POSTERS

Title

A Field Without Borders: One Step Toward Defining Interventional Psychiatry Competencies for Every Resident

Primary Category

Curriculum

Presenters

Jarrod Ehrie, MD, Stanford University School of Medicine, Jeffrey Zabinski, BS, MA, MD, Columbia University/New York State Psychiatric Institute, Snehal Bindra, MBA, MD, Stanford University School of Medicine, Yaakov Green, MBA, MD, NYU Grossman School of Medicine, Simran Ailani, MD, Yale University School of Medicine

Education Objectives

To build such a curriculum nationally, the Interventional Psychiatry Consortium applied the targeted needs assessment phase of Kern's six-step approach to curriculum development.

This study aims to define what every psychiatry resident should learn and know about the growing field of Interventional Psychiatry. Using the principles of targeted needs assessment, we interviewed members of the field to understand how to 1. Conceptualize and define Interventional Psychiatry 2. Identify foundational competencies 3. Determine how to create an equitable and accessible learning discourse. These findings will help inform a national curriculum developed by Interventional Psychiatry Consortium.

Practice Gap

Interventional Psychiatry has become increasingly established as a psychiatric subspecialty and framework encompassing procedural and device-based treatments, such as ECT, TMS, ketamine/esketamine, VNS, and DBS, for psychiatric illness. Prior literature has debated its scope: core modalities and areas of overlap with neurology, neurosurgery, and other specialties. However, there is still no standardized approach to residency education. Current ACGME requirements identify ECT individually and refer more broadly to neuromodulation without defining other modalities or competencies that should be included. The recent work by AADPRT has considered recommending changes to ACGME. As these treatments become more common in psychiatric care, residents need structured training in their indications, mechanisms, risks, and interdisciplinary delivery, regardless of whether they will perform the procedures themselves.

Methods

We conducted semi-structured interviews with interventional psychiatry fellows and faculty, including training directors, across academic programs and career stages. Each interview asked five open questions: how

participants define the field, their training, where it fell short, how they prefer to learn, and what should be standardized nationally. Interview notes were de-identified and analyzed thematically. The Stanford University IRB determined the study exempt, and interviews are ongoing.

Results

Preliminary analysis included seven participants (two fellows and five faculty) representing four academic medical centers. Definitions varied between mechanism-based and pathology-based frameworks, with additional heterogeneity in specialty ownership and credentialing.

Participants identified four competencies for every graduating resident: identifying candidates, placing modalities within treatment algorithms, counseling patients about what treatment involves, and referring appropriately. Participants described residents as generally knowing what these treatments are but struggling to apply that knowledge to clinical decisions. ECT was the most common concern, with resident involvement described as administrative rather than educational. Hands-on exposure depended on what each program offered. Teaching the four competencies, however, was described as lacking even at well-resourced programs.

Conclusions

Despite variation in how participants defined the field, they identified shared priorities for residency education. Because those competencies could form the basis of a shared curriculum that does not depend on local availability of procedural services. That points to a staged approach.

The first step is a national curriculum built around the four competencies, which any program can deliver through shared curricula and case-based teaching. Only a few residents will end up as interventionalists; however every resident will decide which patients access these treatments.

The second step broadens clinical exposure through short away rotations for interested residents, allowing them to learn about modalities unavailable at their home programs. Because training often reflects an institution’s particular strengths, these exchanges could make educational opportunities more equitable and, over time, help expand patient access.

These preliminary findings offer a foundation for a shared core curriculum focused on what every psychiatry resident should be able to do, regardless of where they train.

Scientific Citations

1. Menon SN, Torrico T, Luber B, et al. 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, et al. A model for formal residency training in interventional psychiatry. Acad Psychiatry. 2024;48(5):431-435. doi:10.1007/s40596-024-02058-7



3. Giacobbe P, Tu A, Kaustov L, et al. Advancing education in interventional psychiatry: Scoping review of simulation training and the future of virtual reality-based learning. Front Psychiatry. 2025;16:1432314. doi:10.3389/fpsyt.2025.1432314

4. 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

5. Green YS, Ailani S, Ehrie J, Zabinski J. Building inter-institutional education in psychiatric subspecialties: Experiences from the Interventional Psychiatry Consortium. Acad Psychiatry. Published online April 9, 2026. doi:10.1007/s40596-026-02338-4

6. Accreditation Council for Graduate Medical Education. ACGME Program Requirements for Graduate Medical Education in Psychiatry. 2025. Section 4.6.a.6.

7. Sauvé, W. M., Insel, T. R., Albright, B. B., Koo, M., Berman, R. M., Stahl, S., ... & Qian, J. J. (2026). Defining interventional psychiatry: a framework for professional identity and practice evolution. Nature Mental Health, 1-8.



Title

A Mixed-Methods Approach to Understanding Psychiatry Residents' Liaising Experiences and Perceived Educational Gaps in Consultation-Liaison Psychiatry

Primary Category

Program Evaluation

Presenters

Zehra Aftab, MD, University of Chicago, Alice Li, MD, University of Chicago, Brittany Goldstein, MD, University of Chicago, Alice Bai, BS, University of Chicago, Kristen Jacobson, PhD, University of Chicago

Education Objectives

We aim to explore how psychiatry residents experience, interpret, and navigate inter-professional dynamics during CL encounters. Through this needs assessment, we are identifying recurring challenges, perceived skill deficits, and areas amenable to educational intervention.

Practice Gap

In consultation-liaison (CL) psychiatry, "liaising" refers to psychiatrists' communication and collaboration with their medical and surgical colleagues. As consultants, psychiatrists must provide diagnostic evaluations and therapeutic recommendations while navigating complex inter-professional dynamics. Although the Accreditation Council for Graduate Medical Education has established the consultative role as a core competency, and although all accredited psychiatry residency programs must provide clinical experiences in CL, few studies have focused on psychiatry residents' experiences of CL-related inter-professional interactions. There is also evidence that psychiatry residents on the CL service often experience these interactions as challenging. Further development of residents' liaising skills may improve psychiatry's relationship with primary teams and ultimately benefit patient outcomes.

Methods

This study used a survey with both quantitative and qualitative questions. Participants were psychiatry residents from multiple institutions selected to represent major geographical regions in the United States. Participants were invited via e-mail to complete a 10-minute REDCap survey consisting of questions regarding training level and extent of past CL exposure. The survey also included Likert scale self-assessments of their confidence with different liaising-related tasks, perceived barriers to effective liaising, and degree of satisfaction with current

education on how to liaise. Survey data were descriptively analyzed and responses to open-ended questions will be qualitatively analyzed using thematic analysis. This project was approved under IRB26-0368.

Results

Thus far, 85 participants from 10 residency programs have completed the survey, including 14 (16.5%) PGY-1s, 21 (24.7%) PGY-2s, 28 (32.9%) PGY-3s, and 22 (25.9%) PGY4s or above. Among the 79 participants with CL experience, almost half (37, 46.8%) stated that their residency program did not provide enough formal education specific to how to approach the interprofessional interactions required by liaison work. Residents with CL experience also identified multiple barriers to liaison work, including unclear consult questions (identified as a moderate or major barrier in 69.6% of respondents), consults requesting something beyond the capacity of the CL service (identified as a moderate or major barrier in 75.9% of respondents), and differences in clinical priorities between psychiatry and the primary team (identified as a moderate or major barrier in 65.9% of respondents). Among those who endorsed receiving education on liaising (73 out of the 79 residents with CL experience), the two most cited educational strategies were discussion with senior residents, fellows, or attendings (87.7%) and real-time observation of liaising (86.3%).

In this presentation, we will also explore correlations between residents' amount of CL experience and confidence in certain liaising-related tasks. We will additionally provide qualitative analyses of residents' open-ended responses regarding the most challenging aspect of working with primary medical teams on CL, as well as regarding what educational intervention residents would find most helpful towards the development of their liaising skills.

Conclusions

Preliminary survey results show that there is a significant need for more formal education regarding liaising skills for psychiatry residents. Results from this needs assessment will ultimately help inform future educational goals and objectives related to liaising and performing the consultative role, with implications for CL psychiatry and beyond.

Scientific Citations

1. Beach, S. R., Ernst, C. L., Fipps, D. C., Soeprono, T. M., Lavakumar, M., Greenstein, S. P., Heinrich, T. W., & Schwartz, A. C. (2025). 2024 ACLP Recommendations for Training Residents in Consultation-Liaison Psychiatry. Journal of the Academy of Consultation-Liaison Psychiatry, 66(1), 80–89. https://doi. org/10.1016/j.jaclp.2024.11.001

2. Beach, S. R., Ernst, C. L., Lavakumar, M., Greenstein, S. P., Fipps, D. C., Soeprono, T. M., Heinrich, T. W., & Schwartz, A. C. (2023). A 10-Year Follow-up Survey of Psychiatry



Resident Education in Consultation-Liaison Psychiatry. Journal of the Academy of Consultation-Liaison Psychiatry, 64(3), 199–208. https://doi.org/10.1016/j.jaclp.2022.12.003

3. Howland, M., Peleggi, A., Lee, J., & Soeprono, T. (2023). Psychiatry Residents as Interdisciplinary Teachers: the PIES Process. Academic psychiatry: the journal of the American Association of Directors of Psychiatric Residency Training and the Association for Academic Psychiatry, 47(1), 113–114. https://doi.org/10.1007/s40596-022-01699-w

4. Matsuo, T., Hayashi, K., Uehara, Y., & Mori, N. (2021). Essential consultants' skills and attitudes (Willing CONSULT): a cross-sectional survey. BMC medical education, 21(1), 366. https://doi.org/10.1186/s12909-021-02810-9

5. Patel, H., Perry, S., Badu, E., Mwangi, F., Onifade, O., Mazurskyy, A., Walters, J., Tavener, M., Noble, D., Chidarikire, S., Lethbridge, L., Jobson, L., Carver, H., MacLellan, A., Govind, N., Andrews, G., Kerrison-Watkin, G., Lun, E., Malau-Aduli, B. S., & the ACHIEVE Network (2025). A scoping review of interprofessional education in healthcare: evaluating competency development, educational outcomes and challenges. BMC medical education, 25(1), 409. https://doi.org/10.1186/s12909-025-06969-3

Title

Advancing Mentorship in Psychiatry (AMP): A Resident-Led Model for Intersectional Mentorship, Belonging, and Wellbeing in Academic Psychiatry

Primary Category

Learning Environment

Presenters

Samuel Saenz, MD, MPH, Stanford University School of Medicine

Education Objectives

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

1. Analyze structural barriers to equitable mentorship and belonging among psychiatry residents, fellows, and other behavioral health trainees.

2. Apply principles of cultural humility, intersectionality, and psychological safety to the design of mentorship programs.

3. Utilize a resident-led, longitudinal mentorship framework that integrates individualized matching, peer support, interactive education, and rupture-and-repair skills.

4. Evaluate strategies for sustaining mentorship initiatives through distributed leadership, institutional memory, participant feedback, and departmental resources.

5. Adapt the AMP model to residency and subspecialty fellowship settings while minimizing the additional service burden placed on historically underrepresented trainees and faculty.

Practice Gap

Although psychiatry training programs increasingly prioritize workforce diversity, representation alone does not ensure equitable access to mentorship, sponsorship, belonging, or career development. Trainees from historically marginalized and underrepresented backgrounds may encounter social isolation, microaggressions, limited access to culturally responsive mentors, and additional professional burdens. Existing mentorship models are often informal, dyadic, and dependent on trainees' ability to identify and access mentors independently. This creates a practice gap between increasingly diverse trainee populations and the mentorship infrastructure needed to support their professional development and wellbeing. Advancing Mentorship in Psychiatry (AMP) was developed as a resident-led, structured, longitudinal model integrating



cross-cultural mentorship, cultural humility, peer support, and leadership development to promote belonging and career resilience across psychiatry training.

Methods

AMP was established as a resident-led, structured mentorship program within an academic psychiatry department. The model was iteratively refined over five years using participant feedback and longitudinal program evaluations. Mentees rank preferences for clinical, research, professional, and identity-related alignment; mentors provide self-identified areas of interest and expertise. Participants are intentionally paired and encouraged to meet at least monthly. Monthly programming includes interactive, resident-led large group sessions addressing cultural humility, intersectionality, professional identity development, navigating microaggressions, effective communication, and mentorship rupture-and-repair. Peer mentorship and community-building activities were added as the program expanded. A senior/junior resident executive team is supported by a faculty advisor, program leadership, and program management. Standardized curricula, cloud-based institutional archives, and iterative evaluation support leadership transitions and program continuity. Departmental funding provides participant incentives and educational support, helping reduce the additional service burden associated with participation. Pre-, midpoint-, and post-program assessments evaluate mentorship effectiveness, cultural humility, bias awareness, career advocacy, belonging, and wellbeing; qualitative responses inform program refinement.

Results

During the first four years, AMP included 58 unique mentees and 37 mentors, with participants representing adult psychiatry residents; fellows in child and adolescent, forensic, consultation-liaison, and addiction psychiatry; psychology trainees; and faculty psychiatrists and psychologists. Participants demonstrated pre-to-post improvements across measures of mentorship effectiveness, cultural humility, bias awareness, career advocacy, and belonging/wellbeing. Among respondents, 92% planned to continue their mentorship relationship and 98% would recommend AMP to colleagues. Few mentorship relationships ended despite opportunities for repair. Program adaptations based on participant feedback included expanded interdisciplinary participation, peer mentorship, more participatory sessions, advanced conflict-resolution content, engagement metrics, and a distributed resident leadership structure.

Conclusions

AMP demonstrates a scalable approach to addressing the mentorship gap through intentional matching, cross-cultural mentorship training, peer community, and resident leadership. Its emphasis on belonging and wellbeing extends mentorship beyond career advancement toward

a broader JEDI and educational leadership strategy. Key implementation lessons include building institutional memory, distributing leadership responsibilities, compensating or otherwise supporting participation, and treating mentorship rupture as an opportunity for skill development rather than program failure. The model can be adapted across psychiatry residencies, subspecialty fellowships, and interdisciplinary behavioral health programs. Future evaluation will examine longitudinal effects on wellbeing, burnout, career development, and leadership outcomes.

Scientific Citations

1. Bath EP, Brown K, Harris C, et al. For us by us: Instituting mentorship models that credit minoritized medical faculty expertise and lived experience. Front Med (Lausanne). 2022;9:966193. doi:10.3389/fmed.2022.966193.

2. Fraser K, Dennis SN, Kim C, et al. Designing effective mentorship for underrepresented faculty in academic medicine. Fam Med. 2024;56(1):42-46. doi:10.22454/FamMed.2023.186051.

3. Harris LM, Pierre EF, Almaroof N, Cimino FM. Cross-cultural mentorship in military family medicine: Defining the problem. Fam Med. 2023;55(9):607-611. doi:10.22454/FamMed.2023.794972.

4. Rinderknecht FAB, Kouyate A, Teklu S, Hahn M. Antiracism in action: Development and outcomes of a mentorship program for premedical students who are underrepresented or historically excluded in medicine. Prev Chronic Dis. 2023;20:E49. doi:10.5888/pcd20.220362.

5. Silbersweig D, et al. Perceptions of a faculty-trainee group mentorship program, the mentorship families program, in a residency training program: Results from a cross-sectional survey. BMC Med Educ. 2024. doi:10.1186/s12909-024-06447-2.

6. Sotto-Santiago S, Mac J, Genao I, et al. “Value my culture, value me”: A case for culturally relevant mentoring in medical education and academic medicine. BMC Med Educ. 2023;23:229. doi:10.1186/s12909-023-04148-w.



Title

AI-Assisted, Podcast-Based Asynchronous Curriculum for Foundational Knowledge in the Psychiatry Intern Year

Primary Category

Assessment – learner (summative, formative, programmatic)

Presenters

Omair Abbasi, MD, Memorial Regional Hospital, Emilio Hospedales, MD, Memorial Regional Hospital

Education Objectives

1. Determine the feasibility and effectiveness of a flexible asynchronous psychiatry intern curriculum to accommodate variation in residents' availability, acumen, and preparation for scheduled didactics arising from rotations at disparate service sites and non-psychiatric rotations.

2. Use low-cost or no-cost resources, including a publicly available podcast and large language model–assisted question generation, to support self-directed learning and topic selection relevant to current clinical encounters.

3. Evaluate participant receptiveness pre- and post- curriculum participation and describe preliminary knowledge assessment outcomes to guide curriculum refinement.

Practice Gap

Community-based psychiatry programs may have limited faculty capacity, topic-specific expertise, and funding for curriculum development. Interns may also face competing demands when clinical responsibilities extend into scheduled protected didactic time. A self-directed asynchronous curriculum allows residents to select lessons relevant to current patient encounters, creating opportunities for just-in-time learning while requiring minimum completion expectations. Flexible topic selection and timing may support continued education across variable clinical schedules. Combining publicly available podcasts with AI-assisted question development offers a practical approach to providing flexible, structured education in programs with constrained resources.

Methods

During 2025–2026, four PGY-1 residents participated in a 46-module asynchronous curriculum delivered through Odoo eLearning, a no-cost platform. Modules paired publicly available



PsychRounds episodes, typically 15–25 minutes, with 10-item single-best-answer quizzes, permitting listening during commutes or clinical downtime. Residents selected clinically relevant topics, with at least 70% module completion required by year-end. Two hours of protected flex time were provided weekly for asynchronous learning, remaining clinical duties, research, personal wellness, or other resident-directed activities. An AI-assisted workflow transcribed podcast audio and used a large language model to generate questions. Faculty and senior residents outside the intern cohort shared episode listening and question review to verify accuracy and content alignment and revise items. Feasibility measures included completion and question preparation/review time. Residents completed paired, coded 46-item psychopharmacology assessments before and after the curriculum. Pre- and post-curriculum surveys assessed attitudes, self-reported knowledge, and experiences. Anonymous post-surveys were summarized at the cohort level. Analyses used descriptive statistics and summaries of recurring comments.

Results

All four residents completed both assessments and surveys. Pre-curriculum, three residents reported limited asynchronous learning exposure. All four endorsed podcast learning and audio enjoyment; all strongly agreed that episode-linked questions would reinforce understanding. Only one endorsed baseline confidence in psychotropic medication classes. Mean module completion was approximately 88.5%, exceeding the 70% expectation. Question preparation and vetting for module creation required approximately 20 minutes per module, excluding listening time, with work distributed among three faculty and four senior residents. Mean assessment scores increased from 30.25/46 (65.8%) to 34.50/46 (75.0%), a mean paired gain of 4.25 questions (9.2 percentage points). All four strongly agreed that the self-paced format fit their schedules and endorsed content appropriateness for PGY-1. Three considered it similarly effective to live lectures and one more effective. Two praised flexibility; comments described expanded medication knowledge and resources for review. Mean ratings increased in five of six knowledge and self-efficacy domains: confidence in psychotropic medication classes, identifying side effects and monitoring requirements, understanding pharmacokinetics, preparedness to discuss psychopharmacology, and confidence applying evidence-based literature. Across these five domains, average self-confidence ratings increased by 0.95 points on the five-point scale, from 2.80 to 3.75. Concerns included questions emphasizing minutiae and insufficient quiz feedback and explanations. Two identified rotation demands as barriers; three requested flashcards, reference materials, visuals, or interactive cases.

Conclusions

This pilot supports implementation feasibility and generally favorable receptiveness, particularly to scheduling flexibility. Three participants reported satisfaction and willingness to recommend

the curriculum. The small cohort unlinked post-surveys, and concurrent training without a comparison group limit conclusions about effectiveness. Standardizing to ten questions per episode, including episodes as short as ten minutes, may have lead to MCQs with emphasis on minutiae. Future iterations will adjust question counts to episode length and content, prioritizing bedside knowledge. Embedded learning materials and answer explanations will provide immediate, explanatory feedback and address participant concerns. Subsequent cohorts will inform refinement and evaluation.

Scientific Citations

1. Accreditation Council for Graduate Medical Education. ACGME Program Requirements for Graduate Medical Education in Psychiatry. Effective September 3, 2025. https://www.acgme.org/globalassets/pfassets/programrequirements/2025-reformatted-requirements/400_psychiatry_2025_reformatted.pdf

2. Hanafi S, Nahiddi N, Rana A, et al. Enhancing psychiatry education through podcasting: learning from the listener experience. Acad Psychiatry. 2022;46(5):599–604. https://doi.org/10.1007/s40596-022-01585-5

3. Kelly JM, Perseghin A, Dow AW, Trivedi SP, Rodman A, Berk J. Learning through listening: a scoping review of podcast use in medical education. Acad Med. 2022;97(7):1079–1085. https://doi.org/10.1097/ACM.0000000000004565

4. Kıyak YS, Kaya AB, Emekli E. Validity of AI-generated multiple-choice questions in medical education: a systematic review. Postgrad Med J. 2026 (advance article). https://doi.org/10.1093/postmj/qgag057

5. Larsen DP, Butler AC, Roediger HL III. Repeated testing improves long-term retention relative to repeated study: a randomised controlled trial. Med Educ. 2009;43(12):1174–1181.

6. Larsen DP, Butler AC, Roediger HL III. Test-enhanced learning in medical education. Med Educ. 2008;42(10):959–966. https://doi.org/10.1111/j.1365-2923.2008.03124.x

7. Riddell J, Robins L, Brown A, Sherbino J, Lin M, Ilgen JS. Independent and interwoven: a qualitative exploration of residents' experiences with educational podcasts. Acad Med. 2020;95(1):89–96.

8. Riehm L, Nanji K, Lakhani M, Pankiv E, Hasanee D, Pfeifer W. The use of large language models in generating multiple choice questions for health professions education: a systematic review and network meta-analysis. PLoS One. 2026;21(1):e0340277. https://doi.org/10.1371/journal.pone.0340277



9. Weightman MJ, Chur-Hansen A, Clark SR. AI in psychiatric education and training from 2016 to 2024: scoping review of trends. JMIR Med Educ. 2025;11:e81517. https://doi.org/10.2196/81517



Title

Artificial Intelligence (AI) vs Human Scoring of Applications of Prospective Psychiatric Residents – An Observational and Comparative Pilot Study

Primary Category

Recruitment and Selection

Presenters

Kenneth Fraser, BS, MD, University of Kansas School of Medicine, Wichita, Dalton Doyle, DO, University of Kansas School of Medicine, Wichita, Emily Hughes, DO, University of Kansas School of Medicine, Wichita, Shruti Mishra, MD, Jana Lincoln, MD, University of Kansas School of Medicine, Wichita

Education Objectives

Upon completion of the presentation, participants will be able to:

1. Analyze the similarities and differences between artificial intelligence-generated and human reviewer scores of psychiatry residency applications.

2. Identify application domains in which AI may be utilized to support standardized residency application review.

3. Evaluate the potential benefits and limitations of incorporating AI into residency application review, including efficiency, scoring consistency, bias, and the need for human oversight.

4. Apply study findings to consider appropriate, responsible uses of AI within their own residency application review processes.

Practice Gap

Current processes for psychiatric residency application review are time-intensive and labor-intensive, as they rely heavily on manual review. As AI becomes more commonplace, its utility in streamlining the application review process seems apparent. However, there is limited information regarding its reliability, the most effective use of this technology, or its limitations. In addition, there are no formal recommendations or consensus regarding the types of reviewer tasks that AI would be most useful or appropriate for. These features together lead to inconsistent use types across programs. This research aims to begin to consolidate the evidence base for AI use in application review by analyzing the concordance between AI review and human review of psychiatric residency applications.



Methods

Three evaluators and Microsoft Copilot assessed resident applicants using established scoring rubric that included eight domains: standardized tests, academic performance, letters of recommendation, language skills, social presentation/personality, volunteering/publications/leadership, interest in psychiatry, and global personal impression. Each item was evaluated using a 5-item Likert scale. The sum of items was the final score. Bivariate correlations compared each evaluator and AI scores. Kappa was conducted to assess inter-rater agreement. Domain differences were assessed with Friedman tests. Scores were averaged and compared to AI with Kappa and Wilcoxon Singed Ranks tests.

Results

A total of 70 resident applications were evaluated and scored. High correlations for scores were observed, ranging from r=0.567 to 0.865. Score agreement was low among evaluators, k=0.099 and low between the average evaluator score and AI, k=0.009. AI scored resident applicants significantly higher than evaluators, Z=2.712, p=.006. Domain assessment showed non-significant differences for standardized test performance, academic performance, and letters of recommendation, indicating that AI scores were similar to human evaluators.

Conclusion

Results showed inconsistent scoring between evaluators and AI. Final scores differed significantly, with AI scoring resident applicants more favorably. AI appeared to be most reliable in scoring academic performance, test performance, and letters of recommendation, suggesting that AI might be beneficial in reducing the time burden of evaluating resident applications for psychiatry.

Scientific Citations

1. Burk-Rafel, J., Reinstein, I., Feng, J., Kim, M. B., Miller, L. H., Cocks, P. M., Marin, M., & Aphinyanaphongs, Y. (2021). Development and validation of a machine learning-based decision support tool for residency applicant screening and review. Academic Medicine, 96(11S). https://doi.org/10.1097/acm.0000000000004317

2. Heldt, J., Yang, Y., & DeBonis, K. (2026). Caution advised when using Artificial Intelligence Chatbots to review psychiatry residency applications. Academic Psychiatry, 50(4), 509–511. https://doi.org/10.1007/s40596-025-02296-3

3. Michaelson, G., Karasik, D., Polen, E., Rangarajan, S. V., & Zhao, N. W. (2025). Preparing for AI in resident selection: A scoping review of current applications and limitations. The Laryngoscope, 135(11), 4053–4063. https://doi.org/10.1002/lary.32308



4. Ruiz De Luzuriaga, A. (2024). The potential for artificial intelligence tools in residency recruitment. Cutis, 113(2). https://doi.org/10.12788/cutis.0947

5. Varman, P. M., Nicholas, S., Conner, A., Prabhu, A. S., French, J. C., & Lipman, J. M. (2025). Feasibility of using AI to evaluate general surgery residency application personal statements. Journal of Surgical Education, 82(12), 103655. https://doi.org/10.1016/j.jsurg.2025.103655



Title

Beyond Match Day: Strengthening Peer Mentorship to Support the Transition to Psychiatry Residency

Primary Category

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

Presenters

Christine Glenn, DO, University of Kansas Medical Center, Andrew Wilson, DO, University of Kansas Medical Center

Education Objectives

1. Identify perceived characteristics of effective peer mentors and opportunities to better prepare resident mentors to fulfill this role.

2. Assess residents' perceptions of the accessibility, frequency, and effectiveness of the existing peer-to-peer mentorship system.

3. Implement a more structured peer mentorship model incorporating mentor education, defined expectations, and regular mentor-mentee contact.

4. Evaluate whether the intervention was associated with changes in first-year residents' perceptions of confidence, preparedness, and support from the residency program.

Practice Gap

The transition from medical student to resident physician requires rapid adaptation to new clinical, educational, and professional responsibilities. Mentorship can provide important psychosocial support and facilitate professional development during this transition.[1] However, mentorship experiences may vary in accessibility, structure, and expectations, and recent literature highlights the need for intentional mentor preparation and clearly defined program structures.[2],[3] At the University of Kansas Medical Center, psychiatry residents are paired with peer mentors who initially connect with incoming residents around Match Day. However, sustained engagement and structured follow-up have historically been variable. We sought to identify characteristics of effective peer mentorship and evaluate whether a more structured mentorship program could improve first-year residents' perceptions of readiness, confidence, and program support.



Methods

The transition from medical student to resident physician can be challenging as new residents adapt to increased clinical responsibility, evolving professional identity, and the demands of residency training.[1],[4] Near-peer mentorship and coaching have been described as strategies to support this transition, while structured preparation of peer mentors may enhance the effectiveness of these relationships.[3],[5]

At the University of Kansas Medical Center, the psychiatry residency program has historically assigned peer mentors to incoming residents. Mentors typically initiate contact shortly after Match Day to answer questions about residency and relocation to Kansas City. However, beyond this initial interaction, sustained mentor-mentee engagement and expectations for follow-up were variable. This quality improvement project sought to identify barriers to engagement and determine whether formalizing the mentorship process could improve the early residency experience.

PGY-1 and PGY-2 residents completed anonymous surveys assessing their current mentorship experience and perceptions of readiness for residency and support from the residency program. Survey items evaluated frequency of mentor-mentee contact and characteristics perceived as important in an effective mentor. PGY-2 and senior residents were additionally surveyed regarding their retrospective experiences with resident mentorship and their perceived preparedness to serve as mentors. These assessments were used to identify opportunities to strengthen the mentorship program.

Based on survey findings and the existing literature supporting structured mentorship and mentor preparation,[2],[3] the program implemented a formalized resident mentorship curriculum. Resident mentors participated in a dedicated teaching didactic addressing characteristics and behaviors of effective mentors, suggested topics for mentor-mentee discussions, and strategies for facilitating meaningful engagement. The revised program also established an expectation of at least quarterly mentor-mentee meetings.

