Post-Doctoral Fellowship
Health & Rehabilitation Psychology
Training Handbook
2024-2025

Training Director: Elyse Parke, Ph.D., ABPP-CN

TGH/TGMG Psychology & Neuropsychology

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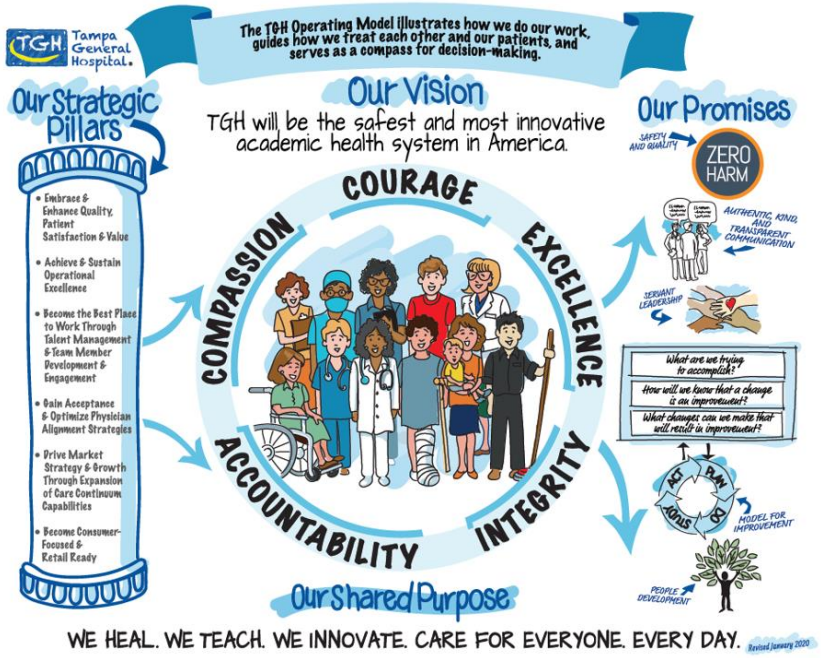
TGH Policies on TGH Portal

- PT 071 TGH Conflict Resolution and Grievance Policy
- HR 070 TGH Code of Conduct
- HR 088 TGH Standards of Attire
- PST 100 Suicide Prevention and Baker Acts

SETTING OVERVIEW

Our objective is to provide a rich, challenging, and varied clinical training experience within the continuum of care for medical populations. Tampa General is a private not-for-profit hospital as well as one of the most comprehensive medical facilities in West Central Florida, serving a population in excess of 4 million across one dozen counties, ranked #1 in Tampa Bay by *US News & World Reports*. TGH is the area's only Level 1 Trauma Center, has one of three American Burn Association verified burn centers in Florida, is a state certified stroke center, and has one of the largest transplant programs in the country. As the region's leading safety net hospital, Tampa General is committed to providing area residents with excellent and compassionate health care. In partnership with the USF Health Morsani College of Medicine, TGH is Florida's leading academic health system for over 50 years.

Our TGMG Psychology & Neuropsychology team provides assessment, consultation, and treatment for both adult and pediatric populations throughout the continuum of care. Currently, the Psychology & Neuropsychology staff represent a high degree of specialization in treating individuals with medical, rehabilitation, and neuropsychological needs. Psychologists have key leadership roles within their multidisciplinary teams and participate in teaching, applied clinical research, and team building activities.



PROGRAM OVERVIEW

The primary goal of the Health and Rehabilitation Psychology Postdoctoral Fellowship Program is to develop professional psychologists who are competent, ethical, and prepared for independent practice in a variety of medical settings. The fellowship program at TGH is designed to meet the postdoctoral supervised practice requirements for licensure within the state of Florida. We achieve this through direct teaching, evidence-based care, and scholarly inquiry, research via a scientist-practitioner model, professional development, and multidisciplinary collaboration.

PROGRAM GOALS AND OBJECTIVES

The primary goal of the Health and Rehabilitation Psychology Postdoctoral Fellowship Program is to develop professional psychologists who are competent, ethical, and prepared for independent practice in a variety of medical settings. Goals and competencies are met through clinical rotations with direct supervision, didactics, a program development project, and case presentations. At the conclusion of training (one year), we expect fellows will meet the following goals and objectives:

- Provide evidenced-based clinical care including advanced skills in assessment, intervention, and/or consultation, depending on individualized training goals.
- Work effectively in multidisciplinary environment, know the roles of other professional providers, and exhibit appreciation for unique knowledge and contributions of other disciplines.
- Practice with mature appreciation for ethical and professional standards in alignment to the American Psychological Association Ethical Codes and standards.
- Provide clinical care in a manner, which respects and is sensitive to individual differences of all persons, is non-discriminatory, and which respects and protects human and civil rights.
- Apply research to clinical practice and program development.
- Demonstrate effective use and understanding of supervision.
- Exhibit self-care behaviors to facilitate competent and professional practice.

COMPETENCIES

Upon completion of the fellowship, the fellow will display competencies in the clinical practice of psychology. Fellow evaluation aligns with the Profession Wide Competencies (PWC's) set forth by APA in the areas of:

- Research
- Assessment
- Intervention
- Consultation and Interpersonal/Interdisciplinary skills
- Supervision
- Ethical and Legal Standards
- Professional values and attitudes
- Administrative Skills
- Individual and cultural diversity

PROGRAM SCHEDULE

Postdoctoral fellows participate in supervised rotations within the Tampa General continuum of care (acute, inpatient rehabilitation, and outpatient). Training is structured into two, 6-month segments. Each rotation allows for two focused rotations 2-days per week for each rotation. Fridays involve weekly didactics, department and hospital committee meetings, and continuing education opportunities as they are scheduled. The remainder of Friday is dedicated to scholarly or clinical projects, EPPP preparation, and additional clinical activities from assigned rotations (example: neuropsychological evaluation feedbacks). Taking the EPPP is strongly recommended by the end of July of the training year. An additional day of a clinical rotation on Fridays may be added in August-September after conclusion of didactic schedules.

FACILITIES AND ROTATIONS

Psychology and Neuropsychology services are located at the TGH main hospital, TGH Inpatient Rehabilitation Hospital, and Westshore Outpatient Center locations within 15-20 minutes from each other in South Tampa. Rotations at the main hospital include adult and pediatric consultation-liaison, oncology, palliative care, transplant, bariatric surgery, pediatric inpatient rehabilitation, and NICU. Adult inpatient rehabilitation is located at the TGH Inpatient Rehabilitation Hospital. Outpatient rehabilitation, pain psychology, and neuropsychology are located at the Westshore Outpatient Clinic. Training is provided by the on-site supervisor with oversight from the Training Director.

Rotations for adult populations include:

- Consultation-liaison
- Hematology/Oncology/Bone marrow transplant
- Palliative care
- Inpatient rehabilitation
- Pain Psychology
- Transplant
- GI/Bariatric surgery
- Medical trauma
- Burn
- Neuropsychology

Rotations in Pediatrics:

- Consultation-liaison
- Inpatient Rehabilitation
- Neonatal Intensive Care (NICU)
- Neuropsychology

ROTATION DESCRIPTIONS

ADULT CONSULTATION-LIAISON

Primary Supervisors: Sherry Leib, Ph.D. and Brett Simpson, Psy.D.

Primary services are provided in the acute hospital setting to individuals with complex medical issues and trauma (TBI, SCI, burn). Services are provided along the continuum of care including ICU, Neurosciences, Burn, and Oncology units. Lengths of stay vary, ranging from less than one week to several months, depending on a variety of individual and systemic factors. The psychologist consults with the trauma team to provide services for acutely injured individuals. The psychologist helps to identify needs of the patient and family related to education, support, and coping with the acute crisis and disruption in the family system. Initially, a crisis

intervention model is applied. After the completion of the initial evaluation, a variety of therapeutic techniques may be employed, including family therapy, grief counseling, behavior management, psychoeducation, and team consultation. Issues frequently encountered during this rotation include crisis intervention, PTSD, anxiety disorders, acute stress issues, death and dying/life support termination, and staff stress reactions.

ONCOLOGY PSYCHOLOGY

Primary Supervisor: Elia Villalobos Soto, Psy.D.

Fellows on this rotation will conduct psychological evaluations and treatments on oncology outpatients and inpatients referred for a wide variety of adjustment, mood, behavioral, cognitive, and/or other health-related concerns. Patients are referred from our TGH Oncology providers for the assessment and treatment of various presenting concerns, including adjustment to a new cancer diagnosis, anxiety, depression, delirium, treatment nonadherence, pain management, caregiver burden, end-of-life concerns, and pre-morbid psychiatric symptoms. In the inpatient setting, fellows will engage in brief bedside interventions with patients and their families, along with care coordination among other members of the medical team to ensure appropriate medical treatment that takes into account pertinent psychosocial factors. In the outpatient setting, fellows will engage in more traditional, 50-minute sessions with patients to implement evidence-based interventions. Fellows may also see patients in the TGH Infusion Center during chemotherapy or other infusion treatments. This rotation emphasizes ACT and other existential-focused interventions, as well as CBT. Additionally, there are opportunities to work in the TGH Interdisciplinary Palliative Care clinic alongside physicians, advanced practice providers, and pastoral care to treat patients with advanced cancer who are in need in additional symptom management. Typically, these individuals have significant symptom burden due to cancer-related pain, sleep and appetite disturbances, nausea/vomiting, cognitive concerns, and mood difficulties that need additional treatment. In this clinic, fellows have the opportunity to engage in goals of care (treatment decision making) conversations with the patient and family, as well as end-of-life psychological interventions. Lastly, there may be opportunities for involvement with clinically-applied research.

PALLIATIVE CARE

Primary Supervisor: Adaixa Wilborn, Ph.D.

The fellow on this rotation will work in the TGH Interdisciplinary Palliative Care clinic alongside physicians, advanced practice providers, spiritual health providers, and nurses to treat patients with advanced cancer or other complex and advanced medical diagnoses (i.e. heart failure, lung disease, failed solid organ transplants, etc) who are in need in additional symptom management. Typically, these individuals have significant symptom burden due to disease-related pain, sleep and appetite disturbances, nausea/vomiting, bowel movement

dysregulation, cognitive concerns, and mood difficulties that need treatment in addition to their ongoing medical care. In this clinic, fellows have the opportunity to engage in goals of care (treatment decision making) conversations with the patient and family, as well as end-of-life psychological interventions. There may also be opportunities to work within the inpatient palliative care team and follow palliative patients on the inpatient floors during their frequent hospitalizations. This rotation heavily emphasizes ACT and existential interventions with patients and their families. A notable aspect of this rotation is dealing with compounded and complex grief as a clinician. Therefore, training in self-care, self-reflection, and managing complex emotions as an early career psychologist is imperative within the palliative care framework.

TRANSPLANT PSYCHOLOGY

Primary Supervisor: Christine Machado-Denis, Psy.D, ABPP, MSCP

The TGH Transplant Institute offers life-saving transplants to patients with end-stage organ diseases. It is the 6th largest transplant center in the country by volume. Organs transplanted at TGH include kidney, liver, lung, pancreas and heart. The living donor program includes liver and kidney altruistic and directed donations. Within the cardiac program, mechanical circulatory support (MCS) or ventricular assist devices (VAD) are offered as either a bridge to transplant or destination therapy. This rotation offers inpatient and outpatient services that include pre-transplant evaluations, post-transplant psychological consultation and psychotherapy services. Fellows will gain experience through case conceptualization with the biopsychosocial framework, increase knowledge of pharmacological and non-pharmacological treatments for medical patients with mental health concerns, and conduct consultations for psychiatrically complex patients many with co-occurring substance use disorders. Fellows will also gain exposure to the health psychologist's role on a multidisciplinary treatment team and work within an integrated medical clinic setting.

Dr. Machado-Denis is a health psychologist, with specialty in transplant psychology. She also holds a postdoctoral master's degree in clinical psychopharmacology. Dr. Machado-Denis serves a pivotal role on the multidisciplinary liver transplant team, assessing individuals with a variety of acute and chronic liver diseases. Dr. Machado-Denis is the primary psychologist within the Alcohol Use Disorder Clinic and provides treatment to liver transplant patients with moderate alcohol use disorder in the post-transplant phase of care.

Throughout the rotation, fellows will conduct integrative pre-transplant psychological evaluations within diverse and complex medical populations across inpatient and outpatient settings as part of an interdisciplinary team. It is expected that the fellows will produce high-quality evaluative reports that demonstrate a sophisticated understanding of diagnostic, socio-cultural, and physiological factors impacting post-operative transplant outcomes as well as

knowledge of interventions for mitigating such outcomes. Fellows will have the opportunity to attend Medical Review Board (MRB) meetings and Multidisciplinary Rounds (MDR), wherein the transplant team convenes to discuss cases and collectively make treatment decisions for patients to maximize health-related outcomes and quality of life.

BARIATRIC SURGERY

Primary Supervisor: Rebecca Klam, Psy.D.

The TGH/USF Bariatric Center is an interdisciplinary clinic that specializes in surgical and medically supervised weight loss for patients with morbid obesity. The team consists of nurse practitioners, dieticians, bariatric surgeons, a bariatrician, and psychologists. The rotation involves participation in both community-based, medically-supervised weight loss and the surgical weight loss program. In the surgical weight loss program, patients are seen for a wellness assessment to ensure preparation and appropriateness for surgery and treatment in mindful eating, positive health behavior to promote weight loss, and the management of mental health symptoms. Surgical patients are also seen inpatient to ensure preparation for discharge and adjustment to the bariatric lifestyle. The psychologist uses clinical interview, chart review, and questionnaire data to assess patients at the wellness assessment. Community weight loss patients are seen on rotating weeks by the psychologist, nurse practitioner and/or bariatrician, and dietician. The psychologist conducts an evidence-based protocol treatment to address healthy eating, stress management, and mindful eating. Issues frequently addressed at the Bariatric Center during this rotation include: anxiety disorders, depression, PTSD, personality disorders, eating disorders, bipolar disorder, schizoaffective disorder, significant medical comorbidities, and brief assessment of cognitive impairments.

PEDIATRIC REHABILITATION/ CONSULTATION-LIAISON

Primary supervisors: Jennifer McCain, PsyD, ABPP-CN, and Nicole Williamson, Ph.D.

The Inpatient Pediatric Rehabilitation Program uses a multidisciplinary team approach to the management of rehabilitation needs in children. The team psychologist provides a range of individual, family and team consultation interventions to promote optimal recovery of the child. Emotional, cognitive, behavioral and academic assessment and treatment approaches are emphasized. Working closely with the family, the psychologist helps to identify issues that may have an impact on progress in rehabilitation, successful adaptation to disability and the development of future productive roles. The team comprises a pediatric physiatrist; a pediatric psychologist; physical, occupational and speech therapists; child life specialists; Hillsborough County Homebound teachers (school onsite); nurses; pastoral care; and other treatment staff.

Evaluations typically involve a chart review, clinical interview, collateral interview, team consultation, administration, scoring, interpretation of relevant tests and preparation of an

initial evaluation report. Reports include a summary of findings as well as the establishment of objective and measurable goals, planned interventions, identification of barriers to rehabilitation, and recommendations for additional needs. Individual and family psychotherapy, education, behavioral management, and ongoing team consultation is provided. **Prior pediatric experience required for this rotation.**

NEONATAL INTENSIVE CARE UNIT (NICU)
Primary Supervisor: Lacy Chavis, Psy.D.

TGH is one of just 12 designated Regional Perinatal Intensive Care Center, with over 7,000 deliveries each year. The Fetal Care Center Team of USF Health Morsani College of Medicine and TGH includes highly skilled and caring professionals who provide specialized care for mothers whose pregnancies are complicated by illness or fetal abnormality. The Jennifer Leigh Muma Neonatal Intensive Care Unit (NICU) at Tampa General Hospital is an 82 bed, level 3 unit providing specialized care to the most fragile infants. Some special services our NICU offers includes management of hypoxic-ischemic encephalopathy with whole body hypothermia therapy, nitric oxide therapy, mechanical ventilation including high frequency oscillator therapy, management of metabolic and genetic disorders, and dialysis (peritoneal and hemodialysis).

The psychology fellow will receive specialized training in providing consultation, screenings, evidenced based intervention, and multidisciplinary consultation to NICU families at the USF Fetal Care Center. Fellows who complete this training program will develop competencies in trauma-informed consultation, post-partum mood and anxiety disorders, screenings and evidence based treatment for PMADs and trauma, infant-early childhood mental health, preterm infant growth over time, as well as psychosocial and behavioral challenges for high risk infants and their families.

ADULT INPATIENT REHABILITATION
Primary Supervisor: Elaine Mahoney, Ph.D.

The fellow on this rotation provides a range of psychological services for patients in a CARF-accredited inpatient rehabilitation center. The fellow helps to identify and conceptualize the nature of personality, emotional, cognitive, and psychosocial issues that may affect the individual's rehabilitation progress, adjustment to disability/illness/injury, and quality of life. This may include interview, collateral interview, review of records, and/or brief evaluation instruments. The fellow also provides brief therapeutic intervention, as appropriate to the level of cognitive functioning of the patient, and coordinates interventions with other care providers to manage emotional or behavioral issues. Common medical presentations include traumatic brain injury (TBI), stroke, spinal cord injury (SCI), trauma, post-surgical, amputation, and burn.

Common emotional presentations include adjustment disorders, acute/post-traumatic stress disorder (PTSD), mood disorders, substance abuse/dependence, changes in relationships and family roles, personality disorders/characteristics, and grief issues. Therapeutic interventions may include brief series of problem-focused interventions, longer-term treatment of adaptation to disability, education/interventions with treatment staff, and couples or family therapy. Fellows may have the opportunity to be involved in co-facilitating supportive group therapy and/or psychoeducational groups. The fellow also provides education and counseling to family members to facilitate appropriate family involvement in care, behavior management, adjustment to the rehabilitation environment, and family adjustment to injury and prognosis. Close involvement and consultation with the treatment team, including attendance at weekly team meetings and effective communication with medical, nursing, and therapy staff, is expected. Fellows also become familiar with disability culture, including learning about ableism, modifications of treatment for various cognitive and physical deficits, relevant laws impacting individuals with disability, and intersectionality between disability and other factors.

OUTPATIENT REHABILITATION

Primary Supervisor: Jennifer Fleeman, Psy.D.

