Common Program Requirements
Frequently Asked Questions
ACGME

Question	Answer
Institutions	
What is the purpose of Program Letters of Agreement (PLAs)? *[Common Program Requirement: I.B.1.; One-Year Common Program Requirement: I.B.1.]*	PLAs provide details on faculty, supervision, evaluation, educational content, length of assignment, and policies and procedures for each required assignment that occurs outside of an accredited program's Sponsoring Institution. These documents are intended to protect the program's residents/fellows by ensuring an appropriate educational experience under adequate supervision. For more detailed information and guidance, see the Program Directors' Guide to the Common Program Requirements.
What is the minimum experience for which a PLA needs to exist between an accredited program and a site involved in residency/fellowship education? *[Common Program Requirement: I.B.1.; One-Year Common Program Requirement: I.B.1.]*	There must be PLAs between an accredited program and all sites to which residents/fellows rotate for required education or assignments.
Are PLAs necessary for "courses," such as the Armed Forces Institute of Pathology course or the Bellevue Hospital Toxicology Course? *[Common Program Requirement: I.B.1.; One-Year Common Program Requirement: I.B.1.]*	These types of courses are not examples of participating sites, and therefore do not require PLAs.

Question	Answer
Are PLAs needed when sites are closely associated? For instance, would PLAs be necessary between a university hospital and the children's hospital with which it has close ties? *[Common Program Requirement: I.B.1.; One-Year Common Program Requirement: I.B.1.]*	A program sponsored by a university hospital that requires a rotation/assignment at the children's hospital would require a PLA if the two entities are operated by two different governing bodies (e.g., two separate Boards of Directors). However, if the two sites operate essentially as one entity, that is, they are governed by one governing body (e.g., a single Board of Directors), a PLA is not necessary. This reasoning applies to all closely associated sites, not only those between university and children's hospitals. A PLA is not required for a rotation to an integrated site if the written document between the sponsor and the integrated site incorporates the elements of the PLA [Common Program Requirements I.B.1.a)-d)]. Including all the required elements in the Integration Agreement will eliminate the need for a separate PLA.
Are PLAs necessary for rotations to physicians' offices, nursing homes, ambulatory surgical centers, and other similar learning environments? *[Common Program Requirement: I.B.1.; One-Year Common Program Requirement: I.B.1.]*	PLAs are not necessary if the following on- or off-campus site is under the governance of the program's Sponsoring Institution or is an office of a physician who is a member of that Sponsoring Institution's teaching faculty/medical staff: nursing and assisted living homes; hospice facilities; faculty members' patient care offices; private physicians' offices (volunteer faculty members); ambulatory surgical centers; diagnostic centers (e.g., imaging, laboratory, etc.); treatment centers (e.g., dialysis, rehabilitation, chemotherapy, etc.); or other similar sites. PLAs *are* required for rotations to these types of sites if not governed by the program's Sponsoring Institution or if they occur in offices of physicians who are not members of the Sponsoring Institution's teaching faculty/medical staff. Some Review Committees have more stringent criteria, so program directors should consult and review the specialty-/subspecialty-specific Program Requirements and the specialty section of the ACGME website for more details, when applicable.

Question	Answer
If a program director and/or faculty member functions within multiple participating sites that educate residents/fellows (e.g., the program director oversees the program at the sponsoring university hospital and is also the local director at the VA medical center), is a PLA required with the program director and/or faculty member? *[Common Program Requirement: I.B.1.; One-Year Common Program Requirement: I.B.1.]*	PLAs are not necessary when a rotation/assignment occurs at a site under the governance of the program's Sponsoring Institution or in an office of a physician who is a member of the Sponsoring Institution's teaching faculty/medical staff. However, in this example, the VA is unlikely to be under the governance of the Sponsoring Institution, so the program director needs to appoint a local director at the VA site who is accountable for the day-to-day activities of residents/fellows [Common Program Requirement II.A.4.b)]. A PLA between the program director and the local director would be necessary in this example.
Who should sign the PLAs for the Sponsoring Institution and for the participating sites? *[Common Program Requirement: I.B.1.; One-Year Common Program Requirement: I.B.1.]*	A PLA should include the signatures of the program director as initiating the letter and the local director at the participating site. The official signing for the participating site to which the residents/fellows rotate should be the individual responsible for supervising and overseeing resident/fellow education at that location (e.g., the local director or, in some cases, the medical director). Although the requirements do not specify that the PLA include the signature of the designated institutional official (DIO), institutions may find it prudent to include this signature. It is the responsibility of the DIO, in collaboration with the Graduate Medical Education Committee (GMEC) of the Sponsoring Institution, to establish and administer the local policies and procedures regarding PLAs.
Does a subspecialty program need a separate PLA if a specialty program already has one in place with a particular institution? *[Common Program Requirement: I.B.1.; One-Year Common Program Requirement: I.B.1.]*	Although a single PLA that provides the Review Committee with appropriate information (i.e., the content of the experience, supervision, evaluation, length of assignment, policies and procedures) for both the specialty and subspecialty programs would be acceptable, such a document may be long and overly complicated. The preferred strategy would be to develop two separate letters, one for the specialty program, and another for the subspecialty program.

