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MENU STRUCTURE

Please provide comments or questions about the menu structure.	
Organization Description	Comments
ACCME Recognized State Medical Society	It will be important to understand that the value of CME will be weighed competitively with other activities that are now burgeoning on the practice of medicine. The time, effort and resources are clearly finite. We must move forward, and this is clearly an attempt to align the value of CME with that which is deemed useful. Never the less, the practicality that is signaled here is important to know.
ACCME Recognized State Medical Society	I understand these new criteria will reflect the diversity of the CME Communities as a whole; never the less in our individual case, all of our providers' CME's are being managed by physicians in societies. Not much diversity there and the time allotted for CME is compromised by patient care either in the office or hospital. This means that getting them to work with other professionals or even students will provoke resistance from them.
ACCME Recognized State Medical Society	The structure (the proposed criteria, elements and standards) in its current form is more specific to certain provider types. This has the potential to create a tiered provider system with some providers achieving commendation and others not able. It does not allow for acknowledgement of a diverse number of provider types and will reward certain ones who are more resource rich. Specifically, the standard system focused on % of activities will create issues for both large and small providers in meeting the numbers.
ACCME Recognized State Medical Society	Our reviewers provided extensive comments on the inadequacy and deficiency of evidence regarding the methodological process validity, reliability and application practicality we would be pleased to provide. Criteria are not mutually exclusive. No validity, reliability studies that demonstrate “equivalency” of mix “A” of eight criteria with mix “B”. The “menu” approach implies ACCME believes performance at certain levels in individual criteria to be equivalent, but what evidence supports this belief? Many terms are undefined and may be unmeasurable. We have inserted a few specific comments, but object to nearly all criteria on the basis of ambiguity, lack of data, and practicality, including the likelihood of gaming. If the ACCME wants to adopt standards based on numeric measures, it should do field testing and validation on the measures.
ACCME Recognized State Medical Society	Not sure the criteria are for everybody. I can see some providers feeling overwhelmed by the new Accreditation with Commendation structure. Can providers opt out of this section? I believe that was the option when C16-C22 first came out?
ACCME Recognized State Medical Society	The menu structure does reflect the diversity of the CME community but several of the criteria would only apply to certain types of organizations such as academic.

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Organization Description	Comments
ACCME Recognized State Medical Society	The intent of the criteria may be achievable for some of our providers but not with the standards attached. It is unclear whether the “% of activities or the % of learners” represents the % of learners in a given activity or the universe of learners for the entire program. Criteria don’t represent the opportunity for all provider types equally. It appears to be designed for specific types of providers with financial/staff resources such as academic medical centers, large health systems, and medical education companies. We would prefer a system that would allow us to choose any 8 criteria that represent our provider type, allowing us to focus on relevant education that meets the goals and needs of our own organization.
ACCME Recognized State Medical Society	To offer a pathway for all CME provider types to achieve accreditation with commendation, we propose changing the eligibility to demonstrating compliance with at least one commendation criterion from at least two or three categories and one or more in any category to demonstrate compliance with at least five of the commendation criteria.
ACCME Recognized State Medical Society	We believe that the general concepts are useful but suggest that the categories be described in terms that are somewhat less restrictive in scope, being broad enough to include additional criteria that might seem appropriate in the future. We have concerns about the attempt to determine compliance based on the percentage of activities or learners. We believe that the relevance, depth, and potential impact of the initiative should be weighed most heavily and the focus should be on the overall program rather than individual activities. Providers with a very narrow scope, an extremely diverse program, or limited resources may have great difficulty in scaling innovations across all of their activities. In addition, focus on one or a few innovations may produce much more substantial and replicable results, providing a great opportunity for the ACCME to promulgate best practices.
ACCME Recognized State Medical Society	The CME process is too complicated and uses hard-to-understand language which is a problem for individuals who have little to no experience planning activities. In the spirit of simplification, I would suggest eliminating a mission statement/C1 and just require that activities be planned with the objective of improving physician ability, performance or patient outcomes. This would be an opportunity to reword and renumber C1 - 13. ('competence' is confusing; would use 'ability' instead. 'strategy' is also confusing.) C5 should be eliminated. It is done intuitively. C6 should also be eliminated. It is just not needed and adds to the arcane process.
ACCME Recognized State Medical Society	Category #2 - change to 'Addressing Public Health and Healthcare Priorities' (here is a reference to why we suggest the change - 'Healthcare in 2032 - Report from the RWJF Future Symposium'). Change compliance to 8 from any of the categories or have organizations select one from each category and demonstrate compliance with 5 instead of 8. Why eight? What evidence was used to determine this number?
ACCME Recognized State Medical Society	CMS agrees that the criteria is aligned with current health care and system changes, but has concerns about the associated standards as currently written and our CME providers ability to meet them.
ACCME Recognized State Medical Society	Having five groups is convenient for organizational purposes, but there is so much diversity in each group that it might be limiting to require providers to comply with at least one criteria from each group.

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Organization Description	Comments
ACCME Recognized State Medical Society	I'm unsure of the menu. I'm not convinced tha the criteria represents opportunities for all provider types. Also I'm concerned overall by the Standards. Many are 25% of activities. If a provider conducts RSS's this could dramatically change their percentage. If we have providers that conduct say 4 RSS's per year, are they only required to show 1 example. Compared to a provider that have many 50 live activites, they would be required to have at least 12. Would our reviewers have to review all 12 activites?
ACCME Recognized State Medical Society	The criteria seemed to be aimed at institutions with mission statements directed toward changing physician clinical care. It may prove difficult for organizations which aim to provide tools for physician engagement (i.e. leadership, business and communication skills) to meet criteria in all 5 categories.
ACCME Recognized State Medical Society	As many of the criteria appear to be written with larger providers in mind, the menu may be achievable if providers have the ability to choose the eight criteria that most closely relates to their provider type in an effort to continue to provide relevant education to their own learners.
ACCME-accredited provider	There should not be a requirement that a provider demonstrate compliance with at least one criteria from EACH of the FIVE categories. The breadth of this requirement far exceeds most provider capabilities. The ACCME should develop a simple, straightforward yet challenging requirement relative to the number of categories and the number of criteria overall. The current menu structure is excessive and overly arduous.
ACCME-accredited provider	I believe the menu structure COULD fulfill this purpose, but I was under the impression that ACCME's Criteria for Commendation would have an enhanced focus on Interprofessional Education. I am not sure if the criteria as written enhance that focus.
ACCME-accredited provider	Different providers may not be able to be compliant with each category. Would prefer to be able to select 8 criteria with no requirement for number of categories that have to be represented.
ACCME-accredited provider	The way you describe how to demonstrate compliance in items 1 and 2 above is confusing. I would suggest saying 'Demonstrate compliance with at least eight of the commendation criteria (C23-C38), including at least one item from each of the five categories.'
ACCME-accredited provider	I think the menu provides too many choices and the need to show that such large percentages of provider's activities meet each criteria is unrealistic.
ACCME-accredited provider	The menu structure provides broad categories covering essential lifelong learning categories and is flexible in how programs can meet the standards within each category.
ACCME-accredited provider	Generally I understand the intent of the menu and it seems that if fulfills the intention. I am a bit concerned that under Addressing Public Health Priorities there are only two options. I'm wondering if there is a third option that can be provided. All the other menu items have at least three options, especially if you're going to have to do more than one item under some of the menu options.
ACCME-accredited provider	I like the menu structure, but if the purpose of the menu structure is to 'create flexibility,' then having a category with only two options (addressing public health) does not allow for very much flexibility.

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ACCME-accredited provider	Yes, the Menu Structure section of the Overview states this; still not clear on what the percentages in the Standard column mean.
ACCME-accredited provider	Given the variety of CME providers it makes sense to have a menu of criteria and choices for compliance within those categories, rather than one given set of criteria to which everyone has to comply.
ACCME-accredited provider	I think the expectations are clear and since only 8 of 16 are required it is fairly flexible.
ACCME-accredited provider	Yes we believe that it does, however these new criteria will require more resources from our very lean/mean office. I believe this will be a concern from many organizations.
ACCME-accredited provider	Two reasons led me to check 'no': 1) A certain percentage or number of activities required to demonstrate compliance. Our program records a large number of RSS activities and makes them available as internet enduring materials. Because we have to count each of these as an individual internet enduring activity (as opposed to the face-to-face RSS counting as one activity), our numbers are artificially high. I believe the required numbers would also artificially limit programs that produce a smaller number of activities. 2) There does not seem to be an equal opportunity to meet one of the criteria for each category (i.e. there are only two choices to meet 'addressing public health priorities').
ACCME-accredited provider	While I like the menu structure concept, I don't know that the delivery as currently proposed is achievable by all provider types & sizes. I feel there are several categories where providers of all types & sizes will be unable to either demonstrate compliance within at least 1 item from each category or achieve compliance within all 8 categories. 25% threshold for many of the proposed criteria would be very difficult to achieve for large programs. I'm concerned reporting might be impacted (i.e., people might report a RSS as a course in order to have the event help meet the % threshold).
ACCME-accredited provider	- What is of concern for the proposed criteria is having 10% to at least 25% of our activities hosted to meet these standards. This % marker is good in theory, but presents problems by: 1) having influence on the design of programs based on goals vs. true
ACCME-accredited provider	Theoretically, the menu structure should accomplish what is outlined. In reality, however, we are concerned about its ability to reflect the diversity of the CME community (specifically our academic medical center) which will be detailed further in the criterion outlines.
ACCME-accredited provider	The menu structure shows flexibility toward emerging trends in excellence of education and responsiveness to various organization types and their strengths. Very good job!
ACCME-accredited provider	I have a question about C33 - Does this speak to the education and training of the CME leaders, planners and committee members. Would attending ACCME workshops meet this one criteria?
ACCME-accredited provider	These concepts will take a while for planners to incorporate into the planning process. They should be applied only to the year prior to evaluation for accreditation.
ACCME-accredited provider	I believe that the menu structure will support the use of best practices in every area of CME

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ACCME-accredited provider	I suggest reconsideration of the requirement for at least one commendation criteria from each of the five categories because of the limited number of criteria in some categories and because some categories may not be applicable in every organization, Please consider as an alternative: Demonstrate compliance with at least eight of the commendation criteria selected from a minimum of three categories.
ACCME-accredited provider	Yes the menu structure goes a long way towards meeting this goal. However, it is still weighted heavily toward providers that work within a healthcare provider system. In general, I think this bias could be reduced by including more 'OR' and less 'AND' statements under the Critical Elements and perhaps reducing the The Standards for some. For example, C23 and C25 this is an important element that we would like to move towards and would be achievable if Critical Elements listed were 'OR'.
ACCME-accredited provider	The concept of a Menu structure is reasonable. However, as noted in subsequent comments on the individual proposed criteria, there are a number of categories where I do not believe that all types and sizes of providers will have a real opportunity of 1) demonstrating compliance with one item in each category, and 2) achieving compliance with a total of 8 categories.
ACCME-accredited provider	The categories overlap somewhat. Descriptively they seem clear.
ACCME-accredited provider	The general concepts are useful but we suggest the categories be described in less restrictive terms, broad enough to accommodate additional criteria that may emerge in the future. Suggested language: <ul style="list-style-type: none"> - “Engagement of Key Stakeholders in the Design and Delivery of CME Activities”, rather than “Inclusive Teaching and Learning”. - “Engagement with Systems of Care and Populations” rather than “Addressing Public Health Priorities”. - “Advancing Professional Competency and Performance” rather than “Creating Behavioral Change”. - “Engagement of the CME Unit with Key Constituencies” rather than “Demonstrating Leadership”. - “Advancing the Outcomes of the CME Program” rather than “Achieving Outcomes”.
ACCME-accredited provider	The menu structure is helpful, with concise statements of the rationale for each criterion.
ACCME-accredited provider	It gives several choices of compliance 1 out of 5 and 8 out of 15
ACCME-accredited provider	Concern remains about the intensity of this process.
ACCME-accredited provider	Some CME is provided by organizations that are, intentionally, PHYSICIAN centric and only intend to offer that type of education. That doesn't make it bad or wrong. They would be excluded from the first section, C 23, 24, 25. It should not disqualify them from Commendation.
ACCME-accredited provider	The intent of these criteria is good. However, the living (or restriction) to working with 'healthcare organizations' is not appropriate. Many professional Societies and CME providers work with other Organizations that are not Healthcare organizations or providers per se. These DO impact learning and outcomes, but there is no mechanism to allow or account for these interactions. Also of note, many organizations do not have direct access to patient care or health care data at the institution, personal or higher level. The regs exclude providers in many categories.

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Organization Description	Comments
ACCME-accredited provider	The Commendation status should be achieved only by a minority of providers. If this is structured so that it is something that can (should) be achievable by all providers, then that's resetting the bar for Accreditation status overall and a new bar should be set for the Commendation status (maybe achieving a greater number of criteria from this menu, or achieving metrics at a higher level?)
ACCME-accredited provider	While the proposed menu approach fulfills this purpose, the ability to meet the thresholds set for Commendation within this proposed structure (particularly 1 from each category) may be limiting for many provider types. While we understand that the intent is to elevate the education being delivered within the CME system, depending on the missions and resources of the providers you may find that many will feel pressured to do things simply to check off a box for Commendation.
ACCME-accredited provider	The menu seems to provide enough different options, so that organizations can achieve Accreditation with Commendation. I was concerned that member organizations might not be able to attain Accreditation with Commendation because they do not have access to patient outcomes, but that does not seem to be the case. The proof will be when it is implemented. I hope we have an opportunity to comment once the first group under the new system has completed a self study.
ACCME-accredited provider	Although the structure fulfills its purpose in terms of providing more options, The Standards for the criteria may make it difficult, if not impossible, for some providers to achieve commendation. This is because of the numbers and types of activities that these providers offer.
ACCME-accredited provider	Several of the categories have very limited options for many providers with standards (% of activities) that may lead to inappropriate application of certain strategies to activities in order to meet the 10 % of 25 % threshold.
ACCME-accredited provider	These categories of criteria are appropriate to the goals of our CME program and our role as provider.
ACCME-accredited provider	I am in favor of the categories that have been created, and having to meet at least one from each category. The thresholds of 10% or 25% for some of the criteria will make it impossible for my organization, and probably many others, to be able to meet compliance.
ACCME-accredited provider	While the menu structure does fulfill this purpose we do feel that it would be very difficult for us to allocate the resources that would be required to accomplish 8 of the commendation criteria and at least one of each commendation criteria. Some of these categories would be very difficult for us to do anything in. Medical schools and/or closed hospitals systems seem better equipped to accomplish the criteria in a few of the categories.
ACCME-accredited provider	The menu structure does not offer a pathway for small CME providers to achieve commendation. We do not believe that small organizations like ours will have the human or financial resources to allocate to fulfilling some of these criteria. It is highly unlikely that our organization would be able to meet any of the benchmarks for the criteria 32-38. At the standards currently outlined, it would be an enormous gamble to invest the resources in one of these criteria only to fall short of the benchmark.
ACCME-accredited provider	For small specialty medical societies, the menu structure would be difficult to achieve. We propose demonstrating compliance in at least 8 criteria from 'any' of the categories, and not designating from 'each' of the five categories.

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Organization Description	Comments
ACCME-accredited provider	Specialty societies are at a marked disadvantage when criteria suggest a need for access to EHR or patient health data or to assess a provider's performance in practice. While we recognize the value of these types of activities it is also important that the commendation criteria be applicable to all provider types to provide an equal opportunity for all providers to pursue commendation. We encourage efforts to offer a balanced menu of criteria that provides equal opportunities for CME providers of all types to achieve commendation. It is also difficult to determine exactly how these criteria will be measured. In general, if an organization has a high volume of activities (maybe online CME/enduring materials), it really could affect the ability to meet some of the thresholds.
ACCME-accredited provider	To be eligible to achieve Accreditation with Commendation, an accredited CME provider will need to demonstrate compliance with existing core Accreditation Criteria 1–13, and: 1. Demonstrate compliance with at least one criterion from each of the five categories and 2. Demonstrate compliance with at least eight of the criteria Does this mean that providers need to meet eight total criteria or 13 total criteria? The wording is unclear.
ACCME-accredited provider	1. We approval of the new menu structure. We approval of the option to select 8 criteria that work best for the organization. 2. Overall, we believe that the standards will be impossible for our specialty society to meet. There will be too many costs/resources required and too few benefits associated with implementing these criteria at the levels/quantity required. 3. It is not clear if each accreditation criterion applies to the entire activity or if it would be possible to include elements from multiple activities – i.e. During our annual meeting’s keynote, the topic is related to addressing and improving public health (C27), we have a workshop to develop technical and procedural skills (C29) and we have a half-day session on health informatics (C26). Would this one activity be counted towards three criteria’s compliance? Or would the entire annual meeting only be eligible for one of the criteria?
ACCME-accredited provider	We strongly recommended the achieving outcomes section be modified to allow providers to demonstrate an effort to reach higher level outcomes consistent with their access to data. The current health care delivery system severely limits medical specialty societies’ ability to access data, such as that from EHRs and CDRs, which would support this level of measurement. Additionally, the arbitrary measurement standards (the percentage numbers) create a barrier in the proposed menu structure achieving its purpose in making Accreditation with Commendation achievable for all CME provider types.

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Organization Description	Comments
ACCME-accredited provider	<p>The criteria reflect a major shift from what organizations are achieving and instead focus on what CME activities are achieving. Would a provider have to demonstrate compliance only through certified CME activities instead of/in addition to non-certified CME activities?</p> <p>Compliance may require significant changes. A long-term, phase-in plan would assist providers in evolving CME programs as needed.</p> <p>A menu should provide equal opportunities for all provider types to achieve commendation; specialty societies are at a disadvantage when criteria suggest a need for access to EHR/patient health data.</p> <p>There are inconsistencies in the Critical Elements in the use of 'and,' 'or,' and 'and/or;' suggest using "or." 'Team-based evaluation,' 'patients/public representatives,' and 'health professions' students' require clear descriptions.</p> <p>Could providers document compliance with more than 8 criteria?</p>
ACCME-accredited provider	<p>The menu structure does not create flexibility in that the requirement that a criterion from each category must be compliant does not take into account that not all ACCME providers are the same (eg, medical subspecialty society, hospital based, education companies). The resources and capabilities of these providers vary greatly leading to bias as to what providers will be able to achieve commendation. A less bias approach and one that would truly reward an organization's efforts to go beyond criteria 1-13 would be to allow the organization to choose which of the 16 criteria they excel at and have a minimum of criteria needed for commendation.</p>
ACCME-accredited provider	<p>I believe it is getting more difficult to achieve all this critical elements. We will try our best as a group but we probably need your help to implement this and probably your expertise and guidance. We may need a sample of how you achieve these critical items in 1 year with meeting schedules for these 16 cores.</p>
ACCME-accredited provider	<p>The ACR has reviewed the proposed changes, and in addition, we contributed to and agree with the input you will receive from the Council of Medical Specialty Societies (CMSS). We have included our own perspectives on the proposed new criteria for Accreditation with Commendation in this comment section. Thank you for considering our input as you draft a response for the entire CME community.</p>
ACCME-accredited provider	<p>The menu structure is impressive. Demonstrating compliance in every category is not inclusive of possibilities for all voluntary physician membership organizations to be able to meet compliance.</p>
ACCME-accredited provider	<p>The menu structure has two significant flaws. First, while the requirement to comply with 8 of 16 criteria is fair, the requirement to comply with at least one criterion in each category is restrictive and could exclude providers doing commendable work. Second, the "Addressing Public Health Priorities" category has only two criteria, dictating that only providers that present CME in the areas of health informatics, the use of practice data, and public health concerns are eligible for commendation. The mechanism would be fairer if it allowed providers to demonstrate compliance with any 8 of the 16 criteria. As proposed, the menu structure is unreasonably restrictive and will exclude otherwise exceptional providers from achieving Accreditation with Commendation.</p>

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Organization Description	Comments
ACCME-accredited provider	The menu structure does offer options, however the proposed criteria within the menu may not be achievable for all providers. Specifically for medical societies by now allowing us to refer to activities outside of the CME program, but the within the organization, we are extremely limited in providing evidence of our work.
ACCME-accredited provider	Although the proposed criteria are worthy, several criteria particularly relating to the demonstration of healthcare improvements in patients and communities would require outcome data. Outcome data requires significant financial resources and infrastructure and is beyond the budgetary restraints of small organizations and facilities. Additionally, outcome data on behavior modification and learning processes through education of medical students, fellows or residents specific to a given organization would require resources and funding also outside of the budgets of smaller organizations. Additionally, behavior modification and demonstration of process changes occurs at multiple levels over time. Attempting to demonstrate these as the result of a single activity may not be possible at all or would require significant long term analysis. Additionally, we are requesting that the number of criteria required be reduced to not more than 5 with not more than one criteria in each category.
ACCME-accredited provider	While we can appreciate the need to measure learners, the percentages indicated as the standard may be unachievable for some. CME providers make every effort to engage learners in their own changes in competence and performance, ultimately leading to patient outcomes, but it is not a mandatory requirement for learners to participate in evaluation and assessment. While some CME providers can tie performance improvement to board certification, not all member boards have such requirements. We recommend that the current standards of measurement be removed as some providers will have an unfair advantage based on their learning setting or learner type. There seems to be the expectation that all CME providers have the same resources and learners. Once in each year of term is more achievable than a percentage of learners, activities, or programs. It is not reasonable to meet all “critical elements” to achieve accreditation with commendation.
ACCME-accredited provider	specialty societies seem to be at a disadvantage with this set of criteria. suggest retaining the current set as an additional menu category Some of the present 16–22 criteria are valuable to advance medical education, and I would recommend adding 16, 19, and 21 to the menu in another section that could substitute for one of the five required sections – I would recommend making the definitions of these three criteria specific to their original meaning and less interpretative. The original set of criteria had no standard or critical elements or even definitions, and these were too freely interpreted.
ACCME-accredited provider	Some of the criteria would be difficult for a physician membership organization to fulfill, which would neither reflect the diversity of the CME community nor offer a pathway for all CME provider types to achieve Accreditation with Commendation.
ACCME-accredited provider	AMIA is in agreement with the CMSS response sent on 2/15/2016. In general we support the menu structure as defined by the ACCME. However, we share the concerns detailed by the CMSS.

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Organization Description	Comments
ACCME-accredited provider	The criteria proposed have laudable goals and expand the reach of CME beyond the traditional concepts. Overall, we find some the proposed commendation criteria to be relevant for academic medical centers but somewhat impractical for medical professional societies. However, it would be helpful for ACCME to provide some realistic examples of the implementation of the critical elements; particularly ways these could be demonstrated across the diverse types of CME providers including medical professional societies. Must an entire activity's focus and content be based on the content outlined in the criteria, or can a portion of the activity be sufficient to meet the standard? The proposed numerical thresholds of many of the standards (?10%, ?25%) are unrealistic for CME providers offering extensive online/on-demand learning since the criteria and critical elements are applicable to live activities rather than to enduring activities, which are the principal modality of some medical professio
ACCME-accredited provider	It is clear that the proposed menu structure is intended to promote best practices, and create flexibility. However, in its current form it does not adequately reflect the diversity of the CME community or offer comparable pathways for all CME provider types to achieve Accreditation with Commendation. Our organization has sent substantive recommendations and explanations in a letter to Dr. McMahon.
ACCME-accredited provider	The proposed criteria and rationale support implementation of best practices in pedagogy, engagement, evaluation, change management and meaningful outcomes. The menu gives consideration to the diversity of organizations providing CME, and offers sufficient opportunities to achieve AWC even with organizational bylaws that may restrict expenditure of education funds to specific member-type or specialty. However, the requirements of the Critical Elements and 'The Standard' may exclude highly qualified and motivated providers. A consideration to replace AND with OR in C23-25 (and others) and a % reduction may be more appropriate.
ACCME-accredited provider	We are concerned that this new system is overly complicated and prescriptive in ways that will not improve the quality of the educational experience or learning while at the same time unnecessarily disadvantage organizations like ours which have a broader mission than simply delivering CME programs.
ACCME-accredited provider	I am constrained by previous commentaries of the Macy Foundation, Steven Nissen's observations (JAMA, 5/15/15 p1813-8114), my own critiques over the years, plus a big etcetera. Limits are imposed within the confines of the menu structure which may be clarified in ensuing notes.
ACCME-accredited provider	If I'm understanding correctly, you will need to show compliance with 2 criterion in 3 of the 5 categories and 1 of the criterion in the other 2 categories. But each provider gets to choose which criterion they will focus on for compliance.
ACCME-accredited provider	Excellent. The intention to not choose all of the criteriae allows for positive deviance to occur. This allows for providers to test a few concepts that may reveal a 'new way' of doing things. In this way ACCME encourages new thinking.
ACCME-accredited provider	Not all organization types can achieve much of these criteria. The resources are not available to them, or they are too small to achieve compliance. I fully agree with the notion that achieving Commendation should be difficult, but on equal playing fields. Suggestion would be to develop different 'sets' of criteria for each sector.

Call for Comment Responses: Proposal for a Menu of New Criteria for Accreditation with Commendation

Please provide comments or questions about the menu structure.	
Organization Description	Comments
ACCME-accredited provider	There are many criteria that as a stand alone Medical Malpractice Insurance and risk management education Company that we cannot do. We do not have access to patient outcome data at all and we cannot request it from clients due to the potential for discovery if there were a malpractice case.
ACCME-accredited provider	While the menu structure fulfills the purpose of the ACCME's aims, there are some biases in the five categories that will support/hinder some organizations' ability to meet the criteria. Also, in an effort to maintain accreditation with commendation for the inclusive teaching and learning criterion, some accredited providers may be forced to water-down some of their learning materials or to incur significantly higher costs of including a diverse group of professionals in 25% or more of their activities. Other organizations that do not have direct access to employing clinicians or do not offer health care services, must partner with willing health systems. This is not always possible when many also have CME accreditation.
ACCME-accredited provider	Requiring at least one criterion from each of the five categories does not reflect the diversity of the CME community, nor offer a pathway for all CME provider types to achieve commendation. Suggest compliance in 3 of the 5 categories, and at least 6 criteria. Some categories cannot realistically be done by some provider types, resulting in contrived situations rather than best practices.
ACCME-accredited provider	The categories are designed to capitalize on the incumbent strengths of two provider types - Schools of Medicine and Hospital/Health Systems. All other provider types are at a resource disadvantage to meet the criteria. If the ACCME is truly advocating for ALL provider types, the barriers to entry should be equal. All providers should not be penalized due to required resources to achieve Commendation status. The ACPE built a rubric; I suggest that mechanism versus the menu concept. Other recommendations: add another category 'Active Engagement with CE/CPD Enterprise', and change the number of criteria to meet commendation to six. Like selecting a meal, one shouldn't be required to eat everything on one's plate.
ACCME-accredited provider	Could simplify the wording of number 1 and 2.
ACCME-accredited provider	I think that the 5 categories provide flexibility and structure for accredited providers that allows for different types of organizations to meet these criteria. It seems reasonable to have representations from each of the 5 categories and then the provider can focus on one particular area as needed. In general, I support the new commendation criteria and think that they can provide more substantive data regarding the work by providers in their constituent areas.
ACCME-accredited provider	You may want to provide a criteria count for each category, such as: Inclusive Teaching and Learning: 3 criteria - 23, 24, 25 Addressing Public Health Priorities: 2 criteria: 26, 27 Etc....
ACCME-accredited provider	Menu structure is fine.

Call for Comment Responses: Proposal for a Menu of New Criteria for Accreditation with Commendation

Please provide comments or questions about the menu structure.	
Organization Description	Comments
ACCME-accredited provider	I believe the ACCME should be applauded for having and promoting this broad vision of the potential strategic value of accredited CME for advancing and improving physician performance, quality of care, and health outcomes. Overall, the proposed criteria help fulfill this purpose. However, given the diversity of our accredited providers and their different missions (e.g. a medical center vs a publishing company), I am concerned that not all will be in a position to achieve Accreditation with Commendation as not all menu categories will apply to all. We should celebrate this diversity of Accredited providers and appreciate that not all can do it all.
ACCME-accredited provider	Although many schools of medicine may be able to achieve these criteria, I feel that many other types of providers will not be able to. Access to QI data is challenging and many institutions who hold this data will not share it with others so collaborating to get access to this data is frequently not possible. Additionally, having to track percentages of programs meeting a minimum of 8 of these criteria will be difficult. Most likely we will need to track all 16.
ACCME-accredited provider	It allows the extra flexibility of determining how an accredited provider can be a best practice instead of a cookie cutter approach that requires each provider to demonstrate the same criteria even though many of our providers are achieving commendation but not necessarily in the old 'mold'.
ACCME-accredited provider	The need to touch on multiple areas, if only in one criteria coupled with the proposed metrics makes this not only challenging, but cumbersome, and potentially requires a provider to be a jack-of-all trades.
ACCME-accredited provider	Accreditation with Commendation ought to be a high standard. It ought to be bestowed rarely and not a common occurrence. The requirement for a certain standard (percentage) is a great step forward. Having one example of compliance is not necessarily representative of an entire CME program. Requiring a minimum percentage of overall program requirements further aligns CME with the healthcare industry we aim to support. As those engaged in lifelong learning, CME Professionals must too engage in continuous professional development. We must become an integral part of healthcare system and the achieving outcomes criteria aid in supporting that. Criteria 23-38 overall are clear as written. Some of the criteria are more challenging and may be problematic to achieve, such as C24 or C25. This includes achieving the required standard of percentage of learners and/or activities. At an institutional level, it is feasible complying with the new criteria.
ACCME-accredited provider	The concept of the menu is good but we believe that the heading descriptors should be edited as follows: Engagement of Key Stakeholders in the Design and Delivery of CME Activities, Engagemnt with Systems of Care and Populations, Advancing Professional Competency and Performance, Engagement of the CME Unit with Key Constituencies, and Advancing the Medical education Outcomes of the CME Program. In addition we suggest that providers be permitted to select 8 criteria from across the categories in order to allow them to choose those areas that are most relevant to their mission.
ACCME-accredited provider	My comments refer to the column labeled 'The Standard.' What is the basis for the proportion of activities required to meet the standard? I don't know that applying these 'standards' will best serve the purpose desired.
ACCME-accredited provider	I think the proposal requires too many categories and elements.

Call for Comment Responses: Proposal for a Menu of New Criteria for Accreditation with Commendation

Please provide comments or questions about the menu structure.	
Organization Description	Comments
ACCME-accredited provider	Attempts to be overly comprehensive and possibly at a cost to actual CME/education process; incredible effort will now be focused on 'did we meet' criteria details for inclusion.
ACCME-accredited provider	The wording is not easy to understand. How about the following: Demonstrate compliance with at least eight of the criteria, with at least one criterion from each of the five categories
ACCME-accredited provider	Although I like the idea of a menu and the options do create flexibility, the minimum standards for compliance (10%, 25% or the equivalent learners) would be extremely difficult for us to manage. Our program had over 400 activities last year including 100 RSS and we've received commendation since 2000. I consider our program to be well-rounded in regard to the 5 categories. I could provide several, and in some cases, many examples meeting each of the criteria 23 - 38, but I seriously doubt I could provide 100 examples to meet the 25% thresholds or 40 to meet the 10% thresholds. So that is the only reason I'm giving this proposal in its current form a thumbs down. Commendation is very important to us, and we are hopeful these minimum standards can be re-visited.
ACCME-accredited provider	Will be very challenging to achieve Accreditation with Commendation if required to demonstrate compliance with all 5 categories. Additional CME staff will be required to help achieve this goal. It is difficult to get approval for more staff when budgets are so tight.
ACCME-accredited provider	The menu structure is sensible and can offer a pathway for all CME provider types to achieve Accreditation with Commendation however, the program size and scope of many providers could be a barrier to their ability to actually achieve. I also believe that the percentage based standards are too rigorous for example, calling for >25% of activities and/or learners or >10% of activities and/or learners. Too many CME providers do not have the volume of CME activities to meet these standards. Meeting the standards for these new criteria will require a lot more data gathering and analysis to be compliant which will result in increased costs. CME offices are already working hard to comply with the current accreditation criteria (including commendation) with continued staff and budget issues.
ACCME-accredited provider	Shifting the focus from individual learner and medical knowledge toward a more inclusive, team-based process, is increasingly important as we move toward individualized, precision medicine. Addressing Public Health Priorities for greater population impact needs to remain in the forefront as medicine races toward infinitely small. As joint accreditation becomes more prevalent, commendation standards should support practice-based learning. Demonstrating leadership in continuous improvement for the continuing medical education industry allows us to be at the forefront of technology for delivery and methodology instead of constantly responding to and playing catch up with the private sector. The compliance criteria is straightforward and flexible enough to accommodate many different types of providers within the industry.
ACCME-accredited provider	This initiative is bold and very promising. I believe it will help move our field to a position of demonstrating accountability in physician/interprofessional team practice, and population health outcomes. The menu will promote best practices. I am concerned that the menu may not recognize the diversity of the CME community or create the

Call for Comment Responses: Proposal for a Menu of New Criteria for Accreditation with Commendation

Please provide comments or questions about the menu structure.	
Organization Description	Comments
	flexibility you describe above.
Media	C29-- Physicians don't know how to access and retrieve literature, thus have a dangerous knowledge gap. They should get CME every time they reach out to a medical library professional for assistance. C32 is right on target. About time innovation in content delivery is recognized. New criteria overall are excellent!
Other	Yes, the menu structure achieves the stated purpose however the titles of the categories do not always give the full picture; particularly "Inclusive Teaching and Learning."
Other	For the criteria where the provider must attain something once per year, would they need to attain it once every calendar year, or lets say 4 times over a period of 4 years? For the activities where the guidelines require that a certain percent of activities comply with a certain criteria, in the case of RSS, does the percent pertain to a percent of the sessions of a given RSS or to a percent of the series meeting the criteria?
Other	The Continuing Professional development (CPD) Directors of the Council of Medical Specialty Societies (CMSS) has quite a few comments, so we will submit them by letter (more than 125 words!).
Other	We consider that the 5 categories outlined in this proposal are too focused on health care institutions/systems and not on the other provider types. We would also suggest the addition of another category 'Active engagement in the CME enterprise' eg., ACEhp member, CHCP members, CME Palooza presenters, publications etc. Due to the above comment, we also think that the need to demonstrate compliance with at least one from each of the 5 (6) would be a huge burden for organizations other than health care institutions/systems. We also do not understand the need to move from the current demonstration of compliance in 6 criteria to 8; this just adds to the burden on each provider. Therefore, we would support keeping this at 6. How will the ACCME provide adequate training for these new criteria?
Physician/healthcare professional	The menu structure is well-designed, and does fulfill the purpose of promoting best practices, with flexibility. The only issue it does NOT address is Joint Accreditation with Commendation. It seems strange that ACCME would offer Commendation to providers for including Inter-professional approaches to CME planning, yet not offer a path to Commendation for providers who have gone to the next level of IPE by obtaining Joint Accreditation status.
Physician/healthcare professional	Not clear regarding Accreditation criteria 1-13
Physician/healthcare professional	While this may be highly subjective, and while creatively interpreting the Inclusiveness and Public Health categories (23-27) and to a lesser degree 28-31, I feel that these sections are lofty. Perhaps so lofty as to be only tangentially associated with real, continuing medical education, and highly dependent on having an academic affiliation to aid in this. Additionally, the Public Health Priorities seem better suited to larger, academic institutions and may require a virtual paradigm shift to achieve. I sense a disconnect between ACCME and practicing physicians.

Call for Comment Responses: Proposal for a Menu of New Criteria for Accreditation with Commendation

Please provide comments or questions about the menu structure.	
Organization Description	Comments
Physician/healthcare professional	The additional criteria are neither necessary nor sufficient to provide high quality, clinically useful, patient-benefitting CME at our hospital. Instead, they add to the burden of providing CME, in an era of great fiscal constraint by community hospitals, including ours. Since CME makes no money for the hospital, our CME staff is all but gone. Your additional criteria, may indeed be the straw that breaks the camel's back. As the physician coordinator of cardiovascular CME at our hospital for the last 15 years, I can assure you, this will be a detriment to CME, not an improvement.
Physician/healthcare professional	I feel that this is extremely cumbersome for small rural hospitals. Inclusive teaching and learning, and addressing public health priorities reasonable expectation, leadership is also reasonable. But, creating behavioral change and demonstrating achievable outcomes is far more difficult to accomplish. Collecting data from community physician is extremely difficult, but necessary to be able to complete the menu structure. This is especially difficult as most community physicians no longer work within the hospital system. This methodology is outdated for the current hospitalist program in which we function.
Physician/healthcare professional	will be difficult if not impossible for smaller facilities
Physician/healthcare professional	The menu does not provide enough flexibility to provide CME targeted at educating physicians regarding new material in their fields or about ways to effectively utilize existing medical information. The requirement to fulfill so many different criteria will prevent this from being achieved optimally.
Physician/healthcare professional	The structure is unbelievably complex.
Physician/healthcare professional	not sure this offers a pathway for all cme provider types. seems this will be much easier for large health care groups and system, not so easy for smaller 'CME provider types'
Physician/healthcare professional	Compliance with 1 criterion from each of the 5 categories is sufficient enough for a menu structure. No need to add 'must comply with 8 criteria' from C23-C38.
Physician/healthcare professional	I like the focus on outcomes. Outcomes that have lasting effects on the participants and the programs are evident in the descriptions that accompany the new criteria. This can lead to a more lasting impact than prior focus areas.
State-accredited provider	The menu structure is very helpful, allowing you to pick the categories you think you can achieve.
State-accredited provider	I like the new structure, but am not sure that the standard (> 25%, >10%, etc) is appropriate.
State-accredited provider	What percentage of accredited providers do you anticipate gaining accreditation with commendation?
State-accredited provider	The menu structure makes sense, because education is not a one size fits all enterprise. This allows us to adapt strategies to our individual institutions.
State-accredited provider	It does not offer a 'pathway for all CME provider types to achieve Accreditation with Commendation' because many of the requirements are not possible for small one-person CME offices.
State-accredited provider	Some of the critical elements will be challenging to achieve if you are a smaller entity.
State-accredited provider	I find this to be confusing to physician CME Committee Members. They prefer straight forward concrete requirements.

Call for Comment Responses: Proposal for a Menu of New Criteria for Accreditation with Commendation

Please provide comments or questions about the menu structure.	
Organization Description	Comments
State-accredited provider	Some of the language is too wordy-- but my primary concern is how an institution as small as ours and with a very limited CME program will ever be able to fulfill enough Criteria for Commendation. (Perhaps, that is 'not the end of the world)
State-accredited provider	Some providers may be unable to to demonstrate compliance with at least one commendation criterion from each category. Perhaps consider revising to compliance with 8 commendation criteria from at least 4 of the 5 categories.
State-accredited provider	While I believe that the most recent simplification of Criterion 1-13 was much needed, my opinion on this current menu structure for Commendation is a bit different. It appears where there was simplification in the root of accreditation, however not so for achieving commendations. I feel that 'The Standard' of achieving greater than 25% of activities and/or learners should be removed completely.
State-accredited provider	Please don't put a standard of the percentage of activities that have to follow this. These are new criteria it will take a while to develop these and putting a percentage of how many activities must meet percentages. Also engaging patient representatives? This should not be inclusive in C24, unless what you mean by this is that patients can come to the CME accredited lectures.
State-accredited provider	I don't know if I fully agree with requiring providers to comply with one criterion per category in order to achieve accreditation with commendation.
State-accredited provider	C26 and C27: not sure how we measure public health impact without the data to support the efforts. If a change took place, using data from the health department, etc. it seems that would be extremely difficult to determine what action or activity was the cause for that change. Seems a little too unreachable especially when the organization has limited staffing in the CME department.
State-accredited provider	I do not take issue with the proposed criteria nor with the menu option of one commendation criterion (C23-C38) from each of the five categories, and compliance with at least eight of the commendation criteria (C23-C38).
State-accredited provider	I like the opportunity to choose. However, I disagree with the need to meet one criteria in each category and the minimum standards (ie 10%, 25% etc). Small programs can't do all 5 categories. They would do better education by focusing on 2 or 3 categories and working to meet the required percentages. Better to do less things well than attempt all - and fail. I think this combined one in each category and % will discourage many programs. (I am a surveyor in my state - so I visit many great small programs with .5 to 1.0 FTEs. They will probably not even attempt commendation - which is sad!)
State-accredited provider	The structure does achieve its goal in theory but is much too much too soon. Most small hospitals and many state societies will not be able to comply with such an expansive addition to the commendation criteria. The agenda is a noble one but should be advanced incrementally.

Call for Comment Responses: Proposal for a Menu of New Criteria for Accreditation with Commendation

Please provide comments or questions about the menu structure.	
Organization Description	Comments
State-accredited provider	Inclusive Teaching and Learning - this would not apply to our hospital - we are not a teaching hospital Addressing Public Health Priorities - yes, we try to this already Create Behavioral Change - yes, I agree to the criteria Demonstrating Leadership - this would be hard of our hospital to show criteria Achieving Outcomes - yes, agree with the criteria but feel with is also part of prior criterias.
State-accredited provider	The structure reflects much of what the CME community has been discussing in terms of interprofessional education, reaching out to the community, and facilitating actual change in practice. The requirement of meeting at least one criteria in each of the five categories allow programs to show a larger breadth that may not be showcased otherwise.
State-accredited provider	The categories are hard to understand and may limit innovation across categories. Has there been consideration for a total number rather than 1 from each category.
State-accredited provider	We need to emphasize on how we can utilize the best practices in healthcare development: effective ways to resolve the gap(s) and cause(s) resulting in a successful best practice.
State-accredited provider	I am new to CME and have not been through the survey process yet. I think it is a great idea to have a way to congratulate and praise those organizations that put the effort in to move CME in a forward direction. It is exciting to know that we can be rewarded for great ideas and thinking outside of the box.
State-accredited provider	Many of the criteria are impossible to meet for small CME programs. Requiring one of each category eliminates the capability of small programs to apply.
State-accredited provider	The requirements are great for long term goals but are unrealistic for the current state of CME in most organizations. The resources and the percent of activities do not seem practical in the near future, especially for organizations with multiple accreditations, stand alone healthcare systems, and community hospitals. These criteria require a culture change which takes time to adapt to and to achieve institutional buy-in . A more realistic goal might be to demonstrate achievement of any five criteria options out of at least three categories and have this demonstrated by two examples as opposed to the percent of achievement.
State-accredited provider	The menu standards are confusing and too stringent for small hospital based CME programs. I would need further clarification how my program could meet compliance with the confusing compliance directions. The menu discourages educating physicians and other healthcare providers within their identified gaps in knowledge, competence or performance. This menu would cause programs to only provide educational activities that would meet the needs of the commendation structure. Example C24 requires patients/public representative for the planning of CME activities, however, many times the planning process involves disclosure of protected health information on patients, which would violate HIPAA. Also, C25 disallows hospitals that only have to 3rd and 4th year medical student that rotate through every 4-6 weeks. All of the criteria involve additional reporting and tracking which would cost additional man hours.
State-accredited provider	You should eliminate Criteria 1 - 22 and then start with 23-38 although most of these will not be achievable with the one person CME Office

Call for Comment Responses: Proposal for a Menu of New Criteria for Accreditation with Commendation

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Organization Description	Comments
State-accredited provider	There is a problem with the suggested percentage of activities required to achieve commendation. It seems that to fulfill 8 criteria in total means that >100% of the activities are devoted to these ends. In other words, some activities must fulfill more than 1 criterion, which, in my opinion, having spent many years as DME, is unrealistic.
State-accredited provider	The tight requirement of number of criteria, and some of the criteria themselves will make it almost impossible for small but meritorious providers to achieve commendation. For example, the 'individualized' criteria in design, followup and evaluation of CME will require several full-time employees. The focus on interprofessional (including public/patients/students) diverts the purpose of 'CME' away from physicians. On the other hand, the Interprofessional CE programs excludes RT, PT/OT, SW, and others with a real stake in patient care. For all its lip service to interprofessionalism, the ACCME's constituent groups do NOT include any non-medical associations.
State-accredited provider	While the diversity reflects the ability to promote best practices and reflects the diversity of the CME community, the demonstrated critical elements and standard makes it difficult for all CME provider types to achieve Accreditation with Commendation. Hospital based CME providers offer many types of education focus to meet the diverse needs of physicians and staff the percentage makes it hard to meet the requested percentage. If the percentage were for all the criteria in the category it would allow flexibility to meet the standard. There is also the concern of staffing for hospital-based providers with ACA causing hospitals to cut costs most look at the ancillary staff. CME is considered value-added as most CME departments do not generate revenue that exceeds the costs. Administrations are looking bottom lines and have reduced staffing. Expecting the use of online education to supplement needs. CME staff become managers of compliance versus leaders and partners of change.
State-accredited provider	good structure
State-accredited provider	While the menu structure does favor diversity of programs the eligibility requirements seem to hamper that goal. My opinion is that different organizations have different focus or resources in how they provide CME. I could see an institution being able to meet multiple criterion from a couple of the menus but unless you had a large education staff I think it would be challenging to meet one criterion from each category AND comply with at least eight of the criteria. Why not say 'OR'? I could see some programs meeting all the criterion from several of the categories but depending on the focus of their institution there might be some categories where it would be difficult to meet any of the criteria. I think this would apply particularly to community hospitals or education departments that have multiple duties besides CME.
State-accredited provider	Wording is difficult to follow - need to clarify compliance better.
State-accredited provider	The original iteration of the the proposed criteria in 2014 included 'Multi-Inverventional or Multi-Strategy' learning. I don't see it here in this set, and I think it would be of value to include in the menu options since 'one-and-done' activities are not a hallmark of adult learning. The percent standards associated with each of the criteria might be difficult to reach and/or verify. I would suggest a construct similar to what is used now, wherein the provider is asked to demonstrates process it uses to meet the criteria and then shows a few examples of selected activities.

Call for Comment Responses: Proposal for a Menu of New Criteria for Accreditation with Commendation

Please provide comments or questions about the menu structure.	
Organization Description	Comments
State-accredited provider	<p>This is the 2nd part of my submission for the Call for Comment. In my previous submission, you should have seen written comments for criteria up through and including c32.</p> <p>In general, I like the construct of having a menu, and i like the 5 categories. I also like the fact that the ACCME is trying to move the bar, including to be more specific in terms of the 'Standards' for each criterion. It seems there's a trend to show the criteria in MORE activities than just a couple examples, and I agree that that is the right direction to go. I'm just not sure how the percentages will work out and if they are realistic for all provider types and sizes. Perhaps the goal can be reached incrementally over time, starting with the standard being a number more than 2 activity examples - - unless of course a provider only does 1-2 activities per year.... But i don't think that is commonly the case. On other hand, perhaps I am not understanding how the standard percentages will be demonstrated.</p>
State-accredited provider	The menu structure itself fulfills the purpose, but there are questions throughout the proposal.
State-accredited provider	Menu selection seems varied and touches on important CME criteria, but the standard (% of activities and/or learners) seems unrealistic for many. For example, our AHEC does about 30-40 one time events yearly, and 25% of all our events would be around 7-8 events that must be done on ONE criteria. I don't think that we would have that many in most of the criteria classifications.
State-accredited provider	Have organizations select 1 criteria form each category and demonstrate 5 of the criteria.
State-accredited provider	<p>We need to focus on identifying, creating and promoting best practices for delivering health care, with an initial focus on wellness and the prediction, prevention and management of chronic diseases. To improve quality, reduce errors, and increase patient safety:</p> <p>a) Emergency Severity Guide b) Safety Guide to Patient and Family Engagement in Hospital c) Hopsital Guide to Reducing Medicaid Readmission d) Improving Patient Safety</p>
State-accredited provider	see comment at end.
State-accredited provider	The following comments are from our perspective as an accredited provider that engages in a number of joint providerships with other organizations in our state.
State-accredited provider	While the categories do span the CME Enterprise, certain Providers of CME will have difficulty fulfilling each category. For instance MECCs will have great challenges with the Public Health requirement due to their funding sources. Small community hospitals and state chapter specialty societies will struggle with the outcomes requirements.
State-accredited provider	It does not provide realistic pathway to ALL CME provider types, especially to those with limited resources and small size.
State-accredited provider	The menu structure looks good -- and -- suggests new directions for our organization to add to our CME offerings. I have shared this with our entire organization to encourage everyone to think of new offerings we could add -- new modules or even entirely new programs.

INCLUSIVE TEACHING AND LEARNING

C23: Engages in interprofessional collaborative practice in the planning and delivery of IPCE.

C23: Since you answered 'no', please explain and/or suggest edits.	
Organization Description	Comments
ACCME Recognized State Medical Society	Please define what is meant by 'team-based evaluation'
ACCME Recognized State Medical Society	Unable to assess. Inadequate and/or deficient methodological evidence of validity, reliability and application practicality of process. Details upon request. E.g. lack of evidence this criteria should carry same “weight” as any other and is mainly exclusive of other criteria to avoid double weighting. Applicability and importance depends on nature and scope of provider. Terms needing definition include: “team-based evaluation” with unambiguous method of determining whether it is present. Rationale and evidence for 25% standard, and data source for surveyors to assess compliance. If PARS, evidence information exists in the system; otherwise field test results indicating feasibility of collecting from another source. Additional details on request.
ACCME Recognized State Medical Society	The percentage (>25%) is it per year or per term? Who calculates that? Or verifies that? It will be an issue if that is the responsibility of the surveyors.
ACCME Recognized State Medical Society	Critical Elements: - Better if allowed for this OR that, instead of this AND that. - What do you mean by, 'team-based evaluation?' The Standard: - It is unclear whether the “% of activities or the % of learners” represents the % of learners in a given year of activities or for the entire accreditation term. - ?25% of activities and/or learners – ?25% too high
ACCME Recognized State Medical Society	Define what will qualify as team-based evaluation. The need to meet all of the Critical Elements may be too strict as a starting point. Allow CME providers to meet one OR more initially to allow for a progression to meeting all of the critical elements. In other words, use OR instead of AND in the “Critical Elements” list.
ACCME Recognized State Medical Society	Under “critical elements”, the term “team-based evaluation” will need to be further defined. Does the term “collaboration” refer to external organization only or are internal collaborations acceptable? Many CME committees already involved people from multiple professions so what would the provider have to demonstrate to raise their program to commendation level? Would we expect practice gaps to be identified for each profession’s practitioners?
ACCME Recognized State Medical Society	'highest quality of care' needs to be further defined here as 'based on substantive evidence-based science. Currently there are all kinds of 'professional' music healers, naturopaths, art therapists and others that regard themselves as 'health' professionals. Science is not a belief, but a method. 'Evidence-based' is widely mis-used and starts with a meta-analysis, a critical look at the published studies and the quality of the studies.

Call for Comment Responses: Proposal for a Menu of New Criteria for Accreditation with Commendation

C23: Since you answered 'no', please explain and/or suggest edits.	
Organization Description	Comments
ACCME Recognized State Medical Society	<p>The rationale is somewhat confusing. Please remove the first sentence. This criterion does not involve engaging with patients, families, caregivers, and communities; having it within the first sentence of the rationale is confusing and misleading.</p> <p>Please clarify the definitions for “planners,” and “team-based evaluation.” Is a “planner” a committee member; or is a “planner” an individual involved in the hands-on development of an activity, including identification of gaps, speakers, etc.? IMS reminds ACCME that activities designed to meet this criterion, may be subject to multiple state licensure board requirements, the use of a single evaluation method may be impossible. The standard states, “?25 % of activities and/or learners,” are these unique learners, total learners, learners within specific activities; and over what period, one year, the full accreditation term, etc.?</p>
ACCME Recognized State Medical Society	<p>Revise to: 'Engages inter-professional and non-clinical representatives in the planning and delivery of CME.'</p> <p>We suggested the revision because Risk management, Quality, Pharmacy, Legal, Housekeeping, Chaplains, etc. can play a role in patient outcomes too.</p> <p>The Standard - decrease to 10%.</p> <p>The expansion of the committee might make the activities cumbersome and excessively time consuming for some organizations that focus more on non-clinical topics, but for the most part a good criterion to include.</p> <p>Critical Element - revise to AND/OR at the end of each element listed.</p>
ACCME Recognized State Medical Society	<p>% of the standard is not a good idea; this will be too complicated to calculate. Providing multiple examples should be sufficient for a compliance finding.</p>
ACCME Recognized State Medical Society	<p>'Team-based evaluation' is unclear and needs definition. IPCE is an admirable goal but fails to consider that the practice gap can be varied enough that a unitary CME activity will not be able to satisfy the need. 'Uses faculty from more than one profession' for 25% or more of activities might be challenging for small providers who may need to spend a great amount of time and effort in grooming non-physician, clinical speakers. Non-physician faculty should be encouraged but 25% might be a high bar.</p>
ACCME Recognized State Medical Society	<p>Need clarification on the final critical element “Uses team-based evaluation” – please explain what this means? And need clarification on the standard of 25% of activities or learners. For example, is it 25% of the total of activities from the entire term of accreditation? Or could it be 25% of activities from 1 or 2 years of accreditation? Suggest lowering the percentage greatly</p> <p>or changing it to a range of activities such as 1-3 per year or 5-6 over the term of accreditation. An across the board standard of 25% of activities or learners will be difficult for many providers in our state system to achieve, and messy for accreditors to work with during the survey process. Example, what activities do we select for review?</p>

Call for Comment Responses: Proposal for a Menu of New Criteria for Accreditation with Commendation

C23: Since you answered 'no', please explain and/or suggest edits.	
Organization Description	Comments
ACCME Recognized State Medical Society	The Standard” section of the proposed criteria requiring a percentage of activities and/or learners is too complicated for providers to calculate and for accreditors to enforce/select for review. Requiring a specific number of activities related to length of term is preferred, such as two or three activities for a four year term and four or five activities for a six year term that demonstrate compliance with the specific criterion in question. Also, what is meant by 'Team-based evaluation,' referred to in the Critical Elements?
ACCME Recognized State Medical Society	What is the definition of 'team-based' evaluations? Standard percentage is a concern - see 1st page for details.
ACCME Recognized State Medical Society	What is team-based evaluation? I am not understanding how '% of learners' applies to any of the proposed criterion where % of learners can be the standard. I am not understanding how '% of activities/learners' applies to RSS for any of the proposed criterion.
ACCME Recognized State Medical Society	Does interprofessional mean any level? How separate must the levels be (i.e. would RN and ARNP work or would it need to be RN and Dr.)? Does it include other office staff (e.g. admin, billing)? What if it doesn't change health outcomes (i.e. admin and Dr. dyad working to improve communication), would that not count? Using 'and' in the critical elements may push some legitimately inclusive education out of the running (i.e. faculty is one person, so not inclusive of other professions). Team-based evaluation is unclear; it would be helpful for more instruction. The ?25% of activities 'and/or' learners would be difficult for surveyors to evaluate.
ACCME Recognized State Medical Society	The criterion is not clear as written without further clarification. In general, what is the rationale or benefit of the percentages? Define of terms: effective collaboration/percentage of learners or activities/how to show improvement of health outcomes. The rationale may be achievable by some providers, the use of the word 'AND' in the rationale and critical elements seems unreasonable. Most small providers hold one hour educational activities and the use of faculty from more than one profession would be cumbersome, and in the event that honorariums are paid, would increase the budget of the activity. The Standard percentage will be very difficult for surveyors to assess and may encourage providers to limit their activity offerings in an effort to achieve the percentage threshold. This criteria would be complicated to achieve and/or be meaningful. Seems to be a complicated version of C20.
ACCME-accredited provider	What does team based evaluation mean? How do the critical elements align with the standard for 'learners'?
ACCME-accredited provider	I always think an example is helpful.
ACCME-accredited provider	The Criterion is clearly written, however, the Standard o have to demonstrate it among at least 25% or more of one's activities or learners is too much for smaller programs to achieve.
ACCME-accredited provider	I think their needs to be more clarification around 'team-based evaluation'. Do we need to have questions related specifically to nurses vs physicians, for example? I also think that the standard is too high for this criteria.

Call for Comment Responses: Proposal for a Menu of New Criteria for Accreditation with Commendation

C23: Since you answered 'no', please explain and/or suggest edits.	
Organization Description	Comments
ACCME-accredited provider	Involvement of a medical information professional on the planning committee will ensure that the latest literature from each discipline or group involved is consulted. This involvement will also provide access to recent literature on the most effective teaching methods.
ACCME-accredited provider	'Interprofessional collaborative practice' seems unnecessarily wordy; why not just 'interprofessional collaboration'? I realize that the core competencies in this area use that phrase, but it's still wordy. Also, it would be helpful to write out IPCE in the criterion for clarity.
ACCME-accredited provider	It's not clear because I'm not sure what =or> 25% of activities is supposed to mean. Does it mean we're not to be commended if we go over that amount? Examples of this would be very helpful.
ACCME-accredited provider	Team-based is not defined. Also, examples for types of professionals who might work together on a CME activity might be helpful.
ACCME-accredited provider	I would define 'faculty'. We are an academic institution, but not all CM providers are, so they may not have academic faculty on their committee. What do you mean by 'uses team-based evaluation'? Do you mean the CME advisory team? This is not clear.
ACCME-accredited provider	Clarification is needed on what team based evaluation means
ACCME-accredited provider	The use of 'AND' concerns me and I feel this may make the criterion difficult to achieve. Can someone who is both a planner & faculty count as compliance? If multiple professions are part of the audience, would a planner/faculty member from each profession need to be included to comply? How are learners defined (unique or PARS - currently PARS is not unique learners)? I feel the 25% threshold will be difficult for large programs to meet (i.e., if a provider has >2,000 events in a term, this would be more than 500 events that would have to meet this, which seems difficult to achieve). How is 'team-based evaluation' defined?
ACCME-accredited provider	Clarity is requested on the meaning of 'team evaluation'.
ACCME-accredited provider	Please explain this Critical Element: Uses team-based evaluation The standard for this criterion should be scaled to adjust for the number of activities conducted by an accredited provider. For example, to comply an organization that does ten or fewer activities a year would need two or three activities, while an organization that conducts more than 400 would need at least 100 activities. Neither may be realistic given what the provider has determined to be their mission and expected results, as well as being relevant to their target audience.
ACCME-accredited provider	Include faculty from more than one profession. Does this mean that mean that that the author is other than a MD. What is meant by team based evaluation?
ACCME-accredited provider	Please define team based evaluation? Is annual evaluation of data enough? Does 25% mean25% of the total library or 25% of new courses each year?

Call for Comment Responses: Proposal for a Menu of New Criteria for Accreditation with Commendation

C23: Since you answered 'no', please explain and/or suggest edits.	
Organization Description	Comments
ACCME-accredited provider	For critical elements, does this mean to demonstrate compliance, all 3 must be present in all activities? Use of “AND” makes it appear all 3 are required. 25% criteria will be difficult for both large and small organizations to achieve. Since ACCME counts each activity in a series as an individual activity (and not the series as a whole), those providers who do multiple series where an activity is repeated 15 or 20 times will have an advantage in achieving this, provided the series is interprofessional. Assuming that “AND” in the critical elements means all three elements must be consistently present, while it would be ideal for there to be faculty from multiple professions, logistically and from cost perspective that may not always be realistic.
ACCME-accredited provider	We endorse this criterion; however, under “critical elements”, “team-based evaluation” should be further defined. As noted above, an evaluation standard of >25% of learners/activities will exclude many providers who may indeed be implementing innovative practices. The issue has particular resonance for this criterion, given that many providers who serve >25% interprofessional audiences may have or be seeking joint accreditation. The ACCME should not penalize providers who are committed to interprofessional education but whose programs do not meet structural requirements for joint accreditation.
ACCME-accredited provider	Consider linking the critical elements with 'AND/OR' instead of 'AND'. Many factors impinge on faculty selection, some outside our control.
ACCME-accredited provider	If you are a professional society of nurses, for example, your target audience is nurses--planners and faculty from more than the profession of nurses would really not be representative of the target audience. Do you mean to say 'have planners and faculty from more than one profession 'dealing with the subject matter' of the target audience.'
ACCME-accredited provider	Should a critical element also include a target audience statement and demographics report that analyzes whether multiple professions were represented among the learners?
ACCME-accredited provider	We request clarification for the required 'uses a team-based evaluation.' Would these questions be up to the provider to determine based on the activity and/or anticipated audience? Does this mean that there are different versions of the evaluation instrument based on learner profession, or does it literally mean that we attempt to evaluate the professions working together? Additionally, the Standard metric of > 25% of activities and/or learners is confusing. Is it across the accreditation period or annually? If we have one extremely large activity that dwarfs all of the other activities in size and it has a multi-professional audience, is that acceptable?
ACCME-accredited provider	1. Does the requirement also pertain to education for an interprofessional audience? 2. Please clarify 'team-based evaluation.'
ACCME-accredited provider	Can a planner also be a faculty member for the same activity? What is team-based evaluation? The critical elements do not specify who the learners for these programs should be. Do they have to be interprofessional as well, per the definition of IPCE given? For specialty societies, the use of multidisciplinary education is often relevant and important. It would be helpful to include this as an option here. Many societies limit their memberships and missions to serving only physicians and thus, by definition, could not achieve this criterion.

Call for Comment Responses: Proposal for a Menu of New Criteria for Accreditation with Commendation

C23: Since you answered 'no', please explain and/or suggest edits.	
Organization Description	Comments
ACCME-accredited provider	We are not clear on what composes interprofessional collaboration. So in our case would an activity designed to educate both lab technicians and pathologists qualify or is that all one profession of pathology
ACCME-accredited provider	Does IPCE mean only non-MDs only? Could it include MDs but in different specialty areas, for example child psychiatrists and pediatricians working together? The standard of greater than or equal to 25% of activities and/or learners is too high. For a sub-specialty medical society who does not have many activities this criterion's standard would be too difficult to achieve. We suggest basing the standard on number of credit hours of activity. A 1 credit activity and a 50 credit activity may have different parameters and not all will include IPCE.
ACCME-accredited provider	If the new criteria will be implemented when an organization is 2 years into its 4 year accreditation cycle, will we be required to implement 25% across all programs in the last 2 years of the cycle? How will previous 2 years worth of activities be reviewed?
ACCME-accredited provider	The criterion only references interprofessional practice in the planning and delivery of education. Does this assume that the education is intended for an interprofessional audience as well, or could an interprofessional team plan activities for learners representing only one provider type to satisfy this? As stated this does not take into account the IOM recommendations around multidisciplinary teams, which play a role in the practice in some specialties and could be more relevant than interprofessional practice. 'Team-based evaluation' needs definition. In the Critical Elements, the 'AND's should be changed to 'AND/OR's to make this more applicable to a wider range of providers. On a related note - can a single individual be both a planner and a faculty member? Also, as an surgical specialty society, our board/members are not ready to fully embrace IPCE on a wide scale meaning that >25% will be impossible for us to reach. I have to meet the needs of my constituents/membership.
ACCME-accredited provider	Define "team-based evaluation". Additional Comments: We strongly recommend that the ACCME use only the term "OR" in each of its criteria, rational, critical elements, and measurement standards.
ACCME-accredited provider	1)RATIONALE:Would request that the ACCME consider changing wording to 'Multidisciplinary &/or Interprofessional Collaborative practice'. 2) RATIONALE:Need to look at IOM recommendations around multidisciplinary team, which is not reflective in proposed C23. 3) RATIONALE:What is the specific intent of C23? 4) RATIONALE AND CRITICAL ELEMENTS:Pathology & lab medicine must strive to incorporate both interprofessional (lab techs, PhDs, pathology, lab medicine) & interdisciplinary (pathologist, oncologist, internists, etc.) education. Measuring outcomes for vast groups of professionals is challenging due to different professional codes, roles, & language for similar components of patient care. 5.CRITICAL ELEMENTS: ACCME needs to define what they mean by 'team-based evaluation? Team-Based Learning Evaluation has specifically defined criteria in medical education literature. Is this what they mean by team-based eval? Or do they mean something else? 6)THE STANDARD:10% or one per yr of term

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Organization Description	Comments
ACCME-accredited provider	<p>This suggests expansion of intended learners that may not be appropriate to a specialty society’s membership/CME Mission Statement. A society could be disqualified from achieving accreditation because it could not demonstrate at least 1 of the criteria. The standard represents a high threshold to meet. Please define 'team based evaluation.’’</p> <p>Does this assume education intended for an IP audience, beyond being planned by an IP team? Would different medical subspecialists be considered IP (e.g., general practitioners & surgeons), or is this only designed to address learning among other professions?</p> <p>How would CME activities designated for other credit types help demonstrate compliance?</p> <p>Can 1 person be both a planner & faculty member?</p> <p>In Critical Elements, “And’s” should be changed to “And/Or’s” to make this more applicable to a wider range of providers.</p>
ACCME-accredited provider	<p>Need to define 'team-based evaluation'.</p> <p>This critical elements for this criterion is onerous. As a subspecialty medical society, having other professionals on our planning committees would not be feasible. Other professionals (eg surgeons) belong to their own subspecialty organizations and they would be not inclined to attend an anesthesia specialty meeting. This would be true for other medical subspecialty organizations as well. Therefore, the first bullet in critical elements should be eliminated. The faculty element is reasonable (and is already being done)</p> <p>Finally, how was 25% as a threshold decided? Is there literature to support that this is the optimal amount? Shouldn't it be what is optimal for the program rather than trying to meet some arbitrary quota?</p>
ACCME-accredited provider	<p>C23: Include planners from more than one profession and faculty from more than one profession... are they supposed to be members of the CME committee or they guests invited during the planning meeting? Or they are target audience during the CME activity giving their evaluation or written input? So, will this mean a minimum of 4 from outside to be invited or involved in the planning? Or both? Are these health care professionals or not?</p> <p>Can you give a sample of the team based evaluation form in detail so not to miss any salient points?</p>
ACCME-accredited provider	<p>The criterion only references interprofessional practice in the planning and delivery of education. Would “interprofessional” include as few as two types of professions, or would it require a broader-based professional team emphasis? As stated, this does not take into account the IOM recommendations around multidisciplinary teams, which play a significant role in the practice in some specialties and could be more relevant than interprofessional practice.</p> <p>'Team-based evaluation' needs definition. In the Critical Elements, the 'AND's should be changed to 'AND/OR's to make this more applicable to a wider range of providers.</p>

Call for Comment Responses: Proposal for a Menu of New Criteria for Accreditation with Commendation

C23: Since you answered 'no', please explain and/or suggest edits.	
Organization Description	Comments
ACCME-accredited provider	If the criterion only rewards accredited providers that work collaboratively with multiple health professions and faculty from more than one profession, it limits medical specialty societies whose members are predominantly all one profession. The collaboration for us involves the fact that we unite physicians from around the globe to work on a particular educational activity so the outcomes for the learners is influenced by different cultures, methodologies, and treatments working collaboratively. According to your criteria, we would not be included.
ACCME-accredited provider	The term 'Team-based evaluation' is not defined. Also, it is not clear if the education must be intended for an interprofessional audience or if it could just be planned by and taught by an interprofessional team. The standard of >25% of activities and/or learners is arbitrary and as medical specialty society we would find it difficult to achieve.
ACCME-accredited provider	Clarification on the definition of interprofessional is necessary. For some, it could mean aligning physicians and allied health professionals, for others it may mean an interdisciplinary team. In addition, for the critical elements, the requirement of 'and' may not be achievable for all provider types, nor will 25% of activities and/or learners. Recommend once a year per accreditation term, and remove 'AND' in standard.
ACCME-accredited provider	"Team-based evaluation" needs to be defined. Implies that a provider would need to expand their learner base, which might not be appropriate for a medical specialty society's organizational mission and/or their CME Mission Statement. It would be difficult for specialty societies to meet the standard; suggest lowering to 10% at most.
ACCME-accredited provider	Agree with CMSS: 'The criterion only references inter-professional practice in the planning and delivery of education. Does this assume that the education is intended for an inter-professional audience as well, or could an inter-professional team plan activities for learners representing only one provider type to satisfy this? As stated this does not take into account the IOM recommendations around multidisciplinary teams, which play a significant role in the practice in some specialties and could be more relevant than inter-professional practice. 'Team-based evaluation' needs definition. In the Critical Elements, the 'AND's should be changed to 'AND/OR's to make this more applicable to a wider range of providers.'
ACCME-accredited provider	Interprofessional education is very important. However, medical professional societies members generally are physicians who do not often come together in educational functions with other professions. Yet physicians do indeed require medical information of a different type than that needed by allied health professionals.
ACCME-accredited provider	How is the provider to construe 'team-based eval?' Wat is the basis for including :'inter professional -----' Delivery of specialty required CME, including concerns for MOC are difficult enough without a requirement for this criterion.
ACCME-accredited provider	Following up on my previous comment, team-based evaluation processes may not be available to all organization types.

Call for Comment Responses: Proposal for a Menu of New Criteria for Accreditation with Commendation

C23: Since you answered 'no', please explain and/or suggest edits.	
Organization Description	Comments
ACCME-accredited provider	What is meant by team based evaluation? Is it the planning committee review of the aggregated summary of the learner evaluations or is it that the learner evals are completed by the team? If the committee review is what is meant, is an annual evaluation of all of the courses enough or is this in addition to that? What is meant by 25%? Our education is mostly enduring material and we have a library of about 100 CME. Is the 25% of the entire library or is it of only the new ones that we develop each year?
ACCME-accredited provider	Not clear what team-based evaluation is. An online search shows many methods. This feels like a niche criteria. Only 26 providers have Joint Accreditation--meaning most likely at most 26 providers could meet this criteria. Seems too small of a % to include as a criteria.
ACCME-accredited provider	The threshold of activities/learners should be no more than 10%. What is the ACCME's definition of 'team-based evaluation' or is this self (provider) defined? What is the rationale for the 25% threshold for activities/learners? Such thresholds favor jointly accredited providers versus single providers.
ACCME-accredited provider	I believe the criterion is clear and the elements are well stated; however, it becomes complicated when you start requiring a percentage of activities. The rationale and critical elements really helped to solidify my understanding of the criterion.
ACCME-accredited provider	You should define 'team-based evaluation'.
ACCME-accredited provider	Rationale and criteria are great, but the standard is untenable for many providers. Consider 10% of all activities.
ACCME-accredited provider	Give example of a team- based evaluation. Percentage is too high for such a slowly evolving type of evaluation Almost all of our events have the first two critical elements--but am not sure the evaluation.
ACCME-accredited provider	It's not clear what 'team-based evaluation' means and how it differs from the type of evaluation CME providers currently undertake.
ACCME-accredited provider	The 25% standard would be impossible for us to even attain unless RSS were eliminated out of the denominator for learners. Consideration should also be given as to whether the metric should be only directly-sponsored activities or a combo of jointly provided activities as the latter potentially impacts both the number of learners and activities. The standard minus metric is clear.
ACCME-accredited provider	'Team-based evaluation' needs to be further defined. We disagree with the standard based on % of learners or activities and suggest instead that providers describe several examples of compliance. The expectation for a % of learners or activities will disadvantage providers who have very robust and substantial initiatives in key areas and reward providers who have superficial and perfunctory practices across many activities/learners.

Call for Comment Responses: Proposal for a Menu of New Criteria for Accreditation with Commendation

C23: Since you answered 'no', please explain and/or suggest edits.	
Organization Description	Comments
ACCME-accredited provider	I believe it is flawed thinking to require that 25% of the faculty represent the target audience if your intent is to ensure that truly interprofessional EDUCATION is occurring. Who teaches is not nearly as critical as how they teach and engage an interprofessional audience in a meaningful and effective learning experience. I think this will lead to selecting faculty to meet criteria vs. selecting the most effective strategy. This can be achieved by eliminating the 25% requirement for this specific element and emphasize how teaching happens rather than who teaches.
ACCME-accredited provider	Is '> 25% of activities and or learners' over the accreditation term? Annually? or other?
ACCME-accredited provider	In general, a glossary (perhaps with case studies) should be submitted with the revised criteria. I will list areas we are confused as to the meaning and standards. Define 'team-based evaluation.' Define 'different professional backgrounds.' Would MD vs. PhD count? (basic and clinical agenda); would a surgeon be considered different than a physician? Clarify greater than 25% activities and/or learners. Does the standard meant greater than 25% of learners for the provider's programs in their entirety only(during the accreditation cycle) or can you meet the criteria by submitting specific programs with greater than 25% diversity among the learners. This penalizes current 6 year providers over current 4 year providers.
ACCME-accredited provider	The rationale is clear. I do not know what you mean by 'team-based evaluation.' This may be an instrument that is completed by a team together, or one that is completed by all professionals in the room. Or it may be a post-activity observation of a team? For a medical school to satisfy the standard of >25% of learners/activities this will warrant a (welcome) overhaul of RSS planning and evaluation. Would you consider some flexibility in assessment here: such as allowing the provider to demonstrate a complex performance assessment with simulation for some activities, and perhaps samples outcomes assessments for RSS learners?
Other	'Team-based evaluation' needs further clarification. In addition I object to the 25% standard. This is too high. I recommend 1 activity per year of accreditation as the standard.
Other	We wondered whether “Engages members of interprofessional teams in the planning and delivery of IPCE” would me more appropriate language here. We feel it would be a bit more explicit in terms of expectations.
Other	Does this mean that for a given RSS 25% of sessions must have non physician speakers? I'm not sure how a provider would comply with 'team based evaluations'. 25% seems unrealistic and perhaps not in the best interest of medical education for most providers.

Call for Comment Responses: Proposal for a Menu of New Criteria for Accreditation with Commendation

C23: Since you answered 'no', please explain and/or suggest edits.	
Organization Description	Comments
Other	The criterion only references inter-professional practice in the planning and delivery of education. Does this assume that the education is intended for an inter-professional audience as well, or could an inter-professional team plan activities for learners representing only one provider type to satisfy this? As stated this does not take into account the IOM recommendations around multidisciplinary teams, which play a significant role in the practice in some specialties and could be more relevant than inter-professional practice. 'Team-based evaluation' needs definition. In the Critical Elements, the 'AND's should be changed to 'AND/OR's to make this more applicable to a wider range of providers. On a related note - can a single individual be both a planner and a faculty member?
Other	Standard requiring only activities with more than 1 faculty rules out many RSS as ineligible toward meeting the standard. Implies that each profession needs its' own type of teacher which negates the concept of all learning at the same time. Also creates same problem that we have now with osteopathic education where 50% of faculty must be DO's. Each faculty equality requirement adds a barrier. Last sentence, "This criterion..." unnecessary and inconsistent with wording of other criteria. Unclear what is meant by team-based evaluation does this refer to unity in collection (1 eval for all) or content (are there content questions unique to each professional sub-group) or something else.
Other	What is the definition of 'team based evaluation', is this group based feedback? Requires further clarification in order to ensure that all providers are working with the same understanding. The threshold of 25% is far too high, suggest 10%.
Physician/healthcare professional	Again in small rural communities getting a mix of providers may be feasible. The standard is too high for our facility, this would be difficult for even a few activities let alone 25% or more.
Physician/healthcare professional	The criteria's Standard of greater than 25% of activities and/or learners is not adequately defined
Physician/healthcare professional	The usefulness of this activity is in the details. The details are not yet provided. As written - Sounds like kind of watered down soft fuzzy thinking criteria.
State-accredited provider	I don't understand what a team-based evaluation would involve. Would a tumor board that includes physicians and the nursing team that evaluates the session jointly meet this requirement?
State-accredited provider	would like more information to describe critical elements
State-accredited provider	What is team-based evaluation exactly?
State-accredited provider	does this mean we will be able to offer credit directly to nurses, psychologists, pastoral care and other ancillary staff rather than certificates of attendance? Would this include medical librarians?
State-accredited provider	...'is defined as when... not ...is when. Line three: ...(IPCE) occurs when.. Perhaps Criterion 24 could be merged with this Criterion

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C23: Since you answered 'no', please explain and/or suggest edits.	
Organization Description	Comments
State-accredited provider	what do you mean by team based evaluation? Does this mean that the team has to write an evaluation together? Please be specific by giving an example.
State-accredited provider	You need to define 'Team based evaluation'. Give samples.
State-accredited provider	I would not like to see this criteria for it would be difficult to rational in our organization
State-accredited provider	What exactly is team-based evaluation? Why is there such variation in the percentage required for each criteria? It will be important to streamline the nursing credit process (and other interprofessional group credits) with CME in order to facilitate this criterion.
State-accredited provider	Not sure who the learners are in this statement. Are they all the participants or only the physicians? If this includes all participants then an infrastructure change needs to occur to have access to track all nursing, PA, RA, Pharmacists, etc. This would be more appropriate for Joint Accreditation.
State-accredited provider	Need clarification on the element of team-based evaluation. Although the standard is easily achievable for hospital-based activities, to expect greater than or equal to 25% of activities is too high, since many CME activities are in an online format to meet the physician's time needs. This standard will increase the cost for most CME providers to either obtain accreditation from other boards or joint provide with providers that can offer credit to other healthcare providers for many do not accept the ACCME participation credit 1 to 1.
State-accredited provider	Take away the percentage. Please correct me if I am wrong but don't we already do this with the RSS's for example the Surgical/ Oncology conferences? Trauma Conferences Adding a percentage would put a strain on the one person CME Office
State-accredited provider	It is very clear for IPCE, but it fails to apply its lofty goals to CME. Also, gramatically,, it should not say: 'XXX is when' . Much better to say: 'XXX occurs when....' Clarity in expressing a purpose does not make it more practical or realistic.
State-accredited provider	To improve clarity and linguistic consistency with the other criteria I have suggested rewording: 'Engages in the planning and delivery of its educational activities with other healthcare professionals to address team-based, interprofessional collaborative practice.' Need to clarify what 'health professionals' mean, not just MDs from other specialties. Is each activity that meets c23 required to include all 3 of the Critical Elements? I would suggest not. Again, I think the % standard might be a high bar to reach for most. I would suggest that the provider demonstrate through documentation and narration that it meets c23 in a 'few or several' activities that it gets to select.
State-accredited provider	Define 'Learners' is that physicians only or ALL attendees of each activity. Are you looking for the percentage of credit hours or a percentage of single activities? Do you want 25% or more of our planners and/or learners to be non-physicians? How often do you want to see non-physician faculty? 25% or more of the time?

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C23: Since you answered 'no', please explain and/or suggest edits.	
Organization Description	Comments
State-accredited provider	I do feel the intent of this Criteria may be achievable for some of my Providers but not with the standards (percentages of activities/learners) attached to them. It would be helpful that all new criteria provide a compendium of examples of Compliance and Non-Compliance to demonstrate what is expected.
State-accredited provider	How realistic is the Team based evaluation? Is it at all feasible to work with caregivers and families of the patients?
State-accredited provider	Question: If our organization already has a large body of existing 'activities', does your standard statement imply that they are updated to meet the 25% goal? Or -- can new materials be created that themselves meet the 25% goal?

Call for Comment Responses: Proposal for a Menu of New Criteria for Accreditation with Commendation

C23: Please provide comments or questions about this criterion.	
Organization Description	Comments
ACCME-accredited provider	Far too high a percentage for many organizations that simply, by their definition, focus little on interprofessional education. Not that it's not worthwhile or 'good' to do so, but there may be other organizations in that fill that spot. Providers can't be all things to all - or even 25% - of their content space.
State-accredited provider	Clarify the team based evaluation format
State-accredited provider	Team based evaluations will be difficult as CME, CNE and other credit systems each have their own requirements for evaluations. I would recommend omitting this item until credit systems can consolidate their requirements. For example, Continuing Nursing (AANC) requires the evaluation of each activity objective but ACCME does not.
ACCME-accredited provider	Does this mean that Jointly Accredited organizations (TJA) automatically achieve this criterion?
Physician/healthcare professional	I'm not sure this should be included; it is noteworthy, but perhaps a different category for types of excellence? A CME provider could provide truly exceptional service in select areas and NEVER have a hint of inclusive teaching and learning as defined here.
State-accredited provider	We have a larger monthly hour long Grand Rounds that draws a large crowd, when a non-physician speaker is scheduled, the physicians tend to not be engaged and less attend which would make it difficult to meet the 25% compliance rate.
Physician/healthcare professional	For Criteria C23 (Engages in interprofessional collaborative practice in the planning and delivery of IPCE), I propose adding a 4th element: Includes input from a medical librarian/information professional. The reason for this element is that medical librarians (aka health information professionals) have expertise in formulating the clinical question, teaching evidence-based medicine, instructing both medical students and faculty, and seeking and finding medical evidence in PubMed and other databases.
State-accredited provider	We vote for changing the Standard to 'equal to or greater than 5%' of activities and/or learners. Overview comment: A clear definition of how to count our number of 'learners' for these criteria is needed. We are assuming that a person participating in an activity counts as 1 learner. We are assuming that same person can also be 1 learner when he/she participates in the next activity. Thus after being at 2 activities this particular person has been counted as 1 learner twice in our records.
State-accredited provider	My CME Committee asked if a Tumor Board would qualify for this? If not, they expressed their concerns with meeting the element of having more than one faculty for >25%, as most of our presentations are given by one speaker.
State-accredited provider	1. Meeting the standards for the new criteria will appear to require a lot more data gathering and analysis to be compliant, which will ultimately result in more costs. 2. The standards for many criteria are too rigorous, for example, in calling for >25% of activities and/or learners or >10% of activities and/or learners. Many CME providers do not have the volume of CME activities to meet this standard.
State-accredited provider	Mostly clear. 'Planners' is used. This is plural. Do you intend to require more than one? One would never be sufficient?

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C23: Please provide comments or questions about this criterion.	
Organization Description	Comments
ACCME Recognized State Medical Society	The criterion sounds reasonable and appropriate. In our environment we will need to work hard to have our participants understand the meaning and accept other health professionals be involved in our CME's. Involving other health care givers is part of physicians every day work at the private practice or hospital, but not for CME. So far, the few occasions other health professionals have been involved in CME as speakers, their ability to get through to physician participants has been poor. It has been appreciated with dieticians, pharmacists, therapists and others. To accomplish the 25% or more, makes it more challenging!
ACCME-accredited provider	What is your intention on how you expect providers to measure the %activities/%learners? How are you defining profession? Do mean different medical specialties or different credential types (PharmD, RN, PA, NP, etc.)
State-accredited provider	I definitely understand multiple professions in the planning but I don't like that it must be multiple faculty from more than one profession as often the timeframe or topic does not warrant more than one faculty. More than one faculty may be more of a distraction than a benefit
State-accredited provider	My biggest concern with this is that >25% of activities and/or learners need to be the standard. As a program with 300 plus activities per year, many of which are journal clubs or RSS or IT classes/leadership forums/healthcare communication and art of medicine activities this seems like an ambitious and more importantly impractical goal. Given the challenges we all face with interdisciplinary education, taking strides in that direction should meet criterial. We are currently doing that but the volume requirement seems quite onerous and potentially an unnecessary barrier to support organizations in championing this important work. I am afraid the quantitative piece will be discouraging to institutions making strides in this direction and attempting to do the right thing.
State-accredited provider	Changes in PARS would need to be made to further break down 'non-physicians' and possibly further break down of types (disciplines) of physicians.
ACCME-accredited provider	I look forward to working on this Criteria. CMDA does a lot of international activities in developing countries developing interprofessional continuing education. I know that CMDA does an awesome job of providing healthcare to patients in developing countries and they do it in a team format that incorporates a variety of healthcare professionals. The patient outcomes are unbelievable even though they are self reported.
ACCME-accredited provider	This makes sense - however, I would like to see a definition of what team-based evaluation means.
Physician/healthcare professional	difficult for tumor boards ,etc

Call for Comment Responses: Proposal for a Menu of New Criteria for Accreditation with Commendation

C23: Please provide comments or questions about this criterion.	
Organization Description	Comments
State-accredited provider	I believe that the standard as written is way too high. and greater than 25% of our activities that would be about 75 activities that would have to meet this and with the number of Journal Clubs and case conferences we hold out of our approximate 300 programs this would be difficult to achieve. I am unclear what is meant by 'and/or learners' and how those number would translate. Also I believe that the increased workload to meet this high number of activities with a CME office that is staffed by a CME director, CME manager and Admin Assistant/coordinator along with additional responsibilities added to the plate with ABIM and other specialty boards this is unrealistic. We have been accredited with commendation for the past 2 cycles and I am not certain this added work is worth the bang of receiving 6 years instead of 4. I also thin that the critical element should include and/or and not just and to make it more realistic.
ACCME-accredited provider	This criterion may be very difficult for some providers who do not have interprofessional membership or access to collaborative practice environments.
ACCME-accredited provider	My only question would be 25% per activity or as part of the overall CME program. I think that additional clarification could be helpful to many of the providers. It would seem that meeting the percentage of learners (depending on the specifics) would be easier in some ways than 25% of the activities, particularly for large programs.
State-accredited provider	Define team-based evaluation. (This may not be appropriate in all cases. We rely on a needs assessment to determine this.) ?25% is a high percentage to meet for community hospitals or non-University settings. The other recommended standards for the other 4 categories are ?10% so we recommend a ?10% standard on this criteria.
State-accredited provider	I think this is a great option, however, I don't feel that it should have a requirement of 25% or greater of activities. Provide 5 examples would be more appropriate.
State-accredited provider	It is very important that we stay focus on the goals the learners set on patient and public healthcare as well as quality of care.
ACCME-accredited provider	This standard is too high to be achievable in our organization. Our members join our subspecialty organization with an underlying board certification in either internal medicine or pediatrics, thereby fulfilling the principals of an Interprofessional collaboration. However, the specialty is less "care team" based than many others and the vast majority of practice is outside hospitals. Only 3% of our membership are allied health. In that capacity, 25% is likely not achievable unless we can consider our members all as interprofessionals.
Physician/healthcare professional	while I see the potential benefit of having different provider types learn with, from, and about each other, my experience with 'CME' type activities that enrolled other health professionals--nurses, administrators, social workers--along with physicians is that the programs ended up being 'neither fish nor fowl' unhelpful to one or more groups and confusing to the other(s)

Call for Comment Responses: Proposal for a Menu of New Criteria for Accreditation with Commendation

C23: Please provide comments or questions about this criterion.	
Organization Description	Comments
ACCME-accredited provider	The standard of 25% is problematic as the majority of CME is typically designed to maintain or enhance 'physician' performance. Best practices in the planning of educational interventions are to address the needs of the targeted learners. IPCE to enhance collaborative care practice serves an important but different purpose. If the vision is to enhance effective interprofessional collaborative care practice, I would have liked this criterion to be 'Implements interprofessional educational activities designed to enhance effective collaborative care practice and the delivery of the highest quality of care'. The critical elements would include such activities but again would not be 25% or more here of all CME activities.
Physician/healthcare professional	Yes, the criterion is clear but instead of making inter professional CME part of 'commendation', there should be an emphasis on physician-specific CME.
State-accredited provider	Like it. Feel we should support interdisciplinary education more. Having the ACCME leading the way makes a big difference in this being more accepted and supported.
ACCME-accredited provider	Achievable
State-accredited provider	Very unlikely this can be achieved at the community level, and probably not worth the effort, despite your lofty goals. CME can be obtained in many ways these days, which results in decreased attendance at on site events.
ACCME-accredited provider	'Uses team-based evaluation' could be expanded, made more descriptive
ACCME-accredited provider	C23: Not all activities designed by our specialty society are appropriate for IPCE. The standard of 25% of activities or learners seems extremely high. Our specialty society is focused on surgeons and surgery – incorporating IPCE into 25% of our activities may be a disservice to our members. We would recommend incorporating IPCE into 1 accredited activity per year as the standard. Additionally, a “team-based evaluation” needs definition.
ACCME-accredited provider	With regard to all percentages, is the expectation to meet that percentage of activities/learners each year or each accreditation cycle? C23 If the planners, presenters, and/or audience are interprofessional but continuing education is only offered for physicians, would this count?
ACCME Recognized State Medical Society	While we understand this Criterion, we feel 25% of activities and/or learners is too high to be achievable.
ACCME Recognized State Medical Society	The Criterion is very clear, however, the % is too high for most SMS accredited providers to comply. And, there is a question is the 25%/year or term?
Physician/healthcare professional	This type of cross pollination is critical for effective health care delivery going forward and not something that happens routinely in training and/or during the traditional educational processes.

