

ACGME Program Requirements for Graduate Medical Education in Addiction Psychiatry

One-year Common Program Requirements are in BOLD

Effective: July, 2003

Introduction

Int.A. Residency and fellowship programs are essential dimensions of the transformation of the medical student to the independent practitioner along the continuum of medical education. They are physically, emotionally, and intellectually demanding, and require longitudinally-concentrated effort on the part of the resident or fellow.

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

Int.B. Addiction psychiatry is the subspecialty of psychiatry that focuses on the prevention, evaluation, and treatment of substance-related disorders as well as related education and research. In addition, the addiction psychiatrist will be fully trained in techniques required in the treatment of the larger group of patients with dual diagnoses of addictive disorders and other psychiatric disorders.

Int.C. Duration and Scope of Education

Int.C.1. The training period in addiction psychiatry must be 12 months. Any program that extends training beyond these minimum requirements must present a clear educational rationale consonant with the special requirements and objectives for residency training in addiction psychiatry.

Int.C.2. Training in addiction psychiatry that occurred during the general residency training will not be credited toward the one-year requirement.

Int.C.3. Training is best accomplished on a full-time basis. If it is undertaken on a

part-time basis, the 12-month program must be completed within a two-year period.

Int.C.4. Prior to entry, each addiction psychiatry fellow must be notified in writing of the required length of training for which the program is accredited. The required length of training may not be changed without mutual agreement unless there is a break in training or the fellow requires remedial training.

Int.D. Educational Goals and Objectives

Int.D.1. The program must offer advanced training such that the knowledge, skills, clinical judgment, and attitudes essential to the practice of addiction psychiatry at the consultant level are provided.

Int.D.2. Clinical experience must include the opportunity to evaluate and follow a variety of patients of both sexes, including adolescents, adults, and geriatric age groups spanning a broad range of diagnoses as enumerated in Program Requirement IV.A.3. Fellows must provide both primary and consultative care in both inpatient (including intensive care) and outpatient settings for patients with a wide variety of types of substance-related disorders. Where the primary site of training is devoted to the care of patients with only a particular form of substance-related disorders, appropriate affiliations must be arranged to ensure that adequate exposure is provided to a sufficient number and variety of patients with substance-related disorders.

Int.D.3. Programs must be based on a structured written curriculum with well-defined goals and objectives. Clinical, basic science, and research conferences as well as seminars and critical literature review activities pertaining to substance-related disorders must be conducted regularly and as scheduled. The curriculum must include sufficient didactic content so that the graduates will have a comprehensive understanding of the pharmacology of all commonly abused substances, as well as the actions of pharmacological agents used to treat these conditions. Clinical experience and didactics should be integrated to provide appropriate progressive learning.

Int.D.4. Training must focus on the biopsychosocial and functional concepts of diagnosis and treatment as applied to inpatient, outpatient, and other treatment settings. Iatrogenic aspects of illness, as well as cultural, ethnic, racial, socioeconomic, ethical, and legal considerations that may affect or interact with the psychiatric care of these patients must be included in the program.

Int.D.5. The program should present the epidemiology of substance-related disorders, such as cultural, ethnic, racial, gender, sexual orientation, socioeconomic, and familial factors affecting the availability and use of addicting substances.

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 fellow assignments at all participating sites.

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

- I.A.1. The program must be administratively attached to and sponsored by a core residency program in psychiatry that holds full accreditation from the Accreditation Council for Graduate Medical Education (ACGME). The program must function in close relationship to the general psychiatry residency.
- I.A.2. The program must take place in facilities approved by the appropriate state licensing agencies and, where appropriate, by The Joint Commission.

I.B. Participating Sites

I.B.1. There must be a program letter of agreement (PLA) between the sponsoring institution 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 fellows;**
- I.B.1.b) **specify their responsibilities for teaching, supervision, and formal evaluation of fellows, 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 fellow 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 fellows, of one month full time equivalent (FTE) or more through the Accreditation Council for Graduate Medical Education (ACGME) Accreditation Data System (ADS).