Question	Answer
When should PLAs be updated? *[Common Program Requirement: I.B.1.; One-Year Common Program Requirement: I.B.1.]*	Agreements should be updated whenever there are changes in program director or participating site director or in resident/fellow assignments, or when there are revisions to the items specified in Common Program Requirements I.B.1.a)-d). PLAs must be renewed at least every 10 years. If nothing in the agreement has changed at the end of ten years, it is acceptable to add an amendment signifying review and extension of the agreement with signatures.
How are PLAs reviewed for purposes of accreditation? *[Common Program Requirement: I.B.1.; One-Year Common Program Requirement: I.B.1.]*	Program directors should have the PLAs available for review by the Accreditation Field Representative during a program site visit. Program directors and DIOs should contact the Review Committee Executive Director for more specific details or further clarification.
Is a Sponsoring Institution required to maintain master affiliation agreements with its major participating sites? *[Common Program Requirement: I.B.1.; One-Year Common Program Requirement: I.B.1.]*	No; the Institutional Requirements (effective since July 1, 2014, including the most recent revision, effective July 1, 2015) no longer require Sponsoring Institutions to maintain master affiliation agreements with their major participating sites.
Resident/Fellow Appointments	
For entry into ACGME-accredited residency programs in specialties that do not require an initial year prior to entry, can residents receive any credit for education and training completed in programs not accredited by the ACGME, the Royal College of Physicians and Surgeons of Canada (RCPSC), or the College of Family Physicians of Canada (CFPC)? *[Common Program Requirement, Residency version: III.A.3.)]*	In specialties that do not require an initial year prior to entry into a program, a credit for one year of education and training may be allowed, at the program director's discretion, for residents who have completed a residency program, in the same specialty, not accredited by the ACGME, RCPSC, or CFPC. Such residents must enter at the PGY-1 level and may be advanced to the PGY-2 level by the Clinical Competency Committee (CCC) based on Milestones assessments. The Review Committees do not review or approve this credit for prior education and training on a per-resident basis. The appropriate American Board of Medical Specialties (ABMS) or American Osteopathic Association (AOA) board should be contacted to determine if a resident will receive credit for prior education and training.

Question	Answer
To what does "…a residency program that was not accredited by the ACGME, RCPSC, or CFPC, or a residency program with ACGME-I Advanced Specialty accreditation…" refer? *[Common Program Requirement, Residency version: III.A.3.)]*	An example is completion of an international residency not accredited by ACGME International (ACGME-I). Individuals who have completed such education and training are eligible for admission to an ACGME-accredited program at the PGY-1 level and advancement to the PGY-2 level based on Milestones assessments. Note that this applies only to programs in specialties for which an initial clinical year is not required for entry.
Are individuals who have completed residency programs not accredited by one of the organizations specified in III.A.2. eligible for appointment to an ACGME-accredited residency program that requires completion of a residency as a prerequisite for entry? *[Common Program Requirements: III.A.2) and III.A.3)]*	Review Committees may grant the exception specified in III.A.4. of the Program Requirements for specialties that require completion of another prerequisite residency program prior to admission. Note this applies only to programs in specialties for which an initial clinical year is not required for entry. The Review Committees for Allergy and Immunology, Nuclear Medicine, and Plastic Surgery may grant the exception specified in III.A.4. of the Program Requirements for residency programs that require completion of another prerequisite residency program prior to admission. The Review Committees for Colon and Rectal Surgery and Thoracic Surgery will not permit this exception. Nuclear medicine programs accept residents at the NM1 (second post-graduate year) after completion of a clinical base year, at the NM2 level after completion of a residency program in another specialty, and at the NM3 level after completion of a radiology residency. Applicants entering at the NM1 level would need to complete a clinical base year in a program accredited by the ACGME, RCPSC, CFPC, or in a program with ACGME-I Advanced Specialty Accreditation. Applicants who have completed a residency program in diagnostic radiology or another specialty not accredited by one of the organizations referenced above could apply for entry at the NM2 or NM3 level respectively per III.A.2.b).

Question	Answer
Are individuals who have completed a combined residency program not accredited by the ACGME eligible for appointment to an ACGME-accredited fellowship program? *[Common Program Requirement Fellowship and One-Year Fellowship VersionsIII.A.1.]*	Examples of such programs include emergency medicine-pediatrics, family medicine-preventive medicine, and psychiatry-pediatrics-child psychiatry. The ACGME website now lists these programs as “Combined Specialty Tracks – components individually accredited.” If each of the programs participating in the combined programs is ACGME-accredited, residents enrolled in the combined program are eligible for transfer into another ACGME-accredited residency program and graduates of the program are eligible for appointment to an ACGME-accredited fellowship. While the ACGME does not accredit combined programs (with the exception of internal medicine-pediatrics), it does accredit each of the programs constituting the combined program. Therefore, graduates of these programs have completed their education and training in ACGME-accredited residency programs.
If a fellowship program is unable to obtain Milestones assessments from the residency program of a fellow entering in a given year, will the program be cited for failing to obtain this information? *[Common Program Requirement: III.A.2.a); One-Year Common Program Requirement: III.A.1.]*	If a program is able to document that the Milestones assessments were requested from the residency program director, the fellowship program will not be cited for non-compliance even if the residency program director does not provide the assessments. A new reporting feature is now available for fellowship programs within the Accreditation Data System (ADS) to provide fellowship program directors access to the final Milestones report for an active fellow's most recently completed residency program. There are a few scenarios in which these reports may not be available, such as if the resident completed residency in a program not accredited by the ACGME, if the resident completed residency prior to the Milestones implementation, or if the resident's previous experience could not be matched when entered into the program. For those without Milestones reports, programs must contact the specialty program director from the fellow's most recent residency program to obtain the required information. This new reporting feature can be found in ADS by logging in and navigating to the program's "Reports" tab, and then selecting the “Residency Milestone Retrieval” option.