Call for Comment Responses: Proposal for a Menu of New Criteria for Accreditation with Commendation

C23: Please provide comments or questions about this criterion.	
Organization Description	Comments
ACCME-accredited provider	We support the adoption of this new Criterion 23. This is completely in alignment with the VHA Current practice for IPCE.
ACCME-accredited provider	Though we wholeheartedly agree with interprofessional collaboration reaching the standard would be difficult as OSU's infrastructure is currently more tailored to specialty-specific education. For the most part, activities are not driven from our office. We certify activities that come to us from other departments of the institution.
ACCME-accredited provider	Healthcare providers must work together as a well-functioning medical team and this criterion emphasizes the importance of interprofessional collaboration
State-accredited provider	Only item that may not be clear is the standard, maybe we are not interpreting it correctly, but it does not seem obtainable.
ACCME-accredited provider	My suggestion for all the criteria is to start with a standard percentage of say 10% for all the criteria except for C33. Then over time you could increase this percentage if wanted/needed. But to begin it might make it a bit more manageable for providers to apply for accreditation with commendation.
ACCME-accredited provider	Most all of our programs involve nursing, pharmacist, or PTs.
State-accredited provider	Decrease the standard to 10%.
State-accredited provider	The first element is easily achieved but including 25% or more of faculty that represents the audience is challenging. Our planners and faculty may include attorneys, law enforcement, coding experts who are not representative of the target audience but who provide valuable information to our learners. Can 'representative of target audience' be removed? We would like instruction on 'team-based evaluation.'
ACCME-accredited provider	The Standard is too high for this. Currently we have activities that incorporate this, but given our large educational portfolio, we could never achieve this standard.
ACCME-accredited provider	This is a fantastic addition! Thank you for allowing organizations to be recognized for their interprofessional education and work.
ACCME-accredited provider	The Standard is very high for providers who have a large number of activities or are specialty medical societies. While some collaborative IPCE occurs, it is unlikely to span over 25% of activities or learners.
ACCME-accredited provider	seems clear enough but metric not supportable
ACCME-accredited provider	It would be useful if the language of The Critical Elements matched The Standards. Critical Elements would become: <ul style="list-style-type: none"> - Includes planners from more than one profession (representative of the target audience) AND/OR - Includes faculty from more than one profession (representative of the target audience) AND/OR - Uses team-based evaluation.

Call for Comment Responses: Proposal for a Menu of New Criteria for Accreditation with Commendation

C23: Please provide comments or questions about this criterion.	
Organization Description	Comments
ACCME-accredited provider	what does ACCME define as a team-based evaluation? Is there a standard for this type of evaluation that a provider would be measured against in terms of being able to demonstrate 'meeting' this critical element?
ACCME-accredited provider	The criterion is very clear; however, there an assumption that at least 25% of CME activities developed by a provider are relevant to more than one profession. There are a number of highly specialized areas of medical practice that are not always relevant to a meaningful level to other professions. For example, pathology, radiology, and neurosurgery which are areas in which a majority of Lippincott CME Institute's activities are associated are not clinically relevant to other health professionals. The 25% of CME activities to have an inclusive target audience would result in learning content that is less meaningful for physician/surgeon professional development.
ACCME-accredited provider	See concerns from page 1 of the survey related to The Standard
ACCME-accredited provider	Please provide examples and further definition to meet the requirement of a team based evaluation. It is our suggestion that as we transition to a new process, that we would like to see the proposed # of activities to meet the requirement (25%) be reduced to 5-10% with an option to increase at a later time.
ACCME-accredited provider	I am not sure that 25% is a reasonable level at this point if this criterion requires inter-professional accreditation. In my experience nursing and pharmacy have been difficult to work with. If this criterion does not require inter-professional accreditation, then 25% may be achievable.
ACCME-accredited provider	As indicated previously, I question the standard.
ACCME-accredited provider	As a school of medicine, we have many IPE activities for students but do not certify them for CME because it is not needed. Developing CME certified activities with other professions for faculty/professional development typically includes additional costs for nursing, social worker, CHES credit-none of which we have funding for. While this is admirable, there appears to be an assumption that funding, personnel time and a broadened scope of content to appeal to other professions is available and/or desired for our CME activities.
ACCME-accredited provider	The criterion is clear but I do not agree with the standard. Currently there is no percentage or number of activities and/or learners required for any of the Commendation Criteria/. I think that more providers will put forth the effort to achieve this and the other criteria if there is no percentage or number standard attached.
ACCME-accredited provider	What is meant by team-based evaluation? Does this involve the assessment of learners, an evaluation by the planners based on the outcomes, etc.? Needs more clarity.
ACCME-accredited provider	The Criterion is clear as written, and I can understand some select educational efforts will encompass patients and/or families. However, 25% of activities in this category will be a monumental task. Again, I ask who the education is directed toward - are we forgetting the professional learners in our attempts toward inclusion of other groups.
ACCME-accredited provider	25% is too high. Progress and change in a large institution with a lot of CME programs is incremental. 10% is a more reasonable percent.

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C23: Please provide comments or questions about this criterion.	
Organization Description	Comments
State-accredited provider	This allows areas to improve access to health interventions and improved coordination between different sectors for individuals and their families with more involvement in decision making; a comprehensive, coordinated and safe health system that is responsive to the needs of the population; and the efficient use of resources.

C24: Engages patient/public representatives in the planning and delivery of CME.

C24: Since you answered 'no', please explain and/or suggest edits.	
Organization Description	Comments
ACCME Recognized State Medical Society	Would it be useful to intentionally mention the concept of diversity in some way when speaking about 'the patient/public'?
ACCME Recognized State Medical Society	Unable to assess. Inadequate and/or deficient methodological evidence of validity, reliability and application practicality of process. Details upon request. E.g. lack of evidence this criteria should carry same “weight” as any other and is mainly exclusive of other criteria to avoid double weighting. Applicability and importance depends on nature and scope of provider and types of activity.
ACCME Recognized State Medical Society	Same questions as C23 ... the percentage, per year or per term?
ACCME Recognized State Medical Society	How much would the patient need to be involved in the planning process.
ACCME Recognized State Medical Society	Critical Elements: - Better if allowed for this OR that, instead of this AND that. The Standard: - It is unclear whether the “% of activities or the % of learners” represents the % of learners in a given year of activities or for the entire accreditation term. - ?25% of activities and/or learners – ?25% too high
ACCME Recognized State Medical Society	Provide definition of public representatives and non-healthcare professionals.
ACCME Recognized State Medical Society	Under “critical elements” we raise concerns about the requirement that patients/public representatives participate as both planners and teachers/authors. We believe that these individuals should be included in the planning but faculty should be selected based on the professional practice gaps identified in the planning process.
ACCME Recognized State Medical Society	Accredited education that is CME certified should primarily be for an MD or DO. I see no role for patients or the public in the planning of CME activities. I don't see hospitals or health systems allowing this kind of collaboration. Also, % of the standard is not a good idea for any Criteria; this will be too complicated to calculate. Providing multiple examples for a Criteria should be sufficient for a compliance finding.
ACCME Recognized State Medical Society	Need clarification on the standard of 25% of activities or learners. For example, is it 25% of the total of activities from the entire term of accreditation? Or could it be 25% of activities from 1 or 2 years of accreditation? Suggest lowering the % greatly or changing it to a range of activities such as 1-3 per year or 5-6 over the term. Change the critical elements to “OR”, not AND. 25% will be extremely difficult for many providers in our state system to achieve, as engaging patients is a very new concept to most CME providers. Percentages are complicated for accreditors to work with during the survey process. For example, what activities do we need to select for review?

Call for Comment Responses: Proposal for a Menu of New Criteria for Accreditation with Commendation

C24: Since you answered 'no', please explain and/or suggest edits.	
Organization Description	Comments
ACCME Recognized State Medical Society	What is meant by a 'public representative?' Please define. The percentage standard is too complicated for providers to calculate and for accreditors to determine and to review. (See C 23).
ACCME Recognized State Medical Society	You have changed CE to CME which clarifies for me that the education referred to is accredited CME. I am not understanding how '% of learners' applies to any of the proposed criterion where % of learners can be the standard. I am not understanding how '% of activities/learners' applies to RSS for any of the proposed criterion.
ACCME Recognized State Medical Society	Who would be eligible for non-healthcare professional (i.e. CME staff)? Do patient satisfaction scores count? The ?25% of activities 'and/or' learners would be difficult for surveyors to evaluate.
ACCME Recognized State Medical Society	This criterion may be achievable for some of our providers, but not with the standards (percentages of activities/learners) attached to them. It would be difficult to achieve 25% of the time. The word 'AND' in the critical elements seems unreasonable; however the use of the term 'AND POSSIBLY' may be acceptable. The Standard percentage will be very difficult for surveyors to assess and determine how the percentage of learners is defined. The percentage is too high, even if we can't define the "activities or learners."
ACCME-accredited provider	We do not fully support this criterion and its required equal or >25% of activities. This should be approached cautiously and we recommend the equal or >10%. Although we see a value in having in the planning phase EITHER patient or public representatives we feel it should not be both. In addition, clarification is needed on the 'learners.' How will these external non-healthcare learners be determined? Selection of patient or public planner and/or learners poses a challenge. IF this were done, it needs to be done on a volunteer basis, avoiding all Conflict of Interest.
ACCME-accredited provider	Example, please.
ACCME-accredited provider	It would be helpful if the Criterion gave examples of how an institution can safely include patients and/or public representatives in the CME planning process. in this litigious environment, our doctors and administration are concerned about the potential legal backlash from bringing patients into a process that may reveal shortfalls in care.
ACCME-accredited provider	It's not clear because I'm not sure what =or> 25% of activities is supposed to mean. Does it mean we're not to be commended if we go over that amount? Examples of this would be very helpful.
ACCME-accredited provider	Are you suggesting that at least 25% of activities must be taught by patients or public representatives? If so, I would suggest that is way too high a threshold. Our Pediatric Grand Rounds sessions that are taught by public representatives instead of physicians are among the worst attended that we have. We have approximately 3000 activities per year. Are you suggesting that 750 of those activities be taught by patients or public representatives? I believe that will water down the educational value of these activities for physicians and be an impossible threshold to meet from a logistical standpoint. We awarded over 44,000 hours of credit in 2015. Your 'standard' for this criteria states '>25% of learners'. Are you suggesting that 11,000 of our hours be awarded to patients or public representatives? That sounds impossible to achieve. I think that you either need to drop the standard or reconsider the thresholds.

Call for Comment Responses: Proposal for a Menu of New Criteria for Accreditation with Commendation

C24: Since you answered 'no', please explain and/or suggest edits.	
Organization Description	Comments
ACCME-accredited provider	Define 'public representative'. Dislike use of AND - feel this should be AND/OR; I feel having patient/public as planners OR teachers can have similar impact and meet the intended goal. How does making them planners AND teachers have a greater impact than one or the other? Concerned that this would be a resource intensive criteria as many patients/public representatives may require honoraria for their involvement.
ACCME-accredited provider	9.1 - Presumably "Teachers/Authors" = speakers, content developers/deliverers? If so, please state this clearly. 9.2 – This is stretch goal in any amount, because this is likely a significant shift for most providers. The volume proposed for compliance is out of reach in our opinion. More realistic goal/expectation would be to simply demonstrate inclusion of patients and/or non-HCP public representatives in planning and or developing/delivering content.
ACCME-accredited provider	The criterion is clear, however, the standard for this criterion is too high and should be scaled to adjust for the number of activities conducted by an accredited provider. For example, to comply an organization that does ten or fewer activities a year would need to involved patients/and or public representatives in two to three activities, while an organization that conducts more than 400 would need at least 100 activities. Neither may be realistic given what the provider has determined to be their mission and expected results, as well as being relevant to their target audience.
ACCME-accredited provider	This is confusing, teachers authors include non MDs? So a non MD person can teach a live lecture?
ACCME-accredited provider	Does patient have to be non-employee? Please further define public representative.
ACCME-accredited provider	Who is a "public representative"? Must both critical elements be present in all activities (referring to use of word "AND")? While involving patients in the planning and teaching is a good goal, setting the percentage at 25% will be difficult for both large and small organizations to achieve. The more activities an organization does, the harder it will be to reach this percentage. This would also likely add to the cost of developing activities as such individuals would likely want to be paid for their time. Getting access to patients if you're not a specialty society, health system or academic provider would also be challenging.
ACCME-accredited provider	We endorse this criterion; however, under "critical elements" we are concerned about requiring patient/public representatives participate as both planners and teachers/authors. We believe these individuals should be selected for these roles, based on the identified professional practice gaps and the expertise required to support the educational intervention – which may involve patients as planners, faculty or both, depending on the specific activity. As noted above, we do not recommend requiring providers to apply this criterion to > 25% of their learners/activities.
ACCME-accredited provider	25% seems like a very high threshold for this, considering the types of education where patients can effectively contribute

Call for Comment Responses: Proposal for a Menu of New Criteria for Accreditation with Commendation

C24: Since you answered 'no', please explain and/or suggest edits.	
Organization Description	Comments
ACCME-accredited provider	Please clarify whether patients/public representatives are expected to be part of the learner population (see Standard) or simply planners and faculty. If the former, this may be outside the mission of some providers. Further, while CME activities focusing on processes of care clearly have a role for patient/public input, there may not be a clear contribution for purely clinical/procedural content. The Standard metric of >25 activities and/or learners is confusing. Is this based on the accreditation period or an annual threshold? If there is one large CME activity that eclipses all of the others in scope and it involves patient planners and faculty is that compliant, or does this large activity simply count as 1 (equivalent to a journal article).
ACCME-accredited provider	Can planners and teachers/authors be the same individuals? Could it be planners and/or teachers are patients? Also, C23 referred to patients as part of the interprofessional education dynamic. Is this potentially redundant?
ACCME-accredited provider	The rationale references patients as “learners” in the CME activities yet the Critical Elements do not include patients/public as learners but rather, only as planners and teachers/authors. Designing education (accredited CME or otherwise) for the patient and public learners is a vital service which can be facilitated by educational providers and should be rewarded within the ACCME system.
ACCME-accredited provider	If the new criteria will be implemented when an organization is 2 years into its 4 year accreditation cycle, will we be required to implement 25% across all programs in the last 2 years of the cycle? How will previous 2 years worth of activities be reviewed? Define 'public representatives'.
ACCME-accredited provider	Because this is a relatively new phenomenon in CME it would be helpful to start at a lower threshold for compliance, possibly 10%, and then scale up to allow providers an opportunity to incorporate this approach into their programs. In the Critical Elements, could 'AND' be 'AND/OR'? As with C23, can a single individual be both a planner and a faculty member for a single activity?
ACCME-accredited provider	The rationale mentions patient/public representatives as learners; however, learners are not mentioned in the criteria or critical elements. Additional Comments: We strongly recommend that the ACCME use only the term “OR” in each of its criteria, rational, critical elements, and measurement standards.
ACCME-accredited provider	1. CRITICAL ELEMENTS: Should be 'OR' teachers/authors include..... 2. THE STANDARD: considering decreasing to 10% (see general comment about standards)y
ACCME-accredited provider	C24: Involved patient and/or public representatives not healthcare professional and teachers/authors and or public not HC professionals... Can these representatives be the representatives of the C23? Or do we have to invite a minimum of 4 in addition of the above (total of 8) in the meeting? It says teachers/authors (plural), this is difficult. During the meeting, meals and transportation have to be free unless we invite them to attend the CME which may be interesting to them or not.

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C24: Since you answered 'no', please explain and/or suggest edits.	
Organization Description	Comments
ACCME-accredited provider	The ACR would like to suggest that it would be helpful to start at a lower threshold for compliance, possibly 3-5%, and then scale up to allow providers an opportunity to incorporate this approach into their programs. This is especially pertinent for very small and specialized societies where 10% of their Program could amount to the majority, or the entirety of their member-directed education offering(s). In the Critical Elements, could 'AND' be 'AND/OR'? Can a single individual be both a planner and a faculty member for a single activity?
ACCME-accredited provider	A Specialty Medical Society whose mission is education needs the expertise of cutting edge planners and faculty in the subject matter of the education. Patients and public reps would not be considered experts in the field who would draw learners to attend an educational event. Again this eliminates some from this commendation opportunity.
ACCME-accredited provider	It is inappropriate to have patients or the public involved in planning all types of CME, particularly discussions of science and translation medicine. It is not clear what is meant by a public representative. It would be more appropriate to count planning with other non-profit groups concerned with patient issues or advocacy, not just patients or a member of the public themselves. This criterion is laudable but restrictive. The standard is likely unreachable for a provider with a large number of activities.
ACCME-accredited provider	The critical elements would be more achievable and realistic if the 'AND' was changed to 'AND/OR'. Also, the >25% standards is unrealistic and should be lowered.
ACCME-accredited provider	<p>Patients is a universal term, but what constitutes a “public representative” is not clear. Recommend providing examples, as within the transplant community, we may include UNOS or organ procurement organizations as those types.</p> <p>In addition, for the critical elements, the requirement of 'and' may not be achievable for all provider types, nor will 25% of activities and/or learners.</p> <p>Recommend once a year per accreditation term, and remove 'AND' in standard.</p>
ACCME-accredited provider	<p>This is problematic for quality education based on challenges that we’ve experienced.</p> <p>This is extremely difficult for a Specialty Society to comply with (especially with the HIPAA requirements, etc). It may be slightly easier for an academic or hospital provider to comply with but still difficult. Given the difficulty in meeting this criteria, “The Standard” should be dropped to 10% at most.</p> <p>It is not clear how to incorporate the public into teaching. Planning, yes, but teaching is not clear. Unless this was an avenue for teaching the non-medical knowledge competencies-such as professionalism, systems-based practice, etc. This may need more specificity as to what is intended.</p>

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C24: Since you answered 'no', please explain and/or suggest edits.	
Organization Description	Comments
ACCME-accredited provider	AMIA believes that 'patient/public representatives' needs more definition. There are patient advocates who are self-proclaimed representatives, which may contribute to education that does not best serve learners. Also, AMIA agrees with CMSS: '...it would be helpful to start at a lower threshold for compliance, possibly 10%, and then scale up to allow providers an opportunity to incorporate this approach into their programs.'
ACCME-accredited provider	How are patient/public representatives to be involved in designing and presenting CME activities for physicians when they lack the content training and expertise? This criterion suggests that non-medical professionals should design continuing education activities for physicians. It is difficult to conceive of a non-medical individual having the competence to design activities around surgical simulations. It seems quite reasonable to include a lay representative on a committee but the criterion suggests that this individual should be planning at least 25% of the CME activities.
ACCME-accredited provider	I believe it would be impossible for my educational institution to fulfill this criterion. We serve physicians from all over the country and from many different specialties. We receive feedback from these physicians, but do not receive feedback directly from patients or public representatives.
ACCME-accredited provider	We have an interprofessional Committee that reviews and approves all new CME, reviews and revises CME for renewals and oversees the annual evaluation of all courses. Several of our non-physician employees (both of LAMMICO and our subsidiary, Medical Interactive) are also patients. Would this suffice to meet the planning part of the criteria or do we need a lay person from outside of our organization? Since our education is mostly enduring, do we need patient reps to be the actual author of the material 25% of the time? It would be extremely difficult to find a lay person with a Risk Management and Patient Safety background to assist in authoring our education.
ACCME-accredited provider	I understand including patients/care givers in planning patient materials, but not for CME activities. Would a patient be a good teacher for how to perform surgery? Not understanding--it's continuing MEDICAL education. Our MD participants are there to learn beyond their current understanding regarding medical care. Patients/care givers need content designed for them, not something designed for a doctor. If it's designed for patients/care givers, then it's not CME.
ACCME-accredited provider	The definition of public representative is vague. Will the ACCME provide a definition or is this self (provider) defined?
ACCME-accredited provider	I believe the criterion is clear and the elements are well stated; however, it becomes complicated when you start requiring a percentage of activities.
ACCME-accredited provider	I am not sure how to interpret the 25% of learners-- who are patients? this standard seems to be more difficult to assess in terms of expectation for patient involvement-- Is the goal to have patients engaged int the planning and or presenting? then it seems to me that you would have to use the metric of activities not learners as the appropriate measure for compliance here--
ACCME-accredited provider	The standard is untenable for many providers. Consider 10% of all activities.

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C24: Since you answered 'no', please explain and/or suggest edits.	
Organization Description	Comments
ACCME-accredited provider	Planners who are not health care professionals? We partner with many public health entities (health depts., etc) but in order to satisfy this one, there must be willing non healthcare professionals. 25% way to high. We do have patients on panels, speakers, but not sure 25% of the time.
ACCME-accredited provider	It is not clear what is meant by 'public representatives'. For example, this could be a staff member from a health advocacy organization (e.g. American Diabetes Association) or a member of congress.
ACCME-accredited provider	My same comments apply to the metrics. Public engagement in theory is a good idea, however, it is often neither feasible or appropriate. This should be one of those items that is desirable but not necessary in order to accomplish meeting the boarder family of criteria.
ACCME-accredited provider	'Public' needs to be better defined. We have concerns about the requirement to for patients/public to participate as both planners and faculty, as there may be instances in which they can be helpful in identifying needs and gaps but may not be qualified to be faculty. The expectation for a % of learners or activities will disadvantage providers who have very robust and substantial initiatives in key areas and reward providers who have superficial and perfunctory practices across many activities/learners. We suggest instead that providers be asked to submit several examples to demonstrate compliance.
ACCME-accredited provider	Again, mandating who teaches misses the point of effective education in 25% of the activities. This has to potential to put planners at odds with meeting criteria vs planning effective education.
ACCME-accredited provider	Rationale states '...patients and the public...'; Critical Elements states '...patients and/or public representatives...' Suggestion to confirm if it is both patients and public or one or the other. Is '> 25% of activities and or learners' over the accreditation term? Annually? or other?
ACCME-accredited provider	What defines a 'healthcare professional'? Is it a licensed person who delivers healthcare to people, or is it a professional who works in some aspect of the healthcare industry? There is a distinct difference. Some examples of where the definition of 'healthcare professional' might be ambiguous: hospital's attorney, social worker or chaplain.
ACCME-accredited provider	If the rationale states 'incorporate patient and public representatives as planners, teachers, and learners in the accredited program,' should the proposed criteria state, 'Engages patient/public representatives in the planning, delivery, and target audience of CME.'? Again, define and/or learners. Larger operations have many more learners. It would be near impossible to hit either >25% of activities and/or learners, but we have a wide variety and large number of programs that where over 25% of the learners are non-physicians and are cooperatively planned with patients and public. Define 'teachers/authors.'

Call for Comment Responses: Proposal for a Menu of New Criteria for Accreditation with Commendation

C24: Since you answered 'no', please explain and/or suggest edits.	
Organization Description	Comments
Other	Should we have patient and public representatives attending our M&M conferences and Case Conferences? I'm not sure if it is a good idea. Even for activities where there would be no confidentiality issues, I'm concerned that the patient/public reps might find most of the planning meetings very boring and tedious and I think we might have a high attrition rate of the reps unless (or even if?) we compensated them financially. For those of us with hundreds of activities, paying patient/public reps to attend 25% of the planning committee meetings would be cost prohibitive and probably not in the best interest of health care.
Other	Clarify >25% standard and if an activity can count more than once toward that standard. Word "teachers" not consistent with wording in C23 when term "faculty" is used. Same for C25.
Other	What is meant by the term 'public representative', a definition will ensure all providers are working with the same goals in mind. The threshold of 25% is far to high and would appear to bias this criteria towards certain provider types
Physician/healthcare professional	See last answer
Physician/healthcare professional	I think it is clear as written, and organizations that have a national best practice Patient/Family Advisory Council will understand how to operationalize this. But others may not. I think more guidance on engaging this type of stakeholder may be helpful.
State-accredited provider	Does this mean 25% or more of the activities would need to be authored or presented by non-healthcare representatives? If so, that would not be doable for us in a hospital so I could never use that criterion.
State-accredited provider	The CME Committee expressed concerns with the standard of >25% for this criterion. We may be able to meet 5 or 10%, but with being a small community hospital it will be hard to have a quarter of our presentations have patient/public members on the planning committee. Would having a patient/public member on the CME Committee that reviews and approves each activity meet this requirement? Also, CME Committee members stated physicians are not going to attend an educational activity presented by a patient. How would someone with a non-clinical background be able to meet the scope of practice of a physician?
State-accredited provider	Critical Elements: 'Teachers/authors' needs definition.
State-accredited provider	When you say it's important to involve patients and the public in the planning of CME are you asking us to have a patient or non healthcare professional on the CME committee to help plan CME?

Call for Comment Responses: Proposal for a Menu of New Criteria for Accreditation with Commendation

C24: Since you answered 'no', please explain and/or suggest edits.	
Organization Description	Comments
State-accredited provider	<p>Questions that will arise from the rationale: If we are providers of professional education - then why do we need to include others as the learners? (Including them as planners is fine). The critical elements help explain but the rationale needs revision.</p> <p>25% is too high. Many of us have many RSS activities that teach highly technical info and are not appropriate for general public input. One series can have 5000 participants and I can't use any of them of this criteria. I also do many series so tough to meet the 25% of activities.</p>
State-accredited provider	I think the standard of > than 25% is unreasonably high. The practicality of planning CME inclusive of patient or public representatives as teachers or planners is already a difficult hurdle, assigning a minimum number is unreasonable and onerous
State-accredited provider	Being not a teaching hospital it would be hard to include patients.
State-accredited provider	The percentage should be lowered for the pilot period.
State-accredited provider	What constitutes healthcare professionals? Allowing patients or public representatives to plan, author, or teach physicians would not help the physicians meet their gaps. Patients and non-healthcare public representatives typically do not understand medical terminology. To create an educational activity for patients or non-healthcare public representative dilutes the activity educational level for physicians, which minimizes achieving their identified gap. If a CME program could meet the critical elements, the standard is too high to meet the level. This would cause the CME program to dilute their activity variety.
State-accredited provider	<p>Please delete the percentage.</p> <p>I was hoping that the accreditation process was going to be simplified, especially for the one person CME Office in a small community hospital that the doctors pay for the speakers to come in. Most of my CME Program is made up of speakers within the system so they do not get paid.</p> <p>This could be doable, but I would only be able to do one or two programs a year, and it would not be part of the needs assessment that we are suppose to go by to schedule the lectures</p>
State-accredited provider	Clear, yes. But from the CME point, involving various and sundry persons as planners, teachers and learners will change the level and quality of the material provided, and will affect the usefulness of the education and its ability to fill real gaps in physicians' daily patient care. It is already onerous for small programs to fulfill the regular criteria; fulfilling the Commendation menu will be close to undoable.

Call for Comment Responses: Proposal for a Menu of New Criteria for Accreditation with Commendation

C24: Since you answered 'no', please explain and/or suggest edits.	
Organization Description	Comments
State-accredited provider	Define 'Learners' is that physicians only or ALL attendees of each activity. Are you looking for the percentage of credit hours or a percentage of single activities? Would appointing the appropriate patient/public representative to our CME Committee meet the requirement for planners? How often would you want to see non-healthcare professionals as faculty or authors? 25% or greater seems to be too many.
State-accredited provider	Although the Criteria is good the Standard will be difficult for surveyors to evaluate. Percentage standards are reminiscent of the old RSS Monitoring Policy that was eliminated. Percentages are difficult for surveyors and providers.
State-accredited provider	I am unsure as to how non healthcare professionals can add to the mission.

Call for Comment Responses: Proposal for a Menu of New Criteria for Accreditation with Commendation

C24: Please provide comments or questions about this criterion.	
Organization Description	Comments
ACCME Recognized State Medical Society	I would suggest that this criteria could be made more applicable to wider number of providers if the AND was removed from the critical elements. This would allow providers a broader opportunity to engage patients and public representatives, something needed and important in the education and improvement of healthcare. The AND creates a restriction that is not necessary.
ACCME Recognized State Medical Society	I've polled many of the ISMA accredited providers. This is a great concept for larger hospitals, but very difficult for the smaller hospitals. And, the % is too high for those that may try to incorporate this type of program/project.
ACCME Recognized State Medical Society	I would eliminate 'who are not healthcare professionals' since this eliminates docs, nurses and others who also are/become patients and can educate the learners from the perspective of being a patient.
ACCME Recognized State Medical Society	IMS suggests the critical elements be changed to state "planners include patient and/or public representatives who are not healthcare professionals OR teachers/authors include patients and/or public representatives who are not healthcare professionals." In doing this, it makes this type of accreditation more assessable to providers, particularly those who do not work in multi-disciplinary focused organizations, or with students and/or residents; for example, an emergency medicine physician organization, which only employs physicians. This would be the only criterion that they could attempt to meet within the "Inclusive Teaching and Learning" section.
ACCME Recognized State Medical Society	<p>The Standard - decrease to 5%.</p> <p>Critical Element - revise to AND/OR.</p> <p>For the first critical element - could this include data gathered from surveys, questionnaires, focus groups, etc. from patient/public representatives and then utilized for addressing needs and incorporating into the planning of the activity(ies) instead of a planning member being included?</p> <p>The expansion of the committee might make the activities cumbersome and excessively time consuming for non-clinical providers, but for the most part a good criterion to include.</p>
ACCME Recognized State Medical Society	The 25% standard should be lowered to 10%; using patients/public reps as teachers in one-quarter of all activities is a lofty standard. How does this criterion serve to narrow a practice gap which is the primary intent of education? Would the effort to comply with this criterion skew decisions about what to offer in the program, leaving out other valuable education? Patient input is valuable but the 25% bar, especially the second element, is very high. Either drop the second element or lower to 10%.
ACCME Recognized State Medical Society	Standard percentage is a concern - see 1st page for details.
ACCME Recognized State Medical Society	This is a very good Criterion, but, again, we think the percent of activities and/or learners is too high to be achievable.

Call for Comment Responses: Proposal for a Menu of New Criteria for Accreditation with Commendation

C24: Please provide comments or questions about this criterion.	
Organization Description	Comments
ACCME-accredited provider	The outcome standard set for this criterion is unattainable for our small, community healthcare organization. Not likely to be able to achieve.
ACCME-accredited provider	I think that targeting patients and the public in more than 25% of activities is challenging. Most topics are clinical in nature and those that aren't often target healthcare professionals (though not necessarily physicians).
ACCME-accredited provider	This requirement reinforces the need for all physicians to practice patient centered care.
ACCME-accredited provider	No comments here
ACCME-accredited provider	Why are both critical elements required? It may not always be appropriate for the patient/public representative to be a teacher or author--while a patient may have feedback and perspectives to share that add value to the education, it does not necessarily follow that he or she would be an effective educator or that he or she would be comfortable in that role (for privacy reasons, for example). Using 'or' instead of 'and' would be more feasible. This criterion will also be challenging for those providers who are not connected to a hospital, health system, or medical center.
ACCME-accredited provider	>25% seems really high. You might get more people to attempt achieving this criterion if the percentage is more manageable. I think even 15% would be a great effort and might make people think about using patients and/or public representatives more strategically and appropriately. With 25% I would be afraid patients and public reps would be involved in a more perfunctory manner, rather than a strategic and meaningful manner.
ACCME-accredited provider	This percentage is very high. This model will take some time to thoughtfully transition to as this is not traditionally done in the CME programs I have encountered.
ACCME-accredited provider	One concern we have with this criterion is patient and/or public knowledge and understanding of practice guidelines. This criterion seems to be trying to be all things for all people. While patient and public input is valuable, we think that learner-focused activities would be best served to provide them with the highest caliber of education.
ACCME-accredited provider	This requirement is much more difficult than it seems. Few patients would be both interested and capable. Perhaps 10% would be a significant accomplishment.
ACCME-accredited provider	What guide will be offered for 'how many' patients and/or public representatives are suggested to be included?
ACCME-accredited provider	Great idea, challenging to implement. Blending CME and patient audiences may result in programs that are unsatisfactory for one or both groups!
ACCME-accredited provider	It would enhance and strengthen patient doctor relationship

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C24: Please provide comments or questions about this criterion.	
Organization Description	Comments
ACCME-accredited provider	>= 25 % seems high. Meetings I have attended with a public/patient speaker have made valuable contributions but 25 percent of a 14hrs CME meeting (3.5 days) is 3.5 hours of a patient (non-evidence based) possibly skewed, unreferreed, biased or prejudiced(by particularly good or particularly bad outcome) information. For example Patient X might say St. Elsewhere gives the very best care in the world for condition A-- a Physician speaker would not be allowed to say something like that. This requirement will put health care providers and CME content reviewers in a position to have to referee or correct patients about their perceived (but biased) experience and that is not going to be something we want to do to a patient. 1 hr of 14 hour CME meeting (7 %) I found very valuable however to hear about patient experience and perception.
ACCME-accredited provider	For medical specialty societies who teach a majority of technique specific courses, this criterion would not be feasible to meet.
ACCME-accredited provider	I think this is an awesome idea. It is something CMDA has not done and we will need to explore how to implement. Patients, often time, know what they need more so than the healthcare provider. This Criteria will broaden Provider efforts to share with their learners what patients and others need.
ACCME-accredited provider	1. The Standard seems high, considering this is a new concept in CME. 2. The Critical Elements should be one or the other -- but not both. We believe the Critical Elements should be as follows: Planners include patients and/or public representatives who are not healthcare professionals AND/OR teachers/authors who are not healthcare professionals.
ACCME-accredited provider	More than 25% is too high a bar for this, since it is so new a concept to most CME planners and will have its challenges with implementation, sort of a paradigm shift. Suggest lowering the bar to 10%
ACCME-accredited provider	I am not convinced that there is a benefit for involving patients and public representations as planners in many if not all of our CME activities. This will just lead to added time and expense without any improvement. I am certain that adding patients and public representatives as teachers at 25 % of events will not be beneficial.
ACCME-accredited provider	Pathologists do not work with patients the same way as other professions do. We have little patient contact. Incorporating patients into over 25 percent of the activities would not be productive/helpful. The public and patients would not really understand the needs of the pathologists in most of our education.
ACCME-accredited provider	This standard is too high if all CME programming is required to have patient/public involvement. If the element were patient/public perspectives and providing educational opportunities-- that would be achievable. It would be possible to have a representative patient and public advocate on the program planning committee to provide input and to attend our sessions and to evaluate some of our programs but not across the board. While there could be specific educational sessions that would benefit from the public as teachers- e.g., legal perspective or patient perspective on food allergy, this would be limited.

Call for Comment Responses: Proposal for a Menu of New Criteria for Accreditation with Commendation

C24: Please provide comments or questions about this criterion.	
Organization Description	Comments
ACCME-accredited provider	The standard of ?25% of activities and/or learners is too high. For a sub-specialty medical society who does not have many activities, this criterion's standard would be very hard to achieve. We suggest basing the standard on number of credit hours of activity. A 1 credit activity and a 50 credit activity may have different parameters and not all will include patient/public representatives. Also, involving patients in pediatric healthcare planning and delivery of CME is not feasible or appropriate for a scientific activity. This is like the phenomenon of having crime victims sit on law enforcement advisory councils. It sounds good and inclusive, but being a victim of crime doesn't suddenly give you the skills of a detective.
ACCME-accredited provider	Medical specialty societies are unable to achieve this criteria due to the inherent nature of there organizational structure. This is a relatively new concept in CME and the standard is set too high.
ACCME-accredited provider	Involving patients with experiences of medical care, delivery, and the safety incidents in training has an ideological appeal and seems obvious. While incorporating patients in educational activities may impact on emotional engagement and learning about communication, will this translate into improved behaviors in the clinical context or will there be any negative effects. A review of the literature has demonstrated arguments on both sides. This should be encouraged but not sure if having a standard of >25% of activities is realistic for the impact this criterion is trying to achieve.
ACCME-accredited provider	C24: Many of the educational activities provided by our society are technique or skill focused. This is not appropriate for non-healthcare professionals to plan or teach. The standard is too high to be reasonable for our membership's needs. We would recommend incorporating non-healthcare professionals into 1 accredited activities in the accreditation period as the standard.
ACCME-accredited provider	<p>Because this is relatively new for CME, it would be helpful to start at a lower standard (e.g., 10%) and then increase steadily to enable providers to incorporate this approach into their programs over time.</p> <p>While patients/public representatives may provide valuable perspective, there is concern that having patients plan AND teach may dilute the level of teaching, as they may not have the skills and expertise to effectively participate in planning and delivering education.</p> <p>In the Critical Elements, could 'AND' become 'AND/OR,'" which could help gain this perspective while still maintaining appropriate levels of teaching?</p> <p>As with C23, can an individual be both a planner and a faculty member for a single activity?</p>
ACCME-accredited provider	<p>This too does not make sense for our society, particularly for anesthesiologists.</p> <p>Again, how was the 25% threshold arrived at and what data is there to support this premise?</p>
ACCME-accredited provider	it might be appropriate to involve patients for some activities but the metric is too high

Call for Comment Responses: Proposal for a Menu of New Criteria for Accreditation with Commendation

C24: Please provide comments or questions about this criterion.	
Organization Description	Comments
ACCME-accredited provider	The Standard is too high for this. Currently we have activities that incorporate this, but given our large educational portfolio, we could never achieve this standard.
ACCME-accredited provider	We believe contributions from patients and/or public representatives in the planning and delivery of CME provide a needed perspective. We also concur that the inclusion of health professions students as teachers/authors can benefit both students and physician learners. However, while some content development processes lend themselves to inclusion, other processes, e.g., case writing, would prove difficult to be inclusive of non-health professionals and/or students in >25% of activities. Because of the potential burden to providers and patients/public representatives, we recommend The Standard be reduced to >10%of activities.
ACCME-accredited provider	Clear enough as to intent and verbiage. I am impressed though, that imposition of this sort of thing will promote further resentment and designs for alternative certification by the medical profession. Cf current journal ads for the 'National Board of Physicians and Surgeons' in response to some ABMS members' reactions to MOC.
ACCME-accredited provider	I would like to see examples of fulfilling this criterion.
ACCME-accredited provider	agree
ACCME-accredited provider	I wholeheartedly agree that patient perspectives should be included in all education.
ACCME-accredited provider	This criterion needs to be more explicit on what is mean by incorporating patient and public representatives as planners, teachers, and learners in the accredited program. There is clearly a difference in educational level between physicians and patients. Therefore, the expectation of 25% or more patient involvement in planning or participating is excessive. There are questions that must be considered: Can patients afford to attend conferences, purchase journals, or pay for CME processing? What about patient confidentiality?
ACCME-accredited provider	Consider reducing The Standard for inclusion of patients in >25% of activities or learners to >10%.
ACCME-accredited provider	We think this will be a stretch for many providers. Under Critical Elements, it would be more doable and reasonable to change 'AND' to 'OR'.
ACCME-accredited provider	The standard of 25% is not practical. Although having patients/ public representatives would enhance some educational activities (e.g. how to deliver bad news or smoking cessation), there is no evidence that it would enhance the majority of CME activities (e.g. RSS, recent advances in the treatment of ...).
ACCME-accredited provider	As indicated previously I question the standard.
ACCME-accredited provider	This criteria is very concerning. Soliciting feedback from the community and non-health professionals is an enormous burden due to HIPAA guidelines and the very different needs of physicians learners versus the patient perspective. The CME environment is for physician learners to engage in knowledge and a free exchange of knowledge and ideas. This criteria would undermine the effectiveness of CME and the value it has to my physician learners.
ACCME-accredited provider	Again, clear as written but unsure how we will achieve greater than 25% participation in our list of activities. An onerous task.

Call for Comment Responses: Proposal for a Menu of New Criteria for Accreditation with Commendation

C24: Please provide comments or questions about this criterion.	
Organization Description	Comments
ACCME-accredited provider	For a large decentralized program, it will take time to educate our CME community on the value of patient engagement and the processes that we would need to put in place. Therefore, it is our suggestion that as we transition to a new process, that we would like to see the proposed # of activities to meet the requirement (25%) be reduced to 5-10% with an option to increase at a later time.
ACCME-accredited provider	Again, this percentage is way too high if you are providing a total of 200 external and RSS programs a year.
ACCME-accredited provider	See concerns from page 1 of the survey related to The Standard
ACCME-accredited provider	Would be ideal to have patients and public involved in the planing phase but not sure if learners would truly attend activities with patients as the teachers. This would be especially challenging if it needs to be >25% of activities.
ACCME-accredited provider	The criterion is clear but I do not agree with the standard. Currently there is no percentage or number of activities and/or learners required for any of the Commendation Criteria/. I think that more providers will put forth the effort to achieve this and the other criteria if there is no percentage or number standard attached.
ACCME-accredited provider	This is clear and it's an excellent criterion. I would love to have patients engaged in the process of planning and evaluating RSS, which would be necessary to achieve the 25% of activities/learners for our medical school. Some guidance on how to engage patients/the public as teachers/authors in RSS would be helpful. Would it be sufficient for them to serve as planners, and as teachers/authors for selected activities? What number would demonstrate compliance (eg for a weekly RSS?)
Media	EXCELLENT idea!
Other	I object to the standard of 25% of activities and or learners. It is too high. I recommend 1 activity per year of accreditation as the standard.
Other	Because this is a relatively new phenomenon in CME it would be helpful to start at a lower threshold for compliance, possibly 10%, and then scale up to allow providers an opportunity to incorporate this approach into their programs. In the Critical Elements, could 'AND' be 'AND/OR'? As with C23, can a single individual be both a planner and a faculty member for a single activity?
Physician/healthcare professional	This is an important and innovative criterion.
Physician/healthcare professional	Same critique as before: I think this sounds great on paper but in practice, I'm not sure how to achieve the kinds of percentages advocated here, and I'm not sure that all of us in medicine really benefit from this. I, for one, am a pathologist, and a CME provider doing truly exceptional work for ME and MY specialty might not achieve a fraction of this. I think it is irrelevant to receiving a 'commendation'.
Physician/healthcare professional	Teacher and authors are very unlikely in small communities. Utilizing the public is achievable and reasonable.
Physician/healthcare professional	tough for smaller institutions

Call for Comment Responses: Proposal for a Menu of New Criteria for Accreditation with Commendation

C24: Please provide comments or questions about this criterion.	
Organization Description	Comments
Physician/healthcare professional	This is worse than the multiple professional groups learning together in the last section. I believe that the public and those served by the healthcare system and the political policy makers need to have a say on the large societal issues of how medical delivery will be organized. But I don't see how the public can direct CME on highly technical topics.
Physician/healthcare professional	I am not sure that patients and the public would make the best choices of what topics physicians need most to learn about, as their perceptions are often skewed by the inaccuracies of the popular media, e.g. most women think they are much more likely to die of breast cancer than heart disease.
Physician/healthcare professional	Yes, the criterion is clear but many times, it is not practical for non physicians to be a part of CME planning process due to the complexity of the CME content that is required for some physician specialties or topics.
State-accredited provider	Clarify the standard part. What is 25% of the learners mean for this criteria?
State-accredited provider	To include patients in 25% of the activities seems high to me!
State-accredited provider	The minimum 25% for this criterion will be difficult to meet for the smaller entity.
State-accredited provider	The response of physicians is mostly derision and adement opposition. Others just laugh.
State-accredited provider	(See previous comment)
State-accredited provider	We suggest The Standard be: no less than 5% of activities and/or learners. We suggest the 'public representatives' not be individuals with a narrow scope of knowledge/goals - but rather be representative of entire community we serve.
State-accredited provider	1. Meeting the standards for the new criteria will appear to require a lot more data gathering and analysis to be compliant, which will ultimately result in more costs. 2. The standards for many criteria are too rigorous, for example, in calling for >25% of activities and/or learners or >10% of activities and/or learners. Many CME providers do not have the volume of CME activities to meet this standard.
State-accredited provider	I believe that having 'the standard' of greater than 25% of activities and/or learners would be almost impossible to reach. Also, even further break-down of 'non-physicians' would be needed in PARS.
State-accredited provider	Modify Critical Elements to AND/OR rather than AND.
State-accredited provider	Again as above. I believe that the standard as written is way too high. and greater than 25% of our activities that would be about 75 activities that would have to meet this and with the number of Journal Clubs and case conferences we hold out of our approximate 300 programs this would be difficult to achieve. I am unclear what is meant by 'and/or learners' and how those number would translate. Also I believe that the increased workload to meet this high number of activities with a CME office that is staffed by a CME director, CME manager and Admin Assistant/coordinator along with additional responsibilities added to the plate with ABIM and other specialty boards this is unrealistic. We have been accredited with commendation for the past 2 cycles and I am not certain this added work is worth the bang of receiving 6 years instead of 4. I also thin that the critical element should include and/or and not just and to make it more realistic.

Call for Comment Responses: Proposal for a Menu of New Criteria for Accreditation with Commendation

C24: Please provide comments or questions about this criterion.	
Organization Description	Comments
State-accredited provider	While we do include patients and the public into the delivery of our CME where appropriate, i.e. Pain Symposiums, Child Abuse Education, etc, I do not agree with the 25%+ requirement. 5 activities/year may be appropriate but as education should change from year to year, it may not always be appropriate.
State-accredited provider	The percentage for compliance is too high in a community hospital setting where it is difficult to drag PCP's into community based learning. A criterion like this will limit the activities drawn from the PPG's presented by our own medical community.
State-accredited provider	The term teacher is used in Criterion 24, but the word faculty is used in Criterion 23. We recommend consistent use of the word. Our institution uses the term faculty. ?25% is a high percentage to meet for community hospitals or non-University settings. The other recommended standards for the other 4 categories are ?10% so we recommend a ?10% standard on this criteria.
State-accredited provider	None
State-accredited provider	Introducing patients/public into planning of activities will lengthen the process without necessarily improving the activity. Involving patients in development of care models and guidelines makes sense, but implementation and CME should be done by the healthcare professionals.
State-accredited provider	Past practice has not yielded significant outcomes by doing this. Sometimes physicians need to be able to discuss from a physician's point of view. Other times this is appropriate but 25% of the time seems too high. This would also require longer planning cycles and staff to coordinate.
State-accredited provider	There is no way our planning process, which is done by a volunteer committee, a dedicated coordinator, and DME, can also include patients/the public in planning. There is no mechanism to reach patients, nor is it shown to be worthwhile. I'd really like to see some evidence that the process as you suggest results in improvements in health care. Do you have any studies you can point to, or is this merely your opinion or something that you 'feel' is worthy.
State-accredited provider	The standard is a challenge. I may do each element of the this category which is above and beyond the criteria for accreditation, but cannot guarantee a percentage each year of my programs or of all my participants. My planners are physician leaders, administration, nursing or other staff who identify the focus the content and the speakers. Additionally many are hesitant about including patients when addressing gaps as planners and presenters as most are lay people who do not have the experience to educate versus complain or be emotional to address gaps.
State-accredited provider	Have suggested this in the past and was told no. Thought of inviting nurse navigators or other patient advocates, someone who works with patient support groups, but these are healthcare professionals. Thought of some of our hospital volunteers as possibilities, but who would be the best choice? Where/how could such people be recruited? If they work for the American Heart Association, etc. doesn't that make them a (healthcare) professional patient advocate? Suggestions and guidance for compliance with the criteria would be most helpful.

Call for Comment Responses: Proposal for a Menu of New Criteria for Accreditation with Commendation

C24: Please provide comments or questions about this criterion.	
Organization Description	Comments
State-accredited provider	I may think this is clear however good luck getting physicians to attend...they won't (or a majority of them won't). It is even challenging to get physicians to attend events where the faculty are qualified nurses or allied health professionals. The exception might be a simulation led by a nurse or a health professional with certification to teach (such as BLS, ACLS, NRP etc.). I generally recommend to anyone planning a CME event that a physician be part of the faculty even if it is just a minor contribution to the program.
State-accredited provider	I think that setting a standard of 25% for this is high.
State-accredited provider	This seems to me to be about patient centered care. I wonder/question if BOTH critical elements are needed in order for a single activity to meet this criterion. I would suggest that either one is sufficient. Also, I have the same concern (and suggestion) as i do with the other criteria about the % standard. Another general question I have about the % standard and in using PARS for determining the % standard, is will the ACCME somehow 'verify' or 'validate' the provider's entries? Will it be more than just a check-off box on PARS? The validity and documentation question seems important because providers that meet Commendation get significant benefits, ie, 2 more years of accreditation.
State-accredited provider	It is clear, but not seem feasible to include patients and community in 25% of all events.
State-accredited provider	Decrease the standard to 5%. Take the 'AND' away and replace with 'OR' in the critical elements section.
State-accredited provider	Again, I am concerned that >25% is just too high. To invoke a patient in 25% of activities and still maintain all the other CME accredited activities we are doing where this criteria is not relevant is an unfair barrier! I think the quantification of all the criteria is unreasonable to success and so instead of motivating people to do this new and improved criteria, the numbers make it defeating.
State-accredited provider	It is doubtful that we could comply with this criterion, particularly the element of 25% patients as teachers.
State-accredited provider	Clear
State-accredited provider	All of our organization's personnel come from outside the healthcare profession. This includes people who are or have been patients as well.

C25: Engages health professions' students in the planning and delivery of CME.

C25: Since you answered 'no' above, please explain and/or suggest edits.	
Organization Description	Comments
ACCME Recognized State Medical Society	This criterion presumes the provider will have access to medical students (extremely busy) or university students for nurses, etc. In our circumstances, the possibility of being able to comply are very slim. Our providers rely on physicians for CME which means schedules are so diverse that communication with students for planning, etc will be too difficult. I understand the importance of their input, but so far, in spite of my efforts no medical student and much less interns and residents have comply with any participation we have offered. Their load is too heavy. About university students, access to them is cumbersome.
ACCME Recognized State Medical Society	Unable to assess. Inadequate and/or deficient methodological evidence of validity, reliability and application practicality of process. Details upon request. E.g. lack of evidence this criteria should carry same "weight" as any other and is exclusive of other criteria to avoid double weighting. Applicability/importance depends on nature and scope of provider and activity. This criterion is one of three that address "inclusive teaching and learning." How does the ACCME know that having 25% of activities' planners including students and 25% of teachers including students is equivalent to C.23 and C.24? If they aren't actually equivalent, shouldn't the ACCME require some level of performance in each criterion? Ambiguous: does the criterion mean both in the same activity, or each in 25% of activities (which may differ)?
ACCME Recognized State Medical Society	Again, the percentage, per year or per term? Also can't see small/rural providers meeting this standard due to lack of resources/staff. Someone (possibly the part-time CME coordinator) would need to oversee 'student engagement' CE in addition to RSS activities.
ACCME Recognized State Medical Society	<ul style="list-style-type: none"> - How much of a planner role would be required from the student? - What if you are a rural clinic and students would have to travel some distance to be involved. This would be a barrier for many. - Does this include residents?
ACCME Recognized State Medical Society	<p>Critical Elements:</p> <ul style="list-style-type: none"> - Better if allowed for this OR that, instead of this AND that. <p>The Standard:</p> <ul style="list-style-type: none"> - It is unclear whether the "% of activities or the % of learners" represents the % of learners in a given year of activities or for the entire accreditation term. - ?25% of activities and/or learners – ?25% too high

Call for Comment Responses: Proposal for a Menu of New Criteria for Accreditation with Commendation

C25: Since you answered 'no' above, please explain and/or suggest edits.	
Organization Description	Comments
ACCME Recognized State Medical Society	<p>The word student needs to be defined. We recommend that this criterion to be amended to include not only student but also trainees and colleagues from across the continuum of health professional education.</p> <p>The intent of this requirement is very important – CME must understand the needs of students and residents so we can prepare them for future practice. There are also many areas of convergence across the continuum, such as faculty development, core competencies, etc. We also have concerns that faculty must include students/residents. Although they may have unique perspectives, they lack the domain expertise and experience required of faculty in many CME activities. It is also not feasible to expect that CME providers in many settings will have access to students/residents. As described above, however, we have concerns about the attempt to determine compliance based on the percentage of activities or learners.</p>
ACCME Recognized State Medical Society	Delete 'CME is an integral' Delete 'Student engagement' since it just restates in the same words the criterion and may not meet their future needs. 'building bridges' is poetic but not needed. I think one could include 'docendo discimus' - by teaching one learns. Encouraging students to teach, it facilitates their own education and promotes other skills.
ACCME Recognized State Medical Society	The criterion statement and first critical element state “health professions’ students,” however, the rationale does not contain any reference to multi-disciplinary or health professions’ students. There is no mention of residents within the criterion statement or rationale.
ACCME Recognized State Medical Society	<p>Revise to: 'Engages health/allied health professions' attending school/training in the planning and delivery of CME.'</p> <p>Revision suggested because allied health plays a role in patient care.</p> <p>Clarify 'students' in the criteria or replace with 'attending school/training' to cover medical students, interns/residents/fellows, nursing, etc.</p> <p>The Standard - decrease to 5%.</p> <p>The expansion of the committee might make the activities cumbersome and excessively time consuming and for non-clinical providers, but for the most part a good criterion to include.</p> <p>Modify critical elements to be AND/OR.</p>
ACCME Recognized State Medical Society	CME is for physicians (not future physicians). The definition of CME needs to be revised in order for the Criterion to be considered. CME is an integral part of continuous professional development. Also, % of the standard is not a good idea for any Criteria; this will be too complicated to calculate. Providing multiple examples for a Criteria should be sufficient for a compliance finding.

Call for Comment Responses: Proposal for a Menu of New Criteria for Accreditation with Commendation

C25: Since you answered 'no' above, please explain and/or suggest edits.	
Organization Description	Comments
ACCME Recognized State Medical Society	Need clarification on the standard of 25% of activities or learners. For example, is it 25% of the total of activities from the entire term of accreditation? Or could it be 25% of activities from 1 or 2 years of accreditation? 25% of activities or learners will be difficult for many providers in our state system to achieve, as this is by far a very new concept to most CME providers. Change the critical elements to OR, not AND. A percentage requirement is complicated for accreditors to work with during the survey process. Example, what activities and/or how many do we need to select for review?
ACCME Recognized State Medical Society	Please clarify whether residents are considered students. (See previous percentage comments.)
ACCME Recognized State Medical Society	You have changed CE to CME which clarifies for me that the education referred to is accredited CME. I am not understanding how '% of learners' applies to any of the proposed criterion where % of learners can be the standard. I am not understanding how '% of activities/learners' applies to RSS for any of the proposed criterion.
ACCME Recognized State Medical Society	Do residents count? It may prove difficult to include students as both planners and faculty without encroaching on the role of medical school or GME. As stated, the criterion may put too much weight on student involvement; moving the target audience from the practicing physician to the learning student. The ?25% of activities 'and/or' learners would be difficult for surveyors to evaluate.
ACCME Recognized State Medical Society	This criterion and the rationale may be achievable by larger providers or academic providers with access to students or residents, however in rural areas this would not be achievable, the use of the word 'AND' in the critical elements seems unreasonable. The Standard percentage will be very difficult for surveyors to assess or providers to achieve.
ACCME-accredited provider	Change C25 from 'student' to 'trainee' as this should include interns, residents and fellows of all relevant professions well as students. Again we recommend the equal or >10% metric for inclusion of trainees.
ACCME-accredited provider	Need further definition of student - for example - is a resident a student? More suited to an academic institution. Not suited for a community hospital.
ACCME-accredited provider	Are these students from all areas, i.e. pharmacy, radiology, nursing, or just medical students? And also an example is helpful.
ACCME-accredited provider	Some institutions do not have medical schools attached to them, if this what you mean by 'students.' How is this to be achieved, especially in 25%+ activities, if an institution has limited access to this demographic?
ACCME-accredited provider	What is meant by 'student' here? Students (pre-MD) enrolled in a medical school? Or would residents, fellows, and other postdoc trainees be included? This criterion will be very difficult for those providers who are in an academic setting.
ACCME-accredited provider	Would participation by medical residents qualify here?

Call for Comment Responses: Proposal for a Menu of New Criteria for Accreditation with Commendation

C25: Since you answered 'no' above, please explain and/or suggest edits.	
Organization Description	Comments
ACCME-accredited provider	How do you define 'health professions' students'? Is this nursing and medical students or are you including residents and fellows? If the latter, than we might be able to achieve the threshold of 25% of learners (though at 44,000 hours credited for 2015 I am not sure that 11,000 of those would be to residents and fellows). If you truly mean students, it would be impossible to have 25% of our learners be nursing and medical students. We are not in the business of educating medical students - that is what medical school is for. This criteria also states that students must be teachers/authors for 25% of the activities. We had 3000 activities in 2015. Are you suggesting that 750 of those activities would need to be taught by students? That makes no sense. I think this needs to be clarified and/or reconsidered.
ACCME-accredited provider	Please clarify-does this mean residents, fellow, nursing students, pharmacy students, etc? Is there a certain level of education?
ACCME-accredited provider	I feel AND should be AND/OR. May be difficult for some providers to get access to students (seems to be targeted more to health system/SOM provider types). Define 'student' - Do residents or fellows count as students since they are still in training?
ACCME-accredited provider	Please clearly indicate if "students" refers to Medical School Students and/or Residents and/or Fellows. 10.2 – In our institution, with one small Med School and residency affiliation, students and residents are invited to attend all CME activities free of charge. However due to their time constraints, they do not make this a priority. Since CME is not required, they are not motivated to attend. Were CME participation a requirement of the med school or GME curriculum – at a significant volume – this might be an approachable goal. However, the volume is far too high for an institution that is not a Medical School.
ACCME-accredited provider	Are interns and residents considered students? The ACGME considers them to be students. Residents should be included in planning and are an asset. Undergraduate students would be essentially of no value as they rotate thru various specialties in a cafeteria fashion are not anyplace long enough to have a meaningful role. They do not know enough to have meaningful input. If you are educating undergraduate students you will not be educating physicians. Undergraduate students should contribute to their school's planning.
ACCME-accredited provider	The criterion is clear, however, it should be scaled to adjust for the number of activities conducted by an accredited provider. This standard may be realistic in a teaching medical center but not in non profit organizations, non teaching hospitals and other types of organizations.
ACCME-accredited provider	Same as before, students will teach live lectures to MDs? Or they are authors of CME?
ACCME-accredited provider	Should the student provide input in 25% of the activities or should student be included as an author?
ACCME-accredited provider	Must both critical elements be present in all activities (referring to use of word "AND")? This criterion would mostly apply to health systems and academic providers. While other providers will use students from time to time, the bar of 25% will exclude most providers since we do not regularly have access to students.

Call for Comment Responses: Proposal for a Menu of New Criteria for Accreditation with Commendation

C25: Since you answered 'no' above, please explain and/or suggest edits.	
Organization Description	Comments
ACCME-accredited provider	We recommend this criterion be amended to include not only students but also trainees and colleagues from across the continuum of health professional education. CME must understand the needs of students and residents, so we can prepare them for future practice, and many areas of the professional development continuum do converge, such as faculty development, core competencies, etc. Separately, we also have concerns about including students as faculty, since they lack domain expertise, and CME providers in many settings may not have access to students. As noted above, we do not recommend requiring providers to apply this criterion to > 25% of their learners/activities.
ACCME-accredited provider	I don't understand how medical students could contribute in a meaningful way to CME when they are still engaged in learning the basics of medicine? Engaging residents & fellows or broadening this to engage planners from a diversity of career stages, practice & geographic locations and disciplines seems like it would better serve this notion of fostering a commitment to lifelong learning?
ACCME-accredited provider	Please clarify whether medical students and residents are considered health professions' students for purposes of this criterion. The Standard metric of >25 activities and/or learners is confusing. Is this based on the accreditation period or an annual threshold? If there is one large CME activity that eclipses all of the others in scope and it involves student planners and faculty is that compliant, or does this large activity simply count as 1 among many (equivalent to a journal article).
ACCME-accredited provider	'Students' requires definition - does this include any level of training, including fellowship and post-doctoral? Trainees by definition are in the process of acquiring the knowledge and skills needed to practice. How then are they prepared to create and teach educational offerings for fully practicing physicians? They don't know yet what they don't know. Perhaps a more useful concept would be to find alignment between the initial training process and the CME curriculum.
ACCME-accredited provider	Can you define health professions students. Does this mean medical school students and residents. How many students need to be involved. Basically if we had a resident part of the planning of over twenty-five percent of our activities, but it was just one resident would that qualify
ACCME-accredited provider	Do residents count in this criterion? The standard of ?25% of activities and/or learners is too high. For a sub-specialty medical society who does not have many activities, this criterion's standard would be very hard to achieve. We suggest basing the standard on number of credit hours of activity. A 1 credit activity and a 50 credit activity may have different parameters and not all will include students in the planning.
ACCME-accredited provider	Medical Specialty Societies are unable to achieve this criteria as it is currently written. What is the definition of a medical student? Do surgical residents count? Medical students have not acquired the knowledge and skills needed to develop continuing medical education activities. In addition, the standard is set too high.

Call for Comment Responses: Proposal for a Menu of New Criteria for Accreditation with Commendation

C25: Since you answered 'no' above, please explain and/or suggest edits.	
Organization Description	Comments
ACCME-accredited provider	<p>We need a clear definition of 'students' (are these medical students? If so, it is not wise to include them here since it is far too early for them to have any idea of what continuing education needs they will have when they haven't even started to select a specialty. If 'students' refer to physicians in training such as residents and fellows, then this might be more reasonable); 'author' (does this mean a publication? lecture? or simply help drive the objectives?).</p> <p>If the new criteria will be implemented when an organization is 2 years into its 4 year accreditation cycle, will we be required to implement 25% across all programs in the last 2 years of the cycle? How will previous 2 years worth of activities be reviewed?</p>
ACCME-accredited provider	<p>Many societies raised a concern about including health professions' students - a group that will require more definition - in the planning and delivery of education for physicians. Is a resident/fellow considered a student? If the students are still in training, what contribution are they intended to make to education designed for specialists and subspecialists? By definition trainees have not yet acquired the knowledge and skills needed to practice as a specialist. Could co-authors on papers fulfill this requirement?</p> <p>C23-25: All three of these criteria suggest an expansion of a provider's intended learners which may not be appropriate to the membership of a specialty society or to an organization's CME Mission Statement. This could mean that a specialty society could be disqualified from achieving accreditation because it could not demonstrate at least one of the criteria in this category. I somewhat alluded to this in C23.</p>
ACCME-accredited provider	<p>Do students teaching physicians make sense? We recommend residents be included as students.</p> <p>Additional Comments: We strongly recommend that the ACCME use only the term "OR" in each of its criteria, rational, critical elements, and measurement standards.</p>
ACCME-accredited provider	<p>1. RATIONALE: Does 'student' in CME include Residents and/or Fellows?</p> <p>2. THE STANDARD: considering decreasing to 10%</p>
ACCME-accredited provider	<p>If the students are still in training, what contribution are they intended to make to education designed for subspecialists? By definition, trainees have not yet acquired the knowledge/skills needed to practice as specialists. While health professions' students may provide valuable perspective, having students plan AND teach may dilute the level of teaching. If a goal is to build bridges, engaging health professions' students in teaching may not be the best way to meet that objective.</p> <p>Does "students" include residents and/or fellows in training?</p> <p>In the Critical Elements, could 'AND' become 'AND/OR?' The standard of 25% or greater is too high for all provider types.</p>

Call for Comment Responses: Proposal for a Menu of New Criteria for Accreditation with Commendation

C25: Since you answered 'no' above, please explain and/or suggest edits.	
Organization Description	Comments
ACCME-accredited provider	<p>C25: planners includes medical students again teachers and authors in planning and delivery. Since, we are not in the hospital setting without residents and medical students, this requirement maybe difficult. I can invite them in the CME meeting and review the evaluation but to sit down in a meeting may or may not be feasible. There is a redundancy in the C24/C25.</p> <p>For C23, C24 and C25: it can be done easier if frame C23: (1) target audience to be involved C24: (1) Patient/teacher/author not in HC. C25: (1) Medical student. With this, we have at least 3 involved in the process of planning, less expense and less intense, more ideal and more achievable. The points are so high, this is >25% each. I think this is impossible. If you do all these 3, at least 75%, you do not even have to do the rest of the activities! Planning is important but the rest is as important or more...</p>
ACCME-accredited provider	There is concern about including health professions' students in the planning and delivery of education for physicians. If the students are still in training, what contributions are they intended to make to professional education designed for specialists and subspecialists? By definition trainees have not yet acquired the knowledge and skills needed to practice as a specialist. Moreover, if students are considered ancillary to the membership of a medical specialty society, the threshold is again far too high for an organization where funds, including dues, are not allocated for students.
ACCME-accredited provider	What is the definition of student? Among a physician audience, can students be residents, fellows and/or young neurologists?
ACCME-accredited provider	If the students are still in training what contributions are the intended to make to educate specialists and sub-specialists.
ACCME-accredited provider	<p>The term "students" should be defined- does it include medical students all the way up to fellows? Can it also include students in other health professions?</p> <p>In addition, for the critical elements, the requirement of 'and' may not be achievable for all provider types, nor will 25% of activities and/or learners.</p>
ACCME-accredited provider	"Health professions' students" needs to be defined. Are "residents" also defined as "students?" Residents definitely should be included. Does "health professions' students" mean medical students, physician assistant and nursing students?
ACCME-accredited provider	AMIA agrees with CMSS: 'Many societies raised a concern about including health professions' students - a group that will require more definition - in the planning and delivery of education for physicians. If the students are still in training, what contribution are they intended to make to education designed for specialists and subspecialists? By definition trainees have not yet acquired the knowledge and skills needed to practice as a specialist.'
ACCME-accredited provider	The term "health professions' student" is not clear. While student feedback is important in determining whether an activity is effective, students, e.g., medical students, do not necessarily have the knowledge to teach senior practitioners. Describe a role for a student in instructing practicing physicians. This criterion does not seem appropriate for a medical professional society of practicing physicians.

Call for Comment Responses: Proposal for a Menu of New Criteria for Accreditation with Commendation

C25: Since you answered 'no' above, please explain and/or suggest edits.	
Organization Description	Comments
ACCME-accredited provider	How does ACCME define 'students'? I work in a physician membership organization. We offer numerous activities and opportunities to increase students' exposure to and interest in our field. By offering these opportunities, we have had to be more specific over the years in what we mean by 'students' - e.g., high school students, college students, medical students, graduate students, PhD candidates, etc.
ACCME-accredited provider	We recommend the term "health professions students" be clearly defined to include students at all levels, including fellows-in-training.
ACCME-accredited provider	As with my precious comments, the resources needed to achieve this may not be available to all sectors.
ACCME-accredited provider	We could easily add residents to our planning committee but it would be very difficult to find residents with the expertise in risk management and patient safety that is the purpose of all of our education? Once again, what is meant by 25% - our entire library every year or only those new ones that we develop every year? Also, do you really want residents to be authors of CME, they could provide input (be a reviewer) into the planning of the content and the design of the education but to be the sole author?
ACCME-accredited provider	define 'student'. does this include residents? When you say this AND that for 25% or more, do both have to be 25% or more? Students have to teach/author 25% of activities? Seems very high. Students may have knowledge on new techniques, but not enough for 25% of our activities. Again, seems like a niche criteria.
ACCME-accredited provider	The threshold should be lowered to no greater than 10%. This criterion favors one provider type distinctly over the other provider types, as well.
ACCME-accredited provider	In this criterion, I have the same questions as the last one. If the goal/desired outcome is to have students engaged in planning and execution of CME activities, then the appropriate metric would be activities and not learners. I would also ask that you be more explicit about students-- does this include interns, residents, fellows etc?
ACCME-accredited provider	Please clarify definition of 'student'.
ACCME-accredited provider	The definition of student needs to be clarified. Are we including residents and fellows who also reflect the continuum of education? What about faculty who are taking courses? Are they considered students of the course? The standard of 25% is not practical. Is that the best use of students' time to plan 25% or more of CME activities? Are they best suited to inform 25% or more of educational needs of practicing physicians? I would have like to see here a criterion that addresses the need to develop the faculty so that CME is aligned with the continuum of education and the need to teach our students 21st century health care and emerging health care needs (e.g. developing the faculty in value-based care and population health so they can teach effectively these topics to the next generation of health professionals).

Call for Comment Responses: Proposal for a Menu of New Criteria for Accreditation with Commendation

C25: Since you answered 'no' above, please explain and/or suggest edits.	
Organization Description	Comments
ACCME-accredited provider	<p>Does this include only students in degree programs (e.g. BSN, MD, DMD, PharmD) or does it also include residents and fellows or others who are engaged in some form of education post receipt of their health care degree?</p> <p>Although I applaud the incorporation of students into education, practicing professionals will not see value in what students in degree programs are able to teach; however their contribution to planning would contribute to improving education.</p>
ACCME-accredited provider	My comments are similar to those in C24.
ACCME-accredited provider	Although students and residents can contribute valuable perspectives to CME, it is unrealistic (and inappropriate) to expect that they will be appropriate as planners and/or faculty for a large proportion of our activities. In addition, many providers do not have ready access to students and trainees. The expectation for a % of learners or activities will disadvantage providers who have very robust and substantial initiatives in key areas and reward providers who have superficial and perfunctory practices across many activities/learners. We suggest instead that providers be asked to submit several examples to demonstrate compliance.
ACCME-accredited provider	Is '> 25% of activities and or learners' over the accreditation term? Annually? or other?
ACCME-accredited provider	The boundary definition of 'student' needs to be clarified. How are those people categorized who are still in training (may or may not be an ACGME-approved path of study) even though have completed the tuition-paying phase of their career development, and may even be getting a salary (residents/fellows)? Is one considered a 'student' if s/he has already matriculated and has been practiced clinically and then goes back for additional training such as a PhD, EDD, MBA, MEd, and simultaneously acts as a planner or teacher in the clinical arena from whence they had previously practiced?
ACCME-accredited provider	<p>What is meant by students?</p> <p>Are residents and fellows considered students?</p>
ACCME-accredited provider	The criterion is clear. I am not sure it is realistic. Students have enough to do learning the basics. It is not clear what the benefits to them would be to plan CME activities and serve as teachers or authors.
ACCME-accredited provider	Define 'student.' A teaching hospital has many different levels of student. We have full professors, current course directors, etc., that are enrolled in MBA and continuous learning programs at the institution, would they count? What about residents, fellows, etc.?
Other	an unintended consequence of this criteria could be that activities designed primarily or nearly exclusively for students/residents could be 'granted CME credit' merely by the presence of one physician involved in planning. Some clarification (probably in an FAQ with examples) might be helpful to delineate circumstances where there might be boundaries (admittedly, the boundaries may be fuzzy)

Call for Comment Responses: Proposal for a Menu of New Criteria for Accreditation with Commendation

C25: Since you answered 'no' above, please explain and/or suggest edits.	
Organization Description	Comments
Other	It is not a good idea to pull medical students or residents out of their courses or curriculum in order to attend a lot of planning meetings. Medical student and resident priority should be preparing for USMLE and seeing patients and I do believe planning CME activities will help a lot in that regard. Medical students and residents have a high intensity curriculum and demands on their time and I don't attending a lot of planning committee meetings should be a priority. Even if the CME leaders of an educational institution wanted this to happen, it would not happen. Most of our providers do not have control over how medical students or residents spend their time. This criteria should be deleted.
Other	Many societies raised a concern about including health professions' students - a group that will require more definition - in the planning and delivery of education for physicians. If the students are still in training, what contribution are they intended to make to education designed for specialists and subspecialists? By definition trainees have not yet acquired the knowledge and skills needed to practice as a specialist.
Other	Need to define student; is this anyone enrolled in study and not yet fully licensed or registered? Some other definition? Is the intent to be inclusive of residents as students?
Other	This threshold is far to high and should be lowered to 10%. This criteria is also biased towards certain provider types.
Physician/healthcare professional	This can be achieved when we have a medical student in our community, keep in mind though that this is a rare event - and may not occur on an annual basis.
Physician/healthcare professional	See last answer
State-accredited provider	clarify students-give examples: medical students, residents, fellows?
State-accredited provider	Does student = resident? If so we could maybe meet this because we have a residency program, if not, we never could because we only have a small percentage of students.
State-accredited provider	Define student more specifically.
State-accredited provider	'how' exactly? Is it enough to have their name on the minutes of the planning committee or is there some specific action required? This is a very weak element.
State-accredited provider	Do Residents qualify as 'students'?
State-accredited provider	What do you consider a 'student'? medical, nursing, resident, fellow? A 'student' needs to be clearly defined.
State-accredited provider	The Standard 'Teachers/authors' needs further clarification
State-accredited provider	Are you saying students need to be in on the planning of CME topics?
State-accredited provider	Are residents and fellows considered to be health professions' students in this definition? Modify Critical Elements to AND/OR rather than AND.

Call for Comment Responses: Proposal for a Menu of New Criteria for Accreditation with Commendation

C25: Since you answered 'no' above, please explain and/or suggest edits.	
Organization Description	Comments
State-accredited provider	What is the definition of student? It is broad or limited to medical students? If it is medical students, then it will be nearly impossible for smaller community hospitals to comply.
State-accredited provider	Can you provide examples of the tasks expected to be executed by students? The percentage should be lowered.
State-accredited provider	What constitutes a student? Is this criteria only for medical students or is it also for healthcare administration students? The standard to meet this criterion is extraordinarily high for hospitals that have only 3rd and 4th year medical students, or cater to nursing students or other healthcare students during their internship/externship rotations of less than 8 weeks.
State-accredited provider	Again please delete the percentage it could not be done in the hospital setting with the one person CME Office. This is geared for the larger institutions Medical Schools and Universities. At this hospital I do have nursing students that attend one CME lecture per month. Otherwise they are required to have class time here. I am not sure that this could be done
State-accredited provider	Too broad and non-specific. Which are the 'health professions' included, and which are not? At what level (s) of their education are the students able to participate in the planning and delivery of Continuing MEDICAL Education ?
State-accredited provider	Define 'Learners' is that physicians only or ALL attendees of each activity. Are you looking for the percentage of credit hours or a percentage of single activities? 25% may be a bit too high. At our hospital, health professions' students are here on a rotating basis. The CME Committee is open to having students (of various specialties) serve on a rotating basis. Would this meet the requirement? How would you propose including health professions' students as faculty for health professionals who already are in practice? We do a good job here of incorporating non-physicians as faculty. I am not certain how students would be viewed/accepted.
State-accredited provider	Decrease the standard to 5%. Please Clarify 'attending school/training'. Take the 'AND' away and replace with 'OR' in the critical elements section.
State-accredited provider	As an organization, we do not have immediate access to students so this criterion would be challenging.

Call for Comment Responses: Proposal for a Menu of New Criteria for Accreditation with Commendation

C25: Please provide comments or questions about this criterion.	
Organization Description	Comments
ACCME Recognized State Medical Society	Here is a good example of how these criteria are designed to reward specific types of providers and not represent the diversity of the CME community.
ACCME Recognized State Medical Society	Again, I believe that this is a great Criterion for a hospital that has the students and the staff to perpetuate this type of program development. However, I believe that the % is too high for the SMS accredited providers.
ACCME Recognized State Medical Society	Allow progression from meeting one to both Critical Elements (OR to AND). In other words, use OR instead of AND in the "Critical Elements" list.
ACCME Recognized State Medical Society	This criterion appears to be written for teaching institutions or those organizations in urban areas who have students who rotate through them and may be impossible to achieve when an organization's infrastructure does not include students. Eliminate the standard of students as teachers in 25% of activities. Criteria 23-25 requirement of 25% non-physician planner/faculty, 25% public planner/faculty, and 25% student planner/faculty doesn't leave much room for other faculty! And yes we understand that only one of this group needs to be met, but when a small provider offers one-hour activities and not multi-day, multi-session conferences, this entire grouping might be harder to meet than an initial reading might suggest, even when trying to address only one of the criteria.
ACCME Recognized State Medical Society	Standard percentage is a concern - see 1st page for details.
ACCME Recognized State Medical Society	This Criterion is achievable only for those providers that are attached to a medical school.
ACCME Recognized State Medical Society	Concerns have been expressed that only a specific subset of CME providers would have the infrastructure for this criterion; thus biasing the criterion to teaching institutions. Many small, local CME providers do not have access to health professions' students.
ACCME-accredited provider	I think the standard is too high for this criteria.
ACCME-accredited provider	Active involvement of medical students and residents will not only enhance their education, but it also provides a channel for feedback from these learners to senior physicians on how they can improve their teaching skills. In addition, it provides an opportunity to 'teach up' where students may introduce senior physicians to new technologies, information sources or tools.
ACCME-accredited provider	For this again clarification on how you expect providers to calculate percent of activities. For students are you expecting them to present to professionals or simply be involved on committee or to develop content under the mentorship of a qualified professional?
ACCME-accredited provider	Include residents and fellows in the description. I might also change the 'AND' to 'OR' in the critical elements. This would make the >25% threshold easier to achieve. If you can only count events that included students in BOTH planning and teaching, I think it would be difficult to get >25%. If they can be included in either, I think it is achievable and would allow some providers to really shine if they do a great job at either one of those elements.

Call for Comment Responses: Proposal for a Menu of New Criteria for Accreditation with Commendation

C25: Please provide comments or questions about this criterion.	
Organization Description	Comments
ACCME-accredited provider	The purpose of the menu structure focuses on reflecting the diversity of the CME community. This criterion appears to overlook academic medical centers as we have a structure in place for educating students and health professionals. While we agree with the concept of building bridges across the education continuum, the standard's expectation of 25% would be extremely difficult to achieve. Other concerns include: would CME take the place of some of the medical students' and residents' formal education; and how would that impact the accreditation process for their academic courses and their clinical training? What is the perspective of the medical school deans? Additionally, our mandated audience of actively practicing physicians obligates us to provide them with the most current and highest caliber of education to equip them to complete their maintenance of certification requirements.
ACCME-accredited provider	This is a really important element, to engage the future clinician in process design.
ACCME-accredited provider	Given that we will be required to meet at least one Criterion in each category, this is the only one that is at all feasible for us to achieve as we do not target non-physicians in our programs (a few PAs and NPs do attend). Involving medical students, residents or fellows in planning activities may be helpful to the programs, but requiring their involvement in teaching as well in >25% of the activities would be difficult and not necessarily well received by participants. Including 'OR' in the Critical Elements for this Criterion would increase the feasibility and still achieve the overall goal of the Criterion.
ACCME-accredited provider	Again 25% is too high. Students just don't know enough yet to give an insightful and comprehensive lecture on a topic unless they are particularly gifted. Students can be involved as planners. 25% is too high if planning committee members need to fly in and stay in hotels (expense). Effective planning committees for a 'good' meeting requires that the planners actually know and have connections with the brightest minds in the field. While this is an excellent opportunity for a student to enhance their professional development and learn about the process, it is not likely that they know 'the movers and shakers' in any field of medicine let alone a super-sub specialty. I would again recommend a modest start with one or two students (probably 5 to 10 %) of a robust and effective meeting planning committee and see how that goes. Some professional societies may have to rewrite bylaws so that students can even be comm. members. Students presenting posters is an excellent inroad.
ACCME-accredited provider	Far too high a percent for some organizations that have very small, but still valuable, student populations.
ACCME-accredited provider	I think ACCME could incorporate students in with C24. Interaction on a planning committee with students, patients and others could be more educational for the student.
ACCME-accredited provider	<ol style="list-style-type: none"> 1. We recognize the value that students can bring to CME. However, it seems too early in their professional development for them to participate as planners and teachers to the extent identified in The Standard. 2. A more detailed definition of student is needed. Are interns and residents considered students? 3. The Critical Elements should be separated by 'and/or.'
ACCME-accredited provider	I do not believe that adding students will be beneficial for the planning process. I know that adding students as teachers will not be beneficial for physician orientated CME.

Call for Comment Responses: Proposal for a Menu of New Criteria for Accreditation with Commendation

C25: Please provide comments or questions about this criterion.	
Organization Description	Comments
ACCME-accredited provider	The Critical Elements and Standard state that students must be included as planners AND teachers within CME activities. The Society supports the inclusion of students in the planning of CME; however, requiring that 25% of CME activities and/or learners include students as teachers may prove problematic from the perspective of the continuing education learner, whose educational needs may surpass the expertise of a trainee. While teaching within a CME activity is a tremendous experience for the trainee, and their perspective is important to include in the planning, it may not be appropriate to expect a CME provider to use students as formal faculty for such a large percentage of its CME activities or learner interactions.
ACCME-accredited provider	We currently engage fellow-in-training in our committee structure and in our annual meeting planning process. We place these “students” as moderators in some of our annual meeting educational sessions. However as students, We find they have limited time to engage with our planning on a day to day basis. We cannot meet the standard of 25%.
ACCME-accredited provider	Peer-teaching in undergraduate medical programs as well as leveraging students in conventional accredited CME/CE teaching when utilized in selected contexts, can be of benefit. There is evidence to suggest that participating student-teachers benefit professionally. Would encourage that the critical elements be more defined so providers have some additional detail in guidance as how to incorporate this method into their activity planning without the potential of sacrificing the quality of their program.
ACCME-accredited provider	C25: In some instances, it is appropriate and reasonable to include students in the planning and teaching process however the 25% standard is too high. When there is little or no evidence to make recommendations on patient care, we rely on the experience of experts to guide our membership. It would be inappropriate for students to be involved in most of the planning and teaching of our activities. We would recommend incorporating student planners and faculty into 1 accredited activity per year as the standard.
ACCME-accredited provider	This criterion is particularly bewildering. CME traditionally has been for those who have completed their medical training. How would a student in training be able to be an 'expert' on a topic such that they can be faculty? It is understandable to include them in the planning process as part of their education for the future, but to include them as faculty is counterintuitive, especially for the type of CME activities provided by medical subspecialties (major annual meetings).
ACCME-accredited provider	The Standard is too high for providers who have a large number of activities and/or learners.
ACCME-accredited provider	have questions about the merit of this one.
ACCME-accredited provider	The Standard is too high for this. Currently we have activities that incorporate this, but given our large educational portfolio, we could never achieve this standard.
ACCME-accredited provider	Quite lucid but not an obvious menu choice for sites having no academe.
ACCME-accredited provider	agree with the criterion
ACCME-accredited provider	This criterion is biased toward medical schools. There would need to be high incentives provided to attract students to planning committees during a time when they are focused on their studies.

Call for Comment Responses: Proposal for a Menu of New Criteria for Accreditation with Commendation

C25: Please provide comments or questions about this criterion.	
Organization Description	Comments
ACCME-accredited provider	Has the ACCME considered at which level a student should have attained prior to being included? There is a broad continuum of experience (i.e., 1st year med student vs. medical intern vs. 2 year resident). Would the student involvement meet a graduation requirement? Incentive for student to be involved?
ACCME-accredited provider	I believe the criterion is clear and the elements are well stated; however, it becomes complicated when you start requiring a percentage of activities.
ACCME-accredited provider	Are residents considered to be 'health professions' students'
ACCME-accredited provider	We do this consistently-not a problem.
ACCME-accredited provider	As indicated previously, I question the standard.
ACCME-accredited provider	Are students medical students? Are you including residents as students? If I understand this criteria correctly, providers will be asked to include students in their activity planning. I think it is irresponsible to put students in that position (when they may not have any idea) and again dilutes the very hard work CME providers do to drill down to identify specific learner needs for each activity. Students are always welcome but requiring their participation is not something I support and dilutes CME's credibility if we begin using students to fulfill accreditation obligations.
ACCME-accredited provider	Clear as written; I don't agree with medical students (or any professional students) required as part of CME planning. Medical students should be focusing on THEIR medical education and not continuing education that is post-graduate.
ACCME-accredited provider	While we understand the intent of this criterion, in reality, given medical school students' schedules and academic demands we believe that it could be difficult to obtain commitments from students for their participation. In addition, we need to be thoughtful about the cultural barriers that we may face from traditionalists.
ACCME-accredited provider	Would membership in our CME Advisory Committee be considered part of the required involvement?
ACCME-accredited provider	Please lower percentages in the Standard.
ACCME-accredited provider	See concerns from page 1 of the survey related to The Standard. Do residents counts as students?
ACCME-accredited provider	The criterion is clear but I do not agree with the standard. Currently there is no percentage or number of activities and/or learners required for any of the Commendation Criteria/. I think that more providers will put forth the effort to achieve this and the other criteria if there is no percentage or number standard attached.
ACCME-accredited provider	Another terrific criterion. Engaging learners as planners, and as teachers/authors for regularly scheduled activities is overdue. Some guidance about how to demonstrate the >25% of activities would be great. They could serve as planners for an RSS, but then how often must the student/resident/fellow serve as the teacher or author of an RSS to demonstrate compliance?
Other	I object to the 25% standard. It is too high. I recommend 1 activity per year of accreditation as the standard.
Physician/healthcare professional	Again this is important and innovative. Engaging students is important - they often are more interested and willing to provide constructive feedback.

Call for Comment Responses: Proposal for a Menu of New Criteria for Accreditation with Commendation

C25: Please provide comments or questions about this criterion.	
Organization Description	Comments
Physician/healthcare professional	This is a great criterion if you work in a system that has residents and students. Perhaps a commendation for 'inclusiveness' as a separate category could be given; not really relevant for most of the physicians that I know, and certainly not for me as a pathologist in a hospital system with no pathology residents.
Physician/healthcare professional	impossible if don't have students in certain areas
Physician/healthcare professional	as a former student myself (!) I think students have no concept of the role of CME and the needs it strives to fulfill. having students learn about the process is a great idea.
Physician/healthcare professional	Yes, the criterion is clear. This is a worthy goal and may be relevant for limited types of CME content offered to physicians but the majority of CME content will be beyond the scope of medical students' knowledge base and skill set and therefore, it will be impractical to implement this criterion for most CME activities. This criterion is relevant when students help develop ways to pursue CME activities, i.e. SMS, smartphone apps, touchscreen laptops, etc not necessarily about CME content.
State-accredited provider	25% of activities or learners seems very high to me - students are already over-burdened with meeting the requirements of their education, without having time to plan and teach CE courses (!)
State-accredited provider	This criteria will be difficult for the small, community hospital to demonstrate compliance with this criteria. This criteria lends itself to the larger, complex delivery systems based in areas with medical schools. Please consider the smaller CME providers and reflect how they will be able to work towards and achieve commendation.
State-accredited provider	Many hospital CME programs do not have students. The ACCME is envisioning CME more as graduate education rather than the reality of arranging for speakers over lunch for a few physicians.
State-accredited provider	And maybe 23, 24 and 25 could all be consolidated.
State-accredited provider	Again, the CME Committee felt >25% was too high for this standard for a community hospital. They would like to see it at no higher than 10%.
State-accredited provider	We vote The Standard be: 'No less than 5% of activities and/or learners'
State-accredited provider	1. Meeting the standards for the new criteria will appear to require a lot more data gathering and analysis to be compliant, which will ultimately result in more costs. 3. The standards for many criteria are too rigorous, for example, in calling for >25% of activities and/or learners or >10% of activities and/or learners. Many CME providers do not have the volume of CME activities to meet this standard.
State-accredited provider	Does this include residents?
State-accredited provider	While this is a positive criterion, not all organizations have students that they can pull into CME activities such as this. Our organization does not have a residency program or any other student involvement.

Call for Comment Responses: Proposal for a Menu of New Criteria for Accreditation with Commendation

C25: Please provide comments or questions about this criterion.	
Organization Description	Comments
State-accredited provider	Again as above. I believe that the standard as written is way too high. and greater than 25% of our activities that would be about 75 activities that would have to meet this and with the number of Journal Clubs and case conferences we hold out of our approximate 300 programs this would be difficult to achieve. I am unclear what is meant by 'and/or learners' and how those number would translate. Also I believe that the increased workload to meet this high number of activities with a CME office that is staffed by a CME director, CME manager and Admin Assistant/coordinator along with additional responsibilities added to the plate with ABIM and other specialty boards this is unrealistic. We have been accredited with commendation for the past 2 cycles and I am not certain this added work is worth the bang of receiving 6 years instead of 4. I also thin that the critical element should include and/or and not just and to make it more realistic.
State-accredited provider	It is clear but does exclude many programs and the 25% again, is high.
State-accredited provider	The 25%+ requirement is too high. We involve students where appropriate, but it would not equal to 25% of the activities.
State-accredited provider	The criterion is clear, however, the standard # is unreasonable
State-accredited provider	Yes, I would encourage student participation
State-accredited provider	?25% is a high percentage to meet for community hospitals or non-University settings. The other recommended standards for the other 4 categories are ?10% so we recommend a ?10% standard on this criteria.
State-accredited provider	Engage the students in the needs of the future of healthcare.
State-accredited provider	Rural programs in particular do not have students or access to students. This is impossible to implement.
State-accredited provider	For non-academic centers this would require identifying and working with student sources. Residents do not have the time or the rotation length to make this realistic. It seems out of the scope of physician education. Novice needs for learning are different from that of which CME is directed towards. This would also increase prep time for activities and require additional resources that are already tapped with physician learning activities
State-accredited provider	Will not happen at a non-academic facility. Why do you assume you need medical students input to CME. They are not attending the lectures. They are in class or on the wards learning about medicine. Do PA students count? How about LPN students?
State-accredited provider	Challenge to meet the percentage for activities or learners. There are activities that we have included or have opportunities to include, but not at the high of a percentage based on audience demographic.
State-accredited provider	Would like to see a variety of students involved and get their take on things: nursing, medical, and administrative. The definition of the CME Committee will have to be changed to include these additional representatives. Their input would be helpful, but currently only physicians have a vote.
State-accredited provider	As I mentioned for the previous criterion unless your organization is a teaching hospital, I doubt physicians would attend an event where a health profession student was the faculty. I think only a teaching hospital could meet the 25% standard. This criterion would be completely impractical for our community hospital.

Call for Comment Responses: Proposal for a Menu of New Criteria for Accreditation with Commendation

C25: Please provide comments or questions about this criterion.	
Organization Description	Comments
State-accredited provider	again, setting a standard of 25% is high
State-accredited provider	Suggest rewording: Engages health professions' students in the planning and delivery of its educational activities to address healthcare educational needs across the spectrum. Again, i pose the same questions and comments as previously made about the use of 'AND' in the critical elements and about the % standard.
State-accredited provider	If students are involved in the planning, the activity will not be able to meet the professionals needs. Maybe for breakouts, but for students to be in the same room as surgeons, someone is not getting their needs met.
State-accredited provider	Recurrent theme for me! Then >25% is just too much!! I worry that these burdens will make CME shops reluctant to accredit as many activities so that the commendation criteria will be met!
State-accredited provider	Clear
State-accredited provider	Although the Criteria itself is good including the standard presents a problem to keep up with. Maybe have a couple of activities required to complete this one.
State-accredited provider	Very important for future of medicine!
State-accredited provider	We currently do not do this, however, we are in negotiation with a medical school which could give us the needed access to students.

