be to keep them on the presentation, especially if it is a requirement of their organization. If we make it mandatory, it will limit our outreach to find speakers.
Other	Disagree	I disagree with the elimination of corporate logo usage for the following reasons: 1. I don't think it enhances the concept of transparency -- in fact I think it makes it more difficult for learners to identify the sources of support. 2. I am unaware of any evidence that indicates that current practices create biased education or entails any undue commercial influence. 3. The choice of use of a logo is not currently mandatory; I think it should be up to each provider to determine its own policy. 4. I fear that this may lead to a decrease in CME funding. The continued ban on slogans I do support fully.
ACCME-accredited provider	Disagree	I agree with the proposed addition to Standard 4.3 but disagree with the proposed changes to Standard 6.4 and the Acknowledgement Policy.
ACCME-accredited provider	Disagree	The inclusion of corporate logos serves as an increased measure of transparency and there is no evidence that it inappropriately influences physicians.

ACCME-accredited provider	Disagree	I agree with the CME Coalition Position on the use of logos.
ACCME-accredited provider	Disagree	I am opposed to the proposed change to Standard 6 which would ban the use of the corporate logos of ACCME defined commercial interests in industry supported accredited CME activities. If our objective is to disclose to learners the sources of all commercial support prior to the start of an activity why would we make it MORE difficult for the learner to identify such support by making them read extensive 'fine print' rather than using readily identifiable symbols of the supporting organizations. This change would make disclosure more challenging for the provider and less effective. For the learner the ban on logo use makes transparency more difficult to ascertain. Thank you for the opportunity to comment.
Other	Disagree	Corporate logos in CME activities do not serve the purpose of corporate branding. Their purpose is to provide transparency for participants as to the source of support for an activity, to allow them them to make an informed decision when gauging the applicability of the CME activity to their clinical practice. Participant survey data has indicated that the presence of logos assists them in that regard, and provides no inappropriate influence or commercial bias; not using logos would provide a barrier to the participant accurately determining the source of financial support.
Other	Disagree	I am in support of continuing the option to use corporate supporters' logos on all CME materials
Other	Disagree	Utilizing the logo is an important means of ensuring transparency to the learner and makes the distinction between supported and unsupported education apparent, it the log is not shown, learners will ask providers engaging a conversation that could have been solved with a logo. In an economic environment where industry providers have shrinking budgets from which to allocate funding and where mergers are reducing the number of companies who are in a position to provide support, it is becoming increasingly difficult to secure funding for vital programs. Because the only benefit supporters receive is public recognition for their commitment to CME, it would be a mistake to eliminate that recognition and jeopardize that irreplaceable source of financial support.
Other	Disagree	These standards should remain unchanged for the following reasons: 1) Utilizing the logo is an important means of ensuring transparency to the learner and makes the distinction between supported and unsupported education apparent. 2) In an economic environment where industry providers have shrinking budgets from which to allocate funding, it is becoming increasingly difficult to secure funding for vital programs. If the opportunity to show a logo for recognition of support is removed, commercial supporters would be less inclined to provide support. 3) There is no evidence that the appearance of a logo as part of the disclosure of commercial support serves a commercial promotional intent or inappropriately influences physicians. I would like to know if these proposed changes to the SCS were part of the simplification effort, or if they arose separately. Also, did all ACCME member organizations decide together that these changes to the SCS should be put forth for comment?
ACCME-accredited provider	Disagree	We should include a corporate logo so learners can easily identify who has supported an activity.
Other	Disagree	The CME Coalition opposes the ACCME proposal to ban corporate logos from CME materials for the following reasons: • Existing ACCME rules are familiar to CME providers, they are clear, and they provide sufficient firewalls between education and promotion. • Utilizing the logo is an important means of ensuring transparency to the learner. • Because the only benefit supporters receive from supporting CME is public recognition for their commitment to CME, it would be a mistake to eliminate that recognition and create the impression that corporate support of CME is worthy of stigma. • There is no evidence that the appearance of a logo as part of the disclosure of commercial support serves a commercial promotional intent or inappropriately influences physicians. • Industry self-regulation that includes commonsense rules, such as the CME Coalition's Voluntary Responsible Logo Use Code of Conduct, can play an important role in ensuring the responsible use of logos.
ACCME-accredited provider	Disagree	I believe the appropriate use of corporate logos aligns with the spirit of disclosure and suggest that logo usage or not should fall within the provider's responsibility for compliantly adhering to the ACCME Standards of Commercial Support. Therefore, I urge the ACCME to reconsider this significant and, in my view, unnecessary change to the ACCME Standards that are recognized nationally by the profession, regulators and by the government as safeguarding the independence of CME.
Other	Disagree	By definition, the corporate logo simply and efficiently identifies the commercial interest which provided support for the accredited activity. It conveys that the corporation recognizes its responsibility for helping provide relevant continuing medical education, within the ACCME guidelines for such support. The logo itself does not advertise or promote a brand or product group, nor does it make or suggest a therapeutic claim. Additionally, usage of the commercial interest's corporate logo does reinforce and ensure transparency to the learner, while clearly differentiating supported and unsupported education. And, since there is no evidence that the appearance of a corporate logo as part of the discliosure of commercial support serves a commercial promotional intent or inappropriately influences physicians, this change should not be implemented until there is unrefutable evidence that it does.
ACCME-accredited provider	Disagree	Oppose ban on corporate logos Provides transparency to Learners Eliminates corporate incentive of 'recognition' for funding Medical Education Activities
ACCME-accredited provider	Disagree	Corporate logos should be used. CME providers are currently free to choose whether or not they include logos in program materials. CME providers should be able to retain that choice.

