

ACGME Common Program Requirements – Section VI Summary and Impact of Major Requirement Revisions

The ACGME Common Program Requirements Phase 1 Task Force has proposed a major revision to Section VI of the Common Program Requirements, with a proposed effective date of July 1, 2017.

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

Requirement #: Preamble to Section VI

Requirement Revision (significant change only):

VI. ~~Resident Duty Hours in~~ The Learning and Working Environment

Residency education must occur in the context of a learning and working environment that emphasizes the following principles:

- *Excellence in the safety and quality of care rendered to patients by residents today*
- *Excellence in the safety and quality of care rendered to patients by today's residents in their future practice*
- *Excellence in professionalism through faculty modeling of:*
 - *the effacement of self-interest in a humanistic environment that supports the professional development of physicians*
 - *the joy in curiosity, problem-solving, intellectual rigor, and discovery*
- *Commitment to the well-being of the residents, faculty members, students, and all members of the health care team*

1. Describe the Review Committee's rationale for this revision: **The preamble was added to emphasize the underlying principles for the requirements included in Section VI.**
2. How will the proposed requirement or revision improve resident/fellow education, patient safety, and/or patient care quality? **The preamble emphasizes excellence in the quality of care provided to patients by residents today and in their future practice. The requirements that follow in Section VI are designed to support this excellence in patient care.**
3. How will the proposed requirement or revision impact continuity of patient care? **No change is anticipated.**
4. Will the proposed requirement or revision necessitate additional institutional resources (e.g., facilities, organization of other services, addition of faculty members, financial support; volume and variety of patients), if so, how? **No change is required.**

5. How will the proposed revision impact other accredited programs? **Not applicable, as these requirements will apply to all accredited programs.**

Requirement #: VI.A. – VI.A.1.b).(3).(a)

Requirement Revision (significant change only):

VI.A. Patient Safety, Supervision, and Accountability

VI.A.1. Patient Safety and Quality Improvement

All physicians share responsibility for ensuring patient safety and enhancing quality of patient care. Graduate medical education must prepare residents to provide the highest level of clinical care with continuous focus on the safety, individual needs, and humanity of their patients. It is the right of each patient to be cared for by residents who are appropriately supervised; possess the requisite knowledge, skills, and abilities; understand the limits of their knowledge and experience; and seek assistance as required to provide optimal patient care.

Residents must demonstrate the ability to analyze the care they provide, understand their roles within coordinated health care teams, and play an active role in system improvement processes. Graduating residents will apply these skills to critique their future unsupervised practice and effect quality improvement measures.

VI.A.1.a) Patient Safety

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

A culture of safety requires continuous identification of vulnerabilities and a willingness to transparently deal with them. To this end, the safety system is perceived as fair and effective in bringing about needed improvements. An effective organization has formal mechanisms to assess attitudes toward safety and improvement in order to identify areas requiring intervention.

VI.A.1.a).(1).(a) The program, its leadership, faculty, residents, and fellows must actively participate in these patient safety systems and culture. ^(Core)

VI.A.1.a).(1).(b) The program director must be committed to and responsible for promoting patient safety and resident well-being design and maintain a program that has a structure that promotes interprofessional team-based care and a culture that provides safe patient care in a supportive educational environment. ^(Core)

