GRASP: Graduate Education & Resource Alignment for Social/Moral Determinants & Patient-Centered Care

Gautam Dagur, MD, PhD; Colin M. Mackay, MD; Jesse E. Doyle, MD; Jacob K. Weinzapfel, MD; Robert D. Ficalora, MD

BACKGROUND

- Only 10–20% of health outcomes stem from medical care; most reflect social, behavioral, and environmental factors
- Despite this, institutions lack structured approaches to identify and address S/MDoH during care transitions

OBJECTIVE/AIMS

Strengthen the ASVE Post-Discharge Clinic (PDC), a hospital-to-outpatient transitional care clinic, while reinforcing education on identifying and addressing S/MDoH factors affecting follow-up and attendance

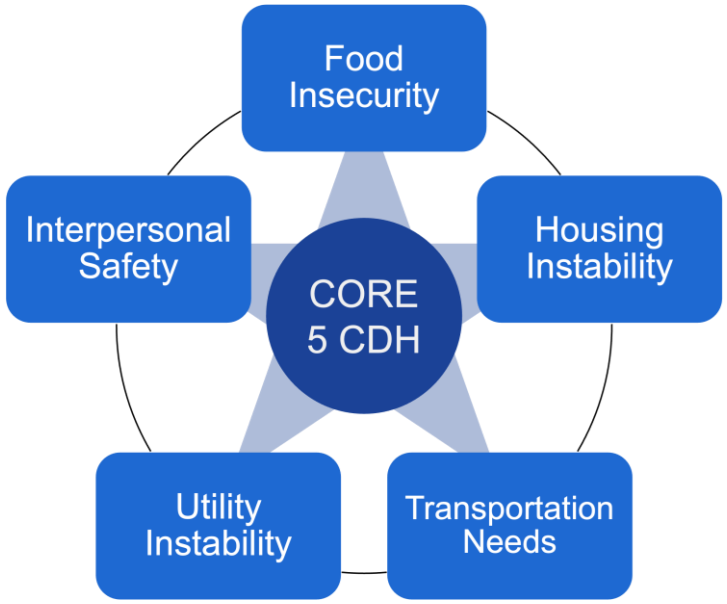
- AIM # 1: Identify disparities using Core-5 SDoH Questionnaire
- AIM # 2: Develop an interprofessional curriculum covering S/MDoH and care transitions
- AIM # 3: Evaluate patient, learner, & system-level outcomes

METHODS

- **Mixed-methods study design:**
  - Cross-sectional survey
  - Retrospective/prospective observational study
  - Hybrid type 2 effectiveness-implementation
- **Data Sources**: EHR data; ADI/Livability Index
- **Statistical Planning**: Descriptive and Inferential analyses +/- Predictive analysis (if relevant)

MEASURES

Patient Outcomes	Educational Outcomes	System Outcomes
Attendance Rate	Knowledge of S/MDoH	30-Day Readmission
Lost-to-Follow Up Rate	Confidence Addressing Barriers	ED Visits
Resources Utilization	Engagement in Care Transitions	Mortality

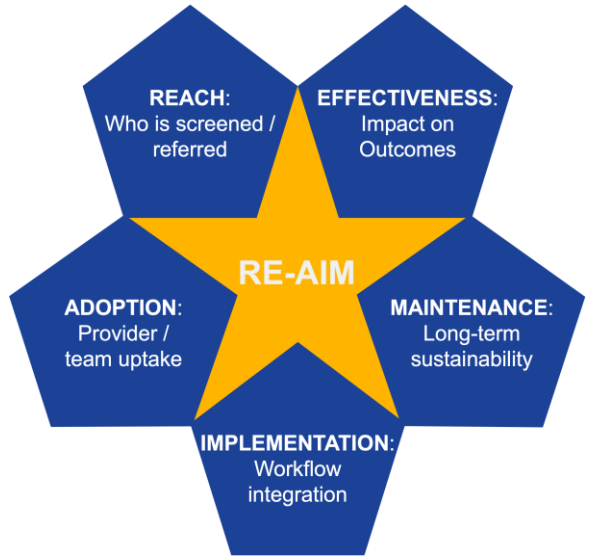


PRELIMINARY RESULTS

- **Baseline Measures –** Outpatient REDCap: N = 4,947
- 39% Lost-to-follow up rate
- 50% Attendance rate
- Inpatient Hospital Admission: (N = ~7,000)

DISCUSSION

- **IRB in review** RIN20260002: GRASP Study
- **Next Steps**
  - Cross-match outpatient and inpatient records
  - Feature engineering, statistical analysis, & dissemination of findings
  - RE-AIM framework guiding implementation
- **Potential Challenges (let's talk!)**



Simulation-based Neonatal and Pediatric Resuscitation Training for Emergency Medicine Residents at SLUHN

Colin Donnelly DO, Genevieve Schmitt MD, Kayla Wilson MD, Parampreet Kaur MD, Andrew Townsend MD

Introduction: Background & Context

A relative lack of exposure to neonatal and pediatric resuscitations leads to decreased preparedness among EM residents potentially compromising patient safety. This project seeks to enhance EM residents' confidence and competence in these high acuity low occurrence (HALO) scenarios through the implementation of a structured simulation curriculum.

Aim/Objectives/Alignment

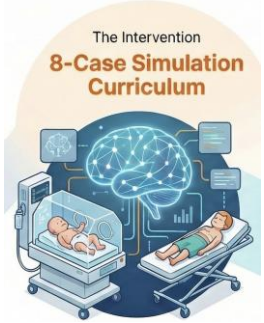
- To evaluate the impact of simulation on residents' knowledge, clinical decision-making, and procedural skills in neonatal and pediatric resuscitations
- To assess changes in residents' self-reported confidence in leading neonatal and pediatric resuscitations
- Identify areas for curriculum improvement based on performance metrics and participation feedback

Project Alignment with Organization

St. Luke's Graduate Medical Education emphasizes the value in consistent improvement of medical education for residents. This study is helping to point out the need for increased familiarity and comfort in neonatal and pediatric resuscitation. These simulations have potential to carry out this objective.

