

ACGME Program Requirements for Graduate Medical Education in Preventive Medicine

Common Program Requirements are in BOLD

Effective July 1, 2011

Introduction

Int.A. Residency is an essential dimension of the transformation of the medical student to the independent practitioner along the continuum of medical education. It is physically, emotionally, and intellectually demanding, and requires longitudinally-concentrated effort on the part of the resident.

The specialty education of physicians to practice independently is experiential, and necessarily occurs within the context of the health care delivery system. Developing the skills, knowledge, and attitudes leading to proficiency in all the domains of clinical competency requires the resident physician to assume personal responsibility for the care of individual patients. For the resident, the essential learning activity is interaction with patients under the guidance and supervision of faculty members who give value, context, and meaning to those interactions. As residents gain experience and demonstrate growth in their ability to care for patients, they assume roles that permit them to exercise those skills with greater independence. This concept—graded and progressive responsibility—is one of the core tenets of American graduate medical education. Supervision in the setting of graduate medical education has the goals of assuring the provision of safe and effective care to the individual patient; assuring each resident’s development of the skills, knowledge, and attitudes required to enter the unsupervised practice of medicine; and establishing a foundation for continued professional growth.

Int.B Preventive medicine is the medical specialty which 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. The identified areas in the field of preventive medicine and the populations on which they concentrate are:

Int.B.1. aerospace medicine, which focuses on the health of a population group consisting of the operational crews, passengers of air and space vehicles, and the support personnel who are required to operate such vehicles;

Int.B.2. occupational medicine, which focuses on the relationships among the health of workers, the arrangements of work, the physical, chemical and social environments in the workplace, and the health outcomes of environmental exposures; and,

Int.B.3. public health and general preventive medicine, which focuses on health promotion and disease prevention in communities and other defined populations.

Int. C. The educational program in preventive medicine must be 24 months in length. This is to include broad-based education followed by focused preventive medicine education.

I. Institutions

I.A. Sponsoring Institution

One sponsoring institution must assume ultimate responsibility for the program, as described in the Institutional Requirements, and this responsibility extends to resident assignments at all participating sites.

The sponsoring institution and the program must ensure that the program director has sufficient protected time and financial support for his or her educational and administrative responsibilities to the program.

I.A.1. The sponsoring institution must provide funds for each resident to attend at least one national professional meeting in which the opportunity to present original scholarship is available.

I.B. Participating Sites

I.B.1. There must be a program letter of agreement (PLA) between the program and each participating site providing a required assignment. The PLA must be renewed at least every five years.

The PLA should:

I.B.1.a) identify the faculty who will assume both educational and supervisory responsibilities for residents;

I.B.1.b) specify their responsibilities for teaching, supervision, and formal evaluation of residents, as specified later in this document;

I.B.1.c) specify the duration and content of the educational experience; and,

I.B.1.d) state the policies and procedures that will govern resident education during the assignment.

I.B.2. The program director must submit any additions or deletions of participating sites routinely providing an educational experience, required for all residents, of one month full time equivalent (FTE) or more through the Accreditation Council for Graduate Medical Education (ACGME) Accreditation Data System (ADS).

II. Program Personnel and Resources

II.A. Program Director

- II.A.1.** There must be a single program director with authority and accountability for the operation of the program. The sponsoring institution's GMEC must approve a change in program director. After approval, the program director must submit this change to the ACGME via the ADS.
- II.A.2.** The program director should continue in his or her position for a length of time adequate to maintain continuity of leadership and program stability.
- II.A.3.** Qualifications of the program director must include:
- II.A.3.a)** requisite specialty expertise and documented educational and administrative experience acceptable to the Review Committee;
- II.A.3.b)** current certification in the specialty by the American Board of Preventive Medicine, or specialty qualifications that are acceptable to the Review Committee; and,
- II.A.3.c)** current medical licensure and appropriate medical staff appointment.
- II.A.4.** The program director must administer and maintain an educational environment conducive to educating the residents in each of the ACGME competency areas. The program director must:
- II.A.4.a)** oversee and ensure the quality of didactic and clinical education in all sites that participate in the program;
- II.A.4.b)** approve a local director at each participating site who is accountable for resident education;
- II.A.4.c)** approve the selection of program faculty as appropriate;
- II.A.4.d)** evaluate program faculty and approve the continued participation of program faculty based on evaluation;
- II.A.4.e)** monitor resident supervision at all participating sites;
- II.A.4.f)** prepare and submit all information required and requested by the ACGME, including but not limited to the program information forms and annual program resident updates to the ADS, and ensure that the information submitted is accurate and complete;
- II.A.4.g)** provide each resident with documented semiannual evaluation of performance with feedback;
- II.A.4.h)** ensure compliance with grievance and due process procedures as set forth in the Institutional Requirements and