Following implementation, residents were again surveyed regarding their experiences with peer mentorship, perceived readiness for residency, and perceptions of program-wide support. We hypothesized that formalizing mentorship expectations and providing dedicated mentor training would increase mentor-mentee engagement and frequency of contact, with corresponding improvements in PGY-1 residents' perceptions of preparedness, confidence, and program support.



Scientific Citations

1. Winderbaum J, Coventry LL. The benefits, barriers and facilitators of mentoring programs for first-year doctors: a systematic review. Med Educ. 2024;58(6):687-696. doi:10.1111/medu.15299.

2. Abdelmannan D, Buhumaid R, Salman H, et al. A scoping review of mentorship in Graduate Medical Education: a proposed conceptual framework. Front Med (Lausanne). 2025;12:1616148. doi:10.3389/fmed.2025.1616148.

3. Leong JR, Lim AYD, Ravindran N, et al. A systematic scoping review of mentor training in medical education between 2000 and 2024. BMC Med Educ. 2025;25:1110. doi:10.1186/s12909-025-07353-x.

4. Winkel AF, Gillespie C, Park A, et al. Bridging the gap from student to doctor: developing coaches for the transition to residency. Med Educ Online. 2023;28(1):2145103. doi:10.1080/10872981.2022.2145103.

5. Callahan DG, Osman NY, Klig JE, et al. Facilitating the transition to residency: a resident-as-coach pilot program. Med Teach. 2024;46(6):849-851. doi:10.1080/0142159X.2024.2326115.



Title

Bridging the LAI Training Gap: A Simulation-Based Curriculum in Antipsychotic Selection, Initiation, and Administration

Primary Category

Teaching, Supervision, Pedagogy

Presenters

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Education Objectives

The workshop aimed to enhance psychiatry residents' knowledge, confidence, and practical skills across the LAI-A treatment process. Following the intervention, residents were expected to identify available LAI-A formulations and their indications; select an appropriate LAI-A based on patient and clinical factors; apply appropriate dosing, initiation, and oral-overlap strategies when transitioning from oral antipsychotics; demonstrate appropriate LAI-A administration technique; counsel patients regarding treatment expectations, risks, and benefits; and identify and manage common adverse effects and complications. The study evaluated changes in these domains following a combined didactic and simulation-based educational intervention.

Practice Gap

Long-acting injectable antipsychotics (LAI-As) are evidence-based treatments for schizophrenia that may improve adherence and reduce relapse and hospitalization, yet remain underutilized in clinical practice. Practitioner-level barriers include gaps in knowledge and training, uncertainty regarding initiation and patient selection, and limited confidence with LAI-A use. Informal needs assessment and faculty observation identified resident uncertainty across the LAI-A treatment process, including available formulations, oral-to-LAI-A conversion, and injection administration. A potential procedural training gap was identified as residents transitioned to outpatient practice, where they may be expected to administer LAI-As despite limited prior hands-on experience. This highlighted the need for structured training integrating pharmacologic knowledge with procedural skills.



Methods

A prospective pre-post survey study was conducted among psychiatry residents across postgraduate training years. Fourteen of 24 residents participated in a structured LAI-A educational workshop and completed an anonymous pre-intervention survey. The workshop combined didactic instruction on available LAI-A formulations, clinical indications, patient selection, dosing, initiation strategies, and oral-overlap requirements with supervised, hands-on intramuscular injection practice using anatomical mannequins. Participants were invited to complete the same anonymous Likert-scale survey following the intervention. Survey domains assessed familiarity with LAI-A options, confidence in selecting appropriate agents, understanding of dosing and initiation, administration technique, patient counseling, management of adverse effects, and likelihood of incorporating LAI-As into clinical practice. Pre- and post-intervention responses were compared descriptively.

Results

All 14 workshop participants completed the pre-intervention survey, and 11 completed the post-intervention survey. Favorable shifts in Likert responses were observed across several assessed domains. For familiarity with available LAI options and indications, Agree responses increased from 35.7% to 72.7%, with no post-intervention Disagree or Neutral responses. For confidence selecting an appropriate LAI based on clinical factors, Agree responses increased from 35.7% to 81.8%, also with no post-intervention Disagree or Neutral responses. Understanding of dosing, initiation protocols, and oral-overlap requirements shifted toward agreement, with Agree responses increasing from 50.0% to 72.7% and Strongly Agree responses from 7.1% to 18.2%. Comfort with LAI administration similarly shifted toward greater agreement. Confidence counseling patients regarding LAI treatment increased, with Agree responses rising from 50.0% to 81.8%. Responses regarding the ability to identify and manage common side effects and complications changed minimally. Likelihood of incorporating LAIs into clinical practice increased, with Agree responses rising from 64.3% to 81.8%.

Conclusion

A structured educational workshop combining didactic instruction with hands-on simulation was associated with favorable shifts in psychiatry residents' self-reported knowledge, confidence, and comfort across several components of LAI treatment, particularly agent selection, dosing and initiation, administration, and patient counseling. Changes were less pronounced in identifying and managing adverse effects, where baseline confidence was already relatively high. These findings support the value of integrating pharmacologic teaching with experiential skills training to address gaps in LAI education during residency. Future work should assess whether these gains are sustained and translate into objective competency and clinical practice.



Scientific Citations

1. Schwartz S, Carilli C, Mian T, Ruekert L, Kumar A. Attitudes and perceptions about the use of long-acting injectable antipsychotics among behavioral health practitioners. Ment Health Clin. 2022;12(4):232-240. doi:10.9740/mhc.2022.08.232.

2. Velligan D, Salinas GD, Belcher E, Franzenburg KR, Suett M, Thompson S, Hansen RT III. Clinician differences in attitudes and perceptions on the use of long-acting injectable antipsychotic agents in treating patients with schizophrenia: results from the US DECIDE survey. BMC Psychiatry. 2025;25(1):232. doi:10.1186/s12888-025-06565-1.

3. Kane JM, McEvoy JP, Correll CU, Llorca PM. Controversies surrounding the use of long-acting injectable antipsychotic medications for the treatment of patients with schizophrenia. CNS Drugs. 2021;35(11):1189-1205. doi:10.1007/s40263-021-00861-6.

4. Citrome L, Belcher E, Stacy S, Suett M, Mychaskiw M, Salinas GD. Management of schizophrenia with long-acting injectable antipsychotic medications: an assessment of the educational needs of clinicians. Neuropsychiatr Dis Treat. 2022;18:111-123. doi:10.2147/NDT.S326299.

5. Zhdanava M, Starr HL, Lefebvre P, Totev TI, Shah A, Sheng K, Pilon D. Understanding the health system conditions affecting the use of long-acting injectable antipsychotics in the treatment of schizophrenia in clinical practice: a US healthcare provider survey. Neuropsychiatr Dis Treat. 2022;18:1479-1493. doi:10.2147/NDT.S369494

Title

Description and evaluation of a longitudinal behavioral health integration curriculum in a psychiatry residency training program

Primary Category

Curriculum

Presenters

Ekanem Nkwocha, MD, MPH, University of Utah School of Medicine, Rachel Weir, MD, University of Utah School of Medicine

Education Objectives

This study describes the development, content, and evaluation of a mandatory, longitudinal BHI curriculum in primary care, with exposure to two BHI models, for postgraduate year (PGY) 3 and 4 residents in a general psychiatry residency program.

Practice Gap

Behavioral health integration (BHI) encompasses a range of care models and is widely recognized as an effective strategy for improving access to mental health services, patient outcomes, and cost-effectiveness. Training in the practice of different BHI models increases residents' competency in interprofessional communication and other skills essential for collaboration with non-mental healthcare professionals. In addition, BHI exposure during training could potentially impact resident career choices and increase the utilization of these models of care, improving patient access and care at a population level. Unfortunately, few psychiatry residency programs provide universal, structured training to prepare residents for practice in integrated care settings.

Methods

We evaluated PGY-3 and PGY-4 BHI rotations during the 2023–2024 and 2024–2025 academic years using anonymous pre- and post-rotation surveys. Surveys were developed de novo to assess residents' perceived knowledge, confidence, comfort in delivering BHI services, and the value of the didactics and clinical rotations to their training, using a five-point bipolar Likert scale. Responses were dichotomized into "low" (1-3: not at all to moderately) and "high" (4-5: very to extremely) to facilitate comparison. Differences between pre- and post-rotation responses were analyzed using two-sided Fisher's exact tests, with statistical significance set at $p < 0.05$. A general psychiatry resident with a faculty mentor developed and distributed the surveys and analyzed the results.



Results

Response rates for the PGY-3 BHI pre-rotation and post-rotation surveys in both the 2023-2024 and 2024-2025 academic sessions were 40.7% (11/27) and 57.9% (11/19), respectively. Response rates for the PGY-4 BHI pre-rotation and post-rotation surveys in both the 2023-2024 and 2024-2025 academic sessions were 52.2% (12/23) and 61.1% (11/18), respectively.

Among PGY-3 residents, perceived knowledge of the psychiatry consultant's role, confidence functioning as a psychiatry consultant, comfort providing short-term outpatient consultation, and comfort responding to informal ("curbside") consults from primary care providers (PCPs) increased significantly from pre- to post-rotation. PGY-3 residents showed no significant changes in knowledge of the roles of social workers or PCPs in mental health care delivery, whereas PGY-4 residents showed significant increases in these areas. In rating the value of the PGY-3 BHI curriculum post-rotation, 82% of respondents reported that the clinical rotation was valuable to their psychiatry training, 73% of respondents reported that didactics and group discussions were valuable to their psychiatry training, and 73% of respondents thought that the rotation prepared them for their role as a psychiatrist in BHI in primary care settings. For PGY-4 residents, we observed significant pre- to post-rotation improvements across all evaluated constructs. In rating the value of the PGY-4 BHI curriculum post-rotation, 82% of respondents reported that the clinical rotation was valuable to their psychiatry training, 45% of respondents reported that didactics and group discussions were valuable to their psychiatry training, and 82% of respondents thought that the rotation prepared them for their role as a psychiatrist in BHI in primary care settings

Conclusions

This study adds to the literature by describing and evaluating a mandatory, longitudinal BHI curriculum spanning multiple years of psychiatry residency training. Findings suggest that progressive exposure across the BHI continuum is associated with increased resident knowledge, confidence, and comfort in integrated care roles. These results support the value of longitudinal BHI training and offer a potential framework for psychiatry residency programs seeking to incorporate integrated care education into their curricula.

Scientific Citations

While there are studies describing integrated care curricula for psychiatry residents at multiple training programs, they describe only a didactic component or do not include outcome data from clinical rotations (such as improved residents' confidence in working in integrated care settings), are typically limited to one training year per trainee, expose residents to a single type of integrated care practice model, and are offered as electives, resulting in unequal exposure among program residents [1].



1. Burruss NC, Murray C, Li W, Sowa NA. Integrated Care Education for General Psychiatry Residents in the US: a Review of the Literature. Academic Psychiatry 2023 47:4. 2023;47(4):390-401. doi:10.1007/S40596-023-01760-2. https://link.springer.com/article/10.1007/s40596-023-01760-2

Title

Development of a Perinatal Consultation Service in a Public Teaching Hospital

Primary Category

Curriculum

Presenters

Marcela Almeida, MD, Cambridge Health Alliance/Harvard Medical School

Education Objectives

The objective of this project was to design and implement a Reproductive & Perinatal Psychiatry Consultation Service within an academic community health system to expand access to evidence-based care, strengthen clinician capacity, and improve continuity across inpatient and outpatient settings.

Practice Gap

Perinatal psychiatric conditions are among the most common complications of pregnancy and the reproductive transition (1). Untreated illness is associated with adverse maternal, obstetric, infant, and family outcomes (2). Despite this, many psychiatrists report limited training and comfort managing psychiatric conditions during pregnancy and lactation, contributing to delays in care and treatment discontinuation (3). Consultation models have emerged nationally to expand access to specialty expertise and support frontline clinicians (4, 5).

Methods

The service was spearheaded by a resident physician in the adult psychiatry training program as part of her Women's Mental Health Chiefship during PGY-4. An announcement was broadcast to the psychiatry department offering inpatient and outpatient consultation. A de-identified log of the consultations received was kept to assess need.

Results

Initial consultations were performed via multiple avenues including telephone, chart review, email, and in-person. The highest need was for inpatient consultations. Logistic barriers around outpatient consultations were identified, and subsequently addressed to create a new pathway, including options for curbside consults, e-consults, and direct referrals for full evaluation.

Discussion

In its pilot phase the consultation service proved to be feasible as a resident-run service with attending supervision, largely for inpatient consultation, as the outpatient workflow presented some logistic barriers. Through the course of the pilot, the chief of the integrated care service created and publicized a more standardized workflow for outpatient perinatal consultations in response to logistic barriers identified through this pilot work, which expanded access, and also brought in other psychiatrists as part of the integrated behavioral health team. There is an ongoing need for a venue for feedback on how helpful to the team and acceptable to the patient recommendations are.

Scientific Citations

1. Howard, L. M., & Khalifeh, H. (2020/2021). Perinatal mental health: a review of progress and challenges. World Psychiatry, 19(3), 313–327.

2. Abdelhafez MA, Ahmed KM, Ahmed NM, Ismail M, Mohd Daud MNB, Ping NPT, Eldiasty A, Amri MFB, Jeffree MS, Kadir F, Pg Baharuddin DM, Bolong MFB, Hayati F, BtAzizan N, Sumpat D, Syed Abdul Rahim SS, Abdel Malek EH. Psychiatric illness and pregnancy: A literature review. Heliyon. 2023 Oct 20;9(11):e20958. doi: 10.1016/j.heliyon.2023.e20958. PMID: 37954333; PMCID: PMC10632674.

3. Osborne, L. M., MacLean, R. R., et al. (2021). Reproductive Psychiatry Education in Residency Training: A National Survey of Psychiatry Program Directors. Academic Psychiatry, 45(4), 425–431.

4. Schaefer, A., Mackie, T., et al. (2024). Increasing Access To Perinatal Mental Health Care: The Perinatal Psychiatry Access Program Model. Health Affairs, 43(4), 512–520.

5. Noulas, P., et al. (2021). Patient satisfaction with and use of telemental health services in the perinatal period: A survey study. Journal of the Academy of Consultation-Liaison Psychiatry, 62(5), 520–528.

Title

Early Multi-Program Implementation of a Modular, AI-Supported Curriculum Model for Residency and Fellowship Education

Primary Category

Curriculum

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. Evaluate the reach and feasibility of implementing a portable, society-maintained psychopharmacology curriculum across residency and fellowship programs and levels of training.

2. Characterize learner engagement through curriculum utilization, module completion, and time spent using the educational resources.

3. Examine preliminary educational outcomes, where available, as exploratory signals of learning rather than measures of curricular effectiveness.

4. Assess the acceptability and educational utility of the curriculum and its AI teaching assistant, including its ability to support learning while maintaining appropriate faculty oversight and safeguards.

Practice Gap

Psychopharmacology curricula are typically developed and maintained by individual training programs, resulting in the same core content being recreated across programs while varying substantially in scope, depth, and utility. Because the evidence base evolves faster than most local curricula can be revised, the recurring challenge is not simply creating a curriculum, but keeping it current. A centrally authored, continuously updated curriculum that spans levels of training and can be adopted modularly provides a scalable approach to addressing this challenge.



Methods

Innovation: The American Society of Clinical Psychopharmacology (ASCP) redesigned its Model Psychopharmacology Curriculum as a portable, society-vetted "living textbook." Content is organized into Crash, Basic, and Advanced courses, spanning foundational PGY-1 material through advanced topics relevant to senior residents and fellows, including treatment resistance, pharmacogenomics, neuromodulation, geriatric psychopharmacology, and complex comorbidity. Each module pairs a brief expert video with high-yield readings, board-style questions, 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. Modules are updated as evidence evolves. The curriculum emphasizes mechanism-informed prescribing, measurement-based care, shared decision-making, and integration with psychotherapy and is designed to support ACGME competency-based education.

Evaluation

We are conducting a multi-program implementation evaluation examining reach and engagement, including program and learner participation, curriculum utilization, module completion, and learning time. Exploratory educational outcomes are also being examined where available. Data collection is ongoing, and updated implementation and educational findings will be presented.

Results

To date, the curriculum has been adopted across multiple training programs and learner groups, with hundreds of users engaging with the curriculum. Preliminary platform data support the feasibility of use across different levels of training. In an exploratory single-program cohort, psychopharmacology PRITE performance is also being examined as a preliminary learning signal; because of the small sample and absence of a concurrent control group, these findings will be considered hypothesis-generating rather than evidence of curricular effectiveness.

Conclusions

Early experience supports the feasibility of deploying a society-maintained, modular psychopharmacology curriculum across residency and fellowship programs while extending rather than replacing local faculty teaching. Ongoing evaluation will further characterize reach, engagement, learner and faculty acceptability, educational outcomes, and the accuracy and educational utility of the AI assistant.

Note: Data collection is ongoing. Implementation, engagement, and educational outcomes data will be available for presentation at the 2027 Annual Meeting if selected. These will include

program and learner participation, curriculum utilization and module completion, learner engagement and confidence, and exploratory educational outcomes, including psychopharmacology PRITE performance where available. Findings will also characterize patterns of curriculum use across levels of training and provide preliminary data on learner experience with the AI teaching assistant.

Scientific Citations

1. Macaluso, M., Swartz, H. A., Goldberg, J. F., Iosifescu, D. V., Zarate, C. A., & Clayton, A. H. (2026). Reframing Psychopharmacology Education: Competency, Integration, and Contemporary Standards. Journal of Clinical Psychopharmacology, 46(5), 654–655. https://doi.org/10.1097/JCP.0000000000022222.

2. Preiksaitis, C., & Rose, C. (2023). Opportunities, challenges, and future directions of generative artificial intelligence in medical education: Scoping review. JMIR Medical Education, 9, e48785. https://doi.org/10.2196/48785

3. Shimizu, I., Kasai, H., Shikino, K., et al. (2023). Developing medical education curriculum reform strategies to address the impact of generative AI: Qualitative study. JMIR Medical Education, 9, e53466. https://doi.org/10.2196/53466

4. Lucas, H. C., Upperman, J. S., & Robinson, J. R. (2024). A systematic review of large language models and their implications in medical education. Medical Education, 58(11), 1276–1285. https://doi.org/10.1111/medu.15402

5. Hale, J., Alexander, S., Towner Wright, S., & Gilliland, K. (2024). Generative AI in undergraduate medical education: A rapid review. Journal of Medical Education and Curricular Development, 11. https://doi.org/10.1177/23821205241266697

Title

Effect of a Point-Based Accountability System on Attendance at Mandatory Educational Events in a Psychiatry Residency Program

Primary Category

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

Presenters

Dustin DeMoss, DO, MSc, John Peter Smith Hospital

Education Objectives

Educational Objectives

1. To describe the design and implementation of a point-based accountability system for tracking resident attendance at mandatory educational events in a community-based psychiatry residency program.

2. To evaluate whether implementation of the point system was associated with improved resident attendance at mandatory educational events, using paired per-resident attendance data.

3. To identify considerations and limitations relevant to residency programs considering similar accountability-based attendance interventions.

Practice Gap

Professionalism is one of the six ACGME core competencies and includes accountability to patients, society, and the profession.[1] Although attendance is not synonymous with professionalism, reliable participation in required educational activities represents an observable behavior related to professional responsibility and conscientiousness.[2,3] Residency programs may face barriers to consistent attendance, including competing clinical responsibilities, workload, and scheduling or location conflicts.[4,6] Point-based accountability systems have been used in other specialties to track professionalism-related behaviors, including attendance, but published data on their effect within psychiatry residency programs are limited.[2] Prior work has examined technological and structural approaches to improving attendance, including audience response systems and protected educational time, but few studies have isolated the effect of structured, points-based accountability interventions on attendance specifically.[5,6]



Methods

A retrospective before-and-after quality improvement study included 28 PGY-1 through PGY-3 residents in a community-based psychiatry residency program. Attendance at mandatory educational events (excluding didactics) was recorded via New Innovations for a 6-month pre-implementation period (7/1/2025–12/31/2025; 53 events) and a 6-month post-implementation period (1/1/2026–6/30/2026; 61 events) following introduction of a structured point-based attendance system on 1/1/2026. Under this system, residents accrued points for missed mandatory events, with a cumulative total of 5 points resulting in an extra call shift. Individual resident-level attendance rates were calculated for each period. Because the same 28 residents were assessed in both periods, paired per-resident attendance rates were compared using a Wilcoxon signed-rank test, given the non-normal (left-skewed) distribution of pre-implementation attendance. A two-sided p-value <0.05 was considered statistically significant.

Results

Mean per-resident attendance increased from 87.06% (SD 12.07%) pre-implementation to 97.72% (SD 2.65%) post-implementation; median attendance increased from 90.57% (IQR 83.02–95.28%) to 98.36% (IQR 96.72–100%), an absolute increase of 10.66 percentage points. Of the 28 residents, 25 showed improved attendance, 1 showed a decline, and 2 were unchanged (already at 100% in both periods). A Wilcoxon signed-rank test demonstrated a statistically significant improvement in per-resident attendance following implementation ($W = 3$, $z = -4.37$, $p < .0001$, $r = 0.86$).

Conclusions

Implementation of a structured point-based accountability system was associated with a significant improvement in resident attendance at mandatory educational events within a psychiatry residency program. The system provided an objective mechanism for tracking attendance and reinforcing participation in required educational activities, with minimal ongoing administrative burden once established. Standardized attendance documentation also provided a consistent mechanism for programmatic monitoring and resident evaluation. Limitations include the single-site, pre-post design, which cannot establish causality, and the fact that attendance does not necessarily reflect educational engagement or outcomes; resident perceptions of the system were also not assessed. Future studies should evaluate the sustainability of these improvements, resident perceptions and acceptability of the accountability system, and whether improved attendance is associated with greater educational engagement or learner outcomes.



Scientific Citations

1. Accreditation Council for Graduate Medical Education. ACGME Common Program Requirements (Residency). Effective July 1, 2026.

2. Frank, R. G., & Shim, R. S. (2023). Toward greater accountability in mental health care. Psychiatric Services, 74(2), 182-187.

3. Peteet, J. R., Witvliet, C. V., Glas, G., & Frush, B. W. (2023). Accountability as a virtue in medicine: from theory to practice. Philosophy, Ethics, and Humanities in Medicine, 18(1), 1.

4. Frohna, J. G., & Padmore, J. S. (2021). Assessment of professionalism in the graduate medical education environment. Journal of Graduate Medical Education, 13(2s), 81-85.

5. DeJong, S. M. (2026). Professionalism. In Graduate Medical Education in Psychiatry: From Basic Processes to True Innovation (pp. 171-183). Cham: Springer Nature Switzerland.



Title

EPAs and Risk Propensity in Psychiatry Preceptors

Primary Category

Assessment – learner (summative, formative, programmatic)

Presenters

Devika Bhatia, BA, MD, University of Colorado Denver, Jay Davis, MD, University of Colorado Denver, Heather Murray, BS, MD, MPH, University of Colorado Denver, Julie Wolfe, MD, Austin Butterfield, MD, University of Colorado Denver

Education Objectives

Leveraging a sample of psychiatry preceptors supervising 2nd year medical students in a Western school of medicine in their longitudinal integrated curriculum (LIC) in academic year (AY) 2024-2025, this study aims to assess the association between preceptor risk-taking propensity and student psychiatry clerkship EPA scores. Secondarily, this study aims to understand how other preceptor characteristics, including experience as an attending physician, gender, and clinical setting, associate with student EPA scores.

Practice Gap

In recent years, delivery of undergraduate and graduate medical education experienced a significant shift toward competency-based training (CBT) curricula (1). This transition led to the development of a crucial tool for evaluation of student performance: Entrustable Professional Activities (EPAs; 2). EPAs are defined as units of significant clinical work entrusted to a trainee once they have demonstrated sufficient competence to practice unsupervised (3,4). As more medical schools and residency programs are adopting EPAs in evaluation of students and residents, it is critical to examine whether preceptor characteristics, such as risk-taking propensity, play a role in EPA scoring. Medical educators and program directors will benefit from results from this study as they consider whether EPAs truly reflect student/trainee progression.

Methods

This is a single-institution cross-sectional study of anonymized EPA evaluations of 2nd year medical students, completed by psychiatry physician attending preceptors from December 2024-August 2025. The study sample consisted of attending physician preceptors in the Department of Psychiatry at a Western school of medicine who utilize EPAs to evaluate medical students rotating in the psychiatry LIC. All psychiatry physician preceptors who supervised LIC students in AY 2024-2025 were approached to participate (n=128), and 87 completed the

survey. The Risk-Taking Scale (RTS) was utilized, a sub-scale of the Jackson Personality Index (first adapted by Pearson et al (1995), a validated self-report measure of context-independent risk propensity; 5). The independent variable of interest was each attending physician's total score on the RTS. The dependent variables were mid-year and end-of-year EPA scores. Potential covariates included preceptor age, preceptor gender, preceptor ethnicity, number of years that the preceptor had been an attending, preceptor practice setting, and number of students that the preceptor was supervising in ay 2024-2025. Descriptive analyses estimated the frequency, percentage, mean, standard deviation, and range of individual preceptor characteristics. Then, distributions of EPA scores for both mid-year and end-of-year evaluations were assessed and sum EPA scores were calculated. Finally, multiple logistic regressions tested the association between RTS score and categorical and sum EPA scores at both mid-year and end-of-year, adjusting for number of years as an attending, and covariates that were significantly correlated with both RTS and EPA scores. P<0.05 was considered statistically significant.

Results

The average age of participating preceptors was 45.0 (SD 9.2). The sample had a slight male predominance (54.9% male) and was majority Non-Hispanic/Latino (85.3%). The average number of years that a preceptor had been an attending physician was 11.1 (SD 8.5). Most preceptors primarily practiced in an outpatient setting (75.9%) and precepted only 1 LIC student in academic year 24-25. The average RTS score among preceptors in the sample was 20.3 (SD 4.4; range 9-29). Overall, EPA scores by category (e.g., for history, physical exam, etc.) were higher at end-of-year evaluation than at mid-year evaluation.At both mid-year and end-of-year, RTS score was not significantly associated with EPA score (p's from 0.30-0.92). At mid-year, number of years as an attending physician was significantly associated with EPA score for Differential Diagnosis (ß=0.06; p=0.01), Management Plan (ß=0.06; p=0.04), and sum EPA score (ß=0.17; p=0.01). At end-of-year, female gender was significantly associated with Differential Diagnosis (ß=1.61; p<0.01), Oral Presentation (ß=1.02, p=0.048), and sum EPA score (ß=4.12; p=0.03).

Conclusions

This study provides empirical data regarding the role of preceptor characteristics in medical student EPA scores. Future studies should seek to replicate our findings in different institutions and clinical departments to determine the generalizability of the results. Further investigation could also examine alternative preceptor characteristics, including trust propensity and other demeanor traits, that may influence trainee assessment. Finally, ongoing effort should be devoted toward uncovering and mitigating external factors impacting assessment such as consequence-driven leniency.



Scientific Citations

1. Damodaran AK, Jones P, Shulruf B. Trust and risk pitfalls in medical education: A qualitative study of clinical teachers. Med Teach. 2021;43(11):1309-1316. doi:10.1080/0142159X.2021.1944613

2. Ten Cate O, Chen HC. The ingredients of a rich entrustment decision. Med Teach. 2020;42(12):1413-1420. doi:10.1080/0142159X.2020.1817348

3. Frenzel, J.E., Richter, L.M., Hursman, A.N. & Viets, J.L. Assessment of preceptor understanding and use of levels of entrustment. Curr Pharm Teach Learn 13, 1121–1126 (2021)

4. Ten Cate O, Balmer DF, Caretta-Weyer H, Hatala R, Hennus MP, West DC. Entrustable Professional Activities and Entrustment Decision Making: A Development and Research Agenda for the Next Decade. Acad Med. 2021;96(7S):S96-S104.

5. Pearson, S.D., et al. Triage decisions for emergency department patients with chest pain: do physicians' risk attitudes make the difference? J Gen Intern Med 10, 557–564 (1995).

Title

Evaluating Psychiatry Residents' Knowledge, Attitude, and Comfort in Articulating Structural Competency: A Mixed-Methods Survey-Based Study

Primary Category

Curriculum

Presenters

Brandi Karnes, MD, McGovern Medical School at UTHealth, Rishab Chawla, MD, McGovern Medical School at UTHealth

Education Objectives

1. Analyze junior resident (PGY-1 and PGY-2) familiarity and comfort with as well as attitudes on articulating structural competency tenets before and after completing an interactive case-based learning (CBL) case.

2. Discuss realistic clinical scenarios and prompt engagement with structural factors such as poverty, racism, and healthcare system barriers.