Interventions/Changes

- Simulation curriculum consisting of 4 neonatal and 4 pediatric resuscitation cases, each followed by debriefing sessions to ensure learning obtained from each simulation



Measures

- Pre and post-simulation surveys inquiring self-reflection of comfort level as well as knowledge-based questions to assess the effectiveness of their learning
- Measure confidence using likert scale questions

Results: Preliminary

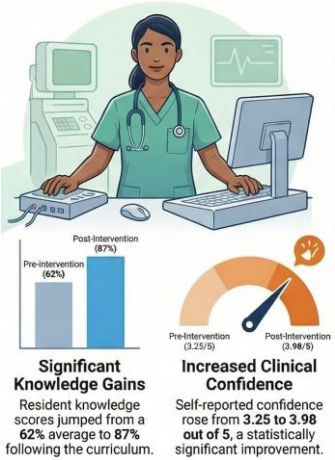
Completed 2 out of 4 simulations so far

Sample:

58% PGY-2 EM residents

42% PGY-3 EM residents

Pending data for PGY-1



Discussion

Preliminary results indicate that simulation in neonatal and pediatric resuscitation are beneficial in improving an EM resident physician's confidence and knowledge of this subject.

Add-ons: skills assessment during the simulations using a critical actions checklist

Barriers & challenges: tracking individual subject's progress, ensuring dedicated time for residents to complete simulations and surveys.

Standardizing Push Dose Epinephrine Administration Across a Multihospital Health Network

Michael Irick, MD | Jennifer Irick, MD | Michael Ghodsi, MD | Christopher Defeo, MD
Parampreet Kaur, MD| Jaskiran Dulai, MBBS | Riley Moran, DO| John Wilson, MD | J.P. Orlando, Ed.D

Introduction: Background & Context

Push dose epinephrine is the administration of small, rapidly delivered boluses of dilute epinephrine to provide immediate, short-acting hemodynamic support. This can be a vital temporizing intervention in critically ill patients with acute hemodynamic instability while more definitive therapies are prepared.

Our hospital system lacked a standardized ordering and preparation process for push dose epinephrine. The medication is compounded at the bedside by clinicians who have variable practice patterns and differing levels of confidence regarding its preparation. This lack of standardization along with its often-infrequent use as well as the high intensity circumstances during which it is often employed create the potential for medical errors.

Aim/Objectives/Alignment

- Standardize push dose epinephrine administration throughout our network of hospitals through specific EMR order sets and kits to streamline the process
- Greater consistency and error reduction with push dose epinephrine administration as well as improved clinician confidence regarding its use along with pre- and post-intervention surveys to quantify this improvement
- Ultimately guide future medication safety initiatives across the health system

Project Alignment with Organization

- Advances organizational priorities of patient safety and standardized care delivery by reducing variability in high-risk medication administration across our hospital network
- Enhances the clinical learning environment by improving clinician confidence while reducing cognitive load during high-acuity emergencies

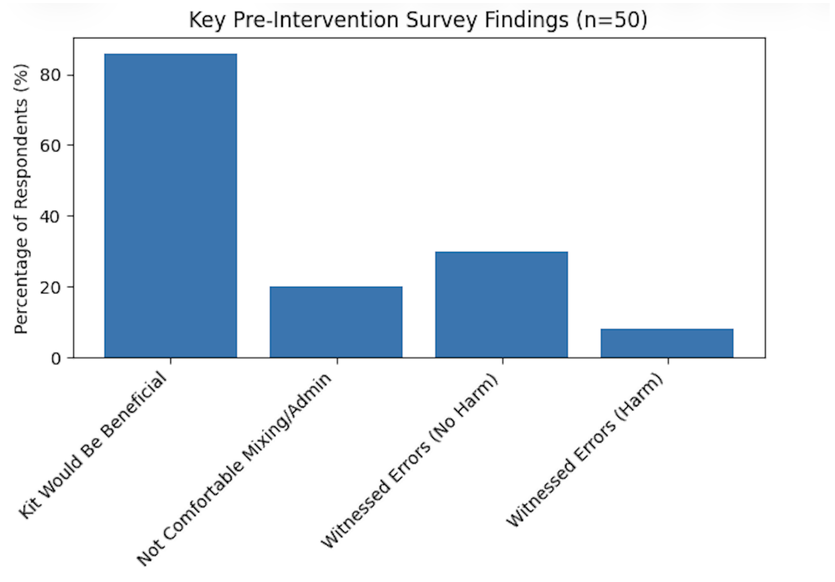
• Interventions/Changes

- Created a standardized push dose epinephrine order set in our EMR which was approved by pharmacy and is currently active
- IRB approval granted
- Obtained baseline assessment of clinician confidence, practice patterns, barriers to use, and witnessed harms of push dose epinephrine use through pre-intervention survey completed by clinicians throughout our hospital network
- Ongoing surveillance of EMR for instances of push dose epinephrine use
- Working on approval from pharmacy for standardized kits to further streamline preparation
- Plan for post-intervention survey following kit deployment and widespread adoption
- Plan for analysis of pre- and post-intervention survey results along with EMR data to quantify change in clinician confidence, frequency of use, and perceived error reduction

Measures

- Primary measures include change in clinician-reported confidence, practice patterns, frequency of use, and perceived medication errors assessed via baseline and follow up surveys
- Process measures to include EMR-derived metrics evaluating utilization of the standardized order set and frequency of push dose epinephrine administration
- Comparative analysis of pre- and post-intervention survey results alongside EMR utilization metrics will demonstrate improvements in clinician confidence and practice standardization directly, while also serving as proxy indicators of error reduction and enhanced patient safety