Fellows provide a range of psychological services for patients in an outpatient clinic setting. The fellow helps to identify and conceptualize the nature of personality, emotional, cognitive, and psychosocial issues that may affect the individual's rehabilitation progress, adjustment to disability/illness/injury, and quality of life. This may include interview, collateral interview, review of records, and/or brief evaluation instruments. The fellow also provides therapeutic intervention, as appropriate to the level of cognitive functioning of the patient, and coordinates interventions with other care providers to manage emotional or behavioral issues. Common emotional presentations include grief issues, adjustment disorders, acute/post-traumatic stress disorder (PTSD), mood disorders, anxiety disorders, changes in relationships and family roles, and other co-occurring conditions such as personality disorders/ characteristics, and substance abuse/dependence. Therapeutic interventions may include brief series of problem-focused interventions, psychoeducation, longer-term treatment of adaptation to disability, and evidence-based interventions for treatment of adjustment disorder and other mental health conditions. If indicated, the fellow also provides education and counseling members of the patient's support system to facilitate adaptive involvement in care, behavior management, and support system adjustment to disability/ illness/ injury and prognosis.

PAIN PSYCHOLOGY

Primary Supervisor: Emily Foard, Psy.D.

The fellow on this rotation will conduct psychological evaluations and treatments with adult patients experiencing a range of chronic pain conditions and/or chronic health conditions associated with pain. Primary clinical opportunities include applying evidence-based approaches for treating chronic pain conditions in an outpatient setting. Frequency of appointments will be based on clinical need and may range from weekly-monthly. Specifically, the fellow will enhance understanding and treatment of chronic pain conditions in an outpatient setting. Primary clinical opportunities include applying evidence-based approaches (CBT, ACT, MI, and mindfulness-based approaches) for treating chronic pain. Opportunities for clinical-based research, training relevant co-treaters (i.e., PT/OT/SLP providers), and program development can be made available based on the fellow's interest.

OUTPATIENT CLINICAL NEUROPSYCHOLOGY: ADULT OR PEDIATRIC

Primary Supervisors: Maya Ramirez, Ph.D., ABPP-CN & Elyse Parke, Ph.D., ABPP-CN

Working with board certified neuropsychologists, this rotation will focus on the assessment of individuals with neurological dysfunction (brain injury, stroke, neurodevelopmental disorders, Parkinson's disease, Epilepsy, Sickle Cell, etc.). The evaluation process integrates premorbid and injury/illness related information with current neuropsychological findings to generate meaningful recommendations with a focus on improving functional skills and quality of life. Fellows will complete clinical interviews with patients and caregivers, use a variety of neuropsychological tests and methods, participate in weekly neuropsychological evaluations and compose neuropsychological evaluation reports.

TRAINING PHILOSOPHY

Our philosophy emphasizes the continual professional development of our fellows. We seek to build on the skills developed during previous training through goal setting, training, and assessment. Fellows gradually take on more independence in their rotations, as determined by their supervisor. By the end of the year, fellows should be competent entry-level health and rehabilitation psychologists who can function in a variety of medical settings. The program uses a developmental approach meeting trainings at their current level and gradually increasing competence and management of complex clinical care.

TRAINING DIRECTOR ROLE

The Training Director has the following responsibilities:

1. Determines training policy for review by the training committee and following TGH policy guidelines.
2. Coordinates all training activities and evaluations completed by supervisors.
3. Meets monthly with fellows to monitor progress and provide mentorship.
4. Facilitates quarterly training committee meetings.
5. Integrates input from training staff, fellows, and other professionals to develop and modify the training program.
6. Reviews, revises, and implements all training procedures.
7. Arranges supervision of fellows and coordinates with training committee to provide training program activities.
8. Coordinates fellow application and selection process.
9. Serves as liaison between fellows and faculty, providing feedback, and processing grievances.
10. Supports the training committee in their roles as supervisors and contributors to the overall training program.

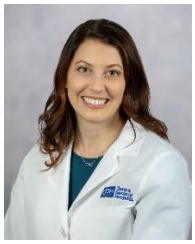
TRAINING COMMITTEE

The fellowship training committee consists of all full-time psychology faculty at TGH/TGMG. Some faculty have appointments in the Departments of Pediatrics and Psychiatry at the USF Morsani College of Medicine. The training committee is committed to the preparation of fellows who can function in a wide range of clinical settings. The committee is responsible for participation in the selection, training, and evaluation of fellows.

MEET OUR FACULTY

Training Director

Elyse Parke, PhD, ABPP-CN
Clinical Neuropsychologist
Board-certified Clinical Neuropsychologist
Pediatric Subspecialty Certification
Assistant Professor USF Department of Pediatrics



Education:

- Post-doctoral Fellowship Neuropsychology - Texas Children's Hospital and Baylor College of Medicine
- Pre-doctoral Internship - The Children's Hospital of Philadelphia (CHOP)
- PhD in Clinical Psychology Neuropsychology Track - University of Nevada Las Vegas

Professional Interests

- Pediatric Neuropsychology
- Program Development

Department Manager

Lacy Chavis, PsyD, PMH-C
Clinical Health Psychologist
Perinatal Mental Health Certification
Assistant Professor USF Department of Pediatrics

Education:

- Post-doctoral Fellowship Clinical Psychology-pediatrics - Andrus Children's Center
- Pre-doctoral Internship Clinical Psychology, pediatrics - New York Center for Child Development
- PsyD in Clinical Psychology - Illinois School of Professional Psychology-Argosy University

Professional Interests

- Neonatal and Perinatal Psychology
- Neurodevelopment
- Acute Stress Disorder and PTSD
- Bioethics

Adaixa (Addie) Wilborn, PhD
Clinical Health Psychologist

Education:

- Post-Doctoral Fellowship Health Psychology - Tampa General Hospital
- Pre-Doctoral Internship - Medical University of South Carolina, Charleston Consortium
- PhD in Clinical Psychology - University of Florida

Professional Interests:

- Palliative care
- Oncology

Brett Simpson, PsyD
Clinical Health Psychologist

Education:

- Post-Doctoral Fellowship Health Psychology -University of Miami
- Pre-Doctoral Internship – Broward Health Medical Center
- PsyD in Clinical Psychology – Nova Southeastern University

Professional Interests:

- Inpatient consultation-liaison
- Burn and trauma

Christine Machado-Denis, PsyD, MSCP, ABPP
Clinical Health Psychologist
Assistant Professor USF Department of Psychiatry

Education:

- Post-Doctoral Fellowship Health Psychology - University of Florida
- Pre-Doctoral Internship - University of Maryland School of Medicine/ VA Maryland Healthcare System
- PsyD in Clinical Psychology - Albizu University
- MS in Clinical Psychopharmacology - Fairleigh Dickinson University

Professional Interests:

- Transplant
- Psychopharmacology

Elia Villalobos Soto, PsyD
Clinical Health Psychologist

Education:

- Post-Doctoral Fellowship in Health Psychology - University of Florida
- Pre-doctoral Internship - Eastern Virginia Medical School
- PsyD in Clinical Psychology, Health Psychology Specialization - Carlos Albizu University

Professional Interests:

- Oncology Psychology
- Psychosocial aspects of reproductive health
- Multicultural Psychology
- Pre-surgical psychological evaluations

Elaine Mahoney, PhD
Rehabilitation Psychologist

Education:

- Post-Doctoral Fellowship Neuropsychology - James A Haley Veterans' Hospital
- Pre-Doctoral Internship - James A Haley Veteran's Hospital
- PhD in Clinical Psychology - University of Wisconsin - Milwaukee

Professional Interests:

- Rehabilitation psychology
- Adult neuropsychology
- Traumatic and acquired brain injury
- Culturally sensitive health care

Emily Foard, PsyD
Clinical Health Psychologist

Education:

- Post-Doctoral Fellowship Pediatric Psychology -Johns Hopkins All Children's Hospital
- Pre-doctoral Internship - Lynn Community Health Center
- PsyD in Clinical Psychology - William James College

Professional Interests:

- Chronic pain conditions
- Functional neurological symptom disorder
- Coping and adjustment to chronic health conditions
- Biofeedback

Jennifer McCain, PsyD, ABPP-CN
Clinical Neuropsychologist
Board-certified Clinical Neuropsychologist
Pediatric Subspecialty Certification

Education:

- Pre-doctoral Internship - North Shore University Hospital/Cornell University Medical College
- PhD in Clinical Psychology - Long Island University

Professional Interests:

- Traumatic brain injury/concussion
- Pediatric trauma
- Medical traumatic stress

Maya Ramirez, PhD, ABPP-CN
Clinical Neuropsychologist
Board-certified Clinical Neuropsychologist
Outpatient Lead

Education:

- Post-Doctoral Fellowship, Neuropsychology -Cleveland Clinic
- Pre-doctoral Internship - James A. Haley Veterans Hospital
- PhD in Clinical Psychology - University of Cincinnati

Professional Interests

- Adult neuropsychology
- Rehabilitation neuropsychology

Jennifer Fleeman, PsyD
Rehabilitation Psychologist

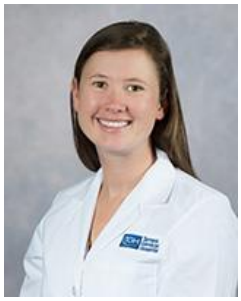
Education:

- Post-Doctoral Fellowship in Neuropsychology - University of Rochester Medical Center
- Pre-doctoral Internship - Mississippi State Hospital
- PsyD in Clinical Psychology - Georgia School of Professional Psychology/ Argosy University

Professional Interests:

- Rehabilitation and health psychology
- Traumatic and acquired brain injury
- Spinal cord injury
- Adjustment to medical conditions and cognitive changes

Nicole Williamson, PhD
Pediatric Clinical Health Psychologist



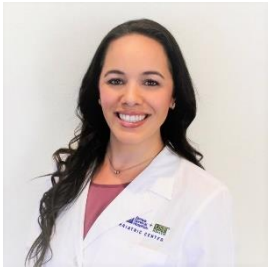
Education:

- Post-doctoral Fellowship - Dana Farber and Boston Children's Cancer and Blood Disorders Center
- Pre-doctoral Internship Specialization in Pediatric Psychology - The Children's Hospital of Philadelphia (CHOP)
- PhD in Clinical Psychology Specialization in Children and Family - University of North Carolina at Chapel Hill

Professional Interests

- Pediatric psychology
- Coping with chronic illness

Rebecca Klam, PsyD
Clinical Health Psychologist
Assistant Professor USF Department of Psychiatry



Education:

- Post-Doctoral Fellowship – Florida International University
- Pre-doctoral Internship – Pacific Psychology and Comprehensive Care Clinic
- PsyD in Clinical Psychology – Nova Southeastern University

Professional Interests

- Bariatric surgery
- Digestive diseases

Sherry Leib, PhD
Clinical Health Psychologist

Education:

- Pre-doctoral Internship - Harbor General UCLA
- PhD in Clinical Psychology - California School of Professional Psychology - Los Angeles
- BS in Occupational Therapy - Boston University

Professional Interests:

- Inpatient consultation-liaison
- Pain management
- Acute Stress and PTSD
- Sex and disability

FELLOWSHIP REQUIREMENTS

FELLOW RESPONSIBILITIES

- Fellows have the responsibility to maintain behavior within: (1) the scope of the APA ethical guidelines (2) the laws and regulations of the State of Florida (3) the regulations for professional staff of Tampa General Hospital and (4) the standards for professional staff outlined in the Tampa General Hospital Policies, located on the Employee Portal.

- Fellows have the responsibility to be open to professionally appropriate feedback from immediate supervisors, professional staff, and agency personnel.

- Fellows have the responsibility to behave in a manner that facilitates professional interaction within Tampa General Hospital and is in accordance with the standards and expectations of the hospital and APA.

- Fellows have the responsibility to provide professionally appropriate feedback regarding all aspects of the fellowship experience, including but not limited to, supervision, seminars, individual counseling experiences, consultation, outreach experiences, and staff meetings.

- Fellows have the responsibility to meet the expectations of the fellowship by developing competencies as defined in the program handbook.

- Postdoctoral fellows have the responsibility to behave in a professionally appropriate manner if due process procedures are initiated.

- The following expectations are the responsibilities of the Postdoctoral Fellows:

    1. Maintain general work hours of 8:00am-4:30pm, with flexibility per supervisor. Patients may only be seen when a designated supervisor is on site.
    2. For inpatient rotations, assess patient consults in the morning with supervisor. In the EMR, assign yourself and your supervisor to patients that you are evaluating.
    3. Maintain a caseload as assigned by supervisor
    4. Bring a list of patients, relevant patient issues you are working on and professional development needs to your weekly supervision sessions.
    5. Address all inpatient consults within 24 hours.
    6. Be certain to complete your paperwork in a timely manner. Please refer to Psychology Documentation Policy. Exceptions are to be discussed with your supervisor.
    7. Complete documentation for outpatients by end of treatment day, unless discussed in advance with your supervisor.

PROGRAM REQUIREMENTS

The fellowship is a 40 hour per week program, and fellows spend at least 50% of their time in direct clinical activity related to patient care. The post-doctoral fellowship program requires 2000 hours of supervised clinical time during a one-year (12 month) period. This requires 50 worked weeks, full time, to meet Florida licensure requirements. Requirements for successful completion of post-doctoral training outlined in detail below.

DIDACTICS

Fellows are required to attend weekly didactics on Friday mornings that include professional development, health, and rehabilitation topics (8am-11am). These didactics include a professional development seminar (8-9am) and rehabilitation seminar (10-11am) in collaboration with the James A. Haley Veterans Hospital. Seminar with TGH/TGMG faculty is from 9-10am. Fellows will also attend Psychology department meetings, Do No Harm meetings for case consultation and safety awareness, grand rounds, and continuing education programs, as they are scheduled. Directed readings are completed as assigned by the primary supervisor.

PROJECTS AND PRESENTATIONS

1. Complete one program development project, as assigned.
2. Mini case presentations (30-minutes) during Post-Doctoral Seminars
3. One formal (1-hour) case presentation at the end of the training year, incorporating key health and rehabilitation psychology concepts.

PROGRAM DEVELOPMENT PROJECT GUIDELINES

- Fellows will identify a project within the first month of their fellowship that aligns with their interests and needs of the program
- Fellows present an overview of their project to the psychology team at the end of their training year.
- Fellows must complete materials for CE requirements 2 weeks before the presentation including CV and PowerPoint Presentation including at least 3-4 learning objectives.
- The presentation should include a portion of didactics related to the project. Provide a review of the literature related to the topic, cultural and ethical considerations, and clinical applications for our team.
- Examples of projects include developing:
    - Brain Injury Patient Education Workbook
    - Group therapy curriculum for oncology patients
    - Assessment guidelines for inpatient rehabilitation
    - Guidelines for managing high risk bariatric patients
    - Transplant patient database resource and publication

CASE PRESENTATION GUIDELINES

- Fellows must complete materials for CE requirements 2 weeks before the presentation including CV and PowerPoint Presentation including at least 3-4 learning objectives.
- Fellows will receive written ratings from attendees, verbal feedback from the psychology team after their presentation, and written feedback from the supervisor of the case and Training Director. Case presentations will also be considered within the competency rating form.
- Guidelines for the mini and formal case presentations are outlined below:

SELECTING YOUR CASE

Be sure to select a case that:

- **You know well, from EVERY angle, because you may be asked about any aspect of it.**
- Is rich, including some successes, challenges, and possible unique, diagnostic, ethical, or supervisory issues.
- You can be confident about.
- Has a clear diagnosis and rationale.
- Has a clear approach / orientation / modality you applied well, and reason for using it.
- You have discussed in advance with your supervisor and they will attend the presentation.
- **You should be prepared to articulate your cases in a clear, concise and coherent manner that allows listeners to form an understanding of your clinical approach to the case.**
- See "Masculinity After Acquired Disability" mapped in MindLab for a sample presentation.

APA RECOMMENDED SECTIONS

- **Introduction:** Provide a brief literature review that presents the background, significance, and aims of the case study presentation, grounding this section in the relevant scholarly literature. Use this section as an opportunity to educate the reader about key issues, theories, or gaps in the field as they inform the case to be presented.

- **Case Context and Method:** Describe the treatment setting, relevant context, and sources of "data" (e.g., notes, patient or therapist self-report measures, diaries or other reporting forms, information from significant others, clinical records, multidisciplinary team information, etc.). Describe the precautions that were taken to prevent disclosure of the patient's identity.

- **Case Description:** Provide details about the treatment context, patient(s), and assessment of presenting problem(s) and situation, including patient history, family history, behavioral health history, medical history, substance use history and other biopsychosocial factors relevant to rehabilitation approach. Also include any explanatory models of illness, stressors, strengths, and supports.

- **Case Formulation and Treatment Plan**

  - **Case Formulation and Treatment Approach:** Describe the therapist's conceptualization of the case as it guided the treatment approach for the target problem(s). Discuss the theoretical, research, and/or biopsychosocial basis for the approach to treating the target problem(s). Note that the relevant research may include qualitative and quantitative studies on therapeutic processes as well as evidence from empirically supported treatments and other practice-based evidence such as other case studies.

  - **Treatment Plan and Goals:** Present the treatment plan and treatment goals, as appropriate to the therapeutic modality applied.

- **Course of Treatment and Monitoring of Treatment Progress:** Describe specific therapeutic strategies and procedures employed by the therapist, and the client's reaction to them. Methods of monitoring or assessment should be appropriate to the therapy modality applied and may include the use of standardized measures at different time points of the treatment (intake, during treatment, termination), a discussion between the therapist and client regarding treatment gains, homework and goal-tracking sheets, collateral information, etc. If applicable, this section should also include a description of how this monitoring feedback was used to revise the treatment approach. This section may also present confounding factors or unanticipated challenges in the therapy. These may include intrapersonal, interpersonal, or external events.

- **Treatment Outcome:** Describe the outcome of the therapy as it pertains to the client's presenting problems and treatment goals, and any follow-up data if available.

- **Discussion and Limitations:** Provide a critical analysis of the strengths and weaknesses of the case formulation and treatment approach as applied to this particular case. Highlight how the case enhances our clinical, theoretical, and/or cultural understanding of the clinical population, treatment approach, and/or therapy processes. Link the case discussion to the prior literature and relevant research findings. Describe any limitations including availability of assessment data or service characteristics.

- **Cultural and Ethical Considerations:** Present at least two considerations related to the case and related literature.