Question	Answer
Why does the ACGME require the GMEC or a subcommittee of the GMEC to review and approve all candidates under the "exceptionally qualified applicant" exception? *[Common Program Requirement: III.A.2.b).(2); One-Year Common Program Requirement: III.A.2.b)]*	The requirement that the GMEC or a subcommittee of the GMEC review and approve all candidates under the "exceptionally qualified applicant" exception is to provide a check on candidates qualifying under the definition of this exception. A graduate medical education program is an educational program associated with health care providers that assume a continued presence of a particular number of residents/fellows at a particular knowledge, skill, and competence level, who both treat patients under physician supervision, and supervise more junior learners. A gap in the number of qualified fellows may be disruptive to the normal provision of health care. In these circumstances, program directors may perceive pressure from individuals within an institution to fill empty slots for the sake of avoiding the disruption, but with less attention to a particular candidate's knowledge, skill, and competence level. The Review Committee sets the requirements and the program determines if a candidate meets the stated criteria. Because the Review Committee does not review or approve the determination of an exceptionally qualified applicant, the ACGME relies on the Sponsoring Institution to provide oversight in the selection of exceptional candidates and monitoring of their performance. This oversight promotes programs' exercise of due diligence in selection. The oversight need not be burdensome or intrusive; rather it provides an opportunity for the GMEC to collaborate with programs to ensure that these select candidates fulfill expectations for entry-level competence.
Educational Program	
What are the ACGME's expectations regarding rotational transitions of care, and how should programs and institutions establish effective curriculum to minimize the risks surrounding such transitions and improve supervisory continuity? (IV.C.1.)	Transitions of care, specifically those occurring at the end of a rotation or service, are associated with worse patient outcomes, disruptions in patient care, increased resident/fellow anxiety, and increased stress on other health care staff members. The process for these transitions is often not standardized at most institutions. While the ACGME recognizes a lack of evidenced-based best practices to address and ameliorate this discontinuity, Sponsoring Institutions and programs are expected to have a documented process by which these rotational transitions are managed at each site. Communication about patient care, the clinical learning environment, and the supervisor roles, should be standardized among residents/fellows rotating in each specific clinical learning environment. For example, rotational transitions should follow the same format for all residents transitioning service on general wards while the format of these transitions may differ for residents rotating in an ICU environment. Although the format of communication may differ for each

	separate type of clinical learning environment to address the individual rotation's communication needs, programs are expected to outline a standardized process to ensure continuity for each rotation. Models used in daily-type transitions, such as SBAR and others, may be useful in guiding the development of standardized processes for rotational-type transitions.
Evaluation	
What is the role of the program director on the CCC? *[Common Program Requirement: V.A.1.; One-Year Common Program Requirement: V.A.1.]*	The requirements regarding the CCC do not preclude or limit a program director's participation on the committee. The intent is to leave flexibility for each program to decide the best structure for its own circumstances. Still, a program should consider: its program director's other roles as resident/fellow advocate, advisor, and confidante; the impact of the program director's presence on the other CCC members' discussions and decisions; the size of the program faculty; and other program-relevant factors. The program director has final responsibility for the program's evaluation and promotion decisions.
How can small programs have three members of the program faculty on the CCC? *[Common Program Requirement: V.A.1.a); One-Year Common Program Requirement: V.A.1.a)]*	The intent is to have enough members to broaden the input on each resident's/fellow's evaluation. Program faculty representation can include more than physician faculty members, such as other physicians and non-physicians who teach and evaluate the program's residents/fellows. For example, a fellowship may include faculty members from the affiliated residency program or from required rotations in other specialties.
Are non-physicians permitted to serve on the CCC? *[Common Program Requirement: V.A.1.a).(1).(a); One-Year Common Program Requirement: V.A.1.a).(1).(a)]*	The requirements are intended to provide the program director with sufficient flexibility to select individuals who have the background and experience needed to evaluate resident/fellow performance based on the Milestones. This may include health professionals who have extensive contact and experience with the program's residents/fellows, such as, but not limited to, nurses, PhDs, physicians' assistants, and therapists.
What is the role of the program coordinator on the CCC? *[Common Program Requirement: V.A.1.a).(1).(a); One-Year Common Program Requirement: V.A.1.a).(1).(a]*	Program coordinators play a critical role in their programs and may, through the program's resident/fellow evaluation system, provide valuable insight on resident/fellow performance in areas such as interpersonal and communication skills, teamwork, and professionalism. Further, the program coordinator may, at the program director's discretion, attend CCC meetings to support the activities of the CCC, such as collation of data on each resident/fellow, taking meeting minutes, recording decisions, and managing the submission of Milestones data to the ACGME. However, evaluation of resident/fellow competence related to the Milestones for patient care and medical knowledge is a vital responsibility of

