

ACGME Program Requirements for Graduate Medical Education in Geriatric Psychiatry

Common Program Requirements are in BOLD

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I. Introduction

I.A. Definition of the Subspecialty

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.

I.B. Duration and Scope of Education

I.B.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 resident education.

I.B.2. Training in geriatric psychiatry that occurred during general residency training will not be counted toward meeting the one-year requirement.

I.B.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.

I.B.4. Prior to entry in the program, each geriatric psychiatry resident 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.

I.C. Educational Goals and Objectives

I.C.1. The goal of residency 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 resident 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.

I.C.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 residents 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.

- I.C.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.
- I.C.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.

II. Institutions

II.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 institutions.

- II.A.1. The program must be administratively attached to and sponsored by a core residency program in psychiatry that holds full accreditation from the ACGME. The program must function in close relationship with the general psychiatry residency.
- II.A.2. The program must take place in facilities approved by the appropriate state licensing agencies and, where appropriate, by the Joint Commission on the Accreditation of Healthcare Organizations.

II.B. Participating Institutions

II.B.1. Assignment to an institution must be based on a clear educational rationale, integral to the program curriculum, with clearly-stated activities and objectives. When multiple participating institutions are used, there should be assurance of the continuity of the educational experience.

II.B.2. Assignment to a participating institution requires a letter of agreement with the sponsoring institution. Such a letter of agreement should:

- II.B.2.a) identify the faculty who will assume both educational and supervisory responsibilities for residents;**

- II.B.2.b) specify their responsibilities for teaching, supervision, and formal evaluation of residents, as specified later in this document;
- II.B.2.c) specify the duration and content of the educational experience; and
- II.B.2.d) state the policies and procedures that will govern resident education during the assignment.

III. Program Personnel and Resources

III.A. Program Director

- III.A.1. There must be a single program director responsible for the program. The person designated with this authority is accountable for the operation of the program. In the event of a change of either program director or department chair, the program director should promptly notify the executive director of the Residency Review Committee (RRC) through the Web Accreditation Data System of the Accreditation Council for Graduate Medical Education (ACGME).
- III.A.2. The program director, together with the faculty, is responsible for the general administration of the program, and for the establishment and maintenance of a stable educational environment. Adequate lengths of appointment for both the program director and faculty are essential to maintaining such an appropriate continuity of leadership.
- III.A.3. Qualifications of the program director are as follows:
 - III.A.3.a) The program director must possess the requisite specialty expertise, as well as documented educational and administrative abilities.
 - III.A.3.b) The program director must be certified in the specialty by the American Board of Psychiatry and Neurology (ABPN) in the subspecialty of geriatric psychiatry, or possess qualifications judged to be acceptable by the RRC.
 - III.A.3.c) The program director must be appointed in good standing and based at the primary teaching site.
- III.A.4. Responsibilities of the program director are as follows:
 - III.A.4.a) The program director must oversee and organize the activities of the educational program in all institutions that participate in the program. This includes selecting and supervising the faculty and other program personnel at each participating institution, appointing a local site director, and

monitoring appropriate resident supervision at all participating institutions.

III.A.4.b) The program director is responsible for preparing an accurate statistical and narrative description of the program as requested by the RRC, as well as updating annually both program and resident records through the ACGME's Accreditation Data System.

III.A.4.c) The program director must ensure the implementation of fair policies, grievance procedures, and due process, as established by the sponsoring institution and in compliance with the Institutional Requirements.

III.A.4.d) The program director must seek the prior approval of the RRC for any changes in the program that may significantly alter the educational experience of the residents. Such changes, for example, include:

III.A.4.d).(1) the addition or deletion of a participating institution;

III.A.4.d).(2) a change in the format of the educational program;

III.A.4.d).(3) a change in the approved resident complement for those specialties that approve resident complement.

On review of a proposal for any such major change in a program, the RRC may determine that a site visit is necessary.

III.A.4.e) Supervising 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.

III.A.4.f) Monitoring the progress of each geriatric psychiatry resident, 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 resident has completed all clinical experiences required by the Program Requirements and the educational objectives of the program.

III.A.4.g) Ensuring that residents 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 residents must be provided with written descriptions of the professional liability coverage provided for each clinical assignment.

III.B. Faculty

III.B.1. At each participating institution, there must be a sufficient number of faculty with documented qualifications to instruct and supervise adequately all residents in the program.

III.B.1.a) In addition to the program director, there must be at least one other faculty member who is certified by the American Board of Psychiatry and Neurology in the subspecialty of geriatric psychiatry or possess qualifications judged by the RRC to be acceptable.

