OPDA
THE ORGANIZATION OF PROGRAM DIRECTOR ASSOCIATIONS

APRIL 2026 NEWSLETTER

Recap of the OPDA Spring Meeting, April 10, 2026

The OPDA (Organization of Program Director Associations) Spring 2026 Virtual Meeting convened program directors and associate program directors across residency and fellowship programs for a full-day session addressing key issues in graduate medical education. This was the first OPDA meeting open broadly to program directors and associate program directors beyond the core OPDA membership. Sessions spanned residency recruitment technology, AAMC application innovations, fellowship start date reform, IM preliminary year challenges, fellowship signaling, ambient AI documentation in the clinical learning environment, and organizational business.

Chaired by: Adena Rosenblatt, MD, PhD — OPDA Chair; Dermatology Residency PD, University of Chicago

Thalamus + Cortex Season Update

Presenters: Jason Reminick, MD, MBA, MS (CEO & Founder); Vlad Eidelman, PhD (Chief Product & Technology Officer); Jeffrey Berns, MD (Chief Academic Officer) — Thalamus

Key Points

Platform Scale: Thalamus processed over 10 million application data points this cycle, completed over 100 million virtual interview minutes (surpassing all prior years combined since 2020), and sent more than 725,000 interview offers. Over 90% of residency specialties now use Thalamus Core for interview management.

Cortex Application Review Tool: Cortex uses optical character recognition (OCR) and large language models to normalize grades across 40+ grading scales from U.S. and international medical schools. The platform has demonstrated >99.3% accuracy. A validated training set of 18,000+ grades across 200 schools underlies the grade extraction algorithm, with a clerkship identification validation set of 65,000+ entries. Programs can access a Cortex Sandbox year-round.

Transcript/MSPE Discordance: Systematic analysis revealed that approximately 0.6% (±3%) of applicants have genuinely discordant grades between their transcript and MSPE — reflecting data entry errors in source documents, not tool inaccuracies. When grade discordance is detected, Cortex withholds the grade rather than displaying potentially incorrect data, and an applicant-facing dashboard is being developed to allow students to review and flag their own grades.

SAVE

The Date!

OPDA Fall Meeting 2026 (In person) San Diego, CA
November 18, 2026

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Upcoming Features: Thalamus is rolling out (1) Applicant Acknowledgement — a DocuSign-equivalent within the platform to capture electronic signatures and track document compliance; (2) Specialty-Specific Dashboards — aggregate, de-identified interview distribution data visible to program director associations; and (3) Hippocampus — an institutional memory layer and command center for GME operations and workforce planning, with 25+ institutions in pilot.

Preference Modeling (Research Preview): Thalamus is developing a customizable preference assessment tool that will allow programs to weight applicant attributes (academics, demographics, research, experiences) and see how different weighting strategies would have affected prior-year selections, with real-time bias dashboard feedback. Specialties interested in collaborating on research previews were invited to reach out directly.

AI Governance: Thalamus launched a partnership with Trustable this week to build an auditable AI governance layer, including a centralized AI inventory, risk-based evaluation workflows, bias monitoring, and alignment with AAMC Principles of Responsible Use of AI and Coalition for Health AI frameworks. Three AI advisory boards have been established (UME, GME, and applicant-facing).

Core Principle: "AI should support, not replace, human decision-making." Cortex is intended to reduce review burden (reported 50% time savings) and surface data — it is not designed to make selection decisions.

Action Items

- Program directors interested in exploring Cortex for application review can access the Sandbox via thalamusGME.com at any time.
- Look out for the release of Thalamus Applicant Acknowledgement feature and Specialty-Specific Dashboards expected over the next month.
- Specialties interested in collaborating on AI preference modeling research previews should contact Thalamus directly.
- Institutions interested in the Hippocampus GME operations pilot should contact Thalamus.

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Residency Recruitment Updates — Program Signals, Specialty-Specific Essays/Statements, ERAS Pilots, and Residency Guides

Presenters: Dana Dunleavy, Rebecca Fraser, PhD, Laura Fletcher, PhD, Richard Peng (AAMC); Marcy Verduin, MD (Univ. of Central Florida); Margaret Lo, MD (OPDA Secretary/Treasurer); Andrea Dutoit, MD (Anesthesiology)

Program Director Associations Guide for Residency Applicants (Version 3.0)

