ACGME Program Requirements for Graduate Medical Education in Public Health and General Preventive Medicine

Common Program Requirements (Residency) are in BOLD

Where applicable, text in italics describes the underlying philosophy of the requirements in that section. These philosophic statements are not program requirements and are therefore not citable.

Introduction

Int.A.

Int.B. Definition of Specialty

The medical specialty of public health and general preventive medicine focuses on the promotion, protection, and maintenance of health and well-being, the

prevention of disease and disability, and the premature death of individuals in defined populations.

Int.C. Length of Educational Program

Educational programs in public health and general preventive medicine are configured in 24-month and 36-month formats. The latter includes 12 months of education in fundamental clinical skills of medicine, and both include 24 months of education in clinical public health and general preventive medicine (PM-1 and PM-2). (Core)*

I. Oversight

I.A. Sponsoring Institution

Background and Intent: Participating sites will reflect the health care needs of the community and the educational needs of the residents. A wide variety of organizations may provide a robust educational experience and, thus, Sponsoring Institutions and participating sites may encompass inpatient and outpatient settings including, but not limited to a university, a medical school, a teaching hospital, a nursing home, a school of public health, a health department, a public health agency, an organized health care delivery system, a medical examiner's office, an educational consortium, a teaching health center, a physician group practice, federally qualified health center, or an educational foundation.

I.A.1. The program must be sponsored by one ACGME-accredited Sponsoring Institution. (Core)

I.B. Participating Sites

I.B.1. The program, with approval of its Sponsoring Institution

I.D. Resources

I.D.4. **The program's educational and clinical resources must be adequate to support the number of residents appointed to the program.** (Core)

I.E. **The presence of other learners and other care providers, including, but not limited to, residents from other programs, subspecialty fellows, and advanced practice providers, must enrich the appointed residents' education.** (Core)

I.E.1. **The program must report circumstances when the presence of other learners i,**

II.A.2. **The program director and, as applicable, the program's leadership team, must be provided with support adequate for administration of the program based upon its size and configuration.** (Core)

II.A.2.a) Program leadership, in aggregate, must be provided with support equal to a dedicated minimum time as specified below for administration of the program. This may be time spent by the program director only or divided between the program director and one or more associate (or assistant) program directors. (Core)

Number of Approved Resident Positions	Minimum Support Required (FTE)
1-6	20 percent
7-15	30 percent
16 or more	40 percent

Background and Intent: To achieve successful graduate medical education, individuals serving as education and administrative leaders of residency programs, as well as those significantly engaged in the education, supervision, evaluation, and mentoring of residents, must have sufficient dedicated professional time to perform the vital activities required to sustain an accredited program.

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II.A.3. **Qualifications of the program director:**

II.A.3.a) **must include specialty expertise and at least three years of documented educational and/or administrative experience, or qualifications acceptable to the Review Committee;**

Background and Intent: The program director, as the leader of the program, must serve as a role model to residents in addition to fulfilling the technical aspects of the role. As residents are expected to demonstrate compassion, integrity, and respect for others, they must be able to look to the program director as an exemplar. It is of utmost importance, therefore, that the program director model outstanding professionalism, high quality patient care, educational excellence, and a scholarly approach to work. The program director creates an environment where respectful discussion is welcome, with the goal of continued improvement of the educational experience.

II.A.4.a).(2) **design and conduct the program in a fashion consistent with the needs of the community, the mission(s) of the Sponsoring Institution, and the mission(s) of the program; (Core)**

Background and Intent: The mission of institutions participating in graduate medical education is to improve the health of the public. Each community has health needs that vary based upon location and demographics. Programs must understand the social determinants of health of the populations they serve and incorporate them in the design and implementation of the program curriculum, with the ultimate goal of addressing these needs and health disparities.

