

# Department of Psychiatry

## General Psychiatry

### Residency Training Manual



**2023-2024**

## DEPARTMENT OF PSYCHIATRY RESIDENCY PROGRAM

### MISSION STATEMENT

Our program operates in the context of a university and its large health science center, UF Health. UF is the flagship state university and a top 10 public university. Despite growing needs for mental health services, Florida ranks 49th in the nation in per capita mental health care funding with only 6.5 psychiatrists per 100,000 population on average. We are in the midst of an opioid epidemic with increasing public and legal acceptance of marijuana use. Burnout and depression are well-known risks of training and practice.

Our program's mission, closely aligned with the institutional mission and goals (<https://med.ufl.edu/about/>), is to develop psychiatrist leaders, scholars, and clinician-educators who are compassionate, provide the safest mental health and addiction care, and are ready for any career opportunity and challenge. We hope to accomplish this through mentoring, educational opportunities both within and outside our institution, and in an environment that promotes inclusivity and personal well-being.

### OVERALL AIMS

1. Produce excellent, trauma-informed general psychiatrists to equitably serve the mental health needs of the state of Florida
2. Educate residents to be excellent general psychiatrists in an integrated addiction care model
3. Train skilled clinician-educators to enter academic practice, and
4. Develop and maintain a diverse and innovative teaching and learning environment where faculty and residents experience enhanced career development and sustained well-being.

Our residents are highly sought after by employers for their ability to provide excellent quality and safe care. We strive for an equal mix (~1/3 each) of graduate outcomes including fellowship training, private/community practice, and academic practice.

The Department of Psychiatry at the University of Florida is committed to achieving excellence in its target missions of patient care, education, research and advocacy. It is the goal of the Department to provide a training model that spans from laboratory bench to the clinical bedside, integrating new findings in basic and clinical neuroscience into the highest quality of care for individuals with psychiatric illness. This includes the development of professional competence and inculcation of the professional attitudes necessary to be a successful physician. The training includes education in the basic sciences, the cognitive and technical skills necessary to practice general psychiatry, and the development of clinical knowledge and maturity so that clinical judgment can be appropriately applied in the care of patients.

The ultimate objective of our training program is to develop highly skilled psychiatrists to fill leadership roles in the various areas of our specialty. A partial list of such arenas includes academic psychiatry, community and public psychiatry, clinical practice, consultation services, quality improvement/patient safety, forensic psychiatry, geriatric psychiatry, addiction medicine, child psychiatry, and neuromodulation. Each resident is expected to become proficient in the diagnostic and therapeutic techniques required of competent clinicians, to be skilled in working with, and coordinating the activities of other mental health professionals, and to develop the necessary skills to critically evaluate relevant research findings in the clinical literature. Every attempt is made to provide a core educational experience as well as tailoring specific training to the special needs and interests of the resident.

Professional attitudes highly valued by this program include complete dedication to patient care, the ability to make sound ethical and scientific judgments in the care of patients, a scholarly mind set and dedication to lifelong learning, the ability to work well with others and to become part of a team, and the capacity for hard work with a positive attitude and flexibility. The residents in this program are expected to teach and share knowledge with colleagues, students and other health care providers. Critical thinking based on a thorough reading of the available literature and respect of the cultural, religious, and individual preference of the patient and family will be the basis for decisions made that affect the lives of patients. The well-trained psychiatrist must be aware of the cost and societal implications of their decisions and be able to adapt to the evolving health care system in this country. It is anticipated that the behavior learned in the psychiatry residency will make the individual a leader and valued member of the medical community in whichever setting that individual wishes to practice.

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Ludmila De Faria, MD  
Program Director

*Robert Averbuch, MD*

Robert Averbuch, MD  
Assoc. Program Director

*Laura Rodriguez-Roman, MD*

Laura Rodriguez-Roman, MD  
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*Gary Kanter, MD*

Gary Kanter, MD  
Assoc. Program Director

## Psychiatry Teaching Faculty

A full list of faculty can be found on the department website: <https://psychiatry.ufl.edu/about-us/faculty/>

### Psychiatry Residents 2023-2024

<b>PGY-1s</b>	
Anna Amare, DO	Campbell University Jerry M. Wallace School of Osteopathic Medicine
Jesse Armstrong, MD	University of Tennessee Health Science Center College of Medicine
Morgan Brasfield, DO	William Carey University College of Osteopathic Medicine
Preston Celico, DO	Nova Southeastern University Dr. Kiran C. Patel College of Osteopathic Medicine
Sahiti Gilela, MD	USF Health Morsani College of Medicine
Minju Hwang, DO	Lake Erie College of Osteopathic Medicine
Eric Lian, MD	Medical College of Georgia at Augusta University
Lake Lindo, MD	University of Central Florida College of Medicine
Daniel McNeil, MD	Marshall University Joan C. Edwards School of Medicine
Tuan Nguyen, MD	Florida State University College of Medicine – Orlando Campus
Giselle Scarano, MD	University of Cincinnati College of Medicine
Laura Vanegas, DO	Nova Southeastern University Dr. Kiran C. Patel College of Osteopathic Medicine
Tristan Pulliam, MD	Saint Louis University School of Medicine
<b>PGY-2s</b>	
Arnold Almaguer, MD	University of Florida College of Medicine
Bruno Aurnhammer, DO	Marian University College of Osteopathic Medicine
Trevin Baird, DO	Alabama College of Osteopathic Medicine
Toni Carter, MD	University of Louisville School of Medicine
Nafisa Choudhury, MD	Nova Southeastern University Dr. Kiran C. Patel College of Allopathic Med
David Cox, DO	New York Institute of Technology College of Osteopathic Medicine
Aleksandra Gasparova, DO	Nova Southeastern University Dr. Kiran C. Patel College of Osteopathic Med
Brittany Milo, DO	Nova Southeastern University Dr. Kiran C. Patel College of Osteopathic Med
Riken Nathu, MD	University of Florida College of Medicine
Hutson Rapier, MD	University of Florida College of Medicine
Ankit Patel, MBBS	Pramukhswami Medical College
<b>PGY-3s</b>	
Beck Brent, MD	University of Florida College of Medicine
Christina Bulleit, DO	Lake Erie College of Osteo Medicine
Michael Gravenstein, MD	University of Florida College of Medicine
Rubab Islam, MD	University of Florida College of Medicine
Georgio Legerme, MD	University of Florida College of Medicine
Manonmani Murugappan, DO	Nova Southeastern Univ of Osteo Medicine
Diego Nolasco, MD	University of Florida College of Medicine
Ana Reyes, MD	University of Florida College of Medicine
Ana Silva Pires Tome, MD	Centro Universitário de Anápolis
<b>PGY-4s</b>	
Nadia Cacodcar, MD	University of Florida College of Medicine
Minyi Lin, MD	Saint Louis University School of Medicine
Katlynn Nason, MD	Eastern Virginia Medical School

Dylan Ong, MD	Florida International University College of Medicine
Jeff Plante, DO	Alabama College of Osteo Medicine
Gerald Richardson, MD	University of Florida College of Medicine
Guru Somesan, DO	West Virginia School of Osteo Medicine
Anu Stephen, MD	California Northstate University College of Medicine
Steven Toffel, MD	University of Florida College of Medicine
Lily Valad, MD	University of Texas Medical Branch Galveston
Lymaries Velez, MD	University of Florida College of Medicine

## **EDUCATIONAL PROGRAM**

### **Graduated Levels of Responsibility**

Graduate medical education is based on the principle of progressively increasing levels of responsibility in caring for patients, under the supervision of the faculty. Faculty members closely monitor the progress of each resident in acquiring the skills necessary for advancement to the next level of training. In their evaluation of a resident's progress, faculty members consider such factors as clinical experience, fund of knowledge, diagnostic abilities, clinical judgment, interpersonal and communication skills, professionalism, and the application of various treatment modalities. Each level of training, or postgraduate year (PGY), is defined by a set of competencies that the resident is expected to master. Upon achieving these standards, residents are afforded greater degrees of independence in patient care, at the discretion of the faculty. At all times, however, faculty remains ultimately responsible for all aspects of patient care. Examples of expected competencies and responsibilities for each level follow:

#### **PGY-1**

During their PG1 year, faculty and senior level residents closely supervise residents. Time is equally divided between a rotating internship (Internal Medicine/Neurology) and psychiatry. Through their experiences in primary care, residents sharpen their skills in performing a history and physical, generating a differential diagnosis, ordering and conducting appropriate tests, analyzing test results, conducting emergency assessments, and considering interventions.

After completing their Neurology rotations, residents are expected to be able to perform a complete neurologic examination, generate a differential diagnosis, order and conduct appropriate tests, analyze results, and develop a plan of treatment.

During their six months of psychiatry, residents gain experience in two different settings, the psychiatry consult liaison service and on the inpatient psychiatry/addiction services. As a PGY 1 resident on the consult liaison service, the resident is introduced to the concept of the interaction between being a psychiatric consultant and interfacing with physicians and other health care providers on medical and surgical services. Under close supervision by faculty and senior residents, the PGY 1 resident is introduced to the variety of psychiatric symptoms that may result from medical illnesses, complications arising from surgical procedures, and the cognitive and behavioral disturbances created by medications and substance abuse. As a consultant, the resident learns how to gather medical information from multiple sources, assess cognitive functioning, communicate with members of the health care team, order appropriate diagnostic studies, and utilize both pharmacologic and psychotherapeutic interventions to enhance patient care.

When assigned to the psychiatric inpatient services, residents learn to manage patients from a biopsychosocial perspective. Residents learn to perform complete psychiatric assessments with particular attention to underlying comorbid medical conditions. Residents are expected to generate a differential diagnosis, propose and institute a thorough patient evaluation, and develop a plan of treatment all under the supervision of the attending psychiatrist.

As members of a multi-modal and multi-disciplinary treatment team, residents learn the importance of collaboration in patient care. Residents participate in group and family (therapy) sessions, as well as active learning in psychotherapy modules. The resident should be able to communicate with patients and families about the psychiatric condition under treatment and the plan of care as outlined by the attending physician. Residents must demonstrate good clinical judgment in their assessment of crises, and understand when to ask for help. Appropriate communication of clinical data to both patients and colleagues is emphasized. Residents are expected to exhibit a dedication to the principles of professional preparation that emphasizes primacy of the patient as the focus for care. In conjunction with the structured didactic teaching program, the first-year trainee must develop and implement a plan for self-study, reading, and research of selected topics that promotes personal and professional growth and be able to demonstrate successful use

of the literature in dealing with patients. At all levels, the resident is expected to demonstrate an understanding of the socioeconomic, cultural, and managerial factors inherent in providing cost-effective care.

In 2011, the ACGME implemented new supervisory requirements for residents at all levels, with the PGY 1 level having particularly stringent requirements of direct supervision. The Psychiatry RRC has further delineated the criteria by which a PGY-1 resident may progress to indirect with direct supervision available. The competencies that must be obtained by PGY 1 residents are as follows:

1. the ability and willingness to ask for help when indicated;
2. gathering an appropriate history;
3. the ability to perform an emergent psychiatric assessment; and
4. presenting patient findings and data accurately to a supervisor who has not seen the patient.

All incoming residents receive a rigorous assessment process to ascertain that these competencies are achieved, including an Objective Structured Clinical Examination (OSCE), during Orientation and the month of July. A second OSCE occurs approximately 9 months later in the intern year to assess overall progression of skills.

#### **PGY-2**

Individuals in the second year of training are expected to perform the duties learned in the first year more independently and may supervise the routine activities of medical students and interns. On the inpatient services, residents are given greater autonomy and encouraged to assume a leadership role in the treatment team under the supervision of an attending. Residents are encouraged to teach trainees and medical students as a means of stimulating their own academic progress. As a psychiatric consultant, the PGY2 resident learns the elements of an appropriate response to consultation in conjunction with a faculty supervisor. The second-year trainee draws upon his/her experiences and knowledge to assist other services in the management of psychiatric patients. Residents at this level are also given supervisory responsibilities with trainees on call. It is expected that the second-year resident will utilize the literature and routinely demonstrate the ability to research selected topics and present these to the team. In the outpatient setting (half-day per week), residents learn to apply psychotherapy techniques learned in PGY1 didactics and hone their psychopharmacology skills through experience. Group psychotherapy supervision is provided.

In the emergency setting, residents develop greater skills in rapid assessment and disposition of patients. While on call, residents are afforded greater autonomy and develop confidence in their acute management of psychiatric patients. Through the supervision of medical students, residents develop greater teaching skills. The second-year trainee should be able to incorporate ethical concepts into patient care and discuss these with the patient, family, and other members of the health care team. Upon completion of the second year, residents should have a mastery of the basics of patient care in the inpatient, consultation, and outpatient settings.

#### **PGY-3**

Third-year residents are full-time in the outpatient setting. Here, residents learn the importance of the therapeutic alliance and begin to develop long-term relationships with their patients. Third-year trainees are afforded greater autonomy in their assessment and treatment of patients.

Residents develop psychotherapy skills through both didactics and case supervision. Understanding of the concepts of transference and counter-transference is emphasized. Trainees build upon their psychopharmacology skills with more advanced didactics and direct applications to patient care. Residents are expected to demonstrate and utilize knowledge acquired from independent reading and study.

Residents complete a yearlong didactic and clinical experience (half-day per week) in Child Psychiatry. Residents learn to communicate effectively with children and their families and the importance of multi-modal assessment.

By the end of the third year, residents should be capable of managing the full spectrum of psychiatric disorders with both biological and psychotherapeutic modalities. Residents should demonstrate continued sophistication in the acquisition of knowledge and skills as well as further ability to function independently in evaluating patient problems and developing a plan for patient care. By the end of the PG-3 year, residents should be capable of assuming the role of clinical chief on selected services.

#### **PGY-4**

Individuals in the fourth post-graduate year assume an increased level of responsibility as the chief or senior resident on selected services. Residents at this level may assume greater administrative responsibilities and pursue selectives/electives in areas of sub-specialization. The senior resident can apply a full range of psychiatric treatments and should continue to develop an individual style of practice. The fourth year is one of senior leadership and the resident should be able to assume responsibility for organizing their service and supervising junior residents and students. The resident should have mastery of the information contained in standard texts and be facile in using the literature to solve specific problems. The resident may be responsible for presentations at conferences and

for teaching junior residents and students on a routine basis. During the final year of training, the resident has the opportunity to demonstrate the mature ethical, judgment, and clinical skills needed for independent practice. The PGY4 should have some understanding of the role of the practitioner in an integrated health care delivery system and be aware of the issues in health care management facing patients and physicians.

**ALL YEARS**

Residents at every level are expected to treat all members of the health care team with respect, and to recognize the value of contributions from others involved in the care of patients and their families. The highest level of professionalism is expected at all times. It is expected that residents will treat others with the same respect and consideration they afford superiors and colleagues. Personality conflicts and selfish pursuit of goals are not conducive to good patient care. Long hours and the stress of practice can precipitate conflict; the resident should be aware of the situations where this is likely to happen and compensate by not escalating the situation.

The resident is expected to develop a personal program of reading. Besides the general reading in the specialty of psychiatry, residents should do directed reading daily with regard to problems that they encounter in patient care. Residents are expected to attend all conferences at the service and program level. The conference program is designed to provide a didactic forum to augment the resident’s reading and clinical experience.

Residents at all levels are expected to participate in annual team QI projects. It is expected that residents will rapidly attain quality improvement/patient safety milestones level 1-3 with final attainment of level 4 by graduation. Quality improvement and patient safety knowledge and skills should be incorporated into daily clinical practice as much as possible.

**Milestones**

Residents are evaluated by the Clinical Competency Committee (CCC) on a semi-annual basis according to the ACGME Psychiatry Milestones 2.0. The CCC is a committee made up of program faculty who are very invested in residency education. The Milestones can be found at: <https://www.acgme.org/Portals/0/PDFs/Milestones/PsychiatryMilestones2.0.pdf?ver=2020-03-10-152105-537>

**Clinical/Experiential Curriculum: Block Diagram**

The Block Diagram is a map of overall expected clinical experiences for your time in residency. It does not reflect your individual rotation schedule.

**Year 1**

Block	1	2	3	4	5	6	7	8	9	10	11	12
<b>Institution</b>	1 or 2	1 or 2	1 or 2	1 or 2	1 or 2	1 or 2	1 or 2	2	2	2	2	2
<b>Rotation Name</b>	Inpt	Inpt	Inpt/Geri	C/L	C/L	C/L or Add	Neuro, C/L, or Inpt	IM (intpt)	IM/ Amb	IM/ Amb	IM/ Pain	Neuro, C/L, or Inpt
<b>% Outpatient</b>	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%
<b>% Research</b>	0-5%	0-5%	0-5%	0%	0%	0-5%	0-5%	0%	0-5%	0-5%	0-5%	0-5%

Emergency Psychiatry met by Potential to Harm and Consult Liaison experience at Institution 1 and 2.

Forensic experience met through Baker Act hearings commitment in Inpatient, Decisional Capacity in Consult Liaison, and Disability in Outpatient at Institution 1 and 2.

**Year 2 – Standard Track**

Block	1	2	3	4	5	6	7	8	9	10	11	12
<b>Institution</b>	1 or 2	1 or 2	1 or 2	1 or 2	1 or 2	1 or 2	1 or 2	1 or 2	1 or 2	1 or 2	1 or 2	1 or 2
<b>Rotation Name</b>	Inpt	Inpt	Inpt	Inpt, Neuro, or Add	Inpt	Geri	C/L or Neuro	C/L	C/L	C/L	C/L	S1/E1
<b>% Outpatient</b>	10%	10%	10%	10%	10%	10%	10%	10%	10%	10%	10%	10%
<b>% Research</b>	0-5%	0-5%	0-5%	0-5%	0-5%	0-5%	0-5%	0%	0%	0%	0%	0-80%

Emergency Psychiatry met by Potential to Harm and Consult Liaison and On-Call experience at Institution 1 and 2.

Forensic experience met through Baker Act hearings commitment in Inpatient, Decisional Capacity in Consult Liaison, and Disability in Outpatient at Institution 1 and 2.

Outpatient at Institution 1 only. Neuro if not completed in Year 1.

OR

**Year 2 – Child Fast Track**

Block	1	2	3	4	5	6	7	8	9	10	11	12
<b>Institution</b>	1	1 or 2	1 or 2	1 or 2	1 or 2	1 or 2	1 or 2	1 or 2	1 or 2	1 or 2	1 or 2	1 or 2
<b>Rotation Name</b>	C&A	Add or S1/E1	Inpt	Inpt	Inpt	Geri	C/L or Neuro	C/L	C/L	C/L	S2/E2	Comm
<b>% Outpatient</b>	10%	10%	10%	10%	10%	10%	10%	10%	10%	10%	10%	10%
<b>% Research</b>	0-5%	0-80%	0-5%	0-5%	0-5%	0-5%	0-5%	0%	0%	0%	0-80%	0-5%

Emergency Psychiatry met by Potential to Harm Consult Liaison and On-Call experience at Institution 1 and 2.

Forensic experience met through Baker Act hearings commitment in Inpatient, Decisional Capacity in Consult Liaison, and Disability in Outpatient at Institution 1 and 2.

Outpatient at Institution 1 only. Neuro if not completed in Year 1.

**Year 3**

Block	1	2	3	4	5	6	7	8	9	10	11	12
<b>Institution</b>	1	1	1	1	1	1	1	1	1	1	1	1
<b>Rotation Name</b>	Outpt	Outpt	Outpt	Outpt	Outpt	Outpt	Outpt	Outpt	Outpt	Outpt	Outpt	Outpt
<b>% Outpatient</b>	100	100	100	100	100	100	100	100	100	100	100	100
<b>% Research</b>	0-5%	0-5%	0-5%	0-5%	0-5%	0-5%	0-5%	0-5%	0-5%	0-5%	0-5%	0-5%

Full-time continuous outpatient experience includes 90% Adult and 10% Child.

OR

**Year 3 – Elective Track**

Block	1	2	3	4	5	6	7	8	9	10	11	12
<b>Institution</b>	1	1	1	1	1	1	1	1	1	1	1	1
<b>Rotation Name</b>	Outpt*	Outpt*	Outpt*	Outpt*	Outpt*	Outpt*	Outpt*	Outpt*	Outpt*	Outpt*	Outpt*	Outpt*
<b>% Outpatient</b>	100	100	100	100	100	100	100	100	100	100	100	100
<b>% Research</b>	0-5%	0-5%	0-5%	0-5%	0-5%	0-5%	0-5%	0-5%	0-5%	0-5%	0-5%	0-5%

Full-time continuous outpatient experience includes 90% Adult and 10% Child.

\*Includes one half-day per week of an outpatient elective experience in either Research or Street Psychiatry.

**Year 4**

Block	1	2	3	4	5	6	7	8	9	10	11	12
<b>Institution</b>	1 or 2	1 or 2	1 or 2	1 or 2	1 or 2	1 or 2	1 or 2	1 or 2	1 or 2	1 or 2	1 or 2	1 or 2
<b>Rotation Name</b>	Add or S1/E1	C&A or S2/E2	Geri	C/L	Comm	Comm	Inpt	S3/E3	S4/E4	S5/E5	S6/E6	S7/E7
<b>% Outpatient</b>	20%	20%	20%	20%	20%	20%	20%	20%	20%	20%	20%	20%
<b>% Research</b>	0-70%	0-70%	0-5%	0%	0-30%	0-30%	0-5%	0-70%	0-70%	0-70%	0-70%	0-70%

Possible selectives/electives (S1/E1-S7/E7): Addiction Medicine/Florida Recovery Center, Cognitive Behavioral Therapy, Community Psychiatry, Deep Brain Stimulation/Electroconvulsive Therapy/Transcranial Magnetic Stimulation (Neuromodulation), Geriatric Psychiatry, Senior Resident/Junior Attending, Research, State Hospital, Teaching & Quality, Telepsychiatry, others upon approval of the Program Director. Forensic Experience if not obtained as part of previous rotations.