ADDRESSING PUBLIC HEALTH PRIORITIES

C26: Provides CME about health informatics and the use of practice data.

C26: Since you answered 'no', please explain and/or suggest edits.	
Organization Description	Comments
ACCME Recognized State Medical Society	This criterion I do not understand. Please excuse my ignorance, what do you mean by 'informatics'. How would my providers be able to contact some one to teach informatics? Do you mean 'computers'? In spite of being 21st century, you would be surprised of the huge number of our physicians still needing much assistance on this matter. I need to better understand the 'how to comply' with it so I can explain it to my providers and/ participants.
ACCME Recognized State Medical Society	Unable to assess. Inadequate and/or deficient methodological evidence of validity, reliability and application practicality of process. Details upon request. E.g. lack of evidence this criteria should carry same “weight” as any other and is mainly exclusive of other criteria to avoid double weighting. Applicability and importance depends on nature and scope of provider. How will surveyors determine whether CME activities are “on” health informatics or “on” the use of practice data? From the title? From some quantitative assessment of activity content? What tool will surveyors use for such an assessment? How will they do it reliably so as to avoid factual disputes and assure consistent accreditation?
ACCME Recognized State Medical Society	Some clinics do not have an EHR implemented and would have to obtain this information externally.
ACCME Recognized State Medical Society	This criterion doesn’t represent the opportunity for all provider types equally. It appears to be designed for specific types of providers. We have a concern that we are driving the topics that will be provided which, while important, may not meet the true learning gaps of our learners. A SMS would not be able to meet this criterion. The Standard: - ?10% of activities – ?10% too high
ACCME Recognized State Medical Society	Please clarify if the CME is on or about health informatics or rather is the education being informed by health informatics (and practice data)?
ACCME Recognized State Medical Society	It is questionable whether this criterion should be included under the public health priority, given that it relates not only to population health but also to clinical healthcare improvement. It is also very specific and might be more valuable if it were framed in terms of practice-based improvement and systems-based practice. As described above, however, we have concerns about the attempt to determine compliance based on the percentage of activities or learners.
ACCME Recognized State Medical Society	I would delete '(i.e., health information) since it adds nothing and can have a wide range of meanings. Make it short and clear.
ACCME Recognized State	Revise to: 'Provides CME about health informatics and the use of practice data; and how it impacts healthcare.'

Call for Comment Responses: Proposal for a Menu of New Criteria for Accreditation with Commendation

C26: Since you answered 'no', please explain and/or suggest edits.	
Organization Description	Comments
Medical Society	
ACCME Recognized State Medical Society	% of the standard is not a good idea for any Criteria; this will be too complicated to calculate. Providing multiple examples for a Criteria should be sufficient for a compliance finding.
ACCME Recognized State Medical Society	Need clarification on the standard of 10% of activities or learners. For example, is it 10% of the total of activities from the entire term of accreditation? Or could it be 10% of activities from 1 or 2 years of accreditation? 10% of activities or learners will be very difficult for many providers in our state system to achieve, as teaching learners about informatics would most likely not occur this often. Suggest lowering percentage to a specific range of activities such as an expectation of one to three per year? A percentage is complicated for accreditors to work with during the survey process. Example, what/how many activities do we need to select for review?
ACCME Recognized State Medical Society	The criterion is confusing. Use of the term Health Informatics or use of the term practice data, but not both. Define health informatics if that is the term to be used or define practice data if that is the term to be used. (See previous comments regarding the percentage standard.)
ACCME Recognized State Medical Society	Does the provider need to show the data? This may prove difficult for organizations which are not privy to health information (e.g. medical society). Would education regarding how a professional can access their own patient data and implement their own lessons learned work? The ?10% of activities 'and/or' learners would be difficult for surveyors to evaluate.
ACCME Recognized State Medical Society	The criterion and the rationale may be achievable by some providers with access to quality information or practice data. Data of private practitioners is not readily available to CME providers. Therefore, it would be difficult to assess outside of the hospital for all learners. Additionally, most providers do not have the staff, time or resources to collect and analyze this data, if available. The Standard percentage will be very difficult for surveyors to assess or providers to achieve.
ACCME-accredited provider	Needs an example.
ACCME-accredited provider	Inclusion of a health information specialist in delivering this content will ensure that new information discovery and management tools are included in these programs. Health information specialists have experience teaching the physicians to search, and evaluate information. These are essential skills physicians need in order to stay informed and to evaluate the latest evidence from clinical studies.
ACCME-accredited provider	Does the entire activity have to be about informatics to be counted toward the 10% or can it be counted if the topic is incorporated as a more global approach to care?
ACCME-accredited provider	Is public health information allowable here? Or does it have to be practice data from a particular institution? In other words, can a MEC pull public health data and develop QI education for its national audience based on that data? Or does this mean that the provider has to use data from a specific institution, then develop QI education for that

Call for Comment Responses: Proposal for a Menu of New Criteria for Accreditation with Commendation

C26: Since you answered 'no', please explain and/or suggest edits.	
Organization Description	Comments
	institution's physicians? If it's the latter, once again, this criterion definitely favors hospitals, health systems, and medical centers.
ACCME-accredited provider	I understand the >10% of activities and think that is a good standard for this criterion, but I don't understand how the standard applies to learners. Do you mean that you train at least 10% of your total learners per year on informatics?
ACCME-accredited provider	What do you mean by 'practice data'? Is this community or hospital data? We had approximately 3000 activities in 2015. Are you suggesting that at least 300 of these activities would need to be about health informatics and the use of practice data? That does not make for a well rounded portfolio. We also have limited resources at our hospital for gathering practice data, so this threshold would be hard to meet.
ACCME-accredited provider	% seems high - recommend lower % (perhaps 5%). Does the CME developed have to be unique each occurrence or could a series be counted towards the % (for example, if my organization offers training on how to use our organization's EMR and they hold 100 trainings throughout the year, would this get counted as 1 event or 100 events?). for providers who do not use an EMR, this may be a difficult criteria to meet.
ACCME-accredited provider	Does health informatics include - EMR, ICD10, EHR, and Epic? Also there are learning opportunities available that meet this criteria when the system is rolling out a new system/program. The need for education and the offerings will decrease dramatically when staff are trained. Thus the 10% goal may be hard to meet annually.
ACCME-accredited provider	We are a Medical Professional Liability company and we currently use data from claims that is analyzed for contributory behaviors or actions to teach about risks and improvement. Will MPL claims data that is analyzed for contributing behaviors count as health informatics when used as a basis for teaching? Can this criterion be expanded to include analyzed claim data?
ACCME-accredited provider	Please further define health informatics.
ACCME-accredited provider	Re; both C26 & 27/ Clarification in Critical Elements would be helpful in that is is not clear whether or not providers will be required to implement CME programs that are 'devoted' to these topics or provide coverage of these topics in within larger programs. We presume it is the latter, but clarification would be very helpful.
ACCME-accredited provider	This criterion is very specific and might yield greater value if it were framed in terms of the practice-based improvement and systems-based practice competency domains. As noted above, we do not recommend requiring providers to apply this criterion to > 10% of their activities.
ACCME-accredited provider	Can the numbers included in the greater than 10 percent include courses that simply have a mention of informatics or does the content of the course need to focus mainly on informatics.
ACCME-accredited provider	Define 'health informatics'
ACCME-accredited provider	confusing – it is “and” or “and/or” or “or” As a technique and skills oriented organization, it will not be appropriate to develop 10% of our activities to incorporate health informatics. We would recommend incorporating strategies to utilize health informatics into 1 accredited activity per year as the standard.

Call for Comment Responses: Proposal for a Menu of New Criteria for Accreditation with Commendation

C26: Since you answered 'no', please explain and/or suggest edits.	
Organization Description	Comments
ACCME-accredited provider	Criteria uses the term “and” while the critical elements state “or”.
ACCME-accredited provider	1. CRITICAL ELEMENTS: Should be 'OR' teach learners how to apply.....
ACCME-accredited provider	As in all criteria with a % threshold, it is unclear what that is exactly referring to. Does it mean if there are 10 activities, 1 has to have this on the agenda? Or for an activity, 10% of the agenda has to be this? And what does 10% of learners mean? This comment applies to all criteria with this type of standard.
ACCME-accredited provider	If the rationale stated '...that teach about health informatics OR teach learners how to apply' then this criterion could be more widely applicable to more providers.
ACCME-accredited provider	It is unclear what would qualify as health informatics. As a provider, we produce CME based on scientific evidence. We use informatics, but not necessarily practice data for our learners. Is this a call for Part IV MOC? If so, even asking for 10% of activities is a challenge to providers with large numbers of activities or learners.
ACCME-accredited provider	Medical Specialty societies do not typically have access to patient data.
ACCME-accredited provider	Does registry data count towards this criterion? Recommend providing examples.
ACCME-accredited provider	its clear only with the rationale. could to be better written to include more of the rationale.
ACCME-accredited provider	'Health informatics' should be defined. 'Health informatics is the collection, analysis, and synthesis of health information relevant to the care of patients and the application of the lessons learned from these data to improve a patient’s health and healthcare.' AMIA agrees with the ACCME regarding inclusion of a criterion that will reward providers that teach about health informatics and teach learners how to apply the wisdom gained from health information to improve the health and healthcare of patients.
ACCME-accredited provider	Medical professional societies do not have access - and could not under existing privacy laws - to health information data since they do not control electronic health records.
ACCME-accredited provider	Criterion says informatics AND practice data, but criterion says OR. Does data from a chart audit alone fulfill this criterion?
ACCME-accredited provider	It will be difficult for my institution to fulfill this criterion. We are not in a position to collect data or do research. Instead we rely on data and studies published from other institutions and journals.
ACCME-accredited provider	What exactly is meant by health informatics? Is this exclusively the electronic health record? What is meant by 10% - we have three 1 hour films on patient safety related to the use of EHRs. These are approved for three years but our library is around 100 courses. So 3 is not 10%. Would we need to have 10 altogether? If we add 30 new courses each year, does it mean that 3 of those need to be related to the EHR? OR does this mean that some of the recommendations that we make to change practice related to the topic can be directed at the EHR to comply?

Call for Comment Responses: Proposal for a Menu of New Criteria for Accreditation with Commendation

C26: Since you answered 'no', please explain and/or suggest edits.	
Organization Description	Comments
ACCME-accredited provider	Seems like a one-event topic, or two at the most. How could 10% of activities cover this--is this only for providers offering 10-15 activities per year?
ACCME-accredited provider	Health informatics may be the wrong term to use. Health informatics is 'the interdisciplinary study of the design, development, adoption, and application of IT-based innovations in healthcare services delivery, management, and planning. suggests IT.' Is ACCME interested in how CME impacts the application of technology to improving the quality of healthcare?
ACCME-accredited provider	The criterion states 'provides CME about health informatics and use of practice data-- the focus seems to be on the utilization of practice data to inform the educational planning and execution process, provide feedback to learners and to help facilitate the development of new competencies in health informatics. do you want courses on health informatics and/or the development of CME that utilizes practice data-- are either one of these options enough to meet this criterion or do you want to be more specific about the criterion? If we provide credit for all of the EPIC training, does this meet this criterion?
ACCME-accredited provider	Clarification needed regarding whether this criterion is related to teaching how to use health informatics (a more singular approach), or actually using data obtained from health informatics to improve practice (a sustained approach). Standard is untenable for many providers. Consider 5% of all activities.
ACCME-accredited provider	I think the critical element is clearer...'Develops and implements CME utilizing health informatics or the use of practice data.'
ACCME-accredited provider	Again, the metric could be challenging depending on what is included in the denominator. Are you talking about use of quality data to drive improvement or the more global health informatics?
ACCME-accredited provider	The term 'informatics' needs to be better defined and may not be the most appropriate verbiage, given the description of what the ACCME is looking for. It seems that something like 'Use Data and Information to Develop CME Targeted to Improvements in Healthcare' might be more appropriate. The expectation for a % of learners or activities will disadvantage providers who have very robust and substantial initiatives in key areas and reward providers who have superficial and perfunctory practices across many activities/learners. We suggest instead that providers be asked to submit several examples to demonstrate compliance.
ACCME-accredited provider	Is '> 10% of activities' over the accreditation term? Annually? or other?
ACCME-accredited provider	See concerns from page 1 of the survey related to The Standard. Are we considering health informatics to include clinical guidelines?
ACCME-accredited provider	If content is derived from health informatics and the collection process and benefits are part of the education, would it count toward this criteria? If so, perhaps the language should read, 'Provides CME about, or derived from, health informatics and the use of practice data.'

Call for Comment Responses: Proposal for a Menu of New Criteria for Accreditation with Commendation

C26: Since you answered 'no', please explain and/or suggest edits.	
Organization Description	Comments
Other	This is confusing with the 'and', 'and/or' and 'or' throughout. Please clarify what exactly we would be expected to develop and implement. I also object to the standard of 10%. It is too high. I recommend 1 activity per year of accreditation as the standard.
Other	10% threshold is too low for commendation on this standard, in this day and age. Suggest a minimum of >25% (and perhaps higher)
Other	I'm don't believe 10% of most providers activities should be on health informatics. Seems pretty high for most of the hospitals and medical schools I am familiar with. 5% might be more ideal in my opinion. It largely depends on if the institution is implementing a new EMR or ICD Codes etc as opposed to whether the CME Division is doing a good job.
Other	>10% standard is too high; prefer 1/year or x/term. As worded it perpetuates the 'single subject' approach to education (CME on health informatics or the use of practice data) and would not support or recognize a provider that integrates the use of practice data into activities where the focus was not specifically informatics. For example, a provider with a series on Congestive Heart Failure might require all faculty to include examples using actual practice data yet this would likely not be considered eligible as compliant for C26. From an adult learning perspective this method would be superior as it demonstrates application of a concept (practice data use) into a real world situation (situational learning).
Physician/healthcare professional	Delete the word 'wisdom' unless you are going to metamorphosize into a social science education provider. Health informatics is an up and coming field that many fields could benefit from; I'm not sure I believe this is a priority enough, however, to count as a criterion for 'commendation'. Could reword it and be OK.
Physician/healthcare professional	I think analytics is absolutely necessary, although many small hospitals including ours do not have professionals that can extrapolate and utilize the data. We currently do not have an analytics program with our EMR. the cost to purchase such a program is over \$50,000 plus the need for an interface and then training of personnel.
Physician/healthcare professional	see last answer
Physician/healthcare professional	I don't think the language is bad but it is lacking in references to population health which is going to resonate more with clinicians and make sure the focus of the education is outcome based. In addition, in order to take full advantage of the opportunity presented, I think it would be beneficial to expand on the quality improvement piece speaking about looking for trends in errors or near misses that can inform improvements.
State-accredited provider	Criterion 26 is not clear. Are you encouraging providers to use health informatics in their programs or educate learners on how to obtain data and analyze it?
State-accredited provider	The percentage should be lowered. Criteria 26 and 27 should be combined and include either (1 of 3) of the critical elements or a combination thereof.

Call for Comment Responses: Proposal for a Menu of New Criteria for Accreditation with Commendation

C26: Since you answered 'no', please explain and/or suggest edits.	
Organization Description	Comments
State-accredited provider	Could you please clarify exactly what you want? Send some examples
State-accredited provider	Suggest to reword: 'Integrates health informatics and/or the use of practice-based clinical data (e.g., registries, databases) into its educational activities.' When the criterion starts with the word 'provides' then one reads it as 'The provider provides....', and that seems confusing language. As for the critical elements sections, is the intent to develop activities that talk 'about' using informatics and practice data? Or, alternatively, is it really meant to develop activities 'using data (gaps, needs) from' those sources? i would respectfully suggest that it should be the latter and to clarify that.
State-accredited provider	Is this academic detailing or is this in reference to how to incorporate informatics into daily use of EMR?

Call for Comment Responses: Proposal for a Menu of New Criteria for Accreditation with Commendation

C26: Please provide comments or questions about this criterion.	
Organization Description	Comments
ACCME Recognized State Medical Society	This section, Addressing Public Health Priorities, is more doable than previous. Every hospital/provider (big or small) needs to address emerging public health issues. Should be able to meet the >10% standard.
ACCME Recognized State Medical Society	The % is a bit better for this Criterion, however, I believe it would be helpful to have examples with some of the Criterion questions.....
ACCME Recognized State Medical Society	Is the intent that these will be stand-alone activities focused on data and informatics, or could it be part of an activity that may have a related focus, such as Grand Rounds? If it is possible to achieve this criterion as part of activities not focusing exclusively on data and informatics, then how will accreditors collect this information to complete an accurate assessment of the providers' compliance with this criterion?
ACCME Recognized State Medical Society	This should be achievable by all provider types as long as state or national data can be used, not just practice data from the provider's learners.
ACCME Recognized State Medical Society	Standard percentage is a concern - see 1st page for details.
ACCME Recognized State Medical Society	Great Criterion - and possible for providers with access to this type data.
ACCME Recognized State Medical Society	You have changed CE to CME which clarifies for me that the education referred to is accredited CME. I am not understanding how '% of learners' applies to any of the proposed criterion where % of learners can be the standard. I am not understanding how '% of activities/learners' applies to RSS for any of the proposed criterion. 10% seems high
ACCME-accredited provider	I think this data can be extremely difficult to get, even from my own hospital.
ACCME-accredited provider	The percentage bit is still unclear, but I understand how health information becomes the PPG in determining what to teach.
ACCME-accredited provider	For a large health system, this amount would be out of reach.
ACCME-accredited provider	This criterion is particularly difficult for us as in our system health information is not readily available to our office, that privilege is reserved for clinicians. Additionally, since we are not permitted to access the health information system, training of clinicians is handled within the Medical Information Management department. Also, there are many different electronic medical record systems throughout the nation and, thus, makes it challenging to globally address the needs of the private sector clinicians.
ACCME-accredited provider	The criterion is clear and the standard, while probably too high for providers who offer many activities, it is more realistic than the standards set for the prior criteria.
ACCME-accredited provider	In order to achieve this criterion, you need to have access to patient care data which many providers do not. The 10% criteria will be difficult for both large and small organizations to achieve.
ACCME-accredited provider	Not clear how we would meet this criterion.

Call for Comment Responses: Proposal for a Menu of New Criteria for Accreditation with Commendation

C26: Please provide comments or questions about this criterion.	
Organization Description	Comments
ACCME-accredited provider	it would help
ACCME-accredited provider	Should add 'and/or quality improvement' to the end of develops and implements CME on health informatics or the use of practice data
ACCME-accredited provider	I find this awfully far 'into the weeds' but I suppose it applies to some.
ACCME-accredited provider	However, this criterion is beyond the scope and reach of many CME providers.
ACCME-accredited provider	Is the Standard metric of >10 activities and/or learners based on the accreditation period or an annual threshold? If there is one large CME activity that eclipses all of the others in scope and it has a large % of its content focusing on informatics is that compliant, or does this large activity simply count as 1 (equivalent to a journal article)?
ACCME-accredited provider	This is an important area and while I am not sure that all Providers can address this Criteria, there are certainly Providers who will. Each Provider has their own 'specialty' for adding rich sources of educational data.
ACCME-accredited provider	Unclear that this is something that our organization can provide.
ACCME-accredited provider	It is important to remember that not all physician practices have been able to implement electronic records yet. Please ensure that teaching about the implementation of these tools would qualify here.
ACCME-accredited provider	It is critical that ACCME reward CME providers for teaching about the practice and principles of using health informatics and practice data. Certain CME providers do not have ready access to practice data yet are still positioned to support learner understanding and strategies for using data to improve their practice. As written, this Criterion does allow for all providers to be rewarded for their efforts to address learner needs related to health informatics and practice data in a way that is appropriate for their organizational situations; the Society requests that ACCME continue to recognize these efforts.
ACCME-accredited provider	Health informatic annual meeting sessions and on-line learning are part of our educational efforts. While an overview of principals can be taught, with most allergists being small 1-2 person practices, out-patient based, with a variety of Electronic health records, some of which have poor capacity for collecting quality improvement data, we will not be able to address specific programs for collecting patient data.
ACCME-accredited provider	We suggest basing the standard on number of credit hours of activity. A 1 credit activity and a 50 credit activity may have different parameters and not all will include health informatics.
ACCME-accredited provider	This is a new standard for many organizations. The standard for this criterion is too high.
ACCME-accredited provider	Curious why C26 has a standard of >10% as compared to use of patients and students which encourages activities >25%. health informatics seems to be of greater importance of the healthcare system so wouldn't it seem that percent of activities by standard reflect that importance?
ACCME-accredited provider	C26: If the rationale stated '...that teach about health informatics OR teach learners how to apply' then this criterion could be more widely applicable to more providers.
ACCME-accredited provider	If the rationale stated '...that teach about health informatics OR teach learners how to apply', this criterion may be applicable to more providers.

Call for Comment Responses: Proposal for a Menu of New Criteria for Accreditation with Commendation

C26: Please provide comments or questions about this criterion.	
Organization Description	Comments
ACCME-accredited provider	C26: This is not a problem. We can review the CME presentation power point and review if the vital informatics or data are included. This is important.
ACCME-accredited provider	The criterion is understood as written; however, there's an assumption in this criterion that the organization is able to capture its own data to instruct on its use and/or to trend practice data to demonstrate results. All specialty medical societies do not have this information available and may want to be responsible for instructing participants on the basics of their specialty.
ACCME-accredited provider	The Standard is too high for this. Currently we have activities that incorporate this, but given our large educational portfolio, we could never achieve this standard.
ACCME-accredited provider	Critical Elements should be amended to "ORs" from "ANDs." Requiring "ANDs" significantly limits the flexibility intended by the introduction of the menu structure. We believe innovation and creativity will be reduced and not all provider types will have the ability to achieve Accreditation with Commendation.
ACCME-accredited provider	While I think it is clear as written for those who understand this emerging aspect of healthcare, I think for some of us, we will need some examples of what this might look like and how we can achieve this.
ACCME-accredited provider	Yes. Will assuredly necessitate examples of appropriate responses.
ACCME-accredited provider	I feel that this is very specific and not broad enough to be included in the criterion. Though health informatics is important within the health system, I'm not sure how practical it is for clinicians to have access to and availability to use the data on a regular basis, thus making this education NOT practice and application based.
ACCME-accredited provider	Excellent. For too long have data been used, and seen as a weapon against front line teams. EG: Unit census leading to reduced unit funding, c section rates etc. It is high time that we de-weaponize data. We need to use it, and see data as the reward of hard work in our patient care, and quality improvement initiatives.
ACCME-accredited provider	Access to health information, informatics, QI data very challenging if not a medical center or provider of direct patient care. Difficult to include in more than 10% of activities or learners.
ACCME-accredited provider	We need clarification on whether this criterion is based on inclusion of actual health information data in developing 10% or more CME activities or teaching how to use informatics in practice / quality improvement. Would a provider that publishes 500 CME activities need to incorporate actual data in 50 or more CME activities each year? If so this is biased in favor of health care organizations.
ACCME-accredited provider	I believe the criterion is clear and the elements are well stated; however, it becomes complicated when you start requiring a percentage of activities. The rationale and critical elements really helped to solidify my understanding of the criterion.

Call for Comment Responses: Proposal for a Menu of New Criteria for Accreditation with Commendation

C26: Please provide comments or questions about this criterion.	
Organization Description	Comments
ACCME-accredited provider	It is important to teach health informatics or the use of practice data. However, given that the majority of CME addresses clinical practice needs, I don't think it would be either practical or desirable that 10% or more of the CME activities are designed to teach health informatics or the use of practice data. More desirable would be that CME be data driven, that educational activities are designed based on that data to best address the needs of learners and health care, and that data be imbedded in educational activities and shared with learners. Further, the use of health informatics and practice data should inform health care in general not just public health priorities. I would like to see this criterion include that 'Health informatics and practice data is used to inform CME activities'.
ACCME-accredited provider	Although the criterion makes sense, having 10% of activities or learners will be extremely challenging to meet and may require providers to skip offering other important topics.
ACCME-accredited provider	As indicated previously I question the standard.
ACCME-accredited provider	Sometimes the information isn't available to providers. As in our case, we are a medical school but not the hospital. The hospitals may not want to release this information to us.
ACCME-accredited provider	It is our suggestion that as we transition to a new process, that we would like to see the proposed # of activities to meet the requirement (10%) be reduced to 5% with an option to increase at a later time.
ACCME-accredited provider	Even 10% too high for this Criterion.
ACCME-accredited provider	Great idea but will be difficult for most to achieve. Medical record systems are not user friendly and if you don't have a group of quality staff people working with you the data and teaching of this it will not be accessible.
ACCME-accredited provider	This is an excellent criterion and is actually overdue.
ACCME-accredited provider	The criterion is clear but I do not agree with the standard. Currently there is no percentage or number of activities and/or learners required for any of the Commendation Criteria/. I think that more providers will put forth the effort to achieve this and the other criteria if there is no percentage or number standard attached.
ACCME-accredited provider	If a school of medicine implements health informatics in their RSS programs, must an individual RSS activity be dedicated wholly to health informatics, or may this be integrated in the planning of an RSS (which might meet weekly for a year)? To demonstrate compliance, we can demonstrate unique activities focused on the health informatics, but to reach the 10% of activities we'd need to know how this might be documented in RSS.
Other	If the rationale stated '...that teach about health informatics OR teach learners how to apply' then this criterion could be more widely applicable to more providers.
Physician/healthcare professional	As long as this is not a way to require providers to develop practice improvement CME activities and require learners must take them --- similar to practice improvement modules in ABMS MOC. This should NOT involve requiring learners to collect and send practice data to providers for analysis and require learners to change behavior based on such analysis.
State-accredited provider	I think this is possibly doable but I think it will be difficult to prove that a certain percentage of events meet this criterion.

Call for Comment Responses: Proposal for a Menu of New Criteria for Accreditation with Commendation

C26: Please provide comments or questions about this criterion.	
Organization Description	Comments
State-accredited provider	How did you determine that > 10% of the activities or learners should reflect this? Seems like that number is high
State-accredited provider	Physicians see this as the responsibility of the quality and safety committee who has staff to assemble data, mostly that required by the Joint Commission or other regulatory bodies. They don't see why CME should be involved in the work of those committees. They also think of the data analysis as the work of staff not physicians.
State-accredited provider	We vote The Standard be: 'no less than 5% of activities and/or learners
State-accredited provider	Meeting the standards for the new criteria will appear to require a lot more data gathering and analysis to be compliant, which will ultimately result in more costs. The standards for many criteria are too rigorous, for example, in calling for >25% of activities and/or learners or >10% of activities and/or learners. Many CME providers do not have the volume of CME activities to meet this standard.
State-accredited provider	Again as above. I believe that the standard as written is way too high. and greater than 10% of our activities that would be about 30 activities that would have to meet this and with the number of Journal Clubs and case conferences we hold out of our approximate 300 programs this would be difficult to achieve. I am unclear what is meant by 'and/or learners' and how those number would translate. Also I believe that the increased workload to meet this high number of activities with a CME office that is staffed by a CME director, CME manager and Admin Assistant/coordinator along with additional responsibilities added to the plate with ABIM and other specialty boards this is unrealistic. We have been accredited with commendation for the past 2 cycles and I am not certain this added work is worth the bang of receiving 6 years instead of 4. I also thin that the critical element should include and/or and not just and to make it more realistic.
State-accredited provider	This is an interesting and good one. 10% is attainable and will encourage us to try!
State-accredited provider	I think this is a great criterion, however I don't see a need for 10%+ if it's not appropriate. 10 activities/year, etc may be a better option and more attainable by smaller organizations.
State-accredited provider	This is a good standard in that informatics is the benchmark on which performance improvement is achieved. The threshold is also reasonable.
State-accredited provider	We are trying to do this already
State-accredited provider	We need to promote the effectiveness of each organization to analysis, manage and use the information and comments and feedback from our learners to improve our healthcare system.
State-accredited provider	This criterion assumes ready access to health information data. In the current state, electronic medical records are barely capable of performing the basic functions, but often lack functionality and sufficient personnel available for data generation. This is another criterion penalizing small resource poor programs.
State-accredited provider	We do this so not a problem but organizations lagging in informatics would struggle with this.

Call for Comment Responses: Proposal for a Menu of New Criteria for Accreditation with Commendation

C26: Please provide comments or questions about this criterion.	
Organization Description	Comments
State-accredited provider	The standard is too high. If a CME program offers multiple formats and has multiple activities, they would have to minimize the number of activities to meet the level of greater than or equal to 10%. In my program all physicians, nurse practitioners, and physicians' assistants have to complete an online EMR training and a live EMR orientation prior to obtaining hospital privileges. However, last year's numbers had less than 50 providers that came on staff, which means we met less than 1% based on the number of activities and/or learners.
State-accredited provider	Redundant as far as hospital systems go. CME committees do not monitor individual practices.
State-accredited provider	This one is truly focused on CME, and reinforces the need for physicians to engage in use of HIT, and for HIT to provide care and more timely information analysis
State-accredited provider	Would love to have far more input from Quality and the Talent Development and Optimization (efficiency) department. We have Epic, but there is a two year waiting list for custom reports being designed. Have meetings planned, but that's not the same as having their input and reports. Much thought will need to go into designing and measuring and tracking of the data. We will eventually get there, but this will not be easy, and it won't be soon.
State-accredited provider	This would require the integration of Practice Support folks (IT) to be engaged and having the time to dedicate to engaging in CME in addition to the support they offer their practices.
State-accredited provider	This criterion is within our ability to achieve.
State-accredited provider	Clear but will be challenging for many providers. It is commendation after all.
State-accredited provider	The Criteria is good but do not agree with standard. Would be too difficult for Providers and surveyors to measure compliance.
State-accredited provider	Only concern is about the availability of the teachers.
State-accredited provider	We currently provide of this information. This criteria would encourage us to expand this part of our programs.

C27: Provides CME about implementation strategies to improve public health.

C27: Since you answered 'no', please explain and/or suggest edits.	
Organization Description	Comments
ACCME Recognized State Medical Society	Unable to assess. Inadequate and/or deficient methodological evidence of validity, reliability and application practicality of process. Details upon request. E.g. lack of evidence this criteria should carry same “weight” as any other and is mainly exclusive of other criteria to avoid double weighting. Applicability and importance depends on nature and scope of provider.
ACCME Recognized State Medical Society	The Standard: - ?10% of activities – ?10% too high
ACCME Recognized State Medical Society	We endorse a criterion that relates to population health and would suggest the use of this term rather than “public health”, as it is becoming more commonly used terminology that extends beyond the traditional public health domain. As described above, however, we have concerns about the attempt to determine compliance based on the percentage of activities or learners.
ACCME Recognized State Medical Society	Make it short and succinct. 'This criterion rewards providers who address the health of populations.' is shorter than the sentence listed but probably can be simply eliminated completely.
ACCME Recognized State Medical Society	Revise to: 'Provides CME about implementation strategies to improve public health and healthcare.' Reason for revision suggested in first question on survey regarding the menu. Modify critical elements to AND/OR. Add 'healthcare' to the first bullet point if criterion is revised.
ACCME Recognized State Medical Society	% of the standard is not a good idea for any Criteria; this will be too complicated to calculate. Providing multiple examples for a Criteria should be sufficient for a compliance finding.
ACCME Recognized State Medical Society	Need clarification on the standard of 10% of activities or learners. For example, is it 10% of the total of activities from the entire term of accreditation? Or could it be 10% of activities from 1 or 2 years of accreditation? 10% of activities or learners will be very difficult for many providers in our state system to achieve, as addressing the health of populations would most likely not occur this often. Suggest lowering percentage to a specific range of activities such as an expectation of one to three per year? A % is complicated for accreditors to work with during the survey process. Example, what/how many activities do we need to select for review?
ACCME Recognized State Medical Society	Fine as written. (Please see previous comments regarding the percentage requirement.)
ACCME Recognized State Medical Society	As written ('change in health behaviors, social and economic factors, and the public's physical environment) this criterion may be too large in scope. Would a provider need to show evidence of implementation of all stated aspects in one activity or all of them throughout the term in various activities? The ?10% of activities 'and/or' learners would be difficult for surveyors to evaluate.

Call for Comment Responses: Proposal for a Menu of New Criteria for Accreditation with Commendation

C27: Since you answered 'no', please explain and/or suggest edits.	
Organization Description	Comments
ACCME Recognized State Medical Society	The use of the word “AND” in the rationale should be replaced with “OR”, ie change in health behaviors, social OR economic factors, OR the public’s physical environment. Please define public’s physical environment. The Standard percentage will be very difficult for surveyors to assess or providers to achieve.
ACCME-accredited provider	Change C27 to 'teach Learners how they can implement change in health behaviors' to 'teach Learners how they can implement change in health behaviors of groups or populations.'
ACCME-accredited provider	Example is helpful.
ACCME-accredited provider	It is clearly written, but for a small subspecialty hospital such as ours, this Criterion is beyond our reach. Most of these new criteria require personnel and financial resources in order to achieve them and we do not have such resources. It appears to me that these Criteria benefit the major university/hospital systems that have big CME programs with CME staff whose job it is to manage informatics, dig for public health information and the like.
ACCME-accredited provider	What is meant by 'public' here? We are a private, nonprofit institution with a defined mission--our hospital only treats pediatric cancer, blood disorders and HIV/AIDS on a referral basis. We do not accept patients outside of these diagnostic groups, and we do not have an emergency room. Can we define our 'population' as the children with or at high risk for these conditions?
ACCME-accredited provider	I am concerned about the 10% threshold. We had approximately 3000 activities in 2015. Are you suggesting that at least 300 of these activities would need to be about strategies to improve public health? That does not make for a very well rounded portfolio. Could you give some examples of what 'implementation strategies to improve public health' means? Does this include AHA training (such as BLS, ACLS)?
ACCME-accredited provider	dislike use of AND - prefer AND/OR as I feel both are important, but not necessary to meet the overall goal. Does entire activity need to meet the criteria to qualify or could individual lectures within an activity meet the requirement?
ACCME-accredited provider	'To achieve compliance, the accredited program will teach learners how they can implement change in health behaviors, social and economic factors, and the public’s physical environment.' - How does this differ from the current needs assessments we conduct?
ACCME-accredited provider	Does Improving Diagnosis of Public Health qualify?
ACCME-accredited provider	See C26 same concern.
ACCME-accredited provider	Must both elements be present in all activities (use of word “AND”)? Also not clear if entire activity needs to address public health, or can only a part of activities address it and meet this criterion? Providers funded by grants and do not have a larger organization to provide budget for the development/execution of CME programs will have a difficult time with this criterion as funding is limited for CME addressing public health. Funding that is available (gov’t, foundations) often comes with so many reporting requirements that only large organizations with significant infrastructure could expect to be able to meet the requirements that go along with such grants. The 10% criteria will be difficult for both large and small organizations to achieve.

Call for Comment Responses: Proposal for a Menu of New Criteria for Accreditation with Commendation

C27: Since you answered 'no', please explain and/or suggest edits.	
Organization Description	Comments
ACCME-accredited provider	We endorse this criterion but suggest linking it to “population health” in lieu of “public health”, as this more widely-used term extends beyond the traditional public health domain. As noted above, we do not recommend requiring providers to apply this criterion to > 10% of their activities.
ACCME-accredited provider	The term 'social and economic factors' is ill defined - this should be clarified or removed. Also, since this criterion includes a wide range of factors that education may not be able to influence, changing the final sentence of the Rationale to read '...OR the public's physical environment' would be more feasible.
ACCME-accredited provider	As written, this Criterion does not explicitly recognize CME efforts to support learners’ knowledge and skills related to navigating healthcare and payer systems, which have significant impact on public health. CME providers should be rewarded for their efforts to educate regarding issues like the Affordable Care Act, Patient Centered Medical Home, and other system-level programs which may affect practice, patient care and public health. In fact, this type of education is not explicitly called out in any Criterion yet reflects a major learner need and should be championed as a strategic value of the CME enterprise.
ACCME-accredited provider	Is the standard for the entire term or for a single year?
ACCME-accredited provider	Surgical CME providers are unable to fulfill this criteria due to the nature of the medical practice of our members. Education advocating for changes in public health policy or public behavior changes is outside the scope of our CME mission and practice of members. Surgical CME inherently does not address public health issues as it is designed to address the knowledge and skills of a surgeon.
ACCME-accredited provider	C27: The term 'CME that directly addresses public health concerns' requires definition. Some specialties deal with medical issues that are the result of health behaviors that are not under a patient's control, yet the criterion does not include any mention of education related to barriers to behavior change. Education that advocates for changes in public policy ('social and economic factors') and 'the public's physical environment' suggests that the provider is assuming an advocacy role. This may not align with an organization's larger mission or policies, disqualifying some providers from potentially achieving commendation because of organizational factors unrelated to the CME program.
ACCME-accredited provider	The criteria and critical elements sections use the term “public health” while the rationale uses “health of populations”. These terms have different meanings which could impact the way a provider demonstrates compliance
ACCME-accredited provider	The phrase “CME that directly addresses public health concerns' requires definition. Some specialties address medical issues that are the result of health behaviors not under a patient's control, yet the criterion does not include any mention of education related to barriers to behavior change.
ACCME-accredited provider	Please see prior comments about % threshold.

Call for Comment Responses: Proposal for a Menu of New Criteria for Accreditation with Commendation

C27: Since you answered 'no', please explain and/or suggest edits.	
Organization Description	Comments
ACCME-accredited provider	The term 'CME that directly addresses public health concerns' requires clarification. Some specialties deal with medical issues that are the result of health behaviors that are not under a patient's control, yet the criterion does not include any mention of education related to barriers to behavior change. Education that advocates for changes in public policy ('social and economic factors') and 'the public's physical environment' suggests that the provider is assuming an advocacy role. This may not align with many specialty societies' larger mission or policies, potentially disqualifying them from achieving commendation because of organizational factors unrelated to the CME program.
ACCME-accredited provider	The meaning behind improving public health is confusing...if an organization is located predominantly in one area they may have a potential impact on public health in that area but if education is drawing people from across states or countries improving public health is an impossibility. Understanding implementation strategies also needs more clarification. Some educational activities that provide CME credits may not be about the need to impact public health. Their objective may just be increased knowledge for the clinician - there should be merit rather than penalty in this.
ACCME-accredited provider	Many CME providers do not focus on public health issues. The standard is likely unachievable for providers with a large number of activities or learners. This criterion needs to be clearer and the compliance standard changed. As a medical specialty society, many of our educational activities focus on rare diseases in very small populations. How small a segment of the public is considered acceptable to improve public health?
ACCME-accredited provider	Our medical society does public health education; however we cannot achieve the standard every year unless new topics evolve specific to our specialists.
ACCME-accredited provider	Recommend providing examples. In addition, for the critical elements, the requirement of 'and' may not be achievable for all provider types, nor will 10% of activities and/or learners.
ACCME-accredited provider	AMIA agrees with CMSS: 'The term 'CME that directly addresses public health concerns' requires definition. Some specialties deal with medical issues that are the result of health behaviors that are not under a patient's control, yet the criterion does not include any mention of education related to barriers to behavior change. Education that advocates for changes in public policy ('social and economic factors') and 'the public's physical environment' suggests that the provider is assuming an advocacy role. This may not align with an organization's larger mission or policies, disqualifying some providers from potentially achieving commendation because of organizational factors unrelated to the CME program.'
ACCME-accredited provider	Not all medical problems are the result of health behaviors that are under a patient's control. A medical specialty may not deal with modifiable health behaviors but rather might deal in elective procedures. Explain "directly addresses public health concerns."

Call for Comment Responses: Proposal for a Menu of New Criteria for Accreditation with Commendation

C27: Since you answered 'no', please explain and/or suggest edits.	
Organization Description	Comments
ACCME-accredited provider	<p>'To achieve compliance, the accredited program will teach learners how they can implement change in health behaviors, social and economic factors, and the public's physical environment.'</p> <p>1. Wordsmithing: To achieve compliance, the accredited program teaches learners strategies to implement change in health behaviors. (The learner themselves may not be able to implement the behavioral change, but their best practices can be a part of an overall strategy for change.)</p> <p>2. The learner many not be able to impact social and economic factors (as written) but they may be able to identify/articulate how social and economic factors impact health behaviors and be able to help locate resources in the patient's community to alleviate barriers to improved health outcomes influenced by social and economic factors.</p>
ACCME-accredited provider	It is unlikely that my institution could fulfill this criterion. We have no way to influence social or economic factors in our students' varied practice environments.
ACCME-accredited provider	We provide a lot of topics related to public health: HIV, Hep C, Sepsis, Sports Concussion, etc. We provide strategies to individual MDs to change their practice which we hope will affect public health. Does this meet the second criteria?
ACCME-accredited provider	<p>Define 'populations', as in affecting the health of 'populations'.</p> <p>By 'directly addresses', do you mean the main focus of the activity is public health concerns, or can that be a portion of the activity and not the main focus?</p> <p>How many providers offer 10% of their activities 'beyond clinical care education'?</p> <p>Another niche criteria?</p>
ACCME-accredited provider	We would suggest substitution of the term 'population health' for 'public health', as this has a broader connotation and is a major goal for healthcare delivery systems. The expectation for a % of learners or activities will disadvantage providers who have very robust and substantial initiatives in key areas and reward providers who have superficial and perfunctory practices across many activities/learners. We suggest instead that providers be asked to submit several examples to demonstrate compliance. It is unclear what is meant by 'directly addresses'. The expectation for a % of learners or activities will disadvantage providers who have very robust and substantial initiatives in key areas and reward providers who have superficial and perfunctory practices across many activities/learners. We suggest instead that providers be asked to submit several examples to demonstrate compliance.
ACCME-accredited provider	Is '> 10% of activities' over the accreditation term? Annually? or other?
ACCME-accredited provider	Even though you use the term 'public health', I wonder if there will be confusion about whether the criterion is focused on 'public health' or 'population health'. The three examples sound like 'population health' to me.
ACCME-accredited provider	Are there any stipulations as to how the provider defines a 'public health concern' or how 'population' is defined?

Call for Comment Responses: Proposal for a Menu of New Criteria for Accreditation with Commendation

C27: Since you answered 'no', please explain and/or suggest edits.	
Organization Description	Comments
ACCME-accredited provider	This is a terrific criterion. I believe that a school of medicine could demonstrate compliance incorporating implementation strategies to improve public health through our RSS programs. I'll ask for clarity in the second sentence of the rationale. We can teach professionals to facilitate change in patient health behaviors - is that what you mean? Are you asking learners to implement social/economic/environmental change? Perhaps through advocacy or community engagement? These factors have critical impact on population health, but are our learners the implementers or the facilitators of these changes?
Other	Some more examples about 'public health' probably warranted. One could make the case that almost any specific disease is a public health concern.
Other	I think I could make a case for most CME Activities being designed to improve 'Public Health'. If we are going to leave this criteria in, we would need to clarify a very strict definition of 'Public Health' and I'm not sure that is possible.
Other	The term 'CME that directly addresses public health concerns' requires definition. Some specialties deal with medical issues that are the result of health behaviors that are not under a patient's control, yet the criterion does not include any mention of education related to barriers to behavior change. Education that advocates for changes in public policy ('social and economic factors') and 'the public's physical environment' suggests that the provider is assuming an advocacy role. This may not align with an organization's larger mission or policies, disqualifying some providers from potentially achieving commendation because of organizational factors unrelated to the CME program.
Other	Suggested wording change to rationale 2nd sentence- To achieve compliance, the accredited program will teach learners how they can implement change in health behaviors, address social and economic factors, and/or alter the public's physical environment to improve community health. >10% standard is too high; prefer 1/year or x/term
Physician/healthcare professional	see last answer
State-accredited provider	clarify implementing change in the public's physical environment.
State-accredited provider	Not sure if our program could provide this 10% of the time and achieve a reasonable attendance without a broad definition of public health concerns. How will 'Public Health' be defined.
State-accredited provider	Stand alone CME activities are not likely to solve public health concerns. Is the requirement to encourage CME activities focused on public health concerns?
State-accredited provider	See 26.
State-accredited provider	I already did this for the Ebola Crisis and Atrial Fibrillation That was for Criterion 2-7 This could be achievable, but do not require percentages

Call for Comment Responses: Proposal for a Menu of New Criteria for Accreditation with Commendation

C27: Since you answered 'no', please explain and/or suggest edits.	
Organization Description	Comments
State-accredited provider	<p>Suggest to re-word: Integrates strategies to improve public health (such as, by addressing factors of patient health, behavior, socioeconomic issues, and/or physical environment).</p> <p>How is this criterion different from c18 except to say that the provider not only must 'identify' the factors/barriers, but (in the case of c27) the provider must address them in the context of its educational activities? Is that the goal here? If so, then I think the word 'AND' in the critical elements section is appropriate. To me, the 10% standard might actually be lower than what i personally would expect could be possible, but again I would probably elect to remove the % altogether.</p>
State-accredited provider	<p>It is unclear to me how CME, powerful as it is, can directly affect social, economic, or physical environmental factors. This seems to me to be a great overreach.</p>

Call for Comment Responses: Proposal for a Menu of New Criteria for Accreditation with Commendation

C27: Please provide comments or questions about this criterion.	
Organization Description	Comments
ACCME Recognized State Medical Society	All that concerns Public Health, I feel must be addressed in CME's. This is an excellent way to have physicians more capable of teaching patients on new health concerns and exercise prevention.
ACCME Recognized State Medical Society	This section, Addressing Public Health Priorities, is more doable than previous. Every hospital/provider (big or small) needs to address emerging public health issues. Should be able to meet the >10% standard.
ACCME Recognized State Medical Society	Better %, however, 5% might be more practical? And, an example would be nice.
ACCME Recognized State Medical Society	Is the intent that these will be stand-alone activities focused on population health or public health, or could it be part of an activity that may have a related focus, such as a state medical society annual conference? If it is possible to achieve this criterion as part of activities not focusing exclusively on population health or public health, then how will accreditors collect this information to complete an accurate assessment of the providers' compliance with this criterion?
ACCME Recognized State Medical Society	We have been challenging our providers to incorporate public health into their programs for a number of years; this will give them the impetus to do so.
ACCME Recognized State Medical Society	Standard percentage is a concern - see 1st page for details.
ACCME Recognized State Medical Society	Great Criterion, especially in today's environment, and achievable by most providers.
ACCME Recognized State Medical Society	You have changed CE to CME which clarifies for me that the education referred to is accredited CME. I am not understanding how '% of learners' applies to any of the proposed criterion where % of learners can be the standard. I am not understanding how '% of activities/learners' applies to RSS for any of the proposed criterion. 10% seems high
ACCME-accredited provider	Clarification is required on measurement of percentage requirements - I feel this way for all menu items and criteria, but I'm not going to continue to write it moving forward.
ACCME-accredited provider	Unlike some of the other criteria that seem to address mostly in-house clinicians, this criteria can be applied to in-house and community clinicians
ACCME-accredited provider	I really like this standard and think it is clearly written.
ACCME-accredited provider	Various areas at our institution manage programs that address public health. However, not all of them are CME certified. Is the expectation that we now specifically create programs to address public health? If so, we have staffing concerns.
ACCME-accredited provider	Somewhat clear. Accreditors will need help on how this can be achieved.
ACCME-accredited provider	The criterion is clear and the standard, while possibly too high, is more realistic than the standard set for prior criterion.

Call for Comment Responses: Proposal for a Menu of New Criteria for Accreditation with Commendation

C27: Please provide comments or questions about this criterion.	
Organization Description	Comments
ACCME-accredited provider	We suggest linking the critical elements with 'AND/OR' instead of 'AND'. We may have difficulty meeting both criteria in this category if all elements are required.
ACCME-accredited provider	will deliver better community health care policy
ACCME-accredited provider	I like this one because it speaks to the larger societal impact CME can have.
ACCME-accredited provider	Is the Standard metric of >10 activities and/or learners based on the accreditation period or an annual threshold? If there is one large CME activity that eclipses all of the others in scope and it has a large % of its content focusing on addressing one or more public health concerns is that compliant, or does this large activity simply count as 1 (equivalent to a journal article)?
ACCME-accredited provider	Some Providers are in a position to affect change in populations. These Criteria will give them an opportunity to shine!
ACCME-accredited provider	This is a good idea. In fact we have a few courses on this. HOWEVER, the basic goal of our education is knowledge of medical skills. We have over 350 courses a year. Having greater than 10 percent of our courses on this content would mean we have 35 plus courses which is not efficient or resource effective. Having a great than 10 percent or great than XX number of courses seems a better alternative for this for those providers where they have a large number of courses.
ACCME-accredited provider	We suggest basing the standard on number of credit hours of activity. A 1 credit activity and a 50 credit activity may have different parameters and not all will address public health concerns.
ACCME-accredited provider	C27: Strategies to improve public health are important to teach. However, it would not be appropriate to develop 10% of our activities to focus entirely on public health – this would be a disservice to our members who rely on us to discuss technique and skills. We would recommend incorporating strategies to improve public health into 1 accredited activity per year as the standard.
ACCME-accredited provider	C27: This is achievable. No issues. This is very important.
ACCME-accredited provider	Suggest a lower percentage given the depth and breadth of traditional medical content we have to deliver as a medical specialty society.
ACCME-accredited provider	The Standard is too high for this. Currently we have activities that incorporate this, but given our large educational portfolio, we could never achieve this standard.
ACCME-accredited provider	Critical Elements should be amended to “ORs” from “ANDs.” Requiring “ANDs” significantly limits the flexibility intended by the introduction of the menu structure. We believe innovation and creativity will be reduced and not all provider types will have the ability to achieve Accreditation with Commendation.
ACCME-accredited provider	Fantastic addition!
ACCME-accredited provider	Added value might be achieved by adding another bullet: 'Provides CME about geopolitics involved in resolving public health problems'
ACCME-accredited provider	I think this is vitally important as more and more organizations focus on systems based care.

Call for Comment Responses: Proposal for a Menu of New Criteria for Accreditation with Commendation

C27: Please provide comments or questions about this criterion.	
Organization Description	Comments
ACCME-accredited provider	Outstanding. It is high time to see leadership in this area, the link between what we do in hospitals and public health outcomes. EG: Breastfeeding, Skin to skin, late preterm inductions to name but a few.
ACCME-accredited provider	Difficult to meet the proposed Standard.
ACCME-accredited provider	This criterion is fair and is consistent with longstanding ACCME standards. The goal of CME is to improve public health so many/most CME activities identify the need based on public health statistics.
ACCME-accredited provider	I believe the criterion is clear and the elements are well stated; however, it becomes complicated when you start requiring a percentage of activities. The rationale and critical elements really helped to solidify my understanding of the criterion.
ACCME-accredited provider	this criterion is relatively clear and I understand that the ACCME doesn't want to be too prescriptive (and I appreciate that fact). It seems that this criterion focuses on the provider creating strategies, opportunities and approaches for collaboration, discussion and implementation of educational approaches that can be translated into actions that improve public/population health.
ACCME-accredited provider	Important criterion but given the diversity of our accredited providers, 10% or more of activities is not practical for all.
ACCME-accredited provider	As with the others, the metrics to achieve need to be clarified if they are to be achieved. In my program, 10% of participants would be nearly 5000 persons; if it's 10% of activities, then it would be 73 activities.
ACCME-accredited provider	As indicated previously I question the standard.
ACCME-accredited provider	It is our suggestion that as we transition to a new process, that we would like to see the proposed # of activities to meet the requirement (10%) be reduced to 5% with an option to increase at a later time.
ACCME-accredited provider	See concerns from page 1 of the survey related to The Standard
ACCME-accredited provider	The criterion is clear but I do not agree with the standard. Currently there is no percentage or number of activities and/or learners required for any of the Commendation Criteria/. I think that more providers will put forth the effort to achieve this and the other criteria if there is no percentage or number standard attached.
Other	I also object to the standard of 10%. It is too high. I recommend 1 activity per year of accreditation as the standard.
Other	While we feel that the criterion is clear we wondered if "public health" should read "population health" since "public health" could be confused with a specific discipline – at least internationally and lead to some confusion related to the scope of what is inferred by 'public health'.
Physician/healthcare professional	My critique of this is that you are trying to use this forum (ACCME) to place more emphasis on social factors and other issues which, while important for those in direct patient care settings, are perhaps not best used as a criterion for determining whether a CME provider is doing a 'commendable' job! Also, it could help to define public health.
Physician/healthcare professional	Yes, this is important and absolutely doing in at least 10% of activities.
Physician/healthcare professional	This is a very worthy criterion!

Call for Comment Responses: Proposal for a Menu of New Criteria for Accreditation with Commendation

C27: Please provide comments or questions about this criterion.	
Organization Description	Comments
State-accredited provider	The criterion is clear. The standard seems unrealistically high
State-accredited provider	This is crucial as our focus shifts from sick care to population health.
State-accredited provider	Public health is not the mission of the hospital. The public health departments have that responsibility.
State-accredited provider	We vote to have The Standard be: 'No less than 5% of activities and/or learners'
State-accredited provider	1. Meeting the standards for the new criteria will appear to require a lot more data gathering and analysis to be compliant, which will ultimately result in more costs. 2. The standards for many criteria are too rigorous, for example, in calling for >25% of activities and/or learners or >10% of activities and/or learners. Many CME providers do not have the volume of CME activities to meet this standard.
State-accredited provider	Modify Critical Elements to AND/OR rather than AND.
State-accredited provider	This one seems a bit unreachable within the context of CME and the data required to meet this requirement. Smaller organizations with limited staffing will not be able to follow up with the data, especially at a public level such as this.
State-accredited provider	Again as above. I believe that the standard as written is way too high. and greater than 10% of our activities that would be about 30 activities that would have to meet this and with the number of Journal Clubs and case conferences we hold out of our approximate 300 programs this would be difficult to achieve. I am unclear what is meant by 'and/or learners' and how those number would translate. Also I believe that the increased workload to meet this high number of activities with a CME office that is staffed by a CME director, CME manager and Admin Assistant/coordinator along with additional responsibilities added to the plate with ABIM and other specialty boards this is unrealistic. We have been accredited with commendation for the past 2 cycles and I am not certain this added work is worth the bang of receiving 6 years instead of 4. I also thin that the critical element should include and/or and not just and to make it more realistic. Addressing public health as indicated very hard.
State-accredited provider	I like it - but here is the question you'll get. In an RSS made of 52 sessions - how many need to include this for the RSS to count?
State-accredited provider	Great criterion, however the 10%+ may not be attainable to smaller organizations.
State-accredited provider	I believe your standard numbers are skewed. The very mission of CME should be and is to address public health concerns and provide strategies to improve public health. Yet this reachable goal has a lower standard number than the earlier more difficult strategies to implement
State-accredited provider	This would be difficult but interesting. Our budget does not allow to pay for high costing speakers.
State-accredited provider	Areas that are useful for improving performance include the education training, process improvemen/t and learners' leadership.
State-accredited provider	Does this change the learner audience to other learners, more than physician learners?
State-accredited provider	Acceptable, addresses root causes of poor health beyond clinical care.

Call for Comment Responses: Proposal for a Menu of New Criteria for Accreditation with Commendation

C27: Please provide comments or questions about this criterion.	
Organization Description	Comments
State-accredited provider	This is reasonable and works. Don't know about the 10%
State-accredited provider	The standard is too high. If a CME program offers multiple formats and has multiple activities, they would have to minimize the number of activities to meet the level of greater than or equal to 10%. The small CME program would have to be devoted to this type of activity in order to meet the standard. How does this meet physician education gap in clinical areas as well?
State-accredited provider	This criteria assumes that doctors, if not for CME, would never think of helping to change health behaviors. Of course, local programs will educate about current issues, but the tone of this criteria, along with other commendation criteria, way exceeds the expected mission of CME, particularly the ACCME. I suggest that as you pursue increasing complex and over reaching criteria based on fanciful, wishful thinking, you will find your organization eventually to be irrelevant.
State-accredited provider	Good focus. Necessary, realistic. May help in productive and economical use of resources
State-accredited provider	Percentage of standard is a challenge. You want accreditors to go above and beyond the criteria. To do so requires additional work and resources. If a provider knows they cannot meet the critical elements or standard because of limited resources or different hospital goals, then they will not strive for more.
State-accredited provider	Have no idea how to make this happen, where to start, or how it could be tracked. If they are not our patients how can we track them? Would this include patients? Would it still be CME if ___% were members of the public? Maybe use enduring materials, but again, the % of attendees could be a problem, especially if from out of state. This is so broad, so general, it could be anything. I doubt we could ever get the funding for something like this.
State-accredited provider	Take the 'AND' away and replace with 'OR' in the critical elements section.
State-accredited provider	<p>If we can accomplish this in a couple programs per year, that is a success but the >10% of programs is unrealistic, especially for CME shops that accredit a large numbers of CME activities per year.</p> <p>This should be more qualitative, i.e. show how your CME department is striving towards incorporating strategies to improve public health and let people tell their stories of good work rather than not making it good enough because of volume requirements.</p>
State-accredited provider	Many of our activities, especially joint providerships, focus on public health.
State-accredited provider	Although the Criteria is clear it will not be able to be attained by all Providers. The standards still remain an issue to determine and measure.
State-accredited provider	Currently not in our programs, however, is a reasonable and useful piece to add.

CREATING BEHAVIORAL CHANGE

C28: Develops communication skills of learners.

C28: Since you answered 'no', please explain and/or suggest edits.	
Organization Description	Comments
ACCME Recognized State Medical Society	Unable to assess. Inadequate and/or deficient methodological evidence of validity, reliability and application practicality of process. Details upon request. E.g. lack of evidence this criteria should carry same “weight” as any other and is mainly exclusive of other criteria to avoid double weighting. Applicability and importance depends on nature and scope of provider.
ACCME Recognized State Medical Society	<p>“Creating Behavioral Change” section – needs new title. It seems to have a negative connotation. Not sure professional people want to be told to change their behavior. Maybe something like “Developing Interactive Strategies.” Plus it would be very hard for any small provider to develop activities that would comply with C28 thru C31.</p> <p>C28 - don't think small providers would develop/implement activities that will “help learners become more self-aware.” Too individualized for hospital with limitations on time, resources, and admin. support</p>
ACCME Recognized State Medical Society	What defines 'objective assessment'? Would there be a tool available or how would this be measured?
ACCME Recognized State Medical Society	<p>Critical Elements:</p> <ul style="list-style-type: none"> - Better if allowed for this OR that, instead of this AND that. Small providers with one person CME office or part-time staff may not be able to address skill building assessment, feedback, and multiple feedback. <p>The Standard:</p> <ul style="list-style-type: none"> - It is unclear whether the “% of activities or the % of learners” represents the % of learners in a given year of activities or for the entire accreditation term. - ?10% of activities and/or learners – ?10% too high
ACCME Recognized State Medical Society	Please clarify what qualifies as an “objective assessment”.
ACCME Recognized State Medical Society	<p>In terms of the critical elements, the definitions of “objective assessment” and “provides feedback” should be clarified.</p> <p>We support the importance of communications skills but question why this core competency area was selected above others. Given that other criteria address medical knowledge, clinical care, systems-based practice, and practice-base improvement, perhaps it would be appropriate to include professionalism in this criterion. This is particularly important in view of national priorities for end of life care, value-based care delivery, and patient centered decision making. We have concerns about the attempt to determine compliance based on the percentage of activities or learners.</p>

Call for Comment Responses: Proposal for a Menu of New Criteria for Accreditation with Commendation

C28: Since you answered 'no', please explain and/or suggest edits.	
Organization Description	Comments
ACCME Recognized State Medical Society	Delete the 2nd sentence. 'educational interventions' is an ambiguous term that is linked to educational activities. Are they the same? I think so. I would encourage revising the ACCME text and delete 'educational interventions'.
ACCME Recognized State Medical Society	The criterion statement is missing one keyword from the critical elements, "assess." For the criterion statement to align with the critical elements, IMS would recommend that the criterion statement be changed to "Assess and develop communication skills for learners." Does the feedback need to be on an individual basis, or could it be general feedback, such as, 22 percent of learners feel they need to improve on ...? Does the provider need to show evidence that the assessment or skills development training was conducted during a specific CME activity or activities? CME is not mentioned within the criterion statement, rational, or critical elements.
ACCME Recognized State Medical Society	% of the standard is not a good idea for any Criteria; this will be too complicated to calculate. Providing multiple examples for a Criteria should be sufficient for a compliance finding.
ACCME Recognized State Medical Society	'Uses an objective assessment of communication skill' needs an explanation. What does this mean in terms of staffing expertise to fulfill this criterion? Is the expectation to determine the skill deficit of each learner or to define (and measure) the expected communication skills for each healthcare professional?
ACCME Recognized State Medical Society	Need clarification on the standard of 10% of activities or learners. For example, is it 10% of the total of activities from the entire term of accreditation? Or could it be 10% of activities from 1 or 2 years of accreditation? Suggestion: 10% of activities or learners will be very difficult for many providers in our state system to achieve, as offering communications courses would most likely not occur this often. Suggest lowering percentage to a specific range of activities such as an expectation of one to three per year? A percentage is complicated for accreditors to work with during the survey process. Example, what/how many activities do we need to select for review?
ACCME Recognized State Medical Society	It is fine as written. (See comments regarding use of percentages.)
ACCME Recognized State Medical Society	Doesn't appear that the 'educational interventions' need to be CME. I am not understanding how '% of learners' applies to any of the proposed criterion where % of learners can be the standard. I am not understanding how '% of activities/learners' applies to RSS for any of the proposed criterion. 10% seems high.
ACCME Recognized State Medical Society	Do writing skills count for communication? Evaluation using an objective assessment and feedback to learners would be resource intensive; it may be hard for provider's with limited staff/resources to comply. The ?10% of activities 'and/or' learners would be difficult for surveyors to evaluate.

Call for Comment Responses: Proposal for a Menu of New Criteria for Accreditation with Commendation

C28: Since you answered 'no', please explain and/or suggest edits.	
Organization Description	Comments
ACCME Recognized State Medical Society	The criterion and rationale may be achievable by some providers. The Standard percentage will be very difficult for surveyors to assess or providers to achieve.
ACCME-accredited provider	Define 'objective assessment' and 'feedback using the assessment'. Can an audience response system achieve both. Can practice in a sim lab achieve both? Also define communication - how much of the activity has to be focused on communication?
ACCME-accredited provider	measurement clarification needed.
ACCME-accredited provider	I do not understand the standard of '>10% of learners and/or activities). We have 44,000 learners and 3000 activities each year. This would suggest that we need to assess the communication skills and provide feedback to 4400 learners during 300 activities. This would be an onerous threshold to meet.
ACCME-accredited provider	This seems to be a very resource intensive criteria and I feel it would be very difficult for all provider sizes to meet the 10% requirement. Recommend the threshold be lowered.
ACCME-accredited provider	Critical Elements should include examples of 'objective assessments of communication skill'
ACCME-accredited provider	Does this center around the communicatio of the provider to the patient population and diversity of patients?
ACCME-accredited provider	The criterion should specify the different types of communication that will be considered for compliance, e.g. oral, written, non-verbal, etc.The criterion indicates that it will reward providers that....more self-aware of their communication skills, and implement educational interventions...., but the Critical Elements require an objective assessment of skill and feedback to the clinician using the assessment. implies that only live and one-on-one or small group training activities can meet this requirement. Is your intent to restrict the methods used to improve communication skills.
ACCME-accredited provider	Please further define objective assessment. Are only specific communication titles required?
ACCME-accredited provider	Criterion is clear but Critical Elements less so. Clarification of 'objective assessment' and form of feedback would be extremely helpful. In general, this is a skill we emphasize in many of our courses based former participant feedback and medical literature regarding the importance of this at many levels.
ACCME-accredited provider	Must both critical elements be present in all activities (referring to use of word "AND")? The critical elements read that the feedback needs to be provided to the individual clinician. Is that what was intended? The 10% criteria will be difficult for both large and small organizations to achieve.
ACCME-accredited provider	We strongly endorse this criterion since it addresses a competency that underpins all the others; however, what constitutes "objective assessment" and "provides feedback" should be clarified. As noted above, we do not recommend requiring providers to apply this criterion to > 10% of their activities.

Call for Comment Responses: Proposal for a Menu of New Criteria for Accreditation with Commendation

C28: Since you answered 'no', please explain and/or suggest edits.	
Organization Description	Comments
ACCME-accredited provider	what is 'objective assessment of communication skill' There aren't that many 'objective assessments' available, e.g. 'Common Ground' in the 2004 article by Lang and McCord. TO use this particular tool one would need trained raters to observe audience members in a communication task--which adds expense to an educational meeting and at some point becomes 'not worth the effort and expense' While I think improved communication teaching at a meeting is a great 10% endeavor--the objective assessment requirement is just going to be too expensive for a small or medium sized society
ACCME-accredited provider	We request clarification of 'uses an objective assessment.' Is there a specific tool or standard mechanism expected to be used across activities? Or, with this be up to each provider to determine based on the activity and the gap(s) it is designed to address? Also, Is the Standard metric of >10 activities and/or learners based on the accreditation period or an annual threshold? If there is one large CME activity that eclipses all of the others in scope and it includes content on and assessment of communication skills, is that compliant, or does this large activity simply count as 1 (equivalent to a journal article)?
ACCME-accredited provider	I am confused by the 'uses an objective assessment of communication skill' - what would that be? Is this readily available somewhere online that organizations like us could use? If we have to create it, we won't do it. The docs don't want to talk about this at all, so we have to carefully sneak the education in while they aren't suspecting it. They are not going to pay for this. Other than this, and I recognize my lack of understanding the term 'Objective assessment' is an issue, but otherwise, all is perfectly clear.
ACCME-accredited provider	'Communication skills' encompasses a wide variety of behaviors and 'improving' these skills is highly subjective. Definite, standard approaches for assessing these skills will be necessary in order for providers to plan activities accordingly and for program reviews to be completed consistently by ACCME reviewers.
ACCME-accredited provider	Further clarification is needed as to what would be considered an "objective assessment." A potential interpretation of this Criterion may be that "objective assessment" of communication skills does not include tools used to facilitate self-reflection and self-assessment related to communication skills. Many CME activities do and can help a learner assess gaps in their own communication skills without employing direct, objective supervision of the skills. As written, it is unclear what would qualify and it does seem to exclude self-assessment of skills.
ACCME-accredited provider	Would a course on communication skill be CME? It this on how to communicate to patients or how to give an effective presentations or both?
ACCME-accredited provider	Is the standard for the entire term or for a single year?
ACCME-accredited provider	Does this criteria need to be fulfilled within the scope of our CME activities only?
ACCME-accredited provider	Define how we are to determine the level of effectiveness of the communication skill.

Call for Comment Responses: Proposal for a Menu of New Criteria for Accreditation with Commendation

C28: Since you answered 'no', please explain and/or suggest edits.	
Organization Description	Comments
ACCME-accredited provider	Can you objectively assess communication skills? ACCME has not defined objective criteria for assessing communication skills that would allow providers to demonstrate that they are 'developing' these in their learners. The use of subjective criteria in the accreditation process raises significant concerns among providers because of the potential inconsistencies that can be encountered in the accreditation review process.
ACCME-accredited provider	Define "objective assessment"
ACCME-accredited provider	1. CRITICAL ELEMENTS: It is very difficult to objectively measure or assess communication skills. Most measurements of communication skills are subjective and not objective. 2. CRITICAL ELEMENTS: ACCME would need to establish set criteria for the objective assessment of communication skills; otherwise, everyone will establish their own criteria.
ACCME-accredited provider	Is there a valid objective assessment of communication skills that can/should be used to satisfy the critical element, or will the definition of 'objective' be up to the discretion of accredited providers? The use of subjective criteria is concerning because of potential inconsistencies that may occur in the accreditation review process. If a portion of many of the activities includes communication tips, would this contribute to demonstrating compliance with at least 10% of learners and/or activities? Will the feedback to clinicians using the assessment need to be individualized or would distribution of aggregated feedback to learners be acceptable?
ACCME-accredited provider	10% threshold is unclear. Needs better delineation. See previous comments.
ACCME-accredited provider	The objective criteria for assessing communication skills have not been clearly defined to allow providers to demonstrate that they are 'developing' these in their learners. The use of subjective criteria in the accreditation process raises significant concerns because of the potential inconsistencies that can be encountered in the accreditation review process. The ACR suggests changing the word "AND" to "OR" in the Critical Elements section.
ACCME-accredited provider	Develops communication skills is ambiguous. This would imply a skills workshop rather than a course that increases knowledge. There are entire companies that devote their objectives to increasing communication skills that is a different twist than preparing physicians to be better at diagnosis and treatment which is what specialty associations do. What is the intent of this - that one course a year may include this or that most courses need to include an assessment on communication skill and then a chance to score it and then provide feedback...then what happens???
ACCME-accredited provider	Most courses would be over by this time. Who develops the communication skill assessment or what will ACCME accept as a valid communication assessment. Then what does it mean to develop. Development goes beyond one meeting, one course, etc. This seems to have a different agenda than a CME activity.
ACCME-accredited provider	It is unclear if this criterion will be satisfied by improving learner self awareness rather than that actual improvement of the skills themselves. Again, the standard of 10% or greater will likely be unachievable for many providers with a large number of activities and learners.
ACCME-accredited provider	An 'objective assessment' needs to be better defined.

Call for Comment Responses: Proposal for a Menu of New Criteria for Accreditation with Commendation

C28: Since you answered 'no', please explain and/or suggest edits.	
Organization Description	Comments
ACCME-accredited provider	<p>An objective assessment may be difficult to achieve, and may deter some clinicians from participating in a course. Recommend removing this requirement and instead make it a subjective assessment/self-reported.</p> <p>In addition, for the critical elements, the requirement of 'and' may not be achievable for all provider types, nor will 10% of activities and/or learners.</p>
ACCME-accredited provider	<p>"Objective assessment" for assessing communication skills needs to be defined. Using subjective criteria could result in inconsistencies during the accreditation review process.</p> <p>Suggest lowering the standard.</p>
ACCME-accredited provider	<p>AMIA agrees with CMSS: 'ACCME has not defined objective criteria for assessing communication skills that would allow providers to demonstrate that they are 'developing' these in their learners. The use of subjective criteria in the accreditation process raises significant concerns among providers because of the potential inconsistencies that can be encountered in the accreditation review process.'</p>
ACCME-accredited provider	<p>How does ACCME define 'communication skills'? Written, oral, both, either? To whom do these 'communication skills' apply? With peers, patients, others?</p>
ACCME-accredited provider	<p>Baseline, Criterion 28 is clear as written. However, this criterion would have more meaning if the words, Effective (as in effective communication skills); Interpersonal, and Verbal and Non-verbal actions were added.</p> <p>Wordsmithing: 'Communication skills are essential to most aspects of professional practice.' Replace with: Effective communication is an essential component of professional practice.</p>
ACCME-accredited provider	<p>'Elocution lessons' -- the first thing that came to mind, not what the framers intended, certainly. But the prospect of designing, evaluating, and judging this item is daunting.</p>
ACCME-accredited provider	<p>Different providers must use different communication skills depending on their environment. We have a varied student population. Our student physicians in military service likely address their patients differently than student physicians in a primary care setting like pediatrics. I do not believe it is the function of my institution to teach communication skills to seasoned professionals.</p>
ACCME-accredited provider	<p>Is an objective assessment in the form of a pre-test good enough? We already provide feedback on our post test - comparison to others who have taken the course. Is this the type of feedback? Most of our courses have recommendations related to communication but for this to count, do the courses need to be specifically related to communication?</p>

Call for Comment Responses: Proposal for a Menu of New Criteria for Accreditation with Commendation

C28: Since you answered 'no', please explain and/or suggest edits.	
Organization Description	Comments
ACCME-accredited provider	Can the assessment be part of an activity, or does it have to be the entire activity? Critical elements don't mention implementing educational interventions to improve those skills. As is, only mention measuring and giving feedback about measurement results. If the entire activity is the assessment, then this seems like a one-event topic, and to meet the 10% of activities criteria you could only offer 10 activities per year. Don't see how 10% of learners works for this criteria. If the entire activity is the assessment, this is a niche criteria.
ACCME-accredited provider	It is not clear what an 'objective assessment of communication skill' might be. For an online activity, could it be a case-based exam that provides a score at the end and correct answers? Or could it only be a live activity in which a learner is given a case example to role play and an instructor provides feedback on the learner's performance? This will require a very high instructor to student ratio which will be difficult to achieve at a cost that is afford able to learners.
ACCME-accredited provider	As with the previous comments, the metrics to achieve may be burdensome.
ACCME-accredited provider	We suggest that this criterion be broadened to include other core competency areas, particularly professionalism. The term 'objective assessment' needs to be better defined. The expectation for a % of learners or activities will disadvantage providers who have very robust and substantial initiatives in key areas and reward providers who have superficial and perfunctory practices across many activities/learners. We suggest instead that providers be asked to submit several examples to demonstrate compliance.
ACCME-accredited provider	Is '> 10% of learners and/or activities' over the accreditation term? Annually? or other?
ACCME-accredited provider	Need clarification on what is meant by objective assessment. Could test questions for online qualify, if feedback is given when not answered correctly?
ACCME-accredited provider	Would speaker development/speaker training or curriculum development courses count or does it just apply to bedside manner?
Other	"Develop" might not be the most appropriate objective since to us, it assumes that the provider is assuming that learners have no communication skills. We would recommend that "develop" be replaced by "enhance" or "improve" as a more appropriate descriptor.
Other	>10% standard is too high; prefer 1/year or x/term
Other	As the ACCME wants all providers to design activities to change behavior, should the threshold for this criteria be higher, say 25%?
Physician/healthcare professional	Of course we would like to see communication skills improve, how this is achieved is unclear. We would need a clear model of expectation.
Physician/healthcare professional	the term 'objective assessment of communication skill' is too vague

Call for Comment Responses: Proposal for a Menu of New Criteria for Accreditation with Commendation

C28: Since you answered 'no', please explain and/or suggest edits.	
Organization Description	Comments
Physician/healthcare professional	How are communication skills being analyzed? Will there be patient surveys? --- which are totally unacceptable and smacks of MOC-like activity. I fear that this criterion will be overbearing and extremely onerous on providers and learners alike.
Physician/healthcare professional	I think more guidance on the fact that this refers to written, oral and non-verbal communication skills. It should be evident to providers of this kind of information, but I think the criteria are an opportunity to coach the designers of programs.
State-accredited provider	I need examples of what you would consider to be an objective assessment of the communication skill.
State-accredited provider	Too easy to confuse objective vs. subjective assessments.
State-accredited provider	this is a relatively new concept and it would be helpful to give examples of exactly what you are asking for
State-accredited provider	Again as above. I believe that the standard as written is way too high. and greater than 10% of our activities that would be about 30 activities that would have to meet this and with the number of Journal Clubs and case conferences we hold out of our approximate 300 programs this would be difficult to achieve. I am unclear what is meant by 'and/or learners' and how those number would translate. Also I believe that the increased workload to meet this high number of activities with a CME office that is staffed by a CME director, CME manager and Admin Assistant/coordinator along with additional responsibilities added to the plate with ABIM and other specialty boards this is unrealistic. We have been accredited with commendation for the past 2 cycles and I am not certain this added work is worth the bang of receiving 6 years instead of 4. I also thin that the critical element should include and/or and not just and to make it more realistic. I would also ask for clarification on assessment.
State-accredited provider	Please DEFINE an objective assessment of communication skills
State-accredited provider	Define objective assessment of communication.
State-accredited provider	This is not clear to me. Please provide paperwork that will explain what is needed
State-accredited provider	It is a valid need. However, what does it mean? What measurement tool would be the valid tool? ACCME will need to provide the objective assessment of communication skill and feedback forms/tools. Otherwise you are asking providers to take on additional costs in a environment asking to reduce budgets and fees and the tool they choose may not be valid in the eyes of the surveyor. Since communication is a key element to improving patient care and patient compliance, this should be a standard for accreditation as long as ACCME provides the accepted tool.
State-accredited provider	This topic area is too broad. Needs further clarification or perimeters.

Call for Comment Responses: Proposal for a Menu of New Criteria for Accreditation with Commendation

C28: Since you answered 'no', please explain and/or suggest edits.	
Organization Description	Comments
State-accredited provider	<p>Suggest to re-word for better clarity and consistency with the language of other criteria: 'Incorporates the development of communication skills in its educational activities.'</p> <p>If the provider does c23, c24, and/or c25, would it not necessarily follow that the provider would be doing c28? It seems to me that there's an overlap between c28 and the other criteria that involve patients and interprofessional collaborative practice. Will a provider automatically meet both criteria? Is that what the ACCME wants to happen? If not, how can this criterion be distinguished from each other. I think the general concept of this criterion is a good one, but i see some overlap.</p>
State-accredited provider	Revise: Develops communication into the planning, implementation & delivery of the CME activity. Take the 'AND' away and replace with 'OR' in the critical elements section.
State-accredited provider	Please clarify 'objective assessment of communication skill.' As a provider, we can offer activities that focus on improving communications with patients and colleagues (it is one of the physician competencies) but on initial reading, this criterion would require additional staff and expertise.
State-accredited provider	Isn't communication a relatively subjective domain? What would 'objective' measures be? I could imagine picking between various communication responses in a multiple choice format, but how would you measure application?
State-accredited provider	Not real sure about what is required or expected of the provider. The standard is still an issue and not all providers will be able to do this Criteria.
State-accredited provider	Who are the expert teachers??
State-accredited provider	It seems to me that 'communication skill' may be too narrow. Our leadership programs stress team-building and relationship building as well as the communication skills that help achieve these. We include stress, trust, fear, and dealing with difficult people and covenants that help achieve these. We stress intact teams taking programs together.

Call for Comment Responses: Proposal for a Menu of New Criteria for Accreditation with Commendation

C28: Please provide comments or questions about this criterion.	
Organization Description	Comments
ACCME Recognized State Medical Society	I love this one. My only concern is how providers will be able to perform on the matter. It is very necessary, but..., physicians that do not want to be cited or not interested in taking time with patients, will stay quiet. For us, this is one of those CME that if our local board requires it, then we will have audience!
ACCME Recognized State Medical Society	This type of program would go nicely with the current onslaught of Leadership programs. However, the % could be high for SMA providers to comply?
ACCME Recognized State Medical Society	Modify Critical Element to AND/OR.
ACCME Recognized State Medical Society	Standard percentage is a concern - see 1st page for details.
ACCME Recognized State Medical Society	Percentage for all 4 of the Creating Behavioral Change Criteria may be difficult for providers of small entities with part-time CME staff to undertake; and would prevent those institutions from achieving Commendation.
ACCME-accredited provider	WE fully support this criterion's adoption. It could be increased to equal to >25%.
ACCME-accredited provider	I think this standard is too high.
ACCME-accredited provider	For the 'objective assessment' in the critical elements for this criterion, it would be helpful to provide examples. Would an online multiple choice question that presents a complicated case and then asks the physician what he or she would say next, with immediate feedback depending on which option the learner chose, be sufficient?
ACCME-accredited provider	This is a very important criteria as it addresses certain lessons that might receive so much attention in medical schools or residencies.
ACCME-accredited provider	It is clear, but examples might be helpful.
ACCME-accredited provider	For a large health system, this amount would be out of reach.
ACCME-accredited provider	We wholeheartedly agree with this criterion. However, as has been mentioned before, meeting the standard would be difficult as activity content is driven by the departments.
ACCME-accredited provider	Providers must be able to communicate with patients!
ACCME-accredited provider	Objective assessments (i.e., validated, standardized tools), while ideal, are expensive and impractical. They may also not be indicative, if administered directly following skills training. Communication skills improvements typically occur over time, with extended practice. Measuring gains in understanding about the importance of enhanced communication skills and in confidence using new skills should be sufficient for brief CME training.
ACCME-accredited provider	Not a fan as it simply may not be in a provider's purview to provide this type of content, for a variety of reasons.
ACCME-accredited provider	No comments
ACCME-accredited provider	1. These are important skill-building activities that we currently develop. However, these activities are very resource-intensive. A large membership organization would be challenged in meeting The Standard.

Call for Comment Responses: Proposal for a Menu of New Criteria for Accreditation with Commendation

C28: Please provide comments or questions about this criterion.	
Organization Description	Comments
ACCME-accredited provider	Again this is a great criteria. Again for a provider with over 350 activities this means 35 courses must address and use an objective assessment of communication skills. That is pretty resource intensive and hard to achieve. Again, a percentage or a minimum amount seems like a better requirement.
ACCME-accredited provider	We suggest basing the standard on number of credit hours of activity. A 1 credit activity and a 50 credit activity may have different parameters and not all will include communication skills.
ACCME-accredited provider	Might want to consider adding to the critical elements that providers use educational strategies that demonstrate how development of communication skills can occur and demonstrate improvement based upon the 'assessment' and 'feedback'
ACCME-accredited provider	C28: Our society is already working on the development of communication skills, training some of our faculty to improve their skills while teaching procedures using a validated, proven process that was developed in the UK. We do not just provide lip-service to this issue. We take this very seriously. It took a budget of \$50,000 to train 10 faculty. It will not be appropriate to develop 10% of our activities to incorporate communication skills with an objective assessment of these skills. We would recommend 1 accredited activity per year that incorporate this into the activity as the standard.
ACCME-accredited provider	C28: This is through the evaluation and objective assessment. This is important.
ACCME-accredited provider	disagree with objective assessment of communication skill and providing feedback
ACCME-accredited provider	The Standard is too high for this. Currently we have activities that incorporate this, but given our large educational portfolio, we could never achieve this standard.
ACCME-accredited provider	Communication skills are an important part of medical practice.
ACCME-accredited provider	We provide CME designed to develop learner communication skills however, as outlined in the ABIM's Assessment 2020 Final Report "competencies such as communication, teamwork, empathy and quality improvement are also vital for effective patient care, but formal assessment of them for practicing physicians is challenging. These skills have some special attributes. They may be context dependent in that the health care systems and teams may influence the ability of an individual to demonstrate them." Until methods emerge that are effective, efficient, and can account for context and convey meaningful information that are accessible to a wider number of providers we recommend C28 not be included as a new criterion.
ACCME-accredited provider	Great criterion!
ACCME-accredited provider	agree
ACCME-accredited provider	Difficult to meet proposed Standard.
ACCME-accredited provider	Clinician-patient communication is a vital component to improving healthcare.
ACCME-accredited provider	While this may be a challenge to include in CME activities, it is fair that providers are proficient in health care communication, health literacy, and patient education.

Call for Comment Responses: Proposal for a Menu of New Criteria for Accreditation with Commendation

C28: Please provide comments or questions about this criterion.	
Organization Description	Comments
ACCME-accredited provider	What does the ACCME consider an objective assessment? Is there a standard communication assessment tool?
ACCME-accredited provider	One may argue that this threshold is too low, as teaching of communications skills is more than essential; it is critical.
ACCME-accredited provider	I believe the criterion is clear and the elements are well stated; however, it becomes complicated when you start requiring a percentage of activities.
ACCME-accredited provider	<p>IS there a required self-assessment component here and is it required for all activities that address communication (greater than 10%) in order to be eligible to meet this criterion?</p> <p>If communication is embedded in case studies on clinical management of a particular condition-- would that be considered appropriate if an audience response system was used?</p>
ACCME-accredited provider	Important area.
ACCME-accredited provider	Developing communication skills of learners is an important criterion. However, that 10% or more CME activities is in the teaching of communication skills is neither practical for all accredited providers nor desirable given the breath, scope of professional practice, and competencies needed by physicians to deliver quality health care. Given the number of learners nationally (as shared in the ACCME Annual Report), providing feedback to 10% of learners (including non-physician learners) would not be feasible either.
ACCME-accredited provider	As indicated previously I question the standard.
ACCME-accredited provider	<p>We would propose that documentation for selected activities included content that documents development and implementation of CME that enhances communication skills of learner, AND (b) Content that includes strategies to achieve improvements in communication skills. Requiring an individualized assessment and feedback to the learners for more than 10% of a provider</p> <p>activities may be difficult for some providers. We are advocating for the formal assessment and feedback to learners to be incorporated into the requirements as the Criteria evolve into the next phase.</p>
ACCME-accredited provider	See concerns from page 1 of the survey related to The Standard
ACCME-accredited provider	Important criterion.
ACCME-accredited provider	The criterion is clear but I do not agree with the standard. Currently there is no percentage or number of activities and/or learners required for any of the Commendation Criteria/. I think that more providers will put forth the effort to achieve this and the other criteria if there is no percentage or number standard attached.
Other	I object to the standard of 10%. It is too high. I recommend 1 activity per year of accreditation as the standard.
Other	ACCME has not defined objective criteria for assessing communication skills that would allow providers to demonstrate that they are 'developing' these in their learners. The use of subjective criteria in the accreditation process raises significant concerns among providers because of the potential inconsistencies that can be encountered in the accreditation review process.

Call for Comment Responses: Proposal for a Menu of New Criteria for Accreditation with Commendation

C28: Please provide comments or questions about this criterion.	
Organization Description	Comments
Physician/healthcare professional	Great in theory, may be hard to assess in practice.
Physician/healthcare professional	This is perhaps the most critical of all the criteria. As in internist, I spend much of my time explaining to patients what their specialists have been unable or unwilling to explain to them
State-accredited provider	The criterion is clear - the standard seems high
State-accredited provider	This criteria could be expanded to include other professionalism and business skills outside the scope of medical knowledge. Why only highlight communication skills? Communication skills and - interprofessional relationships and team-based dynamics, written and verbal communication/interpersonal communication skills, leadership and professional development, commitment to life-long learning, organizational skills, coaching/giving effective feedback, precepting, etc.
State-accredited provider	This seems like it would be better addressed once per year.
State-accredited provider	It will be hard to do with a power point lecture and questions.
State-accredited provider	We vote to have the Standard be: 'No less than 5% of learners and/or activities.'
State-accredited provider	1. Meeting the standards for the new criteria will appear to require a lot more data gathering and analysis to be compliant, which will ultimately result in more costs. 1. The standards for many criteria are too rigorous, for example, in calling for >25% of activities and/or learners or >10% of activities and/or learners. Many CME providers do not have the volume of CME activities to meet this standard.
State-accredited provider	I like this. 10% is attainable!
State-accredited provider	I think this is great, however, I feel the physician response from this would be negative.
State-accredited provider	A campaign to achieve this in one year would be appropriate. To do this for 10% of the activities over a four or six year accreditation term will cause a drop off in attendance.
State-accredited provider	Very important, particularly to patient satisfaction scores.
State-accredited provider	How would the standard for ?10% of learners be measured? Is it 10% of the total learners for the entire accreditation period? Is it ?10% of learners each year? Or is it 10% of learners per activity?
State-accredited provider	The barriers the learners face is lack of communication skills; being able to effectively connect with the patients to built the trust and understanding the patient's need in time of need.
State-accredited provider	Difficult to implement. This is something medical schools should address.
State-accredited provider	Feedback on an individual basis for large groups is not reasonable all of the time. Our physicians get feedback in the group as well as via areas that the organization measures and their chief holds them accountable for. At this level of professional practice physicians need to get feedback from their chiefs. Is this 10% of all learners or activities or 10% or communication skills activities...not clear.

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C28: Please provide comments or questions about this criterion.	
Organization Description	Comments
State-accredited provider	The standard is too high and needs to be revised. If a CME program offers multiple formats and has multiple activities, they would have to minimize the number of activities to meet the level of greater than or equal to 10%. Offering such activities does not mean you will have physicians or other healthcare providers participating.
State-accredited provider	Unrealistic, and to some extent, insulting to the learner. How the heck did these people ever graduate from medical school and successfully practice medicine. It would be interesting to compare the english SAT scores of the average practicing physician with the members of your criteria committee.
State-accredited provider	Much needed
State-accredited provider	Preferred communication styles are also usually the preferred learning styles. Teaching communication skills will help with learning skills, and could be done in a way that is not obvious. Offering a course on 'improving patient compliance with treatment regimens' would be more accepted than 'using adult education skills to improve patient compliance with treatment regimens.' Believe this would be helpful to all groups. Having such listed as from the ACCME will make such topics much more acceptable to the CME Committee.
State-accredited provider	Are we monitoring/providing feedback to ALL learners? What is an example of an 'objective assessment of communication skill?'
State-accredited provider	This is a soft skill, though very much needed. Many providers are not interested in this and feel like they do not need it.
State-accredited provider	I actually love the challenges of these new criteria and think we can accomplish most of them. My only barrier remains the quantification piece---too stringent. The numbers decrease the likelihood for success and feel defeating rather than a welcome challenge. In general I love scorecards, challenges and reaching for laudable goals, so am all in favor of the new criteria. I think the ACCME has to rethink the quantitative wording to be encouraging for success!

C29: Develops technical and procedural skills of learners.

