Interim Report of the FSMB Workgroup on Emergency Preparedness and Response

INTRODUCTION

The Workgroup on Emergency Preparedness and Response (the "Workgroup"), which is chaired by Dr. Walker-McGill, began meeting in May 2020 to discuss the experiences and lessons learned from medical boards (and other health professional regulatory boards, such as nursing and pharmacy) during the COVID-19 pandemic, identify key learnings and best practices, and consider potential recommendations for the ongoing crisis and to better prepare for future pandemics.

BACKGROUND

In February of 2020, the Chair of the Federation of State Medical Boards (FSMB) at the time, Scott Steingard, DO, created an Ad Hoc *Task Force on Pandemic Preparedness,* chaired by FSMB CEO Humayun Chaudhry, DO, MS, to begin addressing the potential needs of state medical and osteopathic boards ("medical boards"), related to medical licensure and regulation, and the U.S. healthcare workforce in the face of a possible pandemic due to the SARS-CoV-2 virus. The novel virus had been identified in Wuhan, China by the World Health Organization (WHO) in December 2019 as the cause of coronavirus disease 2019, also abbreviated COVID-19. On March 11, 2020, the WHO declared COVID-19 a global pandemic[1] and two days later, on March 13, 2020, President Donald Trump declared COVID-19 a national emergency in the United States.[2] Emergency declarations by governors in all U.S. states and territories followed shortly thereafter, resulting in widespread adoption of licensure waivers and modifications to enable and expand licensure portability, increase access to care (for in-person care and telemedicine) and expand healthcare workforce capacity.[3] As the impact of COVID-19 continued into May 2020, FSMB's new Chair, Cheryl Walker-McGill, MD, MBA, transformed the *ad hoc* task force into the *Workgroup on Emergency Preparedness and Response.*

The Workgroup has held Zoom conference meetings almost every three weeks to identify challenges and concerns facing medical boards. The Workgroup will continue to meet in the coming year and offers the following interim report and recommendations to be utilized during this COVID-19 pandemic and for future public health and national emergencies that may develop. The Workgroup may bring additional recommendations for consideration next year, including for other types of national emergencies, as the COVID-19 pandemic continues into 2021.

WORKGROUP CHARGE

The *FSMB Workgroup on Emergency Preparedness and Response* is charged with:

1. Coordinating and working with external stakeholders including but not limited to representatives from Administrators in Medicine (AIM), the National Association of Boards of

[1] The Director of the World Health Organization announces the designation of COVID-19 as pandemic.
[2] President Donald Trump issues a Proclamation on Declaring a National Emergency Concerning the Novel Coronavirus Disease (COVID-19) Outbreak.
[3] Information detailing state licensure modification and waivers during the pandemic is available on FSMB's COVID-19 Site.

Pharmacy (NABP), the National Council of State Boards of Nursing (NCSBN), the Emergency Management Assistance Compact (EMAC), and the federal government; [4]

2. Collecting and evaluating federal and state[5] experiences and outcomes in response to the national emergency caused by the COVID-19 pandemic, including those measures related to expedited medical licensure and other means of mobilizing and expanding the healthcare workforce and its resulting impact on the quality of, and access to, health care;
3. Evaluating existing policy resources including, but not limited to, the FSMB's policies related to telemedicine, physician wellness, and emergency licensure to identify and recommend policy modifications applicable in times of a public health and/or national emergency;
4. Identifying and recommending critical data elements and regulatory safeguards to ensure the integrity of the deployed health professional workforce during a public health and/or national emergency;
5. Evaluating the capacity and readiness of the FSMB's Physician Data Center and other national databases to support the deployment of the healthcare workforce, both in person and through telehealth, in response to a public health and/or national emergency; and
6. Developing recommendations for universal tools and resources that could be used by state and federal agencies to efficiently and safely mobilize and expand the healthcare workforce in response to a public health and/or national emergency.

WORKGROUP PROGRESS & RECOMMENDATIONS TO DATE

Since May 2020, the Workgroup has heard presentations from a number of speakers, including from several outside experts, and discussed the current national and international status of the COVID-19 pandemic; ongoing state and federal response efforts; statistical information related to cases, transmission rates and fatalities; and available updates on vaccine development and administration. The Workgroup used its frequent meetings to identify and discuss the most pressing issues that have arisen, including the application of state and federal Executive and Emergency Orders, the rapidly changing landscape of utilization and regulation of telehealth, the impact of health inequities that the pandemic has underscored, the need to address the spread of misinformation that poses a challenge to public health-focused harm-reduction strategies, and the challenges faced by state medical boards in transitioning work to a remote environment.

The Workgroup has identified several pressing issues that are discussed below and offered several recommendations for further action.

Section 1. Verification of Provider Identity in a Public Health Emergency

At one point or another during the COVID-19 pandemic, all states and territories felt the need to issue temporary emergency waivers and modifications related to licensure requirements to meet surges in

[4] This primarily includes agencies within the U.S. Department of Health and Human Services.

[5] "state" to include state and territorial medical and osteopathic boards, state emergency services offices, departments of public health, and other health professional regulatory boards, including nursing and pharmacy.

healthcare workforce demands.[6] These modifications ranged from the creation of expedited licensure pathways to full waivers of state licensure requirements for certain practitioners with an active license in another state/jurisdiction.[7] As these waivers were put into place, the FSMB's board of directors and senior staff recognized there was a dearth of guidance for rapidly mobilizing the healthcare workforce on a national scale and released its *Recommendations for Medical License Portability During the COVID-19 Pandemic.* These timely recommendations outlined critical licensure portability elements that "contain safeguards that ensure that care being provided balances public health with public safety," including steps that need to be taken to confirm practice eligibility, verify licensure, limit duration, and require documentation of all provider-patient interactions.[8]

The Workgroup discussed the implementation of waivers and modifications and agreed that while enhanced workforce mobility during a public health emergency may be needed to provide necessary patient care, it remains critical that the identity and licensure status of health care practitioners is verified prior to allowing them to provide health care services to patients. The Workgroup identified challenges states were experiencing in conducting and coordinating the necessary verifications in an expeditious manner. In addition to managing large numbers of volunteer applications, particularly in so-called COVID-19 "hot spots," some states also faced challenges in coordinating verification efforts and activating or utilizing existing verification and mobility resources. As one example, the Emergency Management Assistance Compact (EMAC),[9] which has been adopted as law in all U.S. states, territories, and the District of Columbia, was not immediately activated and utilized in all jurisdictions during COVID-19. The Emergency System for Advance Registration of Volunteer Health Professionals (ESAR-VHP),[10] a federal program designed to assist with verification of volunteers' credentials during disasters and was also created prior to COVID-19, was not utilized across all states at the onset of the pandemic.

Early in the crisis, the Workgroup decided to appoint a subcommittee to reach consensus on those critical data elements that could support a uniform approach to verifying the identity and licensure status of volunteers offering their services across state or territorial boundaries in an emergency. In addition to identifying these data elements, the Workgroup served as a resource for the development and implementation of *ProviderBridge.org*, which was created by the FSMB with funding through the Coronavirus License Portability Grant Program of the Health Resources and Services Administration.[11] The *ProviderBridge.org* platform streamlines the process for mobilizing licensed health care professionals during a national emergency such as COVID-19 and is designed to be useful for future national public health emergencies, as well."[12] The platform offers a customer service hub that contains resources for

[6] *See* FSMB's COVID-19 Website.
[7] State-specific information available in FSMB's chart titled *U.S. States and Territories Modifying Requirements for Telehealth in Response to COVID-19*.
[8] FSMB Recommendations for Medical License Portability During COVID-19 Pandemic.
[9] Additional information on the *Emergency Management Assistance Compact* is available at: https://www.emacweb.org/
[10] Additional information on the Emergency System for Advance Registration of Volunteer Health Professionals is available at: https://www.phe.gov/esarvhp/pages/about.aspx
[11] Provider Bridge is supported by the Health Resources and Services Administration (HRSA) of the U.S. Department of Health and Human Services (HHS) under Grant Number H7F-RH-37568 (Coronavirus License Portability Grant Program).
[12] Additional information on *ProviderBridge* is available at: https://www.providerbridge.org/

providers and others seeking to navigate current state licensure requirements, including those specific to telehealth, during these states of emergency.

In addition to the deployment of licensed health care providers across states, the Workgroup discussed the role of medical students, residents and other health care trainees to address workforce capacity during the COVID-19 pandemic. In some cases, fourth year medical students were given the option of early graduation to provide additional capacity for care in heavily impacted regions of the country. Resident physicians were also deployed to assist during the pandemic, oftentimes in areas outside of their accredited GME program. A physician in her 5th year of training as a fellow in cardiology, under a type of scenario that was deemed acceptable by the Accreditation Council for Graduate Medical Education, could spend the bulk of her time engaged in supporting patients in a medicine inpatient unit. The need for additional health care capacity led to at least 22 states approving pathways to practice for early medical school graduates via temporary permits or emergency licenses. In some states, such as New York, early graduates were given the title of "COVID-19 Junior Physician" to distinguish them from residents and fellows in training. The availability of early graduates prompted national medical organizations, such as the Association of American Medical Colleges and the American Association of Colleges of Osteopathic Medicine, to begin discussing the types of guidance and resources that would be needed for early graduates and residents, including training and oversight.[13] The Workgroup noted that while these efforts may be necessary in emergencies, it is critical that early graduates, resident physicians and other health care trainees be appropriately supervised and mentored for their safety and that of patients.

Section 2. Utilization of Telehealth During Public Health or National Emergencies

Enabling continuity of care across state lines can be a major concern during a national health emergency, particularly when travel restrictions are in place that limit travel. Particularly in non-emergency times, continuity of care can be an issue for patients who need to travel to see their healthcare providers. This has already led to several states addressing the issue through adoption of legislation or an Executive Order[14] and has also been a major focus of legislative efforts at the federal level during COVID-19. University students who were unable to access their university health care providers, particularly for mental health treatment, received the attention of policy makers due to the lack of clarity of state requirements regarding access to care across state lines. Healthcare systems took advantage of the relaxed licensure restrictions to take care of their patients with chronic conditions remotely, reducing the potential for exposure for their most vulnerable patients. However, policy inconsistencies among the states for remote access has been cited as problematic, leading to a call by some policy makers to address

[13] Information on these issues has been made available by the American Medical Association, the Association of American Medical Colleges (AAMC), the American Association of Colleges of Osteopathic Medicine (AACOM), and the Accreditation Council for Graduate Medical Education (ACGME). The Coalition for Physician Accountability's Statement on *Maintaining Quality and Safety Standards Amid COVID-19* and additional consensus statements issued during the COVID-19 pandemic are included in Appendix A.