- The OPDA-AAMC-AMA Program Director Associations (PDA) Residency Guides initiative, designed to increase transparency for applicants, advisors and student affairs deans, is now in its third iteration.
- For the 2027 application cycle, Version 3.0 updates of the OPDA PDA Guide for Residency Applicants were intended to:
  - ◊ Align specialty guidance with program-level responses submitted via GME Track Program Survey later this spring/summer.
  - ◊ Address feedback from specialties and advisors to ensure we address critical topics for applicants
- Although there were smaller changes throughout the survey, the main updates are:
  - ◊ A new section capturing **ERAS pilot** participation
  - ◊ Updated **Letters of Recommendation** section to align with GME Track Program Survey questions on LORS, namely asking for information about specialty-specific standardized letters of recommendation or evaluation and letter writers
  - ◊ Updated **Away Rotation** section to clarify that the question focuses on away rotations beyond what applicants may be able to experience at their home institution and improve clarity of response options
  - ◊ And finally, adding a NEW **Research and Scholarly Activity** section for specialties to describe the role and importance of Research/Scholarly Activity in their application review process, specifically
    - ♦ The importance of research or scholarly work to your specialty
    - ♦ How are research or scholarly activity evaluated with respect to quality vs. quantity of activity or effort
    - ♦ Whether there are activities in lieu of typical research or scholarly activity that programs in your specialty may consider acceptable to show professional growth, important competences and/or scholarship

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Important Dates:

Milestone	Date
Save the date!	Week of March 30th
Launch to OPDA Liaisons	April 8th
GME Track Program Survey	*Week of May 11th*
Submission deadline	**May 15th**
Publishing specialty guides	Week of June 1st
Ongoing submission and publishing of guides	June-Aug 2026

- OPDA is asking ***all the specialty OPDA Representatives to complete their specialty-specific OPDA Guide for Residency Applicants no later than the submission deadline of May 15, 2026.*** The AAMC Residency Explorer tool and FRIDA will cross-reference OPDA Guides to increase program awareness of these guides and encourage consideration of specialty's guidance.
- It is important to know GME Track Program Survey will launch the week of May 11th. With that in mind, OPDA and AAMC strongly encourage OPDA specialties to submit their guide by May 15th so that their specialty OPDA guide can be published on the OPDA webpage at the start of June before most programs submit info on the GME Track program survey.
- Each specialty could communicate to their programs when their guide is published to encourage review and consideration before submitting the GME Track Program Survey.

GME Track Program Survey Updates

- The GME Track Program Survey has been substantially updated for the 2026 cycle: questions now focus on the upcoming application cycle, clarify letters of recommendation and letter-writer categories, address DO applicant licensing exam requirements, and add new questions about position types. Many updated questions will not pre-populate prior-year responses.
- Residency Explorer is adding Specialty Pages (moving content from the paywall-limited Careers in Medicine platform), interview likelihood modeling (in research/development, predicting interview probability at program level with 84–91% accuracy across 8 specialties), and family medicine-specific workforce and satisfaction data in collaboration with AAFP/ABFM.

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Program Signal Statements Pilot (Anesthesiology & Plastic Surgery)

- The 2026 cycle included a pilot in anesthesiology and plastic surgery allowing applicants to attach a 300-character (50–60 word) statement explaining why they signaled a specific program. Semantic similarity analysis and natural language topic modeling were applied to the responses.
- Anesthesiology showed a normal distribution of semantic similarity (76% moderate, 18% high, 6% distinct). Plastic surgery showed predominantly low-to-moderate similarity (93%), likely reflecting the smaller number of programs and applicants' greater ability to customize statements. Program directors in anesthesiology broadly found the statements valuable even when similar in content.

Scholarly Work and Publications Data

- Average reported scholarly outputs per applicant rose from 5.9 in 2020 to 9 in 2025, but medians remain low (<2 peer-reviewed papers) for most specialties except neurosurgery, otolaryngology, dermatology, and orthopedics. The increase is substantially driven by extreme outliers and same-type duplicates (70% of duplicates are the same poster presented at multiple conferences).
- Correlation between number of peer-reviewed journal articles and interview invitation was very small ($r < 0.1$) across most specialties and non-research-track programs. Even in otolaryngology and orthopedic surgery, where correlations were slightly stronger, effect sizes remained small.

ERAS Application Updates for 2027 Cycle

- ERAS Scholarly Work section is being redesigned: applicants will highlight up to 3 most meaningful scholarly works, can group related entries (addressing duplicate-listing), and the section will prioritize quality over quantity.
- AAMC Letter Writer Portal launches in June 2026 (2027 ERAS cycle opening), replacing the current fragmented LOR process with a centralized portal, broader file-type acceptance, and a more user-friendly dashboard for frequent letter writers. Joint guidance on narrative letters will be accessible within the portal (AAMC/OPDA/GSA collaboration). Standardized Letters of Evaluation (SLEs) will be piloted in three specialties.
- Geographically screened signals: Select specialties participating in ERAS pilots will not display applicant geographic preferences to programs; this data remains in applicants' files for non-participating specialties.

