## AACOM UME-GME Task Force

# AACOM Roadmap on Transition to Residency: Response to the CPA UGRC Recommendations

### Introduction

The AACOM Board of Deans approved the creation of a task force in November 2021 to address three key issues in osteopathic medical education: 1) The transition to the residency 2) osteopathic graduate medical education 3) strengthening the model of undergraduate medical education.

The first deliverable from the UME-GME Task Force is to propose AACOM's roadmap to respond to the Coalition for Physician Accountability (CPA)'s Undergraduate to Graduate Medical Education Review Committee (UGRC) recommendations published in August 2021[1]. The UME-GME Steering Committee reviewed all 34 recommendations and ranked the potential impact of the recommendations on osteopathic medical students, medical schools and GME programs. The group also recommended AACOM's proposed actions or response for each recommendation.

### Highest Impact & Most Time Sensitive Recommendations

The steering committee indicated that most of the recommendations have the potential to significantly impact osteopathic medical students, schools, and programs. The highest ranked and most time sensitive recommendations are:

- Away rotations (#13)
- Innovations to the residency application process should be piloted (#23)
- Developing and articulating consensus around components of a successful residency selection cycle; exploring the growing number of unmatched physicians and fostering future research to understand which factors are most likely to translate into physicians who fulfill the physician workforce needs of the public (#2)
- Interactive database with verifiable GME program/track information (#6)
- Access to career advising resources (#7)
- Educators should develop a salutary practice curriculum for UME career advising (#8)
- Comparable exams with different scales (COMLEX-USA and USMLE) (#18)
- Virtual interviews (#21)
- Develop and implement standards for the interview offer and acceptance process (#22)

The recommendations on away rotations were perceived as potentially having a negative impact on osteopathic medical students, programs, and schools, if there is a move toward limiting away rotations. Most of the remaining highly ranked recommendations were ranked as having a positive impact on the osteopathic medical education community.

### *Proposed AACOM Actions*

Overall, the UME-GME Steering Committee believes that there are opportunities for AACOM and the osteopathic community to improve the transition to residency process through the UGRC recommendations. Specific actions/recommendations for each recommendation are outlined in Table 2.

[1] https://physicianaccountability.org/wp-content/uploads/2021/08/UGRC-Coalition-Report-FINAL.pdf

Key proposed actions include collaborating with external organizations and development of working groups to address recommendations. There are recommendations for AACOM to gather data and produce research and integrate osteopathic perspectives in existing resources such as the AAMC's Careers in Medicine. Table 1. outlines the proposed AACOM response on the most time sensitive recommendations.

| Table 1. Proposed AACOM response to address the highest ranked and most time sensitive recommendations | | |
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| UGRC # | UGRC Recommendation | Proposed AACOM Response |
| 13 | Convene a workgroup to explore the multiple functions and value of away rotations for applicants, medical schools, and residency programs. Specifically, consider the goals and utility of the experience, the impact of these rotations, and issues of equity including accessibility, assessment, and opportunity for students from groups underrepresented in medicine and financially disadvantaged students. | Given significant concern that the UGRC's recommendation of creating a workgroup may be geared in a direction of limiting away rotations for students, AACOM should 1) communicate the lack of data that speaks from community-based distributed educational models on away rotations and in the considerations by the UGRC 2) propose that audition/away rotations cease for all students attending medical schools with an associated academic medical center, medical students that attend a school not associated with an academic medical center should continue to utilize audition and away rotations. This would reduce the total number of students performing away/audition rotations, addressing concerns raised by the UGRC, while providing opportunities for students who need these opportunities |
| 23 | Innovations to the residency application process should be piloted to reduce application numbers and concentrate applicants at programs where mutual interest is high, while maximizing applicant placement into residency positions. Well designed pilots should receive all available support from the medical community and be implemented as soon as the 2022-2023 application cycle; successful pilots should be expanded expeditiously toward a unified process. | AACOM should advocate to have a voice in the ABMS specialty groups and the NRMP to engage in pilot projects taking place. The UGRC recommendation requests logistical, financial, and analytic resources to aid in pilot projects. AACOM should make a concerted effort to support these efforts. Continued dialogue with the NRMP leadership is critical. Consideration should be given to a tiered match for Dos under the NRMP infrastructure or other organization |
| 2 | In addition to supporting collaboration around the UME-GME transition, this national committee should: develop and articulate consensus around the components of a successful residency selection cycle; explore the growing | AACOM to gather data to show alternative pathways for students that are unmatched and create faculty development for advising on alternative pathways |

