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Abstracts

Meaning *in* Medicine

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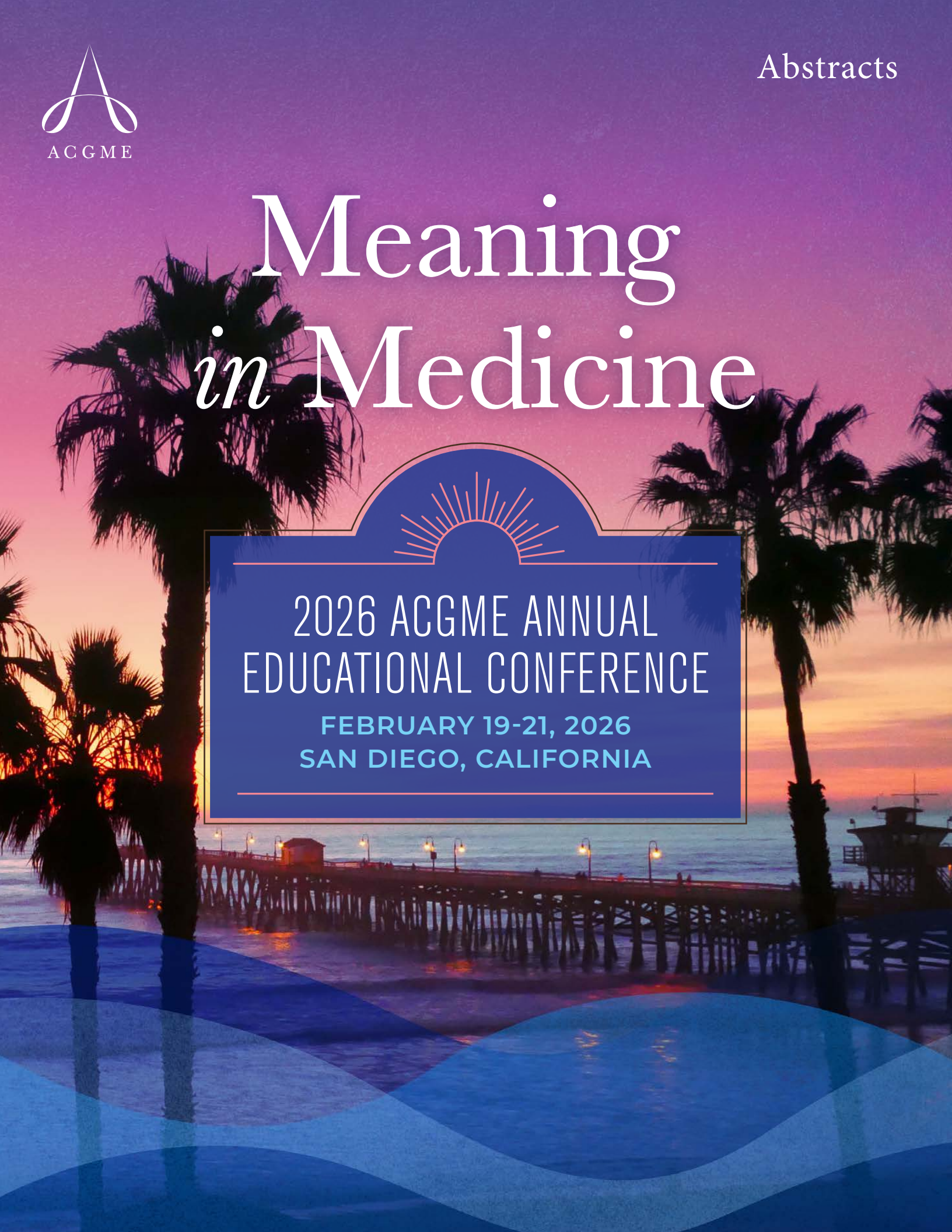

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2026 ACGME Annual Educational Conference Poster Hall

Abstracts displayed in the 2026 ACGME Annual Educational Conference Poster Hall were selected from the 2026 Call for Abstracts. The abstracts represent research and innovations in graduate medical education (GME).

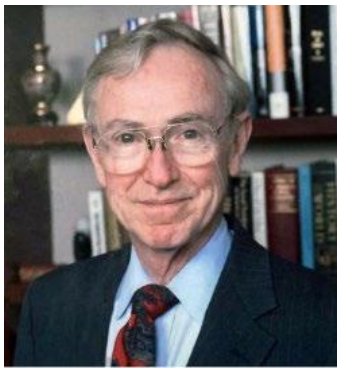
Research Abstracts include completed studies or investigations, with measurable results, that offer new conclusions that contribute to GME research and practice.

Innovation Abstracts include completed programs, projects, or strategies, with measurable results, that share best practices and practical insights with the GME community.

Content displayed in this document is as presented in the authors' submission to the 2026 Annual Educational Conference Call for Abstracts. Poster content of the abstract in this document may vary from the poster displayed in the on-site Poster Hall.

2026 ACGME Annual Educational Conference

Marvin R. Dunn



Marvin R. Dunn, MD

The ACGME lost a beloved colleague and friend with the death of Dr. Marvin R. Dunn on July 30, 2003. Dr. Dunn, 71, was the ACGME's Director of Review Committee Activities, as well as a nationally renowned figure in the medical community.

In 1998, the ACGME was fortunate to have Dr. Dunn join its staff. He brought vast experience, deep wisdom, an unfailing sense of humor, and the capacity to see goodness in each of us. His concern for residents was unfailing. He is greatly missed.

As the ACGME developed clinical work and education hour standards and moved to a competency-based method of evaluating residents and fellows, Dr. Dunn always kept the impact on the learner at the forefront. He had a deep respect for the role of the Review Committees in strengthening the formation of physician learners, and kept the Review Committees and the ACGME on task to improve the quality of life for residents and fellows.

Colleagues and friends across the country contacted the ACGME with memories of Dr. Dunn when he passed. In their letters of condolence, he was remembered over and over again with phrases such as, "a true advocate for excellence in medical education," "the most wonderful combination of wisdom and humor," "wise counsel and gentle style," and "truly one of the good people."

During his distinguished career, Dr. Dunn, a native of Lubbock, Texas, and a board-certified pathologist, held a series of prominent positions. Before joining the ACGME, he served as the AMA's Director of Graduate Medical Education. Earlier in his career he served as Vice President for Health Sciences and Dean of the University of South Florida College of Medicine, Dean of the University of Texas Medical School at San Antonio, Acting Dean and Associate Dean for Academic Affairs at the University of California at San Diego School of Medicine; and Deputy Director of the National Institutes of Health Bureau of Health Manpower.

Dr. Dunn was intimately involved in the institution of poster sessions at the Annual Educational Conference from their inception, as both a judge and councilor. He took great delight in the innovative presentations that encompassed all areas of graduate medical education, and enthusiastically watched the development of best practices related to the Core Competencies and work hours requirements. The ACGME is honored to name its poster reception and Keynote Address in his memory.

Poster #1: What Works, for Who, and in What Context: Initial Realist Evaluation of the Implementation of Competency-Based Assessment in Emergency Medicine

Author(s): Holly Caretta-Weyer, MD, MHPE; Lalena Yarris, MD, MCR

Institution(s): Stanford University School of Medicine; Oregon Health & Science University

Abstract Type: Research-focused

Background
Competency-based medical education (CBME) has established itself as the predominant paradigm for the future of medical education. CBME is comprised of five core components: 1) An outcomes framework; 2) Progressive sequencing of competencies to support progression; 3) Individualized learning experiences; 4) Teaching tailored to competencies; and, 5) Programmatic assessment with emphasis on workplace-based assessment (WBA). Each of these components has given rise to both significant promise and potential pitfalls within the implementation process, particularly when done at scale across an entire specialty, particularly one with as much heterogeneity as emergency medicine (EM).

Objectives
We aimed to identify what is essential for CBME implementation across all programs and contexts and what accounts for acceptable variability in implementation within a given program's context to inform broader adoption of CBME within emergency medicine residency.

Methods
We embarked on implementing the core components of CBME within Emergency Medicine (EM) across eight pilot sites representative of the specialty in the United States. This included the development and implementation of EPAs that span the continuum of EM training, the mapping of developmental milestones to the EPAs, implementation of an adaptable coaching program and individualized learning plan (ILP), and the adoption of programmatic assessment. We subsequently performed a realist evaluation to analyze the implementation across the pilot sites. A realist evaluation examines what works, for whom, and in what context. We performed semi-structured interviews with a broad range of stakeholders including faculty, learners, program leadership, Clinical Competency Committee (CCC) members, coaches, and others and connected context, mechanisms, and outcomes derived from the narratives using an inductive approach.

Results/Outcomes/Improvements
Mechanisms and outcomes of implementation varied significantly between and within contexts. Variability in EPA implementation particularly around who drives the WBA process (faculty vs learners), ranges of milestones ratings tagged to each EPA (most evident in the differences in baseline training duration three versus four years), disparate coaching models based on resource availability, adaptations of ILPs to context, and differences in technology (or absence of it) to collect WBA data, and aggregation and use of programmatic assessment data as well as variation in CCC processes and outputs were identified. Additionally, challenges around faculty development, implementation, and feasibility were identified universally across contexts. However, the five core components of CBME were universally successfully implemented at each program in spite of the variability suggesting that the connections between context, mechanisms, and outcomes can help inform how other programs go about implementing CBME.

Significance/Implications/Relevance

Our realist evaluation of a pilot of implementation of CBME within a single specialty in the United States reveals substantial variability in how the core components are actualized. When implementing across an entire specialty, it is essential to consider feasibility based upon context, what can be transferrable across all programs, and what represents acceptable variability. The mechanisms and outcomes identified can help to inform that. Additionally, change management strategies are key to implementation and stakeholder engagement. The context, mechanism, and outcome triads from this study as well as the identified variability based on setting, resources, learning environment, etc., will help to inform how the full range of programs within EM might consider their own implementations. This will also help to inform the necessary centralized resources and support required for successful specialty-wide implementation.

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Ellaway RE, Kehoe A, Illing J. Critical realism and realist inquiry in medical education. Acad Med. 2020 Jul;95(7):984-988.

Poster #2: Mapping Developmental Progression in a Competency-Based Paradigm: Connecting Milestones and Entrustable Professional Activities

Author(s): Holly Caretta-Weyer, MD, MHPE; Benjamin Schnapp, MD, MEd

Institution(s): Stanford University School of Medicine; University of Wisconsin School of Medicine and Public Health

Abstract Type: Research-focused

Background
The ACGME emergency medicine (EM) subcompetencies provide a framework for programs to assess learners and report on their progress in developmental milestones along a continuum from novice to expert in each subcompetency. Although the Milestones can be helpful in identifying where learners are in their journey toward competence, they were designed to be used by Clinical Competency Committees (CCCs) to make consensus decisions, not as a frontline assessment framework. As such, early attempts to apply the Milestones to workplace-based assessment have been problematic. Given the limitations of the subcompetency and Milestones framework for real-time assessment, proponents of competency-based medical education (CBME) have embraced Entrustable Professional Activities (EPAs) as a more intuitive framework for workplace-based assessment. However, the Milestones remain essential for both ACGME reporting and as a diagnostic assessment tool within the EPAs.

Objectives
To address this gap and allow programs to adhere with current ACGME requirements while implementing EPAs, a fully integrated competency framework was needed. Our goal was to develop this articulation between the EM EPAs and each of the EM subcompetencies and their associated milestones via expert faculty consensus.

Methods
We performed a modified Delphi study to map EM subcompetencies and their associated milestones to each EPA. We convened seven EM faculty members and one PhD education researcher representing the full geographic distribution and spectrum of EM training environments. All except the education research PhD are current or former associate residency program directors or program directors with extensive experience with the EM Milestones and ACGME accreditation standards. Over the course of four months, the group participated in a two-round modified Delphi process to determine, for each of the 22 EM EPAs, for which subcompetencies were necessary to be entrusted to perform that activity. Over the subsequent three months, the group was asked to vote on the following question: If someone were fully entrustable on EPA X, to what Milestones Level would that correspond on subcompetency Y? The Milestones were then mapped backward by supervision/entrustment level to create the final map.

Results/Outcomes/Improvements
We reached consensus on subcompetencies that mapped to each of the 22 EM EPAs in each of the two rounds of voting. These form the backbone of the map as each EPA can be broken down into its component subcompetencies. Each EPA mapped to between two and 10 subcompetencies. Subsequently, we then reached consensus via voting followed by rigorous discussion and debate on the milestone for each subcompetency that mapped to “fully entrustable” on each of the EPAs. To develop a full map of Milestones associated with each of the EPAs, each subcompetency’s milestones were then mapped backward onto the different entrustment levels for each EPA to create the full crosswalk of EPAs to Milestone Levels for reporting purposes.

Significance/Implications/Relevance

This mapping of EPAs to the Milestones serves two purposes: 1) to create an integrated competency framework to allow for the diagnosis of root causes when a resident struggles with a given EPA; and, 2) to allow for easier and more accurate Milestones reporting on a biannual basis to the ACGME. A benefit of using EPAs to derive Milestones ratings is that EPAs assess authentic resident clinical performance. This may increase fidelity of the milestone ratings given that they are derived from direct observations and have the potential to capture resident performance variability and development over time. They may also be less prone to bias than traditional methods of assigning milestones such as faculty gestalt on end-of-rotation forms or in time- and context-separated CCC meetings. While these assertions may be true, this map and its use require us to gather validity evidence to support or refute these assertions and examine the consequences of using an EPA map to assign Milestones ratings.

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Caretta-Weyer HA, Sebok-Syer SS, Morris AM, et al. Better together: A multistakeholder approach to developing specialty-wide entrustable professional activities in emergency medicine. AEM Educ Train. 2024 Mar 25;8(2):e10974.

Poster #3: Exploratory Review of ACGME Site Visit Reports

Author(s): Sonia Sangha, MPH; Lisa Conforti, MPH; Roxana Aleksic, MBA, PMP; Andrea Chow, MA; Cathy Nace, MD; Linda Andrews, MD; Sean Hogan, PhD

Institution(s): ACGME

Abstract Type: Research-focused

Background
The ACGME's current accreditation model, previously dubbed the "Next Accreditation System (NAS)," was implemented beginning in 2013 in part to hold Sponsoring Institutions and programs accountable for safe and effective learning environments. To support this, the NAS added two features: an annual program assessment and review of key performance indicators by specialty Review Committees; and a 10-Year Accreditation Site Visit.[1] Under COVID-19 restrictions, the program 10-Year Accreditation Site Visit was suspended and then discontinued in 2023. Review Committees continue to request site visits for concerns raised on annual program data review. With the near doubling of programs since the advent of the NAS,[2] the ACGME developed a sustainable process to conduct site visits to a portion of programs. A process for random selection from among more than 6,000 programs that had not had a site visit in more than nine years was established to augment the robust annual program data review, ensure compliance with all requirements, and verify annual program review procedures.

Objectives
The objective of the study was to explore Site Visit Reports from the group of randomly selected programs to determine if they uncover themes or signals that point to missing elements that could potentially be captured as additional indicators for the annual program review.

Methods
In 2023-2024, 150 of the 6,502 programs without a site visit in more than nine years were randomly selected for a site visit. One of the 150 programs was removed due to withdrawal; another needed a site visit for other reasons. Following the random site visit and subsequent review, eight of the programs had a status change from Continued Accreditation to Continued Accreditation with Warning or Probationary Accreditation; the remaining 140 programs were granted Continued Accreditation status. We reviewed these Site Visit Reports, focusing on noted issues using grounded theory[3] to develop initial themes. To explore the quality of the themes from the eight programs compared to the 140 programs with Continued Accreditation, we applied a case-control design using template analysis[4] and keyword searches. The process included rigorous human coding and iterative prompt engineering to compare themes. We used NVivo 14 and 15 qualitative software and Rev Insights' private AI software.

Results/Outcomes/Improvements
The analysis identified a difference in the quality of the themes found in the Site Visit Reports for the eight programs with a status of Continued Accreditation with Warning or Probationary Accreditation compared to the rest of the Site Visit Reports. The issues in those eight programs appeared to be more foundational and seemed to permeate throughout the Site Visit Reports, evidenced across multiple program requirements. In contrast, the Site Visit Reports for the programs with a status of Continued Accreditation typically showed more isolated issues rather than widespread problems, and the Site Visit Reports often included more strengths and positive examples of compliance.

Significance/Implications/Relevance

This was an exploratory study of a small sample of Site Visit Reports. The analysis pointed to themes and signals that can be used to design additional research to draw conclusions or point to other research methods to test additional data elements that might be included in future annual review protocols.

Site visit data remain an important tool to support program review to ensure high-quality graduate medical education through the assessment of compliance with specialty/subspecialty-specific Program Requirements.[5] The ACGME cannot conduct site visits for all programs annually, so tracking the findings from site visits to inform the selection of data elements for annual program review is crucial. The ACGME will continue to use an iterative process to analyze site visit findings and their potential implications for informing the annual program review process.

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Poster #4: Urology Resident Surgical Autonomy: A National Analysis of ACGME Case Log Data from 2013-2023

Author(s): Eric Giannaris, BS; Austin Gregory Kinley, MD; Yoon Soo Park, PhD; Niccola Lynch, MD; Sean Hogan, PhD; Kate Kraft, MD; Wesley Adam Mayer, MD; Gina Badalato, MD

Institution(s): CUNY School of Medicine; Baylor College of Medicine; University of Illinois College of Medicine; Columbia University Irving Medical Center; ACGME; University of Michigan Medical School

Abstract Type: Research-focused

Background
Urology residents report limited confidence and readiness upon graduation, with the majority pursuing fellowship to address perceived training deficiencies. A lack of surgical autonomy may contribute to readiness gaps, with smaller-scale studies across various surgical specialties and settings demonstrating decreasing levels of resident surgical autonomy over recent decades. However, urology resident surgical autonomy at the national level has not been studied.

Objectives
To investigate national trends in urology resident surgical autonomy overall and across procedure subtypes by analyzing ACGME Case Log data over an 11-year period.

Methods
Using a novel ACGME database integrating resident characteristics from multiple national data systems, a retrospective analysis of ACGME Case Logs for graduating urology residents from 2013 to 2023 was conducted (N=3,391 residents; 145 programs). Using resident-defined roles (“surgeon,” “teaching assistant,” “assistant”), an autonomy score was determined by calculating the proportion of surgeon or teaching assistant cases to total cases. Overall and procedural subtype trends were analyzed, including general urology, endourology, oncology, pediatrics, and reconstruction.

Results/Outcomes/Improvements
From 2013 to 2023, the mean autonomy score decreased significantly from 94% to 86% ($P<0.001$) and across all procedural subtypes ($P<0.001$); variability in autonomy levels also nearly doubled significantly (8% to 15%, $P<0.001$). Oncology demonstrated the lowest surgical autonomy and the greatest decrease during our study period (83% to 73%, $P<0.001$). General urology and endourology cases maintained the highest autonomy, yet declined similarly (97% to 90%, $P<0.001$; 97% to 91%, $P<0.001$, respectively).

Significance/Implications/Relevance
This study provides the most comprehensive evidence to date confirming a decline in urology resident surgical autonomy on a national scale across all procedure categories. These results underscore the importance of fostering progressive autonomy through targeted educational interventions to better support independent practice readiness.

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Poster #5: The Impact of Transition-Related Negative Goal Expectation Violations on Incoming Medical Residents: An Application of Goal Disruption Theory

Author(s): Jason T. Siegel, PhD; Thomas Coulson-II, MA; Wendy He, MA; Alexander Marshburn, MA; Gregory Guldner, MD, MS

Institution(s): Claremont Graduate University; HCA Healthcare

Abstract Type: Research-focused

Background
The first three months of residency are a time of high risk for physicians. When transitioning into residency, physicians may experience upsetting shifts in their professional or personal lives that can reduce their well-being. These negative expectation violations (e.g., a higher-than-expected cost of living) can threaten residents' psychological well-being. Fortunately, the residents' transition has been gaining additional attention in the literature, and the need for intervention is becoming more accepted. A critical first step in developing effective interventions is to establish a theoretical framework that guides their development. Goal Disruption Theory (GDT) is an ideal framework for this task. GDT explains the personal and goal-relevant factors that dictate when negative expectancy violations are expected to cause psychological disequilibrium, as well as the range of psychological changes that can result from these violations.

Objectives
The current study assessed the extent to which GDT can predict when incoming medical residents' negative expectation violations will be associated with psychological disequilibrium and the changes in thought and action that accompany the disequilibrium. Aligning with GDT, we predicted that more severe negative expectation violations among medical residents, which impacted many outcomes and led them to question their ability to overcome the violation, were associated with psychological disequilibrium. We further predicted that higher levels of psychological disequilibrium would be associated with increased rumination, anxiety, depression, and willingness to endure harm. Although many of these associations have been investigated in the general population, GDT has not been examined in this context.

Methods
A cross-sectional design was employed to investigate the relationship between features of goal violations (e.g., severity, imprint, opinion of efficacy) and psychological disequilibrium, as well as the connection between disequilibrium and psychological adaptations and outcomes (e.g., rumination, anxiety, depression, willingness to endure harm). Data were obtained from a larger study of incoming residents for the 2024-2025 school year. Participants were randomly assigned to one of two survey paths, with only one path including the relevant items (n = 149). For the current analysis, only those who reported experiencing a goal violation related to their upcoming residency were included (n = 113). Measures in the study assessed features of goal violation, psychological disequilibrium, and psychological adaptations.

Results/Outcomes/Improvements
Correlations showed that the imprint of goal violation ($r = .50$, $p < .001$) and opinion of efficacy ($r = .28$, $p = .002$) were significantly and positively related to psychological disequilibrium. In contrast, severity of violation, when combining unexpectedness and the strength of the violated expectation, was not significant ($r = .08$, $p = .407$). Exploratory analyses indicated uncertainty evoked by the violation mediated the relationship between unexpectedness of violation and psychological disequilibrium ($\beta = .25$, $p < .001$, 95% CI [.13, .38]). Regression analysis showed

that imprint of violation explained the most variance in psychological disequilibrium. Psychological disequilibrium was also significantly correlated with anxiety ($r = .22$, $p = .017$), depression ($r = .65$, $p < .001$), burnout ($r = .39$, $p < .001$), willingness to endure harm ($r = .38$, $p < .001$), rumination ($r = .46$, $p < .001$), self-esteem ($r = –.46$, $p < .001$), and stability of self ($r = –.24$, $p = .012$).

Significance/Implications/Relevance

Incoming medical residents are likely to experience numerous expectation violations as they transition to residency. The current data indicate that violations seen as most severe, hardest to overcome, and impacting the most significant number of outcomes are most likely to be associated with psychological disequilibrium. Indicating the potential value in working to minimize these types of negative expectation violations among medical residents, medical residents who had the highest levels of psychological disequilibrium were also those who reported the greatest levels of anxiety, depression, burnout, willingness to endure harm, and rumination. They also reported lower self-esteem and stability of self. In support of applying GDT to the medical resident domain, these data suggest that finding ways to mitigate negative expectation violations can significantly enhance the mental well-being and success of medical residents.

Poster #6: Perceived Help-Seeking of Others Predicts Help-Seeking Intentions Among Residents and Fellows: A Replication and Expansion

Author(s): Jason T. Siegel, PhD; Christopher Falco, MA; Alexander Marshburn, MA

Institution(s): Claremont Graduate University

Abstract Type: Research-focused

Background
Physicians in training experience a high rate of depression; however, not all seek help. Researchers have examined factors related to residents' and fellows' willingness to seek help for depression, so opportunities for intervention may be identified. A recent study posited that residents' beliefs about what most others do or approve of (i.e., perceived social norms) may be such factors. When participants were prompted to indicate the extent to which most of their peers disapproved or approved of seeking help (i.e., a perceived injunctive norm) for depression (1 = Strongly disapprove, 7 = Strongly approve), residents and fellows believed that the majority of their peers approved of others seeking help for depression (M = 5.33). Further, participants' perceived norms of seeking help for depression correlated positively with their own help-seeking intentions, r's = .18–20; perceptions that their peers were disapproving of seeking help related to lower intentions to seek help.

Objectives
The objective of the current study was to replicate the past finding that residents' and fellows' beliefs about whether most of their peers disapprove or approve (i.e., a perceived injunctive norm) positively correlate with their own help-seeking intentions, assessing its reliability. Additionally, the current study sought to examine third variables which may strengthen the relationship between perceived help-seeking norms and help-seeking intentions to identify further targets for intervention: norm certainty (i.e., how certain participants were in their beliefs about their peers), accessibility (i.e., how quickly their beliefs about peers came to mind), elaboration (i.e., how frequently they had thought about their beliefs in the past), and importance (i.e., how important they described their beliefs as), as well as vested interest in seeking help (i.e., how hedonically relevant seeking help would be for them).

Methods
A wellness survey on Qualtrics was sent to incoming residents and fellows at a national hospital organization in 2025, including measures for multiple studies; 1,173 participants gave complete responses (≥ 80% completion; AAPOR RR6 response rate = 84.2%).[1,2] To limit length, participants were randomly assigned to survey paths with different measures. In one, 753 participants completed items for this cross-sectional study: perceived injunctive norms (beliefs of how much most peers approved of seeking help for depression); norm certainty, accessibility, elaboration, importance (how certain they were in their beliefs about peers, how quickly they came to mind, how often they thought about these beliefs, and how important those beliefs were); vested interest in seeking help for depression (the extent to which seeking help for depression would be hedonically relevant); help-seeking intentions; and depressive symptomatology. After listwise deletion and outlier removal, the sample was 500.

Results/Outcomes/Improvements
Like the prior study, when participants (N = 500) indicated the extent to which most of their peers approved of seeking help for depression (i.e., a perceived injunctive norm; 1 = Strongly disapprove, 7 = Strongly approve), participants believed most of their peers approved of help

seeking (M = 5.77). A hierarchical regression indicated that perceived injunctive norms significantly predicted help-seeking intentions, controlling for gender, age, and depressive symptomatology, $\beta = .266$, $p < .001$, with the overall model explaining 11.5% of variance in intentions. Norm certainty strengthened the relationship between perceived norms and intentions, $\beta = .114$, $p = .009$, with the overall model explaining 13% of variance in intentions. The more certain participants were of their beliefs, the stronger the association between perceived injunctive norms and intentions. No other variables (i.e., norm accessibility, elaboration, importance, and vested interest) moderated this relationship.

Significance/Implications/Relevance

The current study indicates that the less approving of help seeking that residents believe the majority of their peers are (i.e., a perceived injunctive norm), the less help-seeking intentions they themselves report. Further, this relationship is strengthened when they report greater certainty in their beliefs about their peers. These findings offer opportunities for further study, specifically testing whether publicizing favorable norms and increasing norm certainty can help increase help-seeking intentions among residents and fellows.

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Poster #7: Virtual Reality Simulation to Improve Ophthalmic Skills in Internal Medicine Residents

Author(s): Aarun Devgan, BA; Jhansi Raju, MD; Joel VandeLune, BS

Institution(s): Loyola University Chicago Stritch School of Medicine; Edward Hines Jr. VA Hospital; Carver College of Medicine

Abstract Type: Innovation-focused

Background
Internal medicine residents encounter a wide range of ocular complaints, yet over 90% of residents receive fewer than 10 hours of formal ophthalmic instruction[1]. This lack of exposure contributes to low confidence in eye examination skills and missed opportunities for timely referral and treatment[2,4]. Given the growing burden of eye disease and limited access to ophthalmologists, equipping internal medicine residents with foundational ophthalmic skills is increasingly essential to improve patient outcomes[3,4]. Virtual reality (VR) technology has emerged as an innovative modality for medical education, allowing learners to engage with interactive 3D anatomy and simulated patients in a controlled environment. While VR has been applied successfully in ophthalmology training for medical students and ophthalmology residents, its potential to enhance ophthalmic competence among internal medicine residents has not been explored[1,3].

Objectives
The purpose of this project was to evaluate the effectiveness of a VR simulation lab in improving internal medicine residents' ophthalmic knowledge, clinical examination skills, and confidence in diagnosing common ocular diseases. Specifically, we aimed to: (1) assess whether participation in a VR session improved residents' ability to identify ocular anatomy and recognize pathology, including cranial nerve and pupillary defects; (2) measure changes in residents' diagnostic accuracy and self-reported confidence in eye examination skills; and (3) explore the perceived relevance and usefulness of VR-based ophthalmic education for future clinical practice. By addressing a gap in residency training where limited ophthalmology exposure reduces competency, this project sought to determine whether VR-based learning could serve as a feasible, scalable educational innovation within graduate medical education.

Methods
Eighty internal medicine residents participated in faculty-led VR simulation sessions. The sessions included interactive stereoscopic models to review ocular anatomy and virtual patient encounters to practice identifying cranial nerve and pupillary dysfunction. VR software from A Nu Reality was used to deliver immersive, case-based training. Pre-session and post-session quizzes assessed knowledge of anatomy and diagnostic accuracy, while surveys measured residents' confidence in examination skills and the perceived relevance of VR to clinical practice. Data were analyzed to compare pre- and post-intervention outcomes, focusing on both objective knowledge gains and subjective attitudes toward the educational value of VR training. This design provided a structured, experiential learning environment with measurable outcomes in knowledge, skills, and confidence.

