

1 **ACGME Program Requirements for Graduate Medical Education**
2 **in Geriatric Psychiatry**

3
4 **One-year Common Program Requirements are in BOLD**

5
6 Effective: July, 2003
7

8 **Introduction**

9
10 **Int.A. Residency and fellowship programs are essential dimensions of the**
11 **transformation of the medical student to the independent practitioner along**
12 **the continuum of medical education. They are physically, emotionally, and**
13 **intellectually demanding, and require longitudinally-concentrated effort on**
14 **the part of the resident or fellow.**

15
16 **The specialty education of physicians to practice independently is**
17 **experiential, and necessarily occurs within the context of the health care**
18 **delivery system. Developing the skills, knowledge, and attitudes leading to**
19 **proficiency in all the domains of clinical competency requires the resident**
20 **and fellow physician to assume personal responsibility for the care of**
21 **individual patients. For the resident and fellow, the essential learning**
22 **activity is interaction with patients under the guidance and supervision of**
23 **faculty members who give value, context, and meaning to those**
24 **interactions. As residents and fellows gain experience and demonstrate**
25 **growth in their ability to care for patients, they assume roles that permit**
26 **them to exercise those skills with greater independence. This concept—**
27 **graded and progressive responsibility—is one of the core tenets of**
28 **American graduate medical education. Supervision in the setting of**
29 **graduate medical education has the goals of assuring the provision of safe**
30 **and effective care to the individual patient; assuring each resident's and**
31 **fellow's development of the skills, knowledge, and attitudes required to**
32 **enter the unsupervised practice of medicine; and establishing a foundation**
33 **for continued professional growth.**

34
35 **Int.B. Geriatric psychiatry focuses on prevention, diagnosis, evaluation, and treatment**
36 **of mental disorders, and signs/ and symptoms seen in older adult patients. An**
37 **educational program in geriatric psychiatry must be organized to provide**
38 **professional knowledge, skills, and opportunities to develop competencyies**
39 **through a well-supervised clinical experience.**

40
41 **Int.C. ~~Duration and Scope of Education-The training period-educational program in~~**
42 **geriatric fellowships-psychiatry must be 12 months in length duration. Any**
43 **program that extends the length of the program beyond 12 months must present**
44 **an educational rationale consistent with the Program Requirements and the**
45 **objectives for fellow education.**

46
47 **Int.C.2. ~~Training in geriatric psychiatry education that occurred during the general~~**
48 **residency will not be counted toward meeting the one-year requirement.**

49
50 **Int.C.3. ~~Training is best accomplished on a full-time basis. If it is undertaken on a~~**
51 **part-time basis, the 12-month program must be completed within a two-**

year period.

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 sponsoring institution must also sponsor ~~program must be administratively attached to and sponsored by an Accreditation Council for Graduate Medical Education (ACGME)-accredited core residency program in psychiatry.~~

I.A.2. ~~The program must function in close relationship with the general psychiatry residency.~~

I.A.3. ~~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.~~

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

- 103 **Education (ACGME) Accreditation Data System (ADS).**
 104
- 105 I.B.3. The number of and distance between participating sites must allow for
 106 fellows' full participation in all organized educational aspects of the
 107 program.
 108
- 109 I.B.4. ~~Presence of Other Training Programs~~ ~~The program should provide peer~~
 110 ~~interaction between its geriatric psychiatry fellows and those of other~~
 111 ~~medical specialties. To achieve this goal, Within the participating sites~~
 112 ~~there should be an ACGME-accredited program in at least one of the~~
 113 ~~following relevant non-psychiatric specialty such as specialties: family~~
 114 ~~medicine, geriatric medicine, internal medicine, neurology, or physical~~
 115 ~~medicine and rehabilitation within the participating institutions of the~~
 116 ~~geriatric psychiatry program.~~
 117
- 118 **II. Program Personnel and Resources**
 119
- 120 **II.A. Program Director**
 121
- 122 **II.A.1. There must be a single program director with authority and**
 123 **accountability for the operation of the program. The sponsoring**
 124 **institution's GMEC must approve a change in program director.**
 125 **After approval, the program director must submit this change to the**
 126 **ACGME via the ADS.**
 127
- 128 II.A.1.a) The program director must devote at least 15 hours per week to
 129 the program, to include activities related to administration, didactic
 130 teaching, and individual supervision outside of clinical activities.
 131
- 132 **II.A.2. Qualifications of the program director must include:**
 133
- 134 **II.A.2.a) requisite subspecialty expertise and documented educational**
 135 **and administrative experience acceptable to the Review**
 136 **Committee;**
 137
- 138 **II.A.2.b) current certification in the subspecialty by the American**
 139 **Board of Psychiatry and Neurology (ABPN) in the subspecialty of**
 140 **geriatric psychiatry, or subspecialty qualifications that are**
 141 **acceptable to the Review Committee; and,**
 142
- 143 II.A.2.b).(1) The Review Committee accepts only ABPN certification in
 144 the subspecialty.
 145
- 146 **II.A.2.c) current medical licensure and appropriate medical staff**
 147 **appointment.**
 148
- 149 **II.A.3. The program director must administer and maintain an educational**
 150 **environment conducive to educating the fellows in each of the**
 151 **ACGME competency areas. The program director must:**
 152
- 153 **II.A.3.a) prepare and submit all information required and requested by**

154 the ACGME;

155

156 **II.A.3.b) be familiar with and oversee compliance with ACGME and**

157 **Review Committee policies and procedures as outlined in the**

158 **ACGME Manual of Policies and Procedures;**

159

160 **II.A.3.c) obtain review and approval of the sponsoring institution's**

161 **GMEC/DIO before submitting to the ACGME information or**

162 **requests for the following:**

163

164 **II.A.3.c).(1) all applications for ACGME accreditation of new**

165 **programs;**

166

167 **II.A.3.c).(2) changes in fellow complement;**

168

169 **II.A.3.c).(3) major changes in program structure or length of**

170 **training;**

171

172 **II.A.3.c).(4) progress reports requested by the Review Committee;**

173

174 **II.A.3.c).(5) responses to all proposed adverse actions;**

175

176 **II.A.3.c).(6) requests for increases or any change to fellow duty**

177 **hours;**

178

179 **II.A.3.c).(7) voluntary withdrawals of ACGME-accredited**

180 **programs;**

181

182 **II.A.3.c).(8) requests for appeal of an adverse action; and,**

183

184 **II.A.3.c).(9) appeal presentations to a Board of Appeal or the**

185 **ACGME.**

186

187 **II.A.3.d) obtain DIO review and co-signature on all program**

188 **information forms, as well as any correspondence or**

189 **document submitted to the ACGME that addresses:**

190

191 **II.A.3.d).(1) program citations, and/or**

192

193 **II.A.3.d).(2) request for changes in the program that would have**

194 **significant impact, including financial, on the program**

195 **or institution.**

196

197 **II.A.3.e) ensure that fellows are provided written descriptions of the**

198 **departmental policies regarding due process, sickness and other**

199 **leaves, on-call responsibilities, and vacation time upon**

200 **appointment to the program.**

201

202 **II.A.3.e).(1) All fellows must be provided with written descriptions of the**