	the CCC and these assessments should be made by individuals with background and experience in health care. Therefore, program coordinators, although they may administratively support the committee and take part in the 360 assessments of the residents/fellows, may not serve as voting members of the CCC.
What role can program residents, including chief residents who have not completed the program, play on the CCC? *[Common Program Requirement: V.A.1.a).(1).(b); One-Year Common Program Requirement: V.A.1.a).(1).(b)]*	Program residents and chief residents in accredited years of the program may provide input to the CCC Chair and/or the program director, outside the context of CCC meetings, through the evaluation system. However, to ensure that residents' peers are not involved in promotion and graduation decisions, and that they are not involved in recommendations for remediation or disciplinary actions, these residents may not serve as CCC members or attend CCC meetings.
Are there any circumstances when would it be acceptable for the Program Evaluation Committee (PEC) to not include a resident/fellow member? *[Common Program Requirement: V.C.1.a).(1); One-Year Common Program Requirement: V.C.1.a).(1)]*	A resident/fellow must always be included on a PEC unless there are no residents/fellows enrolled in the program. The PEC must meet annually, even when there are no residents/fellows enrolled in the program, to evaluate and review the program.

The Learning and Working Environment	
Does the ACGME require electronic, "real-time" monitoring of clinical and educational work hours for all accredited programs? *[Common Program Requirement: II.A.4.j).(2); Institutional Requirement: IV.J.]*	The ACGME requires that Sponsoring Institutions and programs monitor residents'/fellows' clinical and educational work hours to ensure they comply with the requirements, but does not specify how monitoring and tracking of clinical and educational work hours should be accomplished. The ACGME does not mandate a specific monitoring approach since the ideal approach should be tailored to each program and its Sponsoring Institution. For example, the approach best suited for a neurological surgery program will be different from what is most appropriate for preventive medicine, dermatology, or pediatrics programs.
The philosophical statement in the Introduction to Section VI references effacement of self-interest as a component of professionalism. Isn't this in conflict with the emphasis on physician well-being reflected in the new requirements? *[Common Program Requirement: VI. Introduction; One-Year Common Program Requirement: VI. Introduction]*	Effacement of self-interest is an essential component of professionalism for physicians but does not imply that physicians should jeopardize their own well-being to prioritize the well-being of their patients. Prioritization of physician well-being is important in ensuring that physicians remain fit to provide care for their patients. Requirement VI.C.2. requires a process to ensure continuity of care if residents or fellows are unable to perform their patient care duties, and Requirement VI.B.5. addresses the expectation that residents/fellows and faculty members demonstrate responsiveness to patient needs that supersedes self-interest and emphasizes that in some circumstances, the best interests of the patient may be served by transitioning the patient's care to another qualified and rested provider.
Are the requirements related to patient safety and quality improvement intended to apply solely in inpatient settings? *[Common Program Requirement: VI.A.1.; One-Year Common Program Requirement: VI.A.1.]*	The requirements related to patient safety and quality improvement are not limited to inpatient experiences, and are inclusive of care provided in outpatient settings.

With regards to the requirement relating to provision of data to residents/fellows and faculty members on quality metrics and benchmarks related to their patient populations, is the expectation that individual data regarding clinical performance must be provided? *[Common Program Requirement: VI.A.1.b).(2).(a); One-Year Common Program Requirement: VI.A.1.b).(2).(a)]*	Providing individual, specialty-specific data is desirable, but not required. The requirement seeks to ensure that quality metrics used by the Sponsoring Institution are shared with residents/fellows and faculty members. Examples of metrics include, but are not limited to, those provided by the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS), Centers for Medicaid and Medicare Services (CMS), Press Gainey, and National Surgical Quality Improvement Program (NSQIP).
How should the appropriate level of supervision be determined for each resident or fellow? *[Common Program Requirements: VI.A.2.c)-VI.A.2.c).(3); One-Year Common Program Requirements: VI.A.2.c)-c).(3)]*	The assignment of progressive responsibility for patient care to residents and fellows is an essential component of graduate medical education and is necessary to prepare residents and fellows to be independent practitioners. While decisions regarding the appropriate level of supervision are made by the program director and faculty members, the Common Program Requirements provide a framework for the progression from direct supervision to oversight. The program director determines the level of supervision required for an individual resident or fellow both by assessing the abilities and competence of the resident/fellow and the needs of the individual patient. Therefore, the level of supervision required for a resident or fellow may vary based on the circumstances.
How can residents and fellows identify the accountable attending physician for each patient for whom they are providing care? *[Common Program Requirement: VI.A.2.a).(1); One-Year Common Program Requirement: VI.A.2.a).(1)]*	Residents and fellows must know who the accountable attending physician is prior to making any clinical decisions on behalf of a patient. The program and institution are responsible for providing that information to all residents and fellows. Residents and fellows are responsible for keeping the accountable physician informed.
How should residents communicate with the accountable physician? *[Common Program Requirement: VI.A.2.a).(1); One-Year Common Program Requirement: VI.A.2.a).(1)]*	This communication may occur in-person or via portal, fax, text, phone, or email. It is essential that each patient's primary physician be listed in the patient's chart. If that information is not in the chart, the patient should be asked to provide the name of their primary physician. If the patient does not have one, a determination regarding who will assume responsibility for overall care must be made and documented in the patient's chart.

How will compliance with the requirement regarding accurate reporting of clinical and educational work hours, patient outcomes, and clinical experience data be assessed? *[Common Program Requirement: VI.B.4.f); One-Year Common Program Requirement: VI.B.4.f)]*	Approaches for monitoring and documenting are left to the discretion of program and institutional leaders, who should decide on the optimal way to ensure accuracy of reporting.