- **Implications for Clinical Practice and Theory:** Present at least two recommendations for clinicians working with similar cases or problems.

SUPERVISION REQUIREMENT

Formal supervision is at least one hour of formal, face-to-face supervision per week for each rotation. All supervisors are licensed psychologists specializing in Rehabilitation, Health Psychology, or Clinical Neuropsychology. Responsibility for maintaining contact with the supervisor resides with both the supervisor and the fellow. Cancellations for illness, vacation, or other reasons should be made up. Additional consultation with other psychologists in the Psychology Service is available in emergencies.

FELLOW EVALUATIONS

Evaluation is an ongoing process during the fellowship program. Fellows work with their supervisor at the start of a rotation to develop specific, measurable training goals. Supervision logs are completed to track topics discussed and weekly progress. Written **evaluations of competencies and training goals will be completed at 3 and 6 months** of the rotation. These evaluations are reviewed and discussed in individual meetings with the supervisors. Progress is also assessed on an ongoing basis through live observation, detailed reviews of written notes and reports, discussion of case formulations and treatment planning, and informal feedback from the multidisciplinary treatment team. If opportunities for improvement are identified, the primary supervisor is accountable for developing, implementing, and monitoring a remediation plan.

PROGRAM EVALUATIONS

Clinical rotations, scope and frequency of didactics, supervisor availability and quality, and research offerings are reviewed at regular training meetings. At each 6 and 12 month evaluation period, the fellow will also complete a supervisor evaluation form for each supervisor with whom the fellow currently works. These evaluation forms are submitted directly to the Director of Fellowship Training in Psychology. All evaluation forms completed regarding the supervision of the Training Director are submitted directly to the Manager of Psychology/Neuropsychology.

ADMINISTRATIVE ISSUES

CONFLICT RESOLUTION

Should problems occur in supervision, fellows are encouraged to attempt resolution in the context of the supervisory relationship. If such attempts are unsuccessful, trainees are encouraged to contact the Training Director for assistance in problem resolution. Formal grievance policies are maintained by TGH and apply to fellows. Please refer to the Grievance Policy for specific information regarding problem resolution within the supervisory relationship.

ACCRUED TIME OFF (ATO) POLICY

ATO (Accrued Time Off) combines vacation, holiday, and sick pay in one comprehensive time bank. You will accrue 8.31 hours of ATO for each 80 hour pay period worked, for a total of 216 hours (27 days) per year. You are eligible to take ATO after you complete the 90 day probation period per TGH policy.

To request time off, complete a request via Dimensions on the TGH portal (training will be provided). **Time must be requested in advance, after first requesting approval from the supervisor and Training Director.** Put in the comments section when requesting time off that this approval has been granted.

ABSENCE DUE TO ILLNESS

Please do not come to work ill! If you test positive for COVID-19, please follow TGH COVID-19 Guidelines located on the TGH Portal. Currently guidelines are included; however, they are subject to change.

If you are sick (not COVID-19) and unable to come to work, you must:

1. Text and email Dr. Parke (Training Director)
2. Call/email your supervisor to arrange for clinical coverage
3. Contact Department Assistant (Pam Johnson) who will enter missed time in the timekeeping system.

TGH HOLIDAY CALENDAR

The Psychology Department will be closed for the following identified holidays. These days come out of your ATO.

- Thanksgiving Day
- Christmas Day
- New Year's Day
- Memorial Day
- Independence Day
- Labor Day

MEDICAL BENEFITS

Fellows are eligible for benefits available to hospital employees including health, dental, and vision insurance on the 1st of the month, 30 days after employment.

RELEASE OF INFORMATION

Requests for medical record information must follow approved policy. All information contained in the medical record must be released through the Health Information Management (HIM) department using TGH/TGMG approved consent to disclose forms. Communication among team members does not require a formal release. We typically request (and document in the EMR) verbal permission to contact the identified next of kin (caregiver). Any contact with individuals outside TGH/TGMG staff would require a release form.

PATIENT FILES

Patient files should be secured in a locked location when not in use. You will have a locked file drawer available. When you complete fellowship, all client files should be turned over to your supervisor for storage/disposal.

BILLING AND REIMBURSEMENT

Psychologists directly bill for services (we are "unbundled" from the global hospital DRG/CMG payment). Charges are tied to CPT codes (Current Procedural Terminology, published by the American Medical Association). Supervisors must be present for the entire initial outpatient and inpatient assessments but do not need to be present for follow up appointments. Supervisors cannot bill for a post-doc's services unless they are present in the room. Supervisors need to be on site any time a fellow is seeing a patient. Fellows cannot complete telehealth visits independently from home.

HOURS TRACKING

Fellows should track face to face clinical activity to document for licensure using the Fellow Weekly Tracking form. **Weekly tracking forms should be reviewed with the supervisor monthly and discussed with the Training Director as needed.** Fellows will save their logs under path: NasShare (W:) > Common >Ambulatory Services Administration >TGMG >TGMG Psych Neuropsych > Post-Doctoral Fellow Materials>Trainee's name.

STANDARDS OF ATTIRE/WHITE COATS/SCRUBS

See the TGH Standards of Attire policy: HR-88

White Coats

You can order a white coat if you choose; this is not required. You can try on coats in the Med Staff office (a staff member would need to go with you). The coat should have the logo, your name and degree, title "Psychology Fellow" and department name "TGMG Psychology & Neuropsychology." Please list this on the order form.

The coats cost approximately 35.00.

You can email your information to Kristen at Tanner: Kristent1@verizon.net

FYI - if you go to Uniform City, they might have less expensive white coats with just the logo; however, it can take several weeks to order.

Scrubs

For our service, professional dress is required. Scrubs are optional; you can wear scrubs if you choose. Scrubs must be embroidered with the TGMG logo. Color of scrubs are assigned to certain professions (green scrubs - therapy, navy scrubs -nursing, red scrubs - PCTs). Please don't wear these colors as it gets confusing to patients and staff. You can also wear scrub pants and a regular top (color is up to you).

You can also order a black sport jacket with the TGH/TGMG logo and department name "Psychology & Neuropsychology." Speak with Pam Johnson, our Department Assistant, if you would like to order one. The cost is approximately $38.00.

FORMS

SUPERVISION AGREEMENT

Introduction to Supervision Expectations
This Supervision Agreement is intended to establish parameters of supervision, assist in supervisee professional development, and provide clarity in supervisor responsibilities including the responsibility of the supervisor to protect the patient with respect to any fellowship programs with the Psychology and Neuropsychology Services Department at Florida Health Sciences Center, Inc., Tampa General Hospital (TGH) / Tampa General Medical Group (TGMG).

The overarching goals of supervision will be to:
1. Monitor and ensure welfare and protection of patients of the supervisee
2. Serve as gatekeeper for the profession to ensure competent professionals enter
3. Promote development of the supervisee's professional identity and competence
4. Provide evaluative feedback to the supervisee

Supervision Training Program: Start date: _____End date: _____

I. Structure of Supervision
Individual supervision will be provided by the primary supervisor of each major rotation and the supervisor of the minor/elective rotation of the supervisee's choosing. The primary supervisor will provide 1 hour of formal supervision per week and informal supervision as needed. Supervision can include the review of consult/treatment/progress notes, discussion of live observation, instruction, modeling, mutual problem-solving and role-play. The training director will also serve to provide supervision as needed with respect to patient care and professional development.

Delegation of supervision to other psychologists can occur in the event of the supervisor's absence. Please be aware that there are limits of confidentiality for supervisee disclosures in supervision (e.g., supervisor normative reporting to graduate programs, licensing boards, and training teams, program/training directors, upholding legal and ethical standards).

II. Competencies Expectations

A. It is expected that supervision will occur in a competency-based framework.
B. Supervisees will self-assess clinical competencies (including areas such as knowledge base, clinical skills and values/attitudes) at the beginning of their training and periodically throughout the training period.
C. Supervisors will compare supervisee self-assessments with their own assessments based on observation and report of clinical work, supervision and competency instruments.

D. The supervisor and supervisee set goals specific to each rotation. Goals can be derived from the supervisor's observations, rotation requirements, and the supervisee's developmental needs and wishes.

III. Duties and Responsibilities of Supervisor

A. Assumes legal responsibility for services offered by the supervisee.
B. Oversees and monitors all aspects of patient case conceptualization and treatment planning, assessment, and intervention including but not limited to emergent circumstances, duty to warn and protect, legal, ethical, and regulatory standards, diversity factors, management of supervisee reactivity or countertransference to patient, strains to the supervisory relationship.
C. Ensures availability when the supervisee is providing patient services.
D. Reviews and signs off on all reports, case notes, and communications.
E. Develops and maintains a respectful and collaborative supervisory relationship within the power differential.
F. Practices effective supervision that includes describing supervisor's theoretical orientations for supervision and therapy, and maintaining a distinction between supervision and psychotherapy.
G. Assists the supervisee in setting and attaining goals based on competency expectations.
H. Provides feedback anchored in supervisee training goals, objectives and competencies.
I. Provides ongoing formative and end of supervisory relationship summative evaluation on standard fellowship forms retained by the Psychology Services Department at the Hospital.
J. Informs supervisee when the supervisee is not meeting competence criteria for successful completion of the training experience, and implements remedial steps to assist the supervisee's development (which shall be known as a "Training Improvement Plan" as established by the Hospital).
K. Discloses training, licensure including number and state(s), areas of specialty and special expertise, previous supervision training and experience, and areas in which he/she has previously supervised.
L. Reschedules sessions to adhere to the legal standard and the requirements of this contract if the supervisor must cancel or miss a supervision session.
M. At the supervisor's discretion, maintains documentation of the clinical supervision and services provided.
N. If the supervisor determines that a case is beyond the supervisee's competence, the supervisor may join the supervisee as co-therapist or may transfer a case to another therapist, as determined by the supervisor to be in the best interest of the patient.

IV. Duties and Responsibilities of the Supervisee

A. Respects and understands the responsibility of the supervisor for all supervisee professional practice and behavior.
B. Treat all patients and family members and supervisor with respect and dignity.
C. Uphold ethical principles to do no harm to patients and immediately inform supervisor of instances where individual morals/biases may interfere with the ability to provide care.
D. Implements supervisor directives, and discloses clinical issues, concerns, and errors as they arise.
E. Identifies to patients their status as supervisee and the name of the clinical supervisor, and describes the supervisory structure (including supervisor access to all aspects of case documentation and records) obtaining patient's informed consent to discuss all aspects of the clinical work with the supervisor.
F. Attends supervision prepared to discuss patient cases with case conceptualization, patient progress, clinical and ethics questions, and literature on relevant evidence-based practices.
G. Informs supervisor of clinically relevant information from patient including patient progress, risk situations, self-exploration, supervisee emotional reactivity or countertransference to patient(s).
H. Integrates supervisor feedback into practice and provides feedback weekly to supervisor on patient and supervision process.
I. Seeks out and receives immediate supervision on emergent situations. Supervisor contact information, as provided.
J. If the supervisee must cancel or miss a supervision session, the supervisee will reschedule the session to ensure adherence to the legal standard and this contract.
K. Fellows have the responsibility to maintain behavior within:
    1. the scope of the APA ethical guidelines for
    2. the laws and regulations of the State of Florida
    3. the regulations for professional staff of Tampa General Hospital
    4. the standards for professional staff outlined in the Hospital policies and procedures.
L. Fellows have the responsibility to be open to professionally appropriate feedback from immediate supervisors, professional staff and agency personnel.
M. Fellows have the responsibility to provide professionally appropriate feedback regarding all aspects of the fellowship experience, including but not limited to, supervision, seminars, individual counseling experiences, consultation and outreach experiences and staff meetings.
N. If the Fellow does a rotation at the Tampa General Rehabilitation Hospital (Healthcare Facility), fellow understands that health insurance is required by the Healthcare Facility, and they may be required to provide evidence of that coverage upon request by the Healthcare Facility.

V. Expectations

E. Patients may only be seen when a supervisor is onsite.
F. Maintain at a minimum work hours of 8:00am-4:30pm, with flexibility per supervisor and if crisis situations arise.
G. On inpatient days, assess patient consults in the morning with supervisor. In the EMR system, assign yourself and your supervisor to patients that you are evaluating.
H. Maintain a caseload of 10-12 outpatient therapy patients at one time, varies based on patient needs and rotation, or as determined and communicated by the supervisor.
I. Be certain to complete your paperwork within 24 hours pursuant to Hospital policy. Exceptions are to be discussed with your supervisor.
J. All timeframes for patient consultations shall be in accordance with Hospital policy.

VI. Evaluation

A. Feedback will be provided in each supervision session and will be related to competency documents and established goals. Feedback may also be provided immediately following provision of clinical care with patients as appropriate.
B. Attainment towards goals will be completed at the beginning, 3 months, and 6 months of the rotation.
C. Written evaluations of competencies will be completed at 3 and 6 months of the rotation.
D. Supervisor notes may be shared with the supervisee at the supervisor's discretion.
E. If the supervisee does not meet criteria for successful completion, the supervisee will be informed at the first indication of this, and supportive and remedial steps will be implemented to assist the supervisee in accordance with a Hospital Training Improvement Plan.
F. If the supervisee continues to fail to meet the criteria required for successful completion, actions shall be taken that are consistent with the Hospital's policies and procedures.

VII. Resolving Differences/Grievances

The following steps outline the process for approaching differences in opinion and/or grievances:
1. Initially, an attempt to resolve differences and/or grievances will be made within the supervision relationship.
2. If a resolution is not able to be reached, the director of training/training committee will intervene in attempt to facilitate a resolution that is acceptable to the supervisor and supervisee.
3. Issues will be escalated to the Hospital's Human Resources department for resolution if the matter is not able to be resolved by the director of training or within the training committee of the Psychology and Neuropsychology Services Department.

These parties acknowledge the expectations and requirements associated with the Psychology and Neuropsychology Services fellowship rotation and program. Further, the supervisee acknowledges that the provisions of this Supervision Agreement are intended to ensure that TGH/TGMG and the supervisee conduct themselves in a manner consistent with the American Psychological Association (APA) Ethical Principles and Code of Conduct as well as all applicable rules, laws and regulations.

_____

Clinical Supervisor Date

_____

Supervisee Date

_____

Director of Training Date

SUPERVISION LOG

Today's date:

Note any clinical issues discussed and briefly note any ethical, lethality or other significant concerns (Do not use client initials or other protected health information)

Please note the competencies addressed in supervision today and briefly comment on relevant competencies, themes, strength, and growth areas in comment section below.

Topics Discussed

- ☐ Professional Values, Attitudes, and Behaviors
- ☐ Individual and Cultural Considerations
- ☐ Ethical and Legal Standards
- ☐ Communication and Interpersonal Skills
- ☐ Research
- ☐ Assessment
- ☐ Intervention
- ☐ Consultation and Interprofessional/Interdisciplinary Skill
- ☐ Supervision
- ☐ Patient Issues
- ☐ Personal Growth
- ☐ Goals
- ☐ Edits to documentation

Please review the log and denote agreement by checking the relevant box below, once the log has been accurately completed:

- ☐ I, Supervisee, agree that the above log accurately summarizes the supervision session today.
- ☐ I, Supervisor agree that the above log accurately summarizes the supervision session today.

The supervisor should save a copy of this completed form in trainee's folder.

GOAL ATTAINMENT FORM

Instructions

The fellow and supervisor will work on monitoring progress toward training objectives and develop specific goals for the rotation. When developing goals, please be as specific and objective as possible. Goals should be reasonable, attainable, constructive, and measurable. They should also indicate a timeline by which they will be accomplished. Please follow the format provided when developing and submitting your goals. The site supervisor should sign off on your goals form before you submit them. They should be submitted to the Fellowship Training Director **at 3 and 6 month evaluation meetings.**

Post-doc Name:_____
Date: _____

Post-doc Signature: _____
Primary site supervisor signature: _____
Training Director signature:_____

Scaling:
-2 = Much less than expected
-1 = Somewhat less than expected
0 = Expected level of outcome
+1 = Somewhat more than expected
+2 = Much more than expected

Individual Rotation Training Goals	Actions to be Taken to Meet Objectives	Timeline	Date Completed	Supervisor Comments	Rating	
					3 month	6 month

COMPETENCIES RATING FORM

RATING SCALE							
Internship	**Intro to Fellowship**		**Mid-Fellowship**		**Entry to Practice**		**Advanced**
1	2	3	4	5	6	7	8

Instructions: The Fellow should carefully consider their performance in each of the numbered areas within each domain and self-rate their overall performance. The supervisor(s) should then similarly review and independently rate the fellow's performance, and meet with them to review specific and overall performance, and discuss differences in ratings and plans to attain training goals within the training period. Ratings will be completed at 3 months and 6 months for each rotation.