203 **professional liability coverage provided for each clinical**

204 **assignment.**

- 205
206 II.A.3.f) develop and implement a supervision policy that specifies lines of
207 responsibility for program faculty members and fellows that is
208 consistent with the supervision policy in the general psychiatry
209 program; and,
210
211 II.A.3.g) participate in scholarly activities appropriate to the subspecialty,
212 including local, regional, and national specialty societies,
213 research, presentations, or publication.
214
215 **II.B. Faculty**
216
217 **II.B.1. There must be a sufficient number of faculty with documented**
218 **qualifications to instruct and supervise all fellows.**
219
220 II.B.1.a) In addition to the program director, there must be at least one
221 ~~other FTE~~ faculty member ~~who is certified by the American Board~~
222 ~~of Psychiatry and Neurology ABPN~~ in the subspecialty of geriatric
223 ~~psychiatry or possess qualifications acceptable to the Review~~
224 ~~Committee.~~
225
226 II.B.1.b) Each participating site must have a designated site director who is
227 a member of the faculty and who is responsible for the day-to-day
228 activities of the program at that site with overall coordination by
229 the program director.
230
231 **II.B.2. The faculty must devote sufficient time to the educational program**
232 **to fulfill their supervisory and teaching responsibilities and**
233 **demonstrate a strong interest in the education of fellows.**
234
235 **II.B.3. The physician faculty must have current certification in the**
236 **subspecialty by the American Board of Psychiatry and Neurology**
237 **(ABPN) in the subspecialty of geriatric psychiatry, or possess**
238 **qualifications acceptable to the Review Committee.**
239
240 **II.B.4. The physician faculty must possess current medical licensure and**
241 **appropriate medical staff appointment.**
242
243 II.B.5. All faculty members must participate in scholarly activities appropriate to
244 the subspecialty, including local, regional, and national specialty
245 societies, research, presentations, or publications. The responsibility for
246 establishing and maintaining an environment of inquiry and scholarship
247 rests with the faculty, and an active research component must be
248 included in each program. *Scholarship* is defined as the following:
249
250 II.B.5.a) ~~the scholarship of discovery, as evidenced by peer-reviewed~~
251 ~~funding or by publication of original research in a peer-reviewed~~
252 ~~journal;~~
253
254 II.B.5.b) ~~the scholarship of dissemination, as evidenced by review articles~~
255 ~~or chapters in textbooks; and,~~

- 256
257 II.B.5.c) the scholarship of *application*, as evidenced by the publication or
258 presentation of, for example, case reports or clinical series at
259 local, regional, or national professional and scientific society
260 meetings.
261
- 262 II.B.6. Complementary to the above scholarship is the Faculty members must
263 regularly participation of the teaching staff participate in organized clinical
264 discussions, rounds, journal clubs, and research conferences in a manner
265 that promotes a spirit of inquiry and scholarship (e.g., the offering of
266 guidance and technical support for fellows involved in research such as
267 research design and statistical analysis); and the provision of support for
268 fellows' participation, as appropriate, in scholarly activities.
269
- 270 **II.C. Other Program Personnel**
271
- 272 **The institution and the program must jointly ensure the availability of all**
273 **necessary professional, technical, and clerical personnel for the effective**
274 **administration of the program.**
275
- 276 II.C.1. Geriatric Care Team
277
- 278 II.C.1.a) In addition to geriatric psychiatry, the The Geriatric Care Team
279 should include representatives from related clinical disciplines,
280 such as including psychology, neuropsychology, social work,
281 psychiatric nursing, activity or occupational therapy, physical
282 therapy, pharmacy, and nutrition.
283
- 284 II.C.1.b) A variety of individuals representing Qualified clinicians from
285 disciplines within medicine, such as including one or more of the
286 following: family medicine, internal medicine (including ~~their~~
287 geriatric medicine subspecialties), hospice and palliative care
288 medicine, neurology, and physical medicine and rehabilitation,
289 should be available for participation on the Geriatric Care Team
290 as needed for patient care and teaching purposes consultation.
291
- 292 II.C.2. It is highly desirable that geriatric psychiatry Fellows should have access
293 to professionals representing allied disciplines, (such as including ethics,
294 law, and pastoral care) as needed for patient care and teaching purposes.
295
- 296 II.C.3. There must be a designated program coordinator.
297
- 298 **II.D. Resources**
299
- 300 **The institution and the program must jointly ensure the availability of**
301 **adequate resources for fellow education, as defined in the specialty**
302 **program requirements.**
303
- 304 II.D.1. An Acute Care Hospital: The sponsoring psychiatry department of the
305 sponsoring institution must be a part of or affiliated with at least one acute
306 care general hospital.