C29: Since you answered 'no', please explain and/or suggest edits.	
Organization Description	Comments
ACCME Recognized State Medical Society	Unable to assess. Inadequate and/or deficient methodological evidence of validity, reliability and application practicality of process. Details upon request. E.g. lack of evidence this criteria should carry same “weight” as any other and is mainly exclusive of other criteria to avoid double weighting. Applicability and importance depends on nature and scope of provider. Very vague and overlaps with informatics and other criteria. Is using “patient portals” counted as a technical or communication skill or both?
ACCME Recognized State Medical Society	Again this criteria is too individualized for hospital with limitations on time, resources, and admin. support. Of the four criteria in this section, C29 may be the most doable for small providers. Altho, I don't see them devoting much time in developing such activities given that they need to implement activities more pertinent to their learners' clinical needs.
ACCME Recognized State Medical Society	What is the measure? Pre/post tests? Would skill evaluation need to be done by someone with applicable credentials?
ACCME Recognized State Medical Society	Critical Elements: - Better if allowed for this OR that, instead of this AND that. Small providers with one person CME office or part-time staff may not be able to address skill building assessment, feedback, and multiple feedback. The Standard: - It is unclear whether the “% of activities or the % of learners” represents the % of learners in a given year of activities or for the entire accreditation term. - ?10% of activities and/or learners – ?10% too high
ACCME Recognized State Medical Society	Please clarify what qualifies as an “objective assessment”. Will “technical and procedural skills” be defined to be similar to the ACGME/ABMS competency of patient care and procedural skills?
ACCME Recognized State Medical Society	Again, the criterion statement is missing one keyword from the critical elements, “assess.” For the criterion statement to align with the critical elements, IMS would recommend that the criterion statement be changed to “Assesses learners and develops technical and procedural skills.” Would BLS/ACLS/PALS, etc., be an example of activities that would be in compliance with this criterion? Does the provider need to show evidence that the assessment or skills development training was conducted during a specific CME activity or activities? CME is not mentioned within the criterion statement, rationale, or critical elements.
ACCME Recognized State Medical Society	% of the standard is not a good idea for any Criteria; this will be too complicated to calculate. Providing multiple examples for a Criteria should be sufficient for a compliance finding.

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C29: Since you answered 'no', please explain and/or suggest edits.	
Organization Description	Comments
ACCME Recognized State Medical Society	<p>Need clarification on the standard of 10% of activities or learners. For example, is it 10% of the total of activities from the entire term of accreditation? Or could it be 10% of activities from 1 or 2 years of accreditation? Need clarification on why this is a criterion for commendation?</p> <p>Suggestion: 10% of activities or learners will be very difficult for many providers in our state system to achieve, as offering technical skills training is specialized and would not occur that often; we do not believe a criterion such as this has any bearing on a provider's ability to achieve commendation, and further more may waste precious CME resources, and/or promote over utilization of health care services. A percentage requirement is complicated for accreditors to work with during the survey process. Example, what/how many activities do we need to select for review?</p>
ACCME Recognized State Medical Society	Fine as written. (See previous comments regarding the percentage requirement.)
ACCME Recognized State Medical Society	<p>What is the definition of an 'objective assessment...'</p> <p>Standard percentage is a concern - see 1st page for details.</p>
ACCME Recognized State Medical Society	<p>Doesn't appear appear that the development/education of the skills has to be CME?</p> <p>I am not understanding how '% of learners' applies to any of the proposed criterion where % of learners can be the standard.</p> <p>I am not understanding how '% of activities/learners' applies to RSS for any of the proposed criterion.</p> <p>10% seems high</p>
ACCME Recognized State Medical Society	The criterion and rationale may be achievable by some providers. This criteria seems to be directed toward academic providers. This would be possible if there are resources available. Such as access to skills models for teaching, computer programs, etc. The Standard percentage will be very difficult for surveyors to assess or providers to achieve.
ACCME-accredited provider	<p>C29 We are concerned that this simplistically deals with an area rife with ethics and patient safety concerns when addressing new procedure skills learned on living patients. We refer to the AMA PRA Guidance on New Procedures for CME.</p> <p>This criterion as written could refer to procedures other than those involving direct patient care, Does it indeed intend to cut such a broad area, where a procedure could be techniques in documentation of patient encounters or in doing conscious sedation?</p>
ACCME-accredited provider	Example please.
ACCME-accredited provider	This is another subject area where a medical information specialist should be involved. Information sources and technologies are constantly evolving and updating these skills is essential.
ACCME-accredited provider	measurement clarification needed.

Call for Comment Responses: Proposal for a Menu of New Criteria for Accreditation with Commendation

C29: Since you answered 'no', please explain and/or suggest edits.	
Organization Description	Comments
ACCME-accredited provider	Please clarify what 'uses an objective assessment of technical or procedural skill' means. Is this a checklist? We have 44,000 learners and 3000 activities per year. The threshold of >10% or learners and/or activities would suggest that we need to evaluate the technical or procedural skills of 4400 learners during 300 activities. This would put undo burden on the CME staff and/or the teachers. Also, I am unclear as to why we would want to have 10% of our activities be skill based.
ACCME-accredited provider	as in C28, this seems to be a very resource intensive criteria and I feel it would be very difficult for all provider sizes to meet the 10% requirement. Recommend the threshold be lowered. These tend to be very expensive activities to develop and not something practitioners need regularly.
ACCME-accredited provider	Not for sure of the types of technical skills/procedural skills. Is this new skills or refreshing current skills? It would be nice to have examples of specific specialities.
ACCME-accredited provider	Needs clarification of criteria to achieve the standard. Certifying learners technical skills can be a 'can of worms'.
ACCME-accredited provider	Would a post-test be sufficient to meet this criterion?
ACCME-accredited provider	This needs additional clarification as it can be read many different ways.
ACCME-accredited provider	Must both critical elements be present in all activities (referring to use of word "AND")? The 10% criteria will be difficult for both large and small organizations to achieve.
ACCME-accredited provider	Differences between implementation of this Criterion and current CME that teaches healthcare providers to be more technically competent and to perform more effectively. E.g. enhancing surgical skills through CME 'develops technical and procedural skills of learners' I think many current CME courses do.
ACCME-accredited provider	We endorse this criterion. As noted above, we do not recommend requiring providers to apply this criterion to > 10% of their activities.
ACCME-accredited provider	Is the Standard metric of >10 activities and/or learners based on the accreditation period or an annual threshold? If there is one large CME activity that eclipses all of the others in scope and it has a large % of its content focusing on informatics is that compliant, or does this large activity simply count as 1 (equivalent to a journal article)?
ACCME-accredited provider	Please see my confusion on C28.
ACCME-accredited provider	Is the standard for the entire term or for a single year?
ACCME-accredited provider	This criterion will require organizations not currently providing skill sessions to invest in the development of such.
ACCME-accredited provider	In cognitive, as opposed to procedural, specialties, diagnostic rather than technical skills are more essential and more frequently taught. Rephrasing this as 'technical and/or procedural skills' could be more inclusive of the needs of these specialties. From a specialty that conducts skills (procedural) courses, they can also be incredibly expensive and cost prohibitive for many.

Call for Comment Responses: Proposal for a Menu of New Criteria for Accreditation with Commendation

C29: Since you answered 'no', please explain and/or suggest edits.	
Organization Description	Comments
ACCME-accredited provider	<p>1. Consider removing this criterion, as it is not measuring a 'behavioral' skill. In a curriculum based on KSA (knowledge, skills and abilities), this criteria would fall under skills and not attitude or behavioral.</p> <p>2. RATIONALE: It is important to recognize that not all medical specialty curricula include procedural skills education. For diagnostic medical specialties, curricula and more focused on technical skills rather than procedural skills; thus we would recommend rephrasing to 'technical and/or procedural skills'.</p>
ACCME-accredited provider	<p>Seeking a standard of at least 10% of CME activities and/or learners for a non-technical field, like pediatrics, is too high. Because in cognitive specialties, diagnostic (vs. technical) skills are more essential and frequently taught, rephrasing this as 'technical and/or procedural skills' could be more inclusive of the needs of these specialties.</p> <p>Will the feedback to clinicians using the assessment need to be individualized or would distribution of aggregated feedback to learners be acceptable?</p>
ACCME-accredited provider	Please see previous comments about % thresholds
ACCME-accredited provider	In cognitive, as opposed to procedural specialties, diagnostic rather than technical skills are more essential and more frequently taught. Rephrasing this as 'technical and/or procedural skills' could be more inclusive of the needs of these specialties. The ACR request to have the objective criteria more clearly defined in this criterion.
ACCME-accredited provider	Providing feedback to the clinician using the assessment is not developing the skill in the learner. This criterion only makes sense if you had the same audience over a period of time that you could critique development. In the physician world, technical and procedural skills often relate to diagnosis and treatment. Many CME courses don't have the objectives for the course to be both unless part of the course is in a clinical setting. This may satisfy ACCME criteria but it doesn't allow planners to freely determine what their constituents need to learn.
ACCME-accredited provider	Most of neurology is not technical; there are likely other specialty societies for whom this is also the case; psychiatry, for example. Suggest lowering the standard.
ACCME-accredited provider	AMIA agrees with CMSS: 'In cognitive, as opposed to procedural, specialties, diagnostic rather than technical skills are more essential and more frequently taught. Rephrasing this as 'technical and/or procedural skills' could be more inclusive of the needs of these specialties.'
ACCME-accredited provider	I'm not sure what is meant by technical and procedural skills. Is this like how to use an EHR or insurance coding, or is this more like hands-on skills for a clinical procedure?
ACCME-accredited provider	Unclear how this is different than hands-on skills applications/workshops; even if assessment currently a part of process.
ACCME-accredited provider	Facilities to teach technical and procedural educational activities are not available to all sectors.
ACCME-accredited provider	Much of our library is dedicated to the prevention of diagnosis error - one of the leading causes of medical malpractice. Is teaching learners about how to prevent diagnostic error count as technical or procedural skill in the diagnosis process? It is out of our organizational goals to provide technical/procedural education. Once again, what is 10% - whole library of courses or new one each year, or new ones over the 4 or 6 year term?

Call for Comment Responses: Proposal for a Menu of New Criteria for Accreditation with Commendation

C29: Since you answered 'no', please explain and/or suggest edits.	
Organization Description	Comments
ACCME-accredited provider	Why is this considered commendable? It's one of the easier forms of CME activities. Comments similar to those for C28: is this assessment the entire activity or can it be part of a longer activity? doesn't mention anything about teaching skills, just assessing and feedback on assessment. One and done event--limits CME program to 10 activities per year if want to meet this criteria. Niche criteria?
ACCME-accredited provider	Can 'an objective assessment' be better defined? It is also difficult to imagine how this might be done in other settings aside from a live in person classroom. Much like C28, this is difficult to achieve at a cost that can be paid by the learner and significantly limits the number of learners in an activity due to the learner to instructor ratio needed.
ACCME-accredited provider	Again, it's all in the how the metrics for compliance. This is one that may limit uptake of the family of criteria as it requires a unique set of resources that may very well be out of reach for some providers. As to whether 10% is the right percentage, that's another issue.
ACCME-accredited provider	The expectation for a % of learners or activities will disadvantage providers who have very robust and substantial initiatives in key areas and reward providers who have superficial and perfunctory practices across many activities/learners. We suggest instead that providers be asked to submit several examples to demonstrate compliance.
ACCME-accredited provider	Is '> 10% of learners and/or activities' over the accreditation term? Annually? or other?
Other	"Develop" might not be the most appropriate objective since to us, it assumes that the provider is assuming that the participants do not have any technical or procedural skills. We wonder whether "enhance" or "improve" might be more appropriate.
Other	In cognitive, as opposed to procedural, specialties, diagnostic rather than technical skills are more essential and more frequently taught. Rephrasing this as 'technical and/or procedural skills' could be more inclusive of the needs of these specialties.
Other	>10% standard is too high; prefer 1/year or x/term
Physician/healthcare professional	Again I am not sure how this can be demonstrated and a clear model would need to be developed.
Physician/healthcare professional	the term 'objective assessment of technical or procedural skill' is too vague
Physician/healthcare professional	It is not clear whether physical examination skills, woefully inadequate among young physicians, count as technical skills, or whether using a smartphone to search a database or learn how to use a piece of electronic equipment is more what you had in mind as a technical skill. Furthermore, the need goes beyond 'updating, reinforcement, and reassessment.' many physicians have never learned certain skills in the first place!
State-accredited provider	Will need examples of what qualifies as an objective assessment. I don't know how i would again quantify that a certain percentage of my events will meet this.

Call for Comment Responses: Proposal for a Menu of New Criteria for Accreditation with Commendation

C29: Since you answered 'no', please explain and/or suggest edits.	
Organization Description	Comments
State-accredited provider	We will need definitions of technical and procedural skills. The CME Committee constantly complains that the criteria are vague with not help to understand. They also see the mission of CME as providing medical education.
State-accredited provider	I think the question you will get is: If I give a written post test that asks the learner to list the procedural steps in assessing a patient with XXXXX - is that acceptable? We grade the tests and then give them the correct answers for anything they missed.
State-accredited provider	What would constitute an objective assessment? Would it simply be a post activity test as with MOC?
State-accredited provider	Define procedure for a non-procedural specialty such as pediatrics.
State-accredited provider	May be very difficult to implement because of equipment/teaching lab resources, realistic simulators etc. Potentially good, but utopian and not realizable for small providers
State-accredited provider	Suggest to re-word: 'Develops technical and procedural skills of its learners in its educational activities.' The use of 'AND' in the critical elements section seems appropriate here. I have the same concern and suggestion for the % standard. To reiterate, i would suggest something akin to current commendation criteria, wherein the provider 'describes' its practices related to the criterion and the demonstrates those practices with examples from its activities. I would suggest more than 2 examples. For example, the ACCME might even ask for 'one activity per year' starting from the time the provider began implementing these NEW Commendation criteria.
State-accredited provider	Develops technical & procedural skills in the planning, implementation & deliver of the CME activity. Take the 'AND' away and replace with 'OR' in the critical elements section.

Call for Comment Responses: Proposal for a Menu of New Criteria for Accreditation with Commendation

C29: Please provide comments or questions about this criterion.	
Organization Description	Comments
ACCME Recognized State Medical Society	Some of the terms may need to be explained. Such as technical and procedural skills. What exactly is meant? I know I will have questions. So, again, maybe an example?
ACCME Recognized State Medical Society	We support this criterion. As described above, we have concerns about the attempt to determine compliance based on the percentage of activities or learners.
ACCME Recognized State Medical Society	Several years ago the ACGME and ABMS changed their core competency from 'Patient care' to 'Patient care and procedural skills.' This change has never been recognized by the ACCME. I am pleased it is now. I would include in the rationale the specifics about the change by the ACGME and ABMS as part of the rationale.
ACCME Recognized State Medical Society	Not every provider is positioned to offer skills education. If courses such as ACLS and PALS meet this criterion, then hospitals should be able to comply. However, some non-facility providers might be challenged by this criterion. 'Uses an objective assessment...' needs definition.
ACCME Recognized State Medical Society	While this Criterion is achievable, the providers that could do so will be limited.
ACCME Recognized State Medical Society	This criterion would be difficult for organizations which are not technical or procedural in nature (e.g. medical society). Evaluation using an objective assessment and feedback to the clinician would be resource intensive; it may be hard for providers with limited staff/resources to comply. The ?10% of activities 'and/or' learners would be difficult for surveyors to evaluate.
ACCME-accredited provider	Interacting with and successfully navigating the published literature is a key part to this standard. Healthcare workers can sign into POC tools such as UpToDate and earn CE credit while reviewing content or locate a CE offering in a product such as CINAHL and complete for credit. The technical and procedural skills required to find, appraise and synthesize published literature is taught by Medical Librarians. Therefore, there should be an opportunity to include those meaningful and influential interactions for CE consideration.
ACCME-accredited provider	Again, examples of the required 'objective assessment' would be helpful.
ACCME-accredited provider	This is a very important criteria as updates often receive 'short shrift'.
ACCME-accredited provider	This is clear and should include interpretation of tests/ imaging, something that improves with practice and many physicians do not feel completely comfortable with.
ACCME-accredited provider	For a large health system, this amount would be out of reach.
ACCME-accredited provider	We wholeheartedly agree with this criterion. However, as has been mentioned before, meeting the standard would be difficult as activity content is driven by the departments. We do have a Clinical Skills Lab that is dedicated to medical students and residents. It is a very busy enterprise and in many cases not able to serve our needs.

Call for Comment Responses: Proposal for a Menu of New Criteria for Accreditation with Commendation

C29: Please provide comments or questions about this criterion.	
Organization Description	Comments
ACCME-accredited provider	It is of the utmost importance that medical professionals be educated on important skills needed to conduct quality literature searches, and to know how to access and assess quality medical literature. Physicians should be able to get CME every time that they reach out to a medical librarian for help in updating their skills in literature searching, retrieval and assessment.
ACCME-accredited provider	I suggest that the second sentence in the Rationale be changed to better represent what is described in the first sentence. Possibly revision: This criterion will reward providers that help learners gain or retain competence in technical and procedural skills.
ACCME-accredited provider	This criterion is going to favor certain disciplines and certain types of providers over others. Would 'care delivery' be a broader concept that could be accessible to a broader range within medicine?
ACCME-accredited provider	Necessary.
ACCME-accredited provider	1. These are important skill-building activities that we currently develop. However, these activities are very resource-intensive. A large membership organization would be challenged in meeting The Standard.
ACCME-accredited provider	Would this also include cognitive skills such as differential diagnosis strategies, to include specialties that do not rely heavily on skills and procedures training?
ACCME-accredited provider	We suggest basing the standard on number of credit hours of activity. A 1 credit activity and a 50 credit activity may have different parameters and not all will include technical and procedural skills.
ACCME-accredited provider	Our society provides technical and procedural skills clinics during our annual meeting, and with our Fundamental products. However, due to the large number of activities accredited by the organization, this would not represent 10% of activities or learners. This standard is too high (see below). We would recommend 1 accredited activity per year as the standard. SAGES offers hands-on labs at every annual mtg. However, only 3.8% of meeting attendees are involved in the Hands On labs at our Annual Mtg. SAGES would have to hold bigger labs which would either require lower faculty:student ratios or a more resources that probably could not be procured. SAGES has spent millions of \$ developing FLS, FUSE and FES, which are comprehensive web-based education modules that include hands-on skills training component and assessment tools. Thus SAGES produces 4 activities that would meet this standard, however, this is only 3% of our total activities.
ACCME-accredited provider	C29: This maybe achievable, we only need to have a common ground. Unless we have medical students to teach. We will try.
ACCME-accredited provider	We have very few technical or procedural skills in the areas in which our physician members practice. Our activities do not focus on technical skills as would be the case for other physician groups. While we might offer a technical activity, the level would be unlikely to meet the standard of 10% or more.
ACCME-accredited provider	10% of learners and/or activities would not be achievable for some provider types since this can be an intensive and cost-prohibitive mechanism of learning. While there are strides to incorporate technical and procedural learning, it requires a lot of resources.

Call for Comment Responses: Proposal for a Menu of New Criteria for Accreditation with Commendation

C29: Please provide comments or questions about this criterion.	
Organization Description	Comments
ACCME-accredited provider	The Standard is too high for this. Currently we have activities that incorporate this, but given our large educational portfolio, we could never achieve this standard.
ACCME-accredited provider	Skills building is an important aspect of medical training.
ACCME-accredited provider	Critical Elements should be amended to "ORs" from "ANDs." Requiring "ANDs" significantly limits the flexibility intended by the introduction of the menu structure. We believe innovation and creativity will be reduced and not all provider types will have the ability to achieve Accreditation with Commendation.
ACCME-accredited provider	In agreement with the criterion itself. The grey area is, are we assessing competence or practice or both? If the goal of this criterion is to demonstrate (through use of 'an objective assessment') a level of proficiency in technical and procedural skills, then the standard may need to be greater than 10%. If we assessing their knowledge or competence, but not necessarily their application in practice, then the 10% standard is accurate.
ACCME-accredited provider	Perusal of this item by a non-CME physician might cause some indignation. Again, as a provider, I might find the effort to construct such a program rather frustrating. As a learner, I would question the justification for my CME provider having staged such.
ACCME-accredited provider	I would like to see examples of fulfilling this criterion.
ACCME-accredited provider	agree
ACCME-accredited provider	I believe the criterion is clear and the elements are well stated; however, it becomes complicated when you start requiring a percentage of activities.
ACCME-accredited provider	<p>this criterion seems to be relatively straightforward.</p> <p>I would just ask if this should be linked to the ABMS competencies in this area and how it can be linked-- is that an appropriate reference point for this criterion?</p>
ACCME-accredited provider	Developing technical and procedural skills of learners is an important criterion. However, given that the majority of CME is RSS and the dissemination of new knowledge to enhance physician performance, the increasing number of online learning activities, that 10% or more CME activities is in the teaching of technical and procedural skills is not practical for all accredited providers. Given the number of learners nationally (as shared in the ACCME Annual Report), providing feedback to 10% of learners using an assessment tool (including non-physician learners) would not be feasible either.
ACCME-accredited provider	As indicated previously I question the standard.
ACCME-accredited provider	I think this could be considered dangerous territory. As CME providers we do not certify a physician's competence or performance at a specific skill. Once we provide the formal assessment, we may be considered to have granted competence and hospital medical staff offices could consider this for granting specific technical privileges. This could create a legal liability. Currently we say that a physician participated in an activity and do not imply any proficiency. Competence is difficult to measure and putting CME providers/planners/ faculty in this position is worrisome.

Call for Comment Responses: Proposal for a Menu of New Criteria for Accreditation with Commendation

C29: Please provide comments or questions about this criterion.	
Organization Description	Comments
ACCME-accredited provider	We would propose that documentation for selected activities included content that documents development and implementation of CME that enhances technical and procedural skills of learner, AND (b) Content that includes strategies to achieve improvements in technical and procedural skills. Requiring an individualized assessment and feedback to the learners for more than 10% of a provider activities may be difficult for some providers. We are advocating for the formal assessment and feedback to learners to be incorporated into the requirements as the Criteria evolve into the next phase.
ACCME-accredited provider	See concerns from page 1 of the survey related to The Standard
ACCME-accredited provider	Difficult to achieve the 10% standard.
ACCME-accredited provider	Important criterion. Should it include preceptoring at the learner's institution?
ACCME-accredited provider	The criterion is clear but I do not agree with the standard. Currently there is no percentage or number of activities and/or learners required for any of the Commendation Criteria/. I think that more providers will put forth the effort to achieve this and the other criteria if there is no percentage or number standard attached.
Media	Physicians do not know how to access and retrieve medical literature, thus they have a dangerous knowledge gap that affects **every** aspect of their competence and performance in practice. Every time a physician reaches out to a medical library professional for assistance with access and retrieval of medical literature, the physician should be able to claim AMA PRA Category 1(TM) credit. This is different from POC learning as it is currently structured. A new structure to allow this to happen should be put in place.
Other	<p>One of my clients, SAGES offers hands-on labs at every annual mtg, as well several enduring materials that are designed to improve (& measure) technical skills.</p> <p>Annual mtg attendance = 2,400 Hands On lab attendance = 92 % of learners = 3.8%</p> <p>SAGES would not be in compliance with the new standard based on percentage of learners, even though SAGES invests tremendous resources and staff time into these labs. Why does SAGES offer these labs? We have determined they benefit our learners based on self-reported performance change data. SAGES would have to hold bigger labs which would either require lower faculty:student ratios or a huge amount of resources that probably could not be procured.</p> <p>Number of activities offered in 2014 = 111 Number of activities that meet the critical elements: 4 % of learners = 3%</p> <p>These 4 activities have cost millions of \$ to develop and implement. 10% is too high as the standard. I would recommend 1 accredited activity per year as the standard</p>
Other	This threshold should be raised to 25%, 10% is far to low.

Call for Comment Responses: Proposal for a Menu of New Criteria for Accreditation with Commendation

C29: Please provide comments or questions about this criterion.	
Organization Description	Comments
Physician/healthcare professional	Reasonable, if speaking broadly to medical professions.
Physician/healthcare professional	This should be an on going large part of CME for physicians.
Physician/healthcare professional	This is another worthy criterion --- to make sure physician procedural skills are maintained.
State-accredited provider	Again, the criterion is clear, yet the standard seems very high. While we do teach technical and procedural skills (utilizing hands on and simulation center), it does NOT comprise more than 10% of our activities.
State-accredited provider	Perhaps 28 and 29 might be consolidated.
State-accredited provider	We vote to have the Standard be: 'No less than 5% of learners and/or activities.'
State-accredited provider	1. Meeting the standards for the new criteria will appear to require a lot more data gathering and analysis to be compliant, which will ultimately result in more costs. 1. The standards for many criteria are too rigorous, for example, in calling for >25% of activities and/or learners or >10% of activities and/or learners. Many CME providers do not have the volume of CME activities to meet this standard.
State-accredited provider	Many times the people that have to 'teach' technical and procedural skills are those very people that have a direct conflict of interest with the technical/procedural skill being learned. I don't think this should be a part of the criterion.
State-accredited provider	Again as above. I believe that the standard as written is way too high. and greater than 10% of our activities that would be about 30 activities that would have to meet this and with the number of Journal Clubs and case conferences we hold out of our approximate 300 programs this would be difficult to achieve. I am unclear what is meant by 'and/or learners' and how those number would translate. Also I believe that the increased workload to meet this high number of activities with a CME office that is staffed by a CME director, CME manager and Admin Assistant/coordinator along with additional responsibilities added to the plate with ABIM and other specialty boards this is unrealistic. We have been accredited with commendation for the past 2 cycles and I am not certain this added work is worth the bang of receiving 6 years instead of 4. I also thin that the critical element should include and/or and not just and to make it more realistic. Again clarification on assessment.
State-accredited provider	Hard to obtain 10%+ in smaller organizations that aren't university medical centers.
State-accredited provider	Yes very important to Performance Improvement
State-accredited provider	None
State-accredited provider	What assessment is this referring to? --The activity evaluation or is this a separate assessment to gauge and evaluate competence?
State-accredited provider	Good criterion for large professional society meetings. Very difficult to implement in small programs.

Call for Comment Responses: Proposal for a Menu of New Criteria for Accreditation with Commendation

C29: Please provide comments or questions about this criterion.	
Organization Description	Comments
State-accredited provider	<p>This is our bread and butter. Feedback is provided to the chief and physician planner. Elements are embedded in the training to self assess. Not realistic to have 600 people in a session all get individual feedback.</p> <p>PI-CME would lend itself to this easily but having just moved the organization from lectures to active participation this next step needs to happen over time and we are not currently set up to do this on many of our activities.</p>
State-accredited provider	The standard is too high and needs to be revised. If a CME program offers multiple formats and has multiple activities, they would have to minimize the number of activity types they offer to meet the level of greater than or equal to 10%. Offering such activities does not mean you will have physicians or other healthcare providers participating.
State-accredited provider	Not a bad idea, but nearly impossible for a community CME program to develop. this is better done by various specialty colleges and associations.
State-accredited provider	For this element commendation becomes about who has the money for these tools and staff to provide feedback.
State-accredited provider	This would be difficult to achieve for clinical skills---I don't think you're referring to computer skills. We would need a needs assessment or other means of identifying which skills are needed or need updating. Some of these are taught one-on-one amongst the physicians. How best to teach to a class? What method would work best? How to evaluate the skills learned? When could time be booked on new equipment? Who or what would they practice on? What would the costs be?
State-accredited provider	In these cases are proctoring requirements incorporated into this development of technical and procedural skills? Could they be? If so, these could also work for C-30. 10% of activities is too high. Our CME Committee felt 1-2 per year was more appropriate.
State-accredited provider	Having a sim lab on site helps, but it is quite costly so we are not able to use it as often as we would like.
State-accredited provider	>10% again! If there is not the need within the organization for that much in the way of procedural skills why is this random volume the task?
State-accredited provider	We have jointly provided activities that teach skills but we are unsure whether we could meet the 10% standard.
State-accredited provider	Clear
State-accredited provider	Although this Criteria was well written not clear on the expectations of the provider and of course the standard should not be included. Although the Criteria are aligned with the way health care is moving but the standards will not be easy to manage and exceed capabilities for many.
State-accredited provider	This is already happening.
State-accredited provider	It is doubtful if our leadership programs would meet this criteria. We stress adaptive skills that deal with people interactions, not technical skills that demonstrate expertise as healthcare professionals.

C30: Creates individualized learning plans for learners.

C30: Since you answered 'no', please explain and/or suggest edits.	
Organization Description	Comments
ACCME Recognized State Medical Society	This sounds to good to be true! Providers will need qualified personnel that will be able to identify needs and to give appropriate support. Probably in hospital settings this could be attained, but on 'societies' level I can not foresee how it may be accomplished.
ACCME Recognized State Medical Society	Unable to assess. Inadequate and/or deficient methodological evidence of validity, reliability and application practicality of process. Details upon request. E.g. lack of evidence this criteria should carry same “weight” as any other and is mainly exclusive of other criteria to avoid double weighting. Applicability and importance depends on nature and scope of provider. Overlap with 26, 27 and 29 often likely.
ACCME Recognized State Medical Society	This is geared more towards large provider types, i.e. medical schools, large healthcare systems. Can’t see small/rural providers meeting C30, i.e. designing CE that “address the specific needs of an individual with a customized set of educational interventions.’ Just equates to a lot of staff time and resources, which small hospitals just don’t have.
ACCME Recognized State Medical Society	Would this apply to the individuals CME career as a whole or specific gaps/needs?
ACCME Recognized State Medical Society	Critical Elements: - Better if allowed for this OR that, instead of this AND that. The Standard: - It is unclear whether the “% of activities or the % of learners” represents the % of learners in a given year of activities or for the entire accreditation term. - ?10% of activities and/or learners – ?10% too high
ACCME Recognized State Medical Society	We question the critical element to “assess the learner repeatedly”, as the accredited provider may not have a longitudinal relationship with the learner. We support this criterion but suggest that it be reframed as personalized education. As described above, we have concerns about the attempt to determine compliance based on the percentage of activities or learners.
ACCME Recognized State Medical Society	CME should address the specific professional gap(s) of a physician (not learner). Also, % of the standard is not a good idea for any Criteria; this will be too complicated to calculate. Providing multiple examples for a Criteria should be sufficient for a compliance finding.

Call for Comment Responses: Proposal for a Menu of New Criteria for Accreditation with Commendation

C30: Since you answered 'no', please explain and/or suggest edits.	
Organization Description	Comments
ACCME Recognized State Medical Society	The staff requirements for achieving compliance with C30 may be well beyond the capabilities of small providers. Who will assess the learner repeatedly? Who is in the position to provide feedback to the learner and who are the individuals that should make recommendations for closing the learning gap? Is it even the role of a provider to create individual learning? MOC activities, including PiP, would satisfy this criterion but the critical elements are very rigid. Could the elements be changed to demonstrate that a provider has created a system or structure whereby the individual learner is empowered and encouraged to create individualized learning and that the provider takes steps to encourage and support individualized learning plans?
ACCME Recognized State Medical Society	Need clarification on the standard of 10% of activities or learners. For example, is it 10% of the total of activities from the entire term of accreditation? Or could it be 10% of activities from 1 or 2 years of accreditation? 10% of activities or learners will be very difficult for many providers in our state system to achieve, as offering individualized learning would most likely not occur this often. Suggest lowering percentage to a specific range of activities/learners such as an expectation of one to three per year? A percentage is complicated for accreditors to work with during the survey process. Example, what/how many activities do we need to select for review?
ACCME Recognized State Medical Society	Would like 'individualized learning plans' further explained, and how the individuals would be selected. It would be critical for the ACCME to include examples of compliance.
ACCME Recognized State Medical Society	CE has been revised to read CME. How often is 'repeatedly' I am not understanding how '% of learners' applies to any of the proposed criterion where % of learners can be the standard. I am not understanding how '% of activities/learners' applies to RSS for any of the proposed criterion. 10% seems high
ACCME Recognized State Medical Society	How often is 'repeated' assessment? What is the minimum standard for 'longitudinal curriculum'? This criterion may be too resource intensive for providers with limited staff/resources. If a provider uses informatics for the educational intervention, would that also count for C26? The ?10% of activities 'and/or' learners would be difficult for surveyors to evaluate.
ACCME Recognized State Medical Society	The criterion and the rationale may be achievable by a few providers, the use of the word 'AND' in the critical elements seems unreasonable. Again, this criteria seems to be directed toward academic providers. Most providers do not have the staff, time or resources to take on individualized plans that require repeated follow-up which is most likely outside the realm of private practice physicians. The Standard percentage will be very difficult for surveyors to assess or providers to achieve.

Call for Comment Responses: Proposal for a Menu of New Criteria for Accreditation with Commendation

C30: Since you answered 'no', please explain and/or suggest edits.	
Organization Description	Comments
ACCME-accredited provider	We do not support C30, although we can see that for smaller organizations, perhaps medical specialty societies, it would be a boon. In a healthcare system such as the Veterans Health Administration and its 152 Veterans Affairs Medical Center hospitals across the country, the development and monitoring of a health professional's practice gaps is between that individual and her/his supervisor at each facility. Although the VHA System is very interested to begin getting into MOC activities, with almost 25,000 physician employee-learners, the scale of implementing this proposed criterion would be prohibitive, in terms of staffing, cost and documentation.
ACCME-accredited provider	I am curious about how this would interface with the medical staff standards from TJC about Focused Professional and Ongoing Professional Practice evaluation and with the peer review processes.
ACCME-accredited provider	This is, once again, a strategy that requires more personnel than we have. Our Quality Department does monitor physician and staff behavior on a regular basis and has recommended additional CME to doctors who may have had some performance issues. However, designing a CME activity on a per doctor basis has never been requested of the CME department by Quality. And if one would need 10%+ of learners and/or activities to achieve this Criterion, this would mean developing a lot of individualized CME. Who has the resources for this kind of thing?
ACCME-accredited provider	measurement clarification needed.
ACCME-accredited provider	We have 44000 learners and 3000 activities per year. There is no way that we could 'assess the learner repeatedly AND provide individualized feedback AND provide individualized recommendations' to 4400 learners during 300 activities per year. We have neither the staff nor the time for this. We wouldn't even try for this criteria.
ACCME-accredited provider	This seems to be a very resource intensive criteria and I feel it would be very difficult for all provider sizes to meet the 10% requirement. Recommend the threshold be lowered.
ACCME-accredited provider	Can this be achieved through incorporating MOCs into CME activities?
ACCME-accredited provider	I don't know anyone who has ever done this type of plan. Who will do be doing this type of individualized learning plan? We do it for residents only if they are having difficulty.
ACCME-accredited provider	The first Critical Element is too subjective in stating 'repeatedly'
ACCME-accredited provider	Must both critical elements be present in all activities (referring to use of word "AND")? The 10% criteria will be difficult for both large and small organizations to achieve.
ACCME-accredited provider	We endorse this criterion but suggest that it be reframed as "personalized education". Given the requirement to "assess the learner repeatedly", the ACCME should clarify what it interprets as a longitudinal relationship. As noted above, we do not recommend requiring providers to apply this criterion to > 10% of their activities.

Call for Comment Responses: Proposal for a Menu of New Criteria for Accreditation with Commendation

C30: Since you answered 'no', please explain and/or suggest edits.	
Organization Description	Comments
ACCME-accredited provider	Is there an expected frequency associated with 'assesses the learner repeatedly?' Our goal as a CME provider is to provide personalized support to our learners, however we are sensitivity to maintaining a balance with being helpful and supportive while not inundating them to a degree that our ability to impact learner change is compromised. We believe the suggested metric of 10% of learners and/or activities is ambitious and potentially difficult to achieve depending on the period of time this metric is to be measured because (1) the potential cost of technology and infrastructure to support implementation and (2) learners' willingness to give consent to be tracked over time. Our learners and planners have expressed significant concern about the vulnerability of assessments of individual strengths and weaknesses to legal discovery.
ACCME-accredited provider	As written, this Criterion appears to require the CME provider to outline the individualized learning plans for the learner and does not seem to recognize a CME provider facilitating self-directed learning. For example, a learning platform in which the learner assesses their own gaps and selects content to address those gaps is not described within the rationale. Rather, the emphasis (as written) is on "The provider creat[ing] an individual, longitudinal curriculum for each learner, or customizes an existing curriculum for the learner." This seems to be limiting the scope of educational design and delivery unnecessarily.
ACCME-accredited provider	Is the standard for the entire term or for a single year? Likely too costly to be achievable. Designing this type of educational experience is very costly. This is outside our means.
ACCME-accredited provider	This is an unrealistic criteria for a medical society or a CME provider with large learner base.
ACCME-accredited provider	Need additional explanation how this criterion can be achieved. What is a 'longitudinal curriculum'? How often is 'assesses the learner repeatedly'? We anticipate this creating additional workload in order for us to achieve this criterion, for only a small percent of learners/activities.
ACCME-accredited provider	As written, the provider is required to undertake a significant workload in order to develop customized curricula for its learners. If a medical society has 10,000 members they would need to demonstrate that they are undertaking this level of individualized support for at least 1,000 individuals. While we support the concept of encouraging individual learners to identify their practice gaps and undertake interventions to close them it would be logistically difficult if not impossible for many specialty societies to effectively demonstrate this criterion as written.
ACCME-accredited provider	<ol style="list-style-type: none"> 1. RATIONALE: The way this criterion is currently written, this is the CME Provider developing a curriculum FOR each learner, rather than having the curriculum driven BY the learner. Philosophically, we should support the learner by assisting them in identifying their practice gaps and then subsequently providing them with educational interventions to fill their gaps. 2. RATIONALE: As written, this could be a very labor-intensive process or activity; requiring extensive one-on-one time assessing the learners needs. 3. CRITICAL ELEMENTS: ACCME needs to define the word 'repeatedly' in the first critical element. 4. THE STANDARD: consider reducing to 5%

Call for Comment Responses: Proposal for a Menu of New Criteria for Accreditation with Commendation

C30: Since you answered 'no', please explain and/or suggest edits.	
Organization Description	Comments
ACCME-accredited provider	See previous comments. This is not an achievable criterion for large medical subspecialty organizations that have CME activities for a large group (eg, 3000 attendees).
ACCME-accredited provider	C30: Feedback and recommendation during learning. For a group learning, it is difficult to singly evaluate face to face. But we have not done individual learning and evaluation. This entails more effort. But if questionnaires work, then we can use as a measuring tool. We need to be more specific on this.
ACCME-accredited provider	As written, the provider is required to undertake a significant workload in order to develop customized curricula for its learners. With a membership of 36,000, ACR would need to demonstrate that they are undertaking this level of individualized support for at least 3,600 individuals. While the ACR supports the development and implementation of self-assessments and other activities that encourage individual learners to identify their practice gaps and undertake interventions to close them, it would be logistically difficult if not impossible for our organization to effectively demonstrate this criterion as written.
ACCME-accredited provider	The measurement is confusing. Is an activity one event or one course? It seems that one's employer which may be a CME provider or not may be interested in individualized learning for the employees but again some medical societies have voluntary members who attend activities for the purpose of gaining knowledge and not to create learning plans. The confusion may also happen with how many learning plans a clinician may have depending on the activities he/she attends.
ACCME-accredited provider	For a large medical specialty society we are not staffed to be able to manage 10% of learners or activities.
ACCME-accredited provider	AMIA agrees with CMSS: 'As written, the provider is required to undertake a significant workload in order to develop customized curricula for its learners. If a medical society has 10,000 members they would need to demonstrate that they are undertaking this level of individualized support for at least 1,000 individuals. While we support the concept of encouraging individual learners to identify their practice gaps and undertake interventions to close them it would be logistically difficult if not impossible for many specialty societies to effectively demonstrate this criterion as written.'
ACCME-accredited provider	While this may be practical for small groups of learners, it is not very feasible for a population of thousands of physician learners spread across the globe.
ACCME-accredited provider	We recommend the word "repeatedly" be replaced with the minimum number of assessments needed, and ACCME's ideal timing of assessments required to satisfy this criterion be specified. Also Critical Elements should be amended to "ORs" from "ANDs."
ACCME-accredited provider	Resembles very much the AMA planned multi-credit approach. Is this a duplication or override thereof?
ACCME-accredited provider	define 'assess repeatedly'
ACCME-accredited provider	Is there a definition of repeat, eg, would twice satisfy this criterion? In meeting this criterion is this just the planning and implementation, or must a provider demonstrate completed participation? One may suggest that number of activities, rather than number of learners, is a better measure.

Call for Comment Responses: Proposal for a Menu of New Criteria for Accreditation with Commendation

C30: Since you answered 'no', please explain and/or suggest edits.	
Organization Description	Comments
ACCME-accredited provider	Potentially achievable, but can be burdensome in terms of time/effort and staffing for many providers if it's to be done at the highest level. One could have a computer generate out a specific learning plan, but is that the intent? as with the previous, the metrics are questionable.
ACCME-accredited provider	The term 'individual learning plans' needs to be further defined. Although this is a laudable goal, it is unlikely that providers will be able to expend the requisite resources for more than a few learners. In addition, many providers may have little or no longitudinal relationships with their learners. For these reasons, a % of learners or activities is not realistic for this criterion and we suggest instead that providers be asked to submit several examples to demonstrate compliance.
ACCME-accredited provider	Is '> 10% of learners and/or activities' over the accreditation term? Annually? or other?
ACCME-accredited provider	See concerns from page 1 of the survey related to The Standard. 'Longitudinal' should be defined or deleted
ACCME-accredited provider	Would the implementation of a learning management system be sufficient to customize individual learning plans by providing an individual feedback loop and individualized recommendations to the learner to close learning gaps? If a provider does not have a learning management system, could you provide examples of how this standard could be achieved?
Other	This criterion seems to be biased towards those institutions with regular access to the learner, such as hospitals or medical schools, in which tumor boards and/or RSS are held. All criteria should be achievable by all organization types. We recommend deleting this criteria.
Other	Threshold is too low, I believe, for commendation in this area (this is one where it really should be a stretch to achieve). I'd like to see the threshold closer to 25% here.
Other	This would be extremely difficult to attain for providers with a large number of activities and learners and for providers organizing activities out of a particular geographic area (ie international or national conferences). I think it should start at something like 5% of learners and/or activities. It would require a lot of money and/or resources.
Other	While I support the concept it would make more sense to me to have providers demonstrate that they have a system in place that supports ILP activities than this standard that encourages providers to generate x number of these learners per term. In 22 years of practice I have had 6 from a pool of 850 medical staff who requested help with ILP and that was with advertisement and peer encouragement in an environment that rewarded continuous development. The standard should be re-evaluated and clarified as it is based on generation of 'activities' yet the rationale and elements are focused on needs assessment and feedback tools.

Call for Comment Responses: Proposal for a Menu of New Criteria for Accreditation with Commendation

C30: Since you answered 'no', please explain and/or suggest edits.	
Organization Description	Comments
Physician/healthcare professional	The ability to create an individual, longitudinal curriculum for each learner, would require a large staff of people to run this program. Getting providers to repeatedly evaluate and provide feedback about their competence, performance, or patient outcomes is very difficult to achieve. Patient outcomes is a reasonable expectation. Asking physician to repeated assess performance and competence seems more than should be expected with all the new demands on providers at this time.
Physician/healthcare professional	stating the the learner should be assessed 'repeatedly' is too vague
Physician/healthcare professional	I think it should be spelled out that the feedback should be documented and communication closed loop. If a practitioner needs this kind of plan, i think it connotes that they lack a self awareness of their needs. Part of such a plan should be fostering/cultivating the person's own ability to recognize deficiencies and create a customized self driven/self sustaining plan in the future
State-accredited provider	If you have learner's do Computer Based Learning (CBL) does that count for this? This would be an enduring activity. Do you have to offer CME for each CBL?
State-accredited provider	Can this be accomplished by participating in an MOC project (PI CME)?
State-accredited provider	I think this criterion will be incredibly difficult (if not impossible) for most organization's to attain.
State-accredited provider	How this would be done in a small community hospital eludes me at this time. 10% of our learners would be about 20 physicians. An activity would have to be designed to meet specific and detailed needs for a designated group of people with similar individual PPGs. In this era of 9-5 medicine, this might be unrealistic without significant incentives in place for the participant. This might work for programs who sign up as a MOC provider. The ACCME needs more than the ABIM to make this work.
State-accredited provider	How often is meant by 'repeatedly evaluate'? Does this occur within the conference or over time?
State-accredited provider	Delete the percentage and please explain/provide examples of what you exactly want thank you
State-accredited provider	The 'individualized' criterion will require large amouns of human resources dedicated to CME. Small institutions cannot achieve this. Unless there is a charge for CME, only large hospitals, Med-schools etc. can afford to achieve this.

Call for Comment Responses: Proposal for a Menu of New Criteria for Accreditation with Commendation

C30: Since you answered 'no', please explain and/or suggest edits.	
Organization Description	Comments
State-accredited provider	<p>Suggest re-wording: 'Creates a structure for, and implements, individualized learning plans for its learners using its educational activities.'</p> <p>I believe the individual learner should have a role in the development and implementation of the plan/curriculum. I see the provider's role in creating the environment, structure, resources and them showing that the learners implemented the plan. The provider's own educational activities should be a part of the plan/curriculum, as opposed to creating a plan that uses other provider's educational activities.</p> <p>What does 'repeatedly' mean specifically under the critical elements? How would 'non-CME-certified' activities/educational opportunities fit into meeting this criterion, or would they?</p>
State-accredited provider	Seem quite unattainable and over the top for out institution. May be more appropriate for an academic setting or with a network of physician practices managed by one company.
State-accredited provider	We would not be able to comply with this standard. The description would seem to require staff and expertise we don't have. Clarification needed on the elements.
State-accredited provider	We assess learners and feedback to them. We will investigate if we should add creation of individual learning plans. Not clear to us if the value of this would be seen by the participants such that they would cover its costs.

Call for Comment Responses: Proposal for a Menu of New Criteria for Accreditation with Commendation

C30: Please provide comments or questions about this criterion.	
Organization Description	Comments
ACCME Recognized State Medical Society	<p>Here is an example of how the Standard will create challenges for some providers. This type of activity will require a lot of resources, time and skill. For some providers with large programs this will make it difficult to meet the standard, and therefore reluctant to engage in this valuable format.</p> <p>In addition, small more resourced challenged providers will be reluctant to engage this format due to the lack of resources and support many face.</p> <p>Has anyone considered how this will get paid for? The learners will not want to pay the cost that will be associated with this, and again this will then fall into a specific range of providers who have the financial and IT resources to carry out these types of activities.</p>
ACCME Recognized State Medical Society	This particular Criterion will be very difficult for most of the SMS providers to develop. The staffing is just too small for individualized learning. And, the % is too high.
ACCME Recognized State Medical Society	Would performance improvement CME activities be included in demonstrating compliance with this criterion?
ACCME Recognized State Medical Society	<p>The Rationale uses the arcane CME argot. Please try to use plain English.</p> <p>Perhaps as a first edit, 'This criterion rewards providers for developing CME designed to address the specific gaps of an individual. This can be a customized from existing curricula or designed independently.</p> <p>Perhaps the name of the criterion should be C30 Creates individualized CME activities for learners. I am not sure the provider should be required to repeatedly provide feedback to the learner. This suggests a tremendous load on the provider to be involved in one individual's CME. I would hope that component is eliminated.</p>
ACCME Recognized State Medical Society	What does "assesses the learner repeatedly" mean? If this is subjective, than there will be inconsistencies from accreditor to accreditor.
ACCME Recognized State Medical Society	The criterion and rational are clear. An case example would be helpful in showing providers how to meet the critical elements. (See previous comments regarding percentages.)
ACCME Recognized State Medical Society	Standard percentage is a concern - see 1st page for details.
ACCME Recognized State Medical Society	Most CME providers are strapped for resources as is while trying to maintain their current state of CME activities (and budgets continue to be cut). These providers do not have the infrastructure in place to create individualized learning plans. This criterion would be biased to large, multi-staffed CME providers over community-based hospital providers. Our committee is struggling to understand how this criterion would further the CME community as a strategic asset as it's focus is narrow.

Call for Comment Responses: Proposal for a Menu of New Criteria for Accreditation with Commendation

C30: Please provide comments or questions about this criterion.	
Organization Description	Comments
ACCME-accredited provider	our organization does not have the human resources to achieve this criterion
ACCME-accredited provider	While I may be able to do this for one or two activities, to meet the standard of at least 10% of activities seems unrealistic.
ACCME-accredited provider	I think this is great idea. I'm not sure which institution would have time to put it into practice.
ACCME-accredited provider	This criterion standard (>10%) will be difficult to achieve, unless you have a large CME staff and a small group of learners, which is not true of most CME programs. Assessing 10% of learners repeatedly may be particularly difficult. If you really want CME providers to shoot for this, you might consider making the standard lower than 10%. For example, suppose you had a small group of learners (let's say 5) interested in a year-long program. The group meets 4 times during the year and have assignments and assessments that are individualized. This would be a great program, but for most institutions it would come nowhere near 10% of their learners or activities. I would make the percentage lower to encourage more providers to really attempt this.
ACCME-accredited provider	For a large health system, this amount would be out of reach.
ACCME-accredited provider	Though we wholeheartedly agree with this criterion, this is a labor-intensive endeavor for both physicians and CME staffers. Currently, OSU gives individual physician feedback via the QA office. We are not privy to that information. However, as has been mentioned before, meeting the standard would be difficult as activity content is driven by the departments.
ACCME-accredited provider	This appears to be very targeted and would be hard for large systems to gain the knoweldge of individual providers.
ACCME-accredited provider	Curious if best practice tools will be shared for how providers are assessing repeatedly and giving the feedback.
ACCME-accredited provider	I think this is an excellent addition to the Criteria. CME is now delivered to groups, or at least its results are evaluated on the basis of attendees' performance. Focus on individual learners will both broaden and deepen the reach of CME activities.
ACCME-accredited provider	learner has to be engaged
ACCME-accredited provider	again 10% probably too high. the basic small to medium sized professional society could probably shepherd an individual learner through 1hr/of a 14 hr (3 1/2 day) course, i.e. 7%. But to shepherd a learner in an extended fashion through 2 hrs of content is probably an impossible task. Also as I think about my 'learning' after I go home from a meeting, while I took 30 or 40'pictures' of slides with grand ideas that I am going to find that reference and that reference and that one... when I get home I only have time to get in depth on one subject matter if I am lucky.
ACCME-accredited provider	Not a fan of this question because it presumes that this kind of operational strategy is appropriate for all providers when it simply is not. That doesn't make them a poor example or unworthy. It may not be logical based on the audience served. I realize there are other criteria in this section to choose from.
ACCME-accredited provider	I was disappointed to see that professionalism (C16) was not represented in this new menu, particularly since it features so prominently in MOC – I think this could easily fit within this “Creating Behavioral Change” category

Call for Comment Responses: Proposal for a Menu of New Criteria for Accreditation with Commendation

C30: Please provide comments or questions about this criterion.	
Organization Description	Comments
ACCME-accredited provider	This would be a lot of work for a Provider and the rewards financially and educationally may not be as great as other formats.
ACCME-accredited provider	1. These are important skill-building activities that we currently develop. However, these activities are very resource-intensive. A large membership organization would be challenged in meeting The Standard.
ACCME-accredited provider	The workload required to adequately this criterion as stated would be unfeasible for most specialty societies. For membership organizations, achieving the 10% threshold with this level of individualized attention and producing the necessary documentation for ACCME compliance would require significant staff time. Could a similar concept promoting the creation of individualized learning plans that are more self-directed be considered?
ACCME-accredited provider	We have already tried this. Only a few selected individuals were interested and it was a great deal of resources to implement. We are slowly sunsetting this. Having this in greater than 10 percent of the courses is a huge investment and if individuals are not going to use this then we will not be investing resources into an area that is not being used. Great idea and we built the field. No one seems to want to take advantage of it and therefore we cannot continue to invest in this.
ACCME-accredited provider	We suggest basing the standard on number of credit hours of activity. A 1 credit activity and a 50 credit activity may have different parameters and not all will include individualized learning plans.
ACCME-accredited provider	C30: With over 6,000 members, SAGES must balance our educational initiatives with cost, reach, and benefits to our learners. Developing a customized individual learning plan for learners, especially at the level of 10% of learners or activities, is not a feasible project for our society. This criterion also seems to be biased towards those institutions with regular access to the learner, such as hospitals or medical schools, in which tumor boards and/or RSS are held. All criteria should be achievable by all organization types. We recommend deleting this criteria.
ACCME-accredited provider	As written, the provider is required to undertake a significant workload to develop customized curricula for its learners. This workload is compounded for organizations with very large CME programs and hundreds of thousands of learners per year. While we support and encourage learners to identify their practice gaps and undertake interventions to close them, it would be logistically very difficult and resource-intensive (staffing and financial) for large specialty societies and CME providers to effectively demonstrate this criterion as written.
ACCME-accredited provider	Personalized education is ideal, but it must be recognized that learners seek multiple sources in their educational journey. A provider may not have multiple opportunities to 'repeatedly evaluate and provide feedback to the learner' if the learner does not participate in the personalized education program. Perhaps providers who are employers of physicians can achieve this criterion, but it will challenge providers who offer education learners participate in on an ad hoc basis. Also, the standard is too high for providers with many activities or learners.
ACCME-accredited provider	It is clear as written, but providers cannot force learners to participate in these types of activities. While providers can offer this, achieving this may not be possible at 10% for activities or learners. Can this type of learning be extended to other learners, possibly in a non-CME setting, such as fellowship training?

Call for Comment Responses: Proposal for a Menu of New Criteria for Accreditation with Commendation

C30: Please provide comments or questions about this criterion.	
Organization Description	Comments
ACCME-accredited provider	disagree with inclusion of this one on such a short menu
ACCME-accredited provider	The Standard is too high for this. Currently we have activities that incorporate this, but given our large educational portfolio, we could never achieve this standard.
ACCME-accredited provider	I think this could be burdensome for small CME providers (fewer than a couple activities a year). I think this could be achievable with a Learning Management System and providers who offer multiple activities and support materials, but this isn't a reality for small CME providers.
ACCME-accredited provider	I would like to see examples of fulfilling this criterion.
ACCME-accredited provider	agree
ACCME-accredited provider	Ability to work with an individual physician and meet the Criterion is unachievable for some organizations. Who is going to financially support this customized education; other than a medical society or healthcare org with invested interest in improving individual physician behavior or performance?
ACCME-accredited provider	Still need to understand what is meant by 10%. If all we did was live presentations, the 25% or 10% requirement would be easy to understand. But we create >75% as enduring materials.
ACCME-accredited provider	Organizations that only do live events are limited in their ability to meet the critical elements of this criterion.
ACCME-accredited provider	Most activities have a start date and an end date. What does the ACCME expect related to 'repeatedly evaluate and provide feedback'? Can this be done throughout one activity? Financially this would be a large task to repeatedly evaluate learners.
ACCME-accredited provider	I believe the criterion is somewhat clear and the elements are well stated; however, it becomes complicated when you start requiring a percentage of activities. The rationale and critical elements really helped to solidify my understanding of the criterion.
ACCME-accredited provider	My questions related to this criterion relate to the expectation for repeated assessment. If we implement an individualized clinical observation experience that includes dialogue and active feedback mechanisms-- then it appears that the provider needs to do a pre-assessment, immediate post assessment and longer term assessment-- how long and how many assessment are expected to meet this criterion?
ACCME-accredited provider	While it may be admirable to provide this type of CE, for many providers this would be a real stretch.
ACCME-accredited provider	This is impossible to do.
ACCME-accredited provider	Personalized education would be ideal but this criterion would be very difficult to implement and monitor by accredited providers. More easily implemented in academic settings through departmental-based annual reviews or credentialing offices but not feasible by all accredited providers (e.g. publishing companies) or practical for others (e.g. state medical societies) without major reform and manpower that would be needed to collect, review, and monitor individualized learning plans by learners.

Call for Comment Responses: Proposal for a Menu of New Criteria for Accreditation with Commendation

C30: Please provide comments or questions about this criterion.	
Organization Description	Comments
ACCME-accredited provider	In an organization like ours, this criterion will be impossible to achieve. We do not have instructors who could devote the amount of time needed to provide the assessment and feedback needed to more than a few learners. Thus, achieving this for 10% or more of our activities or learners would not be possible.
ACCME-accredited provider	As indicated previously, I question the standard.
ACCME-accredited provider	I do not think this is the role of the CME provider. The CME provider is there to design educational activities to meet the needs of the target audience. Again, this is not realistic for CME providers in my opinion. Our role is to educate, create and inform physicians on the educational process and learning styles, not the medical content.
ACCME-accredited provider	This would be an extremely labor intensive process for a large decentralized CME program. As this is a transition into a new process, we would like to see the proposed standard number of activities (10%) reduced to 5% with a transition to a higher standard at a later time.
ACCME-accredited provider	Time consuming requirement for CME staff members to follow up with the learners. Struggling now with getting replies to competence and performance evals sent out.
ACCME-accredited provider	Challenging but important.
ACCME-accredited provider	The criterion is clear but I do not agree with the standard. Currently there is no percentage or number of activities and/or learners required for any of the Commendation Criteria/. I think that more providers will put forth the effort to achieve this and the other criteria if there is no percentage or number standard attached.
Media	EXCELLENT idea! Criterion C35 will lend itself nicely to this!
Other	As written, the provider is required to undertake a significant workload in order to develop customized curricula for its learners. If a medical society has 10,000 members they would need to demonstrate that they are undertaking this level of individualized support for at least 1,000 individuals. While we support the concept of encouraging individual learners to identify their practice gaps and undertake interventions to close them it would be logistically difficult if not impossible for many specialty societies to effectively demonstrate this criterion as written.
Physician/healthcare professional	Important - should be emphasized perhaps even more than it is.
Physician/healthcare professional	This is one of the best criteria for being a commendable CME provider that I've read thus far.
Physician/healthcare professional	This criterion is totally unacceptable and smacks of practice improvement modules in ABMS MOC process. There is serious and significant grassroots opposition to practice improvement activities to fulfill MOC criteria, so much so that ABIM has suspended practice improvement MOC activities. As such, there is NO place for such practice improvement activities in criteria for CME providers to achieve 'commendation'. CME activities should be about improving medical knowledge NOT about changing how physicians practice medicine (which can be considered a violation of physician business autonomy and an infringement of the US free market, capitalist economic system).

Call for Comment Responses: Proposal for a Menu of New Criteria for Accreditation with Commendation

C30: Please provide comments or questions about this criterion.	
Organization Description	Comments
State-accredited provider	I don't think i could meet this because doing an individualized recommendation is really beyond a one man shop if this needs to be done for 10% or more of activities. If you took the percentage off i could meet it for some of the activities but i doubt 10%.
State-accredited provider	The criterion is clear. The standard seems unreasonably high. We employ over 700 physicians and also teach PA's, NP's and allied health learners. Our CME department does NOT have the resources (time, staff, or technology) to create individualized learning plans for our learners. I would NOT be able to meet this one.
State-accredited provider	This criterion will be difficult to implement for the hospital/health systems focused on educating their entire medical staff on system wide initiatives. Again, how would the office of CME of 1 person in a hospital be able to achieve this criterion?
State-accredited provider	Understaffed hospital CME staff with no training in education will not know what you are talking about and never have time to something like this. Our frustration is that these new criteria as well as some of the current ones are designed using an academic model which does not work in hospital programs.
State-accredited provider	May be almost impossible for small providers with limited resources to implement.
State-accredited provider	We vote to have the Standard be: 'No less than 5% of learners and/or activities
State-accredited provider	1. The C20 criteria on individualized learning plans is a great idea for learning situations involving one person but has the potential to becoming unmanageable and even ineffective for CME providers to handle. It has the potential of really making the lie of CME staff suddenly very busy of the demand for individualized learning plans increases.
State-accredited provider	Do not feel that the standard of 10% of learners and/or activities would be easy for anyone to reach since it is an individualized CME activity.
State-accredited provider	I agree with everything except where the learner has to be assessed repeatedly. We are a one person department and currently have accreditation with commendation.....this particular element is not realistic for providers who wear multiple hats in the CME community to provide this detailed information when there is not enough help, I work for several other areas as well as CME..... though it's a great idea.
State-accredited provider	Again as above. I believe that the standard as written is way too high. and greater than 10% of our activities that would be about 30 activities that would have to meet this and with the number of Journal Clubs and case conferences we hold out of our approximate 300 programs this would be difficult to achieve. I am unclear what is meant by 'and/or learners' and how those number would translate. Also I believe that the increased workload to meet this high number of activities with a CME office that is staffed by a CME director, CME manager and Admin Assistant/coordinator along with additional responsibilities added to the plate with ABIM and other specialty boards this is unrealistic. We have been accredited with commendation for the past 2 cycles and I am not certain this added work is worth the bang of receiving 6 years instead of 4. I also thin that the critical element should include and/or and not just and to make it more realistic. Again clarification on assessment.

Call for Comment Responses: Proposal for a Menu of New Criteria for Accreditation with Commendation

C30: Please provide comments or questions about this criterion.	
Organization Description	Comments
State-accredited provider	Good but REALLY REALLY labor intensive. Few will be able to do even the 10%.
State-accredited provider	I believe this standard will only be met by large teaching universities with substantial CME personnel. The community hospital doesn't stand a chance
State-accredited provider	Yes,
State-accredited provider	This puts a huge burden on the institution to create an automated system to build individual assessments and to track this.
State-accredited provider	None
State-accredited provider	A worthy goal that has no funding, personnel, or time allocated in any system that we are aware of. This is a function of divisions and practice group leaders.
State-accredited provider	This goes away from self directed learning. Would require physician coaching that would impact staff resources and clinic/hospital time which is already over-taxed. We are looking at ways to do this but it will not be implemented until we restructure some of our teams to think this through and get it approved. I am thinking that this may be a year or two down the road as we will have to develop the process, sell to leadership, pilot and spread the practice. Not sure how others with lesser resources would implement this.
State-accredited provider	<p>This criterion and the critical elements creates a hardship to small CME program personnel for it requires a great deal of man hours.</p> <p>Also, the standard is too high and needs to be revised. If a CME program offers multiple formats and has multiple activities, they would have to minimize the number of activity types they offer to meet the level of greater than or equal to 10%. Offering such activities does not mean you will have physicians or other healthcare providers participating.</p>
State-accredited provider	CME committees do not function as career coaches/monitors. Who, by the way, is going to do all the work as you have suggested. And who pays for it? Why not suggest we contact our local medical school and recommend the curriculum, for surely they must be teaching various topics willy-nilly, without direction, unless the ACCME provides such direction. Which brings to mind a question, who is monitoring the professional practice gaps and deficiencies of the ACCME?
State-accredited provider	This is a tool for Academia or possibly Medical Education Companies or Association where participants are paying for the experience. It makes the criteria for those who make money in education and can spend large amounts of money.
State-accredited provider	I am not a physician, so I would not be able to do this. Getting a physician to commit to that much time would be difficult, and the skills needed might not match his/her skill set. It's hard to get anyone to admit to having a professional practice gap, and this would document that gap. If it's a new skill wanted that would be more acceptable, but that's a problem. If it's something TDO can identify as a quality issue it would be easier to work with, as we could require physicians to complete the course as a group.

Call for Comment Responses: Proposal for a Menu of New Criteria for Accreditation with Commendation

C30: Please provide comments or questions about this criterion.	
Organization Description	Comments
State-accredited provider	Nice idea but that would take a lot of manpower to do that much work for an individual learner. Not very practical for small staff.
State-accredited provider	This is going to be very difficult for smaller organizations to obtain. It is very time consuming and not all institutions will have staff dedicated to this.
State-accredited provider	<p>Our CME Committee felt that 10% was too high in this category. Situations like this usually come from the quality process and there is no way to determine how many individual physicians will require this kind of help. This would be out of the control of the CME program.</p> <p>Also to do this correctly and to really provide a benefit to the practitioner, there would quite a large amount of follow-up work.</p> <p>Our committee was not sure if the development of an activity based on a 'practice gap' (depending on how the gap was determined) would be reportable to the National Practitioner Data Bank.</p>
State-accredited provider	Decrease to 5% OR Under the critical elements: leave the first 'AND', take the second 'AND' away.
State-accredited provider	Our organizational scorecard contains an 'educational scorecard' for providers and this criteria matches it nicely. I am ok with the numbers here!!
State-accredited provider	I can't imagine any providers I know being able to meet this criterion. Many many more resources for CME will need to be developed in order to do this one. A real stretch goal.
State-accredited provider	Although well written the standards do complicate it. A plan for implementation of new Commendation criteria into operations will be critical to outline how to achieve compliance for smaller organizations, small staff resources but these organizations probably won't have staff that have time or skills to do so. Need clear examples on each criteria of what truly is expected of the provider to attain for compliance and what would be considered non-compliance.
State-accredited provider	But it is unrealistic in the current situation.

C31: Provides services and resources to generate and sustain long-term behavioral modification of learners.

C31: Since you answered 'no', please explain and/or suggest edits.	
Organization Description	Comments
ACCME Recognized State Medical Society	<p>Critical Elements:</p> <ul style="list-style-type: none"> - Better if allowed for this OR that, instead of this AND that. Small providers with one person CME office or part-time staff may not be able to address this criterion. <p>The Standard:</p> <ul style="list-style-type: none"> - It is unclear whether the “% of activities or the % of learners” represents the % of learners in a given year of activities or for the entire accreditation term. - ?10% of activities and/or learners – ?10% too high
ACCME Recognized State Medical Society	<p>Unable to assess. Inadequate and/or deficient methodological evidence of validity, reliability and application practicality of process. Details upon request. E.g. lack of evidence this criteria should carry same “weight” as any other and is mainly exclusive of other criteria to avoid double weighting. Applicability and importance depends on nature and scope of provider.</p> <p>Again overlap with 26, 27, 29 and 30 very possible depending on specialty and other factors.</p>
ACCME Recognized State Medical Society	Define “tracking and reporting utilization”.
ACCME Recognized State Medical Society	Again, C31 like C30, geared more towards large provider types. Don't think small providers would invest any time, not even >10%, to implement activities that demonstrate 'sustain long-term behavioral modifications of learners.' Not enough staff, time, resources.
ACCME Recognized State Medical Society	<p>We endorse the concept of longitudinal relationships with CME participants but believe that this criterion requires greater definition of “long-term”, as well as “utilization”, “meaningful”, and “behavioral change”. Would RSS’s be an appropriate venue for this criterion?</p> <p>As described above, we have concerns about the attempt to determine compliance based on the percentage of activities or learners.</p>
ACCME Recognized State Medical Society	Isn't this similar to what is being done with enduring materials? Would newsletters be considered as a 'reminder'? What would quantify that this criteria as been met?
ACCME Recognized State Medical Society	When reading the rationale, it appears to be compliant with this criterion, a provider must provide non-educational materials and informational materials. However, the criterion statement simply states services and resources. Services and resources could be additional educational offerings, a help desk, or one-on-one discussions, all of which would be educational/informational. There is a disconnect between the criterion statement and the example given within the rationale, “reminders.”

Call for Comment Responses: Proposal for a Menu of New Criteria for Accreditation with Commendation

C31: Since you answered 'no', please explain and/or suggest edits.	
Organization Description	Comments
ACCME Recognized State Medical Society	Revise to: 'Provides services and resources that align with CME activity(ies) to generate and sustain long-term behavioral modification of learners.' Revisions suggested because 'activities' (along with learners) is mentioned in The Standard, therefore, would we suggest including it in the criterion. My guess is the provider will need to tie this criterion directly to it's activities.
ACCME Recognized State Medical Society	% of the standard is not a good idea for any Criteria; this will be too complicated to calculate. Providing multiple examples for a Criteria should be sufficient for a compliance finding.
ACCME Recognized State Medical Society	The first element of this criterion is achievable and a restatement of C17. Would the provider be required to develop resources specific to their organization or would outside resources made available to the provider's learners satisfy this element? How does the provider document 'ongoing use of the system or resources?' Learner use of online materials might be easy to track but when reminders other learning adjuncts are pushed out to learners, how is use demonstrated?
ACCME Recognized State Medical Society	Need clarification on the standard of 10% of activities or learners. For example, is it 10% of the total of activities from the entire term of accreditation? Or could it be 10% of activities from 1 or 2 years of accreditation? 10% of activities or learners will be very difficult for many providers in our state system to achieve, because providing resources AND especially following up on the use the resources can be difficult given the limited resources in the state system. Suggest lowering percentage to a specific range of activities/learners such as an expectation of one to three per year, and eliminating the second critical element of following up on the use of the resources. A percentage is complicated for accreditors to work with during the survey process. For example, what/how many activities do we need to select for review?
ACCME Recognized State Medical Society	An example of a project that successfully meets C 31 should be developed to demonstrate what ongoing use of systems and resources would look like. How do you track and report utilization? It is unclear whether behavioral modifications of learners needs to be assessed with objective data and/or subjective data, e.g., 'I made the following changes to practice....' (Again-see previous comments regarding percentages.)
ACCME Recognized State Medical Society	The word 'meaningful' is subjective; suggest removing. Would the rationale for this criterion be the same if 'meaningful' was removed?
ACCME Recognized State Medical Society	Regarding the critical element; what if the provider provides services for which no one utilizes, would this count? How long is 'ongoing'? Would resources include instructional material online (i.e. the CME itself), or would this be in the 'non-educational strategy' vein? The ?10% of activities 'and/or' learners would be difficult for surveyors to evaluate.
ACCME Recognized State Medical Society	The criterion and the rationale may be achievable by a few providers, the use of the word 'AND' in the critical elements seems unreasonable. Most providers do not have the staff, time or resources to monitor ongoing use of resources. The Standard percentage will be very difficult for surveyors to assess or providers to achieve.

Call for Comment Responses: Proposal for a Menu of New Criteria for Accreditation with Commendation

C31: Since you answered 'no', please explain and/or suggest edits.	
Organization Description	Comments
ACCME-accredited provider	We support the goal, but are concerned that any institution with an electronic health record (EHR) that incorporates reminders might fulfill this criterion merely by listing their system’s clinical reminders, or by having a link to a commercial clinical information resource. We suggest that provider be required to document the role of the education unit in creating, managing, or improving such reminders or instructional resources.
ACCME-accredited provider	Please give examples of 'demonstrates ongoing use of the system or resources'. This is not clear.
ACCME-accredited provider	Further define the critical element 'demonstrates ongoing use'
ACCME-accredited provider	Feel this should be AND/OR instead of just AND. Also, I feel the 10% threshold will be difficult for providers of all types and sizes to meet.
ACCME-accredited provider	Would a click through system qualify as a tracking tool?
ACCME-accredited provider	We endorse the concept of longitudinal relationships with CME participants but believe this criterion requires greater definition of “long-term”, as well as “utilization” and “behavioral change”. Would a single activity such as an RSS, conducted iteratively, satisfy this criterion? As noted above, we do not recommend requiring providers to apply this criterion to > 10% of their activities.
ACCME-accredited provider	It is clear but could be more broad by allowing providers to utilize or direct Learners to existing adjuncts (e.g. phone apps, websites, etc. - many of which are very good) instead of requiring providers to create new materials. Utilization could then be tracked either by querying Learners about use or utilizing some sort of Intent-to-Change questioning. Seems this would meet the ACCME goal here without biasing Criterion toward CME providers with large IT staffs. We try as much as possible to provide learners with supplemental materials - some which we create and some of which we point them to. Also an 'OR' instead of 'AND' would be good.
ACCME-accredited provider	Must both critical elements be present in all activities (referring to use of word “AND”)? The 10% criteria will be difficult for both large and small organizations to achieve. It is one thing to provide tools to HCPs, it is a whole other thing to “measure ongoing use”. For those of us who do not have HCPs in our system and can track what they do via an electronic health record, I’m not sure how one could demonstrate compliance with this criteria.
ACCME-accredited provider	The use of performance aids to support behavior change in practice is widely accepted, but as written this criterion presents some challenges. It is unclear if the 'ongoing use' needs to be demonstrated for individual users over a span of time, in which case the appropriate time frame needs definition, or if it is acceptable to demonstrate that, in general, the provided resources continue to receive use by learners across the entire learner pool during the accreditation cycle. If the latter, this could be more of an assessment of an organization's marketing efforts than of the usefulness of the tools themselves. Also, since the ACR does not have direct access to their learners' workplaces to monitor clinical behavior it could be difficult to objectively measure the 'ongoing use' of any practice tools beyond asking learners to self-report.

Call for Comment Responses: Proposal for a Menu of New Criteria for Accreditation with Commendation

C31: Since you answered 'no', please explain and/or suggest edits.	
Organization Description	Comments
ACCME-accredited provider	If a CME accredited organization was a hospital or health institute, this criterion is very practical and perhaps even relevant; however, not with a medical society that's CME accredited for its educational activity but may not have individuals with long term membership or participants who attend the educational activity that are non-members of the organization. What is considered long -term behavioral modification? How does a non-healthcare provider monitor behavioral change in the clinical setting?
ACCME-accredited provider	The use of performance aids to support behavior change in practice is widely accepted, but as written this criterion presents some challenges. It is unclear if the 'ongoing use' needs to be demonstrated for individual users over a span of time, in which case the appropriate timeframe needs definition, or if it is acceptable to demonstrate that, in general, the provided resources continue to receive use by learners across the entire learner pool during the accreditation cycle. If the latter this could be more of an assessment of an organization's marketing efforts than of the usefulness of the tools themselves. Also, since specialty societies do not have direct access to their learners' workplaces to monitor clinical behavior it could be difficult to objectively measure the 'ongoing use' of any practice tools beyond asking learners to self-report.
ACCME-accredited provider	For CME providers who are not also healthcare providers it is nearly impossible to accurately assess true behavior in practice beyond self-reporting. If the metric for this is ongoing access of online materials, that could more accurately reflect effective marketing campaigns and not true usefulness to patient care. Please define the standard for 'ongoing use' and what types of evidence would satisfactorily demonstrate this.
ACCME-accredited provider	Ongoing use needs to be defined.
ACCME-accredited provider	The criteria is fairly clear. What is not clear is what the provider needs to track. We have the tools. We can track usage may not be by students. We provide links in education but the tools are also available other ways. Can we simply show the tools are being used or do we need to find a way to track if the students of the activity are using this. The resources to separate out whom is using this is too resource intensive for us to do just to meet this criteria.
ACCME-accredited provider	Define 'meaningful ongoing utility to learners'. Define how we are to demonstrate the ongoing use of the system.
ACCME-accredited provider	The word long-term can have different interpretations. We propose changing "long-term" to "repeated intervention" to align the criteria with the rationale and critical elements.
ACCME-accredited provider	<ol style="list-style-type: none"> 1. CRITICAL ELEMENTS: Should be 'OR' demonstrates ongoing use..... 2. THE STANDARD: consider increasing to 25% (see general comment about standards)

Call for Comment Responses: Proposal for a Menu of New Criteria for Accreditation with Commendation

C31: Since you answered 'no', please explain and/or suggest edits.	
Organization Description	Comments
ACCME-accredited provider	<p>Does 'ongoing use' need to be demonstrated for individual users over time; if so, define the timeframe. If acceptable to demonstrate in general the provided resources are used by learners during a provider's accreditation term, could this be an assessment of an organization's marketing efforts vs. usefulness of the tools themselves? Since specialty societies do not have direct access to learners' workplaces, it could be difficult to monitor clinical behavior and objectively measure 'ongoing use' of practice tools beyond asking learners to self-report. With response rates to follow-up surveys often very low, the standard is set too high.</p> <p>Is compliance with this criterion tied to implementation through accredited CME activities or all activities of the provider, which may not be designated for credit?</p>
ACCME-accredited provider	See previous comment on thresholds.
ACCME-accredited provider	C31: another difficult, time entailing activity. We need a sample tool to use.
ACCME-accredited provider	<p>"Ongoing use" needs to be defined. Is this individual people over a span of time? (span of time would need to be defined.) Or is this use by all learners during the accreditation cycle?</p> <p>Difficult for specialty societies to monitor clinical behavior and objectively measure "ongoing use" beyond asking our learners to self-report.</p>
ACCME-accredited provider	AMIA agrees with CMSS: 'The use of performance aids to support behavior change in practice is widely accepted, but as written this criterion presents some challenges. It is unclear if the 'ongoing use' needs to be demonstrated for individual users over a span of time, in which case the appropriate timeframe needs definition, or if it is acceptable to demonstrate that, in general, the provided resources continue to receive use by learners across the entire learner pool during the accreditation cycle. If the latter this could be more of an assessment of an organization's marketing efforts than of the usefulness of the tools themselves. Also, since specialty societies do not have direct access to their learners' workplaces to monitor clinical behavior it could be difficult to objectively measure the 'ongoing use' of any practice tools beyond asking learners to self-report.'
ACCME-accredited provider	Graduates of our program have opportunities to take advanced studies from other institutions. We do not have the resources to provide and track graduate continuing medical education.
ACCME-accredited provider	<p>Determining how to track the 'ongoing use of the system or resources' is not clear. For how long? How many times would one have to come back and use the resource?</p> <p>This will be extremely difficult to track for any resources that are not provided electronically and even for those it will require a large investment in technology for our organization. This will be possible for us to achieve but will take multiple years to be able to implement.</p>

Call for Comment Responses: Proposal for a Menu of New Criteria for Accreditation with Commendation

C31: Since you answered 'no', please explain and/or suggest edits.	
Organization Description	Comments
ACCME-accredited provider	The term 'behavioral modification' needs to be better defined. Perhaps what is intended here is long-term change in performance and/or patient outcomes. Utilization is not necessarily a valid metric of value (and the ACCME needs to define what is meant by 'value' and to whom it is conferred). The expectation for a % of learners or activities will disadvantage providers who have very robust and substantial initiatives in key areas and reward providers who have superficial and perfunctory practices across many activities/learners. We suggest instead that providers be asked to submit several examples to demonstrate compliance.
ACCME-accredited provider	The metric to achieve need to be rethought.
ACCME-accredited provider	Is '> 10% of learners and/or activities' over the accreditation term? Annually? or other?
ACCME-accredited provider	Please clarify if 'resources' requires more than just recycling already used resources. For example, would it suffice to just put on the web a copy of the individual's PowerPoint presentation and nothing more?
ACCME-accredited provider	Would maintenance of certification programs meet this criteria? Pre and post-test, continuous evaluation, distribution of poc-it guides at the conclusion of a meeting, etc.?
Other	Threshold for commendation is too low for this criteria. There are so many ways to do this (including but not limited to Electronic Health Records, which I recognize can be hard to 'get in the programming queue' for reminders) that the threshold should be much higher here. Also not clear to me how this would be based on a % of learners. I would suggest the standard be > or = to 33% of activities.
Other	Use of term "behavior modification" in the criterion title is troubling and not used accurately from a psychological operant conditioning perspective. I would strongly urge you change that language especially since you want providers to engage in more C23 interprofessional education such as for psychologists. Behavioral change does not = behavior modification.
Other	The use of performance aids to support behavior change in practice is widely accepted, but as written this criterion presents some challenges. It is unclear if the 'ongoing use' needs to be demonstrated for individual users over a span of time, in which case the appropriate timeframe needs definition, or if it is acceptable to demonstrate that, in general, the provided resources continue to receive use by learners across the entire learner pool during the accreditation cycle. If the latter this could be more of an assessment of an organization's marketing efforts than of the usefulness of the tools themselves. Also, since specialty societies do not have direct access to their learners' workplaces to monitor clinical behavior it could be difficult to objectively measure the 'ongoing use' of any practice tools beyond asking learners to self-report.
State-accredited provider	Need more definition to services and resources. Will physicians receive credit every time they repeat something? The idea of doing this in small hospital programs is ridiculous.
State-accredited provider	I understand the concept, but would find this hard to track since CME is only given once for an 'activity'. Are we referring to other sources that are given to our physicians, such as access to DynaMed? And if so then how would there

Call for Comment Responses: Proposal for a Menu of New Criteria for Accreditation with Commendation

C31: Since you answered 'no', please explain and/or suggest edits.	
Organization Description	Comments
	be a 'standard' of 10% of learners and/or activities at all for this?
State-accredited provider	NA
State-accredited provider	The critical elements need further explanation. What encompasses reminders? How is utilization of system or resources from the provider's perspective or the learners' perspective? The sentences in the rationale, 'the provider can demonstrate that their tools have value by tracking and reporting utilization' indicates that only tools online are of value, otherwise paper reminders cannot be tracked. For example, we have paper reminder 'how to' for EMR training. These would not have value to meet C31, since we cannot track which provider has taken a copy or utilized the reminder. Online is not necessarily the best format for providing education to meet a gap in competence or performance.
State-accredited provider	This criterion sounds like a requirement to set-up web based tools since paper based processes would be nearly impossible to administer. Another criterion excluding small resource constrained providers.
State-accredited provider	<p>Delete the percentage.</p> <p>I am not sure that I can do this with feedback, multiple feedback especially since I also support the Medical Staff Office in processing reappointments, hospital letters, insurance company verification letters and the monthly on call for the 22 various departments/ specialties</p> <p>We do not have the capability or the finances to track and report utilization</p>
State-accredited provider	'Services and Resources' implies dollars, staff, and time !!!
State-accredited provider	<p>Suggest rewording: 'Integrates into its educational activities strategies, services, and resources to generate and sustain long-term behavioral modification of its learners.'</p> <p>To me, this is really no different from c17. Is there meant to be a difference? If so, then please clarify. If not, then please so state since i think a lot of providers would appreciate to hear that the essence of c17 is being carried over into the new Commendation criteria.</p> <p>While the % here seems rather easily achievable, I am not sure that, in general, having a percentage as a standard is the way to go, as i've explained earlier.</p> <p>In the way of an observation, I see many providers citing the alerts on an EHR as meeting c17. It is such an easy thing to cite for more and more providers.</p>
State-accredited provider	Depending on how 'demonstrates ongoing use of the system or resources' is defined, it's possible our organization could achieve this.

Call for Comment Responses: Proposal for a Menu of New Criteria for Accreditation with Commendation

C31: Since you answered 'no', please explain and/or suggest edits.	
Organization Description	Comments
State-accredited provider	Most providers will not be able to to keep up with this ongoing expectation of them unless they have a staff to do this. The Standard only hurts the small provider's ability to do this.
State-accredited provider	Burnout is one example where behavioral change is needed. It is our experience, however, that the approach to burnout improvement must include changes to team behavior and organizational impacts as well as changes for the individual. If outside forces continue to create the stressors, the individual will lose the battle for improving.

Call for Comment Responses: Proposal for a Menu of New Criteria for Accreditation with Commendation

C31: Please provide comments or questions about this criterion.	
Organization Description	Comments
ACCME Recognized State Medical Society	This one has been previously considered by my providers as a mean to appreciate their CME effectiveness. So far, I have no information about being done. For me it is an attainable criterion.
ACCME Recognized State Medical Society	Has anyone determined how the learners may react to 'repeated assessment'? 'Demonstrates ongoing use of the system or resources' needs to be more defined in order for providers to determine their abilities to meet this critical element. Demonstrates how exactly?
ACCME Recognized State Medical Society	Standard percentage is a concern - see 1st page for details.
ACCME Recognized State Medical Society	Would like for the ACCME to explain how tracking and reporting would be accomplished.
ACCME Recognized State Medical Society	I am not understanding how '% of learners' applies to any of the proposed criterion where % of learners can be the standard. I am not understanding how '% of activities/learners' applies to RSS for any of the proposed criterion.
ACCME-accredited provider	While this criteria is clearly written, I think it will be extremely challenging to keep a regular dialogue with learners to prove that they are using the system or resources on an ongoing basis.
ACCME-accredited provider	I would like to see mention of medical information skills in this Criterion as well. This area of continuing education is already populated with online instruction modules. However, as with the other skills involved in CME, practice is required to master these skills.
ACCME-accredited provider	This seems like the non-educational strategy criterion (C17), reworked. How will providers be required to 'demonstrate ongoing use of the system or resources'? For example, if we email reminders to our staff physicians to be sure to follow hand-washing guidelines, how do we document 'ongoing use' of that reminder?
ACCME-accredited provider	I believe stake holders would welcome any criteria that support on-going utility to learners
ACCME-accredited provider	This is clear.
ACCME-accredited provider	For a large health system, this amount would be out of reach.
ACCME-accredited provider	Though we wholeheartedly agree with this criterion, this is a labor-intensive endeavor for both course directors and CME staffers.
ACCME-accredited provider	Accrediting organization will need examples of how people have actually done this.
ACCME-accredited provider	These services and resources must include the instructional materials provided by the medical library (ebooks, print books, electronic and print journals, tutorials, online instruction, etc.)
ACCME-accredited provider	The Standard should be scaled based on the number of activities the provider offers annually. An organization that offers a few activities a year may easily demonstrate compliance while a large volume provider would need data from hundreds of activities to demonstrate compliance.

Call for Comment Responses: Proposal for a Menu of New Criteria for Accreditation with Commendation

C31: Please provide comments or questions about this criterion.	
Organization Description	Comments
ACCME-accredited provider	We request clarification of 'demonstrates ongoing use of the system or resources.' While we generate tools and reminders, we have only limited ability to document their use. We can quantify downloads for on-line tools, and we can measure subjective reports of their adoption and use, but objective assessment of their implementation in actual practice is very challenging.
ACCME-accredited provider	This Criteria goes a step further than the original Criteria because evaluating the success of educational resources will help the Provider decide which resources actually help participants once they leave and activity.
ACCME-accredited provider	Simple systems and design are probably feasible at 10% (but only because we already have our own LMS). This may not be achievable for small organizations without an LMS.
ACCME-accredited provider	We would like clarification on whether reminders and resources would also need to provide CME credit. We also suggest basing the standard on number of credit hours of activity. A 1 credit activity and a 50 credit activity may have different parameters and not all may include repeat engagement of the learner.
ACCME-accredited provider	C31: SAGES has engaged in the development of a program which would meet this criteria, called ADOPT or "Acquisition of Data for Outcomes and Procedure Transfer." We initially piloted this program and now have launched a larger program. This program costs over \$50,000 per year for just 20 learners. Therefore, due to the resources required, it would not be possible to meet the standard set here of 10% of learners or activities. We would recommend 1 accredited activity per year as the standard.
ACCME-accredited provider	Again, the standard will likely be unachievable for providers with a large number of activities or learners.
ACCME-accredited provider	It is clear as written, and providers may be able to track whether or not a resource has been accessed, but not necessarily whether or not it has been utilized. In addition, for the critical elements, the requirement of 'and' may not be achievable for all provider types, nor will 10% of activities and/or learners.
ACCME-accredited provider	The Standard is too high for this. Currently we have activities that incorporate this, but given our large educational portfolio, we could never achieve this standard.
ACCME-accredited provider	Excellent requirement
ACCME-accredited provider	Critical Elements should be amended to "ORs" from "ANDs." Requiring "ANDs" significantly limits the flexibility intended by the introduction of the menu structure. We believe innovation and creativity will be reduced and not all provider types will have the ability to achieve Accreditation with Commendation
ACCME-accredited provider	This is great! And I think similar to a current criterion.
ACCME-accredited provider	Many resources are non-electronic handouts with limited use tracking short of follow-up surveys. Doing this for each handout or even activity could become cumbersome for learners. Would refine 'ongoing' use wording to clarify how often and how many times this needs to be assessed.
ACCME-accredited provider	I would like to see examples of fulfilling this criterion.
ACCME-accredited provider	agree

Call for Comment Responses: Proposal for a Menu of New Criteria for Accreditation with Commendation

C31: Please provide comments or questions about this criterion.	
Organization Description	Comments
ACCME-accredited provider	We do some of this already but how do you anticipate demonstrating ongoing use? We could count the 'click throughs' of the reminder emails that we send with resources but we have no way to assess if the learners are using the resources. We can measure the number of courses that a learner and we send a post activity survey that only a small amount return but not long term behavioral modification.
ACCME-accredited provider	What would be considered the evidence for demonstrating ongoing use of the system ? Frequency of downloads of a particular educational tool? This may be more challenging in an OPEN system (i.e., learners use variety of interfaces/providers to get CME) vs. a closed healthcare system/network/university (i.e., has standing educational framework and employee development plans)
ACCME-accredited provider	I believe the criterion is clear and the elements are well stated; however, it becomes complicated when you start requiring a percentage of activities. The rationale and critical elements really helped to solidify my understanding of the criterion.
ACCME-accredited provider	this criterion seems relatively straightforward and something that many providers already provide to learners. I don't have any specific concerns or questions about this criterion.
ACCME-accredited provider	We think this criterion should be deleted from the list. This is more about providing a 'service' rather than providing education. Services may be utilized in education, but a service does not replace or serve as education itself.
ACCME-accredited provider	As indicated previously I question the standard.
ACCME-accredited provider	Could you please clarify if a provider offers a hybrid learning format that would include a live activity and and an online module, would that meet the requirement for sustaining long-term behavioral modifications? As this is a transition into a new process, we would like to see the proposed standard number of activities (10%) reduced to 5% with a transition to a higher standard at a later time.
ACCME-accredited provider	See concerns from page 1 of the survey related to The Standard
ACCME-accredited provider	Tracking and reporting the utilization of the resources will be a challenge.
ACCME-accredited provider	Challenging but important.
ACCME-accredited provider	The criterion is clear but I do not agree with the standard. Currently there is no percentage or number of activities and/or learners required for any of the Commendation Criteria/. I think that more providers will put forth the effort to achieve this and the other criteria if there is no percentage or number standard attached.
Other	Although admirable, due to the resources required, it would not be possible to meet the standard set here of 10% of learners or activities. I would recommend 1 accredited activity per year as the standard.
Other	Threshold should be raised to 25%.
Physician/healthcare professional	May be difficult for some CME providers; our system is fortunate in this regard.

