# Common Program Requirements Section VI
# Table of Implementation Dates

The effective date of the major revision of Section VI of the ACGME Common Program Requirements is July 1, 2017. However, because programs and Sponsoring Institutions will need time to comply with some new requirements related to patient safety, quality improvement, and well-being, no citations will be issued on those requirements before July 1, 2019. There are a few exceptions to this where analogous requirements were already in existence or where no additional resources are required for implementation, and those exceptions have been noted below.

**Programs, in partnership with their Sponsoring Institutions, must begin working toward the implementation of the new Section VI elements immediately**. While citations may not be issued on these areas until 2019, Review Committees may issue Areas for Improvement (AFIs) related to these requirements in the interim. This timeline provides a year for implementation, and a year for data collection on these new areas. The ACGME's Annual Resident and Faculty Surveys will be updated in 2019 to address the new Section VI requirements. The Surveys will be updated in 2018 to reflect new terminology (e.g., elimination of the term "duty hours") and the changes in Section VI.F.

| Requirement | Subject to Citation July 1, 2017 | Subject to Citation July 1, 2019* |
|---|---|---|
| **VI.A.1.a) Patient Safety** | | |
| **VI.A.1.a).(1).(a)**<br>The program its faculty, residents, and fellows must actively participate in patient safety systems and contribute to a culture of safety. (Core) | **X** | |
| *Note: Although this requirement appears in the new Patient Safety section, it is analogous to VI.A.3. in the Common Program Requirements in effect through June 30, 2017, and is thus deemed to be subject to citation on July 1, 2017.* | | |
| **VI.A.1.a).(1).(b)**<br>The program must have a structure that promotes safe, interprofessional, team-based care. (Core) | | **X** |
| **VI.A.1.a).(2)**<br>Education on Patient Safety<br>Programs must provide formal educational activities that promote patient safety-related goals, tools, and techniques. (Core) | | **X** |

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| **VI.A.1.a).(3).(a).(i)**<br>[Residents, fellows, faculty members, and other clinical staff members must:]<br>know their responsibilities in reporting patient safety events at the clinical site; (Core) | **X** | |
| *Note: Although this requirement appears in the new Patient Safety section, it is analogous to Institutional Requirement III.B.1.a), and is thus deemed to be subject to citation on July 1, 2017.* | | |
| **VI.A.1.a).(3).(a).(ii)**<br>[Residents, fellows, faculty members, and other clinical staff members must:]<br>know how to report patient safety events, including near misses, at the clinical site; and, (Core) | **X** | |
| *Note: Although this requirement appears in the new Patient Safety section, it is analogous to Institutional Requirement III.B.1.a), and is thus deemed to be subject to citation on July 1, 2017.* | | |
| **VI.A.1.a).(3).(a).(iii)**<br>[Residents, fellows, faculty members, and other clinical staff members must:]<br>Be provided with summary information of their institution's patient safety reports. (Core) | | **X** |
| **VI.A.1.a).(3).(b)**<br>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) | | **X** |
| **VI.A.1.a).(4).(a)**<br>All residents must receive training in how to disclose adverse events to patients and families. (Core) | | **X** |
| **VI.A.1.a).(4).(b)**<br>Residents should have the opportunity to participate in the disclosure of patient safety events, real or simulated. (Detail) | | **X** |
| **VI.A.1.b) Quality Improvement** | | |
| **VI.A.1.b).(1).(a)**<br>Residents must receive training and experience in quality improvement processes, including an understanding of health care disparities. (Core) | | **X** |