II.A.4.a).(3) **administer and maintain a learning environment conducive to educating the residents in each of the ACGME Competency domains; (Core)**

Background and Intent: The program director may establish a leadership team to assist in the accomplishment of program goals. Residency programs can be highly complex. In a complex organization, the leader typically has the ability to delegate authority to others, yet remains accountable. The leadership team may include physician and non-physician leaders at various levels [illegible]

Background and Intent: The program director has the responsibility to ensure that all who educate residents effectively role model the Core Competencies. Working with a resident is a privilege that is earned through effective teaching and professional role modeling. This privilege may be removed by the program director when the standards of the clinical learning environment are not met.

There may be faculty in a department who are not part of the educational program, and the program director controls who is teaching the residents.

II.A.4.a).(8) **submit accurate and complete information required and requested by the DIO, GMEC, and ACGME; (Core)**

II.A.4.a).(9) **provide applicants who are offered an interview with information related to the applicant's eligibility for the relevant specialty board examination(s); (Core)**

II.A.4.a).(10) **provide a learning and working environment in which residents have the opportunity to raise concerns and provide feedback in a confidential manner as appropriate, without fear of intimidation or retaliation; (Core)**

II.A.4.a).(11) **ensure the program's compliance with the Sponsoring Institution's policies and procedures related to grievances and due process; (Core)**

II.A.4.a).(12) **ensure the program's compliance with the Sponsoring Institution's policies and procedures for due process when action is taken to suspend or dismiss, not to promote, or not to renew the appointment of a resident; (Core)**

Background and Intent: A program does not operate independently of its Sponsoring Institution. It is expected that the program director will be aware of the Sponsoring Institution's policies and procedures, and will ensure they are followed by the program's leadership, faculty members, support personnel, and residents.

II.A.4.a).(13) **ensure the program's compliance with the Sponsoring Institution's policies and procedures on employment and non-discrimination; (Core)**

13) Residents must not be required II.A.4.a).(13)(a) **to work more than 24 consecutive hours in duration.**

Background and Intent: Primary verification of graduate medical education is important to credentialing of physicians for further training and practice. Such verification must be accurate and timely. Sponsoring Institution and program policies for record retention are important to facilitate timely documentation of residents who have previously completed the program. Residents who leave the program prior to completion also require timely documentation of their summative evaluation.

II.A.4.a).(16) **obtain review and approval of the Sponsoring Institution's DIO before submitting information or requests to the ACGME, as required in the Institutional Requirements and outlined in the ACGME Program Directors' Guide to the Common Program Requirements.** (Core)

II.B. Faculty

Background and Intent: "Faculty" refers to the entire teaching force responsible for educating residents. The term "faculty," including "core faculty," does not imply or require an academic appointment.

II.B.1. **At each participating site, there must be a sufficient number of faculty members with competence to instruct and supervise all residents at that location.** (Core)

II.B.2. **Faculty members must:**

II.B.2.a) **be role models of professionalism;** (Core)

II.B.4.a) **Core faculty members must be designated by the program director.** (Core)

II.B.4.b) **Core faculty members must complete the annual ACGME Faculty Survey.** (Core)

II.B.4.c) Not including the program director, programs with up to eight residents must have a minimum of two core faculty members, and programs with more than eight residents must have a core faculty member-to-resident ratio of at least one-to-four. (Core)

II.C. Program Coordinator

II.C.1. **There must be a program coordinator.** (Core)

II.C.2. **The program coordinator must be provided with dedicated time and support adequate for administration of the program based upon its size and configuration.** (Core)

II.C.2.a) The program coo28e6e (i)2.6n (a)10.5 (t)-6.6 (or)4.9(m)-5.9(us)8.9(t)-6.6 yaI(d[The

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III.A.4. **Resident Eligibility Exception**

The Review Committee for Preventive Medicine **will allow the following exception to the resident eligibility requirements** (for residents entering the program via III.A.2.c))**:** **(Core)**

III.A.4.a) **An ACGME-accredited residency program may accept an exceptionally qualified international graduate applicant who does not satisfy the eligibility requirements listed in III.A.1.-III.A.3., but who does meet all of the following additional qualifications and conditions:** **(Core)**

III.A.4.a).(1) **evaluation by the program director and residency selection committee of the applicant's suitability to enter the program, based on prior training and review of the summative evaluations of this training; and,** **(Core)**