Results: Preliminary



Discussion

- Critical next steps
  - Presentation of pre-intervention survey findings and EMR utilization data to network pharmacy committee to obtain approval for standardized push dose epinephrine kits
  - Finalizing kit design and deployment plan pending pharmacy approval
  - Implementing post intervention survey and EMR monitoring following full rollout
  - Analysis of pre- and post-intervention survey data to evaluate

NI X Meeting Two: April 17-18, 2026

Resident Clinic Continuity at JFK Family Medicine Center

Haneen Hussein DO, Adity Bhattacharyya MD, Rosa Mendoza MD, Deborah Metz MD, John Metz MD
Hackensack Meridian Health JFK University Medical Center, Edison, New Jersey
AIAMC NI X Meeting II- Carlsbad, California April 17-18 2026

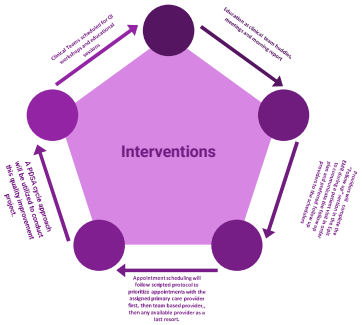
Introduction: Background & Context

Through participation in AIAMC's National Initiative X, our residency program hopes to:

1. provide our clinical care teams with education on quality improvement (QI)
2. familiarize clinical teams with the need to increase resident and patient sided continuity and
3. to engage all team members of the JFK Family Medicine Center in a quality improvement project to increase resident continuity of care while fostering collaborative, interdisciplinary efforts.

Our long term goals are to ensure our quality improvement processes are systematic and sustainable. We seek to enhance the QI knowledge and skills of the core team participating in this initiative, training them to continue to lead similar clinical team-based efforts in the future.

Interventions/Changes



Results: Preliminary

Table 1: Percent of PGY2 and PGY3 Family Medicine Residents meeting ACGME provider centered continuity requirements

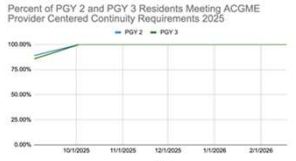


Table 2: Percent of PGY2 and PGY3 Family Medicine Residents meeting ACGME patient centered continuity requirements

Aim/Objectives/Alignment

Provide the four JFK Family Medicine Center clinical teams (composed of staff, medical assistants, nurses, nurse practitioners, faculty and residents) with longitudinal Quality Improvement education.

Familiarize and educate the clinical teams regarding our residency program's gap and priority in the improvement of continuity of care.

Engage the JFK Family Medicine Center clinical teams in a quality improvement project whose aim is: **All PGY 2 and PGY 3 residents will meet the resident and patient sided continuity ACGME requirements during the during the 2025-2026 academic year**

Measures

Resident and patient sided continuity rates will be calculated for the 2024-2025 academic year by mid July 2025 (complete)

Assess quality improvement knowledge before and after each quality improvement educational workshops (ongoing)

Resident sided and patient sided continuity rates for PGY2 and PGY3 residents will be tracked monthly during the 2025-2026 academic year (monthly, ongoing)

Discussion

Challenges

We have seen a significant improvement in continuity percentages and are now meeting ACGME criteria for all residents for both patient and provider centered continuity, for the past 2 months.

A challenge will be to continue this momentum and continue to encourage residents, faculty, MAs, nursing and front desk staff to focus on the importance of continuity.

What's Next?

-Next Educational QI session is scheduled for 4/23/26
- Continue to ensure that residents and faculty are utilizing the EPIC follow up section
- Continue to track continuity percentages monthly
- Follow up with IRB approval
- Check in with clinic administration on progress to transition to clinic fixed schedule

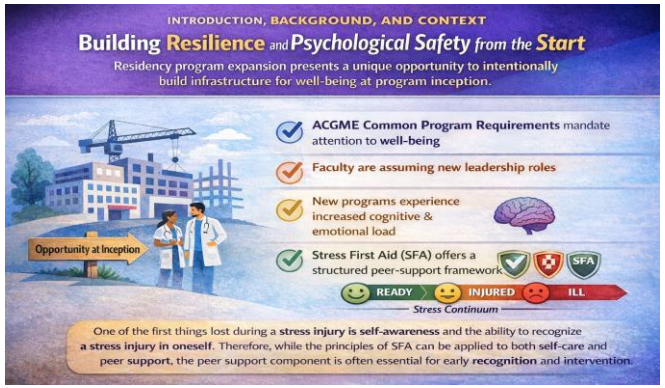
Building Resilience Infrastructure During Residency Program Formation: A Stress First Aid Train-the-Trainer Model Across Emerging GME Programs

Eric Anderson, EdD. Lauren Penwell-Waines, PhD. Elari Guy, M.Ed. Eric Steelman, DHsc