VI.A.1.a).(2) Education on Patient Safety

	<p><u>Programs must provide formal educational activities that promote patient safety-related goals, tools, and techniques. It is necessary for residents and faculty members to consistently work in a well-coordinated manner with other health care professionals using shared methodologies to achieve institutional patient safety goals.</u> (Core)</p>
VI.A.1.a).(3)	<p><u>Reporting, Investigation, and Follow-up of Adverse Events and Near Misses</u></p> <p><i><u>Reporting is a pivotal mechanism for improving patient safety, and is essential for the success of any patient safety program. Feedback and experiential learning are essential to developing true competence in the ability to identify causes and institute sustainable systems-based changes to ameliorate patient safety vulnerabilities.</u></i></p>
VI.A.1.a).(3).(a)	<p><u>Residents, fellows, faculty members, and other clinical staff members must know:</u></p>
VI.A.1.a).(3).(a).(i)	<p><u>their responsibilities in reporting patient safety events at the clinical site; and,</u> (Core)</p>
VI.A.1.a).(3).(a).(ii)	<p><u>how to report patient safety events at the clinical site.</u> (Core)</p>
VI.A.1.a).(3).(b)	<p><u>Residents must participate as team members in real and/or simulated interprofessional clinical site-sponsored patient safety activities, such as root cause analyses or other activities that include analysis, as well as formulation and implementation of actions.</u> (Core)</p>
VI.A.1.a).(3).(c)	<p>The program director must ensure that residents and faculty members are integrated and actively participate in <u>the implementation of interdisciplinary clinical quality improvement and patient safety programs at participating sites to address issues identified by investigations.</u> (Core)</p>
VI.A.1.a).(4)	<p><u>Resident Education and Experience in Disclosure of Adverse Events</u></p> <p><i><u>Patient-centered care requires patients, and when appropriate families, to be apprised of clinical situations that affect them, including adverse events. This is an important skill for faculty physicians to model, and for residents to develop and apply.</u></i></p>
VI.A.1.a).(4).(a)	<p>All residents must receive training in how to</p>

	<u>disclose patient safety events to patients and families.</u> ^(Core)
VI.A.1.a).(4).(b)	<u>Residents should have the opportunity to participate in the disclosure of patient safety events.</u> ^(Detail)
VI.A.1.b)	<u>Quality Improvement</u>
VI.A.1.b).(1)	<u>Education in Quality Improvement</u>
	<u><i>A cohesive model of health care includes quality-related goals, tools, and techniques that are necessary in order for health care professionals to achieve quality improvement goals.</i></u>
VI.A.1.b).(1).(a)	<u>Residents and faculty members must receive training and experience in quality improvement processes, including an understanding of health care disparities.</u> ^(Core)
VI.A.1.b).(2)	<u>Quality Metrics</u>
	<u><i>Access to data is essential to prioritizing activities for care improvement and evaluating success of improvement efforts.</i></u>
VI.A.1.b).(2).(a)	<u>Residents and faculty members should receive specialty-specific data on quality metrics and benchmarks related to their patient populations.</u> ^(Detail)
VI.A.1.b).(3)	<u>Engagement in Quality Improvement Activities</u>
	<u><i>Experiential learning is essential to developing the ability to identify and institute sustainable systems-based changes to improve patient care.</i></u>
VI.A.1.b).(3).(a)	<u>Residents must have the opportunity to participate in interprofessional quality improvement activities, including activities aimed at reducing health care disparities.</u> ^(Core)
<p>1. Describe the Review Committee's rationale for this revision: This new section has been added in recognition of the need to ensure that resident education occurs in an environment that has been designed to emphasize a culture of safety and quality improvement.</p> <p>2. How will the proposed requirement or revision improve resident/fellow education, patient safety, and/or patient care quality? This increased emphasis on patient safety and quality improvement is expected to improve resident education and patient safety.</p>	

3. How will the proposed requirement or revision impact continuity of patient care? **No impact is anticipated.**
4. Will the proposed requirement or revision necessitate additional institutional resources (e.g., facilities, organization of other services, addition of faculty members, financial support; volume and variety of patients), if so, how? **While many of the activities described in the requirements are already occurring in many programs and institutions, in some cases additional resources, primarily related to increased time devoted by faculty members and residents to patient safety and quality improvement activities, will be required. Although the proposed effective date of the revisions to Section VI is July 1, 2017, the ACGME recognizes that programs and Sponsoring Institutions may need additional time to fully comply with the new patient safety requirements. Therefore, there will be a phase-in period during which Review Committees may issue Areas for Improvement related to these requirements, but will not issue citations for non-compliance. Additional information will be provided following final approval of the requirements by the ACGME Board of Directors.**
5. How will the proposed revision impact other accredited programs? **Not applicable, as these requirements will apply to all accredited programs.**

Requirement #: VI.A.2.b).(1)

Requirement Revision (significant change only):

The program must demonstrate that the appropriate level of supervision is in place for all residents ~~who care for patients~~ based on each resident's level of training and ability, as well as patient complexity and acuity. Supervision may be exercised through a variety of methods, appropriate to the situation. ^(Core)

[The Review Committee may specify which activities require different levels of supervision.]