What is work compression and why is it addressed in the requirements? *[Common Program Requirement: VI.C.1.b); One-Year Common Program Requirement: VI.C.1.b)]*	Work compression occurs when physicians are required to do the same amount of work in less time, and is addressed in the Common Program Requirements to ensure that programs consider the impact of work compression on well-being and how the impact can be minimized. To help frame the issue, a review of relevant literature is provided below. Research has found high workload and work compression associated with reduced empathy in medical interns (Bellini, 2002), with residents selectively discharging older inpatients earlier (Hilson, 1993), with increased risk for mortality (Hilson, 1992, Ong 2007) and readmission (Thanarajasingam, 2012), lower patient satisfaction (Griffith, 1998), greater use of diagnostic tests (Griffith, 1996), and shifting from active patient care to monitoring to keep workload manageable (Cao, 2008). Studies of the effect of workload on resident outcomes found reduced educational participation with higher workload (Arora, 2008), an inverse relationship between workload and intern perceptions of the quality of their education and their own professionalism (Auger, 2012), and improved conference attendance with a limit on patient admissions (Thanarajasingam, 2012). Bellini LM, Baime M, Shea JA. 2002. Variation of mood and empathy during internship. *JAMA* 287:3143–46 Hilson SD, Rich EC, Dowd BE, et al. 1993. The impact of intern workload on length of hospital stay for elderly patients. *Gerontol. Geriatr. Educ.* 14(2):33–40 Hillson SD, Rich EC, Dowd B, et al. 1992. Call nights and patients care: effects on inpatients at one teaching hospital. *J. Gen. Intern. Med.* 7(4):405–10 Ong M, Bostrom A, Vidyarthi A, et al. 2007. House staff team workload and organization effects on patient outcomes in an academic general internal medicine inpatient service. *Arch. Intern. Med.* 167(1):47–52 Thanarajasingam U, McDonald FS, Halvorsen AJ, et al. 2012. Service census caps and unit-based admissions: resident workload, conference attendance, duty hour compliance, and patient safety. *Mayo Clin. Proc.* 87(4):320–27 Griffith CH 3rd, Wilson JF, Rich EC. 1998. The effect at one teaching hospital of interns' workloads on the satisfaction of their patients. *Acad. Med.* 73(4):427–29 Griffith CH 3rd, Desai NS, Wilson JF, et al. 1996. Housestaff experience, workload, and test ordering in a neonatal intensive care unit. *Acad. Med.* 71(10):1106–8 Cao CG, Weinger MB, Slagle J, et al. 2008. Differences in day and night shift clinical performance in anesthesiology. *Hum. Factors* 50(2):276–90

	Arora VM, Georgitis E, Siddique J, et al. 2008. Association of on-call workload of medical interns with sleep duration, shift duration, and participation in educational activities. *JAMA* 300(10):1146–53 Auger KA, Landrigan CP, Gonzalez del Rey JA, et al. 2012. Better rested, but more stressed? Evidence of the effects of resident work hour restrictions. *Acad Pediatr*. Jul-Aug;12(4):335-43
Can residents/fellows be required to use vacation or sick time when attending appointments during scheduled working hours? *[Common Program Requirement: VI.C.1.d).(1); One-Year Common Program Requirement: VI.C.1.d).(1)]*	The requirements do not specify whether residents/fellows will be required to use vacation or sick time for medical, dental, and mental health appointments. Programs should comply with their institution's policies regarding time off for such appointments.
Can residents/fellows be encouraged to schedule medical, mental health, and dental care appointments on days they are not assigned call? *[Common Program Requirement: VI.C.1.d).(1); One-Year Common Program Requirement: VI.C.1.d).(1)]*	The intent of this requirement is to ensure that residents and fellows are able to attend appointments as needed, and that their work schedule not prevent them from seeking care when they need it, including during scheduled call days. Programs must not place restrictions on when residents and fellows may schedule these appointments, nor place pressure on them to schedule appointments on days when they are not assigned call.
How can programs located in areas where 24/7 in-person access to mental health professionals is not possible comply with this requirement? *[Common Program Requirement: VI.C.1.e).(3); One-Year Common Program Requirement: VI.C.1.e).(3)]*	The requirement is intended to ensure that residents and fellows have immediate access at all times to a mental health professional (psychiatrist, psychologist, Licensed Clinical Social Worker, Primary Mental Health Nurse Practitioner, or Licensed Professional Counselor) for urgent or emergent mental health issues. Access to a psychiatrist or other mental health professional in the Emergency Department satisfies the expectation for 24/7 access to emergency care. In addition, telemedicine, or telephonic means may be used to satisfy this requirement.