III.A.4.a).(2) **review and approval of the applicant's exceptional qualifications by the GMEC; and,** **(Core)**

III.A.4.a).(3) **verification of Educational Commission for Foreign Medical Graduates (ECFMG) certification.** **(Core)**

III.A.4.b) **Applicants accepted through this exception must have an evaluation of their performance by the Clinical Competency Committee within 12 weeks of matriculation.** **(Core)**

III.B. **The program director must not appoint more residents than approved by the Review Committee.** **(Core)**

III.B.1. **All complement increases must be approved by the Review Committee.** **(Core)**

III.C. **Resident Transfers**

The program must obtain verification of previous educational experiences and a summative competency-based performance evaluation prior to acceptance of a transferring resident, and Milestones evaluations upon matriculation. **(Core)**

IV. Educational Program

not possible. Programs should define core didactic activities for which time is protected and the circumstances in which residents may be excused from these didactic activities. Didactic activities may include, but are not limited to, lectures, conferences, courses, labs, asynchronous learning, simulations, drills, case discussions, grand rounds, didactic teaching, and education in critical appraisal of medical evidence.

IV.A.5. **advancement of residents' knowledge of ethical principles foundational to medical professionalism; and,**

IV.B.1.b).(1).(a).(v)	integrating information to develop a differential diagnosis; and, (Core)
IV.B.1.b).(1).(a).(vi)	developing, implementing, and evaluating a treatment plan. (Core)
IV.B.1.b).(1).(b)	Residents must demonstrate competence in:
IV.B.1.b).(1).(b).(i)	assessing and responding to individual and population risks for common occupational and environmental disorders; (Core)
IV.B.1.b).(1).(b).(ii)	conducting research for innovative solutions to health problems; (Core)
IV.B.1.b).(1).(b).(iii)	diagnosing and investigating medical problems and medical hazards in the community; (Core)
IV.B.1.b).(1).(b).(iv)	directing individuals to needed personal health services; (Core)
IV.B.1.b).(1).(b).(v)	informing and educating populations about health threats and risks; (Core)
IV.B.1.b).(1).(b).(vi)	planning and evaluating the medical portion of emergency preparedness programs and training exercises; (Core)
IV.B.1.b).(1).(b).(vii)	providing clinical preventive medicine services, including the ability to: (Core)
IV.B.1.b).(1).(b).(vii).(a)	diagnose and trea (and t) 0 0()]5.9(e6 481.8)1 (b)6.7

IV.B.1.c).(3)	Residents must demonstrate competence in their knowledge of the use of available technology, such as telemedicine, to reduce health disparities. (Core)
IV.B.1.c).(4)	Residents must demonstrate competence in their knowledge of principles of:
IV.B.1.c).(4).(a)	application of biostatistics; (Core)
IV.B.1.c).(4).(b)	applied epidemiology, including acute and chronic disease; (Core)
IV.B.1.c).(4).(c)	clinical preventive services; (Core)
IV.B.1.c).(4).(d)	health services management; and, (Core)
IV.B.1.c).(4).(e)	risk/hazard control and communication. (Core)

IV.B.1.d) Practice-based Learning and Improvement

IV.B.1.d).(1).(e)	**incorporating feedback and formative evaluation into daily practice; (Core)**
IV.B.1.d).(1).(f)	**locating, appraising, and assimilating evidence from scientific studies related to their patients' health problems; (Core)**
IV.B.1.d).(1).(g)	**using information technology to optimize learning; (Core)**
IV.B.1.d).(1).(h)	using IVmriatiTc 0.005 Tw 1.054 0 0 6.0 0 445.8 747.72 523.2 (o70.5

IV.B.1.e).(1) **Residents must demonstrate competence in:**

IV.B.1.e).(1).(a) **communicating effectively with patients, families, and the public, as appropriate, across a broad range of socioeconomic and cultural backgrounds; (Core)**

IV.B.1.e).(1).(b) **communicating effectively with physicians, other health professionals, and health-related agencies; (Core)**

IV.B.1.e).(1).(c) **working effectively as a member or leader of a health care team or other professional group; (Core)**