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Action Items

- OPDA specialty liaisons: Review, discuss with your PDA, and submit updated responses for your specialty-specific Version 3.0 Program Director Associations Guide for Residency Applicants by May 15, 2026 using your specialty's unique AAMC link (distributed April 9).
- All programs: Log in to GME Track Platform to review, update, and approve your Program Survey by July 10, 2026 to ensure data is current in Residency Explorer by August.
- Programs: Review your data in Residency Explorer; contact the Residency Explorer team via the contact form for any needed updates.
- Note new LOR deadline: All current-season letters must be uploaded by 5:00 PM ET, May 31, 2026 under the existing system. The new Letter Writer Portal opens in June.
- Specialties interested in participating in future ERAS pilots (SLEs, signal statements, specialty-specific questions, or geographic preference screening) should contact the ERAS team (email shared in webinar).
- Counsel residency applicants on scholarly work: Publications are considered in context — medians remain low in most fields; quality and intellectual engagement matter more than volume.

Fellowship Start Dates

Presenter: Jeffrey Berns, MD — Chief Academic Officer, Thalamus; Inaugural President, NADIO (former); Nephrologist, University of Pennsylvania

Key Points

- NADIO has recommended moving fellowship start dates from July 1 to no earlier than July 7 (or later, depending on specialty; surgery, Orthopedics and OB/GYN have largely moved to August 1). The rationale is trainee well-being: requiring fellows to complete residency one day and begin fellowship the next, often in a different city, is challenging.
- The initiative is voluntary but strongly encouraged by sponsoring institutions. NADIO has shared this information with sponsoring institutions, program directors, and specialty societies for implementation with a voluntary adoption target of July 7, 2027–28 academic year. Several institutions are implementing this earlier.
- Coverage gap solutions: Transitions occur only in year 1. Programs have successfully managed the 7-day gap using attending-only coverage, APP/attending hybrid models, graduated research orientation for incoming fellows, or asking graduating fellows to extend voluntarily for a week.

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- Insurance: COBRA, ACA marketplace plans, and institution-sponsored bridging coverage can address the gap. Enrolling fellows in benefits as of July 1 but activating employment July 7 is a commonly used workaround.
- J-1 visa holders: ECFMG/INTELIUS has negotiated a 30-day gap allowance with the U.S. State Department for physicians transitioning between programs; this covers the proposed 7-day gap. Health insurance must still be addressed separately.
- Surgery and OB/GYN experience: Both specialties achieved 80–90% compliance by (1) issuing specialty society statements, (2) creating public tracking lists that created peer pressure, (3) leveraging board exam timing (surgery moved board exams to mid-July), and (4) allowing remote orientation/research activities to bridge the clinical start date.
- ABIM, ACGME, and most specialty boards have confirmed a July 7 (or later) start date does not affect board eligibility; trainees still complete the required number of months of training.
- IM perspective: Internal medicine has the largest fellowship contingent. ABIM does not oppose delayed start; ACGME does not require July 1. The primary barrier has been the lack of ACGME/ABIM mandate and institutional variability.

Action Items

- Program directors and OPDA Representatives: Raise the NADIO recommendation on July 7th delayed fellowship start date with your DIO and sponsoring institution, ideally aligned with your specialty society's recommendation.
- OPDA Executive Board to consider formal endorsement of this NADIO recommendation after surveying member representatives for consensus.
- For specialties that have not yet acted, consider reaching out to Dr. Erika Banks (OB/GYN) or Dr. Dan Dent (Surgery) for practical implementation guidance.
- Counsel incoming fellows: Refill medications before the transition week to avoid coverage gaps.
- Review the NADIO FAQ (posted on nadio.org) that addresses most logistical questions in detail.

