AMA Call for Comment Results

Background and methodology

The American Medical Association Council on Medical Education was interested in obtaining detailed feedback from the CME community at large regarding proposed changes to the AMA PRA credit system standards, so an online survey was crafted to solicit information.

On April 27, 2017, the AMA survey was sent electronically to 11,646 individuals from the AMA's *MedEd Update* newsletter subscription list as well as other stakeholders identified by the AMA's medical education team (e.g., state medical boards and ABMS specialty boards). Targeted state medical societies—those that are neither ACCME recognized accreditors nor ACCME accredited CME providers—were also included.

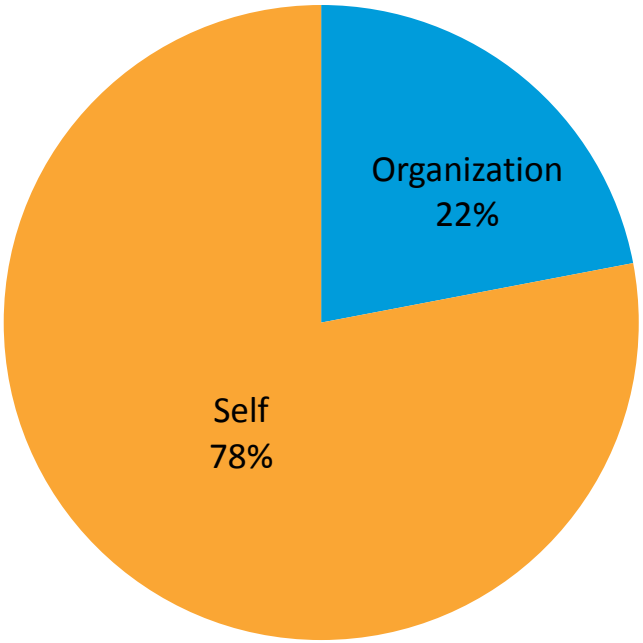
- The questions provided detailed information on proposed changes to the AMA PRA credit system standards, including deletions and edits as well as what remains unchanged.
- A total of 664 individuals responded to the survey.

In the subsequent pages, you will find the following documents:

- Summary of responses to the closed-end questions prepared by AMA Market Research.
- List of the open-end responses to each question, segregated by question. The responses are included verbatim.

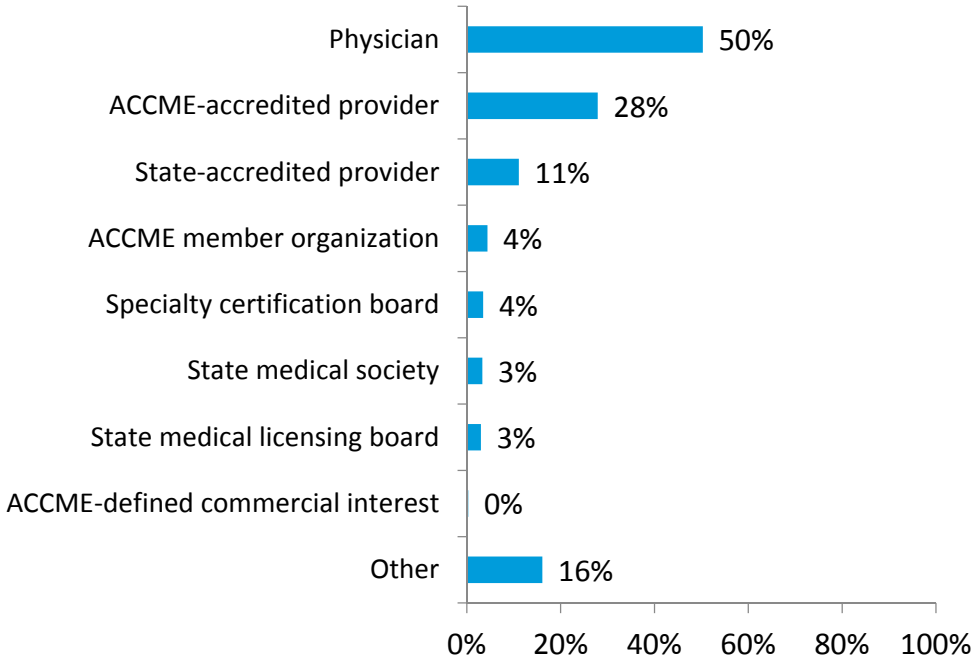
Respondent Profile

Are you responding for an organization or for yourself?



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

(Note: Multiple responses were allowed, so total is more than 100%)



**Note: Categories were self-selected by survey participants, and some potential inaccuracies were noted. However, recalculations were tested in some groups, by eliminating all that probably did not belong in the group, and did not yield a significant change in scores. Therefore, all demographic categories remain as submitted by participants.*

1

Core requirements for certifying activities for *AMA PRA Category 1 Credit*™ (the numbers correspond to the current core requirements as found on page 4 in the AMA PRA booklet). The core requirements apply to all activities certified for *AMA PRA Category 1 Credit™*.

These core requirements would remain the same:

1. Conform to the AMA/ACCME definition of CME.

5. Present content appropriate in depth and scope for the intended physician audience.

These core requirements would be modified:

Additions are underlined; deletions are marked by ~~strikethrough~~.

2. Address a demonstrated educational need (knowledge, competence or performance) that underlies the professional practice gaps of that activity's learners.

3. When appropriate to the activity and the learners, the accredited provider should ~~C~~communicate to prospective participants a clearly identified educational purpose and/or objectives for the activity, and provide clear instructions on how to successfully complete the activity. ~~in advance of participation in the activity.~~

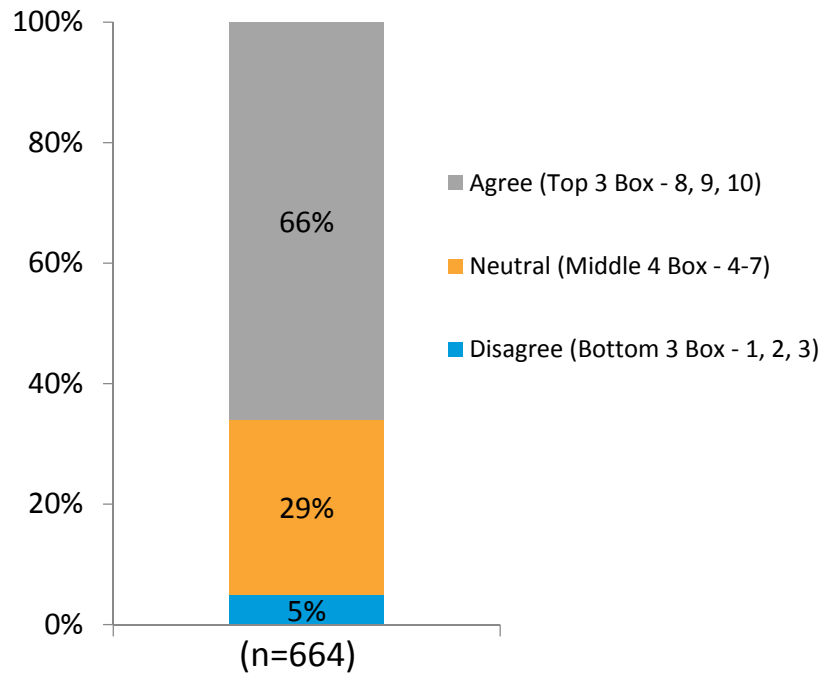
4. ~~Be designed using AMA approved learning formats and~~ Utilize one or more learning methodologies appropriate to the activity's educational purpose and/or objectives.

6. Be planned and implemented in accordance with ~~the relevant CEJA opinions and~~ the ACCME Standards for Commercial Support: Standards to Ensure Independence in CME Activities℠.~~, and be nonpromotional in nature.~~

7. ~~Evaluate the effectiveness in~~Provide an assessment of the learner that measures achievement of the educational purpose and/or objective of the activity.

Q1. These changes to the core requirements should be made

(10-pt Scale: 1 = Strongly Disagree, 10 = Strongly Agree)



Format–specific requirements for certifying activities for *AMA PRA Category 1 Credit*™

2. Enduring materials

This format specific requirement would remain the same:

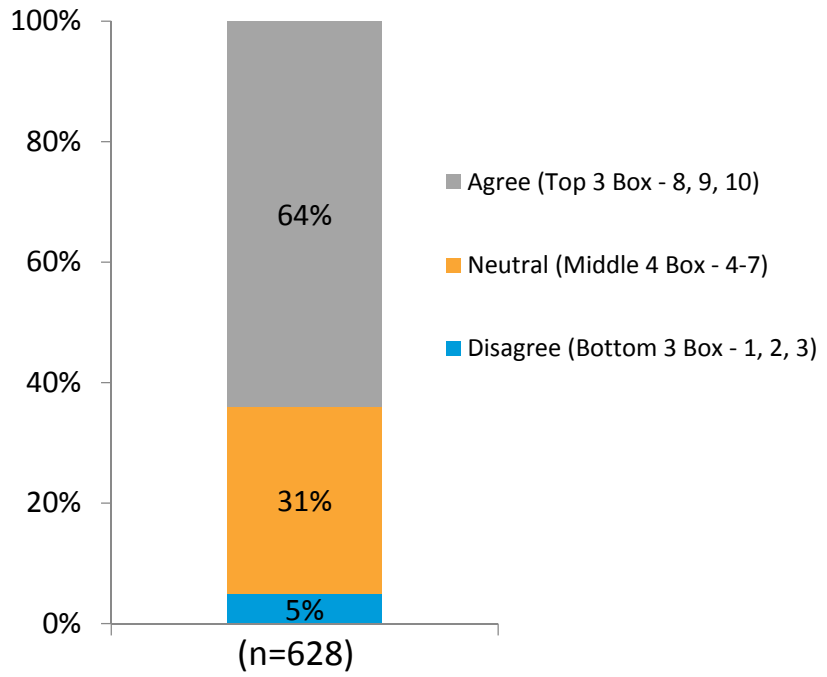
- Provide access to appropriate bibliographic sources to allow for further study.

These format specific requirements would be deleted:

- Provide clear instructions to the learner on how to successfully complete the activity. (This requirement will be subsumed into core requirement 3 so will not be listed separately as a format specific requirement.)
- Provide an assessment of the learner that measures achievement of the educational purpose and/or objective(s) of the activity with an established minimum performance level; examples include, but are not limited to, patient-management case studies, a post-test, and/ or application of new concepts in response to simulated problems.
- Communicate to the participants the minimum performance level that must be demonstrated in the assessment in order to successfully complete the activity for *AMA PRA Category 1 Credit*™.

Q2. These changes to enduring material requirements should be made

(10-pt Scale: 1 = Strongly Disagree, 10 = Strongly Agree)



Format–specific requirements for certifying activities for *AMA PRA Category 1 Credit*™

3. Journal-based CME

This format specific requirement would remain the same:

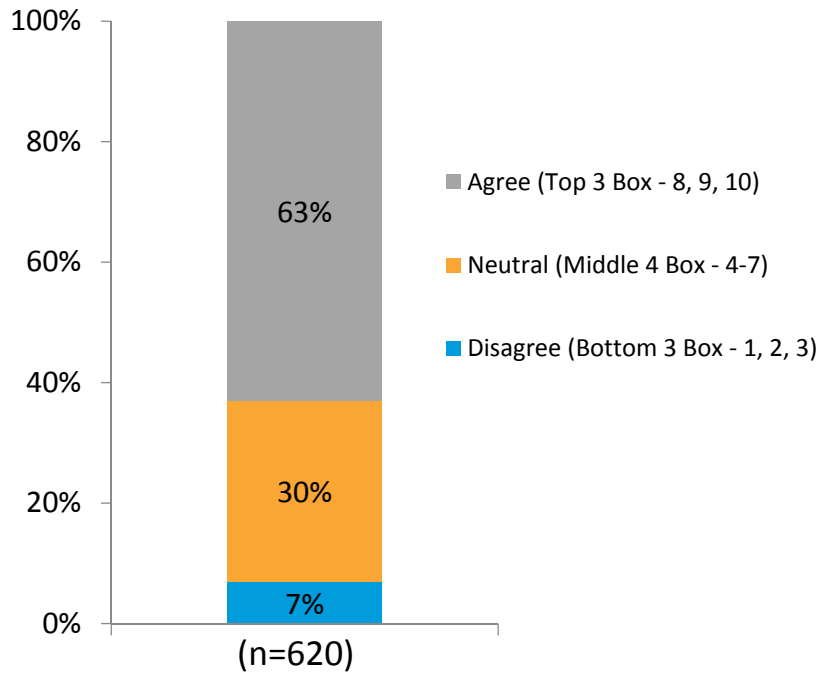
- Be a peer-reviewed article.

These format specific requirements would be deleted:

- Provide an assessment of the learner that measures achievement of the educational purpose and/or objective(s) of the activity with an established minimum performance level; this may include, but is not limited to, patient-management case studies, a post-test and/ or application of new concepts in response to simulated problems.
- Communicate to the participants the minimum performance level that must be demonstrated in the assessment in order to successfully complete the activity for *AMA PRA Category 1 Credit*™.

Q3. These changes to journal-based CME requirements should be made

(10-pt Scale: 1 = Strongly Disagree, 10 = Strongly Agree)



Format–specific requirements for certifying activities for *AMA PRA Category 1 Credit™*

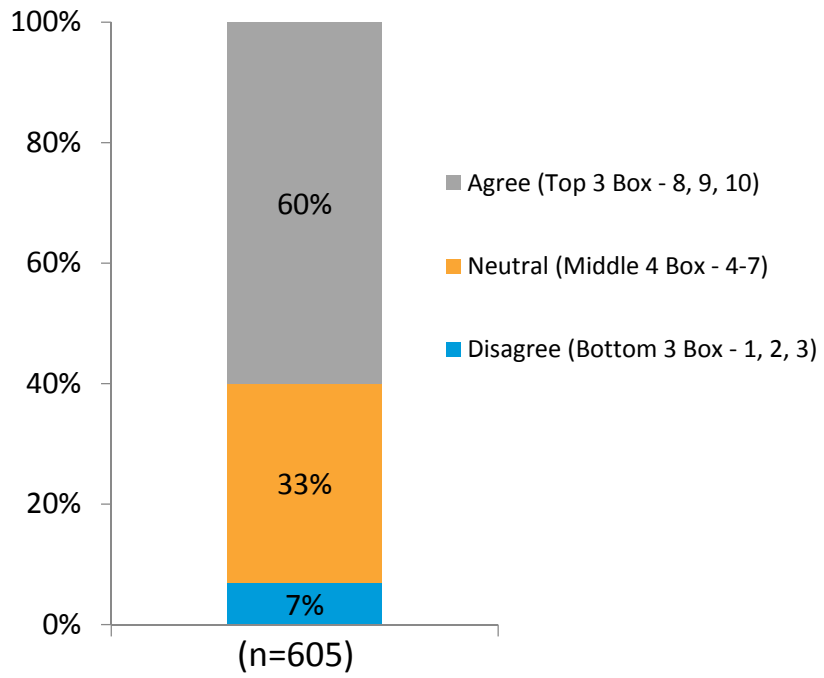
4. Test item writing

All format specific requirements would be deleted:

- Be developed only for:
  - The National Board of Medical Examiners examinations.
  - American Board of Medical Specialties (ABMS) member board certification examinations.
  - National medical specialty society peer-reviewed, published, self-assessment activities.
- Document that guidance was given to the physician question writers on how to use evidence for writing quality questions.
- Be at a depth and scope that require a review of the literature and a knowledge of the evidence base for the questions. (This requirement will be subsumed into core requirement 5 so will not be listed separately as a format specific requirement.)
- Include a group peer review of the questions in which the physician question writers personally participate.

