

ACGME Program Requirements for Graduate Medical Education in Geriatric 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. Geriatric psychiatry is that area of psychiatry which focuses on prevention, diagnosis, evaluation, and treatment of mental disorders and signs/symptoms seen in older adult patients. An educational program in geriatric psychiatry must be organized to provide professional knowledge, skill, and opportunities to develop competencies through a well-supervised clinical experience.

Int.C. Duration and Scope of Education

Int.C.1. The training period in geriatric psychiatry must be 12 months. Any program that extends the length of the program beyond 12 months must present an educational rationale consistent with the Program Requirements and the objectives for fellow education.

Int.C.2. Training in geriatric psychiatry that occurred during general residency training will not be counted toward meeting 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 in the program, each fellow must be notified in writing of the required length of training for which the program is accredited. The required length of training for a particular individual may not be changed without mutual agreement during his/her program unless there is a break in his/her training or the individual requires remedial training.

Int.D. Educational Goals and Objectives

Int.D.1. The goal of training in geriatric psychiatry is to produce specialists in the delivery of skilled and comprehensive psychiatric medical care of older adults suffering from psychiatric and neuropsychiatric disorders. Geriatric psychiatry programs must also provide advanced training for the fellow to function as an effective consultant in the subspecialty. Programs must emphasize scholarship, self-instruction, development of critical analysis of clinical problems, and the ability to make appropriate decisions.

Int.D.2. Clinical experience must include opportunities to assess and manage elderly inpatients and ambulatory patients of both sexes with a wide variety of psychiatric problems. Geriatric psychiatry fellows must be given the opportunity to provide both primary and consultative care for patients in both inpatient and outpatient settings in order to understand the interaction of normal aging and disease as well as to gain mastery in assessment, therapy, and management.

Int.D.3. The program must include training in the biological and psychosocial aspects of normal aging; the psychiatric impact of acute and chronic physical illnesses; and the biological and psychosocial aspects of the pathology of primary psychiatric disturbances beginning in or continuing into older age.

Int.D.4. There must be a focus on multidimensional biopsychosocial concepts of treatment and management as applied both in inpatient facilities (acute and long-term care) and in the community or home settings. There must also be emphasis on the medical and iatrogenic aspects of illness as well as on sociocultural, ethnic, economic, ethical, and legal considerations that may affect psychiatric management.

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 with 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 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 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. Presence of Other Training Programs:

The program should provide peer interaction between its fellows and those of other medical specialties. To achieve this goal, there should be an ACGME-accredited program in at least one relevant non-psychiatric specialty such as neurology, internal medicine, family medicine, geriatric medicine, or physical medicine and rehabilitation within the participating institutions of the geriatric psychiatry 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.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 and 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) supervise the recruitment and appointment process for applicants, including compliance with appropriate credentialing policies and procedures in accordance with institutional and departmental policies and procedures. No applicants should be appointed to the program without written documentation of completion of a general psychiatry residency from the prior program director that verifies satisfactory completion of all educational and ethical requirements for graduation;
- II.A.3.f) monitor the progress of each geriatric psychiatry fellow, including the maintenance of a training record that documents completion of all required components of the program as well as the evaluations of performance by supervisors and teachers. This record shall include a patient log that must document that each fellow has completed all clinical experiences required by the Program Requirements and the educational objectives of the program; and,
- II.A.3.g) ensure that fellows are provided written descriptions of the departmental policies regarding due process, sickness and other leaves, on-call responsibilities, and vacation time upon appointment to the program. All fellows must be provided with written descriptions of the professional liability coverage provided for each clinical assignment.

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 who is certified by the ABPN in the

subspecialty of geriatric psychiatry or possesses qualifications judged by the Review Committee to be acceptable.

- 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. Geriatric Care Team
 - Geriatric psychiatry fellows must be provided with meaningful patient care experiences as part of an interdisciplinary care team.
 - II.C.1.a) In addition to geriatric psychiatry, the Geriatric Care Team should

include representatives from related clinical disciplines such as psychology, social work, psychiatric nursing, activity or occupational therapy, physical therapy, pharmacy, and nutrition.

- II.C.1.b) A variety of individuals representing disciplines within medicine, such as family medicine, internal medicine (including their geriatric subspecialties), neurology, and physical medicine and rehabilitation, should be available for participation on the Geriatric Care Team as needed for patient care and teaching purposes.
- II.C.1.c) It is highly desirable that geriatric psychiatry fellows have access to professionals representing allied disciplines (such as ethics, law, and pastoral care) as needed for patient care and teaching purposes.
- II.C.1.d) Geriatric psychiatry fellows should be provided with opportunities to participate as members of medical geriatric teams in institutions where such teams are present.

