Preliminary Analysis of the Call for Comment

Regarding Knowledge-based CME Activities

On January 22, 2010, in accordance with the ACCME'S 2009 Rule Making Policy, the ACCME issued a call for public comment about knowledge-based CME activities.

Background

To comply with the 2006 ACCME Accreditation Criteria, accredited providers need to design CME activities to change learners' competence (i.e., strategies/skills), or performance or patient outcomes; and measure whether their CME program achieves those goals. The ACCME recognizes that knowledge is a critical element of competence, performance and patient outcomes. The ACCME believes that providers should try to change learners' knowledge — when knowledge acquisition will serve the goal of improving physician competence, performance or patient outcomes.

The ACCME issued a call for comment in response to feedback from some providers and other stakeholders that pure knowledge-based activities are vital to physicians' continuing education and professional development, and that the ACCME should revisit this issue and consider rewording the Criteria.

The Call for Comment: The ACCME issued two options for consideration.

Option A would add the word *knowledge* into Criteria 1, 3 and 11.

Option B would not represent a change in the Criteria, but would clarify the ACCME's intentions by stating that providers can present some activities that are designed to change knowledge.

The full text of the call for comment is appended at the end of this document. The call for comment period opened January 22, 2010 and closed on March 8, 2010. Organizations and individuals submitted written comments using an electronic form on the ACCME Web site. Comments were limited to 500 words.

A summary and counts of responses follows.

Responses

One hundred and nine (109) responses were received by the ACCME. The responses are reproduced *verbatim* as an appendix to this document. Two thirds of the respondents expressed the view that altering the Criteria as described in Option A was the preferred option because a change in knowledge is a valid, expected result for accredited continuing medical education. Most of the other third preferred Option B, because it would facilitate and validate education on knowledge, while preserving the progress made by the ACCME

and accredited providers in promoting changes in competence, performance or patient outcomes.

A summary of the counts of those who supported each option is contained in the following table.

Response	Accredited provider	Recognized accreditor	Member organization	Other*	Total
Support Option A	43	10	3	4	60
Others, who lean toward support**	6	0	0	4	10
Support Option A	**49**	**10**	**3**	**8**	**70**
Support Option B	17	6	0	5	28
Others, who lean toward support***	4	1	0	0	5
Support Option B'	**21**	**7**	**0**	**5**	**33**
Additional comments****	5	1	0	1	7
Additional comments	**5**	**1**	**0**	**1**	**7**
Total	**75**	**18**	**3**	**13**	**109**

*__Other__ includes those who chose "Other" as their organizational type (9), non-accredited provider (2) or commercial supporter (1).
****Others, that lean toward support for Option A** responses include those who did not explicitly state that they chose Option A, but express support for the value of knowledge-based CME activities.
*****Others, that lean toward support for Option B** responses include those who did not explicitly state that they chose Option B, but express support for the current Criteria, oppose any changes and/or oppose purely knowledge-based CME activities.
******Additional Comments** include responses that do not fit into either category or said they could not support either option.

Next Steps

The ACCME thanks all those who submitted comments**.** The Board of Directors will discuss the issues and responses at its next meeting, July 15 – 16, 2010, and the ACCME will continue to communicate the status of these discussions with providers and stakeholders.

Call for Comment

Knowledge-based CME Activities

At the urging of several stakeholders of the ACCME's accreditation system, the ACCME is asking the CME community: Should the ACCME add the word *knowledge* into Criteria 1, 3, and 11?

Until 2006, ACCME accreditation requirements allowed an accredited provider's CME program to focus entirely on changing learners' knowledge. In response to calls from stakeholders, the ACCME changed its requirements in 2006 to better position accredited CME as a strategic asset to physician performance improvement and patient health and safety initiatives. To comply with the 2006 ACCME Accreditation Criteria, accredited providers need to design CME activities to change learners' competence (i.e., strategies/skills), or performance or patient outcomes; and measure whether their CME program achieves those goals. The ACCME recognizes that knowledge is a critical element of competence, performance and patient outcomes. The ACCME believes that Providers should try to change learners' knowledge — when knowledge acquisition will serve the goal of improving physician competence, performance or patient outcomes.

The ACCME has received feedback from some providers and other stakeholders that pure knowledge-based activities are vital to physicians' continuing education and professional development, and that the ACCME should revisit this issue and consider rewording the Criteria. The ACCME wants to be responsive to provider and stakeholder needs, but we are concerned that activities and programs designed solely to change knowledge may not fulfill accredited CME's responsibility to be accountable to the public and may not align with current U.S. quality and safety initiatives. According to ACCME's mission, accreditation standards should support the "incorporation of new knowledge to improve quality medical care for patients and their communities."

The ACCME is considering several options.

Option A

This option would address the concerns expressed by some stakeholders. The ACCME could add the word *knowledge* to the Criteria as follows **(additions in bold):**

Criteria 1. The provider has a CME mission statement that includes all of the basic components (CME purpose, content areas, target audience, type of activities, expected results) with expected results articulated in terms of changes in **KNOWLEDGE**, competence, performance, or patient outcomes that will be the result of the program.

Criteria 2. The provider incorporates into CME activities the educational needs (knowledge, competence, or performance) that underlie the professional practice gaps of their own learners.

Criteria 3. The provider generates activities/educational interventions that are designed to change **KNOWLEDGE**, competence, performance, or patient outcomes as described in its mission statement.

Criteria 11 The provider analyzes changes in learners (**KNOWLEDGE**, competence, performance, or patient outcomes) achieved as a result of the overall program's activities/educational interventions**.**

Option B

This option would not represent a change in the Criteria, but would clarify ACCME's intentions. The ACCME could state:

"Providers **can** present some activities that are designed to change knowledge. However, the provider's overall CME program must focus on changing competence or performance or patient outcomes. Providers must include those goals in their mission (C1) and must analyze the impact of their overall program to determine if those goals have been achieved (C11).

The ACCME is seeking your opinion on these options and welcomes any other suggestions you may have.

The deadline for submitting comments is March 8, 2010. The ACCME limits comments to 500 words and will not consider anonymous submissions. All viewpoints are welcome, but please make your comments constructive. The ACCME considers the comments and the names of those authoring the comments to be public information that may be published on the ACCME's Web site.

Call for Comment: Knowledge-based CME Activities

Ref. #	Feedback Received	Org. Type
1	It would be a grave mistake to add "knowledge" to the criteria as proposed. CME has made significant progress in achieving documented improvements in patient care in the form of competence, performance, and patient outcomes. As most providers are aware, education planners often will do the bare minimum to meet accreditation requirements. If "knowledge" alone is permitted as an option for CME outcomes, it will become the default option for many planners who lack the commitment to achieve real change in practice. The addition of "knowledge" would undermine the long-term efforts of CME professionals to increase the rigor and impact of medical education. CME will only be successful and valued within health care if it can continue to contribute in substantive ways to improved quality and practice.	Accredited CME Provider
2	The Massachusetts Medical Society supports Option B relative to the inclusion of the word "knowledge" into Criteria 1, 3 and 11. The ultimate goal of CME is to improve care...change behavior. In order to to this, a physician does need to acquire additional knowledge. In this context however, changing knowledge is a necessary step, but not the ultimate goal. While it is a much more daunting task to measure the desired outcome - changing behavior and/or improving patient outcomes - we should not change our goal to something that is easier to measure - knowledge. Physicians in practice aren't being 'measured' for their knowledge. They are being evaluated for their skills, performance in practice and patient results.	Recognized Accreditor
3	The Medical Society of New Jersey supports Option B, which will clarify the ACCME's intentions regarding knowledge-based activities. While the MSNJ Committee on Medical Education recognizes and believes in the importance of planning activities to change competence, performance and outcomes, we believe that providers should be able to conduct some activities designed to change knowledge, that can be designated for AMA PRA Category 1 Credit TM. Physicians greatly value education that changes practice and performance, but they also value education that changes knowledge. While such education may not necessarily directly impact their own patient outcomes, it can improve their communication and collaboration with colleagues in their own and other specialties, and benefit practices and patients less directly. Also, it is important for smaller institutions with less or limited access or ability to evaluate performance data continually for all activities to have the option of designing some activities for change in knowledge only in combination with others designed to change competence, performance or outcomes.	Recognized Accreditor
4	The Texas Alliance for Continuing Medical Education (TACME) supports Option A which recognizes the important role knowledge plays as a primary step in the adult education process. It is sometimes years between the time "new knowledge" is reported and the time trends identified as gaps are reported. New knowledge in the hands of intelligent, educated and skilled individuals can actually prevent some gaps from developing. TACME members agree that provider's programs should not be limited solely to the advancement of knowledge. Many providers have made great improvements to advance their programs to support the continuous improvement of physician competence and performance. Providers should continue this advancement by developing activities that seek to overcome competence and performance barriers and gaps to improve patient outcomes whenever possible.	Other
5	Of the two options proposed here, Option A is the preferred one. By including knowledge as an accepted outcome of accredited activities and programs, the ACCME recognizes the need for physicians to maintain a mastery of the current discoveries in their fields, including the scientific advances which may not yet have direct patient care applications. If the discoveries in question are relevant to a physician's scope of practice and	Accredited CME Provider