[14] For example, legislation enacted in New Jersey ensures that out-of-state healthcare practitioners may continue to provide telemedicine to New Jersey residents until 90 days following the public health emergency (S. 2467). In Virginia, Executive Order 57 allowed health care practitioners with an active license issued by another state to provide continuity of care to their current patients who are Virginia residents through telehealth services.

license portability across state lines more uniformly and definitively during COVID-19 and future similar public health emergencies.[15]

Telehealth has been broadly used during the COVID-19 pandemic to address access to care, at one point surpassing all ambulatory in-person visits in the United States. Among its many uses, telehealth enabled providers to prevent potentially exposing patients and themselves to COVID-19 as would occur during in-person visits. In late March of 2020, the Center for Medicare and Medicaid Services (CMS) utilized its ability under section 1135 of the Social Security Act (1135 Waivers) to expand the list of reimbursable telehealth services and remove the state-based licensure requirement for reimbursement when providing telehealth across state lines during a public health emergency.[16] Many different technology platforms and modalities were deemed acceptable during the pandemic for delivering telehealth. For example, audio-only encounters have been widely utilized during COVID-19,[17] and providers have highlighted the need for audio-only visits for those patients without access to smartphones, computers, or broadband internet access. Audio-only has been temporarily reimbursed at the national level to account for this utilization.[18] Store-and-forward, new technology platforms (i.e. *FaceTime*, *Skype*, *Zoom*), and other online means may need to be available during emergencies in the future but patient privacy concerns will need to be addressed in all of them. When retrospective data from the COVID-19 pandemic are made available, successful and appropriate forms of telehealth will need to be identified and evaluated to increase access to care as needed during future emergencies.

Nearly all U.S. jurisdictions created mechanisms during the COVID-19 pandemic to allow for the practice of telehealth across state lines in order to provide timely, safe and robust health care during pandemic surges.[19] The variability by jurisdiction for licensing waivers and processes, however, created confusion for some physicians and regulators.[20] The Workgroup concurred that there is value in the development and promulgation of model state legislative language on the use of telehealth during a public health emergency. Such model language should address the following:

- Intent of the Executive/Emergency Order
- Scope and Duration of the Executive/Emergency Order

[15] In response to these concerns, legislators introduced the *Temporary Reciprocity to Ensure Access to Treatment (TREAT) Act* (S. 4421, H.R. 8382) with bipartisan support to allow health care professionals to provide in-person and telehealth services in any jurisdiction based on their authorization to practice in any one state or territory during a public health emergency.

[16] A summary of the COVID-19 Emergency Declaration Blanket Waivers for Health Care Providers is available at: https://www.cms.gov/files/document/summary-covid-19-emergency-declaration-waivers.pdf

[17] Several states explicitly allowed the use of audio-only telemedicine encounters during the emergency. *See* CT Executive Order 7G, Delaware legislation (H.B. 348), Iowa Emergency Declaration, and Montana directive on expanded telehealth.

[18] The CMS list of covered telehealth services for the COVID-19 pandemic is available at: https://www.cms.gov/Medicare/Medicare-General-Information/Telehealth/Telehealth-Codes

[19] *See* FSMB's chart *titled U.S. States and Territories Modifying Requirements for Telehealth in Response to COVID-19*.

[20] State medical boards have already recognized the need for some uniformity during emergencies. *See* Resolution 19-4: Emergency Licensure Following a Natural Disaster.

- Language providing the jurisdiction in which the patient is located with the ability to verify a provider's identity, investigate complaints, and take disciplinary action against a provider's license in the jurisdiction, when warranted
- Language clarifying that laws of the state where the patient is located will apply for health care providers practicing across state lines
- Clarification regarding remote care where there is an existing physician patient relationship

FSMB policy affirms that the standard of care is the same regardless of a platform, modality, in-person or virtual. The Workgroup agreed that this policy should apply to emergency situations, as well.[21]

Section 3. Commitment to the Utilization of Scientific Evidence

The Workgroup has repeatedly discussed the importance of scientific information in combatting a pandemic. Throughout the COVID-19 pandemic, there have been national and international concerns about the spread of false or misleading information undermining containment efforts and endangering public health. The widespread promotion and sharing of misinformation have often occurred on social media and other platforms, at times by licensed professionals, prompting national organizations to affirm the importance of scientific evidence when combatting a global pandemic.[22]

There have been reports of health care providers ignoring scientific evidence regarding the treatment and/or mitigation of COVID-19. A survey of state medical boards found that 64% of respondents confirmed that they had received complaints of physicians failing to wear face coverings during patient encounters. Accordingly, the FSMB's Ethics and Professionalism Committee, chaired by FSMB Board Member Jeffrey Carter, MD, considered the matter and prompted the FSMB's Board of Directors to issue a public statement that "(w)earing a face covering is a harm-reduction strategy to help limit the spread of COVID-19, especially since physical distancing is not possible in health care settings. When seeing patients during in-person clinical encounters, physicians and physician assistants have a professional responsibility to wear a facial covering for their own protection, as well as that of their patients and society as a whole."[23]

Section 4. Combatting Racial and Ethnic Disparities in Healthcare and Public Health Emergencies

Racial and ethnic disparities in healthcare have historically been underscored and exacerbated during public health emergencies, and this has been the case with the COVID-19 pandemic.[24] The principle of justice dictates that all patients deserve equal consideration and equitable provision of care according to their individual needs. The failure to provide care according to patient needs puts patients at risk. As such, state medical boards have a role in addressing health inequity during emergency and non-emergency times.

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[21] The FSMB's *Model Policy for the Appropriate Use of Telemedicine Technologies in the Practice of Medicine* identifies the need for a consistent standard of care "notwithstanding the delivery tool or business method in enabling Physician-to-Patient communications," at page 2.

[22] *See* Coalition for Physician Accountability's *Statement to Safeguard the Public, Protect our Health Care Workforce during the COVID-19 Pandemic.*

[23] FSMB Statement on Wearing Face Coverings During Patient Care.

[24] *See* American Medical Association's COVID-19 Health Equity Resources.

The Workgroup heard presentations from esteemed scholars with expertise in health equity addressing the root causes of health disparities, health inequity in Community Health Centers, the historical context of inequality in healthcare, and potential resources and strategies that may be used to identify discrimination and systems that exacerbate inequities. These presentations and the diligent Workgroup discussion that followed highlighted the fact that health inequity goes far beyond the scope of the COVID-19 pandemic, and that data related to race, ethnicity, and other risk factors must inform any strategy for addressing it. The Workgroup recognized the lack of data collection in these areas and limited availability of existing data during the pandemic.

The Workgroup acknowledges the systemic causes of many health disparities and recognizes the important role that state medical boards may be able to play in addressing them. However, progress in this area will be limited without the requisite data to foster a greater understanding of the causes of disparities to inform the development of potential strategies that will allow the medical community to combat health inequity beyond the COVID-19 pandemic.

Section 5. State Medical Board Planning for Future Emergencies

The COVID-19 pandemic revealed a dearth of resources for interstate and intrastate coordination in response to national emergencies as states were challenged in facilitating the national mobilization of the healthcare workforce. The pandemic also highlighted challenges related to the emergency training and redeployment of healthcare professionals within their own states, prompting national organizations like the *Coalition for Physician Accountability*, of which the FSMB is a charter member, to develop resources for use during COVID-19.[25] In light of these experiences, the Workgroup agreed that it would be beneficial for state public health and emergency management offices and state medical boards to establish working relationships and procedures to prepare for future emergencies. Periodic meetings between state public health and emergency management offices and state medical boards in non-emergency times may also aid strategic planning efforts when emergencies occur.

The Workgroup recommends emergency planning documents include "all-hazards" approaches to address both short-term incidents and long-term/chronic emergencies like COVID-19. CMS defines an all-hazards approach as "an integrated approach to emergency preparedness planning that focuses on capacities and capabilities that are critical to preparedness for a full spectrum of emergencies or disasters…."[26] Such planning documents take an integrated approach and focus on organizational capacity, which would allow state medical boards to be prepared for a range of emergency scenarios. The FSMB's 2010 document, *Emergency and Disaster Preparedness Plan: A Guide for State Medical Boards*, was created after Hurricane Katrina devastated parts of the United States and focused mainly on the needs of state medical boards during a natural disaster, without including many resources specific to long-term/chronic events. The document requires updating to include a broader range of emergency planning resources.

[25] Coalition for Physician Accountability's Statement on *Maintaining Quality and Safety Standards Amid COVID-19*.
[26] CMS Emergency Preparedness Regulation, Clarifications on Definitions.

The COVID-19 pandemic required state medical boards to transition daily operations to remote work ("Work from Home") and to conduct board meetings and hearings virtually. This was a challenge to many boards as many did not have the authority under their state or territory's Open Meeting laws to meet virtually. Accordingly, Open Meeting laws had to be modified by gubernatorial Executive Orders, state and territorial legislative actions, and emergency declarations in at least 40 states to address this issue.[27]

Section 6. Recommendations

The FSMB recommends that:

Recommendation 1: The FSMB should work with state medical boards, health professional regulatory boards, and relevant stakeholders to develop model language to clarify emergency licensure processes.

Recommendation 2: The FSMB should establish a Workgroup to update the *Model Policy for the Appropriate Use of Telemedicine Technologies in the Practice of Medicine (2014)*, taking into account the lessons learns during the COVID-19 pandemic.

Recommendation 3: The FSMB should develop strategies for state medical boards to help combat health inequities and bias in medical discipline in their jurisdictions.

Recommendation 4: State medical boards should engage in periodic reviews of their emergency preparedness plans to ensure that such plans include current contact information for staff, state emergency management offices, partner organizations and procedures for communications.

Recommendation 5: The FSMB should review and update its *Emergency and Disaster Preparedness Plan: A Guide for State Medical Boards* to encompass lessons learned during COVID-19, including plans for additional types of emergencies and disasters that may occur in the future.

Recommendation 6: State medical boards should identify their capabilities for remote operations during emergencies and remain informed of any emergency changes to their state's open-meeting laws during such times.

[27] *See* Law360, *Public Meeting Requirements in the Age of COVID-19*.