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| **VI.A.1.b).(2).(a)**<br>Residents and faculty members must receive data on quality metrics and benchmarks related to their patient populations. (Core) | | **X** |
| **VI.A.1.b).(3).(a)**<br>Residents must have the opportunity to participate in interprofessional quality improvement activities. (Core) | | **X** |
| **VI.A.1.b).(3).(a).(i)**<br>This should include activities aimed at reducing health care disparities. (Detail) | | **X** |
| **VI.A.2. Supervision and Accountability** | | |
| **VI.A.2.a).(1)**<br>Each patient must have an identifiable and appropriately-credentialed and privileged attending physician (or licensed independent practitioner as specified by the applicable Review Committee) who is responsible and accountable for the patient's care. (Core) | **X** | |
| **VI.A.2.a).(1).(a)**<br>This information must be available to residents, faculty members, other members of the health care team, and patients. (Core) | **X** | |
| **VI.A.2.a).(1).(b)**<br>Residents and faculty members must inform each patient of their respective roles in that patient's care when providing direct patient care. (Core) | **X** | |
| **VI.A.2.b).(1)**<br>The program must demonstrate that the appropriate level of supervision in place for all residents is based on each resident's level of training and ability, as well as patient complexity and acuity. Supervision may be exercised through a variety of methods, as appropriate to the situation. (Core) | **X** | |
| **VI.A.2.c)**<br>Levels of Supervision<br>To promote oversight of resident supervision while providing for graded authority and responsibility, the program must use the following classification of supervision: (Core) | **X** | |

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| **VI.A.2.c).(1)**<br>Direct Supervision – the supervising physician is physically present with the resident and patient. (Core) | X | |
| **VI.A.2.c).(2).(a)**<br>Indirect Supervision:<br>With Direct Supervision immediately available – the supervising physician is physically within the hospital or other site of patient care, and is immediately available to provide Direct Supervision. (Core) | X | |
| **VI.A.2.c).(2).(b)**<br>Indirect Supervision:<br>With Direct Supervision available – the supervising physician is not physically present within the hospital or other site of patient care, but is immediately available by means of telephonic and/or electronic modalities, and is available to provide Direct Supervision. (Core) | X | |
| **VI.A.2.c).(3)**<br>Oversight – the supervising physician is available to provide review of procedures/encounters with feedback provided after care is delivered. (Core) | X | |
| **VI.A.2.d)**<br>The privilege of progressive authority and responsibility, conditional independence, and a supervisory role in patient care delegated to each resident must be assigned by the program director and faculty members. (Core) | X | |
| **VI.A.2.d).(1)**<br>The program director must evaluate each resident's abilities based on specific criteria, guided by the Milestones. (Core) | X | |
| **VI.A.2.d).(2)**<br>Faculty members functioning as supervising physicians must delegate portions of care to residents based on the needs of the patient and the skills of each resident. (Core) | X | |

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| **VI.A.2.d).(3)**<br>Senior residents or fellows should serve in a supervisory role to junior residents in recognition of their progress toward independence, based on the needs of each patient and the skills of the individual resident or fellow. (Detail) | X | |
| **VI.A.2.e)**<br>Programs must set guidelines for circumstances and events in which residents must communicate with the supervising faculty member(s). (Core) | X | |
| **VI.A.2.e).(1)**<br>Each resident must know the limits of their scope of authority, and the circumstances under which the resident is permitted to act with conditional independence. (Outcome) | X | |
| **VI.A.2.e).(1).(a)**<br>Initially, PGY-1 residents must be supervised either directly, or indirectly with direct supervision immediately available. [Each Review Committee may describe the conditions and the achieved competencies under which PGY-1 residents progress to be supervised indirectly with direct supervision available.] (Core) | X | |
| **VI.A.2.f)**<br>Faculty supervision assignments must be of sufficient duration to assess the knowledge and skills of each resident and to delegate to the resident the appropriate level of patient care authority and responsibility. (Core) | X | |
| **VI.B. Professionalism** | | |
| **VI.B.1.**<br>Programs, in partnership with their Sponsoring Institutions, must educate residents and faculty members concerning the professional responsibilities of physicians, including their obligation to be appropriately rested and fit to provide the care required by their patients. (Core) | X | |