Ref. #	Feedback Received	Org. Type
	could enhance his or her understanding of the disease processes which s/he treats, then this information should serve as acceptable content for accredited CME activities. Improving physicians' knowledge and understanding of the patients they treat should ultimately result in improved patient care. While Option B attempts to address this concern, the vagueness of this option makes it unacceptable. Attempting to quantify an acceptable number of knowledge-based activities in a program would prove impossible because of the unique needs of the various specialties and sub-specialties served by CME providers. Therefore, Option A better meets the needs of the physicians participating in CME activities.	
6	While imparting knowledge is one of the basic objectives of education, competency is defined as knowledge in action. It is appropriate to instruct with an increase of knowledge as an end goal however, the end result for all learners should be a change in behavior that demonstrates competency due to an increase in knowledge. NAAMECC is somewhat in agreement with Option B for the purposes of clarification of current ACCME policy however; we believe that there should be further explanation as this statement is ambiguous. ACCME has indicated that when the educational focus is on a topic of research in which there is no patient care application, that looking at the application of the knowledge to research practices is acceptable. Therefore, what does the word “some” mean? Is this a percentage of activities or only activities that are focused on research activities? In addition, are activities outside of research practices to be designed to only change knowledge or does the knowledge based activity have a further goal of putting the knowledge into action? Further clarification is needed prior to a final statement is released.	Other
7	The Wisconsin Medical Society's Council on Medical Education favors Option A, where the word “knowledge” is inserted. Knowledge is an integral part of education. Without imparting knowledge, there is no education. As a profession, we require that knowledge be tempered with appropriate application to meet the needs of individual patients. For this reason, we have gone beyond discussing interesting topics to asking how the information gained can be applied to improve the safe care of patients. We feel knowledge once again should be recognized but it would not and should not detract from the core competencies. As a CME provider, not every topic requested by learners fits a core competency nicely. It is valuable, for example to have a grand rounds by a respected authority as a point of departure for discussion and interaction about a topic or clinical problem. In addition, stating that didactic lectures only increase knowledge is too narrow. If there is time for questions and answers, audience members can refine their understanding of the topic in order to incorporate that knowledge into their practice. Thank you for the opportunity to provide comments on this important issue.	Recognized Accreditor
8	The Michigan State Medical Society Committee on CME Accreditation strongly supports Option A which would add knowledge to Criteria 1, 2, 3 and 11. The MSMS Committee on CME Accreditation supports the rationale given by the AMA opposing Option B listed below: • In many cases new knowledge is an essential part of the groundwork that in the future may lead to new or improved competence but does not necessarily affect an immediate change. In fact some knowledge-based activities serve to enhance or affirm understanding rather than affect any change in performance. • To suggest that CME activities focused on improving knowledge should be prohibited or significantly limited runs counter to well-accepted adult educational principles and theories.	Recognized Accreditor

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	• This position is consistent with the six competencies of the ACGME and the ABMS which include "Knowledge." Further, the AAMC HHMI 'Scientific Foundations for Future Physicians report' states that "a competency is defined as the knowledge, skill, or attitude that enables an individual to learn and perform in medical practice." and the ACCME's Criterion 6: "The provider develops activities/educational interventions in the context of desirable physician attributes (e.g., IOM competencies, ACGME Competencies)." • Allowing activities that target knowledge improvement does not preclude implementation of activities to address other competencies as part of a CME providers overall CME program.	
9	The Florida Medical Association supports the addition of the word knowledge to Criteria 1, 2, 3, and 11 as expressed in Option A. Because acquisition and assimilation of knowledge is the preliminary stepping stone to both improved competence and/or performance, it makes sense to include language that gives providers explicit sanction for offering and evaluating knowledge-based activities. Based on the current perception that CME should encourage performance improvement and enhance patient outcomes, we would recommend revising Criteria 11 as follows: "Providers should evaluate changes in learners that will contribute to improved physician performance and/or improved patient outcomes as a result of the overall program's activities. These changes may be identified as expected and/or demonstrated improvements in knowledge, changes in practice patterns or improvements in patient outcomes." In an effort to measure the results of individual activities more effectively, providers should ask "why" learners attended an activity before they ask "if" and "how" the activity improved their knowledge, changed their competence or will change their performance. This will serve as an acknowledgment that physicians sometimes attend CME to reinforce current knowledge or simply to satisfy their curiosity about aspects of medicine they don't currently practice. We believe that this too is an important aspect of CME and reflects our physicians' reputation as lifelong learners and seekers of knowledge, occasionally for its own sake, or as a recognition that their practice may change.	Recognized Accreditor
10	I encourage ACCME reconsider its position and reinstitute knowledge as a an objective. Option A should be the choice. Knowledge remains the foundation upon which the other objectives depend. Certainly competence, performance, and patient outcomes can only be based on a solid knowledge basis. I have attended several seminars recently. ACCP etc. I received CME which could only be based on changes in Knowledge. There remains a need for Ethics conferences but none can be presented with the current guidelines. In addition, previous conferences involving case presentations in critical care, tuberculosis, cardiology, cancer will no longer qualify for CME.	Accredited CME Provider
11	It is the American Academy of Dermatology's opinion that CME providers have a responsibility to create educational content that is designed to improve the competence and performance of physicians and ultimately improve the patient's outcome. It is our belief that knowledge assessment is also a valuable component of CME programs. Many smaller organizations, particularly at the state level, do not have the necessary resources to manage a CME program that is designed to only measure changes in competence, performance, or patient outcomes. Provided that the ACCME clarifies that not every activity requires assessment of changes in competence, performance, or patient outcomes; and that assessment of changes in knowledge is appropriate for some program activities, then Option B leads CME providers in the right direction: meaningful, care-impacting outcomes for all we invest in providing CME.	Accredited CME Provider

Call for Comment: Knowledge-based CME Activities

Ref. #	Feedback Received	Org. Type
12	The Colorado Medical Society Committee on Prof. Education & Accreditation chooses Option B, which will clarify the ACCME's intentions regarding knowledge-based activities. It is important for CME to keep pace with quality improvement movements that are occurring in today's healthcare environment. It is critically imperative that ACCME work with other professional organizations such as ABMS, CMSS, ACS, ABS, ABTS, ABIM and others that are vitally concerned with outcomes in medical education and already have provisions for certification of competence in clinical practice. CME that is specifically designed to change physician competence or performance is relevant CME that will contribute to improved patient outcomes. Since the implementation of the Updated Criteria, Colorado Medical Society accredited providers are now utilizing performance measurement data, conducting more meaningful needs assessment surveys, developing collaborative relationships both internally and externally, working more closely with CME faculty to ensure the content is aligned with gaps and objectives, and tracking the effectiveness of their CME activities in terms of change in competence, performance or patient outcomes. Yes, this does require more resources than the previous model of CME, which was more about filling the calendars and collecting evaluation forms that were rarely reviewed. But, CME should not go backwards. As performance improvement data become more widely available it will become less of a burden on CME providers to identify gaps and plan CME that will close those gaps. Furthermore, individual activities should specify performance and/or outcome based objectives, not all knowledge based objectives. CME activities that are designed to change knowledge should be allowed, but only as necessary, for example, one or a few in a sequence of sessions within an educational campaign, initiative or series that is designed overall to change competence, performance or patient outcomes. Knowledge-based activities too easily obscure marketing agendas of presenters and risk moving away from self-assessment and patient needs assessment that would result in effective and appropriate care.	Recognized Accreditor
13	The American Academy of Child and Adolescent Psychiatry (AACAP) understands that knowledge is implied but not specifically expressed in criteria 1, 3 and 11. We would like to see the addition of knowledge stated in these criteria. Having it stated as such will reinforce that knowledge precedes any active change in behavior, and that this is an acceptable element of planning and implementing activities. We support Option A.	Accredited CME Provider
14	We are in support of option A. Knowledge is the first step in the journey of lifelong learning. The language used currently in criteria 2, 3, and 11 leaves open for interpretation the role of knowledge based CME in the providers' overall program. Adding the word knowledge provides more clarity for implementation and measurement of criteria 2, 3, and 11 versus the verbiage suggested in Option B. We support the intent of changing competence and practice thus improving patient outcomes, but find the measurement as a provider to be onerous. We also believe that this process is longitudinal; the translation of knowledge to improved patient outcomes can not be measured post a single CME activity. This is further complicated by the fact that we are not the sole provider of CME programming available to our learners on any given practice gap. There needs to be more discussion on how providers can play a documentable role in this process at the learner level.	Accredited CME Provider

Call for Comment: Knowledge-based CME Activities

Ref. #	Feedback Received	Org. Type
15	While I agree in principle that knowledge-based activities have a role to play in physician CPPD, I wonder if the addition of the term “knowledge” to Criteria 1, 2, 3, and 11 will would create an unintended pathway for some providers to revert back to “knowledge” oriented CME activities only, thus undermining the intent of the Updated Criteria. Consider, for example Criteria 1; since a provider need not select all aspects (competence, performance or patient outcomes) with regard to the articulation of expected results, merely adding knowledge to the mix would most certainly lead to some providers choosing only knowledge as the expected result, thus returning us to the old paradigm. One problem with Option B is that it does not delineate what is meant by “some” CME activities. Is this measured as an overall percentage of a provider’s CME activities? And over what span of time, per term, per year? It seems to me that neither Option, as currently written, will effectively address the need to establish a place for knowledge-based activities, while maintaining the emphasis on continuous improvement, through changes in competence, performance and patient outcomes, that the Updated Criteria are designed to support. In order to achieve that, both Option A & B will need to more specifically define what portion of a providers CME activities can be simply knowledge-based and still meet compliance. So while I agree that we have to find an appropriate place for knowledge-based CME activities in CME, I cannot support either of these proposed options as currently proposed.	Recognized Accreditor
16	I support option A, the explicit inclusion of knowledge in the criteria. The vast amount of medical literature now available in textbooks, journals, in classes and on–line assists us in many ways. We look to the literature for new information to use today, in the near future, and for our general fund of knowledge. The category for a general fund of knowledge is particularly problematic for a practicing physician eager to be aware and keeping up with current practices and in preparation for future changes in our practice of medicine. As of now, the panels guiding our continuing post–graduate education declare that the learning of things unrelated to our practice is not useful. The key questions is what happens to us as physicians and as learners? Here is a example from my own experience. In 1984, an article appeared in The Lancet about the identification of Helicobacter Pylori as a bacterial cause of duodenal ulcers. This was followed over the ensuing years with more articles validating the initial discovery and then studies on treatment. In 1992, the treatment of H. Pylori for duodenal ulcers began in to be utilized in clinical practice. When I first read the article in 1984, I had no idea about the subject, nor that in subsequent years, this would turn into an important advance for patient care. If I had heard about this in a lecture in 1985, then I should not receive continuing education credits because it was pure knowledge that I could not commit to practice in that month, or succeeding several years. I recently went to a lecture given by an otolaryngology group about eosinophilic esophagitis. Since I am now a sub–specialist in Sports Medicine, and am no longer in general internal medicine, my need for this particular subject is fairly low. However, it was a completely new topic for me, so I was very interested in “Knowledge for knowledge’s sake.” Today, I saw a brief article about eosinophilic esophagitis. I now added a little more to my fund of knowledge about it. I still don't expect to see anyone with it in the next several years, since it is fairly rare at 52/100,000 persons. Maybe I should be confining myself to “sports medicine” issues only in my education that can be useful in the next several months.	Accredited CME Provider