I.B.3. The number of and distance between participating sites shall not impair training and participation in conferences and other organized educational aspects of the program.

I.B.4. Presence of Other Training Programs

The addiction psychiatry program should provide peer interaction between its fellows and those of other medical/surgical specialties. To achieve this goal an ACGME-accredited training program in at least one nonpsychiatric specialty, such as neurology, internal medicine, or family medicine should be present within the participating sites of the program. Peer interaction among the fellows should occur in the course of clinical and/or didactic work, but is most satisfactory when organized around joint patient evaluation and/or care.

II. Program Personnel and Resources

II.A. Program Director

II.A.1. There must be a single program director with authority and accountability for the operation of the program. The sponsoring institution's GMEC must approve a change in program director. After approval, the program director must submit this change to the ACGME via the ADS.

II.A.2. Qualifications of the program director must include:

II.A.2.a) requisite specialty expertise and documented educational and administrative experience acceptable to the Review Committee;

II.A.2.a).(1) The program director must be an active clinician.

II.A.2.b) current certification in the subspecialty by the American Board of Psychiatry and Neurology (ABPN), or subspecialty qualifications that are acceptable to the Review Committee; and,

II.A.2.c) current medical licensure and appropriate medical staff appointment.

II.A.3. The program director must administer and maintain an educational environment conducive to educating the fellows in each of the ACGME competency areas. The program director must:

II.A.3.a) prepare and submit all information required or requested by the ACGME;

II.A.3.b) be familiar with and oversee compliance with ACGME and Review Committee policies and procedures as outlined in the ACGME Manual of Policies and Procedures;

II.A.3.c) obtain review and approval of the sponsoring institution's GMEC/DIO before submitting to the ACGME information or

requests for the following:

- II.A.3.c).(1) all applications for ACGME accreditation of new programs;**
- II.A.3.c).(2) changes in fellow complement;**
- II.A.3.c).(3) major changes in program structure or length of training;**
- II.A.3.c).(4) progress reports requested by the Review Committee;**
- II.A.3.c).(5) responses to all proposed adverse actions;**
- II.A.3.c).(6) requests for increases or any change to fellow duty hours;**
- II.A.3.c).(7) voluntary withdrawals of ACGME-accredited programs;**
- II.A.3.c).(8) requests for appeal of an adverse action; and,**
- II.A.3.c).(9) appeal presentations to a Board of Appeal or the ACGME.**

- II.A.3.d) 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.3.d).(1) program citations, and/or**
 - II.A.3.d).(2) request for changes in the program that would have significant impact, including financial, on the program or institution.**

- II.A.3.e) devote sufficient time to the program to ensure implementation and achievement of the educational goals and objectives;**

- II.A.3.f) supervise the recruitment, selection, and appointment process for applicants, including compliance with appropriate credentialing policies and procedures in accordance with institutional and departmental policies and procedures. The director must receive documentation from the prior general psychiatry program in order to verify satisfactory completion of all educational and ethical requirements for graduation, before appointment to the program;**

- II.A.3.g) ensure the provision of written descriptions of departmental policies regarding salary and benefits, due process, sickness and other leaves, on-call responsibilities, and vacation time to all fellows upon appointment to the program. All fellows must be provided with written descriptions of the malpractice coverage**

provided for each clinical assignment;

- II.A.3.h) monitor the progress of each fellow, including the maintenance of a training record that documents completion of all required components of the program, as well as evaluations of fellows' clinical and didactic work by supervisors and teachers. This record shall include a patient log which shall document for each addiction psychiatry fellow that he/she has completed all clinical experiences required by the Program Requirements and the educational objectives of the program;
- II.A.3.i) maintain all other training records including those related to appointment, departmental processes regarding due process, sickness and other leaves, on-call responsibilities, and vacation time; and,
- II.A.3.j) ensure the opportunity for fellows to achieve the cognitive knowledge, interpersonal skills, professional attitudes, and practical experience required of an addiction psychiatrist providing acute and chronic care for the patient with substance-related disorders.