- 307
308 II.D.1.a) ~~that has the~~ The acute care hospital must have a full range of
309 ~~services usually ascribed to such a facility,~~ including both medical
310 and surgical services, intensive care units, an emergency
311 department, a diagnostic laboratory and imaging services, and a
312 pathology department. ~~If the acute care hospital is specialized~~
313 ~~(such as in geriatric or psychiatric care) and does not itself have~~
314 ~~the full spectrum of services described above, the program must~~
315 ~~document that it has access for educational purposes to other~~
316 ~~affiliated acute care facilities that have the remaining general~~
317 ~~services not present at the specialized facility.~~
- 318
319 II.D.2. ~~A Long-Term Care Facility: Inclusion of~~ There must be at least one long-
320 term care facility ~~is an essential component of the geriatric psychiatry~~
321 ~~program.~~
- 322
323 II.D.2.a) Such facilities ~~may~~ should be either discrete institutions separate
324 from an acute care hospital or formally designated units or
325 services within an acute care hospital. ~~Suitable sites include both~~
326 ~~nonpsychiatric facilities (such as a nursing facility or chronic care~~
327 ~~hospital) and psychiatric facilities.~~
- 328
329 II.D.3. ~~An Ambulatory Care Service: The~~ There must be an ambulatory care
330 service ~~must be designed to render~~ that provides care in a
331 multidisciplinary environment, ~~such as a geriatric clinic, psychiatric~~
332 ~~outpatient department, or community mental health center where~~
333 ~~nonpsychiatric medical specialists are also available.~~
- 334
335 II.D.4. ~~Ancillary Support Services: At all~~ Each participating site facilities, there
336 ~~must be sufficient administrative support to ensure adequate~~ provide
337 ~~teaching facilities, appropriate~~ and office space, ~~support personnel, and~~
338 ~~teaching resources.~~
- 339
340 II.D.5. ~~Patient Population: At each participating site there~~ There must be
341 ~~sufficient number and variety of patients of each gender and spanning in~~
342 ~~all educational sites to accomplish the educational goals. This should~~
343 ~~include not only the spectrum of psychiatric diagnoses~~ in late life, but also
344 ~~experience with a diversity of patients by sex, from diverse~~
345 ~~socioeconomic, educational, and cultural backgrounds.~~
- 346
347 II.D.6. ~~Library: Fellows must have ready access to a major medical library either~~
348 ~~at the institution where the fellows are located or through arrangement~~
349 ~~with convenient nearby institutions.~~
- 350
351 II.D.6.a) ~~Library services should include the electronic retrieval of~~
352 ~~information from medical databases.~~
- 353
354 II.D.6.b) ~~There must be access to an on-site library or to a collection of~~
355 ~~appropriate texts and journals in each institution participating in a~~
356 ~~residency program. On-site libraries and/or collections of texts and~~
357 ~~journals must be readily available during nights and weekends.~~

358
359 **II.E. Medical Information Access**
360
361 **Fellows must have ready access to specialty-specific and other appropriate**
362 **reference material in print or electronic format. Electronic medical literature**
363 **databases with search capabilities should be available.**
364
365 **III. Fellow Appointments**
366
367 **III.A. Eligibility Criteria**
368
369 **Each fellow must successfully complete an ACGME-accredited specialty**
370 **program and/or meet other eligibility criteria as specified by the Review**
371 **Committee. The program must document that each fellow has met the**
372 **eligibility criteria.**
373
374 III.A.1. Prior to appointment in the program, fellows ~~The geriatric psychiatry~~
375 ~~fellow must have satisfactorily completed either an ACGME-accredited~~
376 ~~general psychiatry residency program or a general psychiatry program in~~
377 ~~Canada accredited by the Royal College of Physicians and Surgeons of~~
378 ~~Canada an ACGME-accredited general psychiatry residency prior to~~
379 ~~entering the program.~~
380
381 III.A.2. ~~Prior to entry appointment in the program, each geriatric psychiatry fellow~~
382 ~~must be notified in writing of the required length of education for which the~~
383 ~~program is accredited. The required length of education for a particular~~
384 ~~individual may not be changed without mutual agreement during his/her~~
385 ~~program unless there is a break in his/her education or the individual~~
386 ~~requires remedial education.~~
387
388 III.A.3. ~~supervise the recruitment and appointment process for applicants,~~
389 ~~including compliance with appropriate credentialing policies and~~
390 ~~procedures in accordance with institutional and departmental policies and~~
391 ~~procedures. No applicants should be appointed to the program without~~
392 ~~written documentation of completion of a general psychiatry residency~~
393 ~~from the prior program director that verifies satisfactory completion of all~~
394 ~~educational and ethical requirements for graduation; Prior to appointment~~
395 ~~in the program, the program director must receive documentation from~~
396 ~~each fellow's prior general psychiatry program verifying satisfactory~~
397 ~~completion of all educational and ethical requirements for graduation.~~
398
399 III.A.3.a) Agreements with applicants made prior to the completion of the
400 general residency must be contingent on this requirement.
401
402 **III.B. Number of Fellows**
403
404 **The program director may not appoint more fellows than approved by the**
405 **Review Committee, unless otherwise stated in the specialty-specific**
406 **requirements. The program's educational resources must be adequate to**
407 **support the number of fellows appointed to the program.**
408

- 409 III.B.1. The presence of other learners must not interfere with the appointed
410 fellows' education.
411
- 412 **IV. Educational Program**
413
- 414 **IV.A. The curriculum must contain the following educational components:**
415
- 416 **IV.A.1. Skills and competencies the fellow will be able to demonstrate at the**
417 **conclusion of the program. The program must distribute these skills**
418 **and competencies to fellows and faculty annually, in either written**
419 **or electronic form. These skills and competencies should be**
420 **reviewed by the fellow at the start of each rotation;**
421
- 422 **IV.A.2. ACGME Competencies**
423
- 424 **The program must integrate the following ACGME competencies**
425 **into the curriculum:**
426
- 427 **IV.A.2.a) Patient Care**
428
- 429 **Fellows must be able to provide patient care that is**
430 **compassionate, appropriate, and effective for the treatment of**
431 **health problems and the promotion of health. Fellows:**
432
- 433 **IV.A.2.a).(1)** must demonstrate proficiency in ~~The epidemiology,~~
434 diagnosis, and treatment of all major psychiatric disorders
435 seen in the elderly, including ~~Such disorders, seen alone~~
436 ~~and in combination, typically include but are not limited to:~~
437 adjustment disorders, affective disorders, anxiety
438 disorders, delirium, dementias, iatrogenesis, late-onset
439 psychoses, medical presentations of psychiatric disorders,
440 personality disorders, sexual disorders, sleep disorders,
441 substance-related disorders, and continuation of
442 psychiatric illnesses that began earlier in life;
443
- 444 **IV.A.2.a).(2)** ~~The performance of~~ must demonstrate proficiency in
445 performing the mental status examination that takes into
446 account the special needs of the elderly, including
447 structured cognitive assessment, community and
448 environmental assessment, family and caregiver
449 assessment, medical assessment, and functional
450 assessment;
451
- 452 **IV.A.2.a).(3)** must demonstrate proficiency in short-term and long-term
453 diagnostic and treatment planning by ~~Such skills form the~~
454 ~~basis for formal multidimensional geriatric assessment~~
455 using the appropriate synthesis of clinical findings and
456 historical as well as current information acquired from the
457 patient and/or relevant others, (such as including family
458 members, caregivers, and other health care professionals).
459 ~~The multidimensional assessment is essential to short term~~