Q4. These changes to test item writing requirements should be made

(10-pt Scale: 1 = Strongly Disagree, 10 = Strongly Agree)



Format–specific requirements for certifying activities for *AMA PRA Category 1 Credit™*

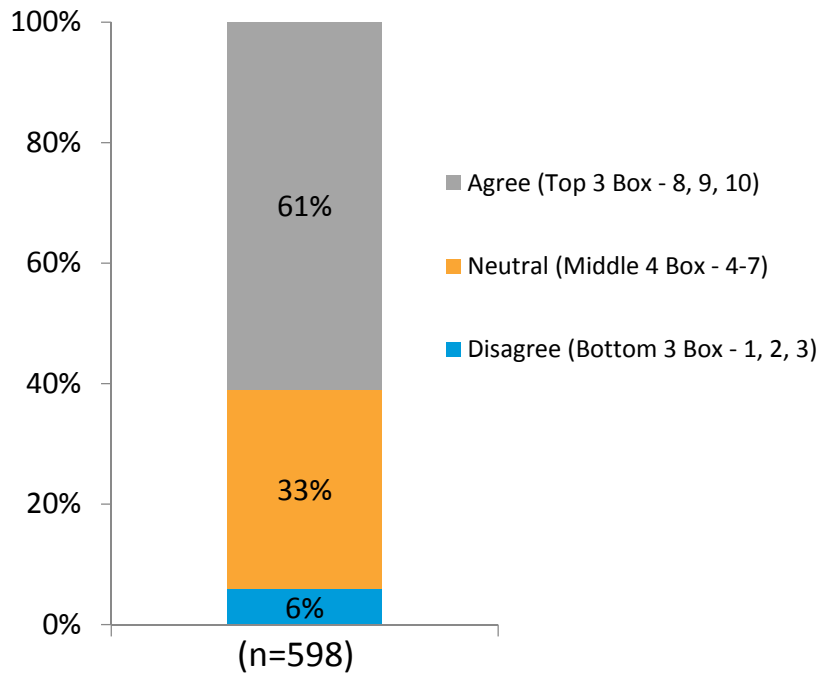
5. Manuscript review (for journals)

All format specific requirements would be deleted:

- Involve a review of an article that has been submitted for publication in a journal that is included in the MEDLINE bibliographic database.
- Involve a review of a manuscript that is an original contribution to the medical literature that requires multiple reviewers.
- Provide clear instructions to the physician on how to successfully complete the activity. (This requirement will be subsumed into core requirement 3 so will not be listed separately as a format specific requirement.)
- Be at a depth and scope that require a review of the literature and a knowledge of the evidence base for the manuscript reviewed. (This requirement will be subsumed into core requirement 5 so will not be listed separately as a format specific requirement.)
- Have an oversight mechanism to evaluate the quality of reviews submitted.

Q5. These changes to manuscript review requirements should be made

(10-pt Scale: 1 = Strongly Disagree, 10 = Strongly Agree)



Format–specific requirements for certifying activities for *AMA PRA Category 1 Credit*™

6. Performance Improvement Continuing Medical Education (PI CME)

These format specific requirements would remain the same:

- Have an oversight mechanism that assures content integrity of the selected performance measures. These measures must be evidence based2 and well designed (e.g., clearly specify required data elements, ensure that data collection is feasible).
- Provide clear instructions to the physicians that define the educational process of the PI CME activity (documentation, timelines, etc.).
- Provide adequate background information so that physicians can identify and understand the performance measures that will guide their PI CME activity, and the evidence base behind those measures.
- Validate the depth of physician participation by a review of submitted PI CME activity documentation.
- Consist of the following three stages:

  Stage A: Learning from current practice performance assessment
  Assess current practice using the identified performance measures, either through chart reviews or some other appropriate mechanism.

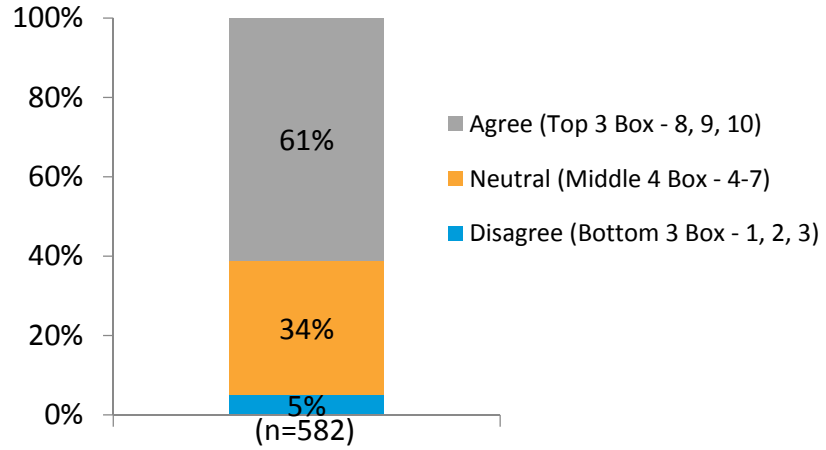
  Stage B: Learning from the application of PI to patient care
  Implement the intervention(s) based on the results of the analysis, using suitable tracking tools. Participating physicians should receive guidance on appropriate parameters for applying the intervention(s).

  Stage C: Learning from the evaluation of the PI CME effort
  Re-assess and reflect on performance in practice measured after the implementation of the intervention(s), by comparing to the assessment and using the same performance measures. Summarize any practice, process and/or outcome changes that resulted from conducting the PI CME activity.

This format specific requirement related to Stage A would be deleted:

Participating physicians must be actively involved in the analysis of the collected data to determine the causes of variations from any desired performance and identify appropriate intervention(s) to address these.

Q6. These changes to PI CME requirements should be made
(10-pt Scale: 1 = Strongly Disagree, 10 = Strongly Agree)



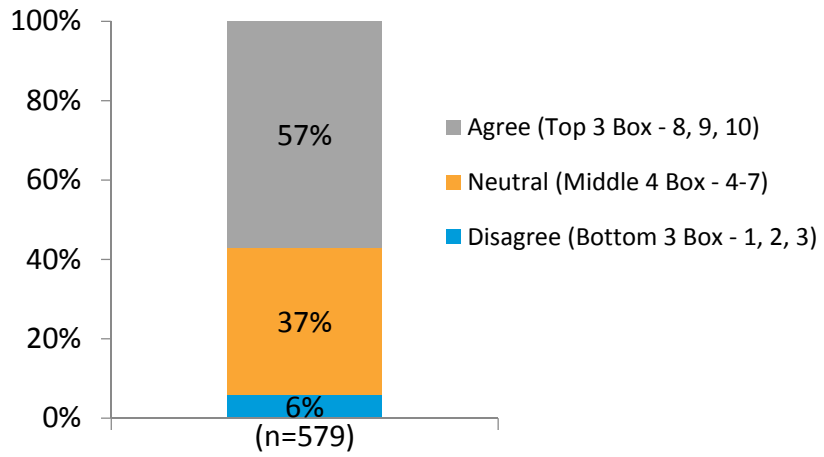
Format–specific requirements for certifying activities for *AMA PRA Category 1 Credit™*

7. Internet point-of-care learning (PoC)

All format specific requirements would be deleted:

- Have an established process for the accredited CME provider to oversee content integrity, with responsibilities that include, but are not limited to, the appropriate selection and use of professional, peer-reviewed literature, and ensuring that search algorithms are unbiased.
- Provide clear instructions to the physician on how to access the portal/database, which databases have been vetted for use, how participation will be tracked and how the accredited CME provider will award credit. (This requirement will be subsumed into core requirement 3 so will not be listed separately as a format specific requirement.)
- Verify physician participation by tracking the topics and sources searched. Implement reasonable safeguards to assure appropriate use of this information.
- Provide access to some mechanism by which physicians can give feedback on overall system effectiveness.
- Establish a mechanism by which physicians may claim *AMA PRA Category 1 Credit™* for this learning activity, by completing and documenting the required three-step cycle:
    1. Review original clinical question(s).
    2. Identify the relevant sources from among those consulted.
    3. Describe the application of their findings to practice and whether it resulted in a change in knowledge, competence or performance as measured by physician practice application or patient health status improvement.

Q7. These changes to internet PoC requirements should be made
(10-pt Scale: 1 = Strongly Disagree, 10 = Strongly Agree)



Results by Organization Type

		*Please tell us which of the following describes you or your organization?																			
		ACCME-accredited provider		State-accredited provider (provider accredited by an ACCME Recognized State Medical Society		ACCME-defined commercial interest		ACCME member organization		Physician		State medical society		State medical licensing board		Specialty certification board		Other (specify)		*Total*	
		n	%	n	%	n	%	n	%	n	%	n	%	n	%	n	%	n	%	*n*	*%*
Q1 These changes to the core requirements should be made.	Top 3 Box (8-10)	127	68.6%	49	66.2%	2	100.0%	19	65.5%	204	61.1%	14	63.6%	11	55.0%	15	65.2%	73	68.2%	*438*	*66.0%*
	Middle 4 Box (4-7)	47	25.4%	23	31.1%	0	0.0%	9	31.0%	109	32.6%	5	22.7%	7	35.0%	7	30.4%	30	28.0%	*193*	*29.1%*
	Bottom 3 Box (1-3)	11	5.9%	2	2.7%	0	0.0%	1	3.4%	21	6.3%	3	13.6%	2	10.0%	1	4.3%	4	3.7%	*33*	*5.0%*
	Total	*185*	*100.0%*	*74*	*100.0%*	*2*	*100.0%*	*29*	*100.0%*	*334*	*100.0%*	*22*	*100.0%*	*20*	*100.0%*	*23*	*100.0%*	*107*	*100.0%*	*664*	*100.0%*
Q2 These changes to enduring material requirements should be made.	Top 3 Box (8-10)	117	65.0%	53	73.6%	1	50.0%	14	51.9%	201	64.6%	14	73.7%	6	33.3%	11	50.0%	56	55.4%	*400*	*63.7%*
	Middle 4 Box (4-7)	54	30.0%	18	25.0%	1	50.0%	12	44.4%	93	29.9%	4	21.1%	12	66.7%	9	40.9%	41	40.6%	*197*	*31.4%*
	Bottom 3 Box (1-3)	9	5.0%	1	1.4%	0	0.0%	1	3.7%	17	5.5%	1	5.3%	0	0.0%	2	9.1%	4	4.0%	*31*	*4.9%*
	Total	*180*	*100.0%*	*72*	*100.0%*	*2*	*100.0%*	*27*	*100.0%*	*311*	*100.0%*	*19*	*100.0%*	*18*	*100.0%*	*22*	*100.0%*	*101*	*100.0%*	*628*	*100.0%*
Q3 These changes to journal-based CME requirements should be made.	Top 3 Box (8-10)	113	63.5%	48	67.6%	1	50.0%	15	55.6%	194	63.4%	13	68.4%	6	33.3%	13	59.1%	62	61.4%	*392*	*63.2%*
	Middle 4 Box (4-7)	52	29.2%	22	31.0%	1	50.0%	12	44.4%	89	29.1%	4	21.1%	11	61.1%	7	31.8%	35	34.7%	*187*	*30.2%*
	Bottom 3 Box (1-3)	13	7.3%	1	1.4%	0	0.0%	0	0.0%	23	7.5%	2	10.5%	1	5.6%	2	9.1%	4	4.0%	*41*	*6.6%*
	Total	*178*	*100.0%*	*71*	*100.0%*	*2*	*100.0%*	*27*	*100.0%*	*306*	*100.0%*	*19*	*100.0%*	*18*	*100.0%*	*22*	*100.0%*	*101*	*100.0%*	*620*	*100.0%*
Q4 These changes to test item writing requirements should be made.	Top 3 Box (8-10)	104	60.1%	45	63.4%	2	100.0%	12	46.2%	184	61.1%	13	72.2%	7	43.8%	12	54.5%	52	53.6%	*363*	*60.0%*
	Middle 4 Box (4-7)	58	33.5%	22	31.0%	0	0.0%	12	46.2%	92	30.6%	2	11.1%	8	50.0%	5	22.7%	38	39.2%	*199*	*32.9%*
	Bottom 3 Box (1-3)	11	6.4%	4	5.6%	0	0.0%	2	7.7%	25	8.3%	3	16.7%	1	6.3%	5	22.7%	7	7.2%	*43*	*7.1%*
	Total	*173*	*100.0%*	*71*	*100.0%*	*2*	*100.0%*	*26*	*100.0%*	*301*	*100.0%*	*18*	*100.0%*	*16*	*100.0%*	*22*	*100.0%*	*97*	*100.0%*	*605*	*100.0%*
Q5 These changes to manuscript review requirements should be made.	Top 3 Box (8-10)	108	62.8%	43	60.6%	2	100.0%	14	53.8%	179	60.5%	11	57.9%	6	37.5%	14	63.6%	51	53.1%	*362*	*60.5%*
	Middle 4 Box (4-7)	53	30.8%	26	36.6%	0	0.0%	11	42.3%	97	32.8%	5	26.3%	9	56.3%	5	22.7%	37	38.5%	*197*	*32.9%*
	Bottom 3 Box (1-3)	11	6.4%	2	2.8%	0	0.0%	1	3.8%	20	6.8%	3	15.8%	1	6.3%	3	13.6%	8	8.3%	*39*	*6.5%*
	Total	*172*	*100.0%*	*71*	*100.0%*	*2*	*100.0%*	*26*	*100.0%*	*296*	*100.0%*	*19*	*100.0%*	*16*	*100.0%*	*22*	*100.0%*	*96*	*100.0%*	*598*	*100.0%*
Q6 These changes to PI CME requirements should be made.	Top 3 Box (8-10)	107	64.5%	49	70.0%	2	100.0%	13	50.0%	162	56.1%	13	68.4%	8	50.0%	10	45.5%	59	63.4%	*357*	*61.3%*
	Middle 4 Box (4-7)	54	32.5%	17	24.3%	0	0.0%	11	42.3%	113	39.1%	5	26.3%	8	50.0%	10	45.5%	31	33.3%	*199*	*34.2%*
	Bottom 3 Box (1-3)	5	3.0%	4	5.7%	0	0.0%	2	7.7%	14	4.8%	1	5.3%	0	0.0%	2	9.1%	3	3.2%	*26*	*4.5%*
	Total	*166*	*100.0%*	*70*	*100.0%*	*2*	*100.0%*	*26*	*100.0%*	*289*	*100.0%*	*19*	*100.0%*	*16*	*100.0%*	*22*	*100.0%*	*93*	*100.0%*	*582*	*100.0%*
Q7 These changes to internet point-of-care requirements should be made.	Top 3 Box (8-10)	98	59.0%	42	60.9%	2	100.0%	13	50.0%	151	52.6%	12	63.2%	6	37.5%	11	50.0%	51	55.4%	*330*	*57.0%*
	Middle 4 Box (4-7)	58	34.9%	25	36.2%	0	0.0%	10	38.5%	120	41.8%	5	26.3%	8	50.0%	8	36.4%	34	37.0%	*213*	*36.8%*
	Bottom 3 Box (1-3)	10	6.0%	2	2.9%	0	0.0%	3	11.5%	16	5.6%	2	10.5%	2	12.5%	3	13.6%	7	7.6%	*36*	*6.2%*
	Total	*166*	*100.0%*	*69*	*100.0%*	*2*	*100.0%*	*26*	*100.0%*	*287*	*100.0%*	*19*	*100.0%*	*16*	*100.0%*	*22*	*100.0%*	*92*	*100.0%*	*579*	*100.0%*

**Note: This question allowed multiple responses so some respondents are included in more than one category.*

AMA Survey: Comments on Proposed Changes

Introduction

This document shows comments received on the AMA survey. Out of 664 surveys, a total of 282 individuals provided 750 written comments.

The comments, segregated by question, are listed verbatim in order by date/time received; the number in the left column is a unique identifier for each respondent.

