INNOVATIONS SHOWCASE

Title

A Living Psychopharmacology Curriculum: Using AI to Extend Faculty Capacity in Residency and Fellowship Education

Primary Category

Teaching, Supervision, Pedagogy

Presenters

Matthew Macaluso, DO, University of Alabama at Birmingham, Gemma Espejo, MD, University of California, Irvine Medical Center, Adam Niolet, MD, University of Alabama at Birmingham, Richard Shelton, MD, University of Alabama Hospital Program - Huntsville

Education Objectives

1. Describe a scalable model for integrating a society-vetted, continuously updated psychopharmacology curriculum into existing residency and fellowship education.

2. Identify opportunities to incorporate expert-developed content, structured assessments, and an AI teaching assistant into didactics, case conferences, clinical teaching, and individualized learning.

3. Apply practical strategies for adopting AI-supported educational resources while preserving faculty oversight, clinical judgment, supervision, mentorship, and clinical role modeling.

Description of Innovation

We developed and are implementing a model in which residency and fellowship programs integrate the American Society of Clinical Psychopharmacology's redesigned Model Psychopharmacology Curriculum, a portable, society-vetted "living textbook," in a manner that augments rather than replaces local teaching.

The curriculum spans Crash, Basic, and Advanced courses and pairs brief content expert videos with high-yield readings, board-style questions, built-in assessments, and an AI teaching assistant that supports curriculum-grounded question answering, explanation, and individualized review, with faculty oversight and safeguards for verification, privacy, and appropriate reliance. Learners can use the curriculum longitudinally, while educators can selectively integrate content into didactics, case conferences, rounds, journal clubs, PRITE/board preparation, and just-in-time clinical teaching.

Content is updated as evidence evolves, reducing the need for individual programs to continually rebuild teaching materials.

Drawing on early implementation across multiple training programs, we will demonstrate how residency and fellowship programs can adopt this model without redesigning their existing curricula and will share updated data on adoption and learner engagement. The model illustrates generativity in education leadership by allowing expert-created content and AI-supported learning to extend faculty capacity while preserving the central roles of faculty judgment, supervision, mentorship, and clinical role modeling.

Description of Interactivity with Audience

- 0:00–1:00 – The problem: expanding psychopharmacology knowledge and uneven local teaching resources.
- 1:00–3:00 – Live demonstration: a learner completing a module and querying the AI assistant, and an educator assigning content for a case conference.
- 3:00–4:00 – Early implementation and engagement experience, presented as feasibility findings rather than outcomes.
- 4:00–5:00 – How residency and fellowship programs can adopt the model: access, onboarding, and preserving faculty-led teaching and supervision.

Scientific Citations

1. Glick ID, Salzman C, Rothschild AJ. Current clinical psychopharmacology integrated practice: the crisis in teaching and its effects on quality of care. J Clin Psychopharmacol. 2026;46:129–131.

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Title

AI in the Service of Trainee Development: A Pilot in Psychodynamic Psychotherapy Supervision

Primary Category

Teaching, Supervision, Pedagogy

Presenters

Ana Ozdoba, MD, Albert Einstein College of Medicine/Montefiore Medical Center, David Stern, MD, Albert Einstein College of Medicine/Montefiore Medical Center, Guiseppe Battaglia, MD, Albert Einstein College of Medicine/Montefiore Medical Center, Vanessa Carroll, MD, Albert Einstein College of Medicine/Montefiore Medical Center

Education Objectives

By the end of this presentation, participants will be able to:

1. Describe a developmental use of generative AI in psychotherapy training that is designed to work in conjunction with, rather than substitute for, human supervision.

2. Identify design principles that preserve trainee-generated material while limiting the software's interpretive and clinical authority.

3. Explain how a structured reflective tool can help trainees organize their own clinical experience without prematurely supplying answers or formulations.

4. Consider how this approach might be implemented and evaluated within psychotherapy training, including what can be learned from early pilot use.

Description of Innovation

This innovation is a self-reflection web-based tool for psychotherapy trainees, designed to be used in conjunction with ongoing human supervision. Its purpose is to help trainees develop their own capacity to notice, articulate and think about what is happening in their clinical encounters.

The trainee begins by giving a thumbnail of the patient and of a situation from an actual therapy session that feels confusing or unresolved. The software works from the trainee's own language, asks one question at a time, and is designed to avoid adding

interpretations, conclusions or material beyond what the trainee has introduced. When the tool asks a question, the trainee can ask for the underlying principle behind it. If the tool goes in a direction the trainee disagrees with, the trainee can simply say stop. Longitudinal case memory allows the trainee to return to prior work and preserves continuity across their reflections on the case.

The design emerged from a problem encountered while building an earlier version of the system. A generative model can produce plausible, sophisticated-sounding interpretations very quickly. In a training context, those interpretations run multiple risks: they can be wrong, they can be harmful, and they can take away some of the practice involved in trying to understand why, not only what. The system was redesigned so the software's authority is limited: it can organize attention and ask follow-on questions, while meaning-making, judgment and clinical authority remain with the supervisor-supervisee dyad.

Initial use is intended to begin within supervision so trainee and supervisor can establish together how to use the tool and where its limits are. Subsequent use can occur between supervision sessions. Use is optional and non-evaluative.

An ongoing pilot is examining engagement, feasibility and the reflective process itself. Preliminary qualitative observations will focus on what trainees bring into the exchanges and how their thinking evolves through use. The broader question is whether generative AI can be designed to support development in the person using it.

Description of Interactivity with Audience

Participants will take part in a brief live stress test of the tool's design. The audience will be asked to suggest a common psychotherapy training situation from their own supervisory experience in which trainees often get stuck. Using a de-identified example, the presenter will enter responses on behalf of a participant. Participants will observe how the tool supports self-reflection and stimulates thinking, as well as how the limits on its scope are architected in real time. The exercise is intended to make the design problem and solution visible through demonstration.

Scientific Citations

1. Markowitz JC, Welton R, Franklin C, Ozdoba A, Ruble A. "Unsafe" Psychotherapy Supervision. American Journal of Psychotherapy. 2026;79(2):78–83. doi:10.1176/appi.psychotherapy.20250002.

2. Shafran R, Bond L, Carlbring P, et al. From innovation to implementation: Artificial intelligence in cognitive behaviour therapy training and supervision. Behaviour Research and Therapy. 2026;197:104945. doi:10.1016/j.brat.2025.104945.

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4. Torous J, Greenberg W. Large Language Models and Artificial Intelligence in Psychiatry Medical Education: Augmenting But Not Replacing Best Practices. Academic Psychiatry. 2025;49(1):22–24. doi:10.1007/s40596-024-01996-6.

5. Cockerill RG, MacIntyre MR, Shima C. Teaching Artificial Intelligence from Conceptual Foundations: A Roadmap for Psychiatry Training Programs. Academic Psychiatry. 2025;49(1):35–39.

Title

Becoming Together: A Longitudinal Community-Based Curriculum for Professional Identity Formation in Psychiatry Residency

Primary Category

Professional Identity Formation (including career development, mentorship, advising, wholeheartedness, meaning/purpose)

Presenters

Lia Thomas, MD, UT Southwestern Medical Center, Julia Chavez, MD, UT Southwestern Medical Center, Adam Brantley, MD, UT Southwestern Medical Center, Nicholas Champagne-Aves, MD, UT Southwestern Medical Center

Education Objectives

Our objective is to develop a longitudinal, structured curriculum for professional identity formation (PIF) within our psychiatry residency program. The curriculum will reduce variability of PIF by reliably exposing residents to critical topics and discussions, including work-life balance, lifelong learning, moral injury, and learning from mistakes. Secondary goals include helping residents develop a more expansive of view of mentor relationships between both peers and faculty, providing senior residents with opportunities to reflect on their own experiences, giving junior residents with a clearer view of what lies ahead, and facilitating mentorship and connection across class years. We will also obtain resident and faculty feedback to guide future improvement of the curriculum and identify additional topics related to PIF for inclusion in future sessions.

Description of Innovation

Building on our existing near-peer and faculty-resident support structure, we developed a year-long curriculum focused on professional identity formation (PIF). The curriculum is embedded within our residency's preexisting "families" structure. Each incoming resident is assigned a "buddy" mentor from the class directly above them, forming longitudinal mentorship chains that remain together throughout residency. Several buddy chains form a "family," with trainees spanning all four years, meeting periodically with consistent faculty mentors.



Previously, family meetings consisted of informal discussions without a curriculum or agenda, leading to variable experiences. Drawing on resident feedback, we designed six structured one-hour sessions, each focused on a predetermined PIF theme. This approach preserves the existing longitudinal community while providing greater consistency and intentionality. It also aligns with the "welcoming community" model, while having faculty share their own reflections and experiences positions them not only "content deliverers," but as "community members" (Cruess et al. 2019).

Session themes were selected by a task force consisting of faculty and resident volunteers to address professional challenges and responsibilities involved in becoming a mature psychiatrist. The six topics are: 1) Work-Life Balance; 2) Life Beyond Residency I; 3) Uncertainty, Ambiguity, and Moral Injury; 4) Lifelong Learning; 5) Countertransference and Boundaries; and 6) Life After Residency II. Topics are sequenced to align with the anticipated experiences during the academic year. For example, Work-Life Balance is discussed early as residents adjust to new schedules and workflows. Life Beyond Residency is revisited at year's end, allowing graduating residents to reflect on job searches, fellowship applications, and other transitions while providing junior residents with practical guidance about what lies ahead. Sessions occur during protected, mandatory didactic time to maximize participation.

Each session has a 1-2 page facilitator guide with recommended time allotments and discussion questions. Sessions begin with a "Mindful Minute," followed by an unstructured check-in that preserves a portion of the prior informal format. Residents then participate in small-group discussions spanning class years before reconvening for a faculty-facilitated large-group discussion. Faculty begin by sharing personal reflections, encouraging vulnerability and modeling reflective practice. Sessions conclude with a brief wrap-up reflection and a "call to action" designed to translate discussion into practical application.

Sessions repeat annually and remain relevant across training levels, allowing residents to revisit them from new developmental perspectives each year. As residents progress, they also assume increasing responsibility as mentors and role models for junior residents, making near-peer mentorship itself an implicit component of PIF. Themes are broad enough to encourage reflection, while discission questions emphasize practical aspects of training. Facilitator guides include more questions than can be addressed in a single session, allowing discussions to evolve each year. Resident and faculty feedback will guide ongoing refinement.



The curriculum deliberately incorporates mentorship, guided reflection, role modeling, and longitudinal engagement, elements identified as important to PIF (De Melo Cunha et al. 2026), within a structured program that can be evaluated and improved over time.

Description of Interactivity with Audience

Audience members will participate in an interactive small group exercise that mirrors one session of this structured curriculum for professional identity formation to gain a deeper understanding of the curriculum's benefits. After being divided into small groups, participants will be invited to focus their awareness on the present moment by engaging in a one-minute mindfulness exercise. Then, each group will be encouraged to share and reflect on clinical experiences pertaining to a predetermined topic. Finally, the exercise will be wrapped up by a facilitator leading a large group discussion to reflect on the exercise and identify other meaningful topics for future professional identity formation sessions.