1. Describe the Review Committee's rationale for this revision: **The requirement has been modified to emphasize the expectation that a resident's level of training and patient complexity and acuity must factor into decisions regarding the level of supervision provided to individual residents.**
2. How will the proposed requirement or revision improve resident/fellow education, patient safety, and/or patient care quality? **This requirement is intended to promote patient safety and the provision of quality care by ensuring that the level of resident supervision provided is appropriate for each patient.**
3. How will the proposed requirement or revision impact continuity of patient care? **No change in continuity of care is anticipated.**
4. Will the proposed requirement or revision necessitate additional institutional resources (e.g., facilities, organization of other services, addition of faculty members, financial support; volume and variety of patients), if so, how? **It is not anticipated that additional resources will be required.**
5. How will the proposed revision impact other accredited programs? **Not applicable, as these requirements will apply to all accredited programs.**

Requirement #: VI.B.2.c)

Requirement Revision (significant change only):

[The learning objectives of the program must] generally ensure manageable patient care responsibilities. (Core)

[As further specified by the Review Committee]

1. Describe the Review Committee's rationale for this revision: **This requirement addresses concerns regarding work compression and its impact on resident education and well-being. It is intended to ensure that residents are not routinely assigned excessive patient care responsibilities.**
2. How will the proposed requirement or revision improve resident/fellow education, patient safety, and/or patient care quality? **Assuring a manageable workload for residents is expected to positively impact resident education and quality of patient care.**
3. How will the proposed requirement or revision impact continuity of patient care? **No change in continuity of care is anticipated.**
4. Will the proposed requirement or revision necessitate additional institutional resources (e.g., facilities, organization of other services, addition of faculty members, financial support; volume and variety of patients), if so, how? **If a program determines that changes in assignment of patient care responsibilities will be necessary to comply with this requirement, additional resources may be required to take on responsibilities previously assigned to the resident.**
5. How will the proposed revision impact other accredited programs? **Not applicable, as these requirements will apply to all accredited programs.**

Requirement #: VI.C. – VI.C.2.

Requirement Revision (significant change only):

VI.C. Well-Being

In the current health care environment, residents and faculty members are at increased risk for burnout and depression. Psychological, emotional, and physical well-being are critical in the development of the competent, caring, and resilient physician. Self-care is an important component of professionalism; it is also a skill that must be learned and nurtured in the context of other aspects of residency training. Programs and Sponsoring Institutions have the same responsibility to address well-being as they do to ensure other aspects of resident competence.

VI.C.1. This responsibility must include:

VI.C.1.a) efforts to enhance the meaning that the resident finds in the experience of being a physician, including protecting time with patients, minimization of non-physician obligations, provision of administrative support, promotion of progressive autonomy and

