

ACGME's Early Adaptation to the COVID-19 Pandemic: Principles and Lessons Learned

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On March 13, 2020, the Accreditation Council for Graduate Medical Education (ACGME) and ACGME International (ACGME-I) took the unprecedented steps of canceling all accreditation site visits, all Clinical Learning Environment Review (CLER) Program site visits, and all in-person educational and accreditation meetings worldwide. Within 5 days, the ACGME and ACGME-I closed their offices in Chicago, and began a process of transforming ACGME Review Committee spring and ACGME-I summer meetings to distance technology. In this article I will outline the framework for ACGME decision making during the COVID-19 pandemic of Spring 2020, and the lessons learned thus far.

While the ACGME has embarked on systematic scenario planning over the past 8 years and has examined a number of “existential threats” in the external environment that could have a direct impact on clinical care and graduate medical education in the United States, planning to accredit through a worldwide pandemic was not discretely planned for. However, a number of principles (see BOX 1) were identified in these existential threat analyses that prepared us to react to the evolving challenges posed by the COVID-19 pandemic.

The Principles

First, and most importantly, we identified that during a national crisis, the ACGME's role would be to create the “accreditation space” required for local decision making centered around the needs of the patients being served. We have come to understand that any national or international crisis has dimensions that are common, and those that are unique to the context. Whether it be rural or urban, warm climate versus cold climate, resource poor or resource replete, the context would shape responses, and the ACGME would need to put forth frameworks that permitted reasonable local adaptation.

Second, and of nearly equal importance, the ACGME would need to place boundaries around the “accreditation space” that remained inviolate. In a setting that involves removal of significant accreditation expectations in order to provide clinical care flexibility and resident workforce redeployment, we needed to understand what rules and frameworks must be in place to protect both patients and residents and fellows in the context of what might be chaotic and occasionally poorly reasoned responses to the crisis nature of the event. And for clarity, consistency, and ease of interpretation, these inviolate rules needed to be few in number, clearly understood, logical, and applicable to all programs regardless of pandemic status.

Third, the ACGME would need to give programs and Sponsoring Institutions a framework from which to assess the nature and severity of the impact of the pandemic on their local context, and the progressive deviation from routine operations through a state of increased but manageable activity, into a crisis situation. These transitions would need to be made deliberately. It was here that the ACGME expressed confidence in the competence, commitment, and courage of its program directors and designated institutional officials (DIOs). The ACGME decided to make declaration of “Pandemic Emergency Status” a local decision, requiring only notification to the ACGME for its establishment. This trust between the ACGME and the educational leadership of the health care field has been established through years of collaboration and participation not only in accreditation, but also in formative evaluation and feedback systems, such as the Milestones, the CLER Program, and joint ACGME/educational community well-being efforts, among many others.

Fourth, the ACGME would need to clearly, calmly, and continuously communicate to the health care field using a number of channels. The graduate medical education community looks to the ACGME for guidance and support in challenging situations, and in these circumstances would require the ACGME to communicate in many modes. As the pandemic evolved over the last 4 weeks, it has become evident that the ACGME needed to take on an advocacy role for residents and fellows as part of “front-line health

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BOX 1 ACGME Principles Guiding Actions During the COVID-19 Pandemic

1. Create accreditation “space” through phased relaxation of requirements and administrative processes to create local flexibility.
2. Identify and communicate “inviolate” requirements that must be observed regardless of severity of the crisis locally.
3. Create a conceptual framework for Sponsoring Institutions that permitted self-designated declaration of crisis that reduced accreditation requirements of the 4 “inviolate” requirements.
4. Establish effective, ongoing, multimodal communication with designated institutional officials and program directors.
5. Develop enforcement tools specific to the circumstances to monitor and motivate compliance with “inviolate” requirements.
6. Enhance distance operational skill sets and tools to accomplish the ACGME’s mission during the pandemic.

care worker” teams caring for patients across the country.

Fifth, the ACGME would also require a method for monitoring compliance with this more restricted set of requirements, and provoking improvement, as it was likely that violations of the core standards in place for all programs (see BOX 2) would come due to forces beyond the program’s or even the Sponsoring Institution’s control.

Finally, the ACGME would need to expand its skill set in supporting remote meetings for all of its staff members. Administrative decisions had been made 4 years ago to move from desktop computers to laptop computers with docking stations. This background permitted the rapid shift from office-based work to remote work, and the wisdom of these previous investments in remote group meeting technology and support became evident. Rapid training, some of it remotely accomplished, would be required to meet the needs of continued operation of the ACGME, as we supported the work of our DIOs, program directors, faculty members, residents, and fellows, as they worked to care for the health care needs of a nation in the midst of a pandemic.

Results: Framing the Accreditation Milieu During the Pandemic

On March 24, 2020, the ACGME published its conceptual framework for Sponsoring Institutions, identifying 3 phases that should guide the organization and operation of educational programs throughout the COVID-19 pandemic. Institutions where circumstances were minimally affected were expected

BOX 2 ACGME’s 4 Pandemic “Inviolate” Requirements¹

The Sponsoring Institution and its programs must ensure the following:

1. Adequate Resources and Training

All residents and fellows must be trained in, and be provided with, appropriate infection protection for the clinical setting and situation. Appropriateness should consider the needs of the patient and the health care team, as well as the range of clinical care services being provided. Residents and fellows must only be assigned to participating sites that ensure the safety of patients and residents and fellows.

2. Adequate Supervision

Any resident or fellow who provides care to patients will do so under appropriate supervision for the clinical circumstance and for the level of education and experience of the resident or 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.