II.B. Faculty

II.B.1. There must be a sufficient number of faculty with documented qualifications to instruct and supervise all fellows.

- II.B.1.a) In addition to the program director, there must be at least one other faculty member certified by the ABPN in the subspecialty of addiction psychiatry. Programs with large patient populations, multiple participating sites, and large fellow complements will be expected to have the number of physician faculty appropriate to the program's size and structure.

II.B.2. The faculty must devote sufficient time to the educational program to fulfill their supervisory and teaching responsibilities and demonstrate a strong interest in the education of fellows.

II.B.3. The physician faculty must have current certification in the subspecialty by the American Board of Psychiatry and Neurology, or possess qualifications acceptable to the Review Committee.

II.B.4. The physician faculty must possess current medical licensure and appropriate medical staff appointment.

- II.B.5. The responsibility for establishing and maintaining an environment of inquiry and scholarship rests with the faculty, and an active research component must be included in each program. *Scholarship* is defined as the following:

- II.B.5.a) the scholarship of *discovery*, as evidenced by peer-reviewed

funding or by publication of original research in a peer-reviewed journal;

II.B.5.b) the scholarship of *dissemination*, as evidenced by review articles or chapters in textbooks; and,

II.B.5.c) the scholarship of *application*, as evidenced by the publication or presentation of, for example, case reports or clinical series at local, regional, or national professional and scientific society meetings.

II.B.6. Complementary to the above scholarship is the regular participation of the teaching staff in clinical discussions, rounds, journal clubs, and research conferences in a manner that promotes a spirit of inquiry and scholarship (e.g., the offering of guidance and technical support for fellows involved in research such as research design and statistical analysis); and the provision of support for fellows' participation, as appropriate, in scholarly activities.

II.C. Other Program Personnel

The institution and the program must jointly ensure the availability of all necessary professional, technical, and clerical personnel for the effective administration of the program.

II.C.1. Addiction psychiatry fellows must be provided with meaningful patient care experiences as part of an interdisciplinary care team. The fellow should work in settings that include representatives from clinical disciplines such as social work, psychology, psychiatric nursing, occupational therapy, pharmacy, and nutrition, as well as clinicians in anesthesia (including pain management), emergency medicine, family medicine, geriatrics, internal medicine, neurology, obstetrics-gynecology, surgical specialties, and pediatrics/adolescent medicine as appropriate for the care of the patient. In addition, fellows should work with other staff such as substance abuse counselors and, where appropriate, with teachers.

II.D. Resources

The institution and the program must jointly ensure the availability of adequate resources for fellow education, as defined in the specialty program requirements.

II.D.1. All elements of the program must be located in designated facilities based on written affiliation agreements between the participating sites and the administration of the program.

II.D.2. Inpatient Care Facility: The sponsor of the program must be a part of, or affiliated with, at least one acute care general hospital with a full range of services, including medical and surgical services, intensive care units, emergency services, diagnostic laboratory, and imaging services. If the

acute care hospital is specialized and does not itself have the full spectrum of services described above, the program must document that it has access for training purposes to other affiliated acute care facilities that have the services not present at the specialized facility.