460 and long-term diagnostic and treatment planning;
461 education must be provided in formulating these various
462 assessments into an appropriate and coherent treatment
463 plan;
464
465 IV.A.2.a).(4) must demonstrate proficiency in the ~~The selection and use~~
466 ~~of clinical laboratory tests, radiologic and other imaging~~
467 ~~procedures, and polysomnographic, electrophysiologic,~~
468 ~~and neuropsychologic tests as well as making appropriate~~
469 ~~referrals to and consultations with other health care~~
470 ~~specialists~~
471
472 IV.A.2.a).(5) must demonstrate proficiency in recognizing and managing
473 ~~The initiation and flexible guidance of treatment with the~~
474 ~~need for ongoing monitoring of changes in mental and~~
475 ~~physical health status and medical regimens. Fellows~~
476 ~~should be taught to recognize and manage psychiatric~~
477 ~~comorbid disorders, (for example, including dementia and~~
478 ~~depression), as well as the management of other~~
479 ~~disturbances often seen in the elderly such as agitation,~~
480 ~~wandering, changes in sleep patterns, and~~
481 ~~aggressiveness;~~
482
483 IV.A.2.a).(5).(a) This must include competence in the ongoing
484 monitoring of changes in mental and physical
485 health status and medical regimens.
486
487 IV.A.2.a).(6) must demonstrate proficiency in recognizing ~~The~~
488 ~~recognition of the stressful impact of psychiatric illness on~~
489 ~~caregivers, - Attention should be placed on the appropriate~~
490 ~~guidance of and protection of caregivers as well as the~~
491 ~~assessment of assessing their emotional state and ability~~
492 ~~to function, and providing guidance and protection to~~
493 ~~caregivers;~~
494
495 IV.A.2.a).(7) must demonstrate competence in recognizing and
496 assessing ~~Recognition and assessment of elder abuse,~~
497 ~~and providing appropriate interventions strategies; and,~~
498
499 IV.A.2.a).(8) must demonstrate proficiency in managing ~~The~~
500 ~~management of the care of the elderly persons with~~
501 ~~emotional or behavioral disorders, including the awareness~~
502 ~~of using age-appropriate modifications in techniques and~~
503 ~~goals in applying the various psychotherapies (with~~
504 ~~individual, group, and family focuses) and behavioral~~
505 ~~strategies.~~
506
507 **IV.A.2.b) Medical Knowledge**
508
509 **Fellows must demonstrate knowledge of established and**
510 **evolving biomedical, clinical, epidemiological and social-**

511		behavioral sciences, as well as the application of this
512		knowledge to patient care. Fellows:
513		
514	IV.A.2.b).(1)	<u>must demonstrate proficiency in their knowledge of the</u>
515		<u>following content and skills areas:</u>
516		
517	IV.A.2.b).(1).(a)	The program must include education in the
518		biological and psychosocial aspects of normal
519		aging, the psychiatric impact of acute and chronic
520		physical illnesses, and the biological and
521		psychosocial aspects of the pathology of primary
522		psychiatric disturbances beginning in or continuing
523		into older age;
524		
525	IV.A.2.b).(1).(b)	The current scientific understanding of aging and
526		longevity, including theories of aging, epidemiology
527		and natural history of aging, and diseases of the
528		<u>elderly, aged. This includes to include:</u>
529		
530	IV.A.2.b).(1).(b).(i)	specific knowledge of: the effects of biologic
531		aging on human physiology with emphasis
532		on altered pharmacokinetics,
533		pharmacodynamics, and sensory acuity in
534		the elderly;
535		
536	IV.A.2.b).(1).(b).(ii)	the differences and gradations between
537		normal and abnormal age- <u>related</u> changes
538		with particular reference to such areas as
539		memory and cognition, affective stability,
540		personality and behavioral patterns, <u>sleep,</u>
541		and sexuality; <u>and,</u>
542		
543	IV.A.2.b).(1).(b).(iii)	There must be an understanding of
544		successful and maladaptive responses to
545		stressors frequently encountered in the
546		elderly, <u>including such as retirement, death</u>
547		<u>of a spouse, widowhood,</u> role changes,
548		interpersonal and health status losses,
549		financial <u>difficulties reverses,</u> environmental
550		relocations, and increased dependency;:
551		
552	IV.A.2.b).(1).(c)	The relevance of cultural and ethnic differences,
553		and the special problems of disadvantaged minority
554		groups, as these <u>relate to mental illness in</u>
555		the elderly bear upon distinguishing and treating
556		abnormal and maladaptive clinical changes as well
557		as the use of psychosocial support services;
558		
559	IV.A.2.b).(1).(d)	The epidemiology, diagnosis, and treatment of all
560		major psychiatric disorders seen in the elderly;
561		

562	IV.A.2.b).(1).(e)	The indications, side effects, and therapeutic limitations of psychoactive drugs and the pharmacologic alterations associated with aging, including:
563		
564		
565		
566		
567	IV.A.2.b).(1).(e).(i)	changes in pharmacokinetics, pharmacodynamics, <u>and</u> drug interactions;
568		
569		
570	IV.A.2.b).(1).(e).(ii)	appropriate medication management and strategies to recognize and correct medication noncompliance; <u>and</u> ,
571		
572		
573		
574	IV.A.2.b).(1).(e).(iii)	Attention should be given to the psychiatric manifestations of iatrogenic influences such as the multiple medications frequently taken by the elderly;
575		
576		
577		
578		
579	IV.A.2.b).(1).(f)	The use of nonpharmacologic approaches with particular reference to applications and limitations of behavioral therapeutic strategies, <u>and</u> physical restraints;
580		
581		
582		
583		
584	IV.A.2.b).(1).(g)	and the appropriate use and application of electroconvulsive therapy <u>and other non-pharmacological somatic therapies</u> in the elderly;
585		
586		
587		
588	IV.A.2.b).(1).(h)	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;
589		
590		
591		
592		
593		
594		
595	IV.A.2.b).(1).(i)	The appropriate use of psychotherapies as applied to the elderly, <u>including individual, group, and family therapies</u> ;
596		
597		
598		
599	IV.A.2.b).(1).(j)	The psychosocial impact of institutionalization;
600		
601	IV.A.2.b).(1).(k)	family dynamics in the context of aging, including intergenerational issues;
602		
603		
604	IV.A.2.b).(1).(l)	The ethical and legal issues especially pertinent to geriatric psychiatry, including competence, <u>capacity</u> , guardianship, right to refuse treatment, wills, <u>advance directives</u> , informed consent, elder abuse, the withholding of medical treatments, and federal legislative guidelines governing psychotropic drug prescription in nursing homes <u>and other settings</u> ;
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612		