ACCME-accredited provider	Disagree	Partially disagree with change to 4.3. An exclusion must be provided for logos that are embedded within radiological images. Practially all radiological images, with the exception of plain films, include the manufacturer's logo. It would be a practical impossibility for providers to remove these logos from the hundreds of clinical images shown at CME activities. There is a general feeling among radiologists that most imaging systems are similar in quality and the corporate logos on clinical images have no real impact on the viewer. More importantly, when HIPAA rules forced the removal of IDing patient info it took years of technical development to allow compliance. There must be an exclusion for the logos in radiological images.
Other	Disagree	In regards to Standard 4.3 - A blanket prohibition of use of trade names is not wise. I agree that when it can be avoided, it should be avoided. However, in the increasingly common world of biopharmaceuticals and products that are similar in all fashions other than the manufacturing process, the only reasonable way to differentiate between similar products is through the use of Trade Names. Classic examples are IVIG products or products such as C1 esterase Inhibitors. In regards to Standard 6.4: This is an unnecessary change that is in all ways detrimental to the enterprise of quality professional CME> It has not value if implemented and serves only to further dis-incentivize the potential funders of CME. Funders which are already dwindle in numbers and are ever more questioning why they are involved in CME
ACCME-accredited provider	Disagree	I believe that utilizing the logo is an important means of ensuring transparency to the learner and makes the distinction between supported and unsupported education. CME providers are currently able to choose whether or not they include logos in program materials. I believe that CME providers should be able to retain that choice
Other	Disagree	appropriate use of a corporate logo - not oversize - provides an appropriate level of acknowledgement of commercial support. Why can't that be a plus for supporters rather than a negative. Provide appropriate guidelines that everyone can follow for size and location. It actually gives the user more information on which to judge the content of the activity. If they feel it is biased, then the corporate logo or not won't make a difference.
Other	Disagree	The corporate logo is a clear indication of a commercial interest's support for an independent CME activity and that it is easily identified by the learner, regardless where it's positioned in educational materials. Rather, finding a text-only acknowledgement of commercial support within a sea of words in a brochure or handout or on a webpage is not as easy or transparent for the learner.
Other	Disagree	The proposed position of no longer allowing the use of corporate logos of ACCME-defined commercial interests in educational materials, disclosure and acknowledgement of commercial support goes against the current climate of transparency and disclosure that is prevalent in CME and healthcare in general. The corporate logo is a clear indication of a commercial interest's support for an independent CME activity and that it is easily identified by the learner, regardless where it's positioned in educational materials. Rather, finding a text-only acknowledgement of commercial support within a sea of words in a brochure or handout or on a webpage is not as easy or transparent for the learner.
ACCME-accredited provider	Disagree	prIME Oncology, an ACCME-accredited provider, does NOT support changes to the Standards of Commercial Support 4.3 and 6.5. Losing this mechanism of acknowledging commercial support disrupts the efforts to ensure transparency to learners of the nature of commercial support for any given educational intervention. If transparency is the ultimate goal, the ability to use this visual cue is vital in transmitting this important requirement. prIME Oncology supports the CME Coalition's 'Responsible Logo Use Guidelines'.
ACCME-accredited provider	Disagree	Albert Einstein opposes the ACCME proposal to ban corporate logos from CME materials for the following reasons: • Existing ACCME rules provide sufficient firewalls between education and promotion. • Utilizing the logo is an important means of ensuring transparency to the learner and makes the distinction between supported and unsupported education apparent. • In an economic environment where industry providers have shrinking budgets it is becoming increasingly difficult to secure funding for vital programs. Because the only benefit supporters receive is public recognition for their commitment to CME, it would be a mistake to eliminate that recognition. There is no evidence that the appearance of a logo as part of the disclosure of commercial support serves a commercial promotional intent or inappropriately influences physicians.
ACCME Recognized State Medical Society	Disagree	These changes concern me for the following reasons... 1. Existing ACCME rules are familiar to MAG's accredited CME providers. They are clear and they provide the necessary firewall between education and promotion. 2. MAG's accredited CME providers should be allowed to choose whether or not they include logos in their program materials. They know their target audience physicians better than anyone and should have the freedom to make this choice. 3. Utilizing the logo is a means of ensuring transparency to the learner. Doing away with logos would actually take away from transparency. A logo adds to transparency and calls the learners attention to the related verbiage. 4. There is no evidence that the appearance of a logo as part of the disclosure of commercial support serves a commercial promotional intent or inappropriately influences physicians.
ACCME-accredited provider	Disagree	I support the CME Coalition position on this, specifically 'Because the only benefit supporters receive is public recognition for their commitment to CME, it would be a mistake to eliminate that recognition and jeopardize that irreplaceable source of financial support.'
Other	Disagree	I am in agreement with the CME Coalition's submission on retention of corporate logos.
Physician/healthcare professional	Disagree	Existing ACCME rules are clear and they provide sufficient firewalls between education and corporate support. CME providers should be able to retain the choice to include logos or not to do so in their programs. The ability to display a logo is an important means of ensuring transparency to the learner and makes the distinction between supported and unsupported education clear to the consumer.There is no evidence that the appearance of a logo as part of the disclosure of commercial support serves a commercial promotional intent or inappropriately influences physicians.

ACCME-accredited provider	Disagree	This is an unnecessary change that will cause more oversite on what is already a fairly cumberson monitoring process. I do not believe that providing the company's logo with its name is in any way offensive to the learner-having the logo with the name doesn't change the message. Commercial supporters deserve appropriate acknowledgement of their commitment to CME. CME providers can make their own rules about logo or no logo- for example, we do not allow logos or company names on slides or conference educational materials.
State-accredited provider	Disagree	Current rules are clear enough and provide sufficient firewalls between education and promotion. I prefer having the option to include corporate logos in program materials and should be able to retain that choice. I feel that for learners, using the corporate logo can be a clear method to ensure transparency. Please don't add this change to the standards/commercial acknowledgement.
Physician/healthcare professional	Disagree	This seems like a tempest in a teapot. Where is there ANY evidence that showing a commercial logo influences MD learning, behavior, or negatively impacts content??? Companies (sponsors) already operate under very strict ACCME regs - showing their logo is often the only public recognition of their (considerable) CME support. And actually, showing the name/logo of the company may alert the physician to be even MORE sensitive to possible bias; it also makes clear that the education is commercially supported. Lastly, under current regs, the CME provider can choose whether or not to show the logo - let them do so.
ACCME-accredited provider	Disagree	In an age where transparency is of highest regard, we need to continue this in the CME industry. It is important for our learners/faculty to understand that a commercial supporter did provide funding support. Text only recognition is easy to overlook.
ACCME-accredited provider	Disagree	The removal of corporate logos in the acknowledgment of commercial support would make it detrimental to accredited providers who sustain themselves on corporate support. It is increasingly harder and harder to obtain funding due to the already restrictive guidelines and economic downturn. Currently, there are plenty of successful and necessary restrictions in place to eliminate commercial influence of CME programs. I further argue that a corporate logo in the current appropriate locations of CME program helps the learner identify who has provided funding for a given program. If you take that away and only allow text, it will not be as evident to the learner.
ACCME-accredited provider	Disagree	Use of corporate logos to provide disclosure of commercial support are not promotional, but make it clear to the learners who provided the educational grant. Logos should only be in the program or on a slide to meet ACCME compliance. If used in this mannner, it is not promotional and in compliance with the standards.
State-accredited provider	Disagree	Logos help us brand our CME programs for external participants and sponsorship logos is sometimes the only real 'draw' to incentivize event sponsors to pay exhibit fees. We utilize Major Sponsor, Sponsor, Minor Sponsor, and Not For Profit sponsors categories to our vendors. Eliminating this portion is extremely minor in simplifying our processes compared to other proposed changes.
ACCME-accredited provider	Disagree	Our organization accepts corporate sponsorship for non-educational events. We do publish the sponsoring company's logo in our printed materials, but not in areas that contain educational content. This change could adversely affect future sponsorships.
ACCME-accredited provider	Disagree	I disagree that corporate logos should be omitted from CME materials. My main objection is because utilizing the logo is an important means of ensuring transparency to the learner and makes the distinction between supported and unsupported education apparent. Additionally, there is no evidence that the appearance of a logo as part of the disclosure of commercial support serves a commercial promotional intent or inappropriately influences physicians.
ACCME-accredited provider	Disagree	Existing ACCME rules are familiar to CME providers; they are clear and provide sufficient firewalls between education and promotion. CME providers are currently able to choose whether or not they include logos in materials. CME providers should be able to retain that choice. Utilizing logos is an important means of ensuring transparency to learners and makes the distinction between supported and unsupported education apparent. In an environment where industry providers have shrinking budgets and where mergers are reducing the number of companies able to provide support, it is becoming increasingly difficult to secure funding for vital programs. The only benefit supporters receive is public recognition for their commitment to CME, thus it would be a mistake to eliminate that recognition and jeopardize that irreplaceable source of support. No evidence exists that logos as part of the disclosure of support serves a commercial promotional intent or inappropriately influences HCPs
ACCME-accredited provider	Disagree	One specific proposed change is to eliminate the use of corporate logos on any CME activity. We believe that this should be deleted because of the following: placing the corporate logo of an ACCME-defined commercial interest who has provided support for an activity is a very clear indication to the attendees regarding if the program has commercial support or not. We have found that many participants do not take the time to read all of the information an accredited provider must include at the start of an activity in order to remain in compliance. Therefore having the logo acts as a “short cut” for the attendees to identify the activity has commercial support and who the supporter(s) is/are. However, we do not believe the logo should be in any way larger or highlighted more than the providers logo and should not be included more than once in activities materials.
ACCME-accredited provider	Disagree	I agree with 4.3 and 6.4 but disagree with the acknowledgement policy. I would like clearer justification for excluding logos in the commercial support acknowledgement. Including the logo actually creates more transparency as it is more easily identifiable to attendees who may just glance at the acknowledgement but might not read all the text that you are allowing to be included (the name, mission, and areas of clinical involvement).
ACCME-accredited provider	Disagree	it seems to me that the goal ultimately is to be transparent as to commercial funding. The logo clearly calls attention to this transparency. By merely having a typography line it seems your unintended consequence is to sublimate the quick visual identification of commercial funding. By eliminating the logo you are countering the very information you want quickly identified.