Institution Site 1=UF Health UF Health Shands Hospital at the University of Florida-Gainesville

Add=Addiction

Amb=Ambulatory

C&A=Child and Adolescent Psychiatry

C/L=Consult/Liaison Psychiatry (may substitute other rotations/electives after 2 month minimum is met per educational needs of resident and as approved by the Program Director)

Comm=Community

Geri=Geriatric Psychiatry

IM=Internal Medicine

Inpt=Psychiatry Inpatient/Night Float

Neuro=Neurology

Outpt=Continuous Outpatient Psychiatry

Vacation time taken at any time throughout the year each year upon approval from supervisors and Program Director. Some rotation restrictions apply.

PGY-2 or above transfer: Rotation trajectory will follow Year 1, Year 2 Standard Track and Year 3. Note – Year 1 may be adjusted based on previous Neurology experience to include Inpatient Psychiatry and C/L experience.

Research percentages reflect QI/PS projects and other scholarly activity.

### **Clinical Service Description:**

#### **a) Primary Care/Internal Medicine/Pediatrics/Family Practice**

- a. 4 month, required rotation, PG-1 year; residents are required to complete 2 of the 4 months on a VA inpatient internal medicine, family practice, or pediatric service. Residents spend 2 months in an outpatient setting at the VA Urgent Care Clinic, the Family Practice Clinic or the Pediatric Clinic.
- b. Both outpatient and inpatient clinical services are staffed by faculty from the corresponding departments at the University of Florida (i.e. Internal Medicine, Pediatrics, or Family Medicine). Full-time attending faculty and senior residents staff inpatient services. Two outpatient attendings work specifically with our residents and are full time faculty.
- c. While on service, residents participate in the teaching rounds and conferences of these departments. Residents also learn through daily patient management, case presentations, and on-site teaching from faculty and senior residents. Additionally, while on inpatient services, residents take overnight call with the team on a regular basis, including cross-coverage. Learning also occurs through the instruction of medical students on service.
- d. Clinical populations vary with the particular service. The VA Medical Services are predominantly male and Caucasian, with a significant minority of African Americans and smaller representations of other minorities. Patients encountered at UF Health Shands Hospital are more diverse in ethnicity, with a more equal distribution between sexes and larger African American and Hispanic populations. In all settings, residents are exposed to a wide range of medical pathology including primary care and tertiary referrals.
- e. Psychiatry residents maintain similar caseloads to their internal medicine, family practice and pediatric counterparts while on service. Average inpatient caseloads run between five and seven. In all of the outpatient experiences residents see on average 6 and a maximum of 8 patients daily.
- f. Supervision is provided in both individual and group settings by the departmental faculty of the individual service. Psychiatry residents receive the same supervision as that provided to residents on the individual services.
- g. Psychiatry residents on medicine services attend Psychiatry block didactic sessions.

#### **b) VA Inpatient Psychiatry – Mood, Anxiety, and Dementia Adult Psychiatry Team**

- a. Residents spend up to 2-4 months on this rotation during the PG-1 year, and sometimes the PG-2/4 year. This rotation is often required in the PG-1 year.
- b. Faculty consists of 1 board certified psychiatrist who is full-time. When on approved leave (vacation, conference attendance, sick), faculty from the other VA inpatient units (Psychosis, Addiction Psychiatry), Consult-Liaison, as well as the Chief of Psychiatry cross-cover).
- c. Residents spend 5-10 hours in rounds with the attending, 3-5 hours in seminars and case conferences, including a 1 hr. weekly teaching session with the attending psychiatrist on service.



- d. The patient population is predominantly lower middle class with about 95% male and 5% female. Approximately 80% are white, 15% black, and 5% others. The average age of the patient population is 50. Diagnostically, about 35% have a primary mood disorder, 30% have Post Traumatic Stress Disorder or another primary anxiety disorder, 15% have an adjustment disorder, 12% have a primary cognitive disorder, and 8% others. A number of the patients have co-morbid personality disorders. Residents are exposed to psychological and neuropsychological testing. Treatment modalities include psychopharmacology, electroconvulsive therapy, group therapy, case management, and psychosocial rehabilitation.
- e. The average case load is 8-10 patients with a maximum of 13 patients.
- f. The residents have clinical teaching and supervision with the attending psychiatrist on a daily basis as part of morning rounds. Residents participate in all aspects of treatment and are taught by an attending faculty member as well as social workers, case managers, pharmacists, and other allied health care professionals.
- g. The residents see a wide range of psychiatric diagnoses in a VA setting allowing them to observe health care in a unique system of care (exemplary EMR, rural setting, intensive longitudinal outpatient care, peer review process, risk management, interdisciplinary teams, unique patient population, and emphasis on research).

**c) VA Inpatient Addiction**

- a. Residents may spend 1 month on this rotation usually during the PG-2 year, occasionally during the PG-1 year. One month of training in addiction is required (and accomplished either on the VA or Vista Service) and electives are also available in the PG-4 year.
- b. The faculty consists of 1 full-time psychiatrist with significant experience in addiction medicine/psychiatry. When on approved leave (vacation, conference attendance, sick), faculty from the other VA inpatient units (Psychosis, Mood), Consult-Liaison, as well as the Chief of Psychiatry cross-cover). Residents also interact with VA licensed therapists who partake in individual and group therapy.
- c. Residents spend 1-4 hours per week in seminars and case conferences in addition to 2-8 hours daily in rounds with the faculty. The faculty supervises the residents on all cases. A broad range of addiction diagnoses is seen.
- d. The patient population is predominantly lower middle class and male. Approximately 80% are white, 15% black, and 5% others. The average age of the patient population is mid-40s. Treatment modalities include medical detoxification; pharmacotherapy for relapse prevention (FDA approved) including disulfiram, acamprostate, naltrexone, vivitrol, buprenorphine, nicotine replacement, varenicline, and wellbutrin; psychopharmacologic management of comorbid psychiatric disorders; individual and group psychotherapy including motivational interviewing, motivation enhancement therapy, rational emotive behavior therapy; psychoeducational classes; nutrition; and recreational and occupational therapy.
- e. The normal case load is 8-12 patients with a maximum of 12 patients. The resident takes part in all aspects of treatment.
- f. The residents have two hours of required individual supervision weekly. Clinical teaching occurs daily during rounds. Also, residents may take part in the group therapy component and work with the addiction therapists.
- g. The resident is exposed to a variety of treatment modalities and participates in all aspects of treatment planning and implementation. Medical/Physician Assistant student teaching is a major emphasis of the resident experience on this service.

**d) VA Inpatient Red Team (Psychosis)**

- a. Most residents will spend 2 months (total) on this rotation in their PG-1, PG-2, or PG-4 year.
- b. Faculty consists of one board-certified psychiatrist who is part-time. When on approved leave (vacation, conference attendance, sick), faculty from the other VA inpatient units (Psychosis, Addiction Psychiatry), Consult-Liaison, as well as the Chief of Psychiatry cross-cover).
- c. Residents spend 5-6 hours per week in seminars and conferences in addition to 3-7 hours daily in rounds with the faculty. The faculty interview all patients with the residents and supervise them on all cases.
- d. The patient population is predominantly lower and lower-middle class. About 95% of the patients are male with 75% white, 20% black, and 5% others. The average age of the patients is approximately 40-45. The most common diagnoses include Schizophrenia, Schizoaffective Disorder, Bipolar Disorder, Substance-Induced Psychotic Disorder, Psychotic Disorder due to a General Medical condition and Major Depressive Episode with psychotic features. Post-traumatic stress disorder (PTSD), generalized anxiety disorder (GAD), and treatment-resistant depression are also common. Not infrequently, patients have co-morbid substance use disorders. Residents are exposed to psychological/neuropsychological testing. Treatment modalities include psychopharmacology, electroconvulsive therapy (ECT), individual psychotherapy including crisis intervention and cognitive-behavioral, family and group therapy, case management, and psychosocial rehabilitation.

- e. The caseload ranges from 6-12 patients with a maximum of 12 patients. The resident participates in the evaluation process, treatment planning, discharge process, and chart documentation.
- f. The residents have 2 hours of required individual supervision weekly. Clinical teaching occurs daily in rounds. Residents participate in all aspects of treatment and the experience is enriched through the contributions of social workers, case managers, and other allied health care professionals.
- g. The residents work primarily with a severely mentally ill population and obtain intense training in the biopsychosocial assessment and treatment. The residents see a wide range of psychiatric diagnoses in a unique setting. Medical/Physician Assistant student teaching is a major emphasis of the resident experience on this service.

**e) Inpatient Neurology**

- a. 2-month required rotation, PG-1 year; 2 months spent at the VAMC on inpatient/consultation services.
- b. Rotations are staffed by full-time faculty of various sub-specialties from the Department of Neurology. Faculty attendings rotate every two weeks, which allows psychiatry residents to be exposed to at least three to four different stylistic approaches to a neurological case and to varying areas of expertise.
- c. Residents participate fully in the teaching rounds and attend the noon conferences and Grand Rounds of the Neurology services. The majority of learning occurs through observation and active participation in patient cases with feedback and instruction from supervising faculty and senior level residents. Residents also learn by teaching medical students on service.
- d. Clinical populations are predominantly male and Caucasian with a significant minority of African Americans and smaller representation (under 10%) of other minorities. The experience at the VAMC covers the full breadth of commonly encountered neurological disorders such as dementias, delirium, epilepsy, tumor, stroke, CNS infections, and demyelinating and degenerative illness. While on consultation service, residents frequently interface with the Psychiatry inpatient services, gaining experience in the interplay between the two disciplines. State-of-the-art treatment techniques are employed in both a clinical and research setting.
- e. Psychiatry residents maintain similar caseloads and patient care responsibilities to their PG-1 neurology counterparts. Inpatient responsibilities may include a caseload of 3 to 5 patients, while consultation volume may vary greatly from day to day (on average 1 to 3 cases).
- f. Neurology faculty and senior residents provide daily supervision on rounds and less formal clinical support on other occasions. Senior residents closely follow PG-1 progress and provide regular and on-the-spot feedback and teaching.
- g. UF psychiatry residents are fortunate to be exposed to a number of Neurology faculty whose specialization is in behavioral neurology. This affords greater exposure to the intricacies of higher cortical functions and greater interplay with psychiatric pathology.

**f) Adult Outpatient Psychiatry**

- a. Required 12-month rotation in the PG-3 year.
- b. Clinic faculty consist of 3 full-time psychiatrists and 10 part-time psychiatrists
- c. Residents spend approximately 5 hours weekly in didactics including seminars, case conferences, and training modules; additionally, residents spend 2 hours weekly in individual supervision with faculty discussing their cases; residents have approximately 25 patient contact hours/week, all of which are directly staffed by an on-site attending; residents are observed interviewing new patients and emphasis is placed on mastery of the biopsychosocial formulation; therapy cases are both staffed on-site, and discussed in more detail later in individual supervision.
- d. The outpatient population is diverse in diagnoses, age, and socioeconomic status. Approximately 60% of patients are female; ages range from 18 to 95, with the majority falling between 30 and 50. While a majority of patients are in the lower middle class, residents are exposed to a large number of indigent cases in government sponsored programs as well as affluent tertiary referrals. Residents get additional experience in such tertiary services as refractory mood and anxiety disorders, and more complex neuropsychiatric patients with a variety of movement disorders and pain management. The majority of patients are Caucasian (approximately 60%), with 30% African American, and 10% Asian or Hispanic; approximately 60% of cases involve depression or anxiety, 30% include some component of psychosis, another 15-30% have some component of substance abuse, 30% have personality disorders or traits, and 10-15% have elements of a psychiatric disorder due to a general medical condition with a significant representation of neurological disorders. A majority of patients receive some component of psychopharmacologic treatment, alone or in concert with psychotherapy; residents spend approximately 15-25% of their clinical time performing psychotherapy; residents also have experiences in couples and group therapies during their PG-3 year.

- e. Average caseload consists of 10-20 patients in some form of psychotherapy and 50-100 patients in medication management.
- f. All PGY-3 residents have required individual supervision 2 hours/week with faculty members specifically qualified to instruct on psychotherapy. Additionally, PGY 3 residents are now divided into 2 cohorts, each meeting 1-15 hours weekly for a group supervision/process group. An attending psychiatrist performs on-site supervision of psychopharmacology management. Additional supervision in clinical issues, research initiatives, and career mentoring is available on an optional basis.

**g) Consult-Liaison Psychiatry**

- a. 2-4 month rotation during the PG-1 year; 4 months on this rotation in the PG-2/4 year.
- b. Faculty consists of one full-time psychiatrist and one part-time psychiatrist (who is board-certified in psychosomatic medicine) with additional departmental psychiatrists to provide back up. Departmental and hospital social work assistance is also present.
- c. Residents spend 1-3 hours daily in rounds. The psychiatric faculty supervises all cases. Residents have 3-6 hours of didactics per week. Residents give presentations on various subjects pertinent to clinical cases.
- d. The patient population consists of approximately 25% mood disorders, 25% substance disorders, 5% adjustment disorders, 25% dementia and delirium, 6% substance-induced psychiatric disorders or psychiatric disorders due to a general medical condition, 10% primary psychotic disorders, 8-10% anxiety disorders and 6-8% somatoform disorders (percentages do not total 100% due to co-morbidities). Residents are responsible for thorough evaluations and providing opinions on civil commitment cases. A number of treatment modalities are experienced including ECT, psychopharmacotherapy, crisis intervention, brief therapy, cognitive-behavioral therapy, and psychosocial rehabilitation. Part of the educational experience is also to effectively interface with other medical teams to provide care for a patient in a treatment team approach.
- e. Residents see approximately 9-10 new cases per week plus follow-ups as needed. The residents cover the floors and emergency rooms at UF Health Shands Hospital and the Gainesville VA Hospital from 8 am to 4 pm. Coverage is provided by on call residents and faculty from 4 pm to 8 am. In addition, children and adolescents are seen in the ER and in the Children's Hospital on this service.
- f. The psychiatric faculty supervise all cases. Residents receive supervision daily in rounds. There are also case discussions and formal lectures on C/L subjects scheduled throughout the week.
- g. All of the faculty, many of which have sub-specialties, are available to the consultant with difficult cases.

**h) Child and Adolescent Outpatient Psychiatry**

- a. Required 12-month rotation in the PG-3 year, ½ day per week.
- b. Clinic faculty consists of 1 full-time child psychiatrist and one advanced registered nurse practitioner.
- c. PG-2 residents are supervised in their clinical experience by on-site faculty and participate in a comprehensive child/adolescent psychiatry orientation before engaging in direct patient care. PG-2 residents also attend a weekly Child seminar for the full academic year, have exposure to child psychiatry-focused case conferences, and have the ability to interact with child and adolescent psychiatry fellows.
- d. The clinic population is comprised of children and adolescents in the age range of 6 to 17 years. The clinic director enhances diagnostic diversity through the periodic review of PGY-2 caseloads. The majority of patients fall within the middle class, and there is exposure to both low and high socioeconomic status families. Patients are predominately Caucasian with a substantial minority of African American, Hispanic and Asian-American descent. A majority of patients receive some component of psychopharmacologic treatment, alone or in combination with various psychotherapy modalities. Other patients are seen for therapy modalities alone.
- e. PGY-2 residents carry an average caseload of 20-40 patients over the course of the academic year.
- f. All PGY-2 residents have new evaluations staffed and seen by a child psychiatry attending physician, and an attending Child Psychiatrist performs on-site supervision and is available for all case discussions.

**i) Child and Adolescent Inpatient Psychiatry**

- a. Required 1 month rotation in PG-2 or 4 year.
- b. Faculty and staff consist of one full-time child psychiatrist, one consulting child psychologist, one full-time social worker (LCSW) functioning as therapist/case manager, and one occupational therapist. When the child psychiatrist is on approved leave (vacation, conference attendance, sick), faculty from the child division cross-cover.
- c. Residents learn through active participation in daily rounds with on-site supervision by faculty and discussion of key diagnostic and treatment issues. The therapies center on a mindfulness based cognitive behavioral therapy model integrated with a token economy. Residents also gain exposure to and participate in group and family therapies on the unit. Finally, residents learn through their instruction of medical students on service.

- d. The program consists of an average of seven inpatients and one partial hospital program patient daily. Boys comprise approximately 55% of the patient population and girls 45% of the population. Both middle and lower middle class socioeconomic status patients are represented. In addition, children of lower socioeconomic status with co-occurring major medical illnesses are treated in this program. Average length of stay is 5 to 7 days. The patient mix consists of approximately 80% Caucasian, 14% African American, and 6% of various other racial/ethnic backgrounds. The main problems requiring admission are affective disorders including depression and bipolar spectrum diagnoses. Post traumatic stress disorder is the most common of the anxiety disorders requiring hospitalization although the full range of anxiety disorders are represented. Conduct disorder and substance use disorders are common comorbidities. Psychotic disorders including schizophrenia and pervasive developmental disorders such as Autism and other developmental delays are represented. Eating Disorders and emerging Personality Disorders are also seen.
- e. Average caseloads range from 4 to 6 inpatients. Most cases are representative of the demographics/diagnoses listed above.
- f. Residents are supervised daily in team rounds and case discussions. They have multiple opportunities for supervision regarding mindfulness based CBT in action whether in the classroom, working with the structured therapeutic workbook, or in direct supervision during family or group.

**j) UF Health Psychiatric Hospital Inpatient Addiction**

- a. Residents may spend 1 month on this rotation during the 2<sup>nd</sup> or 4<sup>th</sup> year. One month of training in addiction is required (and accomplished either on the VA or Vista Service). Electives are also available.
- b. Primary full-time faculty consist of 2 addiction specialists (one board certified in Adult Psychiatry and Addiction Medicine; one board certified in Emergency Medicine and Addiction Medicine). Additional Vista faculty consist of 5 psychiatrists who are not addiction specialists. Residents also interact with VA licensed therapists/counselors who perform individual and group therapy.
- c. Residents spend 3-5 hours per week in seminars (including *Principles of Addiction Medicine* didactic) and case conferences in addition to 3-4 hours daily in rounds with the faculty. The faculty interviews all patients with the residents and supervises them on all cases. A broad range of addiction diagnoses is seen.
- d. The clinical population spans a broad range of socioeconomic classes from the poor to the affluent. Approximately 62% of the patients are male and 38% female, 91% white, 6% black, and 1% Hispanic. The average age at time of discharge is 40. Diagnostically, approximately 50% have a primary alcohol or sedative use disorder, 19% have opioid use disorders, 10% cocaine use disorders and 35% have a polysubstance use disorder. A number of patients have a substance-induced psychiatric disorder or a primary psychiatric disorder. Residents are exposed to the treatment of withdrawal syndromes, substance-induced psychiatric syndromes, primary psychiatric syndromes in conjunction with addiction disorders, and the psychosocial treatments of addictive disorders including the 12-step programs and psychosocial rehabilitation.
- e. The normal case load is 3-10 patients with a maximum of 10 patients. The residents partake in all aspects of treatment.
- f. The residents have required individual supervision twice weekly for 1 hour. Clinical teaching occurs during daily rounds. Also, residents take part in the group therapy component and work with the addiction therapists.

**k) UF Health Psychiatric Hospital Inpatient**

- a. Required 2-month rotation in the PG-2 and PG-4 years; additionally most PG-1's do a 2 month rotation on this service.
- b. Faculty consists of 4 full-time board-certified psychiatrists. Another is additionally board-certified in geriatric psychiatry.
- c. Residents spend 1-3 hours daily in rounds with the faculty. They are in seminars 3-5 hours weekly. The faculty interviews all patients with the residents and supervises them on all cases.
- d. The patient population spans the breadth of socioeconomic classes. Approximately 78% are white, 18% black, and 2.5% Hispanic and 1.5% others. Diagnostically, about 35% have a primary mood disorder 33% primary psychotic disorder, 6% adjustment disorder, 10% primary cognitive disorders. A number of the patients have co-morbid personality disorders and substance use disorders. Treatment modalities include psychopharmacology, individual psychotherapy including brief, crisis intervention, and cognitive-behavioral, family and group therapy, case management, and psychosocial rehabilitation. Residents are exposed to psychological and neuropsychological testing. Residents also have the opportunity to testify at civil commitment hearings.
- e. The average caseload ranges from 8-10 patients. The resident participates in the evaluation, treatment, discharge planning, and chart documentation.

- f. The residents have 2 hours of required individual supervision weekly. Clinical teaching occurs daily in rounds. Residents participate in all aspects of treatment and are taught by an attending faculty as well as social workers and other allied health care professionals.
- g. The residents see a broad range of psychiatric diagnoses in a community setting.

**l) VA Community Psychiatry: Mental Health Intensive Case Management (MHICM) and Healthcare for the Homeless Veterans (HCHV); Helping Hands Psychiatry Clinic**

- a. Residents spend 1-2 months on this service during the PG-2 and 4 year and this rotation is required.
- b. Faculty consists of 1 full-time psychiatrist.
- c. Residents spend 3-5 hours weekly in didactics and 1-3 hours daily in clinical rounds with the faculty.
- d. The Community Psychiatry rotation at the VA has 2 components. Residents primarily care for patients in the intensive case management service in which there are approximately 130 patients with severe mental illnesses, primarily schizophrenia as well as major mood disorders such as bipolar disorder. The age of the patients ranges from 20s-70s. Treatment modalities include psychopharmacology, crisis intervention, group therapy, case management, and psychosocial rehabilitation. At MHICM, residents have the opportunity to learn more about clozapine management and participate in the clozapine group.
  - i. Residents also have the opportunity to rotate with HCHV at the new VA domiciliary or on the inpatient setting to provide treatment for the homeless program that provides resource education and needs-based care to homeless veterans. Residents evaluate and treat veterans with psychiatric and dual diagnoses. Treatment modalities include psychopharmacology, crisis intervention, and supportive therapy. Residents also help engage veterans in the wider VA system by providing consults. In addition, the resident on the MHICM rotation are expected to participate in at least 2 Helping Hands clinics per month while on rotation. Helping Hands is a medical and psychiatry clinic for the homeless and nearly homeless of Gainesville.
- e. The residents are expected to participate in all aspects of the Community Psychiatry Program. The residents participate with the faculty member in the treatment of approximately 150-200 patients. On average, the resident will see 5-10 patients per day. Flexibility is required in the management of these patients. At times the severity of illness dictates the frequency of visits, including crisis interventions to avert exacerbations.
- f. Clinical teaching occurs daily in rounds and during clinic times as appropriate. The attending is always available for consultation. Residents participate in all aspects of treatment and learn from case managers, nurses, and social workers.
- g. Residents are exposed to patients with severe psychiatric illness and are given the opportunity to learn about community psychiatry in 2 distinct programs. Emphasis is placed on the importance of the biopsychosocial model in the evaluation and treatment of patients. The residents are also given administrative duties that often are closely tied to community resources and outreach programs. Additionally, residents, at times, provide education relevant to Community Psychiatry to the MHICM staff.