IV.B.1.e).(1).(d) **educating patients, families, students, residents, and other health professionals; (Core)**

IV.B.1.e).(1).(e) **acting in a consultative role to other physicians and health professionals; and, (Core)**

IV.B.1.e).(1).(f) **maintaining comprehensive, timely, and legible medical records, if applicable. (Core)**

IV.B.1.e).(2) **Residents must learn to communicate with patients and families to partner with them to assess their care goals, including, when appropriate, end-of-life goals. (Core)**

Background and Intent: When there are no more medications or interventions that can achieve a patient's goals or provide meaningful improvements in quality or length of life, a discussion about the patient's goals, values, and choices surrounding the end of life is one of the most important conversations that can occur. Residents must learn to participate effectively and compassionately in these meaningful human interactions, for the sake of their patients and themselves.

Programs may teach this skill through direct clinical experience, simulation, or other means of active learning.

IV.B.1.e).(3) Residents must demonstrate competence in counseling individuals regarding the appropriate use of clinical preventive services and health promoting behavior changes, and providing immunizations, chemoprophylaxis, and screening services, as appropriate. (Core)

IV.B.1.f) **Systems-based Practice**

Residents must demonstrate an awareness of and responsiveness to the larger context and system of health care, including the social determinants of health, as well as

the ability to call effectively on other resources to provide optimal health care. (Core)

IV.B.1.f).(1) **Residents must demonstrate competence in:**

IV.B.1.f).(1).(a) **working effectively in various health care delivery settings and systems relevant to their clinical specialty;** (Core)

Background and Intent: Medical practice occurs in the context of an increasingly complex clinical care environment where optimal patient care requires attention to compliance with external and internal administrative and regulatory requirements.

IV.B.1.f).(1).(b) **coordinating patient care across the health care continuum and beyond as relevant to their clinical specialty;** (Core)

Background and Intent: Every patient deserves to be treated as a whole person. Therefore it is recognized that any one component of the health care system does not meet the totality of the patient' a

IV.B.1.f).(1).(j) identifying and reviewing laws and regulations relevant to the resident's assignments; (Core)

IV.B.1.f).(1).(k) identifying organizational decision-making structures, stakeholders, styles, and processes; (Core)

IV.B.1.f).(1).(l) management and administration, including the ability to: (Core)

IV.B.1.f).(1).(l).(i) assess data and formulate policy for a given health issue; (Core)

IV.B.1.f).(1).(l).(ii) assess the human and financial resources for the operation of a program or project; (Core)

IV.B.1.f).(1).(l).(iii) apply and use management information systems; and, (Core)

IV.B.1.f).(1).(l).(iv) plan, manage, and evaluate health services to improve the health of a defined population using quality improvement and assurance systems. (Core)

IV.B.1.f).(1).(m) analyzing policy options for their health impact and economic costs; and, (Core)

IV.B.1.f).(1).(n) participating in the evaluation of applicants and the performance of staff members, and understanding the legal and ethical use of this information in decisions for hiring, managing, and discharging staff members. (Core)

IV.B.1.f).(2) Residents must learn to advocate for patients within the health care system to achieve the patient's and family's care goals, including, when appropriate, end-of-life goals. (Core)

IV.C. Curriculum Organization and Resident Experiences

IV.C.1. The curriculum must be structured to optimize resident educational experiences, the length of these experiences, and supervisory continuity. (Core)

IV.C.1.a) Rotations in direct patient care should be of sufficient length to allow residents to develop skills in providing ongoing, prevention-oriented care. (Detail)†

within the hospital have adversely affected optimal resident education and effective team-based care. The need for patient care continuity varies from specialty to specialty and by clinical situation, and may be addressed by the individual Review Commid[(e (e)10.5 ( )]TJET11.1 (m)-4.3 (ay)10.5 (b)11.2 (e addr)eu1.28 TCebC2 Tw 11.1(

IV.C.6. Residents must complete a Master of Public Health or another equivalent degree program prior to completion of the residency program. (Core)

