AIAMC NATIONAL INITIATIVE X

Meeting One

Project Presentations - Cohort Breakout Session

Cohort One

Room – Gauguin

Facilitator:
Deb Simpson, PhD, Academic Affairs Education Director, Professor, Family Medicine & Community Health at UWSMPH & MCW, Deputy Editor – Journal Graduate Medical Education

NAC Member:
Carla Dewberry, Healthcare Attorney and Partner, K&L Gates Law Firm

8 Projects: Cleveland Clinic Akron General, UnityPoint Des Moines, OhioHealth Doctors Hospital, Baystate Health, Kaiser Permanente Northern California, Virginia Mason Franciscan Health, Aurora Health Care (Professionalism and AI)

Cleveland Clinic Akron General

Development of an In-Situ Simulation Curriculum to Reduce Latent Safety Threats

National Initiative

Project Overview

A multidisciplinary team will create an in-situ simulation curriculum on the Internal Medicine floors to identify latent safety threats.

Project Aims

- ..Identify latent safety threats
- ..Improve patient safety/quality
- ..Improve resident competence during critical events

Project Measures

- ..Identify baseline SERS reports associated with Code Blue
- ..Create pre-survey & post-survey to identify resident comfort/confidence level running codes

Progress

- Monthly Team Meetings (2 to date)
- Identified multi-discipline Team Members and their roles
- Collaboration with CC Main Campus Simulation

Current/Anticipated Challenges

- Integrate NI IX Mock Codes with existing Code Blue Committee mock codes to prevent “code” fatigue
- Complete logistical needs (equipment, participants, cadence of events.
- Experience of other hospitals who may have this program on general medicine floors would be helpful

What’s Next?

- Formulate Proposal for CC Simulation Research Oversight Committee for approval prior to submission to the IRRB
- Scheduling first Mock Code and finalize who will be notified in advance
- Determine Event Observer/Recorder who provides report to NI IX Team

Measures

- Identify barriers prior to first mock code
- Ensure attending serves as advisor during mock code allowing residents to run code
- Post Mock Code Debrief
- Determining Frequency of Mock Codes to provide measurable data

Methods/Interventions

- ..Monitor Code Blue SERS report trends
- ..Pre & post survey assessment

IRB

- ..Approval of CC Simulation Research Oversight Committee prior to IRB Submission

UnityPoint Health: A Roadmap to Remediating the Struggling Learner

Project Overview

To examine the dynamics between the struggling learner and the residency program. We plan to develop a tool kit that program directors can use for identifying, diagnosing, strategizing, managing, and documenting a path to remediation. The path will attempt to avoid adversarial interactions/relationships and make the learner a partner in the process.

Issues to address will include professionalism, fitness for duty evaluations, diagnosing the learner, developing a strategy to improve performance, and emphasizing the learner as a partner in their own professional formation.

Project Aims

- To develop a roadmap and resources for program directors to use during remediation
- To develop strategies that emphasize the learner as a partner in their own professional formation

Project Measures

- Process goals for team development, meetings, and development of materials
- Data from resident and faculty focus groups/surveys
- Longitudinal assessment of remediation outcomes

Progress

There has been little progress on the project to date. We have identified team members and meeting times. We have prepared preliminary questions for a resident/faculty focus group and plan to have our first team meeting prior to NI Meeting One.

Current/Anticipated Challenges

- Incidents that rise to the level of remediation may be unpredictable. Institution/programs can go substantial amounts of time without incident(s). The hope is that learners are successful and do not need remediation. So, sample size and execution of processes may not be regular practices.
- Collection of data related to remediations that do not rise to the level of institutional involvement may be difficult to documented.
- Understanding current program processes to address remediation may be difficult given heterogeneity between programs and potential changes in program leadership.

What's Next?

We plan to collect baseline information to help guide the development of a toolkit.

Measures

Data sources: historic records; interviews; surveys; and prospective data. A large component will include achievement of planned process steps.

Methods/Interventions

- Review of previous remediation processes with program directors
- Resident focus group
- Survey of program directors
- Achieve process goals

Institutional Review Board

A submission to the IRB will not be necessary. No patient data should be involved. However, prior residents' training files will be reviewed. We plan to frame the project as a process improvement endeavor.

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OSTEO-PRIME or FRAME

OhioHealth Doctors Hospital Family Medicine

Project Overview

Optimizing the feedback process is critical to supporting a psychologically safe and effective clinical learning environment. Within the precepting space, the effectiveness of this interaction is limited by time and the reception and retention of verbal feedback. This project will utilize AI analytics within the family medicine practice precepting space to assess and optimize the exchange of feedback.

The project will use the One-Minute Preceptor model's five microskills as a framework for assessment and development of the faculty. Utilizing Microsoft CoPilot, the AI agent generates a summative and formative evaluation of the precepting interaction in real-time. The faculty output focuses on summarizing the interaction, providing assessment of the attendings use of the One Minute Preceptor five microskills, and program specific teaching metrics.

The resident output focuses on summarizing the interaction and providing feedback around program specific teaching metrics with the goal of improving efficiency, clarity, specificity and retention of teaching points.

Project Aims

- Optimize feedback utilizing the use of the One-Minute Preceptor microskills within the precepting space.
- Improve efficacy of faculty feedback while reinforcing integration of OPP/OMT and SDoH clinical considerations.
- Improve the efficiency of both the resident and faculty within the precepting interaction.
- Deliver objective, timely actionable feedback for learners and faculty preceptors.

Project Measures

•Measure faculty preceptor performance in the five microskills of the One Minute Preceptor model
•Measure the frequency of discussion around OPP/OMT and SDoH considerations within in precepting discussions
•Survey faculty and resident perception of output value after each AI feedback session and quarterly
•Trend performance in the microskills and resident precepting efficiency over time.

Progress

- Team assembled
- Design Drafted
- Prototype AI Agents and outputs available
- IT infrastructure currently being built/refined by OPG and Microsoft
- Pending IRB exemption application
- Pending Legal review for terms and conditions of use and/or FERPA compliance

Current/Anticipated Challenges

•Privacy/IRB (QI vs research). Attempting to get QI exemption. Need clarification regarding consent for participants.
•Secure data handling/FERPA compliance
•Automation of tracking/storage/distribution of outputs to involved
•Model performance & bias monitoring
•Dashboard standup for reliability ease of use

What's Next?

- Apply and receive IRB exemption as QI project by end of November 2025
- Launch version 1.0 of both agents set up and ready to use in learning environment internal to OPG by November e2025.
- Complete IT architecture for cumulative output summary analysis and dashboard trending designed and implemented by February 2026.
- Complete two 3-month long PDSA cycles for intervention based on output results
- Refine workflows and faculty development plans

Measures

- AI interaction logs for microskill performance by attendings and resident efficiency of presentations
- Structured session and quarterly surveys for resident and faculty perception of AI output value
- Objective AI analysis of trends within the dashboard. Focused on Microskill competencies for faculty preceptors and efficiency of presentations for residents.
- Obtain baseline dashboard data. Analyze monthly trends then quarterly outcomes. Compare overtime with interventions.
- Group analysis by level of training for future targeted interventions.

Methods/Interventions

- Real-time AI summaries and Top 3 learning points for resident engagement in learning environment
- Learner prompts for presentation clarity
- Faculty development based on group trends within the five microskills
- Program level dashboards to trend outcomes and determine specific coaching/training interventions
- Long term will look at integration of bias/equity detection metrics in conglomerate dashboard.

IRB

- Submit determination request by October for Exemption as QI
- Include consent language for residents/faculty
- Define data retention & access (Microsoft and OPT IT teams building this architecture that assigns access rights currently)

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Baystate Medical Center – Draft Title: Our World and Our Health – Advancing Knowledge on the Environment-Health Relationship

Project Overview

- Our health and our environment are deeply connected. Clean air, safe water, stable climates, and healthy ecosystems all support human well-being and impact health. At the same time, healthcare processes and decisions can have an environmental impact, either positive or negative.
- This project will improve the knowledge base that healthcare providers have explaining possible cause and effect based on sharing trusted information. It will help identify gaps in provider knowledge and improve comfort with discussing our understanding of how our environment can impact our health—and how healthier choices for people can also mean healthier choices for the planet and vice versa. The goal is to build awareness and encourage actions that create safer, more sustainable, and healthier futures for everyone.

Project Aims

- Assess provider knowledge base before and after an educational intervention.
- Assess provider comfort level with discussing the impacts of the environment on health conditions or the impact of health care on the environment
- Establish resources available to providers to retrieve environment and health related research and discussion points.
- Broaden understanding of the relationship between patient care, the environment, and health of patient.

Progress

- Engaged provider and nursing leadership to establish team to discuss purpose and intent.
- Small project team has met to identify additional stake holders.
- Discussed measures and interventions.

Current/Anticipated Challenges

- Lack of buy in
- Small project team
- How do we generate interest, enthusiasm, buy-in, and follow through?

What's Next?

- Expand project team stakeholders
- Develop and administer pre-intervention survey
- Establish workflow for engaging providers on adding one slide to their presentation regarding how the environment may have impacted health or their care may impact the environment.
- Develop tracking mechanism

Measures

- Pre-Intervention Survey
- Monitoring of number of presentations including an environment/health slide
- Possibly an abbreviated post-presentation survey
- Post-Intervention Survey

Methods/Interventions

- Develop and administer pre-intervention survey
- Establish expectations of adding at least one slide to presentations relating to patient care, the environment, and health.
- Assess effectiveness of presentations via short post presentation survey
- Assess overall effectiveness of project through post-intervention survey

IRB

- In process

Kaiser Permanente Northern California
Integration of Social Determinants of Health Tools and AI Support in the Resident Clinic

National Initiative

Project Overview

Enhance the clinical learning environment for residents by developing skills to identify and apply appropriate patient resources using social determinants of health (SDOH) and technology/AI; Use SDOH and AI-driven approaches to guide patients to appropriate resources

Project Aims

- Assist/train residents to identify and apply SDOH in patient care
- Integrate AI for resource navigation in real-time to connect patients to community resources
- Foster a learning environment that empowers residents to integrate SDOH and AI tools collaboratively

Project Measures

- EHR data on SDOH screening rates and pre/post confidence surveys
- Referral follow up/success rate and resident ease of use surveys
- Resident climate/learning environment surveys

Progress

- Connected with KP THRIVE, which is a current SDOH questionnaire in our EHR
- Generated first PDSA cycle goals and in process of implementing
- Evaluating residents understanding of current THRIVE program and if there are gaps in knowledge

Current/Anticipated Challenges

- KP THRIVE is organizational program that identifies SDOH for patients but is not entirely accessible across all locations and there is limited understanding of how it is being used
- Time is always a challenge, but our leadership is supportive
- Additional challenge is burden already placed on usual clinic visits and how to adapt project to make it more accessible/increase ease of use

What's Next?

- Confirm identified additional KP stakeholders
- Chosen implementation methodology and evaluation
- Ideally, would have completed 1-2 PDSA cycles

Measures

- Assessing whether current AI program can already help generate SDOH at clinic visit
- Obtaining more information about how THRIVE is being used currently – workflows, frequency of use
- Assessing what our residents know currently about THRIVE program

Methods/Interventions

- Will adapt our current AI to obtain and highlight more information on SDOH and will put into practice during clinic visits over the course of 1 week
- Meeting with THRIVE program leadership
- Survey of resident baseline knowledge

IRB

- Working with our Department of Research

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Virginia Mason Franciscan Health & Project Title: Common Curriculum: Wellbeing and Burnout

Project Overview

Goal: Using VMPS principles to create a standardized, Wellbeing & Burnout Prevention curriculum shared across all 14 VMFH programs which helps close identi GME gaps, support CLER goals, and deliver ready-to-use, specialty-adapted learning.