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	The ACCME repudiation of the concept of “knowledge” alone as a learning objective is wrong–headed for physicians who are expected to retain and advance a wide breadth of experience and knowledge. One can hardly do that without a narrowed perspective. Therefore I call on the ACCME to change its stance on the knowledge issue.	
17	The New York County Medical Society's Committee on CME supports Option A, the explicit inclusion of “knowledge” in the criteria. Knowledge for knowledge’s sake is a common theme of our general medical education. On the other hand, knowledge in learning which is developed only with a perspective or result in mind is a completely different type of learning. One wonders what it would mean if workshops, lectures, and courses in medical fields were restricted to gaining knowledge only with the expectation that there needed to be some objective required. We agree that competence, performance and patient outcomes are important targets for education. However, we also believe that the explicit, independent standing of knowledge as the outcome of education must continue to be recognized. Increased knowledge can increase competence, but knowledge also may not have an immediate effect. Pure knowledge is not always applicable at the same time as it is gained; knowledge operates on a time line. The current ACCME criteria misses the element of time in considering the success of an educational endeavor. Chance favors the prepared mind. The competence, performance, or patient outcome may end up relying on something that the physician learned in the past. The frequent beginning of a diagnosis: “I’ve heard of this before . . .” exemplifies the building of knowledge. The fund of knowledge that we began accruing in medical school is not always pertinent right now. Because knowledge may not be connected to any particular competency today, it may not be measured by competence or performance or patient outcome. Yet it may be essential to competence, performance, or patient outcome at a later date. It is an essential building block to the ultimate goal, and therefore knowledge should stand alone as an educational end.	Accredited CME Provider
18	In my opinion, option B is too ambiguous. It would only lead to providers not knowing what is required, how many can be knowledge based, is it a percentage of overall program etc. It is much preferable to add knowledge back into the appropriate criteria. As the accredited provider still has to measure competence, performance or patient outcomes, the addition of knowledge does not dilute the progress we have made to improve the impact on physician practice that we are all trying to achieve. It is also true that knowledge is the basis of these other competencies and therefore is a justifiable measure. We are no longer just looking at an increase in knowledge but more how that increased knowledge changed practice and resulted in better patient care. Another consideration is that in many specialized area (ie Oncology, Cardiology), there is so much new clinical data coming out that being able to gain knowledge on new drugs, new devices, new clinical options are all essential and will ultimately lead to practice improvements and increased competencies in the use of new agents as well as ultimately improving patient care. Therefore the importance of the acquisition of knowledge may be very important for some physicians or in some settings but the measure should be on how that affected their medical practice and ultimately patient care. Would the ACCME please define what it means by knowledge, competence, performance and patient outcomes?	Accredited CME Provider

Call for Comment: Knowledge-based CME Activities

Ref. #	Feedback Received	Org. Type
19	On behalf of the LSMS CME Accreditation Committee (CMEAC), which consists of six members, we are responding to the ACCME's Call for Comment regarding the Knowledge-based CME Activities. The LSMS CMEAC supports Option A. We have discussed this issue on multiple occasions. We are concerned about the complexity of existing criteria as well as proposed changes that will inflict even more detailed paperwork with dramatically increased costs but little, if any, added value for the state accredited providers. The LSMS CMEAC does not support Option B.	Recognized Accreditor
20	I don't believe either option is appropriate or needed. I believe the way to address the calls from accredited CME's stakeholders is to better educate CME providers and physician learners on the appropriate and important role that "knowledge" plays in the current accreditation system. I think that many providers don't realize (1) that activities can be planned and evaluated in aggregate, especially for more complicated issues where knowledge must be incorporated as a necessary component to move physicians towards performance change, (2) that activities need not be evaluated for performance or patient outcome changes, and (3) how simple it can be to measure competence changes. The idea of using metrics such as saying a "certain" "number" or "percentage" of activities must meet specific expectations adds more complexity to the accreditation criteria, rather than less. Some providers do only a few activities, and some do a lot. Some do symposia and multi-day annual meetings. How would the metrics of "certain numbers" or "percentages" apply to those situations? I think it would be difficult to say. I think the current accreditation system is gaining success and acceptance. It does reduce the number of activities that are designed to simply "update" physicians, but we know from limited research that those types of activities do not consistently lead to improvements in physician performance or patient care. In the current milieu, accredited CME needs to support improving performance and patient care. Focusing on activities that only deal with knowledge changes is a step backwards, in my opinion, and this would not be good in the long run for patients or for accredited CME's stakeholders.	Accredited CME Provider
21	On Thursday, March 4, Rhode Island Medical Society's Committee on CME Accreditation held its quarterly committee meeting. Among our agenda items was a discussion regarding ACCME's recent "Calls for Comment." The following is the response from Rhode Island Medical Society Committee on CME Accreditation: 2. Knowledge-based CME Activities Rhode Island Medical Society's Committee on CME Accreditation supports Option A which would add knowledge to Criteria 1, 3 and 11.	Recognized Accreditor
22	Thank you for addressing this very important issue. In my experience, many physicians who are speakers and authors for CME activities (and even some ACCME surveyors) do not understand that ACCME has moved beyond knowledge acquisition as the goal for CME. These professionals do not seem to understand how to make the transition from knowledge to "knowledge in action". Helping CME faculty and planners transition from knowledge to competence and performance has been a large part of my role recently, and so	Accredited CME Provider

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	adopting proposed Option A (adding "knowledge" to Criteria1, 3, and 11) would make my job much easier. (But then I might need to reverse some recent policy and process updates, further confusing faculty and colleagues.) I am in favor of adopting Option A for Level 1 accreditation, with the expectation that more experienced providers move beyond knowledge to enhance competence, performance, or outcomes. Option B would need to be clarified to quantify the acceptable level of knowledge-based education, allowing for some knowledge-based content for Level 2 providers and less for Level 3. And, I believe that ACCME should encourage all providers to promote changes in competence or performance in all activities, regardless of whether changes in knowledge are part of the identified practice gap that the education is designed to address. In any event, clear articulation of ACCME's goals and expectations will be critical to the ongoing discussion of this issue. How can faculty be trained regarding educational design and ACCME criteria? The updated criteria and information about how to interpret them needs to be made more widely available to physicians as faculty and as learners. What role do the medical schools and professional societies have in this huge void?	
23	Texas Medical Association believes that knowledge-based educational activities have a role in the continuum of medical education, including CME. Physicians benefit from CME activities that increase their knowledge on a specific topic and often produce change in competence or performance in the future, not necessarily at the time of the activity. TMA believes that while knowledge should be a component of a CME program, the progress that has been made to encourage CME providers to develop activities to change competence, performance, or patient outcomes should not be discontinued. Option A would enable a CME provider to offer a CME program of knowledge-based activities only and be in compliance with all accreditation criteria. The intent of Option B is good, but the issue becomes one of determining how much of the CME program could be devoted to knowledge-based activities. The policy could be edited to state, “The provider’s overall CME program must focus on changing competence or performance or patient outcomes. However, providers can present some activities that are designed to improve knowledge. Providers must include those goals in their mission (C1) and must analyze the impact of their overall program to determine if those goals have been achieved (C11).” TMA supports Option B with the revised wording and additional mechanisms to determine the appropriate portion of knowledge-based activities and reward providers who make the extra effort to design activities to change competence, performance, or patient outcomes.	Recognized Accreditor
24	Physicians’ Education Resource (PER) supports Option B- clarification of the ACCME’s intentions on the provision of knowledge-based CME activities. Most physicians experience various stages of change in adopting new behaviors and PER believes that knowledge acquisition is the foundation for behavior change. Knowledge-based CME activities play an essential role in facilitating the physicians’ awareness and understanding of the ever-evolving body of knowledge as well as the potential applicability to their practice and their patients. However, knowledge-based activities should provide the foundation for future activities that are designed to change competence, performance or patient outcomes as described in the provider’s mission statement.	Accredited CME Provider