613	IV.A.2.b).(1).(m)	The current economic aspects of supporting
614		services <u>and practice management</u> , including but
615		not limited to Title III of the Older Americans Act,
616		Medicare, Medicaid, and cost containment; <u>and</u> ,
617		
618	IV.A.2.b).(1).(n)	The research methodologies related to geriatric
619		psychiatry, including biostatistics, clinical
620		epidemiology, medical information sciences,
621		decision analysis, critical literature review, and
622		research design (including cross-sectional and
623		longitudinal methods).
624		
625	IV.A.2.c)	Practice-based Learning and Improvement
626		
627		Fellows are expected to develop skills and habits to be able
628		to meet the following goals:
629		
630	IV.A.2.c).(1)	systematically analyze practice using quality
631		improvement methods, and implement changes with
632		the goal of practice improvement;
633		
634	IV.A.2.c).(2)	locate, appraise, and assimilate evidence from
635		scientific studies related to their patients' health
636		problems; and,
637		
638	IV.A.2.c).(3)	Fellows must develop <u>demonstrate</u> administrative and
639		teaching skills. As the geriatric psychiatry fellows progress
640		through the program, they should have the opportunity to
641		teach personnel such as other residents, medical students,
642		nurses and allied health professionals teaching nonmental
643		health professionals about mental health in the aged;.
644		
645	IV.A.2.d)	Interpersonal and Communication Skills
646		
647		Fellows must demonstrate interpersonal and communication
648		skills that result in the effective exchange of information and
649		collaboration with patients, their families, and health
650		professionals.
651		
652	IV.A.2.d).(1)	Fellows must develop administrative and teaching skills.
653		As the geriatric psychiatry fellows progress through the
654		program, they should have the opportunity to teach
655		personnel such as other residents, medical students,
656		nurses and allied health professionals.
657		
658	IV.A.2.d).(2)	<u>Fellows must demonstrate competence in effective</u> The
659		formal and informal administrative leadership of the mental
660		health care team.
661		
662	IV.A.2.d).(3)	<u>Fellows must demonstrate competence including skills in</u>
663		<u>effectively</u> communicating treatment plans to the patient

664		and the family.
665		
666	IV.A.2.d).(4)	Fellows must demonstrate competence in <u>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 <u>obtaining</u> consultations from <u>with</u> other health care specialists.</u>
667		
668		
669		
670		
671		
672		
673	IV.A.2.d).(5)	Fellows must demonstrate competence in providing consultations <u>must attain consultant skills.</u>
674		
675		
676	IV.A.2.e)	Professionalism
677		
678		Fellows must demonstrate a commitment to carrying out professional responsibilities and an adherence to ethical principles.
679		
680		
681		
682	IV.A.2.f)	Systems-based Practice
683		
684		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.
685		
686		
687		
688		
689	IV.A.2.f).(1)	Fellows must <u>demonstrate competence in providing</u> render continuing care and exercise leadership responsibilities in <u>through</u> organizing recommendations from the mental health <u>care</u> team, as well as in and integrating recommendations and input from primary care physicians, consulting medical specialists, and representatives of other allied disciplines.
690		
691		
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696		
697	IV.A.2.f).(2)	<u>Fellows must demonstrate competence in the</u> The appropriate use of community or home health services, respite care, and the need for institutional long-term care.
698		
699		
700		
701	IV.A.3.	<u>Curriculum Organization and Fellow Experiences</u>
702		
703	IV.A.3.a)	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.
704		
705		
706		
707	IV.A.3.b)	Conferences in geriatric psychiatry, such as including grand rounds, case conferences, readings, seminars, and journal club should be specifically designed to augment the clinical experiences.
708		
709		
710		
711		
712	IV.A.3.b).(1)	Regular attendance by the <u>Fellows must attend at least 70% of all required didactic components of the program.</u> Attendance by fellows and the faculty <u>members</u> should be
713		
714		

715 documented.

716

717 IV.A.3.c) The program curriculum must include didactic instruction and

718 clinical experiences to enable fellows to achieve all required

719 competency-based outcomes. ~~address, as a minimum, the~~

720 ~~following content and skill areas:~~

721

722 IV.A.3.c).(1) ~~There must be a focus on multidimensional~~

723 ~~biopsychosocial concepts of treatment and management~~

724 ~~as applied both in inpatient facilities (acute and long term~~

725 ~~care) and in the community or home settings. There must~~

726 ~~also be emphasis on the medical and iatrogenic aspects of~~

727 ~~illness as well as on sociocultural, ethnic, economic,~~

728 ~~ethical, and legal considerations that may affect psychiatric~~

729 ~~management.~~

730

731 IV.A.3.d) ~~Longitudinal Care Experience~~ As part of their longitudinal care

732 experience, fellows must should, at a senior level of responsibility,

733 be assigned to follow and treat a sufficient number of patients

734 requiring continuing care.

735

736 IV.A.3.d).(1) ~~This experience should be of sufficient duration for the~~

737 ~~fellow to understand the problems and learn the skills~~

738 ~~associated with longitudinal management and treatment.~~

739 ~~Emphasis during this experience should be placed on~~

740 ~~approaches to consultation, diagnosis, and treatment of~~

741 ~~the acutely and chronically ill elderly in a diversity of care~~

742 ~~settings, both medical and psychiatric, including those with~~

743 ~~less technologically sophisticated environments. Education~~

744 ~~should include~~ Fellows should have clinical experience in

745 geriatric psychopharmacology; electroconvulsive therapy

746 (ECT); the use of relevant and using individual and group

747 psychotherapies; the use of activity therapies; the

748 bioethical dilemmas encountered when treating illness in

749 the very old; and working within facilities that may have

750 limitations, such as a decreased staff-patient ratio.

751

752 IV.A.3.e) ~~Geriatric psychiatry fellows~~ Fellows must have be provided with

753 meaningful patient care experiences as part of an interdisciplinary

754 geriatric care team (Geriatric Care Team).