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| **VI.B.2.a)**<br>[The learning objectives of the program must:]<br>be accomplished through an appropriate blend of supervised patient care responsibilities, clinical teaching, and didactic educational events; (Core) | **X** | |
| **VI.B.2.b)**<br>[The learning objectives of the program must:]<br>be accomplished without excessive reliance on residents to fulfill non-physician obligations; and, (Core) | **X** | |
| **VI.B.2.c)**<br>[The learning objectives of the program must:]<br>Ensure manageable patient care responsibilities.(Core) | **X** | |
| **VI.B.3.**<br>The program director, in partnership with the Sponsoring Institution, must provide a culture of professionalism that supports patient safety and personal responsibility. (Core) | **X** | |
| **VI.B.4.a)**<br>[Residents and faculty members must demonstrate an understanding of their personal role in the:]<br>provision of patient- and family-centered care; (Outcome) | **X** | |
| **VI.B.4.b)**<br>[Residents and faculty members must demonstrate an understanding of their personal role in the:]<br>safety and welfare of patients entrusted to their care, including the ability to report unsafe conditions and adverse events; (Outcome) | **X** | |
| **VI.B.4.c)**<br>[Residents and faculty members must demonstrate an understanding of their personal role in the:]<br>assurance of their fitness for work, including: (Outcome) | **X** | |
| **VI.B.4.c).(1)**<br>[Residents and faculty members must demonstrate an understanding of their personal role in the:<br>assurance of their fitness for work, including:]<br>management of their time before, during, and after clinical assignments; and, (Outcome) | **X** | |

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| **VI.B.4.c).(2)**<br>[Residents and faculty members must demonstrate an understanding of their personal role in the:<br>assurance of their fitness for work, including:]<br>recognition of impairment, including from illness, fatigue, and substance use, in themselves, their peers, and other members of the health care team. (Outcome) | **X** | |
| **VI.B.4.d)**<br>[Residents and faculty members must demonstrate an understanding of their personal role in the:]<br>commitment to lifelong learning; (Outcome) | **X** | |
| **VI.B.4.e)**<br>[Residents and faculty members must demonstrate an understanding of their personal role in the:]<br>monitoring of their patient care performance improvement indicators; and, (Outcome) | **X** | |
| **VI.B.4.f)**<br>[Residents and faculty members must demonstrate an understanding of their personal role in the:]<br>accurate reporting of clinical and educational work hours, patient outcomes, and clinical experience data. (Outcome) | **X** | |
| **VI.B.5.**<br>All residents and faculty members must demonstrate responsiveness to patient needs that supersedes self-interest. This includes the recognition that under certain circumstances, the best interests of the patient may be served by transitioning that patient's care to another qualified and rested provider. (Outcome) | **X** | |
| **VI.B.6.**<br>Programs must provide a professional, respectful, and civil environment that is free from mistreatment, abuse, or coercion of students, residents, faculty, and staff. 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) | **X** | |
| *Note: Although this is a new requirement, it is analogous to Institutional Requirement III.A, and is thus deemed to be subject to citation on July 1, 2017.* | | |

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| **VI.C. Well-Being** | | |
| **VI.C.1.a)**<br>[This responsibility must include:]<br>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) | **X** | |
| *Note: Although this is a new requirement, it is analogous to Institutional Requirement II.F.1. and is thus deemed to be subject to citation on July 1, 2017.* | | |
| **VI.C.1.b)**<br>[This responsibility must include:]<br>attention to scheduling, work intensity, and work compression that impacts resident well-being; (Core) | **X** | |
| **VI.C.1.c)**<br>[This responsibility must include:]<br>evaluating workplace safety data and addressing the safety of residents and faculty members; (Core) | **X** | |
| *Note: Although this requirement appears in the new Well-Being section, it was determined that no additional resources are required in order to achieve compliance with the requirement, and is thus deemed to be subject to citation on July 1, 2017. Examples of data sources include (but are not limited to) Joint Commission and Occupational Safety and Health Administration (OSHA) reports.* | | |
| **VI.C.1.d)**<br>[This responsibility must include:]<br>policies and programs that encourage optimal resident and faculty member well-being; and, (Core) | | **X** |
| **VI.C.1.d.(1)**<br>Residents must be given the opportunity to attend medical, mental health, and dental care appointments, including those scheduled during their working hours. (Core) | **X** | |
| *Note: Although this requirement appears in the new Well-Being section, it was determined that no additional resources are required in order to achieve compliance with the requirement, and is thus deemed to be subject to citation on July 1, 2017.* | | |