Results/Outcomes/Improvements
Of 80 residents who participated, 62 completed both pre- and post-session assessments. Objective knowledge of ocular anatomy improved by 25.98%, and diagnostic accuracy in recognizing ocular pathology increased by 67.66%. Residents showed measurable

improvement in identifying cranial nerve and pupillary defects, as demonstrated by a 17% post-session quiz increase in average score. Figure data confirmed significant gains in labeling ocular structures and performing exam skills in the VR environment. Subjective survey results indicated higher confidence levels and strong agreement that the session enhanced clarity of ophthalmic concepts and was relevant to clinical practice. Collectively, the data demonstrate that integrating VR into residency training resulted in substantial improvements in both objective performance and residents' self-reported preparedness to evaluate patients with ophthalmic complaints.

Significance/Implications/Relevance

This project demonstrates that a VR simulation lab can effectively improve internal medicine residents' ophthalmic knowledge, diagnostic accuracy, and confidence in eye examination skills. By addressing a critical gap in residency training where ophthalmology exposure is limited, this VR lab offers a scalable, reproducible, and engaging educational modality. The findings suggest that immersive technology can supplement traditional didactics, enhance early recognition of vision-threatening conditions, leading to better patient outcomes. Beyond internal medicine, this innovation can be adapted for other specialties, such as emergency medicine or family medicine, where initial evaluation of ocular complaints is common. The integration of VR simulation into graduate medical education has the potential to advance competency-based training, promote interdisciplinary collaboration, and prepare residents more effectively to meet the needs of patients in diverse clinical settings.

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Poster #8: Use of the Reverse Clinical Competency Committee as an approach for Residency Program Faculty Evaluation and Development

Author(s): Keia Hobbs, MD

Institution(s): University of Illinois Chicago

Abstract Type: Innovation-focused

Background
The relationship between the development of faculty and residents is critical to the functioning of training programs. The ACGME established the Clinical Competency Committee (CCC) (Andolsek, et al., 2020) to review residents' and fellows' progress toward competence in their given field. However, the ACGME often relies on specialties to develop faculty as the program allows. (ACGME, July, 2019). In many residency programs, faculty development is often based on resident evaluations that assess the program and educators. The caveat is that a resident in a larger program may feel more comfortable assessing faculty educators because of the presumed anonymity and confidentiality of the review. Smaller programs (<12 residents) are often faced with the difficulty of giving constructive feedback for fear of reprisal and lack of anonymity/confidentiality.

Reversing this CCC (rCCC) provides feedback from resident to faculty confidentially.

Objectives
1. Understand the concept and purpose of an rCCC process in faculty evaluation.
2. Review techniques for implementing an rCCC process.
3. Utilize an rCCC for faculty development.

Methods
We performed a series of quarterly interviews with surgical subspecialty residents at one institution from August 2018-February 2024 regarding faculty teaching and its impact on residency education. Facilitators met with residents and faculty eight times during the study: October 2018, February 2019, July 2019-August 2019, December 2019, April 2020, June 2020, April 2022, February 2024.

Each session lasted 60-90 minutes, with part of the session reviewing faculty evaluations. We provided residents with guidelines for the process of conducting the rCCC. We discussed each faculty member and provided space for residents to comment or ask questions about the evaluation or the faculty member. Additional time was spent on faculty improvement questions, which were applied to all faculty members. Feedback was then collected on each faculty member with an additional one to two comments on overall performance and given to the faculty during one-on-one sessions to preserve resident anonymity and confidentiality.

Results/Outcomes/Improvements
Before each quarterly rCCC session, we reviewed faculty evaluations with residents, including scores and comments. We inquired of the residents if faculty educators had incorporated previous resident feedback. We also ascertained if facilitator-distilled feedback maintained the anonymity and confidentiality of residents. This was to ensure the effectiveness of this procedure. Residents were also receptive to this format. Many felt it allowed an environment to foster communication and feedback regarding faculty and other educators. Residents discussed evaluations and were instructed to answer feedback questions that would facilitate discussions with faculty regarding clinical teaching.

Faculty evaluations were scored on a five-point scale with 1=poor and 5=excellent. The faculty

evaluation had several subcategories that residents rated. We chose six categories to review over time. These sections were chosen for their direct relation to resident teaching and ease of providing feedback.

Significance/Implications/Relevance

After reviewing faculty evaluations over time, we did not observe a statistically significant improvement in faculty evaluation scores with the reverse CCC. However, with the process allowing for effective anonymity, it is hypothesized that residents were freer to give more accurate evaluations of faculty performance and to decrease overall evaluation inflation for fear of reprisal. Our sample size was small and may not have enough power to represent a change after intervention. We also reviewed information with one program but feel that this could be applicable to other small programs. Faculty development and behavioral change may require more time to observe significant differences. We will continue to revise and enhance this format as this could be a valuable and innovative review of faculty educators and create an effective learning environment.

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Poster #9: Training Through Trauma: A Multivariate Analysis of Burnout and Associated Factors Among Physician Trainees in Guatemala

Author(s): Ekshika Patel, BS; Claire Bradley, BA; Daisy Ramirez-Estrada, MD; Adrienne Mann, MD; Edwin Asturias, MD; Tyra Fainstad, MD

Institution(s): University of Colorado, School of Medicine; Fundación para la Salud Integral de los Guatemaltecos; Texas Health and Human Services, San Antonio State Supported Living Center; University of Colorado Anschutz Medical Campus; Veterans' Health Administration, Eastern CO Health Care System; Children's Hospital of Colorado, University of Colorado Anschutz Medical Campus

Abstract Type: Research-focused

Background
Burnout is a pervasive occupational hazard in medicine, beginning early in training and linked to depression, suicide, medical errors, and attrition. While physician burnout has been extensively studied in high-income countries, limited data exist from Latin America. Guatemala faces unique challenges, including scarce mental health resources, high social differences, and limited regulation of residency training.

Objectives
This study aimed to characterize burnout, psychological distress, and moral injury among Guatemalan medical residents.

Methods
This is a cross-sectional survey of residents in Guatemala between September and October 2024. Surveys included demographic information and validated Spanish-language instruments assessing burnout (Maslach Burnout Inventory), depression (PHQ-9), anxiety (GAD-7), stress (PSS-4), self-compassion (SCS-SF), impostor syndrome (Young Impostor Syndrome Scale), and moral injury (MISS-HP). Logistic regression was used to identify demographic and occupational risk factors for distress.

Results/Outcomes/Improvements
Of 1,729 eligible residents, 589 (34.1%) responded and 504 (29.1%) completed the full survey. Respondents averaged 30.6 years of age; 54.5% were female and 95.6% Guatemalan. Prevalence of distress was high: 83% reported high emotional exhaustion, 90% high depersonalization, and 95% low personal accomplishment. Moderate-to-severe depression was present in 32.7%, anxiety in 40.7%, stress in 49.2%, and impostor syndrome in 41.2%. Moral injury was nearly universal, with 89.3% reporting scores consistent with functional impairment. Harassment and frequent 24-hour shifts were strongly associated with higher burnout, depression, anxiety, and stress. Female and LGBTQ+ residents reported greater emotional exhaustion, stress, impostor syndrome, and lower self-compassion. Mid-level trainees were at increased risk of emotional exhaustion.

Significance/Implications/Relevance
Resident physicians in Guatemala face unprecedented levels of burnout and moral injury, exceeding rates reported globally. Modifiable factors, including harassment and workload intensity, were strongly associated with distress, alongside structural differences tied to sex and sexual orientation. These findings highlight the urgent need for residency reform in Guatemala, including standardized protections, culturally responsive mental health infrastructure, and systemic efforts to address moral injury and safeguard trainee well-being.

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Poster #10: Why Coaching Works: A Grounded Theory Qualitative Analysis of Physician Coaching Through a Self-Determination Theory Lens

Author(s): Tyra Fainstad, MD

Institution(s): University of Colorado

Abstract Type: Research-focused

Background
Physician burnout starts early in training and threatens well-being and the clinical learning environment. Coaching has been shown in randomized trials to improve physician trainee well-being, but the mechanisms remain unclear. Self-Determination Theory (SDT) suggests well-being is promoted when core psychological needs of autonomy, competence, and relatedness are supported. Understanding how coaching aligns with these needs can illuminate why coaching works and how it may foster growth in residents and fellows. This study applied qualitative methods to analyze physician coaching sessions through an SDT lens.

Objectives
To investigate how physician coaching supports well-being by meeting psychological needs, fostering psychological safety, and addressing barriers, such as moral injury, impostor syndrome, and low self-compassion. Specifically, to generate a grounded theory of the mechanisms by which coaching catalyzes intrinsic motivation, identity formation, and perspective shifts in physician trainees.

Methods
This qualitative study analyzed 16 hour-long coaching calls between physician coaches and graduate medical education (GME) trainees (residents and fellows) participating in the Better Together Physician Coaching Program. Participants were recruited through institutional listservs at 26 participating GME institutions. Sixteen coaching sessions from the Better Together Physician Coaching program were transcribed and analyzed using grounded theory. Deductive codes were informed by SDT constructs (autonomy, competence, relatedness) while inductive codes emerged iteratively until thematic saturation. The analysis examined coaching strategies, participant barriers, and evidence of psychological growth across sessions.

Results/Outcomes/Improvements
Three overarching strategies—normalization, validation, and appreciation—created psychological safety, which emerged as a foundational theme. Coaches then consistently used strategies supporting autonomy (reflective questioning), competence (skills reinforcement), and relatedness (empathy, shared identity). Within this environment, participants described shifts in identity, increased self-compassion, and growing intrinsic motivation. They also articulated barriers, such as moral injury and impostor syndrome. Over time, many participants reframed experiences and strengthened internal validation.

Significance/Implications/Relevance
Coaching may enhance trainee experience of the clinical learning environment by addressing vulnerabilities and promoting autonomy, competence, and relatedness. Through providing psychological safety, coaching supports identity formation, self-compassion, and intrinsic motivation, which are critical for mitigating burnout. These findings suggest the mechanisms through which coaching, a scalable intervention with robust quantitative data, has relevance across institutions seeking to improve

graduate medical education outcomes.

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Poster #11: An Organizational Psychology Approach to Advancing Program Coordinator Well-Being

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Institution(s): HCA Healthcare; Claremont Graduate University; HCA HealthOne Swedish Medical Center

Abstract Type: Research-focused

Background
Recent publications from the ACGME highlight the workplace well-being challenges of program coordinators (PCs)[1] and offer supporting strategies.[2] However, to make sustained progress in well-being efforts, understanding well-being through grounding theories may prove beneficial, as theories can be tested, disproven, and provide predictive ability. Thousands of prior publications have shown that Self-Determination Theory (SDT), a well-researched psychological theory of motivation and well-being, explains the mechanisms of well-being and distress in multiple populations, including residents and fellows.[3] In SDT, the extent to which the environment supports, or thwarts, three basic psychological needs (BPNs) – autonomy, belonging, and competence – predicts well-being and distress. Autonomy is the sense of endorsement of one's actions (a sense of agency versus feeling controlled), belonging is a sense of meaningful connection, and competence is a sense of mastery and growth.

Objectives
We sought to duplicate the recent ACGME well-being survey of program coordinators with a large, system-wide sample and include measures of psychological need fulfilment from the SDT literature. Building on decades of research in SDT, we hypothesized that a perception of basic psychological need support would correlate with well-being, and a perception of need thwarting would correlate with distress. Furthermore, while all three of the basic needs are important, in SDT the need for autonomy is frequently the most predictive of psychological outcomes, yet the least likely to be a target of interventions. Accordingly, we hypothesize that autonomy will be the most closely related to well-being among this population.

Methods
The [redacted] developed an online survey that duplicated most of the items in the ACGME PC well-being survey. Items included overall workplace satisfaction, anxiety (GAD-7), depression (PHQ-8), two-item burnout scale from the MBI, professional fulfillment, level of stress, likelihood to leave their position, and a three-item short form of basic psychological needs at work. The survey was released during an [redacted] program coordinator summit with a survey link which was subsequently emailed to all participants as well. All participants work for [redacted] and 47 possible specialties were represented across [redacted]. Pearson correlations were calculated between variables and multiple regression was used to examine the relationship between basic psychological needs and well-being variables. Comparison of [redacted] PCs to the ACGME population were done with two-sided t-tests.

Results/Outcomes/Improvements
248 of 268 PCs completed the survey (92.5%). Compared to the ACGME survey, participants reported less burnout, depression, anxiety, and intention to leave, and greater satisfaction. The mean of BPNs was significantly correlated with overall satisfaction (.39) and work-related satisfaction (.42), stress (-.29), emotional exhaustion (-.27), depersonalization (-.31), overall burnout (-.34) and the likelihood of leaving the position (-.41). While each basic need was independently correlated with each outcome variable, autonomy had the largest associations. A

regression analysis of each BPN found that autonomy was a significant predictor of satisfaction; a significant negative predictor of work-related stress, burnout, depersonalization, and the likelihood of leaving. Competence was a significant predictor of overall satisfaction and a significant negative predictor of the likelihood of leaving the position. Relatedness was not a significant predictor of any outcome.

Significance/Implications/Relevance

SDT provides a well-researched underlying theory to explain workplace well-being and distress. As hypothesized, BPN satisfaction predicted well-being and ill-being variables. Importantly, autonomy – the sense that one's actions are volitional, endorsed, and in alignment with one's values rather than being controlled or coerced – had the strongest relationship to well-being. Although frequently a target of interventions, belonging was not significant after controlling for autonomy and competence support. Researchers in SDT have found that five organizational actions can increase the sense of autonomy: efforts to understand the perspective of the PC, validating emotions, providing explanatory rationale for required activities, allowing choice where possible, and avoiding controlling language. This research provides support for viewing PC well-being through the lens of SDT which allows theory-linked interventions that provide lasting improvements in workplace well-being.

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Poster #12: A Comprehensive Analysis of Administrative Models in Graduate Medical Education: Centralized vs. Departmental Structure

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Institution(s): Marshall University Joan C. Edwards School of Medicine; Sheikh Khalifa Medical City

Abstract Type: Research-focused

Background
Graduate medical education (GME) in the US is a vital, complex, and multibillion-dollar industry that bridges medical school and clinical practice, significantly influencing patient care quality and safety. Funded primarily through public sources, notably Medicare, GME faces criticism for its outdated financial model and lack of transparency. Institutional leaders must navigate various demands to cultivate a medical workforce capable of addressing societal needs, including physician shortages and technological advancements. GME administrative models range from centralized to decentralized structures. Centralized models consolidate decision-making within a singular GME office, promoting uniformity and economies of scale, while decentralized models empower departmental leaders, allowing for tailored strategies and quicker responses to specific needs. An effective GME model balances centralized oversight with decentralized execution.

Objectives
This research aims to deliver a comprehensive, multi-faceted analysis of centralized and departmental administrative models in GME. The principal objectives are as follows:

To specify the distinct roles, duties, and workflows for essential staff within each model, including the DIO [designated institutional official], GMEC [Graduate Medical Education Committee], program directors, and program coordinators.

To evaluate the influence of each model on essential institutional measures, encompassing administrative efficiency, financial performance, accreditation compliance, and stakeholder satisfaction.

To assess each model's ability to accommodate the changing educational environment, encompassing competency-based education and the use of technology and data analytics.

To present an evidence-based framework for strategic decision-making and provide actionable recommendations for institutional leaders aiming to enhance their GME enterprise.

Methods
This research is based on a comprehensive analysis of the supplied research materials, encompassing peer-reviewed academic articles, official policy documents from accrediting organizations, institutional websites, and professional job descriptions. The data were compiled to establish a comparison framework for GME administrative models.

The analysis advances via six fundamental dimensions to guarantee a comprehensive and fair evaluation of each model’s performance:

1. Administrative Efficiency and Operational Management

2. Financial and Economic Implications
3. Accreditation and Compliance Oversight
4. Stakeholder Satisfaction and Wellbeing
5. Educational Quality and Outcomes
6. Scalability and Adaptability

This structured, multi-faceted approach leads the analysis from a mere superficial evaluation of advantages and disadvantages to a profound comprehension of the causal relationships and strategic trade-offs intrinsic to each organizational design.

Results/Outcomes/Improvements
A centralized GME model consolidates functions within one office, enhancing efficiency and reducing costs. It eliminates redundancy and can be more agile than a departmental model, which can produce redundancy and inconsistencies across departments. The ACGME mandates a centralized system for oversight and compliance, which streamlines the management of affiliation agreements and significant program modifications. A centralized approach can improve stakeholder satisfaction by offering equitable resources across the institution. A centralized model can facilitate the transition from conventional training to a competency-based, data-driven approach, while a departmental model may lag behind systemic advancements. A centralized model exhibits significant scalability for large, intricate, or geographically distributed organizations. A hybrid approach is often optimal, combining centralization of strategic oversight of compliance, finance, and technology with departmental autonomy.

Significance/Implications/Relevance
The administrative structure of a GME organization is a strategic decision that impacts an institution’s ability to educate future physicians, address community health needs, and maintain financial and academic competitiveness. A hybrid model that combines the best parts of both methodologies is ideal. The GME Office should oversee all system-wide functions, including accreditation, regulatory compliance, strategic financial management, institutional technology, and well-being services. Departments and program directors should retain authority over program-specific functions, such as specialty-specific curriculum development, daily program operations, trainee recruitment, and mentorship. The recommendations for institutional leaders include strengthening the authority of the Central GME Office, establishing distinct lines of authority and communication, and advocating for local innovation.

Poster #13: Building Leaders Within: Finding Meaning, Connection, and Growth in a GME-Wide Chief Resident Leadership Program

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Institution(s): David Geffen School of Medicine at UCLA; Stanford Health Care; The University of Chicago Booth School of Business; Stanford University, School of Medicine

Abstract Type: Innovation-focused

Background
The chief resident role is a pivotal leadership position, acting as a crucial bridge to future academic leadership for some, while preparing all for the inherent leadership demands of a physician's role. Studies highlight variability in the chief year experience, with many facing unanticipated personal and professional challenges due to insufficient leadership experience and training. To address this leadership preparation gap, we developed a longitudinal, graduate medical education (GME)-wide leadership curriculum designed to empower chief residents with essential skills, fostering both competence and confidence. This program provides practical tools and builds a community of peers to support a meaningful, sustainable experience in this critical role, while laying a foundation for future leadership success, enhancing career longevity, and fostering professional fulfillment.

Objectives
To evaluate a leadership curriculum for chief residents across GME that cultivates role-specific leadership skills, aiming to enhance confidence, foster meaningful connection, and promote purpose and success in their leadership responsibilities.

Methods
A multidisciplinary team of medical educators with leadership training experience, representing five specialties, along with organizational behavior experts and recent chief residents, developed and delivered the curriculum. Informed by leadership theory, applied behavioral science, and a needs assessment of current chief residents, the program was designed using self-determination theory to address skill gaps by improving chief residents' leadership competence, relatedness, and autonomy. Two half-day workshops were held for all incoming chief residents at one institution, covering personalized leadership strengths assessments, conflict resolution, perspective-taking, exercises on challenging scenarios, and strategies for feedback. Participation in cross-departmental groups built cohorts of emerging leaders across specialties. Participants completed pre- and post-session surveys. Data were analyzed using descriptive statistics and free-response questions using thematic analysis.

Results/Outcomes/Improvements
A total of 77 chief residents participated in the course, with 68.8% (53/77) completing evaluations. Participants demonstrated significant improvements in self-confidence across all assessed leadership domains ($p<0.05$): self-awareness and regulation, social awareness, communication, feedback, and role management. Qualitative feedback indicated that participants valued building community across disciplines, learning frameworks to approach difficult situations, gaining perspectives from faculty outside of medicine, and having dedicated time for reflection and intentional skill development. Chief residents also appreciated the institution's commitment to prioritizing their time away from clinical duties and delivering a meaningful leadership curriculum to support their personal and professional growth.

Significance/Implications/Relevance

This longitudinal, GME-wide leadership program for chief residents demonstrates that structured, tailored training can significantly improve self-confidence across essential leadership domains. It also promotes meaningful peer connection, encourages reflective practice, and supports intentional leadership skill development. Additionally, the program underscores the importance of securing stakeholder buy-in and aligning content with the specific skill gaps identified amongst current chief residents. Similar initiatives could be implemented at other institutions to enhance leadership development and professional fulfillment for emerging physician leaders across residency programs and specialties.

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Poster #14: Framing Medical Education Curricula with the ACGME Clinician Educator Milestones

Author(s): Reid Evans, PhD; Stacy Potts, MD

Institution(s): University of Massachusetts Chan Medical School

Abstract Type: Innovation-focused

Background
As interest in medical education increases among residents and fellows, many graduate medical education (GME) programs lack structured, developmental pathways to cultivate future clinician educators. Existing medical education electives often rely on fragmented content without clear frameworks for progression, limiting their impact and sustainability. In response, the ACGME released the Clinician Educator Milestones (CEMs) to support the longitudinal development of teaching competencies across key domains. However, integration of the CEMs into medical education curricula remains limited. This project addresses that gap by designing a practical, replicable elective that uses the CEMs as both a developmental guide and curricular framework. This elective aligns instructional content, self-assessment, feedback, and individualized learning plans with CEM domains to promote teaching excellence, reflective practice, and competency-based clinician educator development.

Objectives
The objective of this project was to design and implement a structured medical education elective for GME trainees that uses the ACGME CEMs as both a developmental framework and a curricular design tool. Specifically, the elective aimed to: (1) promote self-assessment of teaching competencies using milestone descriptors and behavioral examples; (2) guide the creation of individualized learning plans (ILPs) aligned with CEM domains; (3) provide targeted instruction on key educational topics such as didactic teaching, formative feedback, clinical instruction, and reflective practice; and (4) evaluate the feasibility and perceived impact of the curriculum using structured feedback from participants. By grounding the elective in the CEMs, the project sought to offer a coherent, evidence-based approach to developing clinician educator identity and competency across diverse specialties and training contexts.

Methods
This project involved the design, implementation, and iterative refinement of a four-week medical education elective for residents and fellows, drawing on the ACGME CEMs as the theoretical framework. The curriculum was developed using backward design principles and delivered through interactive workshops on didactic instruction, clinical teaching, feedback, reflective practice, and educational scholarship. Participants engaged in milestone-based self-assessment, completed Milestones-focused individualized learning plans, and applied CEM-aligned observation and planning tools. Instructional strategies included small-group discussion, peer observation, structured reflection, and case-based application of teaching techniques. Feedback and survey data were collected to assess feasibility, perceived relevance, and alignment of ILPs with CEM domains. Curriculum materials were refined based on participant input.

Results/Outcomes/Improvements
The elective has been implemented four times across multiple residency and fellowship programs, with participants representing a range of specialties. Survey responses consistently demonstrate increased awareness and understanding of the ACGME CEMs and their relevance to educational development. Participants reported that the CEM-based self-assessments and ILPs helped clarify personal strengths and areas for growth as educators. Review of completed ILPs shows alignment with specific milestone descriptors, suggesting successful application of

the CEMs to goal-setting for clinician educator development. Learners also engaged in structured observation, feedback exercises, and curriculum planning using CEM-based tools. These outcomes indicate that the elective supports developmental growth and offers a practical model for integrating the CEMs into GME faculty development.

Significance/Implications/Relevance
This innovation addresses a persistent gap in GME: The lack of structured, developmentally informed curricula to support residents and fellows pursuing careers as clinician educators. By using the ACGME CEMs as a design framework, this elective promotes self-assessment, individualized learning plans, and curriculum mapping aligned with recognized educator competencies. It supports coherence across educational activities, reinforces evidence-based teaching strategies (e.g., backward design, active learning, formative feedback), and fosters reflective practice and goal setting—areas essential to educator development yet underemphasized in GME. The curriculum's integration of the CEM Supplemental Guide ensures adaptability across institutions and specialties, making it scalable and sustainable. This work responds to national calls for competency-based and precision education and offers a practical model for faculty development programs nationwide.

Poster #15: Graduating Resident Confidence in Essential Emergency Medicine Procedures

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Institution(s): Valley Health System; Tower Health; ACEP; Boston Medical Center; St. Luke's Bethlehem; Vituity/Wichita; Rush University; Allegheny General Hospital

Abstract Type: Research-focused

Background
Invasive procedures are part of the scope of practice of emergency medicine, but they carry significant risk for complications and adverse events. Acquisition and maintenance of procedural skills for both trainees and practicing providers are essential in the prevention of harm to patients who depend on these procedures. Optimal skill performance levels typically peak during or shortly after completing residency training. However, it remains uncertain whether emergency medicine graduates consistently achieve the necessary competence within the three- or four-year residency framework.

Objectives
The primary objective of this study was to identify what factors affect confidence levels in procedural skills as learner-centered proxy for proficiency. A second objective was to determine which common procedures may be associated with lower confidence levels, and if simulation resources were perceived to be successful in filling those gaps.

Methods
The study is a cross-sectional survey of graduating residents of emergency medicine residency programs disseminated and collected in the spring of 2025. Responses used a five-point Likert scale based on similar previously published survey studies. Programs were selected to represent a broad sample of national programs. A 25-item survey was created; content validity evidence was developed via literature review and expert input. Response process validity evidence was developed by piloting with think-aloud testing. Additionally, the survey was pilot-tested with recent graduates in June-July of 2024, to aid in validation of the survey, test electronic interface, and evaluate clarity of email introductions and other communication. Program contacts (PC) were identified from recruited programs who sent out the surveys to their class of seniors; responses were kept anonymous and deidentified; PC did not have access to any data or responses.

Results/Outcomes/Improvements
We received responses from 103 residents from 22 programs (41% of residents; 61% of programs). 79 residents (77%) were from three-year programs, and 24 residents (23%) were from four-year programs. We had 11 programs (55%) from the northeast, but at least one program from each region surveyed. Less than 50% of residents reported ‘agree’ or ‘strongly agree’ for pericardiocentesis, lateral canthotomy, cricothyrotomy, and vaginal deliveries. Procedures clustered together across groups. The four procedures residents were least confident in were clustered together, along with chest tubes. Intubations, procedures with vascular access, and paracentesis were also clustered together. A third clustering centered around resuscitations and procedural sedations. The procedures for which residents most needed simulation to graduate were cricothyrotomy (86%), pericardiocentesis (85%), cardiac pacing (46%), and lumbar puncture (38%). Every program required simulation to complete their requirements in some fashion.

Significance/Implications/Relevance
Identifying factors that align with high confidence levels can guide program curriculum. Despite achieving numeric thresholds set by the ACGME, senior trainees reported low confidence in some procedures considered common. Resident confidence clustered around groups, indicating that programs where residents show low confidence in one procedure may need to focus on other procedures in that cluster. As clinical opportunity to perform these index procedures is inconsistent, simulation has been used increasingly to address experiential gaps. Simulation is a high-resource educational strategy, and this work can potentially determine resource allocation to targeted procedures. At present, simulation resources and curricula vary greatly across programs as standardization for teaching procedures is lacking. More work needs to be done to inform how to guide curricular planning in an evidence-based manner, especially in this subset of skills with both high-cost and high benefit to patients.

Poster #16: Feasibility and Efficacy of a System-Wide GME Orientation in Assessing and Improving Interns' ACGME Core Competencies

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Institution(s): Charles R. Drew University

Abstract Type: Innovation-focused

Background
Graduate medical education (GME) programs are increasingly tasked with ensuring that interns enter residency with foundational clinical and professional competencies. Orientation periods offer a unique opportunity to assess and strengthen these skills, yet few institutions leverage this time for structured, competency-based interventions. This study evaluates a system-wide orientation model designed to assess and improve ACGME Core Competencies among incoming interns.

Objectives
To determine the feasibility and impact of a multi-modal orientation curriculum in enhancing interns' clinical history-taking, feedback delivery, and licensure exam preparedness, while identifying system-level opportunities for targeted support

Methods
This innovation abstract aims to share practical insights with the GME community by detailing a replicable model for competency-based orientation. In 2024 and 2025, all incoming interns participated in a structured, system-wide orientation curriculum designed to assess and enhance the ACGME Core Competencies. Demographic data were collected to assess equity in outcomes.

Interns completed:

- Clinical OSCEs [Objective Structured Clinical Examination] with standardized patients to assess history-taking and physical exam skills. Interns participated in the activity, received targeted teaching, then repeated the OSCE to assess improvement.
- Simulated feedback encounters with standardized faculty. Interns engaged in an initial feedback simulation, received teaching on effective feedback strategies, and repeated the simulation to reinforce learning.
- Mock Step 3 practice exams to assess baseline licensure readiness and guide subsequent support.
- A passing threshold of 60% was used to evaluate performance.

Results/Outcomes/Improvements

- Across two years, 46 interns included 72% female, 39% Black, 24% Hispanic, 22% Asian, and 15% White. The cohort included interns from family medicine = 34.8%; internal medicine = 34.8%; psychiatry = 26.1%; and physical medicine and rehabilitation = 4.3%.
- For the clinical OSCEs, targeted instruction showed improved clinical history-taking in 60% of interns, with 72% achieving passing scores with both attempts.
- In the feedback simulation, 72% showed improvement post-teaching, and 95% met the passing threshold.

- Only 7% initially passed the mock Step 3 exam, prompting focused interventions. Six months later, 72% passed on their first attempt, and 95% ultimately succeeded—highlighting the value of early assessment and structured support.
- No differences were noted based age, gender, or year of orientation. Internal medicine (IM) interns had significantly higher scores on the clinical OSCE (highest mean score for IM = 36.05, other programs (18-30; p =0.003).