3. Synthesize case-specific feedback in order to enhance future curricular development.

Practice Gap

Psychiatric trainees frequently encounter patients with problems whose pathology lies downstream of structural factors. Traditional psychiatric education correctly applies the biopsychosocial framework in case formulation, yet may not fully consider structural forces such as housing instability, food insecurity, and gendered violence. Structural competency was coined by Metzl & Hansen (2014) to describe the phenomenon by which patients' presenting concerns can be conceptualized as downstream sequelae of more upstream factors, and it consists of five key pillars. The LCME has announced that with the removal of Standard 7 beginning in 2027, medical schools will no longer be required to teach structural competency. In the wake of that setback, GME programs become tasked with instilling structural competency in their learners.

Methods

The study was IRB approved (HSC-MS-26-0777). Sessions occurred on two separate dates in August 2026 for the PGY-1 and PGY-2 cohorts. Participants completed an anonymous 5 minutes pre-survey, worked through the case as a large group for 45 minutes (with the study co-investigator as case facilitator), and finally completed a 10 minute anonymous post-survey. The



pre-survey consisted of five Likert-scale items under the familiarity subheading, and six each under attitudes and comfort. The post-survey additionally consisted of free-text responses under the familiarity subheading; five Likert-scale items for case-specific feedback; and three free-text items at the end querying strengths, areas for growth, and general feedback. The surveys were administered on paper and later tabulated into Microsoft Excel and stored in REDCap. Confidential matching codes were used to perform paired analyses. Qualitative themes were extracted from free-text responses.

Results

14 PGY-2 and 9 PGY-1 residents consented to participate in the study (n = 23). All residents who completed the pre-survey also completed the post-survey (0% attrition).

Composite mean for familiarity was 2.18 on pre-survey and 3.81 on post-survey across all respondents. [Change in mean familiarity scores per item on pre-survey → post-survey are as follows: Recognizing structures that shape clinical interactions (2.61 ± 1.12 → 3.91 ± 0.60), Developing an extra-clinical language of structure (2.09 ± 0.90 → 3.65 ± 0.65), Rearticulating "cultural" formulations in structural terms (1.87 ± 0.81 → 3.74 ± 0.81), Observing and imagining structural interventions (2.22 ± 1.09 → 3.78 ± 0.67), Developing structural humility (2.13 ± 1.01 → 3.96 ± 0.77).] A paired t-test was performed yielded a test statistic of 10.28 with a p value of <0.001 and effect size of 2.1.

Composite mean for comfort likewise increased from 3.38 to 4.03 (t=3.51, p=0.002, Cohen's d= 0.73), while composite mean for attitude increased from 3.83 to 4.18 (t=2.69, p=0.014, Cohen's d= 0.56). In the remaining free-text responses, PGY-2s provided more constructive feedback than PGY-1s. The most common theme that arose was a desire for more background information on structural competency prior to doing the cases.

Conclusions

The cases had a clear and consistent effect on residents' self-rated knowledge of all five structural competency components as evidenced by the mean difference in familiarity between pre- and post-survey being several standard errors away from zero. Comfort improved meaningfully across five of six items, mostly in asking about violence/trauma and advocating for structural interventions. Attitude did not change meaningfully, likely due to a ceiling effect as pre-survey means were already high. Learners praised the interactive nature of the case and relevance of clinical scenarios. Advantages of paper surveys as opposed to online surveys likely included higher participation rate and more complete responses in free-text sections, while a disadvantage was the occasional indecipherability of certain words.



Scientific Citations

1. Barry R, Anderson J, Tran L, et al. Prevalence of Mental Health Disorders Among Individuals Experiencing Homelessness: A Systematic Review and Meta-Analysis. JAMA Psychiatry. 2024;81(7):691–699. https://doi.org/10.1001/jamapsychiatry.2024.0426

2. Gao, Y. N., & Olfson, M. (2025). High out-of-pocket cost burden of mental health care for adult outpatients in the United States. Psychiatric Services (Washington, D.C.), 76(2), 200–203. https://doi.org/10.1176/appi.ps.20240136

3. Gholar, V. M., Palokas, M., & Tacy, J. (2023). Structural competency curriculum in health sciences education: a scoping review. JBI Evidence Synthesis, 21(7), 1408–1452. https://doi.org/10.11124/jbies-22-00101

4. Laz-Figueroa, K., Sánchez, B. R. H., García, J. C. S., Guevara-Viejó, F., & Molina-Molina, V. (2025). Gender-based violence and its relationship to the mental health of female university students. Frontiers in Sociology, 10(1597261), 1597261. https://doi.org/10.3389/fsoc.2025.1597261

5. Scott, S. R., Gonzalez, C. M., Zhang, C., & Hassan, I. (2025). Structural competency: A faculty development workshop series for anti-racism in medical education. MedEdPORTAL : The Journal of Teaching and Learning Resources, 21, 11492. https://doi.org/10.15766/mep_2374-8265.11492

6. Teasdale, S. B., Müller-Stierlin, A. S., Ruusunen, A., Eaton, M., Marx, W., & Firth, J. (2023). Prevalence of food insecurity in people with major depression, bipolar disorder, and schizophrenia and related psychoses: A systematic review and meta-analysis. Critical Reviews in Food Science and Nutrition, 63(20), 4485–4502. https://doi.org/10.1080/10408398.2021.2002806

7. Zarzar, T. R., & Pruette, M. E. (2024). Development of a medical student elective in correctional psychiatry with a focus on structural competency. Academic Psychiatry, 48(1), 106–107. https://doi.org/10.1007/s40596-023-01756-y



Title

Exploring program level characteristics associated with child and adolescent psychiatry fellowship fill rates

Primary Category

Recruitment and Selection

Presenters

Jessica Sandoval, BA, MD, MS, University of Texas Health Sciences Center at San Antonio, Denise Baughn, MD, University of Texas Medical Branch, Galveston, Hyelin Oh, MD, University of Texas Health Sciences Center at San Antonio

Education Objectives

1. Describe and consolidate geographic characteristics of CAP programs
2. Describe and consolidate program level characteristics of CAP programs
3. Identify the associations of these characteristics with unfilled CAP positions

Practice Gap

While psychiatry residency becomes increasingly competitive, with consistently more applicants than positions1, this trend does not hold for subspecialty fellowships. In 2026, there were 388 applicants through the National Resident Matching Program (NRMP) for the 399 Child and Adolescent Psychiatry (CAP) fellowship positions available in the United States; a quarter of CAP programs(34 of 127) went unfilled2.

There are efforts to understand applicant level factors that may be associated with their successful match into a program3,4,5, however there is no centralized data or publication considering program characteristics possibly associated program fill rates. Identifying these factors could aid program directors in recruitment efforts and/or guide workforce resource determinations.

Methods

Characteristics of 161 U.S. child and adolescent psychiatry (CAP) fellowship programs with NRMP match data were examined. The NRMP publishes data from all ACGME accredited programs participating in the Match6,7. For match years 2020-2026, the quota and fill rate for all 161 programs were collected. Program data, as published in the FREIDA, including location (city and state), program affiliations (university/community), size, number of CAP physician



faculty, number of interviews conducted, percentage of international medical graduate, doctor of osteopathy and females per class, affiliation with a track in a general residency program and the size of said program, was compiled and linked to the NRMP data. Additionally, information related to the city, including population and region, was taken directly from 2020 U.S. Census data and cost of living data was taken from https://www.numbeo.com/cost-of-living/ and workforce shortage rates (CAP per capita) was taken from AACAP published data (https://www.aacap.org/aacap/Advocacy/Federal_and_State_Initiatives/Workforce_Maps/Home.aspx).

Separate hierarchical linear regression models were estimated for each match year from 2020-26, with percentage of available positions filled as the outcome. Geographic characteristics including region (with southern region as reference as this was the highest represented), city population, and cost of living entered in Block 1, followed by program characteristics in Block 2.

Results

Programs were predominantly university-based (64.6%) and fairly evenly distributed across region (West 23%, Midwest 18%, south 31.7%, northeast25.5%). Mean percentage of positions filled ranged from 69% in 2022 to 79% in 2026. Geographic models explained 11.5% - 23.6% of variance in annual fill percentage and were significant in 2020 and 2023-2026. Addition of program characteristics significantly improved model fit in every year ($\Delta R2 = .218 - .321$, all $p \leq .006$), with final models explaining 38.9% - 48.3% of variance. Number of interviews conducted was the only consistent independent predictor of fill percentage, with more interviews associated with greater fill percentages in all six match years ($\beta = 0.416 - 0.567$, all $p \leq .004$). Additional year-specific associations were observed for cost of living, western region, number of CAP faculty, percentage of international medical graduates, and percentage of female residents. However, these did not demonstrate consistent trends across years.

Conclusions

Based on this analysis, no program specific characteristics were consistently associated with unfilled CAP fellowship spots. Factors such as program size, affiliated psychiatry residency program size, and age of program were not consistent predictors of fill rates. Because number of interviews conducted emerged as the only consistent independent factor in fill percentage, program directors should aim to conduct more interviews when possible.

Limitations/future directions: Access to data regarding applications received by individual programs was not publicly available, which may be a confounding factor as fewer applications may impact the ability to offer additional interviews.



While the majority of CAP positions are offered through the match, as many as 30% may be offered external to the match8; understanding additional considerations between these two populations may provide additional insight to target recruitment efforts and should be explored.

Scientific Citations

1. National Resident Matching Program. 2026. Charting Outcomes™: Characteristics of Applicants Who Matched to Their Preferred Specialty, U.S. MD Seniors, (Main Residency Match, 2026 Appointment Year

2. National Resident Matching Program, Results and Data: Specialties Matching Service 2026 Appointment Year. National Resident Matching Program, Washington, DC. 2026

3. National Resident Matching Program. 2026. Charting Outcomes™: Characteristics of Applicants Who Matched to Their Preferred Specialty, U.S. MD Seniors, (Main Residency Match, 2026 Appointment Year).

4. Madeleine A. Becker, Mark V. Bradley, Cristina Montalvo, Sara S. Nash, Sejal B. Shah, Marie Tobin, Paul H. Desan, Factors Affecting Psychiatry Resident Decision to Pursue Consultation-Liaison Psychiatry or Other Subspecialty Fellowship Training, Journal of the Academy of Consultation-Liaison Psychiatry, Volume 62, Issue 1,2021, Pages 38-45, ISSN 2667-2960

5. Akhtar, R. R., Rana, M. J., Joychan, S., & Malik, S. (2024). Assessing the factors affecting recruitment to child and adolescent psychiatry fellowship programs. Academic Psychiatry, 48(5), 425-430.

6. National Resident Matching Program, Program Results: Specialties Matching Service 2021-2025 Appointment Years.National Resident Matching Program, Washington, DC. 2025.

7. National Resident Matching Program, Program Results: Specialties Matching Service 2020-2024. Appointment Years. National Resident Matching Program, Washington, DC. 2026.

8. Silvestre J, Dubé B, Gray K. Defining Entrants Into the Child and Adolescent Psychiatry Workforce in the United States: Match Results From 2009 to 2025. Journal of the American Academy of Child & Adolescent Psychiatry, 2026; 65, 977-981



Title

Filling the Gap: A Novel Virtual, Asynchronous Curriculum on Autism and Developmental Disabilities for Residents and Fellows

Primary Category

Curriculum

Presenters

Sarah Mohiuddin, MD, University of Michigan, Sally Chu, MD, University of Michigan

Education Objectives

To pilot a multi-institutional, interprofessional virtual didactic series focused on autism spectrum disorder (ASD) and developmental disabilities (DD) for general psychiatry residents and fellows, as well as neurology, family medicine, pediatrics, internal medicine house officers.

The aims were to:

1. Broaden curricular coverage by pooling faculty and resources;

2. Broaden access to didactics on ASD and DD for trainees regardless of training discipline;

3. Improve care for individuals with ASD/DD by enhancing individuals' self-efficacy, knowledge base, and problem-solving skills to care for individuals with ASD/DD.

Practice Gap

Although the prevalence of ASD continues to rise, there are limited training opportunities in the area of ASD/DD given limited access to resources, both curricular and access to trained faculty and rotational experiences, particularly in general psychiatry residency programs. Individuals with ASD, and particularly adults with ASD, are more likely to report lower satisfaction with patient-clinician communication and lower health care self-efficacy in the general clinic setting. Clinicians also report limited knowledge, lack of experience, poor competence, low confidence, and low self-efficacy in supporting autistic youth. ASD curricula and experience with treating individuals with ASD can vary across training programs. Other areas of medicine have shown that virtual education can expand access to expertise and promote more consistent training.

Methods

In March 2026, our team launched the resident/fellow curriculum arm of the TEAM Project (Teaching and Education for Autism and Neurodevelopmental Disabilities Management) to

address critical knowledge gaps among health care providers regarding care of transitional aged youth and adults with ASD nationwide. The curriculum was split into four main courses to address the various levels of experience that an individual may have with ASD/DD: an introductory/foundational course (Course 1), common comorbidities course (Course 2 and Course 3), and special advanced topics (Course 4). Each course was composed of 6-10 modules, with each module composed of 5-8 video didactics and one reading. At the end of each course was a quiz to assess knowledge retention, and each course had a pre- and post-survey to assess need.

Results

During the first six months, engagement with the course was consistently high from month to month with over 150 enrollments. Early feedback from trainees has been positive, with participants noting exposure to broader expertise and a wider range of topics, especially with didactics given from disciplines outside of psychiatry, such as neurology, sleep medicine, and speech language pathology. Trainees also described the modules as being well-put together, and papers as being helpful for clinical practice. Trainees also reported that due to their experience with the curriculum, led them to engage in the live session arm of TEAM. Disciplines beyond psychiatry were represented early, such as family medicine and neurology, and inquiries from other disciplines as well as attending physicians, reinforcing the interdisciplinary and lifelong learning focus.

Conclusions

Preliminary experience suggests that an interprofessional virtual didactic series is feasible and well-received. While further evaluation is needed to assess knowledge outcomes and long-term sustainability, early implementation indicates potential benefits in expanding curricular scope, and offering live sessions by faculty to further enhance trainees' self-efficacy, knowledge base, and problem-solving skills.

Scientific Citations

1. Brice S, Rodgers J, Ingham B, Mason D, Wilson C, Freeston M, Le Couteur A, Parr JR. The importance and availability of adjustments to improve access for autistic adults who need mental and physical healthcare: findings from UK surveys. BMJ Open. 2021 Mar 18;11(3):e043336. doi: 10.1136/bmjopen-2020-043336. PMID: 33737429; PMCID: PMC7978247.

2. Maddox BB, Dickson KS, Stadnick NA, Mandell DS, Brookman-Frazee L. Mental Health Services for Autistic Individuals Across the Lifespan: Recent Advances and Current Gaps. Curr



Psychiatry Rep. 2021 Aug 17;23(10):66. doi: 10.1007/s11920-021-01278-0. PMID: 34402984; PMCID: PMC8961310.

3. Shaw KA, Williams S, Patrick ME, Valencia-Prado M, Durkin MS, Howerton EM, Ladd-Acosta CM, Pas ET, Bakian AV, Bartholomew P, Nieves-Muñoz N, Sidwell K, Alford A, Bilder DA, DiRienzo M, Fitzgerald RT, Furnier SM, Hudson AE, Pokoski OM, Shea L, Tinker SC, Warren Z, Zahorodny W, Agosto-Rosa H, Anbar J, Chavez KY, Esler A, Forkner A, Grzybowski A, Agib AH, Hallas L, Lopez M, Magaña S, Nguyen RHN, Parker J, Pierce K, Protho T, Torres H, Vanegas SB, Vehorn A, Zhang M, Andrews J, Greer F, Hall-Lande J, McArthur D, Mitamura M, Montes AJ, Pettygrove S, Shenouda J, Skowyra C, Washington A, Maenner MJ. Prevalence and Early Identification of Autism Spectrum Disorder Among Children Aged 4 and 8 Years - Autism and Developmental Disabilities Monitoring Network, 16 Sites, United States, 2022. MMWR Surveill Summ. 2025 Apr 17;74(2):1-22. doi: 10.15585/mmwr.ss7402a1. PMID: 40232988; PMCID: PMC12011386.

4. Theodorou CM, Joshi ART, Chahine AA, et al. Multi-institutional collaborative surgery education didactics: virtual adaptations during a global pandemic. J Surg Educ. 2021;78(4):1340-1344. doi:10.1016/j.jsurg.2020.12.013. PMID: 33358934; PMCID: PMC7834110.

5. Villatoro C, Henning E, Ng R, Kogut M, Steinberg J, Chen B, Holingue C, Leppert M, Malone LA. Enhancing Pediatric Long COVID Care Through Telementoring: Insights From an ECHO Program. Clin Pediatr (Phila). 2025 Oct;64(9):1209-1217. doi: 10.1177/00099228251323396. Epub 2025 Mar 12. PMID: 40077880; PMCID: PMC12464857.

Title

From awareness to action: The 5 As cultural competence curriculum for psychiatry residents

Primary Category

Curriculum

Presenters

Raman Marwaha, MD, Hackensack Meridian Health-Ocean Medical Center, Laura Handal Abularach, MD, Louisiana State University (Shreveport) Program

Education Objectives

1. Assess psychiatry residents' baseline knowledge, attitudes, and clinical practices related to cultural humility, structural determinants of mental health, and culturally informed psychiatric assessment.

2. Develop and implement a longitudinal, developmentally tailored 5 As cultural competence curriculum that translates identified educational needs into practical strategies for culturally responsive assessment, formulation, documentation, and treatment planning.

3. Evaluate the curriculum's preliminary impact on trainees' familiarity with the DSM-5 Cultural Formulation Interview and self-reported integration of cultural and structural factors into routine psychiatric care.

Practice Gap

Louisiana's multicultural communities include long-established and newly arrived immigrant populations. In Shreveport, 56% of residents identify as Black and 35% as White, with growing Hispanic and Asian communities. Psychiatry residents at LSU Health Shreveport care for patients whose experiences of mental illness, symptom expression, treatment preferences, and access to care may be shaped by culture, identity, language, family and community systems. Although ACGME standards emphasize responsive care for diverse populations, our residency program lacked a structured, longitudinal curriculum addressing cultural humility, structural awareness, and culturally informed psychiatric formulation. We developed a longitudinal 5 As cultural competence curriculum to address this educational gap and strengthen residents' ability to incorporate cultural and structural factors into psychiatric assessment, formulation, documentation, and treatment planning.



Methods

Phase 1 consisted of an anonymous baseline survey distributed to all psychiatry residents and a forensic psychiatry fellow. The survey assessed cultural humility, self-reflection, structural awareness, comfort discussing culturally relevant issues, prior formal training, familiarity with the DSM-5 Cultural Formulation Interview (CFI), and self-reported integration of cultural and structural factors into clinical assessment and documentation. Quantitative items used 5-point Likert scales; optional open-ended questions explored educational needs and anticipated barriers. Quantitative data were summarized descriptively, and open-ended responses were reviewed for recurring themes.

Intervention

Findings informed development of a longitudinal, developmentally tailored 5 As cultural competence curriculum. In the first year, PGY-1 residents through child and adolescent and forensic psychiatry fellows received a foundational lecture addressing cultural humility, cultural competence, bias, power, structural inequities, and reflection on personal cultural identity through shared narrative. PGY-2 residents receive focused instruction on the DSM-5 CFI and a brief formulation template for inpatient clinical use. PGY-3 residents and child and adolescent psychiatry fellows use a standardized case-conference template developed by the authors to incorporate cultural formulation into weekly presentations. Future phases will include community-engaged activities and a community-tailored intervention developed through a new social media track.

Results

Twenty-seven trainees completed the baseline survey: 8 PGY-1, 7 PGY-2, 9 PGY-3, 2 PGY-4 residents, and 1 forensic psychiatry fellow. Prior formal training was limited: 8/27 (29.6%) reported prior training in cultural competence or humility and 6/27 (22.2%) reported training in structural determinants of mental health. Familiarity with the DSM-5 CFI was low; 17/27 (63.0%) reported no familiarity and 10/27 (37.0%) reported slight familiarity, with none reporting moderate or greater familiarity. Trainees strongly endorsed cultural humility as lifelong learning (mean 4.59/5) and openness to patient feedback regarding cultural misunderstandings (4.67/5), but reported less consistent routine assessment of cultural factors (2.74/5) and social or structural stressors (3.31/5). Among 19 open-ended respondents, recurring needs included language and health-literacy differences, culturally shaped symptom expression and treatment preferences, uncertainty about culturally informed interviewing, implicit bias, and integrating cultural and structural factors into formulation.

Eight trainees have completed the preliminary post-intervention survey. DSM-5 CFI familiarity increased, with 6/8 (75.0%) reporting moderate, very, or extreme familiarity compared with none



at baseline. Mean agreement with routinely assessing cultural factors increased from 2.74 to 4.13/5, and assessment of social or structural stressors increased from 3.31 to 4.25/5. Seven respondents (87.5%) agreed or strongly agreed that the curriculum provided practical strategies applicable to routine psychiatric interviews. Post-intervention data collection remains ongoing.

Conclusions

The needs assessment identified a gap between strong trainee endorsement of cultural humility and its consistent application in clinical practice. A longitudinal, developmentally tailored curriculum was developed to translate cultural humility into practical skills in assessment, formulation, documentation, and treatment planning. Preliminary findings suggest improved CFI familiarity and self-reported integration of cultural and structural factors into psychiatric assessment. Ongoing evaluation will assess implementation, acceptability, and changes in trainee-reported clinical practice using matched pre/post data and Wilcoxon signed-rank testing.

Scientific Citations

1. Accreditation Council for Graduate Medical Education. (2025). ACGME common program requirements (Residency). ACGME-approved interim revision September 3, 2025; effective September 3, 2025; ACGME-approved interim revision September 29, 2025; effective July 1, 2026. https://www.acgme.org

2. American Board of Family Medicine. (2025). Core competencies and procedures for ABFM board eligibility in 2026. https://www.theabfm.org/wp-content/uploads/2026/05/2026-Core-Competencies-and-Procedures.pdf

3. Arshad, H., Bhatia, R., & Pumariega, A. J. (2022). Tools to craft a cultural formulation. Child and Adolescent Psychiatric Clinics of North America, 31(4), 645–657. https://doi.org/10.1016/j.chc.2022.05.001

4. Boatright, D., Ross, D., O'Connor, P., Moore, E., & Ades, V. (2022). Racial and ethnic differences in internal medicine residency assessments. JAMA Network Open, 5(12), e2247649. https://doi.org/10.1001/jamanetworkopen.2022.47649

5. Jarvis, G. E., Kirmayer, L. J., Gómez-Carrillo, A., Aggarwal, N. K., & Lewis-Fernández, R. (2020). Update on the Cultural Formulation Interview. Focus, 18(1), 40–46. https://doi.org/10.1176/appi.focus.20190037

6. Kim, J. G., Lett, E., Boatright, D., & Ades, V. (2026). Sex, race, and ethnicity differences among residents with exceptionally high graduate medical education ratings. JAMA Network Open, 9(1), e264017. https://doi.org/10.1001/jamanetworkopen.2026.4017



7. Lett, E., Dohlman, M., & Boatright, D. (2023). Intersectional disparities in emergency medicine residents' performance assessments by race, ethnicity, and sex. JAMA Network Open, 6(9), e2330847. https://doi.org/10.1001/jamanetworkopen.2023.30847

8. Trinh, N. H., Rho, Y., & Sanders, K. M. (2021). Moving from cultural competence to cultural humility in psychiatric education. Psychiatric Clinics of North America, 44(2), 293–303. https://doi.org/10.1016/j.psc.2021.01.005



Title

From Clinician to Educator: A Longitudinal Faculty Development Program to Build Educator Identity and Competence Ahead of a New Community Psychiatry Residency

Primary Category

Faculty Development

Presenters

Andrew Bregman, MD, Kaiser Permanente Northern California Program (Sacramento), Christina Bilyeu, MD, Kaiser Permanente Northern California Program (Sacramento)

Education Objectives

We designed and implemented an 18-month Faculty Development Program (FDP) consisting of near-weekly half-day workshops for core faculty prior to the launch of our new categorical psychiatry residency. Workshop content included teaching and learning theory, curriculum design, feedback and evaluation, DEI, wellness, scholarly activity, recruitment, remediation, and GME governance. The explicit aim was to build a professional community, educator competence, and restore faculty identity as teachers.

Practice Gap

New residency programs frequently invest in curriculum, accreditation, and operational infrastructure before resident arrival, yet faculty are often expected to assume educator, mentor, and evaluator roles without structured preparation. Little has been written about how programs can intentionally develop educator identity, teaching competence, and faculty community before training begins.

Methods

To evaluate impact, we developed two parallel 7-item surveys administered at intern arrival: an intern survey (perceptions of faculty readiness, engagement, learning environment, and accessibility) and a faculty self-assessment (development, support, teaching self-efficacy, and knowledge of program roles/structure).

Preliminary results are available for 12 of 14 core faculty (86% response rate) and 5 of 6 arriving interns (83% response rate). Faculty and intern perceptions of readiness were highly favorable. Among faculty respondents, 92.9% of ratings were agree/strongly agree, while 97.1% of intern ratings of faculty readiness were agree/strongly agree. No survey item received a response below neutral.

Preliminary findings suggest that intensive, longitudinal faculty development conducted before residency launch may help establish educator identity, shared faculty culture, and readiness for teaching. Both faculty and interns reported highly favorable perceptions of preparedness at the earliest stage of training. This model offers a practical framework for new residency programs seeking to intentionally develop faculty as educators and build a cohesive educational community before residents arrive.

Scientific Citations

1. Silvestre J, Seeger S, Reitman CA, Dubé B. The Impending Psychiatrist Shortage: Projected Deficiencies in the U.S. Adult Psychiatry Workforce. Psychiatr Serv. 2026.

2. Donnelly, J., Ray, A., Lo, M. C., Wardrop, R. M., III, Ficalora, R., & Amin, A. (2021). Common cause and common purpose: Strategies to increase engagement in faculty development activities. American Journal of Medicine, 134(5), 691-698.

3. Puri A, Raghavan S, Sottile E, et al. New ACGME Clinician Educator Milestones as a Roadmap for Faculty Development: A Position Paper From the Society of General Internal Medicine Education Committee. J Gen Intern Med. 2023.

4. Robertson ML, Cofrancesco J, Levine RB. Transforming Individuals and Institutions Through Competency-Based Faculty Development. Front Med (Lausanne). 2025.

5. Triemstra JD, Iyer MS, Hurtubise L, et al. Influences on and Characteristics of the Professional Identity Formation of Clinician Educators: A Qualitative Analysis. Acad Med. 2021.



Title

From Trainee to Teacher: Identifying the Educational Needs of International Medical Graduates in U.S. Graduate Medical Education

Primary Category

Teaching, Supervision, Pedagogy

Presenters

Mary Steinmann, MD, University of Utah School of Medicine, Ioanna Douka, MD, University of Utah School of Medicine

Education Objectives

Assess IMG teaching experiences, confidence, perceived barriers, priority training needs, and interest in an IMG-focused teaching skills micro-series and Community of Practice.

Practice Gap

International Medical Graduates (IMGs) comprise a substantial proportion of the U.S. psychiatry workforce and frequently assume teaching roles during residency and fellowship. Yet transition into U.S. Graduate Medical Education (GME) may involve navigating unfamiliar teaching expectations, feedback practices, educational hierarchies, and communication norms. While general resident-as-teacher curricula address core teaching skills, they may not address challenges specific to IMG educators. To inform the development of Teaching Skills for IMGs: A Micro-Series and Community of Practice for Educators, supported by the Nyapati Rao and Francis Lu IMG Fellowship Award, we conducted a needs assessment of IMG trainees and faculty at the University of Utah.

Methods

We developed an anonymous electronic survey to assess IMG teaching experiences, confidence, perceived barriers, priority training needs, and interest in an IMG-focused teaching skills micro-series and Community of Practice. The survey included multiple-choice and open-ended questions and was distributed to IMGs at the University of Utah. Twenty respondents have completed the ongoing survey to date.

Results

Respondents were predominantly fellows (50%) and advanced residents (25%); 75% were non-U.S. IMGs and 25% U.S. IMGs. Half reported teaching at least monthly, while 25% did not currently teach. Mean confidence in teaching was 3.8/5. The most frequently endorsed training



needs were giving effective feedback and cross-cultural communication (50% each), followed by understanding U.S. teaching expectations, clinical teaching strategies, and mentorship/career development (45% each). Commonly reported challenges included unfamiliarity with U.S. medical education expectations (55%), differences in teaching and learning culture (50%), and navigating hierarchy and relationships with learners and faculty (40%). Interest in targeted programming was high: 90% were interested or potentially interested in an IMG Teaching Skills Micro-Series, and 100% were interested or potentially interested in a Community of Practice. Free-text responses highlighted a desire for experiential rather than exclusively didactic learning, including mentorship, observation of skilled educators, mock teaching, opportunities for deliberate practice, and constructive feedback. Respondents also identified limited time for teaching during clinical work and concerns about psychological safety and feeling respected, including accent-related judgment.