WORKGROUP MEMBERS

Cheryl L. Walker-McGill, MD, MBA
Chair, FSMB Chair, North Carolina

Robin N. Hunter Buskey, DHSc, PA-C
NC Medical Board Presidential Advisory Group

Lawrence J. Epstein, MD
New York

Patricia A. King, MD, PhD, FACP
Former FSMB Chair, Vermont

Susan Ksiazek, RPh, DPh
National Association of Boards of Pharmacy, New York

Anne K. Lawler, JD, RN
President of Administrators in Medicine, Idaho

L. Blanton Marchese
Virginia

Frank B. Meyers, JD (Alternate)
Member FSMB Board of Directors, District of Columbia

Ex Officio:
Kenneth B. Simons, MD
FSMB Chair-elect, Wisconsin

Scott A. Steingard, DO
FSMB Immediate Past Chair, Arizona

Janelle A. Rhyne, MD, MA, MACP
FSMB Foundation, North Carolina

Candace L. Sloane, MD
Massachusetts

Katherine A. Thomas, MN, RN, FAAN
Texas Board of Nursing & National Council of State Boards of Nursing

Jacqueline A. Watson, DO, MBA, CMBE
District of Columbia Department of Public Health

Sherif Z. Zaafran, MD
Texas

Denise Pines, MBA
California

Staff Support:
Humayun J. Chaudhry, DO, MS, MACP
FSMB President-CEO

Michael P. Dugan, MBA
FSMB Chief Operating Officer

Eric M. Fish, JD
FSMB Chief Legal Officer

David A. Johnson, MA
FSMB Chief Assessment Officer

Todd A. Phillips, MBA
FSMB Chief Financial Officer

Lisa A. Robin, MLA
FSMB Chief Advocacy Officer

Kandis McClure, JD, MPH
FSMB Dir., Federal Advocacy and Policy

Appendix

1. Coalition for Physician Accountability's *Statement to Safeguard the Public, Protect our Health Care Workforce during the COVID-19 Pandemic* (April 9, 2020)
2. Coalition for Physician Accountability's *Statement on Maintaining Quality and Safety Standards Amid COVID-19* (May 11, 2020)
3. Coalition for Physician *Accountability's Final Report and Recommendations for Medical Education Institutions of LCME-Accredited, U.S. Osteopathic, and Non-U.S. Medical School Applicants* (May 16, 2020)
4. Coalition for Physician Accountability's *Compendium of Resources for the Implementation of Recommendations for Medical Education Institutions of LCME-Accredited, U.S. Osteopathic, and Non-U.S. Medical School Applications* (May 16, 2020)
5. Coalition for Physician Accountability's *Final Report and Recommendations of the Coalition's Work Group on Learner Transitions from Medical Schools to Residency Programs in 2020* (May 18, 2020)
6. Coalition for Physician Accountability's *Statement on Public Health* (December 1, 2020)
7. Accreditation Council for Graduate Medical Education's ACGME Reaffirms its Four Ongoing Requirement Priorities during COVID-19 Pandemic (April 5, 2020)
8. Accreditation Council for Graduate Medical Education's (ACGME) Updated: Supplemental Guidance Regarding the COVID-19 Pandemic, ACGME Accreditation, and Sponsoring Institution Emergency Categorization (December 21, 2020)

Coalition for Physician Accountability

Safeguard the Public, Protect our Health Care Workforce during the COVID-19 Pandemic

April 9, 2020

The member organizations of the Coalition for Physician Accountability (www.physicianaccountability.org) have released the following statement in support of strengthened efforts that must be in place to safeguard the public, and to protect our nation's health care workforce during the COVID-19 pandemic so they remain able to meet the public's needs.

The Coalition's members include the national organizations responsible for the accreditation, assessment, licensure and certification of physicians throughout their medical career, from medical school through practice. Our membership also includes members of the public and the profession. We share a strong commitment to protect the public's health and safety through the delivery of quality health care.

COVID-19 cases in the United States have now surpassed 450,000 and deaths have exceeded 15,000, an alarming development that has affected patients, families, and communities across the country. We all depend on physicians and other healthcare workers to provide safe and compassionate care. Hundreds of thousands of physicians at every level of training and experience (medical students, residents, and practicing physicians, including retired and inactive physicians volunteering to reenter the workforce) have partnered with countless nurses, respiratory therapists and other health care workers to care for patients. It is critical during this national emergency that the public be provided with the best care possible by qualified health care workers who are themselves adequately protected.

Under the ethical tenets of their profession, physicians routinely care for others despite personal risk. Without safeguards such as proper personal protective equipment (PPE) and adequate testing, they are putting the health of their patients, as well as their own health and that of their families, at risk. The Coalition recognizes that supplies of PPE at this time are inadequate and supports continued studies to examine the safety of reuse and sterilization of PPE as options.

Health care workers are professionally bound to identify inadequate resources that impact their ability to safely treat patients or keep themselves safe. They must not suffer retribution or retaliation for calling attention to unsafe systemic

conditions for patients or caregivers. Conditions for physicians and health care workers on the frontlines of direct patient care must be safe.

It is vital in these uncertain times that our elected leaders and officials be guided by science and evidence-based principles when making decisions on behalf of the entire population to combat the virus causing COVID-19. The American public and the health care workers who care for them in this time of great need are making enormous sacrifices to do their part in stopping the spread of the virus. It is essential that our leaders provide them with resources they need and guidance that is factual and transparent.

Extreme disruption due to the pandemic has occurred in many facets of physician education, training, licensing and credentialing. As rapidly as possible, the Coalition and its member organizations will be providing guidance on important issues such as the trajectory of medical students transitioning from graduation to residency, student and trainee movement across geographic areas for interviews and clinical rotations, guidelines for volunteer work, and maintaining standards for credentials, certification and competencies during this time of emergency. These statements will be carefully reviewed and considered to ensure they represent the best paths forward during these challenging times.

The member organizations of the Coalition are committed to work with governmental agencies and health care delivery systems to safeguard the public, protect our frontline health care workers, and provide our elected leaders with the information they need to support sound, evidence-based decision-making.

The following organizations have signed on to this statement:
Association of American Medical Colleges (AAMC), American Association of Colleges of Osteopathic Medicine (AACOM), American Board of Medical Specialties (ABMS), Accreditation Council for Continuing Medical Education (ACCME), Accreditation Council for Graduate Medical Education (ACGME), American Medical Association (AMA), American Osteopathic Association (AOA), Council of Medical Specialty Societies (CMSS), Educational Commission for Foreign Medical Graduates|Foundation for Advancement of International Medical Education and Research (ECFMG®|FAIMER®), Federation of State Medical Boards (FSMB), Liaison Committee on Medical Education (LCME), NBME, and the National Board of Osteopathic Medical Examiners (NBOME).

About the Coalition for Physician Accountability
The Coalition for Physician Accountability is a membership organization designed to advance health care and promote professional accountability by improving the quality, efficiency, and continuity of the education, training, and assessment of physicians. Founded in 2011, current membership consists of senior leadership and governance representatives from the Association of American Medical Colleges (AAMC), American Association of Colleges of Osteopathic Medicine (AACOM), American Board of Medical Specialties (ABMS), Accreditation Council for Continuing Medical Education (ACCME), Accreditation Council for Graduate Medical Education (ACGME), American

Medical Association (AMA), American Osteopathic Association (AOA), Educational Commission for Foreign Medical Graduates|Foundation for Advancement of International Medical Education and Research (ECFMG®|FAIMER®), Federation of State Medical Boards (FSMB), Liaison Committee on Medical Education (LCME), NBME, and the National Board of Osteopathic Medical Examiners (NBOME). In addition, the Joint Commission and the Council of Medical Specialty Societies (CMSS) serve as liaison members. The Coalition also appoints public members to its membership to ensure adequate representation of the public voice in the deliberations of the Coalition.

Coalition for Physician Accountability

Maintaining Quality and Safety Standards Amid COVID-19

May 11, 2020

The member organizations of the Coalition for Physician Accountability (www.physicianaccountability.org) have released the following statement and table of resources to provide guidance and support to healthcare administrators and credentialing staff who are supporting the contributions of new or volunteer physicians to patient care during the COVID-19 pandemic.

The Coalition for Physician Accountability (Coalition), a cross-organizational group including AACOM, AAMC, ABMS, ACCME, ACGME, AMA, AOA, CMSS (OPDA), ECFMG, FSMB, LCME, NBME, and NBOME, was established in 2009 to promote professional accountability by improving the quality, efficiency, and continuity of the education, training, and assessment of physicians. Its membership includes the national organizations responsible for the accreditation of medical education and training and the assessment, licensure and certification of physicians throughout their medical career, from medical school through practice. Our membership also includes members of the public and the profession. We share a strong commitment to protecting the public's health and safety through the delivery of quality health care.

The pandemic has created a public health emergency that is rapidly altering the provision of health care services across the country. Physicians and other clinicians have responded with offers to provide care outside of their previously licensed jurisdiction and beyond their typical scope of practice.

The Coalition members overseeing physician workforce and training have developed the following guidance and resources for the deployment of physicians, physicians in training (interns, residents and fellows), and retired or inactive physicians, to ensure the safe delivery of quality clinical care during this unprecedented emergency.

The Coalition's Guidance for Maintaining Quality and Safety Standards Amid COVID-19 Pandemic include:

- **Planning:** The pandemic poses a direct threat of over-burdening the health system. The stress to health systems is variable, but all health care facilities should be developing strategies for the optimal use of physician resources as the disease spreads and resource demands fluctuate.
- **Verification:** Acknowledging the additional flexibility that regulators have provided, administrators should access readily available licensing, credentialing, and certification data to verify the attestations of volunteers and new recruits.
- **Provision of Care:** The American Medical Association's *Code of Medical Ethics: Guidance in a Pandemic* states that physicians have an ethical obligation to "provide urgent

medical care during disasters," an obligation that holds "even in the face of greater than usual risk to physicians' own safety, health or life." In a crisis, "(t)he risks of providing care to individual patients today should be evaluated against the ability to provide care in the future."

- **Protection:** Healthcare professionals must be equipped with appropriate Personal Protective Equipment (PPE) to safeguard their health and that of their patients, families, and the general public, and physicians must use this protection. The more transmissible the disease, and the higher the risk of occupational exposure, the more urgent the need for protection.
- **Training, Education, and Support:** Healthcare professionals who may be asked to practice outside their areas of training and expertise must have access to training and educational resources for the type(s) of care they are asked to provide during the COVID-19 pandemic to assure safe patient care. Appropriate mentorship, support, training, and supervision must also be available for healthcare professionals who are asked to provide care to which they are unaccustomed.
- **Maintenance of Safety Standards:** Health care facilities should have contingency plans to maintain customary safety standards in the face of a demand surge. Guidance for the adoption of crisis standards of care is available to help leaders make informed decisions that optimize resources while mitigating the risk of harm.