- II.D.3. Partial Hospitalization and Day Treatment: Programs must have access to a partial hospitalization and/or day treatment program (such as an intensive outpatient program). Such programs may be located in community-based institutions or within the sponsoring department of psychiatry in its acute care hospital. Exposure to self-help and other community programs (such as 12-step programs widely used by patients with Substance-related Disorders) must be provided.
- II.D.4. Ambulatory Care Service: The program must provide experience in a multidisciplinary ambulatory care facility such as a methadone maintenance clinic, an alcohol treatment clinic, or other specialized outpatient program.
- II.D.5. Library: Fellows must have ready access to a major medical library either at the institution where the fellows are located or through arrangement with convenient nearby institutions.
 - II.D.5.a) Library services should include computer support for electronic retrieval of information from medical databases.
 - II.D.5.b) There must be access to an onsite library or to a collection of appropriate texts and journals in each institution participating in the training program. On-site libraries and/or collections of texts and journals must be readily available during nights and weekends.
- II.D.6. Ancillary Support Services: At all participating facilities, there must be appropriate support services to ensure an adequate educational experience. This includes support personnel in all categories including clerical and laboratory and physical resources to ensure that fellows have sufficient time and space to carry out their clinical and educational functions.

II.E. Medical Information Access

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

III. Fellow Appointments

III.A. Eligibility Criteria

Each fellow must successfully complete an ACGME-accredited specialty program and/or meet other eligibility criteria as specified by the Review Committee. The program must document that each fellow has met the

eligibility criteria.

III.A.1. The addiction psychiatry fellow must have satisfactorily completed an ACGME-accredited general psychiatry residency prior to entering the program.

III.B. Number of Fellows

The program director may not appoint more fellows 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 fellows appointed to the program.

IV. Educational Program

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

IV.A.1. Skills and competencies the fellow will be able to demonstrate at the conclusion of the program. The program must distribute these skills and competencies to fellows and faculty annually, in either written or electronic form. These skills and competencies should be reviewed by the fellow at the start of each rotation;

IV.A.2. ACGME Competencies

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

IV.A.2.a) Patient Care

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

IV.A.2.b) Medical Knowledge

Fellows 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.

IV.A.2.c) Practice-based Learning and Improvement

Fellows are expected to develop skills and habits to be able to meet the following goals:

IV.A.2.c).(1) systematically analyze practice using quality improvement methods, and implement changes with the goal of practice improvement; and,

IV.A.2.c).(2) locate, appraise, and assimilate evidence from

scientific studies related to their patients' health problems.

IV.A.2.d) Interpersonal and Communication Skills

Fellows must demonstrate interpersonal and communication skills that result in the effective exchange of information and collaboration with patients, their families, and health professionals.

IV.A.2.e) Professionalism

Fellows must demonstrate a commitment to carrying out professional responsibilities and an adherence to ethical principles.

IV.A.2.f) Systems-based Practice

Fellows 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.

IV.A.3. Curriculum Content

The field of addiction psychiatry requires knowledge of pharmacology, psychiatry, general medicine, as well as an understanding of the interaction of these disciplines. Programs must include both direct experiences in clinical care as well as formal didactic conferences. Instruction and experience must include the performance of the mental status examination, a neuropsychiatric evaluation instrument such as the Mini-Mental Status Examination, community and environmental assessments, family and care giver assessments, medical assessments, and physical and psychological functional assessments. These skills comprise the basis for the formal assessment of the addicted patient using a synthesis of clinical findings, historical and current information, as well as data from laboratory and other special studies.

IV.A.3.a) Fellows must acquire knowledge and skills in the following areas:

IV.A.3.a).(1) knowledge of the signs and symptoms of the use and abuse of all of the major categories of substances enumerated in IV.A.5.b, as well as knowledge of the types of treatment required for each;

IV.A.3.a).(2) knowledge of the signs of withdrawal from these major categories of substances, knowledge and experience with the range of options for treatment of the withdrawal syndromes, and the complications commonly associated with such withdrawal;