What are the ACGME's expectations regarding transitions of care, and how should programs and institutions monitor effective transitions of care and minimize the number of such transitions? *[Common Program Requirement: VI.E.3.; One-Year Common Program Requirement: VI.E.3.]*	Transitions of care are critical elements in patient safety and must be organized such that complete and accurate clinical information on all involved patients is transmitted between the outgoing and incoming individuals and/or teams responsible for the specific patient or group of patients. Sponsoring Institutions and programs are expected to have a documented process in place for ensuring the effectiveness of transitions. Scheduling of on-call assignments should be optimized to ensure a minimal number of transitions, and there should be documentation of the process involved in arriving at the final schedule. Specific schedules will depend upon various factors, including the size of the program, the acuity and quantity of the workload, and the level of resident/fellow education.
How do the ACGME common clinical and educational work hour requirements apply to research activities? *[Common Program Requirement: VI.F.; One-Year Common Program Requirement: VI.F.]*	The clinical and educational work hour requirements pertain to all required hours in the program (the only exceptions are reading and self-learning). When research is a formal part of the residency/fellowship and occurs during the accredited years of the program, research hours or any combination of research and patient care activities must comply with the weekly limit on hours and other pertinent clinical and educational work hour requirements. When programs offer an additional research year that is not part of the accredited years, or when residents/fellows conduct research on their own time, making these hours identical to other personal pursuits, these hours do not count toward the limit on clinical and educational work hours. The combined hours spent on self-directed research and program-required activities should meet the test for a reasonably rested and alert resident/fellow when the resident/fellow participates in patient care. Some programs have added clinical activities to "pure" research rotations, such as having research residents/fellows cover "night float." This combination of research and clinical assignments could result in hours that exceed the weekly limit and could also seriously undermine the goals of the research rotation. Review Committees have traditionally been concerned that required research not be diluted by combining it with significant patient care assignments.

Is there a provision for training pathways with alternative schedules to accommodate the needs of those with the ability to become excellent physicians but an inability to take on the demanding usual schedule described in the requirements? *[Common Program Requirement: VI.F.; One-Year Common Program Requirement: VI.F.]*	There is nothing in the requirements that prevents a program from providing an alternate pathway based on the needs of individuals, as long as the pathway adheres to other relevant dimensions of the requirements, including the maximums specified for clinical experience and education.
What is included in the definition of clinical and educational work hours under the requirement limiting them to 80 hours per week? *[Common Program Requirement: VI.F.1.; One-Year Common Program Requirement: VI.F.1.]*	Clinical and educational work hours are defined as all clinical and academic activities related to the residency/fellowship program. This includes inpatient and outpatient clinical care, in-house call, short call, night float and day float, transfer of patient care, and administrative activities related to patient care, such as completing medical records, ordering and reviewing lab tests, and signing orders. For call from home, time devoted to clinical work done from home and time spent in the hospital after being called in to provide patient care count toward the 80-hour weekly limit. Types of work from home that must be counted include using an electronic health record and taking calls. Reading done in preparation for the following day's cases, studying, and research done from home do not count toward the 80 hours. Hours spent on activities that are required in the accreditation requirements, such as membership on a hospital committee, or that are accepted practice in residency/fellowship programs, such as residents'/fellows' participation in interviewing residency/fellowship candidates, must be included in the count of clinical and educational work hours. Time residents and fellows devote to military commitments counts toward the 80-hour limit only if that time is spent providing patient care.

If some of a program's residents/fellows attend a conference that requires travel, how should the hours be counted for clinical and educational work hour compliance? *[Common Program Requirement: VI.F.1.; One-Year Common Program Requirement: VI.F.1.]*	If attendance at the conference is required by the program, or if the resident/fellow is a representative for the program (e.g., presenting a paper or poster), the hours should be included as clinical and educational work hours. Travel time and non-conference hours while away do not meet the definition of "clinical and educational work hours" in the ACGME requirements.
What are the expectations in terms of a program structure that balances resident/fellow educational opportunities with opportunities for rest and personal well-being? *[Common Program Requirement: VI.F.2.a); One-Year Common Program Requirement: VI.F.2.a)]*	The intent of the requirement is to ensure that programs recognize the need to balance educational experiences with time away from the program. If an imbalance exists, it is expected that it would be manifest in other aspects of the learning environment, requiring the program to make adjustments as needed.
What is meant by "should have eight hours off"? *[Common Program Requirements: VI.F.2.b)-VI.F.2.b).(1); One-Year Common Program Requirements: VI.F.2.b) – VI.F.2.b).(1)]*	While it is expected that residents' and fellows' schedules will be structured to ensure they are provided with a minimum of eight hours off between scheduled work periods, it is recognized that individual residents or fellows 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 the resident or fellow 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. It is important to remember that when an abbreviated rest period is offered under special circumstances, the program director and faculty members must monitor residents/fellows for signs of excessive fatigue.

If a post-call resident/fellow remains on site for up to four additional hours as described in the requirements, does the required 14-hour time-off period begin at the end of the scheduled 24-hour period, or when the resident/fellow leaves the hospital? *[Common Program Requirements: VI.F.2.c), VI.F.3.a).(1); One-Year Common Program Requirements: VI.F.2.c), VI.F.3.a).(1)]*	The 14-hour time-off period begins when the resident/fellow leaves the hospital, regardless of when the resident/fellow was scheduled to leave.
Since the requirements state that residents/fellows must be provided with one day in seven free from all responsibilities, with one day defined as one continuous 24-hour period, how should programs interpret this requirement if the "day off" occurs after a resident's/fellow's on-call day? *[Common Program Requirement: VI.F.2.d); One-Year Common Program Requirement: VI.F.2.d)]*	The requirements specify a 24-hour day off. Many Review Committees have recommended that this day should ideally be a calendar day (i.e., the resident/fellow wakes up at home and has a whole day available). Review Committees have also noted that it is not permissible to have the day off regularly or frequently scheduled on a resident's/fellow's post-call day, but understand that in smaller programs this may occasionally be necessary. Note that in this case, a resident/fellow would need to leave the hospital post-call early enough to allow for 24 hours off from clinical and educational work. Because call from home does not require a rest period, the day after home call may be used as a day off.
What activities are permitted during the four hours allowed for activities related to patient safety and/or resident/fellow education? *[Common Program Requirements: VI.F.3.a).(1)-VI.F.3.a).(1).(a); One-Year Common Program Requirements: VI.F.3.a).(1) - VI.F.3.a).(1).(a)]*	Residents/fellows who have completed a 24-hour clinical and educational work period may spend up to an additional four hours on site to ensure an appropriate, effective, and safe transition of care (including rounds), to maintain continuity of patient care, and to participate in educational activities such as conferences. During this four-hour period, residents/fellows must not be permitted to participate in the care of new patients in any patient care setting; must not be assigned to outpatient clinics, including continuity clinics; and must not be assigned to participate in a new procedure, such as an elective scheduled surgery. Residents/fellows who have satisfactorily completed the transition of care may attend an educational conference that occurs during this four-hour period.