ACCME-accredited provider	Disagree	We believe the existing ACCME rules regarding commercial logos are familiar to CME providers, they are clear, and they provide sufficient firewalls between education and promotion. CME providers should be able to retain the choice as to whether or not they include logos in program materials. Currently our industry providers have shrinking budgets from which to allocate funding. Industry mergers are reducing the number of companies who are in a position to provide support. It is becoming increasingly difficult to secure funding for vital programs. We believe it would be a mistake to eliminate that recognition therefore jeopardizing that irreplaceable source of financial support. Using the logo is an important means of ensuring transparency to the learner. There is no evidence that the appearance of a logo as part of the disclosure of commercial support serves a commercial promotional intent or inappropriately influences physicians.
ACCME-accredited provider	Disagree	As an employee of an ACCME accredited provider, I believe the proposed position of no longer allowing the use of corporate logos of ACCME-defined commercial interests in educational materials, disclosure and acknowledgement of commercial support goes against the concept of TRANSPARENCY and DISCLOSURE that is needed in CME and healthcare in general. I think the corporate logo is a clear indication of a commercial interest's support for an independent CME activity and that it is easily identified by the learner, regardless where it's positioned in educational materials. Rather, finding a text-only acknowledgement of commercial support within a sea of words in a brochure or handout or on a webpage is not as easy or transparent for the learner.
ACCME-accredited provider	Disagree	Our organization is supportive of the changes as outlined, except for banning use of corporate logos of commercial interests. CME providers should be able to retain the choice of whether or not they include logos in program materials. Existing ACCME rules provide sufficient firewalls between education and promotion, and there is no evidence that the appearance of a logo as part of the disclosure of commercial support serves a commercial promotional intent or inappropriately influences physicians. Utilizing the logo is an important means of ensuring transparency to the learner and makes the distinction between supported and unsupported education apparent. We support self-regulation, including the Voluntary Responsible Logo Use Code of Conduct, for ensuring responsible use of corporate logos of commercial interests.
Other	Disagree	This proposed change would prove counterproductive and restrict the free flow of useful educational material. Aside from the massive cutoff of educational grants and funding that would result, the shielding of logos and manufacturer information from learners creates ignorance as to available options for better healthcare. The current measures to eliminate bias are effective, and any further censorship would result in less educated physicians.
ACCME-accredited provider	Disagree	The AAP supports the use of ACCME-defined commercial interest corporate logos only in acknowledging/disclosing commercial support to learners. The AAP also supports the CME Coalition's Responsible Logo Use Guidelines when acknowledging support to learners (http://cmecoalition.org/content/cme-coalitions-responsible-logo-use-guidelines). The AAP concurs that these corporate logos should not be used as part of educational materials, nor in disclosures of individuals' relevant financial relationships to learners.
Other	Disagree	I am not in agreement with the proposed ban of corporate logos from CME materials. As a seasoned CME professional, I believe that the best course is to stay with existing regulations that are more than sufficient for maintaining freedom from commercial bias. I believe that including corporate logos as part of the disclosure of commercial support ensures transparency to the learner. One could surmise that such disclosure could be via text only. However, finding a text-only disclosure of commercial support within a sea of words is not as easy or transparent for the learner. Additionally I am aware of no evidence supporting that inclusion of a corporate logo on CME materials serves a commercial promotional intent or unduly influences clinicians. As a former practicing clinician, I have been a member of many target audiences to which CME is directed. In my experience, the presence of corporate logos has not been an inappropriate influence for myself nor my colleagues.
State-accredited provider	Disagree	I think it should be acceptable to leave the Corporate Logo on the Acknowledgement Statement only. There should be limits of the size and prominence of the logo. the Acknowledgement Statement serves as a method to say, 'Thank you'. I agree with the other changes.
ACCME-accredited provider	Disagree	The Potomac Center for Continuing Medical Education (PCME), an ACCME provider, is dedicated to providing health care practitioners and professionals with the highest quality of continuing education (CE) and continuing medical education (CME). Standard 6 of the ACCME Standards for Commercial Support™, states that providers must disclose to learners the sources of commercial support. Transparency in accredited CME programs is of paramount importance and the audiences at accredited CME programs are well aware of the source of commercial funding. To our knowledge, there has not been objective evidence suggesting that logos creates bias in the mind of learner. Without evidence, adopting more restrictive policies will have potentially negative consequences on CME stakeholders, including decreased funding. PCME recommends that ACCME not adopt this change.
ACCME-defined commercial interest	Disagree	W.L. Gore & Associates, Inc, concurs with the stated position of the CME Coalition with regard to the use of company logos at CME events. Gore is committed to physician education and believes it is important for attendees to understand that we value the opportunity to invest in their continued education through unrestricted funding of CME accredited events. Use of our company logo to communicate such investments amounts to transparent awareness of the investment and is not tantamount to promotional activity.
ACCME-accredited provider	Disagree	There has been much discussion in industry and provider groups about this. One prevailing school of thought is that if disclosure of support does not include logos, learners/attendees may not notice the disclosure and be fully unaware. Some providers have said that they will just use very large font if needed, and the ACCME may want to think about guidelines for publishing disclosure that include font and color standards.