After each comment, the self-selected designation(s) of each respondent is in parentheses, with the following abbreviations (Note: Some respondents selected more than one category):

NP	ACCME accredited CME provider (national provider)
SP	State accredited CME provider
CI	ACCME-Defined Commercial Interest
MO	ACCME-Member Organization
P	Physician
SMS	State Medical Society
MLB	Medical Licensing Board
SCB	Specialty Certification Board
O	Other

The total number of comments by question is as follows:

	Question on Proposed Changes Related to	Number of comments
1.	Core Requirements	141
2.	Enduring Materials	74
3.	Journal-Based CME	66
4.	Test-Item Writing	67
5.	Manuscript Review	47
6.	PI CME	54
7.	Internet Point-of-Care	56
8.	Other Comments on the Proposed Changes	135
9.	Comments on the Glossary	110
	Total:	**750**

NP – ACCME accredited CME provider (national provider); SP – State accredited CME provider; CI – Commercial Interest; MO – Member Organization; P – Physician; SMS – State Medical Society; MLB – Medical Licensing Board; SCB – Specialty Certification Board; O - Other

Table of Contents

NP – ACCME accredited CME provider (national provider); SP – State accredited CME provider; CI – Commercial Interest; MO – Member Organization; P – Physician; SMS – State Medical Society; MLB – Medical Licensing Board; SCB – Specialty Certification Board; O - Other

Q1 – Proposed Core Requirement Changes

Comments Related to Core Requirement		
7	1.	#7 could be modified to "provide an assessment that measures the achievements towards attaining the educational objective and or purpose of the activity (O)
8	2.	It's not always clear that the best or only evaluation of an activity should be an assessment of the individual learner. For example, a CME activity based around improving team performance in patient safety might be best evaluated by assessment of the team or by changes in safety reporting in the system. Focusing exclusively on learner assessment may be overly limiting. (NP)
16	3.	Clarifies the requirements and expectations with standards referenced (P)
19	4.	Item # 7 seems to move the outcome from achieving the goal to assessment of the individual learner. This could inadvertently limit activities that are intended to improve teamwork. I prefer, "Evaluate the effectiveness in achieving the educational purpose and/or objective of the activity." This might include patient outcome measures, system improvements, reflection by the participant at a point in time distance from the activity, other tools such as 360-degree evaluations, tests, or observation. Learner assessment sounds like a test which is at best, Kirkpatrick Level 2 evidence of educational efficacy. (NP, P, O)
22	5.	Point 7, would NOT require an assessment. This will thwart such effective POS CME as provided by Up To Date, one of the most effective real time methods of learning in critical , time sensitive situations. (P)
26	6.	Providing an assessment of the learner will require substantial new effort and resources. Learners are already reluctant to complete even simple forms that assess the value of the CME content. (P)
27	7.	Why fix if it is not broken. A few of the changes are good, others are not needed. Do we need to routinely test adult learners to confirm they were participating? (P)
42	8.	The proposed changes provide clarification and direction in some core requirements, while allowing more flexibility and creativity for the CME provider in others. These modifications continue to protect accredited CME from commercial influence and seem to be more manageable for both physicians and CME providers. (SP)
46	9.	Language largely makes more explicit and clarifies what we do now. I'm not sure all of the assessment noted in 7 should be of the learner, however. (NP, MO, P)
48	10.	My concerns relate to proposed changes in Item 7. I am unsure what is meant by the phrase "provide an assessment". I am also unsure how such assessments would be implemented and managed. (NP, P)
52	11.	Wayyyyy to much over-thinking and over-regulation of an already cumbersome process. (P)
59	12.	Would like to know the rationale for changes (O)
60	13.	It is difficult enough for CME providers (in this case) to follow the regulations - without changing them. If you make any changes, it should only be to simplify by omission. We must constantly be aware of physician burnout and its causes, which include excessive regulations that have very limited impact on patient care and learning. (NP, P)
63	14.	Increasingly we are required to take accredited CME related to institutional or governmental priorities, for example, opioids, safety, etc. I would note that this does not mean it is a gap for each of the individual learners as implied with #2 above. / Why is "should" in item 3? (NP, P, O)
66	15.	Costs of CME especially hands on courses are thousands of dollars for each in neurosurgery. These costs are not covered by most practices, the VA, Government positions and military positions. And they are not tax deductible unless supported by the employer. More industry support for the meetings aned courses is needed to keep up with current information, procedures, and new drug policies. (P)
73	16.	excellent
78	17.	#3 does not look good. It seems to imply that goals and/or objectives are optional (P)
84	18.	#7 "Assessment of the learner..." might add "in a manner consistent with the nature of the activity" since different formats of learning will call for different assessment tactics. (O)
87	19.	CONSIDERO QUE EL PROFESIONAL ,QUE HACE LAS COSAS CON CORRECCION, ESTUDIANDO Y EVALUANDO TODO EL TIEMPO, CADA UNO DEBE HACERSE RESPONSABLE DE SU RENDIMIENTO Y ESTUDIO , A MAS RENDIMIENTO Y SAPIENZA PREMIAR CON MAS ACREDITACION (MO, P, O)
88	20.	I think these are god changes. I like taking AMA out but I think non-promotional was a good thing. (NP, SP, SCB)

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89	21.	Learning outcome should NOT be individual focused, but rather health focused. Measure how the learning is APPLIED not that it has occurred. (NP, SP, MO, O)
93	22.	The requirements are already incredibly cumbersome and nit-picky. They should be simplified, NOT made more complicated. Too much time is wasted in "compliance" paperwork... and the CME is NOT measurably any better. (NP, MO, P)
106	23.	It would be helpful if an example of what you are trying to accomplish is attached. (SP)
111	24.	#7 will in most cases remain superficial and will fail to achieve any reliable measurement. This should be a goal but NOT a requirement. (NP)
112	25.	Under what circumstances would it not be appropriate to communicate an educational purpose? (P)
121	26.	we should be jargon free, the scene to rely on bureaucratic teas and the passive voice. (NP, SP, MO, P)
130	27.	nicely cleaned up (P)
131	28.	The narrow definition down to individual learner's is concerning for all formats. How does a CME provider do this in large symposium settings? Or even at a local level if outside participants attend a general Grand Rounds. You seem to be indicating we need to be able to measure each person who attends and produce specific outcome data. It is simply not possible for all formats. #2 and #7. / Telling physicians what they need to do to complete an activity such as a didactic lecture is overly burdensome to the provider. This should not apply to all formats. #3 / #2 "that activity's learners". / #3 "provide clear instructions on how to successfully complete the activity" / #7 "provide an assessment of the learner that measures" (SMS)
133	29.	#3 should not be left to the discretion of the course; they should always be expected to identify purpose and/or objectives for CME credit. #4 is a welcome change, as the AMA does not hold authority on learning methodologies. (P)
136	30.	These are good aspirations, but I wonder how well they can be implemented in practice. (P)
137	31.	This will decrease confusion among planners and faculty and move CME further in the direction of not just providing knowledge, but of being an agent for both learning and change. (NP)
138	32.	I think it is a bit naive to assume that there is a single way to address a gap. Sometimes it is just a piece of knowledge and that is easy. But if there is a lack of ability to synthesize, unidirectional CME might not be the way to address it. Second, I think most learners can figure out what is being taught without having to express it specifically. (P)
142	33.	I think these changes are clearer than old version. Especially #2. (O)
145	34.	2 - no problem / 3 - the accredited provider should communicate the goals and instructions, preferably in advance so I know whether or not I want to go through the activity. And when wouldn't it be appropriate for the accredited provider to communicate? / 4. the AMA should provide some level of oversight over the learning formats / 6. why wouldn't we want activities to be in line with CEJA opinions? and activities must be nonpromotional in nature. we should not be letting pharma and device manufacturers slide in under the guise of education / 7 no problem with this one (P)
147	35.	assessment of the learner is not necessary (P)
152	36.	I would like to see some clarification of number 7. (SP)
161	37.	I strongly agree with all except 7. I don't think we should have to take a test/assessment after a live CME activity, such as a lecture/small group learn session at a meeting. This is OK for SAMs but not CME. It is OK for the learner to complete an evaluation as to how much was learned and how it will be used as we do now. (P)
163	38.	these seem superficially reasonable but i think we would be better off with less regulation of cme not more and to that end i would prefer the ama leave cme alone (P)
169	39.	Of course CME activities should be non-promotional (NP)
179	40.	Number 7. may require some thought as to the "assessment". These can be included in the lecture with feedback? At the end? I find this a bit of a problem however well meaning. (P)
182	41.	I am not sure if I am understanding #3 strike out of the objectives being submitted in advance of a program. Is this to say the objectives are not required before the presentation? If so I would disagree due to needing to advertise the programs with objectives included. (SP)
186	42.	How does effectively measure "Acheivement of the Educationjal Purpose"? (P)
190	43.	The assessment req is difficult to ascertain unless there would be a follow-up months later. (NP. P)
198	44.	Love the creativity but I think clarification on what qualifies as an assessment of the learner needs clarification and some definition of what learning methodologies are acceptable needs to be enhanced. When appropriate to the activity learning objectives should be communicated. Again, I think this needs some further clarifications. (NP)

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200	45.	There is not much different then what is already required by the ACCME. The update to #6 is imperative. (MO)
202	46.	We should be given the opportunity to address each of these changes individually, NOT lumped together! (NP)
207	47.	I wasn't clear with this is about Standards to Ensure Independence in CME activities / / And someone who participates in CME both as a speaker and learner I would like to know how you envision practically implementing these statements without significantly increasing the cost of CME for creating unnecessary administrative burdens to both Learners and teachers. / / / (NP, P)
210	48.	Educational purpose/objectives should always be communicated to prospective participants, so not seeing the need for 'when appropriate' to the language in #3 (P)
213	49.	I'm not certain these constitute a useful material change. These changes seem like nuance and tweaks. (SCB)
214	50.	I think that #3 should actually be two separate requirements. (SP)
219	51.	Find the addition /modification to 3 confusing. Not sure how one can express how there can be clear instructions given that are not relatively obvious on "how to successfully complete..." Brings to mind that for certain activities one must listen to the lecture portion etc. (SCB)
221	52.	Need to address the valid measurement and identification of educational need as well as the rigor of the assessment of the learner. (P, SCB)
222	53.	Underscores quality but allows flexibility (P)
226	54.	The above changes seem relevant except for 7. It is unclear what type of an assessment needs to be conducted? A post test for each type of activity? Would this be a requirement in addition to completing an evaluation or are we eliminating evaluations all togther? Response rate for evaluations are generally not high so I don't see how we can require this of each participant in an activity. (NP)
227	55.	They make sense; they are logical and appropriate. (SP)
230	56.	On #3..... I feel "When appropriate to the activity and the learners" should be ommitted, because it is ALWAYS appropriate to convey this information to prospective participants. (NP)
233	57.	I believe these are clear yet allow flexibility. (NP, SCB, O)
236	58.	3 no longer seems like a core requirement. Who determines when it is appropriate? If that is the provider, then it essentially gives them the ability to make a judgement call and not treat this as a requirement. (O)
242	59.	I feel the above changes build on the priorities and values of both the ACCME and the AMA. (NP)
244	60.	The assessment piece may be challenging and CME providers may need assistance in understanding how to best do this. (P)
248	61.	In number 3, I would like to see "in advance..." remain in the requirement to allow participants to know what to expect of the activity. (O)
251	62.	#3 - Does removal of "in advance of participation in the activity" mean it does not have to be done in advance, or that it is assumed? / #4 - Concerned that removal of "learning formats" creates ambiguity. / (NP)
252	63.	Depending on the activity, #7 can be very hard to measure. An assessment strikes me as a knowledge quiz. The objective may be documented with a simple survey. Suggest less prescriptive language for #7 (SCB)
255	64.	The proposed changes reinforce the collaboration between AMA and ACCME. provides clear expectations, and flexibility for the ever-changing landscape of physician continuing medical education (SP)
259	65.	Agree with the comments and recommendations. (O)
261	66.	These changes seem to helpfully condense and clarify existing requirements. We presume that the language in core requirement 7 which addresses measuring achievement of the educational purpose of the activity is meant to replace the minimum performance level formerly required for particular activity types. If this is the case, we support the shift to more competency-based language and anticipate that it will have greater applicability to educational activities that address non-cognitive competencies. / / Also, we see core requirement #8 has been deleted which calls for "Document credits claimed by physicians for a minimum of six years." If this is deleted, how long DO we actually keep documentation on file for physicians that have claimed CME credit? Is it based on the current accreditation status of the CME provider? In other words, Provisional Accreditation keeps documentation on file for two years, Accreditation with Commendation keeps documentation on file for six years, etc.? (NP, MO)
278	67.	Common sense approach (P)
284	68.	I think the offering should be nonpromotional in nature. (O)
290	69.	do not object to these changes, but not sure that these changes are really needed (P)

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294	70.	The new wording aligns more with ACCME criteria for providers. (SP)
296	71.	I'm not sure what is meant by "provide clear instructions on how to successfully complete the activity" since many CME programs are presentations (NP, P)
302	72.	2. presupposes "practice gaps," where "practice" would have to be conceived of broadly, and the "gaps," if any, may be different for different learners. 7. appropriately focuses on the learner rather than the activity, but there may be no valid way to attribute achievement of the educational purpose to this particular activity. Still, these are overall improvements. (SMS)
303	73.	Challenging to provide an assessment tool other than MCQ that truly measures achievement. (P)
305	74.	What happened to single stream education with the AMA - AOA? Is this going to change and then another change? (SMS)
309	75.	we were 3 years and the students could not cope with the changing environment in the 80's and were forced to shift to 4 years , how soon do we forget..... (P)
314	76.	Seems to explain well what is required with the changes. (O)
315	77.	#3 seems a bit much to me. . We already describe the educational purpose more than that to suggests there is a clear way to successfully complete the activity cannot be done simply. / #7 suggests that there should be a pre-post exam for each activity. As one who is responsible for a weekly CME I can assure you that my speakers will not write pre-post exams and neither will I. (P)
327	78.	Agree generally with the increased flexibility of these requirements. However, I don't understand why #3 is being edited with the addition of the clause, "When appropriate to the activity and the learners..." When is it ever appropriate to not identify and educational purpose and/or objectives? Agree on the addition of the clause about provision of clear instructions. (NP. P)
330	79.	ACCME standards are can be complex, and often not well communicated. / To have the AMA move toward ACCME standards is likely a step in the wrong direction to help better simplify and make readily understandable expectations for CME standards for physicians. (SP, SMS)
331	80.	These seem straightforward. (NP, P)
335	81.	I don't understand the significance of these changes. On a superficial level, they seem appropriate. (P)
340	82.	Not sure about how to define and who defines educational need (#2) and what is implied about assessing the learner (#7) (P)
342	83.	Does item 7 mean that you have to take a test at the end of each activity and if you do not respond correctly to a certain percentage of the answers you will not get the CME credit? (P)
346	84.	too little too late (P, SMS)
348	85.	If AMA wants to maintain value of CME then stop this menace of MOC (P)
361	86.	tailoring credit to an individual's needs is doomed to fail. tailoring to a groups needs is unmeasurable. (MLB)
369	87.	I don't have any problem with the current requirements, but the changes above make sense. (P)
372	88.	As a physician who has been director for CME conferences, number 2 can consume a lot of time in order to show that an educational need exists for a given topic for a CME conference. As long as all other conditions are met for a CME conference, I do not favor additional specifications on what constitutes educational need, in fact I would prefer that number 2 be deleted. It just provides more paperwork for my CME department to require of me. (P)
373	89.	To change many programs dropping the CME certification, making it more simple and exact. (MO, P)
379	90.	Most are reasonable, however it will be very difficult to accomplish #7 as revised. (SP, P)
392	91.	I strongly support these changes to allow CME providers to innovate and meet the evolving needs of physician-learners. (NP)
393	92.	Provides more explicit methods and standards by which CME activities must be structured and implemented. (P, O)
400	93.	very well written to provide flexibility in programming (O)