IV.C.6.a) All residents must complete graduate-level courses that include the five content areas of: epidemiology; biostatistics; health services management and administration; environmental health; and the behavioral aspects of health. (Core)

IV.C.7. Didactic conferences must be structured to facilitate interaction between faculty members and residents. (Detail)

IV.C.8. Resident education must take place in settings where decisions about the health of defined populations are routinely made and where analyses and policies affecting the health of these individuals are under active study and development. (Core)

IV.C.8.a) Residents must have a minimum of two months of direct patient care experience during each year of the program. (Core)

IV.C.8.b) Residents must have a minimum of two months (or equivalent) experience at a governmental public health agency. (Core)

IV.C.8.c) Resident experiences must include participation in learning activities related to the current recommendations of the US Preventive Services Task Force. (Core)

IV.C.8.d) Residents should be assigned to sites appropriate for specif7 T2(ur)-5.9(6.6 (i(6.5

IV.D.1. Program Responsibilities

IV.D.1.a)

Systematic reviews, meta-analyses, review articles,

V.A.1.c).(1) use multiple evaluators (e.g., faculty members, peers, patients, self, and other professional staff members); and, (Core)

V.A.1.c).(2) provide that information to the Clinical Competency Committee for its synthesis of progressive resident performance and improvement toward unsupervised practice. (Core)

V.A.1.d) The program director or their designee, with input from the Clinical Competency Committee, must:

V.A.1.d).(1) meet with and review with each resident their documented semi-annual evaluation of performance, including progress along the specialty-specific Milestones; (Core)

V.A.1.d).(2) assist residents in developing individualized learning plans to capitalize on their strengths and identify areas for growth; and, (Core)

V.A.1.d).(3) develop plans for residents failing to progress, following institutional policies and procedures. (Core)

Background and Intent: Learning is an active process that requires effort from the teacher and the learner. Faculty members evaluate a resident's performance at least at the end of each rotation. The program director or their designee will review those evaluations, including their progress on the Milestones, at a minimum of every six months. Residents should be encouraged to reflect upon the evaluation, using the information to reinforce well-performed tasks or knowledge or to modify deficiencies in knowledge or practice. Working together with the faculty members, residents should develop an individualized learning plan.

Residents who are experiencing difficulties with achieving progress along the Milestones may require intervention to address specific deficiencies. Such intervention, documented in an individual remediation plan developed by the program director or a faculty mentor and the resident, will take a variety of forms based on the specific learning needs of the resident. However, the ACGME recognizes that there are situations which require more significant intervention that may alter the time course of resident progression. To ensure due process, it is essential that the program director follow institutional policies and procedures.

V.A.1.e) At least annually, there must be a summative evaluation of each resident that includes their readiness to progress to the next year of the program, if applicable. (Core)

V.A.1.f) The evaluations of a resident's performance must be accessible for review by the resident. (Core)

V.A.2. Final Evaluation

residents who have completed core residency programs in their specialty may be members of the Clinical Competency Committee.

V.A.3.b) **The Clinical Competency Committee must:**

V.A.3.b).(1) **review all resident evaluations at least semi-annually;**
(Core)

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V.C.1.c).(2)	**outcomes from prior Annual Program Evaluation(s);** (Core)
V.C.1.c).(3)	**ACGME letters of notification, including citations, Areas for Improvement, and comments;** (Core)
V.C.1.c).(4)	**quality and safety of patient care;** (Core)
V.C.1.c).(5)	**aggregate resident and faculty:**
V.C.1.c).(5).(a)	**well-being;** (Core)

the bottom fifth percentile of programs in that specialty. **(Outcome)**

V.C.3.d) **For specialties in which the ABMS member board and/or AOA certifying board offer(s) a biennial oral exam, in the preceding six years, the program's aggregate pass rate of those taking the examination for the first time must be higher than the bottom fifth percentile of programs in that specialty.** **(Outcome)**

V.C.3.e) **For each of the exams referenced in V.C.3.a)-d), any program whose graduates over the time period specified in the requirement have achieved an 80 percent pass rate will have met this requirement, no matter the percentile rank of the program for pass rate in that specialty.** **(Outcome)**