NOVANT HEALTH
Graduate Medical Education
Charlotte Region

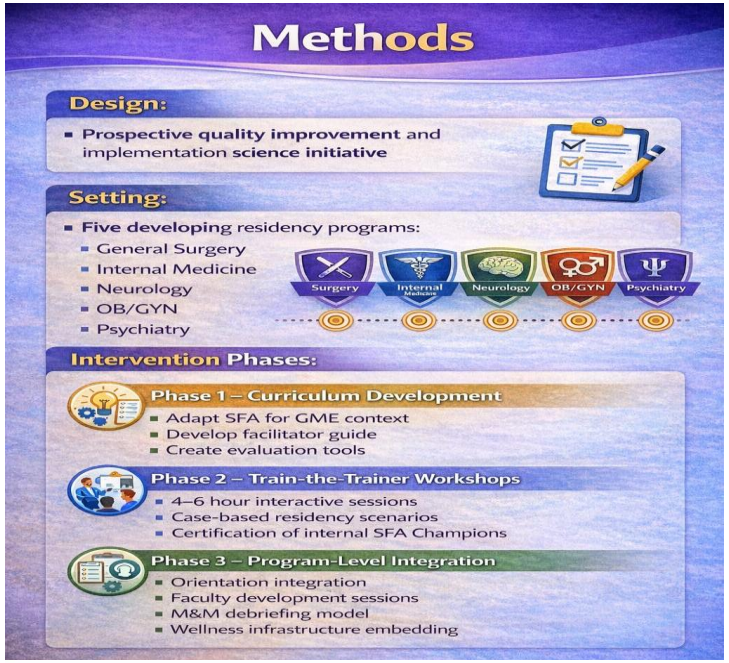
AiAMC Alliance of Independent Academic Medical Centers
National Initiative

Introduction: Background & Context



Aim/Objectives/Alignment

Interventions/Changes



Measures

Pre-Training Assessment

Perceived Stress Scale (PSS-10)
Cohen, Kamarck & Mermelstein, 1983

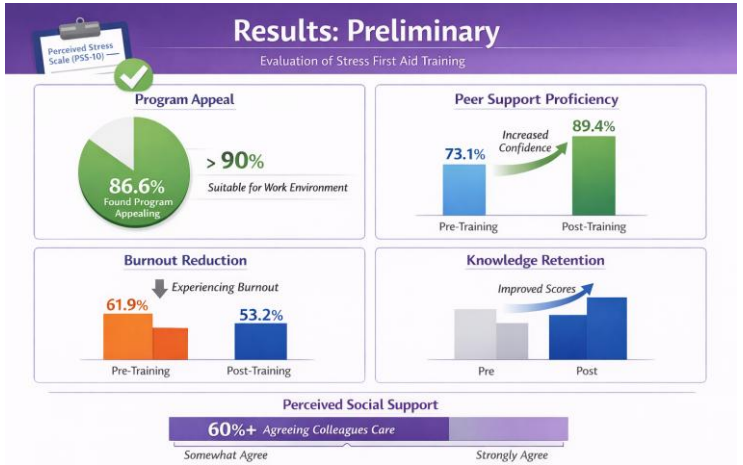
Self-Reported Measure of Perceived Stress
novopsych.com/wp-content/uploads/2023/02/pss-10.pdf

Post-Training Questionnaire

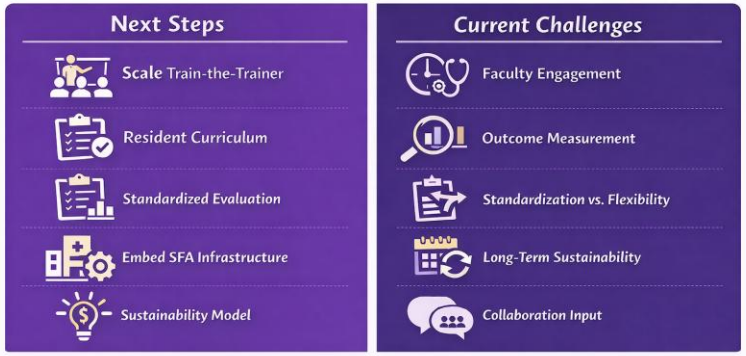
- **Self-Efficacy & Confidence**
  - Ability to handle challenging situations.
- **Skill Application**
  - Frequency of SFA actions used.
- **Support & Comfort**
  - Creating a safe environment for peers.
- **Self-Care Monitoring**
  - Peer supporter's own well-being.

All SFA participants will complete a post-session evaluation assessing the effectiveness of the training.

Results: Preliminary



Discussion



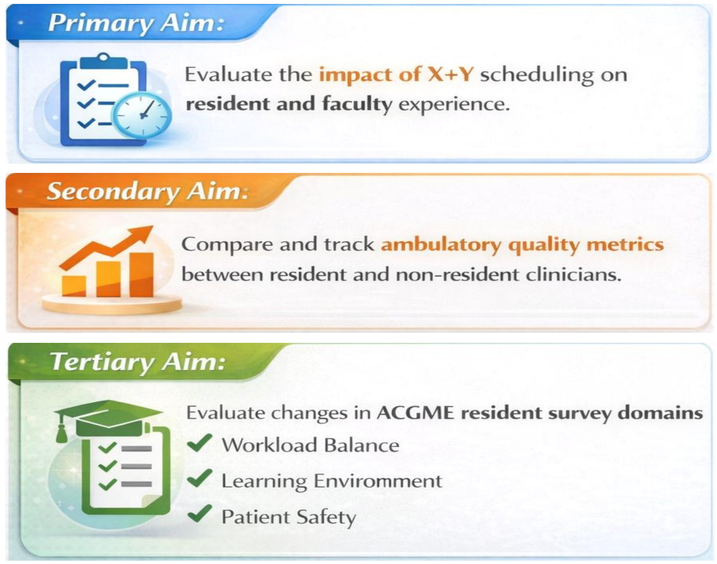
X+Y Scheduling: Assessing Changes in Residents' Experience, Delivery and Quality of Ambulatory Care

Akshay Raut MD, Sophie Roe MPH, and Victor O. Kolade MD

Introduction: Background & Context

- Resident physicians deliver a large share of ambulatory care, making clinic structure critical to care quality and trainee experience.
- Traditional scheduling can fragment clinic exposure, increasing workflow inefficiencies and administrative burden; X+Y models aim to address these gaps.
- This study evaluates the impact of X+Y scheduling on resident experience, ambulatory care delivery, and quality outcomes in a rural academic Internal Medicine program.