The following are some steps that can be taken to prepare for the arrival of a new volunteer:

	Action Step	**Resource**	**Additional questions/resources**
1	Check what licenses the physician has (and/or ECFMG certification if an international medical graduate)	www.Docinfo.org (free service) Physician Data Center www.fsmb.org/PDC/ ECFMG Certification Verification	Email: pdc@fsmb.org Email: cvsonline@ecfmg.org or call ECFMG at 215-386-5900
2	Determine applicable licensing waivers or exceptions (if licensed elsewhere)	FSMB COVID-19 Page for a summary of changes Please check applicable state or territorial medical board website	
3	Check Information on a volunteer's education and training	Physician Data Center www.fsmb.org/PDC/ ECFMG (for IMGS)	Email: pdc@fsmb.org Email: cvsonline@ecfmg.org or call ECFMG at 215-386-5900
4	Determine if the volunteer has a valid	Obtain copy of existing license and see: https://apps.deadiversion.us	https://deanumber.com/default.aspx?relID=33637

	controlled substance license	doj.gov/webforms2/spring/dupeCertLogin?execution=e2s1	
5	Check a volunteer's board certification status	ABMS certification AOA certification https://certification.osteopathic.org/validate/	Call: ABMS Solutions at (800) 733-2267 with questions. Call: AOA at (888)-626-9262
6	Confirm: a) vaccination record b) malpractice insurance c) Review any history of malpractice	Recommended vaccinations for healthcare workers: https://www.cdc.gov/vaccines/adults/rec-vac/hcw.html Guidance on medical liability insurance during the COVID-19 crisis available from the Medical Professional Liability Association National Practitioner Data Bank*: https://www.npdb.hrsa.gov/hcorg/howToSubmitAQuery.jsp	Call: CDC at (800)-232-4636 See also: The Coronavirus Aid, Relief, and Economic Security Act (CARES Act, H.R. 748), *Section 3215: Limitation on Liability for Volunteer Health Care Professionals During COVID-19 Emergency Response* Email: help@npdb.hrsa.gov
7	Other Important Credentialing Resources	NAMSS COVID-19 Resources	Email: info@namss.org

**Only Accessible by Eligible Entities*

If the volunteer is a recently graduated physician, refer to the following resources:

8	Refer to guidance from AAMC, AACOM, ACGME and FSMB	AAMC guidance AACOM Coronavirus Resources ACGME guidance FSMB COVID-19 Page (for training license information)	

To support the volunteer as they start providing care:

9	Provide guidance to the physician	AMA volunteer guide AMA Code of Medical Ethics: Guidance in a Pandemic FSMB COVID-19 Page (for emergency licensure information) AOA COVID-19 Resources	
10	Provide training resources to the physician	ACCME training resources CDC guidance HHS COVID-19 Workforce Virtual Toolkit	Email: info@accme.org
11	Provide information on PPE	CDC guidance for PPE	
12	Share resources on managing telehealth	ACCME telehealth resources AMA Telehealth playbook HRSA Telehealth Website (hhs.telehealth.gov)	Email: info@accme.org

For more information on how to prepare for an anticipated surge in demand for scarce resources during an epidemic:

13	Expand contingency plans to include a process for adopting crisis standards of care to manage scarce physician and other resources	National Academy of Medicine -Discussion Paper on Crisis Standards of Care in response to SARS-CoV-2 National Academy of Medicine -Systems framework for crisis standards of care	

Workgroup Members:

American Board of Medical Specialties (ABMS)
Accreditation Council for Continuing Medical Education (ACCME)
Accreditation Council for Graduate Medical Education (ACGME)
Council of Medical Specialty Societies (CMSS)
Educational Commission for Foreign Medical Graduates (ECFMG)
Federation of State Medical Boards (FSMB)
National Resident Matching Program (NRMP)
Public Member

Final Report and Recommendations for Medical Education Institutions of LCME-Accredited, U.S. Osteopathic, and Non-U.S. Medical School Applicants

Submitted by

The Coalition for Physician Accountability's Work Group on Medical Students in the Class of 2021 Moving Across Institutions for Post Graduate Training

This guidance document was created in response to urgent requests for a consistent approach to medical student away rotations and in-person interviews for the 2020-2021 residency cycle. The organizations supporting the Final Report and Recommendations include the major national medical education organizations, whose representatives worked together to balance the complex needs of the medical education community. These recommendations reflect our collective sense of how to proceed, and we urge each medical school, sponsoring institution, and residency program to carefully consider them and commit to working together to create an equitable, transparent, and successful residency selection cycle.

This guidance is intended to add to, but not supersede, the independent judgment of a medical school, sponsoring institution, or residency program regarding the immediate needs of its patients and the preparation of its learners: Medical school deans have the authority and responsibility to make decisions regarding their medical students, and designated institutional officer (DIOs) and program directors have the authority to make decisions regarding residents in their sponsoring institution and programs. Because students rely on predictable, common practices across schools and programs as they prepare to transition to residency, a shared response to disruptions caused by the COVID-19 pandemic will greatly reduce unnecessary confusion, stress, and inequity among students, while promoting a more successful residency selection process for all.

Introduction

The Coalition for Physician Accountability (Coalition), a cross-organizational group composed of AACOM, AAMC, ABMS, ACCME, ACGME, AMA, AOA, CMSS (OPDA), ECFMG, FSMB, LCME, NBME, and NBOME, was established in 2009 to promote professional accountability by improving the quality, efficiency, and continuity of the education, training, and assessment of physicians. The Coalition has created several work groups to rapidly develop a shared approach to several urgent COVID-19-related education and training issues affecting learners and training programs.

The Coalition established this Work Group on Medical Students in the Class of 2021 Moving Across Institutions for Post Graduate Training (WG) to consider and make recommendations about three major issues facing applicants and training programs as they prepare for the 2020-2021 residency application cycle: (1) away rotations, (2) in-person interviews for residency, and (3) the ERAS® timeline. While there are other important issues to be addressed, the WG was careful to restrict its deliberations to its original charge. WG participants include representatives from AACOM, AAMC, ACGME, AMA, AOGME, ECFMG, NRMP, and OPDA. NBME and NBOME participated for the ERAS timeline discussions.

The COVID-19 pandemic has interrupted the clinical education of most, if not all, medical students. This work group was tasked with considering the impact on current M3/rising senior students, particularly as applicants prepare for the residency selection process. Limitations placed on learners' ability to work in the clinical learning environment, restrictions on individual travel and personal spacing, and inability to complete assessments and educational requirements will render the traditional selection process impossible to

replicate this year. Nonetheless, the WG believes a meaningful and effective selection process can be achieved for both applicants and residency programs.

Strengths of the WG include its diversity of thought and representation from the full spectrum of stakeholders across medical education and the public. The WG established guiding principles as a framework for considering the important issues under its charge:

- Patient care and the safety of the community, patients, and learners are most important.
- Medical schools must prioritize meeting core competencies anchored in accreditation and graduation requirements for their own students. Likewise, residency programs must prioritize fulfilling current residents' competencies and meeting accreditation and specialty board certification requirements.
- The residency selection process should be as equitable as possible for applicants, recognizing the diversity of learners and educational programs and the differing missions and priorities of schools, training programs, and institutions.
- A concerted effort to reduce anxiety and promote well-being of students, program staff, and institutions (home and host) in an already stressed system is critical.
- We anticipate stakeholders will commit to policies that prioritize these guiding principles yet recognize the necessity for innovation and flexibility in this new COVID-19 environment.
- Recommendations at the national level are intended to facilitate transparency, promote fairness across the country, and reinforce our commitment to an equitable process for all.

The WG also considered current data and forecasts about the COVID-19 pandemic. While the temporal progression of the pandemic remains uncertain, estimates indicate there may be an abatement with continued endemicity over the summer and a second surge with geographic variation in the fall or winter. Therefore, periodic limitations on geographic and individual travel will likely persist. The WG recommendations were influenced by concerns that initiating a process only to have it discontinued due to a resurgence of coronavirus would create potential inequities among applicants and increase disruption and stress for both applicants and programs.

The Process

From the outset, the WG sought to be comprehensive, inclusive, and timely in delivering its recommendations, recognizing the urgent need for a common approach to support decision-making around the residency application process. The WG met twice per week over a four-week period, April 14-May 8, to consider the issues within its charge. As the WG deliberated, broader feedback on the guiding principles, away rotations, and in-person interviews was sought from across the constituency and was considered heavily in the WG's deliberations and recommendations. Subject matter experts were invited to discuss the relevant issues and shared feedback and recommendations as appropriate. As final recommendations were drafted, the WG shared them with constituents, member organizations, and the Coalition. The final report has been endorsed by the Coalition organizations. This final report, including recommendations and resources, was released to the public May 11, 2020.

The Deliverables

This document includes:

- An overview of the WG's work, including recommendations for the WG's three assigned issues: (1) medical student away rotations, (2) in-person interviews, and (3) the ERAS timeline.
- An initial compendium of resources to support the implementation of the recommendations.
- General communications guidance for disseminating this report and implementing the recommendations.

As these recommendations are released, the WG recognizes the inherent complexities of the residency selection process (particularly considering COVID-19's impact), the varied circumstances presented by geography, the diversity of applicant and institution type, and the varied missions and strategies of the stakeholders. While there can be no "one size fits all" solution, the WG believes these recommendations can promote consistency and fairness for all applicants.

Recommendation 1 — Away Rotations for Medical Students

Background: As mentioned in the Compendium of Resources, away rotations serve multiple important roles for applicants and residency programs. Applicants use them for career exploration, for support in the residency application process, and for prioritizing geographic preferences. Residency programs use away rotations to assess applicants' capabilities, showcase the benefits of their program and facilities, and preview potential applicants to their programs (which is particularly important to those programs not affiliated with a medical school). Challenges associated with away rotations include the expense to learners (both financial and educational, in lost opportunities at the home institution), competition for rotations that prevents access to some applicants who might be well suited for the specialty or program, the fact that completing an away rotation does not ensure the applicant a residency position at the program or within the specialty, and the burden of onboarding learners into a new clinical environment (the latter is particularly applicable given current stressors on the health systems from the COVID-19 pandemic).

For the 2020-2021 cycle, the COVID-19 pandemic has already created multiple, serious disruptions of core educational experiences and of travel. Limitations placed on students' ability to work in the clinical learning environment, the anticipated surge in students needing clinical experiences created by deferral of core clerkship activities (described as an impending "clinical bulge"), delayed completion of core educational requirements, and restrictions on individual travel and personal spacing (both now and in the eventuality of geographic outbreaks or a national resurgence in the fall or winter) will likely greatly reduce the number of away rotation opportunities available this year. As a result, for most applicants, away rotations may be entirely inaccessible. A shared, altered approach to away rotations may help level the applicant playing field for the upcoming application cycle.

Recommendation: The WG recommends that for the 2020-2021 academic year, away rotations be discouraged, except under the following circumstances:

- Learners who have a specialty interest and do not have access to a clinical experience with a residency program in that specialty in their school's system.
- Learners for whom an away rotation is required for graduation or accreditation requirements.

Individuals meeting these exceptions should limit the number of away rotations as much as possible. Students should consider geographically proximate programs, when appropriate, to meet learning needs.