	<u>flexibility, and enhancement of professional relationships;</u> ^(Core)
VI.C.1.b)	<u>attention to scheduling, work intensity, and work compression that impacts resident well-being;</u> ^(Core)
VI.C.1.c)	<u>evaluating safety data and addressing the safety of residents and faculty members in the learning and working environment;</u> ^(Core)
VI.C.1.d)	<u>policies and programs that encourage optimal resident and faculty member well-being; and,</u> ^(Core)
VI.C.1.d).(1)	<u>Residents must be given the opportunity to attend medical, mental health, and dental care appointments, including those scheduled during their working hours.</u> ^(Core)
VI.C.1.e)	<u>attention to resident and faculty member burnout, depression, and substance abuse. The program and Sponsoring Institution must educate faculty members and residents in identification of the symptoms of burnout, depression, and substance abuse, including means to assist those who experience these conditions. Residents and faculty members must also be educated to recognize those symptoms in themselves and how to seek appropriate care. The program and Sponsoring Institution must:</u> ^(Core)
VI.C.1.e).(1)	<u>encourage residents and faculty members to alert the program director or other designated personnel or programs when they are concerned that another resident, fellow, or faculty member may be displaying signs of burnout, depression, substance abuse, suicidal ideation, or potential for violence;</u> ^(Core)
VI.C.1.e).(2)	<u>provide access to appropriate tools for self-screening; and,</u> ^(Core)
VI.C.1.e).(3)	<u>provide access to confidential, affordable mental health counseling and treatment, including access to urgent and emergent care 24 hours a day, seven days a week.</u> ^(Core)
VI.C.2.	<u>There are circumstances in which residents may be unable to attend work, including but not limited to fatigue, illness, and family emergencies. Each program must have a policy and procedures in place that ensure coverage of patient care in the event that a resident may be unable to perform their patient care responsibilities.</u> ^(Core)
1. Describe the Review Committee's rationale for this revision: The addition of requirements that support resident and faculty member well-being emphasize the need for programs and institutions to prioritize well-being and recognize that physicians are at increased risk for burnout and depression. The incorporation of these new requirements is an important element in addressing this issue.	

2. How will the proposed requirement or revision improve resident/fellow education, patient safety, and/or patient care quality? **Promotion of well-being and ensuring protected time with patients and minimization of non-physician obligations is expected to positively impact resident education and quality of patient care.**
3. How will the proposed requirement or revision impact continuity of patient care? **No change in continuity of patient care is anticipated.**
4. Will the proposed requirement or revision necessitate additional institutional resources (e.g., facilities, organization of other services, addition of faculty members, financial support; volume and variety of patients), if so, how? **Additional resources may be required, particularly with regard to minimization of non-physician obligations, administrative support, and access to confidential, affordable mental health counseling and treatment, including access to urgent and emergent care 24 hours a day, seven days a week. Although the proposed effective date of the revisions to Section VI is July 1, 2017, the ACGME recognizes that programs and Sponsoring Institutions may need additional time to fully comply with the new well-being requirements. Therefore, there will be a phase-in period during which Review Committees may issue Areas for Improvement related to these requirements, but will not issue citations for non-compliance. Additional information will be provided following final approval of the requirements by the ACGME Board of Directors.**
5. How will the proposed revision impact other accredited programs? **Not applicable, as these requirements will apply to all accredited programs.**

Requirement #: VI.F.1

Requirement Revision (significant change only):

Maximum Hours of Clinical and Educational Work per Week

~~Duty~~ Clinical and educational work hours must be limited to 80 hours per week, averaged over a four-week period, inclusive of all in-house ~~call~~ clinical and educational activities, clinical work done from home, and all moonlighting. ^(Core)

1. Describe the Review Committee's rationale for this revision: **The incorporation of clinical work done from home into the 80-hour total weekly limit reflects the increase in the amount of work residents are choosing to do from home.**
2. How will the proposed requirement or revision improve resident/fellow education, patient safety, and/or patient care quality? **No change is anticipated.**
3. How will the proposed requirement or revision impact continuity of patient care? **No impact on continuity of care is anticipated.**
4. Will the proposed requirement or revision necessitate additional institutional resources (e.g., facilities, organization of other services, addition of faculty members, financial support; volume and variety of patients), if so, how? **Programs and institutions not previously accounting for work done from home will now be required to do so, and for some programs, this may require a change in scheduling that includes fewer scheduled hours in-house to ensure that residents doing clinical work from home do not exceed the 80-hour limit. In such instances, additional resources may be required to cover the responsibilities that would have been assigned to the resident.**

5. How will the proposed revision impact other accredited programs? **Not applicable, as these requirements will apply to all accredited programs.**