Significance/Implications/Relevance
System-wide GME orientation incorporating experiential assessment and targeted instruction can effectively identify and address gaps in the ACGME Core Competencies. This model supports individualized remediation, promotes fairness, and enhances institutional readiness for competency-based education. Early identification of licensure vulnerabilities enabled proactive interventions, demonstrating the strategic value of structured orientation in advancing intern success.

Poster #17: Foundations of Excellence: A Modular Handbook to Standardize Graduate Medical Education Program Administration

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Institution(s): Indiana Regional Medical Center; Colquitt Regional Health System; Dr. Kiran C. Patel Institute for Graduate Medical Education: (KPIGME); Great Salt Plains Health Center

Abstract Type: Innovation-focused

Background
Graduate medical education (GME) program administrators, commonly referred to as coordinators or managers, are the operational linchpins of residency training, yet most begin their roles without structured onboarding or standardized workflows. A 2025 needs assessment revealed that 81% lacked a formal handbook at start and 91% valued a standardized resource. Inconsistent orientation contributes to delayed submissions, errors in high-stakes processes (ADS, NRMP/ERAS, ECFMG/J-1), and burnout, particularly in rural and newly accredited programs.

Objectives
To design and implement an ACGME-aligned, template-driven handbook that consolidates dispersed national resources into a single, practical reference and to create companion training that accelerates administrator proficiency while reducing avoidable errors.

Methods
We conducted a cross-sectional survey of program administrators across a range of institutions. Responses were analyzed for onboarding gaps, valued resources, and preferred learning formats. Findings directly informed the handbook's structure; five modules, 18 chapters, and its emphasis on ready-to-use tools such as annual calendars, Clinical Competency Committee/Program Evaluation Committee templates, and visa checklists. Drafts were iteratively refined with stakeholder feedback and anchored to 2023 ACGME Institutional and Common Program Requirements.

Results/Outcomes/Improvements
The resulting resource, Foundations of Excellence, provides standardized onboarding through practical checklists, workflows, and an annual task calendar. It addresses core domains (recruitment, accreditation routines, data systems, GME finance, mentorship/wellness). Companion training sessions (virtual or in-person) supply guided demonstrations with transcripts and printable job aids. Planned evaluation metrics include time to independent task performance, on-time submissions, and self-efficacy ratings. Early pilot feedback indicates reduced variability and greater confidence in high-stakes processes.

Significance/Implications/Relevance
This innovation creates a replicable, scalable pathway to stabilize GME administrative operations, particularly in resource-limited or rural programs. By consolidating fragmented resources and embedding training supports, Foundations of Excellence strengthens accreditation readiness, reduces onboarding variability, and builds a more confident, resilient GME workforce. The model can inform national coordinator development strategies and institutional sustainability efforts.

Poster #18: Validating the Use of Electronic Health Record Audit Logs to Identify Pediatric Intensive Care Unit Teams

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Institution(s): Stanford University School of Medicine; Stanford Children's Hospital; University of California San Francisco; Washington University School of Medicine

Abstract Type: Research-focused

Background
Working in teams influences clinical outcomes and education.[1,2] Assessing and improving graduate medical education (GME) relies on linking trainees' learning to the teams in which they operate. Clinical exposure, supervision, and autonomy exist within interdependent work patterns, making accurate identifications of patients' care teams, and the individuals with whom trainees work, of the utmost importance.[2-6] Unfortunately, the electronic health record (EHR) rarely maintains accurate, comprehensive care-team rosters, limiting our ability to study these dynamics.[7] Passively collected EHR audit logs contain time-stamped records of all actions performed within the EHR (e.g., order entry, documentation, chart review) and offer a continuous record of EHR-mediated clinical work for healthcare workers, including trainees.[8] Given the central role of the EHR in modern medicine, audit logs offer a robust and scalable source of data to identify patient care teams and support trainees' learning.

Objectives
The objective of this study was to validate the extent to which EHR audit logs could be used to accurately identify patient-centric intensive care unit (ICU) primary teams, defined as a patient's bedside nurse, frontline clinician (e.g., resident trainee), and attending physician.

Methods
We conducted a prospective observational study at a quaternary children's hospital, observing intensive care unit (ICU) rounds on 1,931 patient-days (678 development; 1,253 validation) across pediatric (PICU), neonatal (NICU), and cardiovascular (CVICU) settings. We developed two algorithms to identify primary team members: (1) clinically informed heuristics based on predefined actions; and (2) a Longitudinal Contribution Score (LCS) capturing sustained engagement with the patient's chart. For validation, direct observation served as the gold standard. Agreement was evaluated using Cohen's κ with patient-day clustered bootstrap confidence intervals, and algorithm differences (Δκ) were tested with Wilcoxon signed-rank tests.

Results/Outcomes/Improvements
In the development cohort (PICU only), overall agreement increased from $\kappa = 0.521$ with clinically informed heuristics to $\kappa = 0.785$ with LCS (+50.8%, $p < 0.001$). In a separate validation cohort (PICU, NICU, and CVICU), LCS also outperformed heuristics ($\kappa = 0.788$ vs 0.647; +21.8%, $p < 0.001$). Identification of bedside nurses performed best (development $\kappa = 0.934$, validation $\kappa = 0.907$) and identification of attending physicians performed worst (development $\kappa = 0.612$, validation $\kappa = 0.647$).

Significance/Implications/Relevance

Algorithms leveraging EHR audit logs provide a scalable and unobtrusive way to identify patient-centric ICU teams; it also addresses incomplete and inaccurate EHR care team lists. Within GME, this approach enables reliable attribution of trainees to patients and supervisors, supporting precise assessments of clinical exposure, depth of involvement, and supervision patterns. These data make it possible to contextualize learning within the interdependent work of care teams and affords us the ability to monitor how trainees' competence develops throughout their training. Finally, validated team identification can facilitate research on teamwork, patient safety, and quality improvement within and across institutions and health systems.

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Poster #19: GME PRO - From Day One to Year One: Longitudinal Coaching for New Program Directors

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Institution(s): University of Kentucky; University of Kentucky School of Medicine

Abstract Type: Innovation-focused

Background
The role of the graduate medical education (GME) Program Director (PD) has become increasingly complex, requiring expertise in accreditation, recruitment, evaluation, faculty development, and learner support. Despite the pivotal importance of the PD role in ensuring program quality and learner success, structured onboarding and sustained leadership development opportunities remain limited nationally. In response, the University of Kentucky (UK) College of Medicine designed and launched the GME Program Director Coaching Program (GME PRO), a structured, longitudinal coaching initiative for new PDs. This program integrates foundational workshops with individualized monthly coaching sessions tailored to each PD's programmatic context, aiming to provide essential knowledge, skills, and practical tools for success in their program leadership role.

Objectives
The GME PRO Program was developed with three primary objectives:

1. Equip new PDs with foundational knowledge of ACGME and institutional requirements.
2. Provide individualized coaching to address program-specific challenges and opportunities.
3. Foster leadership skills, problem-solving capacity, and resource utilization to support sustainable program improvement.

Methods
Beginning in July 2024, all incoming PDs were enrolled in the GME PRO Program. The curriculum included: (1) a New PD Workshop covering role fundamentals and accreditation essentials; and (2) monthly one-on-one coaching sessions with content experts from GME leadership, faculty development, and institutional offices. Topics included accreditation/Accreditation Data System/Annual Program Evaluation, recruitment, evaluations, Clinical Competency Committee (CCC) processes, faculty development, learner wellness, disability accommodations, and program policies. Sessions were facilitated by the designated institutional official and GME assistant deans, building an opportunity for ongoing connection between GME leadership and new PDs. Each session provided takeaway resources (e.g., templates, toolkits, policy guides). PD progress and engagement were tracked through attendance logs, qualitative feedback, and a post-survey once participants complete the program.

Results/Outcomes/Improvements
In its first year (2024-2025), 12 PDs participated in the program, each completing 11 small-group sessions. Feedback indicated high satisfaction with individualized coaching and resource utility. Early outcomes included improved confidence in navigating accreditation processes, enhanced program orientations, and standardized Annual Program Evaluation/CCC practices across programs.

Several PDs implemented new recruitment and evaluation tools directly derived from coaching

resources. Future iterations will incorporate more structured assessment of PD leadership growth and program outcomes, as well as continuing to add to resources.

Significance/Implications/Relevance
The GME PRO Program demonstrates the feasibility and value of structured, longitudinal coaching for new PDs. By providing individualized, resource-supported guidance, the program enhances PD confidence, promotes alignment with accreditation standards, and supports sustainable program improvement. This model offers a replicable framework for institutions seeking to invest in PD leadership development, improve program quality, and ultimately strengthen the learning environment for residents and fellows. Expansion of coaching programs may help address national calls for improved PD support, leadership training, and faculty development in graduate medical education.

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Poster #20: From Withheld to Welcomed: Turning Accreditation Setbacks into Success

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Institution(s): Doctors Hospital at Renaissance, Ltd.

Abstract Type: Innovation-focused

Background
ACGME accreditation of a residency/fellowship program[1,2,3] is a detailed, lengthy process. Despite extensive preparation, unexpected accreditation decisions can result. Receiving notice of “Accreditation Withheld” can be devastating, causing some programs to abandon the project altogether. Our graduate medical education (GME) program experienced “Accreditation Withheld” more than once, and we used those experiences to develop a “best practices process” that other programs can use for improved accreditation outcomes. Our multi-pronged approach to new program development focuses on stakeholder engagement and has been 91% effective, resulting in the accreditation of and resolution of citations in our programs. With an Association of American Medical Colleges-projected physician shortage of between 13,500 and 86,000 by 2036[4], it is critical that future residencies/fellowships have a blueprint ensuring an attaining pathway to accreditation to provide new physicians with high-quality training to face the health care crisis.

Objectives
To share a detailed best practices process with the GME community for enhanced program applications and faculty preparation for Initial/Continued Accreditation of residency/fellowship programs.

Methods
Our multi-pronged approach to program development and accreditation focuses on engagement of stakeholders, which is imperative to develop a sense of program ownership. The pillars of our accreditation “blueprint” include program faculty development sessions (with defined curriculum that includes mock Program Evaluation Committee (PEC) and Clinical Competency Committee (CCC) meetings), mock site visits, special review of the program, and program director mentorship and peer coaching.

Program directors from accredited programs assist new programs by providing oversight and suggestions while sharing best practices, creating a mentor-like relationship. New program director appointees are required to serve on the CCC and/or PEC of an accredited program to enhance their knowledge and build peer relationships. After programs are accredited, the team approach continues as program directors review the Annual Program Evaluations of other programs annually, providing insight and contributing to achieving/maintaining accreditation.

Results/Outcomes/Improvements
In response to our “Accreditation Withheld” statuses, we implemented our “best practices” program development process with a 91% success rate. We are a newer GME program, accredited in 2023, with 10 [other] ACGME-accredited programs (five with Continued Accreditation) at our Sponsoring Institution. Programs that have utilized our program development process include our diagnostic radiology, emergency medicine, family medicine, internal medicine, obstetrics and gynecology, orthopaedic surgery, psychiatry, surgery, surgical critical care, and urology programs. We are currently awaiting ACGME [Review Committee] meeting decisions on Continued Accreditation for our family medicine and surgery residencies.

Significance/Implications/Relevance

Accreditation of residencies/fellowships has been shown to elevate the quality and perception[5,6] of programs due to the requirement/maintenance of high educational standards and development of defined competencies and skills, while cultivating a culture of continuous improvement via self-assessment and external review by the accrediting body[5]. Accreditation of residencies results in the improvement of programs due to the transparent and extensive accreditation process, leading to high-quality patient care and improved curriculum, faculty recruitment, and resident/fellow scholarly activity[5]. By providing a proven blueprint for successful accreditation to our GME peers, larger of numbers of physicians will have access to accredited training programs, improving the care of patients as health care needs of the global population continue to grow.

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Poster #21: Caucusing: A Salutogenic Approach to Addressing ACGME Survey Results

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Institution(s): John A. Burns School of Medicine; University of Hawaii, John A. Burns School of Medicine

Abstract Type: Innovation-focused

Background
Designed as a tool for program evaluation and improvement, the annual ACGME Resident/Fellow and Faculty Surveys have evolved over time to capture a range of indicators of program quality.[1] Similar to many institutions, low-scoring survey responses are referenced in over 90% of our programs' citations. This generates significant concern for program directors, who feel responsible but may lack the agency and resources to address the drivers of these issues. In turn, this form of moral injury and distress are significant contributors to burnout, making meaningful corrective action for program improvement more challenging.[2] Program directors cited limited opportunities to confer and collaborate on corrective action as a contributing factor and barrier. Caucusing was previously identified and piloted during a program director well-being retreat as a model for creating safe, responsive, and accountable spaces. Favorable responses to this retreat informed the idea for implementing caucusing in program improvement work.

Objectives
Identity-based caucusing is a small-group process intended to allow people to discuss issues in an intentional space with others who share a common experience. It has been used in social groups to explore themes of power, privilege and oppression.[3,4] Our aim was to explore the use of caucusing as a model that would allow program directors across all of our programs to debrief and consult with each other about their ACGME Faculty and Resident/Fellow Survey results. We hypothesized that caucusing in groups, organized based on self-identified affinity around core ACGME Survey themes, would help mitigate moral distress due to low-scoring survey areas, and would increase the sense of self-efficacy in developing actionable responses to those challenges.

Methods
During a regularly scheduled virtual program director meeting, held approximately three weeks after the release of Survey results, PDs/associate PDs (collectively, "PDs") were given the opportunity to participate in caucusing. Pre-and post-caucus, six-question surveys, scored on a Likert-type scale, were administered to assess PD perception of the validity of their survey results, their reaction, and their ability to act upon the results. Breakout rooms, one for each Survey content area plus "well-being," were created, and participants chose which room/topic to attend. PDs were first asked to choose an emoji that represented their feeling about their Survey results, then facilitated caucusing, guided by pre-constructed reflective questions, proceeded for 30 minutes. The groups reconvened to debrief for 40 minutes. Survey responses were analyzed by non-parametric methods, and narrative responses during the debriefing were reviewed for common themes. Significance was determined at $p<.05$.

Results/Outcomes/Improvements
19 PDs participated in caucusing, 10 completed both the pre- and post-caucus surveys. At baseline, 40% of PDs strongly agreed/agreed that they were "disheartened or angry by our program's survey results." This decreased to 14% post-caucusing (p = NS). 53% of PDs agreed

they had the confidence and tools to act upon the less-favorable aspects of their Survey, increasing to 71% post-caucus (p = NS).

Common themes identified: PDs reported being surprised by their Survey results and found it difficult to determine what corrective actions were needed; conjecture that residents' interpretation of Survey questions was different than the intent of the program requirement; a sense of responsibility for Survey results, despite knowing as PDs they had less control over "systems issues;" request for higher-level GME support, e.g., faculty development, to address low-scoring areas. Facilitators noted that the participants used this opportunity to share tactics to address low-scoring areas.

Significance/Implications/Relevance
This pilot project suggests that multi-specialty program director caucusing around ACGME Survey topics soon after the Survey results are transmitted can reduce negative emotions. Furthermore, caucusing provided the opportunity to share tactics to address low-scoring Survey areas. The small number of PDs who completed both the pre- and post-caucusing survey limits our ability to demonstrate a statistically significant improvement. Despite this, we propose that structured group discussion in a caucusing format can help build connections to reduce any sense of isolation, and foster collaboration to create a sense of shared agency in working toward solutions. The persistence of mixed confidence levels after caucusing highlights the need for clearer Survey item interpretation, and additional resources to ensure PDs can act effectively on Survey data.

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Poster #22: Narrative Expressive Writing (NEW) in Graduate Medical Education: Preliminary Results of a Feasibility and Acceptability Study

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Institution(s): Reading Hospital – Tower Health; Tower Health; University of Colorado Anschutz

Abstract Type: Innovation-focused

Background
Physician burnout among US physicians remains a major issue and continues to affect physicians in training and practice[9]. Medical students transitioning to residency face heightened stress, making this period critical for future well-being[10-11]. Burnout and stress in trainee physicians are higher for work-related factors compared with non-modifiable and non-work-related factors[8], underscoring the need for proactive, evidence-based interventions. Narrative Expressive Writing (NEW) is a five-week structured asynchronous writing intervention, in which participants are prompted with weekly writing prompts. A mental health clinician reviews the narratives and gives feedback that promotes resilience through cognitive flexibility and narrative reframing. It has shown promising trends in reducing burnout, distress, and promoting resilience in health care providers, particularly ICU nurses[6]. However, NEW has not yet been evaluated in graduate medical education.

Objectives
This was a study to evaluate the feasibility and acceptability of the NEW intervention for graduate medical trainees at a single institution. Our aim was to determine if NEW will reduce burnout and other measures of distress, including anxiety, depression, and post-traumatic stress disorder (PTSD) in graduate medical trainees at an academic affiliated community hospital.

Methods
This single-center, grant-funded pilot assessed feasibility and acceptability of a five-week NEW intervention among emergency medicine, obstetrics and gynecology, family practice, and internal medicine residents. Residents unable to complete the protocol or with prior moral resilience study participation were excluded. Consent was obtained via REDCap; demographics included residency and year only. Participants completed pre/post surveys: GAD-7, PHQ-9, CD-RISC, PCL-5, and post-VAS (satisfaction). Weekly REDCap prompts guided 20-30 minutes of reflective writing on stressful experiences. Feedback from a mental health professional promoted resilience. Participants were compensated $25 per session.

Results/Outcomes/Improvements
Of 121 eligible residents, 33 (27%) agreed to participate (intent-to-treat), but only 10 (8%) completed all five writing sessions and surveys (per-protocol). In addition to the 10 study completers, the 23 Intent-to-treat participants collectively provided an additional 23 pre-surveys, 1 post survey, 1 satisfaction survey and 23 narratives (three residents contributed one narrative; four wrote two narratives; and four wrote three narratives). Participation did not differ by year or program, although emergency medicine residents trended higher. Completers were more resilient at baseline (M=79) than partial completers (M=67.4, p=.008) but did not differ on distress. Among the study completers (n=10), resilience remained stable (M=79→80, p=.67), but anxiety (M=5.5→3.3, p=.02, d=.84) and depression (M=4.8→1.8, p=.007, d=1.1) decreased, with marginal PTSD improvement

(M=11.2→5.7, p=.06, d=.68). Satisfaction with the narrative expressive writing process was high (M=84.5, range 65–100, N=10).

Significance/Implications/Relevance
This intervention demonstrated that residents with higher resilience scores were more likely to complete all five writing prompts, while those with lower resilience scores tended to engage less, often stopping after the pre-survey questionnaires. The participation rate was notably low however, despite monetary compensation. Despite their greater baseline resiliency, there were still significant reductions in distress and marginal improvements in PTSD symptoms following NEW participation, as well as high satisfaction with the intervention itself. Given these effects were large for anxiety and depression and moderate for PTSD even among more resilient residents, it's reasonable to assume the intervention effects of NEW would be even larger among less resilient residents. While NEW was not feasible as it was delivered in the present study of residents, it would be worth considering implementing NEW in the training curriculum of all residents given its potential large benefits.

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Poster #23: ACGME Well-Being Data: Developing a GME-Wide Process to Transform Data into Meaningful Action

Author(s): Julie Krause, BA; Greg Wallingford, MD, MBA; Jonathan MacClements, MD, FAAFP

Institution(s): Dell Medical School

Abstract Type: Innovation-focused

Background
The ACGME has collected well-being data via its annual survey since 2018, around the time following [introduction of new] Common Program Requirements that formally [addressed] physician well-being. There is a growing body of evidence that well-being is a driver of learning outcomes, physician turnover, patient satisfaction and safety, etc. Despite this, many graduate medical education (GME) programs are uncertain how to utilize the ACGME well-being data. At one site surveyed, 22% of PDs indicated that they were uncertain how to access the data, 61% were uncertain of how to interpret it, and 52% did not have a process to act upon it. Thus, our Office of Professional Fulfillment and Well-Being (PFWB) aimed to support programs in utilizing their data to drive program-level change (specific to local opportunities for improvement) without limiting their actions. We soft-launched in Academic Year 2023-2024 and officially launched in AY 2024-2025. To build buy-in and agency, we engaged the Graduate Medical Education Committee (GMEC) Well-Being Subcommittee and PDs throughout development.

Objectives
The objective of this project was to transform ACGME well-being survey data from descriptive benchmarks into actionable insights that drive meaningful improvements in the learning environment. Specifically, our goals were to: (1) develop a structured process, consistent across specialties, to analyze and present program-specific data in a more interpretable format; (2) create opportunities for programs to contextualize results through resident/fellow listening sessions or targeted follow-up; and, (3) ensure each program translates insights into at least one concrete action item with a plan, fostering accountability, sharing of best practices, and continuous improvement across the institution.

Methods
In 2024, our PFWB partnered with the designated institutional official (DIO) to make ACGME well-being data actionable. The aforementioned PD survey led to development of a new process that centralized data analysis but also empowered programs to identify opportunities for improvement (and targeted interventions) within their local environments. The draft process was reviewed with the GMEC Well-Being Subcommittee and presented to all PDs for input. The final process included: (1) DIO pulls survey reports; (2) PFWB analyzes data by program, including comparisons to national specialty-specific means and year-over-year trends; (3) PDs receive program-specific reports with resources; (4) programs choose follow-up (listening sessions or surveys) to identify drivers of results; (5) programs submit required action worksheet; and (6) PFWB shares best practices with GMEC. PFWB also designed and offered a workshop, designed for program leaders, on hosting an effective listening session.

Results/Outcomes/Improvements
Of the programs eligible for analyzed reports, 56% submitted action worksheets (~68% anticipated by year's end), representing approximately 207 residents. Action items clustered around scheduling (36%), data/feedback (14%), process improvement (21%), and training support (29%). For example, one program elicited stress and exhaustion related to commuting

across town during a clinic day and attempted to keep residents at one site per day. Another program found that there was a large emotional tax in a specific specialty around high-acuity medical care and frequent deaths and implemented a debriefing program. Additionally, eight programs attended a listening session workshop, five engaged our office for follow-up, and at least four hosted listening sessions with trainees. Finally, strategies were shared across programs to spread best practices. Overall, the process improved interpretation and use of well-being data, supporting informed discussion and targeted interventions across GME.

Significance/Implications/Relevance

This project demonstrates a scalable method for transforming ACGME well-being survey data into meaningful, actionable improvements. Many institutions face similar challenges – survey items that represent outcomes like burnout that are broad and difficult to interpret without structured follow-up, and reports that provide little guidance for program-specific action. By combining centralized analysis, structured program engagement, and learner voice through listening sessions, our approach bridges the gap between data and intervention. This process can be adapted by others to strengthen program leadership engagement and ultimately create more responsive, supportive learning environments that promote both resident well-being and educational excellence. We hope that this can serve as a model at other institutions and spur movement in addressing burnout at a national level, enabling more robust insights and interventions to be developed and shared across institutions nationwide.

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Poster #24: Training Program Oversight: Evolution, Efficiency, and Effectiveness of a Web-Based Annual Program Review Process

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Institution(s): University of Michigan

Abstract Type: Innovation-focused

Background
The ACGME requires Sponsoring Institutions to provide oversight of their training programs, although details remain unspecified. Historically, our process relied on a Graduate Medical Education Committee (GMEC) subcommittee, the Special Review Subcommittee (SRSC), comprised largely of current and prior program directors and assistant program directors. The manual process required submission of data from various sources and utilized a traffic light grading system that had been in place for 15 years. Due to overall dissatisfaction with the system, we undertook an evaluation to re-imagine the process.

Objectives
We aimed to a) enhance the efficiency of evaluating programs, b) identify underperforming programs with a cogent, actionable analysis, c) streamline the reporting process, and, d) align evaluation processes with ACGME mandates and expectations.

Methods
Listening meetings with program leaders allowed us to identify sources of unnecessarily repetitive work and reporting processes that lacked clarity. We collaborated with our Information Technology staff to develop a web-based portal that was designed to reduce input burden, optimize information exchange between graduate medical education programs and the institution's SRSC, track program improvements, facilitate data collection, and automate reporting processes.

Results/Outcomes/Improvements
A consistent theme was frustration with the uploading and management of data, much that was maintained and had to be re-entered annually. Implementation of a web-based portal with opportunity to pre-populate data from prior years, as well as a modified Annual Program Review protocol led to a more collaborative and efficient evaluation process. The portal enabled program leaders to report on self-evaluation, program-specific data, and improvement action plans. This provided a valuable tool for monitoring program reaccreditation success. The evolution of the SRSC's process resulted in a more constructive and supportive evaluation system, moving away from the overly critical traffic light grading system. Continued feedback and quality improvement efforts have led to consistently high levels of satisfaction by program leaders and SRSC reviewers.

Significance/Implications/Relevance
Our project demonstrates the collaborative evolution of a sponsoring institution's program oversight process, transitioning to a collaborative, efficient model to reduce administrative burden, improve year over year continuity, and optimize feedback. The portal system creates a valuable means for monitoring program improvement metrics and goals. This approach respects program leadership's efforts to ensure a more effective and meaningful means of program and institutional oversight.

Poster #25: When the Shift Ends Early: EM Residents' Reasons for Voluntary Separation

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Institution(s): Singapore Health Services; Singapore General Hospital

Abstract Type: Research-focused

Background
Emergency medicine (EM) residency attrition causes significant loss in time, money, and labor for both residents and programs. It disrupts continuity, lowers morale, increases workload and stress among trainees and faculty, which indirectly compromises patient care[1]. Current literature has focused on non-EM specialties[2-4]. While a few EM studies cite specialty switches, family/health issues, fatigue, physician-patient conflicts, department crowding, interdepartmental disputes, and workplace violence as causes for attrition[1,5-7], these factors are highly influenced by local health care systems, environment, and culture. Local data are scarce, and the relevance of these factors to the local context is unclear. Residency training is a rigorous journey, but when residents leave prematurely, the consequences ripple far beyond the individual. The knowledge gap in causes for attrition among EM residents leaves EM residencies in Singapore navigating uncertainty in planning for the future.

Objectives
This qualitative educational research study therefore aims to understand the reasons for voluntary separation within SingHealth EM residency – the largest of three EM residency programs in Singapore – and explore whether these factors align with those identified internationally. The authors also seek to use the study findings to inform faculty on potential strategies to prevent attrition and boost residency retention. The research question that guided this study is: Based on the experiences of SingHealth EM residents who have voluntarily separated from residency, why do these residents voluntarily leave residency training prematurely?

Methods
The study participant inclusion criteria included all SingHealth EM residents who voluntarily separated since the start of the program from 2010-2024. Individual exit interviews were conducted by the program director with these residents prior to their voluntary separation from the program and the exit interviews were transcribed. The transcripts and meeting minutes were anonymized before the authors performed content analysis and participant names were not revealed to the authors. Three co-authors read through the transcripts repeatedly to develop familiarity with the dataset and performed coding via template analysis. Based on the available literature, a priori themes were included in the initial template for coding. Each author coded independently to add the value of different perspectives to the analysis. The authors then condensed these codes into three major themes through consensus.

Results/Outcomes/Improvements
Among 130 EM residents from 2010-2024, a total of 14 residents voluntarily separated from the program. Of these, 11 residents voluntarily separated during junior residency and only three residents separated during senior residency. Key reasons identified included changes in career aspirations, evolving family situation and the shiftwork nature of EM which leads to fragmented care without the ability to develop a longitudinal patient-physician relationship. Other factors, like personal health, the non-clinical demands and requirements of the residency program, and

change in outlook following the COVID-19 pandemic (including increased introspection and more demanding workload with restricted leave) were cited as aggravating reasons as well. Yet residents consistently described the program as supportive and well-run, which implied that residency attrition was less about program-specific shortcomings but rather changes in personal life priorities and challenges inherent to EM.

Significance/Implications/Relevance
These insights provide a clearer understanding of why residents leave training prematurely and allow the program to tailor interventions like career counselling or more flexible arrangements to improve resident well-being. Several junior residents expressed a change in inclination away from EM, which suggests young residency aspirants in their early career stages may not be as certain of their career path and may be more vulnerable to attrition. Modifying the selection criteria to ensure aspirants have had more prior working EM experience may enhance program stability. The primary reasons for attrition in this study are consistent with other overseas studies, which suggest the root causes stem from the nature of EM as a specialty rather than program factors. This underscores the importance of a broader collaborative approach across EM residency programs and sharing of strategies and best practices within the global EM community to overcome these universal challenges.

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Poster #26: Would you Trust this Person Professionally? Seeking Agreement on Unprofessional Behaviors

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Institution(s): Aurora Health Care; Advocate Health; Atrium Health Carolinas Medical Center

Abstract Type: Innovation-focused

Background
"That's just your perception" is a frequent response when told "That's unprofessional." Yet unprofessional behavior adversely affects individual learning and team functioning, while increasing avoidable patient complications and malpractice claims. But what if professionalism is reframed as trust? Is there agreement on which behaviors would adversely affect trust; thus, providing a different way to approach this quagmire? Is the person competent with humility? Is [the person] reliable? Do they care about others (beneficence)? Using an established four-component model of trust as a framework, we wondered if key graduate medical education (GME) stakeholders would agree on what were untrustworthy behaviors.