Call for Comment: Knowledge-based CME Activities

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25	I strongly favor Option A, as it allows some CME providers to focus exclusively on improving learners' knowledge, if so desired, whereas it encourages other CME providers to include or focus on the other elements of CME (competence, performance, or patient outcomes). The expertise required to devise CME activities for improving competence, performance, or patient outcomes is qualitatively different from that aimed at improving knowledge. Smaller CME providers, in particular, may not have the resources to be able to satisfy all elements of CME. It is in the public interest to allow for providers who have achieved excellence by focusing on any single element of continuing education.	Accredited CME Provider
26	On behalf of Correct Care Inc, a LSMS CME provider we are in support of Option A to add the word "Knowledge" to Criteria 1, 3 and 11.	Accredited CME Provider
27	AAMC is supportive of the goal of the ACCME to promote educational activities that effect change in physician competence or performance or improve patient outcomes. While some would argue that the notion of competence comprises knowledge, many in the CME provider community believe that a clearer recognition of this fact is necessary. Thus, AAMC supports Option A, including “knowledge” in Accreditation Criteria 1, 2, 3 and 11.	ACCME Member Organization
28	The Carle Foundation Hospital CME Committee supports Option A of the proposed change. The nature of hospital-based education is influenced by the makeup of the hospital medical staff, typically physicians with multiple hospital affiliations who may be part of group clinical practices or who may be independent practitioners. This diversity requires a diverse learning platform that includes knowledge. In our case, we have a large rural provider base with access limitations. The AAMC predicts a national shortage of 124 thousand physicians by 2025, even with a 30 percent recommended increase in medical school enrollment. For rural areas, this shortage will be even more dramatic as they are already undermanned. Add to this the fact that much of what is learned in medical school and residency training is obsolete in a relatively short amount of time (some say five years or less) and we will need even more focus on knowledge not less. Finally, we believe education is a cumulative process and knowledge acquisition is fundamental to that process. We cannot cite a single educational research source that supports the concept that every learning experience/activity will result in competence, however; the current standards place unrealistic expectations on providers to do just that. To be compliant providers now spend excess time in documentation (or in creating a rationale for our documentation) to show competence, performance and outcomes. It is our belief that knowledge is a valid learning platform and the ACCME Criteria should recognize learning as fundamental to continuing medical education of physicians.	Accredited CME Provider
29	I would go for option A. Including knowledge makes it easier for us to measure the outcomes of most of our CME activities. Though it will not be the main purpose and focus of the CME activity but I believe that along with the change in knowledge, follows the change in competence, performance, and patient outcomes.	Accredited CME Provider
30	I favor Option A simply because I believe if we change a learner's knowledge it will be used to positively change pt outcomes. In addition most physicians are interested in gaining new knowledge to use as applicable in whatever their role is in pt mgt (direct or indirect).	Recognized Accreditor

Call for Comment: Knowledge-based CME Activities

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31	Knowledge-based activities can be beneficial to physicians as well as to their patients. However, it is critically important that physicians translate this knowledge into improved strategies and/or skills, thus competence. Perhaps through commitment to change post activity surveys, participants can indicate how the knowledge acquired during an activity changed their strategies and/or skills. Also, several physicians have been put off with the term "practice gap", saying that it implies incompetence. The preferred verbiage is "knowledge or practice gap". My vote is for Option B.	Accredited CME Provider
32	The American College of Medical Genetics would strongly support Option A which would amend ACCME Criteria 1, 3, and 11 by allowing CME providers to plan activities aimed at changing knowledge in addition to changing competence, performance and patient outcomes. The specialty of Medical Genetics is a rapidly evolving field with new advances in our knowledge of the genetic and molecular basis of both rare and common conditions occurring on a regular basis. These genomic advances include new diagnostic modalities which can assist in the diagnosis of underlying medical conditions, new molecularly based treatment modalities to treat previously untreatable genetic conditions, and susceptibility testing for identification of individuals at increased risk for common medical conditions. The application of this new knowledge is directly relevant to the care of patients with both rare and common medical conditions, and, if applied in the patient care setting, would be expected to, by its very nature, lead to a change in physician competence and performance, and in patient outcomes. Providing CME programs that are aimed at improving physician knowledge of new advances in Medical Genetics is of vital importance to our specialty and would supplement programming aimed at improving physician competence and performance.	Accredited CME Provider
33	I completely believe that CME's should focus on the overall quality care provided by physicians rather than a free meal and time of fellowship with other physicians. Therefore, I support the idea of not having the freedom to provide education on any topic which may or may not enhance an area's Medical Staff. Pure knowledge based education may not have focused on providing quality, relevant education, but I think that as a CME provider, especially as a new coordinator, my focus is on quality and safety initiatives. I believe "knowledge" should be added to the criteria, but the performance gap should still be indicated and evaluated. After all, gained knowledge will eventually change patient outcomes, competence, or physician performance. With the current verbiage of the criteria, I feel "backed into a corner" with an inability to provide any education for my Medical Staff. By adding the word "knowledge" and the initiative to focus on quality, we will cover both sides of the argument.	Accredited CME Provider
34	The Society for Academic CME supports ACCME's Option A as it acknowledges the role knowledge-based CME can play in our efforts to change physicians' performance and, ultimately, patient outcomes. Explicit language about knowledge-based CME in the ACCME criteria is also in alignment with the ABMS and ACGME core competencies. That being said, our support of Option A in no way lessens our Society's commitment to advocate for CME activities that seek to achieve higher level learning outcomes. CME providers must implement a balanced portfolio of educational activities. SACME will continue to advocate for CME activities that support the continuous professional development of physicians, including PI-CME.	Other
35	The ACCME's proposals related to knowledge-based CME activities are well-intentioned but not necessary. The ACCME raised the bar with updated criteria that required providers to rewrite their missions and operations to address competence, performance, or patient outcomes. The result? CME quality increased. Knowledge is an underlying component of activities that address competence, performance, and patient	Accredited CME Provider

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	outcomes. Adding the term "knowledge" to the criteria could add complexity and confusion to the existing system of elements, standards, criteria, definitions, policies, and value statements. In addition, the proposed change could raise additional questions, such as: 1. What is wrong with the current system? 2. Did the ACCME make a mistake in implementing the current criteria? 3. Is there a significant number of providers that do not comply with the current criteria? If so, are they on probation? If not, why is this change necessary? 4. Will the proposed changes improve the CME enterprise in some measureable way? 5. Will providers seeking reaccreditation in future cohorts be held to a different standard than providers in recent cohorts? Thanks in part to the ACCME, the CME enterprise has embraced "knowledge" but moved ahead to address competence and performance. The 1978 film "Animal House" lampooned education by placing three words at the base of the founder's statue at the fictional Faber College: "Knowledge is good." With respect to the criteria, we should ask if "knowledge" is good enough?	
36	There are many educational activities that are meaningful under any definition of Adult Learning and are knowledge based. I strongly suggest Option A. I look at programs such as Tumor Boards where many experts share their "knowledge" in hopes of improving the "knowledge" of a continuum of providers present as an example of "Knowledge" being a suitable criteria. I would also point out that until electronic medical records are further implemented and integrated into the many providers most of us deal with, much of the outcome measures you seek from us will not be consistently and reliably available. I would speculate that your criteria in many areas while laudable is ahead of the curve on the day to day compliance at the implementation level.	Accredited CME Provider
37	When an entire CME program is considered, its purpose needs to address physician competence, performance or patient outcomes. Knowledge is an inherent component of “competence,” as it encompasses a physician putting knowledge into action. There is a valid role for increasing knowledge in CME activities, and this may be especially true for medical schools, where research results in greater understandings that may not yet have a clear application. Furthermore, there are instances where an increase in knowledge is a proper educational outcome. Some knowledge that results from a learning activity may never be used, while some knowledge may be applied in practice in the future. By formally adding “knowledge” as a component of “competence, performance, and patient outcomes” in Criteria 1, 3, and 11, the accreditation system may be reverting back to System 98. CME providers already have much experience in measuring knowledge, and many believe it is a sufficient outcome of education. If knowledge becomes a criterion that will meet the aforementioned criteria, it will be the lowest common denominator. With this in mind, Option B, as outlined, seems to be more in the spirit of where the CME enterprise needs to be, especially with implementation of Maintenance of Certification™ as well as Maintenance of Licensure on the horizon. A concern can be raised, however, that “providers can present ‘some’ activities that are designed to change knowledge,” with their overall programs focusing on changing competence, performance, or patient outcomes. In this statement, there is a potential for different interpretations among ACCME site surveyors, ACCME staff, and/or CME providers as to the appropriate volume of activities within a CME program that can be	Accredited CME Provider

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	designed to change knowledge, and this is an aspect of Option B that needs to be considered. In summary, knowledge acquisition can, and should, be a part of CME activities, while CME programs overall should maintain a goal of improving competence, performance, and patient outcomes.	
38	I strongly support the move to the expectation that CME activities will facilitate improved care. By requiring activities to be designed to change competence, performance or patient outcomes, this is now explicit for us as CME providers. I know it can be challenging to plan activities designed for these outcomes and that this is a significant change for some providers. However, I think it is absolutely the right move to continue demonstrating the value and relevance of CME to patient care. The value of CME to professionals, licensing bodies, specialty certification, and especially to patients is increasing the “doing” by physicians in the care of their patients. We all have numerous examples from our personal as well as professional lives where “knowing” is not “doing”. I know that before physicians can “do”, they must “know” so I would support Option B-to recognize that knowledge is essential to competence, performance or patient outcomes, but that it is insufficient in itself to lead to improvements in patient care-which is what CME is all about, right? As a patient, it is less important to me what my physician "knows" than being confident that they can-and will- actually apply that in my care. My patients expect nothing less of me as their physician.	Accredited CME Provider
39	As a chairperson of an accredited CME committee at a small hospital and a practicing physician, I find that the dissemation of knowledge is the first step to changing practice pattern and the potential for improving patient outcomes. At this time when new treatments are appearing rapidly it is very important to get the knowledge of these new therapies out to the practicing physicians, that they may become comfortable with incorporating them into their practice.	Accredited CME Provider
40	pmiCME response—pmiCME does not think it is good policy to make a complete return to previous criteria indicating that knowledge transfer alone is an acceptable outcome for CME. pmiCME believes that competence includes knowledge components and that the ACCME should more clearly acknowledge this in the appropriate accreditation criteria. Therefore, pmiCME is in agreement that Option 2 is acceptable as an adjustment to the explanation that accompanies ACCME Policy. The ACCME has already indicated in previous communications that when the educational focus is on a topic of research in which there is no patient care application as yet, that looking at the application of the knowledge to research ‘practices’ is acceptable.	Accredited CME Provider
41	At the March 2, 2010 meeting of the Swedish Covenant Hospital CME Committee, the call for comment was reviewed. The Committee recommends Option B.	Accredited CME Provider
42	The Alliance for Continuing Medical Education supports Option A as presented in the ACCME “Call for Comment on Knowledge-based CME Activities.” Adult learning theory and behavior change theory both posit that learning and translation of learning to practice is a continuum that begins with the transfer of knowledge. Prochaska and DeClemente would argue that the first stage in changing behavior is for the learner to acknowledge that a change is needed and then to take steps to make that change. We believe CME providers should be able to provide knowledge-based education and have these activities recognized as accredited CME. To not do so suggests that physician learners don’t value	Other