Background and Intent: Setting a single standard for pass rate that works across specialties is not supportable based on the heterogeneity of the psychometrics of different examinations. By using a percentile rank, the [illegible]

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Background and Intent: The revised requirements are intended to provide greater flexibility within an established framework, allowing programs and residents more discretion to structure clinical education in a way that best supports the above principles of professional development. With this increased flexibility comes the responsibility for programs and residents to adhere to the 80-hour maximum weekly limit (unless a rotation-specific exception is granted by a Review Committee), and to utilize flexibility in a manner that optimizes patient safety, resident education, and resident well-being. The requirements are intended to support the development o and r:6 (de)10.(vel)-6

VI.A.1.a) **Patient Safety**

VI.A.1.a).(1) **Culture of Safety**

VI.A.1.a).(1).(a) **The program, its faculty, residents, and fellows must actively participate in patient safety systems and contribute to a culture of safety.** **(Core)**

VI.A.1.a).(1).(b) **The program must have a structure that promotes safe, interprofessional, team-based care.** **(Core)**

VI.A.1.a).(2) **Education on Patient SafetyVEn0.002 Tc 0.v (,)Tj-0.002 Tetiatintem , I**
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VI.A.1.a).(3).(a) Residents, fellows, faculty members, and other clinical staff members must:

VI.A.1.a).(3).(a).(i) know their responsibilities in reporting patient safety events at the clinical site; (Core)

VI.A.1.a).(3).(a).(ii) know how to report patient safety events, including near misses, at the clinical site; and, (Core)

VI.A.1.a).(3).(a).(iii) be provided with summary information of their institution's patient safety reports. (Core)

VI.A.1.a).(3).(b) Residents must participate as team members in real and/or simulated interprofessional clinical patient safety activities, such as root cause analyses or other activities that include analysis, as well as formulation and implementation of actions. (Core)

VI.A.1.a).(4) Resident Education and Experience in Disclosure of Adverse Events

VI.A.1.a).(4).(a) All residents must receive training in how to disclose adverse events to patients and families. (Core)

VI.A.1.a).(4).(b) Residents should have the opportunity to participate in the disclosure of patient safety events, real or simulated. (Detail)

VI.A.1.b) Quality Improvement

VI.A.1.b).(1) Education in Quality Improvement

VI.A.1.b).(1).(a) **Residents must receive training and experience in quality improvement processes, including an understanding of health care disparities.** (Core)

VI.A.1.b).(2) **Quality Metrics**

VI.A.1.b).(2).(a) **Residents and faculty members must receive data on quality metrics and benchmarks related to their patient populations.** (Core)

VI.A.1.b).(3) **Engagement in Quality Improvement Activities**

VI.A.1.b).(3).(a) **Residents must have the opportunity to participate in interprofessional quality improvement activities.** (Core)

VI.A.1.b).(3).(a).(i) **This should include activities aimed at reducing health care disparities.** (Detail)

VI.A.2. **Supervision and Accountability**

VI.A.2.a)

responsible and accountable for the patient's care. (Core)

VI.A.2.a).(1).(a) **This information must be available to residents, faculty members, other members of the health care team, and patients.** (Core)

VI.A.2.a).(1).(b) **Residents and faculty members must inform each patient of their respective roles in that patient's care when providing direct patient care.** (Core)

VI.A.2.b)

Background and Intent: Appropriate supervision is essential for patient safety and high-quality teaching. Supervision is also contextual. There is tremendous diversity of resident patient interactions, education and training locations, and resident skills and abilities even at the same level of the educational program. The degree of supervision is expected to evolve progressively as a resident gains more experience, even with the same patient condition or procedure. All residents have a level of supervision commensurate with their level of autonomy in practice; this level of supervision may be enhanced based on factors such as patient safety, complexity, acuity, urgency, risk of serious adverse events, or other pertinent variables.