755

756 IV.A.3.f) Fellows must have Geriatric Psychiatry Consultation

757 Experience.

758

759 IV.A.3.f).(1) ~~Consultation experiences should be formally available on~~

760 ~~the non-psychiatric services of an acute care hospital.~~

761

762 IV.A.3.f).(2) ~~They should include~~ Experience should include

763 consultation to inpatient, outpatient, and emergency

764 services. ~~There should also be as well as~~ consultative

765 experience in chronic care facilities.

- 766
767 IV.A.3.g) Fellows should have experiences that enable them to become familiar Familiarity with the organizational and administrative
768 aspects of home health care services, ~~should be provided.~~
769 Exposure to outreach services, and crisis intervention services in
770 both community and home settings ~~should be provided.~~
771
772 IV.A.3.h) Each fellow must have a minimum of two hours of individual
773 faculty preceptorship supervision weekly, of which one hour may
774 be group preceptorship supervision.
775
776 IV.A.3.i) ~~Other Medical Specialty Experience There should be an~~
777 ~~identifiable, structured educational experience in neurology,~~
778 ~~physical medicine and rehabilitation, geriatric medicine or geriatric~~
779 ~~family medicine, and palliative care relative to the practice of~~
780 ~~psychiatry that includes both didactic and clinical methods. The~~
781 ~~curriculum should address functional assessment, altered signs~~
782 ~~and symptoms of physical illness that occur in the elderly, and the~~
783 ~~identification of physical illnesses and iatrogenic factors that can~~
784 ~~alter mental status and behavior.~~
785
786 IV.A.3.j) ~~Clinical experience must include opportunities to assess and~~
787 ~~manage elderly inpatients and ambulatory patients of both sexes~~
788 ~~with a wide variety of psychiatric problems. Geriatric psychiatry~~
789 ~~fellows must be given the opportunity to provide both primary and~~
790 ~~consultative care for patients in both inpatient and outpatient~~
791 ~~settings in order to understand the interaction of normal aging and~~
792 ~~disease as well as to gain mastery in assessment, therapy, and~~
793 ~~management~~
794
795 IV.A.3.k) ~~Geriatric psychiatry fellows should be provided with opportunities~~
796 ~~to participate as members of medical geriatric teams in institutions~~
797 ~~where such teams are present.~~
798
799 IV.A.3.l) ~~Peer interaction among the fellows should occur in the course of~~
800 ~~clinical and/or didactic work but is most satisfactory when~~
801 ~~organized around joint patient evaluation and/or care. Each~~
802 ~~fellow must maintain a patient log documenting all clinical~~
803 ~~experiences.~~
804
805
806 **IV.B. Fellows' Scholarly Activities**
807
808 IV.B.1. Each program must provide an opportunity for residents to participate in
809 research or other scholarly activities, and residents must participate
810 actively in such scholarly activities. Fellows must participate in developing
811 new knowledge or evaluating research findings.
812
813 **V. Evaluation**
814
815 **V.A. Fellow Evaluation**
816

817	V.A.1.	Formative Evaluation
818		
819	V.A.1.a)	The faculty must evaluate fellow performance in a timely manner.
820		
821		
822	V.A.1.b)	The program must:
823		
824	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;
825		
826		
827		
828		
829		
830	V.A.1.b).(2)	use multiple evaluators (e.g., faculty, peers, patients, self, and other professional staff); and,
831		
832		
833	V.A.1.b).(3)	provide each fellow with documented semiannual evaluation of performance with feedback.
834		
835		
836	V.A.1.b).(3).(a)	<u>The evaluation must include review and discussion with each fellow of his or her</u> monitor the progress of each geriatric psychiatry fellow, including the maintenance of an educational record that documents <u>documenting completion of all required components of the program, as well as evaluations of his or her fellow's performance</u> evaluations clinical and didactic performance by supervisors and teachers. This record shall include a <u>and his or her patient log that must document that each fellow has completed</u> documenting all clinical experiences required by the Program Requirements and the educational objectives of the program;
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850		
851	V.A.1.c)	The evaluations of fellow performance must be accessible for review by the fellow, in accordance with institutional policy.
852		
853		
854	V.A.1.d)	Assessment will <u>should</u> include <u>quarterly</u> written evaluations of the knowledge, skills, and professional growth of the <u>each</u> fellows using appropriate criteria and procedures. Fellows should be evaluated quarterly by all supervisors and the directors of clinical components of training should be completed <u>the program.</u>
855		
856		
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859		
860	V.A.1.e)	More frequent evaluations should be scheduled and documented if necessary.
861		
862		
863	V.A.2.	Summative Evaluation
864		
865		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
866		
867		

- 868 institution, and must be accessible for review by the fellow in
 869 accordance with institutional policy. This evaluation must:
 870
- 871 **V.A.2.a)** document the fellow’s performance during their education,
 872 and
 873
- 874 **V.A.2.b)** verify that the fellow has demonstrated sufficient competence
 875 to enter practice without direct supervision.
 876
- 877 **V.A.3.** The final evaluation of each fellow must document proficiency in all
 878 required competency-based outcomes.
 879
- 880 **V.B. Faculty Evaluation**
 881
- 882 **V.B.1.** At least annually, the program must evaluate faculty performance as
 883 it relates to the educational program.
 884
- 885 **V.B.2.** These evaluations should include a review of the faculty’s clinical
 886 teaching abilities, commitment to the educational program, clinical
 887 knowledge, professionalism, and scholarly activities.
 888
- 889 **V.C. Program Evaluation and Improvement**
 890
- 891 **V.C.1.** The program must document formal, systematic evaluation of the
 892 curriculum at least annually. The program must monitor and track
 893 each of the following areas:
 894
- 895 **V.C.1.a)** fellow performance,
 896
- 897 **V.C.1.b)** faculty development, and,
 898
- 899 **V.C.1.c)** program goals and objectives as well as program effectiveness in
 900 achieving them.
 901
- 902 **V.C.1.c).(1)** At least one fellow representative and all faculty members
 903 should participate in these reviews.
 904
- 905 **V.C.2.** If deficiencies are found, the program should prepare a written plan
 906 of action to document initiatives to improve performance in the
 907 areas listed in section V.C.1. The action plan should be reviewed
 908 and approved by the teaching faculty and documented in meeting
 909 minutes.
 910
- 911 **V.C.3.** ~~The program should use fellow performance and outcome assessment in~~
 912 ~~its evaluation of the educational effectiveness of the program.~~
 913 ~~Performance of program graduates on the certification examination~~
 914 ~~should be used as one measure of evaluating program effectiveness. The~~
 915 ~~program should maintain a process for using assessment results together~~
 916 ~~with other program evaluation results to improve the program.~~
 917
- 918 **V.C.4.** At least 80% of the program’s graduates from the preceding five years