ACCME-accredited provider	Disagree	CME providers should retain the choice of whether or not they include corporate logos of an ACCME-defined commercial interest in program and activity materials. Existing ACCME Standards for Commercial Support provide sufficient safeguards between education and promotion, and there is no evidence that the appearance of a logo as part of the disclosure of commercial support serves a commercial promotional intent or inappropriately influences physicians. Use of the corporate logo can be an important means of ensuring transparency to the learner and makes the distinction between supported and unsupported education apparent. To quote Dr. Kopelow in a recent Medical Meetings (MeetingsNet) interview, 'I do not believe that there is any mechanism for commercially supported ACCME-compliant accredited CME to become 'tainted by promotion' or to be 'marketing masked as education.' These are concepts made obsolete by the ACCME's Standards for Commercial Support.' We should stand by that idea.
ACCME-defined commercial interest	Disagree	ACCME's current stance of allowing use of corporate logos in commercially supported CME programs seems appropriate and in the public interest. As learners have varied learning styles, they also recognize the format of communications differently. Some learners comprehend text-based disclosures, but corporate logos provide an important visual alternative that a CME program has received commercial support. With full disclosure, a learner can then decide whether or not to attend a commercially supported CME program. A text-only disclosure seems more likely to be overlooked. Additionally, if the elimination of logos only applies to commercial interests, yet providers/educational partners continue to use them, critics may perceive the change as an attempt to hide disclosure rather than the intended purpose of full disclosure. The CME community shares a commitment to transparency let us be as open as possible. Eliminating logos will cast a shadow over disclosure, rather than illuminate it.
ACCME-accredited provider	Disagree	Upon further review of the ACCME call to comment, we discovered that the proposed change was actually two separate issues. • Standard 4.3 relates to the "educational materials" and we agree with prohibiting corporate logos in educational material. • However, in the related Standard 6.4, for the purpose of transparency and clarity of commercial support contributions, we are in support of including the corporate logo
Other	Disagree	As a medical education company collaborating with multiple providers, we believe that banning the use of corporate logos in all educational material is contrary to the full disclosure that ACCME has been advocating in the recent years. As it currently stands, the grant support is being acknowledged in the midst of a large volume of text in the CME page. Having the corporate logo in the midst of these texts makes it clearly visible to the participants which for-profit pharmaceutical and/or device manufacturers are providing support for the educational activity. If this logo is removed, then the acknowledgement becomes buried in the middle of all the text and the participants have to really fish out this information.
Other		We would agree with the elimination of corporate logos on educational materials and individual disclosure statements to learners but we would not restrict the use of the corporate logos on the commercial support acknowledgement materials as per Standard 6.5 and Commercial Support Acknowledgement Policy. We would not agree that a corporate logo is a branding strategy that would introduce any significant bias as part of a sponsorship page but we agree that it could introduce significant bias if used within educational materials.
ACCME-accredited provider		I disagree with the proposed changes to eliminate the use of logos in acknowledgements. It is becoming increasingly difficult to secure funding for programs, particularly utilizing innovative formates and technologies. It is not realistic to expect registration fees to completely cover expenses with these types of programs, particulary where a primary care provider is the target audience. The only benefit supporters receive is public recognition for their commitment to CME, it would be a mistake to eliminate that recognition and jeopardize that irreplaceable source of financial support. I also question that there is suitable evidence to demonstrate that the use of logos makes a difference in a provider's intent to prescribe. Are we making a change due to outside pressure when we should be adocating against that pressue?
ACCME-accredited provider		I disagree with the proposed changes to standards 4.3 & 6.4. I think it is important to have the option to list the trade name during the first mention of a drug in an educational activity in order to orient the learner to both trade and generic name e.g. Amitriptyline (Elavil). All subsequent mentions of the drug would be by generic name. All drugs mentioned in an activity would be handled in the same manner to provide appropriate balance. I believe that displaying the commercial interest logo is the best means to ensure transparency to the learner and make the distinction between supported and unsupported education activities. The disclosure is the only place where this should be allowed. Is there any evidence that the appearance of a logo as part of the disclosure of commercial support serves a commercial promotional intent or inappropriately influences physicians?
Other		Not allowing the use of corporate logos of commercial interests contravenes the existing climate of transparency and disclosure that is currently prevalent in CME. The corporate logo is a clearly identifiable indication of the commercial interest's support for a CME activity. Use of text-based acknowledgements would be much more difficult for learmers to find in the extremely word-heavy front matter provided. I am also concerned that elimination of corporate logos may further reduce commercial support for CME in an enviroment where providers continue to struggle for funding, because the only benefit a commercial supporter receives for the funding of certified CME is acknowledgement in the educational materials and making this support less visible is concerning. If there is concern about branding, please be aware that providers could begin to use oversized fonts or larger pages to acknowledge support from a commercial interest, thus promoting learner perception of branding.

Other		Existing ACCME rules are familiar to CME providers, are clear, and provide sufficient firewalls between education and promotion. CME providers are currently free to choose whether or not to include logos in program materials; they should be able to retain that choice. The logo is an important means of ensuring transparency to the learner and makes the distinction between supported and unsupported education apparent. Because the only benefit supporters receive is public recognition for their commitment to CME, it would be a mistake to eliminate that recognition and jeopardize that irreplaceable source of financial support. There is no evidence that the logo as part of the disclosure of commercial support serves a commercial promotional intent or inappropriately influences physicians. Industry self-regulation that includes commonsense rules, such as the CME Coalition's Voluntary Responsible Logo Use Code of Conduct, is an important tool for ensuring responsible use of corporate logos.

Changes to the Accreditation Policies

Org Description	Vote	Comment
ACCME-accredited provider	Agree	Please CATEGORIZE the Criterion into FOUR SECTIONS by LINKING together similar sections of: MISSION: Criterion that link together and are related to create the foundation of a CME Mission: Criteria 1, 12, and 13. (Also included would be 14/15, but they will be eliminated). COMPETENCY: Criterion that link together and are related to create the foundation of Competency: Criteria 2, 3, 6, 11 and 16. (Also included would be 4, but it will be eliminated). LEVEL 3: Criterion that link together and are related to create the foundation for Level 3 are: Criteria 5, 17 - 21. (C-16 move to competency section - C-5 move to Level 3). COMMERCIAL: Criterion that link together and are related to create the foundation for Commercial Interests are: 7 - 10, and 22. (MUST Move C-22 from Level 3)
State-accredited provider	Agree	I agree with all of the changes. Joint providership may just be semantics but the use of the word sponsorship has created a level of misunderstanding that this should alleviate.
State-accredited provider	Agree	We do not offer online workshops or other events, and have no joint providership with other organizations. We are, however, an affiliate society of the American Group Psychotherapy Association, though we operate independently in every way.
ACCME-accredited provider	Agree	Internet and enduring materials policies were very outdated. I agree with these changes.
State-accredited provider	Agree	I'm especially in favor of the enduring materials and the RSS changes!
ACCME-accredited provider	Agree	The current internet requirements are outdated given technology changes. Other changes to RSS, journals are fine. I am concerned about the 'joint providership' since I feel it conveys two accredited providers are involved. Not certain how to fine the best wording.
Physician/healthcare professional	Agree	One comment about the Regularly Scheduled Series. Some type of monitoring undoubtedly does occur by the department chair, or similarly responsible person, to assure that a broad range of appropriate topics are presented over the course of a year or two or three. I believe this monitoring is a good thing.
ACCME-accredited provider	Agree	We agree with the above, assuming the change to the RSS definition doesn't eliminate the ability to monitor the RSS using a sampling method vs. having to check everything. We are not sure if this language removal of the monitoring system is just being removed here because it's out of place with the definition, or because it's actually eliminating the ability to monitor a percentage of the RSS documentation.
ACCME Recognized State Medical Society	Agree	We agree with the proposed changes to the Accreditation Policies; however, we do not see the need to change the terminology used to describe joint sponsorship.
ACCME-accredited provider	Agree	I agree with the proposed changes in the policies outlined above as they more accurately reflect the realities of current CME practices and update requirements to be more consistent with the evolution of new activity types and current terminology.
ACCME Recognized State Medical Society	Agree	Do we really need to change joint sponsorship to joint providership? Joint providership sort of sounds like two equal accredited providers are involved. The term sponsor infers that one is supporting or helping another in some way, which is what we as accredited providers do for non-accredited organizations. :)
Other	Agree	This makes the process less complicated
State-accredited provider	Agree	Please see my comments on the previous question.
Other	Agree	The Internet CME changes are excellent. The rapidity of technology based changes makes the old standards irrelevant and impossible to remain in compliance with at any rate. The terminology change to Providership is also excellent.
State-accredited provider	Agree	I am very excited about the changes to Enduring Materials and RSS's in particular. Of all of the education types, these three types require my asking assistance from planners/Champions to help facilitate the education. It will be much easier to garner support within the departments by not having to manage these criteria through the hands of others. These changes will make a big impact on my efforts and collaborations with my planners to keep the information accurate and in meeting criteria expectations.
State-accredited provider	Agree	The revisions regarding enduring materials and internet CME are very helpful and will encourage these activities. The changes to RSS may significantly weaken the ability of an RSS to have a defined educational focus, as it is no longer clear that the activities will each be planned and focused on an effective educational activity.
ACCME-accredited provider	Agree	If the above changes transpire, I would appreciate revised 'Toolboxes' be created by the ACCME for accredited providers. These were invaluable to our office when we were first accredited.