Project Aims

- Aim 1: Adapt, pilot, and enhance the existing Pharmacy Residency Wellbeing/Burnout content into a modular, facilitator-ready "Wellbeing & Burnout Prevention Awareness" Common Curriculum
- Aim 2: Design a "Common Curriculum Model" (e.g., toolkit, guidelines) for future common topic development, usable by Medical, Podiatric, and Pharmacy programs
- Aim 3 (Specific to the next 18 months): Fully develop, refine, and begin widespread implementation of the "Wellbeing & Burnout Prevention Awareness" curriculum across at least X% of targeted programs/learners. (X will be discussed with our local committee)

Progress

- Initial Gap Analysis: Confirmed widespread need for common wellbeing training
- Interdisciplinary Team Formation: Core project team including Pharmacy GME partners.
- Initial Content Mapping: Begun aligning Pharmacy content with desired GME learning objectives.

Current/Anticipated Challenges

- Time Constraints: Programs' limited availability for curriculum adoption & facilitator training.
- Content Adaptation: Ensuring relevance & buy-in across diverse medical/podiatric specialties.
- Facilitator Training & Confidence: Equipping program leaders without extensive wellbeing expertise to effectively lead.
- Logistics of Wide-Scale Implementation: Scheduling, tracking, and ensuring consistent delivery across 4 sites.
- Measuring Impact: Moving beyond satisfaction to tangible behavioral/awareness changes.
- Specialty Nuances: How can we best tailor wellbeing content for your specific specialty without losing core message?
- Facilitator Development: Ideas for empowering busy program leaders as effective wellbeing facilitators.
- Resource Identification: Any existing internal expertise/resources (GME/non-GME) for wellbeing content or delivery you're aware of? Besides ACGME
- Implementation Best Practices: Lessons learned from your programs on successfully deploying new curriculum (if applicable).
- Defining what data, we will collect
- Resident Buy-in

What's Next?

- Initial Content Mapping: Begun aligning Pharmacy content with desired GME learning objectives.
- Drafting Curriculum Framework: Developed initial modular structure and content outline
- Kaizen event? Get together and work out the problem

Measures

- ACGME survey results on wellbeing
- Obtain data to view website traffic: Are folks going to the tools and resources
- Program Leader Feedback: Qualitative feedback on ease of use, adaptability Stress scales/burnout scales - where they are at the moment
- MyEvals survey (x2)

Methods/Interventions

- Learning Methodology: Case-based scenarios, interactive discussions, small group activities; emphasis on application over lecture.
- Delivery Model: Modular, flexible formats (e.g., 30-60 min sessions), adaptable for existing didactic schedules.
- Technology?
- Feedback Loop: Continuous collection of qualitative & quantitative feedback from learners/facilitators for curriculum iteration.

IRB

- Exemption: Current planned measures (satisfaction, knowledge, ease of use, program leader feedback) are anticipated to qualify for IRB exemption as QI/educational program evaluation.

Is it or Isn't It (Un)Professional

Aurora Health Care
Now part of ADVOCATEHEALTH

D Simpson PhD; K Agard CMP,PMP; J Bidwell MD; S Caudle MD; L Delfinado MD; D Hamel MD; T La Fratta MBA,: W Lehmann MD, MPH;
W MacDonald MD (w/ A Bernardi MD; I Poulson MD; M Thompson DO); J O'Brien MD; K Ouweneel MBA ; K Patel DO; N Salvo MD; E Santana C-TAGME *, D Irby PhD

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Project Overview

- Professionalism = core competency for all physicians …demonstrating a commitment to professionalism and an adherence to ethical principles [4.3 ACGME CPR]

Project Aim

1. **To enhance our professionalism culture** to create an environment of trust - respectful behavior
   A. Is it just in the eye of the beholder?
   B. Generational and/or role differences?
2. **Create a shared mental model** around professionalism → trust (think EPA)
   A. Why perception matters
   B. Impact on patient care
   C. Impact on health care team

Project Measures – Pre Post

A. Resident Evaluation of Teaching (Aurora)
   A. Demonstrated respect for me as a trainee
   B. Promotes and champions PROFESSIONALISM (e.g., Treats colleagues with kindness, courtesy/respect; high integrity; listens carefully; communicates clearly; accountable for actions)

B. Needs Assessment Pre-Post [Landscape Analysis]

C. ACGME Resident/Fellows Survey – Professionalism

D. ACGME Faculty Survey

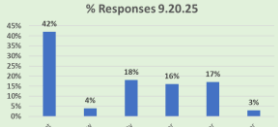
E. # Professionalism Concern Cards in Med Hub
   A. Ob/Gyn & Fam Med already submit

*Authors in Alpha Order after 1st

Progress

1. Literature Review
   A. Professionalism → Entrustment → Trust[2]
   B. Impacts of Unprofessional Behavior on Patient Care – Quality, Safety Experience + Impact on Team[3]
   C. Trainee Physician Milestone Ratings and Patient Complaints in Early Post training Practice[4]
      - ACGME Milestones
      - Patient Advocacy Reporting System(PARS), a reporting and intervention system developed at Vanderbilt Center for Patient and Professional Advocacy (CPPA)

2. 20 -Item Professionalism Needs Assessment
   A. Listed behaviors exhibited by different clinical and/or administrative individuals in our medical education programs from:
      - DIO Office & PDS
      - Residents including Resident Council
      - Faculty
      - Coordinators
   B. Present a behavior: Take days off/no show w/out alerting program
      - Rate the degree to which you would TRUST this person as a professional if you experienced/observed this behavior
   C. 213 responses to date



3. Brainstorm Educ Intervention(s)

4. Review target metrics

Current/Anticipated Challenges

1. Scope /Complexity of Topic
   A. Limited "success" in addressing
   B. It's a few people but resource intensive (Chronic <10% of docs)

2. Professionalism has adverse associations - What's Uptake?

3. Metrics – other ideas

3. Change Attitude /Culture is hard and resource intensive
   A. Trust is part of 2025 Enterprise Action Plan associated with Culture of Safety and Work Environment Survey
   B. Resource Intensive – sustainable?

What's Next?

- **Expand our Timeline x Task**
- **Needs Assessment:** Analyze data
- **Agree upon and Develop Education**
- **Meeting #2**
  - Identify project attendee
  - Prepare poster
- **IRB:** Have determination Not HSR

Methods/Measures/Interventions

Micro Level - Individual

- **Needs Assessment Pre/Post**
  - Consider what are/are not appropriate professional behaviors
- **Identify key elements of professional trust**

Meso – Programs / Groups

- **Interweave with Education Sessions**
  - Family Medicine NI X Project AI
  - Radiology – Simulation
  - Faculty Development – Difficult Education Case
- **Discussion Forums**
  - Lead by "Champions of Trust" [screening]
    - ✓ Residents high on Professionalism Milestones
    - ✓ Faculty high on clinical teaching evals – item professionalism
    - ✓ Champions attend "facilitator training"
  - Interactive, scenario based, seeking agreement around behaviors → "Covenant" or "Accord"
  - Seek to embed into standing sessions
    - ✓ GME: Shared Noon Conference, Resident Council, GMEC, Residency/Fellowship Programs
    - ✓ Academic Affairs 1/mo Faculty Development
    - ✓ UMEC: UMEC
    - ✓ CME: Staff Meetings

Macro – GME Wide / Org

- **Administrative**
  - "Mistreatment" Committee
  - Review Policies on Professionalism
- **Connect with *Enterprise Culture of Safety* efforts around trust**

1. Olle ten Cate & H. Carrie Chen (2020) The ingredients of a rich entrustment decision. Medical Teacher, 42:12, 1413-1420, DOI: 10.1080/0142159X.2020.1817348
2. Hamilton AL, Layden EA, Storrar N, Skinner J, Harden J, Wood M. Definition, measurement, precursors, and outcomes of trust within health care teams: a scoping review. Academic Medicine. 2024 Jan 1;99(1):106-17.
3. Han M, Hamstra SJ, Hogan SO, Holmboe E, et al. Trainee physician milestone ratings and patient complaints in early post training practice. JAMA Network Open. 2023 Apr 3;6(4):e237588-.
4.arga AI, Spehar I, Veggeland F, Skirbekk H. Factors influencing trust among colleagues in hospital settings: a systematic review. BMC health services research. 2025 Jan 3;25(1):16.

Incorporating AI into Family Medicine Residency – Guidelines, Strategies, Metrics

Keyonna Taylor –Coleman MD; Kevin Lee MD; Alonzo Jalan MD; Meinuo Chen Baca MD; Kylie McAllister DO; Devanshi Patel DO; Lindsay Sawyer DO; Katherine Kelly MD; Bonnie Bobot MD; Samantha Ladin BS; Stephanie Malusic BASc; Collin Spencer DO; Clayton Bowes MD; Lindsay Sawyer MD; Willhelm Lehmann MD; Deborah Simpson, PhD

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Project Overview

To elevate learner growth/development and patient care through strategic leveraging of clinical AI use within our residency program (eg, ambient documentation, clinical decision-making supports, teaching & learning interactions)

Project Aims

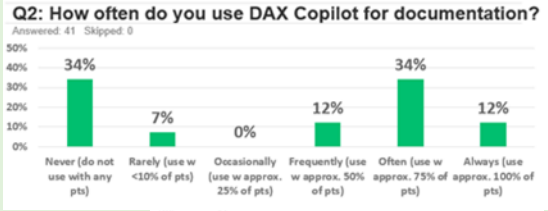
1. **Establish guidelines** for integrating clinical AI in residency programs to prepare our grads for future practice (avoid cognitive never skilling/deskilling.)
2. **Ensure graduates can deliver excellent care w/out AI**—emphasizing clinical reasoning, care plan
3. **Promote ethical and transparent AI use**
4. **Analyze AI use patterns** to inform safe, effective, and context-aware implementation on AI to inform education.
5. **Use AI to minimize admin burden & reduce burnout** via smarter—not harder—workflows.
6. Prepare faculty to teach effectively using AI - enhance learning interactions and impact.

Project Measures

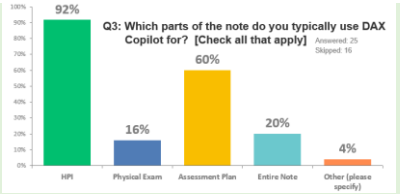
- Pre-Post AI Use Survey for faculty/residents
- EPIC analytics for AI use, (utilization, frequency)
- ACGME - Well Being , Annual Survey Data, Milestones (ICS 3, add own PC milestone?)
- Add AI specific items to existing evaluation forms (eg, use, effectiveness, transparency)?