Objectives
1. To identify an established evidence-based trust framework that intuitively resonated with those in GME.
2. To develop and conduct a needs assessment framed within the trust framework of key GME stakeholders (e.g., residents, faculty, GME leaders, staff) to rate the degree to which selected professionalism-related behaviors are considered untrustworthy.
3. To examine if there are differences by role and/or by selected geographic locations (e.g., Illinois, North Carolina, Wisconsin) to inform future interventions.

Methods
Residents, faculty, GME leaders/staff were asked to submit brief, de-identified unprofessional behaviors that they had experienced/witnessed. The behavior could be exhibited by anyone in GME (e.g., resident, faculty member, coordinator). Behaviors were then categorized into one of four trust categories: reliability; competence (with humility); sincerity; or caring. Five items were selected for each category (to represent an array of behaviors, settings, actors) yielding a 20-item assessment tool with two demographic items (role, state). Respondents rated items on the degree to which they would trust this person as a professional (4-point Likert scale). Protected time was provided in existing forums (e.g., GMEC, faculty/resident meetings) to present a brief introduction to the tool and then complete it using SurveyMonkey® to minimize anonymity concerns.

Results/Outcomes/Improvements
Two hundred-six responses were received between July and September 2025 from residents/fellows (47%), faculty (19%); DIOs, PDs, APDs (16%); and coordinators (18%), with average completion time < 4.5 minutes. Greater than 70% of respondents expressed a lack of trust (rating "No, Probably Not" or "No, Definitely Not" trust) on 75% of the items. For example, respondents expressed lack of trust on items about unapproved days off (85%), being unresponsive to feedback (96%), and heavy cell phone use in front of patients (84%) . Items with less consensus focused on timeliness of certification completions (47%), personal hygiene (46%), and asking for feedback (46%). When items were examined by the four elements of trust "sincerity" related items had the highest not

trustworthy agreement ranging from 78%-86% while “competence with humility” related items had the lowest range of agreement 46%-75% of respondents expressing lack of trust. There were no observed differences by role or location.

Significance/Implications/Relevance
Unprofessional behavior poses a significant challenge in GME, as one’s perception is often reality—adversely impacting patients, teams, and learning environments. However, differing perceptions on what constitutes unprofessional conduct can complicate efforts to address these behaviors effectively. To navigate this complexity, we conducted a needs assessment using the four elements of trust framework to establish common ground as we seek to foster candid conversations about professionalism and appropriate conduct. Using trust as a framework is consistent with EPA decisions and reframes what can be thorny discussions about professionalism into one about trust among team members performing stressful jobs that require individuals to act with integrity, reliability, competence with humility, and caring. Our next steps are to hold scenario-based professionalism/trust discussions in our existing GME forums facilitated by trained residents and faculty).

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Poster #27: Communication Training for Primary Care and Oncology Trainees on Knowledge, Attitudes, and Behavior about Cancer Clinical Trials: The T-CAT Program

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Institution(s): University of Florida College of Medicine; Wayne State University; Durham VA; Blood Cancer United; HC Consulting; University of Florida; Mount Sinai

Abstract Type: Research-focused

Background
Cancer clinical trials are vital to the advancement of cancer treatment. Attaining the full benefit of cancer research requires the participation of cancer patients that represent the variation of the US population; yet accrual to trials is low[1]. Eligible patients are often not offered the opportunity to participate in a trial[2]. Even when trials are discussed, physician communication is often not clear or equitable[3]. Patient-centered communication about cancer clinical trials should occur at multiple points on the cancer continuum, from time of referral throughout different phases of treatment. An ideal time to help future physicians learn good communication skills about clinical trials is during GME training, in line with program-specific milestones focused on interpersonal communication skills. Communication skills training has been shown to improve clinician behavior, yet no published research has examined such training on clinical trial communication in GME[4,5].

Objectives
In collaboration with Blood Cancer United, formerly The Leukemia & Lymphoma Society, we developed the T-CAT Program (Trainees Communicating about Trials) to prepare trainees to communicate with patients about treatment trials across the cancer treatment continuum. The T-CAT Program consists of two different trainings tailored to different disciplinary needs. Our objectives were: (1) To examine the impact of a one-hour online training intervention, Preparing Patients for Cancer Treatment Discussions, on primary care trainees' knowledge, attitudes/beliefs, and communication behavior; and (2) To examine the impact of a three-hour virtual synchronous training intervention, the COMM-CCT communication workshop, on hematology-oncology fellows' knowledge, attitudes/comfort, and behaviors related to discussing trials with patients.

Methods
Primary Care: We worked with US program directors to recruit family medicine and internal medicine residents and geriatric [medicine] fellows for an online interactive training led by a primary care provider, radiation oncologist, and cancer clinical trials expert. Participants engaged in simulated patient and clinical scenarios to practice communication about oncology referrals and cancer clinical trials. Pre- and post-training surveys measured knowledge, attitudes, beliefs, and willingness to discuss trials. Oncology: We implemented the COMM-CCT workshop with seven US fellowship programs. Course faculty outlined barriers to trial participation, introduced the COMM-CCT framework (Check in, Outline Options, Make a Shared Decision, Map Next Steps), and provided trial resources. Fellows participated in a two-hour role-play to practice skills. Pre-, post-, three-, and six-month follow-up surveys and interviews assessed knowledge, attitudes, comfort, practice changes, and patient discussions.

Results/Outcomes/Improvements
Primary Care: 91 trainees participated. Knowledge improved from a mean score of 51.5% to 83.0% correct (p<.001). Mean belief scores about the primary care provider's role in supporting patients about clinical trial decisions improved from 4.1 to 4.6 (1-5 scale; p<.001). Mean scores on willingness to communicate about clinical trials increased from 4.3 to 4.6 (1-5 scale; p<.001). Oncology: 57 fellows completed the pre-survey, 48 the workshop, and 42 the post-survey; 36 and 34 completed three- and six-month follow-ups; 14 were interviewed. Knowledge rose from 76% correct pre-training to 83% correct (3-mo, p<.05) and 81% (6-mo, p<.05). Agreement (1-5 scale) on attitudes/comfort items rose from 3.9 to 4.4 (p<.001) at follow-up. Self-reports of having ≥5 patient trial discussions in the past three months rose from 2% pre-training to 32% (3-mo) and 50% (6-mo). Fellows cited greater comfort with, awareness about, and preparation for trial discussions.

Significance/Implications/Relevance
Trainees reported positive learning outcomes after participating in communication skills training about cancer clinical trial discussions, including increased knowledge, and higher levels of agreement with statements about attitudes, beliefs, and comfort about trial discussions. Furthermore, trainees reported more frequent discussions with patients about trials. Broad dissemination of these two trainings can help to prepare a generation of physicians to be knowledgeable and comfortable talking with patients about trials across the treatment continuum of cancer and other diseases.

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Poster #28: Building Bridges: Implementing an "Opt-Out Counseling" Approach to Enhance Medical Trainee Well-Being

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Institution(s): University of Tennessee Health Science Center- College of Medicine-Chattanooga

Abstract Type: Innovation-focused

Background
The mental health challenges faced by residents, such as burnout, emotional exhaustion, and reduced empathy, are well-documented. Despite increased focus on well-being in medical training, barriers to accessing care persist, particularly on satellite campuses. These challenges often stem from difficulties in maintaining balance across emotional, relational, occupational, intellectual, physical, and financial domains. The ACGME emphasizes addressing resident well-being as mental health concerns frequently emerge within the first three months of training. Evidence suggests medical trainees are more likely to engage in wellness initiatives when recommended by program directors. Opt-out interventions, like initial counseling sessions, can enhance residents' sense of competence and connectedness while normalizing help-seeking behavior. These early prevention efforts reduce barriers to engagement, foster positive attitudes toward mental health services, and support greater flourishing.

Objectives
To identify how opt-out programs lead to greater participation in mental health services.

Describe key steps and approaches in implementing an opt-out program when there are limited resources.

Describe benefits and implications of implementing opt-out programs and its impact on training.

Methods
This quasi-experimental pre-post control group design evaluated the impact of opt-out well-being sessions ("BRIDGE") offered to residents and fellows in 25 training programs during the 2024-2025 and 2025-2026 academic years. Additionally, there was a pilot opt-out program offered to third-year medical students beginning clinical rotations in the 2025-2026 academic year. These 30-minute, pre-scheduled protected work-time sessions are free and voluntary. Surveys and metrics are collected pre- and post-session, assessing satisfaction, willingness to refer, attitudes towards mental health services, and perceived leadership support (Kevern et al., 2023).

Additional tools include the Physician Wellness Index (PWI) for fatigue, burnout, and quality of life (Dyrbye et al., 2014) and the Transition to Residency Risk Index (TRRI) for depression, anxiety, and isolation during early residency (Courand and Dyurich, 2019). The control group comprises retrospective utilization data from the previous cohort.

Results/Outcomes/Improvements
Preliminary participation rates from the 2024-2025 resident cohort demonstrated strong engagement, with over 51% of first-year residents attending opt-out counseling sessions. Of these, 36% scheduled ongoing sessions following their appointment. Feedback indicated high satisfaction, with 71% strongly agreeing the session was worth their time and 84% recommending it for future residents. Early trends suggest the program reduces barriers to mental health services and fosters positive attitudes towards seeking support. Data collection

for the 2025-2026 resident and medical student cohorts is ongoing, with anticipated insights to further validate the program's impact. The study was determined to be exempt by IRB due to qualifying as a qualitative project.

Significance/Implications/Relevance

This project demonstrated that an "opt-out" counseling approach in a medical school setting significantly increased utilization of mental health services, improved attitudes toward counseling and fostered help-seeking behaviors. Participants reported greater willingness to recommend services to colleagues, highlighting the potential for normalizing mental health support in high-pressure environments. The findings suggest that accessible counseling, allocated time, and departmental support are key factors in encouraging engagement. It is anticipated that ongoing data collection will reflect that BRIDGE "opt-out" sessions positively impact the transition to residency and provide a scalable model for other institutions to enhance trainee well-being.

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Poster #29: A Cluster Analysis Approach to Identify Well-Being Profiles Among J-1 Physician Learners

Author(s): Rayan Shammet, MPH; Katie Powell Powell, MA; Nicholas Yaghmour, MPP; Shiyao Yuan, MSEd, MS; Tracy Wallowicz, MLS

Institution(s): ACGME; Inthealth

Abstract Type: Research-focused

Background
Since 2018, ECFMG® and FAIMER®, divisions of Intealth® and the ACGME have partnered to learn about and improve the well-being of foreign national physicians. A key element of this partnership has been the administration of the annual ECFMG J-1 Physician Well-Being Survey. The survey includes 18 well-being items that assess participants' levels of exhaustion and engagement, measured using a Likert scale. The goal of this study is to highlight profile classifications among this varied physician population in order to identify patterns of well-being and inform targeted interventions.

Objectives
1. Identify distinct well-being profiles among J-1 physician trainees using cluster analysis of survey data.
2. Evaluate key differences between cluster groupings based on demographic characteristics, including sex and training level among J-1 physician trainees.
3. Explore how data-driven subgroup identification can inform targeted interventions to improve the well-being of J-1 physician trainees.

Methods
ECFMG-sponsored J-1 physician learners were invited to complete the optional and confidential ECFMG J-1 Physician Well-Being Survey launched on November 30, 2023, and closed on January 2, 2024. This study analyzed survey data from 2023, evaluating 21 well-being variables.

Statistical analysis via SAS was utilized to run exploratory factor analysis with oblimin rotation yielding four factors labeled as engagement, resilience/connectivity, self-care, and emotional exhaustion. Following factor analysis, well-being profiles were identified via k-means cluster analysis utilizing aggregated scores from the resilience/connectivity and the self-care factors. Clusters were determined by balancing statistical fit (BIC) and interpretability. Cluster distributions and membership by gender and training level were also reviewed.

Results/Outcomes/Improvements
In 2023, 8,748 of 14,110 J-1 physicians responded to the survey (61.9%). Seventy participants with partial responses were excluded from the results. A four-cluster solution was identified among J-1 physician trainees, distinguishing groups based on resilience and self-care: Thriving (41.1%, highest well-being scores), Connected (26.8%, moderate resilience/connectivity scores), Coping (26.6%, moderate self-care scores), and Struggling (4.7%, lowest well-being scores).Regarding gender, 35.3% of females were designated as Thriving and 5.5% Struggling, whereas 45.9% of men were Thriving and 4.0% Struggling. Regarding training level, 38.4% of residents were designated as Thriving, and 5.1% Struggling, whereas 47.0% of fellows were Thriving and 3.7% Struggling. A chi-square test showed significant associations between gender and cluster membership, χ^2 (3, N = 8678) = 108.68, $p < .001$, and education/training level and cluster membership, χ^2 (6, N = 8678) = 71.74, $p < .001$.

Significance/Implications/Relevance

The cluster analysis approach yielded four distinct meaningful latent profiles of J-1 physician learners. Cluster membership differed among well-being factors varying by gender, and education/training level. The findings provide a data-driven foundation for designing targeted wellness programs that address the specific needs of J-1 physician learners. It is important to highlight that well-being among J-1 learners is not uniform, but rather shaped by distinct combinations of stressors, coping resources, and institutional supports. Moreover, this work underscores the unique vulnerabilities faced by J-1 learners. Supporting their well-being this can have beneficial effects on patient care, and workforce stability, particularly in underserved areas.

Poster #30: A Practical Approach to Performance Improvement in GME Learners: A Faculty Development Workshop

Author(s): Natalie Mariam Salas, MBBCh; Suman Pal, MBBS; Madelin Whelpley, MS; Timothy Petersen, PhD

Institution(s): University of New Mexico; University of Minnesota

Abstract Type: Innovation-focused

Background
Many graduate medical education (GME) programs experience challenges in supporting learners with performance deficits. Up to 9% of family medicine residents and 31% of surgery residents fall short in one or more core competencies, with similar rates across other specialties.[1-3] Effective remediation requires early identification, clear expectations, and proactive support.[4] Although resource-intensive, remediation succeeds in up to 90% of cases[5], especially when individualized and structured approaches are used.[6-8] However, outcomes depend heavily on faculty, who have varying levels of expertise in assessing and supporting struggling learners, in addition to clinical demands and potential burnout.[9] Therefore, training faculty in effective remediation processes is critical to ensuring success for both learners and programs.

Objectives
To best address our institutional needs, we conducted a needs assessment survey among GME faculty. This revealed key gaps in knowledge around existing resources and structures to support struggling learners. Guided by this data, we developed a workshop geared toward program directors and core faculty with four main objectives: increasing knowledge around the different types of performance improvement interventions, improving structures and supports for assessment, developing skills in feedback and coaching plan development, and clarifying due process around placing someone on remediation.

Methods
We developed a 3.5-hour workshop divided into two parts. Part one focused on identifying the problem underlying a performance deficit. Participants worked through simulated cases, then developed decision trees to guide their responses to the proposed scenarios. Part two focused on developing a remediation plan and ensuring due process for learners. We highlighted institutional and national resources, as well as best practices in creating milestone-mapped education goals and coaching plans. Participants applied these skills in small-group activities to foster near-peer and interdepartmental learning. Engagement in the workshop was assessed by participation in audience response polls. Participants also completed a pre- and post-workshop test assessing their responses to various performance deficits. In the post-session feedback, participants rated the efficacy of the workshop and anticipated changes in practice. Additionally, inductive content analysis was done on free-text responses.

Results/Outcomes/Improvements
Twenty-six faculty from different departments attended the workshop. Eighty-four percent of participants engaged with the session’s audience response systems. The workshop was rated 4.7/5 for efficacy in building skills in addressing learner deficits and teaching the procedure of implementing remediation. Eighty-eight percent of participants noted the workshop would definitely change their practice in supporting struggling learners, with the rest noting it would probably change practice. The workshop improved participants’ ability to respond to

hypothetical scenarios involving struggling learners, with pre- to post-session paired test scores showing an improvement of 2.1, 95% CI (1.4–2.8), p<0.0001. Inductive content analysis of free-text responses showed that participants learned about the process of remediation, specifically differentiating between different performance improvement interventions, as well as institutional resources for remediating GME learners.

Significance/Implications/Relevance
Remediation in GME learning remains a difficult and often uncharted terrain in medical education. Utilizing information processing theory, we successfully developed a workshop that significantly improved faculty confidence in identifying and addressing performance deficits among GME learners. Participants reported increased knowledge and understanding of the process of placing a learner on remediation while engaging in exercises to improve their skills for developing objective feedback, specific measurable learning goals, and coaching strategies. By routinely offering this workshop, we hope to develop skills and expertise in remediation across the institution. We plan to implement a remediation tracking system across GME so that we can measure how successful these interventions are at improving the implementation of effective remediation strategies for our GME learners.

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Poster #31: Assessing Perceived Challenges and Needs of Former and Current Program Directors

Author(s): Arman Hussain, BS, BA; Maureen Lewis, BA; Ashley Crew, MD; Mayra Gutierrez, BA; Lawrence Opas, MD

Institution(s): Keck School of Medicine

Abstract Type: Research-focused

Background
Graduate medical education (GME) relies on program directors (PDs) for program stability and trainees' success in collaboration with the designated institutional official (DIO) and Graduate Medical Education Committee (GMEC). The ACGME closely monitors PD turnover, which averages 11-14% nationally and is linked to burnout and program instability. While research highlights both challenges and rewards of the PD role, most is specialty-specific and survey-based. No literature has examined how career planning influences perceptions of the PD role and retention. Narrative data and open-ended responses are needed to capture PDs' lived experiences across large institutions, understand individualized career fit, and characterize the role of career planning. At our large safety-net hospital and dual Sponsoring Institution with 71 programs and 972 trainees, PD turnover rose from historic rates below 10% to 17% from 2022-2024.

Objectives
Given the recent increase in PD turnover at our large dual Sponsoring Institution, we sought to further understand the needs of the PD population. We sought to assess the experiences of current and former PDs within our large dual Sponsoring Institution, focusing on: motivations for assuming the role of PD; most challenging and rewarding aspects of their position; desired additional support; impact of career planning and tenure length on perceptions of the role; and reason for ending their time as PD if applicable.

Methods
We conducted a qualitative study between January and May 2024, inviting 65 current and former PDs across all specialties to participate. A total of 24 PDs completed interviews, comprising a 37% participation rate. Structured interviews used closed and open-ended questions, which were developed by our team based on existing literature and institutional priorities. Questions focused on: the structure of their program; reasons for taking on the role of PD and/or stepping down; most challenging and rewarding aspects of the job; how the experience of being PD compared to expectations; and desired additional support from department/institution.

Interviews were coded thematically and discrepancies were resolved through group discussion. Themes were stratified by tenure length, program size, and whether participants had planned to assume the PD role. If the participant had not planned to take on the role, this was further subdivided into a crisis step-in or unplanned career progression.

Results/Outcomes/Improvements
Twenty-four PDs (19 current, five former; mean tenure six years; 13 male, 11 female) participated, representing surgical (n=7), hospital-based (n=2), and medical (n=15) programs. Among participants, 33% had planned to be PD, 29% filled last-minute vacancies, and 38% did not view it as a career goal. Participants were evenly split between large (≥20 trainees) and small (<20) programs. Mentorship was the most frequently cited benefit (79%). Common challenges included financial/resource constraints (38 mentions per interview), administrative burden (26), interpersonal tensions (21), and institutional pressures (14). Large-program PDs

reported more financial (22) and interpersonal (15) challenges than small-program PDs (16, 6). Planned PDs described fewer concerns with administrative burden (0.8 vs. 1.3) and institutional tension (0.13 vs. 0.8), more concerns with interpersonal challenges (1.4 vs. 0.6), and equal concerns with finances (1.5) compared with unplanned or crisis step-ins.

Significance/Implications/Relevance

Sustained PD turnover threatens GME stability and highlights the need for systemic interventions. Our findings emphasize that retention requires more than addressing individual stressors; institutions must provide structural financial support, tailored resources for programs of varying size, and mentorship aligned with career stage. Intentional succession planning may also reduce vulnerability from unplanned vacancies. Beyond institutional policy, several PDs expressed a desire for stronger community and peer support. Fostering community among PDs through in person meetings and intentional spaces to connect may help combat increases in turnover. These strategies have relevance across different GME settings, offering a framework to mitigate burnout, enhance leadership sustainability, and promote continuity of residency training nationwide. Expanding narrative-based research across institutions will be critical to inform scalable solutions that address the complex realities of the PD role.

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Poster #32: Basic Psychological Need Fulfillment During Medical School: Association with Problematic Outcomes at the Start of Residency

Author(s): Alexander Marshburn, MA; Wendy He, MA; Gregory Guldner, MD, MS; Sabrina Menezes, MA

Institution(s): Claremont Graduate University; HCA Healthcare

Abstract Type: Research-focused

Background

Research has often explored factors within residency that influence well-being, and interventions have been conducted to increase resident wellness[1]. However, limited research has focused on how medical school experiences impact residents' well-being[2,3]. Highlighting the importance of such research, a recent study by Carpenter and colleagues[4] found that perceptions of lower psychological safety and greater perceptions of a harmful hidden curriculum in medical school were associated with higher levels of imposter phenomena among incoming resident physicians. Additionally, lower psychological safety in medical school was associated with lower levels of meaning in work. Another study[5] indicated that psychological safety and hidden curriculum predict intentions to seek help for depression. These data highlight the utility of knowing about residents' medical school experiences as it influences incoming residents in ways that might not often be considered.

Objectives

The current study expanded upon prior studies[4,5] to understand how basic need fulfillment predicts a suite of variables at the start of medical school. Basic need fulfillment was assessed by focusing on the three constructs that are the focus of Self-Determination Theory[6]: autonomy; belonging; competence. The psychological variables proposed to be associated with these three constructs included career commitment, likelihood of reporting medical errors, imposter syndrome, willingness to seek help for depression, and perceived career consequences of seeking help for depression. These data could also further highlight the extent to which medical school influences incoming residents in more ways than often considered.

Methods

This study used a cross-sectional design to explore the relationships between basic need fulfillment in medical school (i.e., autonomy, competence, belonging) and specific aspects of incoming residents' psychological profile (e.g., imposter phenomenon, willingness to report medical errors, depression, intentions to seek help for depression, and perceived career consequences of help-seeking). It was part of a more extensive data collection of incoming residents of the 2025-2026 school year. An anonymous survey was emailed to residents transitioning to a large national hospital organization. One thousand one hundred seventy-three complete responses (i.e., ≥ 80% completion[7]) indicated a response rate of 84.2%[8]. Participants were randomly assigned to different survey paths. A total of 399 incoming residents filled out scales related to the variables of current interest.

Results/Outcomes/Improvements

The results of the current study indicate incoming residents' fulfillment of basic psychological needs (i.e., autonomy, belongingness, competence) is associated with critical psychological variables that can impact residency success. Overall, the data indicate that incoming residents who report feeling a sense of autonomy, belonging, and competence in medical school are in a more psychologically favorable place at the start of residency. Feelings of autonomy, belongingness, and competence during medical school were statically significantly associated with all included variables: career commitment (r = .30, .39, .42); imposter syndrome (r = -.26, -.28, -.33); willingness to report medical errors (r = .13, .19, .15); depression (r = -.20, -.22, -.20);

intentions to seek help for depression (r = .11, .21, .22); and perceived career consequences of seeking help for depression (r = -.24, -.23, -.16).

Significance/Implications/Relevance
Incoming medical residents who report not having psychological needs fulfilled in medical school are at great risk for problematic outcomes at the start of residency. The extent to which incoming residents reported that their basic psychological needs (i.e., autonomy, belongingness, competence) were not fulfilled was associated with a host of problematic outcomes. Residents who scored the lowest on measures of medical school autonomy, belongingness, and competence, were also the residents who were least likely to be committed to their career, to report medical errors, and were most likely to report high levels of depression. Moreover, these residents were less likely to seek help for depression and had the greatest fears that doing so would hurt their careers. Residency programs will ideally assess their incoming trainees' perceptions related to medical school autonomy, belongingness, competence to identify those who are in need of greater assistance at the start of their residency.

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Poster #33: Chairs, Not Checkboxes: Transforming Resident Committees into Engines of Engagement and Program Improvement

Author(s): Anas Bizanti, MD; Luis Lugo, MD

Institution(s): Lakeland Regional Health

Abstract Type: Innovation-focused

Background
Residency programs often establish resident committees solely to fulfill accreditation requirements, leading to limited engagement and minimal program impact. At Lakeland Regional Health, our internal medicine residency identified underutilized committees as a barrier to resident leadership development, wellness initiatives, and program innovation. Literature supports the importance of resident participation in governance to foster autonomy, professional growth, and satisfaction, yet few practical models exist for transforming committees into meaningful engines of engagement.

Objectives
To design and implement a structured “Committee Ecosystem Model” that empowers residents to take active leadership roles, ensures committees drive measurable program improvement, and fosters sustainable pipelines for resident leadership[, as well as to identify] a measurable way to choose chief residents.

Methods
We transitioned from compliance-driven to purpose-driven committees by implementing the IMPACT framework: Intent, Membership, Process, Accountability, Collaboration, Tracking. Nine resident-led committees (e.g., wellness, recruitment, curriculum, research, community service, clinical operations) were established with defined charters, cross-collaboration expectations, and measurable deliverables. Faculty mentorship was embedded, and committee leadership rotated progressively to foster development of junior residents. A Committee Maturity Matrix and impact dashboards tracked engagement, outputs, and outcomes.

Results/Outcomes/Improvements
Within one year, resident satisfaction with program involvement increased by 35% (annual ACGME survey and local surveys). Committees produced tangible outputs, including a structured resident wellness curriculum, a recruitment pipeline strategy, and multiple resident-led QI projects. Accreditation self-study outcomes were strengthened by documented committee-driven initiatives. Faculty reported greater resident ownership of program improvement, and residents described enhanced leadership confidence. The committee ecosystem demonstrated sustainability through successful transition of leadership across PGY classes.

Significance/Implications/Relevance
This innovation demonstrates that reframing resident committees as interconnected, purpose-driven ecosystems fosters engagement, leadership development, and measurable program improvement. The IMPACT framework and Committee Ecosystem Model provide a replicable template for other programs seeking to transform compliance-based structures into catalysts for meaningful change. Adoption of this model has implications beyond internal medicine, offering a scalable approach to enhancing resident voice, satisfaction, and institutional outcomes across graduate medical education.

Poster #34: Designing a Wellness Initiative Residents Actually Use: Data from Four Years of Opt-Out Check-Ins

Author(s): Emily Lisco, MD; Alexandra Hughes, LCSW; Meghan O'Meara, PhD, LPC; Shawn Blue, PsyD

Institution(s): Sidney Kimmel Medical College of Thomas Jefferson University and Jefferson Health; Jefferson Health

Abstract Type: Innovation-focused

Background
Resident well-being remains a critical concern in graduate medical education (GME), with increasing rates of burnout, mental health challenges, and persistent barriers to accessing care. While the ACGME emphasizes the importance of fostering a culture of wellness, programs often struggle to translate these goals into sustainable, practical interventions. Stigma, time constraints, financial barriers, and long waitlists can further deter residents from seeking support. To address these challenges, we developed an opt-out wellness check-in program designed to reduce barriers and normalize access to care. Over four years, this program has evolved from a pilot into a scalable, data-driven model that can be implemented across residency programs of varying sizes.

Objectives
1. Define the importance of a clear purpose in designing wellness interventions that both meet ACGME well-being requirements and promote meaningful resident engagement.

2. Describe a scalable framework for resident wellness check-ins that balances structure with personalization, including scheduling, facilitation, and follow-up strategies.

3. Identify best practices in data collection to measure program impact and guide continuous quality improvement in resident wellness initiatives.

Methods
The wellness check-in program was piloted by an in-house psychiatrist. Residents were automatically scheduled for a 30-minute, virtual, 1:1 check-in with the option to “opt out.” Prior to the visit, residents completed a consent form and PHQ-9. Sessions followed a structured format while allowing for individualized discussion, including reflection on burnout, coping strategies, barriers to seeking care, and when to consider professional help. Residents could schedule a formal intake appointment during the visit.

All residents received a voluntary feedback survey and information about available wellness resources. The program expanded to additional residency programs, trialed various funding models, and ultimately secured GME funding to provide check-ins for the institution’s 2,000 residents and fellows. The facilitation team grew and refined the program based on resident and facilitator feedback, supporting continuous quality improvement and scalability.

Results/Outcomes/Improvements
The number of attended wellness check-ins and intake appointments scheduled were tracked. Survey responses provided additional feedback.

AY21:
61% (46/76) attended
24% (11/46) scheduled an intake

Survey responses: 8*
5 strongly agreed and 2 agreed that the check-in was helpful
7 recommend it to peers

AY22:
32% (118/369) attended
34% (40/118) scheduled an intake
Survey responses: 43*
26 strongly agreed and 9 agreed that the check-in was helpful
38 recommend it to peers

AY23:
41% (75/184) attended
35% (26/75) scheduled an intake
Survey responses: 34*
16 strongly agreed and 13 agreed that the check-in was helpful
29 recommend it to peers

AY24:
32% (118/371) attended
47% (55/118) scheduled an intake
Survey responses: 88*
59 strongly agreed and 22 agreed that the check-in was helpful
83 recommend it to peers

*All questions were optional and not all respondents answered every question. Additional data and survey comments will be shared.