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	or benefit from knowledge transfer, which is not the experience of Alliance members. Physicians may take part in a certified CME program specifically to assess whether or not the content area is one which he/she feels a need to explore further and perhaps put into practice. We believe it is better for physicians to have the opportunity to conduct this type of self assessment with CME that complies with the ACCME Essentials, Elements, and corresponding criteria rather than through unregulated education that might be biased or promotional in nature. While we believe that the reintroduction of knowledge transfer as an acceptable goal of certified education is wise and supported by prevailing adult learning and behavior change theories, we fully support the principle that certified CME should aspire to achieve a positive impact on physician competence, performance, and ultimately patient outcomes. CME providers should be encouraged to go beyond knowledge-based education whenever feasible. The guidance provided in Option B is valuable, and we urge the ACCME to use this clarifying statement while making the change to criteria that is incorporated in Option A. The Alliance suggests to the ACCME that providers who (1) focus on knowledge, competence, and performance improvement (which hopefully leads to improved patient outcomes) and (2) demonstrate that they have mechanisms in place to measure these three outcomes, be eligible for accreditation with commendation.	
43	I believe that ACCME should go with Option A.	Accredited CME Provider
44	On behalf of the American Medical Association (AMA) Section on Medical Schools (SMS), we write to respond to the ACCME's Call for Comments related to the question, "Should the ACCME add the word knowledge into Criteria 1, 3 and 11?" The AMA-SMS would like to express our strong support for Option A (that knowledge alone should be an acceptable goal for CME activities) as outlined in the call for comments and vigorous opposition to Option B. Our reasoning is as follows: • Accepted adult education principles demonstrate that knowledge improvement is a desirable, necessary goal • The current ACGME and ABMS competency structure explicitly has as one of the six core competencies "Medical Knowledge." These core competencies are also becoming well entrenched in undergraduate medical education and there must be a seamless transition across the medical education continuum. • There is no distinct border between activities that only increase knowledge and those that increase competence. Any time there is a question and answer period for a lecture, the audience is clarifying its understanding of the material presented in order to apply it to their practices, which in turn increases their competence. It would be extremely rare to not have a Q&A time in a knowledge-based CME activity. • Physicians expect to apply the acquisition of new knowledge to their practices, in an effort to improve their competence and performance. • The very articles that the ACCME quotes demonstrating that CME changes physician behavior are derived from the era when an essential purpose of acceptable CME was to increase medical knowledge. • If pure knowledge-based activities alone are no longer going to be permitted, how is it that a history of medicine talk will be acceptable for CME? In that same vein, how can Internet CME or printed enduring materials, which do not allow for interaction between the instructor and audience, be acceptable for CME? Thank you for the opportunity to comment on this vitally important medical education issue.	Other
45	Lilly USA, LLC understands and appreciates the change made in the 2006 updated criteria in an attempt to advance the profession of CME	Commercial Supporter

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	beyond simply educating for knowledge transfer to pursuing competence, performance, and patient outcomes. However, we also understand that educational and practice gaps may exist where knowledge transfer is the solution and therefore is the sole goal for a CME event, specifically when the objectives of the activity are focused on dissemination of new and emerging science. Knowledge and awareness are fundamental prerequisites of the ability to apply learning to practice. Therefore, we understand the need and desire to include knowledge within the ACCME criteria. However, we feel it would be an injustice to the profession to retreat back to the ACCME's previous position and simply add language to each criterion. Rather, Lilly is supportive of "Option B," or some semblance thereof, as we feel this creates a balanced acknowledgement that knowledge gaps do exist and need to be addressed, but the overall goal of CME should be focused on improvement in the areas of competence, performance and patient outcomes. Additionally, Lilly feels this language could be expanded to state that providers can present activities designed to change learner knowledge; however, it should be clearly evident that such improvement in knowledge is expected to create downstream improvements in competence and/or performance. To better clarify this point, we suggest the ACCME provide more detailed guidance as to the appropriate use of knowledge-based CME.	
46	I support Option A.	Accredited CME Provider
47	I support Option B and the ACCME's goal of public accountability and alignment with quality and safety initiatives.	Accredited CME Provider
48	Our Board of Directors discussed the 2 options at our February meeting. Option A was their unanimous selection. Option A will restore a more reasonable, realistic balance to the elements within the general CME Mission and educational activities. Changes in knowledge are often the first steps in change processes which can take months or years to develop to a point at which they can be assessed or measured. Given the complexity of a physician's daily work, the ongoing updating and, where needed, correction of their knowledge base is a primary, necessary first step in creating quality and safety. These programs should not be neglected or shoved outside the limits of CME.	Accredited CME Provider
49	Option A: Knowledge is the fundamental underpinning of enlightened change in competence, performance and patient outcomes.	Accredited CME Provider
50	On behalf of the American Medical Association (AMA) Council on Medical Education, I write to respond to the ACCME's Call for Comments related to the question, "Should the ACCME add the word knowledge into Criteria I, 3, and II?" As you are aware the Council had communicated its concerns regarding ACCME's interpretation of the *AMA*ACCME shared definition of CME in our October 14, 2009 letter (attached) to the ACCME wherein we stated that: "The Council believes that ACCME's new interpretation of the definition of CME excludes important knowledge-based, academic, research-related and/or non-clinical subject matter that is vital to a physician's continuing education and professional development. Consequently, a physician's need to integrate fundamental knowledge through certified CME will be unmet. Therefore, the Council asks the ACCME to change its current accreditation criteria interpretation so that knowledge-based activities will continue to be compliant with accreditation criteria, and thus qualify for AMA PRA Category I Credit TM." We were pleased to receive ACCME's January 4, 2010 reply (letter) to this letter which indicated that: "The ACCME shares with the Council on Medical Education, the view that education designed to change knowledge is of great importance. The ACCME values activities that are designed to change learners' knowledge and recognizes that knowledge is the underpinning to any other learners' change." Further, we were gratified with the further affirmation that knowledge education is recognized as valuable by the ACCME: "While the ACCME 2006 Criteria explicitly reference the importance of identifying knowledge needs that underlie professional practice gaps, we acknowledge that these criteria may not be clear and may create the appearance that education designed to address knowledge may not be valued by the ACCME. This is not the intent of the criteria.	ACCME Member Organization

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	Knowledge is recognized as valuable by the ACCME." We do not share the concern "that activities and programs designed solely to change knowledge may not fulfill accredited CME's responsibility to be accountable to the public and may not align with current U.S. quality and safety initiatives." We are also unsure whether the concern expressed by the ACCME in its call for comment represents a shift in the thinking that was reflected in the January 4 letter. Therefore, at this time the AMA would like to reaffirm our position, as stated in our October 14, 2009 letter, and express our strong support for Option A outlined in call for comments, and register our strong opposition to Option B for the following reasons: • We note that in many cases new knowledge is an essential part of the groundwork that in the *future* may lead to new or improved competence but does not necessarily affect an immediate change. In fact it is reasonable to expect that some knowledge based activities serve to enhance or affirm understanding rather than affect any change in performance. • To suggest that CME activities focused on improving knowledge should be prohibited or significantly limited runs counter to well-accepted adult educational principles and theories. • This AMA position is consistent with the six competencies of the ACGME and the ABMS which include "Knowledge." Further, the AAMC **HHMI** 'Scientific Foundations for Future Physicians Report' states that "a competency is defined as the knowledge, skill, or attitude that enables an individual to learn and perform in medical practice." and the ACCME's Criterion 6: "The provider develops activities/educational interventions in the context of desirable physician attributes (e.g., 10M competencies, ACGME Competencies)." • Allowing activities that target knowledge improvement does not preclude implementation of activities to address other competencies as part of a CME providers overall CME program. The AMA welcomes the opportunity to work with the ACCME as it refines its interpretation and criteria related to knowledge-based CME to assure that the accreditation system remains consistent with the tenets of the AMA PRA credit system that allows accredited providers to designate and award our credits in a way that is reflective of our shared definition of CME which states that: CME consists of educational activities which serve to maintain, develop, or increase the knowledge, skills, and professional performance and relationships that a physician uses to provide services for patients, the public or the profession.	
51	The goal of an expected result of "knowledge' is a passive outcome, much like the objective of "understanding...". That said, I can see times when knowledge alone may result in a foundation of information from which to then change competence, performance or patient outcomes. And the delivery of that educational activity may not occur at the same time as activities that focus on more "active" outcomes. I vote for Option B with possibly a more in-depth outline of how an occasional knowledge based activities may benefit the overall objectives of the CME program.	Accredited CME Provider
52	THE 2006 CERTIFICATION CRITERIA – KILLING THE GOOSE (INTRA-STATE PROVIDER) THAT LAYS THE GOLDEN EGG (LOCALLY-DEVELOPED – CME). I choose Option A. To exclude declarative knowledge from these criteria was a well-meaning mistake, and is indeed a barrier for a local, i.e. community hospital, to	Accredited CME Provider