State-accredited provider	Agree	I have suggested a small syntax in this sentence under Journal Club A journal-based CME activity includes the reading of an article or article(s) (or adapted formats for special needs), a provider stipulated/learner directed phase (that may include reflection, discussion, or debate about the material contained in the article(s)), and a requirement for the completion by the learner of a pre-determined set of questions or tasks relating to the content of the material as part of the learning process.
State-accredited provider	Agree	However, all that the IMQ does is on-site survey. I like the idea of the abstract, the labels are difficult to place... I prefer to make pdf files and use the comment tool to make labels so it could be an electronic document.
ACCME-accredited provider	Agree	Many of these are standard practices. Providership is a good word choice to replace 'sponsorship'
ACCME-accredited provider	Agree	The activitiy types are well defined by the AMA as well as industry standards. It is good to see this become streamlined. All CME must meet standard criteria with educational outcomes. Terminology: It is good to become more aligned, especially in light of the Tri-Accreditation. It will be confusing to some of the older providers for a while.
ACCME-accredited provider	Agree	We agree. The major theme across most of these policy revisions is the ACCME's recognition that a number of detailed documentation requirements are subsumed in the expectations common to all certified CME activities. Other policy revisions acknowledge the impracticality of configuring accreditation requirements around specific digital delivery modalities; these are changing too rapidly, accreditation policy should be more general. Finally, shifting to "joint providership" will take time for the field to adopt, but creates a more consistent nomenclature for CME providers.
ACCME-accredited provider	Disagree	Information to the learner is still very pertinent in enduring and internet activities. Due to the various modes of electronic devices available in the market place it is essential that hardware and perhaps software such as Adobe reader be communicated to the audience; faculty, date and disclosures as well. The changes to the RSS are disastrous!!! As a surveyor, I find that it's crucial that organizations have a system in place to regulate their RSS especially commercial support. RSS are very difficult to control with a system in place, without it how are we to verify compliance? Are we to read their poetic flowed words in the self-study and believe everything written? Perhaps I'm missing something but I think it's a big mistake to ask people to do their RSS as they please.
State-accredited provider	Disagree	Profoundly do NOT support terminology change to Joint PROVIDERSHIP. This is a made-up word that has no meaning in 'regular' speech, contrary to SPONSORSHIP which is a perfectly suitable, well-known word. In fact, in the example above, the texst explains 'providership' as the 'SPONSORSHIP' of a CME activity by one accredited and one nonaccredited organization.' WHY use the word 'Providership' when you must then explain it as 'sponsorship'? That makes absolutely no sense.... in fact, it's downright silly.
State-accredited provider	Disagree	I belive that this language should remain for RSS ACCME-accredited providers that offer regularly scheduled series must describe and verify that they have a system in place monitor these activities' compliance with ACCME accreditation requirements. The monitoring system must: 1. Be based on real performance data and information derived from the RSS's that describes compliance (in support of Accreditation Criteria 2-11). WE ALL SPENT A LOT OF TIME TO ENSURE THAT WE MET THIS REQUIREMENT AND IT IS INSULTIVE THAT ALL THAT HARD WORK WAS FOR NAUGHT.
ACCME-accredited provider	Disagree	1. DISAGREE - I believe that eliminating ALL of the wording in Organizational Framework may be the death of many CME units in hospitals and healthcare systems as there will no longer be institutional support for CME. Many of these CME units are totally supported by their institution and will no longer be deemed as necessary because of cost cutting. 2. End. Materials - I DISAGREE with eliminating any changes except #2. The rest of the information is a good list of important information to the participant and a help to the provider. 3. I disagree totally with eliminating this information! 4. I totally AGREE with the RSS changes.
ACCME Recognized State Medical Society	Disagree	Organizational framework policy-uncertain policy 'is no longer necessary in the current CME environment.' Rapid organizational changes sometimes leave CME programs without necessary resources and organizational support to manage a CME program. Regarding Internet CME-Communication of educational purpose of objectives and faculty and their credentials to prospective participants , in advance, should be required policy for all CME activities. (It may be there, but I could not find it on-line in current ACCME policies.) That 'The special requirements have become incorporated into standard practice and therefore it is no longer necessary to include them in the policies' for internet CME is not always true on intrastate level. Agree with Journal based CME changes, RSS changes and Terminology changes.
State-accredited provider	Disagree	Agree with changes to Organization Framework, Internet, Journal-based CME, and Joint Providership. Disagree with changes to Enduring Materials only in that I would like to retain bullet points 4, 5, and 6. Disagree with changes to RSS. Providers need a framework to ensure and document that the sessions are in compliance with CME requirements, and monitoring provided that. It's oftentimes unrealistic to document compliance for all criteria at the session-level, but it's important that providers maintain a checks and balances that looks at both the sessions and the series overall. I would like the ACCME to explain and provide examples of how it recommends that providers can show compliance with their RSS activities without the use of a monitoring system, which has been a central point of RSS for many years now.

ACCME-accredited provider	Disagree	The organizational framework rule seems valuable; we are unclear as to why it should be removed. We recommend the following change: "The accredited provider must invest in continually improving their organizational…" Rules for Internet CME and Regularly Scheduled Series should relate to the format in which they are being offered (Live, Enduring, etc.). We still recognize value in communicating all information to learners prior to the beginning of an activity, and including information such as faculty and credentials, estimated time to complete, dates of original release and update, date credit expires, and copyright. We support the removal of "media used" and "method of participation in learning process" for enduring materials. We recommend adding clarification regarding how a provider can demonstrate compliance with these policies if retaining the activity is cost prohibitive.
State-accredited provider	Disagree	CME is often short of support by administration.
ACCME-accredited provider	Disagree	Links to Product Web sites: With clear notification that the learner is leaving the educational Web site, links from the Web site of an ACCME accredited provider to pharmaceutical and device manufacturers' product Web sites are permitted before or after the educational content of a CME activity, but shall not be embedded in the educational content of a CME activity. This should be eliminated also. There should not be links to advertising web sites available after an educational activity.
Other	Disagree	No need to change 'sponsorship' to 'providership'. it means the same thing and will only cause confusion.
State-accredited provider	Disagree	Still unclear as to how to apply evaluation to RSS programs. Is each classification to be evaluated as a single activity or course (i.e. one evaluation for 50 M/M sessions? CLARIFY FIRST but glad that the other confusions of RSS are gone. Still concerned that with Internet programs--ability to link to CS comments outside of the CME activity, still caters to the CS programming
State-accredited provider	Disagree	RSS The strikethrough appears to eliminate any need for monitoring RSS's. Clarification is needed; otherwise, as it would now read, there is no need to implement CR2-13 at all, for any RSS. Joint Sponsorship Changing "sponsorship" to "providership" is needless wordsmithing. " Providership" is not defined in the Oxford dictionaries. Programs are used to "sponsorship." There is no need to change it. If a program uses the word "sponsorship," which is in most dictionaries, will they be noncompliant?
ACCME-accredited provider	Disagree	With regard to the enduring material and internet CME changes, we believe that too many items are being eliminated from the required informaiton. While we have found that many learners do not read all this information, we believe it is important to keep nearly all of these (with the exceptions of (enduring-medium; internet-hardware/software requirements. The rest of this information is relevant to learners. If they do not read it that is their choice but to not require means that the information will not be available to them. Furthermore, it will lead to wide variations among provider practices which may affect learners overall perceptions of CME.
ACCME-accredited provider	Disagree	For these changes, can you clarify that these requirements are eliminated or not? The language is not clear. For example, in enduring materials, you cross off many requirements on the list. Does that mean those are no longer required or does it mean that you're assuming that providers know that these must be included? Also, the paragraph underneath seems to indicate that the original release date and expiration and review dates must still be included (which I agree with as I feel it would be a disservice to the learners to not know the original release date).
Other	Disagree	Items #4 and #5 under ENDURING MATERIALS show as strikethrough, however I believe that these pieces if information should remain as requirements.
ACCME-accredited provider	Disagree	These two components are VITAL for enduring materials, especially printed materials: 5. Dates of original release and most recent review or update; and 6. Termination date (date after which enduring material is no longer certified for credit). Without this info, leaners do not understand when credit expires and they are ineligible for credit. It should be clear in a CME-certified activity if it is still a reputable resource or if it may be outdated for the purposes of learning.
State-accredited provider	Disagree	No sure what Policies on PDF is. Section 3 is about the application process and performance in practice.
State-accredited provider	Disagree	Clear linkage to organizational improvement structures are valuable if one is intersted in maintaining the criteria for commendation.
Other		We would agree with the change to the Organizational Framework Policy as we would agree that it is not necessary to retain. We agree that 'providers' of CPD should not be referred to as 'sponsors' but we are not sure we agree with the word 'providership'. Using the word 'providership' implies that both organizations are accredited providers which is not always the case. We feel that the language remains problematic. If joint-providership is retained, we would recommend removing the reference to 'sponsorship' in the definition of 'joint-providership'.
State-accredited provider		If RSS monitoring is no longer described in the CME standards, then.... Will an RSS monitoring system be accepted (even though it's not required) as a way to show compliance? If yes, can providers make up their own monitoring system without any parameters on what is monitored and how ? How will providers demonstrate compliance in the performance-in-practice review ? (please provide some examples)
ACCME member organization		We believe that the Organizational Framework Policy continues to be important. For the Enduring Materials policy, learners should know the faculty, and credentials, responsible for the content, estimated time to complete the activity, the dates of the original release and must recent update/review and the termination date after which the learner will not receive credit for completing it. For the Internet policy, the contact information and the Privacy and Confidentiality information should still be provided to the learner. We agree with the changes to the Journal CME policy