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IM Preliminary Recruitment

Presenters: Jillian Catalanotti, MD, MPH, FACP (George Washington Univ.); Margaret Lo, MD, FACP (OPDA Secretary/Treasurer)

Key Points

- Scope of the problem: Combined TY and preliminary positions in the NRMP Match exceed any individual specialty — more spots than family medicine or internal medicine. In the 2025 Match, 40% of SOAP unfilled positions were TY or preliminary slots, representing substantial wasted applicant cost and program resources.
- Contributing factors: (1) Shift toward categorical training in anesthesia, neurology, PM&R, and others has reduced the pool of truly "advanced" applicants needing TY/prelim positions; (2) applicants applying to advanced programs often cannot know their TY/prelim needs until after advanced program interview offers arrive — but signal deadlines precede interview invitations; (3) NRMP's "all-in" rule creates confusion with linked prelim spots; (4) ERAS historically pools prelim and categorical IM data, obscuring signal utility.
- Program director burden: IM prelim PDs reported receiving >2,500 applications per cycle. Common workarounds, such as interviewing only home medical school applicants or defaulting to SOAP, raise equity concerns and disadvantage DO/IMG applicants.
- **Call for OPDA Representatives for New OPDA Workgroup**: OPDA proposes to create a new cross-specialty task force composed of multiple specialties impacted by PGY1 to advanced residency specialty transition.
- Target specialties include surgery, pediatrics, anesthesia, dermatology, neurology, radiology, TY, IM, as well as DO and IMG representatives.

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Action Items

- Seeking OPDA representatives from surgery, pediatrics, anesthesia, dermatology, neurology, and radiology, TY, and DO associations to volunteer or identify a delegate for this new cross-specialty OPDA PGY1 to Advanced residency transition workgroup. If need be, OPDA Representatives may designate individuals within their PDA to serve on this TYP task force as long as there remains close communication and oversight between the individual task force member and the OPDA liaison
- Confirmed volunteers: Jill Catalanotti/Jennifer Swails/Margaret Lo [Internal Medicine], Dr. Adena Rosenblatt [Derm], Dr. Amit Joshi [Surgery], Dr. Andrea Dutoit [Anesthesia]; Dr. Jim Anderson [Radiology] , Dr. Mona Arbab [Radiation Oncology], Dr. Donald Basel [Genetics], Andrea Keener [Neurology]. Additional specialties and organizations to be contacted include: AOGME C/O AACOM, PM&R, Ophthalmology, Preventive Medicine, DIOs/NADIO.
- First task: Conduct a landscape analysis of TY and prelim position numbers vs. advanced program positions by specialty, and document the timing mismatch between signal submission deadlines and advanced program interview notifications.
- Additional tasks:
  - ◊ Engage NADIO given impact of TYP on sponsoring institutions.
  - ◊ Engage AAMC/ERAS to separate preliminary and categorical IM data streams on the ERAS statistics dashboard.
  - ◊ Work on two way communication between TYP and advanced residencies to improve the transition

Fellowship Signaling

Presenter: Richard Peng — ERAS Director, AAMC

Key Points

- 17 fellowship specialties participated in program signaling in the most recent cycle — a substantial increase from the pilot launch 2 years ago with only 2 specialties. Participating specialties employed small (3–5 signals), large (20 signals), and tiered (gold/silver) models.
- Signal effectiveness was demonstrated: Allergy/Immunology applicants who signaled had a median 60% interview rate vs. 14% for those who did not. Cardiovascular disease applicants who did not signal had a near-zero interview rate (large-model effect). Hematology/Oncology tiered model showed graded effect: gold > silver > no signal.
- Signal distribution: 10% of programs received approximately 22–26% of all signals sent,

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- Applicant survey findings: 89% of fellowship applicants felt their signals genuinely reflected their interest. 55% felt the number of signals was appropriate. Top driver of signaling decisions in fellowship (vs. residency): alignment of program strengths with career interests (rather than likelihood of receiving an interview, which led in residency signaling surveys).
- Two-tier model complexity: 28% of applicants in tiered-model specialties did not clearly differentiate gold from silver signals, with some prioritizing interview likelihood over genuine interest when allocating tiers. Programs should use this data to counsel applicants and refine their model accordingly.
- Application volume: For the first time, the average number of applications per applicant in fellowship slightly decreased this season, mirroring the effect seen 2–3 years post-residency signaling implementation.
- Data limitation: Signal effectiveness data is based on programs using Thalamus Core. Programs using signaling but not Thalamus (~30% in some specialties) are not captured in current analytics.

Action Items

- Fellowship program directors: Review your specialty's signal distribution and interview outcome data on the ERAS Statistics Dashboard (third tab: Fellowship).
- Fellowship society leaders: Use the ERAS data to determine whether your specialty's current signal model (number and type) is achieving its objectives. Opt-out deadline for 2027 cycle: July 1 for July cycle fellowships; November 12 for December cycle.
- Programs considering participation: Contact the ERAS team for a data-oriented conversation about your specialty's goals and current application landscape before committing to a model.
- Fellowship programs currently not using Thalamus Core: Recognize that your interview data is not included in the ERAS signal effectiveness analytics.
- Anesthesia-specific note: Specialty-level guidance on managing home rotator free-signal policies should be reviewed; untracked "free" signals distort published data.