- IV.A.3.a).(3) knowledge of the signs and symptoms of overdose, the medical and psychiatric sequelae of overdose, and experience in providing proper treatment of overdose;
- IV.A.3.a).(4) experience in managing detoxification, including inpatient management of substance-related disorders and working collaboratively with specialists in the emergency department and intensive care units in the diagnosis and management of acute overdose symptoms;
- IV.A.3.a).(5) knowledge of the signs and symptoms of the social and psychological problems as well as the medical and psychiatric disorders which often accompany the chronic use and abuse of the major categories of substances;
- IV.A.3.a).(6) experience in the use of psychoactive medications in the treatment of psychiatric disorders often accompanying the major categories of substance-related disorders;
- IV.A.3.a).(7) experience in the use of techniques required for confrontation of and intervention with a chronic substance abuser, and in dealing with the defense mechanisms that cause the patient to resist entry into treatment;
- IV.A.3.a).(8) experience in the use of the various psychotherapeutic modalities involved in the ongoing management of the chronic substance abusing patient, including individual psychotherapies (e.g., cognitive-behavioral therapy), couples therapy, family therapy, group therapy, motivational enhancement therapy, and relapse prevention therapy;
- IV.A.3.a).(9) experience in working collaboratively with other mental health providers and allied health professionals, including nurses, social workers, psychologists, nurse practitioners, counselors, pharmacists, and others who participate in the care of patients with substance-related disorders;
- IV.A.3.a).(10) knowledge and understanding of the special problems of the pregnant woman with substance-related disorders and of the babies born to these women;
- IV.A.3.a).(11) knowledge of family systems and dynamics relevant to the etiology, diagnosis, and treatment of substance-related disorders;
- IV.A.3.a).(12) knowledge of the genetic vulnerabilities, risk and protective factors, epidemiology, and prevention of substance-related disorders;
- IV.A.3.a).(13) familiarity with the major medical journals and professional-

scientific organizations dealing with research on the understanding and treatment of substance-related disorders;

IV.A.3.a).(14) critical analysis of research reports, as presented in journal clubs and seminars;

IV.A.3.a).(15) experience in teaching and supervising clinical trainees in the care of patients with substance-related disorders;

IV.A.3.a).(16) understanding of the current economic aspects of providing psychiatric and other healthcare services to the addicted patient; and,

IV.A.3.a).(17) knowledge of quality assurance measures and cost effectiveness of various treatment modalities for substance-related disorders.

IV.A.4. Conferences

Conferences in addiction psychiatry, such as grand rounds, case conferences, reading seminars, and journal clubs, should be specifically designed to complement the clinical experiences. Regular attendance by fellows and faculty should be documented.

IV.A.5. Clinical Experiences

The number and variety of new and follow-up patients spanning the life cycle from adolescence to old age must be sufficient to ensure an adequate outpatient and inpatient experience as specified in Int.D.2. The spectrum of patients should include diverse socioeconomic, educational, and cultural backgrounds.

The training program must include the following clinical components:

IV.A.5.a) evaluation, consultation, and treatment of:

IV.A.5.a).(1) patients with primary substance-related disorders and their families;

IV.A.5.a).(2) medical and surgical patients in the emergency department, intensive care units, and general wards of the hospital with acute and chronic substance-related disorders, including acute intoxication and overdose;

IV.A.5.a).(3) psychiatric inpatients and outpatients with chemical dependencies and co-morbid psychopathology to include a broad range of psychiatric diagnoses, such as affective disorders, psychotic disorders, organic disorders, personality disorders, and anxiety disorders as well as patients suffering from medical conditions commonly