Conclusions

IMGs in our needs assessment identified educational needs extending beyond traditional resident-as-teacher curricula, particularly around feedback, cross-cultural communication, navigating U.S. educational expectations, mentorship, and opportunities for supported teaching practice. Strong interest in both a skills-based micro-series and a Community of Practice suggests that teaching competence and educator identity may be best supported through a combination of targeted skills training, experiential learning, mentorship, and longitudinal peer community. These findings are directly informing development of an IMG-focused curriculum designed to help IMGs transition from trainees to confident educators within U.S. GME.

Scientific Citations

1. Pettine WW, Douka I, Tseng A, Yang A, Anticevic A, Docherty AR, Redish AD, Murray JD, Jacob S. Attention and learning strategies reveal distinct dimensions of psychiatric diseases. Res Sq. 2026 Jun 23;. doi: 10.21203/rs.3.rs-9698354/v1. PubMed PMID: 42396492; PubMed Central PMCID: PMC13321270.

2. Osorio PC, Ruitenberg MFL, Weischedel KM, Douka I, Phouthavongsay CA, Weisenbach SL, Mickey BJ, Koppelmans V. Visuomotor adaptation and savings are preserved in individuals with depression. J Mot Learn Dev. 2025 Dec;13(3):752-769. doi: 10.1123/jmld.2024-0105. Epub 2025 Aug 21. PubMed PMID: 42006398; PubMed Central PMCID: PMC13089910.

3. Douka I, Ruitenberg MFL, Weischedel K, Phouthavongsay C, Weisenbach SL, van der Geest JN, Mickey BJ, Koppelmans V. Cognitive and motor disturbances in depression: insights from comprehensive behavioral assessments. Front Psychiatry. 2025;16:1624776. doi:



10.3389/fpsyt.2025.1624776. eCollection 2025. PubMed PMID: 40800628; PubMed Central PMCID: PMC12340722.

4. Huber RS, Weinstein S, Sullivan AE, Batt MM, Vande Voort J, Westlund Schreiner M, Are F, Douka I, DelBello M, Singh MK, Hulvershorn L, Boodoo R, Hammond CJ, Brasic JR, Ghaziuddin N, Dopp R, Miller L. Challenges and Opportunities in Using Cognitive Screeners for Adolescents and Young Adults With Bipolar Disorder. Focus (Am Psychiatr Publ). 2025 Apr;23(2):125-132. doi: 10.1176/appi.focus.20240045. Epub 2025 Apr 15. PubMed PMID: 40235617; PubMed Central PMCID: PMC11995903.

5. Nunez NA, Joseph B, Kumar R, Douka I, Miola A, Prokop LJ, Mickey BJ, Singh B. An Update on the Efficacy of Single and Serial Intravenous Ketamine Infusions and Esketamine for Bipolar Depression: A Systematic Review and Meta-Analysis. Brain Sci. 2023 Dec 2;13(12). doi: 10.3390/brainsci13121672. Review. PubMed PMID: 38137120; PubMed Central PMCID: PMC10741553.

6. Nikolaidis A, Paksarian D, Alexander L, Derosa J, Dunn J, Nielson DM, Droney I, Kang M, Douka I, Bromet E, Milham M, Stringaris A, Merikangas KR. The Coronavirus Health and Impact Survey (CRISIS) reveals reproducible correlates of pandemic-related mood states across the Atlantic. Sci Rep. 2021 Apr 14;11(1):8139. doi: 10.1038/s41598-021-87270-3. PubMed PMID: 33854103; PubMed Central PMCID: PMC8046981.

Title

Generativity in Reproductive Psychiatry: Cultivating the Next Generation of Trainees and Early Career Leaders

Primary Category

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

Presenters

Tolu Odebunmi, MBBS, MPH, University of Minnesota, Briana Clifton, MD, University of California, Davis, Elizabeth DeVore, MD, University of Michigan

Education Objectives

1. Examine the potential barriers to reproductive psychiatry training for advanced stage psychiatry trainees and early career attending psychiatrists

2. Characterize the gaps in education preparation, clinical exposure, mentorship, and career development support among advanced stage psychiatry trainees

3. Differentiate the professional and structural barriers encountered during the transition from advanced training to early-career faculty or attending practice

4. Create potential interventions for educational exposure, mentorship, and institutional support to improve recruitment, training, retention, and transitions for both reproductive psychiatry trainees and attendings

Practice Gap

Reproductive psychiatry is an area of growing interest among trainees, prompting renewed attention to the adequacy of training pathways and the development of a sustainable workforce. Although reproductive psychiatry is not an ACGME-accredited fellowship, some institutions offer fellowships and other advanced-training opportunities. As a result, psychiatry residents and early-career psychiatrists have markedly variable access to clinical exposure, mentorship, and research. The transition from residency training to early-career practice is a relatively unexplored topic within current literature, particularly regarding access to resources that encourage sustained career growth. A clearer understanding of career-stage-specific barriers and professional-development priorities is needed to inform our understanding of the career trajectory for current and future reproductive psychiatrists.



Methods

A cross-sectional, web-based survey was distributed via email to psychiatry trainees and attending psychiatrists across the United States. Eligibility criteria for trainee participants included current enrollment in an accredited psychiatry residency program and intent to pursue a career in reproductive psychiatry. Eligibility criteria for attending psychiatrists included self-identification as an early career professional and current clinical practice involving reproductive psychiatry. The survey consisted of 10 items incorporating multiple-choice and Likert-scale response formats. Items were designed to characterize perceived barriers to the advancement of career-development goals. The survey was disseminated electronically, and responses were collected over approximately one-month period. Of 30 respondents, 19 (63.3%) were early-career attending psychiatrists and 11 (36.7%) were psychiatry trainees. Among trainees, 27.2% were currently involved in research, while 45.4% were seeking research opportunities. Trainees most commonly reported limited mentorship and inadequate access to reproductive psychiatry clinical experiences as barriers to research engagement (72.7% each). Early-career attendings most frequently cited insufficient protected time (63.2%), followed by limited mentorship (42.1%), inadequate funding (36.8%), and lack of professional network (31.6%). Most respondents lacked a current reproductive psychiatry mentor or sponsor (81.8% of trainees; 63.2% of attendings). Trainees reported lower mentorship satisfaction (mean 2.50/5) and professional connection (2.36/5) than attendings (3.10 and 3.26, respectively). When identifying factors that would enhance professional growth, trainees prioritized policy/advocacy education, leadership training, and clinical updates (81.8% each). Attendings prioritized clinical updates (84.2%), research support (68.4%), and policy/advocacy information (63.2%). Both groups reported a desire for expanded networking: trainees preferred one-on-one mentorship (91.0%), while attendings favored virtual communities (94.7%), conferences (84.2%), and regional meetings (73.7%). Resident trainees and early-career attending psychiatrists reported distinct, career-stage-specific barriers to professional development in reproductive psychiatry. Early-career attendings most often identified inadequate protected time as a barrier to research engagement, whereas trainees more commonly cited limited mentorship and insufficient clinical training opportunities. The high proportion of both groups without a current mentor or sponsor highlights a critical gap and suggests that professional isolation may be particularly salient during the transition to independent practice. Priorities also differed by career stage. Trainees expressed greatest interest in policy and advocacy, research support, and skill development, while early-career attendings prioritized clinical updates and leadership development. However, both groups strongly endorsed one-on-one mentorship and virtual professional communities, underscoring demand for accessible, individualized, and geographically inclusive opportunities for connection. Attendings' greater interest in annual conferences and regional meetings may reflect the desire for cross-institutional network development. These findings support career-

stage-specific, multilevel workforce interventions. National organizations could develop structured mentorship networks, longitudinal mentoring programs, pilot funding, and virtual scholarly forums for research consultation and cross-institutional collaboration. Institutions can support trainees and early-career psychiatrists through protected scholarly time, expanded clinical experiences, and targeted leadership and research programming. Formal initiatives should be complemented by low-barrier options, including virtual discussion groups, peer mentorship, and development of online communities of practice. Together, these strategies may strengthen recruitment, retention, and transition to independent practice.

Scientific Citations

1. Nagle-Yang, S., Lebin, L. G., Standeven, L. R., Howard, M., & Toscano, M. (2024). Reproductive psychiatry training: A critical component of access to perinatal mental health treatment. Seminars in Perinatology, 48(6), 151947.

2. Cirino, N., De Faria, L., Hasser, C. et al. The Time Is Now: Barriers and Solutions for an ACGME Requirement in Reproductive Psychiatry. Acad Psychiatry 50, 482–488 (2026). https://doi.org/10.1007/s40596-026-02320-0

3. Koire, A., Cirino, N., Sager, M. et al. Advancing Women's Mental Health Education in Psychiatry Residency Training Programs: Insights from a Trainee Needs Assessment.Psychiatr Q 97, 273–288 (2026). https://doi.org/10.1007/s11126-026-10267-6

4. Chalmers, K., Somerville, C., Koire, A. et al. Reproductive Psychiatry Training in Psychiatry Residencies: A 10-Year National Update on Persistent Barriers and Emerging Interest.Acad Psychiatry (2026). https://doi.org/10.1007/s40596-026-02439-0

5. Erdly, C., Etyemez, S., Standeven, L.R. et al. Setting Common Standards for Reproductive Psychiatry Education: Effectiveness of the National Curriculum in Reproductive Psychiatry. Acad Psychiatry 47, 63–68 (2023). https://doi.org/10.1007/s40596-022-01663-8

Title

Harmonizing Education and Efficiency: A Model for Direct Observation in Outpatient Psychiatry Training

Primary Category

Curriculum

Presenters

Anna Costakis, MBA, MD, Zucker School of Medicine at Hofstra/Northwell - Staten Island University Hospital, Elina Drits, DO, Zucker School of Medicine at Hofstra/Northwell - Staten Island University Hospital, Caroline Harris, DO, Zucker School of Medicine at Hofstra/Northwell - Staten Island University Hospital, Peter Steen, MD, Zucker School of Medicine at Hofstra/Northwell - Staten Island University Hospital, Samantha Getsin, MD, Zucker School of Medicine at Hofstra/Northwell - Staten Island University Hospital

Education Objectives

1. Describe the design of a direct observation model for general, geriatric, child & adolescent, and chemical dependency outpatient psychiatry clinics.

2. Evaluate the impact on attending physician relative value unit (RVU) over a multi-year period.

3. Identify perceived benefits, challenges, and best practices from both faculty and resident perspectives through focus groups

4. Provide a visual framework and key takeaways for other programs considering direct observation in their outpatient psychiatric training settings.

Practice Gap

Direct observation of a psychiatric trainee's clinical encounter is an essential measure in competency-based medical education, as it allows real-time observation, assessment, and feedback, with the literature pointing to better patient outcomes [2, 5]. However, multiple barriers remain, including time constraints, logistical complexities, threats to resident autonomy, and productivity concerns [4, 8, 12]. To bridge this gap, our residency program developed a direct observation model across several outpatient psychiatric clinics to enhance resident training without sacrificing clinical productivity. This poster will explore our supervision model, highlighting its impact on clinic productivity and staff reflections.



Methods

In July 2024, our general psychiatry residency program implemented a direct observation model across its outpatient mental health clinics (general, geriatric, child & adolescent) and the Chemical Dependency Outpatient Program (CDOP). Attending psychiatrists blocked off their clinical schedules to supervise a subset of residents at a defined time each week; they used multiple observation modalities, in person or through a secure video feed (also known as Bug-In-The-Ear supervision). To streamline and standardize feedback, tailored observation instruments were utilized, like P-SCO and DSCO [1, 3, 10, 11]. To assess the model's impact on clinic functioning, attending physicians' RVU data was analyzed from the year before implementation (2023) through the first full calendar year post-implementation (2025) and year-to-date (YTD) June 2026. Qualitative data will be collected through structured focus groups with participating faculty and residents, exploring their perspectives on efficacy, enablers, and barriers.

Results

Quantitative analysis of attending psychiatrists' RVUs demonstrates the ability to implement direct observation in the outpatient psychiatric setting without compromising clinic productivity.

- 2023 (Pre-implementation): 17,204 RVU
- 2024 (Partial implementation, July-Dec): 21,803 RVU (a 26.7% increase from 2023)
- 2025 (Full implementation): 23,478 RVU (a 7.7% increase from 2024 and a 36.5% increase from 2023)
- 2026 YTD June (annualized): 13,247 RVU (annualized to ~26,494 RVU), indicating continued growth.

Overall, the above sustained increase in RVUs, with physician FTE remaining constant at 7.4, suggests that direct observation was successfully integrated without hindering service delivery, potentially even correlating with expanded operational efficiency and provider productivity.

Preliminary qualitative data from focus groups indicate that residents value the accessibility of feedback, as they have immediate, tailored reviews of their performance, all of which fosters confidence and competency in interviewing, diagnosis acquisition, and treatment planning. There remains the issue of performance anxiety, though the development of supportive trainee-observer relationships, clear learning objectives, and the possibility of bi-directional observation may mitigate this [6,8,9]. Another concern is the issue of trainee autonomy, which can be mediated through defined supervisor roles [8]. Faculty detail the benefit of scheduled, longitudinal supervision, allowing for evaluation of resident progress. However, concerns arise

for timing, as often feedback sessions were rushed, yielding a necessity for built-in feedback time.

Conclusion

Direct observation models of trainees can be implemented in diverse outpatient psychiatry training settings, from addiction to child clinics, yielding significant educational benefits without sacrificing clinical operations. This poster will highlight a practical blueprint for integrating direct observation, fueled by both quantitative and qualitative outcomes of residents and faculty, thereby cultivating innovation in educational leadership.

Scientific Citations

1. Butterfield, A., Curry, A., Yager, J., et al. (2023). A direct observation form for evaluation of the psychiatric interview: Pilot testing during the psychiatry clerkship. Academic Psychiatry, 47, 368–373. https://doi.org/10.1007/s40596-023-01762-0

2. Galanter, C. A., Nikolov, R., Green, N., et al. (2016). Direct supervision in outpatient psychiatric graduate medical education. Academic Psychiatry, 40(1), 157–163. https://doi.org/10.1007/s40596-014-0247-z

3. Jibson, M. D., Agarwal, G., Anzia, J. M., et al. (2021). Psychiatry clinical skills evaluation: A multisite study of validity. Academic Psychiatry, 45, 413–419. https://doi.org/10.1007/s40596-020-01388-6

4. Madan, R., Conn, D., Dubo, E., Voore, P., & Wiesenfeld, L. (2012). The enablers and barriers to the use of direct observation of trainee clinical skills by supervising faculty in a psychiatry residency program. The Canadian Journal of Psychiatry, 57(4), 269–272. https://doi.org/10.1177/070674371205700411

5. Murphy, J. E., Khawaja, H., Messina, D., Monteiro, J. F. G., Jeremiah, J., & McGarry, K. (2023). Implementation, reach, and effectiveness of the direct observation of residents in clinic program. Education for Health, 36(3), 104–110. Implementation, Reach, and Effectiveness of the... : Education for Health

6. Rietmeijer, C. B. T., Blankenstein, A. H., Huisman, D., van der Horst, H. E., Kramer, A. W. M., de Vries, H., & Teunissen, P. W. (2021). What happens under the flag of direct observation, and how that matters: A qualitative study in general practice residency. Medical Teacher, 43(8), 937–944. https://doi.org/10.1080/0142159X.2021.1898572

7. Stein, S. P., Karasu, T. B., Charles, E. S., & Buckley, P. J. (1975). Supervision of the initial interview: A study of two methods. Archives of General Psychiatry, 32(2), 265–268. https://doi.org/10.1001/archpsyc.1975.01760200129013

8. Tan, L., & Kam, C. (2020, May 5). How psychiatry residents perceive clinical teaching effectiveness with or without direct supervision. TAPS.

9. Yager, J., & Lee, J. S. (2024). Third-party observation in psychotherapy: Playing to the audience. American Journal of Psychotherapy, 77(1), 35–38. https://doi.org/10.1176/appi.psychotherapy.20230002

10. Young, J. Q., Irby, D. M., Kusz, M., et al. (2018). Performance assessment of pharmacotherapy: Results from a content validity survey of the Psychopharmacotherapy-Structured Clinical Observation (P-SCO) Tool. Academic Psychiatry, 42(6), 765–772. https://doi.org/10.1007/s40596-017-0876-0

11. Young, J. Q., Sugarman, R., Holmboe, E., & O'Sullivan, P. (2019). Advancing our understanding of narrative comments generated by direct observation tools: Lessons from the Psychopharmacotherapy-Structured Clinical Observation. Journal of Graduate Medical Education, 11(5), 518–525.

12. Young, J. Q., Sugarman, R., Schwartz, J., & O'Sullivan, P. (2020, June 12). Overcoming the challenges of direct observation and feedback programs: A qualitative exploration of resident and faculty experiences. Teaching and Learning in Medicine.



Title

Helping the Homeless: Partnering with a legal advocacy group to allow residents an experience in doing disability evaluations for a struggling population in our community

Primary Category

Curriculum

Presenters

Kathleen Crapanzano, MD, Louisiana State University School of Medicine (Baton Rouge) Program, VIvian Dille, BS, Sydney Melancon, MD, Louisiana State University School of Medicine (Baton Rouge) Program

Education Objectives

As a result of the disability evaluation educational experience, program aims are to

1. Encourage residents to participate in doing disability evaluation in their own practices in the future.

2. Give back to our community by using our skills to help address the homeless problem issue in our city.

3. Meet ACGME requirements for a forensic experience in assessing people for disability benefits.

4. Allow residents to see the complexity of homelessness in our society and some of the forces that impact it.

5. Teach residents how to write an appropriate document to submit to the court.

Practice Gap

The ACGME requires residents to have an experience in forensic psychiatry that includes evaluating a person's capacity to work when applying for disability. This is a skill that requires residents to understand the criteria for disability, how to assess those criteria, and how to write a report suitable for the person to use in their disability application. While opportunities to do these evaluations may present themselves in other clinical rotations, a specific experience where this dedicated teaching and supervision could be provided was needed. We developed an experience by partnering with a local legal advocacy group to do disability evaluations for people in our community attempting to apply for disability due to mental health concerns.



Methods

Through a partnership with a local legal advocacy group, 4th year residents are given access to available medical records and did a structured psychiatric assessment geared toward assessing work capacity for people in our community who met indigent criteria. Didactic information on the disability process, qualifying criteria, and legal issues was given to residents by both the attorney and the course supervisor. The residents' written reports were reviewed and submitted as part of the patients' disability claims. Data regarding success rates for obtaining disability, risk factors for homelessness and measures that would better define the population were gathered from reports and reviewed.

Results

From 2016 to 2025, over 110 disability evaluations were performed. Half (55/110) of the clients were homeless or lived in shelters. Half (55/110) were housed, often in unstable housing situations. The medical comorbidity burden increased the odds ratio of homelessness by 1.07 (CI 0.87-1.31, p=0.537) for each additional diagnosis. Cumulative social risk (total number of individual factors each patient presented with) resulted in a higher odds ratio of homelessness (OR=1.11, CI 0.77-1.63, p=0.6).

Discussion

This educational project is beneficial to residents in terms of getting experience with the disability process. It has been an even bigger service for our community with 110 people who could not otherwise afford a psychiatric evaluation receiving documentation to support (in most cases) their disability claims. Receiving disability (either SSI or SSDI) can result in consistent income and health insurance (Medicaid or Medicare) and an opportunity for a more stable housing situation. Furthermore, residents were exposed to the complexity of factors that work to sustain homelessness and poverty. Residents subjectively acknowledged development of more empathy about the plight of some of the people we worked with. We recommend other programs pursue community partners to work with to provide this experience to their residents as well as this service to their community.

Scientific Citations

1. Onapa H, Sharpley CF, Bitsika V, McMillan ME, MacLure K, Smith L, Agnew LL. The physical and mental health effects of housing homeless people: A systematic review. Health Soc Care Community. 2022 Feb;30(2):448-468. doi: 10.1111/hsc.13486. Epub 2021 Aug 22. PMID: 34423491.

2. Cerny-Suelzer CA, Michaelsen K, Wasser T, Kushner D, Friedman SH. Forensic Psychiatry as a Key Part of Residency Training in Social Justice and Mental Health Inequities.



3. Acad Psychiatry. 2024 Oct;48(5):471-475. doi: 10.1007/s40596-024-01989-5. Epub 2024 Jun 6. PMID: 38844657.

4. Guillén AI, Panadero S, Vázquez JJ. Disability, health, and quality of life among homeless women: A follow-up study. Am J Orthopsychiatry. 2021;91(4):569-577. doi: 10.1037/ort0000559. Epub 2021 Jun 3. PMID: 34081497.

5. Lowder EM, Desmarais SL, Neupert SD, Truelove MA. SSI/SSDI Outreach, Access, and Recovery (SOAR): Disability Application Outcomes Among Homeless Adults. Psychiatr Serv. 2017 Nov 1;68(11):1189-1192. doi: 10.1176/appi.ps.201600568. Epub 2017 Aug 1. PMID: 28760095.

6. Tsai J, Szymkowiak D, Beydoun H. Multimorbidity of mental health and substance use disorders among housed and homeless U.S. veterans. Sci Rep. 2025 Apr 30;15(1):15185. doi: 10.1038/s41598-025-99394-x. PMID: 40307423; PMCID: PMC12043799.

Title

How Might Generative AI Assist in Screening Psychiatry Applicants for Interview?

Primary Category

Recruitment and Selection

Presenters

Helena Winston, MD, MSc, University of Colorado Denver

Education Objectives

The research was hypothesis-driven, exploratory, and hypothesis generating.

1. Aim 1 was to investigate whether the Copilot selects the same candidates as the human reviewer using the same selection criteria; the associated hypothesis was that AI Copilot would select 75% of the same candidates.

2. Aim 2 was to assess the efficiency of using AI Copilot for candidate selection versus standard process and the associated hypothesis was that AI Copilot would review and select candidates in a fraction of the time.

3. Aim 3 was to review the AI missed candidates who were identified in standard process; the associated hypothesis was that AI Copilot may miss nuances in affect communicated in applications, leading it to omit good potential candidates.

Practice Gap

Large language model (LLM) artificial intelligences (AI) such as Microsoft 365 Copilot, which is approved by the University of Colorado (UC) for use with confidential and highly confidential data and does not use data to train, are rapidly changing the landscape of residency applications. The potential use of AI to review applicants is regularly discussed at conferences, however, there exist few studies on utilizing AI in the assessment of residency candidates in general, and none in psychiatry. This study was approved by the Colorado institutional review board (IRB) to compare the candidates selected by Copilot to those selected by a human being for interview for a community and public psychiatry residency track within the NRMP match.

Methods

Using the University of Colorado psychiatry residency's interview Selection Criteria Rubric and keeping in mind the nature of the community and public psychiatry track, the human reviewer assessed all 183 applicants to the track, starting with those who had signaled the program, and

selected 20 candidates to interview and 4 backup selections. AI round 1: Copilot was asked to select candidates for interview based on the same Selection Criteria Rubric utilized by the human reviewer. Due to Copilot limitations on number of documents that one is able to upload, batches of personal statements (PS) and curricula vitae (CV) were uploaded sequentially. Copilot sequentially assessed the documents and generated lists of top 20 candidates. AI round 2: All PS and CV were merged into one document, and this one document was uploaded. Copilot generated a list of 20 candidates. Results: Aim/hypothesis 1 was refuted. In round 1, Copilot identified 45% of the same candidates as the human reviewer (see caveat in Hypothesis 2). In round 2, Copilot identified 20% of the same candidates. Aim/hypothesis 2: Round 1: AI was unable to complete the task in full, at one point saying it would continue to work on the assessment; after many hours it was still unable to generate a final list, although it had identified 45% of the same candidates prior to being unable to proceed. Round 2: Copilot generated a list in under 5 minutes. The human review took days. Hypothesis 3: Copilot missed some strong candidates that were selected by the human reviewer. Conclusions: How AI is utilized affects how it is able to function. The crafting of a question and the way in which information is provided to the AI affects its ability to generate results similar to a human. The time it takes for AI to potentially generate a initial list of candidates is miniscule (minutes) compared to the hours and hours it takes a human reviewer to do the same task. The AI suggested some candidates who were good candidates, but who had not been identified by the human reviewer and vice versa. The two together may provide a more fair and equitable assessment of candidates as fatigue and comparison to already reviewed candidates may affect human review. Generative AI may have a useful role in assisting review of candidates for interview.

Scientific Citations

1. Ajmani A, Klufas T, Zhou AE, Sloan B, Grant-Kels JM. Ethical implications of artificial intelligence in residency applicant screening. J Am Acad Dermatol. 2025 May 23:S0190-9622(25)02198-X. doi: 10.1016/j.jaad.2025.05.1416. Epub ahead of print. PMID: 40414605.

2. Carriero S, Cannella R, Cicchetti F, et al. AI Revolution in Radiology, Radiation Oncology and Nuclear Medicine: Transforming and Innovating the Radiological Sciences. Journal of Medical Imaging and Radiation Oncology 2025: 1–11, https://doi.org/10.1111/1754-9485.13880.

3. Hassan M, Ayad M, Nembhard C, Hayes-Dixon A, Lin A, Janjua M, Franko J, Tee M. Artificial Intelligence Compared to Manual Selection of Prospective Surgical Residents. J Surg Educ. 2025 Jan;82(1):103308. doi: 10.1016/j.jsurg.2024.103308. Epub 2024 Nov 6. PMID: 39509905.

4. Markow M, Jebbia M, Hasjim BJ, Nahmias J, Grigorian A, Burruss S, Schubl S, Vilchez V, Fairbairn K, Chau A, Keshava H, Yamamoto M, Smith B, Swentek L. Artificial intelligence:



Reducing inconsistency in the surgical residency application review process. Am J Surg. 2024 Dec;238:115816. doi: 10.1016/j.amjsurg.2024.115816. Epub 2024 Jul 7. PMID: 39079879.

5. Michaelson G, Karasik D, Polen E, Rangarajan SV, Zhao NW. Preparing for AI in Resident Selection: A Scoping Review of Current Applications and Limitations. Laryngoscope. 2025 Jun 7. doi: 10.1002/lary.32308. Epub ahead of print. PMID: 40481757.

6. Nazer LH, Zatarah R, Waldrip S, Ke JXC, Moukheiber M, Khanna AK, Hicklen RS, Moukheiber L, Moukheiber D, Ma H, Mathur P. Bias in artificial intelligence algorithms and recommendations for mitigation. PLOS Digit Health. 2023 Jun 22;2(6):e0000278. doi: 10.1371/journal.pdig.0000278. PMID: 37347721; PMCID: PMC10287014.

7. Subillaga O, Coulter AP, Tashjian D, Seymour N, Hubbs D. Artificial Intelligence-Assisted Narratives: Analysis of Surgical Residency Personal Statements. J Surg Educ. 2025 Jun 18:103566. doi: 10.1016/j.jsurg.2025.103566. Epub ahead of print. PMID: 40537315.

8. University of Colorado. AI at CU Anschutz: University-approved tools, guidelines, and best practices: “Best Practices When Using AI”: https://www.cuanschutz.edu/offices/iss/artificial-intelligence#ft-best-practices-2



Title

Improving Education on Resident Management of Patient Agitation: A Comparison of Clinical Vignettes and Simulation-Based Training

Primary Category

Curriculum

Presenters

Christopher Moreau, MD, University of Iowa Hospitals & Clinics, Brian Kinnaird, MA, MD, University of Iowa Hospitals & Clinics, Alexandra Tamura, MD, University of Iowa Hospitals & Clinics

Education Objectives

Compare clinical vignette-based and simulation-based education for teaching psychiatry residents the management of acute agitation and to identify the complementary strengths, limitations, and resource requirements of each educational approach.

Practice Gap

Management of acute agitation and behavioral emergencies is an essential skill for psychiatrists, yet standardizing education in the nuanced management of these dynamic clinical situations remains challenging. Two potential approaches are clinical vignette-based education, which provides a low-resource method for teaching assessment and management, and simulation-based education, which offers opportunities for experiential learning, direct observation, and individualized feedback. Although simulation has become increasingly common in medical education, its use in psychiatry has been more limited (Wuendrich 2012; McNaughton 2008). Simulation is also more resource-intensive and may present challenges in accurately depicting complex clinical scenarios (Pheister 2015). We evaluated these two educational approaches to identify their respective strengths in teaching psychiatry residents to manage acute agitation.

Methods

In November 2025, junior psychiatry residents (N=14) participated in a peer-led educational session using clinical vignettes addressing common agitation and behavioral emergency scenarios. Residents completed pre- and post-session surveys assessing confidence in behavioral emergency management. Following the session, residents requested additional opportunities for direct practice, particularly in verbal de-escalation. In response, a resident-faculty workgroup developed four simulation scenarios emphasizing verbal de-escalation,



interdisciplinary communication, and workplace safety. The project subsequently received funding through a graduate medical education (GME) educational grant. Simulation sessions were conducted in collaboration with the University of Iowa Center for Procedural Skills and Simulation with first-year residents (R1s; N=18) during orientation in June 2026 and second-year residents (R2s; N=10) in August 2026. Participants completed pre- and post-session surveys assessing confidence and knowledge and provided qualitative feedback. Findings from the two educational interventions were compared to identify differences in their perceived educational benefits.