- implemented by the sponsoring institution;
- II.A.4.i) provide verification of residency education for all residents, including those who leave the program prior to completion;
 - II.A.4.j) implement policies and procedures consistent with the institutional and program requirements for resident duty hours and the working environment, including moonlighting, and, to that end, must:
 - II.A.4.j).(1) distribute these policies and procedures to the residents and faculty;
 - II.A.4.j).(2) monitor resident duty hours, according to sponsoring institutional policies, with a frequency sufficient to ensure compliance with ACGME requirements;
 - II.A.4.j).(3) adjust schedules as necessary to mitigate excessive service demands and/or fatigue; and,
 - II.A.4.j).(4) if applicable, monitor the demands of at-home call and adjust schedules as necessary to mitigate excessive service demands and/or fatigue.
 - II.A.4.k) monitor the need for and ensure the provision of back up support systems when patient care responsibilities are unusually difficult or prolonged;
 - II.A.4.l) comply with the sponsoring institution's written policies and procedures, including those specified in the Institutional Requirements, for selection, evaluation and promotion of residents, disciplinary action, and supervision of residents;
 - II.A.4.m) be familiar with and comply with ACGME and Review Committee policies and procedures as outlined in the ACGME Manual of Policies and Procedures;
 - II.A.4.n) obtain review and approval of the sponsoring institution's GMC/DIO before submitting to the ACGME information or requests for the following:
 - II.A.4.n).(1) all applications for ACGME accreditation of new programs;
 - II.A.4.n).(2) changes in resident complement;
 - II.A.4.n).(3) major changes in program structure or length of training;
 - II.A.4.n).(4) progress reports requested by the Review Committee

- II.A.4.n).(5) responses to all proposed adverse actions;
 - II.A.4.n).(6) requests for increases or any change to resident duty hours;
 - II.A.4.n).(7) voluntary withdrawals of ACGME-accredited programs;
 - II.A.4.n).(8) requests for appeal of an adverse action;
 - II.A.4.n).(9) appeal presentations to a Board of Appeal or the ACGME; and,
 - II.A.4.n).(10) proposals to ACGME for approval of innovative educational approaches.
- II.A.4.o) obtain DIO review and co-signature on all program information forms, as well as any correspondence or document submitted to the ACGME that addresses:
- II.A.4.o).(1) program citations, and/or
 - II.A.4.o).(2) request for changes in the program that would have significant impact, including financial, on the program or institution.
- II.A.4.p) prepare and distribute explicit written descriptions of supervisory lines of responsibility; and,
- II.A.4.q) ensure the timely completion of each resident's Learning Portfolio.

II.B. Faculty

II.B.1. At each participating site, there must be a sufficient number of faculty with documented qualifications to instruct and supervise all residents at that location.

The faculty must:

II.B.1.a) devote sufficient time to the educational program to fulfill their supervisory and teaching responsibilities; and to demonstrate a strong interest in the education of residents, and

II.B.1.b) administer and maintain an educational environment conducive to educating residents in each of the ACGME competency areas.

II.B.2. The physician faculty must have current certification in the specialty by the American Board of Preventive Medicine, or possess qualifications acceptable to the Review Committee.

- II.B.3.** The physician faculty must possess current medical licensure and appropriate medical staff appointment.
- II.B.4.** The nonphysician faculty must have appropriate qualifications in their field and hold appropriate institutional appointments.
- II.B.5.** The faculty must establish and maintain an environment of inquiry and scholarship with an active research component.
- II.B.5.a)** The faculty must regularly participate in organized clinical discussions, rounds, journal clubs, and conferences.
- II.B.5.b)** Some members of the faculty should also demonstrate scholarship by one or more of the following:
- II.B.5.b).(1)** peer-reviewed funding;
- II.B.5.b).(2)** publication of original research or review articles in peer-reviewed journals, or chapters in textbooks;
- II.B.5.b).(3)** publication or presentation of case reports or clinical series at local, regional, or national professional and scientific society meetings; or,
- II.B.5.b).(4)** participation in national committees or educational organizations.
- II.B.5.c)** Faculty should encourage and support residents in scholarly activities.
- II.C.** **Other Program Personnel**
- The institution and the program must jointly ensure the availability of all necessary professional, technical, and clerical personnel for the effective administration of the program.
- II.D.** **Resources**
- The institution and the program must jointly ensure the availability of adequate resources for resident education, as defined in the specialty program requirements.
- II.D.1.** Preventive medicine programs with a concentration in aerospace medicine should have a flight training program available, to develop aeronautical skills and serve as a source of clinical problems for the supervised management of those encountered in flight personnel and passengers.
- II.E.** **Medical Information Access**

Residents must have ready access to specialty-specific and other appropriate reference material in print or electronic format. Electronic medical literature databases with search capabilities should be available.

III. Resident Appointments

III.A. Eligibility Criteria

The program director must comply with the criteria for resident eligibility as specified in the Institutional Requirements.

III.A.1. Prior to appointment in the program, residents must have successfully completed at least 12 months of clinical education in a residency program accredited by the ACGME, Royal College of Physicians and Surgeons of Canada, or the College of Family Physicians of Canada.

III.A.1.a) Resident experience must include at least 11 months of direct patient care in both inpatient and outpatient settings.

III.A.1.b) Residents should develop competency in the following fundamental clinical skills during this experience:

III.A.1.b).(1) obtaining a comprehensive medical history;

III.A.1.b).(2) performing a comprehensive physical examination;

III.A.1.b).(3) assessing a patient's medical conditions;

III.A.1.b).(4) making appropriate use of diagnostic studies and tests;

III.A.1.b).(5) integrating information to develop a differential diagnosis; and

III.A.1.b).(6) developing, implementing, and evaluating a treatment plan.

III.A.2. Prior to appointment to the program, residents must be provided with information that describes the program's current accreditation status, educational objectives, and structure.

III.B. Number of Residents

The program director may not appoint more residents than approved by the Review Committee, unless otherwise stated in the specialty-specific requirements. The program's educational resources must be adequate to support the number of residents appointed to the program.

III.C. Resident Transfers

III.C.1. Before accepting a resident who is transferring from another program, the program director must obtain written or electronic

verification of previous educational experiences and a summative competency-based performance evaluation of the transferring resident.