Significance/Implications/Relevance
Successful wellness interventions require a defined purpose, clear goals, and measurable outcomes. Wellness check-ins provide a structured yet flexible tool for early intervention and preventive support, while addressing common barriers such as stigma, access, and time. By establishing a consistent framework that integrates staffing, scheduling, referrals, and follow-up, GME programs can adopt wellness check-ins as a practical strategy to support resident well-being.

Longitudinal data over four years demonstrates that wellness check-ins are not only feasible but also effective in promoting engagement, driving quality improvement, and securing institutional investment. This model offers the GME community a tangible, scalable approach to building a culture of well-being that is adaptable across programs of all sizes.

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Poster #35: Engaging Residents in Patient Safety Reporting Valued by the Trainees, GME, and the Hospital Partners

Author(s): Sarah Meadows, EdD; Tyler Anstett, DO; Abraham Nussbaum, MD; Geoffrey Connors, MD

Institution(s): Denver Health; University of Colorado Anschutz Medical Campus; University of Colorado School of Medicine

Abstract Type: Innovation-focused

Background
Engaging trainees in quality and patient safety improves patient care, bolsters quality metrics, fosters a culture of safety, and activates trainees' agency.[1,2] ACGME data and other reports show Sponsoring Institutions struggle to generate engagement across training programs and clinical sites.[2,3,4] For the past 10 years, our partnership program with residents sponsored by two affiliated institutions has incentivized residents to participate in patient safety and quality projects. Project involvement was variable, suggesting engagement by a minority of residents.

Objectives
Our goal was to implement a collaborative, stepwise approach to grow resident participation in patient safety reporting, reflection on patient cases, and feedback systems to improve value for resident physicians, hospitals, and sponsoring institutions.

Methods
In 2020, we implemented new metrics at each hospital to drive participation by individual residents. Residents were incentivized to submit patient safety reports and attend case conference reviews (CCRs). Residents were provided education on types of events to report and how to follow each case's progression through the safety reporting system. Between 2022 and 2025, CCR reflection forms were enhanced to prompt residents to identify health-related social needs impacting the case, positive individual or team contributions to the case, and ways hospital leadership could provide support to prevent similar issues from recurring. Monthly emails were sent to all residents highlighting cases from the previous month which promoted hospital leadership changes resulting from resident reporting.

Results/Outcomes/Improvements
Between July 2024 and April 2025, 99% (1311/1330 residents) participated in the patient safety incentive program across the entire GME system comprised of two ACGME-accredited Sponsoring Institutions and representing 146 accredited residencies and fellowships. Between 86% and 100% participation occurred among residents across each hospital training site. During the same period, we received 234 unique resident suggestions for hospital leadership at one training site related to case reviews in which they participated. Actions taken by the hospital training site prompted by resident feedback were highlighted in monthly emails to all residents from November 2024 to May 2025, featuring outcomes of 32 cases. Some of the actions taken included updating an opioid order set, revising a Type 1 Diabetes obstetrics patient policy and hiring a diabetes educator, upgrading a call/bed monitoring system, and adding security team education to clarify involuntary psychiatric hold protocols.

Significance/Implications/Relevance
By aligning with ACGME program and institutional requirements, coaching and education, feedback systems, and individualized responses, resident patient safety reports and quality

initiatives have grown both in quantity and quality. This collaborative, coordinated, and system-wide resident quality and safety incentive program can provide other Sponsoring Institution leaders and program directors with concrete approaches to building programs that impact quality and safety culture. The scaled approach allows institutions to start with quality and safety reporting supported by coaching and education and evolve to a closed-loop feedback system for improving resident reporting quantity and quality.

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Poster #36: Evaluating Mistreatment of Resident Learners by Patients: Differences Across Clinical Learning Environments

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Abstract Type: Research-focused

Background
The clinical learning environment (CLE) is a unique intersection of learners, health care team members, patients/family. Literature shows a high prevalence of mistreatment by various perpetrators characterized by verbal abuse, inappropriate comments, or inappropriate behaviors directed toward the resident learners (RL).[1,2] While studies on RLs have predominantly focused on inter-resident mistreatment/faculty intimidation, more recent attention has been paid to documenting harassment by patients on RLs. A local pilot study and data from GME office demonstrated nearly 50% of residents reported harassment from patients in the past year, but < 2% reported it to program leadership and < 10% reported to supervising faculty. In most cases, no actions were taken to address harassment with the patient/family member. Additionally, RLs reported differences in the amount of patient harassment that occurred between CLEs, with harassment perceived to be higher at Veterans Affairs (VA) CLEs compared to non-VA CLEs.

Objectives
1) Identify the frequency of patient perpetrated mistreatment across institutions, CLEs, and RL characteristics. Hypotheses: The proportion of internal medicine (IM) residents who experience and observe patient perpetrated mistreatment will be a) higher at VA facilities when compared to non-VA health care facilities, and b) higher for women compared to men.

2) Identify rates of mistreatment reporting across institutions and CLEs and the presence and awareness of policies for reporting patient mistreatment. [Hypothesis:] a) The proportion of mistreatment incidents reported to program or institutional leadership by IM residents will be higher at VA versus non-VA sites; b) There will be higher rates of reporting at sites with explicit policies for patient mistreatment reporting compared to those without explicit policies; and c) RLs who are aware of site-specific protocols or policies to report harassment will report higher rates than those who are unaware.

Methods
RLs were surveyed at five IM residency academic sites. Sites were selected as a sample with regionality considerations: four sites with non-VA and VA CLEs and one site without VA CLEs. Survey instrument was created through an iterative process based on literature review, prior pilot survey, site program evaluations/reporting, and internal and external testing and incorporation of feedback and revisions. Survey was programmed into REDCap platform. The study was deemed exempt by the UTHSA IRB #20230268EX. The survey included 18

questions. The survey was distributed at five sites from October 23, 2024-February 28, 2025, via email with five email reminders. A research incentive of a $25 e-gift card was provided via grants to those who filled out at least 75% of the survey questions.[3] Statistical analysis with R and R studio and the representativeness of our sample was compared to the nationwide population [according to] ACGME IM RL demographics.

Results/Outcomes/Improvements
The survey response rate was 54.1% (412/761). RLs representation differed by site. RLs reported mistreatment by patients at 2.64 (p=<0.001) greater odds at VA clinical sites than non-VA clinical sites. RLs identifying as women reported 4.31 (p=<0.001) greater odds of mistreatment at VA clinical site than non-VA clinical sites. Mistreatment was more likely to be disclosed at non-VA sites than VA sites; however, this was not statistically significant. RLs who answered “Yes” to receiving mistreatment training reported 1.98 greater odds of mistreatment disclosure of any kind compared to those who answered “No” (p=0.033). While there is some qualitative literature stating patient-perpetrated sexual harassment towards women staff/women patients at the VA is higher; these results are the first to report higher rates of mistreatment of RLs by patients at VA vs. non-VA facilities[4,5]. We also find self-reported mistreatment training is effective in disclosing mistreatment.

Significance/Implications/Relevance
Being aware of how patient harassment varies across facilities could help to prepare RLs for possible differences in experiences they may encounter while training in those sites. Our study finds there are differences of mistreatment of RLs by patients with reported mistreatment to be higher at VA sites when compared to non-VA sites. This has the potential to not only impact IM RLs, but RLs across all specialties since the VA has “approximately 45,000 residents annually rotating through over 11,000 VA-funded full-time equivalent positions as part of the nation’s largest clinical training platform, second only to CMS funding GME nationally. The VA supports over 120,000 trainees and students annually from over 40 different health professions”; thus, having an impact for all health care team members.[6] Additionally, we find that RLs who reported receiving training on mistreatment had greater odds of disclosing mistreatment-demonstrating training and education are effective.

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Poster #37: Excel-Based System for Resident Biannual Reviews Within a Residency Program

Author(s): Samantha Payer, BS; Kelley Opperman, BGS

Institution(s): University of Michigan

Abstract Type: Innovation-focused

Background
Biannual resident reviews in ACGME-accredited programs require compiling data from multiple sources, including evaluations, Milestones assessments, [work] hour logs, procedures, didactic attendance, In-Service Training Examination (ITE) results, scholarly activity, and feedback.

Monitoring residents' personal and professional goals, as well as wellness, is also critical for meaningful review and support. Previously, managing this information across multiple systems was time-consuming and prone to errors.

Objectives
To design an Excel-based system that streamlines data management for biannual reviews, supports Milestones tracking, and enhances overall efficiency and accuracy in resident performance evaluations.

Methods
A master Excel workbook was developed to consolidate data from multiple sources using formulas and basic automation. After program administrators upload the relevant reports, the system processes and organizes the data. The master file then distributes updated information to individual resident files, each of which contains a comprehensive record of evaluations and other relevant information. These files are accessible only to the respective resident and program leadership to maintain confidentiality.

Results/Outcomes/Improvements
- Centralized data from the Clinical Competency Committee and other sources, including academic metrics, feedback, and scholarly activity
- Automated organization and processing of uploaded reports
- Individualized, easy-to-navigate resident files for streamlined review
- Built-in tracking for ACGME Milestones
- Tools for monitoring resident goals and wellness
- Controlled access to ensure confidentiality
- Reduced manual data entry and increased consistency
- More efficient review preparation and documentation
- Improved support for resident development and wellness
- Enhanced readiness for ACGME site visits
- An intake tool used by residents to quickly submit feedback, supporting meaningful discussions with the program director

Significance/Implications/Relevance
This Excel-based system provides a practical solution for managing biannual reviews in a residency program. It reduces administrative burden, improves data integrity, and enables more structured, personalized, and efficient resident evaluation and feedback. The approach also strengthens the program's ability to monitor progress toward milestones and maintain readiness for accreditation reviews.

Poster #38: Fostering Meaning in Medicine: A Psychiatry Research Lab Model to Cultivate Purpose and Research Literacy in Community Hospitals

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Institution(s): BronxCare Health System; NYC Health + Hospitals/Bellevue

Abstract Type: Innovation-focused

Background
Despite the growing importance of academics in psychiatry, many community hospital residency programs face systemic barriers to research engagement. These include fragmented research opportunities during clinical years, excessive service demands, limited financial incentives, and insufficient institutional infrastructure to support scholarly activity. Literature highlights that mentorship, structured timelines, and accessible resources are essential to fostering research productivity.

Objectives
In response to these challenges, our institution launched a resident-led Psychiatry Research Lab, an initiative designed to centralize research efforts, promote scholarly engagement, develop meaningful professional relationships among residents and faculty, and increase research literacy among psychiatry residents and faculty. The Psychiatry Research Lab was established to provide a structured and supportive environment for both novice and experienced residents.

Methods
The Psychiatry Research Lab serves as a hub for training, collaboration, and innovation, offering one-on-one mentorship that includes protocol synthesis, drafting, and support with IRB and manuscript preparation. The lab is organized under a leadership structure consisting of an administrator, a research lab leader, and specialty-specific interest groups (SIGs) leaders and participants, including child and adolescent psychiatry, forensics, public psychiatry, addiction, geriatrics, and consultation-liaison psychiatry. A shared database was created to consolidate journal submission deadlines, grant opportunities, and active projects. Resident participation was encouraged through various channels, including abstract submissions, quality improvement initiatives, case reports, and original research. Quantitatively, research output from the five years preceding the lab's implementation (2015-2019) was compared to the two years following implementation (2020-2021) using a t-test.

Results/Outcomes/Improvements
In the first academic year of implementation, resident participation in research activities increased by 60%. Survey data showed a marked improvement in residents' confidence in initiating and contributing to research. Faculty involvement also rose, leading to increased interdisciplinary collaboration. Quantitative analysis revealed a statistically significant increase in research output: publications rose from a mean of 9.2 to 13, poster presentations increased from 30.7 to 57, and oral presentations grew from 23 to 35.5 ($p < 0.05$ for all). Qualitatively, testimonials from residents and faculty who have graduated from the program indicate that the lab has helped align personal and professional values, supported resilience in challenging community hospital environments, and contributed to a sense of purpose in psychiatry, ultimately aiding in reaching their career goals.

Significance/Implications/Relevance

The Psychiatry Research Lab demonstrates that a structured, resource-rich, and mentorship-driven approach can significantly enhance research engagement and productivity in underserved, community-based training environments. This model provides evidence that the intervention helped foster personal meaning and purpose for residents and faculty. It helped to interconnect scholarly engagement with overall well-being, identity, building professional relationships, and fulfillment in residency training, as well as reaching super-specialty training goals. This scalable model has the potential to foster a sustainable culture of academic inquiry and advocacy.

Poster #39: Geographic and Program Size Disparities in Medicare Funding for Graduate Medical Education

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Institution(s): Lewis Katz School of Medicine; Fox School of Business and Management at Temple University; Temple University School of Medicine; Temple University School of Medicine; Lewis Katz School of Medicine at Temple University

Abstract Type: Research-focused

Background
Graduate medical education (GME) funding from Medicare is essential to physician workforce development, yet Direct GME (DGME) payments are distributed unevenly. Prior studies have described overall DGME spending, but less is known about per-resident allocations across states and program sizes. Hospitals with similar numbers of residents may receive very different payments, raising concerns about fairness and transparency. Such disparities may disproportionately affect rural and mid-sized programs operating with limited resources. We examined DGME funding patterns to evaluate the equity of current federal allocations and identify whether certain states or hospital types are systematically advantaged or disadvantaged.

Objectives
This project aimed to assess how Medicare DGME payments vary across states and by the size of residency programs. Specifically, we examined whether hospitals with the same number of residents receive different DGME payments depending on geography. Programs were stratified as small (0-20 residents), mid-sized (21-200), and large (200+ residents). Secondary aims included examining how funding trends varied across these strata within states and identifying whether specific states or hospital types consistently ranked among the highest or lowest in DGME support. By characterizing these disparities, we aimed to inform equitable funding policy that sustains diverse residency training programs.

Methods
We performed a retrospective cross-sectional study of Medicare DGME data (2014-2024). Variables included Total DGME, Part A/C, Part B, and hospital resident counts. Hospitals were grouped by state and program size (small, mid-sized, large). Outliers were winsorized at the first and 99th percentiles; Box-Cox transformations normalized skewed variables. Per-resident payments were compared across states and program sizes. Analyses included targeted state comparisons, trends by resident count, and polarized assessment of top and bottom decile hospitals. Sensitivity analyses evaluated resident count and bed capacity as predictors of payment.

Results/Outcomes/Improvements
Marked differences in DGME payments per resident were found across states and program sizes ($p<0.001$). The national median DGME payment per resident was $22,000. Mississippi had the highest median ($30,000), while California ($15,000) and DC ($16,600) were lowest. Mississippi and Kansas had higher average payments, while DC, Louisiana, and West Virginia were consistently lower. Small programs (0-20 residents) received higher mean per-resident

payments than mid-sized programs ($p<0.01$), with some increases in the largest programs (>200 residents). In direct comparisons, California had higher per-resident payments in the smallest and largest sized programs ($p=0.04$), while Alabama had higher averages among mid-sized programs ($p=0.02$). Hospitals in the highest and lowest deciles of DGME payments showed regional variation rather than being evenly distributed across states. Sensitivity analysis revealed that resident count predicted payments more strongly than bed capacity ($p<0.001$).

Significance/Implications/Relevance
DGME funding is not consistently aligned with program size or geographic distribution. Per-resident payments place smaller and mid-sized residency programs markedly below parity, particularly in states with lower average DGME support. It follows that such imbalances can restrict hospitals in underserved regions from expanding training programs. Although the issue of causality has not been solved, these findings highlight the need to reevaluate current formulas to ensure equitable distribution and support a balanced national physician workforce.

Poster #40: Impact of a 24-Hour Call Model on Duty Hour Compliance and Resident Well-Being in a New Hospital-Based Neurology Residency Program in Indonesia

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Institution(s): National Brain Center Hospital Mahar Mardjono Jakarta

Abstract Type: Innovation-focused

Background
Resident duty hours directly influence wellness and education. The ACGME permits 24-hour continuous [work hours] with up to six hours extension for handover or didactics. Indonesia's first hospital-based neurology residency, under a Sponsoring Institution with Initial Accreditation by ACGME International (ACGME-I) at the National Brain Center Hospital Mahar Mardjono (NBCH), Jakarta, implemented a 24-hour call model with post-call release to ensure compliance and protect wellness in its early phase.

Objectives
To evaluate whether a 24-hour call model ensures compliance with ACGME [work] hour standards and promotes resident well-being in a neurology residency program.

Methods
From February-August 2025, duty [work] hours and attendance were tracked via electronic logbook, and monthly five-item well-being surveys (yes/no) were completed. "Yes" indicated burden (fatigue, stress, symptoms); "No" indicated absence of complaints. Duty [work] hour averages, extended shifts, attendance, and well-being trends were analyzed descriptively.

Results/Outcomes/Improvements
Average duty [work] hours were 52-65 per week, within ACGME limits. Only 4-7% of shifts extended beyond 24h (≤28h, mainly for handover and morning report). Attendance exceeded 85% with minimal sick leave. Well-being surveys showed clear improvement from February to August, with fewer reports of burden and more consistent No responses; for example, positive responses increased from 58% in May (when overtime peaked at 7%) to 78% in August (with 5% overtime). Residents felt better rested, though some noted reduced opportunity to attend post-call didactic sessions.

Significance/Implications/Relevance
A 24-hour call model with immediate post-call release is feasible and compliant, and it supports resident wellness in a hospital-based program under an ACGME-I-accredited Sponsoring Institution. The trade-off of fewer didactic hours highlights the need for restructuring academic schedules. This early implementation phase demonstrates continuous quality improvement and may inform other new programs in resource-limited settings.

Poster #41: Impact of an Interprofessional Faculty Development Initiative on Rural Health Professions Education: A Qualitative Evaluation

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Institution(s): VA Puget Sound Health Services Research & Development, Center of Innovation for Veteran-Centered; VA Eastern Colorado Healthcare System; University of Washington School of Public Health, Health Systems and Population Health; Office of Academic Affiliations, Veterans Health Administration

Abstract Type: Research-focused

Background
Rural clinician shortages are a major contributor to widening rural-urban health disparities in the United States,[1] highlighting the need for interventions to build the rural health workforce. Faculty development programs have significant potential to support rural health workforce development. By building clinician-educators' capacity to develop and deliver high-quality health professions education (HPE) in rural facilities, faculty development programs may increase the likelihood that health professionals train and eventually practice in rural communities.[2,3] Improved understanding of the role of faculty development programs in advancing rural HPE is needed.

Objectives
The study objective was to evaluate the impact of a faculty development program on the quality of and capacity for rural HPE from the perspective of program participants. The program under evaluation aims to enhance HPE in rural and under-resourced facilities in a national health care system. It targets clinician-educators from a range of professions and geographic locations. The curriculum incorporates a mix of didactic, experiential, and peer learning approaches, as well as community of practice building, delivered over a period of 16 to 24 months.

Methods
Using a rapid qualitative study design, we conducted 27 semi-structured interviews with program participants across two cohorts. Transcript data were analyzed using template and matrix analysis methods.[4,5] Analysts summarized interview transcript data in a structured template organized by domains reflecting evaluation objectives. Data were then entered into a matrix to facilitate comparison across interviews. Analysts reviewed the matrix to identify patterns and themes within each domain. Themes were iteratively revised based on formative feedback from the full team.

Results/Outcomes/Improvements
Findings revealed three themes related to the program's impact on rural HPE. First, participants perceived that the program offered practical support that was highly valued in settings with limited resources and less developed educational programs. The opportunity to network within a distributed, interprofessional community of practice was viewed as especially useful to rural clinicians who often experienced professional isolation. Second, experiential projects spurred activities designed to improve the educational environment at rural sites, such as faculty development offerings, new curricula, and new rotations. Lastly, participants described ways in which the program advanced a culture of education in rural facilities. Some credited it for "starting the conversation" about the role of HPE in rural care. Participants expressed increased

appreciation for the importance of rural HPE, which fueled motivation to support rural education and recruitment.

Significance/Implications/Relevance

Substantial research demonstrates that faculty development improves the knowledge and skills of individual clinician-educators, but less evidence is available on the ability of these programs to effect positive institutional change.[6,7] Our findings demonstrated three pathways by which a multi-modal, longitudinal faculty development program enhanced rural HPE. These pathways include offering practical support to clinician educators, promoting program development, and cultivating a culture of education. By investing in rural clinician educators, faculty development may help to cultivate high-quality HPE environments, shown in existing literature as a contributor of health workforce recruitment and retention.[3,8]

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Poster #42: Matching Residents with Scholarly Activity Opportunities: Scholarly Activity Fit Assessment Pilot Implementation

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Institution(s): HCA Healthcare, Graduate Medical Education

Abstract Type: Innovation-focused

Background
Physician involvement in scholarly activity enhances quality of care and professional development[1]. Yet only ~15% of physicians engage in research,2 with physician-scientists comprising just 1-2%[3]. Barriers include clinical demands, limited skills, and lack of support. We used Social Cognitive Career Theory[5], Professional Identity Formation[5], and the Theory of Planned Behavior[6] to create a Scholarly Activity Fit Assessment that explores how beliefs, motivations, and perceived control influence residents' engagement in scholarly activity. This pilot study assesses the face validity, internal consistency, and usefulness of the Scholarly Activity Fit Assessment based on a smaller sample of residents in family medicine, internal medicine, and general surgery. This is the first step of a larger project that aims to develop a Scholarly Activity Fit Assessment to create personalized scholarly activity plans that foster meaningful participation.

Objectives
This pilot study assesses the validity and usefulness of the Scholarly Activity Fit Assessment based on a smaller sample of residents.
More specifically, we aim to:

1. Determine validity and internal consistency of the survey tool.
2. Determine if there are differences in trends of residents' motivations, beliefs, and attitudes towards scholarly activity across specialties.

Methods
Utilizing the framework of the Social Cognitive Career Theory, Professional Identity Formation, and the Theory of Planned Behavior, a 45-item "Scholarly Activity Fit Assessment" survey was developed to measure to measure six domains: attitude towards scholarly activity; subjective norms; perceived behavioral control; behavioral intention; identity as a physician-scientist; and prior scholarly activity. The survey was administered to a pilot sample of 47 residents across three specialties: internal medicine (n= 27); general surgery (n=11); and family medicine (n=9).

To assess the internal consistency of the survey we calculated Cronbach's alpha for each of the seven domains. A one-way ANOVA was estimated to assess differences between the three specialties. Pearson's correlation coefficients were calculated to assess the relationship between the identity as a physician-scientist and the other constructs.

Results/Outcomes/Improvements
A sample of 47 residents across three specialties (internal medicine, family medicine, and general surgery) took the survey. All six measured domains/constructs showed good internal consistency with Cronbach's alphas of 0.91, 0.72, 0.81, 0.92, 0.90, and 0.70, respectively. The one-way ANOVA analysis showed no difference in response trends among the seven domains across the three specialties. A Pearson's correlation showed that there was a significant positive correlation between attitude towards scholarly activity ($r = 0.55$, $p < 0.001$) and behavioral intention ($r = 0.53$, $p < 0.001$) with identity as a physician-scientist. No other relationships were present.

Significance/Implications/Relevance

Our pilot analysis showed that our Scholarly Activity Fit Assessment domain and tool display adequate internal consistency and uniform response patterns between the three specialties. This gives us confidence that the tool we are developing will be able to be adopted across different residency programs. We also found that positive attitudes towards scholarly activity and intention to do scholarly activity are positively correlated with identity of a physician scientist, which shows that these two domains might identify high achievers. In future work we will focus on identifying patterns that align residents with specific types of scholarly activity. If validated in larger studies, the Scholarly Activity Fit Assessment could provide an evidence-based method to personalize resident scholarly activity plans, promote professional identity formation, and ultimately foster a stronger physician-scientist pipeline.

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Poster #43: Resident Mental Health: Creating an Innovative, Sustainable, and Scalable Counseling Program

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Institution(s): Sidney Kimmel Medical College of Thomas Jefferson University and Jefferson Health; Jefferson Health

Abstract Type: Innovation-focused

Background
The ACGME entrusts graduate medical education (GME) programs to support resident mental health, yet best practices remain unclear, as residents are both employees and learners. The continuum of medical education, training, and practice requires longitudinal support. Medical students' counseling needs are met by student centers, and residents lose that support at graduation. During and after training, physicians face high rates of burnout and mental health challenges. Suicide is the leading cause of resident death, and 28% of interns experience a depressive episode, yet stigma and barriers such as time, cost, and waitlists limit help-seeking. Residency's unique demands, including lack of autonomy to request time off, long work hours, mandatory educational activities, and limited back up, call for solutions beyond traditional mental health treatment. Effective well-being initiatives require intentional design and efficient resource use to ensure residents access and benefit from support during training and beyond.

Objectives
1. Identify the importance of innovative resource utilization to create a resident-specific counseling center.
2. Analyze benefits and financial costs to ensure sustainability.
3. Appraise the outcome measures that can be used to support scalability.

Methods
Historically, our student counseling center managed resident therapy requests. In 2020, a psychiatrist was hired to provide counseling and medication for 1,000 residents. While researching why residents tend to underutilize existing mental health services, the team innovatively used available resources to build an efficient center with the infrastructure to address those issues. Growth was driven by telehealth appointments, evening hours, being in-network and billing insurance, opt-out wellness check-ins, education, and GME consultation. In 2024, the center received its own budget and scaled up to six full-time clinicians and one administrative staff member, serving 2,000 residents. It is financially sustained through billing revenue and a GME "price-per-resident" subsidy. Utilization is tracked annually, and anonymous surveys provide feedback to understand and improve the resident experience.

Results/Outcomes/Improvements
Total appointments
AY23: 1,476
AY24: 2,132

Individuals seen by center
AY23: 187
AY24: 253

appts/year
AY23: 0-5 (54%), 6-12 (25%), 13+ (21%)

AY24: 0-5 (52%), 6-12 (29%), 13+ (19%)

Satisfaction survey AY23 and AY24 (121 total responses):
“Treatment helped me be more successful in my residency program.”
75% strongly agree, 23% agree
“Treatment helped me stay in residency.”
78% strongly agree,19% agree

Comments:
“This program made my experience at [institution] 1000x better... Not having to worry about money to be able to afford therapy was a huge relief. This program is amazing and should be standard in all academic settings.”
“Please don't ever get rid of this program. It is quite truly a lifeline for many of us."
“My provider helped me stay in residency. I had serious thoughts about dropping out or worse, and therapy has helped me get to a place where I can enjoy residency...”

Additional data, satisfaction survey results, and staffing recommendations will be shared.

Significance/Implications/Relevance
GME must prioritize resident well-being. Professional care is costly, and employee assistance programs are often underutilized by residents. A dedicated counseling center tailored to the demands of residency, including offering confidential support, risk identification, and in-network billing, can increase engagement and sustain higher utilization rates than student counseling centers. Establishing this infrastructure requires resources, but if the program is designed for residents’ unique needs it will improve participation and outcomes. Residents who accessed services reported feeling more successful in training, developing skills to transition into practice, and enhancing their ability to care for patients and themselves. This model is scalable to other institutions, and shared data can help advance conversations with hospital leadership, even in times of financial constraint.

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Poster #44: Resident Team-Driven Screening, Intervention, and Management of Eating Disorders in a Teaching Health Center Serving Underserved Populations

Author(s): Amardeep Khushoo, PhD; Tewodros Tekle, MD; Lydia Herrera-Mata, MD; Stephanie Pablo, MD; Avarpratap Singh

Institution(s): Valley Health Team Family Medicine Residency Program

Abstract Type: Research-focused

Background
Eating disorders (EDs) are serious, potentially life-threatening conditions involving disordered eating and unhealthy weight-control behaviors impacting both physical health and psychosocial well-being.

In the US, about 28.8 million individuals (4.9% of females and 2.2% of males) will experience an eating disorder at some point in their lives. EDs can affect anyone, regardless of age, size, identity, or background, with adolescence and early adulthood being critical development periods. The COVID-19 pandemic has exacerbated the prevalence of EDs, particularly among adolescents, leading to increased treatment and hospitalization needs. In our clinic, the ED prevalence was 1.3%, much lower than the national estimates. We posited that resident team-driven early screening, prompt diagnosis, and treatment in a primary care setting may be critical in detecting and managing EDs effectively, thereby helping to prevent long-term, consequential medical and psychological outcomes for our patients

Objectives
To establish resident team-driven implementation of screening for our continuity of care patients aged 12-35 years for EDs, facilitating early detection, providing brief intervention, initiating referrals, and managing treatments using the NCEED Eating Disorder screening tool and the NCEED SBIRT-ED toolkit, to support patient recovery, thereby improving patient health outcomes.

Methods
Resident team-driven implementation of screening, brief intervention, and referral to treatment for EDs (SBIRT-ED) intervention plan included:

1. Training family medicine residents in screening and diagnosing patients with EDs and implementing the NCEED SBIRT-ED toolkit to conduct brief interventions and make appropriate referrals for treatment.
2. Designate and train a CHAMPION medical assistant to promote team-based care.
3. Periodic review of specialist referral consultations for EDs, such as cognitive behavioral therapy (CBT), psychiatrists, health education, and nutritionists.
4. Data analysis by sociodemographic characteristics (race, ethnicity, gender, age, language, family income, family size, farmworker status, and homelessness) and comorbidities for the screen-positive and negative patients.