Aim/Purpose/Objectives

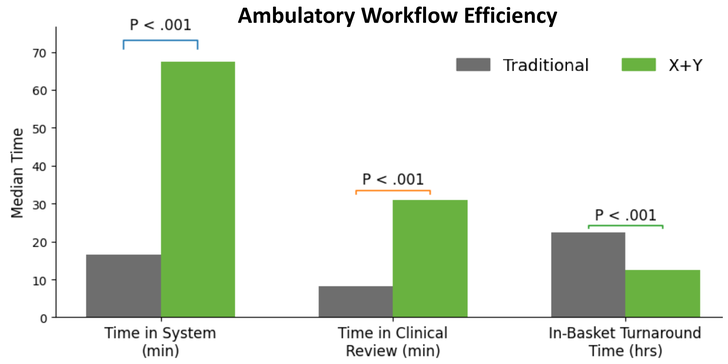


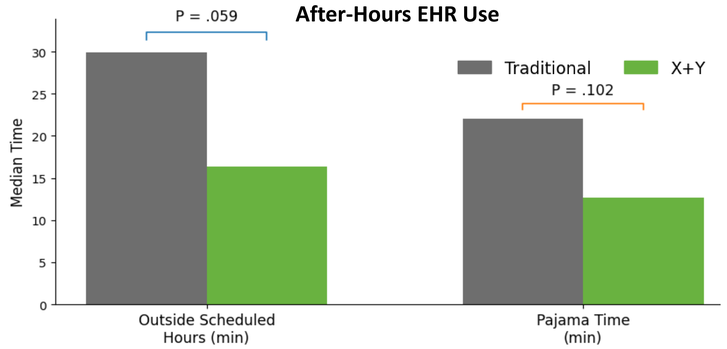
Project Alignment with Organization

- Aligns with organization's priorities for **high-quality, efficient ambulatory care** by evaluating preventive care metrics under X+Y scheduling.
- Supports **provider well-being and workforce sustainability** by assessing resident workload, after-hours EHR use, and clinic efficiency.
- Advances **data-driven quality improvement** using Epic Signal® and population health metrics to inform system-level decisions.
- Demonstrates the residency program's role as a **driver of clinical quality and operational value**, not solely a training program and highlights residents as **contributors to organizational performance and patient outcomes**, reinforcing the long-term value of Graduate Medical Education.

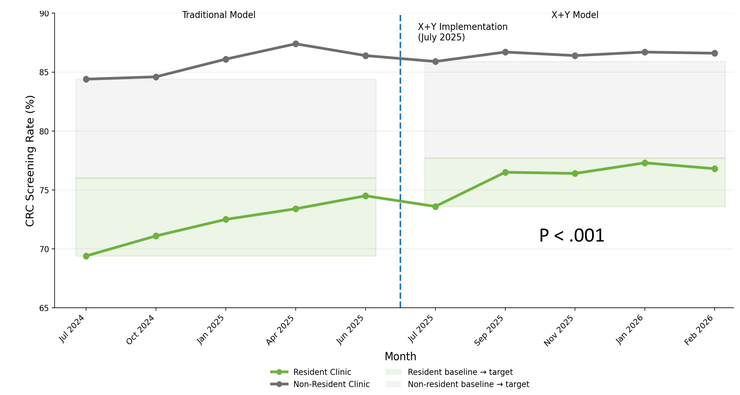
NI X Meeting Two: April 17-18, 2026

Results: Preliminary





Colorectal Cancer Screening Rate (Resident vs. Non-Resident Internal Medicine Clinic)



Changes in Median Epic Signal® Workflow Metrics and Colorectal Cancer Screening Rates for Residents following implementation of X+Y Scheduling Model

Ambulatory Workflow Metrics significantly improved with a meaningful decline in After-hours EHR use, and CRC Screening Rate significantly improved following implementation of the X+2 Model

Methods: Interventions and Measures

Primary Aim — Resident Experience

- **Intervention:** Implementation of the **X+Y scheduling model (X+2 model for our program)**, separating inpatient and ambulatory responsibilities into dedicated blocks with dedicated in-basket coverage system for residents on inpatient blocks
- **Measures: Epic Signal® metrics** evaluating after-hours EHR use, in-basket workload, ambulatory and inpatient efficiency.

Secondary Aim — Ambulatory Quality of Care

- **Intervention:** Structured ambulatory exposure during **Y-blocks (2 weeks)** to improve continuity and panel access
- **Measures:** Ambulatory quality metrics including **Healthcare Screening Metrics, panel access, continuity of care, and patient experience** and comparison of outcomes between resident and non-resident/attending clinics.

Tertiary Aim — Educational Environment

- **Intervention:** Protected ambulatory and educational time during **Y-blocks**.
- **Measures: ACGME resident survey domains** assessing workload balance, learning environment, and patient safety.

Barriers – Strategies

- **Transitional workflow disruption:** Initial restructuring of clinic schedules required adaptation by residents and faculty that was addressed through clear scheduling expectations, and iterative refinement during early implementation.
- **Administrative burden and workload fragmentation:** Competing inpatient, ambulatory, continuity disruptions and off-schedule responsibilities increased cognitive load that was addressed by protected ambulatory blocks, reduced clinic fragmentation, and standardized clinic workflows.
- **Measurement and sustainability challenges:** Difficulty capturing true impact using perception alone that was addressed by pairing resident/faculty surveys with objective EHR-based metrics to support continuous quality improvement.

Discussion

- **Current State**: Completed PDSA Cycle 1, Pending creation of schedules for the 2026-27 academic year to align with ACGME requirements to ensure continuity
- **Critical Next Steps:** Review data for the secondary and the tertiary aims
- **Areas for Guidance/Input: I**nput is needed to guide best practices for X+Y scheduling optimization, interpretation of Epic Signal® workflow metrics, and benchmarking resident ambulatory performance against national standards. Additional guidance is also sought on scalable strategies to address inpatient workload redistribution and resident well-being.