III.C.2. A program director must provide timely verification of residency education and summative performance evaluations for residents who leave the program prior to completion.

III.D. Appointment of Fellows and Other Learners

The presence of other learners (including, but not limited to, residents from other specialties, subspecialty fellows, PhD students, and nurse practitioners) in the program must not interfere with the appointed residents' education. The program director must report the presence of other learners to the DIO and GMEC in accordance with sponsoring institution guidelines.

IV. Educational Program

IV.A. The curriculum must contain the following educational components:

IV.A.1. Overall educational goals for the program, which the program must distribute to residents and faculty annually;

IV.A.2. Competency-based goals and objectives for each assignment at each educational level, which the program must distribute to residents and faculty annually, in either written or electronic form. These should be reviewed by the resident at the start of each rotation;

IV.A.3. Regularly scheduled didactic sessions;

IV.A.3.a) Whether through a Master's in Public Health or other equivalent degree, prior to completion of the residency program, all residents must complete graduate level courses in epidemiology; biostatistics; health services management and administration; environmental health; and the behavioral aspects of health.

IV.A.3.b) Depending on the concentration of the program, residents should complete the following graduate level courses prior to completion of the program:

IV.A.3.b).(1) aerospace medicine: toxicology; global health and travel medicine; principles of aviation and space medicine; and accident investigation/risk management and mitigation.

IV.A.3.b).(2) occupational medicine: toxicology; occupational epidemiology; industrial hygiene, safety and ergonomics; and risk/hazard control and communication.

IV.A.3.b).(3) public health and general preventive medicine: advanced

applied epidemiology (to include acute and chronic disease); advanced biostatistics; advanced health services management; clinical preventive services; and risk/hazard control and communication.

IV.A.3.c) Didactic conferences must be structured to facilitate faculty-resident interaction.

IV.A.4. Delineation of resident responsibilities for patient care, progressive responsibility for patient management, and supervision of residents over the continuum of the program; and,

IV.A.5. ACGME Competencies

The program must integrate the following ACGME competencies into the curriculum:

IV.A.5.a) Patient Care

Residents must be able to provide patient care that is compassionate, appropriate, and effective for the treatment of health problems and the promotion of health. Residents:

IV.A.5.a).(1) must demonstrate proficiency in the following core preventive medicine competencies, regardless of their specialty area:

IV.A.5.a).(1).(a) monitoring health status to identify community health problems;

IV.A.5.a).(1).(b) diagnosing and investigating medical problems and medical hazards in the community;

IV.A.5.a).(1).(c) informing and educating populations about health threats and risks;

IV.A.5.a).(1).(d) mobilizing community partnerships to identify and solve health problems;

IV.A.5.a).(1).(e) developing policies and plans to support individual and community health efforts;

IV.A.5.a).(1).(f) applying laws and regulations that protect health and ensure safety of populations;

IV.A.5.a).(1).(g) linking individuals to needed personal health services and ensuring the provision of health care when otherwise unavailable;

IV.A.5.a).(1).(h) evaluating the effectiveness, accessibility, and quality of individual and population-based health

	services;
IV.A.5.a).(1).(i)	conducting research for innovative solutions to health problems;
IV.A.5.a).(1).(j)	progressive responsibility for patients and the clinical and administrative management of populations or communities;
IV.A.5.a).(1).(k)	skills in clinical preventive medicine, including the ability to:
IV.A.5.a).(1).(k).(i)	develop, deliver, and implement appropriate clinical services for both individuals and populations in order to diagnose and treat medical problems and chronic conditions;
IV.A.5.a).(1).(k).(ii)	apply primary, secondary, and tertiary preventive approaches to individual and population-based disease prevention and health promotion; and,
IV.A.5.a).(1).(k).(iii)	develop, implement and evaluate the effectiveness of appropriate clinical preventive services for both individuals and populations.
IV.A.5.a).(1).(l)	skills in occupational and environmental health, including assessing and responding to individual and population risks for common occupational and environmental disorders; and,
IV.A.5.a).(1).(m)	skills in emergency preparedness programs, including:
IV.A.5.a).(1).(m).(i)	determining the nature and extent of injuries sustained and individuals' need for subsequent treatment;
IV.A.5.a).(1).(m).(ii)	planning emergency preparedness programs and training exercises; and,
IV.A.5.a).(1).(m).(iii)	evaluating emergency preparedness training exercises to ensure the health and safety of those involved.
IV.A.5.a).(2)	in programs with a concentration in aerospace medicine, must demonstrate proficiency in:
IV.A.5.a).(2).(a)	managing aerospace and general medical problems in aerospace personnel;

- IV.A.5.a).(2).(b) developing and applying medical standards, granting exceptions, and facilitating the prevention, early diagnosis, and treatment of health hazards;
- IV.A.5.a).(2).(c) educating passengers and physicians about the hazards of flight with certain medical conditions and serving as passenger advocates to promote flight safety;
- IV.A.5.a).(2).(d) identifying appropriate patients for aeromedical transport and providing guidance for safe aeromedical transport of patients with common medical problems;
- IV.A.5.a).(2).(e) advising in the development of: air and space flight equipment, biomedical equipment, and vehicles for flight and space flight; techniques for enhancing human performance; and techniques of crew resource management;
- IV.A.5.a).(2).(f) providing appropriate safety information and education and conducting the medical aspects of any mishap investigation, including making recommendations to prevent recurrences;
- IV.A.5.a).(2).(g) conducting aeromedical research into health, safety, human factors, and biomedical engineering aspects of the flight environment; and,
- IV.A.5.a).(2).(h) for programs with training in space medicine, developing and applying medical care standards and programs, evaluating the physiologic effects of spaceflight, and conducting and evaluating longitudinal studies on astronauts.
- IV.A.5.a).(3) in programs with a concentration in occupational medicine, must demonstrate proficiency in:
 - IV.A.5.a).(3).(a) managing the health status of individuals employed in diverse work settings, including:
 - IV.A.5.a).(3).(a).(i) supervising direct care of workers, to ensure competency in preventing, mitigating, and managing medical problems of workers; and,
 - IV.A.5.a).(3).(a).(ii) safeguarding employees and others in the workplace, using appropriate techniques to assess safe and unsafe work practices.