**m) Addiction Psychiatry/Florida Recovery Center (FRC)**

- a. 1 month, elective, usually completed in the PG-2 or -4 year.
- b. Faculty consists of 1 full-time board-certified psychiatrist who is also certified in addiction medicine and 2 full-time board-certified addiction medicine specialists. In addition, there are 1 full-time clinical psychologist and 6 full-time certified addiction counselors.
- c. Residents attend weekly 1-hour didactic sessions reviewing chapters in *Principles of Addiction Medicine*. Residents are given additional specific reading assignments designed to enhance their knowledge of addiction medicine that are discussed with the attending physicians. Residents continue to have 2 hours of individual supervision weekly. Residents remain in their usual PGY-specific didactics/conferences 3-5 hours per week. Residents also continue their continuity clinics during their elective time unless otherwise arranged.
- d. The patient population is adults ages 18 and up, with the majority aged 21-50; approximately 80% of patients are Caucasians, approximately 60% male/40% female. Patients are enrolled in a partial hospitalization program for addiction treatment. The program specializes in the treatment of healthcare professionals, so a sizable and variable percentage of the patients are licensed physicians, nurses, etc. Virtually all patients have a diagnosis of substance dependence, and approximately 50% also have significant comorbid psychiatric conditions, most commonly mood disorders and anxiety disorders. Residents spend the majority of their time making clinical rounds with the attending physician(s), actively participating in a variety of group therapy sessions, and participating in outpatient forensic evaluations of patients suspected of having substance use disorders.

- e. The typical census in the partial hospitalization program is approximately 40-45 patients. Residents are assigned specific patients, not to exceed 10. At the discretion of the attending physician(s), residents may take more of a broad role in the overall treatment administration process, rather than taking individual patient responsibilities.
- f. Residents are continuously supervised by the addiction medicine faculty, one of whom is present during all direct patient interactions, with the exception of occasional outpatient forensic evaluations, where the resident may first see a patient alone, then discuss with the attending physician who will see the patient immediately following. Residents continue to have their usual 2 hours per week of individual supervision of their psychotherapy cases.
- g. This rotation allows residents to experience first-hand the world of addiction treatment at a leading institution in the field. The FRC is the training site of the University of Florida's acclaimed addiction medicine training program that has trained more fellows in addiction medicine than any other institution in the United States.

**n) UF Health Shands Consults Junior Attending**

- a. 1 month rotation, elective, usually completed in PG-2 or -4 year.
- b. Faculty consists of one full-time psychiatrist and one part-time psychiatrist (who is board-certified in psychomatic medicine) with additional departmental psychiatrists to provide back up. Departmental and hospital social work assistance is also present.
- c. Residents spend 1-3 hours daily in rounds. The psychiatric faculty supervises all cases. Residents have 3-6 hours of didactics per week. The junior attending teaches junior residents and medical students with oversight and review by the attending.
- d. The patient population consists of approximately 25% mood disorders, 25% substance disorders, 5% adjustment disorders, 25% dementia and delirium, 6% substance-induced psychiatric disorders or psychiatric disorders due to a general medical condition, 10% primary psychotic disorders, 8-10% anxiety disorders and 6-8% somatoform disorders (percentages do not total 100% due to co-morbidities). Residents are responsible for thorough evaluations and providing opinions on civil commitment cases. A number of treatment modalities are experienced including ECT, psychopharmacotherapy, crisis intervention, brief therapy, cognitive-behavioral therapy, and psychosocial rehabilitation. Part of the educational experience is also to effectively interface with other medical teams to provide care for a patient in a treatment team approach.
- e. The junior attending's main role is to receive consults and delegate cases to more junior residents. The junior attending may opt (with attending input) to see and follow certain consult patients (e.g. more complicated or rare cases) that are deemed to enhance the junior attending's learning. Maximum caseload is 3.
- f. The psychiatric faculty supervise all cases. Residents receive supervision daily in rounds. There are also case discussions and formal lectures on C/L subjects scheduled throughout the week.
- g. All of the faculty, many of which have sub-specialties, are available to the consultant with difficult cases. The junior attending may take the opportunity to learn more specialized subject matter such as billing in preparation for transition to a faculty role.

**o) Electroconvulsive Therapy (ECT; UF Health Shands or VA)**

- a. 1 month, elective, usually completed in PG-2 or -4 year.
- b. Faculty consists of 2 board-certified psychiatrists; one is full-time, and one is part-time. When on approved leave (vacation, conference attendance, sick), faculty from the UF Health Shands or VA inpatient/outpatient services provide cross-coverage.
- c. Residents spend approximately 3-4 hours every Monday, Wednesday, and Friday morning in the ECT suite performing ECT alongside the faculty member. Residents are encouraged to attend rounds on the inpatients receiving ECT. Residents spend 3-5 hours per week in seminars and conferences.
- d. The patient population is predominantly middle class but patients from all socioeconomic classes are encountered. About 60% of the patients are female and 40% male, 80% white, 15% black, and 5% other ethnicities. The average age of the patients is approximately 60. Diagnostically, about 15% have a primary cognitive disorder, 75% have a primary mood disorder, 10% have a psychiatric disorder due to a general medical condition or substance induced psychiatric disorder, 5-8% have a primary psychotic disorder, and 2-5% others. Most of the patients have co-morbid medical conditions. Treatment modalities include ECT and psychopharmacology.
- e. The average caseload ranges from 7-9 patients with a maximum of 10 patients. The resident participates in the evaluation process, treatment planning, discharge process, and chart documentation.
- f. The residents have required individual supervision twice weekly for 1 hour. Clinical teaching occurs daily in the ECT suite.

- g. The residents see a broad range of disorders. A number of the patients have co-morbid medical conditions highlighting the interplay between psychiatric and medical illness. Residents teach medical students on this rotation. Inpatient and outpatient ECT (1800+ cases per year) is provided on this unit.

**p) Transcranial Magnetic Stimulation (TMS)**

- a. 1 month, elective, usually completed in PG4 year.
- b. Faculty consists of 2 full-time board-certified psychiatrists with specialized training in TMS.
- c. Educational methods include assigned reading, observation, and performing the TMS procedure under the supervision of the faculty attending. The resident also learns about clinician administered depression scales and patient self-rating scales.
- d. All patients have a primary mood disorder. Patients consist of males and females from the ages of 18-80. All socioeconomic levels are seen but most patients are in the middle to high economic level. The ethnic mix is The majority of patients are Caucasian (approximately 60%), with 30% African American, and 10% Asian or Hispanic; approximately 60% of cases involve depression or anxiety, 30% include some component of psychosis, another 15-30% have some component of substance abuse, 30% have personality disorders or traits, and 10-15% have elements of a psychiatric disorder due to a general medical condition with a significant representation of neurological disorders.
- e. Average caseload is 2 with the maximum of 6.
- f. The resident meets daily with the TMS faculty member to discuss each case.
- g. This rotation allows the resident to learn the latest in device-mediated treatment of mental illness.

**q) Northeast Florida State Hospital (NEFSH)**

- a. 1 month (more if desired), elective, usually completed in PG-2 or -4 year.
- b. Faculty consists of 1 full-time board-certified psychiatrist. When on approved leave (vacation, conference attendance, sick), other facility faculty provide cross-coverage.
- c. Residents spend approximately 20 hours per week at NEFSH during this rotation. They round with the attending psychiatrist/treatment team (approximately 3-5 hours), attend group therapy sessions, and spend time in supportive therapy with the patients. Residents spend 3-5 hours per week in didactics/conferences.
  - i. In addition, the resident on the NEFSH rotation are expected to participate in at least 2 Helping Hands clinics per month while on rotation. Helping Hands is a medical and psychiatry clinic for the homeless and nearly homeless of Gainesville.
- d. The patient population is predominantly lower socioeconomic class but patients from all socioeconomic classes are encountered. About 35% of the patients are female and 65% male; 65% white, 35% black/other ethnicities. The average age of the patients is approximately 70 (ward where residents work) but can range from 20 to 90 plus at the hospital in general. Diagnostically, 86% have a schizophrenia/schizoaffective disorder, 4% have dementia, and 10% have other Axis I disorders. Approximately 30% have a personality disorder and 49% have a substance abuse diagnosis. Approximately 75% have a least one serious medical condition. Treatment modalities include psychopharmacology, ECT (off grounds), individual/group psychotherapy, work/vocational programs, and recovery center classes. Residents also have access to observing forensic evaluation by a forensic psychologist.
- e. The average caseload ranges from 7-9 patients with a maximum of 10 patients. The resident participates in the evaluation process, treatment planning, discharge process, and chart documentation.
- f. The residents have required individual supervision twice weekly for 1 hour. Clinical teaching occurs daily on rounds.
- g. Provides residents experience in the treatment of patients with severe, chronic mental illnesses who are mostly involuntarily committed to a state hospital system. May count towards the Community Psychiatry experience.

**r) Student Mental Health**

- a. 1 month (more if desired), elective, usually completed in the PG4 year.
- b. Clinic faculty consists of 2 full-time and 2 part-time board-certified psychiatrists.
- c. Residents continue to attend 3-5 hours of scheduled didactics/conferences as well as 2 hours of individual supervision each week. Residents see new and follow up patients for evaluation, diagnosis, and treatment in the outpatient setting. Although psychopharmacology is the main treatment modality, the resident can recommend and/or provide individual psychotherapy.
- d. Most patients treated during this rotation are college-age adolescents or young adults. The clinic population consists of about 40% males and 60% females; 80% are Caucasian, 5-10% African American and about 15% Hispanic. Ages can range from 17 to some nontraditional students in their 60's. However, the majority are 18-24 years of age. Approximately 50-60% are treated for depressive disorders and/or anxiety disorders, 20-25% have a primary or co-morbid ADHD diagnosis, 5% with bipolar disorders and/or psychotic disorders, 5-10% with

personality disorders, and 5-10% with adjustment disorders. Residents learn pharmacotherapy and various therapy modalities within the outpatient clinic setting.

- e. An average case load would consist of 20-30 patients for medication management and 3 patients in individual psychotherapy.
- f. Supervision is provided by the assigned supervisor (a board certified psychiatrist) who is present on-site. This is typically one hour face to face supervision to discuss cases the resident has seen throughout the day. The supervisor is also available throughout the day for consultation regarding any complicated issues. Faculty are also available by phone to provide back up. Additional supervision can be arranged by mutual understanding.
- g. Provides resident experience in comprehensive psychiatric evaluations and medication management for adolescents/young adults. Residents may also gain experience working in conjunction with assigned therapists, or they may provide psychotherapy in their own sessions.

**s) VA Teaching**

- a. 1-2 months, elective, usually completed in PG-2 or -4 year
- b. 2 full-time board-certified psychiatrists.
- c. The VA Teaching resident prepares and presents lectures, journal clubs, and case conferences for other residents rotating at the VA. They provide approximately 2 sessions per week. The VA Teaching resident is responsible for maintaining attendance records for the lectures.
- d. N/A.
- e. N/A.
- f. Peers and faculty attend the VA Teaching resident conferences and provide feedback to the Teaching resident both verbally and electronically. The Teaching resident continues to have two hours of individual supervision weekly as well as didactics/conferences 3-5 hours per week. Continuity clinics are continued during this elective unless otherwise arranged.
- g. Allows resident to work independently, develop and practice teaching style and techniques, develop a teaching portfolio, and review for PRITE and ABPN exam.

**t) Research**

- a. 1-2 months (more possible), elective, usually completed in PG-2 or -4 year
- b. Varies depending on research interest of resident. May be psychiatrist, psychologist, basic scientist; full- or part-time.
- c. Laboratory and/or clinical research. Instruction in research methodology, ethical conduct of research, IRB, other regulatory issues, grantsmanship, publication, peer review, and critical appraisal of the literature included.
- d. N/A.
- e. N/A.
- f. Scheduled supervision is per the research mentor. It is recommended that at a minimum the resident and mentor meet weekly to discuss progress and provide instruction. The resident continues to have two hours of individual supervision weekly as well as didactics/conferences 3-5 hours per week. Continuity clinics are continued during this elective unless otherwise arranged.
- g. Allows residents to develop or continue their interest in research. It is expected that some measure of productivity be required by the research mentor such as a publication-quality manuscript, grant application, and/or abstract submission to a meeting.

**Policy: Expectations of Program Residents**

**Purpose:**

To define the expectations of program residents.

**Basic professionalism:**

- Attend to your self-care and well-being. Encourage and assist your peers to do the same. Seek assistance when needed (Program Directors will guide you).
- The Program Director, and Associate Program Directors, are your direct supervisors and the first line of communication if there are any issues with your rotation, teaching faculty or other unexpected developments. Attached is a flow chart of communicating issues.
- Dress professionally and as directed by supervising attendings.
- Demonstrate a professional attitude and professional behaviors at all times. Model such behaviors for others.



- Treat all patients and their families with respect just as you would want yourself and your family to be treated. Use a trauma-informed care approach. Consider the patient's culture in your overall formulation and treatment plan. Practice cultural humility.
- Recognize and learn about your own biases and gain further supervision and training in this area.
- Be inclusive and equitable in your care, work, and education. Promote and support a diverse clinical and learning environment.
- Participate in emergency/disaster (e.g. hurricane, pandemic) preparedness and coverage to ensure continuous provision of safe patient care.

**Time management:**

- Arrive on time, rested, and ready to work and learn. Communicate when you will be tardy or unavailable.
- Be present and available from at least 8 AM to 5 PM Monday-Friday and as required for call or night float. Longer hours may be required for some rotations; please review the reporting instructions before each rotation as listed in the Goals and Objectives in New Innovations. Also, please discuss expectations for individual rotations with your attending(s). Please note that psychodynamic psychotherapy clinic is required once weekly for full-time outpatient clinic residents; this clinic is from 4-6 PM on the assigned day. On the assigned day, the resident is scheduled from 9 AM instead of 8 AM to offset the extra evening hour for this clinic.
- Log duty hours honestly and at least weekly.
- Alert rotation attendings and staff if you are leaving early or will be on leave. Remind other team members and covering residents prior to leave.

**Communication:**

- Communicate effectively and professionally.
- Be truthful and honest in all interactions and duties.
- Demonstrate professional telephone communication.
- Keep outpatient and other major providers up to date on patient conditions and plans. Work with them as a team to provide the best continuity of care for patients.
- Obtain and document collateral information when possible. Document in the medical record all attempts to obtain collateral.
- Respond promptly to work-related emails, telephone calls, pages, and texts.
- Emails: non-urgent emails in 24 hours; urgent and emergent emails STAT
- Text messages and phone calls: As soon as feasible; at most before the closing of business day
- Demonstrate appropriate handoff of patient care.

**Supervision:**

- Ask for help when needed. Seek feedback and supervision.
- Staff all admissions, discharges, and transfers or any major change in the medical status of your patients with an attending (e.g. rotation attending or on call attending as appropriate).
- Staff all patient safety events such as suicide attempts, self-injurious behavior that require medical intervention, major change in medical status [suspected MI/CVA, trauma, falls with significant injury, patient physical aggression, or ETO/seclusion/restraint], and sexual or other abuse allegations with an attending (the RD when on call).

**Teamwork:**

- Demonstrate a high level of teamwork both within the program/department and with other specialties with whom we work. Positive contributions to a healthy work environment are demonstrated by:
- Maintaining personal accountability (e.g., showing up on time, completing assignments)
- Supporting team members and willingness to share work load
- Listening or otherwise engaging with an open mind, while assuming that others generally have good intentions
- Responding constructively and timely to inappropriate behaviors
- Treating all members of the treatment team including physicians, nurses, mental health technicians (MHTs), clerks, trainees, pharmacists, etc. with respect; recognize and value their contributions to the overall care of patients.
- Communicating in a respectful, positive manner to all employees. Our healthy work environment does not tolerate incivility, blatant disrespect, intimidation, or abusiveness, nor sexual misconduct as defined in the UF Title IX policy
- Treat peers and supervisors with respect.

- Medical record keeping:
- Complete all notes including H&Ps, progress, and discharge notes in a timely manner. This is to ensure good communication and enhance patient safety.
- For example, clinic notes are due no later than the end of the next business day (5 PM). Ideally, they should be completed the same day of the encounter. Discharge summaries are due no later than 48 hours post-discharge; they are due prior to discharge if the patient is going to a skilled nursing facility or the emergency department.
- Limit copy/paste in the medical record, and when used, review carefully, quote the source if not your own work, and edit sufficiently to capture the essence/essentials of the current encounter and to avoid medical errors.
- Ensure that medical records document accurately and comprehensively the patient encounter as well as the rationale for assessments and treatments (i.e. each diagnosis should have criteria described in the history and each medication prescribed should have an accompanying rationale/indication). Remember, if it is not documented, it did not happen.
- Check the PDMP/E-FORCSE prior to prescribing controlled substances for all patients 16 years of age or older (for outpatient and at discharge for inpatients).

#### **Safety:**

- Follow all current infection control and prevention requirements/guidelines for the area in which you are working.
- Be aware of your surroundings and environment at all times. Seek assistance from staff and security when needed.
- Complete annual safety training.
- Report all patient safety issues and concerns to supervisors and via the Patient Safety Report, or PSR, system (IDInc).
- Attend root cause analyses (RCAs) as requested by the training program (at least 1 is required prior to graduation).
- Participate annually in a team Quality Improvement (QI) project.

#### **Education:**

- Unless on approved leave, attend all didactics. If you do not attend didactics, you must take leave. Sign in for each didactic session only if you are not missing more than 10 minutes of the session.
- For grand rounds, journal clubs, and other conferences/activities (e.g. fireside chats) that usually occur during the noon hour, you are expected to attend, and attendance will be monitored and be a factor in professionalism metrics. If you miss a session, leave will not be charged. Sign in for attendance only if you are not missing more than 10 minutes of the session. Residents are expected to attend 90% of Grand Rounds unless they are on approved leave.
- Pursue a course of self-study (self-directed reading, conference attendance, etc.) to supplement didactic courses and knowledge base.
- Sit for Step 3 no later than Spring of PGY1 year. The Residency Office must receive a copy of the results by May of PGY1 year.
- Pass 3 clinical skills assessments prior to graduation or transition to a Child and Adolescent Psychiatry training program. Every year residents will have an opportunity to complete 2 CSA during scheduled windows.
- Attend at least 1 (Baker Act) court session and one RCA.

#### **Scholarship:**

- Actively seek opportunities to engage in scholarly activity.

#### **Administrative:**

- Locate and follow ACGME, ABPN, institutional, hospital, and departmental/program policies.
- Complete administrative tasks/evaluations/checklists in a timely manner as requested.
- Report/request all leave promptly, honestly, and accurately as per program policy. Ensure that the Chief Residents and the Residency Training Office are aware of your leave.
- Vacation leave must be requested as soon as possible but no later than 45 days prior to date of leave. If an extended leave is necessary (e.g. parental leave), the program director should be contacted as soon as possible in order to make necessary arrangements for rotation changes, obtain GME approval, etc. If you leave a rotation service for personal reasons for any amount of time, you must request leave. Leave is not allowed during PRITE or the last 2 weeks of June/first 2 weeks of July (exceptions such as for transfer to another ACGME-accredited training program must be pre-approved well in advance by the Training Director).
- If you are out sick for more than 3 days in a rolling month, you must provide a doctor's statement (with the allowed return to work date) before returning to work.
- Use sick leave appropriately for qualifying illness and medical/dental/mental health appointments. Sick leave is not extra vacation time. Requests made to "use up" sick leave at/near the end of the academic year may not be honored.

#### **Portfolio:**

- Maintain timely and accurate case logs. The minimum target per year is 400.
- Complete all portfolio requirements in a timely fashion. Portfolios must be completed no later than May 31 of the final year in the program in order to graduate and be eligible to sit for the ABPN certification exam. Those wishing to transfer to a Child and Adolescent Psychiatry training program must complete their requirements no later than May 31 of the PG-3 year. For those residents who are off-cycle, portfolios will be due 1 month prior to the final day in the program.

**Teaching:**

- Teach junior residents and medical/PA students as assigned.
- Attend institutional Resident as Teacher workshop at start of training.
- Consider participating in the longitudinal Resident as Teacher program to enhance teaching skills.

**Wellbeing:**

- Make sure that you a lot enough time for resting and pursuing your hobbies.
- The GME policy on addressing fatigue can be found at: <https://gme.sites.medinfo.ufl.edu/files/2012/07/Housestaff-Faculty-Fatigue.pdf> (you can request a copy from program coordinators)
- If at anytime you feel work is affecting your ability to rest and learn, reach out to the Chiefs, the PD and the APDs.
- UF Wellness resources include:
- <https://wellness.med.ufl.edu/residents-fellows/>
- <https://gatorcare.org/wellness/>

**Program Goals and Objectives**

**Overall Goals:**

1. To provide qualified physicians with a well-rounded educational training environment, diverse in both didactics and clinical experience.
2. To foster the development of prerequisite knowledge, skills, and attitudes in accordance with the professional guidelines set forth by the Psychiatry Residency Review Committee of the American College of Graduate Medical Education, and the American Board of Psychiatry and Neurology, Inc.
3. To prepare qualified physicians for the independent practice of psychiatry and to expose them to the wide range of career opportunities available in the area of academics, research, clinical practice, and the various psychiatric subspecialties.
4. To provide a solid educational background that prepares residents to successfully pass the certification examination in psychiatry by the American Board of Psychiatry and Neurology.

**Goals and Objectives PGY 1**

**Overall Goals for PGY 1**

**I. Medical Knowledge**

- A. Build a foundation in general adult medical knowledge that includes neurological conditions as well as medical illnesses.