Progress

- Completed Baseline AI Survey



6.25 Results Discussed at APE Mtg



- 9.25 -R/F Approved: PGY 1's DAX Copilot for HPI's
- 10.25 *Draft* of AI Milestone for Res/Fac Mtg

Not Yet Achieved	Level 1 – Awareness and Compliance	Level 2 – Guided Application	Level 3 – Independent Use with Critical Evaluation	Level 4 – Leadership and Optimization	Level 5 – Innovation and Scholarship
	• Communicates basic understanding of AI concepts & terminology to team. • Recognizes institutional, legal, and ethical guidelines for AI use in clinical settings. • Can articulate limitations of AI tools (e.g., bias, data privacy, scope of application). • Seeks supervision before using AI tools in patient care. • Commits to an "adopt but verify" approach	• Is public re: AI use with patients, families and teams = ethical, legal and institutional principles • Uses AI EPIC tools under direct supervision to support clinical decision-making (eg, risk calculators, symptom checkers). • Understands AI role in documentation, scheduling, pt education. • Participates in discussions about AI integration in team-based care. • Begins to evaluate AI-generated outputs for clinical relevance & accuracy. •	• Explains AI implications and responds to patients, families, and team members AI generated information with clarity and relevance. • Uses AI EPIC tools under indirect supervision (eg, predictive analytics note summarizing). • Critically evaluates AI recs with guidance and integrates them with clinical judgment. • effects of using AI tools. • Identifies and reports the unintended side effects / consequences / errors / discrepancies in AI-generated content. • Actively participates in discussions re: FM related appropriate AI uses	• Co-Leads discussions on AI integration with patients, families, and interdisciplinary teams. • Independently uses AI EPIC tools to enhance workflow • Participates/co-l QI initiatives involving AI tools in clinical practice and/or med ed. • Collaborates with IT and clinical teams to refine AI workflows. • Advocates for ethical and equitable use of AI in patient care and/or med educ •	• Serves as a resource & leader in AI integration, contributing to institutional policy, med educ, and/or QI in healthcare • Mentors others in responsible and effectiv AI use. including ethical, legal and institutional principles • Develops or contributes to scholarly activity on A applications in Fam Mec • Participates in national committees on AI in healthcare and/or med med

Current/Anticipated Challenges

- Preferred use guidelines for clinical decision AI assist tools (Never skilling/deskilling)
- Data sources and measures (objective/subjective)
- Keeping UP! Wait– here's a new AI Tool

What's Next?

- Finalize project leadership
- Form workgroups
  - Regular meetings
  - Feasible tasks
  - Accountabilities
- Draft and get approval for 1st Edition
  - DAX Access Guidelines
  - Clinical Decision Access/Use Guidelines
- Finalize project measures (see Column #1-2)
  - Assessment & evaluation items(eg, milestone(
  - Identify project attendee & Prepare poster

Methods/Interventions

- Education during program wide meetings
  - Dedicated time | Standing Topic
  - Res / Fac Meetings
  - Core Curriculum meetings
- Curriculum
  - Establish formal on-going curriculum for resident
  - Faculty development for teachers
- Regular Updates via e-Based Department
  - Newsletter, websites, SharePoint
  - Work with library to establish library AI Feed Clinical & Education

- Rodman A, James CA. Effective engagement with AI is the only path forward for clinician-educators. Academic Medicine. 2025 Jul 28:10-97.
- Abdulnour RE, Gin B, Boscardin CK. Educational strategies for clinical supervision of artificial intelligence use. NEJM . 2025 Aug 21;393(8):786-97.
- Warm E. Deskilling and Automation Bias: A Cautionary Tale for Health Professions Educators – ICE Blog August 21, 2025
- AI in Medical Education ~Acad Med Supplement Sept 2025 100 – 9S

AIAMC NATIONAL INITIATIVE X

Meeting One

Project Presentations - Cohort Breakout Session

Cohort Two

Room – Monet

Facilitators:
Kelly Ussery-Kronhaus, MD, FAAFP, Program Director, Hackensack Meridian Health Ocean University Medical Center Family Medicine Residency and
Joy Walton, MD, Associate Program Director Internal Medicine Residency, OhioHealth Doctors Hospital

NAC Members:
Sam Calabrese, MBA, RPh, FASHP, CPEL, Vice President, Office of Accreditation Services, American Society of Health System Pharmacists and
Jodi Langsfeld, EdD, Senior Vice President of Education and Research, The Arnold P. Gold Foundation

7 Projects: Henry Ford Rochester Hospital, Hackensack Meridian Health Ocean University, OhioHealth Doctors Hospital, St. Lukes University Health Network (Pediatric and Neonatal Resuscitation, Rapid Response Simulation, Push Dose Epinephrine), AdventHealth Orlando

FM Professional Development: Enhancing Residents' Professional Identity Formation via Reflective Writing and Developing Faculty Learning Plans

Eleanor King, MD, Director, FM Residency Program, HFRH; Heidi Kenaga, GME Research Manager, WSUSOM Office of GME; Andrea Milne, MD, PhD, Associate Program Director, FM Residency Program, HFRH; Sheryl Wissman, MD, Chief Medical Officer, HFRH

Overview

The NI X theme accords well with the institutional priorities of our main clinical learning environment, Henry Ford Rochester Hospital (HFRH), home to our Family Medicine (FM) residency program. Our project seeks to learn more about what it *really* means to be a successful physician in an increasingly complex world. Cultivating a resilient professional identity in a demanding milieu will have a major effect on patient care since it impacts a physician's well-being, confidence, and efficacy. HFRH and the WSUSOM Office of GME believe that mobilizing evidence-based approaches about ***professional identity formation (PIF)*** will help us better understand our residents, the faculty, and ultimately those features of the clinical learning environment that will foster their transformation into healers of the first rank.

Aims

HFRH/WSUGME hopes to nurture a microevolution in our clinical learning environment in two interdependent domains:

1. By writing about patient encounters and training experiences, ***residents*** come to see more clearly what their profession entails. We are committed to the use of reflective writing practices to gauge resident well-being and feelings of satisfaction. According to Silver & Hussain, "Empathy, reflection, and social connectedness are important skills for physician identity development" ("A resident narrative medicine curriculum to promote professional identity development," MedEdPORTAL, Oct 2024). Conveying to trainees a sense of professional mission and stewardship of the discipline has become a critical albeit challenging mandate, and as such is a priority of the FM residency program, HFRH, and WSUGME.

2. FM will institute individualized Learning Plans for ***faculty*** centered on procedures increasingly required for board eligibility. The American Board of Family Medicine (ABFM) focuses on skills and competency-based assessments not mandated during the time when most faculty were becoming board eligible. The Plans are self-driven, devised by individual faculty to target those gaps they perceive in their professional identity or allow them to pursue areas of training about which they are passionate. The Plans may address skills that

- meet ABFM or ACGME requirements
- are integral to family medicine practice
- are desired by residents

Faculty will meet monthly to share their experiences and information, cross train, and provide accountability for continuing their professional development as healthcare providers and medical educators. We will measure skills gained as the program as a whole, both faculty and residents.

Measures/Methods

The project will draw upon:

- Qualitative data from multiple *reflection documents*
- Quantitative data from annual *GME resident surveys* on wellness and meaning in work

FM is also considering using a PIF assessment tool to gather additional quantitative data. These multiple **data sources** will illuminate residents' unique training encounters that help form their identity as physicians, focusing on any variations among each postgraduate year. The population comprises FM residents (n = 29) who will have protected free time every 4-8 weeks to write for 1 hour on their experiences being a physician. Project faculty and residents will explore PIF themes across the training cycle by collecting reflective writing documents in response to two prompts: "What made you feel like a doctor this week?" and "What challenged you or what did you struggle with?"

Progress

At the FM faculty meeting in August, attendees committed to mastering one new skill by July 2026. In September, the FM team collected the first resident reflections, one excerpted below:

> ***Another layer of difficulty comes from realizing that being a doctor extends far beyond the medical knowledge taught in school. There are nuances I had never fully appreciated until now . . . billing, charting, communicating with different members of the care team, and documenting in ways that are both clinically meaningful and administratively correct. These responsibilities [and] ability to juggle multiple priorities, which often feels overwhelming when combined with the clinical workload, are demanding.***

Current/Anticipated Challenges

Maintaining steady engagement of residents in reflection activities, given that their primary commitment is to clinical care, ongoing study/didactics, involvement in QI projects, etc. may be one **challenge.** However, we learned from our NI IX project that the institution of dedicated time will likely ameliorate this.

FM faculty did identify CME funding from our sponsoring institution as a potential barrier. All had identified an area or skill they wanted to pursue but the CME they desired to acquire that skill was costly (for example, certification in hormone replacement from The Menopause Society). Most faculty use up their CME funding on license renewal, attending FM conferences, and taking boards. The Program Director and faculty are discussing ways to locate more affordable options.

What's Next?

Resident reflective writing began in September 2025, and given weekly didactics there should be sufficient material for review by spring 2026. Faculty conferred at the program meeting in August for the first monthly check-in. In September, faculty will track progress and milestones on their individual PIF journeys.

HMH Ocean University Medical Center
Improving Clinical Competency Through Direct Observation in Family Medicine Residency

National Initiative

Project Overview

This project aims to address the process of evaluating family medicine residents at HMH Ocean Medical Center. A systematic approach to the development of a clinical competency portfolio will be developed using direct observations and both formative and formal feedback models

Project Aims

- To use a systematic framework to assess the competency of family medicine residents
- To create an effective direct observation assessment tool to be used across four family medicine residency training clinics
- To obtain 300 direct observation evaluations per resident throughout three years of training
- Develop a procedural skills curriculum and direct observation competency tools in order to assess clinical skills across

Project Measures

- The collection of 100 direct observation forms per year of residency training in order to improve the clinical competency of residents
- Create change around “feedback culture” at our program by incorporating regular feedback during each clinical session and clinical encounter
- Each resident will graduate with a direct observation portfolio that will measure progress throughout training and track encounters which can be used to determine eligibility for hospital rights upon graduation

Progress

- This initiative initially started to improve family medicine performance during acute care scenarios during rapid responses in the hospital- led to a change in curriculum and evaluation of rapid response performance across the program.
- We have implemented a new assessment tool to be used for direct observation evaluations.
- Residents are becoming more accustomed to direct observations as part of their training

Current/Anticipated Challenges

- Time- a major barrier to obtaining completed direct observation forms during clinic is finding time to complete to form and provide effective feedback to the residents
- We need buy in from both faculty and residents to ensure the goal and motive behind increasing the number of evaluations per resident is a united front
- For procedures, some residents are more comfortable performing procedures than others. We will need to create more hands on OSCE type experiences in the clinical learning environment to ensure competency across all domains of family medicine

What’s Next?

- Develop a standardized approach to implement the direct observation portfolio in order to increase the amount of direct observations per resident
- Implement multiple PDSA cycles with attendings/residents at all four resident clinics to see how we can smoothly integrate direct observations into practice
- Setup progress charts in each clinic to motivate faculty and residents to participate

Measures

- The amount of direct observations per resident (aiming for 100 per resident per training year)
- Resident performance during clinical encounters
- The initiative will be re-evaluated at 6 month increments with anonymous surveys collected from faculty and residents

Methods/Interventions

- The assessment tool for direct observations will be reviewed by both residents and faculty in order to allow for input from key stakeholders and develop a tool with feedback from all members involved in the project
- The number of direct observations will be reviewed and assessed during quarterly ILP meetings between resident and advisor
- Procedural workshops will be developed and incorporated into curriculum with direct observation opportunities by faculty and will be incorporated into a procedural portfolio ahead of resident graduation and competency to practice independently

IRB

- No IRB approval required given academic nature of project

Heart of a Healer: Developing Professional Identify through the Care of Communities Experiencing Vulnerability

NI X Meeting One| Oct 16 -17, 2025

OhioHealth Doctors Hospital

National Initiative

Project Overview

Through this initiative, we hope to understand how structured exposure to health equity, interdisciplinary education, and patient advocacy at a community-based hospital influences the development of resident physicians' professional identity.

Project Aims

By March 2027, we aim to understand how professional identify formation among resident physicians occurs through the care of communities experiencing vulnerability. We aim to better quantify and qualify how personal values, lived experiences, and professional roles positively shape their evolving identity as developing physicians.