III.B.2. The faculty, furthermore, must devote sufficient time to the educational program to fulfill their supervisory and teaching responsibilities. They must demonstrate a strong interest in the education of residents, and must support the goals and objectives of the educational program of which they are a member.

III.B.3. Qualifications of the physician faculty are as follows:

III.B.3.a) **The physician faculty must possess the requisite specialty expertise and competence in clinical care and teaching abilities, as well as documented educational and administrative abilities and experience in their field.**

III.B.3.b) **The physician faculty must be certified in the specialty by the American Board of Psychiatry and Neurology in the subspecialty of geriatric psychiatry, or possess qualifications judged to be acceptable by the RRC.**

III.B.3.c) **The physician faculty must be appointed in good standing to the staff of an institution participating in the program.**

III.B.4. 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:

III.B.4.a) **the scholarship of *discovery*, as evidenced by peer-reviewed funding or by publication of original research in a peer-reviewed journal;**

III.B.4.b) **the scholarship of *dissemination*, as evidenced by review articles or chapters in textbooks;**

III.B.4.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.

III.B.4.d) 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 residents involved in research such as research design and statistical analysis); and the provision of support for residents' participation, as appropriate, in scholarly activities.

III.B.5. Qualifications of the nonphysician faculty are as follows:

III.B.5.a) Nonphysician faculty must be appropriately qualified in their field.

III.B.5.b) Nonphysician faculty must possess appropriate institutional appointments.

III.C. Other Program Personnel

Additional necessary professional, technical, and clerical personnel must be provided to support the program.

III.C.1. Geriatric Care Team

Geriatric psychiatry residents must be provided with meaningful patient care experiences as part of an interdisciplinary care team.

III.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.

III.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.

III.C.1.c) It is highly desirable that geriatric psychiatry residents have access to professionals representing allied disciplines (such as ethics, law, and pastoral care) as needed for patient care and teaching purposes.

III.C.1.d) Geriatric psychiatry residents should be provided with opportunities to participate as members of medical geriatric teams in institutions where such teams are present.

III.D. Resources

The program must ensure that adequate resources (e.g., sufficient laboratory space and equipment, computer and statistical consultation services) are available.

- III.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.
- III.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.
- III.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.
- III.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.
- III.D.5. Library: Residents must have ready access to a major medical library either at the institution where the residents are located or through arrangement with convenient nearby institutions.
- III.D.5.a) Library services should include the electronic retrieval of information from medical databases.
- III.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.

IV. Resident Appointments

IV.A. Eligibility Criteria

The program director must comply with the criteria for resident eligibility as specified in the Institutional Requirements.

- IV.A.1. The geriatric psychiatry resident must have satisfactorily completed an ACGME accredited general psychiatry residency prior to entering the program.

IV.B. Number of Residents

The RRC will approve the number of residents based upon established written criteria that include the adequacy of resources for resident education (e.g., the quality and volume of patients and related clinical material available for education), faculty-resident ratio, institutional funding, and the quality of faculty teaching.

- IV.B.1. Any permanent changes in the resident complement will require prior approval by the Residency Review Committee.

IV.C. Resident Transfers

To determine the appropriate level of education for residents who are transferring from another residency program, the program director must receive written verification of previous educational experiences and a statement regarding the performance evaluation of the transferring resident prior to their acceptance into the program. A program director is required to provide verification of residency education for residents who may leave the program prior to completion of their education.

IV.D. Appointment of Fellows and Other Students

The appointment of fellows and other specialty residents or students must not dilute or detract from the educational opportunities available to regularly appointed residents.

- IV.D.1. At the same time, the presence of residents in geriatric psychiatry must not substantially dilute or otherwise detract from the didactic or clinical experience available to general psychiatry residents.

V. Program Curriculum

V.A. Program Design

V.A.1. Format

The program design and sequencing of educational experiences will be approved by the RRC as part of the review process.

V.A.2. Goals and Objectives

The program must possess a written statement that outlines its educational goals with respect to the knowledge, skills, and other attributes of residents for each major assignment and for each level of the program. This statement must be distributed to residents and faculty, and must be reviewed with residents prior to their assignments.

V.B. Specialty Curriculum

The program must possess a well-organized and effective curriculum, both didactic and clinical. The curriculum must also provide residents with direct experience in progressive responsibility for patient management.

V.B.1. Didactic Components

V.B.1.a) The program curriculum must address, as a minimum, the following content and skill areas:

V.B.1.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.

V.B.1.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.

V.B.1.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.

- V.B.1.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.
- V.B.1.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.
- V.B.1.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.
- V.B.1.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. Residents 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.
- V.B.1.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.
- V.B.1.a).(9) Recognition and assessment of elder abuse and appropriate intervention strategies.
- V.B.1.a).(10) The appropriate use of community or home health services, respite care, and the need for institutional long-term care.

