

ACGME Program Requirements for Graduate Medical Education in Preventive Medicine

Common Program Requirements are in BOLD

Effective: July 1, 2007

Introduction

Int.A. Definition

Preventive Medicine¹ is the specialty of medical practice that focuses on the health of individuals, communities, and defined populations. Its goal is to protect, promote, and maintain health and well-being and to prevent disease, disability, and death. Preventive medicine specialists have core competencies in biostatistics, epidemiology, environmental and occupational medicine, planning and evaluation of health services, management of health care organizations, research into causes of disease and injury in population groups, and the practice of prevention in clinical medicine. They apply knowledge and skills gained from the medical, social, economic, and behavioral sciences. Preventive medicine has three specialty areas with common core knowledge, skills, and competencies that emphasize different populations, environments, or practice settings: aerospace medicine, occupational medicine, and public health and general preventive medicine.

- Int.A.1. Aerospace medicine focuses on the health of the operating crews and passengers of air and space vehicles, together with the support personnel who are required to operate such vehicles. Segments of this population often work and live in remote, isolated, and sometimes closed environments under conditions of physical and psychological stress.
- Int.A.2. Occupational medicine focuses on the health of workers including the ability to perform work; the physical, chemical, biological, and social environments of the workplace; and the health outcomes of environmental exposures. Practitioners in this field diagnose, treat, and prevent morbid conditions caused by environmental exposures and stressors. They recognize that work and the environment in which work is performed can have favorable or adverse effects upon the health of workers as well as of other populations; that the nature or circumstances of work can be arranged to protect worker health; and that health and well-being at the workplace are promoted when workers' physical attributes or limitations are accommodated in job placement.
- Int.A.3. Public health and general preventive medicine focuses on promoting health, preventing disease, and managing the health of communities and defined populations. These practitioners combine population-based public health skills with knowledge of primary, secondary, and tertiary prevention-oriented clinical practice in a wide variety of settings.

¹Documentation and performance measures are included to assist program directors in the development and administration of preventive medicine residency training programs. Documentation and performance measures are not program requirements.

Int.B. Objectives and Components of the Residency Educational Process

Physicians in preventive medicine develop competencies in the recognized specialty areas. The main components of the residency educational process are:

- Int.B.1. definition of specific educational goals in terms of competencies, skills, and knowledge, expressed in behavioral, measurable terms;
- Int.B.2. assessment of the incoming resident relative to the specific educational goals;
- Int.B.3. design and provision of educational experiences through which specific educational goals may be achieved;
- Int.B.4. documentation of provision of educational experiences and the attainment of educational goals in terms of interim and overall outcome performance measures; and,
- Int.B.5. use of periodic performance measures to determine the quality of the educational experience and the clinical competence of the individual resident, as well as the quality of the program.

Int.C. Duration and Scope of Education

- Int.C.1. An accredited residency program in preventive medicine must provide 36 months of training.
- Int.C.2. The educational program must include the following core components:
 - Int.C.2.a) A 12 month clinical phase leading to the acquisition of clinical competencies as specified in section IV.A.5.
 - Int.C.2.b) A total of 24 months in:
 - Int.C.2.b).(1) An academic phase leading to the acquisition of academic competencies as specified in section IV.A.5. and an MPH or other appropriate post-graduate degree, and
 - Int.C.2.b).(2) A minimum of 12 months in a practicum phase leading to the acquisition of core preventive medicine and specialty (i.e. aerospace, occupational, or public health) competencies as specified in IV.A.5.(2) through IV.A.5.(5).
- Int.C.3. Programs with a status of full accreditation may pursue combined training programs. Programs seeking to integrate preventive medicine training with other training (combined programs) accredited by the Accreditation Council for Graduate Medical Education (ACGME) must meet all preventive medicine requirements. Programs must also meet all requirements as specified by both certifying boards of the integrated residencies.

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. For programs offering training in basic clinical competencies

I.A.1.a) The institution's Graduate Medical Education Committee (GMEC) should approve the program. In addition to the preventive medicine residency, there must be at least one ACGME-accredited residency at the same institution that provides direct patient care.

Documentation Requirement: The program has on file and available to the program director documentation of an ACGME-accredited residency program that provides direct patient care.

Measure: The program has on file and available to the site visitor current documentation of approval of the clinical year by the institution's GMEC.

Measure: Records documenting GMEC review and approval of clinical year.

I.A.2. For programs offering training in core preventive medicine knowledge (academic phase)

I.A.2.a) Core preventive medicine knowledge is offered through a course of study leading to the degree of Master of Public Health or other appropriate postgraduate degree. The MPH or other appropriate postgraduate degree must be accredited by the CEPH or other appropriate postgraduate accrediting body.

I.A.2.b) The sponsoring institution must provide an environment of inquiry and scholarship in which residents have structured research opportunities to participate in the development of new knowledge.

Documentation Requirement: Accreditation documentation. A description of the sponsoring institution must include a statement of its research activities and how participation in these is available to the resident.

Measure: Research opportunities are available to the resident. The accreditation is documented.