Rating period:	3 month / 6 month

		Date
FELLOW:		
ROTATION 1 - SUPERVISOR:		
ROTATION 2 - SUPERVISOR:		

ETHICAL AND LEGAL STANDARDS	
1)	KNOWLEDGE: Demonstrates knowledge of relevant *Ethical Principles of Psychologists and Codes of Conduct* (e.g., APA, BABC)
2)	ETHICS: Acts in a manner consistent with the *Ethical Principles of Psychologists and Codes of Conduct*across professional and personal interactions and roles
3)	AWARENESS: Recognizes ethical dilemmas and applies appropriate clinical decision-making to appropriately resolve them
4)	LEGAL: Engages in professional activities in a manner consistent with the TGH/TGMG policies, and according to Florida laws and statutes related to the practice of psychology

Please review and discuss strengths and areas of growth (numbered above) and collaboratively develop a plan with the fellow to meet expectations and goals.	**Fellow Self Eval**	**Rotation 1 Supervisor**	**Rotation 2 Supervisor**
Carefully consider the above areas of functioning to provide a single overall rating:			

INDIVIDUAL AND CULTURAL CONSIDERATIONS	
1)	AWARENESS: Demonstrates an understanding of how individual background and cultural factors may influence understanding of, an interaction with, individuals from differing backgrounds and cultures, and acts sensitively and in accordance with understanding
2)	KNOWLEDGE: Displays knowledge of the current theoretical and empirical knowledge base related to individual and cultural factors
3)	APPLICATION: Integrates awareness and knowledge of individual and cultural factors into professional activities, and demonstrates the ability to work effectively with a range of individuals

Please review and discuss strengths and areas of growth (numbered above) and collaboratively develop a fellow with the resident to meet expectations and goals.	**Fellow Self Eval**	**Rotation 1 Supervisor**	**Rotation 2 Supervisor**
Carefully consider the above areas of functioning to provide a single overall rating:			

PROFESSIONAL DEVELOPMENT	
1)	INTEGRATION: Accepts and performs assigned duties and seeks out opportunities to improve skills and knowledge base
2)	ORAL COMMUNICATION: Effectively communicates with peers, supervisors, staff, and referral sources in formal and informal settings (e.g., presentations, consultations); effectively varies communication approach depending on audience
3)	WRITTEN COMMUNICATION: Effectively communicates through written text in a professional style that is concise, clear, and free of unnecessary jargon, according to audience
4)	CASE PRESENTATION: Presents in a clear and effective manner. Includes relevant theory, necessary data, and case conceptualization materials succinctly and professionally
5)	PARTICIPATION: Actively and effectively contributes in clinical, training, and professional settings (e.g., interdisciplinary staffing, faculty meeting), including providing and accepting constructive feedback
6)	GOALS: Identifies and clearly articulates short and long-term career goals, and appropriately seeks supervision or mentorship regarding goals
7)	PROMOTION: Pursues skills and experiences necessary for a successful job search: developed a professional CV, interview skills, etc.
8)	WORK-LIFE INTEGRATION: Effectively seeks and facilitates a work-life integration, including obtaining supervision and mentorship to achieve appropriate balance

Please review and discuss strengths and areas of growth (numbered above) and collaboratively develop a fellow with the fellow to meet expectations and goals.	**Fellow Self Eval**	**Rotation 1 Supervisor**	**Rotation 2 Supervisor**
Carefully consider the above areas of functioning to provide a single overall rating:			

ADMINISTRATIVE SKILLS	
1)	DOCUMENTATION: Manages and completes required documentation in an organized, timely, and professional manner
2)	ATTENDANCE: Attends to office and administrative demands and complies appropriately with established practices and policies
3)	TIMELINESS: Completes all clinical, training, and professional duties within specified time frame
4)	BILLING: Demonstrates understanding of payor systems, and nuances of appropriate billing practices, including relevant legal and ethical issues/concerns
5)	COMMUNICATION: Collaborates effectively with administrative staff and other professionals, including the understanding of roles and the use of efficient and professional communication
6)	FOLLOW-THROUGH: Follows through with assigned or other professional tasks, and communicates effectively with those involved during and after task completion

Please review and discuss strengths and areas of growth (numbered above) and collaboratively develop a fellow with the fellow to meet expectations and goals.	**Fellow Self Eval**	**Rotation 1 Supervisor**	**Rotation 2 Supervisor**
Carefully consider the above areas of functioning to provide a single overall rating:			

CLINICAL SKILLS - GENERAL	
1)	KNOWLEDGE BASE: Demonstrates growth and an understanding of the relevant research and methods related to assessment and intervention
2)	CONCEPTUALIZATION: Effectively integrates clinical and assessment data to conceptualize the presenting concern, carefully considers differential diagnoses, and provides recommendations to patients and families.
3)	DOCUMENTATION: Clinical notes and reports are written clearly, succinctly, and completed in a timely and professional manner.
4)	RAPPORT: Establishes and maintains rapport with patients and families, communicating interest, caring, and helpfulness in a professional manner
5)	CRISES MANAGEMENT: Recognizes and effectively handles crises and emergencies, including recognizing limits of position/training and obtaining appropriate supervision

Please review and discuss strengths and areas of growth (numbered above) and collaboratively develop a fellow with the fellow to meet expectations and goals.	**Fellow Self Eval**	**Rotation 1 Supervisor**	**Rotation 2 Supervisor**
Carefully consider the above areas of functioning to provide a single overall rating:			

CLINICAL SKILLS - ASSESSMENT	
1)	CLINICAL INTERVIEW: Independently conducts clinical interviews in a manner that obtains relevant information in a thorough and efficient manner
2)	DIAGNOSIS: Demonstrates well-developed knowledge of diagnostic criteria based on applicable frameworks (e.g., DSM-5, ICD-10), and considers differential diagnoses
3)	DATA COLLECTION: Independently incorporates multiple sources of data to formulate case conceptualizations that are grounded in a theoretical orientation.
4)	TEST ADMINISTRATION: Makes defensible choice of assessment instruments; administers/scores correctly; independently obtains supervision for use of unfamiliar instruments
5)	INTERPRETATION OF DATA: Interprets data accurately while demonstrating appropriate awareness and consideration of patient factors (e.g., education, intellectual functioning, language status)
6)	FEEDBACK: Provides effective communication of results and recommendations to patient and/or family

Please review and discuss strengths and areas of growth (numbered above) and collaboratively develop a fellow with the fellow to meet expectations and goals.	**Fellow Self Eval**	**Rotation 1 Supervisor**	**Rotation 2 Supervisor**
Carefully consider the above areas of functioning to provide a single overall rating:			

CLINICAL SKILLS - INTERVENTION	
1)	PLANS: Independently plans interventions specific to the patient and presenting concerns
2)	IMPLEMENTATION: Demonstrates competence and flexibility in implementing appropriate evidenced based strategies to meet patient and family goals
3)	PROGRESS MONITORING: Demonstrates competence and flexibility in monitoring progress and adjusting treatment as needed

Please review and discuss strengths and areas of growth (numbered above) and collaboratively develop a fellow with the fellow to meet expectations and goals.	**Fellow Self Eval**	**Rotation 1 Supervisor**	**Rotation 2 Supervisor**
Carefully consider the above areas of functioning to provide a single overall rating:			

CONSULTATION AND INTERPROFESSIONAL SKILLS	
1)	KNOWLEDGE: Demonstrate understanding and respect for the roles and perspectives of other professionals
2)	ABILITY: Demonstrates the ability to effectively consult with medical and allied health professionals, including understanding the unique role and perspective of psychology in a multidisciplinary setting
3)	LANGUAGE: Adjusts use of language to avoid jargon when communicating with other professionals
4)	CONTRIBUTION: Meaningfully contributes to interdisciplinary clinical case staffings and/or collaborative projects

Please review and discuss strengths and areas of growth (numbered above) and collaboratively develop a fellow with the resident to meet expectations and goals.	**Fellow Self Eval**	**Rotation 1 Supervisor**	**Rotation 2 Supervisor**
Carefully consider the above areas of functioning to provide a single overall rating:			

SUPERVISION	
1)	PREPAREDNESS: Arrives well-prepared for supervision and uses supervision time effectively
2)	INVOLVEMENT: Takes the initiative to develop and monitor personal training goals, ask questions, and lead professional development conversations during supervision
3)	RESPONSIVENESS: Accepts feedback in a non-defensive and responsive manner, and assimilates feedback into clinical and professional practice in a timely manner

Please review and discuss strengths and areas of growth (numbered above) and collaboratively develop with fellow to meet expectations and goals.	**Fellow Self Eval**	**Rotation 1 Supervisor**	**Rotation 2 Supervisor**
Carefully consider the above areas of functioning to provide a single overall rating:			

RESEARCH	
1)	KNOWLEDGE: Demonstrates a well-developed and broad knowledge base in primary areas of clinical care and program development
2)	APPLICATION: Effectively uses knowledge to improve patient care and program development

Please review and discuss strengths and areas of growth (numbered above) and collaboratively develop a fellow with the resident to meet expectations and goals.	**Fellow Self Eval**	**Rotation 1 Supervisor**	**Rotation 2 Supervisor**
Carefully consider the above areas of functioning to provide a single overall rating:			

CONSTRUCTIVE FEEDBACK

Please describe particular areas of strength, and thoughtfully consider and outline areas of growth and further development. Please be as specific possible with a plan to achieve ongoing growth. Relative strengths, areas of growth, and plans should be thoroughly discussed between supervisor and resident, and all questions answered and disagreements collaboratively resolved, if possible. Unresolved disagreements should be brought to the attention of the Training Director.

Areas of Growth (Self)

Areas of Growth (Rotation 1 - Supervisor)

Areas of Growth (Rotation 2 - Supervisor)

TGH Supervisor Evaluation Form

RATING SCALE				
Less than Adequate	**Acceptable**	**Good**	**Very Good**	**Excellent**
1	2	3	4	5

FELLOW:	
SUPERVISOR	
YEAR	

LOGISTICS		**Rating**
1)	Time was set aside exclusively for supervision.	
2)	Supervisor was punctual.	
3)	Supervisor kept appointments in a timely manner.	
4)	Supervisor was available for case consultation at other times.	

INTERPERSONAL FACTORS		Rating
1)	Supervisor demonstrated good interpersonal skills.	
2)	Supervisor was interested in supervision.	
3)	Supervisor was tolerant of value differences between the two of you and your patients.	
4)	Supervisor respected the boundaries of the supervisory alliance.	
5)	Supervisor conveyed an openness toward dealing with issues of power, authority, and responsibility.	
6)	Supervisor demonstrated openness and skill regarding issues of diversity, sensitivity to culture, gender, race, ethnicity, sexual orientation, gender identity, class, religion, physical ability, and age.	

	SKILL DEVELOPMENT	Rating
1)	Supervisor communicated expectations clearly.	
2)	You and your supervisor set and worked toward clearly stated goals.	
3)	Time was spent on learning practical skills.	
4)	Time was spent on increasing your therapeutic skills.	
5)	We explored new therapeutic techniques.	
6)	Supervisor helped prepare you to work with your patients.	
7)	Time was spent on developing your case conceptualization skills.	
8)	Supervisor shared his or her own theoretical orientation along with rationale.	
9)	Supervisor assisted you in developing your own theoretical framework.	

FEEDBACK		Rating
1)	Time was spent in helping you assess your strengths.	
2)	Time was spent on helping you assess your weaknesses.	
3)	You could discuss your errors comfortably.	
4)	Supervisor gave negative feedback constructively.	
5)	Supervisor was open to feedback from you.	
6)	Feedback was provided in a direct and straightforward manner.	

PERSONAL AND PROFESSIONAL GROWTH		Rating
1)	Supervisor was emotionally supportive.	
2)	Supervisor offered praise and encouragement.	
3)	Supervisor helped you increase your confidence.	
4)	Supervisor encouraged you to explore personal growth as related to your role as a psychologist.	
5)	Supervisor contributed to your professional growth.	
6)	Supervisor modeled ethical treatment of others.	
7)	Supervisor matched supervision to your current experience level.	
8)	Supervisor shared his or her own theoretical orientation along with rationale.	
9)	Supervisor assisted you in developing your own theoretical framework.	

RATING SCALE				
Never	**Rarely**	**Sometimes**	**Usually**	**Always**
1	2	3	4	5

SUMMARY		**Rating**
1)	You looked forward to supervision.	
2)	Quality of supervision was consistently high during the rotation.	
3)	You would recommend this supervisor to another supervisee.	

CONSTRUCTIVE FEEDBACK

What aspects of supervision were most meaningful in your development?

What suggestions do you have to improve the supervisory training process?
Additional comments and recommendations

SEMINAR EVALUATION FORM

Please evaluate each seminar and meeting:

Post-Doc Seminar – VA Professional Development

_____

_____

Post-Doc Seminar – VA Rehabilitation

_____

_____

Post-Doc Seminar – TGH Health and Rehabilitation

_____

_____

Psychology Services Monthly Meeting

_____

_____

Do No Harm Meeting

_____

_____

Suggestions for other seminar topics or training opportunities

_____

_____

TGH/TGMG DEPARTMENT POLICIES

FELLOWSHIP DUE PROCESS, GRIEVANCES PROCEDURE, AND TERMINATION

DUE PROCESS, GRIEVANCES PROCEDURE, AND TERMINATION

Due Process

The primary purpose of the due process is to provide a mechanism to fairly and systematically address postdoctoral fellows' issues regarding evaluation, performance, or because of a violation of the Postdoctoral Program's Standards of Conduct. Supervisors complete two (2) written evaluations (mid-rotation and final rotation) for each postdoctoral fellow that they supervise. However, when a performance deficit or problem is observed at any point during training, the supervisor is encouraged to discuss the issues with the postdoctoral fellow and attempt to arrive at a mutually acceptable solution. Such a situation is not unusual, an in the vast majority of instances would require no further action.

1. All postdoctoral fellows have their progress monitored through monthly meetings with the Postdoctoral Training Director and current supervisors, fellows with the Training Director, as well as quarterly training committee meetings. If the supervisor feels that performance deficit or problem has not been corrected, or the supervisor and postdoctoral trainee are not able to reach an agreement, the Postdoctoral Training Director is informed by the supervisor and fully apprised of the problem. The postdoctoral fellow is notified that the supervisor has formally shared their concerns with the Postdoctoral Training Director and/or Department Manager. The Postdoctoral Training Director will gather information from the primary supervisor and postdoctoral fellow, as well as from other supervisors in positions to provide relevant information.
2. The primary supervisor, other relevant supervisors, Postdoctoral Training Director, and Department Manager will develop a remediation plan if fellows are not making progress towards competencies outlined in the competency rating forms. The Postdoctoral Training Director will meet face-to-face with the postdoctoral fellow to discuss the remediation plan and allow the trainee to provide input on the plan; however, the Postdoctoral Training Director has the final decision on the structure. Following this Hearing, the postdoctoral fellow will receive a copy of the final remediation plan in writing, including the required actions that he or she must take, and the possible consequences for failing to do so. The written remediation plan should define specifically (in behavioral terms) the deficits or challenging behaviors in relation to expected standard of performance, required actions or change, the supervisors and time table involved, and method(s) of evaluation noting the criteria for successful completion. A copy of this correspondence will be place in the postdoctoral fellow file.
3. Based on the timeline and criteria in the original remediation plan, the Department Manager and Postdoctoral Training Director will assess if the postdoctoral fellow has successfully completed the remediation plan and corrected the problem. If the postdoctoral fellow has met the criteria, they will receive a letter indicating that have effectively accomplished the remediation plan. If the problem has not been remedied, then either there will be (a) further remediation, or (b) recommendation for termination.

4. If the Department Manager and Postdoctoral Training Director believes that the postdoctoral fellow is making progress towards meeting the outlined criteria for successful remediation, but has not quite fulfilled all criteria stated in the remediation plan, an extension for an additional period of time may be granted by the Postdoctoral Training Director, not exceeding 90 days.
5. If the postdoctoral fellow does not meet successful criteria for remediation during the stipulated period, the Department Manager and Postdoctoral Training Director can recommend termination. The decision for the determination will be discussed and voted on by supervisors, the Postdoctoral Training Director, and the Department Manager. The decision will be forwarded to Vice President of Ambulatory Care and Transition (Elan Melamed)and Human Resources (People and Talent). The Department Manager and Postdoctoral Training Director will inform the postdoctoral fellow of the separation from the program and the general grounds of the dismissal. Final decision about termination should be notified in writing to the postdoctoral fellow at a meeting between the administrators and the postdoctoral fellow.
6. The postdoctoral fellow has the right to Appeal and follow the conflict resolution, due process, and grievance steps outlined in TGH policy (PT 071). Disagreements should be immediately resolved among the parties whenever possible, as outlined above. Once the Postdoctoral Training Director and Department Manager have approved formal remediation, the involved postdoctoral fellow who disagrees with the decision may appeal in writing to the Postdoctoral Training Director within 10 days after receiving the performance or misconduct notice from the Postdoctoral Training Director and Department Manager.
7. If the issue cannot be resolved at the Department level, the postdoctoral fellow may also appeal in writing within seven (7) days of the meeting with the Department Manager to the Vice President of Ambulatory Care and Transition (Elan Melamed).

Termination of Appointment

Termination of a Postdoctoral fellow from the Postdoctoral Program involves the permanent withdrawal of all privileges at Tampa General Hospital. Dismissal from the program may result for any of the following reasons:

1. The Postdoctoral fellow has committed a violation of federal or state laws, including HIPAA state statutes regarding professional conduct or a severe violation of the Ethical Principals of the American Psychological Association (APA).
2. Violation of Standards of Conduct including Postdoctoral Training Program's policies, procedures, or professional organization guidelines.
3. There has been little to no progress in the competencies evaluated as deficient by supervisors.
4. The Postdoctoral fellow had failed to show improvements of the criteria included in a remediation plan during a probation period because of unsatisfactory clinical performance or judgement.
5. Attempts at remediation, after a reasonable period of time, have not remedied the competency problems.

The decision to dismiss a Postdoctoral fellow will be made by the Postdoctoral Training Director, the Department Manager, and the Director of Rehabilitation Services in consultation with Human Resources. The final decision about termination will be notified in writing to the Postdoctoral fellow at a meeting between Human Resources and the postdoctoral fellow.

Grievances Procedure

The Postdoctoral Program in Health and Rehabilitation Psychology in the Department of Psychology-Neuropsychology adheres to Tampa General Hospital Policies and Procedures.

The purpose of the present Grievance Procedure is to provide a prompt and efficient collegial method for the review and resolution of grievances filed by a postdoctoral fellow who is in disagreement with an evaluation, disciplinary action, or has a complaint about a supervisor or postdoctoral fellow. There are two possible stages in the grievance procedure, as follow: Informal Stage and Formal Stage.

Informal Stage

1. Oral discussion between Postdoctoral fellow and the person(s) alleged to have caused the grievance is strongly encouraged. The discussion should be held as soon as the Postdoctoral fellow first becomes aware of the act or condition that is the basis of the grievance. Additionally, or in the alternative, the postdoctoral fellow may wish to present his or her grievance in writing to the persons alleged to have caused the grievance. In either case, the person alleged to have cause the grievance must respond to the Postdoctoral fellow either orally or in writing.
2. If this first attempt to resolve the complaint is not successful, the Postdoctoral fellow may ask the Postdoctoral Training Director to intervene. In such as case, the Postdoctoral Training Director collects all relevant information from the Postdoctoral fellow and other partied including consultation with supervisors as is appropriate to the specific situation.
3. Subsequently, the Postdoctoral Training Director brings the relevant individuals together and presents a plan for resolution of the problem. The Postdoctoral Training Director then follows up with the postdoctoral fellow and the other relevant parties to determine whether a successful resolution of the problem has been achieved.
4. If the postdoctoral fellow wishes to appeal the Postdoctoral Training Director's disposition, they may bring the problem to the Department Manager and/or the Director of Rehabilitation Services. Finally, if an appropriate solution of the concern cannot be achieved within the Department, the postdoctoral fellow may pursue a Formal Grievance Procedure.