Can clinical and educational work hours for surgical chief residents be extended to 88 hours per week? *[Common Program Requirements: VI.F.4.c)-VI.F.4.c).(2); One-Year Common Program Requirements: VI.F.4.c)-c).(2)]*	Programs interested in extending the clinical and educational work hours for specific rotations for their chief residents can use the "88-hour exception" to request an increase of up to 10 percent in clinical and educational work hours on a program-by-program basis, with endorsement of the Sponsoring Institution's GMEC and the approval of the Review Committee. If approved, the exception will be reviewed annually by the Review Committee. A request for an exception must be based on a sound educational justification. Most Review Committees categorically do not permit programs to use the 10 percent exception. The Review Committee for Neurological Surgery is currently the only Review Committee that allows exceptions.
What qualifies as a "sound educational justification" for a rotation-specific increase in the weekly clinical and educational work hour limit by up to 10 percent? *[Common Program Requirements: VI.F.4.c)-VI.F.4.c).(2); One-Year Common Program Requirements: VI.F.4.c)-c).(2)]*	The ACGME specifies that a rotation-specific increase in clinical and educational work hours above 80 hours per week can be granted only when there is a very high likelihood that this will improve residents'/fellows' educational experiences. This requires that all hours in the extended work week contribute to resident/fellow education. Programs may ask for an extension that is less than the maximum of eight additional weekly hours, and/or for a subgroup of the residents/fellows in the program.

In addition to the 80-hour maximum weekly limit, do all other clinical and educational work hour rules apply to moonlighting (maximum clinical and educational work period length, minimum time off between shifts, etc.)? *[Common Program Requirements: VI.F.5.a)-c); One-Year Common Program Requirements: VI.F.5.a)-b)]*	The hours spent moonlighting are counted toward the total hours worked for the week. No other clinical and educational work hour requirements apply, but the following requirements do: VI.F.5.a) "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." VI.B.3.-VI.B.4.c).(2) "The program director, in partnership with the Sponsoring Institution, must provide a culture of professionalism that supports patient safety and personal responsibility. Residents and faculty members must demonstrate an understanding of their personal role in the: provision of patient- and family-centered care; safety and welfare of patients entrusted to their care, including the ability to report unsafe conditions and adverse events; assurance of their fitness for work, including: management of their time before, during, and after clinical assignments; and, recognition of impairment, including from illness, fatigue, and substance use, in themselves, their peers, and other members of the health care team."
How many times in a row can a resident/fellow take call every other night? *[Common Program Requirement: VI.F.7.; One-Year Common Program Requirement: VI.F.7.]*	The objectives for allowing the averaging of in-house call (in all specialties except internal medicine) is to offer flexibility in scheduling, not to permit call every other night for any extended length of time, even if done in the interest of creating longer periods of free time on weekends or later in the month. For example, it is not permissible for a resident/fellow to be on call every other night for two weeks straight and then be off for two weeks.
Is it permissible for residents/fellows to take call from home for extended periods, such as a month? *[Common Program Requirement: VI.F.8.a); One-Year Common Program Requirement: VI.F.8.a)]*	No. The requirement for one day free every week prohibits being assigned home call for an entire month. Assignment of a partial month (more than six days but fewer than 28 days) is possible. However, keep in mind that call from home is appropriate if service intensity and frequency of being called is low. Program directors are expected to monitor the intensity and workload resulting from home call through periodic assessment of workload and intensity of in-house activities.

Can PGY-1 residents take at-home call, and if so, what are the work hour restrictions for this? *[Common Program Requirement: VI.A.2.e).(1).(a)]*	PGY-1 residents are not initially allowed to take at-home call because appropriate supervision (either direct supervision or indirect supervision with direct supervision immediately available) is not possible when a resident is on at-home call. However, a Review Committee may specify the circumstances and achieved competencies required for residents to progress to be supervised indirectly with direct supervision available at some point after the beginning and before the end of the PGY-1. Program directors should review the specialty-specific requirements for further clarification.
Why do the requirements specify that clinical work done from home must count toward the 80-hour weekly maximum, averaged over four weeks? *[Common Program Requirement: VI.F.1.; One-Year Common Program Requirement: VI.F.1.]*	The requirements acknowledge the changes in medicine, including electronic health records, and the increase in the amount of work residents and fellows choose to do from home. Resident decisions to complete work at home should be made in consultation with the resident's/fellow's supervisor. In such circumstances, residents/fellows should be mindful of their professional responsibility to complete work in a timely manner and to maintain patient confidentiality. The requirement provides flexibility for residents/fellows to do this while ensuring that the time spent completing clinical work from home is accomplished within the 80-hour weekly maximum.
What are the expectations regarding tracking and monitoring clinical work done from home? *[Common Program Requirements: VI.F.1., VI.F.8.a); One-Year Common Program Requirements: VI.F.1., VI.F.8.a)]*	Types of work from home that must be counted include using an electronic health record and responding to patient care questions. Reading done in preparation for the following day's cases, studying, and research done from home do not count toward the 80 hours. Residents and fellows are expected to track the time spent on these activities and report this time to the program director. The program director then will use this information when developing schedules to ensure that residents and fellows are not exceeding 80 hours per week, averaged over four weeks. Decisions about whether to report brief periods devoted to clinical work (e.g., a phone call that lasts just a couple of minutes) are left to the individual resident or fellow. There is no requirement regarding how this time is tracked and documented and no expectation that the program director assume a role in verifying the time reported by the residents and fellows.