- I.A.3. For programs offering training in competencies of preventive medicine practice (practicum phase)
- I.A.3.a) Aerospace medicine
- I.A.3.a).(1) The year of acquisition of competencies in aerospace medicine practice must be accomplished in an institutional setting where operational aeromedical problems are routinely encountered and aerospace life support systems are under active study and development.
- I.A.3.a).(2) Laboratory facilities should be equipped to provide simulated environments in which the effects of and adaptation to extreme conditions of temperature, barometric pressure, acceleration, weightlessness, and psychological stress can be studied.
- I.A.3.b) Occupational medicine
- I.A.3.b).(1) Acquisition of practice competencies in occupational medicine must be accomplished in institutions that provide comprehensive occupational health services to defined work groups, including regular and frequent presence in the work sites served.
- I.A.3.c) Public health and general preventive medicine
- The sponsoring institution may be an academically participating site, an academically affiliated health care organization, or a government public health agency.
- I.A.3.c).(1) If the sponsoring institution is an academic institution or an academically affiliated health care organization, it should have resources for developing a comprehensive graduate program in preventive medicine. An affiliation must be established with a governmental public health agency to ensure appropriate public health practice and research opportunities.
- I.A.3.c).(2) If the sponsoring institution is a health agency, it should offer a comprehensive experience in community or public health. To ensure an appropriate didactic component, affiliations must be established with a medical school or a school of public health.
- Documentation Requirement.* Affiliation agreements are current and provided to the Review Committee and site visitor.

Measure: Appropriate affiliation agreements clearly documenting these requirements.

I.A.4. Support departments

I.A.4.a) The support departments of the sponsoring institutions, such as medical records and the medical library, must contribute to the education of residents in accordance with the *Essentials of Accredited Residencies in Graduate Medical Education*.

Documentation Requirement. The site visitor report must address the availability of medical records and medical reference materials.

Measure: Medical records and medical reference materials are available to the resident and faculty.

I.A.5. Joint Commission on Accreditation of Healthcare Organizations Accreditation

I.A.5.a) The Joint Commission on Accreditation of Healthcare Organizations (JCAHO) must accredit all participating hospitals.

Documentation Requirement. Programs must have on file and readily available for site visitor inspection a copy of current accreditation of all participating hospitals by JCAHO.

Measure: Required documents are current.

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).

I.B.2.a) Individual phases or parts of the training program may be offered at participating sites; however, the sites must meet all requirements of the Institutional Requirements.

I.B.2.b) The participating site must provide experiences through which the appropriate knowledge, skills, and competency may be acquired consistent with the overall educational objectives of the residency.

Documentation Requirement. Copies of these written agreements or contracts must be provided to the Review Committee in advance of a site visit.

Measure: Written agreements or contracts demonstrate that each participating site can provide a well-planned, relevant educational opportunity for the resident. The program director and the supervisor at the participating site must sign these agreements.

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 GMC 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.3.d) clinical, educational, and administrative experience.

Documentation Requirement: The curriculum vitae (CV) of the program director must be submitted in advance of a site visit, when program directors change, and on the request of the Review Committee.

Measure: Documentation in the CV that the requirements are met.

- 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 GMEC/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) counsel residents in the academic phase in the selection of assignments, services, or elective courses that will assist the resident in achieving the skills and knowledge needed in the resident's practicum experiences and intended fields of practice in preventive medicine;
- II.A.4.q) supervise residents for applicable patient care and practicum experiences through explicit written descriptions of supervisory lines of responsibility. Patient care responsibilities include gradual assumption of clinical responsibility under direct supervision for a variety of clinical problems and preventive encounters. Such guidelines must be communicated to all members of the program staff. Residents must be provided with prompt, reliable systems for communication and interaction with supervisory physicians;
- II.A.4.r) provide, to each resident, information that describes the program's accreditation status, educational objectives, and structure to each applicant, or in the event of a major change;
- II.A.4.s) review the interinstitutional agreements with participating sites annually and for scheduling updates as needed to ensure currency;
- Documentation Requirement:* Written plans, policies, evaluations, and other applicable program communications (e.g., letters, memos).
- Measure:* Program files contain the required documentation.
- II.A.4.t) Prepare a written schedule of activities for each resident during the accredited length of the residency that demonstrates the provision of knowledge, skills, and competencies, including directly supervised clinical care, outlined in the educational goals. The residency program must specify a minimum set of competencies that each resident must acquire prior to completion of the program. This statement must be distributed to residents and members of the teaching staff.
- Documentation Requirement:* The written schedule must be submitted in advance of a planned site visit.

Measure: The statement provides a coherent approach to provision of an overall resident experience that will create the opportunity for the resident to acquire the knowledge, skills, and core and specialty area competencies during the accredited length of the residency.

II.A.4.u)

together with the teaching staff, prepare a matrix of educational courses, rotations, supervised clinical experiences, and other educational activities available through the residency by which a resident will have the opportunity to acquire the specific competencies, skills, and knowledge. This matrix must be cross-referenced to the knowledge, skills, and competencies. Ongoing activities that provide an opportunity for group faculty-resident interaction, such as weekly didactic series, journal club, and grand rounds, are essential.

Documentation Requirement. A list of courses, rotations, and activities cross-referenced to the list of competencies, skills, and knowledge must demonstrate how educational objectives are met. Descriptions of each course, rotation, and activity must be submitted to the Review Committee prior to a site visit. The site providing each course, rotation, or activity must be specified.

Measure: The cross-referenced list documents that the program provides courses, rotations, and activities corresponding to the program's knowledge, skills, and competencies list.

II.A.4.v)

together with the teaching staff, prepare a list of specific competencies, skills, and knowledge that they are prepared to deliver to residents through the training program. Competency acquisition must be evaluated through the use of clearly defined performance indicators.