- associated with substance-related disorders such as hepatitis and HIV/AIDS; and,
- IV.A.5.a).(4) medication dependent patients with chronic medical disorders/conditions (such as patients with chronic pain).
- IV.A.5.b) exposure to patients with substance-related disorders related to the following substances:
- IV.A.5.b).(1) alcohol;
- IV.A.5.b).(2) opioids;
- IV.A.5.b).(3) cocaine and other stimulants;
- IV.A.5.b).(4) cannabis and hallucinogens;
- IV.A.5.b).(5) benzodiazepines;
- IV.A.5.b).(6) other substances of abuse, including sedatives, hypnotics or anxiolytics; and,
- IV.A.5.b).(7) miscellaneous/unusual, e.g., nutmeg, designer drugs, organic solvents/inhalants.
- IV.A.5.c) treatment by the fellow of a minimum of five addicted outpatients with a variety of diagnoses requiring individual treatment for at least six months;
- IV.A.5.d) experience in working with multidisciplinary teams as a consultant and as a team leader, including the integration of recommendations and decisions from consulting medical specialists and other professionals in related health disciplines;
- IV.A.5.e) experience in working with patients who are participating in self-help programs; and,
- IV.A.5.f) experience with opiate replacement therapy.
- IV.A.6. Rotations should provide fellows with experience in evaluating acute and chronic patients in inpatient and outpatient settings. There should be an identifiable structured educational experience in neuropsychiatry relevant to the practice of addiction psychiatry that includes both didactic and clinical training methods. The curriculum should emphasize functional assessment, signs and symptoms of neuropsychiatric impairment associated with substance-related disorders, and the identification of physical illnesses and iatrogenic factors that can alter mental status, and behavior.
- IV.A.7. The program must provide specific experiences in consultation to acute and chronic medically ill patients with substance related disorders who

are being treated on emergency, intensive care, medical and/or surgical services of a general hospital. Supervision of addiction psychiatry fellows in their clinical evaluation of such patients, as well as in their consultative role, is essential. The program should provide fellows with the opportunity to function at the level of a specialist consultant to primary care physicians and to intensive care specialists. This should include:

- IV.A.7.a) experience in working with multidisciplinary teams as a consultant and as a team leader, including the integration of recommendations and decisions from consulting medical specialists and other professionals in related health disciplines;
- IV.A.7.b) experience in working with patients who are participating in self-help programs; and,
- IV.A.7.c) experience with opiate replacement therapy.

IV.A.8. Fellow Teaching Experiences

The program should provide appropriate experiences designed to develop administrative and teaching skills for the addiction psychiatry fellows. As the fellows progress through the program, they should have the opportunity to teach personnel such as other residents, medical students, and other allied health professionals.

- IV.A.9. Each fellow must have a minimum of two hours of individual supervision weekly, of which one hour may be group supervision.

- IV.A.10. Supervision must include observation, assessment, and demonstration of the fellows' knowledge and skills in clinical evaluation, technical proficiency, and professional attitudes.

IV.B. **Fellows' Scholarly Activities**

Each program must provide an opportunity for fellows to participate in research or other scholarly activities, and fellows must participate actively in such scholarly activities.

V. **Evaluation**

V.A. **Fellow Evaluation**

V.A.1. **Formative Evaluation**

- V.A.1.a) **The faculty must evaluate fellow performance in a timely manner.**

- 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); and,

V.A.1.b).(3) provide each fellow with documented semiannual evaluation of performance with feedback.

V.A.1.c) The evaluations of fellow performance must be accessible for review by the fellow, in accordance with institutional policy.

V.A.1.d) Assessment should include the regularly and timely performance feedback to fellows that includes written quarterly evaluations of the fellows by all supervisors and the directors of clinical components of training.

V.A.2. Summative Evaluation

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

V.A.2.a) document the fellow's performance during their education, and

V.A.2.b) verify that the fellow has demonstrated sufficient competence to enter practice without direct supervision.

V.B. Faculty Evaluation

V.B.1. At least annually, the program must evaluate faculty performance as it relates to the educational program.

V.B.2. These evaluations should include a review of the faculty's clinical teaching abilities, commitment to the educational program, clinical knowledge, professionalism, and scholarly activities.

V.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) fellow performance, and

V.C.1.b) faculty development

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 approved by the teaching faculty and documented in meeting minutes.

VI. Fellow Duty Hours in the Learning and Working Environment

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

VI.A.1. Programs and sponsoring institutions must educate fellows and faculty members concerning the professional responsibilities of physicians to appear for duty appropriately rested and fit to provide the services required by their patients.

VI.A.2. The program must be committed to and responsible for promoting patient safety and fellow well-being in a supportive educational environment.