Call for Comment Responses: Proposal for a Menu of New Criteria for Accreditation with Commendation

C31: Please provide comments or questions about this criterion.	
Organization Description	Comments
Physician/healthcare professional	I believe this is achievable and could help improve current CME practices.
Physician/healthcare professional	Sounds too much like patient satisfaction surveys will be included. The rationale is fine until last sentence - 'tracking and reporting utilization'
Physician/healthcare professional	Same objection as criterion 30: providers should stick with providing medical knowledge content and NOT engage in changing how physicians practice medicine. This is a backdoor way of requiring all physicians to participate in MOC-like practice improvement activities. This is beyond the scope of what CME should be about.
State-accredited provider	10% how do measure that is it 10% of you attending staff -physicians in the organization. 10% of your staff that would attend that is not physicians.
State-accredited provider	This seems like it might be tough to meet because i don't know how a small shop will be able to track our tools and report utilization. We provide the tools now but tracking if providers actually use them is beyond a one man shop.
State-accredited provider	Criterion is clear; standard seems very high. In the previous 'accreditation with commendation' one only needed to demonstrate an example of meeting the criterion. Where did the numbers come from??
State-accredited provider	We vote to have the Standard be: 'no less than 5% of learners and/or activities.
State-accredited provider	This seem very similiar to C 17
State-accredited provider	Again as above. I believe that the standard as written is way too high. and greater than 10% of our activities that would be about 30 activities that would have to meet this and with the number of Journal Clubs and case conferences we hold out of our approximate 300 programs this would be difficult to achieve. I am unclear what is meant by 'and/or learners' and how those number would translate. Also I believe that the increased workload to meet this high number of activities with a CME office that is staffed by a CME director, CME manager and Admin Assistant/coordinator along with additional responsibilities added to the plate with ABIM and other specialty boards this is unrealistic. We have been accredited with commendation for the past 2 cycles and I am not certain this added work is worth the bang of receiving 6 years instead of 4. I also thin that the critical element should include and/or and not just and to make it more realistic.
State-accredited provider	10% is too high
State-accredited provider	This is clearly written and an important adjunct to learning. It is also included in the original commendation criteria. How would it differ from criterion 17?
State-accredited provider	Yes
State-accredited provider	Demonstrating that there are resources: the learner is changed by situation rather than changing a situation.
State-accredited provider	With thousands of physicians to track following up to make sure they use the resources provided could be problematic. This is a workflow issue that is out of the scope of a self directed learning style for most physicians. We track the larger outcomes of the activity and work with the chiefs and physician committees to provide resources. We do not plan on tracking if physicians, who each have different learning styles/needs, use each of the resources provided.
State-accredited provider	Clear, but, unfortunately, not part of CME committee responsibility.

Call for Comment Responses: Proposal for a Menu of New Criteria for Accreditation with Commendation

C31: Please provide comments or questions about this criterion.	
Organization Description	Comments
State-accredited provider	The critical element of tracking the use of resources requires online capability. Many of the resources are posted on a website, but does not track the number of clicks on the resources once logged in...only the number of log in and length of time spent online.
State-accredited provider	This would require a committment for funds to develop and support enduring materials. We are extremely lean, and I doubt that would happen unless we could get a grant or work with another group to make it happen. We have patient education materials online already, but to develop those directly related to CME would be expensive. It would need to be publicized and to be part of a regular program.
State-accredited provider	10% is too high. Our CME Committee felt that 1-2 activities per year was a more reasonable expectation.
State-accredited provider	May be unattainable beyond the 90 days -opportunity may be there but reality of keeping up with those past activities when there are 5 new activities coming up.
State-accredited provider	Take the 'AND' away and replace with 'OR' in the critical elements section.
State-accredited provider	Numbers easily attainable here!
State-accredited provider	Clear

DEMONSTRATING LEADERSHIP

C32: Engages in CME research and scholarship.

C32: Since you answered 'no', please explain and/or suggest edits.	
Organization Description	Comments
ACCME Recognized State Medical Society	This criterion requires providers invest in scholars whose expertise is 'educational/academic'. This will bring a high cost to them besides of the difficulty of finding such professional. Of my 4 providers, I will have 2 dropping from the system immediately.
ACCME Recognized State Medical Society	<p>Unable to assess. Inadequate and/or deficient methodological evidence of validity, reliability and application practicality of process. Details upon request. E.g. lack of evidence this criteria should carry same “weight” as any other and is mainly exclusive of other criteria to avoid double weighting. Applicability and importance depends on nature and scope of provider.</p> <p>Why would one limit this to CME research since the “provider” is tasked to improve outcomes and performance of targeted populations through multiple integrated approaches including CME?</p>
ACCME Recognized State Medical Society	Would likely only apply to academic settings.
ACCME Recognized State Medical Society	<p>This criterion doesn’t represent the opportunity for all provider types equally. It appears to be designed for specific types of providers. A SMS might not be able to meet this criterion.</p> <p>Critical Elements:</p> <ul style="list-style-type: none"> - Better if allowed for this OR that, instead of this AND that. Small providers with one person CME office or part-time staff may not be able to address this criterion. <p>The Standard:</p> <ul style="list-style-type: none"> - “Once for every year of term,” is too much.
ACCME Recognized State Medical Society	For the third Critical Element specific to publishing, allow for “dissemination” of results through other venues, such as conference presentations. The standard of once for every year of term does not seem feasible. Could there be other forms of dissemination such as a conference or forum?
ACCME Recognized State Medical Society	<p>Under the critical elements, we would suggest that the ACCME further define the term “research” hoping that it could include domains such as implementation science and broaden the dissemination criteria to include not only peer-reviewed journals but also presentations at national and regional meetings.</p> <p>We believe that this criterion should be assessed across the accreditation period, not necessarily in each year.</p>

Call for Comment Responses: Proposal for a Menu of New Criteria for Accreditation with Commendation

C32: Since you answered 'no', please explain and/or suggest edits.	
Organization Description	Comments
ACCME Recognized State Medical Society	There is an explosion of published research going on and it is felt that a serious problem is that a large amount of that research is poorly done, poor quality. CME research should be of high quality. 'best practices' is a catchy phrase but remains simply that. I would urge that this criterion be eliminated. It would be better to instead have a criterion that rewards CME that focuses on the inclusion of and education of learners pertaining to research analysis - statistics, inclusion of number need to treat, absolute in addition to relative risk reduction, etc. These basic elements are not emphasized in CME but should be. They are more important than assessing for COI's as a screen for bias. It is important to understand the nature of the scientific evidence in the medical literature which should be common reading and analysis for physicians. CME should encourage that.
ACCME Recognized State Medical Society	Would each critical elements be required once for every year of term. Thus a provider coming off of a 4-year accreditation term must 1) conduct relevant research 4 times; 2) produce data/information 4 times; and 3) publish 4 abstracts/manuscripts. Small CME providers with <1 FTE do not have the bandwidth and staffing to achieve this biasing the criterion to large CME providers
ACCME Recognized State Medical Society	The criterion and the rationale may be achievable by a very few providers, the use of the word 'AND' in the critical elements seems unreasonable. The critical elements do not appear to achievable by our providers. This criteria seems to be directed toward academic providers. The definition of 'innovative approaches' will be different for each provider and will be left to interpretation by the surveyor. The Standard percentage will be very difficult for surveyors to assess or providers to achieve.
ACCME-accredited provider	C32 Suggest replacing "research" with "inquiry" and expanding goal of this criterion from research to also include scholarly approaches to education improvement that might not meet strict definitions of research. The Critical Element would add another option, such that ""Publishes abstract or manuscript in a peer-reviewed journal OR Presents the work at a conference with peer-review process for accepting presentations."
ACCME-accredited provider	Define CME professional.
ACCME-accredited provider	While I think the intent is good, I don't feel providers should be required to meet all 3 - recommend changing to OR. I don't think it would be fair to penalize a provider who conducted the research and produced data but was not successful in publishing in a peer-reviewed journal. Instead of requiring it to be published, why not give the option to have the data presented at a local/national CME meeting? A lot of great data is presented at Alliance meetings, local society meetings, even internal organization meetings. Also, good research is often time intensive - it seems unrealistic to require providers to do this once/year of term - wouldn't it be enough to do this once per 2/4-year term or twice per 6-year term? Could projects be institution-based or would it have to be initiated by the CME department within the institution to qualify?
ACCME-accredited provider	Can this criterion be met through activities with abstract presentations OR having CME Deans who publish articles within their field?
ACCME-accredited provider	Would an article in a hospital newsletter meet this requirement?

Call for Comment Responses: Proposal for a Menu of New Criteria for Accreditation with Commendation

C32: Since you answered 'no', please explain and/or suggest edits.	
Organization Description	Comments
ACCME-accredited provider	This criterion, while good for the profession, is too esoteric. It would appeal to a small number of organizations or individuals who could have articles published annually in peer reviewed journals. Instead, this should be considered for an annual ACCME Award based on submissions from individual organizations and/or nominations of individuals, and based on more specific criteria than 'relevant' to CME.
ACCME-accredited provider	This is too cumbersome for organizations that are not teaching or research facilities. This criterion will add enormous cost to our type of the organization.
ACCME-accredited provider	What happens if research last longer than 1 year.
ACCME-accredited provider	Must both critical elements be present every year of term (referring to use of word "AND")? Why a peer reviewed journal? While the gold standard, there are lots of good posters/abstracts in forums like Alliance meetings that share good CME research. As written these are not considered. Also, expecting providers to publish every year seems burdensome. Not everything submitted gets published so this will place a burden on smaller providers who don't have a lot of resources to devote to not just doing the research, but getting it accepted. What if someone publishes research in the first 2 years but can't get anything published the third year of their term. Should they be noncompliant even though they tried to get something published?
ACCME-accredited provider	We endorse this criterion. Under the critical elements, we suggest the ACCME further define "research" to include domains such as implementation science. We would also support broadening the dissemination criteria to include not only peer-reviewed journals but also presentations at national and regional meetings. This criterion should be assessed across the accreditation period, as high impact projects often take multiple years.
ACCME-accredited provider	Who is doing this research? Staff? I find that strange and not applicable to MANY providers, especially those with very small staff resources to begin with.
ACCME-accredited provider	Seriously, my organization can't be the only one with no interest in this. Suggest the bar be lowered to one every other year....that is more doable with no support.
ACCME-accredited provider	This criteria does not support a providers CME mission statement. Many smaller providers with less staff do not have the staff, time or resources to conduct research, write manuscripts, and publish.
ACCME-accredited provider	Truly one publication per year or on average one per year?
ACCME-accredited provider	<p>Research could be generated, but not published. Meeting the standard would place added responsibility on a CME provider. It is unclear how publishing data about CME activities contributes to the quality of a provider's program or is equated with high quality education. A well written abstract could be published about a poorly designed/implemented activity.</p> <p>Is the research/scholarship to be based on the effectiveness of a CME program/activities, outcomes, and/or learning strategies and not on clinical topics that inform the development of CME activities?</p> <p>Are there restrictions on the peer-reviewed journal in which the research is published? Could it be published in a provider's own peer-reviewed journal or only in one unaffiliated with an organization (e.g., JCEHP)?</p> <p>Suggest the "And's" in the Critical Elements become "And/Or's".</p>

Call for Comment Responses: Proposal for a Menu of New Criteria for Accreditation with Commendation

C32: Since you answered 'no', please explain and/or suggest edits.	
Organization Description	Comments
ACCME-accredited provider	C32: CME research and scholarships: there is a critical element on research but not on scholarship! This is easy in a hospital setting and teaching hospital but our organization is not. We are really for CME activities. Research will be difficult to fulfill in our setting.
ACCME-accredited provider	Despite the ACR's best efforts, research could be generated but not published. Mandating at least one research publication per year places a significant additional responsibility on a CME provider's program. It is also unclear how publishing data about its CME activities contributes to the quality of a provider's program or that it equates with high quality education. A well written abstract could be published about a poorly designed and implemented activity. This has potential to be an unattainable goal for our society.
ACCME-accredited provider	The standard of once for every year of the term is not realistic when collecting research data. Although, ACEhp provides opportunities the amount of staff time will overwhelm most CME departments. Once every 2-3 years would be more obtainable.
ACCME-accredited provider	Given the nature of the criteria, once every year may be challenging. Suggested lowering the standard.
ACCME-accredited provider	AMIA agrees with CMSS's comments on this. In addition, we believe that requiring research publication once a year from small associations is unrealistic. We propose changing the time frame to 'once every term.' However, even with a change in time frame, this criterion does not account for factors beyond the CME provider's control, like an editorial reviewer's decision to not accept the research abstract for publication. Publication could be modified to include a poster presentation, but again, there are travel and accommodations costs that may present barriers to this kind of publication.
ACCME-accredited provider	While most medical professional societies continually assess the efficacy of CME activities and try new methodologies, these internal research efforts do not necessarily lead to publication. They can result in presentations at meetings of educational professionals at some expense to a society. For smaller societies this can be burdensome and is not a reflection of the quality of their CME offerings.
ACCME-accredited provider	While important, this seems too burdensome for CME providers with limited staff devoted to CME efforts. It seems a lot to ask to publish in a peer-reviewed journal once for every year of term. I suggest adding non-publishing mechanisms to achieve this (e.g., presenting best practices at conferences, supporting colleagues new to CME, conducting self-study or research that is not published, etc).
ACCME-accredited provider	This is not achievable across all sectors.
ACCME-accredited provider	It would be impossible for my institution to fulfill this criterion. We do not have the resources to conduct research relevant to our educational topic.
ACCME-accredited provider	define 'innovative approaches'. what qualifies as 'supporting' innovative approaches? what qualifies as 'disseminating...with our healthcare education community'?

Call for Comment Responses: Proposal for a Menu of New Criteria for Accreditation with Commendation

C32: Since you answered 'no', please explain and/or suggest edits.	
Organization Description	Comments
ACCME-accredited provider	Are there enough peer-reviewed journal opportunities available to the community to make this a viable goal? What about including other outreach opportunities, eg CE/CPD meetings or self-publishing?
ACCME-accredited provider	Does this refer to the CME staff? I am PhD and asst. faculty and do write articles, but not 6 in this time period. Other members of my staff, while very dedicated and hard working, could never do this. The level of CE staff may depend on resources/salaries etc allowed by one's institution. Some of mine only have a BA or BS degree.
ACCME-accredited provider	Need to better define the intent of this criterion. One may interpret here clinical research as 'producing data or information relevant to CME' (one of the critical element). Can better clarify in the rationale by stating '...should share best practices in CME by developing...' and rephrasing the critical elements as follows: Conducts scholarship and research in CME AND; presents peer-reviewed scholarship or research at regional and national meetings OR; publishes abstract or manuscript in a peer-reviewed journal.
ACCME-accredited provider	Perhaps the criterion should be framed as 'innovation' given that this is what is discussed under 'rationale' We believe that this should be assessed across the accreditation term.
ACCME-accredited provider	Is the expectation of publishing once per year achievable? It seems that if you are conducting quality research in year one of your term you may not have results to publish in year one. Perhaps publishing should be limited to 2-3 times per term.
ACCME-accredited provider	Does this really mean for a five year term five abstracts or manuscripts would have to be published? Abstracts seems reasonable but manuscripts can take months to even hear back, then revisions may be required, etc. Maybe instead of published, use submitted?
ACCME-accredited provider	Would the process of peer-reviewing other scholarly work count toward this criterion?
Other	Since research is a sub-domain of scholarship perhaps the wording of this standard should be "Engages in scholarship in CME including research"
Other	I really like that this is a bundled measure, and that the aspiration is publication. An alternate strategy would be to include things like presentation of posters or abstracts/oral presentations at conferences (CME Congress, Alliance, GEA meetings of the AAMC, etc) with a higher threshold for commendation. So something like '1 abstract or manuscript in a peer-reviewed journal OR 4 posters/presentations at educational meetings in each term'
Other	Despite an organization's best efforts, research could be generated but not published. Mandating at least one research publication per year places a significant additional responsibility on a CME provider's program. It is also unclear how publishing data about its CME activities contributes to the quality of a provider's program or that it equates with high quality education. A well written abstract could be published about a poorly designed and implemented activity.

Call for Comment Responses: Proposal for a Menu of New Criteria for Accreditation with Commendation

C32: Since you answered 'no', please explain and/or suggest edits.	
Organization Description	Comments
Other	Historically, medical research refers to a specific standard of research and social science research, of which education research is most closely associated, is quite different. Suggest that language be added to clarify expectations. As written I would not expect any provider without a PhD in Education, Nursing, Medicine, etc. to achieve these criteria. The term “translational” is frequently used along with “social science methodologies” for example. I would clarify with experts in academia. In my opinion, our current lack of educational research is a result of providers sensing that they could not publish their findings since they would not meet a level of evidence that is required for medical research (double blind et al) which is unfortunately been predicated on our field.
Other	We do not consider there are enough peer reviewed journal opportunities available for all providers. Suggest the addition of other CME publications, meeting presentations, other self publish opportunities, to this criteria.
Physician/healthcare professional	We are not in a University setting and publishing and conducting research is not the goal of the average hands on practitioner. They are interested in EBP but to expect them to do this on top of their over worked schedules is too much.
State-accredited provider	Who has time for this?
State-accredited provider	'disseminating the findings with our healthcare education community' is a nebulous statement. How would a CME provider measure this? Is a simple email to a few colleagues about best practices sufficient or does the standard have to be a poster presentation at a CME/CPD conference, etc.? This criterion can be interpreted too many ways and there will be too much discrepancy between providers.
State-accredited provider	Need clarification on the critical elements. What is meant by 'Conducts research relevant to CME', and 'Produces data or information relevant to CME'. Need more explanation, how would we know the research and information is relevant to CME?
State-accredited provider	We are not a teaching hospital and would be hard to rational the criteria
State-accredited provider	Does this refer to research by the CME Committee or by an Activity Director? The critical elements should be 'ORs' not 'AND'. Presents instead of publishes abstract or manuscript in a journal every 3 to 5 years. Also - how should this be funded?
State-accredited provider	Do not currently have the resources nor does it seem appropriate to do this for our 14 programs. Need to do research before publishing and that takes additional time. Need skill development and resources.
State-accredited provider	This criterion provides an economic and personnel hardship for small CME programs, since they cannot hire PhD level researchers to either head their programs or offer research consult. The element 'relevant to CME' is vague. Many hospital-based CME coordinators have other hospital duties to perform and the standard for C32 is too high.
State-accredited provider	This Criterion is meant for the larger institutions, Medical Education Companies, Pharmaceutical Companies, Universities and Medical Schools that have the financial capability to be able to do this. I think that you need to develop two different accreditations, one for the larger, well funded institutions that have a large staff in their CME Office and one for the small community hospital that only has one person in their CME Office

Call for Comment Responses: Proposal for a Menu of New Criteria for Accreditation with Commendation

C32: Since you answered 'no', please explain and/or suggest edits.	
Organization Description	Comments
State-accredited provider	Again, dollars, dollars, dollars !!!
State-accredited provider	Suggest to re-word: 'Engages in research and scholarship about or involving continuing medical education.' I think it's a high bar to suggest that providers will actually be able to 'publish'; instead, i would suggest that the critical element say that providers 'submit for publishing'. Even at that, I think once a year is too high of a bar, at least to start. I would suggest to clarify if the intent here is different than what many national providers already do who have/publish journals about clinical medicine/surgery. The research/scholarship intended here in c32 should be about advancing the field of healthcare 'education', right --and not about 'healthcare'?
State-accredited provider	Consider including in the critical elements: attend or speak at a national CME conference. Take all of the 'AND's away and replace with 'OR' in the critical elements section.

Call for Comment Responses: Proposal for a Menu of New Criteria for Accreditation with Commendation

C32: Please provide comments or questions about this criterion.	
Organization Description	Comments
ACCME Recognized State Medical Society	I think this Criterion is wonderful, for the larger hospitals and associations. Not so good for the smaller ones.
ACCME Recognized State Medical Society	IMS realizes this is one criterion within this section, however, it is the one among all of the proposed new criteria that would be impossible for our CME providers at the local level to meet. We recommend that the CME system reward providers who present at regional or national conferences as well as those who are published. We recommend the final critical element for this criterion state “publishes abstract or manuscript in a peer-review journal, or presents findings at a regional or national conference.”
ACCME Recognized State Medical Society	Modify The Standard to 'Once in each accreditation term.' Reasons for revision - in all reality, it can take 4 years just to do the research, and then having the information published in a peer-reviewed journal takes awhile too. We would be happy do this once in our lifetime!
ACCME Recognized State Medical Society	As written, this criterion focuses on organizations with professional CME staff and would not apply to our providers who would have to achieve compliance with another criterion in this group. Please consider avenues other than research or publications to meet C32. Options might include the ability to share with other providers specific interventions or modifications to educational activities that have helped a provider improve patient care or presenting at a state or local conference.
ACCME Recognized State Medical Society	This criterion as written, will most likely apply to those provider types that have more academic and/or staff and financial resources. The majority of the SMS CME providers will not be able to achieve this criterion.
ACCME Recognized State Medical Society	I dont believe the Standards represents the opportunity for all providers.
ACCME Recognized State Medical Society	This is a good criterion to encourage providers to be creative and think outside the box, i.e., not rely on lectures for all their activities. The younger generation of healthcare professionals are not learning this way and we will need to adapt.
ACCME Recognized State Medical Society	I don't see this criterion as one that a community hospital could ever hope to comply with if they need to publish in a peer-reviewed journal. Once a year may possible by Medical Schools but seems to much for any other organization type.
ACCME Recognized State Medical Society	This criterion seems to overlook sharing and supporting the CME-system at a local level, such as participating in local CME provider conferences, local or regional newsletters, or mentoring CME professionals. As written, this criterion may be best suited for a system-based or medical school provider. This criterion may be too resource intensive for providers with limited staff/resources. The standard seems high for a professional publication, but reasonable if it included practices at the local level.
ACCME-accredited provider	Our small CME Department does not have the research expertise to achieve this Criterion, nor do we have the time and resources to learn how to do it, let alone actually do it. This is for big academic institutions with personnel who understand and are trained in the research process, and are actually being paid to do it.

Call for Comment Responses: Proposal for a Menu of New Criteria for Accreditation with Commendation

C32: Please provide comments or questions about this criterion.	
Organization Description	Comments
ACCME-accredited provider	I think the standard is too high. Once for every two years is much more realistic.
ACCME-accredited provider	This is wonderful however not sure how realistic it is as my team is so busy and have limited resources. I vote yes.
ACCME-accredited provider	Seems a little esoteric for most institutions. This might explain 'once for every year of term'.
ACCME-accredited provider	This is clear, however publishing in a peer-reviewed journal every year could be extremely difficult, especially given the review times for many journals. Once every 2 years might be more reasonable.
ACCME-accredited provider	It is clear but a high standard. This would suggest that the CME professionals must publish 4 times during an evaluation cycle?
ACCME-accredited provider	In an ideal world, this criterion could be accomplished, however, given the other criterion proposed this cannot be a priority.
ACCME-accredited provider	This may have limitation to academia and difficult in clinical practice outside an institution unless one is involved with practice based research
ACCME-accredited provider	Again once for every year of term seems high--by 'forcing production' you may only get what we already have alot of which is mediocre articles alot of the time. To complete a good research paper takes time--once in a review period is probably a fine goal. You are also implying by your 'once every year' that learning from an activity would start and be completed to the point of assessment in one yr--if you are encouraging us in the previous criterion to show learning over time, do you really in the next criterion want to suggest/imply/have me infer 'but just for a yr'
ACCME-accredited provider	Frankly, we would be very surprised of any significant number of providers attempts to meet this criterion, let alone achieving it. Employers would either have to grant time during work hours to conduct this research and prepare manuscript or the individual(s) would have to do it after hours. Either way, the provider would have to grant access to its CME data and findings to the individual(s) in support of their research. If a provider has a CME team of 12 individuals and one engages in scholarly activity of this type, is this sufficient? If a manuscript is submitted to a peer reviewed publication but not accepted, by this definition it would not 'count.' The expectation of annual publication is also very unrealistic, as good quality research is a slow and careful process.
ACCME-accredited provider	This will be a hard Criteria for small CME shops to do. Staff members may only include one or two and the workload may not allow time for research and writing. However, for CME Programs that have ample staff and money, this Criteria will be excellent. It certainly will encourage research, which will add to Provider's body of knowledge.
ACCME-accredited provider	The concept of performing research is clear but it entails a significant amount of extra work and could be very difficult for many providers to complete. Also, there are many factors that could prevent an abstract from being published and an annual publication requirement makes this even less of a realistic goal for most providers. Perhaps this could start with a lower demonstration standard and the baseline could increase over time to allow providers an opportunity to learn how to incorporate this into their programs?
ACCME-accredited provider	Our resources are intended to educate pathologists and laboratory technicians. Given limited resources and our subject matter experts focus I am not sure we would consider this.

Call for Comment Responses: Proposal for a Menu of New Criteria for Accreditation with Commendation

C32: Please provide comments or questions about this criterion.	
Organization Description	Comments
ACCME-accredited provider	Including only scholarly research ultimately published in a peer-review journal doesn't recognize the effort to design and conduct CME research. Submission to a peer-review journal would accomplish the goal of recognizing a broader range of efforts, since acceptance for publication is impacted by many factors which may not have to do with the research outlined in the manuscript or article. Furthermore, would peer-review and acceptance of a meeting abstract (beyond the scope of a journal publication) also be recognized (e.g., acceptance for presentation at a ACEHP meeting)? While providers may "ignore" this Criterion, limiting contributions to purely peer-reviewed journals may only be achievable for providers with deep financial resources, and will not incentivize lesser resourced providers to try to achieve "scholarly efforts".
ACCME-accredited provider	This standard is not achievable for our organization. Once during a term might be feasible but every year – not feasible at all.
ACCME-accredited provider	This is clearly written but, despite an organization's best efforts, research could be generated but not published. Mandating at least one research publication per year places a significant additional responsibility on a CME provider's program. It is also unclear how publishing data about its CME activities contributes to the quality of a provider's program or that it equates with high quality education. A well written abstract could be published about a poorly designed and implemented activity. Plus, many are not familiar with the 'science' behind properly constructed, valid, reliable, etc research.
ACCME-accredited provider	C32: SAGES has engaged in research and publication regarding our CME efforts. However, even the best written abstract or manuscript can be rejected. This seems to be a criterion to provide the JCEHP journal with more articles, which is inappropriate. We would recommend 1 published paper or abstract per accreditation cycle as the standard, or to drop the publishing requirement altogether.
ACCME-accredited provider	We recommend not limiting the measurement standard to just publishing in a peer reviewed journal. Other formal research and scholarship such as poster presentations should count towards meeting this criterion.
ACCME-accredited provider	The critical elements are descriptive enough and there is a defined time provided. I'm not sure though that all CME providers have a publishing opportunity in a peer-reviewed journal.
ACCME-accredited provider	Publication of an abstract or a manuscript in a peer-reviewed journal may be challenging. If all CME providers did this every year of a term, conceivably there could be over 600 abstracts or manuscripts submitted for publication. What happens if a provider can't get published? What happens if a provider can get published 5 out of 6 years? The standard needs to be more reasonable.
ACCME-accredited provider	Clear as written, although research projects may be longer than a year over time, particularly if we are tracking learner change data. Recommend revising to once in accreditation term.
ACCME-accredited provider	Critical Elements should be amended to "ORs" from "ANDs." Requiring "ANDs" significantly limits the flexibility intended by the introduction of the menu structure. We believe innovation and creativity will be reduced and not all provider types will have the ability to achieve Accreditation with Commendation

Call for Comment Responses: Proposal for a Menu of New Criteria for Accreditation with Commendation

C32: Please provide comments or questions about this criterion.	
Organization Description	Comments
ACCME-accredited provider	cf comments to C30
ACCME-accredited provider	I think that the publishing should not be a mandatory requirement. Submission of abstracts for publication (with proof) should be sufficient for meeting this standard. If you feel that you have something worthy of sharing, but it is not chosen for publication, that doesn't mean that it wasn't worth sharing. Also, what about those who share within the community via other means: forums, blogs, etc.
ACCME-accredited provider	While we agree in principle, we wonder if the yearly standard is realistic. It is our experience that many want to hear of new thought and direction at plenaries at conferences. It takes a lot of time and a special skill to publish. We wonder if this criterion may not discourage a provider as it tries to develop this skill.
ACCME-accredited provider	This is clear but impossible for us to do annually. Also, what if a research project takes longer than a year? I recommend changing this to one per 4 year interval. That would still be a stretch for us but potentially more doable if we can partner with someone.
ACCME-accredited provider	i have a problem with this criterion as it assumes that scholarly work is only accomplished through publication-- I think that it should be broadened to national/regional presentations, contributions to white papers-- all of these efforts should be relevant to CME but I think that this is too narrow in scope and implementation.
ACCME-accredited provider	One for every year of term is too much - particularly for very small CME offices. One for every two years is more reasonable. For some small offices this will be out of reach due to budget constraints.
ACCME-accredited provider	Publication on a yearly basis in addition to the many other responsibilities we have is not feasible for office. It would require an additional FTE for which we would not be able to demonstrate a ROI.
ACCME-accredited provider	Educators must be involved in education and furthering our profession.
ACCME-accredited provider	As indicated previously, I question the standard.
ACCME-accredited provider	The limit of once a year is excessive. Once every 5 years is realistic.
ACCME-accredited provider	Eventually there may be more venues for publishing CME research, but at the moment there are limited venues. I suggest including presentation of research at local, regional, national or international meetings, for example, scientific posters, podium presentation.
ACCME-accredited provider	Challenging but important. Peer-reviewed journal might not be achievable by many providers. Maybe include peer-reviewed or invited presentation or poster?
ACCME-accredited provider	The criterion is clear but it should not be included in commendation criteria. I believe that the number of CME professionals who have the time and ability to engage in CME research and scholarship is small in relation to the total number of CME professionals.

Call for Comment Responses: Proposal for a Menu of New Criteria for Accreditation with Commendation

C32: Please provide comments or questions about this criterion.	
Organization Description	Comments
Other	Journal publishing is not predictable - although a manuscript may be excellent, it may not be accepted. I would recommend 1 published abstract or manuscript in a peer-reviewed journal or accepted presentation at a national society level per accreditation cycle. This will also make it easier (and more encouraging) for smaller organizations to achieve this criteria.
Physician/healthcare professional	ACCME is really raising the bar! This is going to be exceedingly difficult in most hospital systems given the current budgetary restraints.
Physician/healthcare professional	smaller hospitals don't have these capabilities
Physician/healthcare professional	as mentioned earlier, smaller organizations would likely have much more trouble meeting this criterion than larger ones
Physician/healthcare professional	This is a very worthy criterion!
State-accredited provider	Probably great for big organizations that have researchers but not for a busy and small CME department. I won't be able to use this one.
State-accredited provider	Very clear - yet unattainable for a small shop. Research and publish / share YEARLY?? This must be designed for CME departments that are very large and well supported.
State-accredited provider	I don't know whether to laugh or cry. Many if not most hospital CME staff' myself included' don't have any educational background or interest in scholarship in continuing education. If we are going to do research it will be in our professional background. Maybe you should be looking at licensing CME managers and requiring what you want. Many of us got stuck with CME as a responsibility to work on when we have time from our real jobs.
State-accredited provider	We vote to have the Standard be: 'Once since last Accreditation'
State-accredited provider	this is much easier to do in the large CME offices, but this will be difficult to do in the one man pony shows
State-accredited provider	I feel this is a more appropriate 'standard' across the board for the commendation criteria.
State-accredited provider	My CME director doesn't have the time to publish abstract or manuscripts. These extra criteria are very time consuming and I don't see it happening unless we can get more FTE's, unfortunately we are all being asked to do more with less so I don't see that happening.
State-accredited provider	Modify standard to once in each accreditation term.
State-accredited provider	This is one of the few commendation criteria I find doable.
State-accredited provider	It would be great if you would have something to include those that do the work - but do not publish. Maybe present at a Statewide or national meeting? I realize this is to reward the best of the best but sometimes great work is done in the education world without the support of your institution so the methods would not meet publication criteria.

Call for Comment Responses: Proposal for a Menu of New Criteria for Accreditation with Commendation

C32: Please provide comments or questions about this criterion.	
Organization Description	Comments
State-accredited provider	Highly unlikely to be possible in a resource strapped community hospital setting.
State-accredited provider	How would credit be awarded. Would it be awarded for articles accepted for publication in peer-reviewed journals, poster presentations at national meetings. Need MUCH more clarification
State-accredited provider	The publication process is long and is not guaranteed. Once a year appears excessive.
State-accredited provider	None
State-accredited provider	This is a requirement that can only be fulfilled by academic institutions. Again, it is not funded or resourced in the majority of existing CME programs.
State-accredited provider	Will not happen on community level. It will be done at the academic level, but not because you try to establish authority in this area.
State-accredited provider	If CME department has a limited staff resources, the critical element of publishing and the annual standard is a challenge.
State-accredited provider	Talked about several possible projects with the now retired Director of Research. His position has been moved to St. Louis, so help is no longer available. This would also require travel and there is no travel budget for any department, and hasn't been for years.
State-accredited provider	Nice idea but again...criteria geared toward large institutions or academic institutions.
State-accredited provider	Once every year of term is too high. I think that should be cut in half
State-accredited provider	Another unattainable for most providers--more directed to those in academia.
State-accredited provider	This standard is quite reasonable. I would argue that for most of the criteria a number per year of terms (i.e. 1-5 programs per year) would be better than >25% or > 10 % of activities/learners
State-accredited provider	Research and publishing is not in the realm of what we can do.
State-accredited provider	Again, an extremely elite criterion. Very few providers are researchers.
State-accredited provider	This criteria will only be achievable by certain providers with large staffs and able to do research to monitor data and information presented.
State-accredited provider	Where is the time to do all this?
State-accredited provider	We are in the process of doing exactly this for Burnout and wellness.

C33: Engages in continuous professional development as educators.

C33: Since you answered 'no', please explain and/or suggest edits.	
Organization Description	Comments
ACCME Recognized State Medical Society	Unable to assess. Inadequate and/or deficient methodological evidence of validity, reliability and application practicality of process. Details upon request. E.g. lack of evidence this criteria should carry same “weight” as any other and is mainly exclusive of other criteria to avoid double weighting. Applicability and importance depends on nature and scope of provider. See comment for #32. Provider is more than CME program. Why not credit for CME providers who develop enhanced QI, informatics or population management skills?
ACCME Recognized State Medical Society	While this would be ideal, I know about half of my providers could not achieve this due to lack of support from C suite. To engage in continuous professional development would mean attending workshops/conferences ... something more than an occasional webinar. Always comes down to who pays for it? And if CE staff can afford to be out of the office for 1/2 day or all day?
ACCME Recognized State Medical Society	- What is the CME team? The planning committee? The faculty? - Are external activities to be provided by a separate entity? What if the budget doesn't allow for this.
ACCME Recognized State Medical Society	This criterion doesn’t represent the opportunity for all provider types equally. It appears to be designed for specific types of providers. A SMS might not be able to meet this criterion. Critical Elements: - Better if allowed for this OR that, instead of this AND that. Small providers with one person CME office or part-time staff may not be able to address this criterion. The Standard: - ?50% of the CME team in external activities annually – ?50% too high. Also, annually and for external activities should not be a requirement.
ACCME Recognized State Medical Society	Who is the CME Team? This Criterion is not clear to the smaller hospitals. What is meant by the 'domains'? And, the % is very very high. More detail is needed.
ACCME Recognized State Medical Society	Define “external” activities. Would attending an accreditor webinar or other event count toward demonstrating compliance with this criterion?
ACCME Recognized State Medical Society	In terms of the standard, there should be flexibility in terms of the definition of the CME “team”, as well as the ability to participate across the accreditation period. Why not allow internal training to count as team could participate in facilitated training together? We endorse the continuous development of our staff. However, it must be recognized that the complement of CME staffing varies within and across provider groups. We would hope that there would be flexibility in the assessment of this criterion in terms of types of activities in which the staff would be engaged as well as the roles involved. We have accredited provider organizations that don’t currently provide financial support for even 1 staff member to attend external training on an annual basis.

Call for Comment Responses: Proposal for a Menu of New Criteria for Accreditation with Commendation

C33: Since you answered 'no', please explain and/or suggest edits.	
Organization Description	Comments
ACCME Recognized State Medical Society	Lots of employee turnover in CME departments in SMS accredited providers. Also, % of the standard is not a good idea for any Criteria; this will be too complicated to calculate. Providing multiple examples for a Criteria should be sufficient for a compliance finding.
ACCME Recognized State Medical Society	Please clarify what constitutes the CME team; and please clarify “external” activities. Should change to “Key people e.g. staff and chair of a CME committee/office” or something similar. Some of our providers have CME committees that are quite large and diverse. In many cases, a single hospital has several mini CME teams from various departments that include CME coordinators and the department chair. Will this be defined as the CME team in its entirety? CMS agrees with a criterion that requires CME professional development. However, 50% of a CME team traveling to external functions seems arbitrary and capricious, and will be impossible financially. Also, the number of CME team members can change from year to year, given the turn over and organizational staffing changes. Difficult for accreditors to measure.
ACCME Recognized State Medical Society	Define the CME team. Define what 'participated in CPD in domains relevant to the CME enterprise' entails. Does reading relevant articles and information, but not participating in formal activities qualify? If a provider is able to comply with accreditation standards, it is necessary for them to participate in CPD in domains relevant to CME? I would eliminate this criterion.
ACCME Recognized State Medical Society	What is the definition of the CME Team, those employed by the organization or volunteers too? In our case, does that include volunteer committee members?
ACCME Recognized State Medical Society	Can reading ACCME transcripts and reviewing ACCME video FAQ's be considered external activities? Would like to see you incorporate the CEO of the organization into this criterion as part of the 'team'.
ACCME Recognized State Medical Society	Which individuals are included in the 'CME team'? Is this only employees/volunteers or does it include joint providers? Would learning needed to report on best practices (C32) count for this criterion? The standard seems reasonable if it includes employees/volunteers of the CME provider, not joint providers.
ACCME-accredited provider	What constitutes 'half' the CME team? What is the scope of the CME team to be included here? Is it the CME staff in the central CME office? The CME faculty in every department who plan RSS's, for example? Is it any faculty member that serves as a planner of content for annual symposia plus all of the above? This element is overly ambitious and needs to be rewritten. The standard is excessive as well.
ACCME-accredited provider	C33 Concern about the critical elements and the standard. What's a “CME Team?” One can envision some providers ‘gaming’ who they define as members of this team in order to get an acceptable result for this criterion. Why does the standard require ‘external activities’? There could be a variety of internal strategies that might be as or more useful than attending external activities. This standard reinforces metrics of participation rather than learning or improvement.
ACCME-accredited provider	Who is included in the CME team? What is the difference between the CME team and the CME professional?

Call for Comment Responses: Proposal for a Menu of New Criteria for Accreditation with Commendation

C33: Since you answered 'no', please explain and/or suggest edits.	
Organization Description	Comments
ACCME-accredited provider	What is meant by the 'CME Team'?
ACCME-accredited provider	Again, I think the standard is too high, particularly for smaller organizations. Does this apply to everyone working in CME? What about administrators who manage data entry?
ACCME-accredited provider	What about 'credit' for internal professional development. We do monthly education on CME accreditation topics in conjunction with external education.
ACCME-accredited provider	Is this meant to address members of a CME committee and to assure that its members are up-to-date on CME requirement?
ACCME-accredited provider	What counts for external activities? Webinars? Alliance meeting? Or do the CME professionals need to take the CHCP certification?
ACCME-accredited provider	I do like this criterion assuming the requirement is NOT that the CPD only consist of external in-person meetings, which may be difficult for providers to comply due to budget limitations. If participation in external webinars, reading relevant published articles, etc. will be counted towards compliance, then I feel this is easily achievable by all provider types. What documentation would be required to demonstrate compliance (attendance certificates? webinar receipts/meeting invitations?)? Would it be considered compliant if 1 team member attends an in-person external meeting and then brings the information back to the team and trains the rest of the staff (and the training was documented in meeting minutes)?
ACCME-accredited provider	I am not for sure when you say half of the CME team who is considered the CME team. Is that program planners, CME committee, CME department, etc.
ACCME-accredited provider	Who are considered the 'CME' team?
ACCME-accredited provider	This criterion is self serving to the profession and is highly subjective in what qualifies as 'relevant: to the CME enterprise. In addition, this can be very costly too an organization and may be out of their reach, either because they struggle financially or have many staff. More importantly, depending on their role and the type of organization, individuals may benefit from professional development in clinical areas, in management, or in other areas that are not traditionally CME so who will determine what is 'relevant' to the CME enterprise. I recommend this criterion be deleted or reevaluated in terms of the Standard.
ACCME-accredited provider	Please further define team.
ACCME-accredited provider	Clarification in what is meant by CPD would be good. Maybe this would become clear if published (or presented in webinars etc.) examples.
ACCME-accredited provider	Must all critical elements be present in each year (referring to use of word "AND")? Who is included in the CME team? Administrative, project managers, only people involved in content and accreditation? Larger the team, the more difficult it will be to achieve this criterion.
ACCME-accredited provider	We endorse this criterion; however, we suggest the ACCME be flexible in terms of the types of staff activities engaged, the definition of the CME "team", and the ability to participate across the accreditation period.

Call for Comment Responses: Proposal for a Menu of New Criteria for Accreditation with Commendation

C33: Since you answered 'no', please explain and/or suggest edits.	
Organization Description	Comments
ACCME-accredited provider	Is the CME team the paid organizational staff or the volunteer member CME committee members. If it includes the latter it is a huge expense for a small or medium sized professional society. IF ACCME is marketing these courses, you have a conflict of interest.
ACCME-accredited provider	I work for a medical specialty society. Please clarify the 'CME team'. Does this mean anyone in a position to affect the content, such as our physician member volunteers or would does this mean the education staff of the medical specialty society?
ACCME-accredited provider	Please clarify if the CME provider is able to define 'CME team' and determine its composition. Also, please confirm expectations, if any exist, related to those activities team members can participate in to meet this criterion. For example, the Standard notes 'external activities.' As such, would this exclude attendance at the in-house faculty development workshops we provide on writing learning objectives, curriculum design, best practices in lectures, adult learning principles, etc? What are 'domains relevant to the CME enterprise'?
ACCME-accredited provider	Not clear who is included in the CME team. Full time employees? Committee members? Planners? Chairs? Faculty?
ACCME-accredited provider	Who constitutes the 'CME team'? If this includes all of the volunteers who participate in the oversight and planning of the CME program in a specialty society it is financially impossible for us to send over half of this group to CPD in education. Also, practicing physicians participating in the CME program may not have the time to pursue this kind of professional development even if they wish. This criterion, as written, seems to benefit academic centers who would have in-house opportunities to provide these kinds of professional development offerings. Please consider the logistics of carrying this out in other settings.
ACCME-accredited provider	It isn't clear who would be classified a part of the CME team (just association staff or volunteer helpers as well). Requiring 50% of our nearly 50+ volunteers wouldn't be sustainable (too many financial/time requirements).
ACCME-accredited provider	What is the definition of 'CME Team'? Our staff engage in this type of professional development, but what other team leaders would be required?
ACCME-accredited provider	Who is part of the CME team - staff? program planners? If program planners are also considered part of the team, this requirement will become very expensive for us since we will be required to provide CPD for at least 25 planners (staff and half of the program committee). In addition, not all of our program committee members are physicians since we are a multidisciplinary organization. It is possible that there might be a year or two when less than half of the members on the program committee are physicians, so we would not be able to achieve this criterion.
ACCME-accredited provider	C33: This criterion is not clear. Who is the CME team in a specialty society? We have hundreds of planners that review abstracts, as well as many staff members who are involved in small pieces of the logistics of educational activities. We do applaud this criterion and we would recommend it's inclusion, however we would suggest that the description be broadened to include internally offered CPD (ie provided by staff to staff.) We would suggest the CME team be narrowed to include the lead planner for the organization (i.e. CME Committee Chair), and staff who spend the majority of their time working on education (i.e. Education Department staff).
ACCME-accredited provider	1. RATIONALE and THE STANDARD: ACCME may want to define 'CME Team'

Call for Comment Responses: Proposal for a Menu of New Criteria for Accreditation with Commendation

C33: Since you answered 'no', please explain and/or suggest edits.	
Organization Description	Comments
ACCME-accredited provider	Define the “CME Team” (e.g., admin staff, managers, directors, physician volunteers). The Standard assumes that education of “CME team” can only occur via external activities. Organizations develop educational materials/professional development activities for staff and leaders, joint providers, etc., because they have the expertise to do so and it is cost effective. The Standard should be expanded to allow for education via internal activities. Would compliance include formal (e.g., attending meetings – ACCME, ACEhp, SACME, etc.) and informal (e.g., journal club discussions) CPD activities? Is there a minimum length of time for the external activities (i.e. 15 minutes, 1 hour, half day, etc.)? How will compliance with this criterion be documented? Will providers need to provide copies of external activities’ programs?
ACCME-accredited provider	A definition of the 'CME Team' is needed to determine if this is achievable. The ACR encourages its members to volunteer to participate in the CME program, it would be impossible to send half of that extended group of volunteers to external professional development activities.
ACCME-accredited provider	What is meant by CME team?
ACCME-accredited provider	While we support the idea of CPD relevant to the CME enterprise, how is 'the CME team' is defined? We have a subcommittee of 6 physicians and a committee of over 25 physicians. ASH has one activity that is planned by a committee of 65+ physicians; are all of them on the “team.” If so, requiring that at least 50% of the “team” participate annually in external activities is unreasonable, given limited time and resources. We support this criterion if the team is narrowly defined or an absolute number of persons engaging in CPD is the standard rather than a percentage.
ACCME-accredited provider	What is defined as the “CME team”? Is it just staff, is it staff and committee members? If the “CME team” is one person, is that sufficient?
ACCME-accredited provider	How does the ACCME define the CME team? Is it all staff who touch CME planning? Is it key lead staff? Does it include physician CME planners? Are there specific recommendations about the organizations that offer the CME development? How do you define “relevant domains”? Suggest not moving forward with this criterion until CME team and domains can be better defined, and even then the standard is too high.
ACCME-accredited provider	AMIA agrees with CMSS: 'A definition of the 'CME Team' is needed to determine if this is achievable. In membership organizations, in which members often volunteer to participate in the CME program, it may be impossible to send half of that extended group of volunteers to external professional development activities.' AMIA also believes 'external' requires more definition. Is online independent study with a presentation to colleagues acceptable? Would a MOOC on a CPD topic be acceptable?
ACCME-accredited provider	This criterion seems quite arbitrary and not based in evidence.
ACCME-accredited provider	The critical elements are too stringent.

Call for Comment Responses: Proposal for a Menu of New Criteria for Accreditation with Commendation

C33: Since you answered 'no', please explain and/or suggest edits.	
Organization Description	Comments
ACCME-accredited provider	What is meant by the CME team? We have a core group of employees who write and oversee the program - these get plenty of CPD. We also have our interprofessional committee which we do not provide education for the non-employees in the group. We also use contracted medical writers and national experts which we do not have any control over. Is the team just the core group of employees who write and oversee the CME program?
ACCME-accredited provider	Does this include webinars or other online learning? Our resources are thin--so that only one of us (and it is generally the Director) can attend one meeting per year. They could take the CCPD exam but most do not have the credentials to pass the eligibility piece. This could be a big problem even for bigger departments with few funds for travel and study.
ACCME-accredited provider	Need to define what is meant here by CME professionals. Are we referring to all those engaged in the teaching of CME activities who should all develop their skills as educators or only to members of a CME Office? If the latter, then the criterion should be clarified to address this group rather than all CME educators: 'CME professionals should engage in continuous professional development'. It would be good if we we could emphasize also here the need for accredited providers to be engaged in the development of educators so that we can enhance the overall quality of CME and application of best educational practices that lead to behavior change and improved learners outcomes.
ACCME-accredited provider	Can 'topics relevant to the CME function' be defined with examples? Would courses in meeting planning or grant writing meet this requirement? This is a really nice addition to the criteria as it is something that all CME providers will value and will help to show leadership that we need additional funding to support the development of our teams.
ACCME-accredited provider	The ACCME needs to define what is meant by CME 'team', as many staff members may not be functioning as educators but rather providing logistical services such as conference management. The criterion should be assessed across the term, should not include a %, and should not be limited to external activities (given that many institutions have considerable internal resources for staff development and education, e.g., a staff member pursuing an advanced degree in education in their own institution).
ACCME-accredited provider	What constitutes 'CME Professionals' and how are they being defined? For example, would CME management be considered CME Professionals, and would be coordination, registration, etc. be included in this definition? Domains relevant to the CME enterprise may be ambiguous. Does the provider ultimately determine the topics they believe to be relevant to CME for continuous professional development? Define 'external activities.' Would this include Hopkins as an institution or the office of continuing medical education specifically?

Call for Comment Responses: Proposal for a Menu of New Criteria for Accreditation with Commendation

C33: Since you answered 'no', please explain and/or suggest edits.	
Organization Description	Comments
Media	What makes anyone believe that the letters 'MD' after a DME's name mean anything in terms of educational expertise?? What coursework in pedagogy is required of CME professionals in the Directorship role? Without setting the entry bar, the rest of this is meaningless fluff.
Other	This is not at all clear. Who is the CME Team? 50% is too high. Why do the activities have to be externally provided if the internal team has the ability to appropriately educate the team? This is a great idea but poorly executed. I would recommend a standard of participation in 1 activity annually by the lead planner and staff primarily dedicated to education.
Other	I understand the intent here is to be flexible about what modes of CPD are utilized (as it should be). Are there any things that would be 'iffy' in your eyes? For example, it might be confounding every day operations for folks to say that every one of their CME team meetings is inherently a CPD opportunity without defining what would be needed to have that count. Similarly, are there there any members of the team who you would not want to require to be in the denominator? For example, a part time admin who is truly performing only admin functions?
Other	A definition of the 'CME Team' is needed to determine if this is achievable. In membership organizations, in which members often volunteer to participate in the CME program, it may be impossible to send half of that extended group of volunteers to external professional development activities.
Other	Remove word "external" from standard and change to ...CME team in CPD activities... If the goal is to only consider 'external CPD' then you would need to add language to critical elements to clarify that the learning should be external or from a source external to the organization. Could a provider bring CPD in-house to avoid travel costs for the team? Also anticipate FAQ's about definition of CME team (part-time staff? MD volunteers? what about other disciplines who participate such as nurse educators helping with interdisciplinary education planning?)
Other	This criteria may become very burdensome for smaller CME units as it will require resources and time. May be useful to define who are the 'CME professionals' within an organization otherwise larger organizations may not achieve as they did not define all staff as CME professionals. Internal educational efforts within an organization should also be included as demonstrating compliance of this criteria.
Physician/healthcare professional	25% is a reasonable number for a small CME committee. To expect 50% when the committee may only have 2-3 physicians is too much on an annual basis.
Physician/healthcare professional	much too vague
State-accredited provider	Several of our attending's present at clinical rounds. This is not part of their job description. Does this count or is it outside presentations. Clarify what is 50% of the CME team.
State-accredited provider	Again, this criteria will be difficult to meet for hospital CME office of 1 person. What will this look like for the CME office with limited resources and budget? How will these CME/CPD offices be able to demonstrate commendation?

Call for Comment Responses: Proposal for a Menu of New Criteria for Accreditation with Commendation

C33: Since you answered 'no', please explain and/or suggest edits.	
Organization Description	Comments
State-accredited provider	I haven't seen CME managers defined as a profession. Much of the work is clerical and enforcement. In the two years since this was added to my work I have seen very little available for 'education' and what little there is was of little use. Lot of opinions and not much agreement among educators. do we need education to ask 'what will the accept as compliant with criteria XX?'
State-accredited provider	Too vague.
State-accredited provider	Please expand on what topics are relevant to CME function...
State-accredited provider	CPD needs much more explanation as it relates to this specific criterion.
State-accredited provider	What constitutes the CME team. The immediate department (Director, Manager, Corrdinator)? The Education committee? Depending on what constitutes the team the 50% may or may not be doable based upon team member numbers and financial implications to pay for CPD, conference etc.
State-accredited provider	Don't understand what this entails. Is it that the CME team participates regularly, takes outside courses? Don't understand what continuing professional development is as it relates to providing CME in a community hospital. Need some examples or better description for both surveyors and CME chairs.
State-accredited provider	Why does this apply to external activities only?
State-accredited provider	Clarification of who is on the "CME Team". Would that be the provider CME Committee (i.e. the Clinical Education Team)? Does participation equal (1) instance of CPD per year? How would this be tracked? Does it have to be external? We offer professional development within our own institution.
State-accredited provider	How do programs with little to no budget accomplish this criterion? Is it the CME Committee or the CME staff or both? Could members who have educational expertise with advanced degrees in teaching provide education or does it always have to be external. Does that include online education?
State-accredited provider	The rationale needs further clarification. What is an acceptable CPD development, i.e. Does attending ACCME or State level accreditation meetings meet elements? or does one person have to be in classes to become certified? This criterion puts an extreme hardship on small CME program budgets, since most CPD webinars or external activities have fees attached and not all CME programs have a budget to purchase membership in the Alliance for Continuing Education in the Health Professions. Also, many hospital based CME programs personnel have high turn-over rates. This minimizes meeting the 5 year criteria for their personnel seeking certification status.
State-accredited provider	Where does one go for the training? The hospital will not pay for my team to attend these I attend my yearly DME Conference at the State Medical Society and also the yearly Alliance for CME Conference of which the Medical Staff pays for me to attend. I also go to the ACCME and Massachusetts Medical Society's website for any updates
State-accredited provider	Please define team- CME staff employees only or would it include CME planning teams/committees?

Call for Comment Responses: Proposal for a Menu of New Criteria for Accreditation with Commendation

C33: Since you answered 'no', please explain and/or suggest edits.

Organization Description	Comments
State-accredited provider	Is 'CME Team' defined as the Hospital employees involved in the CME program or all planners and members of the CME Committee. It would be nice if the ACCME would provide 'enduring materials' for those of us who are not able to get away due to time and/or budget constraints. I personally love and use the videos on the ACCME website. It would be nice to have some verification of my participation/viewing/using those.

Call for Comment Responses: Proposal for a Menu of New Criteria for Accreditation with Commendation

C33: Please provide comments or questions about this criterion.	
Organization Description	Comments
ACCME Recognized State Medical Society	I feel this criterion will enhance providers' expertise and performance. I completely agree. Could your seminars or the ones I give for them to understand accme or update them be considered to comply with criterion?
ACCME Recognized State Medical Society	Who is considered part of the "CME team?" Does this include the committee members, and anyone associated with the CME program, or is it the CME staff that is actually conducting the day-to-day tasks related to the CME program? Can these professional development opportunities be done internally? For example, a staff member attends a national or regional CME training, and then takes that information and does internal training with the remaining members of the "CME team."
ACCME Recognized State Medical Society	The Standard - revise to include internal activities as part of the 50%. Reasons for revision - CME Managers may attend an external conference and then present the key points/information learned to CE staff, CME committee members, etc. Unfortunately, and in all reality, funding for education is cut when healthcare budgets are tight. Define CME team. 50% annually is too high.
ACCME Recognized State Medical Society	We hold one provider conference each year that would allow providers to achieve compliance unless the date conflicts with another organizational initiative, vacation, etc. This criterion would encourage us as an accreditor to expand our training by offering shorter, mid-year trainings, webinars, and so on. Could this criterion include completion of exercises (similar to those the ACCME has developed for accreditors) that the CME team could complete and submit as proof of CPD?
ACCME Recognized State Medical Society	Though we applaud this criterion, it would be help for the ACCME to further define 'CME team' since the majority of our providers are a one-man/woman team.
ACCME Recognized State Medical Society	Suggest that the Standard include internal AND external activities.
ACCME Recognized State Medical Society	The criterion is clear as written and this is one of the new criterion that we would consider to be mandatory for providers. The use of the word "AND' in the critical elements remains a concern. Depending upon the definition of the term 'CME team' this may not be reasonable, does this include the CME coordinator and the full CME Committee? We encourage participation by the CME coordinator and DME.
ACCME-accredited provider	How many activities annually for the team members? We have 1 Director, 1 CME Coordinator and 1 Administrative Assistant. Our hospital will only pay for the Director to attend 2 conferences/year. We will have to get the other CPD from web-based activities, but it would be helpful to know if the CPD has to be sanctions by the Alliance, ACCME or SACME in order to be counted.

Call for Comment Responses: Proposal for a Menu of New Criteria for Accreditation with Commendation

C33: Please provide comments or questions about this criterion.	
Organization Description	Comments
ACCME-accredited provider	'Half the CME team' may not be feasible for smaller providers. And, depending on the roles that those team members play, may not even be appropriate. A CME 'team' at a hospital, for example, might consist of one full-time CME professional and two clerical staff members who are responsible for the administrative details. Two of the 3 in this scenario would have to attend 'external' CPD activities relative to CME, but it may be much more effective for the CME professional to go to these CME CPD activities and then filter out what the admin staff needs to know and educate them just on those items.
ACCME-accredited provider	50% of team every year might be too much to expect, particularly if most of your CME team is practicing physicians. Every other year might be more realistic.
ACCME-accredited provider	A few years ago, I would have been pleased to utilize this requirement as justification to send half or all of my 6 managers to external education events for CME providers/educators. However, the financial climate has shifted in the past one year, making it highly unlikely that even one of our leaders will be able to attend. Additionally, with 17 people on staff, 50% requirement is out of reach.
ACCME-accredited provider	This could be a financial challenge for any CME operation. We have creatively accomplished this because we work for a large institution that enables us to take advantage of low-cost professional development opportunities. We continually review the ACCME® website as well as other related organizations to ensure that we are current with the standards and are executing our duties to the best of our abilities. While not quantifiable, this continuous review is invaluable.
ACCME-accredited provider	This continuous professional development should include the development of literature search and assessment skills, in support of medical research.
ACCME-accredited provider	Good idea but too high a percent and 'annual' requirement. Many CME staff wear multiple hats and can't commit this kind of engagement. This doesn't make the provider unworthy, necessarily.
ACCME-accredited provider	It may be difficult for more complex organizations to determine who should be included in this 'CME team' definition, so this criterion may be much more easily achieved by smaller providers? Additionally, should faculty/planners also be considered for CPD in their role as medical educators?
ACCME-accredited provider	This Criteria will encourage CME professionals to keep their skills current.
ACCME-accredited provider	It seems that the standard states the CPD should be from an external source. We would consider this if we could provide education. That we can afford. External education for over 50 percent of the team could prove to be very expensive. Can you work on defining what is the CME Team. Again, we have 350 courses. Is the team our internal staff which is 37 individuals. Is it our committees. Is it our subject matter experts.

Call for Comment Responses: Proposal for a Menu of New Criteria for Accreditation with Commendation

C33: Please provide comments or questions about this criterion.	
Organization Description	Comments
ACCME-accredited provider	The Society applauds the recognition of CPD of the CME team. However, there are some specifics within the Standard which may unfairly reward only some providers. For example, 50% of the CME team for some providers is quite large; therefore, the expense incurred by those providers to attend external activities is much higher than that incurred by a smaller CME office. It is also unclear why internal educational opportunities would not be recognized. As written, this Criterion would not recognize a provider for providing education to its own staff through in-house or external experts. This is very limiting, appears to benefit only providers with deep financial resources, and doesn't recognize local learning, which, at times, is the most appropriate and impactful education possible.
ACCME-accredited provider	Though laudable and desirable, under current conditions, our organization would not be able to achieve this standard.
ACCME-accredited provider	Would encourage ACCME to align this effort with the Alliance's CCHCP certification process and designation.
ACCME-accredited provider	I have no issue with this as written for the most part and I feel this is easily achievable for my organization because we already do it. That said, for some, you may want to clarify exactly what is meant by CPD. Could viewing a webinar count? In adult education, some unstructured activities are being viewed as continuing education (i.e. internet searches and viewing online videos, etc).
ACCME-accredited provider	We believe the intention is that CPD should be formal, not just external. Some internal training programs are very robust and should count towards meeting this criterion.
ACCME-accredited provider	C33: Half of the CME team must engage in professional development. How many CME credits? Needs more detail in the criteria. This is >50%... I think this is a very generous...
ACCME-accredited provider	We recommend the ACCME provide parameters or identify acceptable types of continuous professional development activities (e.g., in-house training; ACCME trainings) that demonstrate provider compliance.
ACCME-accredited provider	A definition of what constitutes CPD activities or examples may be needed. Some may consider attending a single 1-hour group webinar where the attendees have no choice in the topic to be sufficient CPD, where others may interpret this as attending a yearly meeting.
ACCME-accredited provider	My guess is that this is quite futile. A mandated team effort of this sort outside of academe is unlikely to be a menu choice. Of all the many surveys in which I have been involved, I can recall only one with personnel and resources to carry out this mandate.
ACCME-accredited provider	Agree
ACCME-accredited provider	Have you considered structured staff development within the provider organization as part of this process? I think that the certification of CE Professionals is a great option as well but want to be sure that if we provide our staff with educational courses at our home institution, have staff retreats or other similar activities that these also contribute to this criterion.
ACCME-accredited provider	There are numerous options for professional growth and development. This is critical for CME! If part of our job is making sure physicians learning continually to meet their license and MOC requirements as mandated we too should actively be engaged in learning.

Call for Comment Responses: Proposal for a Menu of New Criteria for Accreditation with Commendation

C33: Please provide comments or questions about this criterion.	
Organization Description	Comments
ACCME-accredited provider	As indicated previously, I question the standard.
ACCME-accredited provider	Our university has frozen travel budgets/funds for the last 8 years. To go to one meeting a year is too frequent and would disqualify me automatically from accreditation with commendation. Once every 2-3 years is realistic.
ACCME-accredited provider	Please clarify the types of positions that qualify for the CME team - for example, some providers CME departments include finance, operations, logistics, marketing and other functions. Would they be included as the CME team or does this apply only to those positions that are engaged in educational planning, development and compliance processes? Please provide definition of external activity? Would participating in one webinar annually fulfill this requirement. If no, the standard of 50% or more of the CME team participating in external activities on an annual basis may be high.
ACCME-accredited provider	CPD is encouraged by many organizations and I think that 50% of the CME team is reasonable but NOT every year. Most organizations do not have the resources to support this. Further, I believe that we do not currently have enough CPD choices for the varying levels of CME professionals.
Physician/healthcare professional	not possible at our hospital
Physician/healthcare professional	ditto above. many CME providers I know do not have a 'CME team' but rather a group of administrators who oversee CME among dozens of other responsibilities. were they required to participate in CPD in each of their job functions, they would scarcely have time to do their jobs!
Physician/healthcare professional	This seems like a worthy criterion but I can see how implementing this criterion might be very onerous for CME providers to accomplish. Plus, once yearly may be too much. I think 100% of CME team once per accreditation term is sufficient.
State-accredited provider	Yes! I think I can meet this one. Wish there were more like this.
State-accredited provider	Clear and do-able! Thank you
State-accredited provider	We vote to have the Standard be: No less than 10% of the CME team participate in external Activities annually. We would like to define our 'CME team' ourselves. (PS: We would like our State Medical Society to grant CME credits for participation in the Update educational activity our State Medical Society presents each year.)
State-accredited provider	Standard of 50% can be unrealistic and unworkable for many CME programs
State-accredited provider	The question will be: Who is the CME team? Paid CME staff or committee volunteers, etc?
State-accredited provider	Have some questions on this one. What do you consider the CME team? We would not be able to do 50% off site
State-accredited provider	None
State-accredited provider	We do this internally for our teams with experts brought in so this would be doable for us if we could include this as part of the criteria.

Call for Comment Responses: Proposal for a Menu of New Criteria for Accreditation with Commendation

C33: Please provide comments or questions about this criterion.	
Organization Description	Comments
State-accredited provider	I do not believe that the majority of committee members will enroll in courses that address only methods of education, unless perhaps it is funded by the ACCME. Most members, if not all, have other professional responsibilities.
State-accredited provider	\$\$\$\$
State-accredited provider	There has been no travel budget for several years and I don't think there will be in the future. We have had trouble getting and keeping enthusiastic CME Committee members. I educate myself as to adult education theory and would love to do more, learn more, take more classes, but my options are limited and I don't think most of the CME Committee would take the time to educate themselves. Those who are passionate about CME will educate themselves, but not those stressed for time. Wish the ACCME would educate hospital administrators as to the importance of CME.
State-accredited provider	Good one...promotes keeping current and learning in the profession. I go to meetings annually and it is amazing on a local level how many attendees are completely new to CME.
State-accredited provider	Members of the CME committee do this on a volunteer basis. Asking 50% of my committee to do this annually is asking a huge time commitment.
State-accredited provider	I think this is a good thing to include in the criteria. I wonder how clear it is who exactly would be included in the 'CME Team' of a particular organization (eg., is it only those that are actively engaged in the planning or does it also include teachersand what about support staff and what defines a support staff) since it seem the ACCME is looking to determine that at least 1/2 of them attended. I think both planner and faculty development could be an important aspect of this criterion. I would suggest that the provider also somehow summarize the 'outcome' of the educational trainings, so that the ACCME does not reward only the 'attendance' at these events, but also expects the provider to implement strategies and improve itself as a result. I would suggest removing the requirement that the training be done 'external' to the provider's own organization. Both internal & external can be valuable. Mentoring programs & engagement with org leadership can also be rewarded here.
State-accredited provider	This is not realistic with the budget constraints of CME in Healthcare Systems. Consider taking the 50% away and saying one person from the CME Team. Please further define 'Team'. Take the 'AND' away and replace with 'OR' in the critical elements section.
State-accredited provider	>50% too high! Perhaps if you worded this around RN, MD, PharmD educators, this makes sense. We include many people in the organization on our committee to have robust representation but some of them are technical folks, community advocates, administrative staff whereby this would not apply. Focus on a meaningful number rather than unrealistic expectations for us please!!
State-accredited provider	This is an important addition to the criteria.
State-accredited provider	THANK YOU!
State-accredited provider	Although Criteria is well written the standard still presents problems on the provider's ability to make this happen. There will need to be a compendium of examples given to know what would be examples of compliance and non-compliance.

Call for Comment Responses: Proposal for a Menu of New Criteria for Accreditation with Commendation

C33: Please provide comments or questions about this criterion.

Organization Description	Comments
State-accredited provider	Again, an Utopian idea!!
State-accredited provider	Reasonable criteria.

C34: Creates collaborations with other organizations to more fully achieve healthcare goals.

C34: Since you answered 'no', please explain and/or suggest edits.	
Organization Description	Comments
ACCME Recognized State Medical Society	<p>This criterion doesn't represent the opportunity for all provider types equally. It appears to be designed for specific types of providers. A SMS might not be able to meet this criterion.</p> <p>Critical Elements:</p> <ul style="list-style-type: none"> - Better if allowed for this OR that, instead of this AND that. Small providers with one person CME office or part-time staff may not be able to address this criterion. - What is meant by "meaningful and measurable collaboration?" <p>The Standard:</p> <ul style="list-style-type: none"> - ?10% of activities – ?10% too high
ACCME Recognized State Medical Society	<p>Unable to assess. Inadequate and/or deficient methodological evidence of validity, reliability and application practicality of process. Details upon request. E.g. lack of evidence this criteria should carry same "weight" as any other and is mainly exclusive of other criteria to avoid double weighting. Applicability and importance depends on nature and scope of provider.</p> <p>Not mutually exclusive of several other criteria that address membership inclusion with potential to count same attribute twice or more.</p>
ACCME Recognized State Medical Society	Clarify what is meant by "measurable" collaboration. What would be acceptable measures of collaboration?
ACCME Recognized State Medical Society	Although I like what I feel it means, I will need examples for a better understanding of it. It may be easy to comply with, but in our environment, most likely will vary from society to society and from president to president on both parts. Is not easy to work with people...
ACCME Recognized State Medical Society	<p>What is meant by meaningful? Does the term "collaboration" refer to external organization only or are internal collaborations acceptable?</p> <p>We endorse this criterion but suggest that this be assessed on the basis of the overall program rather than a percentage of activities.</p>
ACCME Recognized State Medical Society	<ul style="list-style-type: none"> - Is the other organization involved as planners or a consulting collaboration? What is the collaboration need to include? - How would this be measured? Attendance?

Call for Comment Responses: Proposal for a Menu of New Criteria for Accreditation with Commendation

C34: Since you answered 'no', please explain and/or suggest edits.	
Organization Description	Comments
ACCME Recognized State Medical Society	<p>The terminology within the criterion statement and rationale do not match. The criterion statement specifically identifies a collaboration with other organizations. The rationale uses words such as “system” and “enterprise,” both of which could be interrupted to mean a single healthcare system, rather than a collaboration among multiple organizations.</p> <p>Please define “meaningful and measureable collaboration.” CME is not mentioned within this criterion. Does a provider need to demonstrate a relationship between a CME activity or activities, and the initiative? Does it need to be an initiative or could it be two or more organizations collaborating together to provide information on a topic?</p>
ACCME Recognized State Medical Society	% of the standard is not a good idea for any Criteria; this will be too complicated to calculate. Providing multiple examples for a Criteria should be sufficient for a compliance finding.
ACCME Recognized State Medical Society	This criterion already exists but now there is a percentage of activities which is helpful in measuring compliance. 'Meaningful and measurable collaboration' needs clarification. In general, this criterion should be achievable by all provider types.
ACCME Recognized State Medical Society	<p>Do internal collaborations count? E.g. if a hospital quality department collaborates with the emergency department in the planning and development of a CME activity to improve patient safety, does this count? Or must the hospital collaborate with only external organizations? Also, need clarification on the standard 10% requirement. Is this per the entire accreditation term? 10% of activities or learners will be very difficult for many providers in our state system to achieve. Suggest lowering percentage to a specific range of</p> <p>activities/learners such as an one to three per year? A percentage is complicated for accreditors to work with during the survey process. Example, what/how many activities do we need to select for review?</p>
ACCME Recognized State Medical Society	<p>It is unclear whether hospital departments working with the hospital or healthcare system CME unit to achieve healthcare goals are also considered 'other organizations.' Define 'other healthcare or community organizations.'</p> <p>(See comment regarding complications associated with using percentages as a standard.)</p>
ACCME Recognized State Medical Society	<p>What is the definition of 'meaningful and measureable' collaboration?</p> <p>Standard percentage is a concern - see 1st page for details.</p>
ACCME Recognized State Medical Society	<p>Can joint providership meet this criterion?</p> <p>What is meant by meaningful and measureable collaboration?</p> <p>10% seems high</p>

Call for Comment Responses: Proposal for a Menu of New Criteria for Accreditation with Commendation

C34: Since you answered 'no', please explain and/or suggest edits.	
Organization Description	Comments
ACCME Recognized State Medical Society	The rationale includes cooperation and collaboration with people (which overlaps with C23), however the critical elements includes only organizations. What standard would be used to measure 'meaningful and measurable collaboration'? Does the 'initiative' need to be formal? Working to improve healthcare only overlooks initiatives such as leadership (for the learner). Would joint-providerships be included in this criterion? The ?10% of activities 'and/or' learners would be difficult for surveyors to evaluate.
ACCME Recognized State Medical Society	The criterion and the rationale may be achievable by a few providers, the use of the word 'AND' in the critical elements seems unreasonable. Define 'meaningful and measurable collaboration'. This would seem to be something that could be interpreted differently by each surveyor. The Standard percentage will be very difficult for surveyors to assess or providers to achieve. This seems to mirror C23 and/or C20.
ACCME-accredited provider	We endorse this criterion but suggest it be assessed on the basis of the overall program rather than a percentage of activities.
ACCME-accredited provider	My institution is not involved with a centrally located healthcare or community organization.
ACCME-accredited provider	What are 'other' organizations? We are a large institution, so would clinical departments count? What about other CPD departments (our nursing, pharmacy, and medical CE programs are all run out of different departments)? In the critical elements, what is 'measurable' collaboration? How does one measure it? How does one document that it's been measured and that the results are meaningful?
ACCME-accredited provider	what qualifies as 'engages' with...? what qualifies as 'collaborates in initiative'? what qualifies as an 'initiative'? what qualifies as 'meaningful and measurable' collaboration? what qualifies as 'generate'
ACCME-accredited provider	Define 'meaningful and measurable collaboration'
ACCME-accredited provider	Criterion is clear but Critical Elements and or Standard seems excessive. Unless you are a large organization or or part of a large healthcare network these kind of things take a great deal of effort. If the goal of the ACCME is to encourage most providers to strive towards these kind of collaborations then making it more feasible would be great (or have tiers of compliance for various sized organizations). Perhaps once or twice per year of term would be more reasonable for many.
ACCME-accredited provider	The concept of 'meaningful collaboration' needs clarification. Would joint provider relationships qualify as collaborations for this criterion as written? As providers focused on defined specialties and sub-specialties, it may not be appropriate to collaborate with outside organizations for 10% or more of our programs as these kinds of partnerships could result in activities that do not effectively meet our members' needs or our CME mission.
ACCME-accredited provider	We do some of this already but how do you propose to measure collaboration? Need more information about that.

Call for Comment Responses: Proposal for a Menu of New Criteria for Accreditation with Commendation

C34: Since you answered 'no', please explain and/or suggest edits.	
Organization Description	Comments
ACCME-accredited provider	More clarity is needed around the critical elements since they stress AND and not OR. What does meaningful and measurable collaboration mean? Who determines the tool for 'measurable collaboration'?
ACCME-accredited provider	Needs an example.
ACCME-accredited provider	The current criterion on collaborations was ambiguous from the start. This revised C34 criterion is no better. The problem is that it is entirely too open-ended. Also, what do you mean by 'generates meaningful and measurable collaboration?'. I have been in medical education for 40 years and have never, ever heard this phrase. How will the ARC assess this? With tremendous intrepieation and hours of discussion. While it is attractive at first blush perhaps, a better criterion would restrict the universe somewhat and provide some explicit elements that focus C34. For example: 'Develops a collaborative focused on an acute or chronic disease.' Or 'Collects data that measures one or more specific elements of the collaobration.'
ACCME-accredited provider	The concept of 'meaningful collaboration' is unclear and needs definition (rather subjective). It is unclear whether joint providership relationships would qualify as collaborations for this criterion as written. As providers focused on defined specialties and sub-specialties, it may not be appropriate to collaborate with outside organizations for 10% or more of our programs as these kinds of partnerships could result in activities that do not effectively meet our members' needs.
ACCME-accredited provider	What is 'measurable collaboration'? How does one measure a partnership?
ACCME-accredited provider	Access to community organizations is not something all sectors have access to. Collaboration can apply to other organizations.
ACCME-accredited provider	Please define 'meaningful and measurable collaboration' so that we can better determine if this would be achievable. We strongly support a criterion focused on collaboration but the terms used to describe it need more precision.
ACCME-accredited provider	What is 'meaningful and measurable collaboration'?
ACCME-accredited provider	Does collaboration have to be in regards to a CME activity, or can it involve other organization initiatives that are non-CME activities? We suggest basing the standard on number of credit hours of activity. A 1 credit activity and a 50 credit activity may have different parameters and not all may include collaboration.
ACCME-accredited provider	The critical elements and standard are not clear. Does collaboration in planning or preparing an activity count? If only initiatives count toward the standard, but aspects of the initiative are conducted outside of any CME activities, those would not count toward the standard, but should. You may need to devise a standard that takes into account collaboration and other work on initiatives outside a designated CME activity. You may also need to define 'meaningful and measurable collaboration'.
ACCME-accredited provider	C34: We request further clarification of the word "measurable" in the critical elements.
ACCME-accredited provider	Further clarification is required as to what collaborations are considered "meaningful" and what "measurable" information providers would have to gather or demonstrate to achieve compliance.

Call for Comment Responses: Proposal for a Menu of New Criteria for Accreditation with Commendation

C34: Since you answered 'no', please explain and/or suggest edits.	
Organization Description	Comments
ACCME-accredited provider	Must all critical elements be present in all activities (referring to use of word “AND”)? What is a “meaningful and measurable collaboration”? Does joint providership meet this criterion? What about CME programs that collaborate with other non-CME programs, depts., etc in their own organization?
ACCME-accredited provider	The term 'organizations' needs to be better defined. Why is this limited to healthcare and community groups? What is meant by 'meaningful' and 'measurable'? Inherently, collaboration is not quantifiable. This criterion should apply to the overall program, not specific activities.
ACCME-accredited provider	Not sure what 'Generates meaningful and measurable collaboration' means.
ACCME-accredited provider	You will need to better define cooperate and collaborate. It is commonly understood that in the past, ACCME has disputed and denied various forms of collaboration that have been reported in self-studies.
ACCME-accredited provider	This criteria requires clarification. Are these CME activities only? Are non-CME activities eligible? How do you measure collaboration?
ACCME-accredited provider	What is 'measurable collaboration'?
ACCME-accredited provider	I feel all of the critical elements are important, but don't see how any one is more important than the other. I feel the elements could be OR and still meet the intent of the criteria. How is 'meaningful and measureable' collaboration being defined? Would joint providership meet this criterion? Would collaboration within an organization qualify?
ACCME-accredited provider	Clarify the term “collaboration” as well define “meaningful and measureable collaboration”. Define “organizations and people”. Additional Comments: We recommend this criterion not be limited to just CME activities and that the measurement standard be changed to one organizational example for every year of term. We also recommend that in defining “collaborations” providers not be limited to Joint Providerships.
ACCME-accredited provider	1. GENERAL COMMENT: ACCME needs to clarify whether or not Joint Provider relationships ALONE qualify as collaboration in this proposed criterion. 2. THE STANDARDS: considering changing to 2 or 3 activities every year per term
ACCME-accredited provider	The concept of 'meaningful collaboration' is unclear and needs definition. Would joint providership relationships qualify as collaborations for this criterion as written? Depending on the scope of a provider's CME program, it may not be appropriate to collaborate with outside organizations for 10% or more of activities, as these partnerships could result in activities that do not meet members' needs and/or scope of CME programs' mission statements.
ACCME-accredited provider	See previous comments about % threshold
ACCME-accredited provider	What does “meaningful collaboration” mean? Would joint provider relationships included in this criteria? What does the ACCME mean by “measurable.” How do they want this measured?

Call for Comment Responses: Proposal for a Menu of New Criteria for Accreditation with Commendation

C34: Since you answered 'no', please explain and/or suggest edits.	
Organization Description	Comments
ACCME-accredited provider	What is meant by 'Generates meaningful and measurable collaboration? Is '> 10% of activities' over the accreditation term? Annually? or other?
ACCME-accredited provider	How do you measure collaboration?
ACCME-accredited provider	AMIA agrees with CMSS: 'The concept of 'meaningful collaboration' is unclear and needs definition. It is unclear whether joint providership relationships would qualify as collaborations for this criterion as written. As providers focused on defined specialties and sub-specialties, it may not be appropriate to collaborate with outside organizations for 10% or more of our programs as these kinds of partnerships could result in activities that do not effectively meet our members' needs.' In addition, AMIA believes 'initiative' requires definition. Is this one activity, or an educational deliverable of several parts?
ACCME-accredited provider	What is meant by measurable collaboration? Please give some examples.
ACCME-accredited provider	Define 'other organizations.' Would activities that have joint providers count toward this criteria? Would partnerships with government agencies and hospital affiliates count?
ACCME-accredited provider	What would be your recommendation to meet the critical element of 'generates meaningful and measurable collaboration? Could you please elaborate on this?
ACCME-accredited provider	<p>We support what we believe is the intent of this criterion to motivate and empower organizations to work together for the benefit of their shared learners.</p> <p>Our further recommendation is that this NOT be limited to activities alone but to include larger, multi-year and multi-organization initiatives and goals as well.</p>
Other	'Meaningful and measurable' collaboration is vague. Also would suggest excluding ACCME-defined commercial interests, in order to avoid confusion (or potential conflicts) with the SCS.
Other	What does 'measurable collaboration' mean?
Other	<p>As written, collaboration is referred to not at the activity level (collaborate to produce certified activities) but at a more global level (institution to institution) so to have the standard set as a % of activities does not seem copacetic. Global would be a % of stakeholder groups. Change language if intended to be activity level collaboration; however there is a catch 22- for providers who cannot joint provide by ACCME determination, they would be unable to achieve C34.</p> <p>Also check how term "efficacy" is used as this may be confusing to other interdisciplinary groups. Personally I think efficacy is best used as a medical term; it is not an educational term that one would find in education literature.</p>
Other	The concept of 'meaningful collaboration' is unclear and needs definition. It is unclear whether joint providership relationships would qualify as collaborations for this criterion as written. As providers focused on defined specialties and sub-specialties, it may not be appropriate to collaborate with outside organizations for 10% or more of our programs as these kinds of partnerships could result in activities that do not effectively meet our members' needs.

Call for Comment Responses: Proposal for a Menu of New Criteria for Accreditation with Commendation

C34: Since you answered 'no', please explain and/or suggest edits.	
Organization Description	Comments
Other	Need a definition of what is considered a 'collaboration' as this is too open for interpretation. Threshold could be increased.
Physician/healthcare professional	In general OK but would be helpful to give examples of community organizations. Is this schools? health Dept?
Physician/healthcare professional	The standard is poorly explained
State-accredited provider	Define collaboration. We were told by our last surveyors that we could not do joint activities because rules were too difficult to follow. We were unable to find any 'rules'. But we do follow their advise and avoid joint activities. How would we collaborate with this roadblock. I also find that Nursing Education staff want to have nothing to do with CME.
State-accredited provider	Modify Critical Elements to be And/Or
State-accredited provider	Define the types of healthcare or community organizations that are acceptable. Would these activities be considered jointly sponsored
State-accredited provider	We do not collaborate with others
State-accredited provider	What is meant by 'generating meaningful and measurable collaboration'? The percentage should be lowered.
State-accredited provider	Define meaningful and measureable collaboration. Interpretation can vary between individuals, so will vary between CME provider types.
State-accredited provider	Seems kind of vague and maybe even redundant to C23.
State-accredited provider	If a provider collaborates with other organizations outside of the realm of CME, would that meet this criterion. I would suggest that CME somehow be included in what is expected in order to meet this criterion. So, I would suggest to re-word to express a role for CME in the collaboration: Here's an idea: 'Collaborates with other organizations to enhance the achievement of healthcare goals associated with its educational activities.' A general question I have is how is this similar to or different from c20? That would be helpful to know. I think it's perfectly fine to say that c34 is meant to retain all the components of c20 except to say that the collaborations need to be external to the provider's organization. As i've mentioned previously i would suggest removing a % in the standard and instead would suggest to ask for documentation of some specified minimum number (2, 3, 4, or one per year since implementation) of examples, like what is currently required for Commendation.
State-accredited provider	Although we already do a great deal of collaboration, we would like a clarification of 'meaningful and measurable collaboration.'

Call for Comment Responses: Proposal for a Menu of New Criteria for Accreditation with Commendation

C34: Please provide comments or questions about this criterion.	
Organization Description	Comments
ACCME Recognized State Medical Society	To most the language is clear, however, some examples for the smaller hospitals and associations would be wise.
ACCME Recognized State Medical Society	Rationale seems to use the same words as the criterion. I would delete the first sentence since it does not add anything except common jargon words. The 2nd sentence can be reworded to 'This criterion will reward providers that create collaborations with other healthcare or community organizations to enhance the efficacy of CME activities.'
ACCME Recognized State Medical Society	Modify critical elements to AND/OR.
ACCME Recognized State Medical Society	This Criterion is definitely achievable by all providers and we are pleased to see it carried over from C16-22.
ACCME Recognized State Medical Society	The Critical Element: Generates meaningful and measurable collaboration needs to be defined or it would be subjective to the surveyor's opinion.
ACCME-accredited provider	while worded differnetly than Criterion 23, I am not sure Criterion 34 is different in spirit than Criterion 23
ACCME-accredited provider	Good to include.
ACCME-accredited provider	I believe the criterion is somewhat clear and the elements are well stated; however, it becomes complicated when you start requiring a percentage of activities.
ACCME-accredited provider	We would add that this criterion shows to participants that the provider practices what it preaches. We are hardly leaders in education if we do not do this.
ACCME-accredited provider	What would be an example of a 'measurable' collaboration? What are you measuring in the collaboration to document compliance with 'measurable collaboration?'
ACCME-accredited provider	Please define what organizations are deemed 'acceptable' for achievement of this Criterion.
ACCME-accredited provider	Please be specific about whether joint-providership CME activities will count towards compliance.
ACCME-accredited provider	I noticed that identifying and addressing barriers to change (C18-19) was not in this menu – I worry that this could lower the bar of CME to only measure what can be changed easily, instead of having the more difficult conversations about how physicians can be supported in navigating barriers that may limit their ability to change...
ACCME-accredited provider	Is the Standard metric of >10 activities based on the accreditation period or an annual threshold? If there is one large CME activity that eclipses all of the others in scope and it has a large % of its content planned collaboratively, or does this large activity simply count as 1 (equivalent to a journal article)? How does activities synch up with 'initiatives about improving healthcare'--does this only refer to collaboratively-designed CME or do non-CME initiatives also fulfill this criterion?
ACCME-accredited provider	If I understand, this criteria involves healthcare/community organizations and Criteria 24 involves community members NOT in healthcare. Is that correct?

Call for Comment Responses: Proposal for a Menu of New Criteria for Accreditation with Commendation

C34: Please provide comments or questions about this criterion.	
Organization Description	Comments
ACCME-accredited provider	For Provider's who collaborate with many organizations, this Criteria is an awesome way for them to demonstrate how the collaborations have contributed to the education of participants.
ACCME-accredited provider	Again this is a good idea. Hard on a large provider as running and managing over 35 collaborative activities a year is difficult. The percentage standard will tend to favor the smaller providers. We would like you to consider 10 percent or a specific number for large providers who may find it hard to large numbers to meet your percentages.
ACCME-accredited provider	this criterion seems straightforward. It clearly fosters IPCE, collaboratives and other joint providership relationships.
ACCME-accredited provider	Very good criterion.
ACCME-accredited provider	I think we could meet this criteria.
ACCME-accredited provider	Collaboration within organizations and not just other healthcare and community organizations is also very important and should be valued and rewarded. So I would rephrase this criterion as follows: 'Creates collaborations within and with other organizations to more fully achieve health care goals'. The critical elements can be modified to include both within and outside organizations.
ACCME-accredited provider	For a large health system, this amount would be out of reach.
ACCME-accredited provider	12. C34: This is achievable
ACCME-accredited provider	We wholeheartedly agree with this criterion. However, since we are a state institution our legal office must be particularly stringent of our collaboration with other organizations. This makes achieving the standard very difficult.
ACCME-accredited provider	The standard is likely unachievable if a provider has a large number of activities. Collaborations with other organizations are valuable, but also complex. A standard that requires demonstration of collaboration in at least 10% of activities is unreasonable.
ACCME-accredited provider	Recommend providing examples of 'meaningful and measurable collaboration.'
ACCME-accredited provider	The Standard is too high for this. Currently we have activities that incorporate this, but given our large educational portfolio, we could never achieve this standard.
ACCME-accredited provider	Intersociety collaboration can be quite helpful in advancing the CME mission.
ACCME-accredited provider	The threshold may be raised, as this is a criterion open to all providers and is met. Again, it would be helpful if the ACCME provided definitions on what it expects to meet each of these criterion.
ACCME-accredited provider	As indicated previously, I question the standard.
ACCME-accredited provider	To collaborate with other organizations requires other organizations to contract and pay our CME office. I don't think this is realistic for CME providers that cannot provide services to other organizations gratis. As a state agency, we are prohibited from giving away state resources for free.
ACCME-accredited provider	Please define meaningful and measurable collaboration. As this is a transition into a new process, we would like to see the proposed standard number of activities (10%)

Call for Comment Responses: Proposal for a Menu of New Criteria for Accreditation with Commendation

C34: Please provide comments or questions about this criterion.	
Organization Description	Comments
	reduced to 5% with a transition to a higher standard at a later time.
ACCME-accredited provider	See concerns from page 1 of the survey related to The Standard
ACCME-accredited provider	Many providers are in organizations that are moving towards systems and networks. Would members of the systems or networks qualify as 'other organizations'?
ACCME-accredited provider	The criterion is clear but I do not agree with the standard. Currently there is no percentage or number of activities and/or learners required for any of the Commendation Criteria/. I think that more providers will put forth the effort to achieve this and the other criteria if there is no percentage or number standard attached.
Physician/healthcare professional	This is a silly criterion for determining a 'commendation'. It really 'sounds good' but this is not something I need for my CME, as a physician. Let's get back to reality.
Physician/healthcare professional	This is a reasonable expectation in 10% of activities
Physician/healthcare professional	The intent is clear and seems worthy but the content is vague. I fear that actual implementation of this criterion will be onerous for providers.
State-accredited provider	This seems doable for a small organization.
State-accredited provider	It is clear - but why >10% of activities? What happened to simply providing an example. It may not fit within our department mission (and / or we may not have the resources) to spread ourselves so thinly by working with other organizations.
State-accredited provider	Reasonable criteria. We look for such collaborations on a continuous basis.
State-accredited provider	We vote that The Standard be: No less than 5% of activities.
State-accredited provider	Clear
State-accredited provider	>10%??? One or more activities per year of term feels more relevant.
State-accredited provider	What is the definition of 'generating meaningful and measurable collaboration'? All CME is/and should be meaningful and measurable. This seems to be an unnecessary element. The standard of 10% seems a bit high.
State-accredited provider	Although this is well written not sure about the standard and needs to show examples of compliance and non-compliance and what is expected from the provider.