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| | number of unmatched physicians in the context of a national physician shortage; and foster future research to understand which factors are most likely to translate into physicians who fulfill the physician workforce needs of the public. | |
| 6 | Create an interactive database with verifiable GME program/track information and make it available to all applicants, medical schools, and residency programs and at no cost to the applicants. This will include aggregate characteristics of individuals who previously applied to, interviewed at, were ranked by, and matched for each GME program/track. | AACOM to augment Matchbook and collaborate with the AAMC on existing resources |
| 7 | Evidence-informed, general career advising resources should be available for all medical school faculty and staff career advisors, both domestic and international. All students should have free access to a single, comprehensive electronic professional development career planning resource, which provides universally accessible, reliable, up-to-date, and trustworthy information and guidance. General career advising should focus on students' professional development; inclusive practices such as valuing diversity, equity, and belonging; clinical and alternate career pathways; and meeting the needs of the public. Specialty-specific match advising should focus on the individual student obtaining an optimal match. | AACOM to broaden Careers in Medicine to include DO specific information |
| 8 | Educators should develop a salutary practice curriculum for UME career advising. | AACOM to collaborate with AAMC, COMs and other national stakeholders to develop a basic curriculum for advising |
| 18 | To promote equitable treatment of applicants regardless of licensure examination requirements, comparable exams with different scales (COMLEX-USA and USMLE) should be reported within the electronic application system in a single field. | AACOM to support NBOME and USMLE working together to provide ERAS with a score conversion table or percentile converter that allows a direct comparison between a candidate who has taken the COMLEX-USA and a candidate who has taken the USMLE series |