**II. Patient Care**

- A. To diagnose common medical and surgical disorders and to provide the appropriate treatment or management of the patient.
- B. To diagnose common neurological disorders and to provide appropriate management for them.
- C. To understand the need for consultation and the appropriate use of consultative services.
- D. To learn the skills necessary to perform a medical and neurologic examination.
- E. To learn skills necessary in performing a thorough psychiatric evaluation.
- F. To understand the interplay between medical and psychiatric disorders.
- G. To understand the interaction of pharmacologic agents in the treatment of medical and psychiatric conditions.

**III. Interpersonal and Communication Skills**

- A. To develop communication skills that enables the psychiatrist to elicit a thorough history and develop therapeutic

relationships.

**IV. Professionalism**

- A. To become confident in the new role as a physician.
- B. To begin the process of becoming a psychiatrist.
- C. To acquire the sense of responsibility and autonomy necessary to practice medicine.
- D. To behave respectfully and collaboratively with treatment team members.
- E. To dress appropriately for professional/clinical activities.

**V. Practice Based Learning and Improvement**

- A. To establish a philosophy of continual lifelong learning.

**VI. Systems Based Practice**

- A. To work effectively as a member of a multidisciplinary team.

**PGY 1 Objectives by Clinical Rotation**

**1. Internal Medicine: 4 Months PGY1 year**

**Overall goal:** Provide the psychiatry resident with a foundation to understand common medical problems and those often present in the psychiatric patient.

**I. Medical Knowledge**

- A. Recognize general medical illness in adult patients.
- B. List medical disorders likely to present with psychiatric symptoms, and psychiatric disorders likely to present with medical symptoms.
- C. Select laboratory, imaging, radiographic, and diagnostic studies depending on patient presentation.
- D. Interpret chest x-rays, interpret ECGs, and laboratory studies.

**II. Patient Care**

- A. Complete a medical history and perform a physical examination on each patient.
- B. Demonstrate the ability to synthesize data from the history and physical findings.
- C. Order appropriate laboratory, imaging, radiographic, and diagnostic studies.
- D. Formulate a differential diagnosis and treatment plan.

**III. Interpersonal and Communication Skills**

- A. Develop communication skills that will elicit a thorough history and forge a therapeutic relationship.
- B. Demonstrate sound communication with patients, physicians and other health care staff members.

**IV. Professionalism**

- A. Recite the basic tenets of ethics in medicine.
- B. Demonstrate appropriate dress reflecting the professional position of a physician.
- C. Report to all assignments punctually and as required.
- D. Keep records up to date and sign off on charts in a timely fashion.
- E. Avoid banned abbreviations in medical records.

**V. Practice Based Learning and Improvement**

- A. Read current scientific literature and medical texts germane to patient care.
- B. Apply evidenced based data to optimize patient care.
- C. Utilize feedback from attending physicians and senior residents to identify strengths and knowledge deficiencies, and use this information to improve patient care.

**VI. Systems Based Practice**

- A. Collaborate as a member of the medical health care team.
- B. Use all resources appropriately to enhance patient care and safety.
- C. Differentiate and appreciate the roles of ancillary staff such as respiratory therapists, physical therapists, occupational therapists, discharge planners and social workers.
- D. Prepare an adequate discharge summary and plan for follow up medical care.

## 2. **Neurology: 2 Months PG1 year (or possibly 1 month PG1 year and 1 month PG2 year)**

**Overall Goal:** Develop foundational knowledge and clinical skills in neurology.

### I. **Medical Knowledge**

- A. State the signs, symptoms and other manifestations of neurologic illness.
- B. Cite the neurologic disorders that display symptoms largely regarded as psychiatric in nature.
- C. Identify the psychiatric conditions that present primarily with neurological symptoms.
- D. Discuss the appropriate selection of diagnostic laboratory, radiographic, imaging, and encephalographic studies depending on patient presentation.

### II. **Patient Care**

- A. Perform a thorough neurologic examination and history.
- B. Interpret diagnostic studies including CNS MRI and CT imaging studies to facilitate patient care.
- C. Describe the basic interpretation of EEGs.

### III. **Interpersonal and Communication Skills**

- A. Present a patient's case to a neurologist using proper terminology.
- B. Complete comprehensive, timely, and legible medical records.

### IV. **Professionalism**

- A. State the basic tenets of ethics in medicine.
- B. Demonstrate appropriate dress reflecting the professional position of the physician.
- C. Report punctually and as required to all assignments.

### V. **Practice Based Learning and Improvement**

- A. Apply current scientific information and evidenced based principles to the care of the neurologic patient.
- B. Utilize feedback from attending neurologists and senior residents to improve their knowledge base and optimize patient care.

### VI. **Systems Based Practice**

- A. Demonstrate appropriate referral of patients for neurologic consultation.
- B. Prepare an adequate discharge summary and plan for follow up care.

## 3. **Consult Liaison Psychiatry: Up to 3 Months PG1 year**

**Overall Goal:** Introduce the concepts of interaction between psychiatric consultants with other physicians and health care professionals, and initiate the process of becoming a psychiatric consultant.

### I. **Medical Knowledge**

- A. List the diagnostic criteria for psychiatric illnesses commonly encountered in emergency departments, and in hospitalized medically and surgically ill patients.
- B. Recognize the impact of illness, hospitalization and medical and surgical care on the psychological functioning and emotional well-being of patients.
- C. Develop a differential psychiatric diagnosis for all patients seen on the consult liaison service.
- D. Construct a comprehensive formulation regarding psychiatric diagnosis in medical and surgical patients.
- E. Recognize the typical signs of psychiatric disorders, including substance abuse, in medical and surgical patients.

### II. **Patient Care**

- A. Perform a thorough psychiatric assessment of the patient.
- B. Evaluate cognitive ability in medically and surgically ill patients.
- C. Order appropriate diagnostic studies based on patient presentation.
- D. Gather data from appropriate sources including patient chart, family, hospital staff, and other relevant individuals.
- E. Write pertinent and clinically useful consultation notes.

### III. **Interpersonal and Communication Skills**

- A. Communicate information effectively

- B. Demonstrate caring and respectful behaviors when interacting with patients and their families.
- C. Communicate effectively with physicians and other professionals.
- D. Demonstrate increasing comfort and confidence interviewing patients in various clinical settings.

**IV. Professionalism**

- A. Report on time and attend all assignments.
- B. Demonstrate respect, compassion, and integrity in interactions with patients, family, and other health care providers.

**V. Practice Based Learning and Improvement**

- A. Seek feedback from supervisors, attending physicians and other health care providers and utilize this feedback to improve performance.
- B. Use online resources and evidenced based data in the role as a consultant.

**VI. Systems Based Practice**

- A. Work as a consultant member of a team that provides patient care.

**4. Inpatient Psychiatry VA and Vista: Up to 6 Months PG1 year**

**Overall goal:** The overall goal of the first year inpatient psychiatry rotations is to provide the resident the experience necessary to enable building a foundation for the care of the psychiatrically ill inpatient.

**I. Medical Knowledge**

- A. List the diagnostic criteria for the major psychiatric disorders, their epidemiology, presentation, and differential diagnosis.
- B. Name the signs and symptoms of psychiatric disorders typically seen in the inpatient setting.
- C. Review basic psychopharmacology including mechanisms of action, indications for use, dosing, side effects and drug interactions.
- D. Describe the basic concepts, indications for the use of, complications, and contraindications for electroconvulsive therapy.

**II. Patient Care**

- A. Residents are expected to become adept at obtaining a psychiatric history, and
- B. Demonstrate performance of a medical and neurologic examination.
- C. Formulate an appropriate differential diagnosis depending on the patient presentation and order appropriate laboratory studies for further workup.
- D. Design a biopsychosocial formulation from the information obtained in the history, physical and neurological examinations, and laboratory, imaging, and radiographic studies.
- E. Practice psychotherapeutic techniques commonly employed on inpatient psychiatric units including supportive therapy, crisis intervention, cognitive-behavioral techniques, group therapy, and family therapy.
- F. Demonstrate ability to select appropriate laboratory, radiographic, imaging, and encephalographic studies depending on the patient presentation.
- G. Clearly document in the medical record a history, physical, mental status examination, ancillary information, and the thought making process in arriving at the diagnosis and the formation of the treatment plan.

**III. Interpersonal and Communication Skills**

- A. Obtain informed consent, and identify when a patient is unable to provide informed consent.
- B. Communicate with patients, family and other health care providers in a non-judgmental and professional fashion.
- C. Maintain comprehensive, timely, and legible medical records.

**IV. Professionalism**

- A. Dress professionally, report punctually and as required for all assignments.
- B. Demonstrate respect and compassion for patients and their family members.

**V. Practice Based Learning and Improvement**

- A. Apply information technology and evidence based data to enhance patient care.
- B. Read current scientific information daily to build their medical knowledge base.

**VI. Systems Based Practice**

- A. Work within a multidisciplinary team, and begin developing skills that will aid in leadership tasks.
- B. Demonstrate advocacy for quality patient care and cost-effective treatment.
- C. Prepare an adequate discharge summary and treatment plan for follow up care.

**Goals and Objectives PGY 2**

**Overall Goals for PGY 2**

**I. Medical Knowledge**

- A. Demonstrate sound knowledge base in medical, neurological and psychiatric patient care situations.

**II. Patient Care**

- A. Manage the full spectrum of psychiatric disorders using both psychopharmacologic and psychotherapeutic modalities.
- B. Manage patients on inpatient psychiatry units.
- C. Apply basic psychotherapy techniques and hone psychopharmacology skills through experience.

**III. Interpersonal and Communication Skills**

- A. Continue development of excellent communication skills.
- B. Further develop skills in consult-liaison psychiatry.

**IV. Professionalism**

- A. Demonstrate compassion, respect, and tolerance in all interpersonal interactions.
- B. Act as role model for junior residents.

**V. Practice Based Learning and Improvement**

- A. Demonstrate continued sophistication in the acquisition of knowledge and skills
- B. Further the ability to function independently in evaluating patient problems and developing a treatment plan.

**VI. Systems Based Practice**

- A. Demonstrate leadership roles on multidisciplinary teams.
- B. Demonstrate the ability to perform as effective teachers and supervisors of PGY 1 residents as well as of medical students.

**PGY 2 Objectives by Clinical Rotation**

**1. Consult Liaison Psychiatry: 6 Months PG2 year**

**Overall goal:** The overall goal is to master the concepts of interaction between psychiatric consultants and other health care professionals, and become proficient as a psychiatric consultant.

**I. Medical Knowledge**

- A. Demonstrate comprehension of medical illnesses that often present with psychiatric symptoms, and psychiatric disorders presenting with medical symptoms.
- B. Generate a complete DSM differential diagnosis on all patients evaluated.
- C. Demonstrate knowledge of suicidality, including epidemiology, risk factors, patient assessment, treatment, and prevention methods.
- D. Demonstrate knowledge of the epidemiology, differential diagnosis, and treatment of aggression and agitation.
- E. Describe the connection between psychiatric symptoms and the treatment of medical and surgical conditions.
- F. Demonstrate an understanding of the behavioral responses to medical illness.

**II. Patient Care**

- A. Develop a therapeutic alliance with medically and surgically ill patients.
- B. List the indications, contraindications, and adverse effects of electroconvulsive therapy.
- C. Demonstrate mastery at obtaining a psychiatric history including a thorough cognitive evaluation, and performing basic medical and neurologic examinations.
- D. Demonstrate mastery in formulating biopsychosocial diagnoses from the information obtained in the history, chart review, mental status, and physical examination.

- E. Select appropriate laboratory, radiographic, imaging, and encephalographic studies depending on the patient presentation.
- F. Develop expertise at interpreting the results of laboratory, radiographic, imaging, and encephalographic tests.
- G. Demonstrate mastery at treating the disorders seen by a psychiatric consultant including somatoform disorders, delirium and dementia, substance-related disorders, and medical symptoms caused by medication side effects.

**III. Interpersonal and Communication Skills**

- A. Demonstrate the ability to communicate with, and provide treatment recommendations to, other health care providers concerning psychiatric disorders commonly encountered by psychiatric consultants in general hospital settings, clinic settings, and the emergency room.
- B. Dictates and/or writes pertinent and useful consultation notes.

**IV. Professionalism**

- A. Demonstrate mastery of knowledge of legal and ethical issues involving patient care including confidentiality, informed consent, the right to refuse treatment, competency in health care decision making, advanced directives, voluntary and involuntary hospitalization, and be adept at managing these issues in the consult liaison setting.
- B. Demonstrates respect and compassion, and acts with integrity when interacting with patients and their families.

**V. Practice Based Learning and Improvement**

- A. Demonstrate proficiency in teaching other physicians, residents and medical students about psychiatric issues in the consult liaison setting.
- B. Use feedback from attending physicians and/or senior residents to improve their performance as a psychiatric consultant.
- C. Utilizes online medical resources and evidence based medicine to optimize patient care.

**VI. Systems Based Practice**

- A. Demonstrate mastery at working with physicians and other health care workers to provide optimal care for patients.
- B. Demonstrates the ability to practice cost-effective health care and resource allocation that does not compromise quality of care.

**2. Inpatient Psychiatry VA Psychotic Disorders Team: up to 2 Months PG 2 year**

**Overall goal:** The overall goal for the rotation is to provide the upper level resident a concentrated educational experience in the management of seriously ill psychiatric patients.

**I. Medical Knowledge**

- A. Review the diagnostic criteria for the DSM psychotic disorders, and demonstrate the ability to recognize the signs and symptoms of psychotic disorders commonly encountered in the inpatient setting.
- B. State the current scientific data concerning epidemiology, etiology, and treatment of the psychotic disorders.
- C. Demonstrate the knowledge of psychiatric and medical conditions that may be co-morbid in patients with psychotic disorders.
- D. Demonstrate knowledge of psychopharmacologic medications used to treat the psychotic patient including their indications, contraindications, and adverse effects.

**II. Patient Care**

- A. Articulate a biopsychosocial formulation of a patient with psychosis, and utilize this information to formulate a treatment plan.
- B. Demonstrate psychotherapeutic techniques utilized in the treatment of the psychotic disorders.
- C. Demonstrate the clinical ability to utilize psychopharmacologic treatments effectively for the patient with psychosis.
- D. Demonstrate skill in obtaining a complete psychiatric history, and performing a medical and neurologic examination in a psychotic patient.
- E. Demonstrate the ability to differentiate primary psychotic disorders from medication or substance induced psychotic disorders, or psychosis precipitated by medical illnesses.
- F. Demonstrate skill in selecting appropriate laboratory, radiographic, imaging and encephalographic studies to aid in the diagnosis and treatment plan.
- G. Demonstrate knowledge of the rating scales utilized to assess either the signs and symptoms of patients with psychosis, or the adverse effects of pharmacotherapy.



**III. Interpersonal and Communication Skills**

- A. Demonstrate skill in obtaining informed consent and demonstrate understanding when a patient is unable to provide informed consent for treatment.
- B. Assess acuity of psychopathology on the inpatient unit, managing the potentially aggressive patient and effectively communicate the need for intervention to other team members.

**IV. Professionalism**

- A. Treat all patients, their families, team members and staff with respect and compassion.
- B. Dress appropriately, be punctual and present for all assignments.

**V. Practice Based Learning and Improvement**

- A. Use information technology and evidence based data to enhance patient care.
- B. Expand knowledge base by reading current scientific information regularly.
- C. Demonstrate the ability to apply current research findings in the care of the patient with psychosis.

**VI. Systems Based Practice**

- A. Collaborate with team nurses, therapists, social workers, and other health care providers to enhance patient care.
- B. Advocate for quality patient care and cost-effective treatment.
- C. Prepare an adequate discharge summary and treatment plan for follow up care.

**3. UF Health Psychiatric Hospital Inpatient Psychiatry: up to 5 Months PG 2 year**

**Overall goal:** The overall goal for this rotation is to continue honing skills on a psychiatric unit that began in year one, but to demonstrate progress toward greater autonomy and responsibility for the care of the patient admitted to a general psychiatric hospital service.

**I. Medical Knowledge**

- A. Demonstrate knowledge about the neurobiological and psychological underpinnings of mental illness and will apply this knowledge to patient care.
- B. Demonstrate knowledge of the diagnosis, prevalence, treatment, and prevention of psychiatric disorders most likely to affect psychiatric inpatients.
- C. Demonstrate understanding of the psychopharmacologic treatment of mental illness, including the indications, contraindications, and adverse effects of medications, treatment algorithms, augmentation strategies, and combination therapies.
- A. Demonstrate understanding of the indications for and limitations of psychological testing and neuropsychological testing in a psychiatric inpatient setting.

**II. Patient Care**

- A. Gather accurate and complete information about their patients from multiple sources including the patient, the patient's family, friends, health care providers, and the patient's medical record.
- B. Develop a comprehensive biopsychosocial assessment and differential diagnosis that incorporates genetic predisposition, developmental issues, comorbid medical conditions, substance use and abuse, ethnic, cultural, and spiritual factors, economic issues, current relationships, and psychosocial stressors.
- C. Make informed decisions about diagnostic and therapeutic interventions based on patient information and preferences, up-to-date scientific evidence, and sound clinical judgment.
- D. Develop an understanding of the use of specific psychotherapeutic strategies appropriate for an inpatient setting, including supportive techniques, cognitive-behavioral interventions, group and family psychotherapy.
- E. Demonstrate knowledge about electroconvulsive therapy (ECT) including appropriate patient selection, the indications, contraindications, and adverse effects of ECT and is able to educate patients and their families about the risks and benefits of, and alternatives to ECT, and understands the necessity of obtaining informed consent for the procedure.
- F. Demonstrate competence in the management of agitated patients, including verbal and behavioral de-escalation techniques and psychopharmacologic interventions.
- G. Describe and utilize psychotherapeutic techniques that can be helpful in an inpatient group setting, including goal-setting, relaxation strategies, developing & utilizing social support, crisis intervention and safety planning, reducing

emotional lability, and cognitive reframing.

**III. Interpersonal and Communication Skills**

- A. Demonstrates effective communication skills with patients, their families, and other health care professionals.
- B. Demonstrate the ability to effectively communicate with various health care team members, and work as a member of that team.
- C. Create and sustain a therapeutic and ethically sound relationship with patients, including the use of open and honest communication, the maintenance of empathy, and the establishment of appropriate boundaries.
- D. Demonstrate proficiency in conveying sensitive information to patients and their families.
- E. Maintain the medical record appropriately, including an admission history and physical examination, daily progress notes, consent forms, and a dictated discharge summary.

**IV. Professionalism**

- A. Demonstrate respect, compassion and integrity in all interactions with patients, families, team members, and other health care providers.
- B. Demonstrate accountability to patients, other health care providers and to the medical profession, and is responsive to the needs of patients that supersedes self interest.
- C. Appreciate the ethical issues that can arise in an inpatient psychiatric setting including patient autonomy, involuntary treatment, decisional capacity to accept or refuse psychiatric care, informed consent, confidentiality of patient information, and the potential for violation of appropriate boundaries.
- D. Demonstrate sensitivity and responsiveness to patients regardless of cultural background, age, gender, or disabilities.

**V. Practice Based Learning and Improvement**

- A. Use information technology to support patient care decisions and patient education, including on-line literature searches, evidence based data, and other computer-based resources.
- B. Use constructive feedback from attending physicians and senior residents concerning patient care practices, and incorporate this information to improve clinical care of patients.
- C. Use information technology to enhance education.
- D. Apply knowledge of study design, statistical methods, and evidence-based medicine to the appraisal of clinical studies.

**VI. Systems Based Practice**

- A. Work effectively with mental health professionals of other disciplines and with physicians from other specialty services to provide patient focused care.
- B. Demonstrate an understanding of the mental health care system and available community resources and use this knowledge to participate in discharge planning and the development of appropriate aftercare plans.
- C. Facilitate the learning of medical students and other health care providers.
- D. Practice cost-effective health care that does not compromise quality of care.
- E. Prepare an adequate discharge summary and treatment plan for follow up care.

**Goals and Objectives PGY 3**

**Overall Goals for PGY 3**

**I. Medical Knowledge**

- A. State the DSM5 criteria for psychiatric disorders and be familiar with their application to outpatient cases.
- B. Differentiate the various modalities of psychotherapy including cognitive-behavioral, psychodynamic, supportive, brief, couples, group, and combined psychotherapy and psychopharmacology.

**II. Patient Care**

- A. Manage common child and adolescent behavioral disturbances and psychiatric disorders seen in the outpatient setting.
- B. Demonstrate expanded and enhanced skills in psychopharmacology.

**III. Interpersonal and Communication Skills**

- A. Develop an appreciation of the importance of the therapeutic alliance and begin to develop long-term relationships with

patients.

- B. Demonstrate enhanced communication skills with children, adolescents, adults and their family members.

**IV. Professionalism**

- A. Establish a unique identity as an ambulatory psychiatrist.

**V. Practice Based Learning and Improvement**

- A. Demonstrate increased autonomy as a clinician at both the diagnosis and management of common psychiatric conditions.

**VI. Systems Based Practice**

- A. Demonstrate integration of community-based services and health care systems into the overall management of outpatients.
- B. Demonstrate greater confidence in the role of teacher of medical students, and act as a mentor to junior residents.

**PGY 3 Objectives by Clinical Rotation**

**1. Adult Outpatient Psychiatry (AOPC, Psychiatry Specialty Clinics, and Student Mental Health Service), and Child & Adolescent Outpatient Psychiatry: 12 Months PG 3 year**

**I. Medical Knowledge**

- A. Identify the wide range of behavioral disturbances and psychiatric disorders commonly encountered in the outpatient setting among children, adolescents, and adults.
- B. State the available somatic/pharmacological therapies and their use in the outpatient setting.
- C. Recite the risks, benefits, side effects, dosing, drug interactions, and contraindications of these treatments and modalities.
- C. Recognize the more advanced applications of somatic therapies, including off-label uses of medications in children, adolescents, and adults.