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	continue seeking CME accreditation. The 2006 accreditation process has unwittingly produced more barriers than this one; to wit, the decreasing number of CME accredited providers across the nation and the AMA House of-Delegates resolutions in response to these recognized barriers. Here in Pennsylvania our state medical society has adopted a resolution seeking the AMA to fundamentally simplify this process so as to be less burdensome and more user-friendly to CME intra-state applicants. But more than its burdensome nature, this new process has trapped the accreditation survey team members into spending most of their time in bean-counting compliance or non-compliance with criterion, rather than giving these members access-time to imparting their valuable, experienced knowledge so as to encourage local program development. The time-thrust of a survey should be how to encourage CME programs to attain goals of improving physician competence, performance, etc.; not post-hoc judgments. Ask why should a provider with a limited staff (common across Pennsylvania) struggle with increasing time and money costs when excellent CME programs can be easily obtained, plus food costs, from a national speakers' bureau with nationally recognized speakers and beautiful slides? So, who then needs to undergo re-certification? But there is a down side here – nationally-accredited CME programs using in effect money-laundered funds from big pharmacy crowd out locally needs-assessed CME program developments. I have been a CME director at a community hospital for 20 years and I have never seen such negative provider sentiments. Learning can not be legislated, as seems to be the rationale of this 2006 accreditation process. If it continues I suspect CME providers will find other ways and bypass the ACCME's "how many hoops did you jump through" process – as well as for AMA and state medical society hospital CME certification.	
53	I strongly support the Option A--feeling that knowledge as an outcome of CME is a critical component of the educational process and that it was a mistake to have eliminated it in the initial iteration of the criteria. Knowledge may not be immediately applicable to clinical practice (depending on the nature of ones daily practice) but it provides the foundation of potential response to disease and care management at some time in the future--and this may be distant future, not immediate future. It has as much validity as competency which is a strategy to improve (which is actually implied in KNOWLEDGE). It would make much more sense to review C 1-3 to reflect this concept. Wm. G. Gottfried MD	Accredited CME Provider
54	In order to increase competence, performance and improve patient outcomes, the learner MUST have a fundamental basic knowledge base of the condition under discussion. Without knowledge, the learner cannot progress to the higher levels expressed in Criterion 1. Bloom's Taxonomy Cognitive Domain - acquisition of knowledge, lays the concept out perfectly.	Other
55	The Continuing Medical Education (CME) Committee of The Movement Disorder Society (MDS) supports the intent of the ACCME proposal to reincorporate knowledge-based CME activities into the accreditation criteria. We are in full support of option A which incorporates knowledge into Criteria 1, 3 and 11. This option makes it clear to the CME community that knowledge is an integral component of CME. As an international subspecialty organization, the MDS takes very seriously its role as an important and impartial source of educational material and presentations for its members and others interested in movement disorders. This includes dedicating portions of our educational portfolio to basic science and other knowledge-based activities. The need for these knowledge-based activities has been identified through detailed educational needs assessment, and their delivery is a valuable resource for the movement disorders community specifically and the medical community in general.	Accredited CME Provider

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56	Yes to option A. It's valid, it's achievable, and it is basic to the educational process.	Accredited CME Provider
57	Option A is consistently on my physician planner's minds. They do no understand why you cannot have an educational presentation for knowledge sake. While CME should never exclusively be the domain of knowledge for knowledge sake, it does have a place in many activities as even the MOCs include Medical Knowledge as the first area listed.	Accredited CME Provider
58	Our organization is in support of option A. We have always believed that a change in competence, performance or outcomes could not result without a change in knowledge. In fact, we continue to collect and analyze knowledge transfer data in addition to competence, and occasionally, performance and outcome data. This statement of knowledge change is especially important if your target audience (as stated in your mission) involves allied health care providers. I may have a child life specialist who gains knowledge and a self reported increased understanding at a CME program. That staff member may not be able to respond to my Likert Scale assessing how likely a clinical strategy would be used (because they wouldn't have that kind of opportunity in their practice), but they will respond to a question assessing knowledge transfer. And our CME programs are often the only avenue for education other disciplines receive. The addition of knowledge transfer will benefit organizations whose target audiences are multidisciplinary. That said, we would not want the addition of knowledge to become an avenue for "going backwards". We always need to be striving to provide the best of education we can, and ensure that it is education making a difference to the patients/families we indirectly serve.	Accredited CME Provider
59	In my experience, without knowledge a physician doesn't know what changes to make regarding competence, performance and patient outcomes or even that changes need to be made. Providing knowledge is a critical first step in the CME process.	Other
60	I prefer Option A.	Accredited CME Provider
61	ASHP supports ACCME's proposed option A regarding the addition of the word knowledge to the ACCME Accreditation Criteria. Knowledge-based CME activities can be enhanced in their delivery to improve effectiveness. In addition, Knowledge-based CME activities can be used to assess learning needs, and in assessing physicians' ability to apply their knowledge in explaining and managing clinical problems.	Accredited CME Provider
62	I favor option B. How can we measure change in knowledge? Most physicians are resistant to measuring change of any kind and asking providers to measure knowledge will be burdensome.	Accredited CME Provider
63	The Illinois State Medical Society Committee on CME Accreditation strongly supports Option A which would add knowledge to Criteria 1, 3, and 11. At the state medical societies/ACCME annual meeting we talked about the accreditation process as being more akin to a change process model than the more traditional adult learner model. If this is true, then the criteria should reflect all phases of the change process. The current criteria hold providers accountable for the middle of the change process, that is, the assumption is made that a physician has the ability to or is ready to change. This does not address the front-end of the change process: the readiness for change; or the back-end: verification that the change is appropriate. By adding knowledge to the criteria, ACCME would better balance the role of learning in the change process.	Recognized Accreditor

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64	I support Option A.	Accredited CME Provider
65	In order to change competence, performance, or patient outcomes, isn't increased knowledge assumed? How about "knowledge AND competence, performance, or patient outcomes"? Medical Knowledge is a core competency -- we should not be afraid to use the term, but it should more appropriately be incorporated into plans as one of the competencies.	Accredited CME Provider
66	I support the first option as it places "knowledge" in the forefront, but does not allow the provider to assume that knowledge-only based activities are the preferred activity type.	Accredited CME Provider
67	The option A most reflects the feelings I have regarding the issue. The ability to include knowledge will enable us to more accurately tract the total learning experience that should include a change in knowledge.	Accredited CME Provider
68	I prefer Option A. From a practicing physician's perspective, there are limited opportunities to gain knowledge in other areas of Medicine other than in our specialty. Hospital-based CME offerings often are the only source of this knowledge which is essential to understanding the "whole" patient. And such understanding contributes to better patient care. ACCME should add the word "knowledge" into criteria 1, 3 and 11. Peter E. Doris, MD, FACR. ISMS Site Surveyor	Recognized Accreditor
69	YES, We've been doing live lectures with pre/post testing for years. It's very easy to score your participants and show the evidence that knowledge was gained.	Accredited CME Provider
70	I agree with Option A which would include the addition of "knowledge" in Criteria 1, 3, and 11. Otherwise it will fall to the digression of the surveyors to determine if a provider is meeting the criteria or not. Criteria should be as clear as possible to assure compliance. I do believe that activities that are purely knowledge-based are vital to a physician's development and should be included in the CME mission.	Accredited CME Provider
71	Option A states explicitly what is an implicit assumption of all medical school curricula, namely that education in the basic sciences and understanding of basic disease mechanisms is essential to providing quality care. Programs for health care providers which refresh that knowledge base or extend insight into disease biology must be considered to have value for the practitioner. In practice, understanding of basic mechanisms is of greatest utility in dealing with unexpected developments in the evolution of an illness, or in the coincidence of two pathophysiologic processes (e.g. two diseases, or one disease, and the complication of a treatment). Clinicians would refer to this as "showing good judgment". Such occurrences are real, but are difficult to anticipate in any detail, and even more difficult to articulate as performance objectives.	Accredited CME Provider

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72	While I understand the desire to focus CME activities on competence, performance, or patient outcomes, I feel that changes in knowledge can also be a worthy goal for such activities. This is particularly true in the activities we provide for the public health workforce where it may be difficult to judge competence, performance or patient outcomes. Therefore I support Option A.	Accredited CME Provider
73	I absolutely support Option A. Knowledge is an end in itself for physicians. How this knowledge contributes to competence, performance, and patient outcome would depend on the situation and is difficult to assess, but certainly pure knowledge is a vital component of education. Would college courses were taught without knowledge being an end purpose?	Accredited CME Provider
74	I like option B. It is more in line with the way we want to go to make real changes in CME. Option A to me is a return to the past. We have begun to move toward competency, performance and outcomes-let`s keep going	Recognized Accreditor
75	We are in agreement with option B. We agree that knowledge is an important component of continuing professional development. Further, we think that a provider's CME program should strive for the application of knowledge to practice. In this regard, we perceive option A to be a step backwards, as Option A seems to allow knowledge transfer alone as an acceptable metric for meeting C11.	Accredited CME Provider
76	CMSS strongly supports Option A, which would add the word “knowledge” to ACCME Accreditation Criteria 1, 2, 3 and 11. CMSS recognizes and supports the goal of the ACCME to promote educational activities that effect change in physician competence or performance or improve patient outcomes. Acquisition of new knowledge by physicians is an essential component of professional development that leads to improved patient care. New knowledge often does not translate into an immediate change in practice. Thus, it is not appropriate to require that CME activities cause changes in practice in an immediate timeframe. Moreover, changes in physician practice usually are the result of multiple, reinforcing, rather than isolated, educational encounters. CMSS does not support Option B because of the subjective nature of “can provide some activities,” which leaves the quantification of activities that change competence, performance or patient outcomes and the assessment of an overall program open to variable interpretation. Norman Kahn MD Executive Vice-president and CEO Council of Medical Specialty Societies	ACCME Member Organization
77	I choose option A. Enhancing a practioner's knowledge is I think critical to the ultimate goal of providing excellent and outcome oriented patient care.	Accredited CME Provider
78	I understand the concern as well as the intent of the 2006 Criteria. I like Option B because it upholds the intent while recognizing that some activities are designed to increase knowledge. One problem with a solution like Option A is that it could totally remove the incentive to search for the competence and performance which must be achieved if we expect to improve patient outcomes.	Other