II.A.4.v).(1)

Residents in the same program may be in different "tracks" that have a different method or approach to training. Programs are encouraged to seek innovative ways to deliver and fund GME; however, the entire program will be assessed by the Review Committee and no tracks can be accredited separately.

Documentation Requirement. The program must submit a cross-referenced list of specific competencies, skills, and knowledge, including faculty assignments, available through the program. Performance indicators for the assessment of competency acquisition must be specified and tracked for each resident.

Measure: The content is preventive medicine. Depth and breadth are adequate and commensurate with the selected specialty area. Performance indicators are specified and documented for the competencies.

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.

II.B.1.a) The faculty must:

II.B.1.b) 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.c) 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.2.a) Faculty and/or practicum supervisors must be assigned to provide the knowledge, skills, direct clinical supervision, and competencies as outlined in the educational goals of the program, and specific assignments must be indicated in each resident's educational plan. Faculty must have documented qualifications to provide the appropriate knowledge, skill, or competency to which they are assigned.

Documentation Requirement: A matrix must be provided showing faculty assignments to provide appropriate knowledge, skills, and competencies. CVs must demonstrate appropriate qualifications.

Measure: Program files contain matrices and CVs that document faculty qualifications appropriate to provide the knowledge, skill, or competency to which they are assigned.

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.B.5.d) Scholarship implies an in-depth understanding of basic mechanisms of normal and abnormal states and the application of current knowledge to practice.
- Documentation Requirement:* Minutes of planning meetings; logs of journal club, rounds, or case conference attendance; membership on thesis committees; updated CVs for faculty and staff that document continuing education, meeting attendance, and publications.
- Measure:* Program documents attesting to faculty contributions to program planning, review, and resident education.

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. The sponsoring institution must maintain office and laboratory space and access to computer facilities. Funds must be provided for residents for travel to appropriate professional meetings.

Documentation Requirement: Facilities and support are documented at the time of the site visit.

Measure: Facilities and support are provided.

- II.D.1.a) The residency program and its affiliates must maintain adequate facilities, including office and laboratory space and access to computer facilities. Residents should have convenient access to the Internet and other online resources, and when available, the electronic medical information system of participating health care sites.
- II.D.1.b) Access to support services must be provided. Residents must be provided with adequate office facilities during assigned duty hours. All residents must be provided funds for travel to designated professional meetings.

Documentation Requirement: The program must supply in advance of a site visit a description of facilities and general support available to the resident.

Measure: The facilities and general support adequately support resident education.

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.

- II.E.1. *Documentation Requirement:* A description of availability of medical reference materials to residents must be supplied prior to a site visit.
- II.E.2. *Measure:* The resident has the ability to access adequate medical reference materials, e.g., reference texts and journal articles.

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. Entering the clinical phase
- Residents entering the clinical phase must meet one of the eligibility requirements as outlined in the Institutional Requirements section II.A.1. In addition, residents must have completed steps I and II of the United States Medical Licensing Examination (USMLE) or, prior to 1996, its equivalent.
- III.A.2. Entering either the academic or practicum phases
- The entering resident must have completed training in an ACGME-accredited clinical year (12 months) with a minimum of six months of

direct patient care. Direct patient care is the provision of preventive, diagnostic, and therapeutic interventions to patients.²

III.A.3. Entering the practicum phase only

III.A.3.a) The entering resident must have completed an ACGME-accredited clinical year and have an MPH or other appropriate postgraduate degree. The MPH or other appropriate postgraduate degree must be accredited by the Council on Education in Public Health (CEPH) or other appropriate postgraduate accrediting bodies.

III.A.3.b) If the resident has not been awarded an MPH or other appropriate postgraduate degree, then knowledge of each of the four core subjects - biostatistics, epidemiology, environmental and occupational health, and health services organization and administration-must have been obtained through at least 40 contact hours for each course in an academic setting. The resident must complete the accredited MPH, or other appropriate postgraduate degree, prior to the end of the residency program.

III.A.3.c) The entering resident must have completed training in an ACGME-accredited clinical year (12 months) with a minimum of six months of direct patient care. Direct patient care is the provision of preventive, diagnostic and therapeutic interventions to patients.

Documentation Requirement. The program must maintain and make available for site visitor inspection a file for each resident (the resident file) that contains copies of certificates and academic institution records to document the specified requirements. Copies of these documents must be submitted to the Review Committee on request.

Measure: Resident files contain the appropriate documentation.

III.A.4. Change in training period

III.A.4.a) The length of residency training for a particular resident may be extended by the program director if that resident needs additional training. If the extension is for only six months or less, the program director must notify the Review Committee of the extension and must describe the proposed curriculum for that resident and the measures taken to minimize the impact on other residents. Any changes in rotation schedules should be included in the notification. Approval must be obtained in advance from the Review Committee if the extension is greater than six months.

²Hereafter patient care is defined as the provision of preventive, diagnostic, and therapeutic intervention to patients.

III.A.5. Each incoming resident must be assessed as to his/her knowledge, skills, and competencies in relationship to the educational goals for the residency program. This assessment may take the form of a self-assessment, an in-service exam, a structured interview, or other method that assesses knowledge, skills, and competencies. This assessment is used by the program director and faculty to guide the development of an individualized educational plan for each resident.