Scientific Citations

1. Chew QH, Steinert Y, Sim K. Factors associated with professional identity formation within psychiatry residency training: A longitudinal study. Perspect Med Educ. 2021;10(5):279-285. doi:10.1007/S40037-021-00673-W

2. Cruess,SR, Cruess RL, Steinert Y. Supporting the development of a professional identity: General principles. Med Teach. 2019;41(6):641-649. doi:10.1080/0142159X.2018.1536260

3. de Melo Cunha S, Chiesa D, Viana Barroso Ribeiro L, Esmeraldo AG, Landim MA, Sa HL do C. The professional identity formation of undergraduate and postgraduate medical students: An umbrella review. Med Teach. 2026:1-14. doi:10.1080/0142159X.2026.2688552

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8. Koh EYH, Koh KK, Renganathan Y, Krishna L. Role modelling in professional identity formation: A systematic scoping review. BMC Med Educ. 2023;23(1):194. doi:10.1186/s12909-023-04144-0

Title

Beyond the Elective: Building Interventional Psychiatry as a Developmental Curriculum Across Residency

Primary Category

Curriculum

Presenters

Golkoo Hosseini, MD,MS, Perelman School of Medicine University of Pennsylvania, Scott Campbell, MD, Perelman School of Medicine University of Pennsylvania, Zachary Rosenthal, MD,PhD, Perelman School of Medicine University of Pennsylvania, Charles Palmer, MD, Perelman School of Medicine University of Pennsylvania, Mario Cristancho, MD, Perelman School of Medicine University of Pennsylvania

Education Objectives

At the conclusion of this Innovations Showcase, participants will be able to:

1, Describe a developmental framework for interventional psychiatry education that defines foundational knowledge and hands-on experience for all residents while creating progressive pathways for residents seeking greater expertise.

2. Identify key curricular design decisions including timing within residency, allocation of training across ECT, TMS, esketamine, and other neuromodulation modalities, and progression from foundational exposure to advanced competency.

3. Map existing educational resources and potential collaborators within and beyond their institutions including psychiatry, neurology, neurosurgery, neuroscience, anesthesiology, and regional interventional psychiatry practitioners to identify feasible opportunities for building or expanding an integrated interventional psychiatry curriculum.

Description of Innovation

The Penn Interventional Psychiatry Education Program reframes interventional psychiatry from a collection of isolated procedural experiences or senior electives into a developmental curriculum across residency. Beginning in 2022 as a one-week PGY2/PGY3 elective, the program drew greater than 70% voluntary participation and

evolved into a required two-week PGY2 rotation, with additional pathways for residents seeking advanced training.

The curriculum is organized around five principles: early, clinical, hands-on, integrated, and developmental. Interventional psychiatry is introduced during PGY2, rather than reserved for senior elective training, when residents are developing treatment frameworks for patients with severe and treatment-refractory illness. The dedicated rotation allows training time to be intentionally distributed across modalities and educational experiences rather than determined by the resident's assignment to another clinical service.

Residents receive supervised, hands-on training in ECT, TMS, and esketamine treatment delivery. Experiences in VNS, DBS operating-room and programming clinics, interventional psychiatry intake evaluations, translational neuroscience, and didactics broaden understanding of patient selection, brain circuitry, treatment targeting, and longitudinal management. Training emphasizes not only how treatments are delivered, but who should receive them, when they should be considered, how and when to refer, how risks and benefits are discussed, and how interventional treatments are incorporated into longitudinal treatment planning. Modalities are taught together rather than in isolation, allowing shared concepts in neuromodulation and clinical decision-making to become the organizing framework.

The required rotation establishes a foundation for all residents rather than serving as the endpoint. Residents seeking greater depth may progress through a longitudinal Interventional Psychiatry Certificate Program incorporating mentorship, additional clinical experiences, didactics, and scholarship, followed by a PGY4 Junior Attending experience emphasizing graduated autonomy, advanced formulation, longitudinal management, procedural participation, near-peer teaching, and leadership: Required PGY2 Foundation → Certificate/Advanced Training → PGY4 Junior Attending → Scholarship, Teaching, and Leadership.

The framework has subsequently extended beyond the core psychiatry residency curriculum, informing dedicated interventional psychiatry experiences for geriatric psychiatry fellows, neurology residents, and medical students. This expansion demonstrates how a common educational framework can be adapted across disciplines and levels of training.

The model also treats collaboration as curricular infrastructure. Educational experiences connect expertise across psychiatry, neurology, neurosurgery, and neuroscience, and the framework can incorporate additional institutional or regional partners when expertise is not available locally. This allows programs to build from what they have rather than requiring every modality or specialist within a single department.

The innovation is therefore not an individual procedure or rotation, but a scaffolded educational architecture addressing three unresolved curricular questions: when to introduce interventional psychiatry, what and how much every resident should experience, and how interested residents can progress toward greater expertise. The framework is designed to be adapted to each program's available modalities, faculty, partnerships, and educational resources.

Description of Interactivity with Audience

Participants will complete a rapid "Build From What You Have" resource-mapping exercise. A brief audience poll will identify which interventional psychiatry modalities are available at participants' institutions and whether current resident experiences are required, elective, observational, or hands-on. Participants will then identify one existing educational resource and one potential collaborator who could strengthen their curriculum. Collaborators may include psychiatry, neurology, neurosurgery, neuroscience, anesthesiology, regional practitioners, or neighboring institutions. Using the framework "Foundation → Experience → Progression → Partnership," participants will consider: What should every resident know and experience? When should they learn it? How can interested residents progress further? Who could help provide what our program cannot provide alone? Participants will leave with one feasible next step for building or expanding interventional psychiatry education at their institution.

Scientific Citations

1. Menon SN, Torrico T, Luber B, Gindoff B, Cullins L, Regenold W, Lisanby SH. Educating the next generation of psychiatrists in the use of clinical neuromodulation therapies: what should all psychiatry residents know? Front Psychiatry. 2024;15:1397102. doi:10.3389/fpsyt.2024.1397102.

2. Egan D, Bailey KJ, Abu-Hamad S, Kennedy Z, Beck R, Karlay BK, Hubregsen J. A model for formal residency training in interventional psychiatry. Acad Psychiatry. 2024;48(5):431-435. doi:10.1007/s40596-024-02058-7.

3. Lai KSP, Waxman R, Blumberger DM, et al. Competencies for repetitive transcranial magnetic stimulation in postgraduate medical education: expert consensus using a modified Delphi process. Can J Psychiatry. 2023;68(12):916-924. doi:10.1177/07067437231164571.

4. Nikayin S, Taylor JJ, Ostroff RB. Advanced training in interventional psychiatry. J Neurol Sci. 2022;434:120093. doi:10.1016/j.jns.2021.120093.

5. Siddiqi SH, Chen L, Trapp NT, et al. Towards accredited clinical training in brain stimulation: proceedings from the Brain Stimulation Subspecialty Summits. Brain Stimul. 2025;18(2):298-305. doi:10.1016/j.brs.2025.02.012.

6. Egan D, Ragland V, Jha M. Building competency in administering intravenous racemic ketamine: a single site experience of expanding residency education in interventional psychiatry. Acad Psychiatry. 2025;49(6):580-581. doi:10.1007/s40596-025-02167-x.

7. Bridging the gap in transcranial magnetic stimulation training: considerations for enhancing resident education in TMS. Transcranial Magnetic Stimulation. 2026;6:100209. doi:10.1016/j.transm.2026.100209.



Title

Beyond the White Coat: Centering Humanity, Belonging, and Resilience During Transitions in Psychiatry Training

Primary Category

Wellness, Burnout, Resilience

Presenters

Yohanis Anglero Diaz, MD, Boston Children's Hospital/Harvard Medical School, Ethan Anglemyer, MD, Boston Children's Hospital/Harvard Medical School, Elizabeth Steuber, MD, Boston Children's Hospital/Harvard Medical School, Yuri Zoghbi, MD, Boston Children's Hospital/Harvard Medical School

Education Objectives

To introduce Reflect → Connect → Revisit, a longitudinal, human-centered framework that supports residents and fellows during transitions in psychiatric training by integrating identity reflection, community-building, mentorship, and belonging into existing educational structures.

Objectives:

By the end of this session, participants will be able to:

1. Identify challenges affecting trainee well-being, belonging, and identity during transitions in training.

2. Apply the Beyond the White Coat identity and community mapping exercise to help trainees Reflect on the relationships, identities, values, activities, and communities that sustain them beyond medicine.

3. Implement strategies to connect trainees with peers, mentors, program leadership, and supportive communities.

4. Develop opportunities to revisit identity, belonging, and well-being through longitudinal mentorship, supervision, and structured check-ins.

5. Adapt the Reflect → Connect → Revisit framework to their own residency or fellowship program.



Description of Innovation

We developed Beyond the White Coat, a longitudinal approach to supporting trainees through major transitions in psychiatric training. Rather than conceptualizing wellness as a discrete activity or placing responsibility for resilience solely on the individual trainee, we integrated conversations about belonging, identity, community, and personal sustainability into existing educational structures. The approach begins during orientation and continues through longitudinal check-ins, mentorship, and supervision.

A central component is an interactive “Beyond the White Coat” identity and community mapping exercise. During orientation, trainees reflect on who they are beyond their professional role by identifying the people, identities, communities, activities, values, and routines that sustain them. Prompts include: Who am I outside psychiatry? What sustains me? Who are my people? What parts of myself do I want to preserve during training? What community do I need to build? Trainees also identify potential barriers to maintaining these connections during training and develop individualized strategies for protecting them.

Description of Interactivity with Audience

We will start the presentation by asking the audience to reflect on a moment that was difficult during training and to think about what helped them get through it. The presenters will disclose their own answers to the question and may open the floor for others to share. This will serve as a segue to describe the innovation and for further reflection from participants on what their current programs are doing to promote resiliency and how they could incorporate elements of innovation in their own programs.

Title

Creating New Collaboratives: A Statewide Pilot of Shared CAP Didactics

Primary Category

Curriculum

Presenters

Denise Baughn, MD, University of Texas Medical Branch, Galveston, Jessica Sandoval, BA,MD,MS, University of Texas Health Sciences Center at San Antonio, Sarah Wakefield, BA,MD, Texas Tech University Health Sciences Center, Gunit Kahlon, MD, John Peter Smith Hospital, Kari Whatley, MD, University of Texas Austin Dell Medical School

Education Objectives

1. Describe a single state experience developing a shared CAP fellowship didactic lecture series.

2. Analyze potential benefits and challenges of shared didactic collaboratives.

Description of Innovation

Organized by a state-funded consortium targeting CAP workforce development, we established a workgroup of CAP fellowship directors interested in collaboration and togetherness. Despite being a large state with multiple geographically and programmatically diverse fellowships, we quickly identified a shared challenge of providing high-quality and expert-led didactics in subspecialty areas, a problem shared by many PDs in psychiatry and other fellowship subspecialties. We thus set out to share resources and create a new program of select shared didactic lectures for all CAP fellows in the state.