Other		I am surprised that there remains ability to link to a sponsor after/at the end of an online offering. It seems for ease of reading the phrase after the in-quotes statement on joint providership that is specific to stressing no suggestion of legal partnership could be struck. Just leaving the phrase about accredited provider maintaining control for activity. . .
ACCME-accredited provider		Thank you for proposing the internet enduring materials change!

Changes to the Accreditation Process

Org Description	Vote	Comment
Physician/healthcare professional	Agree	LOVE the draft!
ACCME-accredited provider	Agree	The Performance in Practice Abstract is the BEST proposed change! I did something similar to this in our Self Study in 2012, along with using labels. It would be wonderful to have the summary/abstract and not use labels (if that is the plan). Thank you!!
Other	Agree	Before clicking the finish button, I wanted to suggest that the ACCME create a criteria covering the necessity of a CME Coordinator or CME Director or some such language to be consistent with the ANCC that requires a Nurse Planner and ACPE that requires a CPE Administrator (I believe that title is correct!!). Why is it that of the three organizations involved in Joint Accreditation, the ACCME is the only group without a requirement for someone in the CME leadership role? Hopefully raising this question in this section is permissible. Thank you for your consideration. As a past Executive Director of an accreditation agency reporting to the Department of Education and overseeing 900+ programs in the US, this question has always bugged me. I feel better just asking the question.
ACCME-accredited provider	Agree	I agree with this change, but propose 2 changes to the abstract draft: 1) instead of pasting the ACCME accreditation statement, attach the actual document that was used to communicate the information; 2) instead of pasting the commercial support disclosure information, attach the actual document that was used to communicate/document the information - I feel that the ability to simply paste the information would allow for modifications to easily be made after the activity. I feel that some providers may not take the Standards as seriously if they know that only a narrative is required and not actual documentation.
ACCME-accredited provider	Agree	IF YOU CHANGE NOTHING ELSE - PLEASE NO SUBMISSION OF FILES Include 'File' Examples that can be woven into the application itself.
State-accredited provider	Agree	Technology has helped many areas of medicine to evolve. Medical education certainly deserves to be brought up to date as well. The use of an abstract I believe will allow for more adequate description of the work being done. I don't believe the current process allows for that and at the state level has resulted in progress reports when an abstract type of documentation would have eliminated the need for that altogether.
State-accredited provider	Agree	This is a more orderly and easy-to follow format for verifying performance-in-practice.
ACCME-accredited provider	Agree	I'm very much in favor of the abstract. However, I do wish the word minimums would be increased. Although some programs may be able to fit into that narrative, some may be more complex and may require additional space for explanation. Regardless, the labels process is cumbersome and I welcome this attempt to simplify the process.
State-accredited provider	Agree	LOVE the idea of a performance-in-practice review abstract!! Soooo much better than / preferred over the use of labels.
ACCME Recognized State Medical Society	Agree	The performance in practice review abstract appears to be a better alternative to the documentation labels. If it has not already been done, it might be tested on a sample of providers who are or are not due for reaccreditation.
ACCME-accredited provider	Agree	Totally love the idea of a simplified PIP
Physician/healthcare professional	Agree	I am not certain I understand the stated changes, but you show a draft abstract, and that does contain a lot of the busy work associated with preparing a CME approval request, and well as reviewing a CME approval request, and it that form could be slimmed down or eliminated that would simplify the processes. As I said earlier, the CME process has a long history of success. For the Surgery Department to offer a one hour CME presentation by a faculty surgeon on hernia repair update, one should not need to justify that topic by knowledge of poorly done hernia repairs recently in the community, a 'demonstrated need' for the updated information. I think in general that presentation will not be a waste of time, and in the audience, medical students, various residents, practitioners, and even doctors who maybe do not do hernia repairs in their day to day practice will learn and their patients will benefit from the knowledge gained by their being there for that presentation.
State-accredited provider	Agree	Agree with changes for Initial Applicants. Agree with the general concept of an abstract, but the draft version (as presented) has me concerned in some regards. There's nothing in it that addresses c3. The limit on words to under 25 is restrictive. What is there to prevent providers from crafting language about c2, c5, and c6 AFTER the activity is delivered to the learners? What is to prevent providers from writing in an accreditation statement on the abstract, when no such statement was actually delivered to the learners? When pasting something in the abstract it loses the context and makes it difficult to assess. Why include actual content of Internet and Enduring Material activities -- what is gained from that? Why not include the content of other types of activities as well? I'd like to see more explicit instructions on how and what is necessary to show c7 scs2. Overall, I think there's some value with the current system of labeling information selected from activity files.
ACCME-accredited provider	Agree	Regarding Criterion 22: suggested added criteria for Accred with Commendation: The provider incorporates medical data on patients or other objective measurements outside of the actual learner (e.g., 360 review, supervisor and peer reviews, patient surveys, etc) into it's evaluation of educational impact on practice. (sorry to submit 2 surveys, I did not see a place to add this comment). Thanks!