- IV.A.5.a).(3).(b) monitoring and surveying workforces and interpreting monitoring and surveillance data for prevention of disease in workplaces to enhance the health and productivity of workers;
- IV.A.5.a).(3).(c) planning at least one surveillance or monitoring program for different types of workforces;
- IV.A.5.a).(3).(d) managing workers' compensation insurance documentation and paperwork, including the ability to:
- IV.A.5.a).(3).(d).(i) open, manage, and direct workers' compensation treatment plans, and close workers' compensation injury/illness cases following the relevant state, federal, and public workers' compensation insurance rules; and,
- IV.A.5.a).(3).(d).(ii) apply evidence-based clinical practice guidelines in the treatment and management of workers' compensation cases.
- IV.A.5.a).(3).(e) recognizing and responding to outbreak events of public health significance, as they appear in workplace settings, including the ability to:
- IV.A.5.a).(3).(e).(i) assemble and work with a team to evaluate and identify workplace causes of injury and illness;
- IV.A.5.a).(3).(e).(ii) develop plans in response to sentinel events using primary, secondary, and tertiary prevention methods;
- IV.A.5.a).(3).(e).(iii) recognize and evaluate potentially hazardous workplace and environmental conditions, and then recommend controls or programs to reduce exposure, to enhance the health and productivity of workers; and,
- IV.A.5.a).(3).(e).(iv) apply toxicologic and risk assessment principles in the evaluation of hazards.
- IV.A.5.a).(3).(f) approaching the practice of occupational medicine from an ethical base that promotes the health and welfare of the individual worker in the context of the workplace environment and public health and public safety, including the ability to:

- IV.A.5.a).(3).(f).(i) apply an ethical approach to workers' rights and privacy in the context of overriding public health and safety;
- IV.A.5.a).(3).(f).(ii) report outcome findings of clinical and surveillance evaluations to affected workers as ethically required; and,
- IV.A.5.a).(3).(f).(iii) advise Management concerning summary results or trends in disability, disease, or risk that may have public health significance.
- IV.A.5.a).(3).(g) participating in emergency preparedness programs in at least one workplace setting.
- IV.A.5.a).(4) in programs with a concentration in public health and general preventive medicine, must demonstrate proficiency in:
 - IV.A.5.a).(4).(a) public health practice, including the ability to:
 - IV.A.5.a).(4).(a).(i) investigate a disease outbreak, while assessing the medical needs of both individual patients and populations; and,
 - IV.A.5.a).(4).(a).(ii) implement programs to reduce the exposure to risk factors for an illness or condition in a population, with the ability to:
 - IV.A.5.a).(4).(a).(ii).(a) conduct policy analyses to improve the health of a population, and,
 - IV.A.5.a).(4).(a).(ii).(b) design and operate a surveillance system.
 - IV.A.5.a).(4).(b) clinical preventive medicine, including the ability to:
 - IV.A.5.a).(4).(b).(i) select appropriate, evidence-based, clinical preventive services for individuals and populations;
 - IV.A.5.a).(4).(b).(ii) analyze evidence regarding the performance of proposed clinical preventive services for individuals and populations;
 - IV.A.5.a).(4).(b).(iii) manage and administer programs that provide recommended immunizations, chemoprophylaxis and screening tests to individuals and appropriate populations; and,

IV.A.5.a).(4).(b).(iv)

counsel individuals regarding the appropriate use of clinical preventive services and health promoting behavior changes, and provide immunizations, chemoprophylaxis, and screening services, as appropriate.

IV.A.5.b)

Medical Knowledge

Residents must demonstrate knowledge of established and evolving biomedical, clinical, epidemiological and social-behavioral sciences, as well as the application of this knowledge to patient care. Residents:

IV.A.5.b).(1)

must demonstrate expertise in their knowledge of all content areas included in the required graduate courses for completion of the program.

IV.A.5.c)

Practice-based Learning and Improvement

Residents must demonstrate the ability to investigate and evaluate their care of patients, to appraise and assimilate scientific evidence, and to continuously improve patient care based on constant self-evaluation and life-long learning. Residents are expected to develop skills and habits to be able to meet the following goals:

IV.A.5.c).(1)

identify strengths, deficiencies, and limits in one's knowledge and expertise;

IV.A.5.c).(2)

set learning and improvement goals;

IV.A.5.c).(3)

identify and perform appropriate learning activities;

IV.A.5.c).(4)

systematically analyze practice using quality improvement methods, and implement changes with the goal of practice improvement;

IV.A.5.c).(5)

incorporate formative evaluation feedback into daily practice;

IV.A.5.c).(6)

locate, appraise, and assimilate evidence from scientific studies related to their patients' health problems;

IV.A.5.c).(7)

use information technology to optimize learning;

IV.A.5.c).(8)

participate in the education of patients, families, students, residents and other health professionals;