Formal Stage

The Formal Stage of the Postdoctoral Program in Rehabilitation Psychology in the Department of Psychology-Neuropsychology is in line with to Tampa General Hospital Policies and Procedures, outlined in the Conflict Resolution and Grievance Procedure (Policy HR-71). The grievance procedure is not applicable when addressing dissatisfaction with a pay, work schedule, or TGH policies and procedures. Postdoctoral fellows will not be subject to any kind of retaliation as a result of participating in a grievance procedure.

In the event that the postdoctoral fellow considers that the response of the informal discussion is unsatisfactory and feels that the grievance still exists, they should submit a written complaint to the Department Manager. The steps in the formal grievance process are as follows:

1. Submit a formal complaint in writing, with all supporting documentation, to the Department Manager and Director of Rehabilitation Services.
2. The postdoctoral fellow must support his or her position regarding the grievance by providing evidence of the complaint.
3. All documents considered relevant to the grievant's claim will be reviewed by Human Resources and attached to a written report.
4. The Postdoctoral Training Director and Department Manager must provide a written response, forwarded through a Human Resources Consultant, to the Postdoctoral fellow's grievance within fourteen (14) days after the complaint has been submitted. A meeting will be arranged between the Postdoctoral Training Director, Department Manager, a Human Resource Consultant, and the grievant to discuss possible resolution of the grievance.

TGMG EMPLOYED PSYCHOLOGY FELLOWS

POLICY: This policy described the supervision and documentation requirements for the employed Psychology Fellow under the TGMG Psychology & Neuropsychology department.

BACKGROUND:
The "Organization" is defined as Tampa General Hospital TGH and Tampa General Medical Group TGMG.

It is the practice of the departments that involve psychology fellows in provision of services at Organization sites to provide and document supervision of those fellows. Psychology fellows at Organization are employed by Tampa General Medical Group (TGMG).
These standard practices and procedures serve to:

- identify patients who are eligible to receive services from a supervised psychology fellow;
- provide for training of Organization employed psychology fellows; and
- describe the conditions under which such services are provided at the Organization.

These Standard Practices and Procedures do NOT apply to patients covered by federally funded programs such as Medicare, Medicaid, Tricare, and their managed care products, as these payers do not reimburse for services provided by a psychology fellows.

Psychology trainees require clinical experience in order to meet graduate education and licensure requirements.
A psychology trainee includes:

A post-doctoral psychology fellow completing 2,000 hours of supervised experience, after completion of doctoral training from a university-based psychology program accredited through the American Psychology Association (APA).

PROCEDURE:

1. **Psychology Training Director** is responsible for oversight and management of the provision of psychological services by Organization employed psychology fellows in accordance with these Procedures. The credentialed Psychology Training Director must not have a disqualifying relationship with the trainee i.e., relative, friend or other personal relationship and to adhere to state law. The Training Director reports to the department manager who oversees the services for the entire department.
2. **Organization Credentialed Psychologist** will either after a patient's initial evaluation or during the course of a patient's treatment, identify patients who are clinically appropriate for psychological services provided by a psychology fellow. These will generally be patients who have a presenting problem of low risk and will be problems within the competence level. Psychological services include consultation, individual, group, or family psychotherapy and psychological or neuropsychological testing. The Credentialed Psychologist discusses the qualifications of the Fellow and level of supervision with the patient (or, in the case of a minor, the patient and parent).
3. **The psychology fellow** shall inform all service users of their supervised status and provide the name of the supervising psychologist.
4. **Financial Specialist** (or other staff as designated by the Department) reviews the patient's financial status to determine that the patient is NOT covered by a federally administered

program (e.g., Medicare, Medicare Railroad, Medicaid, Tricare or any federal managed care product), either as a primary or secondary payer.

5. **Psychology Training Director** assigns cases to the fellow no more than 25 hours per week to treat outpatient cases for training purposes.
6. **Supervision of Services**: The Credentialed Psychologist supervising the fellow must meet each of the following criterion:
   - Be present within the clinic at the time the fellow is seeing patients and remain immediately available for consultation. If required or requested by the fellow or patient, the Supervisor sees a patient directly to aid in care, address a problem or assist with a treatment plan.
   - Meet with the fellow weekly to discuss all cases.
   - Ensures that each psychology fellow provides adequate and appropriate care; meets TGH/TGMG documentation and coding guidelines; and meets any/all other Departmental clinical care standards.
7. **Documentation Requirements**: At the conclusion of each psychology fellow patient encounter, fellow will document their care of the patient. The psychology fellow will forward/route their note to the supervising Psychologist for review, documentation, and signature. The supervising Psychologist reviews the documentation to ensure the following:
   - Medical care administered was appropriate
   - Treatment frequency is appropriate
   - The psychology fellow is compliant with documentation guidelines and the encounter is coded as the service provider.
   - All patient data, such as self-reports, have been reviewed.
8. **The Psychologist Supervisor** must document for each visit, his/her concurrence with or modifications to the treatment plan, his/her review of the case with the psychology fellow and their signature and the date. This documentation may be via an attestation or addendum to the fellow note.
9. **The Supervisor's notes** along with the fellow's notes are kept as a permanent part of the patient's medical record.

References:

1. Florida Administrative Code: 64B19-11.005
2. Florida Statutes, Title XXXII, Regulation of Professions and Occupations, Chapter 490, Psychological Services.

RESPONSIBLE OFFICE: The preceding was developed by TGMG Revenue Cycle Integrity department and TGMG Psychology and Neuropsychology Department. Any questions or concerns should be directed to 813-844-3956.

http://www.leg.state.fl.us/statutes/index.cfm?App_mode=Display_Statute&URL=0400-0499/0490/0490.html

Tampa General Hospital
POLICY & PROCEDURE

_X_ Organizational __ Hospital __ Ambulatory Services__ Departmental

Title: Conflict Resolution and Grievance Procedure

Original Issue Date: 10/1992 Review Date: 05/31/2024 Revision Date: 9/2021	**Number: PT-071**	**Page:** 1 of 4
Originating Department: People & Talent	**Approved by:** Tyler Carpenter	

POLICY: The Leadership of Tampa General Hospital, as part of their Governance responsibilities, provides a system to address and resolve work-related conflicts or concerns using either informal or formal methods. All Tampa General Hospital team members, management, and non-management, have a responsibility to address and resolve work-related conflicts or concerns informally through open and honest communications. The Grievance procedure outlined in this policy is the formal method team members should use to resolve conflicts; only after all informal methods have been attempted.

PROCEDURE:

I. COLLABORATIVE METHODS OF CONFLICT RESOLUTION (INFORMAL)

A. Communication:

1) Conflicts, concerns, and disputes are often the result of communication failure.
2) Team members should be aware of this and ensure that communications, verbal and written, are clear and explicit.
3) A part of the communication process that is often ignored is the art of listening. A good communicator can express his/her thoughts to others, as well as hearing what the other person has to say.
4) The following concepts may prove valuable when attempting to resolve a conflict:
    a) Listen to the other person's position carefully: Does it make sense? Is it logical? Is it based on facts? Listen closely for any point that you could agree on.
    b) Collaboration and compromise are necessary in conflict resolution to reach a win-win solution. This typically results in the best short- and long-term outcome.
    c) Present your position based on objective facts, not personal feelings or emotions.
    d) The way the message is presented is often just as important as the message itself. Take the time to understand what is motivating the other person.

B. Third-party Facilitation:

Most individuals are very passionate about their position on issues, and at times become so passionate that it is difficult to see an opposing side. When this occurs, it may be helpful to ask a third party to hear the issue and make a recommendation. When a third party is engaged, he/she must be affiliated with TGH, such as the department designated Team Member Relations Consultant.

C. Chain of Command:

When the parties cannot develop a solution on their own, they should make their immediate supervisor(s) aware of the problem and what steps have been taken to seek resolution. The immediate supervisor(s) will either suggest other remedies or attempt to resolve the problem through normal management processes.

II. GRIEVANCE PROCEDURE (FORMAL)

A. Definition:

A grievance is defined as a job-related concern, complaint, or dissatisfaction. Regular team members have the opportunity to submit grievances concerning disciplinary actions, working conditions, supervision, and so forth. Such dissatisfactions, when formally brought to the attention of management, are classified as grievances. For grievances concerning disciplinary actions, the steps below apply. Probationary and temporary team members are ineligible to submit grievances under the provisions of this policy.

B. Retaliation:

A team member who utilizes the grievance procedure will not be interfered with nor retaliated against.

C. Limitations:

The grievance procedure is not applicable when addressing dissatisfaction with an individual's pay, pay grade, promotional opportunities, annual performance appraisal, work schedule, a performance improvement plan, or TGH policies and procedures.

D. Responsibilities:

1) **Team member:**

a) Notify the department designated Team Member Relations Consultant of the request to submit a grievance.

b) If grieving a disciplinary action, submit a written grievance to the Human Resource Consultant within seven (7) calendar days of receiving the disciplinary action whether in person or via certified mail. Failure to sign the disciplinary action may void any ability to grieve. The written grievance should include a desired resolution to the grievance. After each step of the Grievance Process, the team member must submit a written request, including reason for continuance of the grievance, to Human Resources in order to proceed to the next step of the process. Human Resources must receive the written request within seven (7) calendar days after team member's receipt of each level of response.

2) **Human Resources:**

a) Ensure the team member has provided a specific resolution to the grievance.

b) Facilitate the grievance through each step of the process within the allotted timeframes.

c) Facilitate providing team member with written responses following each decision.

3) **Department Director – Step 1:**

a) Review all information related to the grievance.

b) Meet with the team member, their manager, or others, as necessary.

c) Provide a written response to the team member, forwarded through a Human Resources Consultant, within fourteen (14) calendar days of receipt of the grievance.

4) **Vice President – Step 2:**
   a) Review all information related to the grievance.
   b) Meet with the team member, their manager, or others, as necessary.
   c) Provide a written response to the team member, forwarded through a Human Resource Consultant, within fourteen (14) calendar days of receipt of the grievance.

5) **Grievance Committee – Step 3 Final:**
   a) Review written and oral testimony from the grievant, the team member's manager, and others, as necessary.
   b) Render a decision on the grievance within seven (7) calendar days after concluding the investigation, using polices, written and/or oral testimony, past practices, and if necessary, a majority vote.
   c) Provide the Human Resource Consultant with the decision; the Consultant will then prepare a written response for the team member.
   d) The decision of the grievance committee is final and binding.

E. Grievance Committee Structure:

1) The Grievance Committee is selected by Human Resources and shall consist of the following members:
   a) A Divisional Vice President (not from the Division of the team member filing the grievance).
   b) A Department Director or Manager (not from the Division of the team member filing the grievance).
   c) Three (3) Non-Management team members (may be from the Division of the team member filing the grievance or another Division).
   d) The Director of Human Resources.
2) The Divisional Vice President, Department Director or Manager, and three non-management team members, shall have one vote each, should a vote be required. The Director of Human Resources is the Committee chairperson and is a non-voting member.
3) Team members solicited as committee members must have been employed at TGH as a regular full-time or part-time team member for at least one year of continuous service, and must not have had any disciplinary action taken against them within the past 12 months. Committee members cannot be related to the team member grieving or any other member of the committee.
4) On the day of the Grievance Committee Meeting, participants will be provided with all documentation related to the grievance as well as the *Grievance Committee: Structure & Instructions Form (G4001).*
5) The team member submitting the grievance:
   a) May select another team member or a Human Resources Department representative to help in the presentation of the grievance to the committee.
   b) Will be required to present to the Committee, in person, any relevant evidence related to his/her grievance.
   c) May have other team members, who have direct knowledge of the event(s) involved, speak on their behalf. Team members are not permitted to have any non-TGH individuals present during the grievance committee.

F. Grievance Committee Process:

1. **Stage One:** Voting committee members are provided one (1) hour to review related documents (emails, disciplinary actions, etc.) prior to formal testimony. Committee members may request additional documentation.
2. **Stage Two:** The grievant will present testimony (to include oral, and written, or witnesses) related to the disciplinary action/issue. The testimony will address the issue from his/her standpoint and should also indicate what form of resolution (overturn, reduce, etc.) he/she is seeking from the grievance process. At the end of the second hour, the grievant will be excused from the hearing.
3. **Stage Three:** The management member(s) involved in the disciplinary action/issue will provide testimony (oral, written or witnesses) in support of the action. Please note, the committee may request the in-person testimony of any witnesses with direct knowledge of the event, which led to the disciplinary action/issue, even if the witness is not on the agenda for the second hour.
4. **Stage Four:** The committee discusses all information presented and may request any additional testimony or documentation. Once the committee feels that a sufficient amount of information has been presented, the voting phase begins. Please note, if the committee does not feel enough information has been presented to conduct a vote, the Director of Human Resources will facilitate the request for additional information and, if necessary, determine a later date for the committee to reconvene. The outcome of the grievance will be documented on the *Grievance Committee Summary Form (G510).*

G. Miscellaneous:

1) Management responses may be delayed due to certain circumstances, such as availability of those individuals needed to complete investigations and so forth. If this should become necessary, team members will be notified.

2) One or more steps may be bypassed in the procedure for special handling of certain grievances, such as terminations, complaints about the supervisor, or health and safety issues.

3) At any point in the grievance process, should the grievance be overturned or reduced, the grievance process is concluded and the decision stands.

4) In grievance cases related to disciplines for unscheduled absences, tardiness, or no-call / no-shows; the grievance process Step 3 – Final Step will be determined by the Executive Vice President, Chief People & Talent Officer in lieu of the Grievance Committee.

5) In some circumstances, the President & CEO or member of HR leadership may revoke a team member's right to grieve.

Tampa General Hospital
POLICY & PROCEDURE

X Organizational _ Hospital __ Ambulatory Services __ Departmental

Title: Code of Conduct		
Original Issue Date: 8/1998 Review Date: Revision Date: 6/2021	**Number: HR-070**	**Page:** 1 of 10
Originating Department: Human Resources		**Approved by:** Qualenta Kivett

HR Code of Conduct

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FORMS RELATED TO THIS POLICY - Available on the TGH Portal

Core Values – Signature Form (Form #C1709)
Code of Conduct Acknowledgement Form (Form #H124)
Conflict of Interest Certification Statement (Form #C131)

PURPOSE/POLICY

This Code of Conduct, which reflects our tradition of caring, provides guidance to ensure our work is done in an ethical and legal manner. It emphasizes the shared common values and culture that guide our actions. It also contains resources to help resolve any questions about appropriate conduct in the workplace. Your adherence to its spirit, as well as its specific provisions, is critical to our future.

TGH has a rich heritage of values and traditions, which are reflected in our Vision and Mission Statements and in this Code of Conduct. We are equally committed to ensuring that our actions consistently reflect our words. In this spirit, we expect all of our healthcare partners' actions to reflect the high standards set forth in this Code of Conduct.

Definitions:

TGH healthcare partner: For the purpose of this policy, a healthcare partner is defined as a team member, volunteer, or member of the medical staff who holds a medical staff office, or who serves on any medical staff or TGH committee, or who is compensated for services by TGH.

Key leaders: For the purpose of this policy, a key leader includes senior management, department directors, and other managers who are identified as members of the Leadership Group.

This Code of Conduct contains principles articulating the policy of TGH and standards, which are intended to provide additional guidance to our healthcare partners. These standards are neither exclusive nor complete. All healthcare partners are responsible for ensuring their behavior and activity is consistent with this Code of Conduct while on hospital premises or conducting TGH business off site.

Additionally, residents, students, contractors, vendors, and other individuals or entities, who may have a business relationship with TGH, are expected to adhere to the principals espoused in this policy.

Violations of any of the following minimum expectations of behavior by TGH partners may lead to disciplinary actions, up to and including termination of employment or relationship with TGH. In the case of residents, students, contractors, vendors, and other non-team members, the affiliation or relationship with TGH may be terminated.

TGH MISSION

We heal. We teach. We innovate. Care for everyone. Every day.

TGH VISION

TGH will be the safest and most innovative academic health system in America.

PRINCIPLES AND STANDARDS

Principle 1 – Leadership Responsibilities

While TGH healthcare partners are obligated to follow the TGH Code of Conduct, we expect our leaders to set the example and to be a model in every respect.

TGH leaders must ensure that those on their team have sufficient information to comply with law, regulation, and policy, as well as the resources to resolve ethical dilemmas. They must help to create a culture within TGH that promotes the highest standards of ethics and compliance. This culture must encourage everyone in the organization to raise concerns when ethical issues arise. We must never sacrifice ethical and compliant behavior in the pursuit of business objectives.

Guidelines

The conduct of any healthcare partner that interferes with the effective operation of TGH's business is prohibited. The behavior standards listed below and others, which may be established from time-to-time, are not all-inclusive. Rather, they are published to provide a general understanding of what TGH considers to be the minimum acceptable levels of behavior or conduct. The behavior standards are merely examples of the types of conduct to which a healthcare partner is expected to adhere.

TGH may impose disciplinary action in those instances involving team members where management decides it is appropriate. Disciplinary actions include, but are not limited to, verbal warnings, written warnings, suspensions without pay, and discharge. TGH retains the right to determine what discipline will be imposed in each individual situation. See "**Compensation-Salary Administration Program"** (regarding demotions) and **"Progressive Discipline Policy"** policies for further details.

Principle 2 - Workplace Conduct and Employment Practices
TGH is dedicated to high standards of business conduct and will not engage in any activity that unfairly or illegally impacts our patients, healthcare partners, suppliers, or competitors. We encourage a teamwork approach, sound business fundamentals, innovation, and hard work to establish and maintain our leadership position in the markets we serve.

If you learn about a violation of this Code of Conduct or a violation of law taking place at TGH, you must inform your Manager, Director, the Human Resources Director, or the Chief Compliance Officer (CCO) as soon as possible. You may also call the Compliance Hotline 1-833-TELL-TGH (1-833-835-5844). Calls to the Compliance Hotline will be treated confidentially and may, at the caller's request, be anonymous. We assure you that anyone who, in good faith, reports a suspected violation will be protected from retaliation or punishment, even if it turns out that there was no actual violation. We want to know about possible concerns so that we can address them.

Standard 2.1 - Availability for Work
Acceptable attendance by performing your job duties, in appropriate dress or uniform, each scheduled workday, is expected. Sleeping or being under the influence of alcohol or other drugs, except by prescription, during work time, is prohibited. Refer to Standards 2.7 and 2.8 below for additional requirements.