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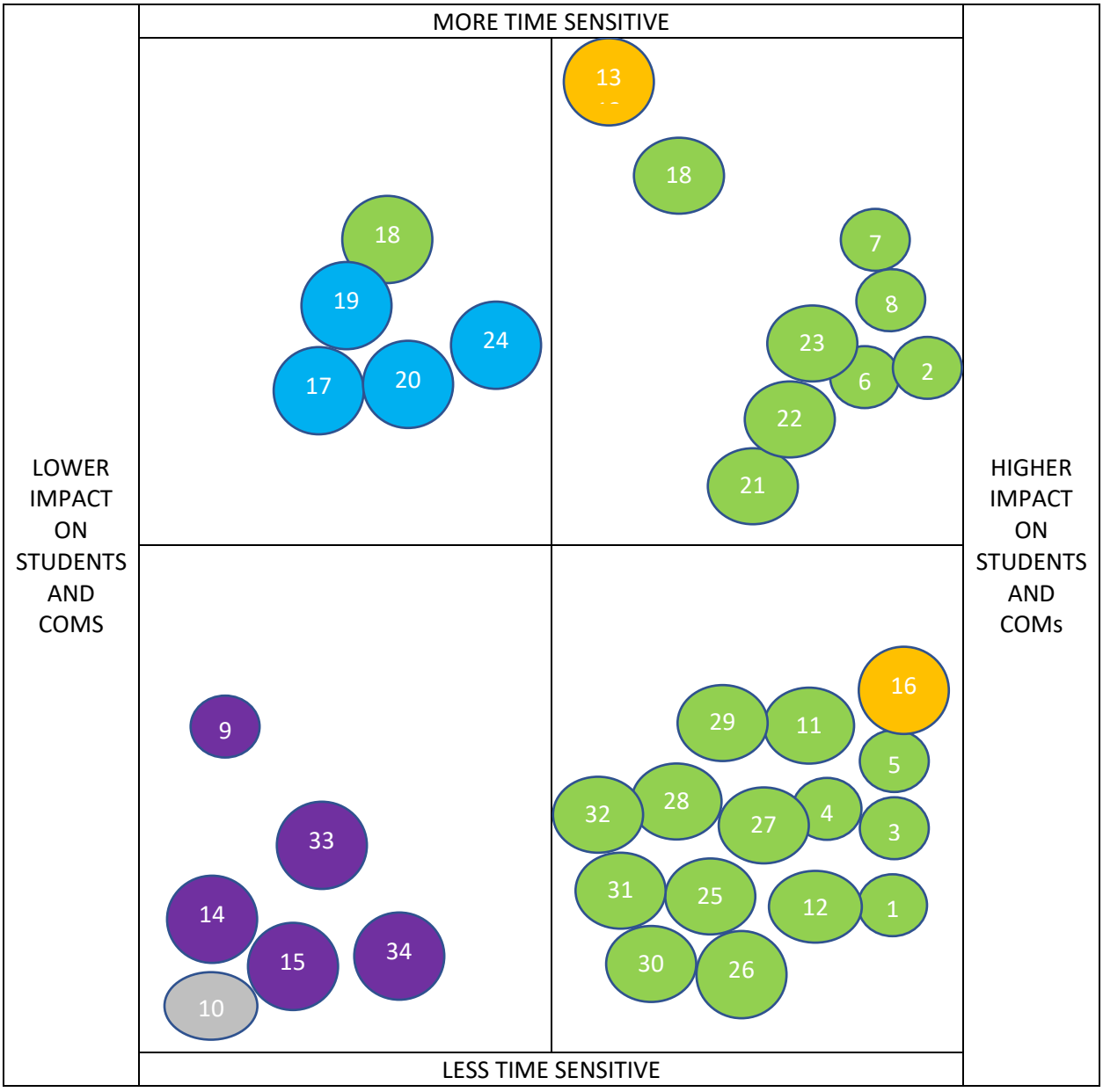
| 21 | All interviewing should be virtual for the 2021-2022 residency selection season. To ensure equity and fairness, there should be ongoing study of the impact of virtual interviewing as a permanent means of interviewing for residency. | AACOM should review virtual interviewing data of osteopathic medical students including the number of interviews received, match rates, overall experience/preference |
| 22 | Develop and implement standards for the interview offer and acceptance process, including timing and methods of communication, for both learners and programs, to improve equity and fairness, to minimize educational disruption, and to improve wellbeing. | AACOM should develop a set of guidelines for the standardized interview offer/acceptance process |

**Additional Recommendations for AACOM Action**

**Advocacy for Increased GME Positions**

AACOM should advocate for the availability of a GME position for all qualified graduates of a COCA-or-LCME accredited school. Expanding GME slots for this expressed purpose is neither a guarantee of employment nor a panacea for filling gaps in the physician workforce. Applicants to GME residencies must still prove themselves a good fit for programs and have their own choices to make should they not wish to accept a certain position available to them. However, we need to eliminate the travesty of the students who have no mechanism for continuing their education despite their qualifications and in the face of unmet needs in patient care. Modernizing the transition from medical school to residency requires a bold approach that addresses this basic failure of the current system and stands to improve the status quo.

Figure 1.

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| Ranking +4 or 5 | |
| Ranking -4 or -5 | |
| Ranking -3 or below | |
| Ranking + 3 or below | |
| Neutral 0 | |

| Table 2. AACOM Proposed Actions/Response | | | | |
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| Theme | # | Recommendation | Proposed AACOM Action/Response | COM vs. National/Collective Response |
| CQI | 1 | Convene a national ongoing committee to manage continuous quality improvement of the entire process of the UME-GME transition, including an evaluation of the intended and unintended impact of implemented recommendations. | AACOM to form a national committee focused on public health issues that can impact all GME programs (nutritional issues, air pollution, obesity, viral outbreaks etc.) | National response |
| | 2 | In addition to supporting collaboration around the UME-GME transition, this national committee should: develop and articulate consensus around the components of a successful residency selection cycle; explore the growing number of unmatched physicians in the context of a national physician shortage; and foster future research to understand which factors are most likely to translate into physicians who fulfill the physician workforce needs of the public. | AACOM to gather data to show alternative pathway options and create faculty development for advising on alternative pathways. Match societal needs while having residency options for unmatched students. | Collective response |
| | 3 | The U.S. Centers for Medicare and Medicaid Services (CMS) should change the current GME funding structure so that the Initial Residency Period (IRP) is calculated starting with the second year of postgraduate training. This will allow career choice reconsideration, leading to improved resident wellbeing and positive effects on the physician workforce. | AACOM should support this effort to change the CMS funding restructure | National response |