Programs and specialty societies are encouraged to develop alternate approaches to meeting goals of away rotations, as described in the Compendium of Resources.

Recommendation 2 — Virtual Interviews

Background: Applicants value in-person interviews for gaining a realistic introduction to and experience of the residency program, including the culture and fit. Similarly, programs value the ability to observe and assess applicants' capabilities and fit in the program environment. While forecasts predict the COVID-19 pandemic will diminish over the summer, there will likely be intermittent geographic hotspots and a projected widespread resurgence in late fall or early winter, just as the residency interview season would typically be ramping up. In addition, it is widely anticipated that ongoing "track and trace" programs will limit individual travel conducted on relatively short notice (i.e., if an applicant is identified to have had contact with a new COVID-19 individual, the applicant may be required to quarantine) and that domestic and international travel bans for quarantine rules will exist.

Recommendation: The WG recommends that all programs commit to online interviews and virtual visits for all applicants, including local students, rather than in-person interviews for the entire cycle and that the medical education community commit to creating a robust digital environment and set of tools that will yield the best experiences for programs and applicants.

Even as we adjust to the inevitability of this new normal of virtual interactions, replacing the benefits applicants and programs derive from in-person interviews will require adjustments on both sides. As more medical schools turn to virtual curricula as stopgap measures to keep advancing the third-year curricula, and the clinical environment looks to telemedicine to provide patient care in a COVID-19 environment, we must also consider how technology can be used to support the upcoming residency application cycle. The Compendium documents well the perceived benefits of in-person interviews. While not all benefits can be replicated in a virtual environment, a thoughtful and dedicated approach can maximize the value of remote interactions.

Recommendation 3 — The ERAS Opening for Programs and the Overall Residency Timeline

Background: The COVID-19 pandemic's impact on the medical education curriculum will ensure that practically every applicant for residency during the ERAS 2020-2021 cycle will face obstacles completing activities usually included in their application. Some will be delayed in completing their clerkship curriculum and early senior rotations, which will delay the collection of letters of evaluation and recommendation. Others will be unable to secure timely dates to complete their COMLEX-USA or USMLE exams. This year, programs face making selection decisions with differing amounts and types of data than they have ever had in the past. These changes necessitate evaluating the ERAS opening date for programs and the medical student performance evaluation (MSPE) release date. It is also critically important that programs have the tools they need to use the data they receive to evaluate the applications holistically.

The traditional ERAS opening for programs on Sept. 15 and MSPE release date of Oct. 1 may not allow sufficient time for learners and medical schools to upload the most complete ERAS applications for programs to review and evaluate. Multiple conversations with medical schools, applicants, AAMC affinity groups, specialty organizations, and the ERAS Advisory Committee reached consensus that an ERAS opening for residency programs could occur in mid-to-late October.

Recommendation: The WG recommends a delayed opening of ERAS for residency programs and a delayed release of the MSPE and that the opening and release happen on the same day.

Recommendation 4 — General Communications

Implementation of these recommendations will require transparency and regular, clear communications among all stakeholders. The WG encourages the medical education community to work together to provide consistency and equity for applicants across the country.

- Specialty organizations should work with the individual programs to develop and communicate to applicants and schools clear, consistent plans and practice around both away rotations and interviews as soon as possible.
- Medical schools should develop clear, consistent policies around any limitations of students' participation in away rotations and in acceptance of visiting students, and the schools should communicate these as soon as possible.
- With a goal of decreasing stress and increasing a sense of fairness, we suggest programs and schools commit to a consistent policy for the entire upcoming residency application and selection cycle.
- Both programs and schools should include statements about COVID-19-related training, testing, and quarantine requirements for any away rotations that are allowed.

Conclusion

Since the arrival of COVID-19, the medical education community has experienced many challenges and has shown great courage, resilience, flexibility, and creativity in facing those challenges. As we look to the next 12-18 months, the response can be no less. Both applicants and residency programs have been thrust into an environment not of their choosing. There is great anxiety about the upcoming residency selection process and the effect changes resulting from COVID-19 will have on the Class of 2021. In developing the recommendations provided herein, the WG considered the current environment, future forecasts, the subject matter expertise, and the perspectives of those closest to the issues the WG sought to address.

Acknowledging that these recommendations cannot address every eventuality, they are offered to provide the best path forward to promote consistency and fairness across the country and to reinforce our commitment to an equitable process for all.

Respectfully submitted,

Accreditation Council for Graduate Medical Education
American Association of Colleges of Osteopathic Medicine
American Medical Association
Assembly of Osteopathic Graduate Medical Educators
Association of American Medical Colleges
Council of Medical Specialty Societies/Organization of Program Director Associations
Education Commission for Foreign Medical Graduates
National Resident Matching Program

Compendium of Resources for the Implementation of Recommendations in the *Final Report and Recommendations for Medical Education Institutions of LCME-Accredited, U.S. Osteopathic, and Non-U.S. Medical School Applicants*

The COVID-19 pandemic necessitates changes for the 2020-2021 residency application cycle that are disruptive for all stakeholders: medical schools, applicants, residency programs, and the associated sponsoring institutions. The Coalition's Current Practices of Student Movement Across Institutions for the Class of 2021 Work Group (WG) believes the medical education community, working together, can minimize these disruptions and mitigate the losses. This document provides additional information to support the implementation of the recommendations contained in the *Final Report and Recommendations for Medical Education Institutions of LCME-Accredited, U.S. Osteopathic, and Non-U.S. Medical School Applicants* and can serve as a foundation for continued work across the UME-GME continuum to address the impact of recommended changes on:

- Away and audition rotations.
- Virtual interviews and program visits.
- The shortened ERAS® timeline and holistic review.

The WG gathered information on the perceived benefits of the traditional approach of each of these domains for students, applicants, and programs. The WG then brainstormed how, with the new recommendations, benefits might be reimagined and recreated and how losses might be mitigated.

The WG hopes this compendium is the beginning of dialogue and concerted work across associations, schools, programs, program director associations, and student groups to develop solutions and share resources.

Away Rotations Resources

The Work Group on Student Movement's Subgroup on Away and Audition Rotations considered the importance of away rotations to U.S. (DO and MD) and international applicants for residency and noted the differences between the two groups of medical students in access to school-affiliated resources and to residency-based rotations in both the third and fourth year. (Away and audition rotations are short-term learning opportunities in locations away from students' home institutions. These opportunities, contrasted with core or required clerkships, are sometimes called "away" rotations, "audition" electives, "clinical" rotations, or sub-Is. Available in teaching hospitals, community clinics, and urban or rural sites, they are generally open to preclinical, clinical, and final-year students, as determined by the host institution.)

The group also discussed differences between those returning to the match after a period of formal or informal training, or even already in medical practice, and those in a more traditional time frame for residency placement.

Recommendation 1 — Away Rotations: The WG recommends that for the 2020-2021 academic year, away rotations be discouraged, except under the following circumstances:

- Learners who have a specialty interest and do not have access to a clinical experience with a residency program in that specialty in their school's system.
- Learners for whom an away rotation is required for graduation or accreditation requirements.

Individuals meeting these exceptions should limit the number of away rotations as much as possible. Students should consider geographically proximate programs, when appropriate, to meet learning needs.

Questions have arisen about how schools and programs might best implement this recommendation and how to communicate with students. Based on conversations with multiple stakeholders, the WG offers the following approaches as a starting point for further discussions.

Each school should review the away-rotation recommendation in the context of their individual elective offerings and graduation requirements and develop a policy and plan for communicating the school-specific implementation of this recommendation to their students and faculty, including substantiating exceptions for away rotations.

- Both the medical school and the program should consider playing a role in confirming the student's eligibility for an away rotation.
- Schools should include processes to validate the reason for an away rotation in institutional documents before the documents are released (e.g., transcripts, insurance).
- The program should validate approval from the medical school that the applicant meets at least one of the established exceptions and decline scheduling of an away rotation for any unsubstantiated applications.
- Recognizing that some students will have a need for an away rotation for the reasons identified as exceptions, programs that have the capacity should consider accepting the students who meet the exceptions, particularly if the students are local.

- Requests for approval of students' eligibility should be responded to as quickly as possible to facilitate scheduling for both parties.

Approval of requests for time off for virtual experiences should not require that the student participate in both an in-person clinical experience at the home institution and a virtual external "audition" experience.

The WG considered the perceived value of away rotations from the perspective of both students and program directors to help with developing recommendations and to consider alternate ways to achieve the goals. The collective thinking of the community was included. While not exhaustive, this Table A is meant to serve as foundational thinking for planning for the upcoming residency application cycle.

Table A. Value of Away Rotations and Suggestions for Achieving Goals in a COVID-19 Environment

Value to Students	Value to Program Directors	Potential Substitutes for Away Rotations
Allows applicants to display a breadth of competencies (e.g., teamwork, effort, work ethic) that may be difficult to assess from application materials*	Provides insights into applicants' clinical capabilities, personality, and professionalism that may not be readily assessed from application materials*	• Provide more holistic elements in school reporting that programs can use to evaluate students • Provide longitudinal online group experiences hosted by programs (e.g., journal clubs, case discussions, group projects) • Relax number of LORs, allow nonspecialty LORs, and standardize LORs to provide critical appraisal in key dimensions
Enables applicants to secure feedback, LORs, and SLOEs from residency program faculty in a chosen specialty*	LORs and SLOEs from colleagues in the specialty are helpful in evaluating applicants	Standardize specialty-based local LORs to provide critical appraisal in key dimensions
Allows students to assess the specialty, program features, and culture of the learning environment in ways that inform personal and career fit with the program*	Allows the program director to assess a given candidate's fit with the culture of the program*	• Offer online specialty-based mentoring programs • Provide longitudinal online group experiences hosted by programs (e.g., journal clubs, case discussions, group projects)
Allows applicants to experience clinical environments different from their home institutions	Allows programs to fully demonstrate the capabilities of the local training environment*	• Offer virtual tours of clinical learning environments associated with the program, including distinguishing clinical services and outcomes metrics • Provide longitudinal online group experiences hosted by programs, as above
Gives students access to specialties they are considering but are not available at home institutions	Allows program directors to assess applicants from lesser-known schools	Offer online specialty-based mentoring programs, as above
Establishes connections in a desired geographic area	Allows program directors to preview potential applicants and gauge applicants' interest in their program	Provide longitudinal online group experiences hosted by programs, as above

*The top three benefits mentioned by constituents for each party.

Note: LOR = letter of recommendation; SLOE = Standard Letter of Evaluation.

Both applicants and programs shoulder the financial and educational costs of away rotations (Table B).