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AI Integration into the Clinical Learning Environment

Presenters: Sachin Shah, MD (Chief Medical Information Officer, UChicago Medicine); Chrissy Babcock, MD (Associate Dean for GME/DIO, Univ. of Chicago); Sara Perkins, MD (Associate Residency Director, Dermatology, Yale); Jean Wong, MD (Family Medicine Residency Director, Univ. of Michigan); Lynn Fitzgibbons, MD, FIDSA (IM Residency Director, Santa Barbara Cottage Hospital)

Key Points

- Attending-level evidence: AI ambient scribing is reducing cognitive load (47% reduction at UChicago), saving attendings 2.5–3 hours/week in documentation, improving patient experience scores, and reducing burnout risk.
- Trainee integration is at an early stage with significant institutional variation: No national guidelines currently exist for any specialty. The central tension is between reducing genuine documentation burden (well-established) and the risk of de-skilling trainees before foundational clinical reasoning and documentation competency is established.
- Consensus across all panelists: Interns (PGY1s) should not use ambient scribing tools until competency in note-writing and clinical reasoning is established. However, the precise threshold and timing varied by program (some use milestone-based, others use a fixed date such as September for lower-volume new PGY2s, others mid-intern year).
- Assessment & Plan section: Strong consensus across sites that AI-generated Assessment & Plan is highest risk for de-skilling and patient safety.
- "Core work vs. chore work" framework (Helen Burstin/Epic): A useful lens for deciding AI adoption by note section. HPIs, drug charts, discharge summary structure may be lower-risk targets for ambient AI assistance; Assessment & Plan is the highest-risk section.
- Key risks identified: Hallucinated or inaccurate content being propagated forward through notes ("AI lore" analogous to existing "copy-paste chart lore"), note errors being incorporated into downstream AI-generated summaries, inability of AI to capture nonverbal pointing (e.g., "it hurts right here"), and over-reliance leading to diminished history-taking depth.

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- Dermatology (Yale) study: 35% reduction in composite NASA TLX workload score (significant across 5 of 6 subcategories). Documentation was less burdensome and no negative impact on perceived performance. However, residents reported spending time removing extraneous information from AI-generated notes.
- Family Medicine (Michigan) experience: Rapid policy development (within 2 weeks, aided by AI) produced a written policy, tip sheet, and a Google quiz (pass at 80%) as the clearance mechanism. Interns were excluded initially and must pass a preceptor note-review rubric before being cleared for PGY2 use.
- Counterpoint raised (Fitzgibbons): Are we training physicians for the career they actually face? If ambient AI becomes standard-of-care by 2029–2030, excluding trainees from early supervised exposure may itself be a form of inadequate preparation. This question was left open for the field.
- Prospective research: Design studies now to capture the impact of AI scribe access on trainee clinical reasoning, milestone progression, and patient safety outcomes. This moment represents the window to generate evidence before the tool becomes universal.
- Key references noted by Dr. Fitzgibbons: (1) Abernathy et al. (Hopkins, 2025/2026) — ambient scribing in trainees; (2) Jones et al. (NEJM/call to action, Feb 2026) — seven best practices mapped to GME competencies.

Action Items

- Program directors: Recommend developing a written institutional AI scribe policy before trainees gain access, even if your institution has already enabled the tool. Work through your CCC and PEC; delineate eligible trainees, approved sites, consent requirements, and monitoring plans. Establish that trainees must review and edit all AI-generated content before signing; treat this as a core competency, not just a reminder.
- Consider requiring a competency readiness rubric (faculty review of 5 notes against documentation standards) before clearing interns/early residents for AI scribe use.
- Faculty/attendings: Recommend shifting preceptor oversight emphasis from sign-off speed to medical decision-making quality and differential generation. Supervising physicians remain ultimately responsible for note accuracy.
- OPDA/specialty societies: Given the absence of national guidance in any specialty, consider developing evidence-based specialty-specific guidelines. The University of Michigan Family Medicine policy has been offered as a template.

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Bylaws Update — Approved

- OPDA bylaws were revised and approved by OPDA representatives present. Changes: (1) Officers selected by general vote at meetings (not electronic vote); (2) core programs with voting rights formalized in Appendix A; (3) name updated from "Pathology Residency Director Society" to "Association for Academic Pathology"; (4) Appendix B (former executive committee list) removed to avoid required biennial updates.

Next Meeting

- OPDA Fall 2026 Meeting: In person, San Diego, CA — November 18, 2026.