Project Measures

Outcome metrics:

- Proportion of residents reporting a stronger commitment to caring for communities experiencing vulnerability
- Proportion of residents reporting increased confidence in advocacy for social drivers, navigation of resources, and application of high-value care

Process metrics:

- Quantitative survey data from quarterly interdisciplinary conferences (IDC)
- Qualitative narrative data from focused resident interviews

Progress

- Kickoff meeting with core team members on 8/26/25 to discuss Toolkits 1 and 2
- Development of survey questions for IDC
- First IDC kickoff on 9/19/25

Current/Anticipated Challenges

- Recruitment of FM residents to core team.
- Analysis of baseline data from previous surveys.
- Development of semi-structured focused interview questions.
- Which tools do you recommend for qualitative data analyses?
- How do you define success for the less tangible aims?

What's Next?

- Completion of analysis of baseline survey data.
- Completion of analysis of new IDC survey data to date (Sept 2025, Dec 2025, March 2026).
- Completion of analysis of five semi-structured interviews from IM residents.

Measures

- Quantitative analysis of survey data with percent change on Likert scale. Qualitative analysis of focused interviews with identified saturation themes.

Methods/Interventions

- TBD

IRB

- QI determination pending.

National Initiative

St. Luke's University Health Network (EM Anderson) :
Simulation-based Neonatal and Pediatric Resuscitation Training in EM Residents

Project Overview

A relative lack of exposure to neonatal and pediatric resuscitations leads to decreased preparedness among EM residents and potentially compromises 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.

Project Aims

- To evaluate the impact of simulation on residents' knowledge, clinical decision-making, and procedural skills in neonatal and pediatric resuscitations
- To access 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 Measures

- Pre- and post-simulation surveys that include medical knowledge questions and measure confidence levels
- Standardized checklists that allow for objective assessment of critical actions during simulation cases

Progress

- Preliminary surveys revealed knowledge gaps and low confidence in managing neonatal and pediatric resuscitations
- 8 simulation sessions scheduled over the next 18 months
- 5/8 simulation cases designed
- Pre and post survey templates created

Current/Anticipated Challenges

- Scheduling simulation sessions to maximize resident and nursing participation
- High patient volumes and ED boarding limit available space to conduct in-situ simulations

What's Next?

- Complete curriculum content: surveys, simulation cases and associated scoring rubrics
- Coordinate with ED leadership to maximize resident and nursing participation
- Discuss potential interdepartmental collaboration with NICU and PICU

Measures

- Pre and post intervention surveys measure knowledge using multiple choice questions and measure confidence using Likert scale questions
- Objective assessment tools measure performance in each case and are based on national neonatal and pediatric guidelines

Methods/Interventions

- Simulation curriculum consisting of 4 neonatal and 4 pediatric resuscitation cases, each followed by debriefing sessions
- Pre intervention surveys will be completed prior to first simulation session
- Post intervention surveys to be completed after final simulation session

IRB

- Approval pending

NI X Meeting One| Oct 16 -17, 2025

St. Luke's University Health Network (IM Anderson)
Rapid Response Simulation Study

National Initiative

Project Overview

Simulation-based learning is a proven tool in medical education, particularly for enhancing teamwork and communication in high-pressure clinical settings. Our study seeks to evaluate whether collaborative simulation training with internal medicine residents and novice nurses improves confidence and perceived competence in applying behavioral skills during rapid-response scenarios. By integrating structured simulation exercises and reflective debriefing, the study seeks to transform the clinical learning environment into a dynamic, team-oriented space that promotes progressive autonomy and fosters the development of a professional identity.

Project Aims

- Improve confidence in applying behavioral skills during rapid-response situations.
- Promote reflective practice: encourage self-assessment and growth through structured debriefing and feedback.
- Enhance interprofessional collaboration by creating structured opportunities for joint learning between internal medicine residents and nurses.
- Improve patient care outcomes by strengthening behavioral competencies critical to rapid-response scenarios, such as communication, leadership, and decision-making under pressure.

Project Measures

- Pre- and post-simulation surveys with both quantitative and qualitative items to assess changes in confidence, perception, and skill application.
- Stratified analysis by learner type, training level, and prior experience to identify targeted development needs.

Progress

Our initiative is structured into 4 phases

- Phase 1: Finalize simulation scenarios, develop pre- and post-surveys, and conduct faculty calibration sessions for standardized facilitation and debriefing.
- Phase 2: Conduct simulation sessions with interdisciplinary cohorts, ensuring multiple iterations to capture diverse learner experiences.
- Thus far, we have conducted 2 rapid response simulations.
    - 3rd session Oct 24

Current/Anticipated Challenges

- Currently, our pre and post simulation surveys are not connected for each participant. There has been an issue of respondents not filling out both surveys.
- We also don't have a way to match pre and post survey responses to the responder which makes it difficult to track discrepancies in survey submissions.
- **What area (s) or questions can the colleagues in your group help you address? List those here.**
    - What are some ways to encourage completion of both pre and post surveys.
    - In addition, advice on how to increase feedback on the open-ended response questions.

What's Next?

- We are considering linking the surveys, so they become a paired result. This could allow better tracking of responses to ensure the complete collection of data points.
- Continue collecting data from each conducted simulation.
- Analyze data using REDCap.
- Use findings to implement changes into the curriculum.

Measures

1. Pre- and post-simulation surveys assessing:
- Confidence in applying behavioral skills.
- Perceptions of teamwork and communication effectiveness.
- Leadership under pressure.
- Interdisciplinary collaboration.

2. Stratification of survey data by:
- Learner type (resident vs. nurse).
- Level of training.
- Prior simulation experience.

3. Longitudinal tracking of perception changes over time.

Methods

Use of high-fidelity, interdisciplinary simulation scenarios focused on rapid-response situations.

Mixed-methods survey design:
- Quantitative: Likert-scale items.
- Qualitative: Open-ended responses.

Data analysis to identify:
- Growth in behavioral competencies.
- Differences in learning needs across professional roles.

Regular debriefing sessions to reinforce reflective practice.

Interventions

1. Implementation of collaborative simulation training sessions involving:
- Internal Medicine residents .
- Novice nurse learners.

2. Focused simulation themes:
- Crisis leadership.
- Communication in high-pressure environments.
- Real-time collaborative decision-making.

3. Structured debriefs to promote:
- Reflective learning.
- Feedback exchange..
- Professional identity formation

4. Integration of findings into curriculum development for sustained impact.

IRB

This study has been approved by the Institutional Review Board.

St. Lukes University Health Network Push Dose Epinephrine

NI X Meeting One| Oct 16 -17, 2025

National Initiative

Project Overview

In emergency departments (EDs), administering push-dose Epinephrine is a critical intervention for acutely decompensating patients. Lack of a standardized protocol for ordering and preparing this medication can introduce risks related to medication errors, inconsistent practice patterns, and reduced confidence among providers. To address these concerns, we propose a system-wide initiative to standardize the administration of push-dose epinephrine, promoting a culture of safety, consistency, and experiential learning.

Project Aims

- Standardize the ordering and administration of push-dose epinephrine in the ED using EPIC order sets and preassembled kits.
- Improve resident and clinician confidence and competence in administering push-dose epinephrine.
- Reduce medication errors and variability in practice patterns.
- Enhance the clinical learning environment by reducing cognitive load and promoting experiential learning during high-acuity interventions.

Project Measures

- Process Measures
  - Utilization rate of EPIC order sets for push-dose epinephrine.
  - Frequency of kit use across campuses.
  - Number of educational materials distributed and accessed.
- Outcome Measures
  - Pre- and post-intervention survey scores assessing:
    - Resident/clinician confidence in administering push-dose epinephrine.
    - Self-reported competence.
    - Perceived risk of medication errors.
    - Number of reported medication errors related to push-dose epinephrine (if available via incident reporting systems)

Progress

- Project approved by leadership
- A multidisciplinary team, including Pharmacy, IT, and ER physicians, met and discussed the project.
- Survey to providers has been created and sent out
- Data obtained, survey is still active
- Epic order sets are being created

Current/Anticipated Challenges

- Creating the official mixing kits and educational materials as well as their distribution across campuses.
- Creating a post-survey measure
- ***What area (s) or questions can the colleagues in your group help you address?:***
  - *What feedback questions would be beneficial*
  - *Best ways to assess for failure*
  - *Are there opportunities to improve communication or coordination?*
  - *What strategies will ensure long-term adoption and consistency?*

What's Next?

- Continue obtaining pre-survey data
- Create educational materials and mixing kits
- Publish Epic order sets
- Begin utilizing the orders, kits, and education
- Send the Post-survey and obtain data
- Publish final outcomes

Measures

- Pre/post confidence and competence surveys
- Medication error tracking
- EPIC usage analytics
- Qualitative feedback from residents and faculty

Methods/Interventions

- Epic Order
- Standardized mixing kit
- Standardized educational material
- Engage pharmacy and IT teams in collaborative rollout
- Feedback logs

IRB

- The study has been approved by the Network IRB

National Initiative

NI X Meeting One| Oct 16 -17, 2025

AdventHealth Orlando- Enhancing the clinical learning environment through fostering optimal communication practices and improving psychological safety

Project Overview

AdventHealth GME has been on a years long path of expanding and improving our programs and the learning experience. Our leadership team takes feedback very seriously and actively makes efforts to grow and improve. Leadership is currently focused on improving wellbeing metrics related to the learning environment reflected in the 2025 ACGME wellbeing survey. Through our involvement in national initiative X, AdventHealth GME hopes to learn and implement best strategies to ensure psychological safety in the learning environment.

Currently, our learning environment has room for growth regarding feeling safe to discuss concerns with faculty as well as receiving feedback from faculty in certain programs. One of the strategic priorities for AdventHealth GME is to grow and expand residency programs over the next few years. In order to assure a quality educational experience, and encourage desirable match rates, we are dedicated to providing state of the art educational facilities and an optimal learning environment which includes safety in the learning environment in both the physical and emotional aspects.

Project Aims

Our project aims to enhance the clinical learning environment by implementing a comprehensive feedback protocol involving a therapist who will shadow, observe, and provide real-time feedback to both faculty and residents.

This initiative focuses on fostering optimal communication practices within inpatient floors and the operating room (OR), thereby promoting a culture of psychological safety.

Project Measures

We will assess the impact of the intervention through validated surveys and feedback mechanisms from both residents and faculty members to ensure continuous improvement of the learning environment. Proposed initial measurement tools include:

- Validated observational tools on interprofessional communication such as the TOSCE
- Psychological Safety tool
- ACGME Wellbeing Survey

Progress

- Presented to the GME leadership cabinet
- Have 2 pilot programs on board: pediatrics and internal medicine.

Current/Anticipated Challenges

- Our current challenge is getting response from TOSCE authors for permission and training to utilize the assessment tool.
- Our anticipated challenge is openness to receive feedback particularly from faculty members.

What's Next?

- Begin to develop intervention strategy
- Begin to implement interventions by mid-spring 2026.
- Collect early data by June 2026
- Complete 2 rounds of interventions by mid-fall 2026
- Complete final data collection by end of 2026

Methods/Interventions

1. Facilitate Effective Communication: By utilizing live feedback from a trained therapist, we aim to improve communication strategies among medical staff, ultimately enhancing the learning experience for residents.

2. Promote Psychological Safety: We are hoping to identify moments of breakdown in communication that sometimes can lead to entering fight-or flight mode which can impact feeling of safety in the learning environment and prevent a further breakdown of communication. We know that when fight-or flight is activated the ability to learn and retain information is negatively impacted. By promoting healthy and effective communication modalities, we are hoping to encourage psychology safety in the learning environment.