Rewiring the Workflow: Optimizing the Clinical Learning Environment through Epic® In-Basket Management in IM Resident Clinic

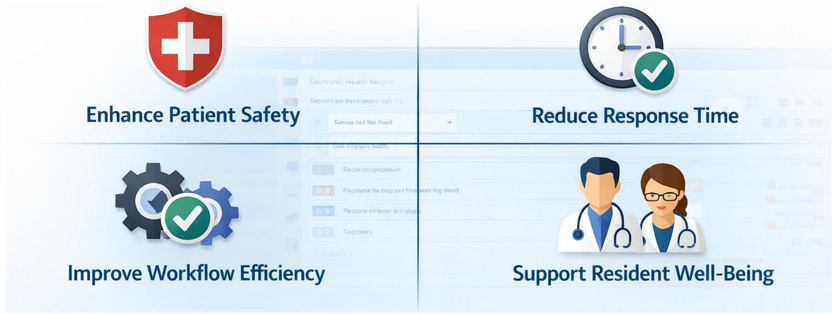
Akshay Raut MD, Sultany Abdullah MD, Vagisha Sharma MD, Solomon Anighoro MD, Adishwar Rao MD, Akriti Agrawal MD, Anubhuti Sharma MD, Rahul Anand MD, Nain Tara MD, Tehseen Hammad MD, Ayesha Asghar MD, Sriharsha Kandlakunta MD, John Pamula MD, and Victor Kolade MD

Introduction: Background & Context

- Widespread adoption of electronic health records (EHRs), including Epic®, has markedly increased the volume of in-basket messages managed by residents.
- High message volume contributes to administrative burden, delayed communication, and resident burnout.
- Resident in-baskets are frequently cluttered with addressed, low-value, or non-actionable messages, limiting visibility of urgent and unresolved items—especially during cross-coverage.
- Inefficient in-basket workflows pose risks to patient safety, delay care delivery, and negatively impact patient satisfaction.

Aim/Purpose/Objectives

- The primary aim of this initiative is to reduce time to address Epic® in-basket messages among Internal Medicine Residents through improvement in message prioritization, elimination of low-value notifications and cross-coverage efficiency.
- Secondary objectives include preventing missed or delayed urgent messages and improving resident satisfaction. Collectively, these interventions aim to enhance patient safety, communication timeliness, and overall quality of care delivery.

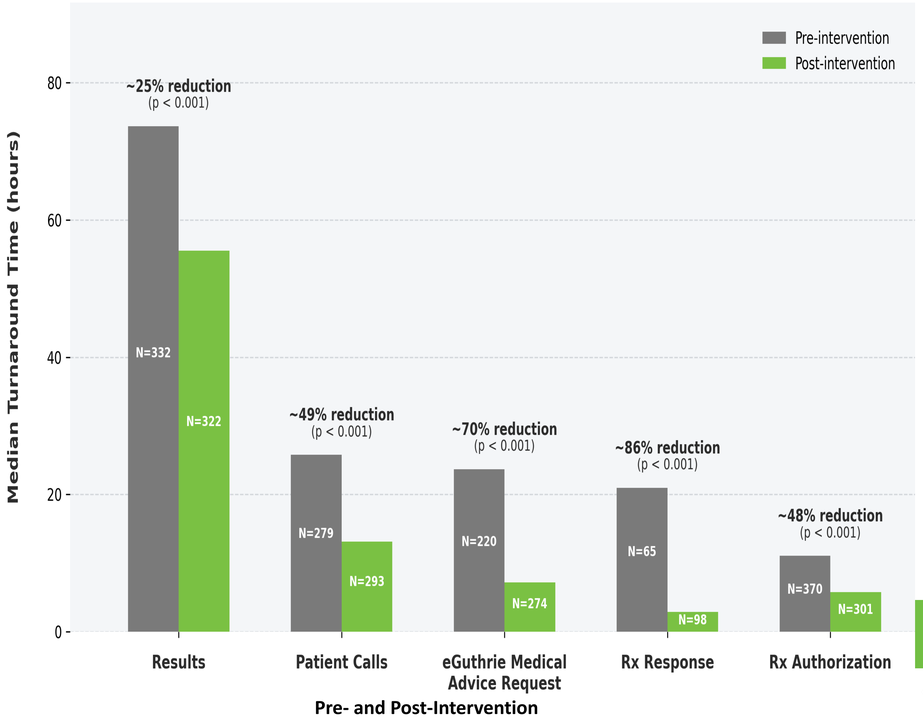


Project Alignment with Organization

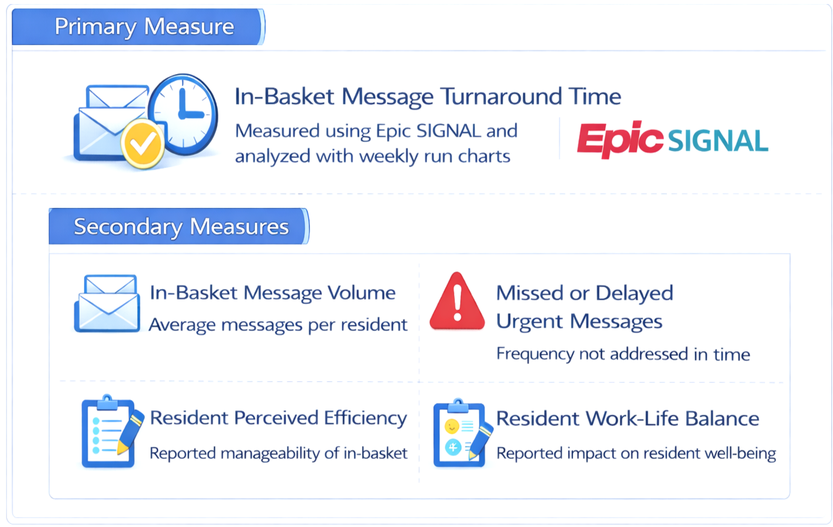
- This project directly supports the hospital's priorities of improving patient safety, care timeliness, provider well-being, and operational efficiency. By reducing delayed or missed in-basket messages, the initiative enhances communication reliability, patient satisfaction, and risk mitigation.
- The project demonstrates the residency program's value by leveraging resident-led quality improvement to address system-level inefficiencies within the EHR, translating frontline clinical insight into measurable institutional gains.
- It highlights residents as key drivers of innovation, safety, and workflow optimization that align with the hospital's strategic goals of high-quality, sustainable care delivery.