Requirement #: VI.F.2.a)

Requirement Revision (significant change only):

Moonlighting must not interfere with the ability of the resident to achieve the goals and objectives of the educational program, and must not interfere with the resident's fitness for work nor compromise patient safety. ^(Core)

1. Describe the Review Committee's rationale for this revision: **The requirement has been expanded in recognition of the potential impact of moonlighting on patient safety and resident fitness for work, and to clarify the expectation that patient safety will be prioritized when decisions regarding moonlighting are made.**
2. How will the proposed requirement or revision improve resident/fellow education, patient safety, and/or patient care quality? **The requirement is intended to promote patient safety and ensure that resident moonlighting does not negatively impact patient care.**
3. How will the proposed requirement or revision impact continuity of patient care? **No impact is anticipated.**
4. Will the proposed requirement or revision necessitate additional institutional resources (e.g., facilities, organization of other services, addition of faculty members, financial support; volume and variety of patients), if so, how? **No additional resources are required.**
5. How will the proposed revision impact other accredited programs? **Not applicable, as these requirements will apply to all accredited programs.**

Requirement #: VI.F.3.a)

Requirement Revision (significant change only):

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

1. Describe the Review Committee's rationale for this revision: **This requirement emphasizes the need to design a program that promotes work-life balance by highlighting the importance of balancing residents' educational and clinical experience with time away from the program.**
2. How will the proposed requirement or revision improve resident/fellow education, patient safety, and/or patient care quality? **Ensuring an appropriate balance is intended to enhance the educational experience for residents and to support well-being, as well as to allow residents to experience joy in their work.**
3. How will the proposed requirement or revision impact continuity of patient care? **No impact is anticipated.**
4. Will the proposed requirement or revision necessitate additional institutional resources (e.g., facilities, organization of other services, addition of faculty members, financial support; volume and variety of patients), if so, how? **It is not anticipated that additional resources**

will be required.

5. How will the proposed revision impact other accredited programs? **Not applicable, as these requirements will apply to all accredited programs.**

Requirement #: VI.F.4.a)-b)

Requirement Revision (significant change only):

VI.F.4.a) ~~Duty periods of PGY-1 residents must not exceed 16 hours in duration.~~^(Core)

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

1. Describe the Review Committee's rationale for this revision **The Task Force examined the question of "consecutive time on-task." It examined the research supporting the current limit of 16 consecutive hours of time on task for PGY-1 residents; the range of often conflicting impacts of this requirement on patient safety, clinical care, and continuity of care by resident teams; and resident learning found in the literature. Finally, it heard a uniform request by the specialty societies, certifying boards, membership societies and organizations, and senior residents to repeal this requirement. It heard conflicting perspectives from resident unions, a medical student association, and a number of public advocacy groups, some arguing for continuation of the requirement, others arguing for extension of the requirement to all residents.**

Of greatest concern to the Task Force were the observations of disruption of team care and patient care continuity brought about with residents beyond the PGY-1 level adhering to differing requirements. The graduate medical education community uniformly requested that the Task Force remove this requirement. The most frequently-cited reason for this request was the complete disruption of the team, separating the PGY-1 from supervisory faculty members and residents who were best able to judge the ability of the resident and customize the supervision of patient care for each PGY-1. Cited nearly as frequently was the separation of the PGY-1 from the team, delaying maturation of clinical skills, and threatening to create a "shift" mentality in disciplines where overnight availability to patients is essential in delivery of care.

The Task Force examined the impact of the request to consider 16-consecutive-hour limits for all residents, and rejected the proposition. It found that model incompatible with the actual practice of medicine and surgery in many specialties, excessively limiting in configuration of clinical services in many disciplines, and potentially disruptive of the inculcation of responsibility and professional commitment to altruism and placing the needs of patients above those of the physician.

After careful consideration of the information available, the testimony and position of all parties submitting information, and presentations to the Task Force, the Task Force removed the 16-hour-consecutive-time-on-task requirement for PGY-1 residents. It remains crucial that programs ensure that PGY-1 residents are supervised in compliance with the applicable Program Requirements, and that

resident well-being is prioritized as described in Section VI.C. of these requirements.