The implementation period ran from September 19, 2024 to September 15, 2025. Resident conducted manual chart reviews (n=379) to calculate the baseline ED prevalence rate.

Results/Outcomes/Improvements
Residents conducted 194 ED screeners for 173 randomly selected patients, finding that 41 (24%) screened positive for an ED. Among these, 63% scored 1 (low risk), 24% scored 2 (low

risk), and 12% scored 3 (medium risk). All screen-positive patients received a brief intervention counseling by the resident, and 76% received a provisional ED diagnosis, with “atypical ED,” “binge ED,” “body image problem,” and “ED unspecified” emerging as the most common diagnoses. Thirty-one patients were identified as appropriate and scheduled for specialty referral(s): 68% (CBT), 17% (psychiatry), 15% (health education), and 12% (nutrition). Five percent of patients declined referrals.

Notably, males accounted for 68% of positive screenings, despite comprising only 45% of the patient population. African Americans had the highest positive rate (57%), followed by multiracial (50%), and Whites (24%). Hispanics had a higher rate (30%) than non-Hispanics (15%). Screening rates were similar for Spanish [speakers] (27%) and English speakers (25%).

Significance/Implications/Relevance
This study demonstrates the effective implementation of a resident-driven early screening program for EDs in a primary care clinic. Utilizing the SBIRT-ED toolkit facilitated early detection and intervention, as well as timely referral for treatment, particularly among adolescents and young adults. The prevalence of EDs was approximately 18%, significantly higher than the baseline rate of 1.3% for our continuity of care patients aged 12-35 years. Males, African American, and Hispanic patients screened ED positive at a much higher rate than the other groups, suggesting they may be historically underdiagnosed for EDs. Routine ED screening during primary care visits can enhance early detection and treatment of EDs in underserved communities. Training resident teams in the early management of eEDs can help prevent serious health and psychological complications, ultimately improving patients’ quality of life.

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Poster #45: Resident-Led Quality Improvement Project to Enhance Electronic Medical Record (EMR) Competencies and Workflow Effectiveness

Author(s): Kirelos Younan, MD; Armando Pichs-Diez, MD; Nivesh Yadav, MD; Meaghan Ruddy, PhD

Institution(s): The Wright Center

Abstract Type: Innovation-focused

Background
Electronic Medical Record (EMR) systems are the backbone of modern medical practice, yet residents are frequently faced with a high learning curve when acquiring the skills necessary to use them optimally, leading to inefficient workflows and possible safety concerns. At our institution, the residents responded by initiating a collective, resident-initiated quality improvement project.

Objectives
The primary goal was to create a centralized, easily accessible repository to aid residents in learning valuable aspects of the MEDENT EMR system. This handbook was intended to optimize clinical workflows and facilitate the ability to deliver effective and safe patient care.

Methods
We created a “living document” that was accessible to all residents and which they could edit and contribute to. The content was condensed from a sequence of resident-directed Plan-Do-Study-Act [PDSA] cycles and written best practices. The guide had step-by-step instructions for the most important functions, such as establishing settings, conducting complete chart reviews, medication management, and documentation assistance tools. The guide was designed as a fast reference work to be used on clinic days with a searchable format to easily access information about topics like “Cologuard” or “Mobile Mammogram.”

Results/Outcomes/Improvements
The project produced a comprehensive, peer-sourced guide that offers one reference point for MEDENT proficiency. The guide includes in-depth, real-world advice on key functions, such as setting up text notification, performing medication reconciliation, creating dot phrases, and utilizing artificial intelligence-supported note-writing. Key clinical workflows, such as the process of ordering mobile mammograms and ordering a 340B discount card, were documented and standardized.

Significance/Implications/Relevance
This resident-led project demonstrates a reproducible model for development and upkeep of an educational resource to address frequent issues in residency education. The shared, dynamic nature of the guide guarantees continued topicality and utilization. This model may be applied to other residency programs and EMR platforms to enable residents, streamline clinical efficiency, and ultimately improve patient care quality and safety.

Poster #46: Residents-as-Teachers: Reintegrating the Hospital Autopsy into Graduate Medical Education to Advance Milestones and Institutional Learning

Author(s): Bilal Khan, DO; Carlyn Attman, MA; Steven Doyle, DO, PhD; Gisette Rodriguez, MD; Catherine Skibiel, MD; Ruth Birbe, MD; Kathryn Behling, MD, PhD; Eric Behling, MD

Institution(s): Cooper University Hospital; Cooper Medical School of Rowan University

Abstract Type: Innovation-focused

Background
Meaningful hospital autopsy participation has dwindled in graduate medical education (GME), reducing tangible, formative opportunities to practice clinicopathologic correlation (CPC), recognize diagnostic discrepancies, and apply findings to close safety loops. We identified a gap in our GME, where autopsy-based training was ad hoc and rarely tied to systems improvement. In response, guided by the ACGME Milestones, we built a resident-centered model that treats hospital autopsy as an educational and institutional learning tool in a low-resource setting. This approach emphasizes residents teaching peers, connects salient findings to quality-improvement initiatives, and aligns with ACGME milestones in Systems-Based Practice (SBP), Practice-Based Learning and Improvement (PBLI), and Interpersonal and Communication Skills (ICS).

Objectives
Design, implement, and evaluate a faculty-supervised, resident-led autopsy curriculum to:

- Increase meaningful resident participation in hospital autopsy and CPC-style reviews.
- Build residents-as-teachers skills.
- Strengthen milestones in SBP, PBLI, and ICS.
- Link autopsy findings to actionable quality improvement (QI) projects and timely feedback to clinical services.

Methods
Setting: Single tertiary care academic medical center

Design: educational innovation with qualitative evaluation plus measurable activity counts, fidelity metrics, and Milestones self-assessments

Components:

1. Tiered participation checklist and brief skills rubric for evisceration, documentation, and CPC synthesis
2. Monthly resident-facilitated autopsy CPC conference with invited non-pathology trainees
3. Brief simulations for informed consent and next-of-kin communication
4. A routing pathway that flags potentially preventable or contributory findings for quality improvement and morbidity and mortality review

Evaluation: participation logs, checklist-use tracking, post-autopsy debriefs, pre/post Milestones self-assessments, faculty narratives on interprofessional communication and feasibility, and tracking of the proportion of autopsy-derived items that progressed to QI actions.

Results/Outcomes/Improvements
Over nine months, we held 26 autopsy-centered CPCs with integrated didactics; completed 26 faculty-supervised, resident-led autopsies with 100% checklist use; and conducted six interdisciplinary brain-cutting sessions. Participation included 13 pathology residents (PGY-1-4), 10 neurology residents, faculty from three specialties (pathology, neurology, neurological

surgery), and five medical students. Residents assumed teaching roles and reported greater confidence in clinicopathologic synthesis, technical steps (e.g., evisceration, grossing), and interprofessional communication. On pre/post Milestones self-assessments, all pathology residents reported ≥1 level improvement across SBP/PBLI/ICS. Faculty narratives described more reliable structure and clearer handoffs to quality improvement pathways. Secondary observations included two medical students subsequently pursuing pathology residency, and one resident cited autopsy exposure as pivotal in choosing forensic pathology for fellowship.

Significance/Implications/Relevance
Even in resource-limited environments, a faculty-supervised, resident-led autopsy curriculum can strengthen milestones in SPB/PBLI/ICS, build residents-as-teachers, and reliably route CPCs to QI initiatives. The components (checklists, conference presentation, brief simulations, pathway for identifying QI issues) require minimal resources and are portable to other institutions. By explicitly linking autopsy to institutional learning, namely through GME priorities, this model reframes autopsy from a discretionary activity to a driver of systems improvement. The approach is compatible with a Milestones-mapping dashboard and QI-closure tracker to support replication across programs, while preserving the qualitative features that foster interprofessional engagement and competency-based training.

Poster #47: Rural Otolaryngology Curriculum: Creating an Oasis in a Healthcare Desert

Author(s): Tony Satroplus, MD; Evan Ryan, MD; Elizabeth Bradford Bell, MD; Christie Barnes, MD

Institution(s): University of Nebraska Medical Center

Abstract Type: Innovation-focused

Background
Rural health care deserts are geographic areas where medical needs remain unmet due to insufficient health care resources. Nationally, approximately 70% of US counties lack otolaryngology coverage. Ninety-four percent of Nebraska's population lives in rural or partially rural areas, with 1.8 million people spread across 77,000 square miles. Access to otolaryngology care is especially limited, with primary clinics located in only 10 of 93 counties. Unique among national otolaryngology programs, the University of Nebraska Medical Center (UNMC) has implemented a standardized rural private practice otolaryngology rotation in Kearney, Nebraska. This valuable rotation began in 2015. We present our experience with making this novel surgical rotation as part of our residency curriculum and the impact this has had on otolaryngology care in our state.

Objectives
1. To review the process of creating an impactful rural rotation focused on comprehensive otolaryngology in the rural setting. The goal of sharing this information is to provide a framework for creating rural rotations that integrate with an established otolaryngology residency curriculum.
2. To evaluate the influence of UNMC's rural otolaryngology rotation on residency graduates' practice locations across Nebraska.

Methods
Development of Idea and Feasibility Assessment
After identifying interest in a rural rotation, a feasibility assessment evaluated the private practice group's capacity to host residents. This included case mix and volume, compliance with ACGME core requirements, staff availability, and partners' interest in teaching. A site visit followed, reviewing clinical facilities and resident lodging.

Implementation of the Rotation
The rotation was incorporated into the curriculum as a four-month experience: two months in the latter half of PGY-3 and two months in the first half of PGY-4. Housing was provided through an agreement with the sponsoring hospital near the practice's medical facilities.

Assessment of Outcomes – Quantitative (career decisions)
Graduate placement since the rotation's initiation in 2015 was also analyzed, focusing on practice distribution across rural and partially rural counties.

Results/Outcomes/Improvements
Initial Feasibility Assessment
Initial assessment revealed that Case Log numbers were at or above average for typical two-month rotation. These included a mix of sinus surgery, thyroidectomy, parathyroidectomy, neck dissections, and basic otologic and laryngologic cases. All didactic requirements continued to be met while the resident was on this rotation.

Impact on Post-Graduation Placement

Since 2015, among 27 total residency graduates, seven have accepted jobs in rural Nebraska counties. Two of these individuals established practices in counties with no prior otolaryngology coverage.

Significance/Implications/Relevance
A novel rural rotation was successfully designed, implemented, and integrated into the otolaryngology residency curriculum in 2015. Resident feedback indicates that the experience not only strengthened surgical and clinical training but also enhanced understanding of rural and often underserved populations.

Though decisions to practice in rural communities are often multifactorial, participation in rural health training experiences appears to increase the likelihood of graduates practicing in rural settings. The UNMC rural rotation represents a unique model among US otolaryngology programs, addressing disparities related to access in underserved regions. This also allows residents relevant exposure to private practice in comprehensive ENT as well. This framework may serve as a blueprint for other institutions to establish rural curricula that both expand access to care and provide residents with robust clinical exposure. Future work will involve a qualitative assessment of resident

Poster #48: GME Crisis Management During Times of Armed Conflict: A Qualitative Study

Author(s): Rajaa Chatila, MD, MHPE; Hiba Moussa, MA; Kayane Tashjian, MA

Institution(s): Lebanese American University

Abstract Type: Innovation-focused

Background
The graduate medical education (GME) office plays an important role in preparing, educating, and building future physicians. Armed conflicts disrupt and threaten both the continuity and quality of medical education within training programs. The recent war in September 2024 in Lebanon posed significant challenges for LAU GME programs, faculty, trainees, and GME staff.

Objectives
The study explores how armed conflict affected GME programs and sheds light on the way the LAU GME leadership, administration and program directors managed their programs during the crisis, the threats they perceived and opportunities that emerged.

Methods
A qualitative research approach, using semi-structured interviews with selected program directors, GME staff, and the GME Assistant Dean at LAU, was adopted in this study.

The sample size consisted of 11 subjects selected by purposive sampling. The study instrument was a questionnaire with open-ended questions, which was used during the semi-structured interviews. IRB approval was obtained prior to conducting the interviews and all participants provided written consent with permission to record the session. The interviews were conducted via WebEx and audio recorded.

After completing data collection, the interviews were transcribed and thematic analysis of the data was done generating codes, sub-themes and themes. We drew on the crisis management shell structure model and the job demands and resources framework to try to answer the research questions based on our findings.

Results/Outcomes/Improvements
The analysis revealed that the recent war affected GME programs and trainees both professionally and emotionally. It affected their training and future careers.

From the perspective of program directors, both trainees' and personal safety were paramount followed by maintaining the curriculum. Trainees were relocated from high-risk hospitals, data about trainees' contacts and second contacts, location of residence, [and] commuting routes were collected. Call schedules were modified to reduce dangerous commutes. Faculty closely monitored trainee well-being. Frequent meetings with trainees and GMEC were held and frequent or daily check-ins with trainees were done.

GME staff reported personal challenges, some being displaced from their homes. All reported the need to rely on their own resources to manage the programs from home, such as using their own laptops, WiFi or 3G, with the institution offering no support besides flexibility allowing working remotely. While working remotely provid

Significance/Implications/Relevance

LAU’s GME system demonstrated resilience during armed conflict. The strategies implemented ensured continuity of training programs. These lessons can serve as a guide for other institutions facing similar crises.

Poster #49: Perspectives and Interest in Fertility Preservation Among Military Graduate Medical Trainees

Author(s): Katherine Claycomb, MD; Sandra Boettcher, MD; Samantha Simpson, MD

Institution(s): San Antonio Uniformed Services Health Education Consortium

Abstract Type: Research-focused

Background
The Association of American Medical Colleges reports that in 2024, 158,466 individuals were participating in graduate medical education, 49% of whom identified as women. Many medical trainees delay fertility decisions until after training, often without understanding the impact of age on fertility. The Military Health System provides access to reproductive planning services, including oocyte cryopreservation, at a substantially lower cost than civilian providers.

Objectives
To our knowledge, no prior studies have examined interest in and utilization of fertility preservation resources among military trainees, who have access to significantly lower out-of-pocket costs compared to civilian trainees and high fertility resource availability in the same building where they work. This study examines military trainees' knowledge of available options for reproductive assistance in a universal health care setting and whether interventions are needed to further support trainees' reproductive planning.

Methods
The study received a non-research determination from our IRB (#24-19637). An anonymous survey was distributed to all residents and fellows (700) via the House Staff Council and remained open for two months. Data were analyzed using descriptive statistics, and categorical variables were compared using Fischer's exact test with an alpha of 0.05.

Results/Outcomes/Improvements
Forty-three residents and fellows (6.1%) across nine specialties responded. Of these, 77% expressed concern about their or their partner's future fertility, with 88% reporting that their education and career plans had influenced their decisions on timing of childbearing. There was no difference in decision to delay childbearing between surgical and non-surgical trainees. Only seven respondents reported prior education on fertility preservation during training, despite 11 obstetrics and gynecology residents responding to the survey. Sixty-seven percent desired further education about available fertility preservation options, but 30% were unsure if their program would support their absence from work for fertility treatments. There was no difference in the level of support perceived between surgical and non-surgical trainees. Among the 21 who had previously considered fertility treatments, only four had pursued treatment during training, citing fears about missing work, cost, and lack of knowledge on options as work as barriers.

Significance/Implications/Relevance
Both medical and surgical trainees at our institution are underinformed on available fertility preservation options despite strong interest in learning more. Several barriers to care were identified despite participants' enrollment in the low cost, universal access-to-care environment provided by the military health care system. In conjunction with the available evidence in the literature, we suspect that these barriers persist in the civilian health care system. Addressing knowledge gaps and institutional barriers through targeted education and leadership advocacy may improve access to fertility care during training.

Poster #50: Integrating Officer Development into Graduate Medical Education: Outcomes from a Military Transitional Year Curriculum

Author(s): Saira Ahmed, MD; Danielle Barnes, MD; Sean Lacey, DO; Denise Martin, BA

Institution(s): Uniformed Services University/Walter Reed National Military Medical Center; Uniformed Services University/Naval Health Clinic Annapolis; National Capital Consortium – Uniformed Services University

Abstract Type: Innovation-focused

Background
Physicians practicing throughout the Military Health System (MHS) must balance their dual roles as physicians and military officers in a multitude of complex environments, from health care delivery to rapidly evolving operational environments. The variable career pathways of MHS physicians, with some becoming general medical officers (GMOs) after internship alone and others matriculating directly into further post-graduate medical education, creates unique challenges for those preparing these future leaders of military medicine. Our transitional year (TY) internship has a sizable number of interns who serve in GMO tours, and, although some interns have prior military service, most have limited to no prior military experience. The short 12-month duration of internship, and the high priority of training operationally competent MHS physicians underscores the profound need for a structured curriculum in military officership—yet there are few published evaluations of such efforts.

Objectives
The objective of this project is to develop, and iteratively improve, a structured curriculum to prepare our program's TY interns for their dual roles as physicians and Military Medical officers through group didactics, small group sessions, and panel discussions designed to strengthen their knowledge and confidence in officership competencies, including military evaluations, promotions, awards, pay, personnel records, and career planning, with the overall aim to equip them for both operational service in military medicine and further graduate medical training.

Methods
A Pediatric Military Medical Officership Curriculum was adapted to the needs of our triservice interns, and survey data was collected from two consecutive classes. Interns in Academic Year (AY) 2023-2024 (n=20 baseline; n=19 year-end) and AY 2024-2025 (n=23 baseline; n=19 year-end) rated their confidence in officership competencies using Likert scales (1-5), and data was analyzed using Wilcoxon rank-sum tests. The curriculum included four, one-hour didactic sessions, broken out by service branch, covering military topics: officer evaluations; promotion; professional education; awards; pay/personal finance; records; career mapping; profiles; and medical evaluation boards. Program leadership and faculty facilitated the sessions, along with guest speakers for an operational medicine panel, and subject matter experts, including local Army administrative leadership.

Results/Outcomes/Improvements
Survey data demonstrated significant improvement across all officership competencies for both intern cohorts. In AY23-24, confidence ratings increased in Defense Health Agency (DHA) knowledge (median 3.0→4.0, p=.002), officer evaluation processes (2.0→4.0, p=.002), and personnel record understanding (2.0→3.0, p<.001), with additional gains in command structure

and resource navigation. Military dress and appearance remained high at baseline. AY24-25 showed a similar pattern, with increases in DHA knowledge (3.0→4.0, p=.006), evaluation processes (2.0→4.0, p<.001), and personnel record knowledge (2.0→4.0, p=.002). Across both years, these results demonstrate consistent year-to-year improvement and show that the curriculum strengthens residents' understanding of administrative systems, promotion and pay processes, and readiness for future roles.

Significance/Implications/Relevance

These results demonstrate a significant improvement in interns' competence in military medicine officership knowledge in the largest internship training program, from among over 200 in the DHA, offering a generalizable and scalable prototype for providing this essential education. These data demonstrate that, despite the time limitations of a 52-week training program, the use of a thoughtfully conceived curriculum in military medicine officership can be balanced among the many foundational medical topics that are critical to cover during the TY internship. Further follow-up will be pursued to keep up with changes in military medicine and assess the lasting impact of the curriculum for interns matriculating into both operational military positions, as well as further graduate medical training.

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2026 ACGME Annual Educational Conference *Back to Bedside* Project Highlights

Poster #51: **Healthcare Team Cards: Utilizing Collecting Cards to Playfully Demystify Roles in Care and Rehumanize Inpatient Hospitalization**

Authors: Christina Sedaghat, DO; Shalinie Dowlatram, MPH; Jennifer Moss, PhD; Christina Scartozzi, DO

Team Institution: Penn State Health Milton S Hershey Medical Center St. Joseph Family and Community Medicine Program

Abstract Type: Back to Bedside

Background
Physician burnout, characterized by emotional exhaustion, depersonalization, and reduced personal accomplishment, remains a major challenge in health care. Hospitalized patients may also experience confusion about who is involved in their care and the roles of each team member. A simple visual display identifying the health care team's names, responsibilities, and "fun facts" may improve patient understanding and provider connection.

Objectives
Health Care Team Cards intends to help familiarize patients with the role each provider plays in their care. Health Care Team Cards involves the creation and distribution of provider-specific collecting cards in the inpatient setting to facilitate patient identification of the various players involved in their treatment plan. The inclusion of personal elements on the cards aims to serve as conversation starters, fostering human connection and strengthening the patient–provider relationship. The project further seeks to assess whether this intervention contributes to greater provider fulfillment and engagement in patient-centered care.

Methods
Two cohorts of participants were recruited through REDCap and were given the opportunity to build their personalized cards. Cohort 1 began in March 2025, spanning 32 weeks. Cohort 2 began 16 weeks later at the start of the new academic year, spanning 16 weeks. Both cohorts concluded October 2025. To evaluate the impact on provider fulfillment, we utilized the Stanford Professional Fulfillment Index (PFI). All participants were asked to take the PFI prior to and after implementation of the project. To evaluate impact from the patient perspective, we utilized the pre-existing Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) survey. Specifically, we evaluated three questions associated with the Dimension "Communication with Doctors," and one question each associated with the Key Metrics "Overall Rating" and "Likelihood to Recommend." All participants were invited for interviews.

Results/Outcomes/improvements
A total of 29 individuals opted to participate. Participants included family medicine residents and attendings; specialists, including hospitalists, palliative care, cardiology, and neurology; pharmacists; nursing; case management; physical therapy; and medical interpreters. Cards were built in English and Spanish and distributed to participants. Two participants opted to be interviewed. Interview questions focused on exploring participant project understanding, feasibility, and impact while also exploring participant motivation and experience. Data analysis will be conducted in January 2026.

Significance/Implications/Relevance
Physician burnout and fragmented patient–provider relationships are universal challenges across health systems. The Health Care Team Cards initiative offers a scalable, low-cost, and

human-centered intervention to address both issues by improving transparency and connection between patients and care teams. Beyond the local setting, this approach can inform efforts to enhance communication, teamwork, and patient trust in diverse clinical environments. By fostering familiarity and empathy through personalized team identification, institutions worldwide could adopt this model to strengthen patient-centered care, improve satisfaction, and promote professional fulfillment.

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2026 ACGME Annual Educational Conference *Back to Bedside* Project Highlights

Poster #52: **Implementing a Modified Promoting Acknowledgement, Unity, and Sympathy at the End of Life (PAUSE) After Death in the Pediatric Emergency Department**

Authors: Rachael Herriman, MD; Heidi Werner, MD; Shruti Kant, MD; Elizabeth Seashore, MD; Myrka Macedo, BS; Kevin Li, BS; Dina Wallin, MD

Team Institution: University of California, San Francisco

Abstract Type: Back to Bedside

Background
Death in the pediatric emergency department (PED) is a rare yet deeply impactful event that may contribute to provider burnout, moral distress, and diminished team cohesion. Health care provider burnout is linked to emotional exhaustion, depersonalization, and increased medical errors, yet structured support following child death remains inconsistent. The Promoting Acknowledgement, Unity, and Sympathy at the End of Life (PAUSE) is a brief reflective practice shown to enhance meaning-making and team connection in adult settings but has not yet been evaluated in the PED. To address this gap, we developed a pediatric-adapted PAUSE to promote collective reflection, emotional processing, and social capital following child death in the PED.

Objectives
The objective of the study was to assess the impact of a pediatric-adapted PAUSE intervention on provider well-being in PEDs, with a focus on reducing burnout and improving social capital following pediatric deaths. The three specific aims were: (1) measure pre- and post-intervention changes in burnout and social capital; (2) determine feasibility in the domains of demand, acceptability, implementation, practicality, and integration; and (3) explore, qualitatively, provider experiences, as well as perceived barriers and facilitators to long-term adoption.

Methods
This mixed-methods pilot study is being conducted at UCSF Benioff Children's Hospitals—Oakland and Mission Bay (July 2024-January 2026). A modified Delphi process guided the adaptation of the PAUSE script for pediatric emergency care. Fellows, attendings, and charge nurses received structured training to lead PAUSE reflections. Following each pediatric death, trained leaders conducted a PAUSE, and participating staff were invited to complete a follow-up survey within 72 hours, which included the abbreviated Maslach Burnout Inventory and measures of social capital. Feasibility was evaluated through implementation metrics (e.g., the proportion of deaths followed by a PAUSE), pre- and post-intervention feasibility domain surveys, and thematic analysis of focus groups.

Results/Outcomes/improvements
To date, 25 charge nurses, five fellows, and 35 attending physicians have been trained in the pediatric-adapted PAUSE. The intervention occurred after five of the six pediatric deaths. A total of 132 pre- and 28 post-intervention surveys have been collected, representing nurses (40%), attending physicians (26%), residents (24%), and others, with a median of nine years of experience. Burnout findings are descriptive only, given the smaller post-sample, with pre- and post-groups showing comparable emotional exhaustion and depersonalization, and a possible increase in personal accomplishment among post-intervention respondents. Preliminary qualitative analyses suggest that users find the PAUSE to be brief, useful, and supportive of reflection and humanization of the patient. Barriers to implementation included time constraints, clinical demands, and the infrequency of PED death. Facilitators included reminders, such as visual cues and establishing the use of PAUSE as the norm.

Significance/Implications/Relevance

Early findings suggest that the pediatric-adapted PAUSE is a feasible, meaningful reflection tool in the PED, demonstrating strong early adoption despite infrequent pediatric deaths. Qualitative data indicate that the PAUSE may help foster team connection, support emotional processing, and align with staff values—factors that may enhance social capital and mitigate aspects of burnout. Although burnout results are exploratory, given the smaller post-intervention sample, early patterns support continued implementation and study. Feasibility and qualitative findings also highlight key facilitators and barriers that can guide future implementation and inform institutional planning. More broadly, these findings may inform the adoption of structured post-death reflection practices across pediatric emergency settings.

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Poster #53: **Bedside Congenital Heart Diagrams in the Pediatric Cardiac Intensive Care Unit**

Authors: Jasmine Ragoowansi, MD; Janelle Buysse, DO; Callie Simon, MD; Laura Smallcomb, MD; Isaura Diaz, MD

Team Institution: Vanderbilt University Medical Center

Abstract Type: Back to Bedside

Background
Children born with structural heart disease represent up to 1% of all births, and up to 25% of those will require surgical intervention. In the pediatric cardiac intensive care unit (PCICU), we care for hundreds of these patients every year. Each patient has a unique heart that requires personalized attention and teaching.

During the critical time spent perioperatively, parents must gain understanding of their child's congenital heart lesion and the implications for current and future treatments.

However, studies often demonstrate lack of complete understanding, even in later years. A 2004 study showed only 59% of patients were able to correctly name their heart lesion, and only 29% were able to indicate their heart lesion on a diagram.[1]

Objectives
Despite the complexity of congenital heart lesions, parents must rapidly gain enough knowledge to feel that they can adequately participate in their child's care. The standardized use of personalized cardiac diagrams may be a valuable tool in improving this learning process and communication around a patient's care.

Additionally, the highly specialized field of pediatric cardiology requires years of training for [development of] competence. It is common for residents, fellows, and nurses to also lack full understanding of the anatomy and physiology of the complex congenital heart disease they are caring for. We expect the use of heart diagrams and models to improve understanding among the staff and thus improve confidence in communicating effectively with our patients and families.

Methods
Providers (nurse practitioners and fellows in the PCICU) were surveyed via RedCap to gauge their subjective understanding of patients' anatomies, time spent educating families, and confidence in communicating with families. These surveys recorded metrics utilizing a Likert scale and were distributed prior to the implementation of our heart diagram intervention. We also distributed similar surveys to families assessing their understanding of their child's diagnosis and ideal method of learning.

The initial intervention is to create a diagram of each PCICU patient's heart that will serve as a discussion tool between providers, nurses, and families. The nurse practitioners and fellows caring for these patients will generate the diagrams utilizing the MyHeartArt software. These diagrams will remain at the bedside for reference throughout the patient's PCICU admission and will be updated, as needed. The effects of this intervention will be measured by a post-intervention survey.

Results/Outcomes/improvements
We received 31 responses to the provider pre-intervention survey. Of the surveyed individuals,

27% stated that they felt “uncomfortable” or “neutral” regarding their knowledge about congenital heart disease. Comfort was lower with discussing congenital heart disease and the care plan with families with 32% of providers selecting “uncomfortable” or “neutral” in this category.

We have received 10 pre-intervention surveys from families and are continuing to collect more. A majority of patient families surveyed had a child in the PCICU for 4-30 days (80%) with two (20%) additional length of stays greater than 30 days. The family pre-intervention survey showed that only 50% of families strongly agreed that they understood their child’s heart and care plan well. Most families indicated that they learn best utilizing visual representations (90%) and verbal communication (80%) and all (100%) stated that a diagram of their child’s heart would strongly benefit their understanding.

Significance/Implications/Relevance

Our pre-intervention surveys identify a potential gap in patient and provider education that can be filled by the implementation of the heart diagram bedside initiative. Should the success of this intervention be supported by post-intervention metrics, bedside heart diagrams may become a key tool used routinely throughout the PCICU beyond the scope of this grant period. Additionally, the program can be extended into the neonatal intensive care unit where patients with congenital heart disease are often cared for pre-operatively.