Patterns of unacceptable attendance will be taken into consideration for disciplinary purposes. One shift no-call/no-show will result in immediate suspension without pay. Consecutive shifts no-call/no-show is considered job abandonment and will result in immediate discharge. Refer to policy **"Attendance & Tardiness"** for additional requirements.

Standard 2.2 – Adherence to Work Schedules and Clocking In /Out
All team members are expected to adhere to their assigned work schedule. Hourly (non-exempt) team members are expected to punch-in, and punch-out, at their assigned time clocks in accordance with their approved schedule unless they have been assigned a Kronos Timestamp license and the ability to remotely access and record their time by computer (ie. those working remotely). Deviations from a team member's approved schedule, as well as missed punches, require authorization and documented approval from management. Patterns of missed punches and /or deviations from the approved schedule which require manual input time-keeping transactions, may delay the timely payment of relevant wages and/or be subject to disciplinary action if repetitive, give the appearance of avoiding tardiness monitoring, or are not a true representation of the time the work was performed.

Non-exempt team members are not permitted to do any work without being clocked in. Each team member is responsible for clocking in and out with his/her own badge. Clocking in or out for another team member is grounds for termination. Each team member is required to be at his/her workstation at their schedule work time.

Standard 2.3 - Team member Etiquette/Behavior that Undermines a Culture of Safety
TGH has created a culture of safety by setting expectations, and subsequent consequences, for actions that could potentially compromise the well-being of our patients. Interaction with patients, visitors, physicians, and team members, in a respectful manner, is expected. Profanity, vulgar gestures, loud/disruptive talking, being discourteous, fighting, or other inappropriate behavior is prohibited. Any assigned duties not completed must be reported to your supervisor within an appropriate time frame. Refusal to comply with requests from management or showing disrespect to any member of management or designee is prohibited. The Medical Staff Professionalism Committee shall address any providers activities, statements, demeanor or professional conduct either within or outside the Hospital that create a reasonable concern for patient safety, for quality of patient care, for clinical competence of any Practitioner, or that such behavior creates a risk of injury or damage to any patient, team member or person present in the Hospital or to the Hospital.

Each TGH healthcare partner is also expected to make every effort to maintain the appearance of TGH and its grounds. This means that every TGH healthcare partner is responsible for picking up trash (as an example). It is also an expectation that TGH healthcare partners will always assist anyone who appears lost or confused by giving directions or taking the person to their destination.

All TGH healthcare partners' actions that should not be viewed or overheard, such as personal conversations, cell phone calls, etc., should be kept within the "Off Stage" areas.

Personal cell phones are not to be used in designated work areas unless the healthcare partner is on an approved break; and are to be set on "silent alert or vibrate" at all times, so that patient care is not disrupted.

Healthcare partners posting information on personal internet blogs and social networking websites, such as, but not limited to, *Facebook, Instagram, SnapChat, Twitter,* etc. may not have a reasonable expectation of privacy in what they do, say, or post. In certain instances, Tampa General Hospital (TGH) may have legitimate business concerns resulting from healthcare partners' outside/off-duty activities that can be considered disruptive to TGH business operations.

Information that may be considered disruptive to TGH's health care mission, when posted on internet sites, includes, but is not limited to: threats of violence or harassment; references to ongoing, illegal drug use or other illegal activity; references to a non-disclosed conflict of interest; sexually explicit material; racist or other discriminatory remarks; disclosure of confidential or proprietary information belonging to TGH; disclosure of confidential patient information, including any digital images with or without patient identifiers; use of TGH's name or logo without permission; representing personal opinions as those of TGH; and anything else that violates TGH policies.

Standard 2.4 - Property of Others/Personal Use of TGH Property
Treating the property of others and TGH with respect is expected. Unauthorized possession, conversion, destruction, removal or defacing of the property of others or TGH is prohibited. It is the responsibility of all TGH healthcare partners to preserve the organizational assets, including time, material, supplies, equipment, and information.
As a general rule, the personal use of any TGH asset without the prior approval of your supervisor is prohibited.

Standard 2.5 - Signing of Personnel Documents
Signing TGH documents, such as performance appraisals and disciplinary forms, is expected. Signing these documents does not necessarily mean you agree with its contents. However, refusal to sign may void any ability to grieve. See the Conflict Resolution and Grievance policy (HR-71). Signing time and attendance records, such as payroll adjustment forms, is considered verification that they are true and correct.

Standard 2.6 – Falsification
Documenting true and accurate entries on TGH records, patient medical records, forms, or other documents, is expected. Falsification of employment applications, employment records, time sheets (including clocking in or out for another team member), hospital records, forms, or other documents, are prohibited. Supplying false information verbally is also prohibited. Falsification may result in discharge for the first offense.

Standard 2.7 – Safety
Compliance with all safety and security rules, such as parking away from fire lanes, is expected. Possession and/or control of weapons, such as guns, knives, or sticks, not authorized for work purposes, as well as possession and/or control of illegal drugs and substances, is prohibited. Healthcare partners with firearms on TGH property (including TGH parking lots), not required for work purposes, is prohibited. This includes healthcare partners who have a Florida Concealed Weapons License. In addition, all healthcare partners are required to submit to inspection of personal items, such as bundles, packages, briefcases, and handbags, by security personnel or management. TGH property, such as lockers and desks, are also subject to inspection by TGH at any time. Healthcare partners have no reasonable expectation of privacy for any item brought on to TGH premises, stored in a TGH locker or desk, or placed on a computer or other electronic device.

To further enhance the security of TGH Healthcare partners, a complete background check is conducted on all new team members prior to being hired. In order to maintain that level of security, any team member who is arrested while employed at Tampa General Hospital must notify their manager within 48 hours of the arrest. Failure to do so is considered falsification and may result in disciplinary action up to and including discharge.

Standard 2.8 – Controlled Substances
Some healthcare partners routinely have access to prescription drugs, controlled substances, and other medical supplies. Many of these substances are governed and monitored by specific regulatory organizations and must be administered by licensed professionals or authorized professionals per physician order only. It is extremely important that these items be handled properly and only by authorized individuals to minimize risks to us and to patients. If it is discovered that the diversion of

drugs from the organization has occurred, a report of the incident should be made immediately. See **"Drug Free Workplace"** policy for further details.

Standard 2.9 – Substance Abuse and Mental Acuity
To protect the interests of our healthcare partners and patients, TGH is committed to an alcohol- and drug-free work environment. All TGH healthcare partners must report for work free of the influence of alcohol and illegal drugs. Reporting to work under the influence of any illegal drug or alcohol, having an illegal drug in your system; or using, possessing, or selling illegal drugs while on TGH work time or property, may result in immediate termination. Drug testing may be used as a means of enforcing this policy.

It is also recognized that individuals may be taking prescription drugs, which could impair judgment or other skills required in job performance. If questions arise about the effect of such medication on performance, consult with a TMHS. See **"Drug Free Workplace"** policy for further details.

Standard 2.10 – Solicitation
Solicitation and distribution or circulation of non-work-related printed material on TGH property is prohibited when the persons soliciting, or the person being solicited is on working time. Working time means the time team members are expected to be working and does not include rest, meal, or other authorized breaks. Distribution of literature by healthcare partners on TGH's property in non-working areas during working time is prohibited. Distribution of literature by healthcare partners on TGH's property in working areas is also prohibited. See **"Solicitation, Distribution, and Loitering" policy** for further details.

Standard 2.11 – Smoking
TGH is a smoke-free environment. Smoking is prohibited in any building on the TGH campus or in TGH vehicles. Smoking is only permitted in designated off-site smoking areas. Additionally, smoking is only permitted during non-paid break times. See **"Tobacco Free Campus" policy** for further details.

Standard 2.12 – Inside Information
From time to time, TGH healthcare partners may be exposed to non-public, material information, which may include plans for mergers, marketing strategy, financial results, or other business dealings. Discussion of this type of information with anyone outside of the organization is prohibited. Within the organization, discussion of this information should be on a strictly "need-to-know" basis only with other healthcare partners who require this information to perform their jobs.

Standard 2.13 - Discrimination
TGH believes that the fair and equitable treatment of TGH healthcare partners, patients, and other persons is critical to fulfilling its mission and goals.

It is the policy of TGH to enroll subscribers and treat patients without regard to any classification protected by law. Discrimination on the basis of race, color, religion, national origin, gender, age, disability, veteran status, sexual orientation, marital status, gender identity or membership in any other protected classification defined under applicable federal, state, or local law is strictly prohibited.

It is the policy of TGH to recruit, hire, train, promote, assign, transfer, layoff, recall, and terminate team members, based on their own ability, achievement, experience, conduct, and business needs; without regard to any classification protected by law. Refer to TGH's employment policies for related information.

Standard 2.14 – Harassment and Workplace Violence
Each TGH healthcare partner has the right to work in an environment free of harassment. TGH will not tolerate harassment by anyone based on the diverse characteristics or cultural backgrounds of those who work with us. Degrading or humiliating jokes, slurs, intimidation, or other harassing conduct is not acceptable in the workplace.

Any form of sexual harassment is strictly prohibited. This prohibition includes unwelcome sexual advances or requests for sexual favors in conjunction with employment decisions. Moreover, verbal or physical conduct of a sexual nature that

interferes with an individual's work performance or creates an intimidating, hostile, or offensive work environment, is strictly prohibited.

Workplace violence is also prohibited. Workplace violence includes robbery and other crimes, stalking cases, violence directed at the employer, terrorism, and hate crimes committed by current or former healthcare partners. Healthcare partners who observe or experience any form of harassment or violence, should report the incident to their supervisor, the Human Resources Department, the Safety Director, a member of management, the CCO or the Compliance Line, 1-800-352-6875. See **"Non-Harassment" policy** for further details.

Principle 3 - Business Ethics
In furtherance of TGH's commitment to the highest standards of business ethics and integrity, all TGH healthcare partners will accurately and honestly represent TGH and will not engage in any unethical activity or scheme.

Honest Communication
TGH requires candor and honesty from individuals in the performance of their responsibilities and in communication with individuals and/or entities conducting business and other activities with the organization, such as attorneys and auditors. Legal or Media inquiries should be directed to the appropriate department. No TGH healthcare partner shall make false or misleading statements to any patient, person, or entity doing business with TGH, about other patients, persons, or entities doing business or competing with TGH, or about the products or services of TGH or its competitors.

Principle 4 - Confidentiality
All TGH healthcare partners shall strive to maintain the confidentiality of patient and other confidential information in accordance with applicable legal and ethical standards.

TGH healthcare partners are in possession of and have access to a broad variety of confidential, sensitive, and proprietary information. Inappropriate release of this information could be injurious to individuals, the TGH business partners, and TGH itself. Every TGH healthcare partner has an obligation to protect and safeguard confidential, sensitive, and proprietary information in a manner designed to prevent the unauthorized disclosure of information. Refer to the TGH Corporate Compliance and Privacy policies for related information.

Personnel Actions/Decisions
Compensation, benefits, and other personal information relating to TGH healthcare partners shall be treated as confidential. HR files, credential files, compensation information, disciplinary matters, and similar information about other team members that was learned as a result of a team member's job duties shall be maintained in a manner designed to ensure confidentiality in accordance with applicable laws. TGH healthcare partners must exercise due care to prevent the release or sharing of information beyond those persons who need to know such information to fulfill their job responsibilities.

Principle 5- Business Relationship

License and Certification Renewals
TGH healthcare partners and individuals retained as independent contractors in positions which require professional licenses, certifications, or other credentials, are responsible for maintaining the current status of their credentials and shall comply at all times with Federal and State requirements applicable to their respective disciplines. To ensure compliance, TGH may require evidence of the individual having a current license or credential status.

TGH will not allow any healthcare partner or independent contractor to work without valid, current licenses or credentials. See the Verification of License, Certification, or Registration policy.

Principle 6 - Protection of Assets
All TGH healthcare partners will strive to preserve and protect TGH's assets by making prudent and effective use of TGH resources and properly and accurately reporting its financial condition.

Standard 6.1 - Internal Control

TGH has established control standards and procedures to ensure assets are protected and properly used and financial records and reports are accurate and reliable. All TGH healthcare partners share the responsibility for maintaining and complying with required internal controls.

Standard 6.2 - Financial Reporting
All financial reports, accounting records, research reports, expense accounts, time sheets, and other documents, must accurately and clearly represent the relevant facts and the true nature of a transaction. Improper or fraudulent accounting, documentation, or financial reporting is contrary to the policy of the Hospital and may be in violation of applicable laws. Refer to Leadership (LD), Human Resources (HR), and Management of Information (IM) sections of the TGH Policy Manual for specific policies related to financial reporting.

Standard 6.3 - Travel and Entertainment
Travel and entertainment expenses should be consistent with job responsibilities and TGH's needs and resources. It is TGH's policy that a TGH healthcare partner should not suffer a financial loss nor receive a financial gain as a result of business travel and appropriate and/or approved entertainment. TGH healthcare partners are expected to exercise reasonable judgment in the use of TGH assets and to comply with TGH policies relating to travel and entertainment expenses.

Standard 6.4 - Personal Use of Corporate Assets
All TGH healthcare partners are expected to refrain from converting assets of TGH to personal use. All property and business of TGH shall be handled in a manner designed to further TGH's interest, rather than the personal interest of an individual. TGH healthcare partners are prohibited from the unauthorized use or taking of TGH open and/or used equipment and supplies, materials, or services. TGH healthcare partners shall obtain the approval of their manager or director prior to engaging in either of the following activities: (1) activities on TGH time which will result in remuneration to the TGH healthcare partner, or (2) the use of TGH open and/or used equipment and supplies, materials, or services for personal or non-work-related purposes.

Standard 6.5 - Computers, E-Mail, and Electronic Communications
TGH's electronic devices, such as computers, facsimile machines, copiers, pagers, and telephonic communications systems are the property of TGH and are to be used for job-related purposes.

All information related to, transmitted to or from, or stored in these devices (including passwords) are also the property of TGH. Healthcare partners are not permitted to use a password to access, alter, copy, or retrieve any stored communications unless authorized to do so. TGH retains the right to monitor any and all systems at its discretion, including listening to and/or reading voice mail, E-mail messages, and Internet web sites. Specifically, access to inappropriate media sites, such as pornographic sites, is prohibited. Any other use requires permission from management. A member of Leadership (Manager, Director, or Vice President) must approve all "Everyone" emails originating in their department.

TGH provided electronic devices and computer software, such as, but not limited to, telephone and similar communications devices and systems, email/webmail, TGH Team member portal, pagers, patient care applications, business intelligence applications, financial applications and departmental applications, represent TGH's primary forms of business communication and recordkeeping. As such, utilizing these forms of communication and record keeping, in accordance with TGH's standard practice or established policy, is required of all healthcare partners. It is each healthcare partner's responsibility to report faulty devices or systems, immediately, to ensure effective communication and record keeping is facilitated and maintained.

Principle 7 - Legal Compliance
TGH will strive to ensure that all activity, by or on behalf of TGH, is in compliance with applicable laws.

Standard 7.1 - Environmental
It is the policy of TGH to manage and operate its business in a manner which respects our environment and conserves natural resources. TGH healthcare partners will strive to utilize resources appropriately and efficiently, to recycle where possible, and otherwise dispose of all waste in accordance with applicable laws and regulations, and to work cooperatively with the appropriate authorities to remedy any environmental contamination for which TGH may be responsible. Refer to TGH's Safety policies on hazardous waste for related information.

In helping TGH comply with environmental laws and regulations, TGH healthcare partners must understand how their job duties may impact the environment. There must be adherence to all requirements for the proper handling of hazardous materials. Any situation regarding the discharge of hazardous substance, improper disposal of medical waste, or any other situation which may be potentially damaging to the environment, must be immediately reported.

Standard 7.2 - Emergency Treatment
TGH follows the Emergency Medical Treatment and Active Labor Act ("EMTALA") in providing emergency medical treatment to all patients, regardless of ability to pay. Provided TGH has the capacity and capability, anyone with an emergency medical condition is treated and admitted, based on medical necessity. In an emergency situation or if the patient is in labor, financial and demographic information will be obtained only after an appropriate medical screening, examination, and necessary stabilizing treatment (including treatment for an unborn child). TGH does not admit, discharge, or transfer patients simply on their ability or inability to pay.

All TGH healthcare partners have a responsibility to understand that their role in ensuring that all people who request medical assistance, within the buildings or any place on the premises, are directed or taken to the Emergency Department or clinic registration desk.

Patients will only be transferred to another facility at the patient's request or if the patient's medical needs cannot be met at TGH (e.g., TGH does not have the capacity or capability) and appropriate care is knowingly available at another facility. Patients may only be transferred in strict compliance with the EMTALA guidelines.

Emergency Medical Treatment and Active Labor Act (EMTALA)
The Federal EMTALA anti-patient dumping laws require a hospital to provide emergency medical treatment to all patients, regardless of ability to pay. This would include, among other requirements, a medical screening examination, stabilizing the medical condition, obtaining acceptance to transfer, and imposes specific hospital and physician responsibilities.
Florida Access to Care

- Similar to the Federal EMTALA regulations, with a few differences.
  - Requires that, when applicable, the patient be transferred to the geographically closest, most appropriate hospital, with the capability and capacity.
  - Applies to inpatient situations
- The Agency for Health Care Administration (AHCA) provides an inventory list of hospital emergency services provided by each hospital in the State.
- Requires that the transferring hospital receive the patient back, once the emergency condition has been resolved.
- AHCA may deny, revoke, or suspend a license, or impose an administrative fine.

ADMINISTRATION OF THE CORPORATE CODE OF CONDUCT

TGH expects each person to whom this Code of Conduct applies to abide by the principles and standards set forth herein and to conduct the business and affairs of TGH in a manner consistent with these principles and standards.

Failure to abide by this Code of Conduct, or the guidelines for behavior which the Code of Conduct represents, may lead to disciplinary action, up to and including termination of one's employment or affiliation with TGH. For alleged violations of the Code of Conduct, TGH will weigh relevant facts and circumstances. The extent to which the behavior was contrary to the express language or general intent of the Code of Conduct, the level of egregious behavior, the person's history with the organization, as well as other factors which TGH deems relevant to the situation, will be considered. Nothing in this Code of Conduct is intended to, nor shall be construed as, attempting to provide any additional rights to team members or other persons.