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408	94.	Overall, AAFP supports AMA and ACCME's efforts to align their requirements, simplify the process and reduce administrative burdens for CME provider organizations as we believe this will have a positive impact on physicians and the patients they serve. / / Core Requirement 6-The AAFP does not support AMA's removal of reference to the CEJA opinions. AAFP believes it is important for CME provider organizations to be aware of those requirements, to ensure they do not put physicians in a position to jeopardize their compliance with CEJA opinions. The AAFP believes the CEJA opinions are so important they are included in our own Credit System Requirements and the AAFP's Bylaws. / / The AAFP does not support removal of the phrase "and be non-promotional in nature." This phrase ensures that all certified CME is free from promotion, beyond the protection against commercial influence. There are no other regulations protecting the education and thereby the learners from promotion of non-commercial interests. The AAFP believes this requirement should be retained. / / Core Requirement 7-The proposed language change will significantly change core requirement seven from evaluating the activity to assessing the learners' achievement of the educational purpose of the activity. / (NP, O)
409	95.	I have heard the CEO of the ACCME make several inspirational presentations challenging his organization and organized medicine to overall the current process of accreditation for CME credit. The changes above appear to be taking hearing and words missing rather than a fresh look at a new process. If this represents the beginning of bigger changes yet to come, so be it. If on the other hand these represent the compromise between change agents and traditionalists, then we will all be disappointed. (NP)
410	96.	My favorite part about these changes are a change to include independence in CME activities. Providing assessment is important but can in someways be somewhat burdensome to the one giving the CME activity but I think it is needed overall. (P)
414	97.	Most of these are already being implemented by my institution (P)
427	98.	This brings some sense into developing educational objectives, style of delivery of CME and evaluation. The education experts have made this a mess. (P)
428	99.	Please keep "in advance of participation in the activity". (NP)
430	100.	It looks as though the 7 core requirements will help providers to have clearer direction. The one area of concern is requirement # 7. As long as the assessment is not rigidly defined to measure whether an accredited educational event met its purpose and objective it is acceptable. (NP)
447	101.	On 3 above - If planned a live activity, does the flyer have to give instructions on how to successfully complete the activity or is this just meant for enduring materials? (SP)
448	102.	should all 6 of the competencies be mentioned in #2? (NP, MO, P)
452	103.	Needed updating! (P)
456	104.	non-promotional... (P)
460	105.	Wordsmithing and neither add nor subtract actual value (P)
468	106.	The flexibility can lead to innovation. (NP, P)
470	107.	"underlies the professional practice gaps of that activity's learners" is too negative. CME can be obtained to stay up to date, which does not necessarily indicate a "gap". I think this statement needs revision, or deletion of the last phrase from the sentence. the rest is fine (NP, P)
473	108.	I don't like #3. Why state "when appropriate" at the beginning - isn't communicating the learning objectives always appropriate? (SP)
479	109.	Seem reasonable (P)
480	110.	The Changes do not appear to be that substantial (P, O)
481	111.	Changes better align with ethical CME (O)
482	112.	The rules and regulations as they stand are so burdensome and arbitrary and unresponsive to different specialties that just changing this language is of no help. This process has become so over reaching that steps may need to be taken to determine other entities to evaluate appropriate education. (P)
483	113.	The demonstrated educational need in point 2 may not be based solely on an identified practice gap of an individual but an opportunity to enhance the practice for all physicians. I think that point 7 is important but there is a need to clarify if the measurement of achievement is in the educational setting alone. (P, O)
485	114.	I like the idea of incorporating the learning goals into the presentation. (P)
487	115.	need to check competence not sit in a lecture after a heavy day of work (P)

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493	116.	Changes look excellent (SP, P)
496	117.	2. is remedial and in obfuscatory in language. Competence should be changed to ability, e.g. Address a need for knowledge, skill or performance relevant to the activity's learners. 3. can be shortened to "When appropriate, the purpose or objectives of the activity and how to successfully complete the activity should be communicated to prospective learners. 4. would change to teaching or learning methodologies. (P)
497	118.	Item 7 is the most important change. (MO, O)
500	119.	Since this is a change of 7 parts, it is hard to give one answer. I am concerned about the wording of number 7. Do you mean that we must provide an assessment of each learner, or do you mean that we measure the learning as a result of the event? Are you suggesting that we provide this as a post test rather than an evaluation? (NP)
504	120.	#3.: purposes and objectives should always be communicated to participants, not only 'when appropriate to the activity and the learners'. (O)
517	121.	I am not sure most learners find the post activity assessments of value. (SMS)
518	122.	The only change that concerns the American Society of Echocardiography is #7. Is it the intent of this core requirement to have all learners tested in order to assess their learning during the activity or can the assessment take the form of self-assessment? We feel it would be helpful to be a little clearer in the requirement as to what is meant by assessment. / / In the past, assessment was defined as patient-management case studies, a post-test and/or application of new concepts in response to simulated problems. If this type of assessment now pertains to all activities, including Live Events, it is not possible for large conferences or medium sized seminars to qualify. It becomes cost prohibitive and labor intensive to gather these types of assessments for 300 - 3000 attendees. / (NP)
521	123.	#7 do not change (P)
523	124.	1. I am glad to see knowledge list as an appropriate target for education. The recent increased focus on changing competence and performance has unfortunately diminished the value of imparting essential prerequisite knowledge and assessing change in this dimension. / 2. The term "professional practice gaps" is notably absent from the ACCME/AMA Glossary of Terms. This phrase can be misleading since it would seem to focus education only on professional behavior that falls short of defined best practices. In reality, clinicians must often make decisions where best practices are lacking and must draw on a strong foundation of contemporary knowledge to make prudent decisions. In addition, an important function of CME is to disseminate new knowledge and advances and provide a venue for discussing ...and debating their implications and appropriate applications. This type of educational need isn't clearly embodied in the concept of professional practice gaps as "the difference between "what is" and "what should be." This seems like an opportune time to consider whether the term "professional practice gap" adequately represents the spectrum of educational needs in an era of rapidly evolving knowledge and medical advances. / 3. Requirements related to evaluating educational outcomes impose a substantial burden on CME providers ...as well as on learners. The increased flexibility suggested by the revisions in #7 suggest that CME providers will now have greater flexibility in designing their evaluation strategy. (NP, P)
527	125.	Agree the core stamentsm (SP)
532	126.	Yes. Through the alignment of the AMA-ACCME requirements, thank you for proposing improvements that would enhance CME providers' abilities to innovate their CME/CPD programs to better meet learners' needs and improve patient care. / To enhance CME providers' understanding of the simplified requirements, please develop cases/examples as to how these new requirements may be implemented (or documented) in practice, similar to the ACCME's compliance examples. / With innovation in the design and delivery of education and providers' ability to define activities in an "other" format, please clarify the distinctions between AMA PRA Category 1 Credit™ and AMA PRA Category 2 Credit™. Without additional clarity (or examples), CME providers may be challenged when working with our stakeholders to confirm the educational formats that may or may not be designated for credit and which may be in an "other" format. (NP)

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533	127.	We support 2, 3,4 and 67, but we do not support AMA's removal of reference to the AMA Council on Ethical and Judicial Affairs (CEJA) Code of Medical Ethics (Code). CAFP believes it is important for CME provider organizations to be aware of those requirements; to ensure they do not put physicians in a position to jeopardize their compliance with the Code's opinions. Our national organization, the AAFP believes the AMA Code of Medical Ethics is so significant that they are included in the AAFP Bylaws(Article XIV - Ethics) and Credit System Requirements. CAFP does not support removal of the phrase "and be non-promotional in nature." This phrase ensures that all certified/accredited CME is free from promotion, beyond the protection against commercial influence (ACCME Standards for Commercial Support). No other regulations protect the education and learners from promotion of non-commercial interests. We believe this requirement should be retained. / (NP, O)
540	128.	Changes to #4 provide more flexibility, but are ambiguous and do not align with the intent of #5 being at an "appropriate depth and scope". We would suggest adding bibliographic references related to learning methodologies and educational design. (NP)
543	129.	RE: Item 6 - Are CEJA Opinions equivalent to the AMA Code of Medical Ethics? I am concerned that the SCS do not explicitly cover 9.6.2 Gifts to Physicians from Industry, item (d). / RE: Item 7 - Changing "Evaluate the effectiveness..." to "Provide an assessment..." if taken literally, would mean that CME providers will need to implement learning assessments (aka: tests) into their live activities. / I am NOT in favor of this change. / Alternative wording could be, "Measure achievement of the educational purpose and/or objective(s) of the CME activity." / (NP)
551	130.	Improved standards may lessen meaningless paper work in presentation (NP)
564	131.	They add clarification. (SP)
591	132.	#6, why only 1 organization can implement? (P)
602	133.	I don't believe providers should be held responsible for the performance of the participants. Providing an assessment is fine, but it should be stated that the purpose of this assessment should be directed to the participant more than the provider. (NP)
651	134.	Looks good. (NP, MO, P)
659	135.	Clarity is needed on how to assess the learner to measure achievement of educational purpose. Does learner self assessment count? (P, O)
697	136.	We only need one set of requirements, not ACCME AND AMA! (NP)
701	137.	Clearer wording that more closely parallels wording used by ACCME, which helps people new to CME administration more quickly understand intent. However, no change is made in the substance of expectations/requirements, which were understood reasonably well previously. (NP)
713	138.	Uncertain why the non-promotional was struck? (P)
769	139.	Not sure how one would reliably measure or demonstrate #2 (P)
877	140.	is 'non-promotional in nature' being removed because it is a given? (SP)
891	141.	This is a ridiculous question (P)

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Q2 – Proposed Enduring Material Changes

Comments Related to Enduring Materials		
19	1.	I agree with deleting the three bulleted format requirements. (NP P O)
22	2.	Again, would modify post test methodology so that time critical learning can take place (P)
42	3.	We don't use Enduring Material so do not have a strong opinion on this. (SP)
46	4.	No assessment? Or is that also assumed by the previous changes? (NP MO P)
48	5.	Reference earlier comments. (NP P)
52	6.	Make it simpler! (P)
62	7.	Deleting a minimum performance level seems like a step backwards. Some organizations pass everyone, so you can pass without even reading/learning anything. Think you should keep the 2nd and 3rd bullet requirements. (NP)
63	8.	why do away with minimum performance level quiz?? / Maybe I am missing the point. I believe we often learn by being asked questions, and thinking about them. I know I do. The new American Board format of frequent questions to be answered off-line, with on-line discussion among participants has proven popular. (NP P O)
66	9.	Still very costly in time and money. (P)
78	10.	Why would you no longer require an assessment or goals and objectives? (P)
87	11.	EN LO QUE RESPETA A MI EXPERIENCIA ME HA SERVIDO ENORMEMENTE, ESTUDIAR CONSECUENTEMENTE CON ESTA METODOLOGIA , VARIOS ANOS EMPLEO ESTA METODOLOGIA CON EXITO. (MO P O)
89	12.	Focus on application of learning not completing the materials (NP SP MO O)
105	13.	Not appropriate to give CME credit for just having bibliographic materials (P)
106	14.	Provide examples of evaluation forms that would meet the suggested goals. (SP)
111	15.	Since most live activities fail to measure improvement, why should enduring materials have a higher standard? Makes no sense. (NP)
115	16.	There should be some assessment of the learner that measures achievement of the educational purpose and/or objective(s) of the activity. (NP)
130	17.	again, nicely edited (P)
131	18.	Leave these applicable to this format. (SMS)
133	19.	no changes noted (P)
138	20.	Less verbiage is usually good. Not clear why the change is being proposed. (P)
139	21.	Second and third bullet are worth retaining, even if redundant to what is covered elsewhere. (P)
142	22.	Why delete the minimum performance level? People should know expectations and most doctors are over-achievers, not under achievers. (O)
163	23.	again, sounds reasonable, but more important than my opinion would be the opinion of cme providers - carlat psychiatry and psychiatric times / (P)
164	24.	Bullets 2 and 3 convey important principles. (P)
167	25.	suggest keeping minimum performance level if the activity has a post-test (P SCB)
172	26.	This is reasonable; I don't I don't think there should be a double standard (NP SP P)
181	27.	Minimum performance good idea (P)
191	28.	Sorry I don't quite understand why we are deleting these three requirements? Are they no long required? (SP)
193	29.	So there will no longer be a POST test? Hmmmm... (SP)
198	30.	again, we need clarification of assessment of the learner. Should all live activities have some assessment other than the evaluation. Do learners need to pass or does the provider just do the assessment (NP)
210	31.	second and third bullet should be retained (P)

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221	32.	Why develop enduring materials if you have no interest in demonstrating their effectiveness? (P SCB)
222	33.	Emphasizes clear communication with participants (P)
225	34.	Why are we deleting these requirements for the enduring materials? Shouldn't the requirements be the same for enduring CME? (O)
244	35.	Unclear to me why the assessment and minimum performance levels are being deleted. Seems that they should remain part of enduring materials. (P)
251	36.	Not clear on what it means to delete these requirements. For example, we don't have to communicate minimum performance levels anymore? (NP)
255	37.	The proposed changes reduce redundancy since the proposed items for deletion are addressed in the designating and awarding credit for participation in an enduring material section (SP)
258	38.	Regarding bullet point 3 above, I believe it is necessary to post the required score to pass/earn credit. The learner needs to know this ahead of time. (NP)
276	39.	It would help if you gave the rationale for the proposed changes (P)
302	40.	I am curious to know the rationale for deleting the last 2 bullets. (SMS)
309	41.	need to be studied followed by a pilot study of eligible students not on hats fits all (P)
314	42.	Yes, delete. Redundant. (O)
324	43.	these requirements are useful - not clear if really subsumed.. (P)
329	44.	no comment (O)
341	45.	Fewer regulatory requirements the better. Many of us who used to provide CME no longer do because of the expense associated with following strict rules. (P O)
346	46.	if you finish it successfully you should be given credit (P SMS)
349	47.	I don't know what this is referring to. (P)
355	48.	Instruction is objective but achievements should not be mandatory. Or if not met, then a refund should be issued for inadequate instruction. (P)
372	49.	would be helpful if you defined enduring materials. I do not know what this means. I am totally in favor of deleting requirements for CME activities, except those related to protection from commercial bias. (P)
400	50.	assessment should be an explicit element of learning (O)
401	51.	It would be helpful to know why the format specific requirements are being deleted. (MLB)
425	52.	Please do not make the assessment piece so stringent that it causes costs to increase, participation to decrease, or the activity has only face validity at a very high cost such as most simulations. (P O)
427	53.	Don't delete 2 and 3. (P)
448	54.	Its very hard to measure post-event improvement as most people's practices don't correspond exactly, and the # of patients with any individual condition is small in most practices. (NP MO P)
449	55.	Hard to review, when only reviewing pieces and not the whole document.... (MLB)
468	56.	This may remove some barriers to participation in enduring material CME activities. The minimum performance level is an artificial measure and learning occurs without it. (NP P)
470	57.	I think the text being deleted is more clear than the new language, proposed on prior screen. (NP P)
479	58.	Seem reasonable. (P)
482	59.	Once again these steps provide little to improve education. (P)
483	60.	Anything that reduces the need to accredit an activity based on format is certainly in the right strategic direction. Enduring materials are important resources to self-learning and blended learning strategies and how they are used should be based - at least significantly - on the learner's intent. (P O)

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485	61.	It is my opinion that more thinking has to go into this assessment issue. Physicians as a group have been tested enough. It is my opinion that the assessment needs to be related as much as possible to clinical applications. (P)
487	62.	this does not check competence (P)
496	63.	To avoid confusion, would add to requirement 3, "e.g. enduring materials-type CME." or leave this instruction here - no problem with repetition. I use the NEJM for CME. It seems useful to keep the last item re: "Communicate to the participants the minimum performance level ...." Or, am I missing something? (P)
498	64.	I believe that some assessment should be done; I also believe that there should be a minimum performance level (expectation) by the provider that outcomes were met. (O)
523	65.	Presumably, it is also expected that enduring materials will appropriately cite the supporting evidence. (NP P)
527	66.	Live cme are unrealistic time wzys.6 (SP)
532	67.	Given these changes, will a minimum passing score for credit to be awarded still need to be established for enduring materials? If so, would an assessment other than one that is quiz-based be acceptable? / Please define the intent for providers to “provide access” to bibliographic resources. For example, would providing a reference list/bibliography to learners be sufficient, or would direct access to those reference materials/bibliographic sources need to occur? (NP)
539	68.	ACCME - AMA should consider the impact removing the assessment / minimum performance threshold will have on ABMS certifying boards (like ABR) that have determined any enduring CME activities would qualify for Self-Assessment CME since a learner assessment must be built in and minimum performance level achieved to earn CME credit. (NP)
540	69.	We agree with these changes only if the changes to the core requirements are made. If the core requirements are not changed, we would not want the requirements to the present enduring materials changed. (NP)
542	70.	I don't understand "Provide access to appropriate bibliographic sources to allow for further study." This is not required in other formats. No doubt, it would be helpful but it would be just as helpful in other formats. (NP)
545	71.	and be patient about new learner (P)
621	72.	If the assessment and communication of minimum performance standards are deleted, does that mean the minimum performance standards no longer exist? (NP)
701	73.	The changes are editorially reasonable, but will not change the substance of what CME providers do. (NP)
769	74.	Some worthwhile programs may not lend themselves to reasonable immediate assessment (P)

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Q3 – Proposed Journal-Based CME Changes