Documentation Requirement. The program must have a written assessment (self-assessment, in-service exam, structured interview, or other method) of incoming resident skills, knowledge, and competencies in the program files.

Measure: The assessment is specific to the educational objectives for the residency program and must be included in the educational plan for each resident.

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

Residency programs must identify the specialty area of preventive medicine of the residency, the period of desired length of accreditation (one, two, or three years), and the planned number of residents in each year.

Documentation Requirement. The appropriate form must be completed and supplied in advance of a planned site visit.

Measure: Accurately completed form.

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;

Documentation Requirement. The written overview statement outlining the educational goals of the program with respect to knowledge, skills, and competencies of residents to be acquired during the training period must be supplied in advance of a planned site visit.

Measure: Overview statement covers core and appropriate specialty area goals and competencies. Content is preventive medicine. Depth and breadth are commensurate with the selected specialty area. Indicates how the knowledge, skills, and competencies are to be met.

IV.A.3. Regularly scheduled didactic sessions;

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:

should acquire competency in their area of preventive medicine, as noted below:

IV.A.5.a).(1) The acquisition of basic clinical competencies will require an ACGME-accredited clinical year (12 months) with six months of direct patient care. (These competencies may also be acquired during academic and practicum training of the residency program and should be incorporated where

applicable);

Documentation Requirement: Resident schedules and incoming resident assessment.

Measure: Resident schedules, incoming resident assessment, and program files document rotations and activities that verify a total of 12 months of clinical experience.

IV.A.5.a).(2)

Preventive Medicine Competencies

The attainment of advanced preventive medicine practice competencies requires a sequence of continued learning and supervised application of the knowledge, skills, and attitudes of preventive medicine in the specialty area. The resident must assume progressive responsibility for patients and/or the clinical and administrative management of populations or communities during the course of training.

The resident shall acquire the following core preventive medicine competencies:

IV.A.5.a).(2).(a)

communicate clearly to multiple professional and lay target groups, in both written and oral presentations, the level of risk from hazards and the rationale for interventions;

IV.A.5.a).(2).(b)

conduct program and needs assessments and prioritize activities using objective, measurable criteria such as epidemiological impact and cost-effectiveness;

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

use computers for word processing, reference retrieval, statistical analysis, graphic display, database management, and communication;

IV.A.5.a).(2).(d)

identify and review relevant laws and regulations germane to the resident's specialty area and assignments;

IV.A.5.a).(2).(e)

recognize ethical, cultural, and social issues related to a particular issue and develop interventions and programs that acknowledge and appropriately address the issues;

IV.A.5.a).(2).(f)

identify organizational decision-making structures, stakeholders, style, and processes;

IV.A.5.a).(2).(g)	assess program and community resources, develop a plan for appropriate resources, and integrate resources for program implementation;
IV.A.5.a).(2).(h)	use epidemiology and biostatistics, including the ability to:
IV.A.5.a).(2).(h).(i)	characterize the health of a community;
IV.A.5.a).(2).(h).(ii)	design and conduct an epidemiological study;
IV.A.5.a).(2).(h).(iii)	design and operate a surveillance system;
IV.A.5.a).(2).(h).(iv)	select and conduct appropriate statistical analyses;
IV.A.5.a).(2).(h).(v)	design and conduct an outbreak or cluster investigation; and,
IV.A.5.a).(2).(h).(vi)	translate epidemiological findings into a recommendation for a specific intervention.
IV.A.5.a).(2).(i)	have skills in management and administration, including the ability to:
IV.A.5.a).(2).(i).(i)	assess data and formulate policy for a given health issue;
IV.A.5.a).(2).(i).(ii)	develop and implement a plan to address a specific health problem;
IV.A.5.a).(2).(i).(iii)	conduct an evaluation or quality assessment based on process and outcome performance measures; and,
IV.A.5.a).(2).(i).(iv)	manage the human and financial resources for the operation of a program or project.
IV.A.5.a).(2).(j)	have skills in clinical preventive medicine, including the ability to:
IV.A.5.a).(2).(j).(i)	develop, deliver, and implement, under supervision, appropriate clinical services for both individuals and populations, and
IV.A.5.a).(2).(j).(ii)	evaluate the effectiveness of clinical services for both individuals and populations.

- IV.A.5.a).(2).(k) have skills in occupational and environmental health, including opportunities for residents to be able to assess and respond to individual and population risks for occupational and environmental disorders.
- Documentation Requirement.* Resident schedules, rotation descriptions, interinstitutional agreements.
- Measure:* Adequate depth and breadth is provided.
- IV.A.5.a).(3) Aerospace Medicine Competencies
- Specialty training for the physician in aerospace medicine must provide for the attainment of competencies relevant to the diagnosis, prevention, and treatment of disorders associated with the unique aerospace environments and with the adaptive systems designed to enhance performance and support life under such conditions.
- IV.A.5.a).(3).(a) Adequate supervised time in direct clinical care of aerospace medical problems must be provided to ensure competency in managing aerospace and general medical problems in aerospace personnel.
- IV.A.5.a).(3).(b) The resident is expected to develop and apply medical standards and grant exceptions and to facilitate prevention, early diagnosis, and treatment of health hazards.
- IV.A.5.a).(3).(c) *For programs with a training track in space medicine:* The resident is expected to perform all activities of a crew surgeon for a space flight, develop and apply medical care standards and programs, evaluate the physiologic effects of spaceflight on crewmembers, and conduct and evaluate longitudinal studies on astronauts.
- IV.A.5.a).(3).(d) The resident is expected to acquire skills to educate passengers and physicians about the hazards of flight with certain medical conditions and to serve as passenger advocates to promote flight safety.
- IV.A.5.a).(3).(e) The resident is expected to identify appropriate patients for aeromedical transport and to provide guidance for safe aeromedical transport of patients with common medical problems.
- IV.A.5.a).(3).(f) The resident will acquire skills to advise in the development of air and space flight equipment,

biomedical equipment, and vehicles for flight and space flight; techniques for enhancing performance; and techniques of crew resource management