Other	Agree	The changes to the application process allows for greater flexibility according to what is appropriate for the individual provider organizations.
ACCME-accredited provider	Agree	As a provider, Mayo Clinic, we agree with these. However, weaing my personal hat as an ACCME surveyor, I would be nervous that the abstract process will give too many providers the ability to realize that their actual course materials didn't provide the right information and change it for the purpose of the abstract. I would still want to see the actual brochures, websites, etc. that the learners obtained/saw to prove items such as the accreditation statement, recognition for commercial support, etc were done properly and not give the provider an opportunity to correct that for the purpose of reaccreditation.
ACCME Recognized State Medical Society	Agree	We support these proposed changes. However, as a State Medical Society accreditor, we believe the decision of whether or not to adopt them with our providers should remain optional.
State-accredited provider	Agree	The teleconference interviews will streamline the process (simplify scheduling) and make it more cost effective.
ACCME-accredited provider	Agree	The abstract is much more streamlined and will make for a better defined and clear process.
Other	Agree	This simplifies the accrediation process
ACCME-accredited provider	Agree	AAHPM offers suggestions for additional criteria for Accreditation with Commendation for consideration by ACCME. • Consider a criterion that allows the provider to demonstrate an impact on population health. CME has the opportunity to play a significant role in the current changes in the structure and provision of healthcare (ACO, PCMH, etc.) CME providers should be recognized for impact on population health. This criterion could include participation in the development of practice standards or guidelines that contribute to quality patient care. • Consider a criterion that allows providers to demonstrate efforts to integrate systems change while working with diverse audiences and/or practice settings. Systems-based practice and professionalism are physician attributes critical to best practices and quality patient care. • Consider a criterion that allows providers to demonstrate CME that is patient-centered and promotes patient-centered care. Thank you.
State-accredited provider	Agree	Regarding the following: Attachment 1: The data or information generated from this activity about changes achieved in learners' competence or performance or patient outcomes (C 11). We are not always able to identify ACTUAL changes ACHIEVED, but can clearly state the the intended changes, depending on the activity. The summary of the activity evaluation forms strives to capture this data to the best of our ability.
ACCME-accredited provider	Agree	These are EXCELLENT changes!
ACCME-accredited provider	Agree	I used a similiar form in the March 2014 cohort and think it helped the surveyors. This appears to help provide improved information for the surveyors.
ACCME-accredited provider	Agree	Simplification of the PIP review abstract is great! Simplification of criteria is better. Simplification and standardization of some FORMS are overdue - especially those used for activity development. This could streamline and standarize surveyor reviews, etc... We all ask for current/best practices and updated criteria requirements with activity development, however, the forms spectrum is all over the place in the CME community. Simplify, standardize and streamlining is the right step, especially for the CME Activity Directors of yesteryear-CME. Thank you for doing this. Thanks for asking for comments. Respectfully, Shaun Ayon
ACCME-accredited provider	Agree	I love the idea of an abstract but I am concerned about some of the word limits and attachment requirements. The gap and justification for format might be longer than the 25 word limit you are allowing. In the area where it says to paste the accreditation statement, that should be an attachment of the page or a screen shot of the website. For disclosure, can we attach the pages from the final program that list disclosures?
State-accredited provider	Agree	Really appreciate the draft performance-in-practice document.
State-accredited provider	Agree	But not applicable to IMQ/CMA because surveys are held on site...Would the IMQ make those changes as well, add and accept non-physician surveyors and have two surveyors per survey to have to set of eyes reviewing the process?
ACCME-accredited provider	Agree	Deleting the travel requirement is good business sense. Performance-In-Practice Review: The abstract is very sensible. It allows for approproate documentation to be provided efficiently. ACCME has always been most thorough with instruction and directions/guidance for providing required documentation. This recommendation, by far seems to facilitate the providers ability to provide evidence and submit documents for verification of performance-in-practice.
ACCME-accredited provider	Agree	We agree. Eliminating a required on-site survey for initial accreditation reduces the cost and administrative burden for all participants, without degrading the process. By retaining the option of other interview formats, surveyors and accredited providers can make alternative arrangements as circumstances warrant. The proposed performance-in-practice review abstract presents a significant potential improvement over the current label-driven process for file preparation. We expect the ACCME would monitor implementation of this proposed abstract process, refining and improving the mechanics based on experience and feedback from the provider community.
State-accredited provider	Disagree	I agree with the application process for initial applicants but not Performance-in-Practice Review Abstract. I believe many applicants will make up the information (gap, objectives) if the activity is chosen instead of doing the work appropriately when planning the activity. I prefer to have to demonstrate proof in the planning forms.
ACCME-accredited provider	Disagree	Do you need to add the AMA credit designation statement to this DRAFT abstract or will that be in a separate section or deleted as not necessary? I think there may be too little space in the answer sections of the abstract for some activities.
ACCME-accredited provider	Disagree	How do we demonstrate compliance for our educational design in 25 words or less? Using MS Word for COI reporting is not ideal. The validity of self-regulation may be threatened by a review of only 15 activities only every 4-6 years and only at 25 words per less per criteria. This may be over-reliant on the self-study report, which is (by title) a narrative self-assessment. The process of validation is critical and should be de-emphasized with great caution.

ACCME-accredited provider	Disagree	I disagree with the PIP abstract review. Once the interview occurs, the auditors will ask for the same information that was previously required and unless the file has been organized in that way to beginwith, it may be difficult to find the 'proof' of what was said in the abstract in a timely fashion.I think the organizing of the file in the original is a really good way to audit our CME files.
State-accredited provider	Disagree	Think actual examples that are labeled help prove compliance and narrative doesn't.
ACCME-accredited provider	Disagree	I believe an organizations first application for accreditation should include a face to face site visit which provides valuable insight about the viability of the applicant organization.
ACCME-accredited provider	Disagree	The draft abstract does not work well for long programs with more than one gap. We have several 25 hour programs for PCP's that it would be hard to document in the limited space.
ACCME Recognized State Medical Society	Disagree	Agree with the first change but not with the abstract. Unfortunately, experience has shown too many times that the information that would now be requested on the abstract is missing from the file because it wasn't addressed during the planning process. If an organization is asked to submit an activity abstract for a file once it is selected for review, why would the organization not take the time to fill in all the blanks now that they know this file is under review. Too easy to make up facts or data that was never considered in the activity planning process.
ACCME-accredited provider	Disagree	We disagree with the elimination of the in person interview. ACCME cannot allow a provider to carry out a lifetime of activity without ever undergoing a live inspection.
State-accredited provider	Disagree	I realize that this will make entire process easier and will be better accepted by most facilities. I am afraid that any educational exchange of ideas will be lost by this process and surveyors will just be checking off boxes of compliance without any opportunity for clarification and discussion. I personally would not continue as a surveyor under these changes--do not want to do clerical assessment.
State-accredited provider	Disagree	Review abstract Assume this is for activities files. Template is confusing. Better to have a list of what is required and indication of what order it should be in in the activity file.
State-accredited provider	Disagree	I agree with the fact that on the abstract you are limited to word counts in response to the questions.
ACCME-accredited provider	Disagree	Performance-In-Practice Review Abstract: While this proposed change may suggest a streamlining of processes, because CHEST already has robust documentation and filing processes, this proposed change would create more work for staff as the number of attachments does not reduce the amount of additional documentation. In addition, the new abstract format does not allow CHEST to highlight areas applicable to accreditation with commendation, nor does it align with CHEST's adherence to the utilization of adult learning principles.
State-accredited provider	Disagree	Application Process for Initial Applicants: I do see a large reduction in cost/time, especially for the site surveyors; however, having on-site survey interviews provides a new applicant an opportunity to build valuable relationships with their experienced counterparts that will carry them through the cycles. Some people have different learning styles and distance or informally scheduled formats may not happen when needed. I think it is also valuable for site surveyors to know the personalities of their sponsors that cannot be learned without direct contact and planning. Providing this required site-survey also lends importance and creditability to the program for Health Care Administrators (ie. CEO, CFO, CMO, and even CME Committee) who may not support or fully recognize the value of their CME program.
ACCME-accredited provider	Disagree	Primarily agree with a caveat . . . The abstract review is a wonderful idea and allows for much better consistency and clear expectations. I do not think there should be a prescribed table for disclosure information. For an activity with a relatively small number of people in control of content, it makes sense. For a conference with a large planning committee, a large abstract process and a large faculty, this could be adding additional, non-additive work to providers who might have disclosure processes that work well for them but don't fit well within a prescribed template.
State-accredited provider	Disagree	We believe in person interviews are invaluable.
ACCME member organization		We agree with eliminating the survey interview conducted on-site. However, it is not clear how would the abstract, the way it is designed, would facilitate the process for the provider. It would still require, as it should, copies of documents to ensure compliance but it would now require more narrative that would be open to interpretation as opposed to original documentation. The AMA Council on Medical Education appreciates the opportunity to provide comments to the ACCME and commend you on this effort to streamline the Criteria. As noted, we are supportive of the majority of the changes proposed and of the process. In addition, we have provided some constructive comments expressing concerns about a few changes and providing suggestions that we believe will contribute to the quality of CME activities that carry our credit.