**II. Patient Care**

- A. List the biopsychosocial factors contributing to the presentation and treatment of common psychiatric disorders seen in children, adolescents, and adults in the outpatient setting.
- B. Demonstrate the ability to use various modalities of psychotherapy, including brief, cognitive-behavioral, psychodynamic, supportive, combined psychotherapy and psychopharmacology, couples or group therapy, play therapy, and family therapy.
- C. Demonstrate the ability to recognize transference and countertransference as it appears in establishing the doctor-patient relationship, and how it affects the therapeutic process.
- D. Demonstrate the ability to perform a thorough initial assessment and formulate a case summary from a biopsychosocial perspective.

**III. Interpersonal and Communication Skills**

- A. Demonstrate the ability to use communication skills to initiate and maintain therapeutic alliances with patients and/or their family members.
- B. Demonstrate the ability to educate patients and their family members about the risks and benefits of pharmacologic treatment options.
- C. Demonstrate the ability to obtain informed consent for psychotherapeutic treatment, as well as the use of psychopharmacologic interventions in children, adolescents, and adults.
- D. Maintain comprehensive, timely, and legible medical records.

**IV. Professionalism**

- A. Demonstrate punctuality, dress professionally and attend all assignments.
- B. Demonstrate respect for patients regardless of age, gender, cultural background, race, religion, sexual preferences, or socioeconomic status.
- C. Maintain confidentiality of medical information obtained through the psychotherapeutic relationship.
- D. Describe medical-legal and ethical issues, including informed consent, criteria for involuntary hospitalization, confidentiality, patient autonomy, and competency to consent for treatment in children, adolescents, and adults.

**V. Practice Based Learning and Improvement**

- A. Utilize the current scientific literature, recent reports of adverse drug reactions of pharmacologic agents, and evidence based data to optimize the treatment of children, adolescents, and adult patients seen in the outpatient setting.
- B. Integrate knowledge and skills learned in supervision to enhance and improve patient care.
- C. Participate in the education of patients, and their family members appropriately.

**VI. Systems Based Practice**

- A. Demonstrate knowledge of and utilize the various community support services that are available to provide comprehensive care to the child, adolescent, and adult patient.
- B. Demonstrate an understanding of the manner in which insurance and managed care company policies, and state and federal regulations, affect the delivery of health care services in the outpatient setting.
- C. Collaborate with psychologists, social workers, and nurses to deliver quality patient care to children, adolescents, and adults.
- D. Advocate for quality patient care of children, adolescents, and adults given cost considerations and risk-benefit analysis of potential treatment options.

**2. PGY2/4 Outpatient Psychiatry**

**Overall goal:** The overall goal of this longitudinal two-year experience is to build on the foundation of the psychotherapy outpatient rotation begun in year two. The goals and objectives are identical except the upper level resident is expected to accept greater patient responsibility and work toward autonomy as a psychotherapist.

**I. Medical Knowledge**

- A. Demonstrate mastery of the concepts from PGY 2 year

**II. Patient Care**

- A. Demonstrate the ability to apply advanced psychotherapy concepts and skills to the treatment of outpatients.
- B. Use advanced psychopharmacology skills, including the off-label use of medications.

**III. Interpersonal and Communication Skills**

- A. Be adept at recognizing and managing transference and countertransference in long-term therapeutic relationships.
- B. Be adept at dealing with termination issues in long-term psychotherapy relationships.

**IV. Professionalism**

- A. Maintain patient confidentiality and preserve patient autonomy over a longitudinal experience.
- B. Demonstrate sensitivity to diversity in patients.

**V. Practice Based Learning and Improvement**

- A. Incorporate knowledge and skills learned in supervision to enhance expertise at psychotherapy.

**VI. Systems Based Practice**

- A. Be knowledgeable of the limitations imposed by modern health care delivery systems on resources, and how it affects patient care.
- B. Be cognizant of the dual role of the psychiatrist as patient care provider and business administrator.

**Goals and Objectives PGY 4**

**Overall Goals for PGY 4**

Residents matriculating into the PGY 4 level must have completed all the requirements for PGY 1-3 levels. The overall goal of the fourth year is to build on the foundation of the first three years, to demonstrate mature ethical judgment and skills necessary for the independent practice as a psychiatrist, and to achieve competency and proficiency in all aspects of psychiatric care so that upon graduation residents are able to practice without direct supervision.

**I. Medical Knowledge**

- A. Fourth year residents are expected to have a superior knowledge base in psychiatry, and solid neurological and general medical skills.

- II. Patient Care**
  - A. Fourth year residents should demonstrate an outstanding ability to evaluate and manage the patient with psychiatric illness.
- III. Interpersonal and Communication Skills**
  - A. By the fourth year, residents are expected to be expert in communication skills.
- IV. Professionalism**
  - A. Fourth year residents are expected to be accountable to the profession and society at large and demonstrate compassion, integrity and respect for others.
- V. Practice Based Learning and Improvement**
  - A. Residents will demonstrate expertise at utilizing current scientific data to optimize patient care and continuously improve their own practice of medicine.
- VI. Systems Based Practice**
  - A. Residents will understand the various components of the health care system and use resources appropriately to optimize patient care.

**PGY 4 Objectives by Clinical Rotation**

**1. Vista Adult Inpatient Psychiatry: 2 Months PGY 4 year**

**Overall goal:** The overall goal for this rotation is to build on the experience gained on prior inpatient psychiatry rotations and to master the art of inpatient psychiatric care. Prerequisite to the fourth year, the resident must have successfully completed the goals for the lower level rotations in inpatient psychiatry.

- I. Medical Knowledge**
  - A. Demonstrate mastery of the signs and symptoms of psychiatric disorders in DSM nomenclature.
  - B. Demonstrate advanced knowledge of psychopharmacology including mechanisms of action, indications, contraindications, side effects, dosing, drug interactions and off label use of medications.
  - C. Demonstrate a thorough knowledge of electroconvulsive therapy including appropriate technique, and demonstrate the ability to handle complications arising from the procedure.
- II. Patient Care**
  - A. Use advanced psychotherapeutic techniques commonly employed on inpatient psychiatric units including brief psychotherapy, group and family therapies.
  - B. Demonstrate competence in the biopsychosocial formulation and utilize this information to design a thorough treatment plan.
  - C. Demonstrate competence in selecting appropriate laboratory, radiographic, imaging, and encephalographic studies depending upon patient presentation.
- III. Interpersonal and Communication Skills**
  - A. Demonstrate excellence in communication skills with the patient, his family, and other health care team members.
  - B. Demonstrate effectiveness as a member of the health care team.
  - C. Demonstrate competence in obtaining informed consent, and understand the limitations concerning the ability of the patient to provide informed consent.
- IV. Professionalism**
  - A. Demonstrate respect for patient privacy and autonomy.
  - B. Abide by ethical principles in the treatment of patients across differences in gender, age, cultural and religious beliefs.
- V. Practice Based Learning and Improvement**
  - A. Be proficient at teaching medical students and physician Assistant students rotating on the inpatient psychiatry service.

- B. Be proficient at teaching and mentoring junior psychiatry residents.

**VI. Systems Based Practice**

- A. Describe the administrative aspects of psychiatry including information on insurance companies, ancillary staff and their importance, and the importance of the physician-hospital relationship.
- B. Be adept at working within a multidisciplinary team and becoming the leader of a multidisciplinary team.

**2. Vista Inpatient Child & Adolescent Psychiatry: 1 Month PG 4 year**

**Overall goal:** This rotation is designed to provide the upper level resident with an experience in child and adolescent psychiatry geared toward inpatient evaluation and management.

**I. Medical Knowledge**

- A. Demonstrate knowledge of the typical signs and symptoms of psychiatric disorders presenting in childhood and adolescence.
- B. Work toward mastery of the DSM criteria for disorders found in childhood and adolescence.
- C. Be adept at applying psychopharmacologic medications in child and adolescent psychiatry, including off-label uses.

**II. Patient Care**

- A. Demonstrate the ability to use the biopsychosocial formulation and understand its importance in developing a treatment plan for the patient and family alike.
- B. Be adept at performing a comprehensive inpatient evaluation including appropriate use of the history and collateral information, physical and neurological examinations, diagnostic tests, and consultations as indicated.
- C. Demonstrate the commonly used psychotherapies applied in the inpatient setting including group therapy, family therapy, and play therapy.

**III. Interpersonal and Communication Skills**

- A. Demonstrate competence in the collection of medical information from all sources such as the patient, his/her family, pediatrician, and school officials.
- B. Excel at communicating ideas to other members of the treatment team.

**IV. Professionalism**

- A. Indicate the legal and ethical issues inherent to the treatment of children and adolescents.
- B. Demonstrate compassion and respect for the child and adolescent patient, and their family members.

**V. Practice Based Learning and Improvement**

- A. Express the utility of the inpatient ward as a therapeutic setting.
- B. Demonstrate competence at teaching medical students and junior residents.
- C. Use evidence based medicine to optimize the care of the child and adolescent patient.

**VI. Systems Based Practice**

- A. Utilize available community resources to manage more complex issues of patient disposition.
- B. Become adept at providing a leadership role in a multidisciplinary treatment team.

**3. Inpatient Addiction Psychiatry (VA or Vista): 1 Block PGY 4 year**

**Overall goal:** The overall goal of this rotation is to provide the resident with the necessary clinical experience to evaluate and manage patients with substance use and/or dependence.

**I. Medical Knowledge**

- A. Identify the signs and symptoms of the DSM substance related disorders.
- B. State the psychiatric and medical comorbidities typically found in patients with substance related disorders.
- C. Recognize the biological and psychosocial underpinnings of substance related disorders.
- D. Cite the epidemiology of the substance related disorders.
- E. Name the pharmacologic interventions utilized in the detoxification and maintenance treatment of patients with substance related disorders.

**II. Patient Care**

- A. Obtain a complete history and performing a medical and neurologic examination.
- B. Formulate a biopsychosocial diagnosis and treatment plan from the information obtained in the history, neurologic and physical examinations.
- C. Select appropriate laboratory, radiographic/imaging, and encephalographic studies depending on the patient presentation.
- D. Discuss group psychosocial treatments utilized in substance related disorders including alcoholics anonymous and narcotics anonymous.
- E. Demonstrate the ability to detoxify, manage overdoses, and treat characteristic intoxication and withdrawal syndromes to minimize morbidity and mortality.
- F. Use rating scales used to assess and manage withdrawal states such as the CIWA.

**III. Interpersonal and Communication Skills**

- A. Effectively communicate with patients with substance disorders, and be able to appropriately educate their family members.
- B. Act in the role of consultant to other health care providers who are treating patients with substance abuse disorders.

**IV. Professionalism**

- A. Treat patients with substance abuse disorders with respect in a non-judgmental fashion.
- B. Apply legal and ethical principles including informed consent, advanced directives, involuntary commitments, and the right to refuse treatment.

**V. Practice Based Learning and Improvement**

- A. Apply current scientific information and evidence based data to the diagnosis and management of patients with substance use disorders.
- B. Incorporate feedback from attending physicians and other health care team members to improve their treatment of patients with substance abuse disorders.

**VI. Systems Based Practice**

- A. Recognize the importance and value the contributions of other health care providers involved in the collaborative treatment of the patient with a substance related disorder.
- B. Work within a multidisciplinary team and learning to become the leader of that multidisciplinary team.

**4. Community Psychiatry (MHICM): Up to 2 Months PGY 4 year**

**Overall goal:** The overall goal of this rotation is to expose the resident to the psychiatric patient who is persistently and chronically ill, and is usually treated in the public sector.

**I. Medical Knowledge**

- A. Know the signs and symptoms of psychiatric illness seen in patients with chronic psychiatric conditions.
- B. Demonstrate knowledge of the indications, contraindications, and adverse effects of psychopharmacologic agents utilized in the treatment of the persistently mentally ill.

**II. Patient Care**

- A. Know the psychotherapeutic techniques commonly employed in community psychiatry including supportive therapy, crisis intervention, cognitive-behavioral techniques, group therapy, family therapy, and psychosocial rehabilitation.

**III. Interpersonal and Communication Skills**

- A. Become expert at communicating with patients with chronic psychiatric illness.
- B. Use expert communication skills in collaborating with other health care professionals, consultants, and community based resources.

**IV. Professionalism**

- A. Be expert at managing the legal and ethical issues including informed consent, advanced directives, involuntary commitments, and right to refuse treatment.
- B. Treat the chronically mentally ill patient and their family members with compassion, integrity, and respect.

**V. Practice Based Learning and Improvement**

- A. Use current scientific information and evidence base data in caring for the chronically mentally ill patient.
- B. Facilitate the education of patients, family members and other health professionals in patient management issues.

**VI. Systems Based Practice**

- A. Understand the administrative aspects of psychiatry including information on insurance companies, ancillary staff and their importance, and the nature of the physician-hospital relationship.
- B. Become knowledgeable of and utilize the community resources available in the care of chronically mentally ill patients.
- C. Become expert at working with limited resources while not compromising patient care of the chronically mentally ill.
- D. Be expert at working within a multidisciplinary team and becoming the leader of a multidisciplinary team.
- E. Provide consultation to other health care professionals caring for the chronically mentally ill patient including telephone consultation to VA Satellite Clinics.

**5. Electives: 6 Months PGY 4 Year**

**Overall Goal:** The overall goals for electives are to enrich the educational experience of residents in meeting their needs, interests and future professional plans. Currently, the Department has five standing electives that residents may choose among. Residents may also design their own elective provided they comply with ACGME guidelines. These guidelines state that electives:

- A. Must be well constructed, purposeful, and lead to effective learning experiences.
- B. The choice of electives must be made with the advice and approval of the Program Director and the appropriate preceptor.
- C. Electives must have written goals and objectives in the format of the six core competencies (medical knowledge, patient care, professionalism, interpersonal and communication skills, practice-based learning and improvement, and systems-based practice).
- D. The specific goals and objectives are dependent upon the elective(s) chosen by the resident. The resident and his/her preceptor bear the responsibility for collaboratively generating the specific goals and objectives for each chosen elective. In addition, they must be approved by the Program Director prior to beginning an elective rotation.

**6. Outpatient Addiction Psychiatry Experience at Florida Recovery Center:**

**7. Overall goal:** The overall goal of this rotation is to provide the resident with the necessary clinical experience to evaluate and manage patients with substance use disorders in an ambulatory setting.

**I. Medical Knowledge**

- A. Master the subtleties of diagnosing DSM-5 substance use disorders, including modifiers and specifiers.
- B. Know the psychiatric and medical comorbidities typically found in patients with substance related disorders.
- C. Understand the biological and psychosocial underpinnings of substance related disorders.
- D. Know the epidemiology of the substance related disorders.
- E. Know the pharmacologic interventions utilized in the detoxification and maintenance treatment of patients with substance related disorders.
- F. Gain mastery of the American Society of Addiction Medicine multidimensional assessment and patient placement criteria.
- G. Learn how to recognize and address defense mechanisms common in this patient population including denial, minimization, rationalization, and justification.

**VII. Patient Care**

- A. Gain mastery of the medical management of an outpatient substance treatment program.
- B. Become adept at the forensic evaluation of impaired professionals via comprehensive outpatient evaluations.
- C. Become expert at obtaining a complete history and performing a medical and neurologic examination.
- D. Become expert at formulating a biopsychosocial diagnosis and treatment plan from the information obtained in the history, neurologic and physical examinations.
- E. Become expert at selecting appropriate laboratory, radiographic/imaging, and encephalographic studies depending on the patient presentation.
- F. Gain working knowledge of the various group psychosocial treatments utilized in substance related disorders including Alcoholics Anonymous and Narcotics Anonymous.
- G. Gain experience in the administration of group therapy for addiction.



**VIII. Interpersonal and Communication Skills**

- A. Effectively communicate with patients with substance disorders, and be able to appropriately educate their family members.
- B. Act in the role of consultant to other health care providers who are treating patients with substance abuse disorders.
- C. Learn how to effectively obtain substance-related collateral information from significant others, families, employers, healthcare providers, pharmacies, etc.

**IX. Professionalism**

- A. Treat patients with substance abuse disorders with respect in a non-judgmental fashion.
- B. Be expert at applying legal and ethical principles including informed consent, advanced directives, involuntary commitments, and the right to refuse treatment.

**X. Practice Based Learning and Improvement**

- A. Apply current scientific information and evidence based data to the diagnosis and management of patients with substance use disorders.
- B. Incorporate feedback from attending physicians and other health care team members to improve their treatment of patients with substance use disorders.

**XI. Systems Based Practice**

- A. Understand the importance and value the contributions of other health care providers involved in the collaborative treatment of the patient with a substance related disorder.
- B. Be expert at working within a multidisciplinary team and learning to become the leader of that multidisciplinary team.

**8. UF Health Shands and VA Consults Jr. Attending**

**I. Medical Knowledge**

- A. Master the DSM-5 criteria for psychiatric disorders as well as advanced treatment modalities utilized in consult-liaison psychiatry.
- B. Become familiar with the various modalities of psychotherapy and how they might be used in consult-liaison psychiatry including cognitive-behavioral, brief psychodynamic, supportive, and combined psychotherapy and psychopharmacology.
- C. Master knowledge of neurologic conditions and considerations as they apply to psychiatric patients in consult-liaison psychiatry.
- D. Increase knowledge of consult-liaison psychiatry areas of specialized emphasis: oncology, transplant, women's health, etc.

**II. Patient Care**

- A. Demonstrate proficient skills in managing team rounds and patient treatment options in a consult/liaison setting.
- B. Thoroughly understand drug-drug interactions, particularly of psychiatric with non-psychiatric medications.
- C. Demonstrate a thorough understanding of the biopsychosocial factors contributing to the presentation and treatment of psychiatric disorders commonly encountered in the consult-liaison setting.
- D. Facilitate transfer of patients from medical/surgical to psychiatric treatment services.

**III. Interpersonal and Communication Skills**

- A. Demonstrate mastery of the ability to communicate with other medical/surgical services as well as with fellow residents.
- B. Gain further experience in teaching and mentoring junior residents and medical students.
- C. Facilitate members of the medical/surgical teams in the understanding of transference/countertransference issues with patients to enhance patient care.

**IV. Professionalism**

- A. Be punctual, dress professionally, and attend all assignments.
- B. Be respectful of patients and learners regardless of age, gender, cultural background, race, religion, sexual preferences, or socioeconomic status.
- C. Maintain confidentiality of all medical information.
- D. Uphold the highest ethical standards in interactions with patients and other members of the treatment team.

- E. Demonstrate a good work ethic.

#### V. Practice Based Learning and Improvement

- A. Become more autonomous as a clinician at both the diagnosis and management of common and uncommon psychiatric conditions encountered in the consult-liaison setting.
- B. Demonstrate motivation for self study.
- C. Demonstrate effective utilization of the current scientific literature and evidence-based data to optimize treatment of patients in the consult-liaison setting.
- D. Demonstrate an understanding of the need for continuing education in consult-liaison psychiatry.

#### VI. Systems Based Practice

- A. Collaborate with other members of the treatment team to deliver quality and safe patient care.
- B. Gain greater confidence in the role as a team leader.
- C. Collaborate with medical/surgical services in the comprehensive care of patients.
- D. Better understand the continuum of psychiatric care from outpatient to inpatient and how consult-liaison psychiatry fits into that continuum of care.

#### 9. ECT Elective; UF Health Shands at UF or VA Hospital:

**Overall goal:** The overall goal for this rotation is to provide the junior or senior resident with an intensive training experience in electroconvulsive therapy. Residents who participate in this elective may choose to do their ECT elective working with patients being evaluated and treated at UF Health Shands at UF (attending is Richard Holbert, MD) or at the VA Hospital (attending is Mala Iyer, MD).

##### I. Medical Knowledge

- A. The resident should know the theory for the proposed mechanism of action(s) of electroconvulsive therapy (ECT).
- B. Know the psychiatric indications, medical and psychiatric contraindications, adverse effects, and the general procedure for the administration of electroconvulsive therapy.
- C. Demonstrate a thorough knowledge of electroconvulsive therapy including appropriate techniques, and demonstrate the ability to manage complications arising from the procedure.
- D. Demonstrate an expert knowledge base of and be able to teach junior residents and medical students about the psychiatric disorders that ECT is generally effective for.
- E. Know and be able to teach junior residents and medical students the theory for the proposed mechanism of action(s) of electroconvulsive therapy.

##### II. Patient Care

- A. Demonstrate knowledge about electroconvulsive therapy including appropriate patient selection, the indications, contraindications, and adverse effects of ECT and be able to educate patients and their families about the risks and benefits of, and alternatives to ECT, and understands the necessity of obtaining informed consent for the procedure.
- B. Demonstrate appropriate techniques for the administration of both nondominant unilateral and bilateral ECT.
- C. Demonstrate the ability to formulate and institute maintenance therapy for a patient who has received an acute series of ECT treatments, which may include pharmacotherapy, maintenance ECT, or their combination when indicated.

##### III. Interpersonal and Communication Skills

- A. Demonstrate how to appropriately communicate with both medical and psychiatric referral sources to aid in the evaluation and management of patients in need of ECT treatment.
- B. Utilize expert communication skills to facilitate transfers and management of patients from other hospital services to the appropriate psychiatric setting for those patients who require ECT.
- C. Demonstrate the ability to work cooperatively and serve as a leader of a health care team that is responsible for treating patients with ECT.
- D. Model for junior residents and students how to maintain comprehensive, timely, and legible medical records for patients receiving ECT treatment.

##### IV. Professionalism

- A. Demonstrating compassion, integrity and respect for patients who are receiving ECT as well as their family members.
- B. Appropriately apply legal and ethical principles to patient care including informed consent, confidentiality, advanced

directives, and the right to refuse treatment.

**V. Practice-Based Learning and Improvement**

- A. Utilize information technology to optimize the care of the ECT patient and teach junior residents and students about available information technology and evidence based medicine to enhance safe and effective ECT administration.
- B. Demonstrate the ability, and model for junior residents and students, how to appropriately educate patients, their family members, and other health care professionals about ECT avoiding the use of medical jargon.

**VI. Systems-Based Practice**

- A. Serve as the ECT team leader, collaborating with the attending psychiatrist, team nurses, therapists, social workers, and other health care providers to identify areas needing improvement for the safe and effective administration of ECT.
- B. Advocate for quality patient care and safety and cost-effective ECT treatment.
- C. Model and assist junior residents in the preparation of an adequate discharge summary and treatment plan for patients who have received ECT.