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Poster #54: **Home Is Where the Healing Begins: Bringing Meaning Back to Medicine**

Authors: Alokika Patel, DO; Jenna Reisler, MD; Elena Diller, MD; Madelaine Khosti, DO; Shahman Shahab, DO; Lindsay Sonstein, MD

Team Institution: University of Texas Medical Branch

Abstract Type: Back to Bedside

Background
Post-hospitalization home visits by medical providers have been shown to reduce readmission rates, improve patients' quality of life and decrease the financial burden on the healthcare system.[1-4] Home visits create meaningful opportunities for medical providers and patients to connect outside of the traditional clinic setting. In a home visit, providers can evaluate medically relevant factors, such as a food pantry's contents, while also enhancing their understanding of the patient's values and identity. In return, this information helps providers recognize specific needs that may otherwise not be apparent in the clinic setting. Medical providers often face time limitations to build relationships with patients, increasing burnout and a diminished sense of meaning in their work.[5] Home visits offer an engaging and novel space to practice medicine while cultivating a stronger patient-provider relationship.

Objectives
The purpose of our project is to enhance internal medicine residents' meaning in work by providing opportunities for authentic, patient-centered interactions through home visits. By facilitating these interactions, it is the goal of our project to help residents understand patients lived experiences and personal contexts, thereby strengthening residents' empathy for their patient. Secondary objectives include 1) improving resident education on social determinants of health as well community resources, 2) reducing barriers to care for vulnerable patients who may otherwise struggle to access outpatient services, and, 3) creating a replicable and sustainable educational model that will be integrated into the internal medicine curriculum, and available for adoption by other residency programs.

Methods
Faculty and residents submit names of patients with complex medical or social needs who may benefit from a home visit. Eligible patients include those needing medication reconciliation, with frequent hospitalizations or uncontrolled conditions, or who would benefit from personalized education. Homebound patients are referred to the Geriatrics house call program. Patients are screened for appropriateness, location, and safety, then contacted and scheduled for a visit; three to four home visits occur per half day. Each visit is completed by two to three residents and one faculty member. The team assesses the home environment and social determinants of health using a structured note template. Residents complete pre- and post-visit surveys, and patients receive a follow-up phone survey about their experience. The project is exempt from University of Texas Medical Branch (UTMB) IRB review.

Results/Outcomes/improvements
A pilot program in spring 2025 was performed. Based on the success of the program, the home visit experience was formally integrated into the UTMB internal medicine curriculum this fall. In sum, there have been 10 home-visit half days with 17 residents, nine faculty and with two to three patients scheduled per session. On a five-point Likert scale, residents reported feeling connected with patients (mean 4.2/5, SD 1.1), connected with their team (mean 4.5/5, SD 0.7), and that the visit helped them connect uniquely with patients (mean 4.2/5, SD 1.2). They rated confidence in identifying SDOH (4.3/5, SD 0.7). The overall program rating was high (mean 4/5, SD 0.9).

Qualitative feedback from residents included: “This reminded me why I went into medicine,” and “It was the most meaningful experience I’ve had in residency.” Qualitative feedback from patients included comments on improvement in comfort level with provider and improvement with medication compliance.

Significance/Implications/Relevance
This project demonstrates that structured home-visit experiences can restore meaning in clinical work while deepening residents’ understanding of patients’ lives, needs, and barriers to care. By fostering empathy, strengthening patient-provider relationships, and improving recognition of social determinants of health, this project supports both educational and patient-centered outcomes. Its streamlined workflow—referral, screening, templated assessments, and brief surveys—makes it low-cost and highly adaptable for other residency programs. Programs can integrate home visits into existing curricula, expand community engagement, and enhance resident well-being and patient care simultaneously.

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Poster #55: **Using an Artificial Intelligence Conversational Agent in Virtual Reality to Teach Serious Illness Communication Skills to Residents**

Authors: Olivia Henry, MD; John Rubin, MD; Rohan Jotwani, MD, MBA; Alexandros Sigaras, MS; Sandhya Sriram; Irene Yeh, MD, MPH, FAAHPM; Eric Brumberger, MD

Team Institution: New York-Presbyterian Weill Cornell

Abstract Type: Back to Bedside

Background
Empathy and strong communication skills are essential in medical care, yet training in serious illness conversations is often limited. These discussions can be emotionally taxing and contribute to stress, compassion fatigue, and burnout. Many residents feel unprepared to lead goals-of-care conversations due to inconsistent curricular exposure. Traditional methods, such as standardized-patient workshops, require trained actors, faculty time, and simulation resources, making them costly and difficult to scale. As a result, many programs lack accessible, repeatable opportunities for trainees to practice these high-stakes communication skills in a supportive environment.

Objectives
To address these barriers, we developed an innovative, artificial intelligence (AI)-powered training tool that allows residents to practice serious illness conversations in a realistic, low-risk environment using AI conversational agents (AI-CA) and virtual reality (VR).

Methods
We created an AI-CA, named “Lisa,” to simulate patient-clinician interactions about serious illness and end-of-life care. Lisa was constructed using Convai, which enables dynamic, unscripted dialogue through natural language processing. The AI-CA was refined iteratively with a palliative care specialist to ensure clinical and emotional realism. Lisa was integrated into a VR environment to create an immersive, scalable training platform.

The curriculum included:
1. Initial Session: Residents engaged in a baseline conversation with Lisa to assess pre-training communication approaches.
2. Education Modules: Residents participated in two 30-minute pre-recorded lectures led by a palliative care physician covering communication frameworks for serious illness discussions, including delivering serious news, responding to emotions, and eliciting patient goals and values.
3. Follow-up Session: Residents completed a second session with Lisa, applying these skills in a simulated patient encounter.

Results/Outcomes/improvements
To date, eight anesthesiology residents completed the AI-CA-based serious illness communication curriculum with pre- and post-intervention assessment. All participants completed the intervention.

Communication performance improved significantly following the intervention. Mean total process scores increased from 6.4 ± 1.7 pre-intervention to 9.6 ± 0.7 post-intervention ($p < 0.001$), with improvements across all domains, including assessing understanding, eliciting goals of care, and discussing prognosis. Empathy scores also improved significantly, increasing from 2.7 ± 0.7 to 4.1 ± 0.6 ($p < 0.001$). Variability between learners decreased following training.

Participants reported the experience as low-pressure and conducive to deliberate practice, with the ability to progress at their own pace. Qualitative feedback highlighted psychological safety and increased confidence in leading goals-of-care discussions.

Significance/Implications/Relevance
These preliminary findings demonstrate strong feasibility, high learner engagement, and early educational benefit. Because the system requires minimal faculty oversight and can be deployed with existing VR hardware, it represents a scalable model for integrating communication skills training across residency programs.

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Poster #56: **Empowering Patients: Improving Health Outcomes Through Collaborative Education via Teaching Cards**

Authors: Hanan Qaqish, MD; Lina Okar, MD; Farzana Hoque, MD

Team Institution: Saint Louis University/SSM Health

Abstract Type: Back to Bedside

Background
Patient education is a cornerstone of high-quality inpatient care and is associated with increased patient satisfaction, improved adherence to treatment, and better clinical outcomes. However, time constraints and lack of structured tools often limit meaningful bedside education.[1]. Researchers have demonstrated that there is a gap between both patients' and physicians' understanding of patient knowledge. Physicians tend to overestimate knowledge gained by patients during their hospital stay, while patients admitted to a smaller percentage in regards to knowing their primary physician's name, how many physicians were involved (frequently, patients mistakenly thought only one provider was involved in their care), and the patient's overall care plan.[2] To optimize health care outcomes, physicians should allocate time specifically for patient interactions. These interactions should reflect enthusiasm, motivation, and responsiveness tailored to each patient's unique needs.

Objectives
As part of the *Back to Bedside* initiative, we developed organ-specific teaching cards to facilitate patient education and promote intentional bedside engagement. The cards are designed to help hospitalized patients better understand their primary diagnosis and hospital course while fostering patient-provider connections.

Methods
Organ-specific teaching cards were introduced in the neurology and internal medicine inpatient services. Trainees select an appropriate card, return to the patient's bedside, introduce the teaching tool, write their name and the patient's primary diagnosis, and review key concepts using the visual aid. Patients are invited to keep the card for ongoing reference and communication with care teams. Educational flyers containing an introductory video and survey links were displayed at workroom entrances. Participants were also provided with a dedicated project email (teachingcards@ssmhealth.com) for feedback and questions. A brief survey was distributed pre- and post-intervention via QR codes placed on posters in physician workrooms, which is the avenue of our data collection.

Results/Outcomes/improvements
Baseline survey data were collected from 59 trainees, including 33.9% from neurology providers and 66.1% from internal medicine providers. Respondents were 46.4% female and 51.8% male. Only 25.4% reported spending at least 10 minutes of dedicated time with patients for education. Of the respondents, 49.2% felt they spent enough time with patients overall, 61.5% reported feeling they were able to build personal connections at the bedside. Post-intervention data collection is ongoing.

Significance/Implications/Relevance
This initiative introduces a low-cost, scalable educational tool aimed at enhancing bedside teaching, patient understanding, and trainee engagement. This tool has implications for improving patient education and subsequently, potentially patient adherence to medical plans discussed with their provider. Follow-up surveys will assess the impact of teaching cards on bedside time, perceived patient understanding, and patient-provider connections. Findings may inform broader

implementation across inpatient and outpatient settings.

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Poster #57: **Trading Confusion for Connection in the Patient-Resident Relationship – A Resident Trading Card Program**

Authors: Jane Tong, MD; Sarah Yang, BS; Kelly Moyer, MD; Elizabeth Guardiani, MD

Team Institution: University of Maryland Medical Center

Abstract Type: Back to Bedside

Background
Studies have demonstrated that photo "trading cards" can help patients identify physicians and facilitate trust in the patient-physician relationship.[1-5] This may be particularly valuable for resident physicians who rotate through many services, which can limit continuity of care. Residents are often at increased risk for burnout due to long work hours, lack of autonomy, administrative task burden, and having their competence questioned.[6,7] Reported rates of resident burnout in otolaryngology have ranged from 35-86%.[7,8]

A few prior groups have applied the concept of trading cards to pediatric resident physicians. With trading card implementation, parents demonstrated greater care satisfaction and acceptance of trainees including medical students and resident physicians, with improved understanding of their respective roles.[2,3,9] Residents also reported increased work satisfaction, better communication, stronger patient-resident relationships, and improved recognition as physicians.[2,9]

Objectives
To our knowledge, outcomes of a trading card intervention have not yet been reported in a surgical specialty. With support from the ACGME *Back to Bedside* initiative, the purpose of this study was to describe the effects of a Resident Trading Card Program on the relationship between patients and resident physicians in an otolaryngology department. More specifically, the study aimed to determine whether exchanging resident trading cards could help patients better understand the role for residents on their care team, as well as increase the meaning residents find in their work.

On the patient side, reactions to receiving resident trading cards, level of understanding of the role for residents, and patient experience with physicians were evaluated. Residents were assessed for burnout, as well as for impressions on creating and distributing trading cards as part of the Resident Trading Card Program.

Methods
Fifteen otolaryngology residents created trading cards describing personal fun facts and hobbies. The Resident Trading Card Program was implemented in June 2025. Patients undergoing surgery with the otolaryngology department and requiring at least overnight observation were prospectively identified. Residents were encouraged to distribute their cards to these patients on the day of surgery in the preoperative area.

During the subsequent postoperative admission, the patient was surveyed using questions from the Consumer Assessment of Healthcare Providers and Systems Survey, National Health Service Inpatient Survey, Patient Satisfaction Questionnaire, Physicians' Humanistic Behaviors Questionnaire, as well as novel questions. Residents were surveyed immediately prior to implementation and thereafter at three-month intervals using the Maslach Burnout Inventory, Professional Quality of Life Scale, along with novel questions.

Results/Outcomes/Improvements
97 patients received trading cards from June to December 2025. Seventy-four (76.3%) patients reported that exchanging cards increased trust in residents, and 72 (74.2%) reported

at least some understanding of residents' roles. Ninety-four (96.9%) reported always having confidence and trust in physicians, and 96 (99.0%) reported always being treated with courtesy and respect.

Using the Maslach Burnout Inventory, residents at baseline averaged 3.1 on emotional exhaustion, 2.1 on depersonalization, and 4.2 on personal accomplishment. After three months, residents averaged 2.5, 1.6, and 4.3; and after six months, 2.7, 2.0, and 4.2. Using the Professional Quality of Life Scale, residents at baseline averaged 21.2 on compassion satisfaction and 21.8 on burnout, indicating average levels. After three months, residents averaged 23.3 and 18.2; and after six months, 25.5 and 18.8. Both patients and residents provided comments stating they enjoyed exchanging trading cards, and that the cards made them feel more connected.

Significance/Implications/Relevance
Implementation of the Resident Trading Card Program in an otolaryngology department resulted in increased trust in resident physicians, as well as improved understanding of the role for resident physicians. This may also contribute to patients' high levels of confidence and trust in physicians. Future studies may consider larger scale implementation of similar Resident Trading Card Programs across other medical and surgical specialties.

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Poster #58: **Utilization of a Resident-Created, Patient-Friendly Autograph and Activity Book to Bring Residents Back to Bedside and Improve Meaning in Work**

Authors: Katie Medcalf, MD; Jessie Smith, MD; Erin Hickey, MD; Madeline Spencer, MD; Jinli Wang

Team Institution: Washington University in St. Louis/St. Louis Children's Hospital

Abstract Type: Back to Bedside

Background
Physician burnout is common and affects both clinicians and patients. The ACGME Council of Review Committee Residents (CRCR) has identified that more time spent at the bedside with patients leads to increased meaning in work, which is protective against burnout.[1] The ACGME has since created the *Back to Bedside* initiative to support resident- and fellow-driven projects that aim to foster meaning in work. The Autograph and Activity Book (AAB) is an exploratory study that was informed by this initiative specifically to address the ACGME CRCR themes to increase meaning in work including more time at the bedside engaged in direct patient care and decrease time spent on nonclinical responsibilities.[1] This tool is specifically aimed at bringing pediatric residents back to the bedside at St. Louis Children's Hospital, and while novel at our institution, similar projects have been successful elsewhere.[7]

Objectives
Our goal is to humanize the patient encounter and instill meaning in residents' work by sharing an interactive and collaborative AAB that improves the provider-patient experience through connection, creativity, and trust. The primary objectives of the AAB are to 1) increase meaning in work, 2) decrease burnout, and, 3) increase physician perception of connection to their patients. The secondary outcomes are increased time spent at the bedside and resident perception of value of the project.

Methods
Pediatric residents on two inpatient teams were given the AAB and instructed to bring it for the initial patient H&Ps from April to November 2025. The resident-created book contains basic hospital orientation information, autograph pages for staff to sign, creative activity and coloring pages, and free writing space for reflections or questions. Participants completed a mixed methods survey immediately before and after their rotation. Primary outcomes were assessed using the Work and Meaning Inventory (WAMI)[4], condensed Maslach 2 Questionnaire[5], and Provider-Patient Relationship Questionnaire (PPRQ).[6] The post-surveys also evaluated time spent at the bedside and perceived value of the project. A subset of participants participated in a focus group to learn about barriers to use and general attitudes. Descriptive statistics and frequencies were computed for primary and secondary outcomes, respectively. Thematic analysis was performed for free-response survey and focus group questions.

Results/Outcomes/improvements
Forty of 70 (57%) eligible participants consented to participate. Participants with baseline and immediate post-data were included in the comparison analyses for WAMI, Maslach, and PPRQ (n=21). Twenty-five participants were analyzed for secondary outcomes. No significant changes were found for the WAMI (p=0.318), Maslach 2 (p=0.4142), and PPRQ subcategories: Effective Communication (p=0.273), Interest in the Patient's Agenda (p>0.99), Empathy (p=0.462), and Patient Involvement in Care (p=0.5764). Most participants agreed or strongly agreed that the book allowed them to feel more connected to their patients. Forty percent of participants agreed or strongly agreed that use of the book allowed them more time at the bedside. Most participants agreed that utilization of the book was a valuable use of their time.

Significance/Implications/Relevance

The AAB was a valuable use of residents' time, resulting in many spending more time at the bedside and feeling more connected to their patients. While the results from the WAMI, Maslach[2], and PPRQ did not show a significant improvement after implementation, they importantly did not decline. A larger sample size may allow for significance to be reached, although it is important to note that there are many contributors to burnout and meaning in work.[8] The AAB is likely one of many interventions that can be co-implemented to combat burnout and increase meaning in work. These findings support continued use of the book within our institution and potential expansion to other teams and residency programs. Future work should identify additional contributors to burnout for residents at our institution to guide complementary strategies.

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Poster #59: **Minds Matter: Briefing Patients about the Psychiatry Consultation-Liaison Team to Reduce Resistance**

Authors: Sushma Srinivas, MD; Sahil Kapoor, MD; Vijaya Padma Kotapati, MD; John Merten, MD; Devin Morris, MD; Alex Malati, MD; Holly Agud, MD

Team Institution: Baptist Health UAMS Medical Education Program

Abstract Type: Back to Bedside

Background
Hospitalized medical and surgical patients frequently present with comorbid psychiatric symptoms, yet many express resistance when psychiatry is consulted. This resistance often arises from stigma, fear, or a lack of understanding of psychiatry's role. The Minds Matter initiative was developed by the Psychiatry Consultation-Liaison (CL) team at Baptist Health–UAMS to improve patient comfort and acceptance of psychiatric care. The intervention involves a brief pre-consultation meeting between a psychiatry resident and the patient, during which the resident explains the reason for the consult, normalizes the process, and introduces the treatment team using a visual support card.

The study utilizes a quality improvement framework to evaluate outcomes among patients and residents. Patients complete anonymous Likert-scale surveys assessing comfort with psychiatric consultation and understanding of the psychiatry team's role both before and after the briefing. Residents complete the Maslach Burnout Inventory (MBI) before and after their CL rotation to assess burnout. Preliminary data suggest that this structured briefing improves patient comfort and understanding while fostering resident well-being. Continued data collection will clarify the magnitude and sustainability of these benefits.

Objectives
Improve patient comfort and acceptance of psychiatric care.

Methods
The project follows a quality improvement design using the RE-AIM [Reach, Effectiveness, Adoption, Implementation, Maintenance] framework. Surveys were administered to patients on the consultation-liaison service at three points: prior to the briefing; immediately after; and following the psychiatry consultation. Each survey utilized a five-point Likert scale to measure comfort level and understanding of the psychiatry team's purpose. Qualitative comments were also collected to capture patient perceptions and suggestions.

Resident wellness was assessed through the MBI, administered before and after the CL rotation. MBI subscales, Emotional Exhaustion, Depersonalization, and Personal Accomplishment were compared to evaluate changes in burnout levels. Descriptive statistics and pre/post comparisons were used to summarize both patient and resident data. Continuous dissemination of findings occurs during Thursday didactic sessions, promoting resident engagement and mentorship continuity across academic years.

Results/Outcomes/improvements
Data were collected from seven patients receiving psychiatric consultation-liaison services. Pre-consultation responses reflected moderate comfort (mean = 3.57) and limited understanding of what to expect (mean = 3.14). After the consultation, there was a marked improvement in perceived comfort (mean = 5.00), understanding of team roles (mean = 4.29), and clarity regarding diagnosis and treatment (mean = 4.43). Post-visit responses indicated sustained confidence and satisfaction, with mean ratings above 4.2 across support, understanding of next steps, and overall experience.

Preliminary results show meaningful improvements in both patient comfort and understanding following the Minds Matter intervention. Among patients surveyed, mean comfort scores increased from baseline to post-briefing, while mean understanding scores also showed upward trends, reflecting enhanced patient clarity regarding psychiatry's purpose. Qualitative feedback emphasized appreciation for the personal explanation and normalization of the consultation process.

Resident data revealed decreases in Emotional Exhaustion and Depersonalization scores, alongside a modest increase in Personal Accomplishment on post-rotation MBI surveys. These findings suggest that structured patient engagement not only benefits patient experience but also enhances the sense of purpose and satisfaction among residents participating in CL psychiatry.

Significance/Implications/Relevance
Patients showed consistent improvement in comfort and understanding after consultation.

The largest positive change occurred in perceived respect, role clarity, and communication of diagnosis/treatment.

One patient (Patient 6) indicated disengagement reflecting variable receptivity in medically referred populations.

Nearly all patients' post-consultation endorsed Strongly Agree for feeling respected, supported, and informed.

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Poster #60: **Delivering Change: Integrating Nutrition and Wellness into the Centering Pregnancy Prenatal Care Model**

Authors: Valerie Moscoso, DO; Jessica Quinn, MD; Anastasia Anazonwu, MD; Avni Mittal, MD; Angelica Johnsen, MD; Mindy Brittner, MD; Melissa Evans, MD

Team Institution: Institute for Family Health - Harlem

Abstract Type: Back to Bedside

Background
Family medicine (FM) residents experience high levels of burnout, often driven by administrative burden and limited continuity with patients. Simultaneously, pregnant patients often feel underprepared for pregnancy and the postpartum period. Group prenatal care models, such as Centering Pregnancy, may enhance patient education and continuity of care while also improving resident engagement and professional fulfillment. As reported in McNeil et al. (2013), providers experienced greater enjoyment and satisfaction in providing care through the Centering in Pregnancy model. These findings suggest that Centering Pregnancy may address both patient educational needs and resident well-being.

Objectives
As a quality improvement initiative, the Centering Pregnancy model was implemented within the Institute for Family Health-Harlem's (IFH) residency clinic, integrating facilitated group prenatal visits led by FM residents and faculty. Sessions emphasized patient education, shared decision-making, continuity of care, hands-on nutrition education, and wellness activities.

Methods
FM residents and faculty led facilitated group prenatal visits. Sessions emphasized patient education, shared decision-making, continuity of care, hands-on nutrition education, and wellness activities. Patient outcomes were assessed using pre- and post-participation self-reported surveys evaluating knowledge, confidence, and preparedness for pregnancy and the postpartum period. Resident outcomes were assessed through a facilitated focus group evaluating burnout and professional fulfillment.

Results/Outcomes/improvements
Following implementation, patient participants were anticipated to demonstrate increased self-reported knowledge, confidence, and preparedness for pregnancy and the postpartum period. Residents were anticipated to report decreased burnout and increased professional fulfillment, attributed to enhanced continuity of care and more meaningful patient relationships developed through the group prenatal care model.

Significance/Implications/Relevance
Implementation of the Centering Pregnancy group prenatal care model represents a feasible quality improvement intervention that enhances the quality of patient care, resident education, and physician well-being. This approach is scalable to other residency training programs seeking to address burnout while improving prenatal care pedagogy and delivery.

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Poster #61: **Bringing Residents, Fellows, and Nurses Back to the Bedside to Support a Mother's Road to Recovery: Interdisciplinary Trauma-Informed Care Curriculum for Perinatal Care**

Authors: Kristen Moriarty, MD; Kelsey Manfredi, MD; Alexandre West, MD; Alison Godfrey, BS; Sahana Chinthak, BS; Patrick Ryan, BS; Andrea Shields, MD, MS

Team Institution: The University of Connecticut

Abstract Type: Back to Bedside

Background
Approximately one-third of pregnant individuals have a traumatic birth experience (TBE). Several screening tools are currently used in pregnant patients to assess maternal mood disorders, but no formal screening tool for TBE exists.

Objectives
The primary objectives of this project were to implement a novel TBE screener, evaluate risk factors associated with TBE, and formulate a curriculum for TBE education for all staff.

Methods
A 16-item pregnancy-adapted Experience of Medical Trauma Scale (EMTS) was administered postpartum (November 10, 2024-February 1, 2025). The screener was adapted from the EMTS and modified for pregnancy-related trauma. The goal was to capture patients before the development of PTSD. A positive total score of >/= 2 on the screener was considered positive and prompted intervention. Primary outcomes for risk factors for TBE included prenatal and postpartum EPDS scores. Secondary outcomes included maternal mental health history, labor induction, unscheduled cesarean delivery, and psychiatric medication. A single-day curriculum was formed to educate residents, nurses, and fellows on TBE. The curriculum incorporated rapid simulation with live patient actors. Participants were given pre- and post-knowledge assessments regarding TBE. Analyses included chi-square and t-tests, with logistic regression (LR) for modeling.

Results/Outcomes/improvements
Fifty-seven trauma-positive and 183 trauma-negative patients were evaluated. The screener had high sensitivity (92.6%), negative predictive value (95.8%), and accuracy (79.4%), suggesting a high effectiveness in identifying patients with TBE. Item-level regression modeling analyses demonstrated that questions relating to feeling isolated (Q8), fear for one's own life (Q10), and feeling numb or detached (Q14) were most sensitive, while those addressing anxiety (Q11), powerlessness (Q12), vulnerability (Q13), and fear for the baby's well-being (Q15) were the most specific. Trauma-positive patients had higher EPDS scores prenatally (6.22 vs. 2.75, p <0.001) and at six weeks postpartum (5.20 vs. 2.60, p <0.001). While EPDS ≥10 at the initial OB visit trended toward significance (p=0.103), no difference was observed postpartum (p=0.945).

Trauma-positive patients had more hypertension (p=0.001), type 2 diabetes (p=0.046), preterm labor (p<0.001), PPROM (p=0.012), low birth weight (p=0.052), and NICU admission (p = 0.007). They discontinued psychoactive medications early in pregnancy (p < 0.001) and were more likely to initiate them during or after pregnancy (p=0.012). In adjusted models, a prior mental health diagnosis showed an association with trauma (p=0.148), while initial EPDS score (p<0.001) and hypertension (p=0.014) were independent predictors. The implementation of a perinatal trauma curriculum was widely received. All participants felt they improved their skills and knowledge set after participation in the curriculum.

Significance/Implications/Relevance

A novel screening tool for TBE demonstrated effectiveness in identifying patients who had experienced trauma. Integrating routine TBE screening into prenatal care is critically needed to ensure timely recognition and intervention for maternal psychological morbidity. Perinatal trauma is associated with elevated EPDS scores at the start of prenatal care. The association between TBE screening and EPDS scores supports their convergent validity and underscores the importance of early screening to enable timely interventions. Introduction of a multi-disciplinary curriculum for TBE education was simple, low-cost, and effective.

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Poster #62: **Revitalizing Resident Bedside Procedural Competency – A Collaborative Effort Between Internal Medicine and Interventional Radiology for Patient-Centered Care**

Authors: Michael Dong, MD; Jenny Liu, MD; Victor Rivera, MD; Christopher Henry, MD; Stephen Topper, MD; Robert Adamo, MD; Frances West, MD

Team Institution: Thomas Jefferson University Hospital

Abstract Type: Back to Bedside

Background
Bedside procedural competence is a powerful driver of resident presence at the bedside, reinforcing clinical ownership, patient trust, and meaningful patient–physician interactions during high-stakes moments of care. When residents perform procedures at the bedside, they engage directly in consent discussions, real-time clinical decision-making, and post-procedural follow-up, anchoring learning within authentic patient encounters. However, over the past decade, bedside procedural training within internal medicine has steadily declined. The removal of procedural requirements and increasing reliance on consultative procedural services have shifted procedures away from the primary team, limiting resident opportunities for hands-on learning and reducing time spent at the bedside. This erosion of procedural competence has contributed to fragmented care, procedural delays, and a diminished bedside presence of residents. Re-establishing structured pathways for bedside procedural training represents a critical opportunity to return residents to the bedside, while improving patient-centered care and educational value.

Objectives
This project aims to develop internal medicine residents' bedside procedural competence through a structured, interdisciplinary training and credentialing pathway. It seeks to enhance resident confidence, satisfaction, and sense of ownership in peri-procedural bedside care. Through increased resident presence and leadership at the bedside, the initiative aims to strengthen residents' ability to build patient trust and deliver patient-centered procedural experiences.

Methods
We developed a longitudinal, interdisciplinary bedside procedural curriculum through a collaboration between internal medicine and interventional radiology at a single academic medical center. The program integrates a longitudinal thread of didactic instruction with high-fidelity simulation using validated procedural checklists, along with a dedicated two-week elective for supervised bedside performance of ultrasound-guided venous catheter placement, thoracentesis, and paracentesis. Interventional radiology faculty serve as procedural preceptors, supporting residents as they build procedural competence, confidence, and clinical judgment. Mixed-methods evaluation includes resident confidence surveys, structured interviews with thematic analysis, and procedural case logs, with planned collection of patient-reported measures of peri-procedural anxiety, satisfaction, and trust.

Results/Outcomes/improvements
Baseline surveys revealed that residents reported very low confidence in performing thoracentesis, paracentesis, and temporary central venous catheter placement. Residents expressed a strong desire for additional opportunities to perform bedside procedures and indicated that performing procedures themselves enhanced their sense of connection to patients' ongoing care. Early implementation demonstrates improved resident engagement in bedside procedural care and increased confidence in performing and supervising core procedures. Residents report greater comfort with consent discussions, universal precautions, and post-procedural follow-up. After the first year of implementation, there is a significant

overall increase in resident-performed procedural logs, with a 35% increase in arterial line placement, 50% increase in central venous catheter placement, 133% increase in thoracenteses, and 161% increase in paracenteses. Ongoing data collection will evaluate patient-reported peri-procedural experiences.