To begin, we surveyed all CAP PDs in our state regarding their interest in participating in a pilot program as well as priorities and goals for the program. Of the 10 responses, 7 programs indicated interest in the program with 3 programs indicating possible interest. We identified current dedicated didactic time for each program (Tuesday afternoon was the most common, though there was wide variability) and asked which days fellows could attend a 12 PM Noon virtual (live) lecture, with Tuesday and Friday being the most popular.



Rather than disrupting current didactic offerings, we chose to offer four, one-hour lectures over the lunch hour. Lecture topics were chosen by the workgroup to address topics with expertise not available in many programs. After reviewing survey responses and literature regarding possible topics, our workgroup identified 4 topics for our pilot year: CAP and the law [5], eating disorders, child/adolescent addiction, and technology use by patients. As a workgroup, we pooled resources/knowledge to identify experts from our state in each of these areas. We developed a list of objectives for each topic and chose dates (2 Tuesdays and 2 Fridays) least likely to disrupt our current fellowship calendars. Surveys were sent to fellows and faculty attendees of lectures to gauge quality and effectiveness of the format in providing expert lectures to the fellows.

We identified several benefits and challenges during the initial pilot of this program, which may help others with similar goals. Despite uncertainty in scheduling, fellows from 8 institutions attended our inaugural lecture. From our initial survey feedback, we are continuing to refine our program to allow for expanded interactivity with the virtual format. We also found that 1-hour lectures for these topics may be insufficient to fully address these topics, though 2/3 of our faculty survey respondents indicate that the lecturer provided expertise not available at the home program/institution. We plan to consider future options to further expand on these offerings. Many of our chosen lecturers (each from a different institution) were already providing the lecture to their home institution. By organizing our efforts, we maximize the benefit of the lecturer's expertise and time. Our goal is to continue to refine the format of this series to best meet program and fellow training needs.

Description of Interactivity with Audience

The presentation will begin with asking audience members to briefly share or reflect on their own challenges recruiting high-quality didactic lecturers for their residents/fellows, especially in subspecialty fields. We will specifically ask them to name an example of a topic they have had challenges recruiting expert lecturers. We will share our statewide innovation to target this challenge and our experience in our pilot, welcoming comments and questions from the audience to continue our own program improvement. Participants will leave with a framework of our process and ideas of how to consider similar didactics collaborations for their program.



Scientific Citations

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Title

Curiosity Curriculum: How a Community Art Show Became Our Skills Lab for Connection and Creative Exploration

Primary Category

Professional Identity Formation (including career development, mentorship, advising, wholeheartedness, meaning/purpose)

Presenters

Belinda Bandstra, MA,MD, University of California, Davis, Dafhney Ferrer, MD, University of California, Davis

Education Objectives

1. Describe how creating art, viewing art, or trying new art forms may support well-being, curiosity, and connection within a learning community.

2. Identify strategies for lowering experiential or skill-based barriers to creative participation.

3. Provide a practical model for training programs to adapt an art show to their curricular needs and available resources.

Description of Innovation

Creative exploration offers multiple pathways into well-being and connection. Research on art-based therapeutic approaches highlights opportunities for reflection, emotional processing, and improved interpersonal relationships. Making art can support self-expression and identity exploration, and observing art can invite attention and positive emotion. A 2026 study found that viewing an art exhibit, compared with neutral and other pleasant activities, was associated with increased subjective well-being and reduced stress. A residency art show brings the experiences of creating and viewing into the same room. Artists are given a place to share creative identities that may be unseen in clinical settings. Attendees are invited to pause, encounter the work, and see their colleagues as individuals beyond their clinical roles.

In 2024, our residency hosted its first art show, developed by a resident exploring resilience and professional development. Although resident-initiated, the event included

the broader department, welcoming residents, fellows, faculty, staff, medical students, and families. Participation was open regardless of prior artistic experience. The inaugural show featured visual art, including painting, photography, quilting, collage, and pottery. The resident who made pottery, the faculty member who quilted, and the staff member whose child painted enthusiastically in every color all became newly visible. The art show offered more than a venue for creative work: it became a shared experience, building connections across our community.

When it returned for the second year, the show expanded to incorporate live performance, including DJ sets and guitar, and introduced an open painting area where attendees could create during the event. The show's growth raised a new question. Beyond celebrating what members of our community already created, could the event encourage them to explore what they had not yet tried?

The third show will introduce an "I Tried Something New" category for work made through an unfamiliar medium, technique, or creative practice. Recent research links curiosity with both seeking new experiences and embracing uncertainty. Task-specific curiosity has also been associated with approaching an unfamiliar task more as a challenge and less as a threat. The new category translates these ideas into an invitation. It aims to welcome people who may not identify as artists and celebrate trying alone as an achievement.

Overall, the model's promise lies in its adaptability. Rather than prescribing a fixed format, the model invites the program to ask what would be meaningful to their community. Future iterations could emphasize storytelling, identity exploration, or shared reflection. The model is also intentionally practical. At our institution, the free, 3-hour event uses a conference room, approximately $200 for refreshments and supplies, one main organizer, and 4-6 volunteers. Artwork is not professionally mounted, often laid out gently on tables. The essential ingredients are an invitation to participate, permission to experiment, and a place for people to encounter art, and one another, with curiosity.

Description of Interactivity with Audience

- From invitation to art show: Walk through the logistics of producing an event including the submission form, artwork handling, opportunities for volunteer involvement, and day-of coordination.

- Creative community inventory: Invite participants to identify creative interests and existing resources within their programs.
- Discussion and adaptation: Explore logistical barriers, other ways to welcome beginner artists, and practical starting parts for organizing a local show.

Scientific Citations

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Title

From Assessment to Action: Teaching Psychiatry Residents to address disparities in care related to Race, Ethnicity and Language

Primary Category

Curriculum

Presenters

Yohanis Anglero Diaz, MD, Boston Children's Hospital/Harvard Medical School, Elizabeth Steuber, MD, Boston Children's Hospital/Harvard Medical School, Yuri Zoghbi, MD, Boston Children's Hospital/Harvard Medical School

Education Objectives

Educational objectives for this project will include highlighting innovations in curriculum that will prepare residents to achieve the following:

1. Identify the difference between race and ethnicity and demonstrate competence in gathering this information as part of their interviewing skills

2. Identify and utilize institutional tools that support accurate documentation of race, ethnicity, and language preferences within the medical record

3. Demonstrate competence in assessing patients' and families' racial and ethnic identities, preferred languages, and the ways in which these factors may influence a patient's biopsychosocial formulation and treatment trajectory

4. Utilize tools within their institution to optimize equitable access to care to individuals with limited-English proficiency to help ensure continuity of language-concordant care throughout hospitalization and during discharge and aftercare planning.

Description of Innovation

The innovation will have three components:

1. An initial lecture on healthcare inequalities related to Race, Ethnicity and Language in child and adolescent psychiatry

2. A bi-weekly huddle facilitated by faculty for active discussion

3. A presentation featuring incorporation of Race, Ethnicity and Language considerations into a biopsychosocial formulation

As part of orientation to the rotation, residents will participate in an interactive session designed to elicit their existing understanding of race, ethnicity, and language and to promote reflection on how these factors may contribute to inequities in clinical care. Rather than beginning with a didactic presentation, the session will use residents' prior clinical experiences as a starting point. Residents will be invited to share examples of situations in which race, ethnicity, or language appeared to influence access to care, communication, diagnostic formulation, treatment, or other aspects of care for their adult patients. Facilitators will then guide residents in considering how similar processes may present differently in pediatric patients and their families.

The orientation will subsequently provide residents with locally relevant data to contextualize these discussions. Trainees will review demographic and language data from the clinical setting in which they will be completing their rotation, including a visual map of the racial distribution of surrounding communities and data describing the racial, ethnic, and language composition of the hospital and clinical unit. By grounding the discussion in the population residents will actually be caring for, the intervention moves beyond an abstract discussion of health inequities and encourages trainees to consider how these issues may arise in their own clinical environment.

Learning will continue longitudinally throughout the rotation. During biweekly clinical huddles, residents will have structured opportunities to identify and discuss cases in which race, ethnicity, or language has raised questions about a patient's clinical formulation, communication, engagement, access to services, or experience of care. Faculty will use these discussions to help residents distinguish between individual-level factors and broader structural or contextual factors and to consider how assumptions or systems of care may contribute to inequities. This repeated application is intended to reinforce the integration of these considerations into routine clinical reasoning rather than treating them as a discrete topic addressed only during orientation.

At the conclusion of the rotation, residents will present a biopsychosocial formulation that includes an additional, structured component addressing race, ethnicity, and language. Residents will be asked to consider how these factors may be relevant to the

patient's presentation and formulation and whether there are potential disparities or inequities in the patient's care.

The educational design is informed by principles of experiential and reflective learning, particularly the concept that learners deepen understanding by connecting prior clinical experiences with reflection, conceptual frameworks, and subsequent application. The intervention therefore follows a longitudinal sequence of reflection, contextual learning, clinical application, and synthesis. Rather than asking residents simply to acquire knowledge about health inequities, the goal is to develop a repeatable approach for recognizing and incorporating race, ethnicity, and language into patient-centered clinical formulation.

Description of Interactivity with Audience

We plan to engage the audience initially by asking Jeopardy-style questions related to facts about race, ethnicity and language data. We will do so with an interactive board where they can pick a category and a question. An example of a question could be "Can you name the three most common languages other than English spoken at home in the USA?". By asking the questions to engage the audience and assess baseline knowledge on the topic, we will in term gather information about how different educators have incorporated this topic in their program's curriculum and will also give them an opportunity to share challenges and wins. We will then proceed to describe how what has worked for us in our curriculum and will provide a handout with our pearls and suggestions for implementation.

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Title

From Curriculum to Community: A Four-Domain Framework for PGY-1 Education in a New Psychiatry Residency

Primary Category

Curriculum

Presenters

Brian Starkman, MD, Woodhull Medical and Mental Health Center

Education Objectives

After participating in this Innovations Showcase, participants will be able to:

1. Identify educational, developmental, and relational functions typically supported by senior residents and established residency culture that may be absent in a new training program.

2. Apply a four-domain framework to organize or evaluate PGY-1 educational programming.

3. Identify opportunities to adapt existing curricular, supervisory, mentorship, and community-building activities to address gaps across the four domains of PGY-1 development.

Description of Innovation

A new community psychiatry residency developed a four-domain framework while building the educational experience of its inaugural PGY-1 class. As curricular, supervisory, mentorship, and community-building activities were developed, four broader functions of early residency education became apparent: Foundations, Clinical Application, Professional Formation, and Community and Reflection. Formalizing these functions into a framework provided a structure for organizing educational experiences and identifying developmental and relational needs that might otherwise be supported informally by senior residents or an established residency culture. The resulting framework supports curriculum planning beyond the content of a didactic schedule alone.