Results

Both clinical vignette-based education and simulation-based education were associated with improved resident confidence in managing behavioral emergencies in multiple domains, although their educational effects differed. Clinical vignettes improved confidence in medication management but did not improve confidence in verbal de-escalation. In contrast, simulation similarly improved confidence in verbal de-escalation but did not increase confidence regarding medication management. R2 residents demonstrated greater baseline confidence than R1 residents, while R1 residents appeared to derive greater benefit from the simulation experience. Qualitative feedback indicated that residents enjoyed both educational formats and wanted both incorporated into future training. Residents particularly valued the opportunity provided by simulation to practice verbal de-escalation, receive peer feedback, and observe different approaches to managing agitation. Residents suggested that simulation occur later in the R1 year rather than during orientation. The initial simulation session with R1s required an estimated $1,152 in resources, while the subsequent R2 simulation required $392 after reducing the number of actors needed. In contrast, the clinical vignette-based intervention had essentially no direct cost to the department.

Conclusions

Clinical vignette-based education and simulation-based education appear to provide complementary approaches to teaching acute agitation management. Clinical vignettes are essentially cost-free and may be particularly useful for teaching medication management, clinical decision-making, and discussion of complex scenarios. Simulation requires greater resources but provides a unique opportunity to practice and directly observe behavioral skills, particularly verbal de-escalation. These findings support incorporating both interventions at different stages of residency, with simulation providing experiential practice of behavioral emergency skills and clinical vignette-based education reinforcing clinical decision-making and medication management.



Scientific Citations

1. Wuendrich MS, Nissen C, Feige B, Philipsen AS, Voderholzer U. Portrayal of psychiatric disorders: are simulated patients authentic? Acad Psychiatry. 2012;36(6):501–502.

2. McNaughton N, Ravitz P, Wadell A, Hodges BD. Psychiatric education and simulation: a review of the literature. Can J Psychiatry. 2008;53(2):85–93.

3. Pheister M, Stagno S, Cotes R, Prabhakar D, Mahr F, Crowell A, Schwartz A. Simulated patients and scenarios to assess and teach psychiatry residents. Acad Psychiatry. 2017;41(1):114–117. doi:10.1007/s40596-015-0477-8.



Title

Improving Resident Satisfaction with Faculty Feedback

Primary Category

Assessment – learner (summative, formative, programmatic)

Presenters

Magnolia Rose Swanson, BA, MD, University of Arizona

Education Objectives

I sought to understand resident and faculty dissatisfaction with our current evaluation system and to implement strategies addressing their concerns. Specific aims were to:

1. Increase resident satisfaction with faculty feedback, as measured by post-implementation survey data.

2. Improve our program's ACGME Resident/Fellow Survey scores for the item "EVALUATION: Satisfied with faculty members' feedback."

Practice Gap

Effective feedback and evaluation are essential to training and certifying competent physicians. Over the past five years, our program's ACGME Resident/Fellow Survey scores for satisfaction with faculty feedback have remained consistently below institutional and national levels. Residents in our training program have expressed dissatisfaction with the discrepancy between summative and formative feedback, a concern echoed in other specialties [2]. Faculty members across specialties and/or institutions have cited evaluations as a contributor to burnout and dissatisfaction with teaching [3-5]. Other specialties have improved evaluation timeliness and narrative quality using more targeted feedback forms [1]. We sought to determine whether a similar approach would improve resident satisfaction with faculty feedback in psychiatry.

Methods

Our existing evaluation form asked supervisors to comment on all 22 psychiatry subcompetencies. We piloted a targeted form selecting 1-3 subcompetencies from each of the 6 core competencies, used on our Consult-Liaison and Inpatient Psychiatry rotations for 6 months. We collected anonymous pre- and post-pilot survey data from residents and elicited feedback from faculty during inpatient faculty meetings. We also reviewed data from the 2026 ACGME Resident/Fellow Survey.



Results

The pre-pilot survey was distributed to residents in all 4 postgraduate years, with 35 of 48 possible responses (73%). The post-pilot survey was distributed only to PGY1 and PGY2 residents, with 10 of 24 possible responses (42%). Resident satisfaction with the targeted form was not lower than with the previous form, and residents did not identify additional subcompetencies or questions they wished to see included. Faculty reported that the new form was less burdensome to complete. On the ACGME survey, the item "Satisfied with faculty members' feedback" increased from 54% to 76%, moving our program above the national compliance benchmark.

Conclusions

The targeted evaluation form was well received by faculty and was not associated with reduced resident satisfaction. The process of discussing evaluation forms with residents and faculty also helped clarify the underlying reasons for their dissatisfaction. Limitations include a small sample size, an optional survey format, and a short follow-up period, all of which limit interpretation of the results. The improvement in ACGME compliance scores may also reflect factors other than the pilot, such as the act of discussing feedback itself or a different cohort of residents completing the survey year to year. Going forward, we plan to tailor evaluation forms across all rotations and to track whether this leads to more timely, higher-quality narrative evaluations.

Scientific Citations

References:

1. Chappell C, Markowiak S, Ren G, Wharry L, Stanek S, Sferra J. Redesign of a resident evaluation tool using exploratory factor analysis. J Surg Educ. 2025;82(12):103477. doi:10.1016/j.jsurg.2025.103477

2. Figg BJ, Bolen O, Wagner MJ, Hicks T, Santen SA. Resident physician interactions and engagement with written assessments of performance. Fam Med. 2023;55(2):103-106. doi:10.22454/FamMed.2022.587346

3. Ott MC, Pack R, Cristancho S, Chin M, Van Koughnett JA, Ott M. "The most crushing thing": understanding resident assessment burden in a competency-based curriculum. J Grad Med Educ. 2022;14(5):583-592. doi:10.4300/JGME-D-22-00050.1

4. Tierney AA, Rosner BI. Clinical assessment of residents: a survey of clinician educators regarding resident assessment burden and modifiable factors. J Grad Med Educ. 2023;15(1):92-97. doi:10.4300/JGME-D-22-00188.1



5. Young JQ, Holmboe ES, Frank JR. Competency-based assessment in psychiatric education: a systems approach. Psychiatr Clin North Am. 2021;44(2):217-235. doi:10.1016/j.psc.2020.12.005

Title

One Team, Twelve Hand-Offs: A Sequential Model for Engaging a Psychiatry Residency Class in a Single Year-Long Quality Improvement Project

Primary Category

Curriculum

Presenters

Eduardo Leonardo, MD, PhD, Columbia University/New York State Psychiatric Institute, Omid Cohensedgh, MD, Columbia University/New York State Psychiatric Institute, Crystal Wang, MD, Columbia University/New York State Psychiatric Institute, Elizabeth Ford, MD, Columbia University/New York State Psychiatric Institute

Education Objectives

1. Describe a novel approach to QI education, in which second-year residents were engaged in a year-long QI project through a sequential hand-off model during one-month rotations.

2. Identify structural elements–faculty continuity, shared documentation, fixed monthly cadence, and a QI topic relevant to PGY2 work – that sustained momentum across multiple resident-owners of a joint QI project.

3. Recognize common points of failure in resident-to-resident QI hand-offs and strategies to mitigate them.

Practice Gap

U.S. residency programs show substantial variability in quality improvement (QI) curricula, often lacking formal training despite ACGME requirements (1). Resident engagement is further limited by competing clinical duties and rotating schedules (2, 3). Published curricula address this with either small resident groups within one rotation (4) or larger, multi-PGY teams whose projects reset annually rather than transfer between cohorts (5) — neither achieves true individual, sequential ownership across an entire class. A fully sequential model, passing ownership resident to resident, has been proposed to work within rotational time limits, but only as a recommendation, without a described case or outcomes (6). No published account details how such a project functions when passed sequentially across an entire resident class.



Methods

Based on a desire to promote earlier and more comprehensive resident experience and education in Quality Improvement, and acknowledging practical time constraints, a pilot QI project for a PGY-2 class (n=12) was designed such that each resident held full ownership of the project for approximately four protected half-days over one month. Each resident's work during the month corresponded to one or more phases of the DMAIC Quality Improvement Model (Define, Measure, Analyze, Improve, and Control), e.g., through process mapping, stakeholder interviews, baseline data collection, intervention design, implementation, or post-intervention measurement–building on the prior resident's work. A hand-off process between residents occurred through a shared project record, verbal sign-outs, and written documentation. A single faculty mentor maintained continuity across hand-offs. The QI project was related to reducing transfer delays from the emergency room to an inpatient unit, both clinical settings in which the PGY2 residents rotated or took call.

Results

The hand-off structure allowed the class to progress through every phase of the DMAIC QI cycle, with project ownership maintained across all 12 transitions without a lapse. Resident feedback identified the monthly structure itself, rather than increased protected time for QI work, as the primary factor sustaining progress. Consistent faculty mentorship and documentation was crucial in reducing the risk of lost context at each hand-off. Coordinating with clinical stakeholders within each resident's narrow time window was the most frequently cited challenge. The QI project met its SMART goal, indicating the hand-off structure did not come at the expense of a meaningful result.

Conclusions

A structured, sequential hand-off model enabled a 12-resident class to sustain a full, multi-phase QI project that no single resident could support alone. Feasibility depended on continuous faculty mentorship and deliberate hand-off practices at each transition. This experience offers a practical, replicable model for engaging a full residency class in QI training while accommodating the restrictions of a traditional rotation-based clinical schedule, and provides a concrete account of a class-wide, sequential hand-off model that prior literature has recommended but not previously reported (4, 5, 6).

Scientific Citations

1. Baker MB, Hoti I, Dienes E, Rubin A, Joyce MF, Conley C, Brook K. Characterizing Quality Improvement Education in Anesthesiology Residencies: A Nationwide Survey. J Patient Saf. 2026 Apr 14. doi:10.1097/PTS.0000000000001510.



2. Mitchell TO, Li L. Overcoming the Barriers to Resident Engagement in Quality Improvement Initiatives in Psychiatry. Acad Psychiatry. 2021;45(4):481–486.

3. Elizalde J, Lumibao J, Lizarondo L. Barriers and facilitators to health professionals' engagement in quality improvement initiatives: a mixed-methods systematic review. Int J Qual Health Care. 2024;36(2):mzae041.

4. Nidumolu A, Freedman D, Bosma M. From Theory to Practice: Development and Evaluation of a Quality Improvement Curriculum for Psychiatry Residents. J Med Educ Curric Dev. 2024;11:1–12.

5. Kim K, Adhyaru B, Doyle J, Bussey-Jones J, Jones D, DiFrancesco L, Fluker SA, itomer R, Ilksoy N. Developing and Implementing a Quality Improvement Curriculum in a Large Internal Medicine Residency Program. J Med Educ Curric Dev. 2025;12:23821205251320482.

6. Smith SR, Bakshi R. Promoting Resident Involvement in Quality Improvement Initiatives Through Faculty Involvement and Curriculum. J Grad Med Educ. 2015;7(1):119–120.



Title

Psychiatry Faculty Perceptions of Entrustable Professional Activities (EPAs) Following Initial Rollout: A Survey Study With Cross-Specialty Context

Primary Category

Assessment – learner (summative, formative, programmatic)

Presenters

Justine Lazatin, DO, Harvard South Shore Psych Res/VAMC, Brockton, Sarah Yasmin, MD, MPH, Harvard South Shore Psych Res/VAMC, Brockton

Education Objectives

To characterize and compare psychiatry faculty impressions of Milestones- versus EPA-based assessment of PGY-1 and PGY-2 residents using matched survey instruments administered pre/post our program's EPA rollout, and to contextualize findings against the more established faculty-perception literatures in general surgery and pediatrics.

Practice Gap

Since 2013, U.S. graduate medical education has used ACGME Milestones to track resident progress across six core competencies. Entrustable Professional Activities (EPAs) complement this by linking assessment to observable clinical tasks. AADPRT proposed a psychiatry-specific EPA set in 2018 [1], and our program used AI to begin EPA implementation in July 2026 for PGY-1 and PGY-2 residents. Faculty-perception data on EPAs in psychiatry remain sparse—favorable in principle but limited in practice [2,3,4]—with a 2025 national task force flagging faculty burden and development as unresolved priorities [7]. In contrast, surgery and pediatrics have established mature national assessment infrastructures with substantial faculty-perception data [9,10,14,15], including a persistent "autonomy perception gap" between faculty and resident ratings [12,13].

Methods

To enable direct comparison, we will administer the same 10-item Likert survey twice using matched item wording, with pre and post surveys separated by three months. Faculty were asked to rate their impressions of Milestones-based assessments (pre) vs. EPA-based assessments (post) for PGY-1 and PGY-2 residents. The survey was administered via VA REDCap and assesses perceived clinical authenticity, workflow burden, confidence in completing assessments, adequacy of faculty development/training, and perceived impact on resident feedback quality, along with a single open-response item soliciting qualitative feedback

on the overall resident assessment process at each timepoint. Likert item domains were informed by themes identified in the cross-specialty literature, including faculty engagement barriers identified in surgery's SIMPL implementation [9,10] and faculty development needs identified by a national psychiatry task force [7]. Quantitative Likert data will be summarized descriptively at each timepoint and compared across timepoints using paired analysis; open-response qualitative data will be analyzed using thematic analysis. Eligible participants include faculty who supervise and assess PGY-1 and/or PGY-2 residents during the study period (estimated n = 28 eligible faculty). Survey links will be distributed via VA REDCap email invitation at each timepoint and remain open for approximately 3-4 weeks, with reminder emails sent to non-responders at 1 and 2 weeks after initial distribution. To enable paired analysis while preserving anonymity, faculty will generate a consistent non-identifying code (e.g., derived from a memorable personal detail) at each timepoint, allowing responses to be matched across surveys without collecting identifying information. A target response rate of ≥50% at each timepoint was set based on comparable single-site faculty survey studies in medical education.

Results

Data collection and analysis is planned for Fall of 2026. This abstract is submitted with complete results pending as of the September 22, 2026 deadline; final results, including response rates at each timepoint, descriptive and comparative statistics across all survey domains, and thematic findings from free-text responses, will be presented in full. Anticipated analyses will compare faculty impressions of Milestones- versus EPA-based assessment within the same cohort and contextualize findings against parallel results reported in the surgery and pediatrics literatures [9,10,12,13,14,15].

Conclusions

This study will provide among the first prospective, faculty-specific data on EPA perceptions in psychiatry, captured at the point of initial program-level rollout rather than after years of institutional habituation. Findings may help identify faculty development priorities for psychiatry programs analogous to those identified in more established EPA-adopting specialties, while accounting for psychiatry's distinct clinical assessment context.

Scientific Citations

1. Young JQ, Hasser C, Hung EK, Kusz M, O'Sullivan PS, Stewart C, Weiss A, Williams N. Developing end-of-training entrustable professional activities for psychiatry: results and methodological lessons. Acad Med. 2018;93(7):1048-1054. doi:10.1097/ACM.0000000000002058



2. Hung EK, Jibson M, Sadhu J, Stewart C, Walker A, Wichser L, et al. Wresting with implementation: a step-by-step guide to implementing entrustable professional activities (EPAs) in psychiatry residency programs. Acad Psychiatry. 2021;45(2):210-216. doi:10.1007/s40596-020-01341-7

3. Pinilla S, Lenouvel E, Strik W, Klöppel S, Nissen C, Huwendiek S. Entrustable professional activities in psychiatry: a systematic review. Acad Psychiatry. 2020;44(1):37-45. doi:10.1007/s40596-019-01142-7

4. Stephan A, Cheung G, van der Vleuten C. Entrustable professional activities and learning: the postgraduate trainee perspective. Acad Psychiatry. 2023;47(2):134-142. doi:10.1007/s40596-022-01712-2

5. Chen WY, Chu CP, Huang TF, et al. Importance-based approach to entrustable professional activities for psychiatric residency training. BMC Med Educ. 2025;25:1068. doi:10.1186/s12909-025-07655-0

6. Szulewski A, Braund H, Dagnone D, et al. The assessment burden in competency-based medical education: how programs are adapting. Acad Med. 2023;98(11):1261-1267.

7. American Association of Directors of Psychiatric Residency Training (AADPRT). CBME in Psychiatry Task Force: Task Force Report. Published February 17, 2025. Accessed September 2026. https://www.aadprt.org/application/files/4117/4412/7602/2025-02-17_CBME_Task_Force_Report_-_FINAL.pdf

8. Accreditation Council for Graduate Medical Education. Rationale for Milestones. Published 2022. Accessed September 2026. https://www.acgme.org/globalassets/pdfs/milestones/rationaleformilestones2022.pdf

9. Eaton M, Scully R, Schuller M, Yang A, Smink D, Williams RG, Bohnen JD, George BC, Fryer JP, Meyerson SL. Value and barriers to use of the SIMPL tool for resident feedback. J Surg Educ. 2019;76(3):620-627. doi:10.1016/j.jsurg.2019.01.012

10. Murillo AD, et al. Comparing high and low faculty EPA assessment completers: insights to improve EPA implementation. J Surg Educ. 2025;82(12):103630. doi:10.1016/j.jsurg.2025.103630

11. Abdou H, Kidd-Romero S, Brown RF, Kavic SM, Kubicki NS. "Keep it SIMPL: improved feedback after implementation of an app-based feedback tool." The American Surgeon. 2022;88(7):1475-1478.



12. Kim GJ, Clark MJ, Meyerson SL, Bohnen JD, Brown KM, Fryer JP, Szerlip N, Schuller M, Kendrick DE, George B. Mind the gap: the autonomy perception gap in the operating room by surgical residents and faculty. J Surg Educ. 2020;77(6):1522-1527. doi:10.1016/j.jsurg.2020.05.017

13. Layne DL, Sethi I, Jung S, Yang Q, Varley PR, O'Rourke AP, Minter RM. Gender differences in entrustable professional activity assessments over five years. J Am Coll Surg. 2024;239(5 Suppl):S404-S436.

14. Schumacher DJ, Kinnear B, Michelson C, et al. Development and validation of a model to predict milestone levels based on entrustable professional activity entrustment-supervision levels. Acad Pediatr. 2021;21(4):735-741. doi:10.1016/j.acap.2020.11.013

15. Mink RB, Schwartz A, Mahan JD, et al. "Level of supervision for the entrustable professional activities common to general pediatrics and the subspecialties decreases from residency to fellowship." Acad Pediatr. 2024;24(7):1025-1030.

Title

Publication Trackers: Reducing Faculty Administrative Burden Through Task Automation

Primary Category

Program Administration and Leadership

Presenters

Dale Peeples, MD, Medical College of Georgia at Augusta University, Harshil Patel, BS, Medical College of Georgia at Augusta University

Education Objectives

1. Outline and explain the process of setting up a spreadsheet with a script that runs a search of faculty publications, which is then updated on a monthly basis.

2. Compare the results of the automatic publication tracker to the results of faculty submitted publication reports.

Practice Gap

Although the Accreditation Council for Graduate Medical Education (ACGME) has loosened the reporting requirements of faculty scholarly activity, it remains a core requirement that programs must be able to demonstrate accomplishments of faculty scholarly activity. Additionally, this data is also vital for annual review and promotion preparation. However, reporting and tracking these activities increases mandatory administrative burden for those tasked with submitting and those tasked with tracking these reports. Various approaches to automating tracking have previously been discussed in the literature but may be difficult for programs with limited resources to implement. With the availability of Artificial Intelligence to help with coding, scripts can easily be developed to review recent publications in departments.

Methods

To track faculty scholarly activity, our department relies on a monthly Qualtrics survey allowing faculty to input data. However, not all faculty respond to the survey, and the survey increases administrative burden on those who choose to complete it.

With the hope of reducing administrative burden and increasing scholarship documentation, we developed a script to run in Google Sheets. A reference list was assembled of faculty names, citation names, and three identifiers: ORCID ID, Scopus ID, and Google Scholar profile. 16 faculty (27%) had none of these identifiers on file, while 8 faculty (14%) had all three. Using ChatGPT, a script was developed for the publication tracker spreadsheet that would perform a

search of the reference information and document identified publications, and the match confidence.

Results

The tracker returned publications for 25 of 59 faculty (42%). Return rate rose sharply with identifier completeness. Among the 16 faculty with no identifier (ORCID, Scopus ID, and Google Scholar profile) on file, the tracker returned results for only 1 (6%). Among the 8 faculty with all three identifiers, the tracker returned results for 7 (88%) — the one exception appears to have no published work since 2022.

Of the 86 publications returned by the tracker, 74 (86%) were correctly attributed to the named faculty member; 12 (14%) were false positives, defined as returned publications associated with authors at other institutions, largely from common-name collisions. Of the 74 correctly attributed publications, 9 (12%) matched an article independently reported on the survey; the remainder were either from faculty who did not respond to the survey that period (30 publications) or from faculty who responded but did not report that specific article (35 publications).

Separately, 23 of 59 faculty (39%) responded to the survey; 10 reported publishing, and the tracker identified work for 8 of these 10 (80%). Of 23 unique articles self-reported, the tracker identified 9 (39%).

Conclusions

This proof-of-concept demonstrates that an AI-assisted publication tracker can identify faculty scholarly output with high accuracy (86%), though a non-trivial false-positive rate (14%) suggests that manual verification remains necessary at this stage. False positives were easily identified using knowledge of a faculty member's research interests. Additionally, the tracker cannot report other scholarly activity, such as presentations or lectures, suggesting the need for a supplemental survey. Tracker performance was strongly dependent on identifier completeness: faculty with a full identifier set were found 88% of the time, compared with just 6% for faculty with no identifier on file. This suggests the tool's methodology is sound, and that its current overall yield largely reflects incomplete identifier data rather than a limitation of the tracker itself. Identification of faculty-reported publications was modest (39%) but is expected to improve as identifier information is added. Thus, collecting a full identifier set for all faculty is an important next step, after which this tracker may substantially reduce administrative burden and improve identification of scholarly activity.

Scientific Citations

1. Accreditation Council for Graduate Medical Education. (2026). ACGME program requirements for graduate medical education in psychiatry including FAQs. Accreditation Council for Graduate Medical Education.

2. Epstein, R.H., Mueller, D.A., Walco, J.P., Manresa, C.D., Banks, S.E., Freundlich, R.E., 2023. Development and Validation of an Automated Tool to Retrieve and Curate Faculty Publications of Academic Departments. Cureus.. https://doi.org/10.7759/cureus.47976

3. Khan, R., Tang, M., Azhar, A., Bruera, E., 2024. The Administrative Burden on Palliative Academic Physicians. Journal of Pain and Symptom Management 67, e399–e402.. https://doi.org/10.1016/j.jpainsymman.2024.01.035

4. Lee, D.J., Stvilia, B., Ha, S., Hahn, D., 2023. The structure and priorities of researchers' scholarly profile maintenance activities: A case of institutional research information management system. Journal of the Association for Information Science and Technology 74, 186–204.. https://doi.org/10.1002/asi.24721

5. Thompson, P.T., Powell, C.D., Moseley, H.N.B., 2022. Academic Tracker: Software for tracking and reporting publications associated with authors and grants. PLOS One 17, e0277834.. https://doi.org/10.1371/journal.pone.0277834



Title

Reshuffling the Deck: A Mixed-Methods Evaluation of an Interactive ACEs Training Tool for Psychiatry Residents

Primary Category

Curriculum

Presenters

Paul Rosenfield, MD, Icahn School of Medicine at Mount Sinai (Morningside/West), Lauren Cottrell, MD, Icahn School of Medicine at Mount Sinai

Education Objectives

Standard training on Adverse Childhood Experiences (ACEs) and Social Determinants of Mental Health (SDOMH) often relies on traditional didactic lectures. This study evaluates the effectiveness of an interactive board game designed to improve trainee knowledge, attitudes, and empathy regarding SDOMH.

Practice Gap

Teaching psychiatrists in training to assess and address ACES and social determinants of health (SDOH) in their patients is essential to improving the quality of mental healthcare. While lectures can provide useful information and resources, residents may fail to fully grasp the importance of these drivers on patient outcomes. The creative interactive experience developed by residents and described here has served to drive home the impact of ACEs and SDOH, and to help empower trainees to address these more effectively.

Methods

Our team of residents and faculty developed a 90-minute educational intervention—a brief lecture, an interactive board game, and facilitated discussion—implemented across three psychiatry residency training sites in New York City. The game uses dice and cards to simulate the structural barriers patients face. Participants completed matched pre- and post-intervention surveys assessing attitudes and clinical confidence across 7 Likert-scale items (1–5 scale) related to ACEs and SDOMH. Post-intervention perceived impact was assessed with additional Likert items. Wilcoxon signed-rank tests with Benjamini-Hochberg false discovery rate (FDR) correction were used for inferential analyses; effect sizes were calculated as Wilcoxon r.

Results

Pilot implementation with psychiatry trainees (N=45; 3 sites) demonstrated statistically significant improvement across all 7 survey items following the intervention (all $p<0.01$ after BH-FDR correction), with effect sizes ranging from medium-large ($r=0.42$) to large ($r=0.56$). The largest gains were observed in referral competency ($\Delta M=+0.57$, $r=0.55$) and mitigation strategy knowledge ($\Delta M=+0.52$, $r=0.52$), the two domains with the lowest pre-intervention scores, suggesting the intervention addressed a specific practical gap. Overall, 76.1% of participants improved on at least one item; declines were rare (<5% across all items). Post-intervention, participants rated the game highly as a learning tool ($M=4.41/5$; 89% rated ≥4) and strongly endorsed improved understanding of challenges faced by patients with high ACE scores ($M=4.52/5$; 91% rated ≥4).

Conclusion

A brief gamified intervention produced statistically significant, medium-to-large improvements in ACEs- and SDOMH-related attitudes and clinical confidence among psychiatry trainees across three training sites. Gains were most pronounced in practical skill domains where trainees entered with the greatest need, supporting targeted use of this modality to address specific competency gaps. Gamification offers a scalable, engaging complement to traditional didactics for teaching structural competency in psychiatry education.

Scientific Citations

1. Nour N, Onchonga D, Neville S, et al.: Integrating the social determinants of health into graduate medical education training: a scoping review. BMC Med Educ. 2024. 24(1):565. doi: 10.1186/s12909-024-05394-2

2. Jiang DH, Kim S, Zaidi A, Cottrell L, Christopher MC, Palacio TR, Rosenfield PJ. Insights from Expanded Adverse Childhood Experiences Screening in a Hospital-Based Outpatient Psychiatry Service. Psychiatr Q. 2022 Jun;93(2):677-687. doi: 10.1007/s11126-022-09982-7. Epub 2022 Apr 5. PMID: 35380332.

3. Davis K, Gowda AS, Thompson-Newell N, Maloney C, Fayyaz J, Chang T. Gamification, Serious Games, and Simulation in Health Professions Education. Pediatr Ann. 2024 Nov;53(11):e401-e407. doi: 10.3928/19382359-20240908-06. Epub 2024 Nov 1. PMID: 39495634.

4. Rosenfield PJ, Jiang D, Pauselli L. Childhood adversity and psychotic disorders: Epidemiological evidence, theoretical models and clinical considerations. Schizophr Res. 2022 Sep;247:55-66. doi: 10.1016/j.schres.2021.06.005. Epub 2021 Jun 28. PMID: 34210561.



5. Huang CX, Halfon N, Sastry N, Chung PJ, Schickedanz A. Positive Childhood Experiences and Adult Health Outcomes. Pediatrics. 2023 Jul 1;152(1):e2022060951. doi: 10.1542/peds.2022-060951. PMID: 37337829; PMCID: PMC10312234.



Title

Revisiting Walden 2: Explorations of AI-Enabled Psychotherapy Training

Primary Category

Teaching, Supervision, Pedagogy

Presenters

James Hambrick, PhD, Zucker School of Medicine at Hofstra/Northwell - Zucker Hillside Hospital, Krima Thakker, MPH, Zucker School of Medicine at Hofstra/Northwell - Zucker Hillside Hospital, Abigail Konopasky, PhD, Zucker School of Medicine at Hofstra/Northwell - Zucker Hillside Hospital, John Q Young, BA, MD, MPP, PhD, Zucker School of Medicine at Hofstra/Northwell - Zucker Hillside Hospital

Education Objectives

1. Utilize AI training platforms to augment didactic instruction in CBT

2. Analyze strengths and weaknesses of AI-augmented training from both program and resident perspectives

3. Apply findings to consideration of specific needs in resident training and how AI-based tools might help meet (and fail to meet) those needs

Practice Gap

Although psychotherapy remains a highly valued aspect of psychiatry resident identity, programs often lack vital resources in supervision staffing, time, and patient flow to help residents grow within that identity, particularly for cognitive behavioral therapy (CBT). Classroom teaching cannot bridge the gap into experiential learning critical to growth as a clinician. This study explored the potential of an artifical intelligence (AI)-based learning platform in helping residents learn about CBT through interaction with virtual patients and AI-enabled feedback.