New TGH healthcare partners will sign a "**Code of Conduct Acknowledgement Form" (Form #H124)**; "**Potential Conflict of Interest Disclosure Form";** and **"Core Values - Signature Form" (Form #C1709)** upon hire and/or appointment. All TGH healthcare partners will be required to sign the Code of Conduct Acknowledgement Form for verification of review and understanding of the Code of Conduct, the TGH Core Values Signature Form, and Potential Conflict of Interest Disclosure Form. Thereafter, the TGH Core Values Signature Form will be signed by all TGH healthcare partners once a year; and only leadership and key team members (defined in policy **CCP 107 Potential Conflict of Interest – TM**) are required to complete the **Potential Conflict of Interest Disclosure Form**. The form is collected and maintained by HR during the onboarding/hiring process and is then collected annually by the Corporate Compliance & Privacy Department in the first quarter of the fiscal year.

Tampa General Hospital
POLICY & PROCEDURE

X Organizational _ Hospital __ Ambulatory Services __ Departmental

Title: Standards of Attire

Original Issue Date: 9/1996 Review Date: Revision Date: 9/2020	**Number: HR 088**	**Page:** 1 of 5

Originating Department: Human Resources **Approved by:** Qualenta Kivett

PURPOSE: Dress and grooming are not only an indication of each Team member's personal pride, but also an expression of Tampa General Hospital's overall high standards. It is important that each team member presents a personal appearance in which both the patients and public alike can place their confidence.

POLICY: It is the policy of Tampa General Hospital to require personal hygiene, grooming, dress, and appearance of staff, to meet appropriate dress code standards while on duty. As such, TGH team members should avoid extremes in dress, grooming, and personal appearance. Considering that appropriate dress is based, in large part, on an individual's perception, TGH management reserves the right to make the final decision on appropriate attire.
Infection Control Standards or Department Policy, such as required uniforms, may supersede this policy's general dress standards. Tampa General Hospital requires certain team members to wear scrubs or other attire for infection control purposes. These team members are the only group of team members that are approved to wear hospital-supplied scrubs.

PROCEDURE: Many departments and units require team members to wear designated uniforms or scrubs, while others only require appropriate business attire. Managers are required to communicate their expectations, relative to wearing apparel, to new employees at the unit or department orientation and, periodically, address the expectations with existing team members. Managers are expected to ensure that team members are dressed and groomed appropriately, based on the guidelines in this policy and the TGH culture.

I. UNIFORMS AND CLOTHING

A) Uniforms Not Required:

1. Some departments do not require a uniform in the traditional sense; however, standards of attire do apply in those departments. As an example, departments that do not require a uniform may require male team members to wear a jacket and tie.
2. Team members, who accept a position that does not require a uniform, will be notified of the appropriate standards of attire during the departmental orientation.

B) Uniforms Required:

1. Uniforms are required for certain job titles and by certain departments.
2. A uniform may consist of scrubs or specific type, style, and color of clothing.
3. Team members, who accept a position that requires a uniform, will be notified of that requirement during the departmental orientation. TGH will provide two sets of required scrubs upon employment for those patient care team members at a pay grade 14 or lower. Additionally, during the course of employment, team

members at a pay grade 14 or lower may receive vouchers for replacement uniforms at management's discretion. All other uniforms are to be purchased at the team member's expense.

4. TGH has established color-coded scrub requirements for all staff that provide hands-on patient care. (Note: All uniforms will be acquired through an established TGH vendor.) This allows patients to easily identify the healthcare provider's role based on the color they are wearing. The following list identifies the designated scrub colors for caregivers:

   Clinical Nurse – Navy
   PCT – Red
   LPN – Chocolate
   CMT/UC – Purple Dress Shirt and Black Scrub Bottoms or Black Pants
   Paramedic – Caribbean Blue
   Respiratory – Royal Blue
   Phlebotomists – Grey
   Pharmacy – Maroon
   Radiology and Imaging – Black
   Rehab Therapies – Forest Green
   Lift Team – Teal
   MAT – Sage Green
   Biomed – Pewter
   Neuro Tech - Purple
   Transporter I – Ceil Blue Top and Black Pants
   Transporter II – Olive Green Top and Black Pants

5. Scrub Jackets may be worn in clinical areas; however, the jacket must either be white in color or match the established scrub color for each position. Additionally, undershirts may be worn underneath scrubs. Undershirts must either be white, black or match the color of scrubs being worn.
6. Shoes worn in clinical settings must be a neutral color and appropriate for patient care areas.
7. In non-direct patient care areas, staff may also have required uniforms. As above, two sets of the required uniform may be provided at initial employment with the department. Replacement uniforms may also be provided at management's discretion.

C) **TGH Scrub Authorization for Use:**

1. TGH scrubs are defined as specialty apparel provided by Tampa General Hospital, including pants and shirts, which are to be worn at the direction of the Infection Prevention Committee or Hospital Administration.
2. Team members assigned to the following departments or units, have been authorized to wear TGH scrubs:
   - Operating Rooms, Main, Cardiac, and Surgery Center
   - Post Anesthesia Care Unit (PACU)
   - Burn Unit
   - Labor & Delivery Newborn Nursery
   - Neonatal Intensive Care Unit
   - CVC Interventional Labs
   - GI Lab
   - Sterile Processing and Supply Distribution
   - Pharmacy (in areas listed above)
   - Radiology (Invasive procedures only)
   - Histology/Cytology
   - Respiratory Therapists (in areas listed above)
   - Patient Transport (in areas listed above)
   - Lift Team (in areas listed above)
   - Biomed (in areas listed above)

- Other staff working in areas listed above

3. Staff members in clinical areas authorized to wear TGH issued scrubs should wear appropriate and professional dress when entering and leaving TGH campus. Please see section E for further clarification of professional dress.
4. So that infection control standards are not compromised, TGH scrubs should not be worn when exiting the building. Team members who exit Tampa General wearing scrubs or having scrubs on their person, that are the property of TGH, will be subject to disciplinary action, up to and including discharge.

D) TGH Scrub Control

1. Scrub attire is provided to authorize users via scrub dispensing equipment. Each authorized user will be given (3) credits to be used to access the scrub dispensing system. After the initial issue of scrubs, subsequent scrubs will be provided based on the return of the soiled scrub attire to the equipment. User's access to the scrub dispensing equipment is achieved by badge access.

2. Staff who does not work for authorized departments to wear scrubs, as mentioned above, but who must enter the above mentioned areas to provide a service, must obtain scrub attire from the scrub dispensing equipment by super user access cards. After the assigned work function has been completed, the scrub attire must be returned to the super user and scrub dispensing equipment for proper credit.

3. Scrub attire not returned to the scrub dispensing equipment requires the area department management to follow up with staff to obtain scrubs back. Staff will not be given additional credits until scrubs are returned.

4. TGH scrub attire may be temporarily provided to staff when non-hospital issued uniform has been contaminated. The scrubs can be obtained by notifying the linen service department.

5. Laundry services are provided for TGH-owned scrub attire. For the safety of our patients, these scrubs are to be worn within the hospital and removed prior to leaving TGH property.

6. New TGH team members will be added to the system after completing the required form provided to them at orientation. The information needed will be 1) name, 2) work area, 3) RFID # located on the back of their badge, and 4) scrub size. Notification of staff that change areas or are terminated will be provided to the IT Analyst thru the terminated team member report sent via Operations.

E) Clothing and Uniform Guidelines for All Team Members:

There are general standards of attire required of all team members, regardless of whether they occupy a position that requires a uniform or work in a department where there is no uniform requirement. These general standards of attire are listed below and are required to ensure that TGH maintains its position of excellence and professionalism:

1. Clothing, including, but not limited to, uniforms and scrubs, should be clean, ironed, in good repair, and fit properly.
2. Clothing, including, but not limited to uniforms and scrubs, should not appear too tight, too short in length, faded, or in need of repair.
3. Extreme, unprofessional, or non-conventional styles are inappropriate**.** This would include, but not be limited to, the following:
    - Tank tops, halter tops or t-shirts
    - Shorts, including wrap-style shorts

- Sleeveless tops or dresses without a jacket are prohibited in patient care areas
- Short skirts
- Cocktail or evening type wear
- Open backs or items that expose the body to a degree that represent an unprofessional appearance (i.e., open midriff styles).

4. Extreme, unprofessional, or non-conventional fabrics and materials are also inappropriate. This would include, but not be limited to, the following:
   - Spandex or clinging knits
   - Metallic or sheer fabrics
   - Denim skirts or jeans of any color
   - Sweatpants
   - Patterns that have large company and non-company logos
   - Patterns that suggest extremely casual sportswear
5. Shirts with collars that display the Tampa General Hospital logo are permissible, with the approval of the department management.
6. Shoes must be professional and safe for the work environment. Open shoes (i.e., Crocs or sandals) with holes on top cannot be worn in patient care areas in which there is a potential for blood exposure. In areas in which blood spills are likely (i.e., OR, Trauma), shoe covers must be worn. Socks may be required by department guidelines.

II. GROOMING, PERSONAL APPEARANCE, AND IMAGE

A) Hair and Hairstyles:

1. The Tampa General culture does not permit extremes in hair dyeing, bleaching, or coloring. If the hair color is changed, it must be natural looking and well maintained.
2. Hair must be clean and well kept. Haircuts/styles must be appropriate for a professional workplace. Extreme hairstyles will not be permitted.
3. Team Members with hair exceeding shoulder length, which have contact with patients or food, must have their hair pulled back, tied up, or they must wear a hair net.
4. Mustaches, beards, and sideburns must be clean and trimmed.
5. Artificial hair is permitted, provided it meets all of the above requirements.

B) Cosmetics, Fingernails, and Jewelry:

1. Fingernail polish must be in good repair, be of one color, and fingernails must be kept at a reasonable length. Artificial nails are not permitted for team members working in direct patient care and those who handle or reprocess equipment, supplies, or instruments. Refer to **"Artificial Nails" policy IC-46 (available on the TGH Portal)** for more detail.
2. Fingernail piercing is not allowed.
3. Team members may wear jewelry in moderation; however, due to Safety and Infection Control guidelines, staff in some areas may not be permitted to wear jewelry.
4. Team members should only wear earrings that are professional in appearance. Dangling jewelry/ earrings are not acceptable in patient care areas.
5. Team members may wear earrings, not to exceed two (2) per ear. If additional earrings are worn, they must not be visible or must be removed.
6. Team members must cover any body-piercing jewelry, other than earrings.
7. If bandages are worn to cover piercings/jewelry, the color of the dressing should be plain and match the color of skin tone as closely as possible.

C) Hygiene:

1. All team members are expected to practice good hygiene to ensure that patients and their families have a positive perception of our staff and to ensure Infection Control procedures are followed.
2. Team members must take steps to avoid offensive odor, such as strong perfumes, strong cologne, and body odor, in consideration of patients, visitors, and fellow team members. In some patient care areas, perfumes and aftershaves may not be permitted.

D) Miscellaneous Guidelines:

In order to provide our patients and their families with a sense of security while in the hospital and to enhance our professional image, the following guidelines are required:

1. Team members must wear their I.D. badge while on duty, on their upper torso, with photograph and name plainly visible.
2. Tattoos must be covered at all times.
3. Exceptions to the dress policy may be made for hospital-sponsored events, such as Hospital fund-raisers for the Foundation, Heart Association, etc.
4. Requests for an exception to this Dress Code policy, based on a medical condition, ethnic background, or other reasons, must be presented to Employee Health Services and/or Human Resources, with supporting documentation. The request will be evaluated. The team member and their manager will be notified of the outcome.
5. Management has the final decision on interpretation of this policy and all questions related to the Tampa General Hospital Dress Code.
6. Initial violation of policy should be addressed with coaching. Team members may be sent home to change if they are out of compliance with required dress codes. After appropriate coaching, disciplinary action may be necessary for repeat offenders.

Tampa General Hospital
POLICY & PROCEDURE

__Organizational _X_ Hospital __ Ambulatory Services __ Departmental

Title: Suicide Prevention and Baker Act Patients		
Original Issue Date: 09/2022 Last Review Date: Last Revision Date: 10/9/2023	**Number: BST 100**	**Page:** 1 of 13
Originating Department: Nursing	**Approved by:** Wendi Goodson-Celerin, SVP and CNO	

POLICY: Suicide Prevention and Baker Act Patients

PURPOSE:
To provide safe care delivery for suicidal patients, and patients under a Baker Act or other court-ordered involuntary hold.

SUICIDE SCREENING AND ASSESSMENT:

Screening

- At a minimum on admission, inpatient adults, obstetrical, and pediatric patients age 12 and older who are being evaluated or treated for behavioral health conditions as their primary reason for care will be screened for suicidal ideation using the Columbia Suicide Severity Rating Scale (C-SSRS). Patients who are being seen for a suicide attempt will be considered high risk until further evaluated with the C-SSRS. The C-SSRS and SAFE-T will be used to assess suicidality.
- At a minimum, the Emergency Department will screen all patients, age 12 and older, for suicidal ideation who are being evaluated or treated for behavioral health conditions as their primary reason for care using the Columbia Suicide Severity Rating Scale (C-SSRS). Patients who are being seen for a suicide attempt will be considered high risk until further evaluated using the C-SSRS. The C-SSRS and SAFE-T will be used to assess suicidality. Ambulatory areas will follow Attachment D- Ambulatory Guidelines: Suicidal Patient or Suicidal Caller.
- Initial mitigation strategies will be implemented based on the patient's screening results as follows:
    - **High Risk:**
      Immediate 1:1 supervision, the observer will maintain line of sight with the ability to immediately intervene
      Room sweep: Any items that can be used for self-harm, that can be removed, and are not required for care delivery will be removed from the room prior to the patient being placed in the room

Note: Camera visualization may only be utilized in lieu of direct line of sight in the event that there is an immediate risk to the observer (i.e.: violent patient). In those instances, the observer will still maintain the ability to immediately intervene.

- **Moderate risk:**

Patient will be observed via remote camera visualization and a room sweep will be performed prior to patient entering the room as above.

- **Low Risk:**
  No special precautions are required

Assessment

All patients who screen positive for suicidal ideation will have an evidence-based suicide assessment (SAFE-T assessment) completed. The combined screening and assessment will directly ask about suicidal ideation, plan, intent, suicidal or self-harm behaviors, risk factors, and protective factors by an appropriately trained individual (licensed provider or behavior support team member).

- Upon completion of the suicide risk assessment, the patient's level of risk for suicide will be reclassified as either low, moderate, or high.
- An order from the provider is required to downgrade the patient from high-risk suicide intervention/mitigation strategies (i.e.: 1:1) to a lesser level (i.e.: video monitoring).
- This assessment is used to help identify the suicide risk level as either low, moderate, or high.
- Once the assessment is complete, the following actions will be taken based on assessed risk level:
  1. ***Low Suicide Risk- No special precautions are required*.**
  2. ***Moderate suicide risk-*** Patients who score as moderate risk on the evidence-based suicide risk tool, require the patient to be placed in a video monitored room (or 1:1 if no video monitored room available).
  3. ***High Risk for suicide***: Patients who score as "high-risk" on the evidence-based suicide risk tool will be assigned a 1:1 bedside sitter. Patient will remain with a 1:1 bedside sitter unless the provider downgrades the risk rating from "high" to "moderate or low" risk, at which point video monitoring then becomes an acceptable form of observation.

Beyond the initial admissions process, all areas will respond promptly to patient verbalizations of suicidal ideation, intent, related behavior and implement the same steps of screening, assessment, and interventions. The first intervention is to ensure the patient is placed on 1:1 observation.

If a patient that is not under any legal hold expresses homicidal thoughts or ideations toward an identifiable victim or victims, promptly notify the provider. Additionally, notifications should be made to the Tampa Police Department and the Office of Patient Safety.

Safety Plan

Every patient that is assessed as high or moderate risk for self-harm will have a safety plan initiated and completed prior to discharge using the Stanley Brown safety plan. It can be initiated by the BST or other trained individuals.

Considerations:

A. A team member is required to accompany all moderate and high suicide risk patients to non-video monitored areas, such as the bathroom. A security team member should accompany patient tor ALL off-unit testing areas (such as CT, MRI, HD, etc.). Patient will not be allowed off unit unless specifically ordered by the physician for medical necessity AND will be accompanied by the assigned 1:1 team member and security escort.

B. A patient who is on a ventilator and is sedated without purposeful movements does not require a 1:1 sitter (unless otherwise specified by the physician). Immediately prior to discontinuing

sedation, a 1:1 sitter will be assigned. The clinical team will promptly notify the BST RN or psychiatry to reassess the patient's level of suicide risk. Following this assessment, the patient will be placed on the appropriate level of monitoring as outlined above.

C. All Baker Act patients require constant observation when they are in a non-video monitored area or off the unit for testing.

IMMEDIATE ACTIONS:

If suicidal behaviors are present or if the patient presents as a harm to themselves or others:

1. Immediately place patient with a 1:1 sitter until suicide risk can be assessed.
2. Notify Security to assist with placing the patient in a gown and to collect and secure the patient's belongings.
3. Notify provider
4. Enter a suicide precaution order.
5. Place a referral for the BST RN (a.k.a. psychiatric resource nurse), who will use an evidence-based suicide risk assessment to determine suicidal risk. If the BST RN is unavailable, another competent RN such as the Rapid Response Team should complete the evidence-based assessment.
6. Initiate appropriate monitoring for patient's assessed risk level (see above for low, moderate, or high risk)
7. The Behavioral Support Team (BST) RN will initiate the NIPP Psychiatric Resource Nurse Protocol, which includes an inpatient consult for psychiatry.
8. Add Suicide Safety Checklist to EMR and complete immediately. Remove any at-risk items from room, while maintaining situational awareness of items that must remain in the room but presents a potential risk.
9. 1:1 sitter or video monitor tech will perform behavioral documentation at least once per hour. This documentation is to be labeled and scanned into the media section of the medical record daily.

ONGOING NURSING INTERVENTIONS:

1. Complete the "Suicide Safety Checklist" flowsheet in the EMR at least one time per shift.
2. Educate patient and family, as applicable, on safety restrictions implemented.

3. Update Plan of Care daily and include discharge planning. Include the patient and family in the care planning process.