2. How will the proposed requirement or revision improve resident/fellow education, patient safety, and/or patient care quality? **The change is expected to improve resident education by permitting PGY-1 residents to more fully participate as a member of the team, assuming call responsibilities with other members of the team, with appropriate faculty supervision.**
3. How will the proposed requirement or revision impact continuity of patient care? **Permitting PGY-1s to remain with the team and provide care to their patients is expected to have a positive impact on continuity of patient care.**
4. Will the proposed requirement or revision necessitate additional institutional resources (e.g., facilities, organization of other services, addition of faculty members, financial support; volume and variety of patients), if so, how? **No additional resources will be required.**
5. How will the proposed revision impact other accredited programs? **Not applicable, as these requirements will apply to all accredited programs.**

Requirement #: VI.F.4.c) – VI.F.4.c).(2)

Requirement Revision (significant change only):

VI.F.4.c) In unusual circumstances, after handing off all patients to the team responsible for their continuing care, residents, on their own initiative, may remain beyond their ~~scheduled 24+~~ up to four-hour period of ~~duty responsibilities~~ 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. Another justification is to attend educational events on the resident's own initiative. These additional hours of care or education will be counted toward the 80-hour weekly limit. ^(Detail)

VI.F.4.c).(1) ~~Under these circumstances, the resident must:~~

VI.F.4.c).(1).(a) ~~appropriately hand over the care of all other patients to the team responsible for their continuing care; and,~~ ^(Detail)

VI.F.4.c).(1).(b) ~~document the reasons for remaining to care for the patient in question and submit that documentation in every circumstance to the program director.~~ ^(Detail)

VI.F.4.c).(2) ~~The program director must review each submission of additional service, and track both individual resident and program-wide episodes of additional duty.~~ ^(Detail)

1. Describe the Review Committee's rationale for this revision: **The requirements regarding documentation and tracking of resident decisions to continue to work beyond the 24 plus up to four hours have been deleted in response to concerns that these**

requirements created burden that resulted in many programs electing not to permit this flexibility. Recognizing that this flexibility is important in the circumstances described in the requirement, the Task Force concluded that the documentation and tracking requirements should be eliminated in support of providing residents flexibility to remain, at their own choosing, in these circumstances. This additional time must be counted in the 80-hour weekly limit.

2. How will the proposed requirement or revision improve resident/fellow education, patient safety, and/or patient care quality? **The change supports providing residents with the flexibility to remain at work in circumstances that will benefit patient care or education.**
3. How will the proposed requirement or revision impact continuity of patient care? **By permitting residents to extend their work period to continue to provide care for a severely ill or unstable patient, the requirement is expected to have a positive impact on continuity of patient care.**
4. Will the proposed requirement or revision necessitate additional institutional resources (e.g., facilities, organization of other services, addition of faculty members, financial support; volume and variety of patients), if so, how? **The elimination of these requirements reduces burden on programs and institutions.**
5. How will the proposed revision impact other accredited programs? **Not applicable, as these requirements will apply to all accredited programs.**

Requirement #: VI.F.5.a) – VI.F.5.c).(1).(a)

Requirement Revision (significant change only):

VI.F.5.a)	PGY-1 residents should have 10 hours, and must have eight hours, free of duty between scheduled duty periods. ^(Core)
VI.F.5.b)	Intermediate-level residents [as defined by the Review Committee] should have 10 hours free of duty, and must have eight hours between scheduled duty periods. They Residents must have at least 14 hours free of duty clinical work and education after 24 hours of in-house duty call. ^(Core)
VI.F.5.c)	Residents in the final years of education [as defined by the Review Committee] must be prepared to enter the unsupervised practice of medicine and care for patients over irregular or extended periods. ^(Outcome)
VI.F.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 [as defined by the Review Committee] when these residents must stay on duty to care for their patients or return to the hospital with fewer than eight hours free of duty. ^(Detail)