Table B. Costs of Away Rotations

Costs or Limitations to Applicants	Costs or Limitations to Programs	Impact of Limitations
Financial costs of travel	Financial costs of orientation and hosting	These costs decrease as the number of away rotations decrease; there could be added investment in technology platforms.
Educational opportunity cost (Is learning taking place during the away rotation? What learning experiences at the home institution are lost?)	• Investment in external learners • Too many visiting students to make a meaningful assessment or connection (Time spent developing learners who will not ultimately be part of the program; potential distraction from providing training and feedback to internal residents and students)	These costs potentially remain for both sides but will decrease overall with fewer rotations.

Encouraging Innovation

Innovative approaches are being developed and implemented by specialties and programs to provide alternatives for students to showcase their knowledge, skills, and attitudes and for programs to ensure applicants receive the curricular content that exposes them to and teaches them about the specialty. The Work Group recommends continued innovation by specialties, institutions, and programs, including developing ways to identify best practices and communicate and share them broadly.

Resources

- American College of Surgeons Fundamentals of Surgery Curriculum (Freely available through May 15, 2020)
- Family Medicine Virtual Clerkship
- Online Diagnostic Radiology Elective
- Virtual Simulation Experiences in an Emergency Medicine Clerkship
- Virtual OB-GYN Clerkship Curriculum

Virtual Interview Resources

Since it is expected that some programs will need additional support, the Work Group on Student Movement's Subgroup on Virtual Interviews met to consider how residency programs might plan for and adjust to residency interviews in a virtual environment and to provide resources to support this effort.

Recommendation 2 — Virtual Interviews: The WG recommends that all programs commit to online interviews and virtual visits for all applicants, including local students, rather than in-person interviews for the entire cycle and that the medical education community commit to creating a robust digital environment and set of tools to create yield the best experiences for programs and applicants.

The in-person interview has been a critical piece of the residency selection process from its inception. The Work Group sought broad input about the importance of in-person interviews from the perspective of both applicants and program directors to determine strategies to recommend that could optimize the virtual interview for the desired goals of each party (Table C).

Table C. The Value of In-Person Interviews to Applicants and Program Directors

Value to Applicants	Value to Program Directors
• To gain a realistic introduction and experience of the residency program, including program culture • To provide a direct face-to-face encounter with the program team to market oneself • To assess program and institution attributes that may affect the applicant's choice of training site • To gather information about the community surrounding the hospital as a potential place to live • To interact with residents in the program in an informal setting to learn about the program and those currently training in it • To observe clinical settings and teaching (e.g., inpatient rounds, morning report, noon conference) to assess the quality of the program and suitability to their role as a learner	• To observe and assess applicants' capabilities and fit in the program environment • To use different methods to gauge applicants' abilities, such as observed behavior, teamwork, and other characteristics best observed in situ • To have the applicant observed in different settings by different people (residents, GME administrative staff, faculty) over a day • To promote the sponsoring institution's and program's educational offerings by demonstrating the capabilities of the training program • To highlight the clinical education experiences at the clinical sites used by the program • To gauge the applicant's interest in the program • To consider applicants from broad geographic areas and schools about which the program has less knowledge and experience

As programs prepare for the 2021 recruitment season, it is expected that the medical education community will prioritize the needs of patients, their care providers, and the safety of applicants and the program personnel considering those applicants. Program staff should consider how best to develop processes that meet program needs while creating an equitable, transparent, and successful residency selection cycle for applicants (Tables D and E).

Table D. Mitigation Strategies for Programs Moving to Virtual Interviews

Impacts for Programs	Possible Mitigation
Resources (e.g., planning, time, deliverable costs) will be required of already financially and time-strapped hospitals and training programs that do not already have virtual touring.	Work collaboratively within the institution to share resources across specialties to highlight the benefits of the institution and the community to applicants; limit programs' investment to highlighting the benefits specific to each program.
Ramp-up time for hospitals and residency programs will be needed to prepare for virtual interviews.	• Begin planning for virtual interviews, incorporating best practices from the literature and other guidance. • Begin preparing or adapting materials for applicants and interviewees that highlight strengths of the program, institution, and clinical training sites. • Acquire appropriate teleconferencing equipment, software, and technology to ensure the program and its interviewers can conduct high-fidelity interactions with applicants.
The programs will need to be able to collect the information they need via virtual interviews to fully evaluate applicants.	• Develop a protocol for interviews that may include group interviews or more structured interviews that have an evidence base of predictive value for identifying applicants who will succeed in the program. • Conduct all interviews (even those of local applicants) in the same manner.
Programs may have a better understanding of the capabilities of applicants from their own medical school than of applicants they can only interact with virtually.	Commit to one standardized process for all applicants for the entire recruitment and use that process consistently.
Costs of technology to ensure high-fidelity interactions for interviews and other virtual interactions with the applicants will need to be accounted for.	Budget for costs of providing meals, transportation, and housing for interviewees

Table E. Mitigation Strategies for Applicants Engaging in Virtual Interviews

Impacts for Applicants	Potential Mitigation
Gaining a realistic introduction to program culture and the community surrounding the hospital is especially difficult to do virtually.	Create virtual tours and record informal interviews with residents; allow virtual attendance at department conferences and teaching rounds.
Opportunity for the applicants to gain valuable insight into the program and its culture while interacting with the program's residents during the time normally allotted for dinners and less formal interactions throughout the day is reduced.	Create informal, private, virtual opportunities to speak directly with residents (individually or in groups).
Interaction with current residents is critical and difficult to replicate in a virtual environment; residents and applicants gain a lot of insight during pre-interview happy hours and dinners.	In addition to the interviews, consider having sessions that include other people from the program who will interact with the applicant, such as an informal Q&A with residents and groups of interviewees or discussions with midlevel providers and research and scholarly activity personnel who support the program.
It is difficult to assess the culture and "fit" of a program virtually without having a secure space to ask difficult questions.	Create informal, private, virtual opportunities to speak directly with residents (individually or in groups). Consider using social media platforms.
Providing applicants with a sense or feel of the environment of the program site and properly introducing the program and the local surrounding community to the candidate are significant challenges.	Ensure applicants can interact with the program team and learn about the program through multiple virtual opportunities and settings.
Applicants may be judged unfairly from virtual encounters; most are not trained in virtual-interview etiquette or have much experience with virtual interviewing.	Develop or disseminate a standard etiquette guide for applicants about how to professionally interact in virtual interviews in various formats, including individual, group, formal, and informal settings.
Applicants from local programs or institutions may be unfairly advantaged because virtual interviews may not replace face-to-face interaction and familiarity.	Implement one interview process for all applicants, regardless of location, and adhere to a standardized interview to mitigate any bias.
Applicants with technical issues or in areas with low bandwidth may be disadvantaged.	Be as flexible as possible with applicants who have challenging technical situations; technical issues can occur for any reason.

Resources

Background research and resources are available at this site.

Other Resources:

- The AAMC Best Practices for Conducting Residency Interviews
- The AAMC Guide for Applicants Preparing for Virtual Interviews
- The AAMC Virtual Interviews: Tips for Program Directors
- University of Utah Health's Virtual Interview Primer
- Jones RE, Abdelfattah KR**.** Virtual interviews in the era of COVID-19: a primer for applicants. *Journal of Surgical Education*. April 2020. doi:https://doi.org/10.1016/j.jsurg.2020.03.020.

Final Report and Recommendations Submitted by The Coalition for Physician Accountability's Work Group on Learner Transitions from Medical Schools to Residency Programs in 2020

Introduction

The COVID-19 pandemic has brought widespread, extreme, and ongoing disruption to healthcare and medical education in the United States. This disruption extends throughout the continuum of physician education, creating novel circumstances for students, residents, faculty members, schools and institutions that provide medical education, and organizations responsible for the regulation of the medical profession. As this disruption continues through the summer of 2020, this year's transition of medical school graduates into their first postgraduate year (PGY-1) appointments in US residency programs demands a coordinated and collaborative approach in order to protect patients, learners, and the healthcare workforce, and to safeguard the interests of the public.

Coalition for Physician Accountability and the Work Group

The Coalition for Physician Accountability (Coalition) "is a membership organization that convenes on a regular basis to engage in discussion and collaboration on matters of common relevance to improve the quality of healthcare."[1] Its members include:

- Accreditation Council for Continuing Medical Education (ACCME)
- Accreditation Council for Graduate Medical Education (ACGME)
- American Association of Colleges of Osteopathic Medicine (AACOM)
- American Board of Medical Specialties (ABMS)
- American Medical Association (AMA)
- American Osteopathic Association (AOA)
- Association of American Medical Colleges (AAMC)
- Council of Medical Specialty Societies (CMSS) *(liaison member)*
- Educational Commission for Foreign Medical Graduates (ECFMG)
- Federation of State Medical Boards (FSMB)
- Joint Commission *(liaison member)*
- Liaison Committee for Medical Education (LCME)
- National Board of Medical Examiners (NBME)
- National Board of Osteopathic Medical Examiners (NBOME)

The Coalition was established to promote professional accountability by improving the quality, efficiency, and continuity of the education and assessment of physicians. Consistent with this purpose, the Coalition created several work groups to develop common

[1] Coalition for Physician Accountability. http://physicianaccountability.org/About.html. Accessed May 3, 2020.

recommendations that address urgent issues related to the COVID-19 pandemic and physician education.

This work group was convened to propose recommendations for the guidance of learners, schools, institutions, and organizations in the transition of medical school graduates into their PGY-1 appointments in US residency programs in 2020. The work group was comprised of representatives from ACGME, AACOM, AAMC, AMA, ECFMG, National Resident Matching Program (NRMP), and Organization of Program Director Associations (OPDA).

Background

In 2020, tens of thousands of medical school graduates will begin PGY-1 appointments in US residency programs accredited by the ACGME. 32,399 graduates have entered into match commitments with programs and institutions through the NRMP to begin their 2020 PGY-1 appointments, and approximately 400 or more graduates have committed to appointments through other matching programs.[2,3] Based on previous years' information,[4,5,6] it is roughly estimated that fewer than 1,000 appointments of PGY-1 residents will be arranged outside of matching programs in 2020. Consistent with well-established precedent in ACGME-accredited Sponsoring Institutions and residency programs, most PGY-1 appointments of residents in 2020 are expected to begin around July 1.

Most incoming PGY-1 residents are graduating from an MD-degree-granting medical school in the United States or Canada accredited by the Liaison Committee on Medical Education (LCME), or from a DO-degree-granting medical school in the United States accredited by the Commission on Osteopathic College Accreditation (COCA).[6,7] The cohort of incoming PGY-1 residents also includes graduates of international medical schools who have obtained a valid certificate from the Educational Commission for Foreign Medical Graduates (ECFMG) or a full medical license in a United States jurisdiction.[6,7]

The recommendations of the work group are intended to address the entire population of US and international medical school graduates who will begin their PGY-1 residency

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[2] National Resident Matching Program (NRMP). 2020 Main Residency Match by the numbers. http://www.nrmp.org/main-residency-match-data/. Accessed May 2, 2020.