Comments Related to Journal-Based CME		
36	1.	Some criteria is needed to insure that the article was, at least, read (NP) (NP)
42	2.	We do not do Journal-based CME so do not have a strong opinion on this. (SP) (SP)
49	3.	There should be more free CMEs that physicians can do on thier own that are relevant to practic (P) (P)
52	4.	Make it easier, not more difficult, to get CME (P)
62	5.	same comment about removing minimum performance requirement--lets people pass/get credit without even looking at the content. (NP)
63	6.	same comment as prior (NP P O)
66	7.	Feedback on reading is important. (P)
78	8.	I think all CME should have some assessment. (P)
87	9.	DE ACUERDO (MO P O)
105	10.	At least document participation in a journal review session (P)
106	11.	Describe examples of how the journal based CME can be tested in the future for efficacy. (SP)
112	12.	Why would there not be a minimum performance level? (P)
115	13.	There should b e some assessment of the learner that measures achievement of the educational purpose and/or objective(s) of the activity. (NP)
121	14.	studies of CME have shown that while they may provide payments for the certified there is little evidence the improve the skills or knowledge of the students attending the courses (NP SP MO P)
126	15.	I don't have an opinion on this because we don't offer this format. (SP)
131	16.	Leave these to the specific format. (SMS)
133	17.	no changes noted (P)
138	18.	No big deal. (P)
139	19.	Retain second and third bullet. (P)
163	20.	depends on what you exactly mean by peer review - how many and which ones. dissent and freely given opinion is essential to prevent a peer reviewed echo chamber (P)
167	21.	keep minimum performance level if there is a post-test and the article will be used to fulfill self-assessment requirements for MOC Part II for some boards. (P SCB)
179	22.	I support the noble "peer review", however, some of the best and succinct things I have learned are not peer reviewed. (P)
191	23.	We do not have to communicate to the attendees about AMA PRA Category 1 Credit? I also need further explanation of your first requirement listed. I don't fully understand why this is no longer important. (SP)
206	24.	NA - At present we do not offer Journal - based CME. (NP)
210	25.	format specific requirements should be retained (P)
221	26.	Same as previous comment (P SCB)
222	27.	Clear expectations (P)
225	28.	Would participants not be quizzed on what they learn from a peer-reviewed article? I still think the requirements to be deleted are still important. (O)
227	29.	We do not currently award credit for any Journal-based CME (SP)
232	30.	Glad it is peer reviewed - and that it doesn't need to be PMID based to make sure we aren't limiting studies that are good but not in elite journal. (SP)
244	31.	Unclear to me why the assessment is being deleted. Seems that should remain part of Journal based CME (P)

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Comments Related to Journal-Based CME		
251	32.	Same comment as EM. (NP)
255	33.	Same comment as for enduring material (SP)
258	34.	I think there needs to be some assessment of the learner. (Bullet point #1). Perhaps, since this is built into the ACCME criteria, it is being deleted in AMA document revision? Still think passing score required (Bullet point #2) needs to be communicated to learner. (NP)
276	35.	Again - why? (P)
278	36.	Need to communicate the "rules". (P)
302	37.	I am curious to know the rationale for deleting the last 2 bullets. (SMS)
309	38.	not appropriate (P)
324	39.	I think the minimum performance level is useful and should not be deleted. (P)
332	40.	What about textbook-based, or other non-journal materials? (NP MO P)
338	41.	It is important to retain the assessment of the learner; however, we support deleting the second bullet (Communicate to the participants...). (MLB)
346	42.	learning is not limited to peer review articles alone (P SMS)
356	43.	our organization does not do journal-based cme. (SP)
400	44.	assessment should be an explicit element of education (O)
401	45.	See above. (MLB)
410	46.	Honestly I almost never complete the journal based CME because I find it takes time. But at the same time the assessment part is important for the learner and the CM?E provider. I don't think the part that starts "Provide an assessment..." should be deleted. (P)
414	47.	Most journal based CME already do this (P)
425	48.	See previous comments (P O)
449	49.	I think some assessment should be required to confirm completion/understanding (MLB)
468	50.	Same comment as above. (NP P)
470	51.	I think the old language is clearer than the proposed (NP P)
478	52.	I have seen this identified as "include one or more peer-reviewed articles" for the new guidelines. The more flexible option is preferred as it allows for more options for developing meaningful activities. (NP)
483	53.	Totally agree that anything in the peer reviewed literature has already gone through a screening process designed to ensure scientific validity for consideration by physicians in informing their practice (P O)
487	54.	that will make sense (P)
496	55.	Would clarify to: "Provide a learner assessment that measures, with a pre-established minimum achievement level, what learners would do, i.e. more than an assessment of knowledge, measuring of how they would apply knowledge. This may include patient-management cases, test questions that reflect what learners would choose to do in circumstances, etc. (P)
523	56.	I like this change. It allows CME providers greater flexibility in deciding how to gauge educational effectiveness and hopefully eliminates the need to require participants to keep repeating the post test questions if they haven't hit the required threshold. (Hopefully, they would be getting corrective feedback to post-test questions answered incorrectly) (NP P)
527	57.	No interested. (SP)
532	58.	Given these changes, will a minimum passing score for credit to be awarded still need to be established for journal-based CME activities? If so, would an assessment other than one that is quiz-based be acceptable? / With these changes, will credit on journal-based CME activities still be based on one article-one credit? If designed as such, could a compilation of numerous journal articles in a year become an enduring material? (NP)

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Comments Related to Journal-Based CME		
539	59.	Similar to my previous comment, ACCME - AMA should consider the impact removing the assessment / minimum performance threshold will have on ABMS certifying boards (like ABR) that have determined any journal-based CME activities would qualify for Self-Assessment CME since a learner assessment must be built in and minimum performance level achieved to earn CME credit. (NP)
540	60.	We agree with these changes only if the changes to the core requirements are made. If the core requirements are not changed, we would not want the requirements to the present journal-based CME requirements changed. (NP)
543	61.	We are not involved with this format, so we prefer to not comment. However, we have to rate in order to proceed. (NP)
591	62.	Journal-based CME is very practical (P)
621	63.	Same comments/questions as identicated in #2: If the assessment and communication of minimum performance standards are deleted, does that mean the minimum performance standards no longer exist? (NP)
701	64.	The changes are editorially reasonable, but will not change the substance of what CME providers do. (NP)
713	65.	Assessment tools used may be dependent on the learned information or skill that is being taught/measured. (P)
801	66.	Currently not doing Journal-based CME (SP)

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Q4 – Proposed Test-Item Writing Changes

		Comments Related to Test-Item Writing
12	1.	Our organization has never been asked to accredit Test item writing material for CME, not sure how to answer regarding proposed changes (NP SMS O)
16	2.	Focuses on only the highest standard exams and activities (P)
22	3.	Again, no test requirements should exist (P)
36	4.	Does this mean that any items for any quizzes will suffice? That seems rather useless (NP)
42	5.	We do not do Test Item Writing CME so do not have a strong opinion on this. (SP)
52	6.	make it simpler (P)
62	7.	Don't develop this format activity, but not sure why you would want to delete the format specific requirements. (NP)
63	8.	reasoning unclear, I don't disagree but unsure why this is being changed (NP P O)
76	9.	There are AOA sponsored boards exam writing that should qualify (SP P)
89	10.	This is a silly CME activity (as a NBME question writer). This does not prepare or allow the public to have confidence that the provider is up to date. This requirement should be deleted. (NP SP MO O)
93	11.	Simplify, simplify, simplify.... (NP MO P)
101	12.	The whole situation of the boards is extremely stressful / The test writers have developed a system irrelevant to the day to day practice / Organizations use board certifications to grant privileges or even continuation of employment / Boards are just doing it because they can (P)
126	13.	i don't have an opinion on this because we don't offer this format (SP)
133	14.	no changes noted (P)
134	15.	Too rigid (NP)
138	16.	I am not clear what is actually changing? The principles of item writing or the explanation. (P)
140	17.	So long as guidance is given elsewhere as to what is constituted as appropriate for this format. Especially because it is not as common a format as live, enduring, journal (O)
163	18.	good / (P)
172	19.	I think that the move to include MOC part two in live activities should allow test item writing to be included for medical schools and teaching hospitals. (NP SP P)
210	20.	Seems to me one would need to state some requirements. / Specialty society self-assessment activities are not 'tests' per se - so the title "Test Item Writing" should be changed to "Item Writing" if that particular piece is contemplated. (P)
222	21.	Standardization and quality but must avoid too much complexity and added cost (P)
226	22.	This would allow for any physician that develops any type of tests to claim CME, I think it needs to remain for those exams listed above. (NP)
227	23.	We do not currently award credit for test writing items (SP)
229	24.	I am concerned that loosening these requirements will decrease the quality of test questions (NP)
233	25.	Would the entire test-writing piece be deleted? We don't work with this currently, but can a physician now receive credit for any test writing time? This is confusing... (NP SCB O)
244	26.	I believe that these format specific requirements are appropriate and necessary (P)
251	27.	Do not use test-item writing so I have no comment. (NP)
255	28.	These seem reasonable, but I have no experience with test item writing (SP)
259	29.	Not quite sure of how this issue is being handle by the AOA Bureau of Osteopathic Specialists (O)

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261	30.	While greater simplicity is achieved by deleting these format-specific requirements, the rationale for removing the group peer review of the questions in which the physician question writer participates is unclear. It reduces the rigor associated with this activity format and may dissuade learners from participating in a potentially valuable educational exercise. Perhaps, however, the credit associated with test item writing is commensurate with the time spent on the activity. (NP MO)
278	31.	Not entirely clear why the changes are proposed. Guidance in question writing is not provided elsewhere. (P)
302	32.	I am curious to know the rationale for the deletions. (SMS)
309	33.	may be (P)
314	34.	Yes, other providers need credits too, like FNP and PA (O)
322	35.	Test questions should be written with the actual evidence basis from psychological research that demonstrates which methods lead to retention and behavioral change. (CI)
324	36.	Need to keep the third point...I didn't see it in core requirement 5 (P)
328	37.	All items should conform to the NBME standards. (P)
332	38.	Should add to this : questions written ACCME approved CME courses, medical schools, residency and fellowships. (NP MO P)
346	39.	ABIM and ABMS have to be restructured - they have abused their power and are not in it for their members (P SMS)
356	40.	our organization does not do test item writing. (SP)
370	41.	First of all, I strongly support maintaining credit for test item writing for NBME, ABMS, etc. These are excellent formats for furthering knowledge and development in education. However, I do think that some guidance as to the type of rigorous test item writing that is expected should be included. / (P)
393	42.	Would allow physicians to receive credit for activities outside of traditional channels for test writing (P O)
400	43.	Allows for changes within the medical profession (O)
401	44.	This is outside the medical boards expertise. (MLB)
408	45.	The AAFP Credit System removed all similar format specific requirements in 2015. Requiring CME provider organizations to certify test item writing as an activity adds administrative burden to both the CME provider organization and the learner. AAFP recommends AMA make this format available for AMA Direct credit. (NP O)
410	46.	I don't understand the reasoning for deleting that. (P)
423	47.	Recommend including Non-American Board of Medical Specialties (ABMS) board certification examinations under "Be developed only for:" / / (Not all physicians seeking CME and/or are certified by peer reviewed and nationally recognized specialty certification bodies that are ABMS members.) (NP P SMS SCB O)
427	48.	There should be some mechanism, documented or not, to ensure people know how to write test questions. (P)
431	49.	Should also include USMLE Step 1, Step 2 and Step 3 questions. Should also include ABMS sub-Board certifications examinations, should also include speciality board questions as a part of CME activities. (SP P)
449	50.	I think test writing does provide for learning, research to confirm answers. (MLB)
453	51.	some guidance may be needed. Item writing is a skill not mastered by all. (NP P)
473	52.	So there will be no expectations provided in regard to this category of credit? (SP)
478	53.	Would this format title still be used, or would an activity like this be considered "Other"? (NP)
482	54.	There are many problems with "evidence" as presented and bias in certain journals to emphasize approaches that editors desire. Some studies are not well done on patient inclusion but give "evidence" that is accepted due to the level of the study only regardless of how well it is done. (P)
483	55.	Developing a written test item should be considered a learning activity based on the design work (and learning) required to develop the question. How these 'learning' activities can be documented for credit still requires defining (P O)
485	56.	More thinking and consultation with education consultants is needed to create more methods to test MD's. (P)
487	57.	important (P)

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496	58.	I am not clear on this. Does the colon at the end of the first mean that what follows is deleted? Or, should it be a period instead of a colon? I think a period would be better. I would deleted "member" after (ABMS) Would change to "question-writers" and would change to " ... and an evidence-based knowledge for the questions." Would change to "... physician question-writers personally participate." (P)
523	59.	Finding individuals with the time and skill to craft well-designed assessment questions can be challenging.This change will allow a broad set of accrediting bodies and CME providers to offer tangible incentives to faculty for developing well-crafted assessment questions. Ideally, test item writing activities will be supported by training in best practices. Further, test writing that is eligible for CME credit should involve a review process and, if warranted, an expectation that revisions will be reasonably made in response to feedback. (NP P)
527	60.	Yes by the board (SP)
533	61.	We support the removal of format specific requirements for test item writing. The AAFP Credit System removed all similar format specific requirements from Test Item Writing in 2015 when this option for CME credit was consolidated under the "Scholarly Activity" category. CAFP thinks requiring CME provider organizations to certify test item writing as an activity adds administrative burden to both the CME provider organization and the learner. We recommend AMA make this format available for AMA Direct Credit. / (NP O)
540	62.	Writing high-quality, relevant questions is extremely difficult. Documentation that item-writers receive some measure of 'guidance or training' is an essential element for optimal activity outcomes. Deleting these requirements unnecessarily loosens the guidelines. We agree that the first guideline regarding what the questions are "developed for" could be deleted and the "depth and scope" requirement be subsumed by core requirement #5; however, the other format specific guidelines should remain in place. (NP)
541	63.	Requirement is very confusing to me as written. (SCB)
543	64.	We are not involved with this format, so we prefer to not comment. However, we have to rate in order to proceed. (NP)
701	65.	The changes are editorially reasonable and may simplify what CME providers do (for a format used by a small number of CME providers). (NP)
788	66.	The purpose of these changes eludes me. (P)
801	67.	Currently not doing Test item writing (SP)

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Q5 – Proposed Manuscript Review Changes

Comments Related to Manuscript Review		
1	1.	I'm no sure what the overview process would look like for the reviews. Who decides what a quality review looks like? (P)
36	2.	It looks like we are going from too many requirements to foo few (NP)
42	3.	We do not do Manuscript Review CME so do not have a strong opinion on this. (SP)
49	4.	I review for a bunch of peer review journals and almost none provide CME stating its too costly for them to do so. If you review a manuscript you should get at 1CME per hour that you spent reviewing (P)
62	5.	Not familiar with this format, so can't comment, but doesn't seem to make any sense to delete format requirements. (NP)
63	6.	why remove? does this mean this is not a learning activity - it is, etc. (NP P O)
88	7.	I feel that these should be more regulated that the above deletion would allow. (NP SP SCB)
89	8.	Should only apply to clinical articles (e.g. should not apply to history of medicine). (NP SP MO O)
126	9.	I don't have an opinion on this because we don't offer this format (SP)
133	10.	no changes noted (P)
181	11.	This is an excellent way to do CME and helps get reviewers. Having been an editor, anything that helps is good. (P)
191	12.	Sorry but I don't do manuscript reviews so I don't know if this is good or bad. (SP)
206	13.	NA - Again we do not presently provide (NP)
207	14.	I wasn't clear why you remove the oversight mechanism. This seems like it would be important (NP P)
210	15.	need mechanism to account for potential COI in reviewers, should retain some degree of quality over the types of journals that would qualify: ie MEDLINE or PUBMED indexed (P)
227	16.	We do not currently award credit for manuscript review (for journals) (SP)
244	17.	First two bullets must remain in my opinion. I actually like the oversight mechanism, as well. (P)
251	18.	Again, does that mean the CME provider does not need to account for any of these things anymore? (NP)
255	19.	Seems reasonable, but again, no experience with this category (SP)
276	20.	Why? (P)
302	21.	I am curious to know the rationale for deleting the first, second and fifth bullets. (SMS)
309	22.	the review process should be adjusted to the new electronic age what is noted is based on the early part of the last century review process,,,, wow back to the old times (P)
314	23.	Delete, not necessary unless you are talking to students. (O)
315	24.	I have never been a fan of providing CME for reviewing a journal article. This should be an obligation and/or labor of love. (P)
324	25.	I think the manuscript review for CME is useful, but these requirements are needed... (P)
331	26.	Proving any of this is burdensome (NP P)
346	27.	show measure quality of reviewers - but giving too much power away (P SMS)
408	28.	The AAFP Credit System removed all similar format specific requirements in 2015. Requiring CME provider organizations to certify manuscript review as an activity adds administrative burden to both the CME provider organization and the learner. AAFP recommends AMA make this format available for AMA Direct credit. (NP O)
410	29.	Don't delete (P)
425	30.	Be careful about bias that may occur in the oversight mechanism (P O)
427	31.	Let's not throw the baby out with the bath water. Manuscript review has to be rigorous. If CME credit is given for the same, then these requirements should not be onerous. (P)
439	32.	I especially like getting CME credit for journal reviews/editing. (NP SP P SMS)