Foundations encompasses sequenced instruction aligned with residents' early clinical responsibilities. Programming begins with an orientation-based "Psychiatry Basics Workshop" and progresses to introductory teaching in areas such as emergency psychiatry, inpatient psychiatry, psychopharmacology, and psychopathology, with content grounded in the realities of an urban community psychiatry setting.

Clinical Application emphasizes active use of knowledge rather than passive receipt of didactics. Psychiatric interviewing sessions, case conferences, and journal clubs provide recurring opportunities to practice clinical reasoning, discuss cases and literature, receive faculty feedback, and connect formal teaching with clinical work.

Professional Formation addresses the development of professional identity and values beyond clinical knowledge and skills. Educational experiences in cultural psychiatry, history of psychiatry, medical ethics, wellness, and narrative medicine explore the cultural, historical, ethical, and human dimensions of psychiatric practice. A longitudinal faculty mentorship program provides individualized guidance and early exposure to professional and career pathways.

Community and Reflection intentionally creates relational supports that often develop organically in established programs. Weekly group supervision with program leadership provides longitudinal mentorship, feedback, and discussion of clinical and professional development. Confidential processing sessions with a wellness coordinator offer protected space for reflection and group development. Structured community-building activities, including an orientation dinner and a department chair–hosted barbecue, as well as informal departmental gatherings, create opportunities for residents and faculty to build relationships outside traditional clinical and educational settings. In-person Grand Rounds and institutional Graduate Medical Education activities further connect residents with broader learning communities.

The four domains are intended as a flexible planning and curriculum-mapping tool rather than a prescriptive curriculum. Individual activities may support multiple domains, and implementation can vary according to program setting and resources. Although developed for an inaugural residency class, the framework may also offer established programs a structured method for examining whether PGY-1 education adequately supports foundational learning, clinical application, professional formation, and relational development.



Description of Interactivity with Audience

Participants will receive a visual representation of the four-domain framework and use it to rapidly assess their own PGY-1 educational structure. They will identify one domain that is particularly well developed and one that may warrant greater attention within their program. Participants will then identify one existing curricular or program activity that could be adapted or expanded to strengthen the identified gap. Brief discussion will highlight how the framework might be applied across programs of different sizes, settings, and stages of development. Participants will leave with a rapid curriculum-mapping tool that can be applied to their own programs.



Title

From Rotating Learner to Treating Psychiatrist: Early Outcomes of an X+Y Scheduling Model in Psychiatry Residency

Primary Category

Professional Identity Formation (including career development, mentorship, advising, wholeheartedness, meaning/purpose)

Presenters

Cara Angelotta, MD, McGaw Medical Center, Northwestern University, Kaitlyn Kuntsman, MD, McGaw Medical Center, Northwestern University, Amy Corcoran, MD

Education Objectives

At the conclusion of this session, participants will be able to:

1. Describe implementation of a reproducible X+Y scheduling model for PGY2 psychiatry training.

2. Examine early resident perceptions of the impact of X+Y scheduling on clinical reasoning, professional identity formation, and career exploration.

3. Identify benefits and challenges associated with integrating longitudinal outpatient continuity clinics, elective experiences, and scholarly activity within a PGY2 X+Y curriculum.

Description of Innovation

Beginning in July 2025, PGY2 residents transitioned to a 3+1 X+Y scheduling model consisting of thirteen 3-week acute care blocks alternating with thirteen 1-week ambulatory blocks. Acute care experiences included adult and pediatric inpatient psychiatry, adult and pediatric consultation-liaison psychiatry, night float, and interventional psychiatry. Ambulatory weeks included a new longitudinal continuity clinic (two half-days weekly), pediatric emergency psychiatry (one day weekly), and resident-selected clinical or scholarly electives (five half-days weekly).

As part of the annual program evaluation, PGY2 residents completed an anonymous survey consisting of six 5-point Likert-scale items and two open-ended questions. Survey items examined resident perceptions of clinical reasoning skill development,

professional identity formation, career exploration, and the continuity-fragmentation tradeoff inherent in X+Y scheduling.

The new continuity clinic allows PGY2 residents to begin following outpatients under direct supervision of the program director and assistant program director one year earlier than in the prior curriculum. Patients are selected to be appropriate for longitudinal resident management, and faculty provide weekly written feedback focused on diagnostic assessment and clinical reasoning. Residents may now follow patients for up to three years rather than two years. In the first year, the new clinic treated 196 unique patients with an average of about 20 patients per PGY2 resident.

The ambulatory block structure also expanded opportunities for career exploration and scholarship. Elective offerings include both part-day and full-day experiences, allowing residents to participate in multiple clinical electives across the year. Residents may dedicate up to two half-days per ambulatory week to mentored scholarly activity. Since implementation, 70% of PGY2 residents have engaged in scholarly work, compared with participation previously limited to research-track residents during the PGY2 year.

The survey response rate was 60% (6/10 residents). All respondents (6/6) strongly agreed that following continuity patients influenced their clinical reasoning on acute care rotations. All respondents (6/6) strongly agreed that longitudinal responsibility for outpatient care helped them feel more like a treating psychiatrist than a rotating learner. All respondents (6/6) strongly agreed that the model helped identify clinical settings or patient populations aligned with their professional interests and career goals. Residents were evenly divided regarding whether transitions between acute care and ambulatory blocks disrupted immersion in acute care training. Despite this concern, all respondents (6/6) strongly agreed that the benefits of the X+Y model outweighed its challenges.

These findings suggest that an X+Y scheduling model paired with early continuity clinic experiences and expanded elective opportunities may enhance clinical reasoning, professional identity formation, career exploration, and scholarly engagement during PGY2 psychiatry training. Early resident feedback supports X+Y scheduling as a promising curricular innovation, although challenges related to continuity and scheduling complexity remain.



Description of Interactivity with Audience

Participants will work in pairs to identify barriers to early implementation of longitudinal care, career exploration, and scholarly engagement in their own programs. Attendees will then engage in a brief brainstorming session to identify strategies to overcome common barriers, fostering a collaborative discussion on practical implementation.

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Title

From Senior Trainee to Emerging Leader: A Transition-to-Practice Curriculum for Second-Year Child Psychiatry Fellows

Primary Category

Curriculum

Presenters

Yohanis Anglero Diaz, MD, Boston Children's Hospital/Harvard Medical School, Elizabeth Steuber, MD, Boston Children's Hospital/Harvard Medical School, Annmarie Caracansi, MD, Boston Children's Hospital/Harvard Medical School, Jad Hilal, MD, Boston Children's Hospital/Harvard Medical School, Ethan Anglemyer, MD, Boston Children's Hospital/Harvard Medical School

Education Objectives

This innovation aims to provide CAP2 fellows with a structured transition from supervised clinical practice to emerging attending-level leadership. Participants will be able to identify gaps in training that may limit readiness for independent practice, describe a framework for graduated autonomy incorporating clinical decision-making, leadership, supervision, teaching, and systems-based practice, and identify strategies for making senior fellows visible and effective multidisciplinary team leaders. An additional aim is to demonstrate that this framework can be adapted across different clinical environments.

Description of Innovation

Our team developed and implemented an approximately eight-week CAP2 transition-to-practice curriculum on a high-acuity inpatient child and adolescent medical-psychiatry unit. The innovation changes both the fellow’s responsibilities and the clinical team’s understanding of the fellow’s role. Fellows progress through graduated autonomy, moving from structured onboarding and supervised interviewing toward increasing responsibility for patient care, clinical decision-making, multidisciplinary rounds, delegation, teaching, and team leadership. CAP2s are explicitly identified as team leaders during rounds, with increasing caseload and responsibility. Weekly protected teaching addresses attending-level clinical decision-making, leadership, supervision, teaching, and systems-based practice. The curriculum engages nurses, social workers,

and attending physicians as stakeholders, recognizing that autonomy requires changes in unit culture and the clinical learning environment. We are evaluating the innovation through trainee, attending, and multidisciplinary team feedback, feasibility measures, and structured assessment of skills gained during the rotation. Early qualitative feedback has supported feasibility and the value of the expanded role.

The curriculum has now been successfully implemented across two distinct clinical units, demonstrating portability beyond its original setting. Although unit workflows and patient populations differ, the core framework has remained consistent, including explicit role definition, graduated autonomy, visible leadership, and structured feedback

Description of Interactivity with Audience

Participants will consider a brief case involving a capable CAP2 who remains positioned as a “senior trainee” despite readiness for greater responsibility. In pairs or small groups, participants will identify one change they could make to move the fellow toward an emerging-leader role, considering four domains: role (what the fellow owns), visibility (how the team recognizes the role), autonomy (how responsibility progresses), and feedback (how leadership is assessed). Participants will share one change they could implement on their own service, which we will map onto our framework and discuss in the context of different clinical settings.



Title

From Silos to Shared Language: Transforming Clinical Proximity Into Interprofessional Partnership

Primary Category

Learning Environment

Presenters

Tyler Fleming, DO,MPH, University of Rochester School of Medicine & Dentistry,
Jessica Moore, PhD, University of Rochester School of Medicine & Dentistry

Education Objectives

By participating in the innovations showcase, participants will:

1. Analyze how differing professional languages, theoretical perspectives, and clinical approaches influence case conceptualization and interdisciplinary training settings.

2. Experience a structured interdisciplinary orientation framework that supports dialogue to refine clinical reasoning and collaborative psychotherapy practice.

3. Develop and apply strategies for building collaborative relationships across professional boundaries within a shared clinical learning environment at their home institutions.

Description of Innovation

Methods: An interdisciplinary case conference was developed within a systemic family therapy clinic to integrate psychiatry residents and marriage and family therapy trainees (MFTTs) into a shared learning environment. Across two academic-year cohorts, learners participated in case conferences in which trainees presented outpatient psychotherapy cases and received feedback from interdisciplinary peers and supervisors in psychiatry, psychology, and marriage and family therapy. Following Cohort 1, learner and supervisor feedback revealed that bringing different disciplines together did not, by itself, establish collaboration. Learners requested more structured opportunities to build relationships and greater exposure to distinct therapeutic frameworks and professional languages since theoretical differences were slow to be



recognized in vivo, contributing to tension and tribalism between disciplines. In response, the Cohort 2 orientation was redesigned using the ASK (attitude, skills, knowledge) framework and expanded from 1 to 4 hours over 1 month. The redesigned orientation established expectations and norms, reviewed resident and MFTT training pathways, included supervisors' professional pathways and theoretical perspectives, and concluded with a dedicated language-building exercise. Mixed resident/MFTT groups collaboratively matched theoretical concepts with associated theorists and definitions, then identified familiar and unfamiliar terms, including synonyms, near-synonyms, and homonyms across professional languages. This made linguistic differences explicit while allowing learners to construct a shared vocabulary for case formulation and discussion.