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. An Acute Care Hospital: The psychiatry department sponsoring the program must be a part of or affiliated with at least one acute care general hospital that has the full range of services usually ascribed to such a facility, including both medical and surgical services, intensive care units, emergency department, diagnostic laboratory and imaging services, and pathology department. If the acute care hospital is specialized (such as in geriatric or psychiatric care) 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 remaining general services not present at the specialized facility.
- II.D.2. A Long-Term Care Facility: Inclusion of at least one long-term care facility is an essential component of the geriatric psychiatry program. Such facilities may be either discrete institutions separate from an acute care hospital or formally designated units or services within an acute care hospital. Suitable training sites include both nonpsychiatric facilities (such as a nursing facility or chronic care hospital) and psychiatric facilities.
- II.D.3. An Ambulatory Care Service: The ambulatory care service must be designed to render care in a multidisciplinary environment such as a geriatric clinic, psychiatric outpatient department, or community mental health center where nonpsychiatric medical specialists are also available.
- II.D.4. Ancillary Support Services: At all participating facilities, there must be sufficient administrative support to ensure adequate teaching facilities,

appropriate office space, support personnel, and teaching resources.

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 the electronic retrieval of information from medical databases.

II.D.5.b) There must be access to an on-site library or to a collection of appropriate texts and journals in each institution participating in a residency program. On-site libraries and/or collections of texts and journals must be readily available during nights and weekends.

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 geriatric 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. Program Design

IV.A.1. The curriculum must contain the following educational components:

IV.A.1.a) 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

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. Didactic Components

IV.A.3.a) The program curriculum must address, as a minimum, the following content and skill areas:

IV.A.3.a).(1) the current scientific understanding of aging and longevity, including theories of aging, epidemiology and natural history of aging, and diseases of the aged. This includes specific knowledge of: the effects of biologic aging on human physiology with emphasis on altered pharmacokinetics, pharmacodynamics, and sensory acuity in the elderly; the differences and gradations between normal and abnormal age changes with particular reference to such areas as memory and cognition, affective stability, personality and behavioral patterns, and sexuality. There must be an understanding of successful and maladaptive responses to stressors frequently encountered in older adults such as retirement, widowhood, role changes, interpersonal and health status losses, financial reverses, environmental relocations, and increased dependency;

IV.A.3.a).(2) the relevance of cultural and ethnic differences, and the special problems of disadvantaged minority groups, as these bear upon distinguishing and treating abnormal and maladaptive clinical changes as well as the use of psychosocial support services;

IV.A.3.a).(3) the epidemiology, diagnosis, and treatment of all major psychiatric disorders seen in the elderly. Such disorders, seen alone and in combination, typically include but are not limited to: affective disorders, dementias, delirium, late-onset psychoses, medical presentations of psychiatric disorders, iatrogenesis, adjustment disorders, anxiety disorders, sleep disorders, sexual disorders, substance-related disorders, personality disorders, and continuation of psychiatric illnesses that began earlier in life;

IV.A.3.a).(4) the performance of mental status examination, including structured cognitive assessment, community and environmental assessment, family and caregiver assessment, medical assessment, and functional assessment. Such skills form the basis for formal multidimensional geriatric assessment using the appropriate synthesis of clinical findings and historical as well as current information acquired from the patient and/or relevant others (such as family members, care givers, and other health care professionals). The multidimensional assessment is essential to short term and long-term diagnostic and treatment planning; training must be provided in formulating these various assessments into an appropriate and coherent treatment plan;

- IV.A.3.a).(5) the formal and informal administrative leadership of the mental health care team, including skills in communicating treatment plans to the patient and the family;
- IV.A.3.a).(6) the selection and use of clinical laboratory tests; radiologic and other imaging procedures; and polysomnographic, electrophysiologic, and neuropsychologic tests as well as making appropriate referrals to and consultations with other health care specialists;
- IV.A.3.a).(7) the initiation and flexible guidance of treatment with the need for ongoing monitoring of changes in mental and physical health status and medical regimens. Fellows should be taught to recognize and manage psychiatric comorbid disorders (for example, dementia and depression) as well as the management of other disturbances often seen in the elderly such as agitation, wandering, changes in sleep patterns, and aggressiveness;
- IV.A.3.a).(8) the recognition of the stressful impact of psychiatric illness on caregivers. Attention should be placed on the appropriate guidance of and protection of caregivers as well as the assessment of their emotional state and ability to function;
- IV.A.3.a).(9) recognition and assessment of elder abuse and appropriate intervention strategies;
- IV.A.3.a).(10) the appropriate use of community or home health services, respite care, and the need for institutional long-term care;
- IV.A.3.a).(11) the management of the care of elderly persons with emotional or behavioral disorders, including the awareness of appropriate modifications in techniques and goals in applying the various psychotherapies (with individual, group, and family focuses) and behavioral strategies;
- IV.A.3.a).(12) the indications, side effects, and therapeutic limitations of psychoactive drugs and the pharmacologic alterations associated with aging, including changes in pharmacokinetics, pharmacodynamics, drug interactions, appropriate medication management and strategies to recognize and correct medication noncompliance. Attention should be given to the psychiatric manifestations of iatrogenic influences such as the multiple medications frequently taken by the elderly;
- IV.A.3.a).(13) the use of nonpharmacologic approaches with particular reference to applications and limitations of behavioral