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79	ACCME should not retreat from a significant forward step it took in properly raising the standard for CME programs. The continuing failure of many providers to demonstrate real changes in physician performance is in part due to the illusion that providing bits of information will miraculously lead to increased competence and performance. Actually the content of many activities is only a profusion of data(often unorganized, factoids), or information, which does not rise to the level of knowledge. Minimally, if the provision of knowledge were to be accorded more recognition as a goal it should always be associated with the promotion of wisdom(how properly to use the information) and never be a stand-alone objective. Knowledge is currently recognized as PART of the expected content of many CME activities and a case can be made for it to be a NECESSARY component of some, but to elevate it to the status of a SUFFICIENT component promotes rather than opposes a widespread fallacy in CME activity planning. To state it simply, this pervasive fallacy is that if physicians know more about something this will, by itself, lead to improved performance and better patient outcomes. My first- hand experience is with California programs and strongly suggests that at least here the correlation between more information and better performance is very weak.It is curious that programs which, at best, measure the quality of care and measure physician performance, rarely have measured the level of knowledge of their potential learners, and when they make the provision of information their principle goal the information-content is usually a presumption and often is left in the hands of a lecturer who frequently is unaware of the performance or outcome data which constituted the need for the activity. I would therefore favor either no change in the criteria or a change which would accord recognition to improved knowledge TOGETHER WITH improved ability to use that knowledge as an acceptable outcome for CME activities. The latter approach recognizes the reality of much current planning and promotes the necessary step to move from ineffectual reliance on solely providing information to the more hopeful provision of information together with the ability to use that information in improving health care. In leaving this subject, I would like to point out its relationship to educational methods. The determination of knowledge alone as a goal correlates highly with the default employment of the lecture as the favored educational method. Once information alone is not acceptable as the desired outcome the weight of current learning theory favors other, more effective, methods. Conversely, were we to accept knowledge alone as a desired outcome we would be encouraging the continued selection of lectures as the default educational method to the detriment of the learners.	Recognized Accreditor
80	I have been involved in teaching and education for several decades. My experience ranges from resident training to post-graduate involvement in CME activity planning, and committee level involvement both on a national and state level. I believe it is very important to adopt OPTION A. Competence, performance and patient outcomes CANNOT be divorced from knowledge. These goals will NOT be accomplished without fundamental improvement of knowledge. As many of us learn during medical school and throughout our training, if the thought of a certain disease or problem doesn't even cross your mind during a diagnostic workup, it will not be included in the differential diagnosis as a possibility and therefore will not serve the patient well. For example, if I as a surgeon am not familiar with the appearance of certain wounds, then I might not recognize similar looking wounds that require markedly different management, depending on whether they were from a certain type of local regional insect bites versus certain plants. Some educational programs may seem removed from actual practice at first glance, but they provide important knowledge in understanding subtle differences in disease process and pathogenesis, and can be extremely important in the clinical arena. It also contributes to the "art" of practicing medicine. The subtle differences we learn and accumulate in our lifetime make clinicians different from computers. As physicians exercising judgment based on knowledge, we do not and should not simply enter data points and come out with a "correct" answer. I hope ACCME will continue to value the tradition of education, which at its core is improvement of knowledge. The practice of medicine is a lifelong learning. When we are taught well, we serve our patients well.	Accredited CME Provider

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81	The discussion on this subject from the CME Committee that I facilitate is summarized below: "The whole point of CME was originally knowledge-based and there are good aspects of knowledge based activities as well as in competence, performance or patient care based activities. Knowledge-based activity results are easier to document and verify impact whereas results from other types of activities cannot easily be tested; giving knowledge based activities an advantage. The committee is against minimizing the value of knowledge-based activities." My personal suggestion would be to quantify option B above. i.e. no more than X% of activities may be planned around knowledge-based results ONLY. All other activities should have at least a component of competence, performance or patient care based outcome goals. Without quantifying I believe you will undo many hard-won efforts enacted in 2006.	Accredited CME Provider
82	The AAFP supports ACCME's Option A as an appropriate way to explicitly acknowledge the need for continuing medical education that facilitates change in knowledge, competence, performance and/or patient outcomes. The AAFP recognizes the provision of optimal patient care can not be assured solely through changes in knowledge. The AAFP also recognizes that accredited CME providers have a responsibility to provide not just knowledge-based CME but also PI-CME and other methods for facilitating continuous professional development. The AAFP applauds ACCME's intention to convey through its accreditation criteria the importance of designing interventions that measurably affect health care professional knowledge, competence, performance and/or patient outcomes. As a medical specialty society for which membership requires completion of accredited CME, the AAFP demonstrates its commitment to physicians' ethical responsibility for lifelong learning and the translation of medical advances across the continuum of research, education and practice. As one of the nation's CME accrediting entities, the AAFP sets a standard for AAFP-accredited CME built upon adult learning principles and educational design models that facilitate needs-driven, evidence-based, clinically-relevant, outcomes-oriented educational activities to address gaps in professional knowledge, competence, practice performance and/or patient outcomes.	Accredited CME Provider
83	I support Option A.	Accredited CME Provider
84	Support Option A.	Recognized Accreditor
85	I believe that this change by ACCME is mis-guided. Making the transmission of knowledge directly linked to patient outcome is laudable, but should not be a clause to hold it hostage. As a practicing physician, as well as a scientist, there are many occassions where I have learned something new, may not have translated this into direct clinical practice, but have been able to use this knowledge to better educate my patients, my trainees and medical students and to help improve my own knowledge base. I strongly believe that a few voices in the ACCME board are partisan and hijacking this process and making it something we do not need to accomplish. If I went to talks by the Nobel prize winners for Medicine from the past 15years, are the ACCME Board members seriously doubting this is not medical education? And many of these advances are not directly translated to a measure after I have attended one of these talks to patient care.	Accredited CME Provider

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	The ACCME should worry more about the physicians who do not go to such talks as their long term education and science base will be outmoded and seriously dangerous.	
86	Option B is not explicit enough. It's too vague and rather than clarifying anything it actually presents itself as a "loophole" or "back-door" feeling to the criteria for knowledge-based activities. Providers ought not to feel guilty for "sneaking" in knowledge-based activities. If knowledge is ok, then go with Option A so it is direct and clear. If knowledge is not ok, then don't put it anywhere.	Accredited CME Provider
87	There is a variety of information which provide a background for decision making or evaluating options but doesn't call for immediate behavioral changes. Some of the more obvious ones address basic science advances such as genetic testing, ethical issues such as end of life decisions and psych-social concerns such as "burn-out". The current wording of the criteria seems to imply that accredited CME should be only a problem solving tool which is too limiting.	Accredited CME Provider
88	As a practicing surgeon who primarily performs procedures I find that the acquisition of pure knowledge is often as valuable or even more valuable than learning activities which may change my own performance. Medicine is a team sport. Pure knowledge which leads to a heightened awareness of advances in other specialty fields is very valuable in knowing what one can aspire to as far as enlisting the aid of colleagues of different specialties in the care of one's patient. Sometimes pure knowledge which on the surface seems far removed from one's practice arena can prove to be useful in ways one never would have expected. As the great Pasteur stated "fortune favors the prepared mind"	Other
89	I am so very glad that someone has raised this concern to the ACCME, as I have had the same concern since I became aware of the new criteria. It is VITAL for us to be able to provide knowledge based educational programs to our physicians. If not, areas of pediatrics that are relatively low volume would not be eligible for CME. Our geneticist provides us wonderful information that helps us to find that 'needle in the haystack,' when it occurs. We couldn't invite him to speak on some of his topics in a 'competency based program.' Please allow knowledge based CMEs. To do otherwise is shortsighted and impractical.	Accredited CME Provider
90	Option A	Accredited CME Provider
91	We believe that option B is appropriate and would be quite helpful. We believe that knowledge is the foundation for what one does; therefore, it is a PART of education. Having said this, if option B is interpreted in such a way that it supports the traditional knowledge-based paradigm instead of performance in more than a small portion of a provider's program, we believe it will damage the cause of CME. CME cannot stop short of providing knowledge and, ultimately, the ability to utilize that knowledge in a meaningful manner.	Accredited CME Provider