Call for Comment Responses: Proposal for a Menu of New Criteria for Accreditation with Commendation

C34: Please provide comments or questions about this criterion.	
Organization Description	Comments
State-accredited provider	Again as above. I believe that the standard as written is way too high. and greater than 10% of our activities that would be about 30activities that would have to meet this and with the number of Journal Clubs and case conferences we hold out of our approximate 300 programs this would be difficult to achieve. I am unclear what is meant by 'and/or learners' and how those number would translate. Also I believe that the increased workload to meet this high number of activities with a CME office that is staffed by a CME director, CME manager and Admin Assistant/coordinator along with additional responsibilities added to the plate with ABIM and other specialty boards this is unrealistic. We have been accredited with commendation for the past 2 cycles and I am not certain this added work is worth the bang of receiving 6 years instead of 4. I also thin that the critical element should include and/or and not just and to make it more realistic.
State-accredited provider	You may need to define (or give examples) of 'meaningful and measureable collaboration'
State-accredited provider	Great Criterion, however 10 activities/year may be more attainable for smaller systems.
State-accredited provider	Other than the 10% threshold, how does this differ from CR 20? Seems redundant.
State-accredited provider	?10% of activities would be high for an organization that does not engage much with other healthcare or community organizations. Recommend the standard to be "once for every year of term".
State-accredited provider	None
State-accredited provider	In many hospital based programs this task is already performed by other committees and leaders. To require this for all CME professionals would be redundant and not a judicious use of resources.
State-accredited provider	We do a lot of internal (national and cross regional) collaboration and sometimes bring in external healthcare or community organizations. Not sure about the 10% for the latter.
State-accredited provider	The elements need clarification or revision for small CME programs would have difficulty meeting 'initiative about improving healthcare'. This is a generic phrase and can be interpreted broadly. The third element needs clarification for meaningful and measurable terms are vague. The standard is also too high and needs to be revised. If a CME program offers multiple formats and has multiple activities, they would have to minimize the number of activity types they offer to meet the level of greater than or equal to 10%.
State-accredited provider	I already do this This is Criterion 20
State-accredited provider	A good goal, but will basically be fulfilled by artful description of some activities.
State-accredited provider	It would eventually involve letting the 'big fish' absorb the small community hospital CME programs

Call for Comment Responses: Proposal for a Menu of New Criteria for Accreditation with Commendation

C34: Please provide comments or questions about this criterion.	
Organization Description	Comments
State-accredited provider	Would like to see more of this. I see advertisements on tv or hear news stories on the radio about and think 'wish we were doing that!' Would need to run it through the CME Committee and get Administration to buy into such efforts, and enlist the help of many others. Not sure how we could measure the results, but have heard of groups working with the tribes on major health problems like diabetes and alcoholism. Money would be a big issue, so doubt I could get approval. Would need a group effort. One person could not make this happen. Would have to generate income or save money for the hospital, or it would not get approved.
State-accredited provider	Take the 'AND' away and replace with 'OR' in the critical elements section. Decrease to 5%
State-accredited provider	It is already happening with some of our providers.

C35: Demonstrates creativity or innovation in the development or delivery of CME.

C35: Since you answered 'no', please explain and/or suggest edits.	
Organization Description	Comments
ACCME Recognized State Medical Society	Unable to assess. Inadequate and/or deficient methodological evidence of validity, reliability and application practicality of process. Details upon request. E.g. lack of evidence this criteria should carry same “weight” as any other and is mainly exclusive of other criteria to avoid double weighting. Applicability and importance depends on nature and scope of provider. Major cross-category exclusivity issue with potential for weighing same attribute multiple time depending on selected mix.
ACCME Recognized State Medical Society	Find this C35 to be subjective. Who decides what is 'creative' or 'innovative'?
ACCME Recognized State Medical Society	This is a great idea but how measured? Wouldn't this be left to interpretation?
ACCME Recognized State Medical Society	This criterion doesn't represent the opportunity for all provider types equally. It appears to be designed for specific types of providers. A SMS might not be able to meet this criterion. Critical Elements: - Who will determine whether we demonstrate the “use of an educational approach that was novel, creative, or innovative in the field of CME at the time it was launched?” This is based on subjective interpretation. The Standard: - “Once for every year of term,” is too much.
ACCME Recognized State Medical Society	Different people will have different ideas about what is considered innovative. Will the CME provider's own definition or perspective be accepted?
ACCME Recognized State Medical Society	too much subjectivity to know how to score this.
ACCME Recognized State Medical Society	Providing multiple examples for a Criteria should be sufficient for a compliance finding. Once for every year of the term will be difficult to meet if there is staff turnover.
ACCME Recognized State Medical Society	Do you mean novel, creative, innovative for the provider, or in the field of cme. This can be very different.
ACCME Recognized State Medical Society	This criterion concerns our committee as we foresee compliance/non-compliance being subjective. What is creative/innovative for a smaller, rural CME provider could be standard of practice for a large CME institution. A baseline must be established to define educational approaches that are novel, creative, or innovative.
ACCME Recognized State Medical Society	Maybe this should read 'educational approach that was novel, creative or innovative for the CME provider'. Can it be the same type of 'innovation' each year or does it have to be different each year?
ACCME Recognized State Medical Society	We feel that it would be very difficult to achieve equivalency with this criterion. The words ‘novel’, ‘creative’, and ‘innovative’ would be left to interpretation by all and would be impossible to assess.

Call for Comment Responses: Proposal for a Menu of New Criteria for Accreditation with Commendation

C35: Since you answered 'no', please explain and/or suggest edits.	
Organization Description	Comments
ACCME-accredited provider	This criteria is totally ambiguous and far too open-ended and subjective in terms of how provider submissions could be deemed compliant or non-compliant by the ARC. This criteria, I predict, will cause endless and extended discussion at ARC meetings during provider accreditation survey reviews. It should be re-written to incorporate explicit, objective criteria by which the provider will be assessed.
ACCME-accredited provider	C35 We are opposed to this criterion. Newer isn't always better. Only better is always better. Given that C36-C38 emphasize program outcome assessment, perhaps C35 can be framed to demonstrate improvement in activity development, delivery, learning, performance, or other appropriate outcome?
ACCME-accredited provider	Novel, creative and innovative are relative to the type of organization you work in. What would be innovative for us, might be something another organization has been doing for 5 years.
ACCME-accredited provider	I think once every year is too much. At a minimum require once per accreditation term.
ACCME-accredited provider	This seems like an extreme expectation - once a year basically for innovation depending on how being innovative is being defined. I would need more clarity here before being ok with this.
ACCME-accredited provider	Who defines 'novel, creative, or innovative' here? My issue with previous criteria was that they seemed to favor hospitals, health systems, and medical centers, but this one probably favors MECs and other for-profit providers. The 'field of CME' is not a monolith with the same expectations for creativity and innovation across all provider types--I have worked at both a for-profit MEC and a nonprofit hospital, and what was creative and innovative for the MEC, with its in-house web developers and flexible staff, is completely out of reach for a large hospital. And what is innovative at the hospital is years behind what most MECs are doing.
ACCME-accredited provider	Seems somewhat subjective. Who determines what is 'creative' yet still compliant for CME?
ACCME-accredited provider	Examples would be good. This is a little vague.
ACCME-accredited provider	Concerned this is too subjective. By whose standards would it be determined that something is 'novel, creative, or innovative'? Is it based on level of innovation for that organization or for the CE profession as a whole (what might be novel, creative, innovative for one provider may not be for another)? Also, concerned about the timing - if a provider implements something innovative at the beginning of a term, by the time they are up for reaccreditation, that innovative thing may no longer be viewed as innovative by the group making the accreditation recommendation.
ACCME-accredited provider	The critical element for this criterion is too vague. How are novel, creative, and innovative defined?
ACCME-accredited provider	This is very subjective: 'novel, creative, or innovative in the field of CME at the time it was launched' and needs to be clarified. An organization that implements a LMS and places recorded videos of live presentations may argue that they were innovating. If someone introduces game technology, flipped classrooms, or simulation into their activities, would that be considered innovative or creative even though these tools and methods have been around for at least forty years, just not in CME? Again, this criterion might be better converted into an annual ACCME Award with criteria established and organizations asked for submissions.

Call for Comment Responses: Proposal for a Menu of New Criteria for Accreditation with Commendation

C35: Since you answered 'no', please explain and/or suggest edits.	
Organization Description	Comments
ACCME-accredited provider	Please further define innovative.
ACCME-accredited provider	“Creativity and Innovation” based on whose standards? What may be creative and innovative for one organization may not be for others. Is a provider who has never done an enduring activity before being creative and innovative if they create one to extend the reach of one of their live programs? Also is “innovation” applied to the education design, oneeds assessment and/or technology?
ACCME-accredited provider	We endorse this criterion but suggest that it be assessed across the accreditation period.
ACCME-accredited provider	Shouldn't the critical element be to demonstrate innovations that did actually lead to improvements, vs. making an assumption that new=better? I worry that if this isn't specifically stated in the critical elements that it's going to be lost. On a side note, won't this overlap with C13 where improvements are described? It sends an odd message..is C13 now only for non-innovative improvements? (said tongue-in-cheek, but I think there could be confusion about how the two criteria relate to each other)
ACCME-accredited provider	Suggest you lower the bar to once every other year. tough to develop something truly novel every year.
ACCME-accredited provider	'Creativity' and 'innovation' are both subjective qualities and cannot be measured accurately without a standard rubric. Will this be provided? The educational format should be determined from the goals of the activity and the needs of the learners, as is discussed in other criteria. Innovation for innovation's sake may not result in improved educational outcomes and we hope the criteria would not be perceived to promote this.
ACCME-accredited provider	What is creative and innovative. This is too open to definition. It is to the individual organization or to the field. So how do we even know if other organizations have tried it. It may be new to us and not to the field of CME
ACCME-accredited provider	As written, this Criterion does not recognize providers for innovating within their own system, but rather only in comparison to the larger CME field. If innovation were recognized within the CME field and/or within the provider's CME environment, the Criterion would recognize all efforts by providers to innovate their CME program and activities, not just those with the resources and awareness of the cutting edge practices of the CME field. Additionally, as written, it will be very difficult to design for and measure compliance for this Criterion. Further information is needed to allow for providers to understand what they will need to demonstrate and how the ACCME will measure this.
ACCME-accredited provider	How will you measure novel, creative or innovative? It would be more feasible to demonstrate improvement year to year on recurring activities OR something novel or innovative every two or three years. It is not easy to change the enterprise and requires a huge level of effort.
ACCME-accredited provider	How long is something considered novel? It seems a bit of a stretch to ask an organization to be on the cutting edge of educational design every year during their accreditation term.

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C35: Since you answered 'no', please explain and/or suggest edits.	
Organization Description	Comments
ACCME-accredited provider	Innovation and creativity are subjective terms. Each can mean different things to each provider. Is the provider expected to set the standard in education or continue to change their activities to meet their learners needs?
ACCME-accredited provider	Is this one educational session during our annual meeting when we have 50+ individual sessions? One complete program/annual meeting? One innovation?
ACCME-accredited provider	Educational activities should be designed in the format that best supports the learners' ability to achieve their learning goals. 'Innovation' and 'creativity' can support this goal but are subjective concepts. Without clear definitions it is impossible to set a standard for achieving this criterion and to assess a provider's efforts in this area. This raises the same concern about a provider's accreditation review raised in relation to C28. In addition, I think many of us have seen novel, creative or innovative approached completely fail. These are not cheap endeavors in terms of budget and time.
ACCME-accredited provider	C35: This criterion is not clear. There is no clear explanation of what would be considered innovative or creative. Additionally, innovation must be balanced with cost, resources, and potential benefit to our members/learners. In order to be fiscally responsible, we cannot innovate just for the sake of innovation. For example, our ADOPT program was first piloted in 2015 and will be expanded in 2016. This measured approach is appropriate to ensure the evidence demonstrates a real benefit to learners. We would recommend that organizations be allowed to consider innovation to include using activities that they had not before - so if a society had only provided live courses previously, if they offer an enduring material, that would be counted. Once this criterion is made more clear, we would recommend the standard be set at 1 activity TOTAL per accreditation cycle.
ACCME-accredited provider	1. RATIONALE and CRITICAL ELEMENTS: Need to define 'innovative'. When does something transition from 'innovative' to 'assimilated into practice' and who makes that determination?
ACCME-accredited provider	'Innovation' and 'creativity' are subjective concepts. Without clear definitions, it is difficult to establish a standard for achieving this criterion and assessing a provider's efforts. Does this criterion reflect creativity or innovation realized in a specific CME activity, one that relates to/supports a provider's CME program, and/or one that impacts the field of CME?
ACCME-accredited provider	13. C35: This is a overboard...
ACCME-accredited provider	Educational activities should be designed in the format that best supports the learners' ability to achieve their learning goals. 'Innovation' and 'creativity' can support this goal but are subjective concepts. Without clear definitions it is impossible to set a standard for achieving this criterion and to assess a provider's efforts in this area.
ACCME-accredited provider	What is the criteria for determining novel, creative or innovative? Since learners achieve learning through different styles, innovation may not imply the best mode for learning.

Call for Comment Responses: Proposal for a Menu of New Criteria for Accreditation with Commendation

C35: Since you answered 'no', please explain and/or suggest edits.	
Organization Description	Comments
ACCME-accredited provider	Novelty, creativity and innovation are aspirational goals; however, what omniscient panel will be able judge novelty, creativity, or innovation? Without clearer elements and a better description of the compliance mechanism, this criterion risks significant criticism for subjectivity in evaluation. In addition, the standard of once per year of the accreditation term seems to value volume over quality. The standard should be reduced to no more than two legitimate examples per accreditation term.
ACCME-accredited provider	The Standard of once for every year of the term is too much. It would be more obtainable if it were every 2 to 3 years.
ACCME-accredited provider	If a CME program is evolving and incorporating new methods for educational delivery, thus being innovative within their own program, could that meet the criterion? Some programs do not have the ability to reach the “innovation” that other CME providers are able to do, but are working towards making their own programs innovative. Also, it seems lofty to think that every year every provider with commendation is doing something innovative or novel. Once a few people do it, it is no longer either innovative or novel. Recommend allowing innovation to be subjective, as it may be innovative for the organization.
ACCME-accredited provider	Given the nature of the criteria, once every year may be challenging. How does one continue to deliver CME via novel methods every year? That may be too frequent of a standard. Using subjective terms like “innovation” and “creativity” could result in inconsistencies during the accreditation review process.
ACCME-accredited provider	AMIA agrees with CMSS: 'Educational activities should be designed in the format that best supports the learners' ability to achieve their learning goals. 'Innovation' and 'creativity' can support this goal but are subjective concepts. Without clear definitions it is impossible to set a standard for achieving this criterion and to assess a provider's efforts in this area.'
ACCME-accredited provider	In The Standard, does 'term' refer to ACCME accreditation term? My organization has Accreditation with Commendation. Would we meet this criterion if we used implemented one novel educational approach during our 6-year accreditation term?
ACCME-accredited provider	Innovative is a flashy word of which there is recent debate on the definition.
ACCME-accredited provider	Creativity and innovation in delivery of CME is subjective.
ACCME-accredited provider	It is unreasonable to expect a novel educational approach to be developed every year. If a new approach is developed, it should be given more than a year to determine if it is working for the benefit of the learners or not.
ACCME-accredited provider	The critical elements are subjective. There needs to be a definition of innovation. Is innovation a new practice for the organization, or new to CME providers, or new to learning/professional development field? What is considered innovative and novel to one CME organization may be simply catching up with the times for another CME provider.

Call for Comment Responses: Proposal for a Menu of New Criteria for Accreditation with Commendation

C35: Since you answered 'no', please explain and/or suggest edits.	
Organization Description	Comments
ACCME-accredited provider	Isn't this standard rather than commendable? Shouldn't all of our activities strive to improve the efficiency, efficacy, and impact of CME? This is very vague and non-measurable. Something innovative to one provider may be old-hat to another. Does that disqualify it for the provider who has never done it before? What determines if it did improve things? evaluation comments?
ACCME-accredited provider	Good goal--need to identify what is novel, creative and innovative. There will be many different interpretations of that. Is this anything other than didactic lecture?
ACCME-accredited provider	The terms 'creativity', innovations, and 'novel' need to be further defined. It may not be readily apparent that something is truly novel, innovative, or creative at the time it is launched. This criterion will be very difficult to assess and may be dependent on the provider's setting and scope of programming (e.g., something may be novel for a community hospital but not for a large academic medical center). This criterion should be assessed across the accreditation term.
ACCME-accredited provider	Critical element seems very subjective. Who is making the decision that the activity is novel and creative-- organizations, learners, educators? Please give examples of what would qualify as creative and innovative.
ACCME-accredited provider	Would this criterion include technologies used by joint providers or medical education communication companies?
Other	This is not clear, nor is it productive. How will organizations be able to prove they are innovative? Additionally, mandating innovation annually seem overly ambitious. If an organization figures out something innovative every 4-6 years, that seems appropriate. I would recommend 1 novel or creative activity every accreditation term be the standard.
Other	At what point is something considered no longer novel? Hard to define exactly what that is -- could be very easy to make the case that something is novel, in which case once per term could be achievable by almost everybody (and therefore not in and of it self a commendation criterion)
Other	What is 'Novel, creative or innovative' will be highly arbitrary and whether or not the criteria is met will be difficult for the surveyors, reviewers and ARC. Opinions on what is novel, creative or innovative will vary from one reviewer to another.
Other	Educational activities should be designed in the format that best supports the learners' ability to achieve their learning goals. 'Innovation' and 'creativity' can support this goal but are subjective concepts. Without clear definitions it is impossible to set a standard for achieving this criterion and to assess a provider's efforts in this area. This raises the same concern about a provider's accreditation review raised in relation to C28.
Other	Change from "implementing innovative programs" to implementing innovative activities if the intent is to be at the activity level vs program level.
Other	Not sure that there is a provider wide understanding of the terms 'creative', 'innovative', and/or 'novel'.

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C35: Since you answered 'no', please explain and/or suggest edits.	
Organization Description	Comments
Physician/healthcare professional	?what criteria are being used to determine if an approach is truly 'novel, creative, or innovative'?
Physician/healthcare professional	Mostly OK, but to qualify does it have to be novel to that organization or to the entire CME community at large?
State-accredited provider	I don't know what 'creative' is considered to be. If it has to be 'novel' and prove that it was not used before i think that would be difficult and doubt i could meet this.
State-accredited provider	This may be doable depending on what constitute an 'educational approach that was novel, creative or innovative'. Being bound by AMA formats is somewhat limiting to this. Once a year is probably doable if the rationale and critical elements are clear.
State-accredited provider	Remove language: "at the time it was launched"? The activity approach may be defined as such if it was not done before either with the target audience or the planning group.
State-accredited provider	If team based learning is used within a CME program - is that considered novel? What is meant by 'novel'? Novel to CME or novel to education?
State-accredited provider	What do you mean by innovation? Are we not to stay within the formats authorized by AMA? The standard is too high for small CME programs to develop new types of CME every year of their accreditation.
State-accredited provider	Not exactly sure what the specific definition of novel, creative, or innovative, but this type of special event will take more time to plan and implement and may be challenging to produce a quality event yearly.
State-accredited provider	Give examples to Creative or Innovative. Please clarify the amount per term?
State-accredited provider	How do you define 'novel, creative or innovative'? I think this is definitely doable, but worry that it is quite subjective.
State-accredited provider	We are a small provider and a one staff shop. Is 'novel, creative, or innovative' in the eyes of the provider? What is creative for us as a provider might be mainstream for others. This criterion seems to be a very fast moving target and ratchets up quickly. What about changing/adding an element that the provider demonstrates that it has moved beyond its standard format offerings over its accreditation term, incorporating new formats, new delivery methods? Would this demonstrate compliance?
State-accredited provider	Who decides what is novel, etc.? Might be extremely creative in one environment and not in another.

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C35: Please provide comments or questions about this criterion.	
Organization Description	Comments
ACCME Recognized State Medical Society	Since this one needs to be demonstrated with only one example for each term, the provider most likely will be able to comply. Again, it may be harder on providers that have no access to educational personnel but being advised on the matter should be an stimuli for them to be in compliance.
ACCME Recognized State Medical Society	This one will be highly subjective in interpretation!
ACCME Recognized State Medical Society	We support this criterion but suggest that it be assessed across the accreditation period.
ACCME Recognized State Medical Society	Who is to say what is “innovative” or “creative” for a program? Incorporating audience response systems into an activity may be innovative to some providers, where others have been using the system for more than a decade. The standard is unrealistic and unobtainable for SMS accredited providers, many of who do not have a full FTE assigned to their CME programs.
ACCME Recognized State Medical Society	Determining compliance/noncompliance for criterion should be more objective to reduce discrepancies. For example, consider these for Critical Elements: 1) Plans an activity using a format previously not used in your CME program. 2) Plans an activity using the following formats - PI-CME, MOC, etc. (I would list the formats/types that should be used for activities that providers rarely utilize) 3) Incorporating the following into your activities: Bring patients, limit formal speaking time, use dynamic titles, follow a curriculum, problem-solving during session (examples pulled from Graham's letter) 4) Presentations (on best practices?) at continuing education health professional meetings (ACEHP, state regional organization meetings) If you 'spell out' the critical elements, I think you could really help push providers in the 'right direction' The Standard - could be reflected by % of activities or per year - should be more often then once per every year of term
ACCME Recognized State Medical Society	The criterion is clear; however, what is creative or innovative today may not be in a few years. What is novel for one provider may be standard for another. We shouldn't expect the same baseline for providers given size, staffing, resources, etc.
ACCME Recognized State Medical Society	Comment/suggestion: As accreditor we may not always know or recall if an approach was novel, creative, or innovative at the time it was launched. Especially when six years will have elapsed since the provider’s last accreditation. Additionally, the Standard of once every year is most likely too difficult to achieve without substantial resources. This criterion will be difficult for the State system to achieve.
ACCME Recognized State Medical Society	Again, this Criterion will become a necessity for younger physicians.

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C35: Please provide comments or questions about this criterion.	
Organization Description	Comments
ACCME Recognized State Medical Society	As written this criterion may be exclusive of smaller organizations which provide innovative education for their program, such as webinars or internet platforms, though it may not be new in the CME field. It may be beneficial to ask the provider to show how new activities were creative for their program and encourage growth that's relative to the size and scope of their program.
ACCME-accredited provider	Please define novel, creative or innovative?
ACCME-accredited provider	I do think the standard is a bit high, again.
ACCME-accredited provider	Very clear and a good criterion.
ACCME-accredited provider	Rather subjective
ACCME-accredited provider	CME providers should work closely with health sciences librarians to remain aware of new and innovative resources.
ACCME-accredited provider	Terrific Criterion. Involves more judgement on the part of reviewers, which could be tricky. However that may be ok in this case. Also, it challenges providers to engage in out-of-the-box thinking, whether or not they ever actually succeed in providing activities that are 'innovative enough'.
ACCME-accredited provider	once for every yr of term seems like a lot. I remember when celluloid slides changed to powerpoint and that was cool. I remember when video clips could be put into a presentation and that was cool. I remember when speakers finally had to start putting references at the bottom of their slides and that was greatly appreciated. I remember when speakers had to disclose their conflicts --because 25 yrs ago even as dumb and obtuse as I am --I felt like I was getting proselytized about a drug and I greatly appreciate COI and disclosure. But I am looking at 4 great improvements to learning in a 1/4 century--that rate is every 6 yrs. Annual requirement is WAY TOO MUCH and I really don't want to be pandered to with stupid changes just for the notch on the belt.
ACCME-accredited provider	As long as 'creativity' has a self-defined (by the provider) meaning, this can work and is a nice way to appreciate innovation.
ACCME-accredited provider	We feel the proposed Standard for 'once every year of term' is an ambitious expectation. While we agree that providers should strive for novel and creative approaches in their portfolio, the amount of resources needed to pull that off annually is likely infeasible for many smaller providers, unless the definition of 'novel, creative or innovative' is very broad. It is also our experience that innovative approaches often require more than a year to develop, implement and refine based on learner feedback. If the expectation is to implement a novel approach annually, this may have the unintended consequence of providers having insufficient bandwidth to institutionalize excellent new approaches, as they would have to shift annually to creating and implementing a 'new' novel approach. Finally, what will the criteria be for novel, creative or innovative at the time it is implemented by the provider?
ACCME-accredited provider	This Criteria needs some examples of what is meant by: demonstrate leadership and creativity by designing and implementing innovative programs.. Also, do you mean PROGRAMS or activities? This could be confusing if the correct word is not used.

Call for Comment Responses: Proposal for a Menu of New Criteria for Accreditation with Commendation

C35: Please provide comments or questions about this criterion.	
Organization Description	Comments
ACCME-accredited provider	Many might associate innovation with technology enhancements. Although that might be part of what providers demonstrate to meet this criterion, might want to specify other examples that are not-technology-based to help providers think more broadly about 'innovation'.
ACCME-accredited provider	Reasonable
ACCME-accredited provider	Creativity, novelty and innovation are subjective terms. Therefore, this criterion would benefit from the inclusion of a rubric for judging compliance that helps ensure there is an acknowledged standard to measure and determine what constitutes innovation.
ACCME-accredited provider	This is a fun new addition!
ACCME-accredited provider	Interesting and exciting notion which should stimulate desired activity.
ACCME-accredited provider	Does novel mean that it was novel for that organization or novel in the whole of the CME world? There have been times when our organization creates what we think is a new idea and with further research, we're able to find someone else who's tried that approach or done something similar, which is helpful because we can learn and improve on it. Thus it is novel for us, but not necessarily novel for the industry.
ACCME-accredited provider	I would like to see examples of fulfilling this criterion.
ACCME-accredited provider	I am unclear with the standard. Are we saying that a provider needs to create a whole new innovative approach to CME per year? This may be unrealistic.
ACCME-accredited provider	The question would be how to know that what we are developing would be considered innovative enough at the time of launch? Also, innovation is usually very time consuming and expensive. We are looking into gaming and other interactivity to be more engaging. One for every year is extremely difficult. I recommend one or two per 4 year term.
ACCME-accredited provider	Novel or creative relative to what a provider has embarked on previously? Novel relative to what standard?
ACCME-accredited provider	does this need to be an educational approach or could it be broader and encompass multiple formats, and other factors that may relate to data collections, post activity assessment etc.
ACCME-accredited provider	We suggest changing the Standard to once for every two years of term. An organization might not do something novel and wonderful every single year.
ACCME-accredited provider	Given that the majority of CME activities are still didactic ('the Sage on the Stage'), a higher impact criterion here would be to demonstrate the use of innovative strategies and active learning strategies in the delivery of CME.
ACCME-accredited provider	This criterion brings us back to the old days of CME prior to the new criteria. It is very hard to determine what is innovative. If our organization has produced online CME games for years but another organization is just attempting it, does it qualify as innovative? It would certainly be innovative for the organization who hasn't done it yet. For how long is something innovative?

Call for Comment Responses: Proposal for a Menu of New Criteria for Accreditation with Commendation

C35: Please provide comments or questions about this criterion.	
Organization Description	Comments
ACCME-accredited provider	The standard does not seem achievable if the goal is sustainability of innovation, constantly moving on to the next innovation. In addition, this criterion might include an OR critical element of implementing approaches novel to the provider. Given the rationale of C33 to engage in professional development to maintain and develop skills, C35 has to potential to sustain what is learned about best practice and furthering the field within your own institution and support the philosophy of continuous improvement.
ACCME-accredited provider	As indicated previously, I question the standard.
ACCME-accredited provider	What is creative and innovative for one individual may not be so for another. Is there a way that a provider could receive guidance from the ACCME as to whether a program/project may be considered creative or innovative before it is moved into the implementation process in order to be considered for C35?
ACCME-accredited provider	Once for every year of term may be impractical.
ACCME-accredited provider	Challenging.
ACCME-accredited provider	The criterion is clear but I do not agree with the standard. Currently there is no percentage or number of activities and/or learners required for any of the Commendation Criteria/. I think that more providers will put forth the effort to achieve this and the other criteria if there is no percentage or number standard attached.
Media	EXCELLENT! At last, innovation in content delivery is finally being recognized!
Physician/healthcare professional	OK.
Physician/healthcare professional	This approach can be tried, I am not sure that all innovative ideas are really educational, how this is determined would be of interest. Clearer expectations need to be developed.
Physician/healthcare professional	Think this is wishful thinking
Physician/healthcare professional	This is a very worthy criterion! However, I would change the criterion to once per term, not once yearly.
State-accredited provider	Criterion is clear - standard seems high (unattainable)
State-accredited provider	Physicians object to pretty much everything but lectures. Any in case it is hard to fit anything else into 1 hour slots at lunch or after departmental meetings. Again I think reality in hospital CME is being ignored.
State-accredited provider	But this duplicates some of the goals of already proposed Criteria and may allow for claiming credit twice.
State-accredited provider	We vote that the Standard be: 'Once during this Accreditation Cycle'
State-accredited provider	Who determines whether or not the educational approach was novel, creative, or innovative? How is it determined that an approach is novel?

Call for Comment Responses: Proposal for a Menu of New Criteria for Accreditation with Commendation

C35: Please provide comments or questions about this criterion.	
Organization Description	Comments
State-accredited provider	I would like to see some examples of acceptable practices for this criterion.
State-accredited provider	Good and reasonable. One a year.
State-accredited provider	also redundant. Seems similar to C32.
State-accredited provider	Yes
State-accredited provider	None
State-accredited provider	A worthwhile criterion that can be fulfilled by anybody.
State-accredited provider	ok with this
State-accredited provider	I try to be creative with the CME Program I'm not sure if one per year is obtainable but maybe one every other year
State-accredited provider	Of course we want to be creative.
State-accredited provider	While a great way to improve delivery types to engage participants, the standard is too much. It is only novel, creative or innovative the first time it is used in the industry by one provider. After that the use is no longer any of those. This is not a realistic to achieve every year of accreditation term.
State-accredited provider	Much could be done with social media, but this was not approved when brought up in the past. It's against corporate policy at this time. Would like to work with game theory. Perhaps we can do something with the Osteopathic residents when the program is established.
State-accredited provider	I like this criterion knowing that it's going to be highly subjective to assess what is innovative. I think it's achievable to ask providers to demonstrate this criterion at least annually, and perhaps even more frequently. To keep the language consistent with other criteria, I would re-word: 'Demonstrates creativity or innovation in the development and/or delivery of its educational activities.' Does the ACCME mean 'activities' instead of 'programs' in the Rationale section? Some examples, as they come up, would really help clarify what the ACCME is looking for here; but i understand that even the ACCME cannot predict what will be innovative until it sees it. :)
State-accredited provider	The one issue with 'innovation' is that there are only so many different ways to 'teach' that haven't been used/attempted previously. After a few years, you may find yourself out of ideas. I am all for this one though, because I am interested in learning more about Adult Learning Principles.
State-accredited provider	Although criteria is written, it does not give us or explain what is truly expected of the provider. Compendium of examples must be written to show examples of compliance and non-compliance for all providers. Not all providers will be able to do this.
State-accredited provider	Creativity can NOT be forced.
State-accredited provider	Reasonable.

ACHIEVING OUTCOMES

C36: Demonstrates the impact of the CME program on the performance of individual health professionals.

C36: Since you answered 'no', please explain and/or suggest edits.	
Organization Description	Comments
ACCME Recognized State Medical Society	I think this is the toughest one of all for our providers. In spite of the effort our CME Council has placed on how to measure performance, we have not been able to get farther than exams of clinical settings. I, as a pediatrician have appreciated how I have improved my patients on different areas. Never the less, how will I demonstrate it to you? How will my providers be able to truly assess their success? It might be inferred from participants answers through appropriate questions, will that be enough to comply? Is not easy to assess physicians in these terms, we are too jealous and..., vain?
ACCME Recognized State Medical Society	The critical elements are not clear. What types of measurement? Demonstrate the impact how? Connect impact on performance how? It is hard to determine how accessible this criteria will be to provider types when the critical elements are this vague.
ACCME Recognized State Medical Society	Unable to assess. Inadequate and/or deficient methodological evidence of validity, reliability and application practicality of process. Details upon request. E.g. lack of evidence this criteria should carry same "weight" as any other and is mainly exclusive of other criteria to avoid double weighting. Applicability and importance depends on nature and scope of provider. Another criteria with major exclusivity issues.
ACCME Recognized State Medical Society	Small providers would never devote time to developing activities that demonstrate 'the impact on the performance of individual learners.' Plus the standard is too high.
ACCME Recognized State Medical Society	What is the definition of a health professional?
ACCME Recognized State Medical Society	Critical Elements: - Better if allowed for this OR that, instead of this AND that. Small providers with one person CME office or part-time staff may not be able to address this criterion. The Standard: - Demonstrated impact on performance for ?10% of program's learners or measured impact on performance for ?25% of program's learners -- too high
ACCME Recognized State Medical Society	Please clarify if the focus is only on measuring the performance for individual learners or if the individual health professionals must also have achieved demonstrated improvement in performance in order to meet this criterion. Possible barrier: Some activities will show longer-term impact/change.

Call for Comment Responses: Proposal for a Menu of New Criteria for Accreditation with Commendation

C36: Since you answered 'no', please explain and/or suggest edits.	
Organization Description	Comments
ACCME Recognized State Medical Society	<p>Need to define what is meant by “measure”, “demonstrate”, and “connect”, as well as how ACCME anticipates that providers will assess change in “individual health professionals, given that we do not have access to these data for participants outside of our own health systems.</p> <p>Our support of this criterion is dependent on the interpretation of the critical elements and standards. The ability of an individual CME activity on change in practice is limited and it is unrealistic to expect that a certain percentage of activities or learners will achieve this goal. As described above, we do not recommend requiring providers to apply this criterion to a certain percentage of their learners/activities, but rather to describe how they have achieved this across their program</p>
ACCME Recognized State Medical Society	<p>CME is for physicians. Demonstrate the impact of the CME program on the performance of physicians. Also, % of the standard is not a good idea for any Criteria; this will be too complicated to calculate. Providing multiple examples for a Criteria should be sufficient for a compliance finding.</p>
ACCME Recognized State Medical Society	<p>How does a provider achieve compliance with this criterion? Possibly by working closely with QI/QA but whether quality divisions will divert resources and staff to report on INDIVIDUAL performance is questionable as their priorities may not align with CME. For those providers unable to access institutional data, this may come down to self-reported change among learners. Providers do not have a good track record of being able to obtain this information as only a very small percentage of learners respond to post-activity evaluations.</p>
ACCME Recognized State Medical Society	<p>Need clarification on the standard of 10% or 25%. Is this for example, 10%/25% of the total of learners from the entire term of accreditation?</p>
ACCME Recognized State Medical Society	<p>This criteria is confusing. If the CME provider 'measures performance of individual health professionals,' what does 'demonstrates the impact on the performance of individual health professionals mean?' Is there a difference? Or does this criterion ask for a measurement of healthcare outcomes resulting from changes in learners? Does the measurement need to be objective or can it be subjective (Self reported change)? (Please see comment regarding confusion and complexity of using percentages to measure compliance.)</p>
ACCME Recognized State Medical Society	<p>Standard percentage is a concern - see 1st page for details.</p>
ACCME Recognized State Medical Society	<p>This criterion seems to overlap C30 (individual behavioral change). As written it would overlook providers which are not in a position to access individual data (i.e. those reliant on public health data or literature to identify gaps or organizations without a QI department, such as a medical society). Would self-reported data be appropriate? This criterion may be too resource intensive for providers with limited staff/resources. As written the standard for measurement would need clarification.</p>

Call for Comment Responses: Proposal for a Menu of New Criteria for Accreditation with Commendation

C36: Since you answered 'no', please explain and/or suggest edits.	
Organization Description	Comments
ACCME Recognized State Medical Society	At this time the resources are not available to our providers to achieve this. Again, this criteria seems to be directed toward academic providers. The use of the word 'AND' in the critical elements seems unreasonable. Most rural providers do not have the staff, time or resources to accomplish the individualized plan and assessment. The Standard percentage will be very difficult for surveyors to assess or providers to achieve.
ACCME-accredited provider	This criterion is the 'gold standard' that the overwhelming majority of CME providers currently with commendation, rarely--if ever--achieve. No provider that I am aware of has the capability today of demonstrating the three components of C36. This criterion should be rewritten to include specific, objective measures by which providers will be assessed for compliance with C36 and the Standard of 10% or 25% should be dropped entirely or significantly decreased.
ACCME-accredited provider	C36 The third part of the critical element is problematic, as “connects impact on performance to the learning activity(ies)” can only be accomplished through selected intervention strategies capable of determining causation, which are not present in the majority of the real-world environments of CME providers. Many performance improvement activities are part of larger educational initiatives (at local, regional, or national levels) so that participants are subjected to many influences, making controlled experiments impossible. Suggest that initially the rigorous critical element of demonstrating cause of improvement from the education not be adopted. If after experience with this criterion too many providers are achieving the standard, then ACCME could later consider raising the bar.
ACCME-accredited provider	Example, please, and how would you measure this?
ACCME-accredited provider	Clarify definition of program learners.
ACCME-accredited provider	'measuring whether change occurred' is a very slippery nut to crack. As most of our CME activities are directed to community doctors, the changes that might happen are likely to occur outside our hospital. Furthermore, changes that the hospital might be able to capture might also be due to education efforts put forth by patient safety, for example, and would not necessarily be a specific CME activity.
ACCME-accredited provider	The difference between measuring performance of individuals and demonstrating the impact on performance of individuals is not clear. This requires further explanation.
ACCME-accredited provider	The Standard is not clear. What is the difference between demonstrated impact and measured impact? Why are the thresholds different? The thresholds are very high. We have 44000 learners each year. This criteria would require us to either demonstrate the impact on performance for 4400 learners or measure the impact on performance for 11000 learners. Does the commitment to change count for measuring or demonstrating impact?
ACCME-accredited provider	Please clarify if it is correct to assume that the model is based on PI-CME.
ACCME-accredited provider	This seems very resource intensive and I feel the % will be difficult for all providers sizes (small and large) to achieve. Unsure how one can truly connect the impact on performance to specific learning activities...often change is a result of multiple factors (some that cannot be easily measured).

Call for Comment Responses: Proposal for a Menu of New Criteria for Accreditation with Commendation

C36: Since you answered 'no', please explain and/or suggest edits.	
Organization Description	Comments
ACCME-accredited provider	There is a choice within The Standard between Demonstrate OR Measure, but within the Critical Elements all three are required ('AND'), which is somewhat confusing! Also, The Standard must define the difference between “demonstrate” and 'measure'. What constitutes adequate “demonstration of impact” and how is it documented? The Standard should include examples of “demonstration” methods, as distinct from “measurement” methods.
ACCME-accredited provider	Not for sure how to measure this for individual providers. Also, how do you calculate 25% of the program's learners? It is based on total in attendance or total in the community
ACCME-accredited provider	Please clarify the difference between 'demonstrated' and 'measured' impact on performance. Why is there a different standard? Would organizations be required to identify individual learners and show specific performance data in order to comply? Would the individual learner need to provide permission? If that is the intent, many providers who may be compliant would not be able to provide this data.
ACCME-accredited provider	Can the impact on performance self reported?
ACCME-accredited provider	Is self-reported data acceptable to demonstrate impact?
ACCME-accredited provider	Percentages may be difficult for small and large organizations to achieve. Not sure how one can truly connect impact on performance to learning activities. Many of our learners indicate that they intend to seek additional info on a topic. How can the influence of this or other education that the learner encounters/seeks be screened out.
ACCME-accredited provider	Our support of this criterion is contingent on the interpretation of the critical elements. The ACCME will need to define what it means by “measure”, “demonstrate”, and “connect”, as well how it anticipates that providers will assess change in “individual health professionals”, given the formidable challenges in accessing these data. Further, it is unrealistic to expect that an individual CME activity demonstrate change in the “performance of individual learners” or even that an arbitrary concatenation of learners or activities learners will achieve this goal. As described earlier, we do not recommend requiring providers to apply this criterion to a fixed percentage of their learners/activities, but rather to describe how they have achieved this across their program (informed the design of all their activities).
ACCME-accredited provider	What tools are available to measure this? May need explanation and examples
ACCME-accredited provider	Are the Standard metrics of >10% and > 25% learners based on the accreditation period or an annual threshold? We are concerned that any CME provider that is outside an institution that has direct access to provider behavior and patient data (e.g., medical societies, free-standing MEC's, non-profit organizations) will be unable to demonstrate direct impact in a valid manner.
ACCME-accredited provider	Suggest you lower the bar from more than 25% of learners -- we don't get that many learners to respond to the detailed questionnaires that C36 necessitates. 10% would give many more organizations a chance at this one.
ACCME-accredited provider	There will need to be more information on how and what is acceptable as far as measurement goes. Is it a post test. What will be acceptable.

Call for Comment Responses: Proposal for a Menu of New Criteria for Accreditation with Commendation

C36: Since you answered 'no', please explain and/or suggest edits.	
Organization Description	Comments
ACCME-accredited provider	As written, it is unclear as to whether learners' self-reported changes to performance would satisfy this Criterion. For some providers, directly measuring performance change would be difficult, given the nature of the CME provider's proximity to physician practice. Therefore, tools such as follow-up surveys asking the learners to report performance impact are one of the most affordable and efficient ways to measure change, especially if 25% of learners must be measured. If this is not acceptable, many providers will be challenged to meet any of the "Achieving Outcomes" Criteria and therefore excluded from achieving Accreditation with Commendation.
ACCME-accredited provider	Not clear what "connects" means – correlates, causal, something else? Very tough for the college to measure (in at least 25% of ACAAI learners) AND demonstrate the impact on individual physicians (on at least 10% of ACAAI learners) AND Connect the impact to the activity. Cost prohibitive for the relatively small number of programs and learners that we serve. This is very close to impossible for member organizations serving non-hospital practitioners to do in any meaningful way.
ACCME-accredited provider	Medical societies are at a disadvantage with this criteria. They do not have access to individual patients, EMR records, or hospital outcomes. Surgical societies are also at a disadvantage. Surgeons do not learn about a skill in one CME activity and try a new skill the next day. There is a slower and more cautious learning process. The standards are unrealistic.
ACCME-accredited provider	I think you mean under the standard 'Demonstrated impact on performance for ?10% of an 'activity's' learners OR Measured impact on performance for ?25% of provider's entire program's learners (in an entire accreditation cycle or one year in the accreditation cycle?)
ACCME-accredited provider	Many of the critical elements of this objective will require either additional resources from us or from the individuals/institutions to directly measure effectiveness. It would be useful to see examples of how this can be met or how it has been met in the past. If the new criteria will be implemented when an organization is 2 years into its 4 year accreditation cycle, will we be required to implement 25% across all programs in the last 2 years of the cycle? How will previous 2 years worth of activities be reviewed?
ACCME-accredited provider	For providers without access to actual provider performance data, such as EMR data, this would prove to be highly difficult to measure by anything other than self-reported learner change. There is also some concern that this criterion shares many qualities with C11 and could be better defined to make the distinctions clearer.

Call for Comment Responses: Proposal for a Menu of New Criteria for Accreditation with Commendation

C36: Since you answered 'no', please explain and/or suggest edits.	
Organization Description	Comments
ACCME-accredited provider	<p>Within the measurement standard, define the difference between “measure” and “demonstrate”.</p> <p>Additional Comments: While we support that CME should be outcomes-oriented and designed to address professional practice gaps; in general, medical specialty societies are challenged to demonstrate changes in performance and patient health outcomes. The current health care delivery system severely limits societies’ ability to access data, such as that from EHRs and CDRs, which would support this level of measurement.</p> <p>Additionally, We strongly recommend that the ACCME use only the term “OR” in each of its criteria, rational, critical elements, and measurement standards</p>
ACCME-accredited provider	<ol style="list-style-type: none"> 1. CRITICAL ELEMENTS: Should change last AND to an 'OR' demonstrates ongoing use..... 2. RATIONALE and CRITICAL ELEMENTS: This criteria seems to be asking for too much measurement. 3. How is this Criterion differentiated from C11? It appears from the current wording that we are speaking of the same criterion as C11 and thus, if we are speaking of a different intent, we would suggest different language in support of that intent.
ACCME-accredited provider	<p>For providers without access to actual provider performance data (e.g., EMR data), this would be difficult to measure other than through self-reported learner change.</p> <p>Would self-report data, in which learners indicate performance-related changes resulting from CME activities, demonstrate compliance; would demonstration of improvement via MOC Part 4-approved and PI CME activities ensure compliance with this criterion?</p> <p>This criterion seems to share qualities with C11 and could be better defined to make the distinctions clearer.</p> <p>In the Standard, define “impact.”</p> <p>Suggest the “And’s” in the Critical Elements become “And/Or’s”.</p> <p>Merge or better differentiate the scope of and expectations for compliance for C36 and 37.</p>
ACCME-accredited provider	<p>See previous % comments.</p> <p>This is an onerous criterion. For a meeting with 3000 registrants, 300 learners would have to be followed. It is known that return on evaluations etc is poor, particularly those that are done months after the CME activity.</p> <p>To do so would create a need for large resources and be a financial burden to the provider. This criterion would be much easier for a hospital based CME provider versus a subspecialty medical society and therefore is biased.</p>
ACCME-accredited provider	<p>C36: Connects impact on performance... need more details on this. Demonstrate the impact...How can you measure impact performance! I need a sample Questionnaire or a sample.</p>
ACCME-accredited provider	<p>For providers without access to actual provider performance data, such as EHR data, this would prove to be highly difficult to measure by anything other than self-reported learner change. There is also some concern that this criterion shares many qualities with C11 and could be better defined to make the distinctions clearer.</p>

Call for Comment Responses: Proposal for a Menu of New Criteria for Accreditation with Commendation

C36: Since you answered 'no', please explain and/or suggest edits.	
Organization Description	Comments
ACCME-accredited provider	Confusion over how one might demonstrate the impact of performance of individual learner. Is self reporting admissible? If not, it is seemingly impossible for a non-healthcare provider or a non-academic provider to track the performance of it's member's participation in CME activities. Specialty medical societies do not have this kind of performance tracking for its members.
ACCME-accredited provider	There needs to be clarify if these are objective or subjective (self-reported) performance measurements.
ACCME-accredited provider	How can we, as CME providers, demonstrate the impact of the CME program of individual health professionals if we are unable to measure them in their practice setting? Can this measurement occur in a simulated environment? This seems to favor institutions with direct patiety care. In addition, the critical elements requiring 'and' and the standard of percentages may not be achievable.
ACCME-accredited provider	Is self-reporting of performance included in the definition? It is very difficult for specialty organizations to measure performance because we are not connected to an academic institution/hospital for chart review, etc. Thus, self-reporting would need to be included in the definition. This criterion is similar to C11 and the distinctions between them should be better defined.
ACCME-accredited provider	AMIA agrees with CMSS: 'For providers without access to actual provider performance data, such as EMR data, this would prove to be highly difficult to measure by anything other than self-reported learner change. There is also some concern that this criterion shares many qualities with C11 and could be better defined to make the distinctions clearer.'
ACCME-accredited provider	Without access to chart/EHR data this is virtually impossible to assess. Thus far, physicians have demonstrated reluctance to audit their own charts and submit their performance data.
ACCME-accredited provider	For this criterion, it would be really helpful to have actual examples of 'demonstrates the impact on the performance of individual health professionals' (e.g., patient surveys).
ACCME-accredited provider	This seems too burdensome for CME providers who do not or cannot already measure activity results above a competency level. It is not clear if this criterion is targeting individual activities or the CME program at large, and if the latter, how that can be achieved.
ACCME-accredited provider	My institution does not have the ability to oversee educational impact on learners' performance in their clinical environments.
ACCME-accredited provider	This criterion on first read, seems clear; however, there is a concern whether 'individual' health professional means that evaluations are no longer anonymous. Also, is this realistic? As an experienced CE/CME professional with nearly 20 years, I see that immediate response to evaluations is the most successful. But this does not show change in performance. Is there a requirement for measurement from 10% or 25% of learners or the opportunity to participate?

Call for Comment Responses: Proposal for a Menu of New Criteria for Accreditation with Commendation

C36: Since you answered 'no', please explain and/or suggest edits.	
Organization Description	Comments
ACCME-accredited provider	<p>What qualifies as measuring whether change occurred? Can it be learner's observation or does it have to be proof of change from medical records?</p> <p>what qualifies for 'measure performance'? what tools can be used to measure? is this pre or post learning or both? not sure what 'demonstrates the impact on the performance' means. is it the same as measures or are you looking for positive results or something else? not clear.</p> <p>how do you connect impact on performance to the learning activity? just ask if the impact was a result of their attending the activity?</p>
ACCME-accredited provider	<p>This criterion seems to coincide with the MOC Part IV criteria-- and focuses on QI/PI projects that reflect actual practice change as part of an overall assessment, education and outcomes process.</p> <p>Are case studies following live activities where clinicians have to manage patient care considered appropriate for this criterion?</p> <p>I would also like for this to consider the individual's impact/performance within a team/workplace setting as an option--</p>
ACCME-accredited provider	<p>This one is not clear. Will self reporting behaviors be allowed?</p>
ACCME-accredited provider	<p>If the standard is 'OR' than the criterion should be 'Measures and demonstrates the impact of the CME program...'. It will be difficult for many accredited providers, such as those providing CME for large scale meetings, to be able to measure performance and demonstrate impact for their learners given that their are designed for a limited time interaction and do not typically involved longitudinal follow-up.</p>
ACCME-accredited provider	<p>While I like the rationale and critical elements, the metrics trouble me.</p>
ACCME-accredited provider	<p>This criterion should apply not only to individual providers but also teams and groups of provides. There need to be more clear expectations about what is meant by 'demonstrated' impact. It is also recognized that performance change may require not only learning activities but also other change strategies. The expectation for a % of learners or activities will disadvantage providers who have very robust and substantial initiatives in key areas and reward providers who have superficial and perfunctory practices across many activities/learners. We suggest instead that providers be asked to submit several examples to demonstrate compliance.</p>
ACCME-accredited provider	<p>How do you measure physician performance? What is performance? Technical skills? patient surveys? Billing? ROI? What is the data source to be used? Can it be self reported? Is the source credible? accurate? I can only get self reported data. Will that suffice?</p>
ACCME-accredited provider	<p>The language of the 2nd and 3rd critical elements is not clear. Is it more appropriate to say 'analyze the impact....' for the 2nd element? We need further definition on the expectations of how to connect the impact on performance to the learning activities.</p> <p>As this is a transition into a new process, we would like to see the proposed standard for impact on performance (10%) reduced to 5% and (25%) reduced to 10% with a transition to a higher standard at a later time.</p>

Call for Comment Responses: Proposal for a Menu of New Criteria for Accreditation with Commendation

C36: Since you answered 'no', please explain and/or suggest edits.	
Organization Description	Comments
ACCME-accredited provider	Is '...> 10% of program's learners OR ...>25% of program's learners' over the accreditation term? Annually? or other?
ACCME-accredited provider	C36 - C38 - In the document Proposal for a Menu of New Criteria for Accreditation with Commendation, The Critical Elements column uses AND between “Measures” and “Demonstrates” statements while The Standard column uses OR between “Measures” and “Demonstrates” statements. Is this correct or should both be either AND or OR?
ACCME-accredited provider	<p>What about beyond individual health professionals (i.e. capturing population data change such as change that is measured in a unit or division as a result of grand rounds, pay for performance date, etc?)</p> <p>List examples of how a provider could demonstrate impact on the performance of individual learners.</p>
Other	<p>Must clarify that self-reported data is accepted.</p> <p>I would recommend 1 accredited activity per year in the accreditation period as the standard.</p>
Other	<p>It is difficult to distinguish between criterion 36 and criterion 37 because we cannot see how one can separate performance of an individual from the process or outcomes of care (criterion 37). How individuals perform will be expressed – at least in part – on changes in behavior that will impact the process of care.</p> <p>We feel that competence (the ability to perform) is missing from the standards. Therefore, we would recommend that 36 ask that the CPD provider demonstrates the impact of the CME program on the competence of health professionals and 37 asks the CPD provider to demonstrate the impact of the CME program on the performance of health professionals in practice.</p>
Other	This criteria will be very difficult for a large percent of providers. It would not be possible for most providers organizing once per year national conferences or to providers providing international activities.
Other	Criteria is far too lofty for where we are as an educational community. Standard should be a % of an activity that is designed to measure performance change and even that will be difficult. For example, out of a typical ATLS class, it would be difficult to measure performance of running an actual code (return demonstration on mannequins would be intent to perform or competence and would not count). Many who are required to have ATLS will not have the opportunity to demonstrate performance but on few if any occasions. Only hospital CME units with access to code documentation could even hope to evaluate the learning at a “performance level”. Even a mock code would only involve a small % of learners out of the entire learner pool. Attribution of performance to a single educational event is a fool's folly, in my opinion. I know of little research that shows cause and effect relationships so why perpetuate this concept. We cannot control the variable of 'the individual learner'.
Other	This criteria would appear to unfairly advantage certain provider types like healthcare systems. In order for this criteria to be applicable to all, self reported physician data must be acceptable otherwise reviewers may only consider patient data. Although it is also worth noting that process/quality improvement of a physician can be measured by more than just patient/outcomes/safety data. A definition of what data is acceptable in this criteria would be advantageous.

Call for Comment Responses: Proposal for a Menu of New Criteria for Accreditation with Commendation

C36: Since you answered 'no', please explain and/or suggest edits.	
Organization Description	Comments
Physician/healthcare professional	The components of the critical elements need to be more completely defined if any organization is to be sure they are accomplishing adequately what is required.
State-accredited provider	Clarify what the standard means. The two are confusing. Critical elements bullet 3 would it be better to read to the learning objectives as you change performance as it relates to the objectives of the activity.
State-accredited provider	Ar e we talking CME or CPD or ????
State-accredited provider	Does 'program' refer to all of the activities offered or just one?
State-accredited provider	This is a highly desirable effect of CME, however, over the many years it has been in effect, only the largest healthcare systems with employed physicians can get anywhere close to a true performance measurement. Without further guidance and more explicit examples on how to do this, it is pie in the sky.
State-accredited provider	The Individual Health Professional piece has me wondering who that includes. We aggregate all of our individual responses to determine overall impact and we do this for physicians as the other healthcare professionals are on different tracks. I think the language is confusing. If you mean we have to report back to each attendee for each session for 10% of our classes this is probably not something we have the resources to do except in Enduring Materials or PI-CME.
State-accredited provider	Please remove the percentage Please clarify with examples what you mean I do not have the staff or finances to be able to accomplish this
State-accredited provider	The aspect of the individual learner is addressed in c30. I would suggest that c36 is about seeing improvements --not just measuring changes in learners, and not just seeing no change or negative impacts of its CME activities. But rather this criterion is (should be) about demonstrating the positive impacts on physician performance that arise from the provider's educational activities. If that's the intent, then I think it could be more clearly written here. I also don't think it is necessary for providers here in c36 to demonstrate those impacts at the level of the individual learner, but rather i myself think it would be ok and valuable if the provider showed aggregate improvement data in physician performance. Again, if that's the intent then it should be made clearer. I'm not sure I understand the %'s described in the Standard or how that would work? See my prior comments on replacing the % with a specified number of activities -since most providers do many activities/yr.
State-accredited provider	Our CME Committee wanted definitions of 'demonstrate' versus 'measure.' If I am understanding it correctly, 'measuring' means, you would like us to look at the impact with the understanding that there may be no change. 'Demonstrate' means that you expect to see the positive change as outlined during the planning and development of objectives. This is something that is not in the control of the CME team. Are 'non-physicians' included in the term 'individual healthcare providers'? Are you looking for us to measure and demonstrate the impact on them. Can we do that instead of measuring/demonstrating the impact on physicians? Here I am referencing 'individual.'

Call for Comment Responses: Proposal for a Menu of New Criteria for Accreditation with Commendation

C36: Since you answered 'no', please explain and/or suggest edits.	
Organization Description	Comments
State-accredited provider	Please clarify the standard; per term, per year?
State-accredited provider	Which is it >10 or >25%. This takes money so you are potentially excluding people from success. We plan to do this and do but consider financial implications when picking volume again.
State-accredited provider	We are unclear on 'demonstrated impact on performance' or 'measured impact on performance' in the standard. As a provider, we are unable to measure individual performance except in a very crude way (post-activity evaluations, self-reported change). And our response rate when we do this is very low.
State-accredited provider	This criteria seems too narrow. It appears useful to also include outcomes for teams and for organizations as a whole. Individuals may contribute to their teams that are not easy to measure on an individual basis. Sports provide a good example. There are some individuals who contribute immensely to team cohesion and unity, yet their individual statistics may not make them star performers. Teams often realize this only after they let such contributors go -- and team performance plummets.

Call for Comment Responses: Proposal for a Menu of New Criteria for Accreditation with Commendation

C36: Please provide comments or questions about this criterion.	
Organization Description	Comments
ACCME Recognized State Medical Society	It has been asked how hard will it be for the recognized providers, during a survey process to determine whether the provider being surveyed has complied or not. With the listed %'s this could be a very convoluted process?
ACCME Recognized State Medical Society	Rationale -many providers already send follow-up surveys to individual learners to measure if, and what change occurred for a specific activity, isn't this the same as demonstrating/measuring the impact on the individual learner and then compiling the data into a report for C12? Or at least fairly similar? Might be confusing for providers. The criterion aligns well with MOC/PI activities. Critical Elements - CME Program is mentioned in the Criterion 36, therefore, may not need to include 'connects impact on performance to the learning (activity(ies))' The Standard - is this per year or per term? How is the number of program's learners defined in this standard - is it learners at the activity or learners on a medical staff?
ACCME Recognized State Medical Society	We recommend lowering the percentages in order to be achievable, as this may be the only one of the three Achieving Outcomes Criteria that most providers could choose to achieve Commendation.
ACCME Recognized State Medical Society	It seems that a provider would have to have Crimson or something similar in order to demonstrate this criterion?
ACCME-accredited provider	not realistic for our organization
ACCME-accredited provider	While the criterion is clearly written, I'm very curious to see how many providers are able to meet this criterion.
ACCME-accredited provider	Clearly written, but will be very difficult for a providers without a clinical connection. Even providers based in hospitals or other healthcare-delivery settings may find it difficult to find clinicians who are willing or able to share their performance data.
ACCME-accredited provider	For a large health system, this amount would be out of reach.
ACCME-accredited provider	We currently have a system in place to measure performance. However, it is based on the learners' willingness to give us their feedback on the impact to their performance. Reaching the standard's expectations would be difficult if not impossible.
ACCME-accredited provider	Interesting that we would break out the demonstrated and measured. Why is that?
ACCME-accredited provider	similar in spirit but an extension of Criterion 30
ACCME-accredited provider	Important since there is no point to our Program if we don't see learners improving their performance.
ACCME-accredited provider	As a specialty society we could only assess this through learner self-report. Would this be adequate? Please remember that not all providers have access to EHR data and other direct indicators of physician behavior in practice.
ACCME-accredited provider	C36: This is an admirable criteria and we would support the inclusion of something similar, but the ACCME must take into account the fact that most professional societies do not have access to provider performance data other than self-reported data. We would recommend a lower standard to ensure the data provided is higher quality. We would recommend 1 accredited activities per year in the accreditation period as the standard.

Call for Comment Responses: Proposal for a Menu of New Criteria for Accreditation with Commendation

C36: Please provide comments or questions about this criterion.	
Organization Description	Comments
ACCME-accredited provider	The standard is likely unachievable if the provider has a large number of learners regardless of whether the impact is “demonstrated” or “measured.” In addition, this criterion requires considerable resources to collect data to comply with the standard. Providing one or two examples of how the provider satisfies the critical elements would be more reasonable.
ACCME-accredited provider	The complexity and cost of implementation of a program of individualized assessment make this a challenging criterion to meet. In its 2020 Task Force Report , ABIM describes the process to implement a thorough and useful plan for learner assessment, which details these challenges (http://assessment2020.abim.org/final-report/ , PDF pgs. 15-23). Regulatory bodies that have the infrastructure, expertise and resources in place to do so efficiently already mandate requirements for broad assessment; the potential redundancy should be eliminated (C36-C38).
ACCME-accredited provider	This C raises the specter of concern to all of us, for years, of trying to assay 'outcomes measurement.' I suspect it will be a minimally elected option
ACCME-accredited provider	Agree
ACCME-accredited provider	We do pre/post test and post activity surveys that ask what practice changes were made. This is all self-reported data. Is that enough? Without being able to get before and after data from learners, I am not sure that we could connect impact. Hospitals can do this since they have QI data readily available but other entities would not.
ACCME-accredited provider	The ability to provide self-reported data would be key.
ACCME-accredited provider	Seems similar to two other previous criterion. I believe the criterion is somewhat clear and the elements are well stated; however, it becomes complicated when you start requiring a percentage of activities. The rationale and critical elements really helped to solidify my understanding of the criterion.
ACCME-accredited provider	This is another criterion that might be a real stretch for many programs. Measuring an individual's performance as directly related to a CE activity would be quite challenging. We suggest deleting this criterion.
ACCME-accredited provider	Standard is untenable for many providers. Consider 15% of all activities.
ACCME-accredited provider	For many providers (including ours) it will be hard to have more than 10% of our program meet quantifiable metrics and will most likely discourage online CME. The amount of support that is needed to engage online learners in PI/QI activities is very difficult to provide.
ACCME-accredited provider	As indicated previously, I question the standard.
ACCME-accredited provider	See concerns from page 1 of the survey related to The Standard
ACCME-accredited provider	This should be the essence of CME of the future. But, better distinguishing definitions of demonstrated impact vs. measured impact would be helpful.
ACCME-accredited provider	The criterion is clear but I do not agree with the standard.
Media	Excellent! Let's engage learners in self-improvement!

Call for Comment Responses: Proposal for a Menu of New Criteria for Accreditation with Commendation

C36: Please provide comments or questions about this criterion.	
Organization Description	Comments
Other	For providers without access to actual provider performance data, such as EMR data, this would prove to be highly difficult to measure by anything other than self-reported learner change. There is also some concern that this criterion shares many qualities with C11 and could be better defined to make the distinctions clearer.
Physician/healthcare professional	This is a great idea, again small facilities need analytics in order to demonstrate change. As mentioned earlier this is costly and requires staff with this training - not readily available in rural areas.
Physician/healthcare professional	physicians have myriad responsibilities and demands on their time. having to complete some kind of survey or data collection project or similar in order to show the benefit of a cme program just so the cme program can get a higher rating is likely to be unpopular among physicians
Physician/healthcare professional	This is totally unacceptable. CME should be about knowledge-based activities. Changing learner performance and measuring whether learner's performance has actually resulted in change is FAR beyond the scope of CME and is moving into MOC/MOL-like territory. The individual health professional should be responsible for improving his/her own performance, not the CME provider.
Physician/healthcare professional	I like the definition of demonstrated impact vs. measured impact which lends clarity.
State-accredited provider	Yes we measure change now. But to show that it actually occurred in the stated percentages -- and be able to actually connect them to the activity is not possible.
State-accredited provider	Criterion is clear. Standard seems unreasonably high. Would there be any consideration for working TOWARDS the standards?
State-accredited provider	Criterion 36 is clear, but the standard is ambiguous. What is the difference between demonstrating and measuring impact? That is not at all clear.
State-accredited provider	Most of my CME Committee members object to the concept of evaluations already. They believe that evaluation of education on physician competence is not possible. Evaluating individual physicians would send them through the roof. This would go to administration and Med Exec Committee to state objections to state medical association.
State-accredited provider	We vote the Standard be: 'Demonstrated impact on performance for no less than 5% of program's learners OR Measured impact on performance for no less than 5% of program's learners.'
State-accredited provider	Standard of 10% and 25% should be dropped because may be unrealistic and unworkable for many CME programs
State-accredited provider	How is the number of program's learners defined in this standard?

Call for Comment Responses: Proposal for a Menu of New Criteria for Accreditation with Commendation

C36: Please provide comments or questions about this criterion.	
Organization Description	Comments
State-accredited provider	Again as above. I believe that the standard as written is way too high. and greater than 10% of our activities that would be about 30 activities that would have to meet this and with the number of Journal Clubs and case conferences we hold out of our approximate 300 programs this would be difficult to achieve. I am unclear what is meant by 'and/or learners' and how those number would translate. Also I believe that the increased workload to meet this high number of activities with a CME office that is staffed by a CME director, CME manager and Admin Assistant/coordinator along with additional responsibilities added to the plate with ABIM and other specialty boards this is unrealistic. We have been accredited with commendation for the past 2 cycles and I am not certain this added work is worth the bang of receiving 6 years instead of 4. I also think that the critical element should include and/or and not just and to make it more realistic.
State-accredited provider	Due to link to individual performance (and not groups like inpatient hospital team or OB surgeons) - this will make it hard to use hospital quality data. We follow things like XXXX medication is best practice when used in heart failure. We can track all of hospitalists before and after an intervention. This is good stuff - my administration wants to see it and my managers want to use it to identify additional training needs. Will this work count for 37?
State-accredited provider	EMR was supposed to make this possible. The data collected in electronic medical record databases is not often accessible at this stage. This criterion should come at a later date. It also will burden local resources.
State-accredited provider	Very similar to other criteria already in place. Seems a duplication
State-accredited provider	None
State-accredited provider	The standard is too high and needs to be revised. Small CME program coordinators/managers do not have the personnel or man hours to devote to measuring to meet identified standards. The standard should be if the CME program has activities that actually are linked to measuring performance and the impact of performance. The critical elements should be or instead of AND. These are unattainable standards for a small CME program.
State-accredited provider	Very unlikely to engage individual practitioners. Will take too much of their time.
State-accredited provider	The individualization involves time, staff and \$\$\$
State-accredited provider	This should not be separate for Criterion 30.
State-accredited provider	How could this be measured? How could it be tracked? Who would set up the individual's curriculum? This would be very difficult. We would need more personnel and a bigger budget.
State-accredited provider	Again, difficult for smaller institutions to obtain.
State-accredited provider	Would be great if we could measure actual performance by observation or chart audits but most of the time performance is measured anecdotally.
State-accredited provider	Almost impossible to connect causal factors to an educational activity. Very very few providers will attempt this.
State-accredited provider	Although the criteria is well written the standard still continues to complicate the expectation of what is expected and what the surveyors will need to measure to attain this criteria. Needs to provide examples of all criteria to better understand what will be expected of them.

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C36: Please provide comments or questions about this criterion.

Organization Description	Comments
State-accredited provider	Very onerous.

C37: Demonstrates the impact of the CME program on process improvement.

C37: Since you answered 'no', please explain and/or suggest edits.	
Organization Description	Comments
ACCME Recognized State Medical Society	Again, the Critical Elements are not clear enough to determine applicability. Measure processes of care how? demonstrate impact in what way? Connect impact on process how?
ACCME Recognized State Medical Society	Unable to assess. Inadequate and/or deficient methodological evidence of validity, reliability and application practicality of process. Details upon request. E.g. lack of evidence this criteria should carry same “weight” as any other and is mainly exclusive of other criteria to avoid double weighting. Applicability and importance depends on nature and scope of provider. Again, major exclusivity issues plus “chicken and egg” application practicality concerns. Often process change and CME are concurrent.
ACCME Recognized State Medical Society	Not possible for small providers. Changing processes of care would take a long time ... plus staff and resources. I would say the standard for C37 would have to be for the term, not year.
ACCME Recognized State Medical Society	This criterion doesn’t represent the opportunity for all provider types equally. It appears to be designed for specific types of providers. A SMS might not be able to meet this criterion. Critical Elements: - Better if allowed for this OR that, instead of this AND that. The Standard: - Demonstrated impact on process(es) or quality of care in ?10% of activities or measured impact on process(es) or quality of care in ?25% of activities -- too high
ACCME Recognized State Medical Society	Need to define what is meant by “measure”, “demonstrate”, and “connect”. The ability of a provider to achieve this will depend largely on their relationship to a health care system. As described above, we do not recommend requiring providers to apply this criterion to a certain percentage of their learners/activities, but rather to describe how they have achieved this across their program.
ACCME Recognized State Medical Society	The rationale uses the same words as the criterion. Part of what is contributing to the burnout and frustration in medicine is the arbitrary emphasis on measuring arbitrary things. I don't think CME helps by trying to justify itself with this criterion.
ACCME Recognized State Medical Society	Revise to 'Demonstrates the impact of the CME program on process and/or quality improvement. Reason for revision-added the word 'quality' so it aligns with the rationale. Critical Elements - CME Program is mentioned in C37, therefore, remove 'connects impact on process and/or quality improvement to the learning activity(ies)' to reduce repetitiveness. Modify Critical Elements to AND/OR. The Standard - is it per year or per term?

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C37: Since you answered 'no', please explain and/or suggest edits.	
Organization Description	Comments
ACCME Recognized State Medical Society	% of the standard is not a good idea for any Criteria; this will be too complicated to calculate. Providing multiple examples for a Criteria should be sufficient for a compliance finding.
ACCME Recognized State Medical Society	The percentages are not clear – is it 10/25% of all activities in a term? This is an important criterion for our system, and 10% of activities that show impact or 25% of measuring for impact of process improvements will be difficult for many providers to achieve. Abandoning other important CME medical knowledge activities in order to focus only on process measures to achieve commendation may result. This could also result in a decrease of physician attendance. Also, percentages are complicated for accreditors to work with during the survey process. Example, what activities/how many do we need to select for review?
ACCME Recognized State Medical Society	Does demonstrating the impact of the CE program on process improvement refer to only observed (objective) changes or can the changes be subjective (self Reported)? Define Process improvement. (See previous comments regarding the complexities involved in requiring percentages.)
ACCME Recognized State Medical Society	Standard percentage is a concern - see 1st page for details.
ACCME Recognized State Medical Society	This criterion may exclude smaller organizations which do not have patient outcome data or whose mission statement does not include changes to patient outcomes. As written the standard for measurement would need clarification.
ACCME Recognized State Medical Society	The criterion and the rationale may be achievable by a most providers, the use of the word 'AND' in the critical elements seems unreasonable. The definition of the Critical Elements needs to be explained in more detail. The Standard percentage will be very difficult for surveyors to assess or providers to achieve.
ACCME-accredited provider	As in C36, this criterion goes to the 'gold standard' as to CME provider capability and sophistication. First, it is extremely difficult to correlate the effectiveness of a CME educational intervention as the cause for an improvement in quality or process. CME providers may claim that a CME intervention as part of a quality improvement intervention has had a positive result, but the reality is that so many other factors are at play typically that it cannot be demonstrated easily if at all. Certainly, CME helps. Again, as in C36, the Standard is excessive.
ACCME-accredited provider	C37 The third part of the critical element is problematic, as “Connects impact on process and/or quality improvement to the learning activity(ies)” can only be accomplished through selected intervention strategies capable of determining causation, which are not present in the majority of the real-world environments of CME providers. Many performance improvement activities are part of larger initiatives (at local, regional, or national levels) so that participants are subjected to many influences in addition to formal educational activities. Suggest that initially the rigorous critical element of demonstrating cause of improvement from the education not be adopted. If after experience with this criterion, too many providers are achieving the standard, then ACCME could later consider raising the bar.
ACCME-accredited provider	Example please.
ACCME-accredited provider	This is nearly impossible for a small CME program to achieve.

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C37: Since you answered 'no', please explain and/or suggest edits.	
Organization Description	Comments
ACCME-accredited provider	The Standard is not clear. What is the difference between demonstrated impact and measured impact? Why are the thresholds different?
ACCME-accredited provider	I am concerned that this is not a responsibility of the CME division, but instead more a responsibility for specific QI divisions. I think it's important for CME to collaborate with QI, but the primary responsibility for the critical elements listed should fall on the QI division. This seems resource intensive and difficult for larger programs to achieve (especially for those institutions with a large number of RSS).
ACCME-accredited provider	There is a choice within The Standard between Demonstrate OR Measure, but within the Critical Elements all three are required ('AND'), which is somewhat confusing! Also, The Standard must define the difference between “demonstrate” and 'measure'. What constitutes adequate “demonstration of impact” and how is it documented? The Standard should include examples of “demonstration” methods, as distinct from “measurement” methods.
ACCME-accredited provider	Can the impact be self reported?
ACCME-accredited provider	Don't you mean the power of a provider's CME program to increase the quality of the learners' procedures/processes of delivering care? Not 'process(es) OR quality of care. IAHB might offer courses to therapy clinics providing care to families dealing with end-of-life situations. We'd measure the clinics'a ability to deliver soup-to-nuts ... value to the family of an IP diagnosed with a terminal illness; then design/deliver training to increase the quality of that process, from counseling re: alternative treatments to providing access to financial advisors to providing help with the legal, moral, spiritual (etc.) as well as medical issues evolving from right-to-die legislation/decisions.
ACCME-accredited provider	Our support of this criterion is contingent on the ACCME defining what it means by “measure”, “demonstrate”, and “connect”. A provider’s ability to achieve this will depend largely on whether they have a relationship with a health care system (not all do). As described earlier, we do not recommend requiring providers to apply this criterion to a fixed percentage of their learners/activities, but rather to describe how they have achieved this across their program (informed the design of all their activities).
ACCME-accredited provider	What does 'process of care' mean. I am not sure this is a useful term. 'process of care' as I understand 'process of care' is a CMS term, referring to how well the entire care team--doctors to hospitals to nurses and all pertinent health care providers accomplish care for 5 specific conditions: Acute MI , Pneumonia, certain surgical care, nosocomial infections, and Vaccination administration. I am not a surgeon nor interest nor primary care provider, so these 'processes of care' are not part of my daily practice. I think I know what you want 'measure of ongoing quality improvement in my practice as a result of a CME activity' I don't think the term 'process of care' is clear or useful and has already been commandeered by CMS

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C37: Since you answered 'no', please explain and/or suggest edits.	
Organization Description	Comments
ACCME-accredited provider	Please clarify the time period for demonstrated impact or measured impact--is the accreditation period, annual, something else? We believe this will be a very difficult criterion to meet successfully by any CME provider that is outside an institution that has direct access to healthcare provider behavior data; further, processes of care extend well beyond our learners--physicians are part of a system but cannot impose change unilaterally. We can educate about how to influence their home institutions and overcome barriers, but how we go about measuring and demonstrating impact is hard to conceive. Is the vision that CME now is supposed to address the entire healthcare system and teams and is broadening well beyond its primary focus on continuing the medical education of physicians? If so, it is diverging from the missions of many current CME providers.
ACCME-accredited provider	I'd like a better explanation of this Criteria. Perhaps defining what you mean by 'processes.' Just state what is meant by 'processes.'
ACCME-accredited provider	Not sure about the difference between 'demonstrate' and 'measure' - candidly I am very confused by this as worded and would skip over it. How would a medical specialty society measure process? Maybe this one is not meant for organizations such as mine? if yes, possibly add text 'hospitals, clinical care providers.....'??
ACCME-accredited provider	Process improvement and quality improvement do not necessarily refer to the same types of programs or outcomes. Please clarify what is meant by these terms. A criterion focused on the integration of CME into quality improvement efforts in healthcare - specifically in support of MOC and quality reporting requirements - would be an excellent addition to the menu.
ACCME-accredited provider	Again, we need help to understand what you will accept for this criteria. We, are a part of the process. Outcomes measurements may not be effective for us as we provide information to the clinician who then does the patient care. Connecting the impact may be more difficult due to our role in the health care environment.
ACCME-accredited provider	Not clear what “connects” means – correlates, causal, something else? This is difficult and the standard is very high. It is not feasible for ACAAI to achieve the requirement to demonstrate process impact (in at least 10% of its activities) AND measure process impact (in at least 25% of ACAAI activities). Cost prohibitive for the small number of programs of learners that we serve. This is very close to impossible for member organizations serving non-hospital practitioners to do in any meaningful way.
ACCME-accredited provider	'Processes of care' needs further definition. Is this criteria looking at quality improvement or processes of care? Again, medical societies are at a disadvantage. They do not function with in a hospital or a practice setting nor do they have access to individual patients, EMR, or hospital outcomes.
ACCME-accredited provider	Provide examples of the 'impact on the process' If the new criteria will be implemented when an organization is 2 years into its 4 year accreditation cycle, will we be required to implement 25% across all programs in the last 2 years of the cycle? How will previous 2 years worth of activities be reviewed?

Call for Comment Responses: Proposal for a Menu of New Criteria for Accreditation with Commendation

C37: Since you answered 'no', please explain and/or suggest edits.	
Organization Description	Comments
ACCME-accredited provider	This criterion is internally inconsistent, which makes it difficult to interpret. The criterion references a connection between the CME program and process improvement but the rationale references 'process and/or quality improvement' which are not necessarily interchangeable. Given the increasing emphasis on quality improvement and reporting for physicians, a more effective and efficient approach may be to build a criterion that emphasizes the impact of the CME program on quality improvement and reporting efforts.
ACCME-accredited provider	Within the measurement standard, define the difference between “measure” and “demonstrate”. Additional Comments: While we support that CME should be outcomes-oriented and designed to address professional practice gaps; in general, medical specialty societies are challenged to demonstrate changes in performance and patient health outcomes. The current health care delivery system severely limits societies’ ability to access data, such as that from EHRs and CDRs, which would support this level of measurement. Additionally, We strongly recommend that the ACCME use only the term “OR” in each of its criteria, rational, critical elements, and measurement standards
ACCME-accredited provider	RECOMMENDATION FOR C37: Reword the Criterion as follows: 'Integrate CME activities into healthcare QI efforts.' In the spirit of collaboration we encourage the ACCME to work with the ACEhp to align C37 with the QIE Roadmap and Initiative. We feel that the CME Community has been engaged in this initiative and thus it makes sense to align this established initiative with a new criterion related to QI. 2.RATIONALE: What does the process really impact? 3.RATIONALE:Implementation science. The Criterion description is not aligned with the stated Rationale. The Criterion indicates process improvement while the rationale indicates process &/or quality improvement. 4.CRITERION/RATIONAL/CRITICAL ELEMENTS: Process improvement of what? 5.CRITICAL ELEMENTS:How do you define 'measures of process of care'? 6.CRITICAL ELEMENTS:The wording of the critical element seems to place the emphasis in the wrong area. Suggest that the impact be on the individual physician performance
ACCME-accredited provider	This criterion is inconsistent; it references a connection between the CME program and process improvement, but the rationale references 'process and/or QI.' Given the increasing emphasis on QI and reporting for physicians, it may be more effective to emphasize the impact of the CME program on QI and reporting efforts. Would self-report data in which learners indicate process-related changes resulting from CME activities demonstrate compliance? Would demonstration of process improvement via MOC Part 4-approved and PI CME activities ensure compliance? Suggest the “And’s” in the Critical Elements become “And/Or’s”. This criterion seems to share qualities with C11 and could be better defined to make the distinctions clearer. Merge or better differentiate the scope of and expectations for compliance for C36 and 37.
ACCME-accredited provider	see previous comments
ACCME-accredited provider	C37: The same with this. More details needed.

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C37: Since you answered 'no', please explain and/or suggest edits.	
Organization Description	Comments
ACCME-accredited provider	This criterion is internally inconsistent, which makes it difficult to interpret. The criterion references a connection between the CME program and process improvement but the rationale references 'process and/or quality improvement' which are not necessarily interchangeable. Given the increasing emphasis on quality improvement and reporting for physicians, a more effective and efficient approach may be to build a criterion that emphasizes the impact of the CME program on quality improvement and reporting efforts.
ACCME-accredited provider	More clarity is needed around process improvement and 'the impact' of the CME program. Again this seems to be exclusive of a specialty medical society's ability to demonstrate whether the end result desired is process improvement or quality improvement.
ACCME-accredited provider	Our medical society changes the process of care; however our examples extend outside of our CME program to our Guidelines and Best Practice Published Papers.
ACCME-accredited provider	Not all CME providers have the ability to evaluate whether or not their program impacts processes or quality of care. Transplantation is unique in that it has had a mandatory national system of risk-adjusted outcomes in place for the entire patient population for more than 25 years. While ASTS incorporates data from SRTR into its educational interventions, it is unable to make a direct link from those interventions to improvements in quality of care. This criterion also seems to favor institutions with direct patient care over medical specialty societies.
ACCME-accredited provider	needs work
ACCME-accredited provider	AMIA agrees with CMSS: 'This criterion is internally inconsistent, which makes it difficult to interpret. The criterion references a connection between the CME program and process improvement but the rationale references 'process and/or quality improvement' which are not necessarily interchangeable. Given the increasing emphasis on quality improvement and reporting for physicians, a more effective and efficient approach may be to build a criterion that emphasizes the impact of the CME program on quality improvement and reporting efforts.'
ACCME-accredited provider	The criterion uses the term 'process' but it is not clear why process is important. The focus should be on the quality of patient care, as stated in the annotated rationale.
ACCME-accredited provider	Other than measurement concerns previously mentioned, I am concerned with the jargonish expression in the last sentence of the Rationale. Generally speaking, one of the most challenging aspects of CME is finding a deliberative, clean, principled method of measurement of the impact and benefit of activities.
ACCME-accredited provider	This criterion seems more ambiguously written than the others. In this instance, an example could help illustrate.
ACCME-accredited provider	I would hope that this would extend beyond institutions.
ACCME-accredited provider	Clearly designed for institutions or hospitals and not stand-alone CME providers. Does the activity have to measure the process, or can already existing records be used? what does 'demonstrates the impact' mean? are you saying shows outcomes? what qualifies as connecting the impact to the activity? can it be a simple question to the learner to that effect?

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C37: Since you answered 'no', please explain and/or suggest edits.	
Organization Description	Comments
ACCME-accredited provider	Process/quality improvement may be measured by so much more than patient safety/outcomes. If the definitions are broadly expanded, this allows the entire community to be fully creative. Any limitations to patient safety/outcomes would greatly favor two providers over the rest of the community.
ACCME-accredited provider	I believe the criterion is unclear. It also becomes complicated when you start requiring a percentage of activities.
ACCME-accredited provider	I am not sure what the difference is between demonstrated and measured impact are-- I think that this needs to be more clear. This also seems to resonate with the MOC Part IV activities, the ACO structure and expectations for healthcare performance and the changes from a CQI/QI/PI process. Since I am not clear on the difference between demonstrated and measured impact, I am unclear as to why the measured benchmarks are different.
ACCME-accredited provider	Need to use consistent language throughout as processes of care are part of, but different from quality improvement and quality of care. For example, an educational activity may lead to improved quality of care but not processes of care.
ACCME-accredited provider	As with the other, I like the rationale, critical elements, but the metrics may be difficult to achieve.
ACCME-accredited provider	The term 'process improvement' needs to be defined. Why is this focused on process and not outcomes? In many cases, CME is a strategy that is part of a QI initiative and it is not possible or feasible to determine the specific impact of the CME component to the overall outcome. The expectation for a % of learners or activities will disadvantage providers who have very robust and substantial initiatives in key areas and reward providers who have superficial and perfunctory practices across many activities/learners. We suggest instead that providers be asked to submit several examples to demonstrate compliance.
ACCME-accredited provider	Is '> 10% of activities OR >25% of activities' over the accreditation term? Annually? or other?
ACCME-accredited provider	As the outcomes and rationale delve deeper in the core competencies, the methods to measure change become increasingly conceptual. Some providers may have difficulty accessing electronic health records in order to demonstrate the impact of the program on patients and communities. Even while adhering to HIPAA compliance, some institutions lean toward an overabundance of caution.
Other	Must include the fact that self-reported data is acceptable. The standards are set too high. I would recommend 1 accredited activity per year in the accreditation period as the standard.

Call for Comment Responses: Proposal for a Menu of New Criteria for Accreditation with Commendation

C37: Since you answered 'no', please explain and/or suggest edits.	
Organization Description	Comments
Other	<p>It is difficult to distinguish between criterion 36 and criterion 37 because we cannot see how one can separate performance of an individual from the process or outcomes of care (criterion 37). How individuals perform will be expressed – at least in part – on changes in behavior that will impact the process of care.</p> <p>We feel that competence (the ability to perform) is missing from the standards. Therefore, we would recommend that 36 ask that the CPD provider demonstrates the impact of the CME program on the competence of health professionals and 37 asks the CPD provider to demonstrate the impact of the CME program on the performance of health professionals in practice</p>
Other	seems to largely overlap with criterion 36 as written. Feels to me like criteria 36 and 37 need more differentiation.
Other	I think this might be a bit of a stretch. I am concerned that “Improving “Process of Care” is not and should not be the responsibility of the CME division of most institutions. In most hospitals and medical schools there are departments that have responsibility for this important function. To the extent that those departments wish to have medical education on a particular process, CME divisions would be pleased to work with them, but that will not happen in 10% of activities. Even less likely for quality of care in 25% of activities. These should be changed to the Standard in C38 - once per year.
Other	This criterion is internally inconsistent, which makes it difficult to interpret. The criterion references a connection between the CME program and process improvement but the rationale references 'process and/or quality improvement' which are not necessarily interchangeable. Given the increasing emphasis on quality improvement and reporting for physicians, a more effective and efficient approach may be to build a criterion that emphasizes the impact of the CME program on quality improvement and reporting efforts.
Other	Criteria narrows the concept of process improvement as only relevant to providers with direct ties to clinical processes when it could be easily adapted to encompass both health care process improvement as well as educational process improvement. The real intent should be to reward providers who can demonstrate engagement of their CME program in more sophisticated process improvement methods regardless of the subject of that improvement. Please make this criteria so more than just medical schools and hospitals can achieve it.
Other	This criteria requires some clarification around what type of data the ACCME is seeking. If you are expecting the provider to provide data that demonstrates learners now have knowledge and ability to improve processes then we are supportive. If however, we have to demonstrate an actual change and improvement in an actual process existing within a clinical setting then this would exclude or be extremely difficult for many provider types.
Physician/healthcare professional	What concerns me is that all of this criteria excludes small rural hospital from offering CME credits. The ideal is lofty and to be applauded but is not a reasonable expectation for communities outside of metropolitan area with educational resources readily available. Small hospital need to be able to offer providers continuing education opportunities. Maybe there needs to be different expectations for different CME programs. Assuming our physicians may need to go to a large program for some credits and be able to take some less vigorous programs here.

Call for Comment Responses: Proposal for a Menu of New Criteria for Accreditation with Commendation

C37: Since you answered 'no', please explain and/or suggest edits.	
Organization Description	Comments
Physician/healthcare professional	Unclear how the Critical Elements are to really be achieved. The elements are vague and incomplete.
State-accredited provider	Clarify the standard. Explain the two processes better. Maybe add examples to these criteria to make it clearer to the user.
State-accredited provider	The standard is confusing as written. Not sure what the difference is between demonstrate and measure would be. I can see mostly anecdotal references here that may be meaningless. Again, I think you are asking for too much too soon.
State-accredited provider	36, 37, and 38 should be combined. Either measure the performance, the process or the impact. There's so much overlap.
State-accredited provider	Because Process Improvement is different than Performance Improvement the way this is written is not what we do in CME. We have teams that work on the process, then our physician education team comes in and do the PDSA cycle on the physician portion of the workflow to address ways to improve performance, patient care and outcomes. We do not have control over the Process Improvement piece which is a different skill set and larger scope than that of Performance Improvement. If you meant to say impact on performance vs process, I would agree with this. Not sure about 25%
State-accredited provider	Rationale and elements need clarification. A small CME program would have difficulty achieving all aspects of the critical elements as well as meet the extremely high standards. This criterion needs to be revised to be obtainable for the small CME program that have minimal staff/man hours.
State-accredited provider	Please remove the percentages that amount should not be required Provide examples of what you want and how to do this
State-accredited provider	Some of the folks within my organization see 'process improvement' as distinct from 'clinical quality improvement'. Somehow, I believe that the ACCME is not using these terms so literally and so distinctly, but rather and rightly here asking providers to demonstrate positive impacts (changes) on process improvement, quality improvement, patient safety, resource utilization as relates to the clinical delivery of healthcare or healthcare leadership or organizations. I would recommend the term 'clinical process or quality improvement' be included in the language of the criterion. Further clarification could help in the Critical Elements section to help us better understand. I like that there is a requirement to link the changes to the provider's educational activities; i think that is key. As for the Standard, i think it would be ok to have the provider both describe & show (document) some pre-defined minimum number of examples, rather than a percentage of its activities or learners.
State-accredited provider	please add '&/or quality improvement. Please clarify if this standard is expected per term, per year, etc. Take the 'AND' away and replace with 'OR' in the critical elements section.