Which requirements apply to time in the hospital after being called in from home call? *[Common Program Requirements: VI.F.8.a)-b); One-Year Common Program Requirements: VI.F.8.a)-b)]*	For call taken from home (home or pager call), the time a resident/fellow spends in the hospital after being called in counts toward the weekly clinical and educational work hour limit. The only other numeric clinical and educational work hour requirement that applies is the one day free of clinical and educational work every week that must be free of all patient care responsibilities, which includes at-home call. Program directors must monitor the intensity and workload resulting from at-home call through periodic assessment of the frequency of being called into the hospital, and the length and intensity of the in-house activities. When residents/fellows assigned to at-home call return to the hospital to care for patients, a new time-off period is not initiated, and therefore the requirement for eight hours between shifts does not apply. The frequency and duration of clinical work done from home and time returning to the hospital must not preclude rest or reasonable personal time for residents/fellows.
General Questions	
How should the averaging of the clinical and educational work hour requirements (e.g., 80-hour weekly limit, one day free of clinical and educational work every week, and call no more frequently than every third night) be handled? For example, what should be done if a resident/fellow takes a vacation week?	Averaging must occur by rotation. This is done over one of the following: a four-week period; a one-month period (28-31 days); or the period of the rotation if it is shorter than four weeks. When rotations are shorter than four weeks in length, averaging must be made over these shorter assignments. This avoids heavy and light assignments being combined to achieve compliance. If a resident/fellow takes vacation or other leave, the ACGME requires that vacation or leave days be omitted from the numerator and the denominator for calculating clinical and educational work hours, call frequency, or days off. The requirements do not permit a "rolling" average, because this may mask compliance problems by averaging across high and low clinical and educational work hour rotations. The rotation with the greatest hours and frequency of call must comply with the common clinical and educational work hour requirements.
Will the Institutional Requirements be revised to address the Sponsoring Institution's role in the areas of the requirements that address responsibilities that must be shared by the Sponsoring Institution and the program?	The statement "Programs, in partnership with their Sponsoring Institutions," throughout Section VI reflects the need for programs and institutions to work together and recognize that institutional support will be necessary for programs to comply with the new requirements. The next revision of the Institutional Requirements will include changes to align the Institutional Requirements with the Common Program Requirements in these areas and as appropriate.

Can the clinical and educational work hour requirements be relaxed over holidays or during other times when a hospital is short-staffed, during periods when some residents/fellows are ill or on leave, or when there is an unusually large patient census or demand for care?	The ACGME expects that clinical and educational work hours in any given four-week period comply with all applicable requirements. This includes months with holidays, during which institutions may have fewer staff members available. During the holiday period, scheduling for the rotation (generally four weeks or a month) must comply with the common and specialty-specific clinical and educational work hour requirements. Further, the schedule during the holidays themselves may not violate common clinical and educational work hour requirements (such as the requirement for adequate rest between clinical and educational work periods), or specialty-specific requirements.
What determines clinical and educational work hour limits for residents/fellows who rotate in another accredited program?	The clinical and educational work hour limits of the program in which the resident/fellow rotates apply to all residents/fellows, both those in the program and rotators from another specialty. This expectation also applies when a program has an exception, but it helps to remember that the standard defines the maximum allowable hours, not required hours or hours for all residents/fellows, so that it is always possible to work fewer hours than the limit.
What is the ACGME Resident/Fellow Survey-Common Program Requirements Crosswalk document? How can it help me understand my ACGME resident survey results?	This is a new resource that helps programs understand and interpret their ACGME Resident/Fellow Survey results by mapping ACGME survey questions to the respective and corresponding Common Program Requirements. If a program has a low compliance rate on a particular Resident/Fellow Survey item, the crosswalk document can help the program director identify the area for improvement to comply with the applicable Common Program Requirements. This resource can also help a program's residents/fellows understand the intent of the individual survey questions. The crosswalk document for the Resident/Fellow survey can be found on the ACGME website: https://www.acgme.org/Portals/0/PFAssets/ProgramResources/ResidentFellow%20Survey-Common%20Program%20Requirements%20Crosswalk.pdf?ver=2021-04-30-150131-890. A crosswalk document is also available for the annual Faculty Survey: https://www.acgme.org/Portals/0/PFAssets/ProgramResources/Faculty%20Survey-Common%20Program%20Requirements%20Crosswalk.pdf?ver=2021-04-30-144956-250.