- V.B.1.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.
- V.B.1.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.
- V.B.1.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.
- V.B.1.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.
- V.B.1.a).(15) The appropriate use of psychotherapies as applied to the elderly.
- V.B.1.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.
- V.B.1.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.
- V.B.1.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).

V.B.1.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 residents and the faculty should be documented.

V.B.2. Clinical Components

V.B.2.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.

V.B.2.b) The training program must include the following clinical components:

V.B.2.b).(1) Longitudinal Care Experience

All geriatric psychiatry residents 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 resident 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 nonmental 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.

V.B.2.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.

V.B.2.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.

V.B.2.c)

Additional Educational Environment

The program must provide opportunities for the geriatric psychiatry resident 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.

V.C. Residents Scholarly Activities

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

V.D. ACGME Competencies

The residency program must require its residents to obtain competence in the six areas listed below to the level expected of a new practitioner. Programs must define the specific knowledge, skills, behaviors, and attitudes required, and provide educational experiences as needed in order for their residents to demonstrate the following:

V.D.1.

Patient care that is compassionate, appropriate, and effective for the treatment of health problems and the promotion of health;

- V.D.2. ***Medical Knowledge*** about established and evolving biomedical, clinical, and cognate sciences, as well as the application of this knowledge to patient care;
- V.D.3. ***Practice-based learning and improvement*** that involves the investigation and evaluation of care for their patients, the appraisal and assimilation of scientific evidence, and improvements in patient care;
- V.D.4. ***Interpersonal and communication skills*** that result in the effective exchange of information and collaboration with patients, their families, and other health professionals;
- V.D.5. ***Professionalism***, as manifested through a commitment to carrying out professional responsibilities, adherence to ethical principles, and sensitivity to patients of diverse backgrounds;
- V.D.6. ***Systems-based practice***, as manifested by actions that 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.

VI. Resident Duty Hours and the Working Environment

Providing residents with a sound didactic and clinical education must be carefully planned and balanced with concerns for patient safety and resident well-being. Each program must ensure that the learning objectives of the program are not compromised by excessive reliance on residents to fulfill service obligations. Didactic and clinical education must have priority in the allotment of residents' time and energy. Duty hour assignments must recognize that faculty and residents collectively have responsibility for the safety and welfare of patients.

VI.A. Supervision of Residents

- VI.A.1. **All patient care must be supervised by qualified faculty.** The program director must ensure, direct, and document adequate supervision of residents at all times. Residents must be provided with rapid, reliable systems for communicating with supervising faculty.
- VI.A.2. **Faculty schedules must be structured to provide residents with continuous supervision and consultation.**
- VI.A.3. **Faculty and residents must be educated to recognize the signs of fatigue, and adopt and apply policies to prevent and counteract its potential negative effects.**
- VI.A.4. **Each resident shall have a minimum of two hours of individual supervision weekly, of which one hour may be group supervision.**

VI.B. Duty Hours

VI.B.1. Duty hours are defined as all clinical and academic activities related to the residency 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.B.2. Duty hours must be limited to 80 hours per week, averaged over a four-week period, inclusive of all in-house call activities.

VI.B.3. Residents must be provided with 1 day in 7 free from all educational and clinical responsibilities, averaged over a 4-week period, inclusive of call. *One day* is defined as 1 continuous 24-hour period free from all clinical, educational, and administrative duties.

VI.B.4. 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.C. On-call Activities

The objective of on-call activities is to provide residents with continuity of patient care experiences throughout a 24-hour period. *In-house call* is defined as those duty hours beyond the normal work day, when residents are required to be immediately available in the assigned institution.

VI.C.1. In-house call must occur no more frequently than every third night, averaged over a 4-week period.

VI.C.2. Continuous on-site duty, including in-house call, must not exceed 24 consecutive hours. Residents may remain on duty for up to 6 additional hours to participate in didactic activities, transfer care of patients, conduct outpatient clinics, and maintain continuity of medical and surgical care.

VI.C.3. No new patients may be accepted after 24 hours of continuous duty.

VI.C.4. *At-home call (or pager call)* is defined as a call taken from outside the assigned institution.

VI.C.4.a) The frequency of at-home call is not subject to the every-third-night limitation. At-home call, however, must not be so frequent as to preclude rest and reasonable personal time for each resident. Residents taking at-home call must be provided with 1 day in 7 completely free from all educational and clinical responsibilities, averaged over a 4-week period.

VI.C.4.b) When residents are called into the hospital from home, the hours residents spend in-house are counted toward the 80-hour limit.

VI.C.4.c) The program director and the faculty must monitor the demands of at-home call in their programs, and make scheduling adjustments as necessary to mitigate excessive service demands and/or fatigue.