VI.A.3. The program director must ensure that fellows are integrated and actively participate in interdisciplinary clinical quality improvement and patient safety programs.

VI.A.4. The learning objectives of the program must:

VI.A.4.a) be accomplished through an appropriate blend of supervised patient care responsibilities, clinical teaching, and didactic educational events; and,

VI.A.4.b) not be compromised by excessive reliance on fellows to fulfill non-physician service obligations.

VI.A.5. The program director and sponsoring institution must ensure a culture of professionalism that supports patient safety and personal responsibility. Fellows and faculty members must demonstrate an understanding and acceptance of their personal role in the following:

VI.A.5.a) assurance of the safety and welfare of patients entrusted to their care;

VI.A.5.b) provision of patient- and family-centered care;

VI.A.5.c) assurance of their fitness for duty;

VI.A.5.d) management of their time before, during, and after clinical assignments;

VI.A.5.e) recognition of impairment, including illness and fatigue, in themselves and in their peers;

- VI.A.5.f) attention to lifelong learning;
- VI.A.5.g) the monitoring of their patient care performance improvement indicators; and,
- VI.A.5.h) honest and accurate reporting of duty hours, patient outcomes, and clinical experience data.
- VI.A.6. All fellows and faculty members must demonstrate responsiveness to patient needs that supersedes self-interest. Physicians must recognize that under certain circumstances, the best interests of the patient may be served by transitioning that patient's care to another qualified and rested provider.
- VI.B. Transitions of Care
 - VI.B.1. Programs must design clinical assignments to minimize the number of transitions in patient care.
 - VI.B.2. Sponsoring institutions and programs must ensure and monitor effective, structured hand-over processes to facilitate both continuity of care and patient safety.
 - VI.B.3. Programs must ensure that fellows are competent in communicating with team members in the hand-over process.
 - VI.B.4. The sponsoring institution must ensure the availability of schedules that inform all members of the health care team of attending physicians and fellows currently responsible for each patient's care.
- VI.C. Alertness Management/Fatigue Mitigation
 - VI.C.1. The program must:
 - VI.C.1.a) educate all faculty members and fellows to recognize the signs of fatigue and sleep deprivation;
 - VI.C.1.b) educate all faculty members and fellows in alertness management and fatigue mitigation processes; and,
 - VI.C.1.c) adopt fatigue mitigation processes to manage the potential negative effects of fatigue on patient care and learning, such as naps or back-up call schedules.
 - VI.C.2. Each program must have a process to ensure continuity of patient care in the event that a fellow may be unable to perform his/her patient care duties.
 - VI.C.3. The sponsoring institution must provide adequate sleep facilities and/or safe transportation options for fellows who may be too fatigued to safely return home.

VI.D. Supervision of Fellows

VI.D.1. In the clinical learning environment, each patient must have an identifiable, appropriately-credentialed and privileged attending physician (or licensed independent practitioner as approved by each Review Committee) who is ultimately responsible for that patient's care.

Only licensed independent practitioners as consistent with state regulations and medical staff bylaws may have primary responsibility for a patient.

VI.D.1.a) This information should be available to fellows, faculty members, and patients.

VI.D.1.b) Fellows and faculty members should inform patients of their respective roles in each patient's care.

VI.D.2. The program must demonstrate that the appropriate level of supervision is in place for all fellows who care for patients.

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

VI.D.3. Levels of Supervision

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

VI.D.3.a) Direct Supervision – the supervising physician is physically present with the fellow and patient.

VI.D.3.b) Indirect Supervision:

VI.D.3.b).(1) with direct supervision immediately available – the supervising physician is physically within the hospital or other site of patient care, and is immediately available to provide Direct Supervision.

VI.D.3.b).(2) with direct supervision available – the supervising

physician is not physically present within the hospital or other site of patient care, but is immediately available by means of telephonic and/or electronic modalities, and is available to provide Direct Supervision.