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448	33.	if these are the things that are added, then I agree. The question format however could be interpreted that the following will be deleted. (NP MO P)
464	34.	Why are these amendments being made? (MLB)
473	35.	Again, no criteria at all? (SP)
478	36.	Will this activity format label continue to be used or will this be considered "Other"? (NP)
483	37.	We would agree and concur that reviewing manuscripts is an educational strategy that should be accredited based on the nature of the review. We require our physicians to simply document what they learned from being a peer reviewer of journal articles to receive credit (P O)
487	38.	ok (P)
496	39.	I assume the colon should be a period at the end of the first sentence and that what follows is not deleted as is implied by the colon. (P)
497	40.	Without some direction, there will be enormous variability in CME for manuscript review. Deleting all requirements is unwise in my view. (MO O)
527	41.	Helpful / (SP)
533	42.	See notes on Test Item Writing. (NP O)
539	43.	Personally, I think an oversight mechanism to evaluate the quality of reviews should remain in place to award credit. (NP)
543	44.	We are not involved with this format, so we prefer to not comment. However, we have to rate in order to proceed. (NP)
701	45.	The changes are editorially reasonable, but will not change the substance of what CME providers do. (NP)
801	46.	Currently not do Manuscript review (SP)
849	47.	The Language of JAMA difficult and has to be read twice / The language of Lancet-British easy for me-- My collegev education was in India where we learned British English. / May be a coincidence--I see the same style of US English written by Aklexander Hamilton (P)

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Q6 – Proposed PI CME Changes

Comments Related to PI CME		
1	1.	I think this is a good waste of time. (P)
7	2.	Include some reference to reviewing outcome or impact on practice (O)
16	3.	Some physicians not in active practice will use tools not collected by them in their practice. This is helpful (P)
22	4.	Very few will do this (P)
42	5.	We do do very little PI CME so do not have a strong opinion on this. We have a Lean Team and data analysts, so they would be the ones primarily involved in analyzing the data. It makes sense that physicians may not be as involved in the deleted step. (SP)
49	6.	Too many different requirements and no proof that physicians doing MOC today are any better than the physicians in the past who simply had to submit ongoing CME credits (P)
52	7.	make it simpler (P)
57	8.	This seems too complex. (P)
62	9.	The requirement to be deleted seems like it would provide good info for the participant. Having someone else tell you what was wrong is not as helpful as figuring it out for yourself. When you realize/discover what the problem is, then you're more likely to fix it. (NP)
66	10.	Waste of time for most physicians (P)
74	11.	These sorts of CME activities should be eliminated as they would be highly variable and encourage the boards to continue to use them as measures for certification. (P)
89	12.	Explain why this is being deleted? (NP SP MO O)
105	13.	Ironic that there are so many details on a performance improvement activity and hardly any on "knowledge acquisition" activities which require hardly any verification or test of competency (P)
106	14.	Provide examples of how organizations can measure performance improvement CME programs. (SP)
126	15.	I don't offer this format because it is too onerous for our users. I don't think the changes you are making would make it that much less onerous. (SP)
133	16.	no changes noted (P)
134	17.	So will B and C become A and B--or 1 and 2? (NP)
138	18.	I'm not sure how this could have been done in practice, so deleting is fine. (P)
140	19.	I would strongly advocate for also adding to Stage B some language around either a formal or informal mid-point data analysis. I encourage this in every talk I give to my colleagues about implementing successful PI activities (O)
158	20.	Some of these seem more specifically directed to physicians in an academic practice environment rather than actual practicing physicians. (P)
163	21.	all cme is in the service of doing better next time. i dont give performances. drop the whole false distinction (P)
190	22.	There is value in being involved in the analyses. (NP P)
222	23.	Added clarity; should include reference to clinical specialty registries (P)
227	24.	Sounds most reasonable (SP)
232	25.	Chart reviews are very time intensive and limiting - so glad other appropriate measures -- including behavior change (e.g., number of conversations initiated about advance directives; incidents files if working on patient safety) (SP)
233	26.	Our organization does not currently work with this. Neutral. (NP SCB O)
251	27.	Not clear on the reason for the deletion. If the physician is not actively involved, then he is not engaged which would decrease his participation in the activity. / (NP)
255	28.	no experience to base the impact of this deletion (SP)
278	29.	Participants need not perform analyses themselves but should understand the principles involved. (P)

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281	30.	The 3 stages should also be deleted, as in reality they are almost impossible to measure in a meaningful manner. (SP)
292	31.	Get rid of the entire PI program: much work for minimal (if any) educational benefit (NP MO P)
302	32.	I am curious to know the rationale for the deletion. (SMS)
309	33.	need more details of a process of learning rather than mandatory cme.....we do not need another 50 years to prove it was worthless process just like those who sign in and leave (P)
314	34.	Yes, you may have situations where the Physician is not actively involved, such as having a Grad student helping out. (O)
324	35.	I think this is the core of the value of the PI CME - the physician needs to analyze his/her own data and determine the accuracy/importance of the variations and plan a meaningful intervention!!!! (P)
331	36.	None of this should have a role in maintainence of certification. (NP P)
369	37.	I have no experience with this kind of CME (P)
370	38.	Interesting how the format specific requirements in the other areas are being minimized - but not in this area. Why do the 3 stages need to be delineated? / / Why does the first bullet need to stay in when similar language has been removed from other requirements? (P)
408	39.	The AAFP strongly supports the language that is being retained, including Stage A, B and C descriptions. / / The AAFP can support removal of language that requires physicians to be directly involved in data collection and the statistical analysis of the data, the AAFP does not support removal of the requirement that physicians be involved in reviewing and understanding the outcomes of the data analysis to determine causes of variance and identification of appropriate interventions. The learning physicians can acquire through those components of a PICME activity should be retained to ensure it is a relevant meaningful experience for the learner. (NP O)
427	40.	These should all be deleted. THe PI and PI CME should just go away. PI is a business requirement. We waste a lot of time with this crap. (P)
432	41.	Data collection (chart redaction) can be done at much less cost by clerical personnel, especially in EMRs (MO P)
468	42.	Utilizing staff and/or computers to perform the analysis will facilitate participation in the activity and will not diminish learning. (NP P)
469	43.	I am not familiar with this form of CME. (SCB)
483	44.	Agree with removing the specific requirement related to Stage A (P O)
487	45.	nonsense as a metric knowledge and competence are too far apart (P)
496	46.	The term "evidence based" lacks substantive meaning and is over-used like "best practice." I would delete it. Instead: "Have an oversight mechanism that assures that performance measures are well designed, e.g. clearly specified data elements, data collection is feasible. / / change to "... and the basis behind those measures." / Re-assess and reflect on performance in practice measured after the implementations of the intervention(s), summarizing any practice, process and/or outcome changes that resulted from the PI CME activity. (P)
523	47.	The PI-CME model is great in theory, but very difficult to implement in totally since it typically requires sustained participant engagement across multiple time points. Further, many quality and performance indicators are relatively insensitive to change over typical pre-post measurement intervals and measure parameters that physicians have diminishing control over / In my experience, a well-targeted PI-CME activity often creates substantial cognitive dissonance in Stage A by giving clinicians tangible evidence about their practice patterns that conflicts with their perceptions. This is a powerful motivator to change. While I can't cite any randomized trials, I suspect that Stage A paired with a thoughtful analysis of an observed gap and detailed Action Plan could stand-alone as a substantive learning activity and should be eligible for CME credit. This Stage A - PLUS model would be much easier to scale up. I hope ACCME and AMA will explore alternatives models for PI-CME that address current barriers. (NP P)
527	48.	Nice updated info. (SP)

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533	49.	We strongly support the language that is being retained and can support the removal of language that requires physicians to be directly involved in data collection/statistical analysis. BUT, we do not support removal of the requirement that physicians be involved in reviewing and understanding the outcomes of the data analysis to determine causes of variance and identification of appropriate interventions. The learning physicians acquire through those components of a PI CME activity should be retained to ensure it is a relevant meaningful experience for the learner. / (NP O)
539	50.	Would performance improvement activities meeting these format requirements still offer 20 credits upon completion of all 3 stages or 5 credits for each individual stage? Clarification here would be helpful. (NP)
540	51.	The requirement to be deleted seems like it would provide good info for the participant. Having someone else tell you what was wrong is not as helpful as figuring it out for yourself. When you realize/discover what the problem is, then you're more likely to fix it. (NP)
621	52.	We understand that the AMA PI CME format remains but we assume that new PI formats are now permissible under this new flexible system. Is that correct? (NP)
701	53.	The changes are editorially reasonable, but will not change the substance of what CME providers do. (NP)
801	54.	Currently not doing PI CME (SP)

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Q7 – Proposed Internet Point-of-Care Changes

Comments Related to Internet Point-of-Care		
1	1.	Other than linking to searches on up-to-date, I'm not sure how this would work practically? Searches of pubmed? Web of science? Google scholar? What would 'count'? (P)
42	2.	We do not do PoC CME so do not have a strong opinion on this. (SP)
49	3.	same comment as last question (P)
52	4.	make it simpler (P)
57	5.	I'm unclear on what this is and why it could not be covered under "enduring materials" (P)
62	6.	If you delete format specific requirements, what's left? Providers can come up with whatever they want for the format? (NP)
115	7.	There should be some internet point-of-care requirements. Google and Wikipedia are not sufficiently vetted by qualified physicians. (NP)
126	8.	I don't have an opinion on this because we don't offer this format (SP)
133	9.	no changes noted (P)
139	10.	What would replace them to ensure active participation by the physician? (P)
145	11.	is this the "UpToDate" cme? (P)
163	12.	bias cannot be eliminated, merely made explicit. stephen stahl is biased towards meds, carlat is skeptical, we need them both (P)
164	13.	Some good educational points are being eliminated, but they are candidates for re-writing. (P)
167	14.	not familiar with this (P SCB)
210	15.	would retain 4th bullet (P)
221	16.	Bullet five should be retained; the others are unnecessary. (P SCB)
222	17.	Not sure how tis includes everyday learning from on-line resources. The documentation might be too burdensome. (P)
223	18.	There needs to be some oversight in this arena (P)
226	19.	A process needs to be defined otherwise physicians will just claim any search for credit. This needs to be defined either by ACCME or the CME provider. (NP)
227	20.	We currently do not award credit for Internet point of care learning (SP)
232	21.	This is excellent but concerned about tracking -- How are we supposed to "track" the topics/sources searched other than self report. We don't have tools/resources to track particularly as a lot of CME is down from home computers. (SP)
233	22.	Our organization currently does not work with this - neutral. (NP SCB O)
244	23.	These requirements should remain to assure quality of the process. (P)
251	24.	Do not use internet PoC. (NP)
261	25.	We agree that the core requirements should suffice for this activity format and feel that simplifying and eliminating the associated requirements could result in physicians choosing to claim a greater portion of credit for activities that form part of their day-to-day processes. (NP MO)
276	26.	WHY? (P)
278	27.	Why would a feedback mechanism be deleted? Last point suggested that this means of obtaining credit would be eliminated? (P)
302	28.	I am curious to know the rationale for the deletions. (SMS)
309	29.	may be (P)
314	30.	Presumed (O)
322	31.	Simple information retrieval should not be eligible for ACCME. There has to be some verifiable process of learning, retention and application. (CI)

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324	32.	Sorry, I think these formatting requirements are helpful and should be kept. (P)
338	33.	We do not want agree to changing Internet point-of-care learning. (MLB)
341	34.	The simpler the regulations the better (P O)
346	35.	should ease access and lower costs (P SMS)
369	36.	no experience with this (P)
400	37.	comports with adult learning (O)
401	38.	Need more information. (MLB)
408	39.	AAFP supports the removal of POC steps two through four, but does not support removal of steps one or five. The AAFP strongly recommends that AMA retain requirements one and five to ensure learners are using appropriately vetted sources for point of care decision making and learning. Additionally, the AAFP believes retaining the clear, simple three step process for point of care learning facilitates important reflection for the learner. (NP O)
427	40.	All these should be maintained. Internet is uncharted territory. People get crazy, unfounded information here. This source of CME is worth guarding. (P)
431	41.	Currently UPTODATE provides CME, but other online medical information should also qualify such as emedicine, MedScape, and others. (SP P)
464	42.	Why are these being deleted? (MLB)
468	43.	Some of the former requirements were unnecessarily complicated. (NP P)
473	44.	No formal criteria at all? (SP)
478	45.	Will the format label continue to be used? (NP)
480	46.	I think that the current criteria are reasonable (P O)
482	47.	Once again, over reaching, burdensome, not proven to be more effective for patient care (P)
483	48.	I think removing all these requirements may be going to far. I would keep the third bullet - re: tracking the topics and sources searched - if this is for credit. In addition, if this is a learning activity then documentation of what was learned would be a reasonable requirement for credit (P O)
487	49.	ok (P)
496	50.	would delete "but are not limited to" ; add a comma after "how participation will be tracked" (P)
498	51.	I do believe that there should still be a mechanism for physician feedback and some method of accountability. (O)
523	52.	The original format-specific requirements are some cumbersome that they make the pursuit of PoC CME pointless for both CME providers and their target audience. Removing these obstacles will make Internet-based PoC CME a more viable option for providers and clinicians (NP P)
527	53.	/ Verify mass completion / / mds (SP)
543	54.	The three-step cycle should be maintained as a requirement. Unless the provider is the company, Up-to-date, some minimum structure is needed. Otherwise this will be "Unstructured online searching and learning." Recommend keeping this text at minimum: / Establish a mechanism for documenting the required three-step cycle: / 1. Review original clinical question(s). / 2. Identify the relevant sources from among those consulted. / 3. Describe the application of their findings to practice and whether it resulted in a change in knowledge, competence or performance as measured by physician practice application or patient health status improvement. / (NP)
701	55.	The changes are editorially reasonable and may simplify some of the substance of what CME providers do (for the relatively few CME providers utilizing this format). (NP)
801	56.	Currently not doing PoC (SP)

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Q8 – Other Comments on the Proposed Changes