Results: Before implementation of the redesigned orientation (on a 4-point scale from absent (4) to very present (1)), Cohort 1 included 9 psychiatry residents and 12 MFTTs, with 7 respondents reporting greater collaboration (mean = 2.4) than the baseline prior year where there was no overlap in the groups (5 respondents noted infrequent collaboration, mean = 3.0), describing the conference as a "great opportunity" to learn from different professional perspectives and valuing exposure to MFT theories and approaches. Following the redesign, Cohort 2 included 8 psychiatry residents and 8 MFTTs. Among 9 respondents, ratings further improved (mean = 1.83), with respondents selecting either "very present" or "intermittently present" collaboration. Qualitative feedback suggested that Cohort 2 participants experienced the conference as a central site of educational growth, highlighting diverse conceptualizations, supervisor expertise, interdisciplinary discussion, and increased interpersonal comfort. Supervisors observed greater vulnerability in case presentations, leading to more meaningful feedback and deeper learning. More senior residents also elected to remain in case conference the following academic year.

Conclusions: Proximity is not collaboration. Our experience demonstrates that bringing disciplines together is only the starting point for interdisciplinary education; collaboration must be intentionally designed, cultivated, and supported. Across two cohorts, learner-reported collaboration improved following a redesign centered on relationship-building, shared professional language, explicit attention to differing clinical frameworks, and reciprocal learning. Qualitative feedback suggested that increased interpersonal comfort supported greater vulnerability in case presentations, enabling more meaningful feedback and deeper learning. This model transforms existing clinical overlap into an

intentional educational resource and offers programs a practical, adaptable framework for building interprofessional partnership, supervision, and learning. The innovation lies not in placing disciplines together, but in designing the relationships and structures that allow their differences to become a source of learning.

Description of Interactivity with Audience

Participants will experience a brief version of the educational problem addressed by our innovation and the hidden gaps that can emerge when working across disciplines. We will present a visual showing the interdisciplinary gaps identified by Cohort 1, the self-assessment conducted by clinical leaders, and how these findings informed an ASK-informed strategic redesign for Cohort 2. Participants will then rate their own interdisciplinary environment across 3–4 dimensions (e.g., shared language, knowledge of professional pathways and training, and awareness of differing theoretical frameworks) using a brief self-assessment. Finally, participants will identify their lowest-rated dimension and one structural change they could implement to strengthen interdisciplinary orientation and support culture change.

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Title

From Simulation to Connection: An Innovation for Teaching Therapeutic Microskills Using Standardized Patients

Primary Category

Curriculum

Presenters

Andrea Huntley, MD,MPH, Northeast Georgia Medical Center Program, Moonpreet Deol, MD, Northeast Georgia Medical Center Program, Samuel Dotson, BS,MD, Northeast Georgia Medical Center Program

Education Objectives

By participating in this Innovation Showcase, participants will be able to:

1. Describe a psychiatry simulation model incorporating pre-simulation dry runs, immediate video-assisted debriefing, and repeated standardized-patient encounters;

2. Apply simulation-based education strategies for providing focused feedback on therapeutic microskills and communication skills within their own psychotherapy teaching; and

3. Create simulation experiences within their own program that apply the principles of immediate feedback and reapplication to reinforce therapeutic microskills.

Description of Innovation

Our residency program had an established simulation-based education program covering twenty-four scenarios across the PGY-1 and PGY-2 years. Each month involved two different 30-minute scenarios completed per session with a standardized patient, followed by a debrief-room where participants reviewed their recordings from the prior month with a faculty member. Feedback from residents consistently noted that scenarios were too focused on making a diagnosis or collecting a full history, which were practices they already were learning with real patients. They also noted that the debriefing room was too far removed from the actual scenario to provide meaningful feedback, and they requested better preparation for difficult conversations and psychotherapy interventions. Based on this feedback and with resident participation, our

faculty therefore redesigned our existing psychiatry residency simulation curriculum to make feedback more immediate and pivot towards a focus on therapeutic microskills to prepare junior residents for the start of their PGY-3 psychotherapy training clinic. Each simulation redesign began with a multidisciplinary dry run involving faculty, senior residents, standardized patients, and simulation staff to refine case flow, realism, and learner expectations. Post-learning articles were selected for each scenario and these standardized “good” and “bad” recordings were made available for residents after each session. As noted, residents previously completed standardized-patient encounters and later reviewed recordings from the prior month, making reflection less timely and limiting opportunities to immediately apply feedback. In the redesigned model, however, residents complete a core standardized-patient encounter followed by an immediate, focused video-assisted debrief highlighting strengths, missed opportunities, and areas for improvement. The resident subsequently completes the same scenario with a different standardized patient, allowing immediate reapplication of feedback. Based on the “second score” concept from “Thanks for the Feedback” (Stone and Heen, 2014), this allows residents to focus on how they apply and react to feedback rather than fixating on their initial “success” at handling the scenario. Therapeutic microskills and communication are assessed using a standardized instrument (the Clinical Communication Skills Scale - Short Version, CCSS-S), which is a published, 14-item rating tool used in psychotherapy training to assess basic communication skills like empathy and open-ended questioning. Cases were also designed to align with monthly didactic themes and target one specific skill per scenario such as motivational interviewing, psychoeducation, verbal de-escalation, boundary setting, CBT techniques, and validation. This creates an iterative cycle of practice, reflection, feedback, and reapplication while supporting ongoing curriculum refinement.

Description of Interactivity with Audience

We will discuss with participants how therapeutic microskills practiced in simulation can translate into real-world psychiatric encounters and help residents become more natural, flexible, and confident as they progress through training. We will also walk through examples from our multidisciplinary dry runs, including the use of a “good psychiatrist” and “bad psychiatrist” approach, and discuss with the audience how these contrasting approaches can reveal gaps, unexpected challenges, and opportunities to improve the scenario before resident participation. Participants will be invited to discuss best-practices for teaching motivational interviewing, validation, psychoeducation,

boundary setting, and de-escalation, including ways in which they could adapt this content for their own programs.



Title

"I Could Build That!": Empowering Residents with EMR Security Clearances

Primary Category

Professional Identity Formation (including career development, mentorship, advising, wholeheartedness, meaning/purpose)

Presenters

Chris Feghali, MD, West Virginia University School of Medicine, Daniel Pustay, MBA,MD, West Virginia University School of Medicine, Camille Leon, MD, Dorothy van Oppen, MD

Education Objectives

1. Synthesize the process of obtaining EMR security clearances in training, and consider how this could be implemented in your program.

2. Analyze the possibilities of clinical, scholarly, administrative, and teaching practice improvement from resident and PD perspectives through lower-level EMR access

3. Consider the interface of healthcare and informatics, along with the career development opportunities therein

Description of Innovation

Provision of EMR security clearances to residents, allowing trainees to actualize ideas for EMR quality improvement, develop interprofessional skills through working with software analysts, and foster self-efficacy through direct quality improvement. Additional administrative benefits for chief residents and program leadership, including ability to reassign inbox coverage, create and edit messaging pools, and modify hospital-wide orders.

Description of Interactivity with Audience

Would gather information about the EMR's utilized by attendees, and what similar programs could be available to them. Would then discuss specifics of program at WVU with Epic Systems, including an active discussion with the audience to help foster how engagement in this endeavor could foster the above quality improvement and career

development. Primary focus on showing what residents have created with Builder accreditation. Would leave time for questions given technical nature of content.

Scientific Citations

https://pubmed.ncbi.nlm.nih.gov/31349321/

Title

Introducing Sleep Apnea Screening and Testing into a Psychiatric Residency clinic

Primary Category

Curriculum

Presenters

Kathleen Crapanzano, MD, Louisiana State University School of Medicine (Baton Rouge) Program, Andrew Aubin, MD, Louisiana State University School of Medicine (Baton Rouge) Program, Natalie Hunsinger, MD, University of Alabama Hospital Program - Huntsville

Education Objectives

This intervention aimed to implement direct HSAT device dispersal from an outpatient academic psychiatric clinic, in collaboration with a local sleep medicine clinic, with the goal of improving patient access to OSA testing and care.

Description of Innovation

This innovation brought home sleep apnea testing access to a psychiatric residency clinic that serves a mixed patient population with a diverse payor base (including both public and private payors). The protocol was developed in conjunction with a sleep medicine physician at our facility to ensure seamless transfer of positive sleep apnea screenings to the sleep medicine clinic. Residents were educated about sleep apnea and its prevalence in psychiatric clinics. They were encouraged in the course of routine patient care, to screen patients with symptoms suggestive of OSA further. Patients with a STOP-BANG score ≥3 (indicating intermediate or high risk) or an Epworth Sleepiness Score (ESS) score >10 (indicating significant daytime sleepiness) were offered HSAT testing with disposable, commercially available kits. Prior authorization was often but not always required to distribute the home sleep apnea devices The results of HSAT testing were analyzed by a sleep medicine provider whose office contacted anyone with a positive sleep apnea screen for follow up.

Over the year of the intervention, 15 patients completed HSAT testing dispersed from the psychiatry clinic without the complication of an in-house sleep study. Thirteen of the 15 patients had a positive screen—10 with mild sleep apnea, 5 with at least moderate

severity OSA and only 2 patients tested negative for OSA. Feedback from the residents has been positive to have this additional tool in their arsenal for assessing and treating patients with concerns about insomnia. Dispersing HSAT testing devices from resident psychiatry clinics is an easy to accomplish intervention that offers the prospect of improving patient access to sleep apnea testing, thereby reducing burdens of testing and treatment, and is a great educational opportunity for psychiatric residents.

Description of Interactivity with Audience

The 5-minute interactive discussion with the audience will focus on communicating the identified clinical problem (barriers to sleep apnea testing) and our attempts to solve the problem in an academic psychiatry clinic. The discussion will begin with a brief description of the overlap between OSA and psychopathology commonly seen in a psychiatry clinic. Then, the identified practice gap (inadequate availability of sleep apnea testing) will be introduced, and the practice gap will be framed as an opportunity for quality/process improvement. Next, our intervention (HSAT testing dispersed directly from the psychiatry clinic) will be discussed, and preliminary results of such testing will be presented. Finally, given the positive results of our intervention thus far, audience members will be encouraged to consider implementing similar interventions in their own ambulatory clinics.

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Title

Law School for Shrinks? Empowering Child Psychiatry Trainees Through Targeted Medicolegal Education

Primary Category

Curriculum

Presenters

Joshua Feriante, BA,DO,MBA, University of Utah School of Medicine

Education Objectives

1. Define medicolegal child and adolescent psychiatry as a structured, case-based approach to navigating state-specific healthcare statutes and malpractice risk management.

2. Describe the structure and key components of a Medicolegal Curriculum designed for child and adolescent psychiatry trainees, with a focus on its interactive learning format, statutory analysis framework, and the development of defensible clinical documentation skills.

3. Explore how the Medicolegal Curriculum addresses broader educational gaps by equipping trainees to navigate statutory uncertainty, complex minor consent scenarios, caregiver EHR access boundaries, and system-level liability challenges.

4. Identify actionable strategies for implementing similar case-based medicolegal training models within other graduate medical education settings.