**10. Northeast Florida State Hospital Community Psychiatry Elective**

**Overall goal:** The overall goal for this rotation is the management of the chronically psychiatrically ill patient in the state hospital setting.

**I. Medical Knowledge**

- A. Demonstrate an in depth understanding of severe chronic mental illness and psychiatric work at a state facility.
- B. Demonstrate an in depth knowledge of biopsychosocial assessment and treatment.
- C. Demonstrate an in depth knowledge of the psychopharmacology of clozapine in the treatment of refractory schizophrenia and bipolar disorder.
- D. Demonstrate an understanding of the involuntary continued commitment process.
- E. Demonstrate an understanding of various treatment modalities: psychopharmacology, electroconvulsive therapy, individual psychotherapy including crisis intervention, cognitive-behavioral therapy, group therapy, case management, and psychosocial rehabilitation.

**I. Patient Care**

- A. Demonstrate the ability to use all available data such as history, family information, chart data, physical and neurological examinations, and laboratory and imaging data to formulate a differential diagnosis and appropriate treatment plan.
- B. Demonstrate the ability to prescribe clozapine for the treatment of refractory schizophrenia.
- C. Demonstrate the ability to use psychopharmacology along or in combination with psychotherapy for the treatment of chronic mental illness.
- D. Participate/testify, with judiciary approval, in civil commitment hearings.

**III. Interpersonal and Communication Skills**

- A. Communicate appropriately with primary care consultants to aid in the diagnosis and management of medical illness in the chronically mentally ill patient population.
- B. Demonstrate ability to work cooperatively as a member as well as the leader of a health care team.
- C. Demonstrate an ability to lead a multi-disciplinary team meeting.
- D. Maintain comprehensive, timely, and legible medical records.

**IV. Professionalism**

- A. Demonstrate compassion, integrity and respect for patients and their families.
- B. The resident will appropriately apply legal and ethical principles to patient care including informed consent, confidentiality, advanced directives, involuntary commitment, and the right to refuse treatment.

**V. Practice Based Learning and Improvement**

- A. Utilize information technology to optimize the care of the patient.
- B. Demonstrate the ability to appropriately educate patients, their family members, students, and other health care professionals avoiding medical jargon.

**VI. Systems Based Practice**

- A. Learn about how community providers interact with the state system in providing care and resources to the patient.
- B. Collaborate with team nurses, therapists, social workers, case managers, and other health care providers to enhance patient care.
- C. Advocate for quality patient care and cost-effective treatment.
- D. Prepare an adequate discharge summary and treatment plan for follow up care.

## **11. University of Florida Student Mental Health Outpatient Psychiatry Elective:**

### **I. Medical Knowledge**

- A. Demonstrate mastery of knowledge of the wide range of behavioral disturbances and psychiatric disorders commonly encountered in the outpatient setting among adolescents and adults at the University of Florida Student Mental Health Clinic.
- B. Demonstrate an in depth understanding of the available somatic/pharmacological therapies and their use in the outpatient setting; as well as, know the risks, benefits, side effects, dosing, drug interactions, and contraindications of these treatments and modalities.
- C. Utilize the most advanced applications of somatic therapies, including off-label use of medications, in adolescents and adults at the University of Florida Student Mental Health Clinic.

### **II. Patient Care**

- A. Demonstrate a thorough understanding of the biopsychosocial factors contributing to the presentation and treatment of common and rare psychiatric disorders seen in adolescents and adults at the University of Florida Student Mental Health Clinic.
- B. Demonstrate the ability to use all modalities of psychotherapy, including brief, cognitive-behavioral, psychodynamic, supportive, combined psychotherapy and psychopharmacology, couples or group therapy, and family therapy.
- C. Demonstrate the ability to recognize transference and countertransference as it appears in establishing the doctor-patient relationship, and use this knowledge to aid the therapeutic process.
- D. Demonstrate the ability to perform a complete initial assessment and formulate a case summary from a biopsychosocial perspective.

### **III. Interpersonal and Communication Skills**

- A. Demonstrate the ability to use communication skills to initiate and maintain therapeutic alliances with patients and/or their family members.
- B. Demonstrate expertise at educating patients and their family members about the risks and benefits of pharmacologic treatment options.
- C. Demonstrate expertise in obtaining informed consent for psychotherapeutic treatment, as well as the use of psychopharmacologic interventions, in adolescents and adults at the University of Florida Student Mental Health Clinic.
- D. The resident will maintain comprehensive, timely, and legible medical records.

### **IV. Professionalism**

- A. The resident will be punctual, dress professionally, and attend all assignments.
- B. The resident will be respectful of patients regardless of age, gender, cultural background, race, religion, sexual preferences, or socioeconomic status.
- C. The resident will maintain confidentiality of all medical information obtained through the psychotherapeutic relationship.
- D. The resident will demonstrate expert knowledge of medical-legal and ethical issues, including informed consent, criteria for involuntary hospitalization, confidentiality, patient autonomy, and competency to consent for treatment in adolescents and adults seen at the University of Florida Student Mental Health Clinic.

### **V. Practice-Based Learning and Improvement**

- A. The resident is expected to demonstrate an expert utilization of the current scientific literature, recent reports of adverse drug reactions of pharmacologic agents, and evidence based data to optimize treatment of adolescents and adults seen at the University of Florida Student Mental Health Clinic.
- B. The resident is expected to become proficient at incorporating knowledge and skills learned in supervision to enhance and improve their patient care.

- C. The resident is expected to demonstrate expertise in the education of patients and their family members appropriately.
- D. The resident will demonstrate a leadership role in the health care team discussions with fellow psychiatrists, case managers, psychologists, and primary care physicians who provide care to patients seen at the Student Mental Health Clinic.
- E. The resident is expected to demonstrate expertise in Clinical Skills Assessment examinations utilizing patients seen at the University of Florida Student Mental Health Center.

#### **VI. Systems-Based Practice**

- A. Demonstrate mastery of knowledge of and utilize the various community support services that are available to provide comprehensive care to the adolescent and adult patient seen at the University of Florida Student Mental Health Clinic.
- B. Demonstrate expert understanding of the manner in which insurance and managed care company policies, and state and federal regulations affect the delivery of health care services at the University of Florida Student Mental Health Clinic.
- C. The resident will collaborate with psychologists, social workers, and nurses to deliver quality patient care to adolescents and adults at the University of Florida Student Mental Health Clinic.
- D. The resident will advocate for quality patient care of adolescents and adults at The University of Florida Student Mental Health Clinic given cost considerations and risk-benefit analysis of potential treatment options.

### **12. VA Teaching Resident**

#### **I. Medical Knowledge**

- A. Review and master DSM-5 criteria for psychiatric disorders and appropriate treatments.
- B. Become well acquainted with common PRITE, psychiatry board and medical student shelf examination material, and convey such material to residents, students and faculty in a structured and unstructured fashion.

#### **II. Patient Care**

- A. Become familiar with oral board structure for Psychiatry boards and Medical student oral examination and provide demonstrations and evaluation of mock oral exams.
- B. Provide a VA case conference on a weekly basis for residents and medical students.

#### **III. Interpersonal and Communication Skills**

- A. Develop an appreciation of the importance of education of colleagues via hands on and conference style teaching.
- B. Enhance communication skills with fellow residents, medical students and faculty.
- C. Develop a teaching portfolio consisting of PowerPoint presentations, handouts, and other teaching materials.

#### **IV. Professionalism**

- A. Be punctual and dress professionally.
- B. Be respectful of all learners.
- C. Establish a unique identity as an educator.
- E. Uphold the highest ethical standards in interactions with learners at all levels.

#### **V. Practice Based Learning and Improvement**

- A. Become more aware of literature regarding treatment measures for patients and disorders presented during case conference.
- B. Present a residency wide M&M or case conference when indicated based on evaluation of patient care during rotations.
- C. Resident will demonstrate an understanding of the need for continuing medical education.

#### **VI. Systems Based Practice**

- A. Integrate medical student, resident and faculty education into the study of psychiatry.
- B. Gain greater confidence in the role of teacher of medical students and fellow residents, and act as a mentor to PGY-1 residents.

### **13. UF Health Shands and VA Research Elective**

**Overall goal:** The overall goal of this rotation is to facilitate the interested resident to learn about and participate in

research activities, tailor research experiences to individual resident's interests and future career, and to enhance the training and education during the residency.

**I. Medical Knowledge**

- A. Understand the biomedical and social-behavioral knowledge needed by a competent psychiatric researcher.
- B. Meet regularly with the research mentor, generate clinical research questions based on interesting patient cases, and conduct a suitable research project.
- C. Know how to search literature efficiently to assess what has already been studied and what questions have been asked.
- D. Identify and select the appropriate type of study to best answer the question.
- E. Demonstrate the ability to acquire, critically interpret and apply this knowledge in patient care.

**II. Patient Care**

- A. Develop research question based on one's experiences from patient care.
- B. Know the indications for IRB approval if the study involves human subjects, their medical records and other data that can compromise confidentiality.
- C. Continue continuity clinics during research months; be an expert at obtaining a complete history, formulating a biopsychosocial diagnosis and treatment plan; Know the psychotherapeutic techniques commonly used in community psychiatry.

**III. Interpersonal and Communication Skills**

- A. Effectively communicate with a mentor to develop a research topic and plan a study design.
- B. Discuss project with appropriate consultants including statisticians and other specialists if needed for conducting research.
- C. Be expert at working within a multidisciplinary research team and learning to become the leader of that multidisciplinary research team.
- D. Write an abstract for potential submission to a national meeting if an experimental study is proposed.
- E. Attend the annual meetings, such as the Biological Psychiatry and APA conferences for career networking and being updated on the newest findings in the area of interest.
- F. Try to write a review article to summarize one particular research topic.

**IV. Professionalism**

- A. Be punctual, dress professionally, and attend all required meetings.
- B. Maintain the patients' privacy involved in research.
- C. Know the ethics of research, including subject recruitment, obtaining informed consent, and working with IRB for the subject's protection.
- D. Be accurate in presenting research data, include the names of collaborators on the research proposal and manuscripts for publication.
- E. Be responsible for all research activities.

**V. Practice-Based Learning and Improvement**

- A. Compare the study results to the currently available scientific information and evidence-based data.
- B. The resident will incorporate feedback from the research mentor and collaborators.
- C. Be familiar with the history and current research findings in the particular field of interest.
- D. Examine the potential application of research results to daily patient care.
- E. Set up and accomplish at least one clinical skills assessment per month.
- F. The resident is expected to demonstrate effective utilization of the current scientific literature and evidence-based data to optimize treatment of patients.
- G. The resident is expected to demonstrate competence in the education of patients and their family members on the latest findings from psychiatric research.
- H. The resident will demonstrate an understanding of the need for continuing education in psychiatric research.

**VI. Systems Based Practice**

- A. Know the cost and other constraints in doing research during the residency and in general.
- B. Know the best methods of performing research to answer the proposed questions.
- C. Understand the pros and cons of the proposed research.
- D. Understand the importance and value of the contributions of research in advancing our understandings of various

- mental disorders.
- E. Advocate for research during residency to attract more colleagues to be involved in research.

## **Psychotherapy Competencies**

### **1. Brief Psychotherapy**

#### **a. Knowledge**

- i. The resident will demonstrate understanding of at least one theoretical model of brief psychotherapy.
- ii. The resident will demonstrate understanding of the use of a focus and time limit as therapeutic tools, and with the patient, will collaboratively set goals for the therapy.
- iii. The resident will know the indications and contraindications for brief psychotherapy.
- iv. The resident will demonstrate how the use of brief psychotherapy is effective in meeting the overall treatment needs of the patient.
- v. The resident will demonstrate the ability to maintain focus throughout the course of brief psychotherapy.
- vi. The resident will demonstrate understanding that competence at brief psychotherapy is contingent upon continued education and practice.

#### **b. Skills**

- i. The resident will be able to utilize at least one well defined model of brief psychotherapy.
- ii. The resident will be able to select appropriate patients for the particular model chosen for brief psychotherapy.
- iii. The resident will be able to establish and maintain a focus and time limit.
- iv. The resident will be able to establish and maintain a therapeutic alliance.
- v. The resident will demonstrate their ability to educate the patient about the goals, objectives, and time frame of brief psychotherapy.
- vi. The resident will demonstrate their ability to develop a formulation using the brief psychotherapy model selected.
- vii. The resident will demonstrate their ability to seek appropriate consultation and or referral for specialized treatment.

#### **c. Attitudes**

- i. The resident will demonstrate empathy, respect, collaboration with, and an open and nonjudgmental approach toward the patient in brief psychotherapy.
- ii. The resident will demonstrate the ability to tolerate ambiguity and display confidence in the efficacy of a least one model of brief psychotherapy.
- iii. The resident will demonstrate sensitivity to the sociocultural, socioeconomic, and educational issues that arise in the therapeutic relationship during brief psychotherapy.
- iv. The resident will be open to constructive feedback from supervisors by permitting review of audio or videotapes, or direct observation of brief psychotherapy sessions.

### **2. Cognitive Behavioral Therapy**

#### **a. Knowledge**

- i. The resident will demonstrate understanding of the basic principles of cognitive behavioral therapy including the relationship of thoughts to emotion, behavior, and physiology.
- ii. The resident will demonstrate an understanding of the concept of automatic thoughts and cognitive distortions, common cognitive errors, and the significance and origin of core beliefs to dysfunctional thoughts and psychopathology.
- iii. The resident will demonstrate the indications and contraindications for cognitive behavior therapy.
- iv. The resident will demonstrate the ability to structure a cognitive behavior therapy session with a focus on active, collaborative problem solving.
- v. The resident will demonstrate the ability to perform psychoeducation and skill training during therapy, and relapse prevention as termination approaches.

- vi. The resident will utilize basic behavioral techniques including activity scheduling, exposure and response prevention, relaxation training, graded task assignment, and exposure hierarchies for systematic desensitization.
- vii. The resident will utilize basic cognitive techniques including identifying automatic thoughts, cognitive restructuring, problem solving, examining the evidence, thought recording, and modification of core beliefs.
- viii. The resident will demonstrate appreciation that rating scales are an integral part of cognitive behavioral therapy.
- ix. The resident will acknowledge that competence at cognitive behavior therapy is obtained by continued education and skill development.

**b. Skills**

- i. The resident will be able to establish and maintain a therapeutic alliance with the patient in cognitive behavioral therapy.
- ii. The resident will educate the patient about the centrality of core beliefs and cognitive schemas, and the responsibility of the patient in actively engaging in treatment.
- iii. The resident will educate the patient about core beliefs and cognitive schemas most relevant to the presenting problem, and help the patient understand the basic origin of these beliefs.
- iv. The resident will structure the therapy session to collaboratively set the agenda, review homework and assign appropriate new homework, work on key problems, summarize and close the session, and elicit and respond to feedback.
- v. The resident will educate the patient how to use relaxation techniques, exposure and response prevention, and graded exposure to feared situations.
- vi. The resident will utilize the dysfunctional thought record and measure the impact it has on the patient's mood and behavior.
- vii. The resident will effectively plan termination with patients, employ booster sessions as needed, and teach relapse prevention techniques.
- viii. The resident will seek appropriate consultation and supervision for a patient treated with cognitive behavioral therapy, and understands the need for specialized treatment.

**c. Attitudes**

- i. The resident will demonstrate empathy, respect, collaboration with, and an open and nonjudgmental approach toward the patient in cognitive behavioral therapy.
- ii. The resident will demonstrate the ability to tolerate ambiguity and display confidence in the efficacy of cognitive behavioral therapy.
- iii. The resident will demonstrate sensitivity to the sociocultural, socioeconomic, and educational issues that arise during the therapeutic relationship.
- iv. The resident will be open to constructive feedback from supervisors by permitting review of audio or videotapes, or direct observation of treatment sessions.

**3. Psychodynamic Psychotherapy**

**a. Knowledge**

- i. The resident will demonstrate understanding of at least one model of psychodynamic psychotherapy.
- ii. The resident will demonstrate understanding of the clinical psychodynamic psychotherapy concepts of the unconscious, defense mechanisms, resistance, and transference and countertransference.
- iii. The resident will acknowledge that symptoms, behaviors, and motivations may often have multiple and complex meanings that may not be readily apparent.
- iv. The resident will demonstrate an understanding of the influence of psychosocial development through the life cycle on the patient's thoughts, feelings, and behavior.
- v. The resident will know the indications and contraindications for the psychiatric disorders treated by psychodynamic psychotherapy.
- vi. The resident will demonstrate understanding that competence at psychodynamic psychotherapy requires continued education and skill development.



**b. Skills**

- i. The resident will be able to evaluate the capacity of the patient to engage in and utilize psychodynamic psychotherapy.
- ii. The resident will use effective interpersonal skills to collaboratively build and maintain a therapeutic alliance to promote self-reflection and inquiry into the patient's inner life.
- iii. The resident will establish treatment goals with the patient.
- iv. In order to understand the presenting problems, the resident will engage the patient in exploring their history of experiences, sociocultural influences, relationships, coping mechanisms, fears, traumas, losses, and hopes and wishes.
- v. The resident will be able to listen effectively to the patient to understand nuance, meanings, and indirect communications.
- vi. The resident will be able to recognize and manage transference and countertransference, defense mechanisms, and resistance during the course of therapy.
- vii. The resident will be able to use self-reflection to learn about their own responses to patients in order to further the goals of psychodynamic psychotherapy.
- viii. The resident will demonstrate the use of clarification and confrontation.
- ix. The resident will utilize interpretation to manage transference and countertransference that otherwise would disrupt the therapeutic process.
- x. The resident will be able to understand and manage the termination process.
- xi. The resident will demonstrate the ability to write a psychodynamic formulation.
- xii. The resident will seek supervision, consultation, or referral for specialized treatment.

**c. Attitudes**

- i. The resident will demonstrate empathy, respect, collaboration with, and an open and nonjudgmental approach toward the patient in psychodynamic psychotherapy.
- ii. The resident will demonstrate the ability to tolerate ambiguity and display confidence in the efficacy of psychodynamic psychotherapy.
- iii. The resident will demonstrate sensitivity to the sociocultural, socioeconomic, and educational issues that arise during the therapeutic relationship.
- iv. The resident will be open to constructive feedback from supervisors by permitting review of audio or videotapes, or direct observation of treatment sessions.

**4. Supportive Psychotherapy**

**a. Knowledge**

- i. The resident will acknowledge that the principal goals of supportive psychotherapy are to maintain or improve the patient's self-esteem, minimize or prevent recurrence of symptoms, and maximize adaptive capacities.
- ii. The resident will demonstrate knowledge that supportive psychotherapy is commonly utilized in many therapeutic encounters.
- iii. The resident will acknowledge that the patient-therapist relationship is critically important in supportive psychotherapy.
- iv. The resident will know the indications and contraindications of supportive psychotherapy.
- v. The resident will understand that competence in supportive psychotherapy requires continued education and skill development.

**b. Skills**

- i. The resident will demonstrate the ability to establish and maintain a therapeutic alliance, and establish treatment goals.
- ii. The resident will demonstrate their ability to interact in a direct and nonthreatening manner.
- iii. The resident will demonstrate responsiveness to the patient and appropriately give feedback and advice.
- iv. The resident will demonstrate the ability to understand the patient as a unique member of their family, sociocultural, and community structure.

- v. The resident will demonstrate the ability to choose interventions that are therapeutic for the patient without introducing their own beliefs or values.
- vi. The resident will demonstrate the ability to collaboratively confront behaviors that may pose a danger to the patient.
- vii. The resident will demonstrate the ability to both recognize, and identify, affects in their patient and themselves.
- viii. The ability to provide reassurance to minimize symptoms, improve morale and adaptation, and prevent relapse will be demonstrated by the resident.
- ix. The resident will support, promote, and recognize the patient's ability to achieve goals that will foster the patient's well-being.
- x. The resident will teach the patient strategies to manage problems with affect regulation, thought disorders, and impaired reality testing.
- xi. The resident will demonstrate the ability to provide education and advice about the patient's psychiatric condition, treatment, and adaptation while being cognizant of sociocultural issues and community systems of care.
- xii. In patients with chronic psychiatric disorders, the resident will focus their therapeutic efforts at enhancing adaptive skills, relationships, and sources of anxiety or worry.
- xiii. The resident will assist the patient with developing self-assessment skills.
- xiv. The resident will utilize consultation and supervision appropriately, and refer for specialized treatment if indicated.

**c. Attitudes**

- i. The resident will demonstrate empathy, respect, collaboration with, and an open and nonjudgmental approach toward the patient in supportive psychotherapy.
- ii. The resident will demonstrate the ability to tolerate ambiguity and display confidence in the efficacy of supportive psychotherapy.
- iii. The resident will demonstrate sensitivity to the sociocultural, socioeconomic, and educational issues that occur in the supportive psychotherapy relationship.
- iv. The resident will be open to constructive feedback from supervisors by permitting review of audio or videotapes, or direct observation of treatment sessions.

**5. Psychotherapy Combined with Psychopharmacology**

**a. Knowledge**

- i. The resident will demonstrate knowledge of the diagnoses and clinical conditions that warrant the combined use of psychopharmacology and psychotherapy.
- ii. The resident will demonstrate knowledge of different methods of combining psychotherapy and psychopharmacology.
- iii. The resident will demonstrate knowledge of the specific indications for a recommendation of psychotherapy and psychopharmacology, and the rationale for the type of psychotherapy and medication recommended.
- iv. The resident will demonstrate knowledge of potential synergies and/or antagonisms in combining psychotherapy and psychopharmacology.
- v. The resident will demonstrate understanding that taking medications may have multiple psychological and sociocultural meanings to a patient.
- vi. The resident will know the background, education, and training of other mental health professionals who may provide psychotherapy in patients who are receiving psychopharmacologic treatments.
- vii. The resident will understand that competence in combined psychotherapy and psychopharmacology requires continued education and skill development.

**b. Skills**

- i. The resident will be able to gather sufficient information from a clinical assessment to determine the need for, recommend, and implement combined psychotherapy and psychopharmacology.