VI.B.3. **The program director, in partnership with the Sponsoring Institution, must provide a culture of professionalism that supports patient safety and personal responsibility.** (Core)

VI.B.4. **Residents and faculty members must demonstrate an understanding of their personal role in the:**

VI.B.4.a) **provision of patient- and family-centered care;** (Outcome)

VI.B.4.b) **safety and welfare of patients entrusted to their care, including the ability to report unsafe conditions and adverse events;** (Outcome)

Background and Intent: This requirement emphasizes that responsibility for reporting unsafe conditions and adverse events is shared by all members of the team and is not solely the responsibility of the resident.

harassment, mistreatment, abuse, or coercion of students, residents, faculty, and staff. (Core)

VI.B.7. **Programs, in partnership with their Sponsoring Institutions, should have a process for education of residents and faculty regarding unprofessional behavior and a confidential process for reporting, investigating, and addressing such concerns.** (Core)

VI.C. Well-Being

VI.C.1.a) efforts to enhance the meaning that each resident finds in the experience of being a physician, including protecting time with patients, minimizing non-physician obligations, providing administrative support, promoting progressive autonomy and flexibility, and enhancing professional relationships; (Core)

VI.C.1.b) attention to scheduling, work intensity, and work compression that impacts resident well-being; (Core)

VI.C.1.c) evaluating workplace safety data and addressing the safety of residents and faculty members; (Core)

Background and Intent: This requirement emphasizes the responsibility shared by the Sponsoring Institution and its programs to gather information and utilize systems that monitor and enhance resident and faculty member safety, including physical safety. Issues to be addressed include, but are not limited to, monitoring of workplace injuries, physical or emotional violence, vehicle collisions, and emotional well-being after adverse events.

VI.C.1.d) policies and programs that encourage optimal resident and faculty member well-being; and, (Core)

Background and Intent: Well-being includes having time away from work to engage with family and friends, as well as to attend to personal needs and to one's own health, including adequate rest, healthy diet, and regular exercise.

VI.C.1.d).(1) Residents must be given the opportunity to attend medical, mental health, and dental care appointments, including those scheduled during their working hours. (Core)

Background and Intent: The intent of this requirement is to ensure that residents have the opportunity to access medical and dental care, including mental health care, at times that are appropriate to their individual circumstances. Residents must be provided with time away from the program as needed to access care, including appointments scheduled during their working hours.

VI.C.1.e) attention

emergencies, and parental leave. Each program must allow an appropriate length of absence for residents unable to perform their patient care responsibilities. (Core)

VI.C.2.a) **The program must have policies and procedures in place to ensure coverage of patient care.** (Core)

VI.C.2.b) **These policies must be implemented without fear of negative consequences for the resident who is or was unable to provide the clinical work.** (Core)

Background and Intent: Residents may need to extend their length of training depending on length of absence and specialty board eligibility requirements. Teammates should assist colleagues in need and equitably reintegrate them upon return.

VI.D. Fatigue Mitigation

VI.D.1. Programs must:

VI.D.1.a) **educate all faculty members and residents to recognize the signs of fatigue and sleep deprivation;** (Core)

VI.D.1.b) **educate all faculty members and residents in alertness management and fatigue mitigation processes; and,** (Core)

VI.D.1.c) **encourage residents to use fatigue mitigation processes to manage the potential negative effects of fatigue on patient care and learning.** (Detail)

Background and Intent: Providing medical care to patients is physically and mentally demanding. Night shifts, even for those who have had enough rest, cause fatigue. Experiencing fatigue in a supervised environment during training prepares residents for managing fatigue in practice. It is expected that programs adopt fatigue mitigation processes and ensure that there are no negative consequences and/or stigma for using fatigue mitigation strategies.