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| DEI | 4 | Specialty-specific salutary practices for recruitment to increase diversity across the educational continuum should be developed and disseminated to program directors, residency programs, and institutions. | AACOM should support continued diversity efforts in UME and GME, and holistic review for residency. | UME schools and GME programs should move towards a holistic review of candidates. Demographics of schools/programs should be posted on the website. |
| | 5 | Members of the medical educational continuum must receive continuing professional development regarding anti-racism, avoiding bias, and ensuring equity. Principles of equitable recruitment, mentorship and advising, teaching, and assessment should be included. | AACOM should support DEI training as a mandatory part of all training of physicians throughout the continuum from UME-GME-CME. Furthermore, all faculty and staff that have interactions with students, residents and patients should be part of ongoing training in DEI | National response |
| Advising Resources | 6 | Create an interactive database with verifiable GME program/track information and make it available to all applicants, medical schools, and residency programs and at no cost to the applicants. This will include aggregate characteristics of individuals who previously applied to, interviewed at, were ranked by, and matched for each GME program/track. | Augment matchbook through AACOM and collaborate with the AAMC. | National response |
| | 7 | Evidence-informed, general career advising resources should be available for all medical school faculty and staff career advisors, both domestic and international. | Broaden Careers in Medicine to include DO specific information | COM level for regional differences |

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| | | All students should have free access to a single, comprehensive electronic professional development career planning resource, which provides universally accessible, reliable, up-to-date, and trustworthy information and guidance. General career advising should focus on students' professional development; inclusive practices such as valuing diversity, equity, and belonging; clinical and alternate career pathways; and meeting the needs of the public. Specialty-specific match advising should focus on the individual student obtaining an optimal match. | | National for Careers in Medicine |
| | 8 | Educators should develop a salutary practice curriculum for UME career advising. | AACOM should collaborate with AAMC, colleges of osteopathic medicine (COMs)/BOD and other national stakeholders to develop a basic minimum curriculum for advising. | National and COM level approach Foundational curriculum needs to consider for regional differences COM maintained database of student population metrics and placement |
| Outcome & Assessment | 9 | UME and GME educators, along with representatives of the full educational continuum, should jointly define and implement a common framework and set of | AACOM should establish a working group and work collaboratively with stakeholders (e.g., students, residents, faculty, curriculum committees) to determine and establish | National response |

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| | | outcomes (competencies) to apply to learners across the UME-GME transition | benchmarks and deliverables. The group should show how decision-making will be better informed by useful real-time data. A working group should propose what competencies to define and put forward items such as programmatic level educational objectives while making them known to students, faculty, others with responsibility for student education and assessment | |
| | 10 | To eliminate systemic biases in grading, medical schools must perform initial and annual exploratory reviews of clinical clerkship grading, including patterns of grade distribution based on race, ethnicity, gender identity/expression, sexual identity/ orientation, religion, visa status, ability, and location (e.g., satellite or clinical site location), and perform regular faculty development to mitigate bias. Programs across the UME-GME continuum should explore the impact of bias on student and resident evaluations, match results, attrition, and selection to honor societies. | AACOM should recommend that COCA and LCME share a "comparability report" that ensures the curriculum includes comparable educational experiences, has equivalent methods of assessment, and has a continuous quality improvement process for evaluating bias | Collective response and share best practices for continuous quality improvement process for evaluating bias in clinical grading and assessment. |
| | 11 | The UME community, working in conjunction with partners across the continuum, must commit to using robust assessment tools and strategies, improving upon existing tools, developing new tools where needed, and gathering and reviewing additional evidence of validity. | AACOM should establish a working group and work with stakeholders to determine and establish benchmarks and deliverables | Collective response |