- ii. The resident will forge an active therapeutic alliance with the patient to facilitate adherence to combined psychotherapy and psychopharmacology.
- iii. By monitoring the patient's condition, the resident will modify the psychotherapeutic or pharmacologic approach as indicated
- iv. The resident will be able to appreciate and assess the importance of timing of psychotherapeutic and psychopharmacologic interventions.
- v. The resident will develop an appreciation of factors that influence the combined use of psychotherapy and psychopharmacology, such as conscious and unconscious aspects of the doctor-patient relationship, the placebo effect, and concurrent medical conditions.
- vi. The resident will be able to recognize and identify affects in the patient and himself.
- vii. By using psychotherapeutic techniques, the resident will diminish resistance to and facilitate the use of psychopharmacology when appropriate.
- viii. The resident will be able to articulate both the potential beneficial and detrimental effects of medication use in the context of a psychotherapeutic treatment.
- ix. The resident will explore and understand the psychological and sociocultural meaning to a patient who is taking a pharmacologic agent.
- x. The resident will be able to collaborate effectively with nonpsychiatric psychotherapists, and respond to conflicts and problems that arise in the therapeutic triad.

**c. Attitudes**

- i. The resident will demonstrate empathy, respect, collaboration with, and an open and nonjudgmental approach toward the patient in combined psychotherapy and psychopharmacology.
- ii. The resident will demonstrate the ability to tolerate ambiguity and display confidence in the efficacy of combined psychotherapy and psychopharmacology.
- iii. The resident will appreciate that combined psychotherapy and psychopharmacology is an integrated treatment and not divisible into independent parts.
- iv. The resident will be open to constructive feedback from supervisors by permitting review of audio or videotapes, or direct observation of treatment sessions.

**CONFERENCES/LECTURES/DIDACTICS/SEMINARS**

**Lectures/Didactics: General Comments:**

The psychiatry didactic curriculum is designed to provide an interactive forum to augment the resident's independent reading and clinical experience. Residents are required to attend a minimum of 70% of all didactics in accordance with ACGME guidelines for graduation. If a resident does not attend 70% of the lectures in a given seminar, they will be required to repeat the seminar or complete a remediation project approved by the seminar director and residency Program Director. It is expected that each resident will attend all didactics, unless excused by the seminar director and residency Program Director. Attendance is monitored by way of UF badge scanning or sign-in logs, available at each lecture site. These logs will be collected by the Graduate Education Committee resident representative for each year of training, and submitted to the Residency Office. Attendance will be tallied and tracked by the Residency Training Office.

The didactic curriculum consists of PGY-1 Tuesday lectures from 1-5pm and PGY 2,3,4 Wednesday lectures from 1-5pm. Friday didactics are for all residents at all levels and consist of Grand Rounds, journal club, and case conferences. There is an annual PRITE/Board Review curriculum woven into the didactic sessions. Topics covered include but are not limited to psychopharmacology, psychotherapy, DSM, addictions, child/adolescent, forensics, and geriatrics.

**SUGGESTED ACTIVITIES:**

**Research:**

1. Original research—hypothesis-driven, experimental in nature
2. Case reports/series
3. Literature review(s)
4. Textbook chapter(s)

Original, investigator-initiated research is the cornerstone of innovation in Psychiatry. Residents are encouraged to identify mentors working in basic, clinical, and/or educational research and begin formulating a project that can be completed during residency training. Case reports generate the interest and provide impetus for further, more rigorous investigations in our field. Should a resident and/or faculty member identify an interesting or unusual case, s/he is encouraged to further research and write up the case. Literature reviews and textbook chapters provide a summary and synthesis of current knowledge on a relevant topic in Psychiatry and often provide the novice's first understanding of an often overwhelming topic. Interested residents and faculty are encouraged to work together to review topics of mutual interest and that will contribute to the field.

#### **Teaching:**

1. *Resident as Teacher:* A good teacher is hard to find but absolutely necessary in academics. Breaking down a subject to its essence so that it can be understood by the audience is imperative to outstanding teaching. Rarely are professional students and residents taught how to teach. This apprenticeship is designed to do that and should be a rigorous teaching experience. The resident will identify a faculty mentor who does a significant amount of teaching (e.g. a whole series of lectures to the residents on psychopharmacology). It is also expected that the mentor has a significant literature-based knowledge of the field and possibly clinical/basic experimental research experience in the area and/or has been honored for teaching expertise/leadership. The resident will be mentored in learning the subject matter and reading appropriate literature. The resident will be given graded experience in teaching (e.g. 1-2 lectures at first with the goal of the resident giving an entire set of lectures).
2. *Evidence-Based Medicine (EBM) Scholar:* EBM is crucial to quality psychiatric care. The resident will work closely with a faculty mentor (with peer review experience) to keep abreast of the latest evidence related to Psychiatric practice. The resident will post relevant updates to the Department website accessible to faculty, residents, students, and staff.
3. *Continuing Medical Education (CME) Scholar:* Lifelong learning is crucial to psychiatrists in order to stay abreast of the latest advances in our field. The resident will work closely with a faculty member to organize CME activities (including Grand Rounds presentations and required courses for licensure) for faculty, staff, and residents.

#### **Creative:**

1. History of Psychiatry—the history of Psychiatry is rich and fascinating and can inform our present and future work. This is an opportunity to explore an area of Psychiatry, Medicine, and/or Science in depth. This would require the resident along with their mentor to thoroughly research a person or group of persons who has made significant contributions to Psychiatry, Medicine, or Science (e.g. famous women in Psychiatry; Nobel Prize winners from Neuroscience or Psychiatry), or to thoroughly review the history of a particular breakthrough (e.g. introduction of antipsychotics or ECT) that contributed to furthering our field.
2. Creative Writing in Psychiatry—Creativity and Psychiatry go hand-in-hand. This should be a rigorous creative writing (e.g. short story, essay, poetry, etc.) experience under the mentorship of a faculty member or other established/published writer (e.g. in the local community or elsewhere). Coursework in creative writing is strongly encouraged.
3. Art and Psychiatry—Art can be an expression of our daily work as Psychiatrists and can be healing. Residents may pursue scholarly activities in specific artistic domains such as photography, music, sculpture or painting/drawing or multi-media presentations. Residents are expected to develop a body of work grounded in the science and practice of Psychiatry, created with the support and direction of an appropriate mentor. Mentors must have demonstrated expertise in their artistic domains. It is expected that the development of the work will take place over a minimum of 1 to 2 years and will be worthy of presentation in recital, showings, concert and/or publication as appropriate for the art form.

These creative options are for those residents who have particular talents, interests, and passion in literature and art that can be harnessed to further advance or shape their career in Psychiatry. Strong emphasis on the Psychiatrist-Patient Relationship; the effects of mental illness on providers, patients and families; or other aspects of psychiatric practice is encouraged.

#### **AREAS OF EMPHASIS:**

The following areas of emphases in psychiatry may be pursued for research, teaching, and creative activities:

1. Addiction Medicine/Psychiatry
2. Administrative Psychiatry
3. Advocacy
4. Child/Adolescent Psychiatry
5. Community Psychiatry
6. Continuing Medical/Psychiatric Education (CME)
7. Diagnosis
8. Diversity/Cultural Awareness in Psychiatry

9. Evidence-Based Medicine (EBM)
10. Forensic Psychiatry
11. Geriatric Psychiatry
12. Medical/Psychiatric Ethics
13. Neuroscience
14. Psychopharmacology
15. Psychotherapy
16. Quality Care/Patient Safety (QC/PS); Quality Improvement (QI)
17. Telepsychiatry
18. Treatment modalities--other (e.g. ECT)
19. Other (with prior written approval from the mentor and RSA committee)

**SUGGESTED OUTCOMES:** Documentation of the resident's work and progress in the chosen area/activity must be submitted and will be required. This will help provide a "paper trail" that will assist the program in the accreditation process and in writing letters of recommendation as well as assignment of elective time and determinations of the need for protected time for the activity should this be requested. Once the project is initiated and underway, the resident, mentor, and RSA committee must agree on an expected outcome(s). The following are suggested outcomes:

**Research:**

1. Publication-quality manuscript for submission to a peer-reviewed journal. The resident should be the first author or provide evidence of significant contribution (e.g. experimental work and/or writing). For case reports and literature reviews, the resident should be the first author.
2. Poster and/or oral presentation at a clinical/scientific/educational meeting. A copy of the abstract and relevant meeting program details should be provided as evidence of participation. The resident should be the first author, the presenter, or provide evidence of significant contribution as above for manuscripts.
3. Submitted, pending, or funded grant application. The resident should be the principle investigator (PI) or demonstrate significant scholarly input as a Co-PI (i.e. the resident should write a significant portion of the application or generate preliminary data).

**Teaching:**

1. A portfolio of resident-produced teaching materials (e.g. PowerPoint presentations, handouts, etc.) AND teaching evaluations from "students" and the mentor AND self-evaluation of the teaching experience.
2. Publication-quality manuscript (e.g. teaching experience-based, literature review, meta-analysis) for submission to a peer-reviewed journal. The resident should be the first author or provide evidence of significant contribution (e.g. significant portion of the writing and editing).

**Creative:**

1. Publication-quality manuscript or thesis for submission to a peer-reviewed journal. The resident should be the first author or provide evidence of significant contribution (e.g. significant portion of the writing and editing).
2. Portfolio of creative work with a written description of the work AND mentor's written evaluation AND written self-evaluation of the experience.
3. Evidence of public exhibition of the work (e.g. programs, flyers, announcements, videos).
4. Publications in non-peer-reviewed journals, magazines (e.g. a foundation publication).

Residents will also be encouraged to share their work with fellow residents and faculty as well as the broader community via Grand Rounds or other seminar presentations or via the department website.

**MENTORS/SUPERVISORS:** A list of potential mentors (updated yearly on the website) and available projects will be provided. Residents may (and are encouraged to) seek out other mentors, including those outside the department. Each mentor should be willing to meet regularly with the resident to make sure that there is timely progress on the project. It is suggested that a mentor be sought out as early as the first year of residency to start planning the project. The mentor may (and is encouraged to) be a co-author on the resident's work provided that the mentor makes a significant contribution (guidelines for authorship will be provided on the website).

**RECOGNITION/AWARD:** All scholarly activity projects should be submitted for review for completeness and quality. Some may be sent out for external review. Each year at graduation, 1-3 projects (depending on number and quality) will be selected for recognition/award. Any resident, at any level of training, is eligible for award...

## **Resources**

### **Counseling and Support Services:**

<https://gme.med.ufl.edu/housestaff-affairs/resident-fellow-concerns-confidential-and-anonymous-resources-and-suggestions/>

### **Housestaff Affairs Office**

The Housestaff Affairs Office was developed to provide an ombudsman role for all housestaff physicians who are rotating through UF Health Shands Hospital at the University of Florida in Gainesville. Moving into a new city and a new part of the country in a new job can bring on many questions and concerns. This office was established to support the housestaff in a variety of these areas as well as provide support for residents within the hospital environment, overseeing such requirements as sleep room facilities, access to counseling services and facilitating problems that arise within the housestaff. The office is located on the 6th floor of UF Health Shands Hospital and the telephone number is 265-0787.

### **Housestaff Exercise Room**

UF Health Shands Hospital and the University of Florida have developed an exercise room specifically for housestaff. It is located on UF Health Shands, North Tower, 6th floor. Free access to UF Residents/Fellows

The equipment in this area was chosen to support the mental and physical well-being of residents. Aerobic stair steppers, wind and friction resistant bicycles and a universal gym encompass an array of opportunities for housestaff to release energy and stress as well as develop a personal fitness program.

### **Housestaff Lounge**

A lounge, located on the 6<sup>th</sup> floor of UF Health Shands North Tower and the Ground floor of the East Tower were established by UF Health Shands Hospital and the University of Florida specifically for housestaff physicians. Location and the current door lock combination can be obtained from your chief resident or through the Housestaff Affairs Office personnel.

### **Housing**

The Housestaff Affairs Office provides resources for housing for incoming residents and fellows by making available a listing of homes, condos, etc. which the completing residents and fellows are selling.

### **Library**

The University of Florida maintains a full-service medical library located on the first floor of the Communicore Building.

### **Loan Deferment**

Housestaff Affairs Office handles all loan deferments and forbearance forms.

### **Loans**

The University of Florida Alumni has an interest free loan for unplanned emergency situations available to residents and fellows. The forms for this loan are available in the Housestaff Affairs Office.

### **Medline/Computers/Information Resources**

UF Health Shands Hospital has placed a computer in the Housestaff Lounge on the sixth floor of UF Health Shands Hospital. This computer has EPIC, Citrix, Aidslite, Medline, Foxline, AMA FREIDA, etc. available for residents and fellows in the College of Medicine to use. The Medical Center Library has an Informatics Lab available for residents and fellows in the College of Medicine. There are several computers available in the SpringHill Medical Office Building. Residents also have access to computers in all essential clinical sites

### **Resident Assistance Program**

<http://gme.med.ufl.edu/contact-us/insurance-benefits-health-life-disability-etc/resident-assistance-program/>

### **Social Events**

#### **Graduation Reception**

In honor of the graduating general psychiatry residents, this event is usually held in June. All residents, fellows and faculty members are invited to attend.

## Holiday Reception

A Departmental reception is held for all the Department faculty, residents and staff; this usually is held early in the month of December.

## Department Sponsored Membership APA and Florida Psychiatric Society

Annual Membership Dues are paid by the department

## 2023 Graduate Medical Education Policies & Procedures

<https://gme.med.ufl.edu/policy-procedures/gme-policies-and-procedures/>

Password: GME1234

Department of Psychiatry Policies and Procedures are available on the "Internal Resources" page of the website.

<https://apps.psychiatry.ufl.edu/webcall/>

## LETTER OF OFFER TO RESIDENTS OF THE UNIVERSITY OF FLORIDA COLLEGE OF MEDICINE

Dear [Click or tap here to enter text.](#)

The College of Medicine, University of Florida (hereinafter "the University") is pleased to offer you a position as a resident or fellow at the program training level year 1 PGY Level PGY 1 and compensation level 1 CS in the graduate medical education program, General Psychiatry, in the Department of Psychiatry.

This contract describes various aspects of the graduate medical education programs for residents and fellows at the University. Trainees in such programs (residents and fellows) are hereinafter referred to as "residents." The University reserves the right to make changes without notice in the future to any aspect of these programs.

During your residency you will be required to exhibit the qualifications and talents for the specialty to which you have been accepted for graduate medical education training. For each specialty, you must possess and demonstrate critical thinking skills, sound judgment, emotional stability and maturity, empathy for others, physical and mental stamina, and the ability to learn and function in a variety of settings. You must also be able to perform the essential functions of the specialty and meet the academic standards of the curriculum.

This contract is contingent upon the completeness and accuracy of the appointment documents prepared and submitted by you. Falsification of any of the appointment documents or failure to meet eligibility requirements may result in non-appointment or termination. This contract, in conjunction with University rules, policies and procedures, governs the relationship between the University and you. This contract constitutes the entire agreement between the parties and supersedes any and all prior and contemporaneous oral or written agreements or understandings between the parties.

### **Resident Responsibilities:**

The position of resident involves a combination of supervised, progressively more complex and independent patient evaluation, management functions and formal educational activities. Among a resident's responsibilities in a training program of the University are the following:

- 1) To meet the qualifications for resident eligibility outlined in the Essentials of Accredited Residencies in Graduate Medical Education in the AMA Graduate Medical Education Directory or the Specialty Guidelines of the American Dental Association's Council on Dental Accreditation;
- 2) To develop a personal program of self-study and professional growth with guidance from the teaching staff;
- 3) To provide safe, effective, and compassionate patient care, commensurate with the resident's level of advancement, responsibility, and competence, under the general supervision of appropriately privileged attending teaching staff;
- 4) To participate fully in the educational and scholarly activities of their program and, as required, assume responsibility for teaching and supervising other residents and students;
- 5) To participate in institutional orientation and educational programs and other activities involving the clinical staff;
- 6) To submit to the program director confidential written evaluations of the faculty and the educational experiences;
- 7) To participate on institutional committees and councils to which the resident is appointed or invited, especially those that

- relate to their education and/or patient care;
- 8) To adhere to established practices, procedures, and policies of the University and of those applicable from affiliated institutions.
  - 9) Communication Requirements: All residents are expected to maintain cellular connection, using a smart/cell phone that is compatible with the University's Electronic Medical Record and/or appropriate app. Residents will be expected to use their personal cell phones during business hours, as part of employment. Residents are expected to share their cell phone numbers with the Institution for patient care reasons and the Institution will protect this data from the public.
  - 10) Licensure: All residents are required to comply with state licensure requirements for physicians in training. Residents must hold before the start date of training either a valid unrestricted Florida medical or dental license or be registered with the Florida Board of Medicine/Board of Dentistry for a Training License or Dental Residency Permit. All residents will be required to obtain a National Provider Identifier (NPI) number. Failure to meet applicable eligibility requirements without delay and obtain and maintain a training license/permit or a valid unrestricted Florida license may result in one or more of the following:
    - delay or revocation of appointment
    - preclude advancement to the next program level
    - preclude continuation in the program
    - disciplinary action for non-academic deficiency

An unrestricted Florida license is not required of residents; however, should a resident obtain an unrestricted medical license in Florida, it is solely his/her responsibility to maintain active status with the Medical / Dental Board, including timely renewal and payment of all associated fees.
  - 11) Confidentiality: all residents have an obligation to conduct themselves in accordance with the Confidentiality policies of the University and its primary teaching hospitals, including Veterans Affairs Medical Center. Failure to follow these policies may be cause for immediate dismissal.
  - 12) Background Checks: All residents/fellows are required to have a federal background check completed with the submission of the Training License Application. Your acceptance and continued participation as a resident/fellow in the Graduate Medical Education Program is contingent upon review and approval of the background check and the Florida Board of Medicine.
  - 13) OIG/GSA Checks: Your acceptance and continued participation as a resident in the graduate medical education program is contingent upon your eligibility to participate in Medicare, Medicaid, Tricare or other Federal health care programs. A check will be performed of the U.S. Department of Health and Human Services Office of Inspector General ("OIG") list of excluded individuals and the U.S. General Service Administration ("GSA") excluded parties' list system as part of your appointment process. If your name appears on the OIG or GSA excluded party lists or if you are at any time excluded from participation in Medicare, Medicaid, Tricare or other Federal health care programs or are convicted of a criminal offense related to the provision of health care items or services, your participation as a resident in the graduate medical education program may be terminated immediately.
  - 14) Case Documentation: documentation of clinical experiences, cases and/or procedures is mandated by the Residency Review Committees. Residents who do not maintain accurate case documentation may not advance to the next level of training or be allowed to complete their program until compliance is achieved.
  - 15) To develop competencies in:
    - Patient care that is compassionate, appropriate, and effective for the treatment of health problems and the promotion of health
    - Medical knowledge about established and evolving biomedical, clinical, and cognate sciences and the application of this knowledge to patient care
    - Practice-based learning and improvement that involves investigation and evaluation of their own patient care, appraisal and assimilation of scientific evidence, and improvements in patient care
    - Interpersonal and communication skills that result in effective information exchange and teaming with patients, their families, and other health professionals
    - Professionalism, as manifested through a commitment to carrying out professional responsibilities, adherence to ethical principles, and sensitivity to a diverse patient population
    - Systems-based practice, as manifested by actions that demonstrate an awareness of and responsiveness to the larger context and system of health care and the ability to effectively call on system resources to provide care that is of optimal value
  - 16) To comply with duty hours assignments consistent with patient safety, educational requirements and personal development as outlined in departmental and institutional policies.

**Duration of Appointment and Conditions for Reappointment:** Your initial appointment will begin on July 1, 2023 and may continue for a period of 12 months. Your appointment will be processed by the University after you have accepted this official letter of offer, have met the conditions stated, and completed applicable registration, licensure, and proof of the right to work in the United



States as required by law. We anticipate you will remain in the prescribed course of your residency until completion. However, it is understood that appointments are renewed annually and that continued retention in the training program depends on your satisfactory performance/training progress, including your adherence to acceptable professional behavior, as well as the continuation of requisite funding for the program and the best interests of the program as determined by the Associate Dean. A resident's reappointment and progression to more advanced levels will be based on the results of periodic reviews of the resident's educational and professional achievement, competence and progress as determined by the program director and teaching faculty. However, no appointment shall create any rights, interests, or expectancies of continuation beyond the term of the appointment itself. At the completion of each academic year, your performance will be reviewed and the recommendations for continuation communicated to you by the Program Director or designee. Unsatisfactory progress or performance may result in probation, non-advancement, dismissal or non-renewal. Residents may review their evaluations with their advisor, the program director, or University representative.

The primary site of your graduate medical training will be the University Of Florida College Of Medicine with its major teaching hospitals and affiliates, but the location of the training for any resident may occur at various additional sites. All assignments and call schedules are made at the discretion of the appropriate program director. In addition, should residency programs be closed or downsized, the University will inform the resident well in advance of such events. Every effort will be made to complete the resident's course of training or to find another site for the resident to complete training.

Residents are not automatically entitled to additional training beyond the prescribed number of years in order to achieve board eligibility in the designated specialty. Any such extension of the residency and the required funding must be approved by the Program Director and the University's College of Medicine Associate Dean for Graduate Medical Education/Designated Institutional Official (Director of Graduate Medical Education).

Residents in all core residency training programs sponsored by the University Of Florida College Of Medicine Gainesville must pass the USMLE/COMLEX Step 3 examination by the completion of the PGY-2 year. Failure to pass USMLE/COMLEX Step 3 by the conclusion of the PGY-2 year may result in suspension from training without pay until USMLE Step 3 is successfully passed. No resident may receive a salary increase to the PGY-3 level without prior passage of USMLE Step 3, but may, at the discretion of the program director, be promoted to the PGY-3 level clinically. Alternatively, programs may elect to non-renew residency training contracts for residents who have not successfully completed USMLE/COMLEX Step 3 by March 1 prior to the PGY-3 year. International Medical Graduates who first enter US GME training at the fellowship level (i.e. have not completed core residency training) are exempt from this policy. Other individual exceptions to this policy may be granted only by appeal to the Designated Institutional Official.