IV.A.5.c).(9)

use computers for reference retrieval, statistical analysis,

graphic display, database management, and communication;

- IV.A.5.c).(10) use epidemiology principles and biostatistics methods, including the ability to:
 - IV.A.5.c).(10).(a) characterize the health of a community;
 - IV.A.5.c).(10).(b) evaluate a surveillance system;
 - IV.A.5.c).(10).(c) select and conduct appropriate statistical analyses;
 - IV.A.5.c).(10).(d) design and conduct a virtual or actual outbreak or cluster investigation;
 - IV.A.5.c).(10).(e) translate epidemiologic findings into a recommendation for a specific intervention; and,
 - IV.A.5.c).(10).(f) measure, organize, or improve public health care.
- IV.A.5.c).(11) design and conduct an epidemiologic study; and,
- IV.A.5.c).(12) conduct an advanced literature search for research on a preventive medicine topic.

IV.A.5.d) Interpersonal and Communication Skills

Residents must demonstrate interpersonal and communication skills that result in the effective exchange of information and collaboration with patients, their families, and health professionals. Residents are expected to:

- IV.A.5.d).(1) communicate effectively with patients, families, and the public, as appropriate, across a broad range of socioeconomic and cultural backgrounds;**
- IV.A.5.d).(2) communicate effectively with physicians, other health professionals, and health related agencies;**
- IV.A.5.d).(3) work effectively as a member or leader of a health care team or other professional group;**
- IV.A.5.d).(4) act in a consultative role to other physicians and health professionals; and,**
- IV.A.5.d).(5) maintain comprehensive, timely, and legible medical records, if applicable.**

IV.A.5.e) Professionalism

Residents must demonstrate a commitment to carrying out

- resident's specialty area and assignments;
- IV.A.5.f).(9) identify organizational decision-making structures, stakeholders, styles, and processes;
- IV.A.5.f).(10) assess program and community resources, develop a plan for appropriate resources, and integrate resources for program implementation;
- IV.A.5.f).(11) demonstrate skills in management and administration, including the ability to:
 - IV.A.5.f).(11).(a) assess data and formulate policy for a given health issue;
 - IV.A.5.f).(11).(b) develop and implement a plan to address a specific health problem;
 - IV.A.5.f).(11).(c) conduct an evaluation or quality assessment based on process and outcome performance measures;
 - IV.A.5.f).(11).(d) manage the human and financial resources for the operation of a program or project;
 - IV.A.5.f).(11).(e) apply and use management information systems; and,
 - IV.A.5.f).(11).(f) plan, manage, and evaluate health services to improve the health of a defined population using quality improvement and assurance systems.
- IV.A.5.f).(12) assess organizational performances against stated goals;
- IV.A.5.f).(13) analyze policy options for their health impact and economic costs; and,
- IV.A.5.f).(14) evaluate applicants and the performance of staff, and understand the legal and ethical use of this information in decisions for hiring, managing, and discharging staff.

IV.A.6. Curriculum Organization and Resident Experiences

IV.A.6.a) All Preventive Medicine Programs

IV.A.6.a).(1) Each incoming resident (PM1) must be assessed as to his/her knowledge, skills, and competencies in relationship to the educational goals for the program.

IV.A.6.a).(1).(a) The assessment should include a self-assessment, an in-service examination, and a structured interview or other method that assesses

knowledge, skills, and competencies.

IV.A.6.a).(1).(b)

The assessment should be used by the program director and faculty to guide the development of an individualized educational plan for each resident. The plan must:

IV.A.6.a).(1).(b).(i)

direct the acquisition of a core set of competencies, skills, and knowledge appropriate to the objectives of the individual resident based on assessment of each resident;

IV.A.6.a).(1).(b).(ii)

denote the courses, rotations, and activities to which the resident will be assigned in order to achieve the designated clinical skills, knowledge and competencies; and,

IV.A.6.a).(1).(b).(iii)

be reviewed as part of the semiannual evaluation.

IV.A.6.a).(2)

Residents must have educational experiences within a patient care environment that address direct clinical issues relevant to their area of concentration.

IV.A.6.a).(2).(a)

Each resident must have progressive responsibility for direct patient care.

IV.A.6.a).(2).(b)

Each resident must have progressive responsibility for the management of health and provision of health care for a defined population, as specified for their area of preventive medicine.

IV.A.6.a).(2).(b).(i)

These patient care experiences must be appropriately supervised.

IV.A.6.b)

Aerospace Medicine

Resident education must take place in a setting where operational aeromedical problems are routinely encountered and aerospace operations and human life support systems are under active study and development.

IV.A.6.b).(1)

Resident experiences must include: pilot medical certification, operational flight medical support, disability assessment of pilots, and aircraft and/or spacecraft accident investigation of problems directly applicable to the specialty and the aviation/space environment.

IV.A.6.b).(2)

Residents must have a minimum of four months of direct patient care experience during each year of the program.

IV.A.6.c) Occupational Medicine

Resident education must take place in settings that provide opportunities for residents to manage the clinical, scientific, social, legal, and administrative issues from the perspectives of workers, employers, and regulatory or legal authorities.

IV.A.6.c).(1) Residents' clinical experiences must include participation in learning activities based on the American College of Occupational and Environmental Medicine (ACOEM) Core Competencies and Skill Sets for Occupational and Environmental Medicine.

IV.A.6.c).(2) Residents must have a minimum of four months of direct patient care experience in an occupational setting during each year of the program.