COUNCIL OF MEDICAL SPECIALTY SOCIETIES

COMMITTED TO EXCELLENCE IN PROFESSIONALISM, EDUCATION AND QUALITY OF CARE

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February 3, 2014

Murray Kopelow, MD, MS (Comm), FRCPC
Chief Executive Officer
Accreditation Council for Continuing Medical Education
515 North State Street, Suite 1801
Chicago, IL 60654

Dear Dr. Kopelow:

The Council of Medical Specialty Societies (CMSS), with 39 Member Societies representing 750,000 physicians in the US, is pleased to comment on the ACCME's "Proposal for Simplifying and Evolving the Accreditation Requirements and Process."

CMSS supports efforts on the part of ACCME to simplify and evolve the accreditation requirements

In general, we find most of the proposed changes to make sense and be supportable.

On behalf of many of our member societies, we would like to share a few specific comments:

- This organizational framework rule seems valuable; we are unclear as to why it should be removed. We recommend the following change: "The accredited provider must invest in continually improving their organizational…"

- Rules for Internet CME and Regularly Scheduled Series should relate to the format in which they are being offered (Live, Enduring, etc.). We still recognize value in communicating all information to learners prior to the beginning of an activity, and including information such as faculty and credentials, estimated time to complete, dates of original release and update, date credit expires, and copyright. We support the removal of "media used" and "method of participation in learning process" for enduring materials.

- We recommend adding clarification regarding how a provider can demonstrate compliance with these policies if retaining the activity is cost prohibitive.

- How do we demonstrate compliance for our educational design in 25 words or less?

- Using MS Word for Conflict Of Interest reporting is not ideal.

- The validity of self-regulation may be threatened by a review of only 15 activities only every 4-6 years and only at 25 words per less per criteria. This may be over-reliant on the self-study report, which is (by title) a narrative self-assessment. The process of validation is critical and should be de-emphasized with great caution.

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- Consider a criterion that allows the provider to demonstrate an impact on population health. CME has the opportunity to play a significant role in the current changes in the structure and provision of healthcare (Accountable Care Organizations, Patient Centered Medical Homes, etc.). CME providers should be recognized for impact on population health. This criterion could include participation in the development of practice standards or guidelines that contribute to quality patient care.

- Consider a criterion that allows providers to demonstrate efforts to integrate systems change while working with diverse audiences and/or practice settings. Systems-based practice and professionalism are physician attributes critical to best practices and quality patient care in the evolving healthcare arena.

- Consider a criterion that allows providers to demonstrate CME that is patient-centered and promotes patient-centered care.

Corporate Logos

The issue of the use of corporate logos is a complex one. Corporate logos are clearly associated with the company providing the support. That's both bad and good news. If the ACCME's intent is to decrease the appearance of a relationship between the commercial supporter and the CME activity, then prohibiting the use of corporate logos may make sense. If the priority, however, is clearly communicating to learners that the event has received commercial support, then prohibiting the use of corporate logos may be counterproductive. Identifying corporate supporters in regular type font may very well get lost in the administrivia associated with announcements of CME activities, and thus be functionally invisible to learners. Learners look for the corporate logos to see if there is commercial support.

CMSS values open and transparent disclosure. Given the binary options between corporate logos or not, we recommend that open and transparent disclosure to learners of the corporate support is best achieved by including corporate logos which will be immediately recognizable by learners. At the same time, we agree with prohibiting corporate slogans, product group message, tag lines, trade name, areas of therapeutic focus, or any other message which appears promotional on the part of the company.

Finally, there is the issue of timing. ACCME has been successful in obtaining national recognition for the Standards for Commercial Support, particularly by CMS through the new Open Payments program, the current iteration of the Physician Payments Sunshine Act. As the Open Payments program is in its first year, now is not the time to make any changes in this critical set of standards which have been adopted *as is* by CMS. It is not time to threaten the whole by tinkering with a part. It's just too risky right now.

We strongly recommend not changing the CME community's self-regulatory standards right now, which could put the standards and the CME community at risk in the current political environment.

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As a founding Member of ACCME, CMSS is pleased to provide these comments on the ACCME's proposal for simplification and evolution of the system of accreditation of continuing medical education. For the most part, with the comments above, we find these suggestions to be well-thought out and appropriate.

Sincerely,

Norman Kahn MD

Norman Kahn, MD
Executive Vice President & CEO

The Society for Academic Continuing Medical Education
www.sacme.org

January 31, 2014

Accreditation Council for CME
515 N. State Street, Suite 1801
Chicago, IL 60654

Re. Call for Comment: Simplifying the Accreditation Requirements and Process

Dear ACCME:

The Society for Academic Continuing Medical Education (SACME) welcomes the opportunity to respond to the ACCME's "Call for Comment: Simplifying the Accreditation Requirements and Process." SACME's response is based on a survey of our membership as well as on discussion by our Board of Directors.

SACME wholeheartedly endorses the idea of simplifying the accreditation requirements and process. We believe simplification will benefit everyone and will facilitate accredited CME offices' efforts to apply their resources to enhance the performance of physicians and other healthcare providers, while still ensuring the scientific integrity of CME activities.

We are pleased to inform you that the responses reported from our member survey, as well as those developed in the Board's discussion, reflected overwhelming approval of every item submitted for comment. The responses reached or exceeded 90% on items 1, 2, 3, 6, 7, 8, and 12. The positive response on the rest of the items exceed 80% with the sole exception of item 11 (eliminating the requirement to have on-site initial accreditation interviews), which received approval by 75%.

There were several comments the SACME Board thought should be passed on to the ACCME.

There was a significant minority opinion expressed by some of our members regarding the use of Corporate Logos that we

believe is worthy of your consideration. Their position was as follows:

> The ACCME position should "reflect the principles outlined in the CME Coalition's Responsible Logo Use Guidelines, rather than eliminate ACCME-defined commercial interest logos as outlined in the proposed changes." As another member stated, "When commercial support is acknowledged to participants, greater transparency can be shown by showing the corporate logos, which are recognizable, with size limitations and restraint."

Page Two

There was some concern about the impact of the changes regarding RSS:

> "The ACCME must not merely eliminate requirements for RSSs. It must overtly state how RSSs are to be reviewed as part of reaccreditation. The process of requiring a 'meta-review' of RSSs by providers, with documentation of such a review, made it clear to providers what documentation would be required upon reaccreditation. This process recognized and addressed the burden of having to submit RSS session documents, and providers were able to manage their RSS programs accordingly. In the past two years, ACCME seems to be receding from this commitment and requiring more specific RSS activity and session documentation. Are we returning to those days when every RSS session is fair game for ACCME review upon reaccreditation?"

There were also comments regarding the performance-in-practice files:

> "The ACCME proposed performance-in-practice purports to be an abstract that reduces the paperwork of activity file documentation. However, a significant number of the proposed requirements of the abstract still call for documents to be attached. It is misleading to call this an abstract, when the process requires so many attachments."
>
> "For [the] performance in practice piece, I think that the 15 files reviewed should be spread out over the 4 or 6 year accreditation period… [I]t might be 3-4 files a year and [the provider would] receive feedback about those files. [That]… way providers have a chance to make changes and to improve as they move forward. If a provider has files that are deficient in year 2 or 3, they can still improve their systems in time for their reaccreditation in year 4."

Thank you for your consideration of this feedback from SACME.

Sincerely,

Deborah A. Samuel, MBA, FACEHP
President, Society for Academic CME

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