AIAMC NATIONAL INITIATIVE X

Meeting One

Project Presentations - Cohort Breakout Session

Cohort Three

Room – Renoir

Facilitators:

Dania Mosquera, MS, Quality Improvement Initiative Program Manager St. Lukes University Health Network and

Theresa Azevedo Rousso, MPA, Regional Senior Director and Designated Institutional Official, Kaiser Permanente Northern California

NAC Members:

John Andrews, MD, Group Vice President, Medical Education, American Medical Association and Rance McClain, DO, Sr. VP of Medical Education, American Association of Colleges of Osteopathic Medicine

7 Projects: Mountain Area Health Education Center, Aurora Health Care, Ochsner Health, St. Lukes University Health Network (Resident Clinics and Clinic to Curb), RWJBH/Monmouth Medical Center, Atrium Health,

National Initiative

NI X Meeting One| Oct 16 -17, 2025

Mountain Area Health Education Center

Project Overview

Direct Observations are the highest level of evaluation, allowing evaluators to see what learners actually do and give real feedback about real situations to promote growth.

We will implement an Inpatient Direct Observation pilot to evaluate resident performance for Entrustable Professional Activities related to inpatient wards. This builds on successes with Ambulatory Direct Observations currently done in the outpatient setting and will align with professional identity formation of residents interested in hospital medicine.

Project Aims

- Implementation of Inpatient Direct Observations.
- Develop resident proficiency in Entrustable Professional Activities related to inpatient wards.
- Develop faculty proficiency with Direct Observations and coaching.

Project Measures

- Faculty and Resident evaluation/feedback on Inpatient Direct Observation pilot.
- Measure pre-implementation perceived needs and barriers.
- Measure pre- and post-implementation of pilot.

Progress

- Faculty Needs Assessments completed and reviewed, identified a common theme of faculty asking for use cases as part of utilizing coaching strategies.
- Faculty Development Sessions planned and scheduled.
- Identified pilot group.
- Sending out Resident Needs Assessment.
- Designing Direct Observation refresher course for Faculty with use cases.

Current/Anticipated Challenges

- Current Challenges: Inpatient Direct Observation has been attempted at the start of the program's lifespan and did not sustain. Our Needs Assessment and Pilot Group are critical to identifying and overcoming historical barriers.

TIMELINE	MILESTONE
Aug	Phase 1: Needs Assessment
	Review Dr Spell's Faculty Interests
	Design Fac/Resident Needs Assmt
	Collect Fac/Res Needs Assmt
	Clone Amb Direct Obs for Inpt
	Design any Inpt-specific Direct Obs
	NI X Team review of data
Sept	Phase 2: Faculty Development
	Identify and Recruit Pilot Attendings
	Pilot Attendings go through ADAPT
	? Use MAHEC sim center
	ACGME permissions for content
	NI X Team review of data
Oct-Dec	Phase 3: Roll Out Pilot Phase
	Recruit Intern for NI X Team
	Roll out Inpatient Direct Obs
	Collect Inpt Direct Obs eval data
	Get monthly attending feedback on pilot
	NI X Team review of data
Jan-Mar	Phase 4: Roll Out Resident Phase
	Implement pilot feedback
	Collect Inpt Direct Obs eval data
	Get monthly senior feedback on pilot
	NI X Team review of data

What's Next?

- Faculty Development sessions – Coaching and Direct Observation.
- Finalize Direct Observation refresher course for Faculty with use cases as part of the pilot.

Measures

- Needs Assessment Surveys.
- Inpatient Direct Observation evaluations.
- Pre- and post- pilot evaluations from Faculty and Residents.

Methods/Interventions

- Planned roll-out of Inpatient Direct Observations, using Ambulatory Direct Observations as an archetype.
- Direct Observation refresher course with use cases for Faculty to take Faculty Development skills for coaching to the bedside.

IRB

- TBD.

Greening the Future: Reducing Regulated Medical Waste on L&D

Haley Primuth MD, Kari Schmidt Oliver MD , Anne Getzin, MD, Deborah Simpson, PhD

Aurora Health Care
Now part of ADVOCATEHEALTH

National Initiative
NI X Meeting #1 | Oct 16 -17, 2025

Project Overview

This sustainability project is aimed at reducing regulated medical waste in L& D through education of residents and faculty in Aurora Ob/Gyn Residency Program

Project Aims

1. **Educate Ob/Gyn Residents & Faculty**
   - A. **Knowledge:** ObGyn Faculty and Residents re: impact of planet and organization and how to appropriately dispose of waste
   - B. **Values/Ethics:** It's in patients' interest to value sustainability including awareness about environmental impact of care choices
   - C. **Skills:** Appropriate disposal of medical waste
2. **Decrease by 10%** proportion of Red Bag Waste vs Municipal waste per delivery
3. **Shift the "culture" of L&D** to one that recognizes how to minimize our adverse environmental impact

Project Measures

- Pre-Post medical waste knowledge assessment of faculty/residents
- % of Red Bag Waste weight compared to municipal waste (Baby Scale)
- Evaluation of education sessions

Progress

1. **Determined domains for a brief quiz:**
   - A. Personal attitudes to sustainability
     - ✓ Commitment/personal motivation to change
     - ✓ Is correct waste disposal within their scope
   - B. Cost of disposal to Aurora and planet
   - C. What waste goes where
     - ✓ Classification: Identify what type of waste it is (how much blood on gown is "red bag")
     - ✓ How disposed appropriately
   - D. Environmental Impact of waste processing
2. **Identified Timeline x Task**
3. **Outlined Education Intervention**
4. **Identified Aim Target metric**

Current/Anticipated Challenges

1. **Pre-Post Waste Measure**
   - A. **Formula: 20 deliveries each period?**

$$\frac{\text{Weight Red Bag}}{\text{Weight Red Bag + Municipal}} = \text{\% Red Bag Waste}$$

   - A. **Variability** by patient preferences & case (complexity; # of people in room)
   - B. **Differentiate** Residency program waste vs others in room (midwives, techs, FM residents, MSs)
   - C. **Right Aim**: Decrease by 10% when standard for Red Bag is 3-5% of total? [1,2]
2. **Education vis Gamification:** Feasible, Generalizable?
3. **Change Attitude /Culture** towards sustainability

What's Next?

- **Quiz:** Generate questions x domain + administer
- **Develop Education**
- **Champions?** Consider identifying others in L&D (eg, tech, nurse, midwife)
- **Meeting #2**
  - Identify project attendee
  - Prepare poster
- **IRB:** Have determination Not HSR

Methods/Measures/Interventions

- **10-11.25**: Baseline Medical Waste Weight
- **12.25:** Administer Baseline Quiz - 15 min
- **1-2.26**: Provide Interactive Education – 45 min
  - During program wide meetings (M&M)
  - Gamification –sustainability waste stations
    - ✓ Timed staggered starts - finish time
    - ✓ Accurately sort regulated medical waste (simulated)
    - ✓ Debrief and discuss waste infographic tailored to L&D waste (to be posted in L&D as reminder)
  - Supply Chain Traceability:
    - ✓ Trace the course of blood -oaked sponge to - from L&D to ultimate disposal
    - ✓ Webinar with Daniels (AI Agent Elmo asking the Qs)
  - Why as OB/Gyn's we should care about waste
    - ✓ Health of patients (Red Bag incineration & quality; $$
- **2-3.26** Feb –March: 2 Weeks Post Educ
  - Redo Waste Quiz
  - Red Bag/Municipal Waste Weights
  - PDSA and determine steps

- Practice Greenhealth. Regulated Medical Waste. Accessed September 12, 2025
- Healthier Hospitals – Less Waste How to Guide. Access September 12,2025

Optimizing the Clinical Learning Environment Through Structured Faculty Development

Brittany Ducote; Rajiv Gala, MD; Amy Lin, MD; Anna White, MD; Roneisha McLendon, MD; Donna Guidroz

Ochsner Clinic Foundation
NI X Meeting One| Oct 16 -17, 2025

Project Overview

This initiative aims to unify and expand faculty development efforts into a comprehensive, measurable program that enhances teaching competence and supports academic excellence across the Clinical Learning Environment (CLE).

PROJECT AIMS

- Strengthen teaching quality through scaffolding self-reflection and structured development.
- Promote lifelong learning and mentorship among faculty.
- Align faculty development with institutional priorities and strategic goals.

PROJECT METRICS

- Baseline self-assessments of educator competence using a modified version of the ACGME Clinical Educator Milestones; and build in the modified clinical educator Milestones into programs resident evaluations of faculty.
- Engagement of the community as measured by the number of participants completing the course
- Faculty sense of value for the time required to complete the course

PROGRESS

- **Phase 1:** Needs assessment and stakeholder engagement.
- **Phase 2:** Curriculum development and pilot testing.
- **Phase 3:** Full implementation and evaluation over 18-months.

CURRENT/ANTICIPATED CHALLENGES

- Defining engagement across micro, meso, and macro levels
- Delivery route of education (in person, modules, podcast, etc.) because of clinical faculty having variable schedules.
- Integrating siloed faculty development efforts.
- Ensuring consistent measurement and feedback loops.

MEASURES

- **Baseline Data Collections:** Initial faculty engagement levels (attendance, participation); Existing feedback quality metrics from evaluations; and CLE culture indicators (i.e. survey results, wellness scores).
- **Monitoring Plan:** Track faculty participation in CBFD modules; Measure changes in teaching effectiveness using learner evaluations; Monitor feedback quality and alignment with CBME principles; and collect qualitative feedback from residents and program directors.
- **Outcomes Measures:** Improvement in faculty teaching scores; Increased engagement in faculty development activities; Enhanced CLE culture metrics (i.e. psychological safety, mentorship quality); and evidence of sustained faculty development across departments.
- **Data Sources:** Internal GME and UME evaluation systems; Resident and Faculty surveys; and Institutional dashboards and academic performance reports.

WHAT'S NEXT?

- Needs Assessment on faculty development
- Finalize curriculum and pilot structure
- Launch pilot with selected departments
- Begin data collection and feedback analysis
- Prepare for broader rollout and scaling

METHODS/INTERVENTIONS

- A **Residents-as-Teachers Seminar**, integrated into the GME didactic curriculum beginning AY 2026–2027
- A **Clinical Educator Series** featuring flexible online modules to support busy faculty schedules
- An **Academic Leader Coaching Program** to build mentorship capacity and develop future academic mentors

IRB

- Project is educational in nature and may qualify for IRB exemption.
- Any data collection involving human subjects will be reviewed for compliance and institutional support and ethical oversight will be maintained throughout the project.

NI X Meeting One| Oct 16 -17, 2025

St Lukes University Health Network
Resident Managed Clinics: A Holistic Approach to Wellness

National Initiative

Project Overview

Through a partnership with a local laundry ministry, Family Medicine Residents serve our patient population both in the office and in the community, thus optimizing their clinical learning environment. Family Medicine Residents will rotate at a local laundromat to conduct evaluations, provide screenings and issue education to community members during a laundry cycle. Residents will connect community members with Star Community Health for follow up care. The goal is to measure resident perceptions of this unique rotational experience.

Project Aims

- Provide Residents with hands-on experience in addressing health disparities through direct service and community outreach
- Reinforce the principle that medical training and practice extend beyond the office walls, deeply rooted in the surrounding community
- Address directly our Community Health Needs Assessment (CHNA), which identified access to care, chronic disease prevention, and improved mental and behavioral health as top priorities

Project Measures

- To track the total number of participants served
- To monitor number of individuals who attended follow-up care at Star Community Health
- To assess the impact of this unique rotation outside the traditional office setting, residents will complete pre-, mid-, and post-rotation surveys. These surveys will evaluate changes in their perceptions of how community-based experiences enhance clinical training and understanding of health disparities

Progress

- Created a timeframe for our project
- PGY 1 & 2 Residents will begin rotating at Laundry on Linden late September 2025
- Pre-Survey distributed to Residents early October 2025

Current/Anticipated Challenges

Scheduling follow-up appointments and maintaining the same level of responsiveness

- Previously, team members called the office receptionist directly to schedule appointments.
- With the transition to "Project Access," calls are now routed through a different system, which may limit our ability to schedule appointments as seamlessly as before.
- We are actively exploring ways to adapt and ensure continuity of care for those we serve.