Methods

Despite the importance of psychotherapy training to psychiatry, it can be difficult for programs to provide the resources critical to developing competency in psychotherapy. Increasingly, AI-based solutions have been considered to meet a variety of gaps in practice and training; this study explored the potential of an AI psychotherapy training platform called LYSSN, designed to help clinicians from a variety of backgrounds learn fundamentals in evidence-based psychotherapy. Clinicians using the program watch a brief training video from a CBT expert regarding a particular CBT competency (e.g., cognitive restructuring). The clinicians

subsequently “work” with a simulated patient, who describes a problem and experience they are having, at which point clinicians are prompted to respond, practicing the competency. Using AI and natural language processing, the platform gives the clinician real-time feedback on how closely they came to the target, with narrative on what the clinician did well and feedback on what he/she/they can improve. Residents (n=25) in a training program were asked to complete one of the training modules that LYSSN offers, the CBT Fundamentals module. Residents from every training year were represented; residents also varied in level of training and experience in CBT. They were briefly oriented to the project and logging into LYSSN, and completed the module on their own time. Quantitative data regarding engagement and skill improvement was collected by the program. A retrospective pre/post self-efficacy questionnaire showed improvements in all identified CBT areas, with the greatest in linking early experiences with current behavior and agenda setting. Survey items and focus group interviews indicated that LYSSN generally had a positive impact on resident engagement and competency in CBT, but residents earlier in their training experience with relatively less exposure to CBT tended to report higher impact on their work than more advanced residents. Residents overall thought LYSSN had potential utility as a training tool, allowing them to learn CBT in an engaging way without concern about others' judgment. However, concerns were expressed around the security and ethics of AI, as well as some feeling like they had to "parrot" the expert's language to get higher level feedback. We suggest that AI training platforms can be a useful tool in CBT training for psychiatry residents, particularly early in training or in places where programs have fewer resources in supervision and case flow. AI training programs still struggle with many of the same existential questions that plague psychotherapy training—that by taking a general approach focused on developing expertise, CBT training fails to consider many of the specialized needs of psychiatry residents who need directed assistance in working with patients with higher acuity and complexity, adapting these strategies in a variety of settings, and balancing their roles as psychotherapist and prescriber.

Scientific Citations

1. Bugatti, M., Imel, Z. E., & Owen, J. (2023). Technology and psychotherapy training. In L. G. Castonguay & C. E. Hill (Eds.), Becoming better psychotherapists: Advancing training and supervision (pp. 215–236). American Psychological Association.

2. Creed, T. A., Salama, L., Slevin, R., Tanana, M., Imel, Z., Narayanan, S., & Atkins, D. C. (2022). Enhancing the quality of cognitive behavioral therapy in community mental health through artificial intelligence generated fidelity feedback (Project AFFECT): a study protocol. BMC health services research, 22(1), 1177.



3. Kopelovich, S. L., Slevin, R., Brian, R. M., Shepard, V., Baldwin, S. A., Ben-Zeev, D., ... & Imel, Z. (2025). Preliminary investigation of an artificial intelligence-based cognitive behavioral therapy training tool. Psychotherapy, 62(1), 12.

4. Prégent, J., Chung, V. H. A., El Adib, I., Désilets, M., & Hudon, A. (2025). Applications of artificial intelligence in psychiatry and psychology education: scoping review. JMIR Medical Education, 11, e75238.

5. Young, J., Schruff, M., Mudryk, E., & Bentley, J. P. (2026). Artificial intelligence-generated feedback as a training tool for enhancing psychotherapy skill. Journal of Technology in Behavioral Science, 1-10.

Title

Scheduling Fun?

Primary Category

Program Administration and Leadership

Presenters

Helena Winston, MD, MSc, University of Colorado Denver

Education Objectives

To assess whether a gamified schedule activity in which 3 providers were able to participate, would be well-received and generate an accurate, feasible schedule for 11 different providers (2 of whom had less than 1.0 FTE for clinical service) to cover 6 teams (2 of which were teaching, and 2 of which were 7-on/7-off a week schedules), ensuring that most providers were assigned some of each type of team.

Practice Gap

Making a work schedule is time consuming and hardly ever results in total satisfaction. Gamification offers a way to innovate mundane tasks. Factors that influence scheduling include: FTE breakdown, work schedule type (5-days a week, 7-on/7-off), needed days off, type of team (teaching, non-teaching), and provider preferences. Fee-based apps exist that can help create schedules, however many programs may not be able to afford these technologies. Free services such as Generative AIs might hypothetically work but often fracture when complexity of scheduling increases, causing double listing of providers and unfeasible schedules. In addition, a schedule provided by an employer or program director can be a source of frustration for employees or learners who had no input into the final outcome.

Methods

Time was divided into 2-week blocks. Each team was assigned a different colored plastic gem: Red, Blue, Purple, Green, Orange, Pink. Each time block required 1 gem each for 5-days/week teams (Red, Blue, Purple, Green), and 2 gems each of for 7-on/7-off teams (Orange, Pink), as when one person is “on” for one week, the other person is “off.” Green, despite being 5-days/week, was allowed (but not required) to have multiple providers due the nature of the team. Each provider was assigned a equal number of each of color gem totaling the needed schedule (1 or 2 gems per 2-week block). If someone worked less (lower FTE), they received fewer total gems of each color. A large butcher block piece of paper was procured and labeled with 2-week blocks on the rows and provider name on the columns. Providers were then

allowed to place their gems onto the calendar based on their preferences and needed days off (PTO/conferences). They were also permitted to trade gems if they preferred one type of team over another. All colors had to be placed per row.

Results

The entire schedule, which had taken over 20 hours for the medical director to try to create to no avail, was completed in 2.5 hours. The 3 providers reported gaining a new appreciation for the complexity of schedule making and were happy with the result. They also did not want their colleagues to be displeased with their choices, so they were incentivized to fairly assign the gems of their coworkers, some of whom had voiced particular preferences beforehand. All 3 providers enjoyed the experience as a team-bonding exercise.

Conclusion

The gem schedule game was time saving and enjoyable. Such a schedule-game might be useful in creating resident or fellow schedules and empower leaners to participate in their own work assignment.

Scientific Citations

1. Almodovar F. Beyond clocking in: Understanding the impact of unstable work schedules. Blog Posts, Aspen Institute. Nov 29, 2023. https://www.aspeninstitute.org/blog-posts/beyond-clocking-in-understanding-the-impact-of-unstable-work-schedules/

2. Bolino MC, Kelemen TK, Matthews SH. Rethinking work schedules? Consdier these 4 questions. Personal Productivity. Harvard Business Review. July 6, 2020. https://hbr.org/2020/07/rethinking-work-schedules-consider-these-4-questions

3. Cheng VWS. Recommendations for Implementing Gamification for Mental Health and Wellbeing. Front Psychol. 2020 Dec 7;11:586379. doi: 10.3389/fpsyg.2020.586379. PMID: 33365001; PMCID: PMC7750532.

4. Fadous MC, Zeeny C, Cheiban K, Margossian G, Ghorayeb Z, Massoud C, Rihana S. Critical thinking gamification in medical education. BMC Med Educ. 2025 Dec 11;26(1):90. doi: 10.1186/s12909-025-08446-3. PMID: 41382146; PMCID: PMC12801931.

5. Gue S, Ray J, Ganti L. Gamification of graduate medical education in an emergency medicine residency program. Int J Emerg Med. 2022 Aug 30;15(1):41. doi: 10.1186/s12245-022-00445-1. PMID: 36042403; PMCID: PMC9425934.



6. Khazaei MR, Hosseini MA, Ramezani G. Gamification in medical sciences education: a scoping review. Recenti Prog Med. 2025 May;116(5):291-301. doi: 10.1701/4495.44949. PMID: 40376901.

7. Xu M, Luo Y, Zhang Y, Xia R, Qian H, Zou X. Game-based learning in medical education. Front Public Health. 2023 Mar 3;11:1113682. doi: 10.3389/fpubh.2023.1113682. PMID: 36935696; PMCID: PMC10020233.

Title

Sharing-Compliment-Listening-Reward (SCLR): A Structured Group Intervention to Mitigate Emotional Exhaustion Among Psychiatry Residents — A Quality Improvement Study

Primary Category

Wellness, Burnout, Resilience

Presenters

Adam Jara, DO, PhD, Riverside Methodist Hospitals (OhioHealth) Program, Clint Woods, DO, Riverside Methodist Hospitals (OhioHealth) Program, Ayah Shehata, DO, Riverside Methodist Hospitals (OhioHealth) Program, Ellie Rizzo, DO, Riverside Methodist Hospitals (OhioHealth) Program, Alan Szymanski, MD, Riverside Methodist Hospitals (OhioHealth) Program

Education Objectives

Evaluate the feasibility and acceptability of monthly SCLR sessions among psychiatry residents across all training years, and assess preliminary changes in emotional exhaustion over the intervention period. Specifically, participants and program stakeholders will apply structured peer-sharing and reflective-listening processes, utilize affirmative feedback and positive reinforcement, and analyze changes in emotional exhaustion and resident wellness associated with the intervention.

Practice Gap

Physician burnout affects nearly half of practicing physicians in the United States, with substantial costs attributable to turnover and reduced clinical hours. Residency training represents a period of heightened vulnerability, yet most studied interventions target single therapeutic modalities and lack integration of multiple evidence-based traditions. SCLR is a structured group intervention synthesizing person-centered therapy, humanistic group therapy, narrative therapy, positive psychology, and compassion-focused therapy into four components: facilitated sharing of occupational stressors, structured peer complimenting, reflective listening, and tangible reward reinforcement.

Methods

This single-site quality improvement study was conducted from May 2025 through August 2026 among psychiatry residents (PGY-1 through PGY-4). A baseline MBI-HSS Emotional Exhaustion (EE) assessment was obtained before initiation of SCLR, followed by approximately monthly assessments during the intervention period. Eleven MBI-HSS survey points yielded 116 complete responses. The 9-item EE subscale was scored from 0–54, with scores ≥27



categorized as high EE. Post-SCLR acceptability was assessed after 11 sessions (117 responses) using an 8-item survey addressing sharing comfort, reception, connectedness, reward satisfaction, future sharing likelihood, concentration, compassionate care, and coping with emotionally taxing scenarios. A 10-item Resident Wellness Scale (RWS; 1–5, higher scores indicating greater wellness) was administered at three sessions as a secondary outcome. Surveys were anonymous and therefore analyzed as repeated cross-sections rather than paired observations. Exploratory ordinary least squares regression assessed EE trends over time; one-way ANOVA with Tukey HSD compared EE across training years and survey points. Free-text comments underwent thematic coding. “I did not share” responses were excluded from numeric analyses of share-dependent items.

Results

Across 116 MBI-HSS responses, mean EE decreased from 22.3 (SD 10.3) at baseline to 19.5 (SD 9.6) at the final survey; however, the overall longitudinal slope was not statistically significant (−0.32 points/month; R^2=0.01; p=0.25), and EE did not differ significantly across survey points (F=0.47, p=0.90). The proportion of responses meeting the high-EE threshold decreased from 33.3% to 27.3%. PGY-2 residents demonstrated a steeper exploratory decline in EE (−1.31 points/month; p=0.002), although subgroup findings are limited by small cell sizes and changing cohorts across academic years. Post-SCLR acceptability was high: mean comfort sharing was 4.64/5 overall; 85% of respondents reported being more likely to share with co-residents after a session, while among those who shared, 95% reported that their sharing was very well received and 96% reported greater connectedness. Among 54 free-text comments, the most frequent themes were general endorsement (63%), connection/community (20%), and perceived wellbeing benefit (13%). RWS scores remained stable across the three assessment points.

Conclusions

Monthly SCLR sessions were feasible, highly acceptable, and associated with a non-significant overall trend toward reduced emotional exhaustion among psychiatry residents over 13 months and across 11 sessions, with a statistically significant reduction observed among PGY-2 residents. Although overall emotional exhaustion declined numerically over the observation period, the study did not demonstrate a statistically significant reduction in MBI-EE. The stronger signal in acceptability and qualitative outcomes supports further evaluation of SCLR as a group-based resident wellness intervention. Future studies should use paired longitudinal measurement, prespecified primary outcomes, analytic methods that account for clustering and cohort effects, controlled or randomized designs, and mediation analyses to determine which components of the SCLR model contribute to meaningful changes in burnout and resident wellbeing.



Scientific Citations

1. Han S, Shanafelt TD, Sinsky CA, et al. Estimating the Attributable Cost of Physician Burnout in the United States. Ann Intern Med. 2019;170(11):784-790. doi:10.7326/M18-1422.

2. Shanafelt TD, Dyrbye LN, Sinsky C, et al. Changes in Burnout and Satisfaction With Work-Life Integration Among U.S. Residents and Fellows and the General U.S. Working Population Between 2012 and 2023. Acad Med. 2025;100(12):1486-1498. doi:10.1097/ACM.0000000000006294.

3. Shanafelt T, Goh J, Sinsky C. The Business Case for Investing in Physician Well-being. JAMA Intern Med. 2017;177(12):1826–1832. doi:10.1001/jamainternmed.2017.4340.



Title

Teaching Psychosis Differently: An Experiential CBTp Curriculum for Psychiatry Residency

Primary Category

Curriculum

Presenters

Icelini Stavers-Sosa, MD, Kaiser Permanente Northern California Program (Oakland)

Education Objectives

1. The curriculum aims to increase residents' confidence and skill in engaging patients with psychosis; teach core CBTp principles through experiential participation rather than didactics alone; and foster flexible use of CBTp-informed interventions within routine psychiatric encounters, including medication-management visits.

2. A secondary aim is to identify which interventions residents find most transferable to clinical practice and use resident feedback to iteratively refine the curriculum for patients with differing levels of organization, insight, engagement, and symptom burden.

Practice Gap

Cognitive Behavioral Therapy for Psychosis (CBTp) is an evidence-based treatment for psychotic disorders, yet formal CBTp training remains limited in psychiatry residency. Residents routinely care for patients with psychosis, often in medication-management rather than dedicated psychotherapy visits. Traditional didactics may provide knowledge without developing the procedural and interpersonal skills needed to integrate psychotherapeutic interventions into these encounters. We developed a longitudinal PGY-3 curriculum using an experiential model: an expert CBTp psychologist conducts teaching sessions using methods analogous to those employed with patients, allowing residents to experience CBTp techniques from the patient perspective, reflect on their therapeutic impact, and practice adapting them to routine psychiatric care.

Methods

A year-long CBTp curriculum for PGY-3 psychiatry residents was implemented at an integrated health system residency program and delivered to two consecutive cohorts. Sessions are co-led by psychiatry faculty and a psychologist with CBTp expertise. Rather than relying primarily on lectures, the psychologist models CBTp through an experiential format analogous to her work with patients. Residents participate in exercises, experience interventions from the patient

perspective, and subsequently examine their rationale and clinical application. Skills include collaborative exploration of psychotic experiences, normalization, formulation, ABCDE, cost-benefit analysis, “act as if,” coping strategies, and examination of beliefs.

At year-end, residents completed an open-ended course reflection addressing three domains: whether the course was helpful, which skill or approach they had used or anticipated using most, and recommendations for improvement. Reflections from two cohorts were reviewed for recurring themes.

Results

Residents consistently described the curriculum as helpful, clinically applicable, and unlike prior training in psychosis. They reported that the course changed how they conceptualized psychotic experiences and how they approached conversations with patients, particularly by providing therapeutic steps beyond simply avoiding direct confrontation of delusional beliefs. Residents emphasized collaborative, patient-led exploration and meeting patients “where they are.”

ABCDE, cost-benefit analysis, and “act as if” were specifically identified as useful tools. Residents particularly valued interventions that could be incorporated naturally within a brief medication-management encounter. Others reported using elements of the CBTp framework less explicitly, describing a broader shift toward creatively integrating psychotherapy into their role as psychiatrists rather than viewing care for psychosis primarily as medication management.

Suggested improvements focused on extending the curriculum to challenging clinical situations: negative symptoms; severe thought disorganization; limited insight and paranoia; difficulty engaging or retaining patients in treatment; psychosis occurring during mood episodes; and additional brief interventions suitable for time-limited visits. Residents also valued clinical examples from the CBTp psychologist’s experience and requested further case-based application.

Conclusions

A longitudinal, experiential CBTp curriculum was highly acceptable and perceived as directly relevant to residents’ clinical work. Learning CBTp partly from the patient position may make therapeutic principles more accessible and encourage residents to flexibly incorporate psychotherapy into routine psychiatric care. Resident feedback also identified opportunities to expand training toward more complex presentations and brief, readily deployable interventions.

Scientific Citations

1. Kimhy D, Tarrier N, Essock S, Malaspina D, Cabannis D, Beck AT. Cognitive behavioral therapy for psychosis—training practices and dissemination in the United States. Psychosis. 2013;5(3): 296-305.

2. Hardy KV, Espil FM, Smith CL, et al. Training early psychosis community clinicians in CBT for psychosis: implementation and feasibility. Early Intervention in Psychiatry. 2021;15(3):697-704.

3. Bennett-Levy J, McManus F, Westling BE, Fennell M. Acquiring and refining CBT skills and competencies: which training methods are perceived to be most effective? Behavioural and Cognitive Psychotherapy. 2009;37(5):571-583.

4. Laireiter AR, Willutzki U. Self-reflection and self-practice in training of cognitive behaviour therapy: an overview. Clinical Psychology & Psychotherapy. 2003;10(1):19-30.

5. Gale C, Schröder T. Experiences of self-practice/self-reflection in cognitive behavioural therapy: a meta-synthesis of qualitative studies. Psychology and Psychotherapy. 2014;87(4):373-392.



Title

Teaching the Therapist: A Scoping Review of Psychotherapy Education, Supervision, and Competency Development in U.S. Psychiatry Residency Programs

Primary Category

Teaching, Supervision, Pedagogy

Presenters

Melanie Gentry, MD, Mayo School of Graduate Medical Education, Benjamin Dralle, MD, Mayo School of Graduate Medical Education, John Powers, MD, Mayo School of Graduate Medical Education, Kristin Somers, MD, Mayo School of Graduate Medical Education, Ann Marie Rydberg, MD, Mayo School of Graduate Medical Education

Education Objectives

1. To characterize the literature on psychotherapy education in U.S. psychiatry residency programs, including curriculum design and implementation, supervision practices, skill development, and educational innovations designed to support the development of residents as psychotherapists.

2. To identify how psychotherapy competence is conceptualized, taught, supervised, and evaluated across required therapeutic modalities and educational settings, with particular attention to supportive, psychodynamic, and cognitive-behavioral psychotherapies.

3. To examine strengths, gaps, and emerging trends in psychotherapy training scholarship, including psychotherapy pathways and tracks, supervisor training and development, virtual and telehealth innovations, and the use of artificial intelligence, to inform future psychotherapy education priorities.

Practice Gap

Psychotherapy remains a core competency and an important component of the psychiatrist's professional identity. Residency programs must prepare psychiatrists not only to understand psychotherapeutic principles but also to develop the skills necessary to provide psychotherapy as part of comprehensive psychiatric care (1-3). Despite longstanding Accreditation Council for Graduate Medical Education (ACGME) requirements, approaches to psychotherapy education vary considerably between residency programs. The extent to which current educational practices define, teach, and assess competencies necessary for residents to become psychotherapists remains unclear, particularly in an era of competency-based medical education and evolving professional roles. This scoping review examines the literature on



psychotherapy training in psychiatry residency with particular attention to how programs prepare residents for the therapist role.

Methods

A scoping review was conducted using an established six-stage scoping review framework and subsequent methodological refinements. With assistance from a medical librarian, multiple databases were searched from their inception through September 2026 for literature addressing psychotherapy training in U.S. psychiatry residency programs. Two reviewers independently screened titles and abstracts and conducted full-text review using predefined inclusion and exclusion criteria. Publications related to supportive, psychodynamic, and cognitive-behavioral psychotherapies were included because of their central role in ACGME training requirements. Included articles were organized using descriptive and qualitative content analysis to characterize educational approaches, outcomes, and recurring themes.

Results

The search identified 2,099 studies with 234 selected for full-text review and 77 meeting inclusion criteria. Included studies were published from 1964 to 2026. 53% were published in medical education journals, whereas 47% were published in clinically focused or specialty-specific journals. Sample sizes ranged widely depending on the study design, with a minimum of two residents participating in a discrete educational intervention and a maximum of 249 residents responding to a survey. Most studies were descriptive in nature, with relatively few employing more rigorous educational research methods.

Several major areas of scholarship emerged. First, a substantial body of literature describes psychotherapy curricula, including modality-specific training experiences, longitudinal educational sequencing, and setting-specific psychotherapy curricula (e.g., psychotherapy on inpatient units). Second, supervision emerged as a central component of psychotherapy education with studies consistently identifying supervision as highly valued by learners while simultaneously highlighting concerns regarding supervisor preparation, variability in supervisory practices, and the limited availability of trained supervisors. Third, educational innovations were common and included specialized tracks and training pathways, apprenticeship models, near-peer and chief resident teaching roles, tele-supervision, the use of standardized patients, and emerging applications of artificial intelligence. These innovations were frequently developed to address recurring educational challenges, including providing more intensive psychotherapy training opportunities, expanding access to qualified supervisors and teachers, and improving psychotherapy competency assessment.

Important gaps were also identified. Despite being among the most commonly practiced psychotherapies and a required area of training, supportive psychotherapy was comparatively

underrepresented in curriculum development, educational research, supervisor training, and competency assessment. Across therapeutic modalities, few studies clearly defined psychotherapy competencies, used validated assessment tools, or linked educational interventions to measurable learner outcomes. Existing assessment approaches varied considerably, and evidence supporting best practices for competency evaluation was limited.

Conclusions

Psychotherapy remains a foundational component of psychiatric training, yet the evidence base guiding how residents develop competence as psychotherapists remains underdeveloped. Existing scholarship describes numerous creative curricula, supervision models, pathways, and educational innovations but less often establishes whether these approaches produce measurable psychotherapy competencies. The field appears rich in educational innovation yet limited by the absence of shared evaluation systems and validated assessment strategies (4,5). Future work should focus on competency-based frameworks that align educational methods, supervision, assessment, and professional identity formation (6,7). Such efforts may help residency programs preserve and strengthen the therapist role for psychiatry residents while advancing the quality of psychotherapy education.

Scientific Citations

1. Wolfe, D. (2024). Psychotherapy is essential to psychiatry training. Academic Psychiatry, 48(5), 530-531.

2. Sudak, D. M., & Brenner, A. M. (2024). The future of psychotherapy training. Academic Psychiatry, 48(5), 511-515.

3. Salgado, R. M., & von Doellinger, O. (2024). Psychotherapy training in psychiatry residencies: a review of trainees' perspectives. The European Journal of Psychiatry, 38(4), 100263.

4. Belcher, R., MacLean, R. L., Beach, S. R., & Waldinger, R. J. (2023). Senior resident as junior supervisor: Case report of an apprenticeship model for training psychotherapy supervisors. American Journal of Psychotherapy, 76(4), 154-158.

5. Chang, S. K., Pellegrino, L. D., & McCann, B. S. (2023). Development of Psychiatric Residents as Psychotherapists: Effectiveness of a Psychotherapy Pathway. American Journal of Psychotherapy, 76(2), 87-90.

6. Fefergrad, M., & Mulsant, B. H. (2022). Psychotherapy training in a competency-based medical education psychiatry residency: a proposal for a practical and socially responsible model. The Canadian Journal of Psychiatry, 67(6), 423-427.



7. Kennedy, K., Balasanova, A., Gilbert, C., Welton, R., Crocker, E., Sudak, D., & Ruble, A. (2026). The Future of Psychotherapy Training Requirements: A Call to Action. Academic psychiatry, 1-6.

Title

That'll Teach 'em a Lesson: Improving Resident Confidence and Efficiency in Teaching Medical Students Through a Standardized Curriculum via Interactive Application

Primary Category

Teaching, Supervision, Pedagogy

Presenters

Christine Glenn, DO, University of Kansas Medical Center, Rachel Pellegrino, DO, MBA, University of Kansas Medical Center, Elissa Freberg, MD, University of Kansas Medical Center

Education Objectives

1. Create an interactive application (teaching tool) accessible via desktop or mobile phone for psychiatry residents that includes high-yield, clinically relevant topics designed to prepare medical students for their psychiatry shelf exam and future practice.

2. Evaluate the impact of a standardized teaching curriculum and teaching tool on resident confidence, enjoyment, and workflow burden related to teaching medical students.

Practice Gap

Residents are considered frontline teachers of medical students. It is estimated that 25% of residents' clinical time is spent teaching medical students and may be responsible for up to half of medical students' clinical knowledge (1,2). While "educating patients, families, students, residents, and other health professionals" is a common core competency by ACGME for residency programs, formal training in teaching skills is often limited due to competing demands on clinical time (3,4). Residents identified barriers to teaching medical students including time constraints, uncertainty about teaching methods, and lack of readily accessible, structured content (5). Structured, standardized teaching resources delivered via mobile application have been shown to reduce this burden while improving the frequency and student-perceived quality of resident-led teaching (6,7).

Methods

Residents in Psychiatry and Internal Medicine-Psychiatry Residency Programs completed a pre-implementation survey assessing time spent teaching medical students, enjoyment of and attitudes toward teaching, confidence across discrete teaching skills (e.g., bedside teaching, feedback, topic selection), perceived impact of teaching on clinical workflow and current methods used to select teaching topics. In partnership with the School of Medicine, a



standardized curriculum of high-yield, psychiatry shelf-exam-relevant topics was implemented from Summer 2026 through Winter 2026 to guide residents in selecting what to teach medical students during clinical rotations (for 3 cohorts of students). Residents were then taught during didactic sessions how to use the interactive application created by the authors both via desktop and mobile phone as a tool for teaching medical students. An identical post-implementation survey will be administered to allow paired comparison of pre/post responses, along with curriculum-specific items assessing usage frequency and satisfaction.

Anticipated Outcomes (Results)

Data collection including pre-implementation surveys completed prior to curriculum rollout in Summer 2026 is still ongoing. Post-implementation surveys are planned following completion of the teaching tool trial in Winter 2026. We anticipate presenting paired pre/post survey results at the annual meeting, focused on changes in resident confidence (overall and by specific teaching skill, including topic selection), time spent teaching, enjoyment of teaching, and perceived workflow burden. We suspect the teaching tool will produce improvement in resident preparedness and satisfaction for teaching, while enhancing the medical students' educational experience.

Conclusions

We hypothesize that a standardized, high-yield teaching curriculum accessed via interactive application will improve resident confidence and reduce the perceived burden of teaching medical students. Previous data suggests that structured, targeted teaching for medical students better prepares them for their psychiatry shelf exam and future clinical practice, and we anticipate this interactive application will provide this structured education without requiring additional protected time or strain on resident educators [8]. If effective, this approach can provide residency programs a practical approach to support resident-as-teacher development without impacting clinical obligations.

Scientific Citations

1. Snell L. The resident-as-teacher: it's more than just about student learning. J Grad Med Educ. 2011;3:440-441. doi: 10.4300/JGME-D-11-00148.1 [DOI] [PMC free article] [PubMed] [Google Scholar]

2. Bernal Bello D, García de Tena J, Jaenes Barrios B, Martínez Lasheras B, de Arriba de la Fuente G, Rodríguez Zapata M. The resident as teacher: medical students' perception in a Spanish university. Rev Clin Esp (Barc). 2014;214(7):371-376. doi: 10.1016/j.rce.2014.04.009 [DOI] [PubMed] [Google Scholar]



3. Seelig, S., Bright, E., Bod, J., Della-Giustina, D., Goldflam, K., Coughlin, R. F., & Tsyrulnik, A. (2021). Educating Future Educators-Resident Distinction in Education: A Longitudinal Curriculum for Physician Educators. The western journal of emergency medicine, 23(1), 100–102. https://doi.org/10.5811/westjem.2021.11.53890

4. Chochol MD, Gentry M, Hilty DM, McKean AJ. Psychiatry Residents as Medical Student Educators: a Review of the Literature. Acad Psychiatry. 2022;46(4):475-485. doi:10.1007/s40596-021-01478-z

5. Zackoff MW, Real FJ, DeBlasio D, et al. Objective Assessment of Resident Teaching Competency Through a Longitudinal, Clinically Integrated, Resident-as-Teacher Curriculum. Acad Pediatr. 2019;19(6):698-702. doi:10.1016/j.acap.2019.01.011

6. Zessis NR, Dube AR, Sadanand A, Cole JJ, Hrach CM, Daud YN. Teaching scripts via smartphone app facilitate resident-led teaching of medical students. BMC Med Educ. 2021;21(1):331. Published 2021 Jun 8. doi:10.1186/s12909-021-02782-w

7. Ginsburg J, Sande M, Ahmed A, Moak J, Sudhir A, Mutter MK. A Smartphone Resource for Just-in-Time Medical Student Teaching by Emergency Medicine Residents. Cureus. 2024;16(9):e70117. Published 2024 Sep 24. doi:10.7759/cureus.70117

8. Siddiqi, S. H., Black, K. J., & Womer, F. Y. (2015). Impact of a structured review session on medical student psychiatry subject examination performance. F1000Research, 4, 897. https://doi.org/10.12688/f1000research.7091.2



Title

The Child DI-SCO: A Novel Workplace-Based Assessment Tool for CAP Diagnostic Interview Proficiency

Primary Category

Assessment – learner (summative, formative, programmatic)

Presenters

Pascale Chrisphonte, MD, MS, Zucker School of Medicine at Hofstra/Northwell - Zucker Hillside Hospital, Emma Banasiak, MD, Zucker School of Medicine at Hofstra/Northwell - Zucker Hillside Hospital

Education Objectives

Aims: This project aimed to address a critical assessment gap in Child and Adolescent Psychiatry (CAP) fellowship training. Our objectives were to:

1. Develop and implement a novel, feedback-driven workplace-based assessment (WBA) program within a longitudinal continuity clinic for first-year CAP fellows.

