Common Program Requirements: Section VI
2017 Revision
Questions and Answers

Note that the term "resident(s)" in this document refers to both residents and subspecialty fellows.

Q1. What is the timeline for implementation of the new requirements?

A1. The effective date of the major revision of Section VI is July 1, 2017. However, because programs and institutions will need time to comply with the new requirements related to patient safety (VI.A.1-VI.A.1.a).(4).(b)), quality improvement (VI.A.1.b)-VI.A.1.b).(3).(a).(i)), and well-being VI.C-VI.C.1.e).(3), no citations will be issued on those requirements before July 1, 2019. In the interim, Review Committees may issue Areas for Improvement (AFIs) related to those requirements.

Note that VI.C.2., which requires policies and procedures that ensure coverage of patient care in the event that a resident may be unable to perform their patient care responsibilities, is similar to the currently in-effect requirement VI.C.2., which requires that programs ensure continuity of patient care in the event that a resident may be unable to perform their patient care duties. Therefore, programs are expected to comply with VI.C.2, and may be cited for non-compliance, effective July 1, 2017.

This timeline provides a year for implementation, and a year for data collection. The ACGME's Annual Resident and Faculty Surveys will be updated in 2019 to address the revisions to Section VI. In addition, the 2018 surveys will be updated to reflect new terminology (elimination of the term "duty hours") and changes in section VI.F.

Q2. Many of the new requirements address responsibilities that must be shared by programs and Sponsoring Institutions. Will the Institutional Requirements be revised to address the Sponsoring Institution's responsibilities in these areas?

A2. The phrase "Programs, in partnership with their Sponsoring Institutions" is used throughout Section VI to reflect 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 consideration of changes that will ensure alignment of the Institutional Requirements with the changes in Section VI.

Q3. The new requirements specify that clinical work done from home must count toward the 80-hour weekly maximum, averaged over four weeks. Why was this change made?

A3. The new requirements acknowledge the changing landscape of medicine, including electronic health records, and the resulting increase in the amount of work residents choose to do from home. The requirement provides flexibility for residents to do this while ensuring that the time spent by residents completing clinical work from home is accomplished within the 80-hour weekly maximum. 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. Resident decisions to leave the hospital before their clinical work has been completed and to finish that work later from home should be made in consultation with the resident's supervisor. In such circumstances, residents should be mindful of their professional responsibility to complete work in a timely manner and to maintain patient confidentiality.

Q4. What are the expectations regarding tracking and documenting time spent on clinical work done from home?

A4. The new requirements are not an attempt to micromanage the process for documenting and tracking time residents spend on clinical work from home. Residents are to track the time they spend on clinical work from home and to report that time to the program. Decisions regarding whether to report infrequent phone calls of short duration are left to the individual resident. Programs will need to factor in time residents are spending on clinical work at home as schedules are developed to ensure that residents are not working in excess of 80 hours per week, averaged over four weeks. There is no requirement that programs assume responsibility for documenting this time. Rather, the program's responsibility is ensuring that residents report their time from home and that schedules are structured to ensure that residents are not working in excess of 80 hours per week, averaged over four weeks.

Q5. Does the entire at-home call period count as "clinical work done from home"?

A5. No. Only the time residents devote to patient care activities, such as completing electronic health records and taking calls related to their patients, counts toward the 80-hour maximum.

Q6. Do studying and research done from home count as "clinical work done from home"?

A6. No. Reading done in preparation for the following day's cases, studying, and research done from home do not count toward the 80 hours.

Q7. Requirement VI.A.1.d).(1) states that residents must be given the opportunity to attend medical, dental, mental health, and dental care appointments, including those scheduled during their working hours. Can residents be encouraged to schedule these appointments on days they are not assigned call?

A7. The intent of this requirement is to ensure that residents are able to attend appointments as needed, and that their work schedule not prevent them from seeking care when they need it, including scheduled call days. Programs must not place restrictions on when residents may schedule these appointments.

Q8. Can residents be required to take vacation or sick time when attending appointments during scheduled working hours?

A8. The requirements do not specify whether residents will be required to use vacation or sick time when taking time off to attend these appointments. Programs should comply with their institution's policies regarding time off for medical appointments.

Q9. Requirement VI.A.1.a).(3).(a) states that residents, fellows, faculty members, and other clinical staff must be provided with summary information of their institution's

patient safety reports. What if the Sponsoring Institution does not provide medical care (medical school, OPTI, etc.)?

A9. If the Sponsoring Institution is not the primary clinical site, summary information of the primary clinical site's patient safety reports must be provided.

Q10. Requirement VI.A.1.b).(2).(a) states that residents and faculty members must receive data on quality metrics and benchmarks related to their patient populations. Does this mean that individual data regarding clinical performance must be provided?

A10. While specialty-specific data is desirable, it is not required. Rather, the requirement is intended to ensure that data on the metrics used by the institution are shared with residents and faculty members. Examples of metrics include, but are not limited to, those provided by the following: Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS), Centers for Medicaid and Medicare Services (CMS), Press Gainey, National Surgical Quality Improvement Program (NSQIP).

Q11. Requirement VI.C.1.e).(3) requires that the program, in partnership with its Sponsoring Institution, provide access to confidential, affordable, mental health assessment, counseling, and treatment, including access to urgent and emergent care 24 hours a day, seven days a week. How is "affordable" defined?

A11. Access to mental health care is essential in supporting resident well-being. "Affordable" means that cost must not be a barrier for residents in obtaining care. It is expected that Sponsoring Institutions will work with their programs to ensure that residents have access to affordable care.

Q12. How can programs located in areas where 24/7 in-person access to mental health professionals is not possible comply with this requirement?

A12. The requirement is intended to ensure that residents 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. In-person, telemedicine, or telephonic means may be utilized to satisfy this requirement.