Enhancing the tracking process for community members who receive services at Laundry on Linden

- In collaboration with Star Community Health, we are exploring effective ways to verify which individuals engaged at Laundry on Linden follow through with their scheduled appointments.
- This will help us better understand care continuity and improve outreach efforts.

What's Next?

- By April 2026 we plan to have the Pre, Mid and Post survey distributed and completed by participating Residents.
- By April 2026 we plan to have tracked the number of community members seen at Laundry on Linden and how many of those have received follow up care at Star Community Health.

Measures

- We will utilize RedCap to deliver the Pre, Mid and Post survey to Residents.
- We will collaborate with Star Community Health to track number of community members that have received follow-up care at Star Community Health.

Methods/Interventions

- Distribute pre-, mid-, and post-rotation surveys to Residents to assess their experience and learning outcomes.
- Identify a smooth tracking system to monitor community members engaged at Laundry on Linden and who have received follow-up care through Star Community Health.

IRB

- In progress
- To complete by November 1, 2025

St. Luke's University Health Network
"Clinic to Curb: Resident Physicians in Street Medicine"

NI X Meeting One| Oct 16 -17, 2025

Project Overview

The St Luke's Rural Family Medicine Residency offers primary care to homeless and domestic violence shelters on a walk-in basis, regardless of payment ability. A new "Street Medicine" curriculum, including point-of-care ultrasound and wound care, is being developed using nontraditional settings like shelter chapels. Resident knowledge, skills, and attitudes will be assessed before and after the rotation, and data will be collected on graduates continuing care for marginalized patients.

Project Aims

AIM# 1 Develop and implement a curriculum integrating ultrasound and wound care for homeless shelters using unique learning environments.

AIM# 2 Evaluate residents' competencies before and after the Street Medicine rotation.

AIM# 3 Track how many residents continue serving marginalized populations after graduation.

Project Measures

1. Achieve at least a 30% improvement in residents' knowledge of point-of-care ultrasound and wound care by the end of the rotational experience. This will be measured through pre- and post-rotation assessments 1.

2. Target a 30% increase in the proficiency of residents' clinical skills in providing primary care to homeless patients. This will be evaluated by faculty through direct observation and practical exams.

3. Strive for at least 20% of residents to continue providing services to marginalized patients one year after graduation. This will be tracked through follow-up surveys and interviews with graduates.

Progress

- The team leads are working on establishing project roles
- Brainstorming data collecting methods

Current/Anticipated Challenges

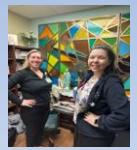
- **HRSA Grant approved:** 5 Year Grant, $2 million in approved funding
- **PAFP Grant approval:** 1 Year Grant, $11,237 in approved funding

Grant Funding: Grant management involves following established procedures to maintain appropriate use of funds.

Data Collection Methods: The team is working on establishing standardized approaches for collecting accurate data to assess the project.

IRB Training and Application: All team members are required to complete IRB training and submit applications by late October 2025.

Carbon & Schuylkill County



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What's Next?

- Identifying the data, it's sources and collection plan
- Define improvement goal and measures of success utilizing data that is gathered from November 2025 – April 2026

Measures

- Data will be gathered via the Research Electronic Data Capture System (REDCap)
- Residents will be surveyed during the Pre, Mid, and Post
- Faculty will monitor education and outcomes
- Faculty will be surveyed during the Pre, Mid, and Post

Methods/Interventions

- **Curriculum:** "Expedition to Equity: Medical Training in Wilderness, Street Medicine, and Rural Frontiers". A 30-month curriculum focused on all areas of street medicine in rural health.

Months	Focus
November 2025 – September 2026	Street Medicine Topics
October 2026 – July 2027	Rural Health Topics
August 2027 – May 2028	Wilderness Medicine Topics

- Residents will be surveyed at Pre, mid-point, and post during first 10-months of the program.
- CEU's will be provided for faculty

IRB

- All should complete this by late October 2025.

NI X Meeting One| Oct 16 -17, 2025

RWJBH Monmouth Medical Center - Integrating Competency-Based Medical Education into EPIC: Creating a Resident-Facing Dashboard for Real-Time Learning and Performance

National Initiative

Project Overview

Our project aims to develop a resident-facing EPIC dashboard that integrates educational and clinical performance metrics to support Competency-Based Medical Education (CBME) and time-variable progression. This dashboard will allow residents to view their individual metrics alongside the hospital's quality scorecard, connecting learning outcomes with patient care outcomes in real time.

By providing transparent, data-driven insights, this initiative strengthens the link between education and quality improvement, promoting resident engagement, self-directed learning, and faculty coaching grounded in real clinical performance.

Project Aims

- Develop and an EPIC-integrated dashboard, pilot in the OBGYN & PEDS.
- Align resident metrics (e.g., patient encounters, procedural logs, documentation timeliness) with hospital performance indicators.
- Strengthen feedback loops by giving residents and faculty shared access to individualized progress data.
- Evaluate impact through pre- and post-intervention knowledge and satisfaction surveys among residents and faculty.
- Support institutional goals of data-driven education, transparency, and continuous improvement in the clinical learning environment.

Project Measures

- **Resident Measures**: Knowledge, satisfaction, and engagement scores (via pre/post surveys).
- **Faculty Measures:** Satisfaction with feedback and assessment efficiency.
- **Process Measures:** Frequency of dashboard utilization; time between encounter completion and feedback.
- **Outcome Measures:** Alignment between milestone attainment and clinical performance metrics.
- **Data Sources:** EPIC reports, New Innovations, institutional quality dashboards.

Progress

- Concept finalized and approved for pilot within OBGYN and Pediatrics.
- IT and GME collaboration initiated; data fields identified for dashboard integration.
- Pre-implementation knowledge check survey drafted and ready for dissemination.
- QI integrated into the project team to ensure we are in line with hospital metrics.

Current/Anticipated Challenges

- Ensuring EPIC integration aligns with hospital IT security and data-sharing protocols.
- Balancing the level of data transparency with psychological safety for learners.
- Gaining early faculty engagement and consistent usage.
- Maintaining dashboard updates and sustainability post-pilot.

Peer feedback: Best practices for evaluating behavioral change after dashboard implementation? Strategies for scaling CBME dashboard models across specialties?

What's Next?

- **Complete baseline (pre-survey) data collection.**
- **Finalize and launch pilot dashboard in OBGYN and Pediatrics.**
- **Conduct 3–6-month post-launch evaluation.**
- **Begin data analysis and early dissemination planning.**
- **Prepare scholarly abstract/manuscript for AIAMC and other academic venues.**
- **Being launch in other specialties.**

Measures

- **Data:** EPIC data fields (encounters, notes, procedures), milestones and data from New Innovations, and quality metrics from the institutional scorecard.

Collection Plan- Baseline: Pre-implementation surveys assessing familiarity with metrics and satisfaction with feedback.

- **Monitoring:** Monthly dashboard usage and data accuracy checks.
- **Outcomes:** Post-intervention surveys, focus groups, and metric comparison.
- **Analysis:** Quantitative (pre/post survey comparisons) and qualitative (resident/faculty feedback themes).

Methods/Interventions

Short-Term: Build dashboard prototype and validate data fields. Conduct faculty/resident orientation on dashboard use. Launch pre- and post-knowledge check surveys.

Long Term: Expand dashboard use to additional residency programs, Integrate goal-tracking and automated milestone mapping and develop framework for scholarly dissemination (abstracts, manuscripts, presentations).

Implementation Approach: Plan–Do–Study–Act (PDSA) model for iterative testing and refinement.

IRB:IRB review planned under Quality Improvement/Program Evaluation category. Pre-post survey instruments and data use procedures will be submitted for determination to ensure compliance with institutional review requirements.

Carolinas Medical Center: Pathway to Patient Safety Professional

Aaron Williams, MPS, CPPS; Jennifer Wellington, DO,MSC; Emily Harrison, MBA; Jennifer Molino, PT, DPT, WCS, CPPS; Daniel Handel, MD, MBA,MPH; Suzette Caudle, MD

NI X Meeting One | Oct 16 -17, 2025

Project Overview

We aim to develop a pathway of distinction in Patient Safety for residents/fellows interested in furthering their knowledge in high reliability, cause analysis, and systems thinking.

Project Aims

- Integrate High Reliability Training into GME
- Enhance Psychological Safety & Just Culture
- Provide in-depth knowledge on patient safety and systems thinking
- Develop future patient safety leaders for our enterprise and beyond

Project Measures

- Completion of curriculum development and enrollment in pilot program
- Culture of Safety and Work Environment survey results and participation
- ACGME institutional survey with focus on patient safety specific questions

Progress

Surveyed resident & fellows for insights on:

- Event reporting
- Culture of Safety results/ACGME survey
- Analysis participation/closed loop communication

Current/Anticipated Challenges

- Current event reporting system allows anonymous reporting
- Time commitment/management
- Trainee participation with program director support
- Recruitment into the program
- Finding the right balance between program and other responsibilities
- What are ways that your institution encourages event reporting by trainees despite a clunky reporting system?
- What does your institution do for patient safety education?
- Do you have a similar program or recognition pathway? If so, what types of incentives does it include?

What's Next?

- Develop project timeline
- Develop pathway requirements
- Develop patient safety curriculum
- Choose a pilot group & date
- Gather data from surveys

Measures

- Safety Event Reporting
- Culture of Safety Results
- Good Catch Submissions
- Conduct a knowledge assessment
- Evaluation of curriculum from pilot group.
- Percentage of program participants who complete

Methods/Interventions

Micro Level:

- Individual Pre- & post Assessment
- Program Pre-& Post assessment
- Individual curriculum
- Activities: Event reporting, surveys, cause analysis, risk management, QI projects, etc.
- Recognition & incentives

Macro Level:

- IHI Basic QI Certificate
- Assignment to Safety Event Group
- ACA in 30 days then presented to Resident SETF
- Just Culture, Forums, & Didactics, Literature Review

AIAMC NATIONAL INITIATIVE X

Meeting One

Project Presentations - Cohort Breakout Session

Cohort Four

Room – Executive Boardroom

Facilitator:
Victor Kolade, MD, Core Faculty, Internal Medicine Residency, The Guthrie Clinic; Professor of Medicine & Regional Clerkship Director for Internal Medicine

NAC Member:
Catherine Apaloo, MD, FACP, Designated Institutional Official and Internal Medicine Program Director at Piedmont Healthcare, American College of Physicians

8 Projects: Ascension St Vincent Evansville, TriHealth, Hackensack JFK, Novant Health, Baptist Health, Guthrie Robert Packer Hospital (3 projects),

NI X Meeting One
Oct 16 -17, 2025

Ascension St. Vincent Evansville — GRASP: Graduate Education & Resource Alignment for Social/Moral Determinants & Patient-Centered Care

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

National Initiative

Project Overview

- Builds on NI VIII/IX → strengthens **Post-Discharge Clinic (PDC)**
- **Goal**: integrate **S/MDoH screening + resource referral** into transitional care while **training residents** in equity & advocacy

Project Aims

- **Aim 1:** Screen S/MDoH → connect patients to resources (CAP Evansville, Homeless Connect, universities, etc.)
- **Aim 2:** Develop curriculum → train interprofessional teams (residents, nurses, social work, students)
- **Aim 3:** Evaluate outcomes → patients, providers, system-level

Project Measures

- Social and moral determinants of health measures; Follow-up rates of Post-Discharge Clinic.