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| **VI.C.1.e)**<br>[This responsibility must include:]<br>attention to resident and faculty member burnout, depression, and substance abuse. The program, in partnership with its Sponsoring Institution, must educate faculty members and residents in identification of the symptoms of burnout, depression, and substance abuse, including means to assist those who experience these conditions. Residents and faculty members must also be educated to recognize those symptoms in themselves and how to seek appropriate care. The program, in partnership with its Sponsoring Institution, must: (Core) | | **X** |
| **VI.C.1.e).(1)**<br>[The program, in partnership with its Sponsoring Institution, must:]<br>encourage residents and faculty members to alert the program director or other designated personnel or programs when they are concerned that another resident, fellow, or faculty member may be displaying signs of burnout, depression, substance abuse, suicidal ideation, or potential for violence; (Core) | | **x** |
| **VI.C.1.e).(2)**<br>[The program, in partnership with its Sponsoring Institution, must:]<br>provide access to appropriate tools for self-screening; and, (Core) | | **X** |
| **VI.C.1.e).(3)**<br>[The program, in partnership with its Sponsoring Institution, must:]<br>provide access to confidential, affordable mental health assessment, counseling, and treatment, including access to urgent and emergent care 24 hours a day, seven days a week. (Core) | | **X** |

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|---|---|---|
| **VI.C.2.**<br>There are circumstances in which residents may be unable to attend work, including but not limited to fatigue, illness, and family emergencies. Each program must have policies and procedures in place that ensure coverage of patient care in the event that a resident may be unable to perform their patient care responsibilities. These policies must be implemented without fear of negative consequences for the resident who is unable to provide the clinical work. (Core) | **X** | |
| **VI.D. Fatigue Mitigation** | | |
| **VI.D.1.a)**<br>[Programs must:]<br>educate all faculty members and residents to recognize the signs of fatigue and sleep deprivation; (Core) | **X** | |
| **VI.D.1.b)**<br>[Programs must:]<br>educate all faculty members and residents in alertness management and fatigue mitigation processes; and, (Core) | **X** | |
| **VI.D.1.c)**<br>[Programs must:]<br>encourage residents to use fatigue mitigation processes to manage the potential negative effects of fatigue on patient care and learning. (Detail) | **X** | |
| **VI.D.2.**<br>Each program must ensure continuity of patient care, consistent with the program's policies and procedures referenced in VI.C.2, in the event that a resident may be unable to perform their patient care responsibilities due to excessive fatigue. (Core) | **X** | |
| **VI.D.3.**<br>The program, in partnership with its Sponsoring Institution, must ensure adequate sleep facilities and safe transportation options for residents who may be too fatigued to safely return home. (Core) | **X** | |

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| **VI.E.1.**<br>Clinical Responsibilities<br>The clinical responsibilities for each resident must be based on PGY level, patient safety, resident ability, severity and complexity of patient illness/condition, and available support services. (Core) | X | |
| **VI.E.2.**<br>Teamwork<br>Residents must care for patients in an environment that maximizes communication. This must include the opportunity to work as a member of effective interprofessional teams that are appropriate to the delivery of care in the specialty and larger health system. (Core) | X | |
| **VI.E.3. Transitions of Care** | | |
| **VI.E.3.a)**<br>Programs must design clinical assignments to optimize transitions in patient care, including their safety, frequency, and structure. (Core) | X | |
| **VI.E.3.b)**<br>Programs, in partnership with their Sponsoring Institutions, must ensure and monitor effective, structured hand-over processes to facilitate both continuity of care and patient safety. (Core) | X | |
| **VI.E.3.c)**<br>Programs must ensure that residents are competent in communicating with team members in the hand-over process. (Outcome) | X | |
| **VI.E.3.d)**<br>Programs and clinical sites must maintain and communicate schedules of attending physicians and residents currently responsible for care. (Core) | X | |
| **VI.E.3.e)**<br>Each program must ensure continuity of patient care, consistent with the program's policies and procedures referenced in VI.C.2, in the event that a resident may be unable to perform their patient care responsibilities due to excessive fatigue or illness, or family emergency. (Core) | X | |