4. Ensure consult to Pastoral Care is place if appropriate, or if requested by the patient.

5. Ensure consult to Social Worker is placed if appropriate

6. Communicate changes in the patient's condition. Call a Code BERT (Behavioral Emergency Response Team) if the patient begins escalating and is not redirectable. Call a Code Gray if the patient's behavior begins making threatening remarks or displays aggression towards self or others.

7. Ensure the Stanley Brown safety plan is completed prior to AVS printing and review with the patient prior to discharge. If the patient has any questions or concerns call the BST.

Reassessment

- The Suicide Risk Assessment should be completed once per day by the Behavioral Support Team or another trained team member. Patients will be maintained at the appropriate level of monitoring based on their current assessed level of suicide risk. If a patient's level of assessed risk changes from the previous assessment, the provider should be notified, and appropriate monitoring should be initiated.

Additional Considerations

A. Patients who voice suicidal thoughts are not able to independently sign out AMA until their suicidality has been assessed by a physician.

B. In select instances, the psychiatrist may write an order for a patient to visit a pre-established enclosed area for therapeutic healing. This would exclude outdoor hospital grounds. Patients that are expressing current suicidality are prohibited from leaving the unit unless for medically necessary testing or procedures.

C. If the patient is on a police hold and assessed to be a suicide risk, appropriate monitoring must be maintained. The police escort does not take the place of a 1:1 sitter or video observation. Staff should confirm that the officer is aware to remain in the patient's room, within sight of the patient, and maintain one arm's length during all care procedures and while hospital staff are present. This includes when a patient is escorted to the bathroom by staff.

BAKER ACT PATIENTS

Baker Act

The Florida Baker Act law allows doctors, mental health professionals, judges, and law enforcement to commit a person for up to 72 hours if they meet the specific Criteria. See Attachment A- Baker Act Overview. Attachment B - When the Patient Lacks Capacity, and Attachment C- Duties of the Hospital, Maintaining the Baker Act Patient's Rights.

Physician/Psychiatrist

1. Examines the patient and initiates/completes - Certificate for Professional Initiating Involuntary Examination Form (CF-MH 3052b) if patient meets criteria.

2. If the patient is medically clear, stable for transfer, and requires a hospital admission solely for psychiatric services, transfer the patient to a Baker Act receiving facility pursuant to EMTALA policy and guidelines.

3. If the patient does not meet criteria for Baker Act:
    - If Certificate for Professional Initiating Involuntary Examination form (CF-MH 3052b) was already completed prior to exam – release the person from the Baker Act.
    - Discharge a patient who is medically stable.

RN Actions:

1. Once Baker Act is initiated, staff should implement all items from above under "Assessment," "Immediate Actions" and "Ongoing Nursing Interventions."

2. The primary RN will review Baker Act paperwork and place a consultation to Case Management/Social Worker and scan into EMR. The BST RN may also be resourced for questions related to the Baker Act paperwork or process.

3. If a patient is placed on a Baker Act after admission, the RN will notify the attending physician, place a consult to case management/social work, and implement all items from above under "Assessment", "Immediate Actions" and "Ongoing Nursing Interventions."

4. Once the patient is under Baker Act status, he/she is not allowed to leave TGH until he/she is released from the Baker Act, or the patient is transferred to a Baker Act receiving facility.

Case Manager/ Social Work (CM/SW) Actions:

1. The CM/SW coordinates the implementation of Baker Act proceedings.

2. Upon consultation, Social Work/Case Management will ensure that the EMR indicates that the patient is on a legal hold.

3. Once MD places order "Medically Cleared for Psych," CM/SW makes arrangement to transfer to a Baker Act receiving facility (refer to Case Management Procedure and EMTALA policy).

4. CM/SW continues to contact receiving facilities until an appropriate transfer can be arranged. If the delay is greater than 12 hours, notify DCF and AHCA at the 12-hour time via email two times a day until placed.

5. Once accepted at the appropriate Baker Act receiving facility, transportation will be arranged.

PATIENT EDUCATION/TEACHING:

Patients and family will be provided with suicide prevention education and a community resource list for crisis intervention and counseling (available in the After Visit Summary).

CONSIDERATIONS FOR MINORS ON BAKER ACT

When the patient is a Minor on a Baker Act, and the examining physician has determined that the patient continues to meet the criteria for a Baker Act, but the parent or guardian refuses the safe transfer of the patient to a receiving facility, the following steps should be taken:

1. The treating Physician and team should discuss options with the parent/guardian to determine if the parent/guardian has a preference for a receiving facility. If so, the team should honor that preference if possible. The team should remind the parent/guardian that the physician believes the patient continues to meet the criteria for a Baker Act and that the immediate goal is for the safety of the patient and support for the parent/guardian to ensure this safety.

2. If parent/guardian continues to refuse transfer, the team should inform the parent/guardian, that because a physician has determined that it is necessary for the safety of the patient for the patient to be held for treatment, that the hospital will file a petition with the court asking the judge to intervene and order the patient be transferred to a receiving facility.

3. If the parent/guardian continues to refuse a safe transfer, Case Management shall initiate the petition to the court. The Office of Patient Safety (aka Risk Management) is also contacted.

4. In the interim, if the parent/guardian attempts to leave with minor patient, DCF should be contacted. TPD or Security should not prevent the parent from taking the child.

5. The events, refusals, disclosures, discussions with parent/guardian and parent/guardian refusals must be documented in the patient's medical record.

Attachments:

Baker Act overview: Attachment A

Consent for Treatment when the physician has determined that the patient lacks capacity to provide informed consent**:** Attachment B

Duties of the Hospital, Maintaining the Baker Act Patient's Rights**:** Attachment C

TGH Ambulatory Guidelines: Suicidal Patient or Suicidal Caller*:* Attachment D

Attachment A

Baker Act Overview:

SUPPORTIVE DATA: (Baker Act 52) Petition for Involuntary Examination
(Baker Act 40) Voluntary Admission for Psychiatric Care
(Baker Act 32) Petition for Involuntary Placement
(Baker Act 8) Court ordered for Involuntary Treatment for up to 6 months
(Ex Parte) Court ordered Involuntary Examination

Under the Baker Act (BA52 Petition for Involuntary Examination), a patient may be held involuntarily for up to 72 hours. This 72-hour period is intended to allow time for the patient to be psychiatrically evaluated for danger to self or others, or the likelihood to suffer from neglect without care or treatment. Tampa General Hospital cannot hold patients beyond this 72-hour period under the Baker Act.
Per Florida Statute 394.463 (2)(g), the 72-hour period begins when the patient arrives at the hospital, is suspended when the attending physician documents that the patient has an emergency medical condition and resumes after the attending physician has documented that the patient is stabilized and that the emergency medical condition does not exist. Our 'clock' begins when the MD orders "Medically Cleared for Psych" under the behavioral health services order.

DEFINITIONS:

- **"Incapacitated"** means that a person has been adjudicated incapacitated pursuant to Part V of Chapter 744 and a guardian of the person has been appointed.

- **"Incompetent to consent to treatment"** means that a person's judgment is so affected by his or her mental illness that the person lacks the capacity to make a well-reasoned, willful, and knowing decision concerning his or her medical or mental health treatment.

- **"Mental Illness"** means an impairment of the mental or emotional processes that exercise conscious control of one's actions or of the ability to perceive or understand reality, which impairment substantially interferes with a person's ability to meet the ordinary demands of living, regardless of etiology. The term does not include retardation or developmental disability, intoxication, or conditions manifested only by antisocial behavior or substance abuse impairment.

- **"Receiving Facility"** means any public or private facility designated by the Department of Children and Families to receive and hold involuntary patients under emergency conditions or for psychiatric evaluation and to provide short-term treatment. The term does not include a county jail.
- "**Stable for Transfer**" for psychiatric conditions, for purposes of transferring a patient from one facility to a second facility, means that the patient is unlikely to experience a deterioration of condition during or because of a transfer.

1. A person may be taken to a Baker Act receiving facility or a hospital for an involuntary examination if there is reason to believe the person is mentally ill and because of this mental illness:

A. The person has refused a voluntary examination after explanation and disclosure of the purpose of the exam,

OR

B. The person is unable to determine whether an examination is necessary,

AND

C. Without care or treatment, the person is likely to suffer from neglect or refuse to care for himself/herself; such neglect or refusal poses a real and present threat of substantial harm to his/her wellbeing and is not apparent that such harm may be avoided through the help of willing family or friends or the provision of other services,

OR

D. There is substantial likelihood that without care or treatment the person will cause serious bodily harm to self or others in the near future, as evidenced by recent behavior.

2. An involuntary examination may be initiated by:

A. Court ordered Ex Parte Order for Involuntary Examination form (CF-MH 3001) stating the person appears to meet criteria for involuntary exam. If no time is specified in the order, the order shall be valid for seven (7) days after the date the order was signed. A law enforcement officer must take the person named in the certificate into custody and deliver him/her to the nearest receiving facility. Social work should be notified of the law enforcement officer's arrival and note where the patient was taken and the deputy's name. The officer's written report and the certificate shall be scanned in and made a part of the patient's medical record. A nurse-to-nurse report should be called to the receiving facility.

B. A law enforcement officer shall take a person who appears to meet criteria for involuntary examination into custody and deliver the person to the nearest receiving facility for examination. An officer's written report form (CF-MH 3052A), detailing the circumstances under which the person provides assistance with the transfer, must be made a part of the patient's medical record and the facility must send a copy to AHCA on the next working day.

C. The psychiatrist or other physician may execute a certificate form (CF-MH 3052B) stating that he/she examined a person within the preceding 48-hours and found that the person appears to meet the criteria for involuntary examination and stating the observations of the authorized professional upon which the conclusion is based. Upon determination by a physician that the person's medical condition has stabilized or that an emergency medical condition does not exist, and the physician places the order into

the EMR, "medically cleared for psych," Social Work will coordinate medical transport to a receiving facility.

Tampa General Hospital is **not** a Baker Act Receiving Facility.

3. A patient shall be examined by a physician, nurse practitioner, physician assistant, or clinical psychologist without unnecessary delay which should include a thorough review of any observations of the person's recent behavior; a review of the document initiating the involuntary examination and the transportation forms; a brief psychiatric history; and a face-to-face examination of the person in a timely manner to determine if the person meets criteria for release.

4. If a patient's behavior presents an immediate danger to the patient or others, Emergency Treatment Orders for the administration of psychotropic medications may only be issued by a physician. (BST 19, Emergency Treatment Orders).

5. The patient may not be discharged during the 72-hour hold period without documented approval to release the patient from the Baker Act, by the psychiatrist or physician in the hospital's emergency department.

6. A patient may not be held for a psychiatric involuntary examination longer than 72 hours.

7. For the person who has an emergency medical condition, the 72-hour period begins when the patient arrives at the hospital and is suspended when the attending physician documents that the patient has an emergency medical condition. The 72-hour period resumes upon the determination by a physician that the person's medical condition has stabilized or that an emergency medical condition does not exist, and the physician places the order into the EMR, "medically cleared for psych".

Attachment B

Consent for Treatment when the physician has determined that the patient lacks capacity to provide informed consent

1. In an emergency situation, exhibiting immediate danger to self or others, treatment may be provided to the patient without consent.
2. In non-emergent situations, consent for treatment may be provided by an existing court appointed guardian, guardian, court order, designated health care surrogate, or Advance Directive. Confirmation should be made regarding whether consent is designated for medical or mental health treatment, or both.
3. In non-emergent situations, in the absence of #2 above (or limited consent-- medical vs. mental health treatment), consent for medical and/or mental health treatment may be obtained from a proxy/surrogate. The determined health care proxy/surrogate (i.e., health care agent) will be notified in writing of his/her authority to consent for treatment for the patient; and how the proxy/surrogate was determined (per Policy RM 102 Right to Refuse Medical Treatment and RI 001 Consent for Medical and Surgical Procedures re. determination hierarchy), will be documented in the medical record.
4. When a proxy/surrogate is determined for consent in the interim, TGH (Tampa General Hospital) (Case Manager) will immediately file a petition for appointment of a guardian advocate. Unless already authorized to consent to medical treatment such as with a court appointed guardian or a health care surrogate, it will be requested that the guardian advocate be granted authority to make medical decisions as well as mental health decisions. If the patient is transferred before the hearing for guardian advocate, the petition will be withdrawn.
5. When TGH files for a guardian advocate, that person is informed of his/her responsibilities, including completion of the guardian advocate training. The training is a 4 hour online (free) program offered by the DCF.https://www.myflfamilies.com/service-programs/samh/crisis-services/training/index.shtml . The guardian is informed that this training must be completed before exercising his or her authority.
6. Note 1: for Minor patients, consent for all treatment is to be obtained by the parent/guardian; unless an emancipated minor.
7. Note 2: if the adult patient has been determined to have capacity, unless in an emergency situation, consent for treatment will be obtained from the patient, unless existing documentation per #2 above indicates otherwise.

Attachment C

Duties of the hospital, Maintaining the Baker Act Patient's Rights:

Persons held under the Baker Act, whether at a designated receiving facility or at a hospital where they may be undergoing evaluation or treatment of an emergency medical condition, must have their rights upheld.

Florida's hospital licensure law places certain responsibilities on all hospitals, not just those designated as Baker Act receiving facilities. Some of these responsibilities are as follows:

395.003(5)(a) Adherence to patient rights, standards of care, and examination and placement procedures provided under Baker Act shall be a condition of licensure for hospitals providing voluntary or involuntary medical or psychiatric observation, evaluation, diagnosis, or treatment. At the discretion of the Charge RN or Unit Manager, personal cell phone use (without a cord) may be granted.

395.1041(6) Rights of persons being treated. A hospital providing emergency services and care to a person who is being involuntarily examined under the provisions of s.394.463 shall adhere to the rights of patients specified in the Baker Act and the involuntary examination procedures, regardless of whether the hospital, or any part thereof, is designated as a receiving or treatment facility and regardless of whether the person is admitted to the hospital.

395.1055(5) AHCA shall enforce Baker Act law and rules, with respect to the rights, standards of care, and examination-placement procedures voluntarily or involuntarily admitted to hospitals providing psychiatric observation, evaluation, diagnosis, or treatment.

395.1065(4) In seeking to impose penalties against a facility for a violation of Baker Act, AHCA is authorized to rely on the investigation/findings by the Department of Health in lieu of conducting its own investigation.

395.3025 Patient and personnel records; copies; examination. This section does not apply to records maintained at any licensed facility the primary function of which is to provide psychiatric care to its patients, or to records of treatment for any mental or emotional condition at any other licensed facility which are governed by the provisions of s.394.4615. This section does not apply to records of substance abuse impaired persons, which are governed by s.397.501.

11. Within the 72-hour exam period after medical clearance, except if the 72 hours ends on a weekend or holiday, then no later than the next working day, the patient shall:

A. Be released unless charged with a crime (then the person must be returned to custody of a Law Enforcement Officer), or

B. Be transferred to a receiving facility.

Attachment D

TGH Ambulatory Guidelines: Suicidal Patient or Suicidal Caller

1. When a patient in an off-site ambulatory location without a physician present, verbalizes suicidal ideation (thoughts of wanting to harm self) or intent to harm self, or demonstrates related behavior, a 1:1 is immediately assigned to monitor the patient and ambulance transport is arranged by calling 911, with the request for the patient to be transported under close observation to the nearest hospital emergency department for evaluation, with consideration to a receiving facility. ED is contacted so they are aware of transport. If transport is to TGH ED, the ED Communication Desk/Charge Nurse is contacted. Communication with the patient in a calm and reassuring manner, emphasizing that safety for him/her is our priority. If resources are available e.g., contact the Behavior Support Team (BST) RN if on site, or psychology services; they are contacted to assist. The treating physician is notified.
2. **Note:** If the treating physician* is present, he/she will assess the patient before transfer, and if needed, initiate the Baker Act by completing the Baker Act form (found on the TGH Portal). EMS transportation is arranged to a Baker Act receiving facility (if on site, utilizing TransCare Ambulance Transport.) Follow TGH policy BST 074 Baker Act Patients. *A Clinical SW/Psychologist/MH Counselor may also initiate the BA52 prior to patient being transported to a hospital ED for physician evaluation.
3. While the patient is waiting for the ambulance, the 1:1 always maintains constant visualization of the patient, including if the patient is using the bathroom. A same/preferred sex 1:1 is assigned unless not available. Assistance of another team member is recommended to be immediately available for the 1:1 if on location and able to support.
4. The patient is requested to hand over all belongings (empty out pockets) to be held temporarily by a team member and then provided for transport. If the patient refuses, the patient is not forced to comply; but this information is shared with the transport team-- so they are aware of the potential risk.
5. If the off-site patient refuses to be transported, is considered an elopement risk, becomes agitated or attempts to leave, or verbalizes homicidal ideation, this information is provided when calling 9-1-1 for assistance including transport to the hospital ED (or if physician evaluated, BA52 receiving facility). If a patient attempts to leave, no physical attempt is made to hold the patient; but responding police are provided with the details needed to assist in locating the patient. If on site, security is contacted.
6. With the patient's permission, the patient's family is contacted and informed of a plan.
7. If patient is a minor; it is recommended to the parent/guardian that patient be transported by ambulance to the hospital emergency room for evaluation (or if physician evaluates, to Baker Act receiving facility), and strongly discouraged to not drive patient themselves (if this is suggested by parent/guardian.) Transportation is arranged. If there are any concerns that the parent/guardian is not acting in the best interest of the patient, contact the Department of Children and Family Services and TGH's Office of Patient Safety (formerly Risk Management).
8. When a **Caller** verbalizes suicidal ideation or intent; the team member will attempt to confirm the location of the patient and silently (mute self/hand over mouthpiece) request that another team member contact the police with request to make a wellness check on the patient/take to ED for evaluation. The caller's telephone number is recorded, if displayed. If location is not confirmed by the patient, the police are provided with the last recorded patient address. The patient will be kept engaged on the phone by the responding team member until the police arrive, if possible. If the caller

indicates he/she is going to hang up, provide the National Suicide Hotline Number: 800-273-8255. *Guidance*: Listen attentively to the patient, let the patient know that you are glad he/she called, and you want to understand what he/she is feeling and experiencing, that even if he/she does not believe it now, things can get better. Approach is reassuring and non-judgmental. If resources are available e.g., BST RN if on site, or psychology services, contact them to assist.

9. All patient assessments, intervention and contacts made, as well as belongings transported are documented in the EMR. If the caller is not a patient, this documentation is recorded in the Event System.