919		<u>should have taken the ABPN certifying examination in geriatric psychiatry.</u>
920		
921	V.C.5.	<u>At least 80% of the program's graduates from the preceding five years</u>
922		<u>taking the ABPN examination for geriatric psychiatry for the first time must</u>
923		<u>pass.</u>
924		
925	VI.	Fellow Duty Hours in the Learning and Working Environment
926		
927	VI.A.	Professionalism, Personal Responsibility, and Patient Safety
928		
929	VI.A.1.	Programs and sponsoring institutions must educate fellows and
930		faculty members concerning the professional responsibilities of
931		physicians to appear for duty appropriately rested and fit to provide
932		the services required by their patients.
933		
934	VI.A.2.	The program must be committed to and responsible for promoting
935		patient safety and fellow well-being in a supportive educational
936		environment.
937		
938	VI.A.3.	The program director must ensure that fellows are integrated and
939		actively participate in interdisciplinary clinical quality improvement
940		and patient safety programs.
941		
942	VI.A.4.	The learning objectives of the program must:
943		
944	VI.A.4.a)	be accomplished through an appropriate blend of supervised
945		patient care responsibilities, clinical teaching, and didactic
946		educational events; and,
947		
948	VI.A.4.b)	not be compromised by excessive reliance on fellows to fulfill
949		non-physician service obligations.
950		
951	VI.A.5.	The program director and sponsoring institution must ensure a
952		culture of professionalism that supports patient safety and personal
953		responsibility. Fellows and faculty members must demonstrate an
954		understanding and acceptance of their personal role in the
955		following:
956		
957	VI.A.5.a)	assurance of the safety and welfare of patients entrusted to
958		their care;
959		
960	VI.A.5.b)	provision of patient- and family-centered care;
961		
962	VI.A.5.c)	assurance of their fitness for duty;
963		
964	VI.A.5.d)	management of their time before, during, and after clinical
965		assignments;
966		
967	VI.A.5.e)	recognition of impairment, including illness and fatigue, in
968		themselves and in their peers;
969		

970	VI.A.5.f)	attention to lifelong learning;
971		
972	VI.A.5.g)	the monitoring of their patient care performance improvement indicators; and,
973		
974		
975	VI.A.5.h)	honest and accurate reporting of duty hours, patient outcomes, and clinical experience data.
976		
977		
978	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.
979		
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981		
982		
983		
984	VI.B.	Transitions of Care
985		
986	VI.B.1.	Programs must design clinical assignments to minimize the number of transitions in patient care.
987		
988		
989	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.
990		
991		
992		
993	VI.B.3.	Programs must ensure that fellows are competent in communicating with team members in the hand-over process.
994		
995		
996	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.
997		
998		
999		
1000	VI.C.	Alertness Management/Fatigue Mitigation
1001		
1002	VI.C.1.	The program must:
1003		
1004	VI.C.1.a)	educate all faculty members and fellows to recognize the signs of fatigue and sleep deprivation;
1005		
1006		
1007	VI.C.1.b)	educate all faculty members and fellows in alertness management and fatigue mitigation processes; and,
1008		
1009		
1010	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.
1011		
1012		
1013		
1014	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.
1015		
1016		
1017		
1018	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.
1019		
1020		

1021		
1022	VI.D.	Supervision of Fellows
1023		
1024	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.
1025		
1026		
1027		
1028		
1029		
1030		Only licensed independent practitioners as consistent with state regulations and medical staff bylaws may have primary responsibility for a patient.
1031		
1032		
1033		
1034	VI.D.1.a)	This information should be available to fellows, faculty members, and patients.
1035		
1036		
1037	VI.D.1.b)	Fellows and faculty members should inform patients of their respective roles in each patient’s care.
1038		
1039		
1040	VI.D.2.	The program must demonstrate that the appropriate level of supervision is in place for all fellows who care for patients.
1041		
1042		
1043		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.
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1052		
1053		
1054	VI.D.3.	Levels of Supervision
1055		
1056		To ensure oversight of fellow supervision and graded authority and responsibility, the program must use the following classification of supervision:
1057		
1058		
1059		
1060	VI.D.3.a)	Direct Supervision – the supervising physician is physically present with the fellow and patient.
1061		
1062		
1063	VI.D.3.b)	Indirect Supervision:
1064		
1065	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.
1066		
1067		
1068		
1069		
1070	VI.D.3.b).(2)	with direct supervision available – the supervising physician is not physically present within the hospital
1071		

- 1072 or other site of patient care, but is immediately
1073 available by means of telephonic and/or electronic
1074 modalities, and is available to provide Direct
1075 Supervision.
1076
- 1077 **VI.D.3.c) Oversight – The supervising physician is available to provide**
1078 **review of procedures/encounters with feedback provided**
1079 **after care is delivered.**
1080
- 1081 **VI.D.4. The privilege of progressive authority and responsibility, conditional**
1082 **independence, and a supervisory role in patient care delegated to**
1083 **each fellow must be assigned by the program director and faculty**
1084 **members.**
1085
- 1086 **VI.D.4.a) The program director must evaluate each fellow’s abilities**
1087 **based on specific criteria. When available, evaluation should**
1088 **be guided by specific national standards-based criteria.**
1089
- 1090 **VI.D.4.b) Faculty members functioning as supervising physicians**
1091 **should delegate portions of care to fellows, based on the**
1092 **needs of the patient and the skills of the fellows.**
1093
- 1094 **VI.D.4.c) Fellows should serve in a supervisory role of residents or**
1095 **junior fellows in recognition of their progress toward**
1096 **independence, based on the needs of each patient and the**
1097 **skills of the individual fellow.**
1098
- 1099 **VI.D.5. Programs must set guidelines for circumstances and events in**
1100 **which fellows must communicate with appropriate supervising**
1101 **faculty members, such as the transfer of a patient to an intensive**
1102 **care unit, or end-of-life decisions.**
1103
- 1104 **VI.D.5.a) Each fellow must know the limits of his/her scope of**
1105 **authority, and the circumstances under which he/she is**
1106 **permitted to act with conditional independence.**
1107
- 1108 **VI.D.6. Faculty supervision assignments should be of sufficient duration to**
1109 **assess the knowledge and skills of each fellow and delegate to**
1110 **him/her the appropriate level of patient care authority and**
1111 **responsibility.**
1112
- 1113 **VI.E. Clinical Responsibilities**
1114
- 1115 **The clinical responsibilities for each fellow must be based on PGY-level,**
1116 **patient safety, fellow education, severity and complexity of patient**
1117 **illness/condition and available support services.**
1118
- 1119 **VI.F. Teamwork**
1120
- 1121 **Fellows must care for patients in an environment that maximizes effective**
1122 **communication. This must include the opportunity to work as a member of**