2. Create and utilize the Child Diagnostic Interview Structured Clinical Observation (Child DI-SCO) a novel WBA tool to assess core CAP interview and assessment skills.

3. Leverage direct observation and structured, bidirectional feedback to confer entrustment and cultivate measurable fellow growth.

Practice Gap

The youth mental health crisis highlights an urgent need for competent Child and Adolescent Psychiatrists (CAP). While adult psychiatry has advanced competency-based medical education (CBME) with Entrustable Professional Activities (EPAs) and validated workplace-based assessment (WBA) tools, CAP fellowship training significantly lags, lacking specific EPAs or direct observation tools. We aimed to cultivate fellow growth by developing a novel, feedback-driven WBA program and WBA tool focused on the CAP diagnostic interview to address this critical gap.

Methods

We implemented a longitudinal continuity clinic at Zucker Hillside Hospital, Northwell Health, where first-year CAP fellows conducted diagnostic intake evaluations under direct attending supervision. We developed the Child Diagnostic Interview Structured Clinical Observation (Child

DI-SCO) tool, assessing core CAP diagnostic skills. Attendings made entrustment decisions and provided structured bidirectional feedback after each observation, fostering repeated opportunities for growth. Six fellows and four supervising faculty completed post-program surveys.

Results

Fellows' self-rated skills shifted significantly from novice/beginner to intermediate/advanced across all assessed domains. All fellows found direct observation important for skill improvement and feedback constructive/actionable. All faculty confirmed fellows' longitudinal application of feedback. Faculty overwhelmingly agreed that fellows demonstrated proficiency in CAP diagnostic interview skills. Qualitative themes highlighted valued longitudinal mentorship/clinical development. The American Board of Psychiatry and Neurology (ABPN) approved the Child DI-SCO as a direct observation tool that can be used for Clinical Skills Verification (CSV) so fellows can sit for boards.

Conclusions

This program, embedding structured feedback and longitudinal mentorship within a CAP continuity clinic, cultivates meaningful, measurable fellow growth. It addresses a critical CAP fellowship assessment gap, offering a replicable, growth-oriented framework aligned with principles of advancing learner success through feedback with formative assessment for learning.

Scientific Citations

1. Shaligram D, Bernstein B, DeJong SM, et al. “Building” the Twenty-First Century Child and Adolescent Psychiatrist. Academic Psychiatry. 2022;46:75–81.

2. Young JQ, Frank JR, Holmboe ES. Advancing Workplace-Based Assessment in Psychiatric Education: Key Design and Implementation Issues. Psychiatric Clinics of North America. 2021;44(3):317-332.

3. Young JQ, et al. Developing End-of-Training Entrustable Professional Activities for Psychiatry: Results and Methodological Lessons. Academic Medicine. 2018;93(7):1048-1054.

4. Young JQ, McClure M. Fast, Easy, and Good: Assessing Entrustable Professional Activities in Psychiatry Residents With a Mobile App. Academic Medicine. 2020;95(10):1546–1549.

5. Young JQ, Holmboe ES, Frank JR. Competency-Based Assessment in Psychiatric Education: A Systems Approach. Psychiatric Clinics of North America. 2021;44(3):303-316.

Title

The Cost of Competence: Weighing the Costs and Benefits of Implementing Competency Based Medical Education in Psychiatry Residency Training

Primary Category

Assessment – learner (summative, formative, programmatic)

Presenters

Emily Bray, DO, Jefferson Health Medical Education/Jefferson Einstein Philadelphia Hospital Program, Dennis Grapsas, MD, Jefferson Health Medical Education/Jefferson Einstein Philadelphia Hospital Program, Jessica DePalma, DO, Jefferson Health Medical Education/Jefferson Einstein Philadelphia Hospital Program

Education Objectives

1. To analyze the CBME implementation and assessment burden among psychiatry faculty and residents.

2. To evaluate whether the anticipated benefits of CBME outweigh its administrative and financial costs in psychiatry residency training programs.

3. To identify priority areas for pilot studies that evaluate implementation strategies and generate best practices for cost-effective CBME implementation in psychiatry training.

Practice Gap

Despite the introduction of competency-based milestone assessments, psychiatry continues to rely heavily on time-based advancement, in which promotion is determined by rotation rather than demonstrated skill (1). Evidence suggests that time-based training does not reliably ensure graduates are prepared for independent practice or to work effectively in complex health systems (7,5), raising questions about whether time is an adequate proxy for competence. Competency-based medical education (CBME) addresses these concerns by shifting the focus from time-based training to direct assessment of specific clinical competencies, ensuring better alignment of medical education with population health (14). Though CBME offers a more rigorous and individualized pathway to competence, both immediate and long-term costs associated with CBME have contributed to difficulties with implementation (5,10).

Methods

We conducted a narrative review of the peer-reviewed literature on the implementation, cost, and outcomes of competency-based medical education (CBME) in graduate medical education,



with particular attention to studies examining psychiatry and other specialty residency programs. Findings were synthesized to characterize direct implementation costs, indirect and downstream costs, and reported or theorized benefits, to evaluate whether current evidence supports the substantial resource investment CBME requires.

Results

The literature consistently identifies CBME as resource-intensive though to date, no study has yet quantified the full financial cost of CBME implementation (5,10). Direct, immediate costs include faculty development time needed to build shared assessment standards and reliably use new tools, along with development or purchase of assessment platforms and data-management systems (10). In one multiprogram emergency medicine implementation, program coordinators spent an estimated 2–15 hours per month and program leadership 4–21.4 hours per month on CBME-related tasks (4), illustrating that even “low-cost” rollouts carry substantial labor costs. A qualitative study of structured feedback in a psychiatry CBME residency program similarly identified organizational readiness and faculty self-efficacy as key implementation factors (11). Indirect and downstream costs are harder to quantify but include reallocation of clinical coverage, adjusted supervision models, workflow disruption during rollout, and unknown effects on trainee attrition and workforce stability (5,10).

Early-stage potential benefits include closer alignment of residency training with societal health needs (14), earlier identification of performance gaps with reduced remediation (8), and improvements in learning culture, interprofessional relationships, and professional growth and job satisfaction, however, the effects on burnout remain mixed (3). Some authors have also proposed that CBME could shorten training for select learners, though this remains theoretical and controversial (8). A systematic review of CBME in anesthesia similarly concluded that evidence remains largely limited to competency acquisition, with too few studies to determine whether CBME can be implemented “wisely and cost-effectively” (13).

No study has directly compared patient outcomes between CBME-trained and time-based-trained graduates, and some experts argue this should not be read as a failure of CBME: patient outcomes are shaped by many variables beyond training model, are difficult to attribute to specific educational elements, and may be an inherently premature or inappropriate yardstick for judging CBME’s effectiveness at this stage (6,12).

Conclusions

CBME implementation carries substantial, well-documented direct and indirect costs, alongside real but largely unproven benefits. Absence of comparative patient-outcome data should not be read as evidence against CBME, given legitimate questions about whether outcomes are even a feasible metric at this stage (6,12); and neither should cost alone justify preserving a time-

based model already shown to leave some graduates underprepared for independent practice. AADPRT's 2025 CBME in Psychiatry Task Force Report has itself called for a cost analysis of CBME in Psychiatry and its return on investment (2). Accordingly, what is needed now is not necessarily more outcome-comparison research, but coordinated multicenter pilot projects, ideally sponsored at a national level, to test implementation strategies in diverse program settings, generate real-world cost and process data, and disseminate best practices for cost-effective CBME implementation in psychiatry training.

Scientific Citations

1. Accreditation Council for Graduate Medical Education. (2026). ACGME program requirements for graduate medical education in psychiatry including FAQs (effective July 1, 2026). https://www.acgme.org/globalassets/pfassets/programrequirements/2026-prs/400_psychiatry_2026.pd

2. American Association of Directors of Psychiatry Residency Training (AADPRT). CBME in Psychiatry Task Force Report. Published February 17, 2025. Available at: aadprt.org.

3. Birman NA, Vashdi DR, Miller-Mor Atias R, Riskin A, Sagi D, Zangen S, Litmanovitz I. Is competency-based medical education sustainable? A pilot study on well-being impacts. Med Teach. Published online August 6, 2025.

4. Caretta-Weyer HA, Schnapp BH, Brown CA, et al. Implementing the 5 Core Components of Competency-Based Medical Education in US Emergency Medicine Residency Programs. J Grad Med Educ. 2025;17(2 Suppl):57-63.

5. Cooper D, Holmboe ES. Competency-Based Medical Education at the Front Lines of Patient Care. N Engl J Med. 2025;393(4):376-388.

6. Dagnone JD, Bandiera G, Harris K. Re-examining the value proposition for Competency-Based Medical Education. Can Med Educ J. 2021;12(3):155-158.

7. Daniel J. Schumacher, Benjamin Kinnear, Patricia Poitevien, Robert Daulton, Ariel S. Winn; Advancing, Graduating, and Attesting Readiness of Pediatrics Residents With Concerns. Pediatrics April 2025; 155 (6): e2025070594. 10.1542/peds.2025-070594.

8. Fraser AB, Stodel EJ, Chaput AJ. Curriculum reform for residency training: competence, change, and opportunities for leadership. Can J Anaesth. 2016;63(7):875-884.

9. Mattar SG, Alseidi AA, Jones DB, Jeyarajah DR, et al. General surgery residency inadequately prepares trainees for fellowship: results of a survey of fellowship program directors. Ann Surg. 2013;258(3):440-449.



10. Nousiainen MT, Caverzagie KJ, Ferguson PC, Frank JR; ICBME Collaborators. Implementing competency-based medical education: What changes in curricular structure and processes are needed? Med Teach. 2017;39(6):594-598.

11. Thakur A, Darani S, Kalocsai C, Silver I, Sockalingam S, Soklaridis S. Implementation of structured feedback in a psychiatry residency program in Canada: a qualitative analysis study. Front Psychiatry. 2023;14:1276985.

12. Van Melle E, Hall AK, Schumacher DJ, et al; ICBME Collaborators. Capturing outcomes of competency-based medical education: The call and the challenge. Med Teach. 2021;43(7):794-800.



Title

The Handal Protocol for the Pediatric MSE: Standardizing developmentally appropriate Mental Status Examinations in Child and Adolescent Psychiatry

Primary Category

Assessment – learner (summative, formative, programmatic)

Presenters

Pamela McPherson, MD, Louisiana State University (Shreveport) Program, Laura Handal, MD, Louisiana State University (Shreveport) Program

Education Objectives

The main goal is to improve age-appropriate MSE through implementation of a structured pediatric MSE protocol- The Handal Protocol for the Pediatric MSE. The Handal Protocol is also designed to facilitate the identification of learning and speech-related concerns among patients and improve concordance between known movement disorders and their identification on the MSE. A branded EHR template was developed to support implementation.

Practice Gap

Developmentally appropriate Mental Status Examination (MSE) documentation is essential for diagnostic clarity, interdisciplinary communication, and patient safety in child and adolescent psychiatry. Adult-derived MSE frameworks may not adequately capture developmental differences in cognition, language, insight, judgment, and behavior. To our knowledge there are no identified studies documenting the creation and use of developmentally appropriate pediatric MSE frameworks.

Methods

The Handal Protocol began as a quality improvement project reviewing two hundred pediatric psychiatric encounters at a tertiary academic center: one hundred pre-intervention encounters reviewed from July through September 2025, and one hundred post-intervention encounters reviewed from April through June 2026. Encounters included inpatient, outpatient Child and Adolescent Psychiatry (CAP) clinic, and consult settings. Documentation of core MSE domains and developmental appropriateness was assessed using a three-tier rating system [Yes/Partial/No]. Pre-intervention surveys and knowledge assessments of faculty, general psychiatry residents, and CAP fellows identified barriers and educational needs. The multifaceted intervention to provide education and remove barriers included targeted resident

education, Departmental Grand Rounds, a branded EHR template with age-stratified Epic smart phrases, and setting-specific, age appropriate, portable developmental assessment toolkits.

Results

Six months after implementation, age-appropriate MSE documentation increased from 1/100 encounters (1%) pre-intervention to 55/100 encounters (55%) post-intervention, an absolute increase of fifty-four percentage points. Among post-intervention encounters, documented use of the Handal Protocol was associated with a higher proportion of age-appropriate MSE documentation to inform clinical decision making. Documentation of learning and/or speech-related concerns increased from 4/100 encounters (4%) to 11/100 encounters (11%), an absolute increase of seven percentage points. Among patients with a previously documented movement disorder, movement-related findings were documented in the MSE in 1/6 encounters (16.7%) pre-intervention and 5/5 encounters (100%) post-intervention, an absolute increase of 83.3 percentage points. Post-intervention adherence was highest in CAP clinic encounters and lower in inpatient and consult settings. PGY-1 and PGY-3 trainees demonstrated the lowest adherence.

Conclusions

The Handal Protocol was associated with markedly improved age-appropriate MSE documentation with significant implications for clinical decision making. The intervention also improved documentation of learning/speech concerns and alignment of known movement disorders with motor MSE findings. Further improvement efforts should focus on abbreviated workflows for inpatient, consult, and on-call settings, along with targeted orientation and feedback for PGY-1 and PGY-3 trainees. Expansion to pediatric and medical-pediatric residents is planned for the coming year.

Scientific Citations

1, Ebbers, T., Kool, R.B., Smeele, L.E. et al. The Impact of Structured and Standardized Documentation on Documentation Quality; a Multicenter, Retrospective Study. J Med Syst 46, 46 (2022). https://doi.org/10.1007/s10916-022-01837-9

2. Evelyn Berger-Jenkins, Jennifer K. Poon, et al. . Committee on Psychosocial Aspects of Child and Family Health, Section on Developmental and Behavioral Pediatrics; Framework for Approaching Healthy Mental and Emotional Development in Pediatrics: Clinical Report. Pediatrics May 2026; 157 (5): e2026076620. 10.1542/peds.2026-076620

3. Lenouvel E, Chivu C, Mattson J, et al. Instructional Design Strategies for Teaching the MentalStatus Examination and Psychiatric Interview: a Scoping Review. Acad Psychiatry. 2022;46(6):750-758.



4. Lobo SE, Rucker J, Kerr M, et al. A comparison of mental state examination documentation by junior clinicians in electronic health records before and after the introduction of a semi-structured assessment template (OPCRIT+). Int J Med Inform. 2015;84(9):675-682. doi:10.1016/j.ijmedinf.2015.05.001

5. Mikkelsen N, Larsen EB, Arnfred SM. Authentic Versus Simulated Patient Videos: Effect on Mental Status Examination—An Educational Randomized Controlled Trial. Acad Psychiatry.2025;49(3):222-230.

6. Dulcan MK. Dulcan's Textbook of Child and Adolescent Psychiatry. 3rd ed. American Psychiatric Association Publishing; 2021.



Title

The Hippocampus Awards: Influencing Practice Testing Behavior in Residents

Primary Category

Assessment – learner (summative, formative, programmatic)

Presenters

Aaron Iuppa, MD, MPH, Henry Ford Allegiance Health

Education Objectives

Our objective was to increase practice testing behavior among our residents, with the hope that this would improve their medical knowledge, performance on the annual PRITE exam, and improve preparation for the ABPN board exam.

Practice Gap

Residents must build an extensive knowledge base to practice effectively. Retrieval practice and spaced repetition are among the best-studied learning strategies in medical education. Studies have found that completing more exam-style practice questions is associated with greater annual improvement on in-training exam scores. Yet, programs often struggle to get residents to complete practice questions. One study found that reminders alone were not an effective intervention. Despite providing a question bank and scheduling weekly practice tests with email reminders for our residents, engagement in practice testing was limited.

Methods

Intervention: We developed a multi-pronged influence strategy to promote retrieval practice and spaced repetition using board-style questions, implemented in February 2026 and designed using the six sources of influence model from Crucial Influence. Personal motivation was addressed through a didactic session presenting the evidence base for retrieval practice and spaced repetition, introducing the voluntary Hippocampus Awards program as a tool to build knowledge and improve patient care. Social motivation was targeted through public recognition, with a Silver award for 18+ completed tests, a Gold award for 30+, and a wearable enamel brain pin representing commitment to self-improvement and patient care. Chief residents ran monthly competitions comparing completion percentages across classes, and the training director sent monthly reminder emails updating residents on their progress and gently encouraging participation. Structural motivation was reinforced with the pin, a certificate, and the ability to list the award on a CV. Structural ability was enhanced by scheduling 10-question practice tests weekly through the TrueLearn question bank, delivered via email reminders, with residents



encouraged to download the app. At the intervention's end, residents were surveyed on what motivated their participation (or lack thereof) and what barriers they encountered.

Results

The number of weekly 10-question tests completed rose from 3.93 per resident in AY 2024–2025 to 20.25 per resident in AY 2025–2026, a 5.5-fold increase. Completion rates showed a temporal association with the intervention when plotted. Total questions completed (assigned plus self-directed) rose from a mean of 113.7 to 559.9 per learner (median 90 to 475), and percent correct improved from 53.9% to 61.1%. Of 16 residents, 4 earned Silver awards (18–29 tests) and 9 earned Gold (30+ tests); the 3 residents who earned no award were all PGY1s. In the post-intervention survey (n = 12, including all 3 non-awardees), 58% cited structural motivators (the pin or award), 42% cited social factors, and 33% cited personal motivation as reasons for engagement. The most common barriers were forgetting (42%), lack of time or competing priorities (33%), and fatigue or burnout (33%).

Conclusions

In our small residency, a multi-pronged influence strategy substantially increased engagement in practice testing, using an intervention that was inexpensive and simple to implement. Accuracy did not decline, suggesting genuine engagement rather than superficial participation. Residents reported that multiple elements were motivating, including alignment with personal growth and exam-preparation goals, social factors such as competition and recognition, and the tangible award and pin. Despite email reminders, forgetting remained the most commonly cited barrier to completing practice questions, alongside competing clinical responsibilities and fatigue or burnout.

Scientific Citations

1. Serra MJ, Kaminske AN, Nebel C, Coppola KM. The use of retrieval practice in the health professions: a state-of-the-art review. Behav Sci (Basel). 2025;15(7):974. doi:10.3390/bs15070974

2. Maye JA, Hurley F. The effectiveness of spaced repetition in medical education: a systematic review and meta-analysis. Clin Teach. 2026;23(2):e70353. doi:10.1111/tct.70353

3. Nelson A, Mohammed A, An A, Traba C. Testing the effects of individual residents' retrieval practice on standardized examination scores. Med Sci Educ. 2024;34(3):647-652. doi:10.1007/s40670-024-02031-x



4. Green I, Weaver A, Kircher S, et al. Impact of Question Bank Use for In-Training Examination Preparation by OBGYN Residents - A Multicenter Study. J Surg Educ. 2022;79(3):775-782. doi:10.1016/j.jsurg.2021.12.014

5. Nelson A, Broder M, Schwartz A, Thomas C, Abramson E. Daily text-message retrieval practice for pediatric residents. Cureus. 2025;17(10):e95568. doi:10.7759/cureus.95568

Title

The Next Step: A Pilot Simulation Program for Preparing PGY-1 Psychiatry Residents

Primary Category

Learning Environment

Presenters

Julia Triggs, BS, MD, Novant Health New Hanover Regional Medical Center Program, David Schroeder, BS, DO, Novant Health New Hanover Regional Medical Center Program

Education Objectives

1. Initiate a pilot program of simulating scenarios of patient care for psychiatry residents.

2. Assess residents experience with said program to determine if participant's confidence with relevant aspects of patient care upon starting residency was improved from residents who had not participated previously.

3. Gather feedback to guide further improvements to subsequent simulated training experiences.

Practice Gap

Note, the work was produced by a PGY-2 Psychiatry Resident with Program Director/AADPRT member mentorship.

The works surrounding this abstract came about from the desire to best prepare upcoming first-year psychiatry residents for the most challenging and critical patient encounters. Other medical specialties such as surgery, OBGYN, internal medicine, etc., within our hospital routinely participate in simulations to expand their reliability and comfortability within specifics aspects of their professional duties. During orientation, prior to beginning their PGY-1 year, this past year residents participated in two separate series of simulations themed around verbal de-escalation of psychiatric patients and triaging medical situations for behavioral health hospital patients.

Methods

A pilot simulation program was incorporated into upcoming psychiatry resident's orientation schedule. A questionnaire was generated to assess participants experience with the program, evaluate their experience with their relevant work duties over the first several months of residency, and compare their self-assessments with residents who were not offered simulations in years past. As of the time of this abstract submission, results are currently pending; this was



intentionally timed to allow first-year residents time have have relevant experiences to most appropriately reflect on the simulation activities. These results will be accompanied with a collection of plans for improvement with subsequent simulations to hopefully create an evolving and productive experience for trainees in years to come.

Scientific Citations

1. https://www.sciencedirect.com/science/article/abs/pii/S0013700624000174
2. https://www.ncbi.nlm.nih.gov/books/NBK551665/
3. https://pubmed.ncbi.nlm.nih.gov/41583282/
4. https://www.frontiersin.org/journals/psychiatry/articles/10.3389/fpsyt.2021.658967/full
5. https://www.sciencedirect.com/science/article/abs/pii/S0013700624000071

Title

The Sustaining Power of Signals - 2026 and Beyond

Primary Category

Recruitment and Selection

Presenters

Lia Thomas, MD, UT Southwestern Medical Center, Shambhavi Chandraiah, MD, East Tennessee State University/James H. Quillen College of Medicine, Denise Baughn, MD, University of Texas Medical Branch, Galveston, Jessica Sandoval, BA, MD, MS, University of Texas Health Sciences Center at San Antonio

Education Objectives

1. To assess the use of Program Signals by psychiatry Program Directors
2. To ascertain the attitudes of Psychiatry Program Directors about Program Signals.
3. To determine future directions in Psychiatry Residency Recruitment

Practice Gap

Psychiatry remains a popular specialty for medical students, with 4135 applicants applied for 2516 positions in Match 2026.

Since Match 2023, Psychiatry has used program signaling as part of residency recruitment. This practice has been implemented withing 29 residencies including otolaryngology (Pletcher 2025) and obstetrics-gynecology (Fei-Cai 2025) . A review of 31 studies of signals across specialties indicate signals are generally viewed positively by both program directors and applicants and can help to reduce overall application volume and increase interview yield (Valadez 2025) Psychiatry began with 5 signals and increased to 10 signals for Match 2025. In 2026, members of the AADPRT Recruitment Committee surveyed the AADPRT Membership about their continued use of signals in residency Recruitment.

Methods

A 23-item survey was sent to Program Directors who were also registered members of AADPRT. The survey inquired about program characteristics (size of program, location, age of program, affiliations), use of signals in Match 2026 (for screening or in ranking decisions), distribution of signals, program director perception of signals and geographic preference, and



future directions of signals. This study was deemed exempt by [redacted]'s IRB. The survey opened in April 2026 and ran for 2 weeks.

Emails were sent to 232 program directors, and we received 118 responses (50.8% response rate). 63% of respondents were at programs that had existed for 20 years or more, and 28% of respondents were programs that existed for 10 years or less. 53% of respondents were affiliated with an academic/university program, 25% were Community/Academic affiliations and 23% were Community/Hospital based. The average size of the incoming PGY1 class was 8.92 residents (min = 3, max =26.)

Programs received an average of 861 applicants, and most signals were sent by US MD applicants. Among the 38 programs with complete signal counts for all four applicant types, the median total number of signals received was 100.5 (IQR 59.2–167.0). The mean was 134.1 (SD 110.4), with a range of 12 to 436. Respondents noted receiving an average of 79.77 signals from US MD applicants, 28.15 signals from US DO students, 22.27 signals from non-US IMG applicants, and 14.27 signals from US IMG students. There was a statistically significant moderate positive association between application volume and total signal volume (Spearman $\rho = 0.480$, $p = 0.002$)

While a majority of respondents noted that they use signals in screening (99%), 20% of respondents noted that signal information was disseminated to interviewers, and 18% of respondents noted that they used signal in making rank order list decisions. 72% of respondents noted that they reviewed applications they would not have reviewed in the past because of receiving a signal, ultimately resulting in interviewing and ranking those applicants.

26% of respondents noted that 100% of their matched class was made up of students who signaled their program. 32% of programs noted that 50-75% of their matched class was made up of students who signaled them.

In terms of perception, program directors strongly believe that an applicant sending a signal means there is a genuine interest in the program (93% Agree or Strongly Agree) and not a desire to use signals more in future recruitment cycles. Respondents were less certain about geographic signals and the urban/suburban/rural designation.

Survey respondents chose to remain with 10 signals for Match 2027. Respondents believe that a signal shows a genuine interest in programs, and programs directors noted a willingness to review and interview applicants not previously viewed if they sent a signal. Further studies on how programs use signals are encouraged, looking both at applicant and program director behaviors around signals.



Scientific Citations

1. NRMP Releases Results of the 2026 Main Residency Match for More Than 38,000 Future Residents. NRMP Press Release on March 20, 2026. https://www.prnewswire.com/news-releases/nrmp-releases-results-of-the-2026-main-residency-match-for-more-than-38-000-future-residents-302719870.html Accessed 9/6/2026

2. Marvin R, Park YS, Dekhtyar M, et al. Implementation of the AAMC's Holistic Review Model for Psychiatry Resident Recruitment. MedEdPORTAL. 2023;19:11299. Published 2023 Feb 7. doi:10.15766/mep_2374-8265.11299

3. Valadez J, Liang A, Goldin M, et al. A Review of Program Signaling Effects, Perceptions, and Trends for Medical Residencies. J Grad Med Educ. 2025;17(4):453-463. doi:10.4300/JGME-D-24-00670.1

4. Cai F, Southworth E, Santiago S, et al. The golden tickets: impact of preference signaling on obstetrics and gynecology residency applicants. Am J Obstet Gynecol. 2024;230(2):262.e1-262.e9. doi:10.1016/j.ajog.2023.10.014

5. Steven D Pletcher, C W David Chang, Marc C Thorne, Sonya Malekzadeh, The Otolaryngology Residency Program Preference Signaling Experience, Academic Medicine, Volume 97, Issue 5, May 2022, Pages 664–668, https://doi.org/10.1097/ACM.0000000000004441



Title

Trainee to Leader: Conceptualizing a Pathway for Resident Development into Educational Leaders

Primary Category

Teaching, Supervision, Pedagogy

Presenters

Deepika Sundararaj, MD, UMass Chan -- Baystate Medical Center, Anya Brych, MD, UMass Chan -- Baystate Medical Center

Education Objectives

1. Review existing literature regarding the role of residents as teachers and educators, within and beyond psychiatric training programs

2. Identify and characterize opportunities for residents to transition from learners to educational leaders through appraisal of existing teaching opportunities for psychiatric residents at Baystate Medical Center

3. Develop a framework conceptualizing the transition of residents into education leaders potentially adaptable to other residency programs

Practice Gap

Residency programs increasingly recognize the importance of developing residents as educators, given their frequent interface with other medical learners. Often taking the form of resident-as-teacher (RaT) training, these opportunities allow residents to gain competency as instructors and evaluators. However, there currently remains limited guidance to support the progression of residents from participants in teaching activities to independent educational leaders apart from more formalized clinician-educator tracks. This project aims to establish a preliminary framework for identifying and facilitating opportunities for resident growth in this domain, with future application to psychiatric training programs specifically.

Methods

A literature search of PubMed database was conducted to examine current approaches to resident teaching and development as educators. Our initial search generated 223 results, from which a step-wise screening process was performed. Initial review was conducted of published article titles to screen-out based upon general relevance to project frame. Following the initial screen, articles published outside of the timeframe of 2010-2026 were removed. Remaining

articles were then reviewed based upon determined inclusion and exclusion criteria. To broaden generalizability, we considered studies involving medical or surgical residents in postgraduate training roles across the United States and other countries, as well as across residency specialities. Studies focused on faculty, fellow or undergraduate populations exclusively were excluded, as were articles pertaining primarily to research skills teaching, procedural or clinical non-educational teaching, patient education, general leadership training, or training where residents served exclusively as learners. Following removal of duplicates, a total of 32 articles were reviewed.