#### **University of Florida College of Medicine Policies and Procedures for Grievances, Suspension, Non-renewal, or Dismissal of a Resident.**

The University of Florida College of Medicine Policies and Procedures for Grievances, Suspension, Non-Renewal or Dismissal of a resident are enclosed and hereby incorporated herein. If you need a new copy of the Policies and Procedures or have questions regarding them, please contact the Graduate Medical Education office at (352) 265-0152.

**Financial Support and Other Benefits Stipend:** Each resident is given a stipend to pursue the resident's graduate medical education in an amount appropriate to the resident's level in the program. Stipend levels are reviewed annually by the Graduate Medical Education Committee of the College of Medicine and recommendations for changes are subject to approval by University's Dean of the College of Medicine. Stipend levels begin on 7/1/2023 of each contract year and are paid biweekly. Residents are eligible to defer up to 20 percent of income in a 403(b) plan via payroll reduction.

Living quarters, meals, laundry, and other such expenses are the resident's responsibilities. In some cases and at the discretion of the University, a meal subsidy may be issued to the resident; similarly, living quarters may be provided during some rotations outside of the primary location of the program.

**Health, Life and Disability Insurance, Worker's Compensation Insurance:** Health insurance is provided to the resident and his/her family; life and disability insurance are provided to the resident. If a resident suffers a work-related injury, the resident is generally covered under the workers' compensation program of the University provided the resident complies with the requirements of the worker's compensation program.

**FICA Alternative Plan:** As a resident, you automatically will be enrolled in the University of Florida's FICA Alternative Plan. Under the provisions of this retirement plan, instead of paying 6.2 % social security taxes post-tax, you will contribute 7.5% of your pre-tax wages into an investment account in your name. The Medicare contributions at 1.45% will continue to be withheld from your biweekly paychecks and will be matched by the University of Florida. Information regarding this program is available at: [UF - FICA Alternative Plan](#)

**Employee Assistance Program (EAP):** is designed to help residents and their families with concerns or problems that may be

troubling them. The mission of the program is to develop and maintain a positive and productive work environment. The program helps by providing a system of short-term, confidential, professional counseling and referral services to residents and their families. The Resident Policy and Procedure Manual provides details of coverage.

UF-Employee Assistance Program (EAP)

**24 hours:** 833.306.0103, TTY: 800.697.0353

**Website:** [eap.ufl.edu](http://eap.ufl.edu)

**Professional Liability Coverage:** Professional Liability Coverage: As a participant in a clinical graduate medical education program of the University, a resident is an employee of the University of Florida, Board of Trustees (UFBOT), and the State of Florida agency that operates the University of Florida. Under Section 768.28, Florida Statutes, residents are personally immune from civil liability for any injury or damage suffered by a patient as a result of negligence occurring while residents are acting within the course and scope of their employment. The UFBOT is responsible for any civil claims or actions arising from the negligent acts of its employees and agents, including residents in University graduate medical programs.

The University of Florida J. Hills Miller Health Center/Gainesville Self-Insurance Program (SIP), a self-insurance program established by the Florida Board of Governors pursuant to Florida Statutes Section 1004.24, provides professional liability protection to the UFBOT and Shands Teaching Hospital and Clinics, Inc. for incidents in which patients suffer bodily injury, personal injury, or property damage caused by the negligence of UFBOT residents.

SIP also affords residents professional liability protection when residents act in the role of a "Good Samaritan", when involved in community service work that has been pre-approved by the University, and when serving on a University educational assignment outside of Florida. In light of the benefits of immunity provided by law, residents, while performing their duties must identify themselves at all times as UFBOT employees. Accordingly, residents must wear the University ID badge at all times while participating in the graduate medical education program.

**Institutional Leave Policy:** A comprehensive leave policy is outlined in the UF College of Medicine Graduate Medical Education Time Away from Training and Leave policy which is incorporate herein by this reference. The comprehensive leave policy may be modified from time to time at the University's sole discretion.

**Medical Requirements:** Prior to your appointment as a resident, you are required to complete a University pre-employment health screening questionnaire. In addition, screening of the resident for infectious diseases, prophylaxis/treatment for exposure to communicable disease, and immunizations will be provided by the University or through arrangements with other health providers. The resident will have documentation of immunity to measles, mumps, hepatitis B, rubella and varicella (chicken pox); the resident will be required to have periodic tuberculosis skin tests. The resident must comply with the infection control policies and procedures of the institutions where the resident is assigned. A resident must meet the technical standards set by the College of Medicine and his/her respective program.

**Americans with Disabilities Act:** The University of Florida, under the guidelines of ADA and 504 federal legislations, is required to make reasonable accommodations to the known physical and mental limitations of otherwise qualified individuals with disabilities. For assistance contact:

**ADA Compliance Office: 352.273.1094**

**TTY: 800.955.8771**

**Website: [ehs.ufl.edu/programs/ada/](http://ehs.ufl.edu/programs/ada/)**

**Policies Regarding Sexual Harassment:** Complaints of sexual harassment will be handled in accordance with the specific published policies of the University of Florida and the College of Medicine (as contained in the Resident Policy & Procedure Manual).

**Physician Impairment and Substance Abuse:** The University of Florida is a Drug Free Workplace. Violations can result in disciplinary action up to and including termination. Residents may be required to undergo and pass Drug Toxicology screening at University of Florida. In addition, random drug testing maybe required during training at the University of Florida. A violation may also be reason for evaluation and treatment of a drug and/or alcohol disorder or referral for prosecution. In addition to any disciplinary action, residents identified as such will be referred to the Professionals Resource Network (PRN). The Florida Medical Practice Act (F.S. 458) rule calls for all licensed practitioners to report to the appropriate authority any reasonable suspicion that a practitioner is impaired to practice. The legislation provides for therapeutic intervention through the Professionals Resource Network (PRN). This organization works closely with the State Board of Medicine and is recognized as the primary method of dealing with physician impairment in the state. Faculty, staff, peers, family or other individuals who suspect that a resident is suffering from a psychological or substance abuse problem are obliged to report such problems. Reporting can be directly to the PRN or to the program director, Chairman, or Associate Dean for Graduate Medical Education. Residents suspected of impairment will be relieved of all patient care responsibilities. Early involvement of the PRN is essential. All referrals are confidential. If the PRN feels

intervention is necessary, they handle the situation and provide for treatment and follow-up. Residents can only return to clinical duties with the approval of the PRN. Re-entry into the Program is not automatic. The PRN maintains contact with the program directors about residents in the program of recovery.

The University makes available an Employee Assistance Program to its residents. The University also provides an educational program for residents regarding physician impairment, including substance abuse.

**Disclaimer or Resident Assertions; Invention and Copyright Agreement:** The resident agrees that unless approved by the University's Chair, all materials compiled or published by the resident relative to training and experiences received at the University and its affiliated hospitals, or arising from participation in training, patient care, or research pursuant to this agreement, will clearly state that the opinions or assertions contained therein are those of the resident and not those of the University. Pursuant to the University's rules, the resident must execute the University's Invention and Copyright Agreement.

**Outside Professional Activities:** All programs have established rules regarding outside and extracurricular activities that meet their RRC requirements and University policy. A prospective, written statement of permission from the program director and University's Associate Dean for Graduate Medical Education, Designated Institutional Official (DIO) is required and is made part of a resident's file. Resident performance is monitored for the effect of these activities and adverse effects may lead to withdrawal of permission.

**Moonlighting activities** are initiated by departments to provide clinical experiences which often are not afforded within the standard curriculum. All programmatic activity must be approved by the program director and/or department chairman, and the Designated Institutional Official (DIO). For approval forms contact your program.

**External Moonlighting activities** are initiated by the resident and do not involve any agreement between the University and the outside employer. Individual programs have total authority to decide whether non-programmatic activities are allowed in keeping with their Residency Review Committee guidelines and curriculum.

All non-programmatic activity must be approved by the program director and/or department chairman, and the Designated Institutional Official (DIO). For approval forms contact your program.

**Certificate of Completion:** A certificate of graduate medical training will be issued to a resident on the recommendation of the University's appropriate Chair and Program Director only after satisfactory completion of service, educational requirements, and fulfillment of all other obligations and debts. Information regarding specialty board examinations can be found at the American Board of Medical Specialties: [www.abms.org](http://www.abms.org)

**Medicaid Credit Balance:** Your signature below affirms that you have diligently inquired and to your knowledge you have no outstanding Florida Medicaid credit balances that you incurred prior to your employment with the University of Florida that would in any way bar or delay Florida Medicaid reimbursement for your services rendered with the University of Florida. If any such credit balances are revealed at any time and results in the University of Florida being unable to collect from Florida Medicaid reimbursement for services you render on behalf of the University of Florida, you will be considered to have failed to effectively maintain eligibility with that program, which is a condition of your employment. Should such an event occur and should you fail to promptly resolve the credit balance issue to the satisfaction of the University of Florida, you will be subject to immediate termination of your employment with the University of Florida.

#### **Florida Medicaid Provider Services**

**Website: [ahca.myflorida.com](http://ahca.myflorida.com)**

**Federal Levy Program:** The Taxpayer Relief Act of 1997, Section 1024, authorized the Centers for Medicare & Medicaid Services (CMS) to reduce certain federal payment, including Medicare and Medicaid payments, in order to allow collection of an employee's overdue federal debts. Please be aware that if any such overdue federal debts are revealed at any time during your employment with the University of Florida resulting in the university being unable to collect Medicare or Medicaid reimbursement for your services, you will be considered to have failed to effectively maintain eligibility with that program, which is a condition of your employment. Should such an event occur and should you fail to promptly resolve the personal overdue debt issue to the satisfaction of the University of Florida, you will be subject to immediate termination of your employment with the University of Florida.

**HIPAA Statement:** All University of Florida College of Medicine employees are required to sign a statement agreeing to maintain the confidentiality of protected health information. Enclosed is a copy of the University of Florida's confidentiality statement. Please read, sign and return the confidentiality statement to me. All University of Florida Health Science center employees also are required to complete specialized training regarding privacy and security that involves HIPAA general awareness and Principal Investigator training, as applicable. Arrangements will be made to assist you with accessing this on-line training following your arrival at the university. Please be aware that all Health Science Center employees are required annually to re-sign the

confidentiality statement and to complete on the on-line privacy and security training.

**Employment Eligibility:** This offer and your active employment status are contingent upon your eligibility to work under the provisions of all applicable immigration laws and regulations including the Immigration Reform and Control Act of 1986, as amended, and you're providing the necessary documents to establish identity and employment eligibility to satisfactorily complete U.S. Citizenship and Immigration Services' Form I-9. As a federal contractor, the University of Florida also participates in E-Verify, the federal on-line verification system. To comply with these requirements, on or before your first day of employment, you must complete Section 1 or Form I-9. Additionally, you must present documents that verify your identity and work authorization within the first three business days of your start date. Should you fail to provide the appropriate documentation by the end of the third business day as required by law; your appointment will be terminated until you can provide such documentation. A list of acceptable documents to establish identity and employment eligibility can be found at: [List of Acceptable Documents](#)

Sincerely,

Accepted:

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Signature

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Signature

Program Director Name:  
Ludmila Barbosa De Faria, MD

Resident Name:

Date:  
Click or tap to enter a date.

Date:  
Click or tap to enter a date.

## TOP Laws and Rules Every Physician Should Know

The following information is being provided as a resource to remind you of important laws and rules that affect your medical practice. It is still your responsibility to read and become familiar with the laws and rules of the State of Florida.

Law and/or Rule with cite	Description
<p><b>1. You must update your Practitioner Profile within <u>15 days</u></b></p> <p>s. 456.042, F.S.</p>	<p>This includes changes in –</p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Address</li> <li><input type="checkbox"/> Staff privileges</li> <li><input type="checkbox"/> Medical malpractice history</li> <li><input type="checkbox"/> Financial responsibility</li> <li><input type="checkbox"/> Board certification</li> <li><input type="checkbox"/> Education</li> <li><input type="checkbox"/> Disciplinary/criminal history</li> </ul>
<p><b>2. Before you move to a new practice, notify the Board</b></p> <p>s. 456.035, F.S.; s. 458.319(3), F.S.; s. 458.327(2)(e), F.S.</p>	<p>No current address on file? Here is what can happen:</p> <ul style="list-style-type: none"> <li><input type="checkbox"/> crisis at renewal time</li> <li><input type="checkbox"/> late renewal may mean practicing on an inactive license</li> <li><input type="checkbox"/> practice on inactive license = criminal offense</li> </ul>
<p><b>3. Do not pre-sign prescriptions</b></p> <p>s. 458.331(1)(aa), F.S.</p>	<p>Board of Medicine Disciplinary Guidelines provide a maximum penalty of -</p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Reprimand</li> <li><input type="checkbox"/> \$5,000 fine</li> <li><input type="checkbox"/> 2 years probation</li> </ul>
<p><b>4. At license renewal, read the fine print before you renew</b></p> <p>s. 458.319, F.S.</p>	<ul style="list-style-type: none"> <li>• Renew you license every 2 years</li> <li>• CME and Financial Responsibility requirements are audited</li> <li>• Maintain copies of your CME certificates for at least 2 biennium</li> <li>• DIDN'T RECEIVE YOUR RENEWAL POSTCARD? Call (850) 488-0595 extension #3</li> <li>• RENEW ONLINE at <a href="http://www.doh.state.fl.us/mqaservices">www.doh.state.fl.us/mqaservices</a></li> <li>• The Preventing of Medical Errors course has specific requirements including a study of root cause analysis, error reduction, prevention and patient safety, and the 5 most mis-diagnosed medical conditions in Florida during the previous biennium and those conditions are:             <ul style="list-style-type: none"> <li><input type="checkbox"/> cancer</li> <li><input type="checkbox"/> cardiac</li> <li><input type="checkbox"/> acute abdomen</li> <li><input type="checkbox"/> timely diagnosis of surgical complications</li> <li><input type="checkbox"/> stroke and related cranial conditions</li> </ul> </li> <li>• CME providers may be located on the Internet by typing “continuing medical education” in the search field, or by contacting the American Medical Association at (312) 464-4952.</li> </ul>
<p><b>5. You must keep charts on the family, employees and friends that you treat</b></p>	<ul style="list-style-type: none"> <li>• A prescription creates the physician/patient relationship</li> <li>• Records are required even for family</li> <li>• Spouses/friends may become adverse parties</li> </ul>

<p>s. 458.331(1)(r), F.S. and s. 458.331(1)(m), F.S.</p>	<ul style="list-style-type: none"> <li>• Cannot self-prescribe controlled substances</li> </ul>
<p><b>6. Patient Boundaries</b>  S. 458.329, F.S. and s. 458.331(1)(j), F.S.</p>	<p>Board of Medicine has a zero tolerance policy on physician/patient sexual misconduct</p> <ul style="list-style-type: none"> <li>• Typical penalty is suspension/revocation</li> <li>• Remember: A prescription creates a physician/patient relationship</li> </ul>
<p><b>7. Pause before you make the incision on the correct site of the correct patient</b>  s. 458.331(1)(t), F.S.; s. 456.072, F.S.;456.062,F.S. and Rule 64B8-9.007, F.A.C.</p>	<ul style="list-style-type: none"> <li>• The “pause” before the procedure must be in the patient chart</li> <li>• If you make the mistake, inform the patient and/or the patient’s representative and document it or the Board will increase the penalty.</li> <li>• Read the rule at <b>64B8-9.007 Standards of Practice.</b></li> </ul>
<p><b>8. Internet Prescribing</b>  s. 458.331(1)(t), F.S. and Rule 64B8-9.014, FAC</p>	<ul style="list-style-type: none"> <li>• Prescribing without a history and physical is both a standard of care violation and a violation of Board rule</li> <li>• Physician have been disciplined for this with penalties ranging from revocation to suspension, reprimands and fines</li> <li>• DO NOT JEOPARDIZE YOUR LICENSE – DON’T PRESCRIBE ON THE INTERNET!</li> </ul>
<p><b>9. Relocating Practice?</b>  Rule 64B8-10.002, FAC</p>	<p>You are responsible to:</p> <ul style="list-style-type: none"> <li><input type="checkbox"/> hold patient records for 5 years</li> <li><input type="checkbox"/> notify patients in letters or by sign as to where to pick up records</li> <li><input type="checkbox"/> place a notice in newspapers and notify the Board of Medicine 30 days <u>before</u> you move</li> <li><input type="checkbox"/> complete your hospital charts if leaving the area!</li> </ul>
<p><b>10. Help for impaired practitioners</b>  s. 456.076, F.S.</p>	<p>Do you know a colleague with drug, alcohol, or psychiatric problems?</p> <ul style="list-style-type: none"> <li>• You can get them help without subjecting them to disciplinary action</li> <li>• The Board has an excellent evaluation and rehabilitation program that is a phone call away: Professional Resource Network (PRN) – 1-800-888-8776</li> <li>• For most practitioners, this is and remains a confidential process that offers help to those willing to change</li> <li>• This program was recently expanded to include medical students as well</li> </ul>
<p><b>11, Controlled Substances</b>  <b>House Bill 21</b> <b>Chapter 2018-13</b></p>	<p>CS/CS/HB 21 amends various sections of law to increase the regulation, training, and reporting required when controlled substances are prescribed and dispensed. The bill:</p> <ul style="list-style-type: none"> <li>• Requires all prescribing practitioners who are authorized to prescribe controlled substances to complete a two-hour training course prior to biennial licensure renewal on the safe and effective prescribing of controlled substances, unless such practitioner is already required to take such a course by his or her practice act.</li> <li>• Defines “acute pain” as the normal, predicted, physiological, and time-limited response to an adverse chemical, thermal, or mechanical stimulus associated with surgery, trauma, or acute illness. The term specifically does not include pain related to: <ul style="list-style-type: none"> <li>○ Cancer;</li> </ul> </li> </ul>

- A terminal condition;
- Palliative care to provide relief of symptoms related to an incurable, progressive illness or injury; or
- A serious traumatic injury with an Injury Severity Score of 9 or greater.
- Provides restrictions on certain prescriptions written to treat acute pain by:
  - Requiring applicable health care regulatory boards to create guidelines for prescribing controlled substances for the treatment of acute pain.
  - Limiting a prescription for an opioid listed in Schedule II to no more than three days if prescribed to treat acute pain as defined. This limit is increased to seven days if determined to be medically necessary by the prescribing practitioner and with proper documentation.
  - Requiring a prescriber to co-prescribe an opioid antagonist when prescribing controlled substances for serious traumatic injury.
- Requires clinics that are exempt from the requirement to register as a pain management clinic to obtain and maintain a certificate of exemption from the Department of Health (DOH). These provisions take effect January 1, 2019.
- Requires pharmacists and dispensing practitioners to verify a patient's identity prior to dispensing controlled substances.
- Conforms an exemption allowing health care practitioners to dispense controlled substances in connection with a surgical procedure to the limits on prescribing established for Schedule II opioid medications.
- Creates an exemption to allow a physician to dispense Schedule II and III controlled substances approved by the United States Food and Drug Administration (FDA) for the medication-assisted treatment (MAT) of his or her own patients.
- Explicitly authorizes electronic prescriptions for controlled substances.
- Adds and reschedules substances to the various schedules of controlled substances.
- Substantially rewords the Prescription Drug Monitoring Program (PDMP) with changes including, but not limited to:
  - Including Schedule V controlled substances in the list of drugs that must be reported to the PDMP;
  - Requiring prescribing practitioners to consult the PDMP before prescribing controlled substances with certain exceptions;
  - Allowing the DOH to coordinate and share Florida's PDMP data with other states' PDMPs and to enter into contracts to establish

secure connections between the PDMP and prescribing or dispensing health care practitioner's electronic health records; and

- Allowing prescribers and dispensers with Veterans' Affairs, the military, and the Indian Health Services, and Florida medical examiners access to data in the PDMP.
- Increases the penalty from a 3rd degree felony to a 2nd degree felony for a patient or health care practitioner who knowingly obtains or provides a controlled substance that is not medically necessary.
- Creates a new 3rd degree felony for unlawfully possessing and using tableting or encapsulation machines.

### Accessing the laws and Rules

Laws: <http://www.leg.state.fl.us/statutes/index.cfm>

s. 458, Florida Statutes – Medical Practice Act

s. 456, Florida Statutes – General Provisions Applicable to All Health Care Practitioners

Rules: <https://www.flrules.org/Default.asp>

Chapter 64B8, Florida Administrative Code

### Contact Information

#### Psychiatry Residency Training Office

The Psychiatry Residency Training Office is located in the UF Health Shands Psychiatric Hospital (Vista). The Education Program Coordinator and Program Coordinator provide support for all Psychiatry residents, including day to day activities such as pagers, call schedules, vacations, pay issues, lab coats, loan deferments, applications for licensure, etc., and are in general the point of first contact for Psychiatry Residents. The Program Office handles applications and coordinates interviews for fourth year medical students who are applying for general psychiatry at the University of Florida.

#### Psychiatry Office Contact Information:

##### Interim Program Director:

Ludmila De Faria, MD

Associate Professor

E-Mail address: [l.barbosadefaria@ufl.edu](mailto:l.barbosadefaria@ufl.edu)

##### Associate Program Director:

Robert Averbuch, MD

Associate Professor

E-Mail address: [averbuch@ufl.edu](mailto:averbuch@ufl.edu)

##### Associate Program Director:

Laura Rodriguez-Roman, MD

Associate Professor

E-Mail address: [laurarr@ufl.edu](mailto:laurarr@ufl.edu)

##### Associate Program Director

Gary Kanter, MD

Associate Professor

E-Mail address: [kanter@ufl.edu](mailto:kanter@ufl.edu)

##### Education Program Coordinator:

TBD

##### Program Coordinator:

Jacqueline Garcia

E-Mail Address: [restore@ufl.edu](mailto:restore@ufl.edu)

Phone: 352-265-2862

Fax: 352-265-2873

##### Program Coordinator:

Shelly Miranowicz

E-Mail address: [smiranowicz@ufl.edu](mailto:smiranowicz@ufl.edu)

Phone: 352-265-2865