1123		effective interprofessional teams that are appropriate to the delivery of care
1124		in the specialty.
1125		
1126	VI.F.1.	Contributors to effective interprofessional teams include consulting
1127		physicians, psychologists, psychiatric nurses, social workers and other
1128		professional and paraprofessional mental health personnel involved in the
1129		evaluation and treatment of patients.
1130		
1131	VI.G.	Fellow Duty Hours
1132		
1133	VI.G.1.	Maximum Hours of Work per Week
1134		
1135		Duty hours must be limited to 80 hours per week, averaged over a
1136		four-week period, inclusive of all in-house call activities and all
1137		moonlighting.
1138		
1139	VI.G.1.a)	Duty Hour Exceptions
1140		
1141		A Review Committee may grant exceptions for up to 10% or a
1142		maximum of 88 hours to individual programs based on a
1143		sound educational rationale.
1144		
1145	VI.G.1.a).(1)	In preparing a request for an exception the program
1146		director must follow the duty hour exception policy
1147		from the ACGME Manual on Policies and Procedures.
1148		
1149	VI.G.1.a).(2)	Prior to submitting the request to the Review
1150		Committee, the program director must obtain approval
1151		of the institution's GMEC and DIO.
1152		
1153	VI.G.2.	Moonlighting
1154		
1155	VI.G.2.a)	Moonlighting must not interfere with the ability of the fellow
1156		to achieve the goals and objectives of the educational
1157		program.
1158		
1159	VI.G.2.b)	Time spent by fellows in Internal and External Moonlighting
1160		(as defined in the ACGME Glossary of Terms) must be
1161		counted towards the 80-hour Maximum Weekly Hour Limit.
1162		
1163	VI.G.3.	Mandatory Time Free of Duty
1164		
1165		Fellows must be scheduled for a minimum of one day free of duty
1166		every week (when averaged over four weeks). At-home call cannot
1167		be assigned on these free days.
1168		
1169	VI.G.4.	Maximum Duty Period Length
1170		
1171		Duty periods of fellows may be scheduled to a maximum of 24 hours
1172		of continuous duty in the hospital. Programs must encourage
1173		fellows to use alertness management strategies in the context of

1174 patient care responsibilities. Strategic napping, especially after 16
1175 hours of continuous duty and between the hours of 10:00 p.m. and
1176 8:00 a.m., is strongly suggested.
1177

1178 **VI.G.4.a)** It is essential for patient safety and fellow education that
1179 effective transitions in care occur. Fellows may be allowed to
1180 remain on-site in order to accomplish these tasks; however,
1181 this period of time must be no longer than an additional four
1182 hours.
1183

1184 **VI.G.4.b)** Fellows must not be assigned additional clinical
1185 responsibilities after 24 hours of continuous in-house duty.
1186

1187 **VI.G.4.c)** In unusual circumstances, fellows, on their own initiative,
1188 may remain beyond their scheduled period of duty to
1189 continue to provide care to a single patient. Justifications for
1190 such extensions of duty are limited to reasons of required
1191 continuity for a severely ill or unstable patient, academic
1192 importance of the events transpiring, or humanistic attention
1193 to the needs of a patient or family.
1194

1195 **VI.G.4.c).(1)** Under those circumstances, the fellow must:
1196

1197 **VI.G.4.c).(1).(a)** appropriately hand over the care of all other
1198 patients to the team responsible for their
1199 continuing care; and,
1200

1201 **VI.G.4.c).(1).(b)** document the reasons for remaining to care for
1202 the patient in question and submit that
1203 documentation in every circumstance to the
1204 program director.
1205

1206 **VI.G.4.c).(2)** The program director must review each submission of
1207 additional service, and track both individual fellow and
1208 program-wide episodes of additional duty.
1209

1210 **VI.G.5.** **Minimum Time Off between Scheduled Duty Periods**
1211

1212 **VI.G.5.a)** Fellows must be prepared to enter the unsupervised practice
1213 of medicine and care for patients over irregular or extended
1214 periods.
1215

1216 Geriatric psychiatry fellows are considered to be in the final years
1217 of education.
1218

1219 **VI.G.5.a).(1)** This preparation must occur within the context of the
1220 80-hour, maximum duty period length, and one-day-
1221 off-in-seven standards. While it is desirable that
1222 fellows have eight hours free of duty between
1223 scheduled duty periods, there may be circumstances
1224 when these fellows must stay on duty to care for their

1225		patients or return to the hospital with fewer than eight
1226		hours free of duty.
1227		
1228	VI.G.5.a).(1).(a)	Circumstances of return-to-hospital activities
1229		with fewer than eight hours away from the
1230		hospital by fellows must be monitored by the
1231		program director.
1232		
1233	VI.G.5.a).(1).(b)	There are no circumstances under which fellows
1234		may stay on duty with fewer than eight hours off.
1235		
1236	VI.G.6.	Maximum Frequency of In-House Night Float
1237		
1238		Fellows must not be scheduled for more than six consecutive nights
1239		of night float.
1240		
1241	VI.G.7.	Maximum In-House On-Call Frequency
1242		
1243		Fellows must be scheduled for in-house call no more frequently than
1244		every-third-night (when averaged over a four-week period).
1245		
1246	VI.G.8.	At-Home Call
1247		
1248	VI.G.8.a)	Time spent in the hospital by fellows on at-home call must
1249		count towards the 80-hour maximum weekly hour limit. The
1250		frequency of at-home call is not subject to the every-third-
1251		night limitation, but must satisfy the requirement for one-day-
1252		in-seven free of duty, when averaged over four weeks.
1253		
1254	VI.G.8.a).(1)	At-home call must not be so frequent or taxing as to
1255		preclude rest or reasonable personal time for each
1256		fellow.
1257		
1258	VI.G.8.b)	Fellows are permitted to return to the hospital while on at-
1259		home call to care for new or established patients. Each
1260		episode of this type of care, while it must be included in the
1261		80-hour weekly maximum, will not initiate a new “off-duty
1262		period”
1263		
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