Call for Comment Responses: Proposal for a Menu of New Criteria for Accreditation with Commendation

C37: Since you answered 'no', please explain and/or suggest edits.

Organization Description	Comments
State-accredited provider	My comment is the same as C36. Please give an example of process improvement within criteria to better define this for people.
State-accredited provider	Since we are an organization outside the healthcare provider organizations, it is hard for us to get this information on the individual level. We are more likely to get it on the team or organizational level.

Call for Comment Responses: Proposal for a Menu of New Criteria for Accreditation with Commendation

C37: Please provide comments or questions about this criterion.	
Organization Description	Comments
ACCME Recognized State Medical Society	I believe this is doable for all providers. However, the survey/measuring process for the SMS providers might be very difficult?
ACCME Recognized State Medical Society	Maybe this could be achieved by offering CME activities that are 'hands on' which according to specialty and/ theme may be easy. I think about CPR's, etc.
ACCME Recognized State Medical Society	Hospital providers should be able to comply with C37 but non-facility providers will have a much more difficult time. Some examples of how other providers could approach C37 would be valuable.
ACCME Recognized State Medical Society	We believe this is doable for only a small percentage of providers.
ACCME-accredited provider	not realistic for our institution
ACCME-accredited provider	This might be easier to capture that data for C36, however, again, while we have mechanisms in place that show improvements in patient safety, if we cannot draw a line between this improve and a specific CME activity, would we not be commended for this improvement?
ACCME-accredited provider	We wholeheartedly agree with this criterion. However, as has been mentioned before, meeting the standard would be difficult as activity content is driven by the departments. We do have activities that meet this criterion but the standard set is difficult to reach.
ACCME-accredited provider	For a large health system, this amount would be out of reach.
ACCME-accredited provider	Curious again about the demonstrated vs measured impact, and the choice in percentage margins.
ACCME-accredited provider	Unlike the prior criterion, a CME provider may be more willing to share organization-wide performance data to demonstrate their compliance.
ACCME-accredited provider	Percentages may be difficult for small and large organizations to achieve.
ACCME-accredited provider	The and/or in the critical elements doesn't make much sense to me. I would think that a change in process that does not impact the quality of patient care is not something that would have much value?
ACCME-accredited provider	The standard is likely unachievable for providers with a large number of activities. Demonstrating or measuring impact on process is laudable, but it is also an expensive and resource-heavy process that is unlikely to be attempted for 10-25% of activities. A better standard would be an absolute number of examples rather than a percentage.
ACCME-accredited provider	How are small member-services associations, especially those in the psychiatry sector, expected to try and meet this requirement? The standard of number of activities and/or number of years in the term to show impact is unreasonable.
ACCME-accredited provider	C37: This is an admirable criteria and we would support the inclusion of something similar. However, specialty societies typically do not have access to the learner at their place of work. We would recommend a standard that indicates self-reported data would be acceptable. We would recommend 1 accredited activity per year in the accreditation period as the standard.

Call for Comment Responses: Proposal for a Menu of New Criteria for Accreditation with Commendation

C37: Please provide comments or questions about this criterion.	
Organization Description	Comments
ACCME-accredited provider	This Criterion will be very difficult to achieve for CME providers which are removed from “processes of care” as measuring and demonstrating impact on these processes will be problematic.
ACCME-accredited provider	Please note that this may be difficult for small nonprofit medical specialty societies to measure. Please provide examples for medical specialty societies.
ACCME-accredited provider	Reword the Criterion as follows: 'Integrate CME activities into healthcare QI efforts.' (supporting narrative) In the spirit of collaboration we encourage the ACCME to work with the Alliance to align C37 with the QIE Roadmap and Initiative. We feel that the CME Community has been engaged in this initiative and thus it makes sense to align this established initiative with a new criterion related to QI.
ACCME-accredited provider	Quality of patient care is already measured and reported through multiple mandated mechanisms, including PQRS, Meaningful Use, and Value Based Modifier reporting. As of 2016, eligible physicians will be able to use Qualified Clinical Data Registries for quality reporting and will be able to participate in registries that provide a robust tool for continuous quality improvement. Based on this, we recommend measurement of the impact of CME on process improvement or health of patients communities, be removed.
ACCME-accredited provider	I think it is hard to say that one educational activity impacted an entire process of care. Also, for those of us who do not work in a clinic setting, this criterion becomes extremely hard to initiate and track.
ACCME-accredited provider	This criterion is clear but not fair to CME provider organizations that are not health care organizations. Therefore, the requirement of 10%/25% are excessive and probably not achievable for most CME providers. There is also a concern that CME providers who are not health care organizations may be limited because of patient confidentiality.
ACCME-accredited provider	Agree
ACCME-accredited provider	Several of these Criteria could overlap with a given project or activity; however may not meet the Standard(s) for each w/ learner or activity penetration.
ACCME-accredited provider	As a non-hospital based organization, we would not be able to get QI data. Recommend adding more to the Outcomes category for stand alone education companies.
ACCME-accredited provider	Challenging for medical education companies who do not have regular access to patient outcomes and safety data. HIPPA requirements may produce limits on how information can be gathered and used. This criterion may be out of reach for MECC.
ACCME-accredited provider	Didactic lectures are far less effective at learner change compared to activities like PI CME and case review conferences. We have had other format options for several years and this criteria encourages greater use of other learning formats.
ACCME-accredited provider	Standard is untenable for many providers. Consider 15% of all activities.
ACCME-accredited provider	We're not sure you can 'measure' a process. You can impact, describe, demonstrate, define, strategize. or improve upon a process. But we're not sure you can measure it. A better word should be selected for that first Critical Element for this criterion.

Call for Comment Responses: Proposal for a Menu of New Criteria for Accreditation with Commendation

C37: Please provide comments or questions about this criterion.	
Organization Description	Comments
ACCME-accredited provider	As indicated previously, I question the standard.
ACCME-accredited provider	As this is a transition into a new process, we would like to see the proposed standard for impact on performance (10%) reduced to 5% and (25%) reduced to 10% with a transition to a higher standard at a later time.
ACCME-accredited provider	See concerns from page 1 of the survey related to The Standard
ACCME-accredited provider	This should be the essence of CME of the future. But, better distinguishing definitions of demonstrated impact vs. measured impact would be helpful.
ACCME-accredited provider	The criterion is clear but I do not agree with the standard. Currently there is no percentage or number of activities and/or learners required for any of the Commendation Criteria/. I think that more providers will put forth the effort to achieve this and the other criteria if there is no percentage or number standard attached.
Physician/healthcare professional	same as above
Physician/healthcare professional	This is totally unacceptable and FAR beyond the scope of what CME providers should be responsible for. Moreover, to fully implement this criterion will be a significant burden on CME providers and may inhibit their ability to fulfill other, more relevant criteria for 'commendation'!
State-accredited provider	Once again, the criterion is clear but the standard is ambiguous--what's the difference between demonstrated or measured impact?
State-accredited provider	We may be able to do the first two bullets but again connecting the event's impact on the quality improvement is not possible.
State-accredited provider	The criterion is clear - the standard seems unreasonably high. We are a small department in a large institution. While we do a lot of process and / or quality improvement education - it is not ALL that we do.
State-accredited provider	We have an well staffed department that do process improvement and another for quality and patient safety. When I have approached them about integrating CME into appropriate initiatives they are very sceptical and very disinclined to spend time on any effort.
State-accredited provider	We vote the Standard be: 'Demonstrated impact on process(es) or quality of care in no less than 5% of activities OR Measured impact on process(es) or quality of care in no less than 5% of activities.
State-accredited provider	This is part of the Quality and Safety committee, Despite what you would like, CME committee is not in charge of the entire healthcare organization in which it resides.
State-accredited provider	Standards of 10% and 25% may be unrealistic and unworkable for many CME programs.

Call for Comment Responses: Proposal for a Menu of New Criteria for Accreditation with Commendation

C37: Please provide comments or questions about this criterion.	
Organization Description	Comments
State-accredited provider	Again as above. I believe that the standard as written is way too high. and greater than 10-25% of our activities that would be about 30-75 activities that would have to meet this and with the number of Journal Clubs and case conferences we hold out of our approximate 300 programs this would be difficult to achieve. I am unclear what is meant by 'and/or learners' and how those number would translate. Also I believe that the increased workload to meet this high number of activities with a CME office that is staffed by a CME director, CME manager and Admin Assistant/coordinator along with additional responsibilities added to the plate with ABIM and other specialty boards this is unrealistic. We have been accredited with commendation for the past 2 cycles and I am not certain this added work is worth the bang of receiving 6 years instead of 4. I also thin that the critical element should include and/or and not just and to make it more realistic.
State-accredited provider	Very similar to other criteria already in place. Seems a duplication
State-accredited provider	The standard measured impact of 25% of activities seems relatively high. Most programs that measure patient outcomes and safety is often rare. Recommend a lower percentage such as ?10%.
State-accredited provider	Provide emphasis on the core competencies of interprofessional patient outcomes and patient safety.
State-accredited provider	Process improvement has been embraced by many practice environments. The measurement of improvement is usually not the CME department but Quality Departments where it should stay. CME planners could attempt to obtain data but should not be made responsible for generating the data.
State-accredited provider	This is the next step if you do Criterion 26. The Standard should be the same.
State-accredited provider	Would like to see far more involvement with the Quality and Talent Development and Optimization departments. Believe we could do much to improve processes and support change to support better patient outcomes if allowed. Must have full involvement of CME Committee and Administration. Can only do what I get approval for. Need a team to make things happen. Alone, little can be accomplished. Need more communicaiton and interaction.
State-accredited provider	Again, we would be interested in an explanation of 'measure' and 'demonstrate.' I actually am a big fan of this one, if we in fact are focusing on all disciplines. It takes the entire team to really affect change, especially process change!
State-accredited provider	Is challenging for traditional CME but would work in places where there is a quality staff person on board to identify problem and measure change.
State-accredited provider	We are not facility based and neither are our joint providers so may not be able to comply with this criterion. We would appreciate examples of how non-facility providers could achieve compliance.
State-accredited provider	Although Criteria is well written, the standard complicates measuring this by surveyors and the time spent in doing this. This also puts extra work on the staff and if they are part time and can be able to do this.
State-accredited provider	Clear
State-accredited provider	Too demanding

C38: Demonstrates the impact of the CME program on the health of patients/communities.

C38: Since you answered 'no', please explain and/or suggest edits.	
Organization Description	Comments
ACCME Recognized State Medical Society	Again without a clearer understanding of what ACCME means in the language of the Critical Standards, this one is hard to evaluate (see comments for 36 & 37) and again appears designed to reward a specific provider type not a diverse community of providers.
ACCME Recognized State Medical Society	Unable to assess. Inadequate and/or deficient methodological evidence of validity, reliability and application practicality of process. Details upon request. E.g. lack of evidence this criteria should carry same “weight” as any other and is mainly exclusive of other criteria to avoid double weighting. Applicability and importance depends on nature and scope of provider. Unclear what “every year of term” means. Again, major exclusivity and “chicken and egg” application practicality issues. Poorly and vaguely written.
ACCME Recognized State Medical Society	C38 ideal but not easy to accomplish for small providers.
ACCME Recognized State Medical Society	- This is too vague to know what is specifically being looked for. Would this apply to a activity(ies) or the program as a whole? - How would it be measure or is that up to the provider? - Data may take some time to compile for analysis such as in a
ACCME Recognized State Medical Society	This criterion doesn’t represent the opportunity for all provider types equally. It appears to be designed for specific types of providers. A SMS might not be able to meet this criterion. Critical Elements: - Better if allowed for this OR that, instead of this AND that. The Standard: - Demonstrated impact on the health of patient/communities at least once in each year of term or measured impact on the health of patient/communities at least once for every year of term -- too high
ACCME Recognized State Medical Society	Need to define what is meant by “measure”, “demonstrate”, and “connect As described above, we do not recommend requiring providers to apply this criterion to a certain percentage of their learners/activities, but rather to describe how they have achieved this across their program.
ACCME Recognized State Medical Society	The arbitrary measurement of things does not help. It only contributes to more paperwork and bad data.
ACCME Recognized State Medical Society	Providing multiple examples for a Criteria should be sufficient for a compliance finding.

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C38: Since you answered 'no', please explain and/or suggest edits.	
Organization Description	Comments
ACCME Recognized State Medical Society	Connecting the dots between learning activities and patient/community health may be tenuous. We understand that in order to be relevant, CME needs to demonstrate impact, but there are many additional factors affecting health outcomes that are beyond the provider's control. Could a provider develop an initiative over one or two years that is designed to improve the health of patients or communities, describe how and why the initiative was developed and implemented, and document that it made an effort to demonstrate impact? A thoughtful analysis showing no impact on health outcomes, including describing outside factors (in other words failure), should be allowed under C38.
ACCME Recognized State Medical Society	Standard percentage is a concern - see 1st page for details.
ACCME Recognized State Medical Society	The criterion and the rationale may be achievable by a few providers, the use of the word 'AND' in the critical elements seems unreasonable. Description of how the Critical Elements can be achieved is necessary. Define patient/community. The Standard percentage will be very difficult for surveyors to assess or providers to achieve. How will the last standard be measured?
ACCME-accredited provider	C38 as proposed should be deleted. It's overly ambitious. Many of us would argue that the CME program is not responsible for the health of communities. While it is appropriate that the Criteria for Accommodation should be provocative and encourage CME programs to go well beyond standard lectures and dive into new arenas and be innovative, but there are reasonable limits to what a CME program can (and should) do. I think C38 goes beyond these limits and as such the ACCME should strive to craft criteria that are achievable.
ACCME-accredited provider	C38 The third part of the critical element is problematic, as "Connects impact on the health of patients/communities to the learning activity(ies)" can only be accomplished through selected intervention strategies capable of determining causation, which are not present in the majority of the real-world environments of CME providers. Many performance improvement activities are part of larger initiatives (at local, regional, or national levels) so that participants are subjected to many influences in addition to formal educational activities. Suggest that initially the rigorous critical element of demonstrating cause of improvement from the education not be adopted. If after experience with this criterion, too many providers are achieving the standard, then ACCME could later consider raising the bar
ACCME-accredited provider	What qualifies as a 'community' here?
ACCME-accredited provider	The Standard is not clear. What is the difference between demonstrated impact and measured impact? Can you give some examples of how to measure and demonstrate the impact? I think it is an extremely high expectation that a CME provider can measure impact on the health of patients and communities. I am not sure that public health officials or hospital administrators can do this, let alone a CME program, especially if resources are limited.

Call for Comment Responses: Proposal for a Menu of New Criteria for Accreditation with Commendation

C38: Since you answered 'no', please explain and/or suggest edits.	
Organization Description	Comments
ACCME-accredited provider	There is a choice within The Standard between Demonstrate OR Measure, but within the Critical Elements all three are required ('AND'), which is somewhat confusing! Also, The Standard must define the difference between “demonstrate” and 'measure'. What constitutes adequate “demonstration of impact” and how is it documented? The Standard should include examples of “demonstration” methods, as distinct from “measurement” methods.
ACCME-accredited provider	This appears to duplicate or at least overlap with Criterion 27. If you are implementing strategies to improve public health (Cx27), would you then need to measure those strategies to comply with this requirement? Need clarification about the differences between these criteria and what is expected to demonstrate compliance.
ACCME-accredited provider	This seems to be written for hospitals or organizations that have access to patients and their information.
ACCME-accredited provider	This would not work for providers who are not in a hospital setting.
ACCME-accredited provider	Our support of this criterion is contingent on the ACCME defining what it means by “measure”, “demonstrate”, and “connect”. As described earlier, we do not recommend requiring providers to apply this criterion to a fixed percentage of their learners/activities, but rather to describe how they have achieved this across their program (informed the design of all their activities).
ACCME-accredited provider	A CME provider is NEVER going to be able to measure a specific patient health outcome as a result of a CME participant's CME attendance because the CME provider is not a privileged recipient of HIPAA protected health information. SO as criterion 38 applies to 'patient' it is somewhat disingenuous. A CME provider may be able to follow health trends like 'after the agent X meeting, the use of Agent X went up/ or down (if Agent X is harmful) but I don't know that the CME provider has any ability to assign direct cause to this trend. MANY large meetings or meetings with current hot-button content are covered by the media so the increased or decreased use of Agent X might be a result of media broadcasting and not a specific CME attendee to Patient 1:1 relationship at all.
ACCME-accredited provider	The definitions of community and patients is overly broad. Many CME providers do not have direct access to these constituencies.
ACCME-accredited provider	I would like to see a better explanation of this Criteria. How do you evaluate a community? What do you mean by demonstrate the impact on the health... Is it the impact of the education on the health of patients? I thought we were looking at the impact of the education on the healthcare professional and how that impacts patient outcomes? Just seems confusing.
ACCME-accredited provider	Would need help with terms. Would a random sampling be sufficient? Could complications be used as proxy? Declining insurance claims?

Call for Comment Responses: Proposal for a Menu of New Criteria for Accreditation with Commendation

C38: Since you answered 'no', please explain and/or suggest edits.	
Organization Description	Comments
ACCME-accredited provider	<p>Not clear what “connects” means – correlates, causal, something else?</p> <p>This is costly, difficult and the standard is very high. It is not feasible for our organization to achieve the requirement to demonstrate impact on patient/community health (in at least once a year of reaccreditation term) AND measure impact on patient/community health (in at least once a year of reaccreditation term). Cost prohibitive for the small number of programs and learners that we serve. This is very close to impossible for member organizations serving non-hospital practitioners to do in any meaningful way.</p>
ACCME-accredited provider	Many providers do not have access to this data, patients, or EMR. They cannot fulfill this criteria.
ACCME-accredited provider	Define how we are to measure community health outcomes.
ACCME-accredited provider	By focusing only on the CME program, this criterion ignores the contributions of an organization's quality improvement initiatives - which may not be certified CME activities - on the health of patients and communities.
ACCME-accredited provider	<p>Within the measurement standard, define the difference between “measure” and “demonstrate”.</p> <p>Additional Comments: While we support that CME should be outcomes-oriented and designed to address professional practice gaps; in general, medical specialty societies are challenged to demonstrate changes in performance and patient health outcomes. The current health care delivery system severely limits societies’ ability to access data, such as that from EHRs and CDRs, which would support this level of measurement.</p> <p>Additionally, We strongly recommend that the ACCME use only the term “OR” in each of its criteria, rational, critical elements, and measurement standards</p>
ACCME-accredited provider	<p>GENERAL COMMENTS ABOUT 'ACHIEVING OUTCOMES' CRITERIA:</p> <p>Current medical education evaluation models, such as Moore’s or Kirkpatrick’s models, are focused on measuring individual-level changes. Recently there has been considerable attention given to evaluation models that address group (health care team) and system (QI, Six Sigma, team-based) changes. This document focuses in the beginning on group and systems-level changes. However, the evaluation criteria remain at the individual level (performance, impact, “our patients and communities”). Addition of some measure of system and team approaches to measurement (as well as design) would create more alignment in the document. We should recommend adding criteria or two that point to group, team, and system level evaluation models/metrics.</p>
ACCME-accredited provider	<p>By focusing only on the CME program, this criterion ignores the impact of an organization's QI activities, which may not be certified CME activities, on the health of patients and communities.</p> <p>Suggest the “And’s” in the Critical Elements become “And/Or’s”.</p>
ACCME-accredited provider	C38: this is also very difficult to achieve. What are your core measurement? How do you measure? Needs more details.
ACCME-accredited provider	By focusing only on the CME program, this criterion ignores the contributions of an organization's quality improvement initiatives - which may not be certified CME activities - on the health of patients and communities.

Call for Comment Responses: Proposal for a Menu of New Criteria for Accreditation with Commendation

C38: Since you answered 'no', please explain and/or suggest edits.	
Organization Description	Comments
ACCME-accredited provider	By focusing only on the CME program this criteria ignores the contributions of our organizations quality improvement initiatives.
ACCME-accredited provider	This criterion seems to require a significant amount of resources to achieve. Some providers may not be able to demonstrate the impact of their activities on community outcomes based on their resources.
ACCME-accredited provider	There are too many factors that affect the health of our patients and communities. How does one determine that it is "your CME" that had this impact – or what factor(s) made the change? There are non-CME quality improvement initiatives and efforts to positively impact the health of patients and communities. This criterion could benefit from including efforts outside of the CME program.
ACCME-accredited provider	AMIA agrees with CMSS: 'By focusing only on the CME program, this criterion ignores the contributions of an organization's quality improvement initiatives - which may not be certified CME activities - on the health of patients and communities.'
ACCME-accredited provider	Does this criterion mean to suggest that only organizations with established patient registries qualify for commendation regardless of the quality of the education?
ACCME-accredited provider	As with C36, this seems too burdensome for CME providers who do not or cannot already measure activity results above a competency level. It is not clear if this criterion is targeting individual activities or the CME program at large, and if the latter, how that can be achieved. For example, my organization does not have access to the patients served by our activities, we could not measure the impact of our program or activities on their health outcomes.
ACCME-accredited provider	My institution does not have the ability to measure community health outcome. We do not work in or have influence in a central community.
ACCME-accredited provider	Does measurement have to be part of activity or from existing records? define 'community' health. what does 'demonstrates the impact' mean? are you saying it has to have outcomes? or has to have positive outcomes? what qualifies as connects impact to learning activities? is a learner question to that effect sufficient?
ACCME-accredited provider	How is this different than the public/population health criterion? Is the expectation that providers will look at their patient populations and then design programming to change/improve that specific population-- so could it focus on stroke prevention in women? How would that be assessed? What metrics would be required to determine how the CME program impacted this outcome? It seems that the CME program can influence the outcomes -- is that what this criterion is seeking? Cervero's article questions whether patient outcomes can be directly related to CME activities and so I am a bit concerned that there are additional factors here that need to be included if the goal is to determine how the CME program contributed to the change in patient outcomes.
ACCME-accredited provider	You might give examples of how to link the learning activity with patient outcomes. Wow This is difficult to do. Would be fantastic to show a strong link for 6 of these.

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C38: Since you answered 'no', please explain and/or suggest edits.	
Organization Description	Comments
ACCME-accredited provider	While the standard is not as burdensome as the other proposed criteria, it also does not recognize that there is often significant time lag between the intervention and impact/change in either the health of patients and/or communities. Potentially, it could be several years before relevant data become available. Furthermore there is no way to isolate the impact of a single (or even multiple activities). CME can be one element of a larger systematic educational campaign.
ACCME-accredited provider	The terms 'impact', 'measure', 'health of patients' and 'communities' need to be defined. As noted with Criterion 37, it is not usually possible to determine the specific contribution of CME to an overall outcome. This criterion should be assessed across the accreditation period.
ACCME-accredited provider	What about the impact on the university? As a CME provider, I serve my university community first. Credit for providing value across the university community is not recognized in the criteria. The focus on changing the community you serve has a role as well.
ACCME-accredited provider	Is a community a geographical area? Would a hospital or a physician's clinical practice qualify as a community?
ACCME-accredited provider	See 37.
Other	For standard, change wording to be consistent; use either “once in each” or “once for each” but not both.
Other	Requires a definition of communities in this setting.
Physician/healthcare professional	Again an analytics issue. I think an ongoing study over more than a year is doable to do this annually is not.
Physician/healthcare professional	Details of how this is to be accomplished are missing.
Physician/healthcare professional	Given the criteria used in the preceding criteria I think consistency would be helpful. Maybe the % difference is not the same, but it should appear.
State-accredited provider	Clarify standard and how to measure it. Provide examples.
State-accredited provider	Isn't this the same as C27?
State-accredited provider	not sure how we can measure this
State-accredited provider	Almost impossible to measure
State-accredited provider	How can programs be sure that it was the CME activity that affected change in communities when it could be other environmental, social, economic, political, and cultural factors.
State-accredited provider	How do you demonstrate impact? What is considered impactful?
State-accredited provider	The elements need clarification. A small CME program would have difficulty achieving all aspects of the critical elements as well as meet the extremely high standards. This criterion needs to be revised to be obtainable for the small CME program that have minimal staff/man hours.
State-accredited provider	I do not have the staff or resources to track this information every year

Call for Comment Responses: Proposal for a Menu of New Criteria for Accreditation with Commendation

C38: Since you answered 'no', please explain and/or suggest edits.	
Organization Description	Comments
State-accredited provider	<p>Given that impact of CME on patient outcomes is a much more challenging achievement as proven by the CME literature, is successful change a requirement? What if we look at potential impacts and do all that work just to find that the impact was not as we expected. Does that count? We are currently partnering with our IHR (institute for health research) in a prospective trial of CME impact on behavior change and are very excited about this work. However, we are fully aware that most research projects do not end with the desirable result. We are moving forward as we think this will be a learning experience whether patient outcomes are changed or not and will help guide our work. This feels like what you want CME shops to be doing and is the ideal, yet not sure this criteria rewards the process, but only the outcome. Not the right message??</p>

Call for Comment Responses: Proposal for a Menu of New Criteria for Accreditation with Commendation

C38: Please provide comments or questions about this criterion.	
Organization Description	Comments
ACCME Recognized State Medical Society	This criterion is the goal and desired 'gold'. As I see it, only through Public Health in th Health Delartment we will be able to appreciate it. In other words, reliability of success is not possible for our providers to achieve it. I will gladly listen to ways of assessing it, I hope it will be reachable.
ACCME Recognized State Medical Society	This should be the essence of CME of the future. But, better distinguishing definitions of demonstrated impact vs. measured impact would be helpful.
ACCME Recognized State Medical Society	Critical Elements - CME Program is mentioned in C38, therefore, remove 'connects impact to process and/or quality improvement to the learning activity(ies)'
ACCME-accredited provider	This criterion is clearly written, but I think it is extremely challenging to meet.
ACCME-accredited provider	Patient/Community outcomes might be better to capture because they are a matter of public record. Still as with C37 I would be concerned about make a one-to-one correlation between community improvement and a specific bit of CME.
ACCME-accredited provider	Change the first 'AND' to 'OR' at the end of the first bullet point in Critical Elements.
ACCME-accredited provider	Do have concerns about whether an activity can be directly connected to impact on the health of patients/communities as often this is a result of multiple factors (many of which are unknown).
ACCME-accredited provider	True impact can be difficult to measure impact on the 'community' with limited resources for many CME providers.
ACCME-accredited provider	No comments
ACCME-accredited provider	Yes, but you also mean patients within communities: research and interventions that clearly articulate and address issues that evolve from conflicts between or differing needs of these two 'logical types', or 'classes' (in Bertrand Russell's terms) of CME recipient. The patient and the patient's community are both potential CME recipients. In some cases they have very different needs.
ACCME-accredited provider	Our primary learners offer supportive consultative and diagnostic services to other physicians, who in turn make treatment decisions that are likely to impact patients but may or may not impact the health of communities. There are so many intervening variables and environmental forces between what our learners do and how the health status of a community varies--whether for good or bad--that it would be disingenuous to claim that these variations have a demonstrable line back to one of our CME activities. To make the claim that we have this effect annually would border on the absurd and flies in the face of valid epidemiologic research.
ACCME-accredited provider	1. The Criterion would would be difficult, if not impossible, to achieve for providers that do not have access to the patient data of its learners.
ACCME-accredited provider	It appears that only providers who have chosen patient-level outcomes as an outcome for their programs will be able to achieve this criterion. It is also limited to CME providers who are also healthcare providers. A large national organization such as a specialty society would not have an opportunity to demonstrate this type of outcomes from its program. Are there comparable criteria for providers who have identified competence or performance as their program outcomes?

Call for Comment Responses: Proposal for a Menu of New Criteria for Accreditation with Commendation

C38: Please provide comments or questions about this criterion.	
Organization Description	Comments
ACCME-accredited provider	While this may, at a stretch be possible for pathologists given our national audience, compounded by the lack of direct patient care we think, depending on how a provider is expected to demonstrate this that it may be beyond our scope of resources to do this.
ACCME-accredited provider	This Criterion will be very difficult to achieve for CME providers which are removed from “patient/community outcomes.”
ACCME-accredited provider	Again, this maybe hard for small medical speciality socieites to measure. Can you provide examples of how this might be accomplished?
ACCME-accredited provider	How are small member-services associations, especially those in the psychiatry sector, expected to try and meet this requirement? The standard of number of activities and/or number of years in the term to show impact is unreasonable.
ACCME-accredited provider	C38: This is an admirable criteria and we would support the inclusion of something similar. Again, specialty societies typically do not have access to data on patients or communities. If a society were to attempt a project, this would be above and beyond what most attempt. We would recommend 1 accredited activity in the accreditation period as the standard.
ACCME-accredited provider	Since anesthesia in of itself does not impact public health, this would be a very difficult criterion to demonstrate compliance.
ACCME-accredited provider	We believe this is achievable by only a small percentage of providers.
ACCME-accredited provider	Take the 'AND' away and replace with 'OR' in the critical elements section.
ACCME-accredited provider	Various areas at our institution manage programs that address public health. However, not all of them are CME certified. Additionally, our system health information is not readily available to our office, that privilege is reserved for clinicians. Finally, much the comparison data is managed by our QA office and we are not privy to such information. Our goal in working with the departments is to always create content that is designed to change patient outcomes and improve the quality of physician performance and competency. We do not have the ability to orchestrate annual surveys of patients nor the community.
ACCME-accredited provider	I would like to see examples of fulfilling this criterion.
ACCME-accredited provider	Agree. This is likely the single most important criterion.
ACCME-accredited provider	Same as previous.
ACCME-accredited provider	This can be achieved by all types of CME organizations using public health data and community partnerships.
ACCME-accredited provider	This criterion may be out of reach for MECC. If organization does not have ready access to patient outcome and safety data.

Call for Comment Responses: Proposal for a Menu of New Criteria for Accreditation with Commendation

C38: Please provide comments or questions about this criterion.	
Organization Description	Comments
ACCME-accredited provider	Critical elements and The Standard needed to satisfy proposed criterion C38 are not equally applicable and providers not in teaching hospitals, or those without similar access to patients and/or patient data, would be at a disadvantage in satisfying it. In keeping with ACCME's stated desire to "reflect the diversity of the CME community, create flexibility, and offer a pathway for all CME provider types to achieve Accreditation with Commendation," we recommend the Critical Elements and Standards for satisfaction for C38 be removed or tailored by provider type (e.g., teaching hospitals, medical specialty societies, state medical societies, etc.), offering providers in various practice areas comparable opportunities to achieve or continue Accreditation with Commendation.
ACCME-accredited provider	Many providers would find this very difficult. It's a nice goal in CME, but we would delete this criterion.
ACCME-accredited provider	Very important criterion but the standard is not applicable to all accredited providers as they may not be in a position to measure and demonstrate outcomes, and connect these outcomes to their learning activities. In addition we know that health care outcomes may be affected by many factors outside of the provider's control making it difficult to connect impact to the learning activity.
ACCME-accredited provider	It will be very hard to 'connect impact on the health of patients/communities to the learning activity'. Frequently public health campaigns take years to have an impact. To expect a yearly activity in this realm is more than commendation, it's pretty much a miracle.
ACCME-accredited provider	As indicated previously, I question the standard.
ACCME-accredited provider	Again, clarify whether the measurement needs to be objective or can be self reported impact on the health of patients or the community
ACCME-accredited provider	A CME provider may not have within its mission the care/health of patients and communities. Some specialty organizations focus only on the education and training of the physician without concern about the impact on the community. In an international CME provider, who is the community?
ACCME-accredited provider	This is really a community event which would be great to do but not sure that CME is the best way to address. Public health workers and others in the community would be in a better position .
Other	In order to be fair to all organization types and sizes, I would recommend 1 accredited activity in the accreditation period as the standard.
Other	I like the 'Standard' for this criteria and I think many of the other criteria should be changed this standard.
Other	By focusing only on the CME program, this criterion ignores the contributions of an organization's quality improvement initiatives - which may not be certified CME activities - on the health of patients and communities.
Other	Demonstrating this would be very challenging. It might take longer than one year to bring about the change we are looking for. Maybe 1 every two years would be more attainable.

Call for Comment Responses: Proposal for a Menu of New Criteria for Accreditation with Commendation

C38: Please provide comments or questions about this criterion.	
Organization Description	Comments
Physician/healthcare professional	I think these criteria, and this one in particular, will be difficult to achieve for any CME provider with less than a system wide hospital/ company and those resources to prove outcomes are achieved. This doesn't mean it's not worth having, but that should be considered.
Physician/healthcare professional	not sure we can do this annually.
Physician/healthcare professional	This seems impossible. How can a CME program measure health outcome in a community, esp. on short term basis.
Physician/healthcare professional	This an extremely worthy goal but I fear it may be too onerous for CME providers to fulfill and take away their ability to provide new, innovative forms of CME to physicians.
State-accredited provider	Probably won't work for a small hospital.
State-accredited provider	The criterion is clear. The standard is very high. Just last week at the Alliance meeting, an awards was given to A group who was able to do this. Is this reasonable for providers?
State-accredited provider	Standard is unclear.
State-accredited provider	I don't think this could be accurately measured without a formal research effort. Most of my physicians claim that their lectures will have an improve patient health until I ask how do you know, can we measure it? Doing this in the community? Again hospital CME is being ignored.
State-accredited provider	Once again, extremely difficult for Providers that are small with limited resources.
State-accredited provider	We vote the Standard should be 'Demonstrated impact on the health of patients/ommunities at least once in the Accreditation cycle OR Measured impact on the health of patients/communities at least once in the Accreditation cycle.
State-accredited provider	This is another one that may be unreachable for the smaller, less staffed healthcare CME department. Measuring patient/community health outcomes can be extremely time consuming and if it is in fact accomplished it take even more time to determine whether or not it was the CME activity that was the reason for the outcome. I just think it's a lot for the smaller department or hospital.
State-accredited provider	Again I thin it should be more of an and/or under critical elements and the standard is probably doable if one feels they can impact patient/communities health. Measuring of this can be very difficult.
State-accredited provider	Very similar to other criteria already in place. Seems a duplication
State-accredited provider	None

Call for Comment Responses: Proposal for a Menu of New Criteria for Accreditation with Commendation

C38: Please provide comments or questions about this criterion.	
Organization Description	Comments
State-accredited provider	Similar to criterion 37. It puts the burden of data collection and linkage on the CME provider. In today's complex healthcare pinpointing a single intervention to a positive outcome is a rare occurrence since most outcome changes only come about with multiple interventions including public health initiatives. This requirement is way beyond the capabilities of local CME departments. It would be more productive to encourage planning of CME activities targeted to major community health problems. Tracking of improvement is the responsibility of the agencies or clinical departments who identified the problems and gaps.
State-accredited provider	This is what we do so there is not problem with this.
State-accredited provider	Improvement of public health is an important goal for all of us in the field. There are committees, societies, academic institutions, and government organizations that focus on this with much greater expertise than the ACCME. It is too bad, but the ACCME is not in charge of everything, not does it dictate policy.
State-accredited provider	Great goal. Not easily or cheaply achieved.ay need collaboration of local/regional state agencies who have the data
State-accredited provider	Don't know how this could be done, or how it could be measured. Would like more input from the ACCME on how these could be accomplished, especially when you have no budget. Hospitals are businesses, and if your department doesn't generate income your budget is small or none. CME is limited to what you can get approved. Please reach out to hospital administrators and educate them as to your expectations with regard to these changes. I have been told that some of what you are proposing has been seen as radical ideas. Support from the top will be necessary for change to take affect, and for services to expand.
State-accredited provider	The standard is likely unachievable for the many providers who don't measure the impact of CME on patients/communities. The standard should be reduced to no more than two legitimate examples per accreditation term.
State-accredited provider	Directly linking the activity to an community outcomes is VERY HARD. There are always outside factors. This is unreasonable.
State-accredited provider	I like the intent of this criterion in that it asks providers to make changes in patient outcomes. Just to be clear, does a provider meet this criterion (and, for that matter, c36 and c37) if the provider 'measures' the impacts of change but does not show/demonstrate that there actually was a change or if the change was a negative or adverse one? I would suggest that the provider must go beyond the measurement of patient outcomes and show that it actually did make a change. (That's probably where the 'AND''s come in in the Rationale section?) Again, i like that the provider is asked to link the changes to its educational activities. I think the Standard could reflect a finite minimum number of examples or a minimum number of examples per year since the time when the provider implemented these new criteria.
State-accredited provider	Clearer understanding of what is expected and how each provider will be able to attain this criteria.
State-accredited provider	Already happening in the form of QA activities

Call for Comment Responses: Proposal for a Menu of New Criteria for Accreditation with Commendation

C38: Please provide comments or questions about this criterion.

Organization Description	Comments
State-accredited provider	We are very interested in being part of such activities, So far it has been hard to form the wide range of collaborations needed to make this happen.

ADDITIONAL COMMENTS

We welcome any additional feedback you may have about the Proposed Menu of New Criteria for Accreditation with Commendation.	
Organization Description	Comments
ACCME Recognized State Medical Society	The criteria presented demonstrate a lot of effort and are very well aligned for evaluating providers' success in changing performance and attaining improved health care for our patients. Our opinions are based on the possibility of our providers being able to perform/document and therefor demonstrate compliance. Since I know they are truly interested in complying with accme criteria and essentials to reach their mission, goal, I need to make certain they will be able to continue accredited. There are several criteria that will put our providers in jeopardy for accreditation.
ACCME Recognized State Medical Society	There is no question that at the core these proposed new criteria are well intended and focused on improvement of practice and patient outcomes. But as they are currently constituted they do not allow for the diverse provider types, nor are they clear enough for full evaluation. The danger here is that without more clarity we will move to a system that will end up rewarding only certain provider types and disenfranchising others from the achievement of Commendation. I am not opposed to improving the current system, but these are not ready for prime-time just yet.
ACCME Recognized State Medical Society	Our issues with the merit and wording of each of the criteria are minor, Most criteria address factors we now consider in evaluating commendable performance. Our issues involve the lack of evidence that the methodological process has integrity as concerns validity, reliability and application practicality. There is no evidence that varying mixes of criteria compliance (8 of 16 and 1 from each group) would constitute equivalency with different varying mixes of criteria compliance to validly and reliably demonstration compliance with the "whole" - "commendation". We are not even aware of "concordance analysis" within each criteria to establish reliability. The need to guarantee "mutual exclusivity" is crucial where optional mixes of criteria compliance are utilized to assure one is not measuring the same thing multiple times but missing the "whole". When all criteria must be met overlap is less of an issue.
ACCME Recognized State Medical Society	As evident in many of my responses in this survey, I think most of the new criteria are geared more towards large provider types and I don't see many of my small/rural providers meeting the critical elements or standards due to lack of resources/staff/C Suite support. I don't think these criteria are for everybody. My providers stress over C1-C15 and I can see them being overwhelmed by C23-C30. Is it possible to let them opt out of Commendation section? If Commendation is not for them, let them decide. They know best what they are capable of doing given the structure of their institution ... both operationally and administratively. Working within their means doesn't indicate they aren't providing meaningful and effective CE. Looking to achieve full accreditation, and not Commendation, just represents who they are. They may be limited in resources, but they are still dedicated to achieving and maintaining their CME accreditation.
ACCME Recognized State Medical Society	My providers felt that almost all of the criteria was attainable but would need to know how criteria was to be measured. Another suggestion is allowing them to choose the eight they felt achievable instead of requiring a minimum of one from each category especially those geared toward academic settings. Would also like to have updated examples of noncompliance and compliance.

Call for Comment Responses: Proposal for a Menu of New Criteria for Accreditation with Commendation

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Organization Description	Comments
ACCME Recognized State Medical Society	<p>These are important directions for CME. From a realistic perspective, during implementation of the new requirements, there will be tension between what busy physicians want to do to get the CME credit they need for a variety of regulatory requirements and what they will need to do to get CME credit under the new commendation criteria,</p> <p>To meet the new commendation requirements, many academic-based CME offices will have to be transformed and add resources. They will need help not only to know how to do this but also how to get support from their organizations. Most people in the 'C-suite' still don't get 'CME as a strategic asset'.</p>
ACCME Recognized State Medical Society	<p>To all who worked on this proposed menu, thank you for all of your hard work.</p> <p>I do have a few comments that have been asked by some of the ISMA accredited providers:</p> <ol style="list-style-type: none"> 1. When working with other entities on CME programs there is a fear that there could be HIPPA issues. 2. Most ISMA accredited providers stated that they cannot comply with the Menu and will settle with a 4 years accreditation. 3. The Criteria seem to be more inline with larger hospitals and not so much the smaller SMS providers? 4. Some of the Criteria would benefit from taking out the 'and' and allowing an 'or'. 5. Are these Commendation Criteria really equivalent to all providers? <p>Thank you for the time to comment.</p>
ACCME Recognized State Medical Society	<p>IMS believes that it is possible for SMS providers to achieve accreditation with commendation under these proposed criteria, if the standards are realistic. The current proposed standards for each of these criteria are unrealistic and unattainable for our providers. The CME programs in Iowa conduct between three and a few hundred activities per year. Providers on either end of this spectrum would have difficulty retaining their current accreditation with commendation status, simply due to the standards. In addition, our providers are concerned there will be a shift in CME programs from conducting activities that meet the needs of their learners to those that meet the standards to achieve this level of accreditation. Such a shift in focus would be detrimental to CME. IMS strongly believes that CME at the local level is critical to ensuring that patients receive some of the highest quality of care in the country. Achieving a higher level of accreditation status should not interfere with this goal.</p>
ACCME Recognized State Medical Society	<p>Lots of discussion on 'The Standard':</p> <ul style="list-style-type: none"> -consider types of organizations and number of activities offered -consider the non-clinical provider -The Standards were not previously included, why now? What is the goal of The Standard? -May increase burden on providers/surveyors dependent upon the structure of the CME Program and/or organization type which our goal is not to do - Consider an organization setting out to meet a specific set of 8 criteria and then they decide the following year they want to address different criteria - what happens? Will they be locked in to those 8?

Call for Comment Responses: Proposal for a Menu of New Criteria for Accreditation with Commendation

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Organization Description	Comments
	<p>-Rather than having any of The Standards as a percentage, have a minimal number required (like 1 per year during the accreditation cycle). To measure a percentage, you need to begin with a percentage - otherwise it may be difficult to set a target - for example Healthy People and cancer plans are based on percentages and organizations have had difficulty achieving a percentage measurement typically because objectives have not been settled or there has been no previous data to base the percentage. Perhaps we should look at the entire program as opposed to activities.</p> <p>-Keep the end in mind for The Standard when it comes to tracking data - could some of the commendation criteria be tracked by adding fields to PARS that would allow providers to select 'Critical Elements/Elements' for specific activities or sessions within activities to meet criteria? This would potentially make the process for accreditors and decision-making more objective and enable the accreditors to select activities for review that incorporated the criteria and allow an organization a snapshot of their CME program where the commendation criteria has been included. Perhaps this data would be useful for the entire system. With this suggestion, consider changing 'Critical Elements' to 'Elements', expand the list of Elements and request the provider to address 2/3 of the elements or check a certain number of boxes under the 'Critical Elements/Elements for a certain number of activities, learners, session, etc.</p> <p>-Many providers shared they would potentially turn down an activity to remain within 'The Standard'.</p>
ACCME Recognized State Medical Society	<ol style="list-style-type: none"> 1. Intent of some of the Criteria may be achievable for some SMS-accredited providers but not with the standards (percentages of activities/learners) attached to them. % of the standard is not a good idea for any Criteria - this will be too complicated to calculate. Providing multiple examples for a Criteria should be sufficient for a compliance finding. 2. Criteria don't appear to represent an opportunity for all provider types. They appear to be designed for specific types of providers with financial and staff resources like one would find at academic medical centers, large national health systems or for-profit medical education companies. The small community hospital accredited by a SMS will be challenged by a majority of the proposed new Criteria and will not be positioned to try for Commendation. 3. There should be leeway to choose one Criteria from each category. I don't like that some categories are weighted more important than others. 4. Don't forget about the ACCME's definition for CME. It specifically references 'physician' not learner, or student or healthcare practitioner. If you want to change the reach of CME then submit a call-for-comment soliciting feedback on an updated definition of CME.

Call for Comment Responses: Proposal for a Menu of New Criteria for Accreditation with Commendation

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Organization Description	Comments
ACCME Recognized State Medical Society	<p>How will the standards be measured? In PARS? File selection for review? I would like to see a selection of any eight to be compliant rather than the menu - allows a true reflection of your individual programming</p> <p>Many criteria will be difficult for smaller institutions or institutions with a small CME staff - will limit successful commendation attempt.</p> <p>More activity focused than a true reflection of the individual programs.</p>
ACCME Recognized State Medical Society	<p>If the goal of these new commendation criteria is to give more providers opportunities to achieve higher standards in CME, then the percentage of activities/learners standards needs to be removed. I recommend Once or twice within a term for each criteria. You will see more providers challenging themselves to achieve commendation than before. I disagree with those who argue that commendation criteria do not need to be attainable by all providers. All providers should be encouraged to engage with a variety of stakeholders, be innovative, and take chances with new ideas. I thought that this was the original goal. Let's make it so that everyone feels included and has the opportunity to be rewarded for the good work that they do in the CME field.</p>
ACCME Recognized State Medical Society	<p>As cited earlier, the new criteria supports improvement in healthcare through education. I responded to this survey from the perspective of a national provider with available resources. However, achieving Accreditation with Commendation for a small community hospital with limited resources is somewhat impossible. The Elements and The Standard should be re-evaluated again, and consideration of allowing options (OR) in the Critical Elements may enable more, well intended organizations to achieve this commendation. Caroline Carregal</p>
ACCME-accredited provider	<p>Overall, the revised, proposed Criteria for Commendation are an excellent addition to the process for accreditation. Many providers will feel challenged by the new criteria while others will feel frustrated and overwhelmed. The criteria will provide positive incentives for directors of CME, CME Committees and the like to encourage reorganization with a new focus of their programs in order to achieve accommodation under the new criteria. They will serve to truly distinguish those providers that are doing extraordinary work from those that are doing the basics and not much more. However, the new criteria should strive to be reasonable. As such, the volume percentages in the Standards for most of the criteria are set too high and will in and of themselves, eliminate many providers from qualifying for compliance. I encourage ACCME staff to reexamine the Standards. Along with my other comments, I hope staff and ACCME leadership will modify the criteria in ways that make them less ambitious and more accessible for providers to achieve commendation. Best of luck!</p>

Call for Comment Responses: Proposal for a Menu of New Criteria for Accreditation with Commendation

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Organization Description	Comments
ACCME-accredited provider	<p>It's almost as if you must pick one criteria to do for the entire term to achieve the established metrics for an organization our size.</p> <p>The majority of the criteria seemed more appropriate for larger, academic focused organizations. These will be difficult to achieve for smaller community based hospitals. We don't have hundreds of activities. The pool of our total activities is small. It becomes about providing activities that meet criterion versus meeting identified needs of our organization.</p>
ACCME-accredited provider	I believe it will be extremely unlikely that my facility, with less than a 1.0 FTE, could ever achieve Commendation due to the lack of resources. Congrats to those who can.
ACCME-accredited provider	These Criteria benefit large institutions that employ high level (MDs, PhDs, etc) CME professionals who understand how to measure the things you are asking us to measure. Smaller institutions, like our sub-specialty hospital, with limited resources and personnel, will be hard-pressed to achieve these new criteria. This is very disheartening to those of us who have learned CME from the bottom up and have achieved accreditation with commendation in the past. I'm not sure it will be possible going forward.
ACCME-accredited provider	I'm very disappointed with the proposed criteria. Initially, I saw a great benefit from the menu proposal, but now I feel like the way the criteria are being implemented is actively trying to limit the number of providers who will earn Accreditation with Commendation. Due to lack of staff, resources, etc, I don't think I will even apply for Commendation on my next accreditation cycle.
ACCME-accredited provider	Thank you for soliciting feedback from such a broad audience. I appreciate the opportunity to express my opinions.
ACCME-accredited provider	Thank you. This reflects what we are currently trying to do at Sharp HealthCare, not easy but making progress. Look forward to seeing the results.

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Organization Description	Comments
ACCME-accredited provider	<p>I have made comments throughout on specific criteria or, more often, critical elements that are vague or that seem to favor one type of provider over another. What gives me the most pause, though, is the standards for each criterion. How will those be measured? How will they be documented? How were they developed, and by whom? What's the rationale for the cut-off for each? What's the denominator for each (for example, does learners=all learners, learners per year, learners for a subset of activities addressing the criterion? For activities, how are RSSs counted? If our Grand Rounds addresses communication skills in 3 of its 45 sessions, does that count toward the standard? As one activity or 3?)?</p> <p>Between the new requirements of the critical elements and the quantity requirements of the standards, the sheer amount of extra work needed to document compliance with these new criteria seems exponentially greater than that for the old criteria. In addition to many of the criteria seeming to favor certain provider types, this increase in and of itself automatically favors providers with large staff. A provider whose CME team consists of one full-time employee plus two administrative staff (part-time) may already be providing education that meets the criteria but may not be able to adequately document it according to the elements and standards set for each one.</p> <p>Dr. McMahon has said that these criteria should be attainable for all provider types. As written, these are not.</p>
ACCME-accredited provider	<p>I am very motivated to have our institution be accredited with commendation. I believe we run a tidy ship and we do our best to provide relevant medical education which helps our doctors to help children, families and their community. I'd welcome the opportunity to put our program through some kind of "commendation stress test" so that we can see what we need to accomplish between now and next summer when we are due for accreditation. I think I could understand all of this more if I could see how each of these Commendation Criteria expands on a specific Accreditation Criteria. Just as the ACCME would like to see a "through line" between teaching, learning and improved practice, I would like to see more clearly how C23-C38 speaks toward an expansion of C1-C15.</p>
ACCME-accredited provider	<p>In general, I think that clarifying many of the criteria is important and required. Also, I don't understand why the thresholds are so high. Will there be a phase-in period? For our program, the next accreditation evaluation would be in approximately 2 years. Which criteria will we be evaluated on? Will there be consideration in terms of the standards (% of learners and % of activities) for programs that have limited time to implement the new criteria?</p>
ACCME-accredited provider	<p>I like the idea of having a number of criteria to choose from; I think the details still need to be refined.</p>

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ACCME-accredited provider	While I like the intent of the proposed criteria, I feel the delivery is not there yet. Several of the categories do not include options that all provider types (or sizes) would be able to reasonably achieve. While I do agree that it's important for the CME system to improve and focus on the ultimate goals of improving competence, performance, and/or patient outcomes, it seems that for providers to achieve commendation, the primary focus will have to be on performance/patient outcomes. I feel that providers may find the new criteria to be too unachievable that they don't even attempt them, creating a lost opportunity to improve the CME system. I recommend lowering the percentages and either removing categories OR adjusting the requirement so that providers are better able to select those criteria that best reflect their provider type and what their organization does best.
ACCME-accredited provider	Great job on formulating the Five Categories and the 16 Criteria Menu. The development of these Criteria seems to exactly respond to the trends we are seeing in our institution, and will help us prioritize the emphasize we give to program elements and resource. Thank you for creating an objective standard to rally around, respond to the changing landscape and still keep our Commendation!
ACCME-accredited provider	Thanks for the opportunity to comment.
ACCME-accredited provider	These are worthwhile and lofty goals (other than including undergraduate medical students in planning as noted). If you want your CME organizations to make an effort to incorporate them, you need to make the criteria more realistic to achieve. Few have the resources or personnel time to do what you expect.
ACCME-accredited provider	Like I said previously in the survey, I would recommend starting all Criteria with a >10% of activities and or learners except for C33 and then consider increasing this percentage over time.
ACCME-accredited provider	In general these criteria are not consistent with your plan to simplify accreditation. The standards set up mathematical nightmares regardless if you mean per year or per accreditation term which is not clear. The criteria discriminate against providers who produce small numbers of activities and/or with large attendance per year. Rather than achieve your desire to have accredited providers demonstrate a commitment to these 5 areas, I predict providers will instead commit to a budget to be able to afford to do 8 of these items which effectively removes those with limited means from achieving commendation and placing all at the mercy of commercial interests to fund special CME projects. Some criteria are very topic oriented (public health, communication, informatics...) while others are process oriented creating an apples and oranges system which can be confusing to providers.

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	<p>I am not sure that you can find literature to support some concepts as being “efficacious” in adult learning literature. You might consider toning back the rhetoric before committing it to policy.</p> <p>Thanks for the opportunity to submit comments and suggestions. As a consultant I tried to calculate how each of 4 different provider types that I work with would fit into this new rubric. A large hospital system should do fine as well as a SOM if state funding has not been tightened. Small hospitals will have difficulty with faculty % requirements as many of their activities have but one faculty person. PMO’s will be challenged to meet the % requirements based on attendees as well as lack of direct access to data and have no chance with performance based standards. P/EC’s will be extremely challenged by both the subject areas as well as the standards criteria as many offer few activities with very large numbers of participants in very specialized niche education.</p>
ACCME-accredited provider	It's my opinion that the proposed criteria are better than prior drafts and the menu approach is preferred. However, the standard set for some criteria are too high when applied to providers with a high-volume of CME. Some criteria use the term 'relevant' and thus compliance would be too subjective. A few criteria should be converted to annual ACCME Awards to recognize individuals or organizations, but they don't appear to be appropriate across most organizations. I hope these concerns will be addressed before the criteria are finalized.
ACCME-accredited provider	More clarification is needed.
ACCME-accredited provider	General comments - For smaller CME providers or those that do not work within a large healthcare organization, this 'menu approach' is a great improvement but still difficult to achieve as written. A few things that could be considered to ease the burden while still accomplishing the goals of the ACCME may be to 1. Change many of the 'ANDs' in the Critical Elements to 'OR', 2. Change the requirement of meeting one Criteria from each of the 5 topic areas to 4 or less areas (or dropping that requirement all together while still requiring compliance with at least 8 individual Criteria). Perhaps if the ACCME was comfortable with less topics several most critical could be designated.

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ACCME-accredited provider	Several categories do not include options that all types of providers can reasonably achieve. We currently have commendation and I would be hard pressed to see how my org could achieve commendation today using these criteria. Achieving 8 criteria as currently written will be difficult from both a process and resource perspective. Also I have questions about how the 25/10% thresholds—Who decides and how will it be documented what activities meet a criterion? It seems to me that academic/large health systems may have an easier time meeting a greater number of these criteria than other providers (however, due to numbers of activities these providers generate, their challenge may be reaching the set percentages.) As a surveyor, I still see providers who don't respond to the current commend criteria in self-studies. The proposed raises the bar much higher (a good thing so long as orgs don't find them so daunting that they don't try to meet them.) If that happens, an opportunity to improve the CME enterprise will be lost. I recommend lowering the percentages and removing the categories so that organizations can pick the 6 or 7 or 8 criteria that reflect what their organization does well from the ENTIRE list of commendation criteria or more options in categories need to be provided. I know this is based on the last call for comments but the previous draft of the criteria for commendation seemed to be more doable and reasonable than the current proposed version.
ACCME-accredited provider	I've thought this was an important mandate since it was first presented, in somewhat different form, several years ago. IAHB would be honored to be actively involved in its development, in helping to beta-test some of the proposed Criteria, or in any other way we might be able to help move it along.
ACCME-accredited provider	Although not every provider should be awarded accreditation with commendation, all providers, no matter the size or type, should have the opportunity to achieve commendation. Some of the criteria are well outside the ability of some smaller providers to attain and it seems that some providers would be in a much more favorable position to meet the elements and standards. Another concern in operational and has to do with surveying providers. How are surveyors to determine whether the 10% or 25% standard has been achieved? Will this change how surveys are conducted or how activities are selected for review? Will the self-study change? Does this increase the burden on surveyors?
ACCME-accredited provider	We appreciate the inclusion of flexibility into the criteria for commendation, reflective of the recognition that CME provider organizations and their goals vary. We also appreciate the opportunity to comment on this draft. We have concern about our ability to meet the category of criteria "Addressing Public Health Priorities" as drafted. Our focus is communication skills, and the connection between individual and organizational communication skill enhancements and objective measures of public health or practice performance is difficult to measure and document in a meaningful way. We would appreciate added flexibility, for example, to meet at least 8 of the criteria in at least 3 of the categories.
ACCME-accredited provider	Love to work with them
ACCME-accredited provider	I can't thank you for Power point or Video clips, but I probably can thank you for references at the bottom of slides and COI/disclosure. I generally appreciate your efforts after having a chance to mull them over. All my comments have been offered with the most sincere motivation.

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ACCME-accredited provider	I like the variety of areas included. Overall I feel that most of the proposed criterion favor larger organizations with multiple CME staff, or with true medical education practitioners on staff (those with PhDs, MDs, etc., heavily involved in the CME program administratively), which is rare in the smaller specialty society world. I think this is a way to begin to squeeze them out of Commendation. Perhaps that's the unlisted objective; if not it may be the unintended consequence.
ACCME-accredited provider	Having to meet eight of the criteria seems reasonable, but how to meet eight with the minimum level of 10 % of activities (or similar) seems almost impossible. almost every activity produced would need to be related to these criteria.
ACCME-accredited provider	I feel that the new criteria were well thought out and much less ambiguous than previous ACCME Elements. I applaud that! I think these will be tough to achieve, but is the point. If it was easy, it wouldn't be prestigious. I would ask that if/when these are adopted education sessions are provided so that we CME practitioners will have a strong footing to be successful.
ACCME-accredited provider	This is a nice idea. However, the criteria are written to advantage health care institutions, medical schools, Boards and State level systems. They do not include all segments of the CME enterprise equally.
ACCME-accredited provider	We applaud the ACCME for looking at ways to evolve the existing Commendation criteria with the intent of elevating the overall quality and impact of CME while still offering flexibility within a diverse CME community. That being said, we believe that the proposed menu criteria--particularly within the Achieving Outcomes category--represents a dramatic shift in what is expected from good quality CME providers. Further, we believe that these criteria reflect a real change in the underlying understanding of the role of CME in the larger healthcare enterprise. While we understand that the ACCME hopes to influence the behavior and programs of its providers, we think that these criteria are such a dramatic overreach that they will have the unanticipated consequence of dis-incentivizing providers to attempt to achieve Accreditation with Commendation, whether because providers are unable to meet these expectations or because they feel that implementing all of the mechanisms to hit all of the buttons distracts them from their primary missions. Should these criteria be enacted as written, it is likely that we would have a very serious internal discussion about the appropriateness and desirability of attempting to maintain our Commendation status.
ACCME-accredited provider	Thank you ACCME for all of the work you do to improve the CME process and for all you do to train Providers. I have been in the world of CME for around 30 years and I see how the ACCME has worked to improve over the years. I look forward to the challenge of this new Criteria.
ACCME-accredited provider	Counting each journal article as a separate activity makes journal CME a disproportionately large percentage of our CME program. Many of our activities would fulfill many of these proposed criteria. However, counting each journal article as a separate activity makes it impossible to meet The Standards associated with these Criteria.
ACCME-accredited provider	Good job!
ACCME-accredited provider	This will be very difficult for most of us to reach at the present time.

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ACCME-accredited provider	We recognize that the provider community requested specific metrics on how the proposed criteria would be assessed to determine that they had been achieved. The percentages as they are currently defined set an unreasonably high bar in some cases, and in others could create a significant administrative burden to document compliance. Providers with large CME programs serving large numbers of learners, such as specialty societies, would struggle to reach many of these percentages for participation. It is also unclear whether these percentages are based on annual totals, on totals from throughout the accreditation cycle, or if it is at the discretion of the provider.
ACCME-accredited provider	When I think about the thresholds, if an organization is meeting one or two of the thresholds, it would make it likely they could not meet the others, because otherwise every single activity that a provider would offer would need to meet at least one or more of the Commendation Criteria. That is an unrealistic expectation. You will have greatly reduced numbers of Commendation compliance.
ACCME-accredited provider	Our mission is basically to improve competence and performance. That is where to put our resources and feel we can have a positive impact on medical care. While most of these criteria are a lofty goal we cannot devote a great deal of resources to this as we need to stick to our mission and devote our resources to the mission we have chosen. Please consider an alternative to your percentages system. For large providers this may make the goal very hard to achieve and not be cost effective. You may not need 35 plus courses on informatics or advocacy.
ACCME-accredited provider	Regarding the “Standards” articulated for each of the Criteria, the Society suggests two implementation approaches. First, the ACCME should consider recognizing incremental percentages of activities/learners during the transitional period. The Criteria provide sound goals for the CME system to achieve. To move the system forward, providers will need to invest resources to change current programming or implement new programming. This investment would be undercut by a failure to achieve compliance because the required number of activities or learners are not met. Second, ACCME should support providers in “doing the math” by modifying PARS to allow providers to track which activities (and therefore # of learners) are compliant for each Commendation criterion. This infrastructure modification will simplify providers’ administrative practices and expenses greatly. Endocrine Society staff thank the ACCME for the opportunity to provide feedback. Reflection on these Criteria has been a valuable first step in determining how the Society will continue to achieve Accreditation with Commendation under this new set of Criteria.
ACCME-accredited provider	I really liked the public comment survey. Thank for being more open. Please keep in mind the differences between medical speciality societies, hospitals and medical academic institutions when it comes to measuring outcomes.

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ACCME-accredited provider	<p>Overall, we believe that the proposed new criteria will if passed as is will preclude ACAAI (and similar sized subspecialty orgs) from achieving Accreditation with Commendation. Not achieving commendation will eliminate most sources of commercial support. We predict that if these criteria are passed in their current state, our organization, and perhaps others of similar size, will be forced to (1) limit risks by not focusing on commendation, (2) will not be able to acquire commercial support (3) will eventually have to decrease the size of the program and learners served (4) will be forced to give up accreditation and seek joint providership. Clearly a doomsday scenario! If ACCME’s goal is to decrease the number of providers, this proposal will facilitate that.</p> <p>This proposal is part of the ACCME’s initiative called “Simplifying and Evolving the Accreditation Requirements & Process”. That title is NOT reflected in this new process. The system this is meant to simplify had 15 accreditation criteria and 7 commendation criteria – all 22 had to be met for commendation. The proposed simplified system would have 13 accreditation criteria and 16 commendation criteria (of which you must achieve 8) still a total of 21 – hardly a simplification just from a quantitative perspective.</p> <p>As educators, there was hope that with the “Simplification” of CME that the burden of maintaining accreditation and commendation would finally shift in favor of spending more time, effort and funding in producing effective education and a little less time on CME documentation. These requirements will not change that equation for the better but will actually force us again to shift focus from the quality of the activity to how we can document the requirements.</p>
ACCME-accredited provider	<p>We appreciate the ACCME's proposal for revising the commendation criteria, however for a sub-specialty medical society, the criteria and especially the standard number of activities for each criteria are prohibitive and some may be impossible to achieve given current resources. Basing the standard on the number of credit hours awarded per activity seems more reasonable than total number of activities. For example, a one hour journal CME activity may have less ability to incorporate the commendation criteria and may have a different structure and parameters than an annual meeting that has 50 hours of credit and greater leeway to include the commendation criteria. We would also suggest the ACCME provide resources on how to achieve the criteria. We hope the ACCME elaborates on what constitutes an 'extended transition period' for complying with the criteria. Finally, the new criteria may weed out providers who once achieved commendation but are now not able to comply for a variety of reasons. This seems counter to the ACCME's philosophy of wanting providers to obtain accreditation with commendation and assuring them that it is achievable.</p>
ACCME-accredited provider	<p>We applaud the ACCME for re-visiting accreditation with commendation criteria; however, it appears that there is a large emphasis on hospitals and medical schools. There is distinctly less emphasis on the role of professional medical societies. The criteria as currently proposed would limit medical society opportunities because they do not have direct access to patients, EMR, or hospital outcomes. We hope that ACCME will take into consideration the needs, capabilities, contributions of all accredited providers.</p>

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ACCME-accredited provider	There are a number of variables that are creating change within our health-care system. No matter what variable one chooses, the transformation of health-care management and delivery system and the health care professional work themselves, are progressing through the learning and change process. The proposed ACCME commendation criteria are aligned with the new framework that is emerging and how providers need to operate their programs to facilitate the change process further. It would be good for ACCME to align these commendation efforts by integrating MOC and CME and CE state licensing requirements as for the learner, such integration will be welcomed in an era of over regulation from their perspective.
ACCME-accredited provider	The percentages are high across the board making achievement difficult. Philosophically this is okay, however, practically that will make the number of organizations achieving Commendation small. The additional workload required to achieve the criteria is high, with no guarantee of achieving Commendation. We welcome changes, however, the phase-in period also is too short for such dramatic changes. And as noted throughout the survey, if the new criteria will be implemented when an organization is 2 years into its 4 year accreditation cycle, will we be required to implement 25% across all programs in the last 2 years of the cycle? How will previous 2 years worth of activities be reviewed?
ACCME-accredited provider	When I first looked at the new criteria, I was mortified. I do think some are achievable but perhaps not at the thresholds at which you have them. There are many factors to consider regarding size of the organizations CME program and size of the activities themselves. I also feel it will be much simpler for some provider types to achieve than others which seems inherently wrong. This is a big change!
ACCME-accredited provider	Again, with regard to all percentages, is the expectation to meet that percentage of activities/learners each year or each accreditation cycle?
ACCME-accredited provider	Our organization obtained Accreditation with Commendation in 2015. We are committed to excellence and quality in our CME program. We agree that commendation should be challenging and require organizations to really excel in order to obtain it. However, we find the majority of the new criteria, and especially the proposed standards for each criteria, to be too onerous to meet, even for an organization as focused on education such as ours. In general, the new criteria seem to be mandating that organizations make a leap of tremendous proportions from what is currently commendable to what is proposed. Finally, we think the ACCME should lead and encourage organizations towards innovation and improvement through ATTAINABLE standards, not dishearten and disengage them through impossibly high standards that would require undue financial hardship or inappropriate allocations of resources by the organization. We appreciate the opportunity to provide input and we look forward to working with the ACCME to continue to refine and strengthen these criteria. We believe that working with your stakeholders, we can develop criteria that will ultimately encourage and reward excellence in medical education.

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ACCME-accredited provider	<p>We appreciate the ACCME’s transparency and the movement towards specificity, but the AAFP strongly recommends that the ACCME use only the term “OR” in each of its commendation criterion, rationale, critical elements, and measurement standards, both to avoid potential inconsistency in the way various reviewers could interpret those words, and in the spirit of flexibility that ACCME is demonstrating with its use of a menu approach to the Commendation criteria. At a minimum, we recommend the ACCME eliminate their inconsistent use of the terms 'AND', 'AND/OR', and 'OR.' Those words have different meanings, which would make the criteria confusing and challenging to comply with.</p> <p>Additionally, we ask that if ACCME reviewers receive specific criteria for demonstrating compliance, then the ACCME share that information with providers to allow for a comp</p> <p>Finally, we are concerned that the way the ACCME defines an activity is not the best way to measure compliance with these criteria or demonstrate the true impact of these criteria. We recommend that the ACCME modify the measurement standards as well as give providers the flexibility to define activities as they see best.</p>
ACCME-accredited provider	<p>These appear to move CME/CPD forward and be associated with the CME program vs. current commendation criteria that look broadly at an organization’s activities. Many relationships with specific constituents (i.e., patients/students) may not be embedded in CME; QI initiatives may address some criteria, but may not be offered as certified CME. Some criteria address relatively new developments in CME, i.e., IPE, which will take providers time to incorporate. The removal of a criterion focused on supporting professionalism does not take into account increasing integration of CME/CE with QI initiatives.</p> <p>The adoption of the MOC process suggests a growing need for more focus on QI and its integration with CME. There are references to 'quality,' and the only similar reference is to a proposed criterion for 'process improvement' which is not necessarily the same thing.</p> <p>Providers could face significant reporting requirements. How will providers be expected to document compliance (via PARS, performance in practice abstract)?</p> <p>Will the metrics be based on a provider’s accreditation cycle?</p>
ACCME-accredited provider	<p>It is commendable that the ACCME wants to raise the bar for commendation, but the proposed criteria and menu raised the bar much too high, particularly for certain ACCME providers putting them at a disadvantage. Not all categories are easily attainable by all types of providers. It would be better if there were a list of criteria to choose from without categorizing them and awarding providers for doing things above the usual standard.</p> <p>Also, the % thresholds are unclear and would favor those providers with smaller programs, since by absolute numbers it would require less resources and be economically more feasible.</p>

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ACCME-accredited provider	This is the dissected opinion for these 16 activities with 38 critical elements with percentile that is not equivalent to 100. But this is a criteria of Commendation, which I believe for 6 years. At this point, I believe it is getting more difficult to achieve all this critical elements. We will try our best as a group but we probably need your help to implement this and probably your expertise and guidance. We may need a sample of how you achieve these critical items in 1 year with meeting schedules for these 16 cores. With your support, guidance and encouragement, I hope these requirements will be easier. Sometimes, it is easy said than done. Ideal situations may not be ideal to others. Sometimes, we have to step our foot in the other side to experience the reality of situation. Thank you.
ACCME-accredited provider	We are confident there are providers who will achieve Commendation provided some of the percentages are lowered. Thank you for the opportunity to comment on the criteria.
ACCME-accredited provider	We support the ACCME's preference for objective, reliable methods to determine provider compliance with its criteria. However, with respect to the proposed criteria, we are very concerned about the attempt to determine compliance based on a percentage of activities (or learners) to which the criteria applies (12 of 16), frequency within the term (3 of 16), or percentage of the CME team involved (1 of 16). To promote innovation, we believe the relevance, depth and potential impact of the initiative should carry the most weight, with a focus on the overall program rather than individual activities. Providers with a very narrow scope, an extremely diverse program, or limited resources may have great difficulty scaling innovations across a certain proportion of activities. Further, a focus on one or a few innovations may produce more substantial and replicable results, providing a great opportunity for the ACCME to promulgate best practices. We strongly urge the ACCME to develop a more flexible methodology to assess the new criteria.
ACCME-accredited provider	See concerns from page 1 of the survey related to The Standard
ACCME-accredited provider	As CME providers we are not medical content experts, data miners or primary drivers of change in medical institutions. As much as that is admirable and certainly something to strive for, the ACCME must understand our role across institutions can vary greatly. While accreditation with commendation is voluntary, these new criteria are far-reaching, very ambitious and come at a time when the ACGME and AAMC are requiring more and more from our universities. Recognition for running solid ACCME activities that provide confidence and quality in the educational process to educate physicians is somewhat lost in these new criteria because they increasingly require partnerships that really just may not be possible in a budget-starved state where resources are at an all time low. As we do more with less these criteria feel a bit like a future fatal blow. My concern is to not have commendation may give the impression that I have not tried hard enough when, in fact, we have an excellent, well-run, efficient CME program. Thanks for soliciting feedback from providers.

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ACCME-accredited provider	<p>Although the proposed criteria are worthy, several of these criteria particularly relating to the demonstration of healthcare improvements in patients and communities would require outcome data. Outcome data such as this requires significant financial resources and infrastructure and is beyond the budgetary restraints of small organizations and facilities. Additionally, outcome data on behavior modification and learning processes through education of medical students, fellows or residents specific to a given organization would require resources and funding also outside of the budgets of smaller organizations. Additionally, behavior modification and demonstration of process changes occurs at multiple levels over time attempting to demonstrate these as the result of a webinar, or particular course may not be possible at all and if it is demonstrable, it would require significant long term analysis out of the budget of small organizations such as ours.</p> <p>Additionally, 5 new categories have been added to this proposal with 16 new criteria , we are requesting that the number of criteria required be reduced to not more than 5 rather than the 8 being proposed with not more than one criteria in each category required.</p>
ACCME-accredited provider	<p>While we commend that the ACCME wishes to raise the bar and encourage providers to reach Moore's Level 6 and 7, the 'reward' to providers seems to be an additional documentation workload.</p> <p>“The Standard” of percentages of activities and/or learners is absolutely unreasonable. It is possible that some surveyors will be counting hours for an overall program and doing math to evaluate whether or not a provider has actually met that amount. And then there’s the larger discussion of multiple concurrent sessions within an activity- would a single session count if it reached multiple learners? For some of the criteria, once every year of term is achievable as long as some effort is made, but any more than that will create an increased amount of work to document this.</p> <p>Many of these criteria would require providers to force learners into activities they may not want to do. While some of these echo requirements for MOC, if it is too difficult to achieve, learners will go elsewhere for MOC where it’s easier. Our learners may still be in the Pre-Contemplation phase (not knowing that they need to change) and therefore may not participate in such analysis, but will only participate to get credit.</p> <p>Each of the “Critical Elements” must be met in order for compliance, which seems overwhelming. I would recommend an “and/or” versus an “AND.”</p> <p>When the initial commendation criteria was released in 2006, they were difficult to understand. Over time, these were further clarified what the criteria meant and examples were provided. Recommend that case studies be developed of compliance and non-compliance before implemented incorrectly.</p>

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ACCME-accredited provider	<p>i believe this set of criteria would be difficult for a medical specialty society.</p> <p>The new criteria are described in the introductory material as being selected to advance interprofessional collaboration, address public health priorities, create behavioral change, show leadership, leverage educational technology, and demonstrate the impact of healthcare education – and these goals fit well with the goals and direction of our association. However, the definitions of these goals as laid out in the criteria, critical elements, and standards seem somewhat limited, arbitrary, and rigid.</p> <p>The numerical standard, as the only standard available to meet the criteria, is too rigid. The standard should be flexible and create a range of options. I recommend removing the numerical standard or adding a non-numerical standard related to accomplishment as well.</p> <p>Criteria that fit best with our medical specialty association are 23, 26, 27, 28, 31, 34, 35, and 36.</p> <p>Regarding Criteria 28 – the communication criteria – the essential elements seem too prescriptive regarding how communication should be advanced, and the numerical standard is too rigid.</p> <p>Some of the present 16–22 criteria are valuable to advance medical education, and I would recommend adding 16, 19, and 21 to the menu in another section that could substitute for one of the five required sections – I would recommend making the definitions of these three criteria specific to their original meaning and less interpretative. The original set of criteria had no standard or critical elements or even definitions, and these were too freely interpreted.</p>
ACCME-accredited provider	<p>AMIA agrees with CMSS: 'Specialty societies are at a marked disadvantage when criteria suggest a need for access to EHR or patient health data or to assess a provider's performance in practice. While we recognize the value of these types of activities it is also important that the commendation criteria be applicable to all provider types to provide an equal opportunity for all providers to pursue commendation. We encourage efforts to offer a balanced menu of criteria that provides equal opportunities for CME providers of all types to achieve commendation.'</p>
ACCME-accredited provider	<p>I appreciate ACCME's thoughtful development of the Proposed Menu of New Criteria, the goal driving it, and the opportunity to comment. Overall, I like the direction that ACCME is taking with the criteria and accompanying rationales and critical elements. However, 'The Standard' items per criterion are detailed in such a way that providers may miss the goal/intention of a criterion while focusing on the specific measurements/deliverables.</p>
ACCME-accredited provider	<p>Please provide all requirements in PARS for easy tracking of percentages. Or, consider not using %'s and choose another form of measurement.</p>

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ACCME-accredited provider	<p>We are puzzled by the rationale for the standard percentages. How were these numbers determined?</p> <p>Overall, these criteria have the potential of decreasing course director interest in holding a CME certified event if they become a requirement. We already receive a lot of pushback from course directors regarding the CME activity expectations. In a time when we are trying to increase our program output and creativity this seems counterproductive. Additionally, these criteria appear to be mandating us to take on the work of other areas within our institution. They will require a restructuring of our office and organizational infrastructure.</p> <p>These are all great ideas but without an extended timeline to adjust our program infrastructure to these criteria, we will not be able to reach Commendation. We believe that we run a high-quality program that is deserving of Commendation which is evidenced by our past performance.</p>
ACCME-accredited provider	<p>I am curious why there is a minimum requirement for the number of activities that must meet that criterion in order to meet the standard. Some of these criterion are VERY high reaching and it seems that if an organization is able to produce even ONE activity that meets that criterion, they have gone above and beyond the standard and should be recognized as such.</p>
ACCME-accredited provider	<p>We agree fully with, and are happy to see the direction of this Commendation approach.</p> <p>We ask the following question: How does this impact the TJA accredited organizations? Do they automatically become elevated to this commendation level? If not, might this reduce the effectiveness of the TJA?</p> <p>Thank you for the leadership role in this critical area that we, as an organization, have been convinced of for years.</p>
ACCME-accredited provider	<p>At best, the proposed commendation criteria offer academic healthcare organizations opportunities to achieve 'stellar' benchmarks. At worst, the majority of CME providers cannot afford the time and resources to explore, establish collaborations, develop and implement to achieve the proposed Commendation Criteria. Realistic, achievable Commendation for all CME providers, or a mechanism for an elite few?</p>
ACCME-accredited provider	<p>I'll repeat what I've said earlier. I fully agree with the notion that achieving Commendation should be difficult, but on equal playing fields. Suggestion would be to develop different 'sets' of criteria for each sector. Not all organization types can achieve much of these criteria. The resources are not available to them, or they are too small to achieve compliance. But this doesn't mean they shouldn't be able to achieve a higher status which sets them in a class above their peers within their organization type sector.</p>
ACCME-accredited provider	<p>These new criteria go beyond the ACCME's basic mission statement and are not realistic for my institution. They will make the reaccreditation process more difficult.</p> <p>I believe we provide a valuable service for our learners. These learners are then able to take their new skills back to their practice environments to improve the health of their patients. My institution does not have direct access to or influence on these practice environments, nor is it in a position to conduct research or studies. The planners and faculty keep up-to-date on advances in our field, relying on research published in leading journals and information from educational symposiums.</p>

Call for Comment Responses: Proposal for a Menu of New Criteria for Accreditation with Commendation

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Organization Description	Comments
ACCME-accredited provider	As a longstanding CME provider, Lippincott Continuing Medical Education Institute (LCMEI), has complied with CME standards and achieved accreditation with commendation, a prestigious honor that we wish to maintain. The newly proposed criteria are biased and would result in LCMEI and other high quality CME programs losing their status of accreditation with commendation. Also, has the cost of maintaining such standards been considered including additional staff, technology, costs of more planners and presenters? While it is commendable to raise the standards, there may be gradual steps taken to do so. This set of criteria would be arduous for even the largest and well-staff CME organizations, and but it would be nearly impossible for smaller volunteer organizations. So I ask for consideration of the levels of commendation or a long range plan to implement.
ACCME-accredited provider	- ACR would like more details are needed about the plan and timeline for implementing these revised criteria. - Meeting the percentages set forth in the standards will be difficult based on the activities a specialty society creates. Small group training
ACCME-accredited provider	Medical Education Companies may be challenged to reach the level of commendation based upon these revised criterion.
ACCME-accredited provider	We understand this is a step in an iterative process and the ACCME can expect the ACR to remain engaged as the process continues. If you have questions about these responses or would like to schedule a discussion about our recommendations please contact me via email: lamaker@rheumatology.org or by telephone: 404-633-3777 ext. 327. Thank you for the opportunity to comment.
ACCME-accredited provider	It seems there are a few criterion that are the same or very similar. I believe requiring a percentage of activities for different criterion extremely complicates this process.
ACCME-accredited provider	I think that this is a great start-- just some additional clarification is needed on several of the criteria. I look forward to the next round of criteria
ACCME-accredited provider	Excellent list. Consider updating the outcome expectation to patient outcome / systems improvement instead of just patient outcome.
ACCME-accredited provider	The comments we have provided are from our team at the medical school and not from any single individual. Also, you would have potentially received better and more honest responses if you had made this survey anonymous. Thank you for the opportunity to weigh in on these proposed criteria for accreditation with commendation.
ACCME-accredited provider	The 'standards' favor very small programs, where a handful of activities could satisfy several criteria. For programs with 400-500 activities annually, the standards may be much more difficult given the broader stakeholder populations. If programs find most of the criteria to be unattainable, it may be a disincentive to keep improving.

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ACCME-accredited provider	<p>UMMC's CHPE office is dedicated to the CME mission and already fulfill most of the requirements of the new criteria. However, we have a limited budget and the institution is reducing numbers of support staff for every dept. I fear that some of these requirements are prohibitive, due to resource restraints, even for larger organizations like ours. I agree with the theory behind each of these but feel that a few are beyond the scope of most CME offices. We have commendation and plan to try again the next cycle. We do strong work and provide quality education for HCP in a very poor and sick state. I do hope that our resources will allow the time, staff and funding some of these criteria will cost.</p>
ACCME-accredited provider	<p>Overall the scope of the criterion is great and important in advancing CME as a strategic resource in improving physician performance, the quality of care and population health. However the standards are problematic as they will be very difficult to achieve by some providers (who may therefore lose their commendation status), will encourage the provider to favor quantity over quality to achieve the required %, and potentially have providers refuse to engage in some educational activities so as not to jeopardize their % and commendation status. Data collection to meet % with also be very cumbersome. In addition not all categories are applicable to all providers and thus they should be given an opportunity to be exempted from having to demonstrate compliance in order to achieve commendation status. I would recommend eliminating the standards and have providers demonstrate meaningful activities to meet a menu of these criterion as is currently being done for criterion 16-22. Other comments: Criterion 19 should be retained or imbedded in the new categories; given the importance of designing CME based on QI data, retaining criterion 21 is also important and should be expanded to include QI data to drive CME; under the leadership category, I would have liked to see the role of CME leaders and CME offices within accredited organizations in leading and driving meaningful educational activities; the new criterion do not specifically address the need to leverage educational technology.</p> <p>Thank you to the ACCME for their work in leading the CME community towards a vision for CME and providing a guidepost for the future of CME.</p>
ACCME-accredited provider	<p>How will this new proposal contribute to the simplification process? It appears that now we will need to measure for up to 16 new criteria to see which ones we may be able to meet. Just measuring for 8 criteria will not be sufficient as if we are not successful in meeting the 8 we have selected, that would rule out the possibility of achieving commendation. This new plan definitely raises the bar in CME but it also appears to add a significant amount of paper work and data tracking. It will create a large burden on most providers and may discourage people from even attempting to achieve commendation.</p> <p>If the number of activities that must meet these could be lowered and providers were given the opportunity to choose more than 8 criteria, it would open the door to providers testing new methods of education. Setting targets will make achieving the goals very restrictive.</p>

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ACCME-accredited provider	<p>I am very concerned about how the criteria will be measured. If a provider undertakes a large series-type effort where one or more lectures are offered multiple times, how should that be counted? As one activity with multiple occurrences or as many singular activities? If a provider has a strong RSS program, then learner numbers are skewed thereby making a metric relying on % of learners difficult to achieve.</p> <p>I am also concerned about the potential for more creep in PARS. As it stands now, my program loses valuable staff time each year simply doing quality control to ensure what we report is accurate. From my perspective, PARS has very little value to providers. ACCME would need to demonstrate how PARS benefits the provider.</p>
ACCME-accredited provider	<p>While laudable, the proposed criteria are in general poorly defined and not necessarily. Accreditation with Commendation should be a goal that is potentially feasible and aspirational for any provider group and organization. As currently stated, the proposed Criteria seem to be applicable to only a small cohort of providers, not necessarily because they will require extra effort and resources, but because the inherent scope of activities and nature of the organization preclude providers from achieving them. The categorization and number required for Commendation also do not seem appropriate. The proposed standards do not reflect the reality of achieving significant change and raise the possibility that providers will either choose to eliminate certification from some activities that are otherwise beneficial and/or implement less rigorous interventions in a large number of activities rather than substantial efforts in a few activities that might represent true innovation and improvement.</p>
ACCME-accredited provider	<p>I think that the menu of new criteria for accreditation with commendation will move the field forward. However, I believe that the approach to developing the standards is too focused on numbers. How do these standards compare to actual current practice that incorporate the critical elements identified? How were these standards derived? Thank you for the opportunity to comment.</p>
ACCME-accredited provider	<ol style="list-style-type: none"> 1) A compendium of cases to show examples of compliance developed with implementation of the criteria would be helpful. 2) Determining percentages of activities or learners that must comply is complex for providers and accreditors. Requiring a specific of number of activities per accreditation term seems a better option. RSSs would present problems for determining percentages. Indicating that at least 3 or 4 sessions (of a RSS) on the same topic would count as one activity might be a way around the confusion. 3) a glossary of terms would be helpful 4) Keeping the five categories serves an organizational purpose. However, with the diversity of criterion in each category, requiring providers to comply with at least one criterion from each of the 5 groups might be limiting. <p>Thank you for the opportunity to comment.</p>
ACCME-accredited provider	<p>I stopped about one-third of the way through this survey as I am overwhelmed with thoughts of how to comply just in the reading/completion of the survey. The Criterion as set forth seem task oriented (checking off boxes on a list) and not actually education/learner results driven.</p>

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Organization Description	Comments
ACCME-accredited provider	<p>Overall, we are pleased with the menu of options to achieve Accreditation with Commendation.</p> <p>In general, we would like to see the number of activities and/or learners that are required to meet each criterion be reduced, initially, and that a phased in approach for an increased standard be considered for implementation at a later time.</p> <p>As we reflect over how these criteria may impact the larger community, we have concerns that the smaller providers may not have the resources to achieve Accreditation with Commendation.</p> <p>We appreciate the opportunity to provide feedback on the new criteria.</p>
ACCME-accredited provider	The Standards make several criteria quite challenging, especially for Providers who have a larger number of activities/learners.
ACCME-accredited provider	There are accredited programs that provide only a few programs a year. The introduction of percentages puts providers with a lot of programs at a serious disadvantage.
ACCME-accredited provider	<p>The intent of the criteria may be achievable for some of our providers but not with the standards attached. The standards are confusing and it is unclear whether the “% of activities or the % of learners” represents the % of learners in a given activity or the universe of learners for the entire program. We feel this will be difficult to report and measure by the survey team and could be particularly difficult for new staff coming in during the accreditation term, especially a 6 year term. In addition, we will need to know EXACTLY what the ACCME will be looking for with each criterion.</p> <p>Also, the criteria don’t represent the opportunity for all provider types equally. It appears to be designed for specific types of providers with financial/staff resources such as academic medical centers, large health systems, and medical education companies. We have a concern that the criteria is driving the topics that will be provided which, while important, may not meet the true learning gaps of our learners. We would prefer a system that would allow us to choose any 8 criteria that represent our provider type, allowing us to focus on relevant education that meets the goals and needs of our own organization.</p> <p>We are doubtful that many of the state accredited providers will try to go for accreditation with commendation once the new criteria are fully implemented. We are concerned with the example that this might set for our providers – that Full Accreditation is good enough.</p>
ACCME-accredited provider	I applaud the ACCME for what I think are well reasoned new criteria that reward organizations that raise the educational bar.

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ACCME-accredited provider	Thank you for an opportunity to provide feedback. Our intention is to be constructive and hope that our comments are strongly considered. We agree that the proposed commendation criteria are congruent with changes in health care, however; the associated critical elements and standards need modification if any of our CME providers in the state system are to achieve commendation. We have received feedback from some of our commendation providers who expressed that focusing on reaching “unreachable” percentages of activities or learners can potentially waste valuable resources and/or risk the quality of their overall CME program. And, to have the designation of commendation, will not be in the best interest of their overall program’s mission and goals. “Full Accreditation will be satisfactory to us.” Thank you!
ACCME-accredited provider	I believe ACCME wants to be inclusive and provide an opportunity for all its providers to achieve commendation. There may need to be more alternative criteria for non-academic and non-healthcare provider organizations. In the grouping of the criteria, there are some that none of the criteria could be acceptable for a specialty medical society so that even choosing one criterion from each grouping would not be possible for success. The criteria seems to call for lots of demonstrations and much tracking/ documentation. Many CME providers do not have the staff that can even make tracking possible. I spent 20 years in a number of different hospitals and the CME Program within a hospital would be able to accomplish everyone one of the criteria because by mission its responsible for the care of its patients and community; it tracks the utilization and quality improvement of its physicians; its care and disease statistics are used in public health reporting. None of this is true about medical specialty societies. Perhaps ACCME cannot continue with one size fits all.
ACCME-accredited provider	Menu offering are really diverse. No complaints there. It is not clear how many/which criteria actually need to be met. One page says we must continue to do 1-13 AND 16-22 AND C28-C38. In another place, it sounds like the new criteria (28-38) will replace the old (16-22) or you can choose which set of criteria to meet for commendation. The standards seem to high for a smaller organization like ours where there are only 2 CME staff. 10-25% is a lot--we like to do as much as possible but will be more varied in the types of activities, not necessarily doing 25% activities for students like in C25.
ACCME-accredited provider	The standard for every criterion seems very high. Could they be made more realistic or is the idea to have only a few organizations able to achieve accreditation with commendation?