Progress

- Protocol drafted
- eIRB in preparation
- Preliminary analysis tools identified

Current/Anticipated Challenges

- Integrating screening into discharge workflow
- Ensuring cultural/linguistic appropriateness of screening tools
- Ensuring follow-up & patient engagement
- Coordinating with multiple community partners
- Resident/staff time & training burden
- Resident turnover impacting continuity of project

What's Next?

- Finalize & submit IRB
- Pilot combined S/MDoH survey in PDC
- Develop/refine referral pathways
- Launch resident education modules

Measures

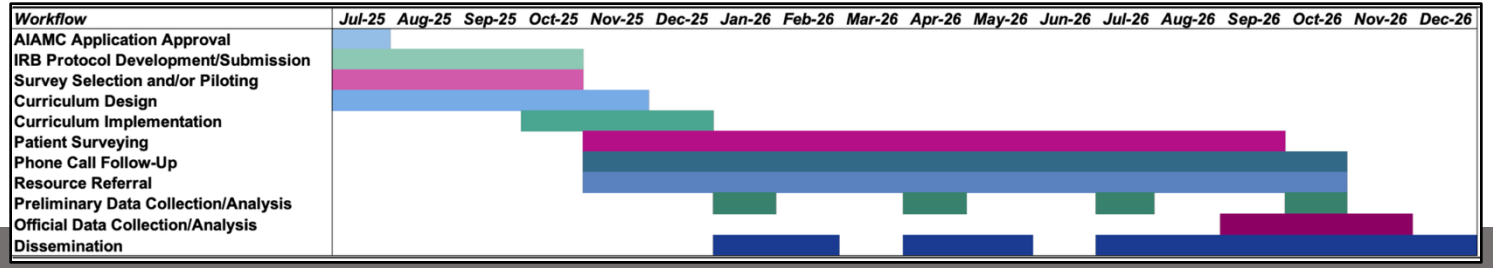
- **Patient** → PDC follow-up, readmissions, ED visits, QoL, mortality
- **Program/Institution** → successful PDC transition, linkage to resources, system-level readmissions/mortality
- **Team** → pre/post knowledge, confidence, skills, engagement

Methods/Interventions

- **Screening:** 15-min combined S/MDoH survey (PRAPARE, HealthBegins, Health Leads, Moral Injury Scale)
- **Observation:** Track patient outcomes (referral uptake, PDC attendance, readmissions, ED use, mortality)
- **Implementation Eval (Hybrid Type 2):** Assess effectiveness + process (feasibility, fidelity, acceptability)
- **Education:** Interprofessional training on screening, referral, advocacy

IRB

- **In the drafting and preparation stage**



TriHealth

Development of a Collaborative Learning Model Among DO Medical Students and Residents

Project Overview

TriHealth will focus on strengthening the osteopathic education experiences with both residents and students as we foster our collaboration with a new osteopathic school of medicine.

Project Aims

- Develop a collaborative learning model where DO residents can have more continuous exposure to osteopathic manipulation.
- Build a curriculum to allow osteopathic residents to maintain their OMM skills with appropriate supervision and support from qualified faculty.

Project Measures

- Increased resident satisfaction with learners in the clinical environment.
- Positive feedback on osteopathic students' experience.

Progress

- Engaged current residents in project to ensure we capture their perspective.
- Conducted literature search on current practices in expanding osteopathic education and enhancing medical student experiences.
- IRB Submission

Current/Anticipated Challenges

- Major partner osteopathic medical college (Xavier University) won't have students till 2027 and rotations at TriHealth starting in 2029.

What's Next?

- Create a survey tool for student experiences
- Review current resident data regarding other learners in the clinical environment.

Measures

- ACGME Resident Survey Data
- Pre/Post Rotation Evaluation/Feedback
- Resident feedback on collaborative learning model

Methods/Interventions

IRB

- Teaching residents how to be teaching
- Integrating Osteopathic Manipulative Medicine (OMM) experience.
- Collecting data from medical students about their expectations and experiences.

PGY 2 and PGY 3 Patient and Provider Continuity at JFK Family Medicine

National Initiative

Project Overview

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.

Project Aims

1. 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.

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

1. Engage the JFK Family Medicine Center clinical teams in a quality improvement project whose aim is: All PGY2 and PGY3 residents will meet the resident and patient sided continuity ACGME requirements during the during the 2025-2026 academic year.

Project Measures

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

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

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

Progress

August 19, 2025: Foundations of Quality Improvement Session
August 26, 2025: Team Meeting: Clinic wide introduction to project (aims 2,3).
September 3 & 24 2025: Reminder to Core Faculty regarding utilization of follow up section when seeing patients in clinic and while precepting
September 4, 2025: Reminder for residents to utilize follow up section
September 26, 2025: As per practice manager, nursing/medical assistants will be reminded to utilize follow up section.

We have noted increased awareness of continuity amongst residents, faculty and clinic staff. We started tracking monthly continuity rates in September.

Current/Anticipated Challenges

Need advice regarding garnering complete buy in from entire clinic staff and providers in regard to the project

There is difficulty with having residents, faculty, MAs, nursing use the follow up section in EPIC -still not being used consistently

Not all residents/faculty were at team meeting, initial QI education session

Need advice regarding our project aim, we decided to focus more on the number of residents meeting the continuity requirement vs the actual percentage of continuity for each resident

What's Next?

-Next Educational QI sessions- will be 10/23/25, 2/17/26, 4/23/26
-Continue to ensure that residents and faculty are utilizing the follow up section -Continue to track continuity percentages monthly
-Monitor progress to transition to fixed schedule -practice team taking lead

Measures

Baseline data is PGY2 and PGY3 resident and patient sided continuity percentages from the 2024-2025 academic year.

-73% of PGY2 and PGY 3 residents met patient sided continuity requirement
-80% of PGY2 and PGY 3 residents met resident sided continuity requirements

[]September
-96% of PGY2 and PGY 3 residents met resident sided continuity requirement.
-44% of PGY2 and PGY 3 residents met patient sided continuity requirement.

Will consistently update running documents to keep track of project interventions through the AIMC project cycle.

Methods/Interventions

Clinical teams will be educated on quality improvement through a series of educational sessions and workshops.

Through in-person meetings, huddles, didactics, and email communication, clinical teams will be educated on current resident continuity of care rates and the importance of improvement.

Appointment scheduling will follow scripted protocol to prioritize appointments with the assigned primary care provider first, then team-based provider scheduling second, then any available provider as a last resort.

All clinic providers will be required to complete the "Follow up" section in the Epic EMR during a patient visit in order to communicate the follow up plan and preferred follow up provider to the team members who schedule follow up visits.

Clinical teams including residents, faculty, nurse practitioners, medical assistants, and nursing will be informed of the modified follow up visit workflow.

A PDSA cycle approach will be utilized to conduct this quality improvement project.

Transition to fixed clinic schedule by July 2026 to improve continuity.

IRB

We have submitted a human subject's research determination worksheet to our IRB to determine if an IRB submission or approval is needed.

NOVANT HEALTH

From the Ground Up: Designing a Resilient and Inclusive Clinical Learning Environment—aims to create a CLE framework that supports professional identity formation, psychological safety, learner well-being, and inclusive culture.

PROJECT OVERVIEW

The purpose of this project is to develop and impiernent a Well-Being Certificate Program aimed at equipping faculty with the knowledge. skills, and tools to become designated Well-Being Champions across departments and training programs within Novant Health. The program will foster a culture of psychological sarety resilience, and weliness in the clinical learning environment (CLE), aligned with ACGME prioritles and institutional values of holistic. human-cetered care.

PROJECT AIMS

- To develop a faculty-focused Well-Being Certificate Program that builds capacity for wellness leadership across Novant Health's clinical learning environments.
- To promote a culture of psychological safety, resilience, and professional fulfillment through faculty development.
- To establish and sustain a network of Well-Being Champions who support resident and fellow well-being at the department and system levels.

PROJECT MEASURES

PARTICIPATION & ENGAGEMENT
Enrollment Rate
Completion Rate
Session Attendance
Engagement Score

WELL-BEING CHAMPION ACTIVATION
- Number of Champions
- Designated
- Champion Project Completion Rate

KNOWLEDGE & SKILL ACQUISITION
- Pre/Post Assessment Scores
- Self-Reported Confidence
- Departments with Active Champions

CULTURE & ENVIRONNMENT IMPACT
- Resident/Fellow Perception of Faculty Support
- Psychological Safety Scores
- Reported Burnout Rates

IRB Approval Pending

PROGRESS

We've made meaningful progress in refining and advancing this initiative:

- **Narrowed Focus:** The project is now centered on launching a Well-Being Certificate Program to train faculty as departmental Well-Being Champions.
- **Institutional Support:** We've secured both financial and operational backing from leadership to develop and implement the program.
- **Expanded Team:** Key stakeholders have joined the project, including the Chief Wellness Officer, Chief Academic Officer, Chief Culture Officer, resident representatives, and program directors.

CHALLENGES

FACULTY TIME & ENGAGEMENT
Competing clinical and academic responsibilisilities may limit participation.
Faculty may need protected time or incentives to fully engage.

SUSTAINABILITY & LONG-TERM ADOPTION
Ensuring the Well-Being Champ-ion role is maintained beyond initial certification.
Avoiding wellness fatigue or perceptions of "one more thing".

MEASURING IMPACT
Defining meaningful and measurable outcomes-tied to well-being.
Capturing data across varied programs and departments.

CONSISTENCY ACROSS DEPARTMENTS
Adapting the program to suit diverse specialties and department cultures.
Avolding duplication of existing initiatives while ensuring alignment

Questions for Cohort Feedback

- How have you engaged faculty meaningfully in well-being or professional development programs at your institution?
- What strategies have worked for sustaining interest and momentum over time?
- How are you measuring the impact of well-being initiatives within the clinical learning environment?
- Have you identified effective incentives (CME, recognition, time off, etc.) for faculty participation in longitudinal programs?

WHAT'S NEXT?

CURRICULUM DEVELOPMENT	PILOT ROLLOUT	EVALUATION & REFINEMENT	FULL IMPLEMENTATION
Fall 2025	Spring 2026	Summer 2026	Fall 2026

MEASURES

BASELINE ASSESSMINNT
Establishing a clear pictrure of where we're starting.

Data Focus: Use surveys or assessment tools before and after certificate completion to measure knowledge gained and changes in well-being.

Sources:

OUTCOMES & IMPACT
Evaluating efectiveness and long-term impact.

Data Focus: Post-program assessments (knowledge-confidence, skill use)
Champion-led project completion

Sources: Resident and fellow perceptions of faculty suppart
Changes in burnout and psychological sscores

ONGOING MONITORING
Tracking progress and participation in real-time

Data Focus: Session attendance, ergagement scores, certificate completion and faculty self-reflection logs

LONG-TERM SUSTAINABILITY METRICS
Ensuring enduring benefits and integration into system culture.

PROJECT METHODOLOGY

- Needs assessment survey of faculty and residents/fellows
- Curriculum development using best practices in wellness and adult learning
- Quarterly touchpoints with faculty participants for reflection and feedback
- Partnership with GME leadership, health equity and institutional wellness office
- Evaluation via post-program surveys, focus groups, and CLE observations

NI X Meeting One| Oct 16 -17, 2025

IMPACT: Initiative for Mentorship and Peer Advancement in Clinical Training

Tina Sanjar, JoVonnda Chresfield, and Seema Chandra
Florida International University/Baptist Health South Florida

National Initiative

Project Overview

Recognizing the limitations of conventional academic mentoring - such as inconsistent engagement, lack of structure, and poor alignment between mentors and mentees - this initiative seeks to create a more effective, meaningful, and sustainable mentorship experience for both residents and faculty.