Serving as a single-site exemplar, a community-based university-affiliated psychiatry residency program was reviewed to identify existing opportunities for residents to serve as teachers/educators. Appraisal included both one-off experiences as well as longitudinal opportunities for residents across all four training years. Informal teaching interventions and formal didactics were included in assessment. A total of 17 experiences were identified and considered.

Findings from the literature review and appraisal of existing residency programming were synthesized to develop a framework to conceptualize stages of resident educator development.

Outcomes

Existing literature largely focused on foundational resident-as-teacher curricula and formal clinician-educator tracks. Limited research addressed the progressive development of residents from learners to independent educational leaders within the existing framework of residency training.

Appraisal of educational opportunities within our psychiatry residency program identified 17 unique educational opportunities. These ranged from informal oversight of medical students during their psychiatry clerkship experiences to capstone projects dedicated to creating, facilitating, and evaluating didactic curricula. Building upon principles outlined in Mahan et al. regarding Clinician Educator Milestones as well as Harden and Crosby's proposed 12 roles of medical teachers, we identified four primary levels of resident involvement: learner, facilitator, educator, and educational leader.

Each level was further defined by identification of key roles and responsibilities. Learners are those who receive teaching, be it through didactics or in clinical instruction. By contrast, facilitators can be conceptualized as residents who deliver educational content through peer-to-peer and near-peer teaching. This content is often informal, such as through bedside teaching, or exists within a previously-established curriculum. In comparison, we propose that a key tenet of educators is direct development of educational content, including lectures or teaching materials. The final level is that of educational leader. This role is unique in its focus on



appraisal of educational programs through programmatic assessment and evaluation to allow for iterative improvements.

Conclusion

This framework provides a preliminary structure through which residency programs may identify existing opportunities for resident educational development, recognize gaps in progression toward educational leadership, and consider intentional pathways for residents to advance from learners and facilitators to educators and educational leaders.

Scientific Citations

1. Yang, Yihan et al. “Structure and impact of longitudinal Graduate Medical Education curricula designed to prepare future clinician-educators: A systematic scoping review: BEME Guide No. 74.” Medical teacher vol. 44,9 (2022): 947-961.

2. Chochol, Megan D et al. “Psychiatry Residents as Medical Student Educators: a Review of the Literature.” Academic psychiatry : the journal of the American Association of Directors of Psychiatric Residency Training and the Association for Academic Psychiatry vol. 46,4 (2022): 475-485.

3. Mahan, John D et al. “Clinician Educator Milestones: Assessing and Improving Educators' Skills.” Academic medicine : journal of the Association of American Medical Colleges vol. 99,6 (2024): 592-598.

4. Hashimoto, Tadayuki, and Makoto Kikukawa. “Identifying teaching competencies for medical residents using a modified Delphi method.” Korean journal of medical education vol. 36,1 (2024): 51-63.

5. Liang, Jen-Feng et al. “Developing a competency-based framework for resident-as-teacher.” Journal of the Formosan Medical Association = Taiwan yi zhi vol. 121,10 (2022): 1956-1962.

6. Gleason, Augustus et al. “Evaluating General Surgical Residency Education Structure and Incorporation of the Resident as Educator Model.” Journal of surgical education vol. 79,6 (2022): 1387-1393.

7. Bengiamin, Deena Ibrahim et al. “Implementation of a Medical Education Rotation for Senior Emergency Medicine Residents.” Journal of education & teaching in emergency medicine vol. 6,3 C1-C8. 15 Jul. 2021.

8. AlMarzooqi, Lateefa Mohamed, and Nandu Goswami. “Residents as Teachers in postgraduate medical education: a structured review of global evidence and emerging gaps.” BMC medical education vol. 26,1 1392. 14 Jul. 2026.

9. Paul, Caroline R et al. “Training Radiology Residents in Teaching Skills: Using the Kern Curriculum Model to Develop a Pilot, Residents-as-Teachers Curriculum.” Cureus vol. 18,3 e104629. 3 Mar. 2026.

10. Alwazzan, Lulu et al. “Dermatology residents as educators: a qualitative study of identity formation.” BMC medical education vol. 23,1 199. 30 Mar. 2023.

11. Koppula, Sudha et al. “Teaching Experiences of Family Medicine Residents: Toward an Encompassing Teaching Framework.” Journal of medical education and curricular development vol. 13 23821205261424384. 16 Feb. 2026.

12. Daaboul, Yazan et al. “Current status of clinician-educator tracks in internal medicine residency programmes.” Postgraduate medical journal vol. 97,1143 (2021): 29-33.

13. Freedman-Weiss, Mollie R et al. “Teaching the Learner to Teach: An Effective and Reproducible Curriculum to Engage Junior Residents as Educators.” The American surgeon vol. 92,9 (2026): 2442-2451.

14. Lee, Janice C L et al. “Validity and Utility of the CanMEDS "Resident as Teacher Multisource Feedback" Assessment Tool for Resident-led Structured Teaching.” Canadian geriatrics journal : CGJ vol. 28,2 154-160. 4 Jun. 2025.

15. Sabir, Farzana et al. “Resident-Led Workplace-Based Assessment of Surgical Interns: Exploring Trained Resident-as-Assessor Experiences.” Journal of surgical education vol. 82,9 (2025): 103567.

16. Kahn, Mauricio J et al. “Creating Clinician Educators: Evaluation of a One-Month Medical Education Curriculum for Senior Residents.” The American journal of the medical sciences vol. 362,6 (2021): 606-611.

17. Casas, Rachel S et al. “Preparing for the Transition to Academic Practice: A Graduate Medical Education Elective.” Journal of graduate medical education vol. 16,4 (2024): 461-468.



Title

Want residents to learn Psychodynamic Psychotherapy? Teach it like it's CBT.

Primary Category

Curriculum

Presenters

Belinda McIntosh, BA, MD, Emory University School of Medicine, Ann Schwartz, MD, Emory University School of Medicine

Education Objectives

Learners will be able to:

1. Identify one contributor to the practice gap between Psychodynamic Psychotherapy (PP) training during residency and residents' perceived ability to conduct PP
2. Describe how one program taught PP technique using an operationalized approach that aligns with adult learning theory
3. Identify five required elements for successfully implementing an operationalized approach to teaching PP
    a. Engage an interested faculty member (analytic training not required)
    b. Choose structured course materials suitable for residents
    c. Develop structured lesson plans that focus on key concepts
    d. Emphasize clinical relevance
    e. Actively engage learners
4. Describe how this operationalized approach can be adapted to teaching PP across
    a. Multiple PGY levels
    b. In-person, virtual, and asynchronous learning formats

Practice Gap

PP is a core competency and an effective treatment for many common mental disorders. However, PP training in psychiatry residency programs has declined, and residents are often dissatisfied with psychotherapy curricula.



Compared to training in Cognitive Behavior Therapy and other manualized therapies, PP teaching is often less structured. Theory-focused didactic teaching alone can leave learners struggling to connect PP concepts to their clinical work. Residents may benefit from a structured approach to teaching PP.

Adult learning theory suggests that effective teaching is focused, clinically relevant, and builds on learners' experiences. Evidence supports using this approach in teaching psychotherapy to psychiatry residents.

We implemented an innovative approach to teaching PP that is operationalized, focused, and immediately applicable to residents' experiences.

Methods

In response to several senior residents identifying significant knowledge and skill gaps in the core competency area of PP, we developed and implemented a seminar for teaching PP technique.

From January to June, 2025, four learners (three PGY-4 psychiatry residents and one advanced practice registered nurse) participated in a weekly sixty-minute PP small-group seminar led by a core faculty member experienced in conducting PP. All participants were engaged in clinical work in a high-acuity outpatient psychiatry clinic focused on diagnostic assessment, treatment planning, and pharmacotherapy. The PGY-4s were also engaged in ongoing psychotherapy work and supervision through the residency program's outpatient psychotherapy training program. Session content was guided by a syllabus based on a standard PP text that takes an operationalized approach to PP.

Learning objectives specified that upon completion of the course, learners would be able to:

1. Assess function and develop an initial psychodynamic formulation in the context of a diagnostic assessment

2. Use supporting interventions with patients and explain their therapeutic strategy

3. Use uncovering interventions with patients and explain their therapeutic strategy

We used a flipped classroom method. Before each session, learners completed assigned readings and suggested exercises. The sessions began with open reflection on core takeaways from the assigned readings and activities, followed by in-depth discussion of key topics. Sessions featured active engagement through eliciting questions and relevant examples from learners' clinical and supervision experiences. Learners were encouraged to share case examples from across their clinical experiences, reinforcing the applicability of PP to a variety of



settings. Emphasis was placed on facilitating a safe and supportive learning environment that encouraged peer-to-peer interaction.

A post-course evaluation was administered to assess fulfillment of learning objectives, evaluate learners' experience of the course, and determine the course's impact on learners' confidence in, understanding of, and interest in conducting PP. Qualitative questions sought to identify the course's most valuable and impactful features.

Results

All participants reported that the course met its learning objectives, improved their confidence and perceived competence in conducting PP, increased their likelihood of using PP in the future, and contributed to their professional development.

Key factors to the course's success were identified:

- Operationalized text and structured learning sessions focused on evidence-driven topics directly relevant to learners' clinical experiences
- Interactive flipped classroom discussion-based format

The course's benefits extended beyond skill acquisition, with learners noting reduced burnout, increased excitement about clinical work, greater sense of connection to colleagues and the profession, and increased enthusiasm for psychotherapy training and practice.

In response to the overwhelmingly positive response from learners, the residency program expanded this course offering so that in future years, all PGY-3s will receive this seminar.

Conclusions

An operationalized approach to teaching PP was feasible and well received in this small pilot and may provide a replicable model for other residency programs. The combination of a structured text, evidence-based approach, flipped classroom model, discussion-based format, and content adjacent to learners' experiences promoted deep engagement and increased confidence in using PP.

Scientific Citations

1. American Council for Graduate Medical Education. (2026). ACGME program requirements for graduate medical education in psychiatry, including FAQs. https://www.acgme.org/globalassets/pfassets/programrequirements/2026-prs/400_psychiatry_2026.pdf



2. Leichsenring, F., Abbass, A., Heim, N., et al. (2023). The status of psychodynamic psychotherapy as an empirically supported treatment for common mental disorders—An umbrella review based on updated criteria. World Psychiatry, 22(2), 286–304. https://doi.org/10.1002/wps.21104

3. Levendosky, A. A., Turchan, J. E., Luo, X., et al. (2023). A re-introduction of the psychodynamic approach to the standard clinical psychology curriculum. Journal of Clinical Psychology, 79(10), 2439–2451. https://doi.org/10.1002/jclp.23551

4. Lafont, E., Sheppe, A. H., Malberg, N., et al. (2025). Training in psychodynamic psychotherapy. Child and Adolescent Psychiatric Clinics of North America, 34(3), 493–509. https://doi.org/10.1016/j.chc.2025.03.002

5. Salgado, R. M., & von Doellinger, O. (2024). Psychotherapy training in psychiatry residencies: A review of trainees' perspectives. The European Journal of Psychiatry, 38(4), 100263. https://doi.org/10.1016/j.ejpsy.2024.100263

6. Gorun, A. (2026). Reframing psychodynamics for contemporary psychiatry training. Academic Psychiatry. https://doi.org/10.1007/s40596-026-02426-5

7. Cassioli, E., Rossi, E., Aguglia, A., et al. (2026). From training to practice: The influence of education and training on attitudes towards psychotherapy among psychiatry residents and early-career psychiatrists. Academic Psychiatry. https://doi.org/10.1007/s40596-026-02391-z

8. Taylor, D. C., & Hamdy, H. (2013). Adult learning theories: Implications for learning and teaching in medical education: AMEE Guide No. 83. Medical Teacher, 35(11), e1561–e1572. https://doi.org/10.3109/0142159X.2013.828153

9. Schwartz, A. C., Stiles, C., Smith, A. K., et al. (2026). A flipped classroom curriculum for psychiatry consultation-liaison services in a high-volume safety-net hospital. Academic Psychiatry. https://doi.org/10.1007/s40596-026-02417-6

10. Cassidy, K. L. (2004). The adult learner rediscovered: Psychiatry residents' push for cognitive-behavioral therapy training and a learner-driven model of educational change. Academic Psychiatry, 28(3), 215–220. https://doi.org/10.1176/appi.ap.28.3.215

11. Cabaniss, D. L., Cherry, S., Douglas, C. J., et al. (2016). Psychodynamic psychotherapy: A clinical manual (2nd ed.). Wiley-Blackwell.



Title

We’re All in this Together: A Collaborative Internal Medicine-Psychiatry Ambulatory Curriculum for Internal Medicine Residents

Primary Category

Curriculum

Presenters

Winston Li, BA, MD, University of North Carolina Hospitals, Tommy Baumel, MD, University of North Carolina Hospitals

Education Objectives

1. Collaborate with interprofessional colleagues for behavioral health interventions
2. Construct curriculum for Internal Medicine resident didactic education
3. Manage suicidal ideation in the primary care setting
4. Assessment of comfort and content knowledge with regard to ambulatory, primary care of depressive disorders
5. Analyze and iteratively apply lessons-learned to additional behaviors health curricula

Practice Gap

Major depressive disorder is a leading cause of disability worldwide and frequently presents in primary care settings. Despite its prevalence, non-psychiatric clinicians often report discomfort with its evaluation, initiating or adjusting psychiatric medications, and assessing for suicidal ideation (SI) contributing to underdiagnosis and undertreatment. Existing guidance on depression management is often not optimized for primary care clinics. Interdisciplinary collaboration can combine psychiatric expertise with the realities of internal medicine (IM) primary care clinic. Here, we present a targeted interdisciplinary educational intervention aimed at increasing the comfort and understanding of the evaluation and management of depression among IM residents in the ambulatory clinic setting.

Methods

We discerned a qualitative needs assessment with internal medicine outpatient stakeholders across resident, attending, and social worker leadership. Specific assessments included a) what are the current resources IM primary care clinics currently utilize, b) comfort level with first-line antidepressants and common augments, c) specific areas of discomfort in depression



management, d) how their workflow differs compared to a psychiatric outpatient practice and e) understanding of program-specific psychiatric referral resources.

Utilizing the data from the qualitative needs assessment, we co-created a training that opened with a PowerPoint presentation delivered by an upper-level internal medicine or psychiatry resident that taught diagnosis and holistic management of depression. [MOU2.1]This educational intervention was delivered during dedicated ambulatory didactics for 18 categorical interns at an academic internal medicine program, with each intern attending a one hour and fifteen-minute session. Next, interns learned about management of suicidal ideation (SI) in internal medicine clinic and clinic-specific algorithms for patients who screened positive. Participants were provided a two-page medication reference document.

To assess the efficacy of the educational intervention, interns completed a pre- and post-survey composed of: 1) Ten questions on content knowledge on evaluating and managing depression and SI and 2) A six-question Likert scale survey measuring comfort with discussing medication options, discussing side effects, using referrals to adjunctive supportive programs, treating refractory depression, managing SI, and using clinic resources for active SI. A two-sample t-Test was performed to assess efficacy.

Results

Surveys showed an improvement in average content knowledge in the pre vs post surveys (7.28 vs 9.28, $p<0.01$). Additionally, participants reported improved comfort with discussing medication options (3 vs 3.44, $p=0.01$), medication side effects (2.56 vs 3.22, $p=0.01$, using referrals to adjunctive supportive programs (2.11 vs 3.17, $p<0.001$), managing SI (2.11 vs 2.78, $p=0.01$, and using clinic resources for SI management (1.72 vs 2.61, $p<0.001$)

Conclusions

This curriculum incorporated expertise from psychiatry, IM, and LCSW colleagues to enhance teaching regarding depression and SI. The intervention led to improved content knowledge and increased comfort in providing patient care.

This project demonstrates the feasibility of a psychiatry-IM collaborated curriculum integrated into IM primary care practice. Moreover, such interdisciplinary collaboration to address our colleagues' needs can also serve as an educational tool for residents involved, deepening their understanding of depression management, healthcare systems, and interdisciplinary professionalism.

The tools developed here can be viewed as a starting point from which other gaps in care can be filled—whether other gaps in behavioral health concerns such as anxiety, or gaps in other colleagues such as family medicine or pediatrics. Currently, this blueprint is being utilized to

construct a collaborative curriculum for the evaluation and treatment of anxiety disorders in IM primary care clinic.

Scientific Citations

1. Pincus HA, Tanielian TL, Marcus SC, et al. Prescribing trends in psychotropic medications: primary care, psychiatry, and other medical specialties. JAMA. 1998;279(7):526–531.

2. Sinyor M, Schaffer A, Levitt A. The sequenced treatment alternatives to relieve depression (STAR*D) trial: a review. Can J Psychiatry 2010; 55: 126–135.

3. Mitchell AJ, Vaze A, Rao S. Clinical diagnosis of depression in primary care: a meta-analysis. Lancet 2009; 374: 609–619. DOI: 10.1016/S0140-6736(09)60879-5.

4. Stilwell K, Pelkey L, Platt T, Nguyen K, Monteith S, Pinheiro A, Achtyes ED. Survey of Primary Care Provider Comfort in Treating Psychiatric Patients in 2 Community Clinics: A Pilot Study. Prim Care Companion CNS Disord. 2022 Feb 3;24(1):21m03020. doi: 10.4088/PCC.21m03020. PMID: 35114740.

5. American psychiatric association workgroup on major depressive disorder. Practice guideline for the treatment of patients with major depressive disorder, 3rd ed. Arlington, VA: American Psychiatric Association, 2010. 5) Depression in adults: the treatment and management of depression in adults NICE guidelines [CG90]. https://www.nice.org.uk/guidance/cg90/ (2009, accessed 18 February 2016).



Title

What Pediatric Medical Issues Do Child Psychiatrists Wish They Were Better Equipped to Address? A Qualitative Needs Assessment to Inform Psychiatric Education

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, Celeste Weise, BA, Case Western Reserve University/University Hospitals of Cleveland Program, Larry Brown, MD, Brown University Program/Butler and Rhode Island Hospitals, Molly McVoy, MD, Case Western Reserve University/University Hospitals of Cleveland Program

Education Objectives

1. Identify pediatric medical topics that practicing child and adolescent psychiatrists perceive a need for greater preparation to address in outpatient practice.

2. Describe how pediatric medical knowledge may support psychiatric assessment, safe psychotropic prescribing and monitoring, and management of common medical concerns encountered in psychiatric practice.

3. Consider how clinicians' perceived needs and the functions medical knowledge serves in psychiatric practice can guide prioritization of pediatric medical content in psychiatry residency and CAP fellowship curricula.

Practice Gap

Mental and physical health conditions frequently co-occur in childhood, and youth with mental health symptoms often experience unmet preventive healthcare needs. Physical health diagnoses may be missed or delayed in psychiatric populations, and medical conditions can contribute to behavioral presentations in psychiatric practice. Pediatric medical knowledge is an established competency within child and adolescent psychiatry (CAP), and recent work has identified opportunities to reinforce primary care knowledge in psychiatric residency. However, little is known about whether and where practicing child psychiatrists perceive a need for greater preparation to address pediatric medical issues in psychiatric practice. Identifying these needs may help residency and fellowship programs prioritize clinically relevant medical content within this broad competency domain.



Methods

Semi-structured interviews were conducted as part of a broader mixed-methods study examining child/adolescent psychiatrists' perspectives on addressing patient health needs beyond traditional psychiatric care, with particular attention to sexual and reproductive health. Outpatient CAP clinicians (physicians and advanced practice providers) were recruited through professional networks and listservs, public outreach, ResearchMatch, and participant referrals; eligibility was confirmed by self-report of current licensure and outpatient CAP practice. Interviews began by asking participants whether there were particular issues beyond core psychiatric training that they wished child and adolescent psychiatrists were better equipped to address in practice. Two researchers independently coded interview transcripts using iterative qualitative content analysis to identify pediatric medical topics and recurring functions these topics served in psychiatric practice.

Results

Preliminary analysis included nine outpatient child and adolescent psychiatrists practicing across five U.S. states, and based in academic (n=5), public mental health (n=2), health system/hospital-owned (n=1), and private practice (n=1) settings. Five (56%) identified as female, and seven (78%) identified as non-Hispanic White. Three had ≤5 years in practice, five had 11-20 years, and one had ≥21 years. Participants identified a broad range of pediatric medical topics they wished psychiatrists were better equipped to address. Sexual and reproductive health, obesity/metabolic health, laboratory interpretation, and nutrition were each identified by three participants; menstrual health, neurologic issues, sleep problems, and parent guidance were each identified by two. Despite this topical diversity, participants described pediatric medical knowledge as relevant to psychiatric practice through three recurring functions: (1) informing psychiatric assessment; (2) supporting safe psychotropic prescribing and monitoring; and (3) addressing common medical concerns encountered in psychiatric practice. Examples related to psychiatric assessment included menstrual, nutritional, and neurologic contributors. Psychotropic treatment considerations included metabolic effects, laboratory abnormalities, and reproductive risks. Common medical concerns included sexually transmitted infection screening, supplement questions, and headache management. Individual topics sometimes supported more than one function; for example, nutrition was relevant both to psychiatric assessment and to monitoring medication-associated effects. Participants described potential benefits including improved diagnostic assessment, safer psychotropic management, responsiveness to patient and family concerns, and identification of additional opportunities for intervention.

Conclusions

Practicing child/adolescent psychiatrists identified pediatric medical knowledge and skills that they perceived as relevant to psychiatric assessment, treatment, and longitudinal care. Rather than suggesting broad expansion of psychiatrists' medical scope, findings may help educators identify targeted content that supports core psychiatric functions. Organizing medical education around its application to psychiatric practice—not simply around individual pediatric diagnoses—may offer a useful framework for prioritizing curricular content and contextualizing it within the psychiatric functions that knowledge is intended to support. These practice-informed findings may inform targeted educational approaches in CAP fellowship and, where relevant, general psychiatry residency.

Scientific Citations

1. American Board of Psychiatry and Neurology. Child and Adolescent Psychiatry Core Competencies Outline. Accessed September 7, 2026.

2. Arrondo G; Solmi M; Dragioti E; Eudave L; Ruiz-Goikoetxea M; Ciaurriz-Larraz AM, et al. Associations between mental and physical conditions in children and adolescents: An umbrella review. Neuroscience & Biobehavioral Reviews. 2022;137:104662.

3. Bui AL; Ball AM; Ko LK; Ng M; Rivara FP; Coker TR. Foregone Preventive Care and Unmet Mental Healthcare Needs Among U.S. Youth. American Journal of Preventive Medicine. 2025;69(2):107644.

4. Liberati E; Kelly S; Price A; Richards N; Gibson J; Olsson A, et al. Diagnostic inequalities relating to physical healthcare among people with mental health conditions: a systematic review. eClinicalMedicine. 2025;80.

5. Lichtor SA; Berk R; Gimler K; Siegel M. Communicating Constipation: Differential Diagnosis of Agitation in Autism at a Pediatric Hospital. Pediatrics. 2026;157(5).

6. Meadows AL; Brahmbhatt K; Shaw RJ; Lee J; Malas N; Fuchs DC, et al. Training Needs Assessment Survey in Pediatric Consultation-Liaison Psychiatry. Academic Psychiatry. 2022;46(1):60-4.

7. Nathani Z; Murphy K; Jordan L; Kahl E. Closing the Gap: A Primary Care Refresher for Psychiatry Residents. Academic Psychiatry. 2026.

Title

Who Checks the Machine? A Six-Dimension Expert-Panel Framework for Evaluating AI-Assisted Resident Study Resources

Primary Category

Research and Scholarship

Presenters

Samuel Martin, MD, Oklahoma State University Center for Health Sciences Program, Erik Odom, DO, Oklahoma State University Center for Health Sciences Program

Education Objectives

Participants will be able to: (1) apply a structured six-dimension expert-panel framework to evaluate any question bank their program recommends, assigns, or funds, including banks whose items were produced with artificial intelligence; (2) describe what a defensible evaluation requires: an explicit sampling frame, probability sampling against a published test blueprint, a rating instrument fixed before item selection, and separation of the parties who sample, deploy, and analyze; (3) situate resource selection within a program's program-evaluation and resource-stewardship responsibilities; and (4) state realistic expectations for expert-panel recruitment, per-rater burden, and completion, leaving with a one-page instrument to adapt for local use.

Practice Gap

Residents rely heavily on commercial question banks for PRITE and board preparation, and program directors are routinely asked to recommend, assign, or fund them. No commercially available psychiatry preparation product has published independent content validity evidence; vendors describe internal review, but it is unpublished and conducted by reviewers the vendor compensates. Artificial intelligence has made item production fast and inexpensive. A 2026 systematic review of 71 studies found expert review is the dominant validation approach for machine-generated items, with reported error rates from under 1% to 45%. The question for educators is not whether machines can produce plausible items but who is accountable for what reaches a learner. Program directors have no published method for making that judgment themselves.

Methods

A stratified random sample of 65 items was drawn from a deployed 3,970-item PRITE-aligned question bank produced with large language model assistance inside a physician-designed quality-control pipeline. Items not ratable as standalone units were excluded, leaving 3,581



eligible. Domain quotas were set a priori in proportion to the 2024-2025 PRITE content outline and met exactly; the random seed was generated at runtime and withheld from the developer. Twelve board-certified academic psychiatrists, including out-of-region candidates, were invited; six agreed. Panelists rated each item on six dimensions (Relevance, Accuracy, Clarity, Distractor Quality, PRITE Fit, Cognitive Level) on a four-point scale, with Relevance pre-specified as primary and retention requiring unanimous endorsement. Sampling, instrument population, survey administration, and analysis were performed by different independent parties under an institutional conflict-of-interest management plan, with a data firewall preventing the developer from accessing sampled items or individual ratings.

Results

Three panelists completed the full protocol, yielding 1,170 dimension-level ratings. Experts agreed items were factually correct and disagreed about whether they made residents think. Accuracy ratings qualified 98.5% of the time. Cognitive Level, whether an item demands applied clinical reasoning rather than recall, was rated non-unanimously for 13 of 65 items, the weakest agreement of the six dimensions. A single global quality rating would have shown a high score and concealed the difference. Relevance I-CVI was 1.00 for 63 of 65 items; S-CVI/Ave was 0.99 and S-CVI/UA 0.97. Modified kappa was excellent for 359 of 390 item-by-dimension evaluations. Of 195 judgments on whether an item's topic appears on the PRITE, 185 were affirmative and none negative. Recruitment was itself instructive: completers finished in a single session of 69 to 170 minutes, under the advertised burden, and all rating activity fell in the final nine days of a three-week window. One decline was structural: a director of the certifying board reported being unable to participate in board preparation activities in any capacity.

Conclusions

A six-dimension framework separates a bank's factual soundness, near ceiling here, from its cognitive demand, which experts disputed: the distinction a program director needs when deciding what to assign, and one a single global rating obscures. Machine-produced content is not uniformly good or bad; the useful question is which of its properties can be verified and by whom. The framework is replicable, applicable to any question bank, and gives program directors a concrete instrument for local judgment and standing to ask vendors for comparable evidence. Content validity does not establish that a resource improves examination performance, which a planned prospective study will address.

This content was produced by a trainee with a faculty mentor/AADPRT member. Disclosure: the lead author holds a 50% equity interest in the entity that developed the question bank evaluated. The study ran under a conflict-of-interest management plan accepted by the institutional COI committee requiring independent oversight, independent statistical analysis,

and a data firewall; the institutional review board determined the project is not human subjects research.

Scientific Citations

1. Kiyak YS, Kaya AB, Emekli E. Validity of AI-generated multiple-choice questions in medical education: a systematic review. Postgrad Med J. 2026. doi: 10.1093/postmj/qgag057

2. Riehm L, Nanji K, Lakhani M, Pankiv E, Hasanee D, Pfeifer W. The use of large language models in generating multiple choice questions for health professions education: a systematic review and network meta-analysis. PLoS One. 2026; 21 (1): e0340277.

3. Alani NHS, Amaranathan J, Dandoush A, Rye S, King PT, Chin MH. Can large language models generate exam questions comparable to humans? A systematic review and meta-analysis study in medical education. Med Teach. 2026. doi: 10.1080/0142159X.2026.2691072

4. Emekli E, Emekli E, Özel B. Artificial intelligence-assisted generation of case scenarios and multiple-choice questions in psychiatry: a pilot study. Acad Psychiatry. 2026; 50 (4): 391-397.

5. Zahn A, Overla S, Lowrie DJ, et al. An artificial intelligence-driven platform for practice question generation. Acad Med. 2026; 101 (3): 279-283.

6. Green I, Weaver A, Kircher S, et al. Impact of question bank use for in-training examination preparation by OBGYN residents: a multicenter study. J Surg Educ. 2022; 79 (3): 775-782.