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Other	<p>I am a consultant for medical education organizations, including specialty societies, hospitals, medical education companies and other non-profits. I work with reaccreditation applications and medical education programs every day. The more I dug into the details, the more convinced I became that the ACCME is asking the impossible, at least for many of my clients.</p> <p>Almost all of the standards for the new criteria seem to be set at unreasonably high levels. I believe that organizations should be encouraged to improve and innovate but I'm afraid these criterion will discourage and disenchant organizations instead.</p> <p>The leap between what we have been expected to do to meet commendation and these criteria seems vast and for many, impossible. In most cases, the 10% or 25% standard is much too high.</p> <p>Additionally, the standards appears to indicate that the ACCME cares more about quantity than quality. Numerous organizations produce one outstanding activity per year, or just a few per year. By requiring the commendation standards be met every year, instead of a few times during an accreditation cycle (as is the standard now), many organizations will not be able to meet the new criteria.</p> <p>For this reason, I urge the ACCME to re-engage stakeholders from all different provider types and sizes to determine appropriate standards for compliance for these criteria.</p>
Other	<p>We applaud the ACCME for developing these proposed criteria for commendation! We support the menu approach allowing the CPD provider to pick and choose the criteria according to their own context. The ACCME has also defined an appropriate transition phase.</p> <p>The Criteria for Accreditation with Commendation give an opportunity to reflect on our own Accreditation Standards for CPD Provider Standards to see how we could raise the bar of our own standards while providing an opportunity for accredited CPD providers to demonstrate excellence in CPD program development, delivery, and evaluation.</p>
Other	<p>I think the 10% or 25% standard is unattainable or unrealistic for most of the criteria. I like the Criteria 38 where providers would need to demonstrate the criteria in a least one activity per year and I think some of the other criteria should be changed to this standard.</p>
Other	<p>CMSS appreciates the opportunity to comment. On your initial slide, you should offer an opportunity to check a box identifying the respondent as a Member Organization of ACCME. As we have additional comments which exceed the word limit, we will also be sending a letter.</p>
Other	<p>We would like to propose a C38 Active Engagement in the CME Enterprise</p> <p>This criterion promotes volunteerism for the betterment of the provider and of the CME/CPD field. It recognizes providers and their staff for contributing time and expertise within the CME/CPD community. Critical elements include but not limited to: staff volunteering as surveyors for accreditation agencies and/or as committee members for local, regional, national or international CE-related organizations. The Standard: at least 2 staff members contribute each year of the accreditation term and the provider staff volunteers for more than one of the following organizations; ACEhp, SACME, NAMEC, etc.</p>

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Physician/healthcare professional	Explicit mention of collaboration with Quality Improvement peers would be a welcome addition, consistent with the other measures, as well as aligned with societal movements towards measuring health outcomes using Quality Metrics.
Physician/healthcare professional	In general, I'm sad to see how far Continuing Medical Education has strayed from the mission of educating health care providers. I find the increasing complexity to be self serving to organizations such as ACCME and large CME providers. While I'm not sure the old model of having an industry sponsored lecture was good, I find some of these criteria to be irrelevant to what I need as CME, and what I find useful as CME, as a physician.
Physician/healthcare professional	Most of the proposed criteria are an unnecessary burden that will contribute to the eradication of CME at community hospitals like ours. C 36, C 37, and C 38, however are a joke for a community hospital. Anyone who thinks we have the time or resources for outcomes data collection or performance measurements of any kind, needs to take a step out of his or her ivory tower for a dose of reality. Thirty - eight criteria is an exceptional way to keep CME in the hands of academics, for-profit businesses, and industry; but certainly not to help my patients. Paul J. Grunenwald, MD, ABMC Chairman of Cardiology
Physician/healthcare professional	Providing analytics to small rural hospital, offering the services of analytic specialist and training of staff would help in reaching these goals.
Physician/healthcare professional	Everything is clear, but also not achievable at smaller institutions -maybe there could be a 'tiered' approach for community hospitals
Physician/healthcare professional	These criteria are counterproductive to the ability of a variety of medical organizations to be able to provide focused CME to their members. This menu will concentrate the provision of CME to a handful of organizations who will be required to achieve so many different goals that they will be unlikely to provide high quality medical education to physicians.
Physician/healthcare professional	Lots of wheel spinning for activities which will likely do very little to impact on the health outcomes of communities or groups. CME that keeps us updated with latest research, best practices, evidence based treatment of disease, is needed to provide good medical care to our individual patients. This includes CME on public health issues, such as immunizations, which will affect the larger community. But please get rid of the soft fuzzies.
Physician/healthcare professional	The new criteria are completely unnecessary, too onerous and a significant burden on how providers provide CME activities and on how physicians gain knowledge from those activities. The only criteria that are 100% acceptable are 25, 27, 29, 32. Any criteria that smacks of MOC/MOL-like territory are totally unacceptable, particularly 30, 31. In general, I strongly believe that the current accreditation criteria are completely appropriate for the 21st century US healthcare system and that there is NO need to add new criteria in order for CME providers to achieve 'commendation'.
Physician/healthcare professional	Great to see the flexibility and innovation in the criteria and in what it is trying to achieve. Thanks

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State-accredited provider	In theory, meeting these requirements does make sense, but I wonder how the small community institutions can obtain commendation when they are competing with providers who are off to hospitalists, have revenue focused practices, and obtain their educational requirements by doing on-line CME on their own time. As a small institution, we see providers who are no longer interested in attending live activities and are less interested in participating in developing programs. In addition, most small CME offices have their staff also performing other medical staff duties and limited budgets that don't allow many options for developing other formats of offering education.
State-accredited provider	We do not need additional criteria at this time as we were in the process of simplification of the accreditation criteria and were decreasing the number of criteria instead of increasing them. CME at this time is taking increasing institutional resources and is not really seen in a positive light by the healthcare provider community because of the restrictions it places on use of commercial resources and lack of funds. Even with the existing criteria the planning and conduct of CME activities is a challenge. There are already too many rules and regulations. We just do not need additional criteria.
State-accredited provider	Concerns are: 1. Trying to keep track of the percentages of activities or learners that fulfill these requirements pretty much shuts out the small shops (1-2 size CME person programs). The previous commendation program was achievable for smaller hospitals but I think these percentage requirements will shut us out which is really too bad for the little guys. 2. I hope you will keep the previous commendation option open for several years. For instance my accreditation expires in February 2019 and I have been keeping track of how I can meet the current commendation so it would be difficult for me to try to make a sudden switch mid-stream. Please keep the old program open for the next few years so smaller places have a shot at making commendation at least one more time. 3. I wish smaller organizations (we're on a shoestring budget) could have had input in this proposal. It seems more designed for large hospitals and research-based organizations that have lots of IT resources to measure all that is required here. Thank you for reading my comments!
State-accredited provider	I like the menu idea a great deal. It values that each of our operations is different. I am surprised by the prescriptive nature and the number of each activity that must be documented to meet these new criteria. Perhaps since we are a field in MASSIVE transition, we could work TOWARDS these numbers - and for a transition period (5-10 years?), simply provide evidence of tackling some of the items on the menu - rather than having to meet the steep number of activity (or learner) requirements in order to be considered for commendation. We received accreditation with commendation for the first time in the history of our hospital this last time (which was a great source of personal and professional pride for me) - but in reviewing the new recommendations - I'm not sure we would be able to ever again receive commendation - which makes me sad....
State-accredited provider	The standard requirement of % learners and/or activities is high for each of the criterion.
State-accredited provider	Weighted against small one-person CME offices.

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State-accredited provider	I believe the only accredited providers that will be able to achieve the new criteria will be academic medical systems or specialized societies that have sufficient information technology (IT) resources. The new criteria will definitely penalize the smaller accredited providers providing services to the rural CME providers with limited IT resources.
State-accredited provider	the more I think about these criteria the angrier I become. I am at a loss for words at these grandiose ideas and how oppressive they will be for CME staff. You also don't have any idea how angry they are making the physicians.
State-accredited provider	Try to consolidate some Criteria and make them more workable for ALL Providers.
State-accredited provider	In summary, our CME felt that >25% was too high of a standard for criteria 23-25 due to us being a small, community hospital. The committee also suggested dropping the total amount of criteria needed from 8 to 6, and still meet at least 1 from each category. They also questioned the involvement of patient/public representatives as teaches/authors due to their lack of medical knowledge. The Committee stated having a patient/public representatives join the CME Committee would be reasonable, but questioned how could you ensure their time spent on the Committee would be meaningful and productive. If the current proposal stays as is, I think it will be extremely hard for our organization to meet the requirements.
State-accredited provider	In 2014, at our Community Hospital system, we had about 3000 Physician learners and 2000 non-physician learners. The definition of 'learners' to be used in Criteria 23 thru 38 is important to us. 10% of 5000 learners is 500. it will be very difficult for us to have 10% of our learners meet 8 of these specific Criteria when most of our Learners are participating in Regularly Scheduled Series (RSS) each with specific patient care goals. These RSS have consistently proved most useful to our physicians and so they have grown to be the bulk of our CME offerings. We do not want to take our limited resources away from our RSS offerings but also wish to strive for Accreditation with Commendation. Therefore we suggest 5% (approximately 250 learners for us in 2014) is a more realistic goal for us. We suspect we are typical of the many smaller programs throughout the USA of CME providers. We continue to creatively do more with less resources at our disposal than we had years ago. Thanks for asking for our input.

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State-accredited provider	<ol style="list-style-type: none"> 1. The new criteria are tilted in favor of larger academic CME providers because the criteria requirements demand larger staff commitment and a greater volume of CME activities. 2. Meeting the standards for the new criteria will appear to require a lot more data gathering and analysis to be compliant, which will ultimately result in more costs. 3. The standards for many criteria are too rigorous, for example, in calling for >25% of activities and/or learners or >10% of activities and/or learners. Many CME providers do not have the volume of CME activities to meet this standard. 4. Many CME providers may not be able to meet the minimum of 8 criteria (50% of all the criteria) for commendation especially if the standards remain so rigorous. 5. The older C31 criteria from 2014 that talked about utilizing strategies to remove, overcome or address barriers to physician should be reinstated. 6. The C20 criteria on individualized learning plans is a great idea for learning situations involving one person but has the potential to becoming unmanageable and even ineffective for CME providers to handle. 7. The older C23 criteria developed in 2014 on multi-interventional approach to maximizing the impact of CME should also be reinstated in some form because of the value of offering a series of educational opportunities over time in varying formats greatly the effectiveness of CME.
State-accredited provider	Please allow for those currently under commendation to be able to continue doing what they are doing to remain in commendation next accreditation. We have worked very very hard over the years to get to commendation status and would hate to lose it because now the commendation requirements have changed. Thank you for allowing us to give comments it is very much appreciated!
State-accredited provider	I would hope that when these are finalized, ACCME provides some examples of how to achieve compliance with these criteria.
State-accredited provider	Our main question about the Standard is this: Is the number of activities based on total activities like we report in PARS? So that each RSS is one activity (no matter how many annual sessions), each Course is one activity, etc? We especially like the standards that specify “at least once in each year of term.” However, for C36, how is the number of learners defined?
State-accredited provider	As a provider that was one of the first to be recognized with accreditation with commendation, I am no longer certain with a limited CME staff in the CME office that doing all of this additional work that will be very taxing and demanding on the staff is worth the additional 2 years. It may be simpler to just do the self study every four year. Although I believe in the proposed criteria and fee that they are necessary to continue to move CME in the direction it needs to go I really do believe that the critical elements and the standards are unrealistic is CME offices with small or limited staffs that also produce a high volume of activities. I do not feel it would be in our program's best interest to cut back on CME offerings just to be able to meet numerical criteria and that is what we would have to do to continue to achieve accreditation with commendation. The other option would be to forego accreditation with commendation which would be a travesty in a highly recognized CME shop.

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State-accredited provider	The 10%+ and 25%+ are too high for smaller organizations to achieve. It is important to change how physician education is delivered and ensure an impact is being made but a 10 activities/accreditation period may be a better way to achieve long term success.
State-accredited provider	I am the volunteer CME director for our medical center. The last director quit in 2010 because the increase in work required of the 2004 changes overpowered him. The hospital simply did not have the resources to help him. We did achieve commendation in 2014, but will not have the resources for these criteria going forward. If my math is right, in order to achieve commendation, over 45% of the activities put on by programs would be devoted to commendation. Finding PPGs relevant to the issues in many communities like ours that constitute a defined 45% of activities will be problematic and poorly attended. I am also a CMA/IMQ CME surveyor and wonder how these criteria are going to be tested without a massive increase in time and resources. This is a major undertaking that might better be accomplished over time by introducing each section individually. The concept is academically excellent but from a practical point is unlikely to achieve its goals due to its strain of local resources.
State-accredited provider	I am not in favor of Inclusive Teaching and Learning criteria or Demonstrating Leadership criteria. Achieving Outcomes and Create Behavioral Change criteria seems repetitive to criteria already in place. Addressing Public Health Priorities is a good addition.
State-accredited provider	Patient care should be our main goal.
State-accredited provider	I hope we can continue to provide exceptional CME to our providers and the community.
State-accredited provider	The new criteria can only be addressed by large academic institutions or national professional societies. The tracking and measuring requirements for individual physicians or community health improvements cannot be performed by small CME programs prevalent in most communities. Expanding the responsibilities of the education department into a data gathering and data analysis function is unrealistic since it is already under sourced and underfunded. This should remain the domain of quality departments. The basic menu structure requiring one of three choices could potentially be very productive if actual criteria within the individual groups contained goals achievable by small programs.
State-accredited provider	These criteria are a big improvement in the educational process. Without the percentages and requirement to do one in each category plus an additional three I would like to approach this and set a baseline to see how many we can achieve. Picking one from each category would be approachable. In order for us to make the necessary changes to the entire scope of this proposal we would need to put in place processes, and staffing as well as train and allocate time to achieve these. In addition we would need to change our culture to accept these changes as we do not operate outside of the system that we work in. A less aggressive plan that raises the bar over time can be done. Thank you for your work to begin this effort.

Call for Comment Responses: Proposal for a Menu of New Criteria for Accreditation with Commendation

We welcome any additional feedback you may have about the Proposed Menu of New Criteria for Accreditation with Commendation.	
Organization Description	Comments
State-accredited provider	<p>I think the proposed menu needs to be revisited to make the standards obtainable for all CME programs regardless of size. The menu structure should allow small CME program volumes to be counted in value. The various standards requiring greater than equal to 10% or 25% of activities or learners are too rigorous and would require additional man hours that small CME programs do not have.</p> <p>Also clarification of directions on how to achieve compliance should be provided with examples. The current compliance directions are extremely confusing!</p>
State-accredited provider	<p>I am disappointed, I thought that the process of Accreditation was going to be simplified.</p> <p>My hope is that you will develop two different requirements for the community hospital that has the one person office and for the larger institutions that has multiple persons in their office.</p> <p>My fear now is; if this is implemented that the smaller institutions will drop their CME Program, not only because they would be set up to fail, but it will cost more to meet the regulations and the hospitals would not be able to afford that. For my last two reaccreditations, I have received 6 years with commendation. I thought that I was going to tear my hair out going through the last one, I can't imagine what the next one would be like. But I know that right now I could not get a six year with commendation with the proposed requirements.</p> <p>Please reconsider and reduce the amount of requirements for us</p> <p>Thank you for your time</p>
State-accredited provider	<p>Clearly, you have overstepped your bounds in many ways. I suspect most community organization will not bother with your 'Commendation'. It doesn't really matter in terms of presenting good, solid educational programs for our community. Many times, I find that practitioners of all types will attend/utilize an educational activity if it interests them, regardless of CME credit. What really counts is the knowledge gained, not the one or two credits, which by themselves, are useless. Despite your desires, I doubt that the ACCME, which is basically a commercial organization, not a true college like that of a medical specialty with a long history and academic expertise and standing, will ascend to the role of healthcare 'czar'. Quite the contrary, I suspect your group will lose its relevance. I have been involved in CME as a DME since 1996. I believe I have as much experience as any member of your group.</p>
State-accredited provider	<p>Small programs who have only one full-time staff, limited capabilities and few resources, human or financial will find it impossible to fulfill eight criteria, including one from each of the 5 categories.</p> <p>I feel that some of the lofty goals subvert and corrupt the CME purpose, by potentially degrading the quality and applicability of the MEDICAL aspect of CME.</p> <p>Remember that you can please all of the people some of the time, or some of the people all of the time, but you can't please all of the people all of the time.</p> <p>In this 'collaborative and cooperative' approach, whose needs take priority? Who gets the scarce financial resources, when CME is no longer the primary goal. Are we sacrificing CME in the altar of IPCE??</p>

Call for Comment Responses: Proposal for a Menu of New Criteria for Accreditation with Commendation

We welcome any additional feedback you may have about the Proposed Menu of New Criteria for Accreditation with Commendation.	
Organization Description	Comments
State-accredited provider	<p>Thank you for the opportunity to provide additional comments. Achieving commendation should stretch and develop a provider skill set to improve educational offerings and assess the impact of CME. However, it should be achievable for those providers who have a staff of 1 or limited budgets as well. The standard percentages for the recommended Commendation criteria keep this from being possible. Commendation might be perceived as being for those who can 'pay' for it versus those providers striving to continually improve their program for healthcare stakeholders.</p> <p>Commendation should be possible for those who go above and beyond standard accreditation repeatedly throughout their accreditation period. With 5 categories, if providers are trying 2 or more each year of their accreditation period then they may be perceived as going above and beyond standard accreditation. At least 2 categories instead of 3 or all 5 because some of the categories are geared more for hospital based or MEC/Association or Academic based. Each Commendation criteria is not for every type of institution who are providers. The recommended Commendation criteria offer flexible options for commendation for all types of providers. However to make it achievable for those providers with limited resources, please reassess the requirements: one from each category; 8 criteria; and the standard percentages.</p>
State-accredited provider	<p>Hospitals are business and budget cuts have been a fact of life for many years. No travel money and no budget for speakers limits programs. Related departments like Medical Libraries have been cut or closed down. Libraries support lifelong education for physicians and nurses. Eliminating their resources dumbs us down individually and collectively, and has an effect on patient care. CME is one of the basic needs, like air, food, and water. How can the medical staff and patient care be healthy without CME?</p> <p>Focusing on what is immediately before us is easiest. Seeing the big picture, the global overview, is hardest. Seeing how we can connect what is local to what is regional, national, and international can be difficult. Just because we see a need does not mean we know how to best meet that need, or have the funding to do so. We need leaders with vision, approval and exploration instead of no as an answer. We need teamwork to make it happen. One is a lonely number.</p>
State-accredited provider	<p>I would really like to see criteria that are achievable for small, community-based programs. When manpower is limited that doesn't mean we aren't trying to achieve the higher standards with the resources available to us. I have concerns that the percentage required to achieve the standard would be difficult for the smaller institutions. Many times when I look at the standards for CME it feels like ACCME would like to squeeze out the 'little guys' in favor of consolidating into large institutions or the academics.</p>

Call for Comment Responses: Proposal for a Menu of New Criteria for Accreditation with Commendation

We welcome any additional feedback you may have about the Proposed Menu of New Criteria for Accreditation with Commendation.	
Organization Description	Comments
State-accredited provider	<p>The critical elements and standards are problematic. We suggest that ACCME set an absolute, rather than relative, number of examples required to demonstrate a commendable provider. While it is laudable that ACCME is seeking a more objective means to measure compliance, tying the results to learners or activities may have unintended consequences. Providers with large numbers of activities and/or learners are going to have a much larger denominator, making the 10 – 25% thresholds that must be met to achieve compliance unreasonably difficult and penalizing them for providing a high volume of educational experiences. Providers may choose to develop and present fewer activities to reduce that denominator. Under the current criteria, it has been acceptable to submit a few examples of how the provider met the criteria. Those examples could be CME activities demonstrating compliance with the critical elements, other educational or health practice efforts, or evaluation of learner or patient outcomes. This system would allow a provider to focus its efforts and resources on a few valuable but perhaps complex projects, rather than add gratuitous programming to some volume of certified activities in order to meet ACCME metrics.</p>
State-accredited provider	<p>Overall, it is becoming harder and harder to maintain 6 years accreditation. After reading this, my first thought is that I am fine with 4 years.</p> <p>My CME department jumps thru so many hoops now in order to obtain accreditation, many departments have stopped requesting Category 1 credit for their activities.</p> <p>My numbers of hours have dropped every year & I do not see an end to the decline.</p>
State-accredited provider	<p>I will come back to finish filling out this Call for Comment. I was only able to complete the sections up through c32 at this sitting just now.</p> <p>Thank you for giving all of us this opportunity for feedback on such an important and ambitious endeavor as advancing the Commendation criteria. The thought and consideration that the ACCME put in to this are quite evident! Thanks again!</p>
State-accredited provider	<p>I really appreciate the innovative approach of a menu of options. I think this approach will allow for much more flexibility among CME providers, especially the smaller providers.</p> <p>I am concerned, however, about the Achieving Outcomes category. For CME providers who do not go beyond competence, I think this category is too burdensome as it is currently presented. Since these providers would not be able to meet C36 or C38, they would have to meet C37 in order to achieve commendation. This seems like an unfair burden for smaller CME providers who do not have the means to measure above competence.</p> <p>I am also cognizant of the CME providers who might only offer one or two activities per year and what affect the Standards might have when a percentage of activities is specified. For these providers, they don't have the luxury of just applying the criteria to 10% or 25% of their activities like the bigger CME providers do. I think it could be helpful to include a percentage for learners, when appropriate (as criteria do), or at the very least specifying that the percentage of the activity could be over the term and not annually.</p> <p>Thank you again for considering this new approach and for seeking feedback.</p>

Call for Comment Responses: Proposal for a Menu of New Criteria for Accreditation with Commendation

We welcome any additional feedback you may have about the Proposed Menu of New Criteria for Accreditation with Commendation.	
Organization Description	Comments
State-accredited provider	As a recognized provider, I'm concerned about the number of activities, examples required to meet the standards and how our surveyors are going to review and verify them. Also as staff, determining if a provider meets the standard requirements seems very burdensome vs the previous way of everyone providing 2 examples. How are you going to simplify this process?
State-accredited provider	<p>This is the 2nd part of my submission to this Call for Comment and includes comments on the introduction and about c33 through c38. My prior submission addressed the earlier criteria.</p> <p>Thank you again for this opportunity and taking the needed and bold steps to advance the profession and value of CME through the introduction of these new criteria! It will take some time, but I think the long-term benefits will ripple and be seen for good throughout the CME world.</p>
State-accredited provider	<p>In summary, I really like the new criteria!!! My main concern is around the quantitative standards which may be too stringent and not award the good work based on a random volume requirement. My plea for the ACCME is to think hard about this. If your goal with the new criteria is to move the needle, then rethink the quantitative standards. These criteria should be motivating and uplifting, rather than defeating. When I look at the volume of our programs, I am thinking about what I should cut so that the programs that we really put our efforts into and can comply with these criteria are not lost in the shuffle of other accredited activities (i.e. journal clubs or IT programs) that could potentially skew our numbers and the good work we are accomplishing.</p> <p>Thanks</p>
State-accredited provider	<p>On behalf of the IMQ President & CEO, the CME Chair and Program administrator, we are concerned about the implementation of "The Standard" because it requires providers to identify a specific percentage of their activities as achieving a criterion in order to be compliant. This is a different approach to determining compliance than existed with C16-22, where a narrative/description and at least two examples, were sufficient. It is unclear whether the surveyors or the accreditor need to determine if the provider is meeting the standard, or if the providers will be self-reporting? Regardless, it appears that 'The Standard' would require that, at some point, all activities must be reviewed in order to determine if the correct percentage of activities is meeting that standard. This quantitative assessment could be a large and burdensome undertaking for either the surveyor/accreditor or the provider. While we understand that commendation should be reserved for those providers going above and beyond, the introduction of 'The Standard' could create a large workload for the monitoring aspects of the practice. It seems it would be preferable to focus attention on achieving the criteria. We suggest that the percentage compliance requirement of the new commendation Criteria be revisited, and that the ACCME consider a simpler mechanism for monitoring compliance.</p>

Call for Comment Responses: Proposal for a Menu of New Criteria for Accreditation with Commendation

We welcome any additional feedback you may have about the Proposed Menu of New Criteria for Accreditation with Commendation.	
Organization Description	Comments
State-accredited provider	The proposed criteria are streamlined, well-organized and support the future of CME. However, as CME chair of a small regional specialty society composed of specialists from a number of loco-regional hospitals and practices, many of the criteria remain challenging. I think the 'degree of difficulty' for achieving commendation is appropriate; it simply may not work for all organizations.
State-accredited provider	I applaud the ACCME for revisiting its Commendation Criteria. I feel, however, that the pendulum swung too far in the opposite direction. Instead of requiring all criteria areas to be addressed, I suggest setting a bar of maybe 2/3 (or half) of the total proposed criteria from all domains. As it stands, only extremely well-funded, professionally-staffed, integrated health systems would be able to be commended (in my view). let's open up the possibility to more providers.
State-accredited provider	Although I know great work went into developing these Criteria, it will still need compliance/non- examples for providers and surveyors to reference for this process of each. Employee turnover during accreditation term, especially 6 year term, could be problematic when trying to meet standards based on % of activities/learners because new person might not know a lot and be able to step right in and continue. CPD for CME staff will need to allow internal and external training to count.Does this mean providers will be looking for more training from accreditors? An unintended consequence may be more providers dropping accreditation, similar in 2006 implementation, because of the perception once again that CME is too hard for the staff in place. The Call for comments was distributed in January with a February due date need more time for CME Community to digest and respond. The new criteria are well intentioned but need to be refined and thus not ready for prime time.
State-accredited provider	This is a laudable goal BUT impractical for smaller programs with limited resources. Furthermore, for the accreditors,who rely heavily upon volunteer members and surveyors it poses an enormous challenge. The idea of percentages is complicated. Clearly, needs more work to make it applicable.
State-accredited provider	We applaud the idea of making CME strategic to the healthcare field. This is especially critical as the field faces immense change. We deliver face-to-face leadership development primarily to doctors (and welcome mixed cohorts involving admin and other healthcare individuals). Our biggest challenge is getting doctors to realize that leadership (and its related relationship building skills are strategic to effecting meaningful change. Medical education is so intense that it leaves little room for leadership and social skill development, yet these are critical to future of the field. The best form for this development are intact teams that work together on a regular basis.

Responses Received Via Letter



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February 24, 2016

Graham McMahon, MD, MMSc

President and CEO

Accreditation Council for Continuing Medical Education

515 State St., Suite 1801

Chicago, IL 60654

Dear Dr. McMahon,

The Alliance for Continuing Education in the Health Professions (Alliance), following input from its Board of Directors, wishes to offer commentary regarding the proposed new Criteria for Accreditation with Commendation. We urged all of our Alliance members to offer comments during the survey comment period and hope that many chose to do so, as our membership represents CME Professionals working in a variety of provider practice settings.

We applaud the ACCME for thinking deeply about how to encourage innovation and excellence in CME; we have the same mission at Alliance. We value our relationship and dialogue with all of our accrediting bodies and look forward to continuing that dialogue whether on these Proposed Criteria for Accreditation with Commendation or other issues moving forward.

Looking broadly at the Proposed Criteria, several themes emerge:

- A much expanded view of the role of CME, such as involving students and patients, and having a focus on public health/population health;
- An emphasis on Interprofessional Education;
- A need to access clinical data from a broad perspective down to a more focused perspective at the individual practitioner's level; and,
- Percentage metrics regarding the frequency of criteria usage.

An overall concern we have with the Proposed Criteria is that they appear to represent a significant shift that may not be obtainable for CME Providers unless they operate in a large hospital, medical group, clinic or academic medical setting. Many of our members belong to organizations that do not have the financial or personnel resources or access to clinical data that are needed to comply with the Proposed Criteria. For these CME Providers, the Proposed Criteria, if considered unattainable, may become a disincentive to achieving excellence, and may have the unintended consequence of promoting a minimal approach to CME; one that focuses on "just getting accredited."

Some specific concerns are:

- Overall: The measure of use seems to be too high. Twenty-five percent (25%) of activities for many criteria will be difficult, if not impossible, depending on the CME Provider setting, to achieve. Other questions related to the criteria include:
 - How to accurately document compliance with the criteria selected without adding significantly to the workload?
 - Would providers have the ability to change the criteria they are tracking from year to year if they make changes to their program or are unable to meet certain standards?
 - Without flexibility in the criteria, would providers not implement certain activities or topics that do not fit their identified criteria?
- Overall: Certain types of providers, especially, academic medical centers, seem to be much more likely to be able to address these Criteria.
- Overall: Many Criteria use “And” for Critical Elements when “and/or” would be much more likely to happen.
- Overall: Clearer definitions are needed for terms such as, “healthcare professional”, team-based evaluation, CME team, and “innovative programming” for examples.
- C24 & 25: Many providers may not have access to students, even if involving them would be desirable. We suggest involving students and patients in planning or in the implementation as an option.
- C28: Developing objective criteria for assessing communication skills and providing feedback to learners may be beyond the capabilities for most providers when, while much needed, few providers offer much in the way of communication skills training currently.
- C28: This Criterion favors providers that teach procedural skills, but is potentially unattainable even for those who do offer procedural skills, given the low number of participants in this type of education (i.e., they may not meet the 10% threshold if they do other larger-scale activities in addition).
- C30: In our view, this Criterion will be impossible to meet without vast new resources and most likely changes in infrastructures to meet the current standard of 10% or greater.
- C32: Most CME Providers do not have a research Mission. Even for those that do, one publication per year of term is a very high bar.
- C35: The definition of “creative” and “innovative” is unclear and we are uncertain as to how these could be applied evenly across the CME Enterprise.
- C36-38: These outcomes goals require that CME Providers have access to performance data and population health data. Very few CME Providers will be able to demonstrate compliance with these Criteria.

While we have offered critical comments, we do want to reinforce that the Alliance is very supportive of efforts to encourage excellence among CME Providers and to establish goals that raise the performance bar and reward the demonstration of program excellence. We applaud C33, the reestablishment of a requirement of continuous professional development for CME professionals, which is directly aligned with the mission and vision of Alliance.

In general, we believe that if the ACCME is willing to modify some of its Standards (i.e. 25% or greater), allow somewhat more flexibility in the Critical Elements (“or” rather than “and”), and provide definitions, the Criteria could both be strengthened, and be made more accessible and motivating for a wider range of CME Providers.

As always, we appreciate your efforts to promote the highest standards of professionalism in the CME community and look forward to continuing our dialogue.

Sincerely,

A handwritten signature in black ink, appearing to read "Bob Addleton". The signature is fluid and cursive, with a long horizontal stroke extending to the right.

Robert L. Addleton, EdD, CHCP, FACME
President

February 4, 2016

Graham McMahon, MD, MMSc
President and CEO
Accreditation Council for Continuing Medical Education
515 N. State Street, Suite 1801
Chicago, IL 60654

Dear Dr. McMahon:

Thank you for providing the opportunity for the CME provider community to share comments on the proposed accreditation criteria. Our organization has been an accredited provider for several years and our ability to provide specialty-specific continuing medical education to our members is one of the most valuable services we provide. Our members – practicing allergist/immunologists – look to their specialty society as their professional home and depend on us to keep their knowledge and skills up to date, so that they can provide optimal care for patients with allergic and immunologic conditions. For this reason we take our responsibility as an accredited provider very seriously and value the chance to provide feedback on the proposed criteria by which we would be assessed. We have submitted criteria-specific comments through the online survey but also wanted to share some overall comments with you to provide a better understanding of our experience and perspective as a specialty society CME provider.

To begin, we feel that the menu-based approach suggested here is a positive development and one that we support. This should allow providers with a range of missions and programs to find opportunities to demonstrate excellence in their work and to achieve commendation. This status is a valuable commodity that can impact a provider's perception in the field and in some cases its ability to secure necessary funding to support the important education needed to improve provider performance and patient outcomes. Because of the value placed on commendation within the CME enterprise it is essential to ensure that all providers, regardless of their type, have the ability to pursue this achievement.

While we feel that the general categories of proposed commendation criteria are appropriate, there are some trends in the criteria themselves that could by their nature exclude some types of providers from even attempting to achieve commendation status. These include:

1. An emphasis on practice data as an assessment tool: Measuring actual performance in practice as an outcomes tool for a CME program is a laudable goal. Many of the proposed criteria suggest that this type of hard data, often requiring access to electronic health records, would be required to document compliance. This puts

organizations that are not also healthcare service providers at a distinct disadvantage. We encourage the ACCME to consider how these types of accreditation criteria could be either revised or expanded to allow specialty societies to also achieve commendation.

2. A more narrow focus on only CME activities: The current menu of commendation criteria look beyond a provider's CME program to include related activities undertaken by the organization. These additional activities and programs – including advocacy for patients and medical students, participation in FDA and NIH standards-setting and guidelines development, and patient and public education efforts – can directly relate to and enhance a provider's CME program but include activities that are not eligible to be certified as Continuing Medical Education. We encourage the ACCME to keep the full range of a CME provider's activities in mind as it determines eligibility for commendation as a CME provider, and to remember that not all valuable education needs to, or should, be certified CME activities.
3. A lack of coordination with quality improvement and reporting requirements: Our physician members report a high degree of frustration and challenge with the changes in the healthcare system as it moves to quality-based reimbursement, as well as meeting the quality improvement demands of the Maintenance of Certification process. They look to the specialty society as a source of information and support in meeting these requirements. In the proposed criteria only one mentions process and/or quality improvement and only in the context of certified CME activities (see above). Many programs in the quality improvement arena do not fit the definitions for CME activities and so could not be considered toward a provider's efforts to achieve commendation. We urge the ACCME to help to unify the accreditation criteria with at least the MOC criteria so that we, as education providers, can more easily and efficiently support our members in their efforts to satisfy these regulatory requirements.
4. Performance metrics: We realize that the provider community has in the past asked the ACCME to define how much a provider's program would have to demonstrate a criterion to determine that it was met. The percentages provided, though, would be very challenging for a member organization with thousands of members and extensive CME programs to satisfy. This is especially true since implementing many of these criteria would require additional preparation, assessment, and documentation on the part of the provider to demonstrate their compliance. We suggest that the performance metrics be lowered, perhaps even initially to allow providers time to adopt new programming processes and integrate these new challenges into their programs.

We support a set of commendation criteria that challenge the provider to work at a higher level and to achieve higher outcomes. As described above, though, we have concerns about an accreditation system that could unfairly benefit some provider types over others. The benefit of having a variety of CME provider types is that each can fill a unique niche in the overall CME enterprise and each one of these providers value to the learners we serve and the patients they care for. We encourage you and the ACCME Board to keep this in mind as you revise the commendation criteria, so that all providers have the chance to demonstrate the high level of their work.

Sincerely,



Robert F. Lemanske, Jr., MD FAAAAI
President, American Academy of Allergy, Asthma & Immunology



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*ex officio

Chief Executive Officer
Shalom Jacobovitz

*The mission of the American College of
Cardiology and the American College
of Cardiology Foundation is to transform
cardiovascular care and improve heart health.*

February 24, 2016

Graham McMahon, MD, MMSc
President & CEO
Accreditation Council for Continuing Medical Education
515 N. State Street, Suite 1801
Chicago, IL. 60654

Dear Dr. McMahon:

On behalf of the American College of Cardiology, thank you for the opportunity to provide our comments regarding the proposed new Criteria for Accreditation with Commendation. We are pleased provide to feedback from the ACC perspective, which we feel is in alignment with ACCME's forward vision. ACC applauds and supports ACCME's efforts to revise the criteria in support of provider progress towards personalized, purposeful and impactful continuing medical education.

Overall Feedback

From ACC's perspective, compliance with at least one commendation criteria from each of the categories seems feasible. Many of our comments below reflect our need for more detailed definitions of the terms used as well as our need to better understand the level of flexibility we will have in offering evidence that we are meeting these criteria. We anticipate that many of our best practice efforts will be evidenced through how we develop the framework for designing and delivering our overall curriculum rather than overt elements within each individual activity. As examples, we collaborate with other organizations on many, but not all, of our activities – we address health informatics and gaps related to population health in various ways throughout our curriculum and incorporate practice data and other evidence of clinical performance in determining knowledge and performance gaps among our cardiovascular professional population, but these data are used as appropriate in educational activities and not spread across all. We would recommend that consideration be given to offering evidence for meeting several of these criteria at a global level by describing best practice standards and processes that are set across all activities that are part of our overall program. We think that the specific statement of quantitative metrics currently listed under “the standard” (i.e.25% of activities and/or learners) may be restrictive and/or may force organizations to focus on achieving minimum numbers rather than focusing on quality. We would want to submit as evidence of meeting certain criteria processes in gap analysis, needs assessment, practice trend data, etc. that keep us at a consistent level of commendable performance. Such tools are used at a global level across our entire curriculum.

Definition of terms used

It would be valuable to have a definition for many of the terms used within the Menu of New Criteria.

Those include (but are not limited to):

- Team-based evaluation

- Health professions students (at what level?- fellowship in a cardiology sub-specialty?)
- Activities and/or learners (does this mean % of all activities in our program or % of learners in a specific activity or the overall CME program?)
- Objective assessment of communication skills
- CME team
- Meaningful assessment
- Meaningful collaboration
- Novel, creative or innovative (subjective, what is novel for one provider might be mundane for another)
- Demonstrate the impact of the CME Program
- Addresses public health concerns

Overarching Questions

- Currently, there is room for interpretation of Criteria, and types of evidence that might be used to demonstrate compliance by providers. Is this by design?
- Will surveyors be accountable for determining if the evidence a provider puts forth around a criteria meets the defined standard?
- Will there be an ACCME contact person from whom we may obtain guidance and/or feedback regarding our plan for demonstrating compliance with a Standard for an individual criterion prior to completing our next self study?
- Would it be possible to convene a task force or focus group of providers during the implementation phase to share best practices, challenges faced, etc.?

Transition Phase

ACC would appreciate more specific information on what the “extended” transition phase might be relative to our current accreditation cycle. At what point would the option of demonstrating compliance with either the new or old commendation criteria end?

Adoption of some of the new commendation criteria will impact the ACC educational planning process moving forward (e.g. engaging patient/public and health professions students in the planning and delivery of CME). Additionally, it would require an extended period of time to implement and quite possibly influence a decision to seek joint accreditation. At least a two year transition time would be appreciated due to our current timeline for activity planning

Metrics and Documenting compliance

ACC supports the establishment of standards and associated metrics and looks forward to continued dialogue around this topic.

Criteria-specific Feedback

Inclusive Teaching and Learning

C23-Engages in interprofessional collaborative practice in the planning and delivery of IPCE

Are two planners or faculty sufficient if aligned with the corresponding target audience? The standard is high for the number of activities ACC develops annually. Is it 25% of learners participating in a specific activity?

C24-Engages patient/public representatives in the planning and delivery of CME

While ACC is not currently positioned to meet this standard, in conceptualizing our educational planning table of the future, it would make sense to include the voices and input of patients and public representatives. The result would be a far richer and impactful educational experience for learners.

C25-Engages health professions' students in the planning and delivery of CME

ACC is supportive of the concept of including health professions' students in the planning and delivery of CME. We interpret health professions' students as being Cardiovascular Fellows-in-Training (FITs). Currently, FITs are included in and are a vital part of our education process, serving as content planners, faculty speakers and members of various educational committees.

Addressing Public Health Priorities

C26-Provides CME about health informatics and the use of practice data.

ACC currently has numerous large and small activities, including the Annual Scientific Session, the National Cardiovascular Data Registry Conference and the Cardiovascular Summit and others, in which we are educating our learners in how to look at and utilize quality data and health informatics to support their clinical practice and optimal care of patients. As our physicians now practice in the era of big data, quality based reimbursement and personalized medicine, ACC endorses the need to continue providing more CME around health informatics and the utilization of practice data.

C27-Provides CME around implementation strategies to improve public health

ACC has recently integrated with the Society for Cardiovascular Patient Care whose primary mission is to improve the care and outcomes of patients with CV disease worldwide. Additionally, this integration affords the opportunity to reduce the variation of care in any size hospital or hospital system. ACC is well positioned to provide CME impacting the ability of our physicians to contribute to an improvement in public health and endorses this criterion.

Creating Behavioral Change

C28-Develops communication skills of learners

ACC recently published document; "2016 Lifelong Learning Competencies for General Cardiologists" contains four specific competencies related to the ACGME/ABMS competency domain of Interpersonal and Communication skills, in addition to the recognition of the key role communication skills play across competencies within the other domains. ACC fully endorses the development of communication skills as an essential element of CME.

Assessment of this skill can be challenging in the educational setting and ACC will need to give careful consideration to assessment strategies and appropriate documentation that would allow us to meet this criterion.

C29- Develops technical and procedural skills of learners

ACC endorses the use of medical simulation experiences to support the development of technical and procedural skills in our learners and is moving forward in that direction. We have recently developed a live Clinical Decision Making Simulation and an ECG Drill and Practice activity. We are in alignment with ACCME's future vision and will be interested to hear how ACCME might further define technical and procedural skills. This criterion should be expanded to include knowledge acquisition, translation of knowledge to practice, diagnostic skills and treatment options.

C30-Creates personalized learning plans for learners

One of the strategic themes at ACC is personalized education which embraces a competency-based educational experience. We are in the process of onboarding a new learning management content system which will position us to better provide personalized assessment, recommendations and feedback to our learners. We endorse this criterion as an important marker for commendation status.

C31- Provides services to generate and sustain long-term behavioral modification of learners

ACC currently provides services and resources for learners to sustain change, and this criterion may present an opportunity for us to scale up efforts to re-engage our learners on an ongoing basis, thereby impacting long-term modification of practice behaviors.

Demonstrating Leadership

C32-Engages in CME research and scholarship

While ACC supports CME research and scholarship, this criterion may prove to be an unrealistic expectation considering the resources and available expertise to conduct and publish in a peer-reviewed journal annually. The standard of once a year is high.

An alternative or addition to this criterion may be to include contributions to the field of CME via peer-reviewed presentations at ACEhp and other teaching roles assumed by CME professionals. Other scholarly endeavors, such as the development of clinical and professional competencies, editorial boards and clinical guideline development would be appropriate to include in this criterion.

C33-Engages in continuous professional development as educators

ACC supports the continuous professional development of its education staff and endorses this criterion. It would be helpful to define or have some guidance on what is meant by the "CME Team". Does this include clinicians that contribute to ACC's educational program?

There are always budget constraints and staffing issues which may factor in to which members of the team can participate in CPD activity annually, so perhaps the standard $\geq 50\%$ of the team is too high.

C34- Creates collaborations with other organizations to more fully achieve healthcare goals.

ACC currently collaborates with a number of healthcare organizations on some of our educational activities. Additionally, ACC currently maintains joint providerships with 13 of its national chapters and would consider this to be a strong area of collaboration to build on in the future.

We look forward to understanding more fully from ACCME the critical elements of this criterion (e.g engagement, collaboration and the generation of meaningful and measurable collaboration).

C35- Demonstrates creativity or innovation in the development or delivery of CME

While as an organization ACC strives to nurture innovation and creativity in its educational program, it is difficult to comment on this criterion until the terms; novel, creative or innovative

are more clearly defined. A concern would be the subjective nature of these terms and how they would be measured or demonstrated. Additionally, how would we know if a CME activity is novel or innovative relative to the activities of other providers? Would it just be because we consider it to be so?

Achieving Outcomes

C36- Demonstrates the impact of the CME program on the performance of individual health professionals

ACC supports and agrees with the value of this criterion. However, what form(s) of evidence might be acceptable here? For example, would self-reported learner data (Moore's Level 5) be appropriate documentation for the demonstrated impact standard? Would we be documenting that across 10% of the learners for all activities in our program we have achieved this outcome level?

C37- Demonstrates the impact of the CME program on process improvement

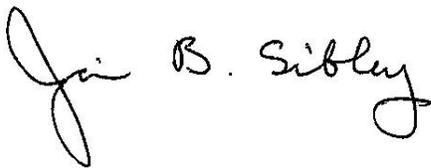
As that process has changed, would we need to document a baseline performance standard using the current process and a new level of performance based on objective measures with a new process/system in place?

C38 – Demonstrates the impact of the CME program in the health of patients and communities

ACC supports the intent of this criterion, however establishing a direct link from our CME program to the health of patients and communities would pose a challenge. Is the impact regarding our overall CME program or linked to specific programs & topic areas pertinent to the patient populations that our learners care for?

We hope our comments and questions will be helpful in supporting the development of the new Criteria for Commendation and look forward to the next steps in this process.

Sincerely,



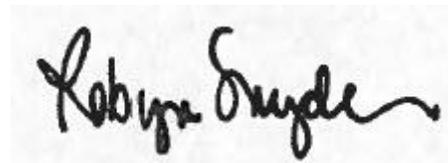
Janice Sibley, MS, MA
Vice President, Education



Ellen Cohen, Cert.Ed., Dip.Ed., CHCP
Director, Accreditation and MOC



Melissa Ketchum, CHCP
Senior Specialist, Accreditation and Compliance



Robyn Snyder
Director, Education Design



February 16, 2016

Sent via email

Graham McMahon, MD, MMSc
President and Chief Executive Officer
Accreditation Council for Medical Education
515 North State Street
Chicago, IL 60654
Email: gcmahon@accme.org

Dear Dr. McMahon,

On behalf of the American College of Rheumatology (ACR), thank you for inviting comment on the ACCME's proposal for a menu of new criteria for Accreditation with Commendation. The ACR's Committee on Education supports the objective of lifelong learning for physicians to ensure the best outcomes for our patients. To that end, we are aligned with ACCME's goals of regular and intentional examination and revision of accreditation criteria to guarantee application of best practices in pedagogy, engagement, and evaluation in order to leverage the power of education to improve healthcare and generate meaningful outcomes.

Further, the ACR values ACCME's practice of recognizing provider achievements designed to advance interprofessional collaborative practice, address public health concerns, create behavioral change, exhibit leadership, leverage educational technology and, where possible, demonstrate the impact of education on healthcare professionals and their patients. We applaud ACCME's desire to "reflect the diversity of the CME community, create flexibility, and offer a pathway for all CME provider types to achieve Accreditation with Commendation," and in response, respectfully submit, for your consideration, the following recommendations:

Critical Elements should be amended to "ORs" from "ANDs." Requiring "ANDs" significantly limits the flexibility intended by the introduction of the menu structure. We believe innovation and creativity will be reduced and not all provider types will have the ability to achieve Accreditation with Commendation.

Reduce the number of new criteria required for achieving Accreditation with Commendation.

Achieving Accreditation with Commendation is a rigorous process and providers that have it are high performers who have demonstrated a commitment to excellence in medical education. Despite the benefits of the new menu of criteria in maintaining high standards, requiring compliance across each of the five categories would be process laden resulting in fewer opportunities for inventiveness in content delivery. We recommend providers be required to demonstrate compliance in a minimum of eight of any of the 16 proposed criteria.

Criteria-Specific feedback:

C24: Inclusive Teaching and Learning: Engages patient/public representatives in the planning and delivery of CME. We believe contributions from patients and/or public representatives in the planning and delivery of CME provide a needed perspective. We also concur that the inclusion of health professions students as teachers/authors can benefit both students and physician learners. However, while some content development processes lend themselves to inclusion, other processes, e.g., case writing, would prove difficult to be inclusive of non-health professionals and/or students in $\geq 25\%$ of activities. Because of the potential burden to providers and patients/public representatives, we recommend The Standard be reduced to $\geq 10\%$ of activities.

C25: Inclusive Teaching and Learning: Engages health professions students in the planning and delivery of CME. We recommend the term “health professions students” be clearly defined to include students at all levels, including fellows-in-training.

C28: Creating Behavioral Change: Develops communication skills of learners. As outlined in the ABIM’s Assessment 2020 Final Report “competencies such as communication, teamwork, empathy and quality improvement are also vital for effective patient care, but formal assessment of them for practicing physicians is challenging. These skills have some special attributes. They may be context dependent in that the health care systems and teams may influence the ability of an individual to demonstrate them.”ⁱ Until methods emerge that are effective, efficient, and can account for context and convey meaningful information that are accessible to a wider number of providers we recommend C28 not be included as a new criterion.

C30: Creating Behavioral Change: Creates individualized learning plans for learners. We recommend the word “repeatedly” be replaced with the minimum number of assessments needed, and ACCME’s ideal timing of assessments required to satisfy this criterion be specified.

C33: Demonstrating Leadership: Engages in continuous professional development as educators. We recommend the ACCME provide parameters or identify acceptable types of continuous professional development activities (e.g., in-house training; ACCME trainings) that demonstrate provider compliance.

C36: Achieving Outcomes: Demonstrates the impact of the CME program on the performance of individual health professionals. The complexity and cost of implementation of a program of individualized assessment make this a challenging criterionⁱⁱ to meet. In its 2020 Task Force Reportⁱⁱ, ABIM describes the process to implement a thorough and useful plan for learner assessment, which details these challenges (<http://assessment2020.abim.org/final-report/>, PDF pgs. 15-23). Regulatory bodies that have the infrastructure, expertise and resources in place to do so efficiently already mandate requirements for broad assessment; the potential redundancy should be eliminated (C36-C38).

C37: Achieving Outcomes: Demonstrates the impact of the CME program on process improvement. Quality of patient care is already measured and reported through multiple mandated mechanisms, including PQRS, Meaningful Use, and Value Based Modifier reporting. As of 2016, eligible physicians will

be able to use Qualified Clinical Data Registries for quality reporting and will be able to participate in registries that provide a robust tool for continuous quality improvement. Based on this, we recommend measurement of the impact of CME on process improvement or health of patients communities, be removed.

C38: Achieving Outcomes: Demonstrates the impact of the CME program on the health of patients/communities. Critical elements and The Standard needed to satisfy proposed criterion C38 are not equally applicable and providers not in teaching hospitals, or those without similar access to patients and/or patient data, would be at a disadvantage in satisfying it. In keeping with ACCME’s stated desire to “reflect the diversity of the CME community, create flexibility, and offer a pathway for all CME provider types to achieve Accreditation with Commendation,” we recommend the Critical Elements and Standards for satisfaction for C38 be removed or tailored by provider type (e.g., teaching hospitals, medical specialty societies, state medical societies, etc.), offering providers in various practice areas comparable opportunities to achieve or continue Accreditation with Commendation.

We understand this is a step in an iterative process and the ACCME can expect the ACR to remain engaged as the process continues. If you have questions or would like to schedule a discussion about our recommendations please contact Lisa Amaker, Director, Continuing Medical Education, via email: lamaker@rheumatology.org or by telephone: 404-633-3777 ext. 327.

Sincerely,



Carol Langford, MD
Chair, ACR Committee on Education

Committee on Education

Juliet Aizer, MD, MPH
Mara Becker, MS, MSCE
Christopher Collins, MD
Donna Hoyne, VP, Education (Staff Liaison)
Carol Langford, MD (Committee Chair)
Jiha Lee, MD

Richard Loeser, MD
Sandra Mintz, BSN
Amanda Myers, MD
Erica Noss, MD
Susan Richmond, MS, PA-C
Kenneth Saag, MD (ACR Board Liaison)

ⁱ Assessment 2020 Final Report: *A Vision for Certification in Internal Medicine in 2020*, pg. 32. <http://assessment2020.abim.org/final-report/>

ⁱⁱ Ibid, pg. 15-23 in PDF (11-19 in report)



February 16, 2016

Graham McMahon, MD, MMSc
President and CEO
Accreditation Council for Continuing Medical Education
515 N. State Street
Suite 1801
Chicago, IL 60654

RECEIVED
FEB 17 2016
ACCME

Re: Comments on the New Criteria for Commendation

Dear Dr. McMahon:

On behalf of the American Society of Hematology (ASH), thank you for the opportunity to provide feedback on the proposed commendation criteria beyond the provider survey. ASH is the world's largest professional society serving clinicians and scientists worldwide who are working to conquer blood diseases. The Society has more than 15,500 members from nearly 100 countries and provides live educational programs and enduring materials in multiple languages for a global audience.

ASH appreciates that the Accreditation Council for Continuing Medical Education (ACCME) has spent several years working on a new set of commendation criteria to recognize exceptional providers. While the majority of the criteria themselves are laudable, the Society finds that the standards for compliance are unreasonable. ASH's concerns include having the criteria tied to CME credit-earning activities alone and requiring demonstration of meeting at least one criterion in each category. The Society is also concerned about requiring excessive documentation for meeting the critical elements and standards and the lack of a transparent transition plan to the new criteria.

Limitation to Activities

In the past, commendation criteria were not tied solely to CME credit-earning activities, and ACCME allowed providers to submit other institution-wide efforts as evidence for commendation. For example, many providers made efforts to expand their reach in education and services around the globe, improving healthcare practice beyond the United States. These efforts may or may not have been certified CME activities as defined by ACCME, but they did reflect the providers' commitment to establishing cooperative relationships and to improving health systems. ASH believes providers that make such efforts should be able to provide evidence of those efforts in seeking Accreditation with Commendation. Tying compliance for many of the criteria only to a provider's CME activities arbitrarily limits the eligible examples of commendable educational practice.

Menu Selection Criteria for Commendation

ASH applauds the ACCME for proposing a menu selection that allows for flexibility in the criteria selection. However, the mechanism for the menu as it is currently being offered is not reasonable in light of the ACCME's desire to "reflect the diversity of the CME community, create flexibility, and offer a pathway for all CME provider types to achieve Accreditation with Commendation."

ASH strongly objects to the requirement that a provider must address at least one criterion in each of the five categories. This is particularly alarming given that "Addressing Public Health Priorities" has only two criteria. ACCME is saying, essentially, that only providers that present CME in the areas of health informatics, the use of practice data, and public health concerns are eligible for Accreditation with Commendation. ASH believes this requirement restricts, rather than expands, the pool of exceptional providers eligible for Commendation, in contradiction to ACCME's own stated purpose.

The Society believes it would be more equitable for the ACCME to revise its proposal to allow providers to present evidence of compliance in at least 8 of any of the 16 overall criteria. ASH believes this would result in greater diversity of CME provider types obtaining Accreditation with Commendation without diminishing the quality of the cohort of commended providers.

Critical Elements and Standards

The critical elements and standards also are problematic. ASH suggests that the ACCME set an absolute, rather than relative, number of examples required to demonstrate a commendable provider. Although it is laudable that the ACCME is seeking a more objective means to measure compliance with the new criteria, tying the results to learners or activities may have unintended consequences. Providers with large numbers of activities and/or learners are going to have a much bigger denominator to reach the 10-25% thresholds that must be met to achieve compliance. Providers may be encouraged to develop and present fewer activities to reduce that denominator.

Under the current criteria, it has been acceptable to submit a few examples of how the provider met the criteria. Those examples could be CME activities demonstrating compliance with the critical elements, other educational or health practice efforts, or evaluation of learner or patient outcomes. We support continuing this system to allow providers to focus resources on a few valuable but perhaps complex projects.

Should ACCME adopt the proposed "Standard," then ASH would question the feasibility of evaluating compliance. Will providers that present 600 activities in an accreditation period be required to submit documentation for 60-150 activities in multiple criteria? Has the ACCME considered the burden that the data collection and reporting to these benchmarks could create for providers? This burden on providers is only equaled by the burden of reviewers in analyzing and verifying the compliance of the submitted activities and learner data. Are the volunteers who review self-study reports and files capable of analyzing this amount of data?

Transition Process

Providers should be given a chance to comment on the transition mechanism in the same way we are commenting on the proposed system. ASH agrees with the statement that providers widely supported the criteria when they were distributed in 2014. However, providers might have viewed the proposal quite differently had all implementation details been available at that time. ASH itself reacted positively not only to the language and spirit of the criteria, but to the possibility of a menu structure. However, the detail ACCME now proposes regarding the mechanism of compliance compels us to strongly suggest changes, not to the criteria, but to that compliance mechanism which we are only seeing for the first time. ASH urges the ACCME to provide the details about the transition mechanism and allow for a comment period before the criteria and compliance details are finalized.

ASH appreciates the ACCME's work on this new system, but we feel that serious revision is needed in line with our comments and suggestions above. ASH stands ready to provide any assistance to ACCME in helping develop and implement a system for Accreditation with Commendation that is fair, feasible, and advances the practice of continuing medical education. Please contact ASH Education Programs and CME Manager, Ana Velarde, at (202) 776-0544 or avelarde@hematology.org with questions or comments concerning this letter.

Sincerely,

A handwritten signature in cursive script that reads "Martha Liggett".

Martha Liggett, Esq.
Executive Director



February 16, 2016

Graham McMahon, MD, MMSc
President and Chief Executive Officer
Accreditation Council for Continuing Medical Education
515 N. State Street, Suite 1801
Chicago, IL 60654

RECEIVED
FEB 22 2016
ACCME

Dear Dr. McMahon

This letter is a response to the call for comment on the new proposed Criteria for Accreditation for Commendation on behalf of Association for Hospital Medical Education (AHME), a member organization of the ACCME. We are most grateful for this opportunity to contribute to the conversation about this important matter.

Overall, AHME believes the new criteria for commendation include elements that will motivate our providers to move in new directions and provide incentive for improving health care. The menu structure is clear, but will not provide equivalent degrees of difficulty across the various types of member organizations.

Our main overall concern with the proposed plan has to do with the standards or metrics. We believe the >25% standard will be unattainable by the great majority of our member institutions. What is the basis for these standards? Has the ACCME gone through past providers documents to get some idea of what some of the better institutions or providers have attained or were these numbers arbitrarily decided without any systematized investigation? Further, the percent of a certain type of activity that we would want for a given provider will vary by the type of organization, type of patient population (i.e. socioeconomic status, insured/uninsured/Medicaid/Medicare ratios), and institutional priorities. Perhaps the standards for all of the criteria should be more like those for C38 or perhaps the provider should be responsible for setting goals for a certain percent improvement each year or each accreditation cycle and then assessed on how they progressed toward those goals.

Another overall clarification has to do with the metrics for RSS. For standards that have >25% of activities, does that mean (1) > 25% of sessions of every RSS activity; (2) one session per year of > 25% RSS activities; (3) 25% of the total number of sessions in all RSS? Similar questions arise for providers that organize one activity per year with many speakers and topics.

For criteria with a percent of learners as the standard, if a practitioner attends one session of one RSS but no other activity, are they going to be included in the denominator of "learners"? These criteria would then be unattainable for institutions that have a large number of activities attended by a large number of practitioners external to their institution. Even if it does not include practitioners external to the institution, it would be difficult or sometimes impossible to obtain the denominator for some of us. Whether the practitioners are internal or external is somewhat arbitrary as many physicians practice with somewhat fluid and complex inter-institutional allegiances.



AHME also has a concern with regard to the resources our member hospitals would need to expend to comply with or even monitor these criteria. Has ACCME done any preliminary analysis to determine how many man-hours would be required for a provider to determine the numerators AND denominators for each of the proposed criteria for an average sized hospital, medical school or specialty society? Do we want providers concentrating on counting percent of activities or percent of learners or would we rather have them concentrating on improving health care?

Comments on the Individual Criteria:

C23 (IPE): The use of "AND" in critical elements is difficult to interpret. In order to comply would an activity be required to have speakers from more than one profession? This would not always be desirable? How is "team-based evaluation" defined? There would be very few, if any, of our AHME member institutions that would be able to meet the 25% standard for this criterion.

C24 (Patient/Public Reps on planning committees): Define "public representative". Critical element should be AND/OR; having patient/public as planners OR teachers can have similar impact and meet the intended goal. How does making them planners AND teachers have a greater impact than one or the other? For providers where the majority of the activities are RSS, this would be unattainable. Should we have patient and public representatives attending our M&M conferences and Case Conferences? Even for activities where there would be no confidentiality issues, the patient/public reps might find some of the planning meetings very boring and tedious and we might have a high attrition rate of the reps unless (or even if?) we compensated them financially. For those of us with hundreds of activities, paying patient/public reps to attend 25% of the planning committee meetings would be financially prohibitive and might not be the best way to spend health care dollars.

C25 (Students): Critical element should state AND/OR. Define 'student' - Do residents or fellows count as students since they are still in training? Is it a good idea to pull medical students/residents out of their courses or curriculum in order to attend a lot of planning meetings? Medical student/resident priority should be preparing for USMLE/Certification exams/procedural skills, and helping plan CME activities will not help a lot in that regard? Medical students/residents have a high intensity curriculum and demands on their time and attending tons of planning committee meetings should not be a priority. Some provider types do not have access to students/residents.

C26: (Informatics): It might not be in the best interest of health care for 10% of most providers' activities to be on health informatics. This figure seems pretty high for most of the hospitals and medical schools. 5% might be more achievable. It largely depends on if the institution is implementing a new EMR or ICD Codes etc as opposed to whether the CME Division is doing a good job. Does the CME developed have to be unique each occurrence or could a series be counted towards the % (for example, if a hospital offers training on how to use our organization's EMR and they hold 100 trainings throughout the year, would this get counted as 1 event or 100 events?). For providers who do not use an EMR, this may be a difficult criterion to meet.

C27 (Public Health): Critical Element should be AND/OR. Define "Public Health". One could make a case for some public health aspects in most medical education activities. Does entire activity need to meet the criteria to qualify or could individual lectures within an activity meet the requirement?



C28 (Communication): >10% of learners is not attainable for most AHME member hospitals, especially ones with a large number of multi-disciplinary and inter-professional practitioners attending one session of one RSS but otherwise not integrally associated with the institution. If one practitioner attends one session of one RSS but no other activity, are they going to be included in the denominator of “learners”? (The same question arises for all of the criteria with a certain percent of “learners” as the standard).

C29 (Skills): These are very resource and manpower intense activities. Need varies greatly from one provider type to another. Standard percent should be lower and perhaps dependent on type of provider. For instance, it should be higher for providers whose learners are primarily surgeons and obstetricians compared to providers whose learners are primarily primary care providers.

C30 (Individualized plans): We recommend a lower standard, though you might be able to increase it gradually. Providers cannot develop these types of initiatives quickly for a large number of physicians.

C31 (Reminders): The standard of >10% would be difficult for providers with a large number of RSS.

C32 (Research): Should not require publication in peer reviewed journal. Presentation at a local, regional or national meeting **OR** publication in a peer reviewed journal should be the criterion.

C33 (CPD): Need to define “CME Team”. What about student assistants that work a few hours a week. Need to define “participation in CPD”. If participation in external webinars, reading relevant published articles, etc. will be counted towards compliance, then this is easily achievable by all provider types. What documentation would be required to demonstrate compliance (attendance certificates? webinar receipts/meeting invitations?)? Would it be considered compliant if 1 team member attends an in-person external meeting and then brings the information back to the team and trains the rest of the staff (and the training was documented in meeting minutes)?

C34 (Collaboration): Define “meaningful and measureable collaboration”. What about Joint Providership?

C35 (Creativity): This criterion is extremely subjective and will vary from surveyor to reviewer to ARC to Board. Also what is creative and innovative at the beginning of an accreditation cycle may no longer be so by the time the provider is reviewed.

C36 (Performance of practitioners): Unsure how one can truly connect the impact on performance to specific learning activities...often change is a result of multiple factors (some that cannot be easily measured). Would not be attainable for a Provider such as AHME where the impact of any given activity would be incrementally small and not systematically measureable except by self report.

C37 (Process Improvement): Improving “Process of Care” is not and should not be the main responsibility of the CME division of most institutions. In most hospitals and medical schools there are departments and individuals that have responsibility for this important function. To the extent that those departments wish to have medical education on a particular process, most CME divisions would be pleased to work with them, but that might not happen once per year and it isn’t necessarily



something CME professionals should try to force programs on unless they are programs the QI team feels are appropriate.

C38 (Patient/Community Improvement): It would not be possible, except in rare activities, to directly connect the CME activity to an impact on the health of patients/communities. Patient/Community health is a result of multiple factors (many of which are unknown).

Thank you again for affording us an opportunity to offer these comments and questions. We hope this response will be of some value as you refine the proposed criteria for ACCME Accreditation with Commendation in preparation for implementation.

Sincerely,

David Pieper

David Pieper, PhD, Chair
Council on Continuing Medical Education
Association for Hospital Medical Education

February 15, 2016

Graham McMahon MD MMSc
 President and CEO
 Accreditation Council for Continuing Medical Education
 515 N. State St., Suite 1801
 Chicago, IL 60654

Dear Dr. McMahon,

The Council of Medical Specialty Societies (CMSS), a founding member of the Accreditation Council for Continuing Medical education (ACCME), is pleased to comment on the proposed new Criteria for Accreditation with Commendation. Our comments reflect input from the Continuing Professional Development (CPD) Directors of the forty-four member societies of CMSS, which in the aggregate represent 750,000 physicians in the US.

In general, the menu format suggested is a positive approach for these proposed criteria. We also believe that the types of issues addressed in the proposed criteria were useful and relevant. There were, though, several **concerns** raised both about the new commendation proposal overall and about the individual criteria as presented. These comments are included below, first the overall comments and then criteria-specific feedback.

I. General Feedback:

Due to word limitations, these general comments are not included in our on-line survey comments.

More details are needed about the **plan for implementing** these revised criteria. Providers in the middle of their accreditation cycle will be challenged to transition to these new expectations as they reflect a significant change from the current criteria. Several societies noted that the transition process would significantly impact their feedback about some of the individual criteria depending on how they would be expected to make this transition, should these be implemented.

There are many concerns about the **metrics used to determine compliance**. For providers with large programs encompassing many activities, reaching these percentages could be challenging. Those who offer small group skills training or discussion formats - both of which could potentially reflect educational innovation - would suffer by these standards because of the low faculty-to-learner ratio. Smaller providers with very limited programs may also be challenged to meet the metrics due to having very few activities in which to attempt to demonstrate the new criteria. This could result in a requirement to reflect all eight of the needed commendation criteria in every activity offered.

Some of the criteria address relatively new developments in the CME enterprise, such as inter-professional education, which will take providers time to realize in their activities; it was suggested that perhaps the metrics could use a **phase-in approach** to allow providers a chance to ramp up these efforts.

It is unclear how these metrics will need to be documented and reported, and providers could face the potential for significant reporting requirements being added to **document compliance**. Also, when the metrics are calculated it is not clear if the percentages are based on number of activities/learners per year or per accreditation cycle.

All of the criteria are **directly tied to the CME program** unlike the current commendation criteria, which look more broadly at an organization's programs. Many of a society's relationships with specific constituencies, such as patients and students, may not be embedded in the CME program, and many quality improvement initiatives

may also address some of these criteria but not be offered as certified CME activities, in some cases because the activities do not fit the existing CME activity descriptions.

When comparing the proposed criteria to the Critical Elements there are **inconsistencies** in the use of "and," "or," and "and/or" in describing the expectations of providers. More consistent and direct descriptions of these criteria and elements are necessary to prevent inconsistency in interpretation by both providers and accreditation reviewers. Comments related to specific criteria below indicate examples where adapting this language in the criteria could make them more inclusive so that more providers could demonstrate compliance.

The adoption of the MOC process and the increasing requirements for quality reporting and improvement in practice suggest a growing need for more focus and **attention on quality improvement** and its intersection with the CME enterprise. There are references to "quality" in the new criteria but the only similar reference is to a proposed criterion for "process improvement" which is not necessarily the same thing. Also, the removal of a criterion focused on supporting professionalism, another component of MOC, was noted as a concern as many societies are moving toward better integration of their continuing education and quality improvement initiatives in an effort to support the MOC requirements faced by our members.

Many terms, such as "team-based evaluation," "patients/public representatives," and "health professions' students" require **clear descriptions**. These are specified below in the feedback on individual criteria.

Specialty societies are at a marked disadvantage when criteria suggest a need for access to EHR or patient health data or to **assess a provider's performance in practice**. While we recognize the value of these types of activities it is also important that the commendation criteria be applicable to all provider types to provide an equal opportunity for all providers to pursue commendation. We encourage efforts to offer a balanced menu of criteria that provides equal opportunities for CME providers of all types to achieve commendation. Some supporters have adopted policies that limit their educational support to providers who have achieved commendation; a set of criteria that are out of reach of some provider types simply by nature of their organizational type could unfairly impact these organizations' ability to provide education at all.

II. *Criteria-Specific Feedback:*

These criteria-specific comments are also included in our on-line feedback.

C23: The criterion only references **inter-professional practice** in the planning and delivery of education. Does this assume that the education is intended for an inter-professional audience as well, or could an inter-professional team plan activities for learners representing only one provider type to satisfy this? As stated this does not take into account the IOM recommendations around multidisciplinary teams, which play a significant role in the practice in some specialties and could be more relevant than inter-professional practice. "Team-based evaluation" needs definition. In the Critical Elements, the "AND"s should be changed to "AND/OR"s to make this more applicable to a wider range of providers. On a related note - can a single individual be both a planner and a faculty member?

C24: Because this is a relatively new phenomenon in CME it would be helpful to start at a lower threshold for compliance, possibly 10%, and then **scale up** to allow providers an opportunity to incorporate this approach into their programs. In the Critical Elements, could "AND" be "AND/OR"? As with C23, can a single individual be both a planner and a faculty member for a single activity?

C25: Many societies raised a concern about including **health professions' students** - a group that will require more definition - in the planning and delivery of education for physicians. If the students are still in training, what contribution are they intended to make to education designed for specialists and subspecialists? By definition trainees have not yet acquired the knowledge and skills needed to practice as a specialist.

C23-25: All three of these criteria suggest an expansion of a **provider's intended learners** which may not be appropriate to the membership of a specialty society or to an organization's CME Mission Statement. This could mean that a specialty society could be disqualified from achieving accreditation because it could not demonstrate at least one of the criteria in this category.

C26: If the rationale stated "...that teach about **health informatics** OR teach learners how to apply" then this criterion could be more widely applicable to more providers.

C27: The term "CME that directly **addresses public health concerns**" requires definition. Some specialties deal with medical issues that are the result of health behaviors that are not under a patient's control, yet the criterion does not include any mention of education related to barriers to behavior change. Education that advocates for changes in public policy ("social and economic factors") and "the public's physical environment" suggests that the provider is assuming an advocacy role. This may not align with an organization's larger mission or policies, disqualifying some providers from potentially achieving commendation because of organizational factors unrelated to the CME program.

C28: ACCME has not defined **objective criteria** for assessing communication skills that would allow providers to demonstrate that they are "developing" these in their learners. The use of subjective criteria in the accreditation process raises significant concerns among providers because of the potential inconsistencies that can be encountered in the accreditation review process.

C29: In cognitive, as opposed to procedural, specialties, diagnostic rather than technical skills are more essential and more frequently taught. Rephrasing this as "**technical and/or procedural skills**" could be more inclusive of the needs of these specialties.

C30: As written, the provider is required to undertake a significant workload in order to develop **customized curricula for its learners**. If a medical society has 10,000 members they would need to demonstrate that they are undertaking this level of individualized support for at least 1,000 individuals. While we support the concept of encouraging individual learners to identify their practice gaps and undertake interventions to close them it would be logistically difficult if not impossible for many specialty societies to effectively demonstrate this criterion as written.

C31: The use of **performance aids** to support behavior change in practice is widely accepted, but as written this criterion presents some challenges. It is unclear if the "ongoing use" needs to be demonstrated for individual users over a span of time, in which case the appropriate timeframe needs definition, or if it is acceptable to demonstrate that, in general, the provided resources continue to receive use by learners across the entire learner pool during the accreditation cycle. If the latter this could be more of an assessment of an organization's marketing efforts than of the usefulness of the tools themselves. Also, since specialty societies do not have direct access to their learners' workplaces to monitor clinical behavior it could be difficult to objectively measure the "ongoing use" of any practice tools beyond asking learners to self-report.

C32: Despite an organization's best efforts, **research** could be generated but not published. Mandating at least one research publication per year places a significant additional responsibility on a CME provider's program. It is also unclear how publishing data about its CME activities contributes to the quality of a provider's program or that it equates with high quality education. A well written abstract could be published about a poorly designed and implemented activity.

C33: A definition of the "**CME Team**" is needed to determine if this is achievable. In membership organizations, in which members often volunteer to participate in the CME program, it may be impossible to send half of that extended group of volunteers to external professional development activities.

C34: The concept of "**meaningful collaboration**" is unclear and needs definition. It is unclear whether joint providership relationships would qualify as collaborations for this criterion as written. As providers focused on

defined specialties and sub-specialties, it may not be appropriate to collaborate with outside organizations for 10% or more of our programs as these kinds of partnerships could result in activities that do not effectively meet our members' needs.

C35: Educational activities should be designed in the format that best supports the learners' ability to achieve their learning goals. "Innovation" and "creativity" can support this goal but are subjective concepts. Without **clear definitions** it is impossible to set a standard for achieving this criterion and to assess a provider's efforts in this area. This raises the same concern about a provider's accreditation review raised in relation to C28.

C36: For providers without access to actual provider **performance data**, such as EMR data, this would prove to be highly difficult to measure by anything other than self-reported learner change. There is also some concern that this criterion shares many qualities with C11 and could be better defined to make the distinctions clearer.

C37: This criterion is internally inconsistent, which makes it difficult to interpret. The criterion references a connection between the CME program and process improvement but the rationale references "**process and/or quality improvement**" which are not necessarily interchangeable. Given the increasing emphasis on quality improvement and reporting for physicians, a more effective and efficient approach may be to build a criterion that emphasizes the impact of the CME program on quality improvement and reporting efforts.

C38: By focusing only on the CME program, this criterion ignores the contributions of an organization's **quality improvement** initiatives - which may not be certified CME activities - on the health of patients and communities.

The Council of Medical Specialty Societies (CMSS) is pleased to submit these comments on the new proposed criteria for Accreditation with Commendation. We look forward to participating with ACCME in a process of strengthening the new criteria, which should serve the CME community, and the public, well.

Sincerely,



Norman Kahn MD
 Executive Vice-president and CEO

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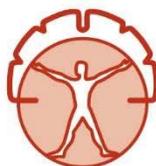
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International Parkinson and
Movement Disorder Society

Graham McMahon, President and CEO
Accreditation Council for Continuing Medical Education
515 N. State Street, Suite 1801
Chicago, IL 60654

February 16, 2016

Dear Dr. McMahon,

I'd like to thank you for inviting comments on the proposed accreditation criteria. I have reviewed all the suggested New Criteria for Commendation and although I always appreciate expanding the menu of opportunities for Providers to receive Commendation, I have a few concerns. I am the Chair of the Continuing Medical Education Committee of the International Parkinson and Movement Disorder Society. Our Committee acts as the reviewers for any educational activity that requests CME credits. Our Society received Commendation in 2010 during the Reaccreditation Process at that time. Our Medical Society would struggle to receive commendation using your current criteria.

Our Society is a voluntary organization of 6000 neurologists, basic scientists, movement disorder specialists and allied health workers whose purpose is to provide education to its membership so that they can improve on their patient outcomes. Since we are not a hospital or medical institution, nor a part of a clinical setting, we do not have access to patient outcomes directly provided by our membership, we also do not maintain a quality improvement database or have a data analyst employed by our organization to track assessment tools for CME activities. A few reasons why your new criteria does not fit a Medical Society like ours is the following:

1. Our membership act as teachers in providing education to current and future movement disorder specialists with no access to patient data except as related to the local clinical setting they are employed by. Some basic scientists might have no access or relation to patient data at all. We should not exclude them from CME activities.
2. The pathophysiology and understanding of disease is different. Movement Disorders works often with "rare diseases". That means, that patient outcomes are difficult to get (because there are only so few patients) or you might need extremely long times to find out about any trends in treatment.

I recognize the importance of always improving on criteria but I hope this new criteria doesn't jeopardize a medical society like ours. I would hope there would be room for our valued Society to also receive commendation.

Best regards,

A handwritten signature in blue ink, appearing to read "Lars Timmermann", is written over a light blue horizontal line. The signature is fluid and cursive, with a large loop at the beginning.

Lars Timmermann

Chairperson, MDS Continuing Medical Education Committee

Society for Academic Continuing Medical Education (SACME) Board Response to the proposed
ACCME Criteria for Commendation
February 19, 2016

The ACCME is to be commended for creating accreditation criteria that encourage improvement in the effectiveness of CME and engagement of the CME office and enterprise with key stakeholders. In the ensuing years since the 2008 criteria went into effect, an increasing number of providers have achieved accreditation with commendation. It is appropriate and timely for the ACCME to re-examine its requirements and reflect on how it can further advance the practice of CME.

The ACCME has designed its criteria in a manner that requires all providers to demonstrate compliance with traditional principles underlying activity and program planning and evaluation/improvement, as well as the Standards for Commercial Support (Level I and II criteria). The Level III criteria, which form the basis for commendation and are now being reconsidered, are intended to encourage providers to pursue educational and strategic innovation. As the ACCME develops these new aspirational standards, it is important to strike a balance between the expected outcomes and the feasibility of providers being able to attain them. In this process, the accreditation system should ensure the requirements are achievable by any of the diverse array of provider groups and CME settings. In addition, the vision of the accreditation system for continuing professional development should be aligned with that of other stakeholders in the field, including patients and their advocates, health care providers and payers, learners, health professions educators and researchers, other accrediting and certifying bodies (e.g., ABMS and ACGME), key thought leaders, and clinical researchers. Assessment of compliance should be realistic in terms of the ability of the accreditation system to gather meaningful evidence of innovation and to evaluate the use of resources available to providers to effect these changes.

SACME heartily endorses the ACCME's efforts to advance our field by developing new criteria for Accreditation with Commendation and offers the following comments to assist the ACCME in promulgating standards that will help providers (in academic as well as other environments) enhance physician competency and performance, as well as improve the health of our nation's population.

1. The Menu Structure

We believe that the general concepts are useful but suggest that the categories be described in terms that are somewhat less restrictive in scope, being broad enough to include additional criteria that might seem appropriate in the future. Suggested verbiage could include:

- **“Engagement of Key Stakeholders in the Design and Delivery of CME Activities”**, rather than “Inclusive Teaching and Learning”: The field of CME is moving beyond the traditional teacher-learner dyad to an environment in which the practitioner seeks out and is offered a variety of strategies to improve his or her practice. The term “inclusive” seems rather vague and non-descriptive of the intended scope of the category.

- **“Engagement with Systems of Care and Populations”** rather than “Addressing Public Health Priorities”: C26 seems to address not only public health but also clinical patient data. This category could address systems-based practice for issues such as value-based care delivery and new delivery models.
- **“Advancing Professional Competency and Performance”** rather than “Creating Behavioral Change”: The criteria in this category address not only behavioral competencies but also technical skills and it would seem the use of broader language would help convey that point.
- **“Engagement of the CME Unit with Key Constituencies”** rather than “Demonstrating Leadership”: The criteria here seem to be more related to engagement rather than strictly leadership. The concept here seems less related to expecting that every accredited provider will hold a CME leadership role than developing competencies within the CME unit and collaborations to advance both the individual CME program and the field.
- **“Advancing the Medical Education Outcomes of the CME Program”** rather than “Achieving Outcomes”: The criteria in this category address the process of measuring and demonstrating medical education and patient outcomes rather than achieving the outcomes.

We believe the current accreditation requirement for each provider to define their mission and demonstrate how they are pursuing it is a critically important component of the accreditation process. With that in mind, we believe it would be important to have each provider not only select the criteria they wish to use for commendation, but to explain how those selected criteria enable them to advance their own particular mission. We are concerned that the way it is designed now (simply select eight across five categories) could potentially allow, if not incent, some providers to select criteria for the ease that would bring to achieving commendation regardless of the value those selections might or might not bring to achieving the mission of the overall program.

We believe there should be more flexibility in the selection process and recommend that the eight criteria be selected from four of the categories (not all five) based on what is most relevant to their mission.

2. Standards for Measuring Compliance

We understand that the ACCME wishes to have clear, measurable and reliable methods for determining compliance with its criteria. In regard to the proposed criteria, however, we have concerns about the attempt to determine compliance based on the percentage of activities or learners for which the criteria were applied (12 of 16), the frequency within the term (3 of 16), or the percentage of the CME team involved (1 of 16). When attempting to promote innovation, we believe that the relevance, depth, and potential impact of the initiative should be weighed most heavily and the focus should be on the overall program - namely how is it contributing to achieving the mission –rather than individual activities.

In addition, providers with a very narrow scope, an extremely diverse program, or limited resources may have great difficulty scaling innovations across a certain proportion of activities. Focus on one or a few innovations may produce much more substantial and replicable results, providing a great opportunity for the ACCME to promulgate best medical education and patient care practices. We strongly urge the ACCME to develop flexibility in the methodology used to assess these new criteria.

3. Specific Criteria

- **Criterion 23: Engages in interprofessional collaborative practice in the planning and delivery of IPCE.**
We endorse the inclusion of this criterion. Under “critical elements”, the term “team-based evaluation” will need to be further defined. As noted above, the evaluation standard of $\geq 25\%$ of learners/activities will exclude many providers who may indeed be implementing innovative practices. The issue is particularly relevant to this criterion, given that many providers who serve $\geq 25\%$ interprofessional audiences may have or be seeking joint accreditation. It is very important for the ACCME to recognize providers who are committed to interprofessional education but whose programs can not inherently meet the requirements for joint accreditation.

- **Criterion 24: Engages patients/public representatives in the planning and delivery of CME.**
We endorse the inclusion of this criterion. Under “critical elements” we have concerns about the requirement that patients/public representatives participate as both planners and teachers/authors. We believe that the roles of these individuals should be selected on the basis of the professional practice gaps identified in the planning process as well as the expertise required to support the educational intervention. This could involve patients as planners, faculty, or both, depending on the specific activity and specific capabilities. As described above, we do not recommend requiring providers to apply this criterion to $\geq 25\%$ of their learners/activities, but rather to demonstrate compliance through examples throughout the program.

- **Criterion 25: Engages health professions’ students in the planning and delivery of CME.**
We recommend this criterion be amended to include not only students but also trainees and colleagues from across the continuum of health professional education. The intent of this requirement is very important – CME must understand the needs of students and residents so that we can prepare them for future practice. There are many areas of important convergence across the continuum, such as faculty development, ACGME Core Requirements (competencies), etc. Faculty Development is a critical area where CME units can be a great resource to Graduate Medical Education (GME) programs and Undergraduate Medical Education (UME) programs if the CME unit is based in an academic medical center or system. We have concerns about the inclusion of students, and, in some cases, residents, as faculty. Although they may offer unique perspectives, students often lack the domain expertise and experience required of faculty in many (if not most) CME activities. It is also not feasible to expect that CME providers in many settings will have access to students. As described above, we do not recommend requiring providers to apply this criterion to $> 25\%$ of their learners/activities, but rather to demonstrate compliance through appropriate situations and examples.

- **Criterion 26: Provides CME about health informatics and the use of practice data.**
It is questionable whether this criterion should be included under the public health priority, given that it relates not only to population health but also to clinical healthcare improvement. It is also very specific and might be more valuable if it were framed in terms of domains associated with practice-based improvement and systems-based practice. Finally, it is so general that it could apply to almost any knowledge based CME activity addressing any patient care issue. As described above, we do not recommend requiring providers to apply this criterion to $\geq 10\%$ of their activities, but rather to demonstrate compliance through examples.

- **Criterion 27: Provides CME about implementation strategies to improve public health.**

We endorse a criterion that relates to “population health” and would suggest the use of this term rather than “public health”, as it is becoming more commonly-used terminology that extends beyond the traditional public health domain. As described above, we do not recommend requiring providers to apply this criterion to > 10% of their activities, but rather to demonstrate compliance through examples.

- **Criterion 28: Develops communications skills of learners.**

We support the importance of communications skills but question why this Core Requirement (competency) area was selected above others. Given that other criteria address medical knowledge (or knowledge to practice), clinical care, systems-based practice, and practice-based improvement, we believe it would be appropriate to include professionalism in this criterion. This is particularly important in view of national priorities for end-of-life care, value-based care delivery, and patient-centered decision making. In terms of the critical elements, the definitions of “objective assessment” and “provides feedback” should be clarified. Perhaps this criterion could be reconsidered as: “Develops the full range of ACGME competencies of the learners.” Another option would be to say Interpersonal and Communication skills and Professionalism within learners as some of the other types of skills/competencies are addressed in different Criteria. As described above, we do not recommend requiring providers to apply this criterion to \geq 10% of their learners/activities, but rather to demonstrate compliance through examples.

- **Criterion 29: Develops technical and procedural skills of learners:**

We support this criterion. As described above, we do not recommend requiring providers to apply this criterion to \geq 10% of their learners/activities, but rather to demonstrate compliance through examples.

- **Criterion 30: Creates individual learning plans for learners and promotes lifelong learning.**

We support this criterion but suggest that it be reframed as “personalized education” which we define as interventions that are intended to address the distinct learning needs, interests, aspirations, or cultural backgrounds of individual learners. We question the critical element to “assess the learner repeatedly”, as the accredited provider may not have a longitudinal relationship with the learner. At the very least, the ACCME should clarify its interpretation of a longitudinal relationship. It appears the core principle is designed for providers to promote the on-going use of personalized education and formal assessment. As described above, we do not recommend requiring providers to apply this criterion to > 10% of their learners/activities, but rather to demonstrate compliance through examples.

- **Criterion 31: Provides services and resources to generate and sustain long-term behavioral modification of learners.**

We endorse the concept of longitudinal relationships with CME participants but believe this criterion requires more thought on the teaching and research methods that are required to effect such lasting changes. In addition, the ACCME must more explicitly define what is meant by “long-term”, as well as “utilization” and “behavioral change”. Many, if not most, CME providers do not have such relationships with the majority of their learners and, in addition, do not currently have the expertise, resources, or research capability to employ evidence-informed teaching and research/assessment methods. It will be critical that they do have these in the future to justify their efforts. As the literature demonstrates, enduring behavioral change is dependent on a variety of factors beyond the educational activity, for example, self-efficacy. As described above, we do not recommend requiring providers to apply this criterion to > 10% of their learners/activities, but rather to demonstrate compliance through examples.

- **Criterion 32: Engages in CME research and scholarship.**

As an academic CME society, we strongly endorse this criterion and will gladly collaborate with the ACCME to further define the expectations. Under the critical elements, we would suggest that the ACCME further define the term “research” hoping that it would include domains such as implementation science and scholarship. We would encourage the dissemination criteria be broadened to include not only publication in peer-reviewed academic journals but also presentations at international, national and regional meetings and/or other legitimate scholarly dissemination vehicles. We believe that this criterion should be assessed across the accreditation period, not necessarily in each year as research; publication and dissemination are competitive and take time to accomplish.

- **Criterion 33: Engages in continuous professional development as educators.**

As an academic CME society, we strongly endorse the continuous professional development of each CME unit staff member particularly in regard to the body of research from Psychology, Cognitive Neuroscience, and Education/the Learning Sciences on what teaching and learning methods are effective and how activities should be delivered to improve medical education outcomes. This will require an investment in CME unit staff member’s academic and professional training. However, it must be recognized that the complement of CME staffing varies within and across provider groups. This criterion should apply to those who have some programmatic engagement in the process, but should not be required, for example, of staff who are strictly administrative. We strongly suggest that there be sufficient flexibility in the definition and assessment of this criterion in terms of the types of professional development activities in which the staff would be engaged in relationship to the roles they play. In terms of the standard, there should be flexibility in terms of the definition of the CME “team”, as well as the ability to participate in professional development across the accreditation period.

- **Criterion 34: Creates collaborations with other organizations to more fully achieve healthcare goals.**

We endorse this criterion but suggest this be assessed on the basis of the overall program rather than a percentage of activities.

- **Criterion 35: Demonstrates creativity in the development or delivery CME.**

We believe the standard of “novel, creative, or innovative” will be extremely difficult to demonstrate. How does one operationalize creativity in the development or delivery of CME? How much difference does one provider’s educational approach need to be from that of another provider’s approach to be considered “novel, creative, or innovative”? What if it is “novel, creative, or innovative” for that particular CME provider, but it has been used before? Does a single use of an approach disqualify anyone else from using it for commendation? We suggest that this be reworded as “Demonstrate and give examples of the application of evidence-informed teaching and learning methods. The intent here appears to be about doing the teaching effectively not creatively.

We suggest this criterion be assessed across the accreditation period.

- **Criterion 36: Demonstrates the impact of the CME program on the performance of individual health professionals.**

Our support of this criterion is dependent on the interpretation of the critical elements and standards. The ability of an individual CME activity on change in practice is limited and it is unrealistic to expect that a certain percentage of activities or learners will achieve this goal. The ACCME will need to define carefully what it means by “measure”, “demonstrate”, and “connect”, as well as how it anticipates that providers will assess change in “individual health professionals,” given that we often do not have access to these data for participants outside of our own health systems. As described above, we do not

recommend requiring providers to apply this criterion to a certain percentage of their learners/activities, but rather to demonstrate compliance through examples across the program.

- **Criterion 37: Demonstrates impact of the CME program on process improvement.**

The ACCME will need to define what it means by “measure”, “demonstrate”, and “connect”. The ability of a provider to achieve this will depend largely on their relationship to a health care system. In addition, it will be important to define clearly what is within or outside the domain of “processes of care.” For example, is this meant to apply only to patient care and not to educational or administrative improvements? As described above, we do not recommend requiring providers to apply this criterion to a certain percentage of their learners/activities, but rather to demonstrate compliance through examples.

- **Criterion 38: Demonstrates impact of the CME program on the health of patients/communities.**

The ACCME will need to define what it means by “measure”, “demonstrate”, and “connect”. As described above, we do not recommend requiring providers to apply this criterion to a certain percentage of their learners/activities, but rather to demonstrate compliance through examples.