- therapeutic strategies, physical restraints, and the appropriate use and application of electroconvulsive therapy in the elderly;
- IV.A.3.a).(14) the appropriate use of psychodynamic understanding of developmental problems, conflict, and adjustment difficulties in the elderly which may complicate the clinical presentation and influence the doctor-patient relationship or treatment planning;
- IV.A.3.a).(15) the appropriate use of psychotherapies as applied to the elderly;
- IV.A.3.a).(16) the ethical and legal issues especially pertinent to geriatric psychiatry, including competence, guardianship, right to refuse treatment, wills, informed consent, elder abuse, the withholding of medical treatments, and federal legislative guidelines governing psychotropic drug prescription in nursing homes;
- IV.A.3.a).(17) the current economic aspects of supporting services, including but not limited to Title III of the Older Americans Act, Medicare, Medicaid, and cost containment; and,
- IV.A.3.a).(18) the research methodologies related to geriatric psychiatry, including biostatistics, clinical epidemiology, medical information sciences, decision analysis, critical literature review, and research design (including cross-sectional and longitudinal methods).
- IV.A.3.b) Conferences
- Conferences in geriatric psychiatry, such as grand rounds, case conferences, readings seminars, and journal club should be specifically designed to augment the clinical experiences. Regular attendance by the fellows and faculty members should be documented.
- IV.A.4. Clinical Components
- IV.A.4.a) Patient Population
- There must be sufficient number and variety of patients in all institutions where training takes place to accomplish the educational goals. This should include not only the spectrum of psychiatric diagnoses, but also experience with a diversity of patients by sex, socioeconomic, educational, and cultural backgrounds.
- IV.A.4.b) The training program must include the following clinical components:

IV.A.4.b).(1)

Longitudinal Care Experience

All geriatric psychiatry fellows should have the opportunity at a senior level of responsibility to follow and treat a sufficient number of patients requiring continuing care. This experience should be of sufficient duration for the fellow to understand the problems and learn the skills associated with longitudinal management and treatment. Emphasis during this experience should be placed on approaches to consultation, diagnosis, and treatment of the acutely- and chronically-ill elderly in a diversity of care settings, both medical and psychiatric, including those with less technologically sophisticated environments. Training should include clinical experience in geriatric psychopharmacology; electroconvulsive therapy (ECT); the use of relevant individual and group psychotherapies; the use of activity therapies; the psychosocial impact of institutionalization; family dynamics in the context of aging, including intergenerational issues; teaching non-mental health professionals about mental health in the aged; the bioethical dilemmas encountered when treating illness in the very old; and working within facilities that may have limitations, such as a decreased staff-patient ratio.

IV.A.4.b).(2)

Geriatric Psychiatry Consultation Experience

Attaining skills as a consultant is an essential part of training. Consultation experiences should be formally available on the nonpsychiatric services of an acute care hospital. They should include consultation to inpatient, outpatient, and emergency services. There should also be consultative experience in chronic care facilities. Familiarity with the organizational and administrative aspects of home health care services should be provided. Exposure to outreach services and crisis intervention services in both community and home settings should be provided.

IV.A.4.b).(3)

Other Medical Specialty Experience

There should be an identifiable, structured educational experience in neurology, physical medicine and rehabilitation, geriatric medicine or geriatric family medicine, and palliative care relative to the practice of psychiatry that includes both didactic and clinical training methods. The curriculum should address functional assessment, altered signs and symptoms of physical illness that occur in the elderly, and the identification of physical illnesses and iatrogenic factors that can alter mental status and behavior.

IV.A.4.b).(4) Each fellow shall have a minimum of two hours of individual supervision weekly, of which one hour may be group supervision.

IV.A.4.c) Additional Educational Environment

The program must provide opportunities for the geriatric psychiatry fellow to render continuing care and to exercise leadership responsibilities in organizing recommendations from the mental health team as well as in integrating recommendations and input from primary care physicians, consulting medical specialists, and representatives of other allied disciplines.

IV.A.4.d) Fellow Teaching Experiences:

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

IV.B. Fellows' Scholarly Activities

Each program must provide an opportunity for fellows to participate in research or other scholarly activities, and residents 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 assessment 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 will include written evaluations of the knowledge, skills and professional growth of the fellows using appropriate criteria and procedures.

V.A.1.e) More frequent evaluations should be scheduled and documented if necessary.

V.A.1.f) Fellows should be evaluated quarterly by all supervisors and the directors of clinical components of training should be completed.

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 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 and approved by the teaching faculty and documented in meeting minutes.

- V.C.3. The program should use fellow performance and outcome assessment in its evaluation of the educational effectiveness of the program. Performance of program graduates on the certification examination should be used as one measure of evaluating program effectiveness. The program should maintain a process for using assessment results together with other program evaluation results to improve the program.

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**

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.

Geriatric 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