Other Comments		
12	1.	It's a little early in the process to make concise comments since materials were just released two days ago. (NP SMS O)
19	2.	It would be great if active learning modalities that tend to lead to better retention and focus on individual goals were able to obtain CME more easily than sessions such as lectures that are less powerful but less costly to provide CME. An alternative would be for active learning opportunities to award more CME for the same amount of time. (NP P O)
28	3.	In general, CME should be offered in various formats to allow physicians to obtain current, quality CME in the mode or fashion they find most efficient and most informative. (P)
43	4.	I do not feel that the extra effort to develop and complete high-level questions or other assessment mechanisms will be worthwhile. The learner needs to participate in the activity and assimilate the information. Making credit contingent on completing a very detailed assessment or essay about how the activity impacted practice will make physicians less likely to participate in the activities. This is analogous to ACGME's overemphasis on administrative and assessment activities that actually takes time away from teaching and learning and is unlikely to result in more effective CME since every learner's needs and learning styles are different. (P)
55	5.	Minimize bureaucratic nuisances (P)
57	6.	Just keep it as simple as reasonably possible. Most of us never stop learning, and complex documentation takes up our time that would be better spent actually learning, teaching, reviewing, researching etc. (P)
62	7.	What is the rationale for deleting the requirements? Seems like you're turning it into a free for all for providers to decide what the various formats of activities are. (NP)
63	8.	the deletions suggest those types of activities will no longer meet the rules, but yet that is not how I read the intent. Perhaps providing examples of how to meet the rules could clarify this. / / (NP P O)
66	9.	Can you present the total new document as proposed next to the current document? This side by side comparison would be easier to comment on. (P)
69	10.	Glad to see changes from a system that was too specific and, sometimes at conflict with good instructional design. (O)
70	11.	I disagree with removing all format requirements for reviewing, because there are a plethora of spurious pseudo-journals which have propagated and are damaging the medical evidence base. Review credits should be given for only reputable, indexed journals. (NP)
73	12.	very good (P)
84	13.	These changes seem to consolidate guidance for Providers for the benefit of physician learning. Responsible oversight without dictating the specific details. (O)
87	14.	SI UN PROFESIONAL LLEVA MUCHO TIEMPO , HACIENDO CME FREE, SERIA MUY BUENO , QUE HA CIERTA CANTIDAD DE CREDITOS TUVIERA UNA CERTIFICACION FINAL.LLEVANDO AUN MAS AL ENTUSIASMO DE SEGUIR. / (MO P O)
88	15.	Are these changes really gonna improve medical education? Are any changes made to policy really gonna improve education? Who's to say. (NP SP SCB)
89	16.	These changes are minimal and do little to promote and assure the health of the public. How can the public be assured their doctor is up to date and current? This is not about tests but about "best practice" and these are minimal and do little to advance the field of CME or apply adult learning to this woefully inadequate activity. (NP SP MO O)
91	17.	The changes should make CME activities possible across all media (P)
93	18.	It appears that there is an effort to simplify the overall process. GOOD! (NP MO P)
96	19.	Here is something that goes through my mind: occasionally there are important advances in basic sciences. They don't have an immediate impact on clinical care. However, they help a physician gain a current understanding of the basis for clinical care. I am concerned that the emphasis on application to direct clinical care might lead to neglect of communication of important advances in basic sciences. (P)

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105	20.	Seems that I could get CME credit for just subscribing to a peer reviewed journal and stating I read some articles (P)
106	21.	Provide a contact person (s) to call if any questions on the new changes. (SP)
131	22.	As a provider who offers predominately live activities and internal QA programs such as M & M's and Tumor Boards, moving the format specific requirements recommended to apply to all formats would provide burdensome and extremely difficult to comply with for each activity and each learner levels. (SMS)
134	23.	This is a long overdue step. (NP)
138	24.	it looks like a bit less verbiage. Not sure what substantive changes are being implemented or the motivation. (P)
139	25.	PoC is the most challenging to modify to make it both efficient and accountable. Good luck on that one! (P)
142	26.	Streamlining is good. (O)
143	27.	PoC should have rules, regs and guidelines to monitor and assess the activity as well as the impact of the intervention. This is and will continue to develop as one of the main sources of CME and with the evolving technology and our increasing use, guidelines or minimum requirements should be in place. (NP MO P)
145	28.	any changes made should not favor any commercial entity. (P)
158	29.	Once again more targeted to academic physicians rather than actual practicing physicians. (P)
163	30.	focus on how health plans have gutted medicine and nps and pas are scooping up the entrails / (P)
164	31.	Important and positive progress. (P)
165	32.	the process should be as simple and straightforward as possible. it should be clear and easy when the benefits are real (such as point of care patient research on vetted resources). (P)
171	33.	I am not sure why any of these changes are needed - all of these for the most part protect the integrity of the CME process. To make sure that physicians are held to a high standard for continuous education. While we should make CME more accessible - it's not by lowering our standards to earn CME. (P)
175	34.	Consider establishing flexibility around the 0.25 credit/15 minute time equivalency. New formats allow learners to learn more efficiently than in the past. For example, imagine two videos about CME posted on YouTube: one is a 55-minute webinar and one is a seven-minute tutorial (with a one-minute case study intro, infographics, animation). By the current standards, the seven-minute video would not even qualify for .25 credit, while the static webinar would be a full credit. Regrettably, today's physician would likely pass over the 55-minute webinar altogether in favor of the seven-minute quick bite of knowledge. Help us meet our learners where they are and get value for their efforts. (NP)
183	35.	thank you for deleting unnecessary requirements (O)
184	36.	consider allowing physicians to earn credits for completing activity-related assessments (especially given the new 'Achieves Outcomes' requirements to achieve Accreditation with Commendation from ACCME. Currently credits cannot be awarded for time spent completing an assessment. Response rates may increase if credit can be awarded for this task. (NP)
186	37.	Make as simple as possible. (P)
191	38.	I don't agree to some of the proposed changes but then our hospital is a small potato compared to others and it might benefit them more. (SP)
204	39.	In general the assessments of knowledge from multiple accredited CME providers to demonstrate effect of CME are of no value. They are at best rudimentary assessments and done only to fulfill the ACCME requirement. They should be eliminated. (P)
213	40.	The current approval cycle is too long. There are not good ways to adapt to rapidly changing situation where CME would be helpful to facilitate learning such as with crises involving ebola, zika, and opioids. / Good luck with this survey. Thank you for the work you do. (SCB)
221	41.	Many of the proposed changes weaken the integrity of the educational activities being accredited and the ability to measure their effectiveness. (P SCB)
222	42.	Clear expectations; flexibility and automation of CME credit with decreasing physician burden should be guiding principles. (P)

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226	43.	More clarification is needed to some of the proposed changes and what that means for CME providers and the physicians claiming credit. (NP)
227	44.	I think it is very positive, that the AMA and ACCME are working together on this initiative. It really makes sense. Thank you! (SP)
229	45.	These changes seem to open the door to a lower level of scrutiny and educational rigor for developing content and might be counterproductive. Hard to appreciate the edits without understanding how these protections will be maintained (NP)
230	46.	None (NP)
236	47.	The AMA PRA booklet no longer, to my knowledge, includes a requirement that physcians must be part of the target audience in order for an activity to be designated for AMA PRA Category 1 CME credit. This is frequently abused by providers who only target PAs and NPs, but designate their activities for AMA PRA credit. / / Other than that we support simplification to allow for more innovation in CME. (O)
242	48.	Glad to see this alignment coming about! (NP)
249	49.	Thank you for simplifying CME requirements. This is a significant improvement for the CME community. (O)
251	50.	For planning purposes, it would help to know when these proposed changes may go into effect. (NP)
254	51.	The more flexibility the better (SCB)
255	52.	Thank you for continuing to assess the requirements for educational activities and for the collaborative effects between AMA and ACCME. (SP)
259	53.	None (O)
260	54.	all in favor of flexibility for the approved provider and the ability to use blended learning experiences (SP)
261	55.	Thank you for the opportunity to review. (NP MO)
269	56.	Strongly support these changes and feel it will expand our opportunity to offer more meaningful CME (NP P O)
275	57.	The AMA should STRONGLY OPPOSE maintenance of certification, recertification, and other similar bureaucratic nonsense. (P)
276	58.	As noted, it would have been more helpful and meaningful if you gave details on the thinking behind these proposed changes (P)
278	59.	Physicians in academic environments can easily obtain ongoing education. The focus should be on physicians without such "automatic" access - to provide the means for them to remain up to date in their specialty so as to continue to provide high quality care. (P)
280	60.	Why isn't this addressed / / https://www.ama-assn.org/education/teaching-medical-students-residents (NP)
283	61.	great job (O)
285	62.	appropriate change (P)
290	63.	Unless I have misunderstood come of the proposed changes, in general, these proposed changes appear to simplify the processes for CME and that is positive. (P)
292	64.	None (NP MO P)
294	65.	Like them - thank you. (SP)
296	66.	Overall they seem very appropriate and do not appear to seriously complicate the process. (NP P)
301	67.	none (P)
305	68.	The AMA PRA guide has always been very easy to navigate but finding anything on the ACCME website is like running in circles. Please keep it simple and user friendly. Keep it all in on place, not do this and then have to dig to find another rule and oh there is another layer. We are all busy people who can do a better job with straightforward information. (SMS)
309	69.	reading all make me believe that those involved in writing the questions need to move to the future.... what is the future in medical education ... more fragmentation or more core based .... it seems they are still so back word in their orientation that there will not be any advances in med ed till we move out of the traditional med ed box... look at the products retail shops with out a basic sales (P)

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314	70.	Be sure to keep the FNP and PA in mind who need the credits as well. We all work together for the same purpose, to improve the health of all Americans and we need the credits too. (O)
322	71.	I commend the efforts by these organizations to make CME activities more beneficial in terms of verifiable learning outcomes. (CI)
325	72.	Will I receive CME credit for completing this survey (just kidding). (P MLB)
329	73.	These changes must be tried by all physicians. See how it turns out and put out report card in the following year! (O)
341	74.	Rules and regulations regarding CME have become cumbersome. Agencies that used to provide CMS occasionally no longer do because the of the expense required to fulfill requirements. The rules and regs should be clear, simple, concise, and evidence based. Administrative expenses around administering CME should be lessoned so that it becomes less of a business and less restrictive to those who still can provide intermittent valuable CME activities. (P O)
342	75.	Thanks for revisiting and simplifying (P)
345	76.	Support (P)
346	77.	have complete transparency of AMA - open your books to the public for criticism and evaluation of finances (P SMS)
353	78.	Streamlining it is a very wise idea. Thanks for the opportunity to take this poll. (P)
364	79.	Category 1 AMA credits can be applied to Maintenance of certification requirements (P)
366	80.	Rationale for some of these changes is not clear from the materials provided. Specifically, some of the deletions appear to introduce some risk of dilution of the desired activity, but it is unclear whether there is other context that protects the integrity of these activities. (NP P)
367	81.	The PI portion will not work well for those in private practice as it will be time intensive to perform chart reviews etc, also one will be dependent on an outside agency to evaluate the PI, much like JCHO such agenies will become a policing body not really adding meaningful content to patient care but rather coming up with burdensome regulations or requirements that are a result of people no longer involved in clinical care and whom pay no attention to the fact that they are the ones that contribute or rather cause the ever increasing cost of healthcare!! (P)
373	82.	Not yet. / But remember the explosion of material and records have decimated the enthusiasm to have conferences because their are too many that are not infected with enthusiasm. (MO P)
374	83.	None. (P)
385	84.	All seem very peripheral and not ground breaking (MLB)
387	85.	i think there should be more mechanisms for CME for things one learns from having learners in one's clinical setting. They ask me questions all the time i have to look up, and i learn from them daily. This would also encourage physicians to take more learners in their busy practices, if getting CME for it was fairly straightforward (P)
388	86.	If all format specific guidance is eliminated, does this mean as long as the activity meets the core requirements it may be certified? (NP)
398	87.	It is fine (P)
405	88.	N/A (SP)

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408	89.	The new “Other” activity format: / o AAFP strongly discourages AMA from creating a new activity format titled “other.” / ♣ The credit format and credit statements (which include the activity format) are designed to inform the learner and the end consumer of credit (State Medical Boards, SCBs, etc.). A format titled “other” does not inform the learner, or consumers of credit, what they can expect of the activity. / ♣ This new format will duplicate AMA’s existing formats, direct credit and AMA Category 2 credit. / ♣ The creation of a format titled “other” with no format specific requirements could lead to inappropriate activities being certified for AMA Category 1 credit, or credit that a learner could receive via other avenues (Direct credit or Category 2 credit), this may attribute to administrative complexity and burden for physicians/learners and CME provider organizations. / o The AAFP strongly encourages AMA to instead consider “Blended Learning” as a new activity type. This will recognize new types of physician learning where different formats are combined to offer one educational experience for a learner. / / Glossary Feedback: / 1. Knowledge - In reviewing the other outcomes definitions (competence and performance), we noticed that the knowledge definition, by comparison, was not focused on the evaluation of learners. / 2. In terms of Moore's outcomes, we noticed there were no definitions for patient outcomes or community health. / 3. AMA PRA CME Credit System - Unlike the definition of an accreditor, this definition does not describe what the AMA Credit System currently does. / 4. Committee learning includes the statement, "ACCME definition of CME"; since this is a joint glossary you might consider removing this statement or changing it to ACCME/AMA? (See similar statements in the outcomes definitions) / 5. Internet live activity - the example provided is "webcast". The AAFP Credit System defines a "webinar" as live activity. We define a "webcast" as an Enduring Material. From our perspective webinar's are in real time and provide opportunity for live interaction with faculty. Webcasts are typically a recording of the webinar and can be accessed on-demand by learners and does not allow real time interaction with faculty. / / ACCME and AMA Activity Format Alignment / o This proposal does not address the lack of alignment between ACCME and AMA’s existing formats. For example, what AMA lists as “live,” ACCME lists as “course.” We recommend the ACCME/AMA Bridge Committee review and align formats to reduce administrative burden and complexity for CME provider organizations. (NP O)
410	90.	I don't understand the reasoning for some of the questions. I think there needs to have a follow up document that explains these changes a little better (P)
413	91.	Board MOC is expensive and usually not clinically useful ! (SCB)
421	92.	I support any measures that might make this labor-intensive, confusing process more user friendly for CME programs. (P)
425	93.	Again, consider rigidity of implementation when balanced with reality of both physician time and money and true validity of rigid process to affect a better outcome. (P O)
427	94.	Fire the whole ACCME, or have competition. Same thing goes for ABMS and its subsidiary organizations. They are out there to make money under the rubric of professionalism, altruism, you name it, NOT for the profession. (P)
439	95.	It is good and proper that the AMA is codifying the rules on getting CME credits in our ever-changing world of medicine. (NP SP P SMS)
445	96.	None (O)
447	97.	Enduring Materials - if test is deleted, how do we know if learners really participated? (SP)
448	98.	the way they are presented here is not clear as to what is added and what deleted. A true red-line version would be very helpful in completing this survey (NP MO P)
453	99.	I wonder if a pilot project would better inform these changes rather than 'jumping into the deep end'? (NP P)
456	100.	not change them (P)
465	101.	none (P)
467	102.	The proposed changes provide for consistency across all education formats while encouraging innovation and change. (NP SMS)
468	103.	Thanks for the opportunity to comment. (NP P)
470	104.	none (NP P)

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478	105.	It seems that some of the format labels are being kept and other completely eliminated. How will this impact the designation statement provided to learners? I would propose eliminating all of the format labels and referring to all offerings as "accredited CME activity" or something along those lines. (NP)
479	106.	Seems like you are simplifying this, which is typically a good idea. (P)
483	107.	This is an important and thoughtful attempt to simplify the current requirements to simplify the system without a loss of focus on learning and continuous improvement as the primary goal. (P O)
485	108.	What is missing is a means for MD's teaching in medical school and post grad environments to receive CME for their lectures. (P)
487	109.	all stress is on knowledge as a surgeon judgment , self interest and competence need to be part of the metric for CME (P)
493	110.	What is the overall plan and what do you plan to implement to replace the deleted formatting requirements? / (SP P)
496	111.	I would like another opportunity to provide feedback on the next version. It is invaluable to have well-written documents that are clear and unambiguous. Providing a time-limited opportunity for final comments would save a lot of confusion, added work, etc. (P)
500	112.	As I represent an organization that strictly provides only live events, much of this survey was about activities that I don't have to facilitate. However, I can't help mentioning that if you are trying to make things easier for CME providers, I am all for it. I do worry at times - and I must fulfill requirements for a number of CE accrediting organizations - that the documentation requirements will eventually exceed the human resources allocated to fulfill them, especially forr tiny, rural health care settings, but who in very good faith, want to provide CME and CE opportunities for both staff and community, but feel buried by the paperwork and redundancies. Thank you then for trying to simplify things. (NP)
501	113.	None (P)
508	114.	ACPE is pleased with the proposed changes for accredited CME activities certified for AMA PRA Category 1 Credit. These requirements are very similar to ACPE Standards for Continuing Pharmacy Education. ACPE-accredited providers are required to plan an activity that addresses a specific practice/skill gap and underlying need, utilize this information in the development of a CPE activity appropriate for the target audience, including the creation of specific learning objectives, educational content, and the rationale for the designated activity type (e.g., knowledge, application, or practice). Delivery within our standards includes appropriate faculty guidance with inclusion of active learning methodologies, applicable instructional materials, and an opportunity for the learner to assess what has been learned with appropriate feedback. And, obviously, that this information is planned and presented in accord with the Standards for Commercial Support. We hope these proposed requirements are accepted. It will allow collaboration amongst CE providers to provide innovative and effective continuing education opportunities for healthcare professionals. (O)
514	115.	Pleased to see this effort to streamline medical educational process (NP)
517	116.	Physicians appreciate simple straightforward processes. (SMS)
518	117.	Overall, we are very pleased with the effort to simplify activity types and streamline the acceptance process. We do remain concerned that the assessment you require is specifically asking for a test for each session. If that is the case, it will be unworkable for large meetings causing our member to lose access to a large number of CME credits. (NP)
519	118.	none (P)
520	119.	We think these changes are great, and will help to simplify the CME process. (NP)
522	120.	none (SP)
523	121.	I've made my key points on previous pages. Thank you for providing this opportunity to comment on your proposal. (NP P)
524	122.	Reading of the proposed changes, it seems the focus is overall simplification and condensing the requirements to the core essentials which apply to ALL formats. If this is not the intention then please email me! (SMS)
527	123.	No (SP)
529	124.	Add CME credit for review of AMA's Morning Rounds. (P)