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92	I strongly believe that Knowledge should be included. In Louisiana where I have my medical license it necessary to accrue 20 hours of CME activity each year to maintain a medical license. I have attended the Radiology residents presentations at the Ochsner Clinic and the presentations are excellent. I can accrue the credits on line but would prefer attending the Radiology resident lectures. The residents attend in force and they benefit and receive CME credits as well.	Other
93	Strongly prefer Option A. Advances in knowledge add to performance long before a "gap" can be identified. Waiting for a "gap" to become apparent in quality reviews requires years to clarify. Advancing knowledge is the first step to preventing the appearance of "gaps."	Accredited CME Provider
94	Including "knowledge" in C1, 3 an 11 does not provide incentive (related to accreditation) for providers to develop their CME program to affect competence, behaviors or ultimately to affect patient outcomes. Option B appears to be the better option. Knowledge is a necessary component of change. A challenge for accreditors and accredited providers is identifying the measures used to determine when "the provider's overall CME program focuses on changing competence or performance or patient outcomes."	Recognized Accreditor
95	I support option B, that is, do NOT add knowledge to the wording of C1, C3 and C11 but instead create supportive language that recognizes that a knowledge component is necessary but not sufficient for education outcomes. Certainly medical schools' mission includes advancing scientific knowledge, and many of the advancements may not yet have an identifiable application. These advances in factual knowledge can form the basis of valid educational interventions, and should be valued. However, when considered in the entirety of the organization's entire CME program, knowledge advances are insufficient. Some of what a CME organization accomplishes must include advancing learners' abilities in some manner. For this reason, I favor Option B.	Accredited CME Provider
96	I choose Option B.....we should focus on changing behavior as a way of improving patient outcomes. That has always been our goal but now it is stated explicitly. Some basic, short courses may focus on knowledge only as an expected outcome.	Accredited CME Provider
97	To : ACCME I have been the Medical Director of CME at our institution for 10 years, and involved with our CME program for 16 years. My answer is based on providing CME in an academic center, and I would strongly encourage ACCME to value knowledge as the required precursor to competency and desired patient outcomes. While at the recent Alliance of CME annual meeting, I attended a breakout session put on by Amit Ghosh MD. He and his colleagues at the Mayo Clinic have put together a CME course based on "Group completion of ABIM knowledge modules". The course is structured with Mayo experts evaluating the modules and then, based on the ABIM questions therein, they provide the education needed to understand and answer all questions. At the conclusion of Dr. Ghosh's presentation, a "CME professional" questioned whether this course met the criteria for accreditation since it provided only knowledge and had as its goal, passing the module exam. I do not want to engage in that debate, but use this as an example of	Accredited CME Provider

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	what I think is wrong with the changes since 2006. The American Board of Internal Medicine develops what it considers to be important knowledge requirements for maintenance of certification, and one of our nation's most respected institutions of academic medicine (The Mayo Clinic) develops a course to aid physicians in the attainment of that knowledge-- and the validity of it's category 1 accreditation is questioned. This is simply wrong. I encourage you to clarify the importance of knowledge in our criteria, and I strongly support Dr. Ghosh and his colleagues in their efforts for professional development. Sincerely, Bruce A. Nitsche, MD Medical Director CME, Virginia Mason Medical Center	
98	I think there should be 'no retreat' from the current criteria. We frame knowledge as a necessary but not sufficient component of leading to improvements in competence, performance and outcomes, and are telling our planners we assume they will be covering any necessary knowledge but should not stop there. This provides us (and all providers) and opportunity to do fewer CME things better, and focus on what's really important.	Accredited CME Provider
99	I believe that knowledge change is vital and that it should be added back into criteria 3 and 11. Basic knowledge about processes, changes in care, are foundations upon which future competences and performances are built and are important cornerstones in the educational process. It is impossible to know what or which basic information (knowledge) is needed for future patient care but it is a critical component of CME.	Recognized Accreditor
100	I think Option B is ideal. It provides flexibility, to CME providers, yet keeps us on track to strive to produce ed activities, that focus on improvements in competency, performance and pt outcomes.	Accredited CME Provider
101	I would wholeheartedly support Option A. It is not feasible for all organizations to be able to assess changes in performance or outcomes as they are out of their direct control or data to measure same would need to have been reported by the individual learner. The quality of such reporting is suspect. Increased knowledge DOES often lead to improved performance and thus, in turn to improved outcomes and enhanced patient safety. Clinical outcomes are also dependent upon multifactorial processes which may or may not be impacted by a specific CME activity.	Accredited CME Provider
102	I believe Option B is the best way to go. If the ACCME continually changes or edits their criteria, providers will never feel stable in what we are required to do. But continuing to clarify what the criteria MEAN or INTEND is an excellent idea. More importantly, I think if you add knowledge into these criteria, you will be taking a step backward in what you are trying to achieve. If providers can go back to "just knowledge," that's what most of them will do. However, by clarifying in Option B that it's okay, but not the focus, I think you will continue on the journey you have begun!	Accredited CME Provider

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103	As many providers have noted, some programs will increase knowledge without a direct improvement in outcomes, for example when addressing a knowledge gap that may not be immediately applied. An example of this would be a PCP learning the up-to-date recommendations about HIV prophylaxis after a needle stick, and the resource to consult should this particular issue present in his/her practice. However, the situation itself might not occur for some time, or ever. I agree, though, with the intent of ACCME, that most programs be designed to specifically impact a change in practice. Therefore I would most agree with Option B. It remains the responsibility of ACCME to let providers know how to define the proportion of "some activities" to meet this goal.	Non-Accredited CME Provider
104	I am opposed to any change in ACCME accreditation criteria that would allow CME providers to offer “knowledge only” CME activities. Criteria 1 is fine as it is stated. The United States probably has the best graduate and postgraduate medical education in the world. US biomedical science leads the world in discovery. US expenditures on health care lead the world. Despite this, US healthcare is mediocre in terms of delivering all of the care we know how to deliver. Albert Einstein is said to have defined insanity as “doing the same thing over and over again and expecting different results”. Continuing to increase the knowledge of physicians would in some ways be fulfilling Einstein’s definition of insanity. We can’t expect improve the quality of care because we are doing a great job of sharing knowledge with physicians. Paul Baltalden says “Every system is perfectly designed to get the results it gets.” The United States healthcare system has demonstrated it is perfectly designed to deliver innovation and discovery. But what the system does not do as well is deliver care based on these discoveries. Goethe said, “Knowing is not enough; we must apply. Willing is not enough; we must do”. Systematizing quality care has the potential to improve health and healthcare more than any scientific advances in the foreseeable future. If CME is to be a “bridge to quality” it must focus its efforts on developing the capability (competence) of healthcare providers to engage in quality improvement. Why? To deliver the care we know we should deliver that will have a demonstrated positive impact on the heath the health status and quality of life of people. Capability (or competence) goes beyond knowing. Capable (competent) healthcare providers know how to apply knowledge in the context of patient care and they do just that. CME providers should be required to provide learning resources that enhance the capability of healthcare professional to provide quality care. This requires that we go beyond simply sharing knowledge. CME providers should be required to show that the knowledge shared with healthcare providers in their CME activities can be appropriately used by the healthcare provider in the delivery of patient care. Gaining knowledge may satisfy a professional curiosity. But disseminating knowledge as end in itself is not adequate enterprise for accredited CME providers. CME providers calling for the inclusion of “knowledge-based CME” in the ACCME essential areas cannot possible expect these efforts alone will lead to improvement in the delivery of patient care. The CME literature shows that "one off" CME activities primarily focused on sharing knowledge are not effective in changing physician capability. CME providers calling for the inclusion of “knowledge only CME” cannot possibly expect that this alone will position CME as a “bridge to quality”. CME providers must be required to go beyond knowledge sharing only (as important as that is) and provide learning activities that assure that physicians appropriately apply that knowledge in the context of patient care.	Accredited CME Provider

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105	We are very much in favor of and wholeheartedly support Option A	Accredited CME Provider
106	Agree with Option A	Accredited CME Provider
107	I prefer Option B. I think the emphasis on competence, performance, and patient outcomes over knowledge is of benefit to the patients. However, today many activities are part of larger programs, and it may be necessary for physicians to acquire knowledge about an area before they can improve their competence or performance. For example, my organization often develops a group of 4 to 12 short (1/2 credit) online activities, which together, are designed to improve the competence or performance of our target audience. These activities are most successful in improving the learner's competence and performance when they are narrowly focused. However, one of those activities may focus on a topic such as a presentation of the neuroreceptors that are active in depression. That activity would be better presented as one designed for knowledge acquisition. Under the current system, we have to broaden the scope of this activity to include competence and/or performance, which is not beneficial to the learner.	Accredited CME Provider
108	I would prefer option B or something similar. True, sometimes knowledge is all you can change, but changing knowledge (however measured) for its own sake is not why we went to medical school or what the public needs. On a secondary note, I think it is virtually impossible to show that CME improves patient outcomes because of the problems with confounding. Having unmeasurable goals is no better than having irrelevant ones. I prefer a focus on the student's skills, competence, attitudes, behaviors, and, yes, even knowledge rather than patient outcomes. It is a valid research question to confirm that improvement in student attributes improves outcomes, but patient outcomes, per se, are probably not a useful metric for CME programs.	Non-Accredited CME Provider
109	As a member of our CHE Committee here at the Uniformed Services University, I was recently invited to comment about the possible changes concerning the use of the word "knowledge". You have given two options to choose from, either Option A, or Option B. Some recommend that we choose Option B. I disagree. I seek knowledge. I hunger and thirst after knowledge. Knowledge is power. Knowledge is a great force for good in medicine. For the ACCME to attempt to limit the use of that word in its lexicon is just silly. It makes you look ridiculous. When those sorts of changes (failing to justify CME on the basis of the expansion of "knowledge") are proposed to medical providers like me, I really wonder about the leadership and the direction of ACCME as an organization. Do you really believe that you are helping organized medicine with such rules? For your own good, for your reputation and for your ability to relate to physicians and hopefully help them in getting CME credits, you need to change the rules about knowledge. You need to be in the business of promoting knowledge dissemination. You should not have to apologize every time you use the word. Please put me down as having voted for Option A, which will once again allow a better and more full use of the term "knowledge". David R. Welling Colonel USAF MC (ret) Associate Professor of Surgery and Anatomy Chief Division of General Surgery The Norman M. Rich Department of Surgery Uniformed Services University	Accredited CME Provider