Description of Innovation

Child and adolescent psychiatry (CAP) fellows and pediatric residents frequently encounter high-stakes medicolegal challenges (e.g., minor consent exceptions, electronic health record confidentiality, involuntary commitment, and mandated reporting), yet formal legal instruction remains sparse in postgraduate training. To bridge this gap, we developed an interactive, case-based medicolegal curriculum that explicitly teaches sound legal principles in clinical practice. We did so by providing trainees with a comprehensive forensic framework, core legal knowledge, and actionable risk-management skills.



The curriculum translates complex statutory and malpractice concepts into practical clinical workflows across five core domains:

1. Medicolegal Fundamentals & Malpractice Epidemiology: Examines the four elements of negligence, standard of care, and specialty-specific liability drivers in pediatric and psychiatric care [2,3].

2. Minor Consent & Electronic Health Record (EHR) Privacy: Clarifies state statutory rules for minor consent exceptions (STIs, substance use, reproductive health), caregiver access boundaries under federal/state regulations (e.g., 42 Code of Federal Regulations Part 2), and privacy rules in adolescent care [4,5].

3. Civil Commitment & Caregiver Refusal: Establishes clear protocols for involuntary statutory detention timelines and managing legal/ethical options when caregivers refuse recommended care or invoke exemptions [5].

4. Duty to Warn & Mandated Reporting: Provides cross-jurisdictional comparisons of statutory duty-to-warn thresholds (imminent threat vs. identifiable target) and child protective reporting triggers [5].

5. Status Sexual Offenses: Delineates legal age-of-consent thresholds, statutory rape definitions, and "Romeo and Juliet" statutory protections.

Moving beyond passive lecture formats, the curriculum utilizes real-world case vignettes, state statutory comparison tables, and interactive exercises (e.g., "audit my note" documentation reviews and group case discussions) to foster active reasoning. Trainees learn to apply "defensible documentation," explicitly capturing clinical rationale, third-party risk assessments, and caregiver communication during high-risk encounters or transitions of care. Initial trainee survey data showed a consistently positive experience with the didactic curriculum.

Description of Interactivity with Audience

Agenda

1. Introduction & Background (1 min): Brief overview of the medicolegal curriculum and its essential role in equipping child psychiatry trainees to navigate high-stakes statutory and liability challenges.



2. Curriculum Overview & Interactive Showcase (5 min): Demonstrates the module's active-learning methodology using a live QR-Code Poll. Participants complete a brief mobile quiz on statutory gray zones (minor consent, EHR privacy, duty-to-warn). Real-time results highlight baseline faculty knowledge gaps, illustrating the need for structured legal training.

3. Q&A & Implementation Discussion (4 min): Facilitates group dialogue on integrating the curriculum into existing fellowship programs.

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Title

Learn Your Way: A Flexible, Portable Curriculum for Teaching Geriatric Psychiatry

Primary Category

Curriculum

Presenters

Haley Solomon, BS,DO, University of Utah School of Medicine, Gregory Schreck, MD, University of Utah School of Medicine, Mary Steinmann, MD, University of Utah School of Medicine

Education Objectives

To develop and implement a needs-informed, flexible geriatric psychiatry curriculum for PGY-2 psychiatry residents that emphasizes clinically oriented learning and supports adaptation across programs with varying faculty and resources.

Description of Innovation

Methods

As part of an IRB-exempt educational study at the University of Utah, psychiatry residents completed a needs assessment evaluating self-rated comfort managing 14 geriatric psychiatry topics, overall confidence treating older adults with psychiatric conditions, and preferred instructional formats. Descriptive statistics, including means, standard deviations, frequencies, and percentages, were used to characterize educational needs and instructional preferences. Curricular content was prioritized using needs-assessment findings and competencies outlined in the ACGME Geriatric Psychiatry Milestones, with learning objectives aligned with Level 1–2 milestone expectations appropriate for general psychiatry residents.

We developed a multi-departmental and multi-institutional collaboration to create a 10-hour geriatric psychiatry curriculum comprising six lessons for PGY-2 residents and implemented during protected psychiatry didactics. Content included psychiatric evaluation of older adults, neurocognitive assessment, mild cognitive impairment and dementia, late-life depression, geriatric bipolar disorder, and neuropsychiatric symptoms of dementia and delirium, with MoCA certification incorporated as an additional component. Lessons used self-paced e-modules, in-person instruction, or paired

asynchronous and in-person formats based on content and learning objectives. Standalone e-modules and facilitator guides were developed to allow the entire curriculum to be completed asynchronously when live instruction is unavailable. Pre- and post-curriculum surveys assess resident knowledge and self-rated confidence.

Results

Thirty-two residents completed the needs assessment; PGY-4 residents comprised the largest respondent group (34.4%). Across 14 geriatric psychiatry domains, mean self-rated comfort was 4.63/10 (SD 2.63), with nearly half (47.9%) of individual ratings ≤4/10. Regarding preferred learning formats, residents most frequently selected clinical pearls/practical guidance (87.5%) and case-based learning (65.6%) as engaging instructional approaches. These findings supported the need for broader geriatric psychiatry education and informed an emphasis on clinically applicable, case-based instruction. The resulting curriculum incorporates evidence based practical guidance, case application, and clinical pearls across both live and asynchronous formats. Its modular structure allows delivery as a comprehensive 10-hour curriculum or as individual lessons, while asynchronous alternatives permit completion when live teaching is unavailable. Post-curriculum evaluation of resident knowledge and self-rated confidence is ongoing.

Conclusions

This needs-informed, modular curriculum provides a flexible framework for delivering structured geriatric psychiatry education within general psychiatry residency. By embedding case-based learning and practical clinical guidance across delivery formats, the model preserves clinically oriented, applied learning even when instruction must occur asynchronously. Its packaged structure and flexible delivery options may facilitate adaptation by programs with varying faculty availability, scheduling constraints, and educational needs.

Description of Interactivity with Audience

Audience members will participate in a brief “What’s Your Geri-Psych Challenge?” exercise identifying common barriers to geriatric psychiatry education at their institutions, such as limited faculty expertise, challenges with resident engagement, or limited availability for live instruction. Using the most frequently selected challenge, we will demonstrate how the curriculum’s modular structure, asynchronous e-learning, and

facilitator guides can be adapted to different program needs. Attendees will then briefly explore the curriculum materials directly. The session will conclude by inviting participants to consider how they might adapt or implement components of the curriculum within their own programs.

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Title

Making Space to Lead: Preserving Organizational Memory Through a Chief Resident Operations System

Primary Category

Program Administration and Leadership

Presenters

Brandi Karnes, MD, McGovern Medical School at UTHealth, Kacy Smith, MD, McGovern Medical School at UTHealth, Josh Chen, MD, McGovern Medical School at UTHealth, Stephanie Ding, MD, McGovern Medical School at UTHealth

Education Objectives

1. Identify chief resident responsibilities and organizational knowledge vulnerable to loss, duplication, or inefficiency during leadership transitions.

2. Describe a framework for converting fragmented operational information into a living system that preserves organizational memory across chief resident cohorts.

3. Explain how externalizing routine operational knowledge may preserve capacity for higher-order leadership, including mentorship, stakeholder engagement, program improvement, creativity, and innovation.

4. Apply the framework to a recurring workflow within participants' own residency or fellowship programs.

Description of Innovation

To reduce the repeated reconstruction of operational knowledge across annual chief resident transitions, psychiatry chief residents developed a centralized, longitudinal operations system designed to make recurring responsibilities and organizational memory visible, retrievable, and transferable across cohorts. Using existing Microsoft Teams and SharePoint infrastructure, chief residents mapped recurring administrative, educational, communication, and leadership responsibilities into a living operational resource. For each process, the system can capture what must be done, timing or recurrence, ownership, completion status for that academic year, instructions and resources, relevant documents, rationale for prior decisions, stakeholder context, prior



approaches and outcomes, and lessons learned. Customized views allow responsibilities to be organized by timeline, owner, category, and status.

Approximately 80 responsibilities and workflows have been consolidated into the system. Unlike a static handbook or end-of-year handoff document, the resource is designed to evolve as chief resident work occurs. New responsibilities can be incorporated when identified, workflows can be refined after implementation, and lessons from both successful and unsuccessful approaches can remain attached to the relevant process for future cohorts. The resulting structure is designed to allow incoming chiefs to begin with accumulated organizational knowledge rather than reconstructing the role from prior emails, dispersed files, and individual memory.

The broader goal is not simply better task management, but making space to lead. Routine operational reconstruction carries an opportunity cost: time and cognitive bandwidth devoted to determining what is due, locating information, identifying stakeholders, and rediscovering prior processes are unavailable for higher-order leadership work. Recent evidence suggests that cognitive offloading can reduce internal memory demands in memory-based tasks [4]. Research on team creativity and innovation likewise suggests that team structure and autonomy-supportive leadership can influence creative and innovative performance [5]. By externalizing operational knowledge and preserving organizational memory, this system is intended to reduce reconstruction burden and create greater capacity for mentorship, advocacy, stakeholder engagement, program improvement, succession planning, creativity, and innovation. Although developed within Microsoft Teams and SharePoint, the underlying framework is technology-agnostic and can be recreated in other shared digital platforms.

Description of Interactivity with Audience

During the Showcase, participants will be prompted to reflect on how chief resident responsibilities and resources are communicated and stored in their home program. Participants will see the innovative chief dashboard system applied to a recurring chief resident workflow and consider how the framework could be adapted to a process within their own program. Participants will discuss how the streamlined storage of organizational knowledge can promote cognitive offloading, freeing their chief residents for creativity and innovation.



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Title

Peds4CAPs: a Pediatric Medicine Didactics Curriculum for Child and Adolescent Psychiatry Fellows

Primary Category

Curriculum

Presenters

Kevin Makino, MD,PhD, Case Western Reserve University/University Hospitals of Cleveland Program, Anna Hankins, MD, Case Western Reserve University/University Hospitals of Cleveland Program, Christopher Gomez, DO, Case Western Reserve University/University Hospitals of Cleveland Program

Education Objectives

By the conclusion of this presentation, participants will be able to:

1. Describe a novel problem-based learning curriculum designed to teach key pediatric medicine topics within CAP fellowship training and support development of clinical reasoning skills as well as practical “next steps” for the psychiatrist when a medical problem is identified.

2. Evaluate how a problem-based learning approach can be utilized to strengthen fellows' abilities to navigate diagnostic uncertainty and complex comorbid clinical presentations.

3. Apply strategies for constructing broad differential diagnoses that incorporate both medical and psychiatric conditions in clinically challenging cases.

4. Implement actionable strategies and curricular materials to adapt and integrate this problem-based learning curriculum within other fellowship training programs.

Description of Innovation

We developed a novel “Peds4CAPs” curriculum with the goal of enhancing CAP fellows’ ability to generate a broad differential, gather relevant medical history, and recognize “red flag” symptoms, in order to identify when further medical evaluation is required, and to respond appropriately to relevant medical concerns within psychiatric scope of practice. At our institution, CAP fellows are integrated with Post-Pediatric Portal to

Psychiatry (PPPP) fellows in clinical rotations and didactics. The PPPP is a fellowship program for pediatricians to train in psychiatry. During informal conversations between CAP fellows and PPPP fellows over the course of training, CAP fellows expressed a desire to acquire additional pediatric medical knowledge. Similar educational needs have been identified by psychiatry residents, who have reported a desire for additional general medical knowledge in the course of their training.