VI.D. Moonlighting

VI.D.1. Because residency education is a full-time endeavor, the program director must ensure that moonlighting does not interfere with the ability of the resident to achieve the goals and objectives of the educational program.

VI.D.2. The program director must comply with the sponsoring institution's written policies and procedures regarding moonlighting, in compliance with the ACGME Institutional Requirements.

VI.D.3. Any hours a resident works for compensation at the sponsoring institution or any of the sponsor's primary clinical sites must be considered part of the 80-hour weekly limit on duty hours. This refers to the practice of *internal moonlighting*.

VI.E. Oversight

VI.E.1. Each program must have written policies and procedures consistent with the Institutional and Program Requirements for resident duty hours and the working environment. These policies must be distributed to the residents and the faculty. Duty hours must be monitored with a frequency sufficient to ensure an appropriate balance between education and service.

VI.E.2. Back-up support systems must be provided when patient care responsibilities are unusually difficult or prolonged, or if unexpected circumstances create resident fatigue sufficient to jeopardize patient care.

VI.F. Duty Hours Exceptions

An RRC may grant exceptions for up to 10% of the 80-hour limit to individual programs based on a sound educational rationale. Prior permission of the institution's GMEC, however, is required.

VI.G. Presence of Other Training Programs:

The program should provide peer interaction between its geriatric psychiatry residents and those of other medical specialties. To achieve this goal, there should be an ACGME-accredited training program in at least one relevant nonpsychiatric 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 residents should occur in the course of clinical and/or didactic work but is most satisfactory when organized around joint patient evaluation and/or care.

VI.H. Resident Teaching Experiences:

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

VII. Evaluation

VII.A. Resident

VII.A.1. Formative Evaluation

The faculty must evaluate in a timely manner the residents whom they supervise. In addition, the residency program must demonstrate that it has an effective mechanism for assessing resident performance throughout the program, and for utilizing the results to improve resident performance.

VII.A.1.a) Assessment should include the use of methods that produce an accurate assessment of residents' competence in patient care, medical knowledge, practice-based learning and improvement, interpersonal and communication skills, professionalism, and systems-based practice.

VII.A.1.b) Assessment should include the regular and timely performance feedback to residents that includes at least semiannual written evaluations. Such evaluations are to be communicated to each resident in a timely manner, and maintained in a record that is accessible to each resident.

VII.A.1.b).(1) Assessment will include written evaluations of the knowledge, skills and professional growth of the residents using appropriate criteria and procedures.

VII.A.1.b).(2) More frequent evaluations should be scheduled and documented if necessary.

VII.A.1.b).(3) Residents should be evaluated quarterly by all supervisors and the directors of clinical components of training should be completed.

VII.A.2. Final Evaluation

The program director must provide a final evaluation for each resident who completes the program. This evaluation must include a review of the resident's performance during the final period of education, and should verify that the resident has demonstrated sufficient professional ability to practice competently and independently. The final evaluation must be part of the resident's permanent record maintained by the institution.

VII.B. Faculty

The performance of the faculty must be evaluated by the program no less frequently than at the midpoint of the accreditation cycle, and again prior to the next site visit. The evaluations should include a review of their teaching abilities, commitment to the educational program, clinical knowledge, and scholarly activities. This evaluation must include annual written confidential evaluations by residents.

VII.C. Program

The educational effectiveness of a program must be evaluated at least annually in a systematic manner.

VII.C.1. Representative program personnel (i.e., at least the program director, representative faculty, and one resident) must be organized to review program goals and objectives, and the effectiveness with which they are achieved. This group must conduct a formal documented meeting at least annually for this purpose. In the evaluation process, the group must take into consideration written comments from the faculty, the most recent report of the GMEC of the sponsoring institution, and the residents' confidential written evaluations. If deficiencies are found, the group should prepare an explicit plan of action, which should be approved by the faculty and documented in the minutes of the meeting.

VII.C.2. The program should use resident performance and outcome assessment in its evaluation of the educational effectiveness of the residency 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 residency program.

VIII. Experimentation and Innovation

Since responsible innovation and experimentation are essential to improving professional education, experimental projects along sound educational principles are encouraged. Requests for experimentation or innovative projects that may deviate from the program requirements must be approved in advance by the RRC, and must include the educational rationale and method of evaluation. The

sponsoring institution and program are jointly responsible for the quality of education offered to residents for the duration of such a project.

IX. Certification

Residents who plan to seek certification by the American Board of Psychiatry and Neurology in the subspecialty of geriatric psychiatry should communicate with the office of the Executive Vice President/Secretary of the Board regarding the full requirements for certification to ascertain the current requirements for acceptance as a candidate for certification.

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