NI X Meeting Two: April 17-18, 2026

Results



Methods: Measures



Methods : Intervention

Barriers – Strategies

- Key barriers to this initiative include high baseline message volume, resistance to adopting new inbox workflows, and ambiguity around message ownership during cross-coverage.
- These challenges will be addressed by prioritizing elimination of low-value notifications, establishing clearly defined team-based roles, and providing targeted training for residents and support staff.
- Continuous monitoring with feedback loops will support sustained adoption and iterative improvement.

Discussion

- **Current State**: PDSA Cycle 1 was initiated in July 2025 and completed in February 2026. PDSA Cycle 2 from March 2026 to March 2027.
- **Critical Next Steps:** Complete PDSA Cycle 2, collect responses for the resident's well-being survey at the end of PDSA Cycle 2 and analyze the results, analyze the missed/delayed critical results identified through audits, compile results of all PGY-1 to PGY-3 residents after PDSA Cycle 2 to compare the annual data
- **Areas for Guidance/Input:** Guidance on advanced in-basket configuration, signal-to-noise reduction, benchmarking inbox metrics against peer institutions, support on safe and effective integration of AI-assisted triage and automation tools, review of message triage workflows to ensure compliance with medicolegal standards, and documentation requirements.

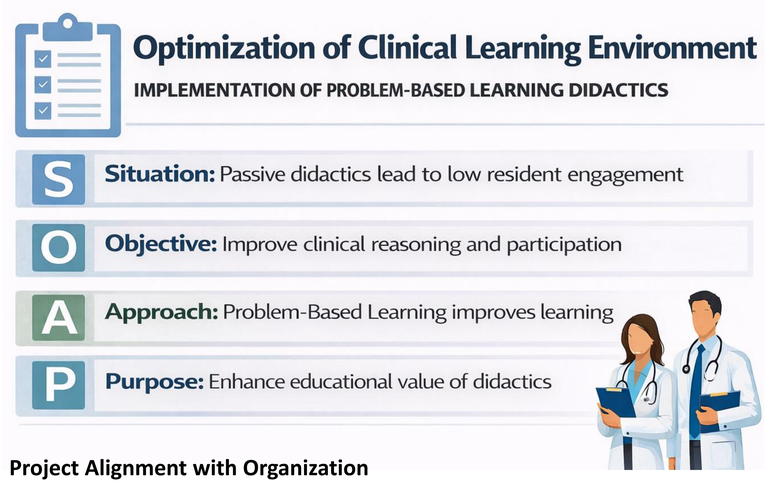
From Tradition to Transformation: Using Problem-Based Learning to Shape the Clinical Learning Environment in a Rural Academic Medical Center

Akshay Raut MD, Sultany Abdullah MD, Vagisha Sharma MD, Solomon Anighoro MD, Adishwar Rao MD, MPH, Akriti Agrawal MD, MPH, Anubhuti Sharma MD, Rahul Anand MD, Nain Tara MD, Tehseen Hammad MD, Ayesha Asghar MD, Sriharsha Kandlakunta MD, John Pamula MD, and Victor Kolade MD

Introduction: Background & Context

- Traditional lecture-based didactics and teaching rounds in Internal Medicine rely heavily on passive learning and are associated with lower engagement and limited clinical reasoning development.
- These limitations are further amplified in rural community-based academic residency programs due to constrained faculty resources and competing clinical demands.
- Problem-Based Learning (PBL) is an evidence-based, learner-centered approach that promotes active engagement and clinical reasoning but remains under-utilized in residency education curriculum.

Aim/Objectives/Alignment



Project Alignment with Organization

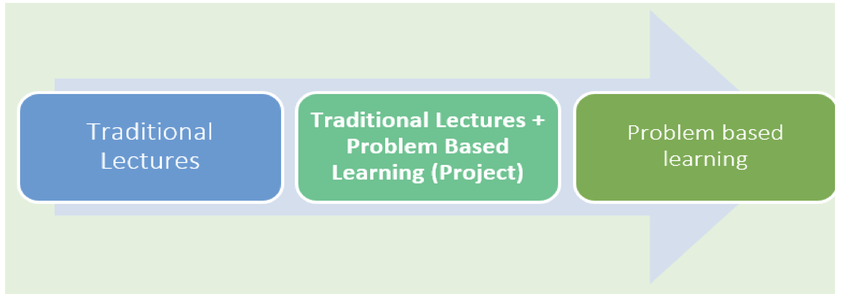
- **Advances the Organization's commitment to high-quality patient care** by strengthening resident clinical reasoning and decision-making, directly supporting patient safety and evidence-based practice.
- **Elevates the Organization's Academic Standards** by implementing a structured, evidence-based educational model that enhances the quality and consistency of inpatient teaching.
- **Demonstrates the Residency Program's value as a driver of quality improvement**, using innovative, structured educational interventions aligned with the hospital's academic mission.

Barriers and Strategies

- Key barriers included limited protected educational time, competing clinical demands, and initial resistance to moving away from traditional lectures, which was addressed with providing brief facilitator training and standardized case templates, and aligning content with residents' clinical workflows.