IV.A.5.a).(3).(g)

The resident will acquire skills to provide appropriate safety information and education and to conduct the medical aspects of any mishap investigation, including recommendations to prevent recurrences.

IV.A.5.a).(3).(h)

The resident will acquire skills to effectively conduct aeromedical research into health, safety, human factors, and biomedical engineering aspects of the flight environment.

Documentation Requirement. Resident schedules, rotation descriptions, interinstitutional agreements.

Measure: Adequate depth and breadth is provided.

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

Occupational Medicine Competencies

Residents must be able to perform the following tasks:

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

manage the health status of individuals who work in diverse work settings;

IV.A.5.a).(4).(a).(i)

Adequate supervised time in direct clinical care of workers, from numerous employers and employed in more than one work setting, must be provided to ensure competency in mitigating and managing medical problems of workers.

IV.A.5.a).(4).(a).(ii)

Residents must be able to assess safe/unsafe work practices and to safeguard employees and others, based on clinic and worksite experience.

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

monitor/survey workforces and interpret monitoring/surveillance data for prevention of disease in workplaces and to enhance the health and productivity of workers;

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

active participation in several surveillance or monitoring programs, for different types of workforces, is required to learn principles of administration and maintenance of practical workforce and environmental public health

- programs. Residents must plan at least one such program;
- IV.A.5.a).(4).(d) manage worker insurance documentation and paperwork, for work-related injuries that may arise in numerous work settings
- IV.A.5.a).(4).(e) initially learn worker insurance competencies under direct supervision of faculty and demonstrate competency to “open,” direct”, and “close” injury/illness cases.
- IV.A.5.a).(4).(f) recognize outbreak events of public health significance, as they appear in clinical or consultation settings:
- IV.A.5.a).(4).(f).(i) Residents should understand the concept of sentinel events, and know how to assemble/work with a team of fellow professionals who can evaluate and identify worksite public health causes of injury and illness;
- IV.A.5.a).(4).(f).(ii) Residents must be able to recognize and evaluate potentially hazardous workplace and environmental conditions, and recommend controls or programs to reduce exposures, and to enhance the health and productivity of workers; and,
- IV.A.5.a).(4).(f).(iii) Reliance on toxicologic and risk assessment principles in the evaluation of hazards must be demonstrated.
- IV.A.5.a).(4).(g) report outcome findings of clinical and surveillance evaluations to affected workers as ethically required; advise management concerning summary (rather than individual) results or trends of public health significance.

Documentation Requirement: Resident schedules, rotation descriptions, interinstitutional agreements.

Measure: Competencies, skills and knowledge relevant to preventive intervention in the workplace are addressed in workplace settings. The resident has the opportunity to demonstrate constructive participation in comprehensive programs to prevent occupational injury and illness and maintain worker health. Clinic settings demonstrate bridging from clinical activities to effective preventive intervention in the workplace.

IV.A.5.a).(5)

Public Health and General Preventive Medicine Competencies

Residents in public health and general preventive medicine must attain competencies in public health, clinical preventive medicine (as appropriate to the specific program), epidemiology, health administration, and managerial medicine.

IV.A.5.a).(5).(a)

Public Health Practice

At least one month must be spent in a rotation at a governmental public health agency and must include participation in at least one of the following essential public health services:

IV.A.5.a).(5).(a).(i)

monitoring health status to identify community health problems;

IV.A.5.a).(5).(a).(ii)

diagnosing and investigating health problems and health hazards in the community;

IV.A.5.a).(5).(a).(iii)

informing and educating populations about health issues;

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

mobilizing community partnerships to identify and solve health problems;

IV.A.5.a).(5).(a).(v)

developing policies and plans to support individual and community health efforts;

IV.A.5.a).(5).(a).(vi)

enforce laws and regulations that protect health and ensure safety;

IV.A.5.a).(5).(a).(vii)

linking people to needed personal health services and ensuring the provision of health care when otherwise unavailable;

IV.A.5.a).(5).(a).(viii)

ensuring a competent public health and personal health care workforce;

IV.A.5.a).(5).(a).(ix)

evaluating the effectiveness, accessibility, and quality of personal and population-based health services; and,

IV.A.5.a).(5).(a).(x)

conducting research for innovative solutions to health problems.

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

Clinical preventive medicine

- IV.A.5.a).(5).(b).(i) Residents shall acquire an understanding of primary, secondary, and tertiary preventive approaches to individual and population-based disease prevention and health promotion.
- IV.A.5.a).(5).(b).(ii) Residents shall be able to develop, implement, and evaluate the effectiveness of appropriate clinical preventive services for both individuals and populations.
- IV.A.5.a).(5).(c) Residents shall design and conduct health and clinical outcomes studies.
- IV.A.5.a).(5).(d) Health administration
- IV.A.5.a).(5).(d).(i) Residents shall design and use management information systems.
- IV.A.5.a).(5).(d).(ii) Residents shall plan, manage, and evaluate health services to improve the health of a defined population using quality improvement and assurance systems.