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532	125.	What changes will be made to the credit designation statement? With more innovative formats in CME/CPD being developed, it would be preferable for the credit designation statement to state that the provider designates "the educational activity" for credit vs. distinguishing specific formats, since some may be in an "other" format. However, if formats will continue to be specified in the credit designation statement, how would an "other" activity be listed? (NP)
533	126.	CAFP strongly discourages AMA from creating a new activity format titled "Other." The credit format and credit statements (which include the activity format) are designed to inform the learner and the end consumer of credit (State Medical Boards, SCBs, etc.) regarding the format of the activity. A format titled "Other" does not inform the learner, or consumers of credit, what they can expect of the activity. This new format duplicates AMA's existing formats available via: AMA Direct Credit and AMA PRA Category 1 and 2 Credit™. The creation of a format titled "Other" with no format specific requirements could also lead to inappropriate activities being certified for AMA PRA Category 1 Credit™, or credit that a learner could receive via alternative avenues (Direct credit or AMA PRA Category 2 Credit™), this may attribute to administrative complexity and burden for physicians/learners and CME provider organizations. CAFP encourages AMA to instead consider "Blended Learning" as a new activity type. This will recognize new types of physician learning where different formats are combined to offer one educational experience for a learner. / (NP O)
534	127.	I appreciate the flexibility and standardization these changes are designed to provide. (NP)
536	128.	SIMPLIFY ALL THE PAPER WORK. / DECREASE THE NUMBER OF QUESTIONS. (SMS)
538	129.	We thank the AMA and the ACCME for their efforts to align and simplify the requirements for ACCME-accredited activities eligible for AMA PRA Category 1 Credit and will look forward to seeing the impact of these modifications on the frequency with which these formats are employed by CME providers and learners in the future. (NP MO P)
539	130.	It would be helpful for the AMA to confirm that this new proposal essentially creates the opportunity for accredited providers to offer an "other" format; and that the existing types of designated activities and how credit should be assigned to them as not changed? Or if this simplification and alignment proposal would alter existing formats (e.g., Faculty credit – awarding 2 credits for every hour of presentation at a live CME activity; Manuscript Review – 3 credits per accepted manuscript review)? / / What, if any, impact would accepting this proposal have on the AMA Credit Designation Statement? Would a provider simply note "other" as the [learning format] within the statement? / / What, if any, impact would accepting this proposal have on activities for which Category 1 credit is awarded directly by the AMA (e.g., publishing articles, poster presentations, etc.)? Would accredited providers now be able to award CME credit directly to physician learners provided the activity is structured to abide by the 7 core requirements within the proposal? (NP)
542	131.	This is all great. Thank you for doing this. It would be even better if the two organizations were so in sync that ACCME providers would not even need to refer to AMA rules. In other words, anything the AMA required would simply be in the ACCME rules. For new staff, it is confusing to have two sets of rules. (NP)
543	132.	Thank you for working toward alignment and simplification. / (NP)
605	133.	Thank you for your willingness to vastly improve these requirements! (NP)
709	134.	The proposed changes will allow more flexibility for the planning and delivery of high quality CME. (NP)
770	135.	Make CME easier and not so burdensome (P)

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Q9 – Comments on the Glossary

Comments related to the Glossary		
4	1.	None (P)
9	2.	It seems comprehensive and appropriate. (P)
12	3.	Too early in the process (NP SMS O)
16	4.	Very complete and probably too many items listed but necessary (P)
28	5.	Seems very comprehensive (P)
42	6.	I'm not clear on what has been added, deleted or modified from the glossary. I saved and printed it. I find it a valuable reference tool. (SP)
43	7.	Lots of technical terms. Key attributes of CME are insulation from excessive commercial input, balance of content to reflect needs of most learners, honest review of both positive and negative attributes of products/tests/algorithms, and ability of learners to clarify their knowledge by asking questions. (P)
49	8.	Too many administrative tasks and costs involved with CME (P)
57	9.	"learning from teaching" is ambiguous and what you really mean is "teaching preparation" (P)
62	10.	"commercial bias" needs a better definition: "...promotes the products or business lines of an CI". Need a definition of what qualifies as "promotes". If there is a drug that does a good job and I said that during an activity, would that be labelled as promoting and commercial bias? Read a definition of bias as "unfounded personal belief". Maybe adding "unfounded" (or unsubstantiated?) to the definition would help. "...an unfounded promotion of the products or business lines of an CI." / Also, because you list products and business lines as plural, does that mean it's not bias if I'm only talking about one specific product? (NP)
63	11.	already embedded my comments (NP P O)
66	12.	I see the ACCME and ABIM as self perpetuating for the Staff and member organizations. They make money and cost too much to get CME. (P)
73	13.	The glossary of terms is too extensive and too hair splitting - I recommend simplifying - to assure that AMA Requirements are Assured and Authentic by ANY institution and ALL institutions - make this crystal clear - make it fraud-resistant - make any CME valid and authentic and REAL. (P)
84	14.	None (O)
87	15.	INTERESANTE (MO P O)
93	16.	Apparently a necessary evil.... (NP MO P)
96	17.	The focus on commercial sources of conflict of interest fails to deal with academic sources of conflict of interest. For example a medical school faculty member may depend very heavily on Grant support for research in a given field. This may lead to bias in a presentation. Current approach his place heavy emphasis on identifying commercial sources – but do not deal with academic sources very well. (P)
107	18.	Very useful guide (NP P)
112	19.	It's clear, don't know if it's necessary. (P)
113	20.	It seems clear. It makes sense to consolidate the glossary. (SP)
121	21.	a lot of effort has been put interactivity which is will clear evidence of its value to practitioners. It will be far better to provide and epidemiologic analysis of individual practitioners practice and get their assessment of those activities that occur frequently and strengthen the skills for those activities. This should be a partner shaped effort rather than bureaucratic top-down effort (NP SP MO P)
123	22.	The term "jointly provided" is confusing when you are a Joint Accreditation provider. Wish that could be changed to something that doesn't involve the word "joint." (NP)
130	23.	none (P)
131	24.	None (SMS)

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136	25.	none (P)
138	26.	A few moments? This glossary is long. If there are important areas to review, please let me know, but truthfully I don't have time to inspect it right now. (P)
139	27.	None (P)
140	28.	This appears to be a nice comprehensive glossary of terms (O)
152	29.	I could not get this to open. (SP)
164	30.	None, excellent. (P)
171	31.	none (P)
174	32.	Seems Reasonable. (P)
181	33.	Looks good. (P)
182	34.	No commments (SP)
191	35.	No comments at this time. (SP)
209	36.	No comments (SP)
211	37.	None (SCB)
219	38.	Reviewed no suggestions for change (SCB)
221	39.	NONE (P SCB)
225	40.	It's fine (O)
227	41.	Incredibly helpful to have everything spelled out! I have a brand new CME coordinator starting next week, and this will be so useful - thank you! (SP)
230	42.	None (NP)
248	43.	None (O)
251	44.	It would help to see the former and proposed glossary side by side, or with track changes, so we can see the differences. (NP)
254	45.	N/A (SCB)
258	46.	Under the PARS entry, include the acronym MOC in parentheses after Maintenance of Certification, since people often go to the glossary to see where MOC fits into ACCME. (NP)
259	47.	none (O)
261	48.	I would suggest including a definition for Joint Providership. Although “jointly provided activity” is defined the providership relationship is not, which is one that trips up non-accredited organizations. / / You may also want to consider including a basic definition of Maintenance of Certification (MOC). (NP MO)
262	49.	The glossary is complete and appropriate. (P)
278	50.	None (P)
292	51.	Excellent and clear piece (NP MO P)
293	52.	A (P)
302	53.	None. (SMS)
305	54.	Get rid of things that say see... such as activity - see CME activity. Just call it activity. / Documentation review - that is what it is, call it that - Performance in Practice review get rid of wordy spurious phrases. / Just use provider - no see accredited CME provider - the rest is given in the definition. There are a few of those. I can't say it enough, keep it simple. (SMS)
309	55.	you be my guest.... (P)
314	56.	Other learners should include FNP and PA as well. (O)
325	57.	None (P MLB)

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334	58.	Uncertain of some of the new definitions and what the impact of these definitions have on our activity design, particularly knowledge, competence and performance. (NP)
342	59.	None (P)
345	60.	None (P)
352	61.	none (NP)
353	62.	Thank you (P)
370	63.	A 10 page glossary shows how out of control and bureaucratic this whole process has become. (P)
371	64.	none (MLB)
374	65.	None. (P)
378	66.	Good as is. (NP)
388	67.	The term committee learning is confusing. Perhaps peer-to-peer discussion or small group discussion would be better. / / Enduring material and enduring internet material could be combined into just enduring material (NP)
392	68.	I appreciate the efforts of both organizations to harmonize the CME environment to ensure clear understanding and high-quality results. (NP)
398	69.	These are fine (P)
405	70.	It appears comprehensive and clear in content. (SP)
408	71.	Glossary Feedback: / 1. Knowledge - In reviewing the other outcomes definitions (competence and performance), we noticed that the knowledge definition, by comparison, was not focused on the evaluation of learners. / 2. In terms of Moore's outcomes, we noticed there were no definitions for patient outcomes or community health. / 3. AMA PRA CME Credit System - Unlike the definition of an accreditor, this definition does not describe what the AMA Credit System currently does. / 4. Committee learning includes the statement, "ACCME definition of CME"; since this is a joint glossary you might consider removing this statement or changing it to ACCME/AMA? (See similar statements in the outcomes definitions) / 5. Internet live activity - the example provided is "webcast". The AAFP Credit System defines a "webinar" as live activity. We define a "webcast" as an Enduring Material. From our perspective webinar's are in real time and provide opportunity for live interaction with faculty. Webcasts are typically a recording of the webinar and can be accessed on-demand by learners and does not allow real time interaction with faculty. (NP O)
427	72.	A solution to end this madness of CME (P)
430	73.	The glossary is helpful. When I began in CME I suggested this, because there are so many unfamiliar terms. This is a good idea and one that should be well publicized. (NP)
431	74.	I have not additional recommendations or comments. (SP P)
438	75.	I really don't have an issue to current CME processes. (P)
439	76.	none (NP SP P SMS)
442	77.	Very good reference. Thank you. (NP)
443	78.	The term "physician learners" should not be limited to MDs or DOs because contiuing education programs may attract a broader audience of "learners." Even if those learners might not all qualify for PRA Category 1 credit, they should not be educated differently or provided fewer protections than the MDs and DOs attending the activity.. / (P)
445	79.	None (O)
465	80.	none (P)
468	81.	It will be helpful for those who are confused by our terminology. (NP P)
470	82.	none (NP P)
478	83.	The distinction between "certified" and "accredited" CME seems unnecessary, and the definitions provided in the glossary are different than those I'd heard in the recent past. I think it's addressing a technical concept that isn't meaningful to learners. Given the current move toward simplification and alignment could this be addressed as well? (NP)
479	84.	Pretty dense, but that's probably unavoidable. (P)

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481	85.	Thorough glossary (O)
482	86.	read the others (P)
483	87.	There is a standard definition of competence that is different than the one proposed in the glossary. I would encourage you to examine the alternatives as competence is always judged in a specific context at a specific point in time. / / Conflict of interest may be broader than the influence of financial relationships. The Cologne Consensus conference in 2015 proposed a definition of conflict of interest that may be worth considering / / Is enduring material an activity or a resource? / / Co-provider and jointly provided are very similar and could be easily combined as two or more providers -one of which must be an accredited CPD provider organization / / (P O)
484	88.	Thanks. Great to have these in one place. (NP)
485	89.	None (P)
487	90.	the system need a revamp , by physicians in the field taking care of patients more than by bench specialists (P)
490	91.	None (P)
493	92.	Definitions look fine. Consistency between the two organizations will be very helpful. (SP P)
496	93.	ACCME Recognized Accreditors add "and" i.e. "ACCME requirements and the Markers of Equivalency." Accreditation interview - delete comma after "requirements" ARC - ACCME Decision Committee is never defined. Accreditation statement: semi-colon should be a colon. Accreditation with Commendation - semi-colon should be a comma. Accredited CME provider - would change to " ... accredited to provide certified continuing medical education." AMA House of Delegates - delete comma after "year" AMA PRA Category 1 Credit - State/Territory Medical Society should be all lower case. AMA PRA Category 2 Credit - delete semi-colons and "and" and just make commas, i.e. ...definition of CME, comply with ...., are not promotional, and the physician finds to be .... CME credit - would suggest delete "currency" since it means money and instead use "numerical value" i.e. "The numerical value assigned to CME activities. In-kind commercial support - would include that food is not considered an acceptable "in-kind" support and is prohibited from commercial entities. Commonly, as in disasters or for charities, in-kind support frequently includes food. Competence - would add the word "ability" or "skill" to explain the use of this word in CME argot. Financial relationships - this needs to be defined here and not conflated with relevant financial relationships which are defined as those that are a COI. Here is where it would help to separate financial relationships as "those relationships in which the individual benefits by receiving salary, ..." The on-going confusion with all the regular newbies to CME is that there is confusion about disclosing just those financial relationships that are a COI - i.e. a relevant financial relationship - and disclosing all financial relationships with any defined commercial interest. (P)
498	94.	The glossary seems comprehensive and helpful. (O)
504	95.	Very long glossary which makes me think that the system or language could be simplified. (O)
508	96.	No comments. (O)
517	97.	thorough (SMS)
520	98.	The glossary is a nice document to have for reference purposes and will be a useful guide going forward. (NP)
522	99.	Glossary is thorough and adequate (SP)
523	100.	1. Like the option for Committee Learning. Is this a new or existing format? / 2. The definition of "Knowledge" doesn't make sense to me. / 3. Learning from Teaching - Is this a new or existing format? / 4. A definition for "Professional Practice Gap" seems needed if this is a concept that factors into the standards for developing accredited CME (NP P)
527	101.	No (SP)
529	102.	0 (P)
532	103.	It would be beneficial to organize the extensive items in the glossary by category, such as ACCME accreditation processes and procedures, ACCME accreditation requirements, AMA PRA requirements, and general terms. / / Please clarify the definition of an internet enduring material, as it currently states no time is specified for participation. However, providers designate credit for enduring materials based on the estimated time to complete them, with learners claiming credit commensurate with their participation. / / Please clarify in the definition of a jointly provided activity that the non-accredited organization cannot be a commercial interest. (NP)

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535	104.	acceptable (P)
536	105.	NONE (SMS)
539	106.	Regarding the 'shared glossary of terms and definitions' it would be helpful to confirm which definition is the AMA/ACCME definition of CME. Is it accredited CME? Certified CME? Continuing Medical Education (CME)? Having multiple "CME" definitions included in this glossary may contribute to confusion in trying to abide by Core Requirement #1 if the definition being referred to is not specified. / / It would be helpful to add "assessment" to the 'shared glossary of terms and definitions' to set parameters of what's expected generally to adhere to Core Requirement #6. (NP)
540	107.	Possibly include terms such as 'educational design', 'educational intervention', 'learning methodology', 'scope'. (NP)
543	108.	Council on Ethical and Judicial Affairs (CEJA): Will the definition change considering Core Requirement Item 6? (I do not think this should change.) / Internet Point of Care (PoC) learning: This definition would change if all format requirements are deleted. / Other learners: I find this definition confusing considering interprofessional education includes "other learners" from inside the US. (NP)
709	109.	Shared Glossary of Terms is clearly written. The AMA PRA Booklet has not been updated for many years. Does the AMA plan to update it soon? (NP)
886	110.	N/A (O)

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