Project Aims

- **Design** and **Implement** a structured mentorship program within the newly established FIU/Baptist Internal Medicine residency program
- **Develop** faculty into high-quality mentors by supplying the tools to coach, assess, and support trainees effectively
- **Integrate** strengths-based matching to align residents and mentors based on personality traits, values, and communication styles

Project Measures

- Resident and Faculty written evaluations (qualitative and quantitative methods) of the program
- Resident overall satisfaction with faculty mentorship using the Mentorship Effectiveness Scale and ACGME annual survey

Progress

- All 30 interns were matched with faculty mentors based on a strengths assessment as well as career/fellowship plans
- All faculty mentors completed an initial faculty development on mentorship and were given reference materials
- Standardized introductory form designed and completed by all mentor-mentee pairs including initial goal setting
- 3 month follow up meetings underway now

Current/Anticipated Challenges

- Turnover of faculty
- Time constraints around meeting times and additional development for both mentors and residents
- Developing accurate assessments
- Scaling project to more residencies and larger volumes of trainees
- Additional support for selected faculty and residents

What's Next?

- Complete initial written evaluations and review 3- and 6-month follow-up data from mentor/mentee pairings
- Explore additional resources from partner institutions for both faculty development and resident development
- Obtain preliminary feedback from residents doing supplementary programs such as AMWA EVOLVE

Methods/Interventions

- After Match Day, residents and mentors receive structured questionnaires to determine optimal pairing
- Introductions done prior to orientation with initial meetings planned during orientation with protected time for faculty and resident development
- Mentor reports reviewed every three months by residency program leadership
- Written evaluations of the mentorship program every six months

IRB

Not yet submitted

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

X+Y scheduling: Assessing changes in residents' experience, delivery and quality of ambulatory care

NI X Meeting One| Oct 16 -17, 2025

Project Overview

Primary care quality has been assessed for years using standardized metrics in U.S. medical centers. Residents provide a large share of primary care visits; outcomes are similar or sometimes worse than staff physicians (1,2). "X+Y" scheduling (Y = 1–4 weeks clinic block; X = 3–8 weeks non-clinic block) is now used by 44% of internal medicine programs (3).

Broad Project Aims

Primary: Assess the impact of X+Y scheduling on resident and faculty ambulatory care experience.

Secondary: Identify and track gaps in ambulatory quality between resident and non-resident patient cohorts.

Tertiary: Evaluate IM residency program compliance on key ACGME survey items before and after X+Y scheduling.

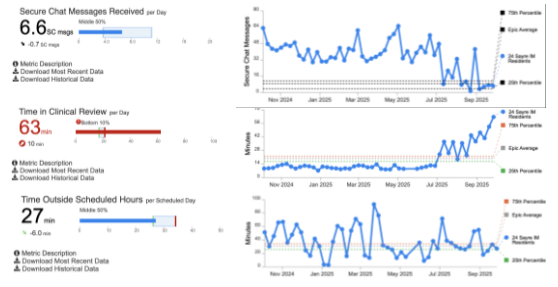
Project Measures

Primary Aim: Epic Signal data including daily appointments per resident/faculty, % same-day appointment closure, time outside scheduled hours ("pajama time"), Time in Notes, Note Composition, Time in Clinical Review, Time in System, Secure Chat, In-basket messages, and In-basket turnaround time.

Secondary Aim: Monthly CPHO reports on ambulatory quality metrics: Lung, Colorectal, and Breast cancer screening; Diabetes bundle; Pneumonia vaccination; Hypertension control; Depression screening; Transition of Care Management visits; Medicare Wellness visits.

Tertiary Aim: Improve IM Residency program compliance on key ACGME survey items by ≥3% by Spring 2026: Faculty fosters environment of inquiry, Balance between education and patient care, 80-hour week adherence and Culture reinforces personal responsibility for patient safety

Progress



Current Challenges

System primary care quality metrics increased from 6 to 10 in August 2025.

Patient panels were locked on 7/1/25 for the purpose of metric attribution, whereas resident patients may change hands as they are seen.

Epic efficiency statistics are possibly confounded by year of residency training.

What's Next?

Measures & Methods

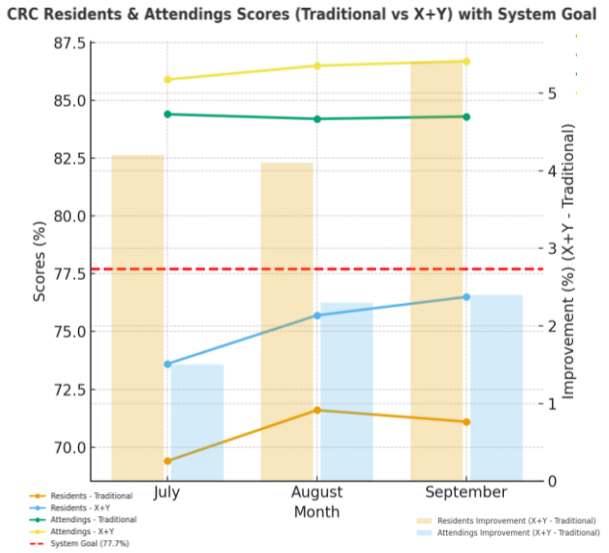
Primary Aim Data: Updated in Signal weekly and includes line charts that look back 12 months (refer to the figures above)

Secondary Aim Data: Updated monthly and will be collated for the project accordingly

Tertiary Aim Data: Updated annually and will be collated for the project when available

Interventions

Individual quality improvement projects for resident patient diabetes bundle and colorectal cancer screening compliance will run through April 2026



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Rewiring the Workflow: Optimizing the Future Clinical Learning Environment through Epic In-Basket Management in Resident Clinics

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

Project Overview

- Streamline Epic inbox workflows by eliminating low-value messages, automating tasks, and promoting team-based coverage.
- Use iterative Plan–Do–Study–Act cycles to reduce message volume and improve timely message resolution.
- Measure success via provider burnout reduction, improved workflow efficiency, and maintained patient safety.

Project Aims

Streamline Epic in-basket workflows to reduce burden on residents

↓

Improve timely handling of clinically relevant messages

↓

Enhance efficiency, cross-coverage safety, and clinician well-being

↓

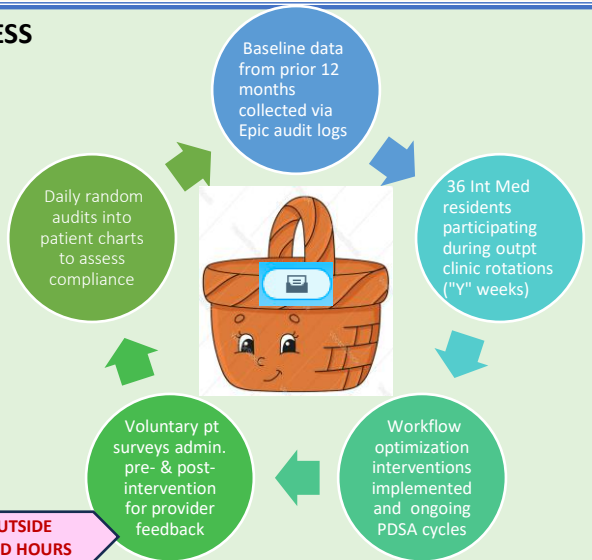
Support sustainable, patient-centered communication and reduce burnout

Project Measures

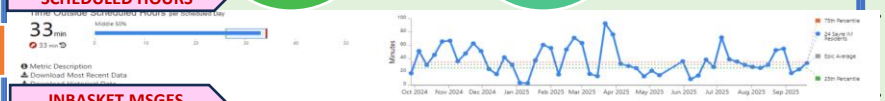
Efficiency & Workload | Resident Experience | Safety & Access:

- Message resolution times, volume reduction, balanced team workload
- Burnout, satisfaction, and work-life balance scores
- Zero missed results/refills, maintained patient access and care availability

Progress



TIME OUTSIDE SCHEDULED HOURS



INBASKET MSGES RECEIVED DAILY

Current/Anticipated Challenges

Operational Challenges

- Balancing clinical work with in-basket tasks
- Ensuring adherence to new workflows and coverage models

Data & Evaluation Challenges

- Maintaining survey response rates
- Protecting patient confidentiality in retrospective review

What's Next?

Measures and Methods

Message resolution	• <24 hrs urgent, <48 hrs routine
In-basket vol	• Avg. msgs/resident/day (target ↓2.5%)
Resident experience:	• Satisfaction, burnout, work-life balance (target ↑2.5%)
Workload distribution	• Overtime hours & message handling time/member
Pt safety	• Zero missed critical results or delayed refills
Ptaccess	• Appointment wait times & call abandonment (no degradation)

Interventions

Eliminate: Remove low-value messages such as automatic ADT notifications, non-actionable alerts, and cancelled order notifications

Automate: Embed protocols for routine tasks including automated prescription refills, templated responses, PDMP integration, AI software (Regard AI)

Delegate: Establish team pools for administrative message handling and patient safety audits

Collaborate: Implement shared coverage and coverage pools with an "empty inbox" policy before vacations

- Use Plan–Do–Study–Act (PDSA) cycles for iterative workflow optimization during the 18-month intervention

IRB # 2508-42

NI X Meeting One| Oct 16 –17' 25

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

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Project Overview

- Introduce problem-based learning into residency didactics and teaching rounds by replacing some traditional lectures, to boost engagement and clinical reasoning.
- Evaluate impact through resident surveys to improve educational quality and alignment with core competencies.

Project Aims

Program specific
- Enhance didactic educational value and facilitator effectiveness
- Empower faculty and residents as effective PBL facilitators

Resident specific
- Improve resident engagement and clinical reasoning confidence
- Provide time efficient high value learning experience

Project Measures

- Questionnaire based assessment of:
- **Knowledge gain:** Understanding before vs. after the session
- **Engagement:** Most useful/engaging elements (case discussions, visuals, peer interaction, instructor style)
- **Learning preferences:** Efficiency of format and preference for traditional vs. PBL sessions

Progress

Traditional Lectures → **Traditional Lectures + Problem Based Learning (Project)** → Problem based learning

- 18-month intervention with ~36 Internal Medicine residents (PGY-1 to PGY-3), currently at month-3.
- Facilitator education completed and PBL integrated into curriculum
- Ongoing collection of pre-, post-session, and post-intervention survey data
- Positive initial engagement from participants and facilitators

Current/Anticipated Challenges

Study Design & Methodology	Participation & Attendance	Facilitation & Implementation	Measurement & Outcomes
Limited sample size & resident participation due to clinical duties and busy rotations	Risk of non-response bias, High survey response rates required for meaningful analysis	Despite training, facilitator consistency and skill in moderating PBL sessions may differ.	Potential researcher bias mitigated by independent datareview

What's Next?

Measures and Methods

Pre– vs Post-intervention surveys → Paired t-test / Wilcoxon signed-rank test for engagement, educational value, reasoning confidence, facilitator effectiveness

Post-session surveys trends analysis over 18 months	Participation metrics → Attendance and survey response rates	**Subgroup analysis** among PGY levels, and amongst resident-faculty facilitators

Interventions

- Weekly PBL sessions replace one traditional didactic and one teaching round
- Sessions are case-based, interactive, and learner-driven
- Faculty and residents trained as PBL facilitators

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