Documentation Requirement. Resident schedules, rotation descriptions, interinstitutional agreements.

Measure: The resident demonstrates competency in public health agency administration and public health program planning and implementation, as well as managerial medicine competencies.

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) in collaboration with the program director and teaching staff, must prepare a written educational plan that directs the acquisition of a core set of competencies, skills, and knowledge appropriate to the objectives of individual residents, based on the residents' assessments. The educational plan will detail the courses, rotations, and activities to which they will be assigned to achieve the designated skills, knowledge, and competencies during their residencies;

Documentation Requirement. The program must have a written educational plan on file for each resident prior to a site visit.

Measure: The educational plan documents each resident's baseline skill, knowledge, and competency inventory; the resident's individual educational objectives; and the courses, rotations, and activities schedules that will provide the opportunity for each resident to meet the educational objectives.

- IV.A.5.b).(2) must have the assigned activities organized into a structured schedule prior to each year of residency experience. A record of courses, rotations, and activities attended must be completed at the close of each year;
- IV.A.5.b).(3) may, in those residencies that offer two- or three-year programs, create schedules that concurrently integrate courses, rotations, and activities that incorporate the following criteria:
 - IV.A.5.b).(3).(a) adequate time is available to complete each objective;
 - IV.A.5.b).(3).(b) the sequential acquisition of knowledge, skills, and competencies is clinical, academic/didactic, practicum;
 - IV.A.5.b).(3).(c) the practicum experiences may be concurrent with academic experiences, but may not precede didactic experiences;
 - IV.A.5.b).(3).(d) residents must have a keen sense of personal responsibility for continuing patient care and must recognize that their obligation to patients is not automatically discharged at any given hour of the day or any particular day of the week;
 - IV.A.5.b).(3).(e) resident care in the clinical setting must be directly supervised;
 - IV.A.5.b).(3).(f) in no case should a resident go off duty until the proper care and welfare of patients have been addressed and, if applicable, until responsibilities to the community and public have been fulfilled;
 - IV.A.5.b).(3).(g) duty hours and night and weekend call for residents must reflect the responsibility for patients and provide for adequate patient care; and,

IV.A.5.b).(3).(h)

must comply with the duty hour requirements, as listed in Section VI below.

Documentation Requirement: The program must submit the educational plans for all current residents and the final completed schedules for residents who have completed the program since the prior site visit.

Measure: Resident schedules show progressive responsibility.

Current residents: Documents the learning goals for an individual resident in terms of competencies, knowledge, and skills. Documents creation of a schedule that includes courses, rotations, and activities conducive to the accomplishment of the learning plan.

Former residents: Documents completion of an educational program in preventive medicine.

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

must have adequate depth and breadth of the following competencies, skills, and knowledge that underlie the practice of preventive medicine:

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

Core knowledge content areas:

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

Health services administration

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

Biostatistics

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

Epidemiology

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

Clinical preventive medicine

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

Behavioral aspects of health

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

Environmental health

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

Aerospace medicine knowledge content areas:

IV.A.5.b).(4).(b).(i)

History of aerospace medicine

IV.A.5.b).(4).(b).(ii)

The flight environment

IV.A.5.b).(4).(b).(iii)

Clinical aerospace medicine

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

Operational aerospace medicine

IV.A.5.b).(4).(b).(v)

Management and administration

IV.A.5.b).(4).(c)	Occupational medicine knowledge content areas:
IV.A.5.b).(4).(c).(i)	Disability management and work fitness
IV.A.5.b).(4).(c).(ii)	Workplace health and surveillance
IV.A.5.b).(4).(c).(iii)	Hazard recognition, evaluation, and control
IV.A.5.b).(4).(c).(iv)	Clinical occupational medicine
IV.A.5.b).(4).(c).(v)	Regulations and government agencies
IV.A.5.b).(4).(c).(vi)	Environmental health and risk assessment:
IV.A.5.b).(4).(c).(vi).(a)	Health promotion and clinical prevention
IV.A.5.b).(4).(c).(vi).(b)	Management and administration
IV.A.5.b).(4).(c).(vi).(c)	Toxicology
IV.A.5.b).(4).(d)	Public health and general preventive medicine
	The knowledge content areas for public health and general preventive medicine, while similar to those of the core content areas, emphasize more in-depth knowledge in each area:
IV.A.5.b).(4).(d).(i)	Health services administration, public health practice, and managerial medicine
IV.A.5.b).(4).(d).(ii)	Environmental health
IV.A.5.b).(4).(d).(iii)	Biostatistics
IV.A.5.b).(4).(d).(iv)	Epidemiology
IV.A.5.b).(4).(d).(v)	Clinical preventive medicine

Documentation Requirement: Resident schedules, resident academic records, rotation and course descriptions, academic transcripts.

Measure: The academic courses cover the knowledge areas listed above.

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; and,
- IV.A.5.c).(8) participate in the education of patients, families, students, residents and other health professionals.