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| | 12 | Using the shared mental model of competency and assessment tools and strategies, create and implement faculty development materials for incorporating competency-based expectations into teaching and assessment. | AACOM should offer/propose sessions at the AACOM annual conference and the ACGME Annual Educational Conference and/or conduct ongoing webinars to highlight and educate faculty on the materials developed for incorporating competency-based expectations into teaching and assessment. | AACOM to develop courses, CME activities, webinars for faculty development based on competency-based expectations into teaching and assessment |
| Away Rotations | 13 | Convene a workgroup to explore the multiple functions and value of away rotations for applicants, medical schools, and residency programs. Specifically, consider the goals and utility of the experience, the impact of these rotations, and issues of equity including accessibility, assessment, and opportunity for students from groups underrepresented in medicine and financially disadvantaged students. | The UGRC recommendation of creating a workgroup, and the supporting documents provided, seem to already lay out a direction to discourage, or significantly limit, audition rotations for all students. We have concerns that any workgroup would be heavily weighted on the side of academic medical centers and not truly look through the lens of medical schools with distributed teaching models.<br><br>Therefore, considering the evidence presented, and understanding that none of the data speaks to students from community based, distributed educational models, AACOM should propose that all audition/away rotations cease in their entirety for all students attending medical schools with an associated academic medical center. Medical | Collective Response |

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| | | | students that attend a school not associated with an academic medical center should continue to utilize audition and away rotations as they currently do. This would dramatically reduce the total number of students performing away/audition rotations in the U.S. and ensure that those that really need this experience are granted that opportunity. | |
| Application Review | 14 | A convened group including UME and GME educators should reconsider the content and structure of the MSPE as new information becomes available to improve access to longitudinal assessment data about applicants. Short-term improvements should include structured data entry fields with functionality to enable searching. | AACOM should assess from PDs what information they deem to be important that they would want updated and be able to search. AACOM should determine what searchable elements would disadvantage students from any subset and manage perceived bias accordingly. | Collective response |
| | 15 | Structured Evaluative Letters (SELs) should replace all Letters of Recommendation (LORs) as a universal tool in the residency program application process. | AACOM should advocate for unification of letters required by different specialties. AACOM should organize a group of specialists to agree on what aspects are important to be included in the ERAS standard questions | Collective response |
| | 16 | To raise awareness and facilitate adjustments that will promote equity and accountability, self-reported demographic information of applicants (e.g., race, ethnicity, gender identity/expression, sexual identity/orientation, religion, visa status, or ability) should be measured and shared with key stakeholders, including | AACOM should study the impact of teaching and delivering culturally sensitive care to minimize implicit bias in care delivery. Increase transparency of demographic matching rationales for residency candidates and make this information available on residency websites. | Collective response |

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| | | programs and medical schools, in real time throughout the UME-GME transition. | Offering programs the ability to select based on demographics has the potential to seriously disadvantage a broad swath of candidates and could present legal ramifications. | |
| | 17 | To optimize utility, discrete fields should be available in the existing electronic application system for both narrative and ordinal information currently presented in the MSPE, personal statement, transcript, and letters. Fully using technology will reduce redundancy, improve comprehensibility, and highlight the unique characteristics of each applicant | AACOM should facilitate further discussion about what types of filters would be applied, and get student and GME program input. Filter features have potential to screen out excellent candidates | Collective response |
| | 18 | To promote equitable treatment of applicants regardless of licensure examination requirements, comparable exams with different scales (COMLEX-USA and USMLE) should be reported within the electronic application system in a single field. | Create a new scoring paradigm for reporting the Level 2/Step 2 exam result. NBOME and USMLE should come together to provide ERAS with a score conversion table or percentile converter that allows a direct comparison between a candidate who has taken the COMLEX-USA series and a candidate who has taken the USMLE series. This reporting number should be the only one available on ERAS and should be on a different scale than either exam currently uses (e.g., use a scale of 0-100) – eliminating bias introduced by seeing a numeric score that is wildly different between the two exams or that is unlike either exam's current reporting structure. | Collective: NBOME and USMLE, ERAS |
| | 19 | Filter options available to programs for sorting applicants within the electronic | AACOM should recommend looking at other alternatives other than a filter of applicants | Collective response |