VI.F.5.c).(1).(a)

~~Circumstances of return-to-hospital activities with fewer than eight hours away from the hospital by residents in their final years of education must be monitored by the program director.~~^(Detail)

1. Describe the Review Committee's rationale for this revision: **The requirements regarding time off between clinical and educational work periods have been eliminated in support of providing programs with increased flexibility in scheduling. It is emphasized that programs are expected to comply with the 80-hour weekly limit, averaged over four weeks.**
2. How will the proposed requirement or revision improve resident/fellow education, patient safety, and/or patient care quality? **The change is intended to support resident education by allowing programs increased flexibility to develop schedules that work best at the local level.**
3. How will the proposed requirement or revision impact continuity of patient care? **No change in continuity of patient care is anticipated.**
4. Will the proposed requirement or revision necessitate additional institutional resources (e.g., facilities, organization of other services, addition of faculty members, financial support; volume and variety of patients), if so, how? **No additional resources will be required.**
5. How will the proposed revision impact other accredited programs? **Not applicable, as these requirements will apply to all accredited programs.**

Requirement #: VI.F.6.

Requirement Revision (significant change only):

~~Maximum Frequency of In-House Night Float~~

~~Residents must not be scheduled for more than six consecutive nights of night float.~~^(Core) **Night float must occur within the context of the 80-hour, and one-day-off-in-seven requirements.**^(Core)

[The maximum number of consecutive weeks of night float, and maximum number of months of night float per year may be further specified by the Review Committee.]

1. Describe the Review Committee's rationale for this revision: **This change was made to provide programs with increased flexibility in scheduling.**
2. How will the proposed requirement or revision improve resident/fellow education, patient safety, and/or patient care quality? **No change is anticipated.**
3. How will the proposed requirement or revision impact continuity of patient care? **No change is anticipated.**
4. Will the proposed requirement or revision necessitate additional institutional resources (e.g., facilities, organization of other services, addition of faculty members, financial support; volume and variety of patients), if so, how? **No additional resources will be required.**
5. How will the proposed revision impact other accredited programs? **Not applicable, as these requirements will apply to all accredited programs.**

Requirement #: VI.F.8.a)

Requirement Revision (significant change only):

Time spent in the hospital or at home performing clinical responsibilities by residents on at-home call must count toward the 80-hour maximum weekly ~~hour~~ limit. The frequency of at-home call is not subject to the every-third-night limitation, but must satisfy the requirement for one day in seven free of ~~duty~~ clinical work and education, when averaged over four weeks. ^(Core)

1. Describe the Review Committee's rationale for this revision: **Residents taking at-home call frequently spend a significant amount of time performing clinical responsibilities, and the addition of clinical responsibilities to the requirement is intended to ensure that at-home call does not result in residents working more than 80 hours a week, averaged over four weeks.**
2. How will the proposed requirement or revision improve resident/fellow education, patient safety, and/or patient care quality? **By ensuring that all clinical activities are counted toward the 80-hour limit, the requirement seeks to ensure that residents are provided with adequate time free from program responsibilities. Eliminating the potential that at-home call may result in residents working more than 80 hours, averaged over four weeks, may support resident well-being and help reduce fatigue, which is likely to positively impact education, patient safety, and the quality of patient care.**
3. How will the proposed requirement or revision impact continuity of patient care? **No impact on continuity of patient care is anticipated.**
4. Will the proposed requirement or revision necessitate additional institutional resources (e.g., facilities, organization of other services, addition of faculty members, financial support; volume and variety of patients), if so, how? **For programs utilizing at-home call, this may require a change in scheduling that includes fewer scheduled hours in-house to ensure that residents taking at-home call do not exceed the 80-hour weekly limit. In such instances, additional resources may be required to cover the responsibilities that would have been assigned to the resident.**
5. How will the proposed revision impact other accredited programs? **Not applicable, as these requirements will apply to all accredited programs.**