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 professional responsibilities and an adherence to ethical principles. Residents are expected to demonstrate:

IV.A.5.e).(1)

compassion, integrity, and respect for others;

IV.A.5.e).(2)

responsiveness to patient needs that supersedes self-interest;

IV.A.5.e).(3)

respect for patient privacy and autonomy;

IV.A.5.e).(4)

accountability to patients, society and the profession; and,

IV.A.5.e).(5)

sensitivity and responsiveness to a diverse patient population, including but not limited to diversity in gender, age, culture, race, religion, disabilities, and sexual orientation.

IV.A.5.f)

Systems-based Practice

Residents must demonstrate an awareness of and responsiveness to the larger context and system of health care, as well as the ability to call effectively on other resources in the system to provide optimal health care. Residents are expected to:

IV.A.5.f).(1)

work effectively in various health care delivery settings and systems relevant to their clinical specialty;

IV.A.5.f).(2)

coordinate patient care within the health care system relevant to their clinical specialty;

IV.A.5.f).(3)

incorporate considerations of cost awareness and risk-benefit analysis in patient and/or population-based care as appropriate;

IV.A.5.f).(4)

advocate for quality patient care and optimal patient care systems;

IV.A.5.f).(5)

work in interprofessional teams to enhance patient safety and improve patient care quality; and,

IV.A.5.f).(6)

participate in identifying system errors and implementing potential systems solutions.

Documentation Requirement: Resident schedules and incoming resident assessment.

Measure: Resident schedules, incoming resident assessment, and program files document rotations and activities that verify a total of 12 months of clinical experience.

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.1.d) The program will evaluate in writing the provision of and individual resident participation in assigned courses, rotations, and activities. The method will evaluate achievement of competency, skill, and knowledge objectives from the perspectives of both the resident and the faculty.

Documentation Requirement. The program will submit a written description prior to the site visit of the method by which the program director and the resident will document resident participation in assigned courses, rotations, and activities as well as acquisition of skills and knowledge and demonstration of competencies.

Measure: Evaluation method provides for documentation by the supervisor and the resident of the resident's participation in learning experiences, the skills and knowledge acquired, and the competencies demonstrated.

V.A.1.e) Faculty and residents will use the evaluation method to evaluate the courses, rotations, and activities of each resident on at least a semiannual basis.

Documentation Requirement. The program will maintain and make readily available to site visitors copies of evaluations by both the residents and the faculty of courses, rotations, and activities for the prior five years. Evaluation of residents in the academic phase will be the responsibility of the sponsoring institution and will include a transcript or equivalent document provided to each resident. The evaluations for each resident must be available for review by the individual resident.

Measure: Documents for each resident for each experience that learning opportunities were provided, skills and knowledge were acquired, and competencies were demonstrated.

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.A.3. The program director, with participation of the faculty, shall evaluate resident progress toward educational goals in writing at least

semiannually. Where progress toward educational goals deviates significantly from the educational plan, counseling or corrective actions must be documented. Fair procedures, as established by the sponsoring institution, and in compliance with the ACGME Institutional Requirements regarding academic discipline and resident complaints or grievances, must be implemented.

- V.A.4. The evaluations must be reviewed with the resident formally and in a timely manner. Where appropriate, interim evaluation is encouraged.

Documentation Requirement. These evaluations must be on file for the prior five years and readily available to the site visitor.

Measure: Documents that the resident has been supplied feedback on progress against plan on acquisition of knowledge, skills, and demonstration of competencies. Final evaluation documents completion of learning plan.

- V.A.5. The program director and faculty must document completion of courses, rotations, and activities and must certify that residents completing the program have fulfilled all established requirements of their educational plan. This final evaluation must be part of the resident's permanent record and must be maintained by the sponsoring institution.

- V.A.6. Although a person may have entered a practicum phase with an incomplete academic phase, that person may not be certified as having completed the practicum phase in the absence of a transcript certifying that all the requirements for the Master of Public Health or other appropriate postgraduate degree have been completed.

Documentation Requirement. This documentation must be readily available for site visitor review.

Measure: Documents status in and/or completion of the educational plan by each resident. Documents that a resident completing the practicum has achieved the planned competencies.

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. The annual evaluation by residents shall be based on completion of a written questionnaire. This evaluation shall be provided to the program director. An additional confidential evaluation shall be provided to the chair of the residency advisory committee (RAC).

Documentation Requirement. Confidential written evaluations by each resident of the program must be maintained on file for the prior five years, be noted in the RAC minutes, and be readily available to the site visitor.

Measure: Documents that each resident has provided annual feedback to the program on the program structure, factors considered conducive to acquisition of skills and knowledge and demonstration of competencies, activities planned but not provided, and suggestions for program enhancement.

V.C.4. The RAC shall consist of faculty, external members, practicum supervisors, and at least one resident representative. A majority of the members must have their primary affiliation outside the sponsoring institution. Members must be certified in preventive medicine or knowledgeable about specialty training in preventive medicine. The RAC chair must be a physician. The program director must serve in an ex-officio capacity.

- V.C.4.a) The RAC must meet at least semiannually.
- V.C.4.b) The mission of the RAC is to promote a residency training experience that is aligned with preventive medicine practice. The RAC, as an external body, complements the graduate medical education committee (GMEC), which serves to evaluate and support the residency from within the sponsoring institution.
- V.C.4.c) The functions of the RAC are to advise and assist the program director to:
- V.C.4.c).(1) develop and update a written residency mission statement that describes goals and objectives;
 - V.C.4.c).(2) develop educational experiences and practicum rotations;
 - V.C.4.c).(3) provide new or emerging knowledge, skills, or competencies that may influence the content or conduct of preventive medicine education;
 - V.C.4.c).(4) review the GMEC review of the residency program;
 - V.C.4.c).(5) review confidential and written resident evaluations of the program and make recommendations for changes;
 - V.C.4.c).(6) review the program director evaluation of individual residents; and,
 - V.C.4.c).(7) provide an annual report to the sponsoring institution through the chair of the committee.