3. Work Hour Requirements

The ACGME Common Program Requirements (Section VI.F.) addressing work hours remain unchanged. The safety of patients and residents and fellows is the ACGME’s highest priority, and it is vital that 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. Deviations in this domain could increase risks for both patients and residents and fellows.

4. Fellows Functioning in Core Specialty

Fellows in ACGME-accredited programs can function within their core specialty, consistent with the policies and procedures of the Sponsoring Institution and its participating sites, if:

- They are American Board of Medical Specialties or American Osteopathic Association board-eligible or board-certified in the core specialty;
- They are appointed to the medical staff at the sponsoring institution; and
- Their time spent on their core specialty service is limited to 20% of their annual education time in any academic year.

to maintain normal operations, including continued satisfaction of all relevant accreditation requirements, including the 4 “Pandemic ‘Inviolate’ Requirements” (see BOX 2). Institutions in this circumstance were considered to be in Stage 1 of adaptation to the pandemic. Stage 2 institutions were defined as those encountering increasing volumes of COVID-19 patients, often requiring staff shifting and institutional preparation for peaking clinical impact. These institutions often fall along a continuum, moving toward Pandemic Emergency Status. Institutions in Stage 2 were permitted to vary from specialty requirements, as directed in frequently asked questions, outlined on the ACGME website.² Stage 3 institutions³ were experiencing crisis levels of patient volume, with service disruption requiring redeployment. As of the

date of the preparation of this article, there are 151 Sponsoring Institutions in 26 states with self-declared Pandemic Emergency Status. They represent 18% of the Sponsoring Institutions, 31% of the accredited programs, and 33% of the residents and fellows in ACGME-accredited residency and fellowship programs in the United States.

In addition to the cancellation of all accreditation and CLER site visits, the ACGME made completion of the Resident and Faculty Surveys optional, and removed the requirement for Milestones reporting in the May to June time period, all done with a goal of removing administrative burden to the program directors and faculty members, and decreasing work for residents and fellows.

Results: Communications and Collaborations

The ACGME Department of Communications and Public Policy has guided efforts to reach out to the community during these challenging times. The ACGME has strived to open lines of communication, and to listen to the field through numerous channels. The ACGME website has been expanded to include a COVID-19 section dedicated to communication of the latest ACGME-related information to the health care field. The Communications team uses social media both to communicate information and to identify areas for potential ACGME action.

The ACGME website has also been used to communicate joint announcements from the ACGME and other organizations, such as the American Board of Medical Specialties,⁴ among others. Each position taken by the ACGME, such as the one related to resident furloughs,⁵ is posted in the ACGME Newsroom in addition to the weekly COVID-19 communication sent to DIOs and program directors.

Resident and fellow concerns and complaints functions remain active, and the ACGME has received calls regarding concerns from residents, fellows, faculty members, nurses, and others about the adequacy of personal protective equipment (PPE) and other issues. These concerns have been dealt with not only in discussions with individual institutions, but also through advocacy. The ACGME delivered a letter to the President of the United States⁶ concerning the ongoing shortages of PPE in many teaching institutions dealing with the pandemic, and has worked with other organizations, such as the Coalition for Physician Accountability, to advocate for adequacy of PPE in all clinical care settings.⁷

The ACGME has reached out directly to DIOs using videoconferencing. After an initial exploratory

videoconference with DIOs in New York City, the ACGME Institutional Accreditation team has sponsored regional and national DIO meetings on a weekly basis, providing a venue for DIOs to teach and learn from each other, and to assist the ACGME in understanding the challenges being faced by residents, fellows, and faculty members in dealing with the COVID-19 pandemic. We have used this vehicle to assemble individuals engaged in the well-being efforts of our Sponsoring Institutions, as the impact of this crisis on the well-being of all engaged in the care of these patients will be significant and potentially long-lasting. We have channeled our efforts at the National Academy of Medicine Action Collaborative on Clinician Well-Being toward supporting clinicians during this pandemic.⁸

Results: Administrative Support

In the month of March, the ACGME hosted more than 1750 videoconferences. The work of accreditation continues. Review Committee meetings have continued on schedule, all held remotely. Few programs have received deferred accreditation decisions. The ACGME will host 24 Review Committee meetings remotely during the months of April and May. Despite the tremendous clinical responsibilities facing Review Committee members, nearly all members have participated in these meetings thus far. The transition to a single graduate medical education accreditation system will end on schedule (June 30, 2020), with all elements of the Memorandum of Understanding completed or met.

Early Lessons Learned

There are 5 lessons that the ACGME has learned early from the COVID-19 pandemic. First, ongoing communication, both to the field and from the field, is essential for successful management of a national challenge of this magnitude. Second, the interdigitation of the oversight elements of the continuum of medical education are tenuous and occasionally challenging to manage in the absence of an organizing body. Third, the concepts of competency-based medical education that have been introduced over the past 7 years position us favorably to deal with individual decisions that program directors will face as we emerge from the first phase of this crisis. Fourth, the trust and goodwill of all of us in the US health care field are necessary if we are to emerge from this crisis stronger tomorrow than we were yesterday. Finally, the disruption of this pandemic has forced us to develop new tools, concepts, frameworks, and policies that are not likely to disappear when the crisis is overcome.

Summary

The ACGME has adapted in support of the clinical care mission that we and our more than 850 accredited Sponsoring Institutions, 12,500 accredited programs, and nearly 140,000 residents and fellows share. That is, shepherding our society through this truly historic pandemic. This effort has required loosening of accreditation requirements, modification of educational and clinical care activities, and loss of clinical experiences for residents and fellows across the country. It will require continued collaboration among program directors, residents, and fellows, with the ACGME and the certifying boards to place individuals back on the path to successful completion of education and training. Graduate medical education and its oversight are likely to look very different at the end of 2020 than they did in 2019.

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