Following Kern's Model of Curriculum Development, we conducted a needs assessment to inform a list of key topics and learning objectives relevant to the child psychiatry scope of practice. We subsequently developed clinical cases designed to address the identified topics and learning objectives. Cases are set predominantly in a CAP outpatient clinic setting with selected topics for the psychiatrist in the emergency and inpatient context. Sessions were designed using an interactive problem-based learning (PBL) format as this is effective in encouraging high learner engagement and promoting clinical thinking and problem-solving skills. Through PBL, learners think creatively, generate clinical hypotheses, tolerate clinical ambiguity, and navigate complex patient scenarios. Content was produced by PPPP trainees with faculty mentorship by a PPPP graduate. After each session, learners completed evaluations that were used to improve subsequent sessions.

Curriculum topics include:

- Evaluation and Differential Diagnoses for: acute agitation in patients with Autism Spectrum Disorders; fatigue; Avoidant/Restrictive Food Intake Disorder; inattention and hyperactivity beyond Attention Deficit Hyperactivity Disorder (including atopic conditions and Obstructive Sleep Apnea); voiding dysfunctions (encopresis and enuresis); medically complex patients in psychiatry
- Nutrition: nutritional history taking; when to evaluate further
- -Interpretation of Laboratory and Vital Sign Abnormalities
- Sexual and Reproductive Health: sexual history taking; screening for sexually transmitted infections; harm reduction strategies

Using the detailed learning objectives and clinical cues already developed, our team plans to utilize large language models to generate additional novel clinical cases to allow for varied repetition of content across the two years of CAP training. By developing thorough facilitator guides, learning objectives, and handouts for each case, we are generating materials that can be implemented at other training programs.



Description of Interactivity with Audience

During our presentation we will use an interactive audience response system (e.g., Poll Everywhere) to have participants generate a differential diagnosis for new onset agitation in a child with autism. By turning audience responses into a live "word cloud" we will demonstrate visually the broad scope of psychiatric and medical topics that must be considered.

We will then ask participants to suggest next steps in the care of the autistic patient with new onset agitation, given the broad differential diagnosis just generated. Participants will be able to upvote and downvote other submitted suggestions so that the group can generate a ranked list of next steps.

After the audience has participated in this exercise we will provide a brief overview of our curriculum and PBL, followed by Q&A in which participants can discuss the case, the curriculum, and how they might implement a similar curriculum within their own programs.

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Title

Practicing Motivational Interviewing With a Generative AI Virtual Patient: A Pilot Educational Intervention for Psychiatry Residents

Primary Category

Curriculum

Presenters

Melissa Lavoie, MD, University of Maryland/Sheppard Pratt Program

Education Objectives

1. Explain how an LLM-based virtual patient can support independent, low-stakes practice of MI skills.

2. Analyze key design considerations when using an LLM as a simulated patient.

3. Describe strategies for using virtual patient encounter transcripts to guide faculty feedback and reflection.

4. Identify opportunities to adapt this model for communication skills training within participants' own residency programs.

Description of Innovation

We developed an LLM-based virtual patient to provide learners with independent practice applying MI skills. The intervention was previously piloted with fourth-year medical students enrolled in a transition to residency course for students entering psychiatry and is now being adapted for a group of PGY-3 psychiatry residents. The resident intervention will combine structured MI instruction, asynchronous practice with an LLM-based virtual patient, and instructor-guided review of learner transcripts.

The virtual patient, developed using ChatGPT, portrays a patient with unhealthy alcohol use who does not view their drinking as problematic and presents for treatment at the urging of a spouse. The prompt specifies the patient's history, perspective on alcohol use, and interactional style and directs the LLM to remain in the patient role throughout the encounter. The LLM is explicitly instructed not to coach the learner or provide feedback. Instead, it functions as a simulated patient with whom residents can practice applying skills introduced during instructor-led teaching.

Development involved iterative testing and refinement of the virtual patient. Testing identified challenges including inconsistent information disclosure, departures from the patient role, and the potential for the LLM to adopt unsupported assumptions introduced by the learner.

Residents have been participating in structured MI instruction led by an LCSW-C who is a member of the Motivational Interviewing Network of Trainers (MINT). Following this instruction, residents will independently complete the virtual patient encounter and each submit a transcript of one encounter to the instructor. They may interact with the virtual patient as many times as they would like, allowing for repeated, self-paced practice.

Submitted transcripts will then be reviewed by a faculty facilitator and the MI instructor to identify recurring strengths and opportunities for improvement. These observations will inform a follow-up teaching session in which selected transcript excerpts may be reviewed with the group. In this framework, the virtual patient provides an opportunity for independent practice while human educators provide feedback and facilitate reflection.

Surveys will assess residents' prior MI experience, changes in confidence in MI skills, and perceptions of the virtual patient's realism and usefulness. Pilot implementation and evaluation will be completed before the 2027 AADPRT Annual Meeting.

Description of Interactivity with Audience

Audience members will be invited to reflect on opportunities and challenges associated with using LLM-based virtual patients for MI training. Brief examples from the development or implementation of the virtual patient will be used to prompt reflection on design considerations, potential challenges, and applications of this approach to communication skills practice. During the Q&A, participants will be encouraged to identify ways in which this model could be adapted within their own residency programs.

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Title

Preparing Trainees for Attendinghood: Values-Based Tools for Evaluating Early-Career Opportunities

Primary Category

Professional Identity Formation (including career development, mentorship, advising, wholeheartedness, meaning/purpose)

Presenters

Jennifer O'Donohoe, MD, University of Utah School of Medicine, Kristi Kleinschmit, MD, University of Utah School of Medicine

Education Objectives

1. Identify the gap between existing ACGME Milestones/transition-to-practice guidance and trainees' actual need for support in evaluating early-career opportunities.

2. Describe the structure and content of two ready-to-use tools.

3. Generate ideas for adapting and implementing these tools within their own residency or fellowship programs.

Description of Innovation

Residents and fellows in our program's leadership seminar identified a specific and recurring anxiety about the transition to independent practice: whether they would know how to manage the influx of clinical and non-clinical opportunities that they would be presented with in the first few years of becoming an attending. In program discussions, fellows described watching recent graduates either say yes to everything in their first year (committees, extra call, side projects, informal favors) and burn out within 18 months or become so wary of over-commitment that they turned down opportunities that would have meaningfully shaped their careers. They explicitly asked for a session that would give them a practical framework for making these decisions before facing them under time pressure.

In response, we developed two sequential tools grounded in values-based decision making, a framework in which decisions are evaluated not against external metrics of prestige or opportunity alone, but against an individual's explicitly identified personal

and professional values, so that each choice reinforces rather than erodes the life and career the person is trying to build.

The Values Worksheet moves fellows from reflective prompts (admired role models, meaningful experiences, envisioned life in five to ten years) through general and career-specific value banks, ending with a ranked set of three to six core values that becomes their decision-making reference point.

"Practicing the Yes and the No" tool operationalizes those core values. Fellows apply a three-question filter (alignment with values, the hidden trade-off of every yes, and the cumulative effect of saying yes repeatedly) to twelve realistic early-attending scenarios (committee invitations, moonlighting, informal favors, media requests, QI leadership, and more). The trainees then draft personal "default yes" and "default no" statements to rehearse the language of a values-aligned answer before facing the real decision.

Together, the tools translate the conceptual "transition to practice" language in the Milestones into a concrete, reusable decision-making practice, filling a gap that neither ACGME guidance nor existing career-transition literature currently addresses, and offering other program directors a low-resource, adaptable session they can incorporate into their own transition-to-practice curricula.

Description of Interactivity with Audience

1. Present the gap (1.5 min): A brief framing of the ACGME Milestones' "transition to practice" language and the disconnect between that conceptual systems-based-practice knowledge and the lived experience of fielding real opportunities in year one.

2. Present the tools (2.5 min): A walkthrough of the Values Worksheet and "Practicing the Yes and the No," showing how the two tools sequence together — from identifying core values, to applying the decision filter, to rehearsing default yes/no language.

3. Discuss fellow response (1 min): A summary of how fellows in our leadership seminar responded to the tools — what they found clarifying, any adjustments made based on their feedback, and early signals of usefulness.

The remaining 5 minutes will be open discussion, inviting program directors to ask questions and consider how the tools might be adapted for their own transition-to-practice curricula.



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Title

Shark Week: A Fun and Practical Approach to Easing into EPA Evaluations

Primary Category

Assessment – learner (summative, formative, programmatic)

Presenters

Jessica Obeysekare, MD, Prisma Health- Upstate/University of South Carolina School of Medicine Greenville (Greer) Program, Christine Sawhill, DO, Prisma Health-Upstate/University of South Carolina School of Medicine Greenville (Greer) Program

Education Objectives

The objective was to use a change management lens to successfully roll out EPA evaluations in the residency program. The theory of change by the training directors was that EPA evaluations would be more likely to be successful if there was shared understanding of EPAs, agreement on what gap they would fill, a time-limited effort, fun, and gamified.

Description of Innovation

The introduction of a new evaluation approach to faculty and trainees can be seen through the lens of change management. In change management approaches, identification of a shared vision, clear communication regarding the reason for the change, engagement with others in the development process, and providing proper support improves trust and ownership in the change process [5]. Once those facets have been met in the development and planning of change, gamification can help further reinforce skill acquisition and acceptance.

Education about EPAs was provided to the faculty and residents during faculty meetings and program director meetings. While EPAs could be completed at any time, four discrete timeframes were chosen for the program to promote EPA evaluations: two one-week evaluation windows and two one-day evaluation windows. EPA evaluations were built in Microsoft Forms. The training directors had access to all of the evaluation results, viewable in a Microsoft Excel linked to the Forms. The training directors viewed the number of evaluations completed during each evaluation episode.

In alignment with the program's theory of change concept of increasing the enjoyment of the EPA process, the training directors chose to create a theme for the EPA evaluation windows and to decorate the office and QR code signs to the EPA evaluation form. The theme was "shark week," and decorations including small shark statues placed in the resident and faculty mailboxes, shark signs on the walls, and a large inflatable shark in the breakroom. This was meant to provide frequent visual cues to the faculty to complete EPA evaluations, while also making it fun.

In order to gamify the process, the training directors created a competition among the faculty to see who would complete the most evaluations during each EPA window. The winner was given a large shark plastic figurine to keep in their office, which they would keep possession of until the next EPA window. Results of the EPA competition were shared with the department to celebrate the faculty achievement.

Description of Interactivity with Audience

- 0-30 seconds: Provide brief context for the upcoming presentation.
- 30 sec – 3 min: Presenters will simulate presenting the roll-out to the faculty and describe the plan for EPA window theming and gamification.
- 3-4 min: Review results (share number of evaluations completed during each window, comparison of day versus week window, share faculty and resident qualitative feedback) and next steps.
- 4-5 min: To demonstrate the principle of gamification, a short simulated EPA evaluation will be completed and the fastest respondent will receive a small shark figurine

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Title

The Model Patient: Using AI Large Language Models as a framework for interactifying didactics.