[3] American Urological Association. Urology Residency Match statistics. https://www.auanet.org/education/auauniversity/for-residents/urology-and-specialty-matches/urology-match-results. Accessed May 2, 2020.

[4] NRMP. Results and data: 2019 Main Residency Match. http://www.nrmp.org/main-residency-match-data/. Accessed May 2, 2020.

[5] American Osteopathic Association (AOA). AOA Intern/Resident Registration Program. Summary of positions offered and filled by program type: results of the 2019 match. National Matching Services, Inc. https://natmatch.com/aoairp/stats/2019prgstats.html. Accessed May 2, 2020.

[6] Accreditation Council for Graduate Medical Education (ACGME). Data resource book: 2018-2019. https://www.acgme.org/About-Us/Publications-and-Resources/Graduate-Medical-Education-Data-Resource-Book/GraduateMedicalEducation/GraduateMedicalEducationDataResourceBook. Accessed May 2, 2020.

[7] ACGME. Institutional requirements. https://acgme.org/Designated-Institutional-Officials/Institutional-Review-Committee/Institutional-Application-and-Requirements. Effective July 1, 2018. Accessed May 2, 2020.

appointment in the US no later than January 31, 2021, and the institutions and programs that will appoint them.

Process, Goal, and Considerations

In a series of video conference meetings in April and May 2020, work group members described various issues related to the transition of medical school graduates into PGY-1 residency appointments in 2020 and summarized published guidance relevant to those issues. The work group then outlined recommendations addressing aspects of the 2020 transition that were likely to be affected by the pandemic.

The goal of the recommendations is to promote public and professional safety by mitigating the effects of pandemic-related disruption in the transition from undergraduate to graduate medical education (UME to GME). When formulating the recommendations, the work group considered the needs of learners, medical schools, organizations involved in GME, and organizations with regulatory responsibility, and balanced those needs with the interests of patients, communities, and the public.

Some of the work group's considerations deserve explicit mention. It was hypothesized before the COVID-19 pandemic that stressors associated with this transition may compromise the well-being of the learner,[8] and the work group formulated its recommendations with concern that pandemic-related disruption could exacerbate learners' stress. This includes new challenges that US and international medical school graduates may encounter related to relocation, personal health risks, and personal health screening as they transition into PGY-1 residency appointments. Many incoming PGY-1 residents will enter clinical learning environments under considerable stress at a time that institutions and programs are planning for increases in disease burden that may occur this fall and winter. Social isolation of PGY-1 residents outside the clinical learning environment may also be a threat to well-being in some locations.

Many institutions and programs are experienced in supporting and monitoring the well-being of incoming PGY-1 residents and are planning to adapt their approaches to reflect complex well-being challenges that have emerged inside and outside the clinical learning environment this year. The work group's recommendations acknowledge that there may be elevated risks to the well-being of PGY-1 residents in 2020, and that any such risks may persist for the duration of their PGY-1 appointments.

The work group also took into account widespread reports of pandemic-related financial and operational emergencies in healthcare and educational organizations and recognized that international medical graduates may face unique challenges in this year's transition.

Finally, the work group's recommendations are based on the current knowledge of COVID-19 and its anticipated impact in the coming months, which is expected to vary by location. The work group acknowledged that future developments in the pandemic response may affect healthcare and medical education needs in unexpected ways, and therefore may call

[8] Yaghmour NA, Brigham TP, Richter T, et al. Causes of death of residents in ACGME-accredited programs 2000 through 2014: implications for the learning environment. Acad Med. 2017;92:976-983. doi: 10.1097/ACM.0000000000001736

for superseding recommendations from the Coalition for Physician Accountability or its member organizations. The recommendations are not presented in order of priority.

This report and its recommendations were reviewed prior to publication by representatives of ABMS, FSMB, and LCME. (A list of reviewers is Appendix 2.) The work group gratefully acknowledges the reviewers' comments.

Recommendations

1. 2020 Match Participation Agreements
   a. Match participation agreements and match commitments for PGY-1 residency appointments should remain in effect for all residents, programs, and institutions, and all matches (e.g., NRMP, Urology Residency Match Program).
   b. Any modifications to, or cancellations of, match commitments for PGY-1 residency appointments should conform to the policies and procedures of the organization that provides the match (e.g., NRMP waiver process). Programs and applicants seeking waivers of a match commitment due to delays in graduation, United States Medical Licensing Examination (USMLE) or Comprehensive Osteopathic Medical Licensing Examination (COMLEX) testing needs, etc., are encouraged to consider a deferral of training to the next academic year.
   c. Match commitments are contractual obligations. Deployment or assignment of matched applicants to PGY-1 positions should adhere to match participation agreements and match commitments, including any prohibition against enrolling applicants into residency programs into which they did not match.

2. Residency Appointments
   a. Appointment to a PGY-1 residency position should comply with ACGME Institutional Requirements.
   b. Conditions of appointment provided in PGY-1 residency appointment contracts should be consistent with information provided to applicants at the time of recruitment and interview or that were provided in post-match communications.
   c. In accordance with institutional policies and procedures, Sponsoring Institutions should consider requests for leaves of absence or for reasonable accommodations from incoming PGY-1 residents whose ability to participate in resident assignments or the residency program is affected by the COVID-19 pandemic. Additionally, modification or cancellation of a match commitment (e.g., NRMP waiver) must be discussed with the organization that provides the match to determine available options.

3. Transitions to a New Location to Begin a Residency Program
   a. Sponsoring Institutions and their programs are encouraged to provide augmented relocation resources to assist incoming PGY-1 residents in the transition to 2020 appointments. Examples may include referrals for services such as healthcare, housing, legal assistance, transportation, and childcare.
   b. The Sponsoring Institution and its programs should provide policies and communications to incoming PGY-1 residents regarding any quarantine measures to which residents will

be subject before starting their program or rotations. A suggested approach is to allow residents under quarantine to participate in activities such as virtual orientation, information systems training, or research/scholarly activity.

c. The Sponsoring Institution should ensure the provision of appropriate resources to support incoming PGY-1 residents who are subject to quarantine. (See 7.b below.)

d. Orientation to infection protection for residents, including the provision of personal protective equipment (PPE) and training in its use, should precede incoming PGY-1 residents' participation in any clinical setting. If a GME boot camp is required for incoming PGY-1 residents, it should be conducted in accordance with the Sponsoring Institution's policies and procedures for infection protection.

e. It is essential for Sponsoring Institutions to be mindful of regulations pertaining to medical licensure for PGY-1 residents.

4. Flexibility in Requirements
   a. See 1.b above.
   b. Some variance in ACGME Common and specialty-/subspecialty-specific Program Requirements is available under a Sponsoring Institution's pandemic emergency status, as described on the ACGME web site.
   c. There is no variance in ACGME Institutional Requirements.

5. Early Medical School Graduation
   a. See published guidance from ACGME, NRMP, AMA, LCME, and COCA.
   b. Early medical school graduates should be able to opt out of engaging in clinical care prior to their PGY-1 residency appointments without intimidation or retaliation.
   c. Early medical school graduates who engage in clinical care prior to their PGY-1 residency appointments should be provided appropriate PPE, training in its use, and appropriate supervision; and should be released from duty on a schedule that allows for reasonable transition time so that the PGY-1 residents may begin their appointments without delay.

6. Delayed Medical School Graduation; Delayed Arrival in Residency Program
   a. Per NRMP guidance, in the absence of a waiver or deferral of a match appointment, matched applicants are to begin their PGY-1 residency appointments by January 31, 2021.
   b. During the 2020 appointment year, Sponsoring Institutions should seek to accommodate the delayed graduation of medical students who are transitioning to residency, and the delayed arrival of PGY-1 residents due to reasons that include international travel, health concerns (including quarantine not required by the Sponsoring Institution/program), visa issues, or licensure delays. See Section 3.e.

7. Resident Obligations Regarding Pre-Employment Health Screening or Quarantines
   a. See 3 above.
   b. Any PGY-1 resident obligations regarding pre-employment health screening or quarantines should be guided by institutional policies and procedures. If a Sponsoring

Institution requires a health screening, it should be provided by the Sponsoring Institution in partnership with its participating sites. If an institution requires pre-employment physicals or quarantines, these requirements should be viewed as responsibilities under the residency appointment.

c. As a resident assignment, time in quarantine should not be classified as vacation or leave of absence within a PGY-1 residency appointment.

8. Impact of Transitioning to a Clinical Environment during the COVID-19 Pandemic
   a. Given anticipated challenges to the well-being of PGY-1 residents during the COVID-19 pandemic, Sponsoring Institutions, in partnership with their programs, should consider providing augmented assessment and monitoring of PGY-1 residents' well-being throughout the appointment year.
   b. Sponsoring Institutions and programs should disclose to incoming PGY-1 residents any deviations from the expected curriculum due to the response to the COVID-19 pandemic. The disclosure should specify the effects of curriculum deviations on PGY-1 residents' ability to satisfy requirements for program completion, and on eligibility for specialty board examinations.
   c. Sponsoring Institutions and programs should consult published ACGME guidance regarding the COVID-19 pandemic to ensure compliance with Institutional Requirements, and with program requirements for safety, supervision, and clinical and educational work hours.
   d. Given the clinical environment in 2020, there should be augmented consideration of the amount of incoming PGY-1 residents' previous clinical experience in the United States when determining the residents' initial clinical assignments.

9. International Medical Graduates
   a. Sponsoring Institutions, programs, and training program liaisons should proactively communicate with incoming PGY-1 residents who are international medical graduates to confirm their status and to understand if there are any barriers to beginning their residency appointments.
   b. Sponsoring Institutions, programs, and training program liaisons should contact ECFMG for information and assistance, as needed.
   c. Early appointment of international medical graduates to PGY-1 residency appointments should be consistent with visa-specific regulations and immigration law and should follow ACGME, NRMP, FSMB, and state-specific guidance, requirements, policies, procedures, rules, and regulations.
   d. Sponsoring Institutions and their programs are encouraged to provide augmented relocation assistance to incoming PGY-1 residents who are international medical graduates in the transition to 2020 appointments. Examples may include referrals for services such as healthcare, housing, legal assistance, transportation, and childcare.
   e. Recognizing the increased risk of social isolation and other unique circumstances related to COVID-19, Sponsoring Institutions, programs, and training program liaisons are strongly encouraged to facilitate enhanced cultural and community support for international medical graduates beginning PGY-1 residency appointments in 2020.

f. See 6.b above

Impact of a COVID-19 and a Shortened ERAS Timeline on Programs' Implementation of Holistic Review Resources

Recommendation 3 — ERAS Timeline: The WG recommends a delayed opening of ERAS for residency programs and a delayed release of the MSPEs and that the opening and release happen on the same day.