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| | | application system should be carefully created and thoughtfully reviewed to ensure each one detects meaningful differences among applicants and promotes review based on mission alignment and likelihood of success at a program. | that can truly give the program directors what they ultimately want, a good match to their program. Perhaps a different look should be taken at the entire process. For example, applicants to medical school, dental school, optometry school, veterinary school, etc. do not use the same application process, why should family medicine and surgery? | |
| | 20 | Convene a workgroup of educators across the continuum to begin planning for a dashboard/portfolio to collect assessment data in a standard format for use during medical school and in the residency application process. This will enable consistent and equitable information presentation during the residency application process and in a learner handover | AACOM should facilitate discussions and conversations regarding what benefits this effort would truly bring to UME and based on that discussion if a continuation of the current MSPE is needed or not. | Collective response |
| Optimization of Application, Interview and Selection Process | 21 | All interviewing should be virtual for the 2021-2022 residency selection season. To ensure equity and fairness, there should be ongoing study of the impact of virtual interviewing as a permanent means of interviewing for residency | AACOM should review virtual interviewing data of osteopathic students (# of interviews, match rates, overall experience/preference, etc.) - comparing to prior in-person rates & MD applicant responses/data | Collective/national response |
| | 22 | Develop and implement standards for the interview offer and acceptance process, including timing and methods of communication, for both learners and programs, to improve equity and fairness, to minimize educational disruption, and to improve wellbeing. | The current system of waiting to be notified about an interview offer and needing to respond immediately at the risk of losing the offer is unnecessarily stressful and distracting from continued clinical rotation learning. AACOM should develop a set of guidelines for the standardized interview offer/acceptance | Should be a collective/national response (all programs should agree to proceed with a standardized interview offer and |

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| | | | process including when & how interview offers occur; allowing students 24-48 hours to respond to an offer; not offering more interview spots than are available; applicants not accepting concurrently scheduled interviews; etc. | acceptance process) |
| | 23 | Innovations to the residency application process should be piloted to reduce application numbers and concentrate applicants at programs where mutual interest is high, while maximizing applicant placement into residency positions. Well-designed pilots should receive all available support from the medical community and be implemented as soon as the 2022-2023 application cycle; successful pilots should be expanded expeditiously toward a unified process. | AACOM should advocate for a voice at the table in the ABMS specialty groups and the NRMP where decisions are being made about pilot projects. The recommendation requests logistic, financial, and analytic resources to aid in pilot projects. AACOM should make a concerted effort to assist with funding and logistical support, assuming we can determine where pilot projects are being conducted and find a way to insert ourselves into the process. Continued dialogue with the NRMP leadership is critical as changes are considered. Consideration should be given to the possibility of a separate DO match or tier under the infrastructure of the NRMP or other organization. | Collective response |
| | 24 | Implement a centralized process to facilitate evidence-based, specialty-specific limits on the number of interviews each applicant may attend. | AACOM needs to assist in compiling data on how many interviews are appropriate for DO students in each specialty beyond which there is no real benefit. Caps do make sense, but students and programs all have a fear of missing out, and we need data to demonstrate that interview caps are a good thing for DO students and for GME programs. We need to | Collective response |

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| | | | make sure that DO applicants are specifically studied since the MDs will either lump everyone together or exclude us completely, therefore skewing the data and outcomes.<br><br>Finally, the creation of a centralized process needs to have AACOM input. A ticket system for interviews in ERAS or a single scheduling platform is possible, but we must make sure there are no unintended consequences for DO students or community based GME programs. | |
| Resident Readiness | 25 | Early and ongoing specialty-specific resident assessment data should be automatically fed back to medical schools through a standardized process to enhance accountability and to inform continuous improvement of UME programs and learner handovers. | AACOM should establish a working group/work collaboratively with stakeholders to determine and establish benchmarks and deliverables. Instruments for feedback from GME to UME should be standardized and utilized to inform gaps in curriculum and program improvement. | |
| | 26 | Develop a portfolio of evidence-based resident support resources for program directors, designated institutional officials (DIOs), and residency programs. These will be identified as salutary practices, and accessible through a centralized repository. | AACOM should establish a working group and work collaboratively with stakeholders (e.g., residents, faculty, curriculum committees) to determine and establish benchmarks on competency-based remediation and resident wellbeing resources for support around the UME-GME transition. | |
| | 27 | Targeted coaching by qualified educators should begin in UME and continue during GME, focused on professional identity formation and moving from a performance | AACOM should consider forming student affinity groups within AACOM and COMs to improve a sense of belonging. Include milestones to track progress, opportunities to | National & COM level |