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| **VI.F. Clinical Experience and Education** | | |
| **VI.F.1.**<br>Maximum Hours of Clinical and Educational Work per Week<br>Clinical and educational work hours must be limited to no more than 80 hours per week, averaged over a four-week period, inclusive of all in-house clinical and educational activities, clinical work done from home, and all moonlighting. (Core) | **X** | |
| **VI.F.2.a)**<br>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) | **X** | |
| **VI.F.2.b)**<br>Residents should have eight hours off between scheduled clinical work and education periods. (Detail) | **X** | |
| **VI.F.2.b).(1)**<br>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) | **X** | |
| **VI.F.2.c)**<br>Residents must have at least 14 hours free of clinical work and education after 24 hours of in-house call. (Core) | **X** | |
| **VI.F.2.d)**<br>Residents must be scheduled for a minimum of one day in seven free of clinical work and required education (when averaged over four weeks). At-home call cannot be assigned on these free days. (Core) | **X** | |
| **VI.F.3.a)**<br>Clinical and educational work periods for residents must not exceed 24 hours of continuous scheduled clinical assignments. (Core) | **X** | |

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| **VI.F.3.a).(1)**<br>Up to four hours of additional time may be used for activities related to patient safety, such as providing effective transitions of care, and/or resident education. (Core) | **X** | |
| **VI.F.3.a).(1).(a)**<br>Additional patient care responsibilities must not be assigned to a resident during this time. (Core) | **X** | |
| **VI.F.4.a).(1)**<br>[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:]<br>to continue to provide care to a single severely ill or unstable patient; (Detail) | **X** | |
| **VI.F.4.a).(2)**<br>[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:]<br>humanistic attention to the needs of a patient or family; or, (Detail) | **X** | |
| **VI.F.4.a).(3)**<br>[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:]<br>to attend unique educational events. (Detail) | **X** | |
| **VI.F.4.b)**<br>These additional hours of care or education will be counted toward the 80-hour weekly limit. (Detail) | **X** | |
| **VI.F.4.c)**<br>A Review Committee may grant rotation-specific exceptions for up to 10 percent or a maximum of 88 clinical and educational work hours to individual programs based on a sound educational rationale. | **X** | |

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| **VI.F.4.c).(1)**<br>In preparing a request for an exception, the program director must follow the clinical and educational work hour exception policy from the *ACGME Manual of Policies and Procedures*. (Core) | **X** | |
| **VI.F.4.c).(2)**<br>Prior to submitting the request to the Review Committee, the program director must obtain approval from the Sponsoring Institution's GMEC and DIO. (Core) | **X** | |
| **VI.F.5.a)**<br>Moonlighting must not interfere with the ability of the resident to achieve the goals and objectives of the educational program, and must not interfere with the resident's fitness for work nor compromise patient safety. (Core) | **X** | |
| **VI.F.5.b)**<br>Time spent by residents in internal and external moonlighting (as defined in the ACGME Glossary of Terms) must be counted toward the 80-hour maximum weekly limit. (Core) | **X** | |
| **VI.F.5.c)**<br>PGY-1 residents are not permitted to moonlight. (Core) | **X** | |
| **VI.F.6.**<br>In-House Night Float<br>Night float must occur within the context of the 80-hour and one-day-off-in-seven requirements. (Core) | **X** | |
| **VI.F.7.**<br>Maximum In-House On-Call Frequency<br>Residents must be scheduled for in-hour call no more frequently than every third night (when averaged over a four-week period). (Core) | **X** | |
| **VI.F.8.a)**<br>Time spent on patient care activities by residents on at-home call must count toward the 80-hour maximum weekly limit. The frequency of at-home call is not subject to the every-third-night limitation, but must satisfy the requirement for one day in seven free of clinical work and education, when averaged over four weeks. (Core) | **X** | |

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| **VI.F.8.a).(1)**<br>At-home call must not be so frequent or taxing as to preclude rest or reasonable personal time for each resident. (Core) | **X** | |
| **VI.F.8.b)**<br>Residents are permitted to return to the hospital while on at-home call to provide direct care for new or established patients. These hours of inpatient patient care must be included in the 80-hour maximum weekly limit. (Detail) | **X** | |

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