Documentation Requirement. Minutes document the functions of the RAC.

Measure: Minutes are available in the program files that document the activity of the RAC and faculty/member participation.

- V.C.4.d) The program director and the chair of the RAC must provide to the director of graduate medical education, or equivalent, at the sponsoring institution an annual written report of the residency quality. The program director and the chair of the RAC must provide a written plan of corrective actions for any recommendations received from the director of graduate medical education.

Documentation Requirement. Reports and plans for corrective actions written since the prior site visit must be readily available to the site visitor.

Measure: Recommendations are acted upon by the residency program director.

- V.C.5. The residency must maintain a database of all residents participating in the program and their professional status for five years.
- V.C.6. The program must monitor the percentage of entering residents who take the certifying examination of the American Board of Preventive Medicine (ABPM). A minimum of 50% of entering residents must take the certifying exam averaged over any five-year period.
- V.C.7. Of those residents taking the certifying examination, a minimum of 50% must pass the certifying examination averaged over any five-year period.

Documentation Requirement. Prior to the site visit the program must provide documentation of the residents participating in the program, their professional status, the percentage taking the certifying examination, and the percentage passing the certifying examination.

Measure: 50% of entering residents must take the certifying examination of the ABPM, and of those taking the examination, 50% must pass.

VI. Resident Duty Hours in the Learning and Working Environment

VI.A. Principles

- VI.A.1. The program must be committed to and be responsible for promoting patient safety and resident well-being and to providing a supportive educational environment.**
- VI.A.2. The learning objectives of the program must not be compromised by excessive reliance on residents to fulfill service obligations.**
- VI.A.3. Didactic and clinical education must have priority in the allotment of residents' time and energy.**
- VI.A.4. Duty hour assignments must recognize that faculty and residents collectively have responsibility for the safety and welfare of patients.**

VI.B. Supervision of Residents

The program must ensure that qualified faculty provide appropriate supervision of residents in patient care activities.

VI.C. Fatigue

Faculty and residents must be educated to recognize the signs of fatigue and sleep deprivation and must adopt and apply policies to prevent and counteract its potential negative effects on patient care and learning.

VI.D. Duty Hours (the terms in this section are defined in the ACGME Glossary

and apply to all programs)

Duty hours are defined as all clinical and academic activities related to the program; i.e., patient care (both inpatient and outpatient), administrative duties relative to patient care, the provision for transfer of patient care, time spent in-house during call activities, and scheduled activities, such as conferences. Duty hours do *not* include reading and preparation time spent away from the duty site.

- VI.D.1. **Duty hours must be limited to 80 hours per week, averaged over a four-week period, inclusive of all in-house call activities.**
- VI.D.2. **Residents must be provided with one day in seven free from all educational and clinical responsibilities, averaged over a four-week period, inclusive of call.**
- VI.D.3. **Adequate time for rest and personal activities must be provided. This should consist of a 10-hour time period provided between all daily duty periods and after in-house call.**
- VI.E. **On-call Activities**
- VI.E.1. **In-house call must occur no more frequently than every third night, averaged over a four-week period.**
- VI.E.2. **Continuous on-site duty, including in-house call, must not exceed 24 consecutive hours. Residents may remain on duty for up to six additional hours to participate in didactic activities, transfer care of patients, conduct outpatient clinics, and maintain continuity of medical and surgical care.**
- VI.E.3. **No new patients may be accepted after 24 hours of continuous duty.**
- VI.E.3.a) A new patient is defined as any patient for whom the resident has not previously provided care.
- VI.E.4. **At-home call (or pager call)**
- VI.E.4.a) **The frequency of at-home call is not subject to the every-third-night, or 24+6 limitation. However at-home call must not be so frequent as to preclude rest and reasonable personal time for each resident.**
- VI.E.4.b) **Residents taking at-home call must be provided with one day in seven completely free from all educational and clinical responsibilities, averaged over a four-week period.**
- VI.E.4.c) **When residents are called into the hospital from home, the hours residents spend in-house are counted toward the 80-hour limit.**

VI.F. Moonlighting

VI.F.1. Moonlighting must not interfere with the ability of the resident to achieve the goals and objectives of the educational program.

VI.F.2. Internal moonlighting must be considered part of the 80-hour weekly limit on duty hours.

VI.G. Duty Hours 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.

VI.G.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.2. Prior to submitting the request to the Review Committee, the program director must obtain approval of the institution's GMEC and DIO.

VII. Experimentation and Innovation

Requests for experimentation or innovative projects that may deviate from the institutional, common and/or specialty specific program requirements must be approved in advance by the Review Committee. In preparing requests, the program director must follow Procedures for Approving Proposals for Experimentation or Innovative Projects located in the ACGME Manual on Policies and Procedures. Once a Review Committee approves 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.

ACGME: September 2000 Effective: July 2001
Editorial Revision (Common Program Requirements): December 2004
Revised Common Program Requirements Effective: July 1, 2007