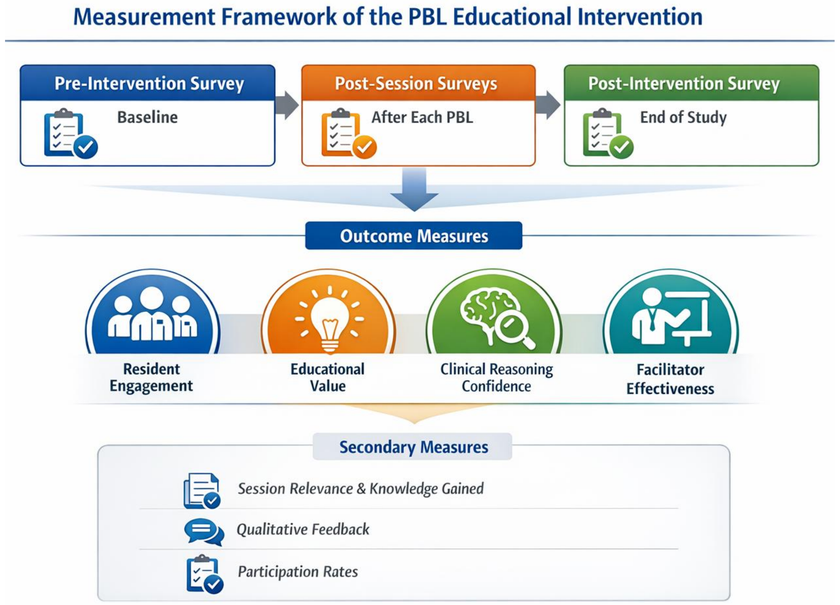
NI X Meeting Two: April 17-18, 2026

Interventions/Changes

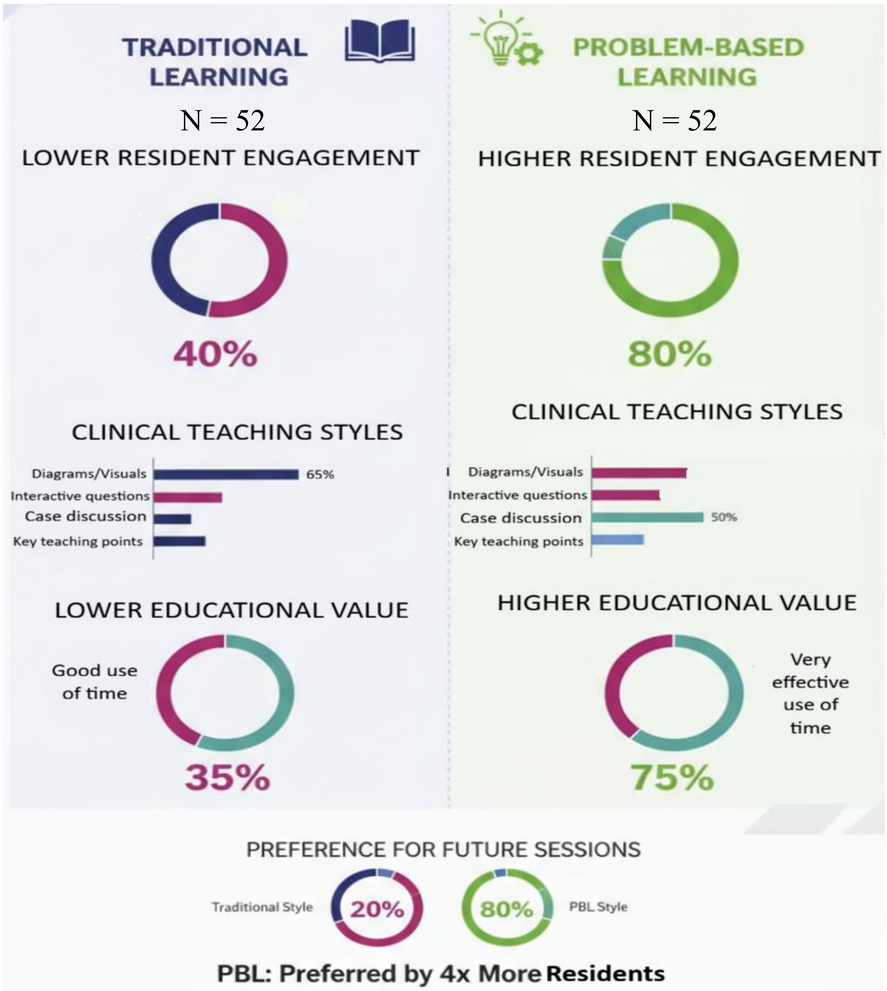


- **Design:** Prospective Quality Improvement project in a rural IM residency program.
- **Intervention:** Replaced 1 weekly didactic + 1 weekly teaching round with structured Problem-Based Learning (PBL); remaining sessions served as traditional control.
- **Format:** 60-minute case-based sessions using progressive clinical triggers, guided discussion, and evidence-based takeaways.
- **Facilitator Training:** 1-hour workshop with standardized case templates and adult learning principles.
- **Evaluation:** Pre-intervention, post-session, and post-intervention surveys using 5-point Likert scales + qualitative feedback.

Measures



Results: Preliminary



Discussion

- **Current State**: PDSA Cycle 1 was initiated in December 2025 and completed in February 2026. PDSA Cycle 2 has been started in March 2026 and will conclude in March 2027.
- **Next Steps:** Complete PDSA Cycle 1, collect responses for the survey till the end of PDSA Cycle 1 and analyze the results, compile results after PDSA Cycles 1 and 2 to compare the annual data.
- **Areas for Guidance/Input:** Integrating PBL into Residency Curriculum, aligning cases with ABIM Blueprint, lessons learnt from similar PBL or active learning initiatives, guidance on curriculum integration and sustainability, as well as collaboration opportunities.