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| | | to a growth mindset for effective lifelong learning as a physician. Educators should be astute to the needs of the learner and be equipped to provide assistance to all backgrounds. | celebrate achievement, and allow for mentorship feedback. | |
| | 28 | Specialty-specific, just-in-time training must be provided to all incoming first-year residents, to support the transition from the role of student to a physician ready to assume increased responsibility for patient care. | AACOM and COMs should share best practices on specialty-specific training for interns. AACOM should create a working group and collaboratively work with stakeholders to determine strategies for achieving these goals – including financial strategies, internal processes to support these, and the growth processes necessary to get results. For each strategy, list the actions required, by whom, and by when. | National and COM level response, COMs should share best practices |
| | 29 | Residents must be provided with robust orientation and ramp up into their specific program at the start of internship. In addition to clinical skills and system utilization, content should include introduction to the patient population, known health disparities, community service and engagement, faculty, peers, and institutional culture. | AACOM should convene a working group that would propose programmatic level educational objectives that can be shared with students, faculty, and others with responsibility for student education and assessment. | Collective response |
| | 30 | Meaningful assessment data based on performance after the MSPE must be collected and collated for each graduate, reflected on by the learner with an educator or coach, and utilized in the development of a specialty-specific, | AACOM should establish a UME/GME working group that would collaboratively work with stakeholders (e.g., students, residents, faculty, curriculum committees) to develop an individualized learning plan and determine what materials and areas should be covered, | Collective response |

| Table 2. AACOM Proposed Actions/Response | | | | |
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| | | individualized learning plan to be presented to the residency program to serve as a baseline at the start of residency training. | therefore establishing benchmarks and deliverables. Develop a formal document that lays out the case for change | |
| Health & Wellness | 31 | Anticipating the challenges of the UME-GME transition, schools and programs should ensure that time is protected, and systems are in place, to guarantee that individualized wellness resources – including health care, psychosocial supports, and communities of belonging – are available for each learner. | AACOM should strongly support individualized wellness resources and offer a program to COMs to facilitate this process. One of the challenges for enrolling students for health insurance is that they are not yet employees. However, the health systems where students match should provide information of primary care providers, therapist, etc. well in advance, or within several weeks of matching. This would no doubt be helpful to optimize the well-being of our students as they transition from medical school to residency. AACOM can put out a policy statement advocating that medical schools and residency programs collaborate on wellness resources in this transition period | Collective response |
| | 32 | Adequate and appropriate time must be assured between graduation and learner start of residency to facilitate this major life transition. | AACOM should provide education to respective residency programs on the needs of osteopathic medical students prior to matriculation to residency. One other suggestion would be to ensure a composite minimal amount of time from graduation of medical school to matriculation to residency. This might mean across the board suggesting that graduation dates be in early May. Instead of late May or early June (preferably at least 4 weeks). To ensure students have sufficient | Collective response |

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| | | | time to adjust to their new location, acclimate, and secure necessary support services. | |
| | 33 | All learners need equitable access to adequate funding and resources for the transition to residency prior to residency launch. | AACOM should support funding and resources for the transition to residency and determine potential funding sources and areas for advocacy. Potential funding from federal/state/local government or private entities. Consider if funds may be repayable on graduation if obtained from government? Should AACOM fund its student committee members? | Collective response |
| | 34 | There should be a standardized process throughout the United States for initial licensing at entrance to residency to streamline the process of credentialing for both residency training and continuing practice. | AACOM could advocate to the FSMB & state licensure boards (both MD and DO). This could be helpful for students who are not taught/coached much on how to navigate licensure requirements in school and for schools needing to sign off on student documents for various states. For programs, whose staff spend much time onboarding interns – including obtaining training licenses where required. | Collective response |
| Ranking Legend | | | | |
| Ranking +4 or 5 | | | | |
| Ranking -4 or -5 | | | | |
| Ranking -3 or below | | | | |
| Ranking + 3 or below | | | | |
| Neutral 0 | | | | |