- VI.D.3.c) Oversight – the supervising physician is available to provide review of procedures/encounters with feedback provided after care is delivered.
- VI.D.4. The privilege of progressive authority and responsibility, conditional independence, and a supervisory role in patient care delegated to each fellow must be assigned by the program director and faculty members.
- VI.D.4.a) The program director must evaluate each fellow’s abilities based on specific criteria. When available, evaluation should be guided by specific national standards-based criteria.
- VI.D.4.b) Faculty members functioning as supervising physicians should delegate portions of care to fellows, based on the needs of the patient and the skills of the fellows.
- VI.D.4.c) Fellows should serve in a supervisory role of residents or junior fellows in recognition of their progress toward independence, based on the needs of each patient and the skills of the individual fellow.
- VI.D.5. Programs must set guidelines for circumstances and events in which fellows must communicate with appropriate supervising faculty members, such as the transfer of a patient to an intensive care unit, or end-of-life decisions.
- VI.D.5.a) Each fellow must know the limits of his/her scope of authority, and the circumstances under which he/she is permitted to act with conditional independence.
- VI.D.6. Faculty supervision assignments should be of sufficient duration to assess the knowledge and skills of each fellow and delegate to him/her the appropriate level of patient care authority and responsibility.
- VI.E. **Clinical Responsibilities**
- The clinical responsibilities for each fellow must be based on PGY-level, patient safety, fellow education, severity and complexity of patient illness/condition and available support services.
- VI.F. **Teamwork**
- Fellows must care for patients in an environment that maximizes effective

communication. This must include the opportunity to work as a member of effective interprofessional teams that are appropriate to the delivery of care in the specialty.

VI.F.1. Contributors to effective interprofessional teams include consulting physicians, psychologists, psychiatric nurses, social workers and other professional and paraprofessional mental health personnel involved in the evaluation and treatment of patients.

VI.G. Fellow Duty Hours

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

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

VI.G.1.a) Duty Hour Exceptions

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

VI.G.1.a).(1) In preparing a request for an exception the program director must follow the duty hour exception policy from the ACGME Manual on Policies and Procedures.

VI.G.1.a).(2) Prior to submitting the request to the Review Committee, the program director must obtain approval of the institution's GMEC and DIO.

VI.G.2. Moonlighting

VI.G.2.a) Moonlighting must not interfere with the ability of the fellow to achieve the goals and objectives of the educational program.

VI.G.2.b) Time spent by fellows in Internal and External Moonlighting (as defined in the ACGME Glossary of Terms) must be counted towards the 80-hour Maximum Weekly Hour Limit.

VI.G.3. Mandatory Time Free of Duty

Fellows must be scheduled for a minimum of one day free of duty every week (when averaged over four weeks). At-home call cannot be assigned on these free days.

VI.G.4. Maximum Duty Period Length

Duty periods of fellows may be scheduled to a maximum of 24 hours of continuous duty in the hospital. Programs must encourage

fellows to use alertness management strategies in the context of patient care responsibilities. Strategic napping, especially after 16 hours of continuous duty and between the hours of 10:00 p.m. and 8:00 a.m., is strongly suggested.

VI.G.4.a) It is essential for patient safety and fellow education that effective transitions in care occur. Fellows may be allowed to remain on-site in order to accomplish these tasks; however, this period of time must be no longer than an additional four hours.

VI.G.4.b) Fellows must not be assigned additional clinical responsibilities after 24 hours of continuous in-house duty.

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

VI.G.4.c).(1) Under those circumstances, the fellow must:

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

VI.G.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.

VI.G.4.c).(2) The program director must review each submission of additional service, and track both individual fellow and program-wide episodes of additional duty.

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

VI.G.5.a) Fellows must be prepared to enter the unsupervised practice of medicine and care for patients over irregular or extended periods.

Addiction psychiatry fellows are considered to be in the final years of education.

VI.G.5.a).(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 fellows have eight hours free of duty between scheduled duty periods, there may be circumstances