IV.A.6.d) Public Health and General Preventive Medicine

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.

IV.A.6.d).(1) Resident clinical experiences must include participation in learning activities related to the current recommendations of the US Preventive Services Task Force.

IV.A.6.d).(2) Residents must have a minimum of two months of direct patient care experience during each year of the program.

IV.A.6.d).(3) Residents should be assigned to sites appropriate for specific learning activities, including hospitals, managed care organizations, health departments, non-governmental organizations, and community-based organizations.

IV.A.6.d).(4) Residents must have a minimum of two months experience at a governmental public health agency.

IV.A.6.e) All residents must maintain a Resident Learning Portfolio. This portfolio must be reviewed with the program director as part of the semiannual evaluation, and must include the following:

IV.A.6.e).(1) Patient Care

IV.A.6.e).(1).(a) work products demonstrating competency-based outcomes;

IV.A.6.e).(2) Medical Knowledge

- IV.A.6.e).(2).(a) documentation of performance in required courses, including course descriptions and transcripts;
- IV.A.6.e).(2).(b) documentation of performance on in-service examinations or other structured objective examinations;
- IV.A.6.e).(3) Practice-based Learning and Improvement
- IV.A.6.e).(3).(a) annual resident self-assessment and educational plan;
- IV.A.6.e).(4) Interpersonal and Communication Skills
- IV.A.6.e).(4).(a) formal faculty evaluation of presentations and report quality;
- IV.A.6.e).(5) Professionalism
- IV.A.6.e).(5).(a) documentation of compliance with institutional and program policies;
- IV.A.6.e).(6) Systems-based Practice
- IV.A.6.e).(6).(a) work products demonstrating required competency-based outcomes;
- IV.A.6.e).(7) Evaluations
- IV.A.6.e).(7).(a) faculty evaluations and multi-source evaluations.

IV.B. Residents' Scholarly Activities

- IV.B.1. The curriculum must advance residents' knowledge of the basic principles of research, including how research is conducted, evaluated, explained to patients, and applied to patient care.**
- IV.B.2. Residents should participate in scholarly activity.**
- IV.B.3. The sponsoring institution and program should allocate adequate educational resources to facilitate resident involvement in scholarly activities.**

V. Evaluation

V.A. Resident Evaluation

V.A.1. Formative Evaluation

- V.A.1.a) The faculty must evaluate resident performance in a timely manner during each rotation or similar educational**

assignment, and document this evaluation at completion of the assignment.

- V.A.1.b) The program must:**
- V.A.1.b).(1) provide objective assessments of competence in patient care, medical knowledge, practice-based learning and improvement, interpersonal and communication skills, professionalism, and systems-based practice;**
- V.A.1.b).(2) use multiple evaluators (e.g., faculty, peers, patients, self, and other professional staff);**
- V.A.1.b).(3) document progressive resident performance improvement appropriate to educational level; and,**
- V.A.1.b).(4) provide each resident with documented semiannual evaluation of performance with feedback.**
- V.A.1.c) The evaluations of resident performance must be accessible for review by the resident, in accordance with institutional policy.**

V.A.2. Summative Evaluation

The program director must provide a summative evaluation for each resident upon completion of the program. This evaluation must become part of the resident's permanent record maintained by the institution, and must be accessible for review by the resident in accordance with institutional policy. This evaluation must:

- V.A.2.a) document the resident's performance during the final period of education, and**
- V.A.2.b) verify that the resident has demonstrated sufficient competence to enter practice without direct supervision.**

V.B. Faculty Evaluation

- V.B.1. At least annually, the program must evaluate faculty performance as it relates to the educational program.**
- V.B.2. These evaluations should include a review of the faculty's clinical teaching abilities, commitment to the educational program, clinical knowledge, professionalism, and scholarly activities.**
- V.B.3. This evaluation must include at least annual written confidential evaluations by the residents.**

V.C. Program Evaluation and Improvement

- V.C.1. The program must document formal, systematic evaluation of the curriculum at least annually. The program must monitor and track each of the following areas:**
- V.C.1.a) resident performance;**
 - V.C.1.b) faculty development;**
 - V.C.1.c) graduate performance, including performance of program graduates on the certification examination; and,**
 - V.C.1.d) program quality. Specifically:**
 - V.C.1.d).(1) residents and faculty must have the opportunity to evaluate the program confidentially and in writing at least annually, and,**
 - V.C.1.d).(2) the program must use the results of residents' assessments of the program together with other program evaluation results to improve the program.**
- V.C.2. If deficiencies are found, the program should prepare a written plan of action to document initiatives to improve performance in the areas listed in section V.C.1. The action plan should be reviewed and approved by the teaching faculty and documented in meeting minutes.**
- V.C.3. Residency Advisory Committee**
- Each program must have a Residency Advisory Committee (RAC), which must consist of faculty, external members, supervisors, and at least one resident representative, and must include the program director as an ex-officio member. A majority of the members must have their primary affiliation outside the sponsoring institution. Members must be certified in preventive medicine or be knowledgeable about specialty education in preventive medicine. The RAC chair must be a physician other than the program director.
- V.C.3.a) The RAC must meet at least semiannually.**
 - V.C.3.b) The RAC must advise and assist the program director to:**
 - V.C.3.b).(1) develop and update a written residency mission statement that describes goals and objectives;**
 - V.C.3.b).(2) develop educational experiences and clinical rotations;**
 - V.C.3.b).(3) provide new or emerging knowledge, skills, or competencies that may influence the content or conduct of preventive medicine education;**