Primary Category

Learning Environment

Presenters

Daniel Ortiz, BS,MD, University of Kansas Medical Center, Christine Glenn, DO, University of Kansas Medical Center

Education Objectives

At the conclusion of this Innovations Showcase, participants will be able to:

1. Describe a structured framework for creating reproducible generative AI standardized patient encounters that preserve both the fixed case information of a clinical vignette and dynamic interpersonal responses of a practical encounter.

2. Identify opportunities for integrating generative-AI standardized patient simulations into medical and/or graduate medical education for interviewing practice, clinical reasoning, and formative feedback.

3. Demonstrate how learner communication can influence disclosure, rapport, and the trajectory of an AI standardized patient encounter without altering predetermined clinical facts.

Description of Innovation

The Virtual Interactive Patient (VIP) Framework is a structured approach for using generative AI to create reusable standardized patient encounters for medical learners. Unlike a simple prompt instructing an AI model to portray a patient, the framework establishes fixed clinical facts, information layers, patient temperament, disclosure logic, interactional difficulty, relational responsiveness, timing parameters, and post-encounter feedback. Major elements of the patient's history are established before the encounter and remain consistent, while communication style, rapport, trust, and learner behavior influence how and when information emerges.



As part of the simulation, educators may select no feedback, patient-perspective feedback, educator feedback, or combined feedback. Feedback remains separate from the patient simulation so that assessment instructions do not influence patient behavior during the encounter. The framework also incorporates explicit bias checks intended to prevent patient behaviors from being inferred solely from diagnosis or identity.

The framework was piloted by five participants representing medical students, residents, and attending physicians; four completed a post-simulation survey. All respondents reported opportunities to practice clinical interviewing and case conceptualization/formulation, and three of four identified practice navigating challenging patient interactions. Participants rated the realism of the simulated patient highly, with three of them rating realism 4/5 and one 5/5. Three of four reported increased confidence conducting clinical interviews after the simulation, and all reported that post-encounter feedback helped identify opportunities to improve communication.

Qualitative feedback emphasized realistic patient responses, engagement, deliberate question selection, and the potential value of conversational voice interaction. Pilot testing also directly informed iterative framework development, including the addition of encounter timing modes, patient temperament and relational states, formulation exercises, self-contained learner feedback, and optional voice encounters.

Description of Interactivity with Audience

During the five-minute interactive portion, participants will experience a brief “same patient, different interviewer” demonstration. Attendees will be shown a short psychiatric patient vignette and asked to choose between two contrasting learner approaches to the next portion of the interview. The presenter will demonstrate how the standardized patient framework allows the patient's response and relational state to change based on the learner's communication while maintaining the same fixed clinical history. Participants will then discuss how the interaction might differ using an alternative approach and identify one potential application for AI standardized patients within their own training programs. Remaining time will be used for informal questions regarding implementation, case development, and limitations.

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Title

The Rhythms of Research: Designing a Program to Support Faculty Educational Scholarship

Primary Category

Research and Scholarship

Presenters

John Q Young, MD, MPP, PhD, Zucker School of Medicine at Hofstra/Northwell - Zucker Hillside Hospital, Abigail Konopasky, PhD, Zucker School of Medicine at Hofstra/Northwell - Zucker Hillside Hospital, Dustin Avery Brinker, MD, Zucker School of Medicine at Hofstra/Northwell - Zucker Hillside Hospital

Education Objectives

This presentation will showcase our innovative approach to designing a series of supports for psychiatry faculty in educational scholarship, including the following objectives:

1. Carry out a qualitative needs assessment through research brainstorming sessions
2. Examine both individual and institutional indicators of capacity
3. Develop educational scholarship mission aligned with institutional mission
4. Draw from assessment results and literature to craft goals and corresponding action plans

Description of Innovation

While our institution values and supports clinical research, we felt that our understanding of educational research efforts—who is interested, what faculty are already doing, what institutional resources faculty need and are already using—was thin. So we launched a study of our department's educational research capacity. Our institution is large, covering multiple hospitals, across which we have 5 residency and 4 fellowship programs. We met with fellowship program directors, associate program directors, and department chairs. Further, we used snowball sampling, meeting with



others both within and outside the department whom these individuals identified as connected to educational research in psychiatry.

Our project had four stages of innovation corresponding with our objectives. First, rather than surveying a survey-fatigued group, we scheduled one-on-one research and scholarship brainstorming sessions with participants, led by a PhD-trained educational researcher new to our department in an educational support role. This innovative approach meant that faculty wanted to be a part of the study because it offered them support. The structure was open-ended, with questions about previous research experience, areas of research interest, and institutional supports and barriers. Most participants also shared beliefs about their educational research efficacy, something we had not initially thought to examine. The researcher took detailed notes which served later as our data.

Second, using a theory from evaluation studies developed to build health research capacity in universities, we examined both individual and institutional factors.4 This theory-driven approach allowed us to more easily distinguish between faculty development needs (e.g., building educational research skills, developing confidence in educational scholarship) and infrastructure needs (e.g., connection and collaboration across institutional silos).

Third, after analyzing the data, we determined that we needed a mission to guide our work. To align ourselves with institutional goals, we tied our mission directly into our institution's mission, seeking "to advance this [institutional] mission by advancing the science and practice of clinical workplace learning in the health professions." We also were mindful of the kinds of support we could provide, focusing our efforts on research areas in which our department already had expertise: assessment, instruction, equity, agency, and workplace learning.

Fourth, we drew evidence-based strategies from the literature5 that aligned with our findings and mission to develop a set of 5 clear goals for our program, including developing educational research leaders, improving quality and quantity of faculty and trainee scholarship, building communities of educational researchers, publicly celebrating achievements, and supporting professional identities as educational researchers. Our action plan developed directly from these goals.

While stretching across several months, this creative approach only took several hours per week and served to introduce the researcher to important stakeholders. The



familiarity with faculty needs and experiences gained in this process was invaluable as she worked with the leadership team to develop supports such as a research consultation service, an annual education retreat, weekly writing groups, and on-demand video resources.

Description of Interactivity with Audience

This innovation session will offer an opportunity for audience members to assess their own educational research and scholarship needs. There will be time for Q&A and we will also ask the following questions:

- What is your experience with educational research and scholarship?
- What, if any, are your area(s) of interest?
- What supports for educational scholarship do you have at your institution?
- What barriers to educational scholarship do you face at your institution?
- How confident are you that you can...
    - design a scholarly project in education?
    - collect data for that project?
    - analyze data for that project?
    - develop a presentation or poster for an educational conference?
    - write and submit a manuscript in an educational journal?

Participants will be invited to share their responses and be given paper and electronic worksheets so that they can take their responses home with them.

Scientific Citations

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Title

There’s No “I” in “Call”: Co-Creating a Team-Based Call Model Through Generative Leadership

Primary Category

Learning Environment

Presenters

Samuel Saenz, MD,MPH, Stanford University School of Medicine, Jarrod Ehrie, MD, Stanford University School of Medicine, Anita Kishore, MD, Stanford University School of Medicine, Sahar Ashrafzadeh, MD, Stanford University School of Medicine, Austin Valido, MA

Education Objectives

By the end of this presentation, participants will be able to:

1. Analyze their current call or clinical learning structures to identify opportunities for greater peer learning, psychological safety, progressive autonomy, and shared accountability

2. Apply a stakeholder-informed co-design approach to engage residents, faculty, and program leadership in developing or refining clinical structures

3. Utilize iterative feedback and stakeholder perspectives to identify tradeoffs, adapt programmatic structures, and align clinical learning environments with the unique needs of their training program.

Description of Innovation

Our adult psychiatry residency redesigned traditional single-resident call into a team-based clinical learning model through an iterative quality improvement and participatory approach. Rather than treating call as solely an operational scheduling problem, residents, faculty, and program leadership co-designed a call structure intended to promote peer learning, psychological safety, shared problem-solving, camaraderie, and progressive autonomy. Early discussions explicitly considered potential tradeoffs, including increased call shifts, role ambiguity, and the possibility of decreased autonomy of junior residents.



The resulting model incorporates complementary resident roles, shared accountability, resident-driven division of labor, group teaching, and longitudinal progression toward greater responsibility and autonomy. On weekdays, a PGY1 and PGY2 are on call simultaneously, with the PGY2 shift extending later into the evening to provide transition coverage for the PGY2 night-float resident. On weekends, two teams of two residents-each pairing a junior and a senior resident-divide clinical responsibilities, with one team focusing on consult-liaison psychiatry and the other on psychiatric ward and emergency room consults. At the beginning of shifts, team members discuss goals and growth edges. Residents use closed-loop communication and default to evaluating clinically complex or uncertain situations together, creating structured opportunities to voice uncertainty, seek support, and engage in shared clinical reasoning. At the same time, this model creates opportunities for residents to practice clinical responsibilities at an appropriate level of autonomy while receiving graduated supervision and real-time feedback. The team therefore functions as both a clinical resource and an intentional learning environment.

A defining feature of the innovation is that the model was not considered complete at implementation. Before implementation, residency leadership met four times with individual residency classes and six times with chief residents to solicit feedback and develop an initial team-based call structure. After implementation, ongoing resident and faculty feedback prompted modifications to further clarify senior and junior roles, refine shift timing, strengthen supervision structures, and expand teaching related to clinical decision-making and hospital policies. The schedule itself became a product of continuous dialogue.

Pre-implementation survey data, with 28.6% resident participation, indicated that most respondents viewed call as important for developing independent clinical practice, while also reporting limited camaraderie and mixed effects on well-being. Regular informal post-implementation feedback venues with residents and faculty created ongoing feedback loops between program leadership and those directly experiencing the system. Post-intervention survey analysis will be completed by January 2027.

Importantly, the co-design process itself became an educational intervention. Residents practiced communicating needs, negotiating roles, providing feedback to leadership, tolerating uncertainty, and adapting program structures based on trainee experience. The innovation therefore lies not simply in adding residents to call, but in creating a

generative leadership process through which trainees and faculty jointly design and continuously refine the clinical learning environment.

This model offers a transferable framework for training programs seeking to transform operational requirements into collaborative educational experiences while adapting their call structures to the unique needs of their learners and clinical settings.

Description of Interactivity with Audience

Participants will first view a simple visual contrasting a single-resident call model with our team-based model and be asked: “What educational opportunities become possible when we move from an individual to a team-based call structure?” After brief audience responses, participants will then consider the tradeoffs inherent in redesigning call, such as increased call shifts, role ambiguity, and balancing collaboration with progressive autonomy. Participants will identify which tradeoff they would anticipate as most challenging in their own program. The presenter will connect these responses to our iterative co-design process, highlighting how resident and faculty feedback helped identify and address challenges as the model evolved. This interactive format allows participants to experience the central principle of the innovation: transforming clinical learning environments requires not only a new structure, but an ongoing process of shared problem-solving, feedback, and adaptation to the unique needs of each program.

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