Because of COVID-19-related disruptions to the implementation of third-year curricula, Board exam schedules, visa processing, and travel, applicants are experiencing challenges completing the requirements that would normally prepare them for the residency recruitment cycle. This is of concern to all engaged in the residency selection process. As programs consider historical eligibility requirements that may not be readily attainable for every applicant in the COVID-19 environment, they will be faced with individuals who have limited or no clinical experience in the specialty, limited letters of recommendation, and/or incomplete USMLE or COMLEX examinations. Employing the traditional evaluation approach may result in applicants being automatically screen out.

In the pandemic environment, program directors can expect even more challenges to the recruitment cycle as program staff are required to screen applicants with even fewer letters of recommendation, fewer rotation evaluations (away and at home), and fewer test scores. Programs with severe financial burdens may face challenges with availability of program personnel funds. Furthermore, once the acute phase of the pandemic has passed, the clinical workload of program faculty will have increased, which may further affect the faculty's availability for recruiting.

Even as ERAS considers a delayed opening to allow additional time for applicants to complete their applications, it is unclear how long COVID-19-related disruptions may last, how much information programs will have available to make decisions, or how the compressed recruitment cycle will affect programs that wish to conduct holistic review of their applications. This lack of clarity may trigger other behaviors in applicants (e.g., increasing the number of programs they apply to) and programs (e.g., extending more interview invitations) that could exacerbate an already difficult situation.

To ensure a consistent, fair process for all applicants, and to make the most of the recruitment cycle, residency programs should conduct a holistic review of all applicants. They should:

1. Review specialty guidance from their program director organizations, ACGME, and other authoritative organizations.
2. Consider letters of recommendation outside the program's discipline.
3. Consider alternative validated methods of assessment, such as COMAT and NBME shelf examinations, while awaiting completion or availability of USMLE and COMLEX examinations.
4. Consider adapting the virtual interview processes that provide multiple opportunities for maximum information exchange between applicants and programs:
    a. Best practices for applicant assessment may include collating input from official interviewers and current trainees and staff who are encountering the applicants, behaviorally based interview questions, and recording select interview segments.

   b. Best practices for promoting the program may include live or recorded videos of a program overview, community information, informal interaction with current trainees in large and small groups that facilitates frank discussion, and virtual tours of facilities that portray conditions honestly.
5. Be consistent with interview methods throughout the recruitment season, recognizing that the timing of interviews for individual programs and applicants may be affected by the evolving local impact of the pandemic.
6. Clearly inform potential applicants of the eligibility criteria for the program and the program's curriculum and training.
7. Partner with sponsoring institutions and local resources that promote the community.
8. Be aware of variations in the medical student performance evaluations (MSPEs) compared with previous years due to limitations in clinical experiences and other disruptions to medical education due to COVID-19.

Resource

AAMC Holistic Review Resources and Tools for Program Directors

Coalition for Physician Accountability

Statement on Public Health

December 1, 2020

The Coalition for Physician Accountability shares a strong commitment to protect the public's health and safety through the delivery of high-quality health care. Public health officers and physicians involved in various public health roles, including advocacy and leadership, have recently been criticized by elected officials and members of the public for following evidence-based practices. Recognizing that understanding of the SARS-CoV-2 virus and its transmission and pathogenicity continues to evolve, the member organizations of the Coalition for Physician Accountability strongly:

1. Support public health officials and workers at the local, state, territorial, tribal, and national levels committed to acting upon prevailing evidence-based public health practices to contain and mitigate transmission of the virus;
2. Encourage greater integration of public health practices and principles – including epidemiology, statistics, population health, health policy, social determinants of health, and equity and diversity – across the continuum of medical education, from medical school through residency and fellowship training, and throughout practice;
3. Support a commitment from local, state, territorial, tribal, and federal officials to protect the public by closely collaborating with health officials and to substantively increase funding and resources for local, state, territorial, tribal, and federal health departments and agencies, especially for the prevention and management of COVID-19 and future pandemics;

4. Endorse a commitment by all physicians at every level of training and practice to follow prevailing expert advice for the reduction of viral transmission, including wearing a face covering (mask) when engaged in the in-person care of patients; and
5. Recognize that physicians have an ethical responsibility to follow evidence-based practices; provide high quality health care for the nation's most vulnerable populations disproportionately affected by the pandemic; maintain professionalism, accountability and competence; collaborate with colleagues across the health professions; respect science and the scientific method; support ongoing research that improves our understanding of COVID-19 and the impact that health inequities and social determinants of health play; and understand their own role as trusted spokespersons of the medical profession.

Endorsed by Members of the Coalition for Physician Accountability:

Accreditation Council for Continuing Medical Education (ACCME)
Accreditation Council for Graduate Medical Education (ACGME)
American Association of Colleges of Osteopathic Medicine (AACOM)
American Board of Medical Specialties (ABMS)
American Medical Association (AMA)
American Osteopathic Association (AOA)
Association of American Medical Colleges (AAMC)
Council of Medical Specialty Societies (CMSS) (liaison member)
Educational Commission for Foreign Medical Graduates (ECFMG)
Federation of State Medical Boards (FSMB)
Joint Commission (liaison member)
Liaison Committee for Medical Education (LCME)
National Board of Medical Examiners (NBME)
National Board of Osteopathic Medical Examiners (NBOME)

April 5, 2020

ACGME Reaffirms its Four Ongoing Requirement Priorities during COVID-19 Pandemic

As the nation and world face the evolving COVID-19 (SARS COV2) crisis, the ACGME has granted a significant degree of flexibility to accredited Sponsoring Institutions and programs to realign their resident and fellow workforce to meet the increased clinical demands created by the pandemic. This flexibility with expectations is provided consistent with the ACGME's commitment to patient safety and resident/fellow safety. In exchange for this flexibility, the ACGME expects strict compliance with the following four requirements:

1. **Work Hour Requirements**
   The ACGME Common Program Requirements Section VI Work Hour Requirements remain unchanged. Safety of patients and residents/fellows is the ACGME's highest priority, and it is vital all residents and fellows receive adequate rest between clinical duties. Violations of the work hour limitations have been associated with an increase in medical errors, needle sticks, and other adverse events that might lead to lapses in infection control, slips in this area could increase risks for both patients and residents/fellows.

2. **Adequate Resources and Training**
   Any resident, fellow, and faculty member providing care to patients potentially infected with COVID-19 must be fully trained in treatment and infection control protocols and procedures adopted by their local health care setting (e.g., personal protective equipment [PPE]). Clinical learning environments must provide adequate resources, facilities, and training to properly recognize and care for these patients, including the need to take a complete travel and exposure history in patients presenting with signs and symptoms associated with COVID-19.

3. **Adequate Supervision**
   Any resident or fellow who provides care to patients will do so under the appropriate supervision for the clinical circumstance and the level of education of the resident/fellow. Faculty members are expected to have been trained in the treatment and infection control protocols and procedures adopted by their local health care settings. Sponsoring Institutions and programs should continue to monitor the CDC website.

4. **Fellows Functioning in their Core (Primary) Specialty**
   Fellows in ACGME-accredited programs can function within their core specialty (i.e., the specialty in which they completed their residency), consistent with the policies and procedures of the Sponsoring Institution and its participating sites, if:

   a. they are American Board of Medical Specialties (ABMS) or American Osteopathic Association (AOA) board-eligible or -certified in the core specialty;

   b. they are appointed to the medical staff at the Sponsoring Institution; and,

   c. their time spent on their core specialty service is limited to 20 percent of their annual education time in any academic year.

December 21, 2020

Updated: Supplemental Guidance Regarding the COVID-19 Pandemic, ACGME Accreditation, and Sponsoring Institution Emergency Categorization

The ACGME continues to maintain a process for the Emergency categorization of Sponsoring Institutions that face operational disruption resulting from the COVID-19 pandemic, and to issue guidance statements that address emerging pandemic-related accreditation issues. Based on its continued monitoring of the effects of the pandemic on graduate medical education, health care providers, and the public, the ACGME is providing the following supplemental guidance:

1. The ACGME continues to maintain its process for the Emergency categorization of Sponsoring Institutions as described on the ACGME website. In a modification to this process, the days of a Sponsoring Institution's Emergency Category status will be counted cumulatively in each academic year (July 1-June 30). A Sponsoring Institution's first request for Emergency categorization in a given academic year should be submitted to the ACGME using the Request Form for 1-30 Days.

2. All Sponsoring Institutions, in partnership with their programs, must ensure the safety of resident, fellow, and faculty member assignments that may include responsibilities for the care of patients with COVID-19. As stated in previous ACGME guidance ["ACGME Reaffirms Its Four Ongoing Requirement Priorities during COVID-19 Pandemic"], "any resident, fellow, and faculty member providing care to patients potentially infected with COVID-19 must be fully trained in treatment and infection control protocols and procedures adopted by their local health care setting (e.g., personal protective equipment [PPE])." When setting priorities for vaccination against COVID-19, inclusion of residents/fellows and faculty members who serve as frontline caregivers is considered an essential part of this requirement.

   These obligations to ensure safety extend to the protection of faculty members, residents, and fellows who inform Sponsoring Institutions and programs of health conditions or impairments that are likely to be associated with a high risk of morbidity or mortality in the event of COVID-19 infection. Sponsoring Institutions and programs must ensure that faculty members, residents, and fellows with such health conditions or impairments are informed of safety measures associated with their patient care assignments. Per the ACGME Institutional Requirements, Sponsoring Institutions must have policies addressing leaves of absence and accommodations for disabilities. Sponsoring Institutions should consider requests for leaves of absence or for accommodations made by faculty members, residents, and fellows whose ability to participate in patient care assignments or other program activities is affected by health conditions (including COVID-19-related illness) or impairments. Reasonable accommodations should include arrangements that avoid risks to personal safety associated with residents', fellows', and faculty members' health status (e.g., alternative rotations).

3. All programs must continue to assess residents and fellows in all six Core Competencies, and such assessments must form the basis for decisions regarding promotion to subsequent appointment levels or satisfaction of requirements for program completion. The ACGME has issued guidance ["Guidance Statement on Competency-Based Medical Education during COVID-19 Residency and Fellowship Disruptions"] for program directors, faculty members, and Clinical

Competency Committees in completing the required assessments when educational components of the programs have been disrupted as a result of the COVID-19 pandemic. Programs should follow the principles of competency-based medical education, as described in the above-referenced guidance statement, to make determinations regarding the advancement, graduation, and Board eligibility of individual residents and fellows.