This requirement emphasizes the importance of adequate rest before and after clinical responsibilities. Strategies that may be used include, but are not limited to, strategic napping; the judicious use of caffeine; availability of other caregivers; time management to maximize sleep off-duty; learning to recognize the signs of fatigue, and self-monitoring performance and/or asking others to monitor performance; remaining active to promote alertness; maintaining a healthy diet; using relaxationn-0.002 (hy(m)-4.3 (po)11.2 (r)-42e2 (r

assigned work periods when developing schedules, to avoid exceeding the 80-hour maximum weekly limit, averaged over four weeks. The ACGME Review Committees will strictly monitor and enforce compliance with the 80-hour requirement. Where

VI.F.2.a) **The program must design an effective program structure that is configured to provide residents with educational opportunities, as well as reasonable opportunities for rest and personal well-being.** (Core)

VI.F.2.b) **Residents should have eight hours off between scheduled clinical work and education periods.** (Detail)

VI.F.2.b).(1) **There may be circumstances when residents choose to stay to care for their patients or return to the hospital with fewer than eight hours free of clinical experience and education. This must occur within the context of the 80-hour and the one-day-off-in-seven requirements.** (Detail)

Background and Intent: While it is expected that resident schedules will be structured to ensure that residents are provided with a minimum of eight hours off between scheduled work periods, it is recognized that residents may choose to remain beyond their scheduled time, or return to the clinical site during this time-off period, to care for a patient. The requirement preserves the flexibility for residents to make those choices. It is also noted that the 80-hour weekly limit (averaged over four weeks) is a deterrent for scheduling fewer than eight hours off between clinical and education work periods, as it would be difficult for a program to design a schedule that provides fewer than eight hours off without violating the 80-hour rule.

off is defined in the ACGME Glossary of Terms as "one (1) continuous 24-hour period free from all administrative, clinical, and educational activities."

VI.F.3. Maximum Clinical Work and Education Period Length

VI.F.3.a) Clinical and educational work periods for residents must not exceed 24 hours of continuous scheduled clinical assignments. (Core)

Background and Intent: The Task Force examined the question of "consecutive time on task." It examined the research supporting the current limit of 16 consecutive hours of time on task for PGY-1 residents; the range of often conflicting impacts of this requirement on patient safety, clinical care, and continuity of care by resident teams; and resident learning found in the literature. Finally, it heard a uniform request by the specialty societies, certifying boards, membership societies and organizations, and senior residents to repeal this requirement. It heard conflicting perspectives from

VI.F.3.a).(1).(a) **Additional patient care responsibilities must not be assigned to a resident during this time.** (Core)

Background and Intent: The additional time referenced in VI.F.3.a).(1) should not be used for the care of new patients. It is essential that the resident continue to function as a member of the team in an environment where other members of the team can assess resident fatigue, and that supervision for post-call residents is provided. This 24 hours and up to an additional four hours must occur within the context of 80-hour weekly limit, averaged over four weeks.

VI.F.4. **Clinical and Educational Work Hour Exceptions**

VI.F.4.a) **In rare circumstances, after handing off all other responsibilities, a resident, on their own initiative, may elect to remain or return to the clinical site in the following circumstances:**

VI.F.4.a).(1) **to continue to provide care to a single severely ill or unstable patient;** (Detail)

VI.F.4.a).(2) **humanistic attention to the needs of a patient or family; or,** (Detail)

VI.F.4.a).(3) **to attend unique educational events.** (Detail)

VI.F.4.b) **These additional hours of care or education will be counted toward the 80-hour weekly limit.** (Detail)

Background and Intent: This requirement is intended to provide residents with some control over their schedules by providing the flexibility to voluntarily remain beyond the scheduled responsibilities under the circumstances described above. It is important to note that a resident may remain to attend a conference, or return for a conference later in the day, only if the decision is made voluntarily. Residents must not be rdy2p[(or)6.Tnded care 3and

week. At-home call activities that must be counted include responding to phone calls and other forms of communication, as well as documentation, such as entering notes in an electronic health record. Activities such as reading about the next day's case, studying, or research activities do not count toward the 80-hour weekly limit.

In their evaluation of residency/fellowship programs, Review Committees will look at the overall impact of at-home call on resident/fellow rest and personal time.

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***Core Requirements**: Statements that define structure, resource, or process elements essential to every graduate medical educational program.

†**Detail Requirements**: Statements that describe a specific structure, resource, or process, for achieving compliance with a Core Requirement. Programs and sponsoring institutions in substantial compliance with the Outcome Requirements may utilize alternative or innovative approaches to meet Core Requirements.

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