- V.C.3.b).(4) review the sponsoring institution's internal review of the program;
- V.C.3.b).(5) review confidential and written resident evaluations of faculty and the program;
- V.C.3.b).(6) review the program director's evaluations of individual residents; and,
- V.C.3.b).(7) review faculty evaluations of the program director and the program.
- V.C.3.c) Resident and faculty evaluations must be provided to the chair of the RAC.
- V.C.3.d) The program director, with assistance from the chair of the RAC, must provide to the DIO an annual written report of the program's quality. The program director, with assistance from the chair of the RAC, must respond to any recommendations from the DIO with a written plan of corrective actions.
- V.C.4. The program should obtain feedback from its graduates on practice profiles, licensure, and board certification. The data from the evaluation of graduates should be used as part of the program's determination of the degree to which the program's stated goals are being met.
- V.C.5. At least 50% of those completing their education in the preceding five years must take the American Board of Preventive Medicine certifying examination.
- V.C.6. 75% of a program's graduates from the preceding five years who took the certifying examination for preventive medicine for the first time must have passed. In those programs having fewer than 10 graduates in the past five years, at least 75% of the 10 most recent graduates must have passed.

VI. Resident Duty Hours in the Learning and Working Environment

VI.A. Professionalism, Personal Responsibility, and Patient Safety

- VI.A.1. Programs and sponsoring institutions must educate residents and faculty members concerning the professional responsibilities of physicians to appear for duty appropriately rested and fit to provide the services required by their patients.**
- VI.A.2. The program must be committed to and responsible for promoting patient safety and resident well-being in a supportive educational environment.**
- VI.A.3. The program director must ensure that residents are integrated and**

actively participate in interdisciplinary clinical quality improvement and patient safety programs.

- VI.A.4. The learning objectives of the program must:**
- VI.A.4.a) be accomplished through an appropriate blend of supervised patient care responsibilities, clinical teaching, and didactic educational events; and,**
 - VI.A.4.b) not be compromised by excessive reliance on residents to fulfill non-physician service obligations.**
- VI.A.5. The program director and institution must ensure a culture of professionalism that supports patient safety and personal responsibility. Residents and faculty members must demonstrate an understanding and acceptance of their personal role in the following:**
- VI.A.5.a) assurance of the safety and welfare of patients entrusted to their care;**
 - VI.A.5.b) provision of patient- and family-centered care;**
 - VI.A.5.c) assurance of their fitness for duty;**
 - VI.A.5.d) management of their time before, during, and after clinical assignments;**
 - VI.A.5.e) recognition of impairment, including illness and fatigue, in themselves and in their peers;**
 - VI.A.5.f) attention to lifelong learning;**
 - VI.A.5.g) the monitoring of their patient care performance improvement indicators; and,**
 - VI.A.5.h) honest and accurate reporting of duty hours, patient outcomes, and clinical experience data.**
- VI.A.6. All residents and faculty members must demonstrate responsiveness to patient needs that supersedes self-interest. Physicians must recognize 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.**
- VI.B. Transitions of Care**
- VI.B.1. Programs must design clinical assignments to minimize the number of transitions in patient care.**
 - VI.B.2. Sponsoring institutions and programs must ensure and monitor**

effective, structured hand-over processes to facilitate both continuity of care and patient safety.

- VI.B.3. Programs must ensure that residents are competent in communicating with team members in the hand-over process.**
- VI.B.4. The sponsoring institution must ensure the availability of schedules that inform all members of the health care team of attending physicians and residents currently responsible for each patient's care.**
- VI.C. Alertness Management/Fatigue Mitigation**
 - VI.C.1. The program must:**
 - VI.C.1.a) educate all faculty members and residents to recognize the signs of fatigue and sleep deprivation;**
 - VI.C.1.b) educate all faculty members and residents in alertness management and fatigue mitigation processes; and,**
 - VI.C.1.c) adopt fatigue mitigation processes to manage the potential negative effects of fatigue on patient care and learning, such as naps or back-up call schedules.**
 - VI.C.2. Each program must have a process to ensure continuity of patient care in the event that a resident may be unable to perform his/her patient care duties.**
 - VI.C.3. The sponsoring institution must provide adequate sleep facilities and/or safe transportation options for residents who may be too fatigued to safely return home.**
- VI.D. Supervision of Residents**
 - VI.D.1. In the clinical learning environment, each patient must have an identifiable, appropriately-credentialed and privileged attending physician (or licensed independent practitioner as approved by each Review Committee) who is ultimately responsible for that patient's care.**
 - VI.D.1.a) This information should be available to residents, faculty members, and patients.**
 - VI.D.1.b) Residents and faculty members should inform patients of their respective roles in each patient's care.**
 - VI.D.2. The program must demonstrate that the appropriate level of supervision is in place for all residents who care for patients.**

Supervision may be exercised through a variety of methods. Some

activities require the physical presence of the supervising faculty member. For many aspects of patient care, the supervising physician may be a more advanced resident or fellow. Other portions of care provided by the resident can be adequately supervised by the immediate availability of the supervising faculty member or resident physician, either in the institution, or by means of telephonic and/or electronic modalities. In some circumstances, supervision may include post-hoc review of resident-delivered care with feedback as to the appropriateness of that care.

VI.D.3. Levels of Supervision

To ensure oversight of resident supervision and graded authority and responsibility, the program must use the following classification of supervision:

- VI.D.3.a) Direct Supervision – the supervising physician is physically present with the resident and patient.**
- VI.D.3.b) Indirect Supervision:**
 - VI.D.3.b).(1) 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.**
 - VI.D.3.b).(2) 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.**
- VI.D.3.c) Oversight – the supervising physician is available to provide review of procedures/encounters with feedback provided after care is delivered.**
- VI.D.4. 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.**
 - VI.D.4.a) The program director must evaluate each resident’s abilities based on specific criteria. When available, evaluation should be guided by specific national standards-based criteria.**
 - VI.D.4.b) Faculty members functioning as supervising physicians should delegate portions of care to residents, based on the needs of the patient and the skills of the residents.**
 - VI.D.4.c) Senior residents or fellows should serve in a supervisory role**

of 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.

VI.D.5. Programs must set guidelines for circumstances and events in which residents must communicate with appropriate supervising faculty members, such as the transfer of a patient to an intensive care unit, or end-of-life decisions.

VI.D.5.a) Each resident must know the limits of his/her scope of authority, and the circumstances under which he/she is permitted to act with conditional independence.

VI.D.5.a).(1) In particular, PGY-1 residents should be supervised either directly or indirectly with direct supervision immediately available.

VI.D.6. Faculty supervision assignments should be of sufficient duration to assess the knowledge and skills of each resident and delegate to him/her the appropriate level of patient care authority and responsibility.

VI.E. Clinical Responsibilities

The clinical responsibilities for each resident must be based on PGY-level, patient safety, resident education, severity and complexity of patient illness/condition and available support services.

VI.F. Teamwork

Residents must care for patients in an environment that maximizes effective 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.

VI.G. Resident Duty Hours

VI.G.1. Maximum Hours of Work per Week

Duty hours must be limited to 80 hours per week, averaged over a four-week period, inclusive of all in-house call activities and all moonlighting.

VI.G.1.a) Duty Hour Exceptions

A Review Committee may grant exceptions for up to 10% or a maximum of 88 hours to individual programs based on a sound educational rationale.

The Review Committee for Preventive Medicine will not consider requests for exceptions to the 80-hour limit to the residents' work

week.

- VI.G.1.a).(1)** In preparing a request for an exception the program director must follow the duty hour exception policy from the ACGME Manual on Policies and Procedures.
- VI.G.1.a).(2)** Prior to submitting the request to the Review Committee, the program director must obtain approval of the institution's GMEC and DIO.
- VI.G.2. Moonlighting**
- VI.G.2.a)** Moonlighting must not interfere with the ability of the resident to achieve the goals and objectives of the educational program.
- VI.G.2.b)** Time spent by residents in Internal and External Moonlighting (as defined in the ACGME Glossary of Terms) must be counted towards the 80-hour Maximum Weekly Hour Limit.
- VI.G.2.c)** PGY-1 residents are not permitted to moonlight.
- VI.G.3. Mandatory Time Free of Duty**
- Residents must be scheduled for a minimum of one day free of duty every week (when averaged over four weeks). At-home call cannot be assigned on these free days.
- VI.G.4. Maximum Duty Period Length**
- VI.G.4.a)** Duty periods of PGY-1 residents must not exceed 16 hours in duration.
- VI.G.4.b)** Duty periods of PGY-2 residents and above may be scheduled to a maximum of 24 hours of continuous duty in the hospital. Programs must encourage residents to use alertness management strategies in the context of patient care responsibilities. Strategic napping, especially after 16 hours of continuous duty and between the hours of 10:00 p.m. and 8:00 a.m., is strongly suggested.
- VI.G.4.b).(1)** It is essential for patient safety and resident education that effective transitions in care occur. Residents may be allowed to remain on-site in order to accomplish these tasks; however, this period of time must be no longer than an additional four hours.
- VI.G.4.b).(2)** Residents must not be assigned additional clinical responsibilities after 24 hours of continuous in-house duty.

VI.G.4.b).(3) In unusual circumstances, residents, on their own initiative, may remain beyond their scheduled period of duty to continue to provide care to a single patient. Justifications for such extensions of duty are limited to reasons of required continuity for a severely ill or unstable patient, academic importance of the events transpiring, or humanistic attention to the needs of a patient or family.

VI.G.4.b).(3).(a) Under those circumstances, the resident must:

VI.G.4.b).(3).(a).(i) appropriately hand over the care of all other patients to the team responsible for their continuing care; and,

VI.G.4.b).(3).(a).(ii) document the reasons for remaining to care for the patient in question and submit that documentation in every circumstance to the program director.

VI.G.4.b).(3).(b) The program director must review each submission of additional service, and track both individual resident and program-wide episodes of additional duty.

VI.G.5. Minimum Time Off between Scheduled Duty Periods

VI.G.5.a) PGY-1 residents should have 10 hours, and must have eight hours, free of duty between scheduled duty periods.

VI.G.5.b) Intermediate-level residents should have 10 hours free of duty, and must have eight hours between scheduled duty periods. They must have at least 14 hours free of duty after 24 hours of in-house duty.

PM-1 residents are considered to be at the intermediate level.

VI.G.5.c) Residents in the final years of education must be prepared to enter the unsupervised practice of medicine and care for patients over irregular or extended periods.

PM-2 residents are considered to be in the final years of education.

VI.G.5.c).(1) This preparation must occur within the context of the 80-hour, maximum duty period length, and one-day-off-in-seven standards. While it is desirable that residents in their final years of education have eight hours free of duty between scheduled duty periods, there may be circumstances when these residents must stay on duty to care for their patients or return to

a project, the sponsoring institution and program are jointly responsible for the quality of education offered to residents for the duration of such a project.

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