Significance/Implications/Relevance
This project addresses a critical gap in internal medicine education by restoring bedside procedural training through an innovative, interdisciplinary curriculum designed to re-engage residents in hands-on patient care. By shifting common procedures back to the bedside, the initiative strengthens residents' clinical ownership, procedural confidence, and presence during meaningful patient interactions, while also supporting patient trust and continuity of care. The program fosters the development of a group of experienced resident supervisors who can form a bedside procedure team, supporting peers and sustaining procedural expertise within the residency. This learner-centered approach reinforces the bedside as a central site of learning in internal medicine and serves as a model that can be disseminated and adapted across institutions seeking to revitalize bedside procedural education.

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Poster #63: **Spanish Perioperative Augmentation Initiative (SPAIN)**

Authors: Bridgette Love, MD; Emily Rabinovich, MD; Mmesoma Anike, MD; Christopher Pastrana, MD; Ariunzaya Amgalan, MD; Erin Hennessey, MD MEHP; Sunny Chiao, MD; Kamilla Esfahani, MD

Team Institution: University of Virginia

Abstract Type: Back to Bedside

Background
Central Virginia has a large population of native Spanish speakers who do not have a strong knowledge of the English language. In the past year alone, UVA Health had over 55 patients a month who needed surgery in either an elective, urgent, or emergent manner who required a Spanish language interpreter to properly receive care. However, the Departments of Anesthesiology and Surgery combined have fewer than five faculty who are fluent in the Spanish language. Despite the availability of interpreters, Spanish-speaking patients are more likely to experience dissatisfaction with their care and rate their provider as less respectful or concerned about their health care. They also encounter other health care disparities, such as elevated rates of Cesarean sections compared to epidurals and higher peri-operative anxiety among children of non-English speaking parents compared to non-Hispanic White patients.

Objectives
Our project aims to provide resident physicians with education in medical Spanish language to facilitate patient connections in the peri-operative period, with the ultimate goal of reducing health care disparities and improving the patient-physician relationship.

Methods
Selection of resident participants occurred within the Departments of Anesthesiology, Surgery, and Obstetrics and Gynecology. This study includes online and in-person components, focusing on language acquisition, cultural awareness, and cognitive aids for urgent situations. The Canopy Learn program offers a 40-hour curriculum spanning three proficiency levels, and residents will receive one-year subscriptions to support their learning. Benchmarks via quarterly assessment will ensure prompt progress. The in-person initiative involves collaborating with the Spanish Language department at UVA and engaging faculty, graduate students, and postdoctoral fellows. We will organize themed events every six to eight weeks, aligned with Canopy's curriculum, to reinforce learning. The UVA Latino Health Initiative will assist in engaging the community through activities that enhance residents' cultural understanding. Highly visible aids will be made for providers in the peri-operative environment.

Results/Outcomes/improvements
Due to initial delay in IRB approval, the study timeline was adjusted. Resident participant recruitment for phase 1 has been completed. A total of 23 resident participants and five resident leads have been recruited for the study. Of the 23 participants, 17 are eligible, and six are ineligible based on study criteria. Of the five resident leads, four are non-native speakers requiring enrollment. Of the 17 eligible participants, nine are from the Department of Anesthesiology, seven are from the Department of Surgery, and one is from the Department of Interventional Radiology. Of the seven participants from the Department of Surgery, four are from General Surgery, two are from Plastic Surgery, and one is from Cardiac Surgery. The next, ongoing steps entail participant enrollment to and completion of Canopy Learn and in-person collaborative efforts.

Significance/Implications/Relevance

The relevance of this study is to improve peri-operative experience for the Hispanic population of Central Virginia and enhance the patient-physician relationship. To that end, we will improve patient safety and quality of care by empowering resident participants to communicate in emergencies and reduce delays in care. Participants will be able to build rapport and trust, helping patients feel comfortable and respected. This study will help facilitate professional development and skill-building by improving Spanish proficiency through structured training. Community needs will be addressed as we facilitate provision of high-quality service to the large Spanish-speaking population. It will help foster efficient workflow and reduce reliance on interpreters for routine interactions. Lastly, it will enable participants to connect with patients on a deeper personal level.

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Poster #64: **Drawn Together: A Collaborative Art Project**

Authors: Anthony Bernick, MD; Sarah Foley, DO; Emily Rembetski, DO; Charles Kwon, MD

Team Institution: Cleveland Clinic Children's

Abstract Type: Back to Bedside

Background

Resident burnout is an increasing problem in medical training. In some studies, pediatric residents have been shown to experience burnout at a rate of over 50%.[1] This leads to emotional exhaustion, reduced empathy, and medical errors.[2] Wellness programs often fail because they are unsuccessful in restoring patient connection,[3] The ACGME *Back to Bedside* program offers grants directly aimed at restoring that connection with patients.[4] Art-based interventions have been shown as effective ways of combating burnout.[5-7] Our project builds upon the effectiveness of art-based interventions and encourages residents to go back to the bedside to restore meaningful connections with their patients and reduce burnout.

Objectives

1. To create an art installation within the Children's Hospital featuring collaborative resident and patient art.

2. To improve resident well-being by allowing for protected time to complete an art project with a patient of their choosing.

3. To assess if this intervention has an impact on improving resident wellness at work and reducing burnout.

Methods

Prior to the introduction of the project, residents completed the Stanford Professional Fulfillment Index (SPFI). The project was then introduced to the residents. An art cart was created so that residents could easily access art supplies. Residents then identified patients with which they hoped to complete a piece of artwork. The residents were excused from their hour-long noon education and given protected time to complete the artwork. After completing the artwork, the residents were asked to write a brief reflection on their experience. These reflections were compiled and analyzed for recurrent themes. After 10 pieces of artwork were completed, a second SPFI was administered. The artwork was collected and used to create a permanent installation within the Children's Hospital. A mixed-method analysis was conducted using quantitative data from the SPFI and qualitative data from the resident reflections to assess the intervention's impact on resident wellness.

Results/Outcomes/improvements

Independent t-tests comparing pre- and post-intervention SPFI scores revealed a significant increase in Professional Fulfillment following participation in the art-based intervention (M_{pre} = 14.4, M_{post} = 17.35, p = 0.0266). While there were decreases in Work Exhaustion (M_{pre} = 6.63, M_{post} = 5.64, p = 0.247) and Interpersonal Disengagement (M_{pre} = 4.75, M_{post} = 3.71, p = 0.259), these changes did not reach statistical significance. The qualitative analysis of themes directly aligned with significant improvement in Professional Fulfillment. While Work Exhaustion and Interpersonal Disengagement did not show statistically significant reductions, the qualitative data suggest movement in the same direction. These findings suggest that even short-term interventions can shift emotional tone and engagement before producing statistically detectable changes in burnout measures.

Significance/Implications/Relevance

This project was easy to implement, cost-effective, and brought trainees back to bedside, which

enhanced trainee fulfillment. While our patient population was pediatric, this could easily be implemented in other patient populations as multiple adolescent patients participated. The startup cost for the Art Cart was ~$250, and the frames for installation cost ~$13 each, making this project easily accessible from a cost standpoint. Therefore, this is a low-cost investment for a high-value intervention. This intervention not only provided a positive impact on our residents and their patients, but an enhanced connection with their families as well. Finally, we hope that by creating a permanent reminder of this project in our Children's Hospital, we can affect the environment in a positive way for our trainees, nurses, patients, ancillary staff, and all others who encounter the installation.

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Poster #65: **A Resident-Led Internal Medicine Program Integrating Empathy Training with Burnout Surveillance**

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Team Institution: UTRGV-Knapp Medical Center

Abstract Type: Back to Bedside

Background
Empathy is central to patient-centered care, yet it commonly declines during residency—often in parallel with distress and burnout. Skills-based communication training can improve empathic behaviors, but many interventions are limited by feasibility challenges in busy training environments and by reliance on single-perspective outcomes. To address this, we implemented a longitudinal, resident-led curriculum designed to build practical communication behaviors while tracking empathy and burnout over time.

Objectives
To evaluate whether a year-long, multi-modal communication curriculum could reduce resident burnout and stabilize or improve self-reported empathy across an academic year, and to examine the relationship between burnout dimensions and empathy.

Methods
We conducted a longitudinal pre-mid-post evaluation within the internal medicine residency program at the University of Texas Rio Grande Valley (UTRGV) Knapp Medical Center after receipt of an ACGME *Back to Bedside* grant. The curriculum ran over one academic year and included: (a) a *Back to Bedside* elective emphasizing real-time clinical application with reflection and faculty feedback; (b) resident-led didactics grounded in The Language of Caring framework; and (c) standardized-patient simulations with structured debriefing. Empathy was measured using the Toronto Empathy Questionnaire (TEQ; range 0-64). Burnout was measured with the Oldenburg Burnout Inventory (OLBI; Exhaustion and Disengagement). We used descriptive statistics and panel/mixed-effects models (adjusting for sex and post-graduate year) to assess change across time points and to test associations between burnout dimensions and TEQ scores (Stata MP v19).

Results/Outcomes/improvements
Thirty-seven residents were eligible (mean age 30.7 years; 57% female; 32% PGY-1, 32% PGY-2, 35% PGY-3). Survey completion declined over time (baseline n=33; mid-year n=24; post n=9). Across the year, burnout decreased steadily, with statistically significant reductions by the post-intervention assessment across OLBI dimensions (Exhaustion, Disengagement, and total burnout). Empathy (TEQ) showed a modest upward trend at mid-year and post-intervention, though changes were not statistically significant. In mixed-effects modeling, TEQ was strongly and inversely associated with OLBI Disengagement ($\beta = -1.23$, $p < 0.001$), while Exhaustion was not significantly associated with empathy ($\beta = 0.10$, $p = 0.72$). Female residents reported higher empathy scores than male residents ($\beta = 5.15$, $p = 0.001$). Third-year residents showed lower Exhaustion compared with PGY-1 residents.

Significance/Implications/Relevance
A feasible, resident-led, longitudinal curriculum was associated with meaningful reductions in burnout and helped maintain empathy during a period when empathy typically erodes. Disengagement—not exhaustion—emerged as the burnout dimension most closely tied to lower empathy, suggesting that interventions that sustain clinical connection and meaning may be key to preserving empathic

capacity. Attrition was a major limitation; future iterations should incorporate strategies to improve follow-up rates and add multi-source empathy outcomes (observer and patient-reported measures) to strengthen evaluation.

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Poster #66: **Beyond the Procedure: Non-Pharmacologic Approaches that Support Ob/Gyn Residents in Delivering Patient-Centered In-Office Care**

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Team Institution: Rush University Medical Center

Abstract Type: Back to Bedside

Background
The essential care obstetrician-gynecologists (Ob/Gyns) provide for patients often occurs during vulnerable moments in patients' lives. Common in-clinic procedures include uterine aspiration for pregnancy loss or abortion care, IUD insertion, and colposcopy for abnormal Pap smears. Resident physicians learning these procedures describe concerns about their confidence, technical skill, and ability to remain connected to patients during the process. Though non-pharmacologic interventions do not improve patient's pain, patients do report decreased anxiety and greater trust in their provider when offered supportive measures, while also increasing patient satisfaction and coping.

Objectives
Our goal was to assist resident physicians' development as patient-centered clinicians providing support to patients during Ob/Gyn office procedures by utilizing multiple non-pharmacologic mechanisms. Interventions include music, aromatherapy, visual distraction, and stress balls. Our hypothesis was in providing non-pharmacologic interventions for patients, there will be a deepened sense of connection for the trainee with the patient and an increase in empathy scores on the Jefferson scale of empathy.

Methods
Current ob/gyn residents at Rush University were recruited to participate in a two-hour didactic session which included patient-centered practices and incorporation of new non-pharmacological interventions. Interventions included the presence of the physical tool kit in the clinic that includes music, aromatherapy, visual distraction, and tactile stimulation (e.g., stress balls). Pre-intervention surveys were collected, which included a baseline of the Jefferson empathy scale survey and questionaries regarding in-clinic procedures and current practices.

The tool kit was implemented in the Family Planning Clinic, as this rotation offers the most in-office procedure training. At this point, we again disseminated the Jefferson empathy scale, which included an assessment tool for patient-physician connection, and preformed semi-structured interviews to gain further insight on each resident's experience.

Results/Outcomes/improvements
Fourteen residents participated in the two-hour didactic session which included patient centered practices. Pre-intervention surveys showed a range of empathy scores from 102-135 (140 being maximum score) and an average of 118. After implementation of non-pharmacological interventions empathy scores have shown a range of 118-130 with an average of 124. Residents quoted the tool kit has been "Very positive" and "It's been great to feel that you can offer patients something to help make their overall experience better and more comfortable." We are continuing our post-intervention surveys as well as semi-structured interviews.

Significance/Implications/Relevance
Overall, our toolkit is demonstrating positive progress in increasing empathy scores among residents. They feel more empowered to offer patients a wider range of non-pharmacologic

options to address their patient's anxiety, pain, or discomfort. In addition, medical assistants are becoming more involved in presenting these options to help address time constraints in the clinic. This toolkit has proven to be a cost-effective way to enhance patient-centered care while supporting residents in their clinical practice. It can be implemented across a variety of procedures in multiple medical fields and has the potential to benefit both patients and residents in inpatient settings as well.

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Poster #67: **Resident-Led Nutrition and Dietary Counseling Curricula: A Sustainable ACGME Back to Bedside Project for Internal Medicine Residents**

Authors: Jessica Darden, DO; Joo Young Kang, MD; Zach Dunton, MD; Amir Hobson, MD; Alexander Poblete, MD; Teja Chandrabatla, DO; Anna Newcomb, PhD; Shirley Kalwaney, MD

Team Institution: Inova Fairfax Medical Campus

Abstract Type: Back to Bedside

Background
Despite growing evidence of an association between nutrition and chronic disease outcomes, most residency and fellowship programs provide limited training in dietary counseling. This contributes to an educational gap for residents and a clinical care gap for patients with metabolic disease. As part of the ACGME *Back to Bedside* 2024-2026 cohort, we designed a resident-led nutrition counseling curriculum to integrate nutrition-focused education into an internal medicine residency's inpatient practice.

Objectives
To build and evaluate a longitudinal, resident-driven curriculum that teaches motivational interviewing (MI)–based dietary counseling for inpatients with diabetes or prediabetes (HbA1c >5.7%), with goals of increasing counseling activity, improving observed counseling behaviors (SMART goal documentation), and increasing resident self-reported confidence while keeping counseling time within a 10-minute threshold.

Methods
The curriculum used peer-to-peer teaching and an online nutrition toolkit, supported by an interprofessional team (registered dietitian, two standardized patient actors, and faculty). Components included: (1) a two-hour training for five senior residents on nutrition fundamentals, MI techniques, and dietary counseling; (2) standardized patient practice with feedback using the MITI-4 behavioral system; (3) bedside counseling of hospitalized patients meeting eligibility criteria; and (4) senior residents training incoming interns. From September 2024-May 2025, we tracked process measures (monthly/weekly encounters per resident), outcomes (competence via direct observation and % encounters with patient SMART goals in the electronic medical record (EMR); confidence via a validated MI tool administered pre-training and after ≥1 month of practice), and a balancing measure (counseling time).

Results/Outcomes/improvements
Residents identified 111 eligible inpatients (mean HbA1c 7.3%) and delivered 66 counseling sessions over nine months; 59% produced patient-generated dietary SMART goals. Counseling activity increased from a mean of 5.72 encounters per resident in Months 1-3 to 10.09 in months 6-7 (median 7; range 4.66–10.67), achieving seven encounters per resident per week by Month 6. SMART goal documentation showed a median of 62.5% (range 35%-75%) from early (mean 52.3%) to later (mean 62.3%) implementation. Confidence increased from mean 2.8 (SD 0.6) to 3.9 (SD 0.5); 31% (5/16) reported ≥1-point Likert increases in MI comfort and 25% (4/16) reported ≥1-point increases in dietary counseling confidence. Counseling time remained brief (median 7.1 min; mean 8.35; range 5.38–15.7), with most encounters ≤10 minutes.

Significance/Implications/Relevance
A resident-led MI-based nutrition counseling curriculum can strengthen bedside dietary counseling skills with measurable improvements in activity, SMART goal documentation, and resident self-assessed confidence, without extending typical encounter duration. Minimal resource requirements (lowest grant tier, semiannual faculty didactics, and monthly QI check-

ins) and a recurring senior-to-intern training model may facilitate adaptation in other institutions. Planned on-demand videos may further broaden access and standardize dissemination across residency programs.

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Poster #68: **Evaluating the Effect of a Simple Intervention to Reducing Stigma Among Psychiatric Residents**

Authors: Vighna Patel, MD; Mallory Myers, MD

Team Institution: Louisiana State University Baton Rouge Psychiatry Residency

Abstract Type: Back to Bedside

Background
The stigmatization of people with mental illness has a negative impact on psychiatric residents' well-being and professional fulfillment.

Objectives
The stigmatization of the mentally ill and its impact on their well-being and clinical outcomes is well established. Less attention, however, has been given to the impact of stigma on the well-being and professional fulfillment of psychiatric residents who care for these patients. One subtle example of stigma within our electronic medical record (EMR) is that in the emergency department, patients with mental illness are often represented by photographs taken during periods of acute distress while wearing institutional green scrubs. When these images remain in the chart as patients recover and continue care, they can serve as enduring visual cues that emphasize psychiatric illness, potentially activating implicit biases from health care providers. For residents, repeated exposure to these images may influence their empathy, sense of meaning in their work, and professional satisfaction. Little research exists on this dimension of stigma and its consequences for psychiatric trainees.

Methods
Following IRB approval, the first round of pilot data was collected. Psychiatric residents were invited to participate in the project, provided with education about its purpose, and formally consented. The intervention aimed to replace green scrub photographs of patients in EMRs with updated images once patients had reached a degree of recovery, thereby offering a more representative and respectful depiction. Residents received a script to guide discussions with patients about the process of changing their pictures. Participation was voluntary and flexible: residents could choose to engage at varying levels, including refraining altogether, updating patient photographs, contributing to monthly data collection using the Professional Fulfillment Index (PFI), and/or completing a qualitative structured interview at the six-month mark. Data were also collected on the number of pictures changed during the study. At the end of six months, all willing participants engaged in semi-structured interviews, which were recorded and transcribed. These interviews explored residents' perceptions of how the intervention influenced their clinical practice, views of patient care, and awareness of stigma associated with the green scrub imagery. Transcripts underwent thematic analysis, independently reviewed by three project team members. Coding discrepancies were resolved through discussion and consensus to ensure reliability of the identified themes.

Results/Outcomes/improvements
Quantitative findings from the PFI were available for up to eight residents, though not all completed the measure at every interval. Overall, residents reported moderate to high levels of professional fulfillment throughout the study, but these results showed no meaningful correlation with the number of photographs changed. The number of images replaced was minimal, averaging fewer than one per participating resident, and regression analyses revealed no significant associations. In contrast, qualitative analysis of eight resident interviews highlighted several important themes. Residents described developing stronger relationships with patients whose photographs were updated, experiencing greater professional fulfillment from the activity, and expressing a commitment to continuing the practice beyond the study. Many reported that

the intervention reaffirmed their choice of psychiatry and increased awareness of the stigmatizing potential of images taken in green scrubs. They also noted stigma toward psychiatric patients across other specialties. Collectively, these insights underscore the educational and attitudinal benefits of the intervention despite limited quantitative change.

Significance/Implications/Relevance
This pilot version of the project resulted in a lot of lessons learned, but the preliminary results from qualitative data suggest the intervention has the potential to empower psychiatry residents to better connect to their patients and to be advocates for their patients across healthcare systems.

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Stigmatization of psychiatrists and general practitioners: results of an international survey by Wolfgang Gaebel et al.

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Poster #69: **Inclusive Hair, Inclusive Care**

Authors: Brittney Bruno, MD, MPH; Alayna Kelly, MD; A. Chisom Okuagu, DO; Isaiah Herrera, MD; Tara Ghalambor, MD; Vy Bui, MMS; Miriam Robin, MD

Team Institution: University of Arizona College of Medicine, Phoenix

Abstract Type: Back to Bedside

Background
Hair is a vital aspect of personal identity and cultural expression, particularly within ethnic minority communities, yet culturally appropriate hair care is often overlooked in medical settings. Patient perceptions of physicians' cultural competence are closely linked to trust and satisfaction in healthcare. At our institution, the available hair care products often fail to adequately meet the needs of patients with textured hair, sometimes causing damage and distress. To address this gap, we created a quality improvement initiative at Banner – University Medical Center Phoenix (BUMCP) to enhance our cultural competency curriculum and expand access to inclusive hair care products. This initiative aims to create a more inclusive care environment, elevate overall hospital care quality, and improve patient satisfaction as defined by fulfillment of hair care needs and perceptions of inclusivity.

Objectives
This project seeks to enhance residents' awareness, confidence, and responsiveness in addressing diverse hair care needs. Additionally, it aims to evaluate the effectiveness and inclusivity of hair care kits by assessing users' experiences, the fulfillment of their hair care needs, and their perceptions of inclusivity.

Methods
This mixed-methods quality improvement project implemented two interventions to promote inclusive hair care in the hospital setting.

Resident Education: An educational seminar was developed and presented to the residents of the internal medicine, family medicine, and obstetrics an gynecology programs. The seminar focused on the diversity of hair types, hair physiology, hair care needs, and patient perspectives. Pre- and post-quizzes assessed changes in resident knowledge and responsiveness. Questions 1-9 were multiple choice and worth one point for correct answers; 10-14 were free responses.

Patient Intervention: A cross-sectional study evaluated the impact of providing Inclusive Hair Kits to adults on the Antepartum and Medical Oncology units at BUMCP. Flyers, nurses, and providers informed patients of the project. Nurses distributed kits with an affixed QR code that linked to English/Spanish patient surveys.

Quantitative and qualitative data were analyzed to evaluate changes in resident knowledge and patient perceptions of inclusivity.

Results/Outcomes/improvements
Results of the T-test from the resident seminar showed a significant difference between the mean total points in the pre- and post-data. The pre-group had a mean total point score of 6.30 out of 9 total points while the post-group had a mean total point score of 7.02 out of 9 ($p=0.02$, 95%CI: 0.103 – 1.338). The primary themes highlighted in the free-response questions from the pre-quiz include "acknowledgement and validation," "apology and accountability," "cultural sensitivity and learning," and "commitment to improvement;" primary themes in the post-quiz

include “empathy & emotional validation,” “cultural sensitivity & identity,” “patient-centered communication,” and “action-oriented solutions.”

Thus far, 34 hair kit patient surveys have been completed. Most participants reported positive experiences with the hair kits: 88% found them easy to obtain; 91% felt more valued; 88% reported the products worked well; 82% noted improved hair care; and 88% felt a stronger sense of belonging.

Significance/Implications/Relevance
Our dual-arm initiative improved resident knowledge and culturally responsive care while directly enhancing patient experience. The seminar led to higher haircare knowledge scores and more active, thoughtful responses to culturally sensitive scenarios, highlighting its impact on trainee awareness and patient-centered care. Inclusive Hair Kits were warmly received, increasing patients’ sense of belonging, comfort, and value during hospitalization. Together, these interventions address a long-standing gap in culturally inclusive care, elevate the sense of belonging for patients with textured hair, and support a more equitable care environment. Early results suggest that expanding this work hospital-wide could enhance patient satisfaction, strengthen trust, positioning culturally responsive hair care as a scalable, high-impact strategy for improving both clinical training and patient-centered care.

Poster #70: **Shared Decision-Making: An Exploration of Provider, Caregiver, and EMR Accounts of Shared Decision-Making Practices During Pediatric Patient Encounters.**

Authors: Amanda Quijano, MD PhD; Karen Joanie Campoverde Reyes, MD; Victoria Dabrowski; Hayly Caruso; Sarah Van; David Chartash, PhD; Kravetz Zachary, MD; Paul Aronson, MD MHS

Team Institution: Yale-New Haven Hospital/Yale School of Medicine

Abstract Type: Back to Bedside

Background
Shared decision-making (SDM) and its impact on health quality and fairness have been a recent focus in medicine, including emerging work on the understanding and implementation of SDM within the complex milieu of pediatrics. Notably missing from this work is a key stakeholder group: pediatric trainees, who are essential to our immediate understanding of the complexities of pediatric SDM and are instrumental in enacting lasting change in the culture of SDM as they become the next generation of pediatricians. Additionally, as the execution of SDM in practice is complex and nuanced, it is challenging to study in the setting of actual patient encounters. To date, little is known about real-world SDM use by trainees or the perspectives of caregivers on SDM use during pediatric patient encounters.

Objectives
Our study aimed to assess pediatric trainees' perceptions and documentation of SDM use during patient encounters and to compare these with the caregivers' perceptions of SDM use and documentation of SDM use in the same patient encounter. Primary outcomes included: 1. Frequency of SDM use rated by trainee providers, caregivers, and EMR documentation; and 2. Trainee satisfaction with medical decision-making. Secondary outcomes included: 1. Concordance of caregiver-trainee perceptions of SDM use; 2. Association of SDM use with caregiver demographics and trainee's perception of caregiver's health literacy; and 3. Caregiver satisfaction with medical decision-making.

Methods
We performed a single-institution cross-sectional study using convenience sampling and emergency department (ED) and inpatient encounters from March-September 2025 of patients <6 years-old with six included languages. ED ESI levels 1/2 and ICU and hematology-oncology admissions were excluded. Caregivers and pediatric trainees completed brief, multiple-choice surveys assessing their perceptions of use of three key elements of SDM, and trainee perception of caregiver's health literacy, desired involvement in SDM, and satisfaction. Deidentified clinical and demographic data was linked to survey data and electronic medical record (EMR) documentation. Encounters with >75% completion of both surveys were analyzed. Trainee and attending documentation of SDM was analyzed using previously validated and published natural language-processing techniques developed with both pediatric and adult ED documentation at the same institution. Chi-squared was used to test paired associations and Cohen's kappa was used for measures of agreement.

Results/Outcomes/improvements
Ninety-eight encounters were included that spanned had a broad range of patient ages, clinical diagnoses, and caregiver demographics and trainee data reflected a broad distribution of training years and race/ethnic/gender identities representative of the institution's residency program. Use of all three queried elements of SDM was perceived to occur in 51% and 35% of encounters by caregivers and trainees, respectively. There was poor agreement between caregivers' and trainees' perceptions regarding use of individual SDM elements and overall

SDM use (k= - 0.014, 0.063, 0.165, and -0.014). There was minimal trainee documentation of SDM (8%) with poor agreement with reported SDM use (k = -0.04). Trainees were more likely to perceive non-English speaking caregivers to have lower health literacy, even when adjusted for race ($p<0.001$) and more English-speaking caregivers perceived that their values/preferences were included compared to non-English speaking (88% v. 71%, $p=0.09$).

Significance/Implications/Relevance

Trainees and caregivers report substantial use of SDM during pediatric patient encounters, however, there are conflicting perceptions between trainees and caregivers of when and which elements of SDM are being use between trainees and caregivers, with the potential for existing implicit bias playing a role in these findings. Additionally, despite their reported frequent use of SDM, neither trainees nor attending physicians consistently documented it. Further exploration of factors contributing to the discordance in perceived SDM use is needed. These findings also offer a potential opportunity for EMR-based interventions aimed at standardizing SDM use and documentation as a means to addressing both the discordance in perceptions of SDM use and potentially addressing the role implicit bias plays in how and when SDM is used in patient encounters.

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Poster #71: **Innovating Medical Conferences: Patient Narratives as Educational Tools**

Authors: Maham Vaqar, MD; Clinton Tang, MD MBA; Christopher D'Adamo, PhD; Prashant Chaulagain, MD; Sahil Thapaliya, MD; Asha Thomas, MD; Farhan Ali, MD

Team Institution: Sinai Hospital of Baltimore

Abstract Type: Back to Bedside

Background
Effective communication in the intensive care unit (ICU) is essential for high-quality care, yet residents often receive limited training in this area. This study introduces Patient-Centered Conferences (PCCs) integrating didactic teaching with direct patient interaction as an innovative approach to address this gap in medical education.

Objectives
The primary objectives of this study were to evaluate the impact of PCCs on internal medicine residents' empathy levels, communication skills with ICU patients and their families, and overall understanding of the ICU patient experience.

Methods
As part of an ongoing randomized crossover study utilizing a mixed-methods approach, 28 internal medicine residents were invited to attend three PCCs between November 2024 and February 2025. Each 60-minute PCC included a case presentation on a patient who had been discharged from the ICU within the last eight months, followed by a patient interaction component with the same patient, exploring their ICU and post-discharge experiences. Quantitative data from pre- and post-conference surveys were analyzed using unpaired t-tests for the first two PCCs and paired t-tests for the third PCC. Qualitative insights were drawn from six semi-structured resident interviews and 38 free-text survey responses. Changes in empathy were assessed using the Jefferson Scale of Physician Empathy (JSPE) and analyzed with a linear mixed effects regression model.[1]

Results/Outcomes/improvements
Qualitative analysis revealed themes of enhanced empathy, shared decision-making and patient-centered approaches, increased awareness of the ICU patient experience and the value of learning through real patient stories. Quantitative outcomes are summarized in Table 1. A linear mixed effects regression analysis of JSPE scores, accounting for sequence, carryover, period, level of training, and gender, found no statistically significant difference in empathy levels between residents who attended PCCs and the control group (estimate: -0.96, 95% CI: -5.66 to 3.74, p=0.66). The crossover design was robust, with no significant sequence or carryover effects.

Significance/Implications/Relevance
Findings from our mixed-methods study suggest that PCCs are an effective tool for enhancing resident communication skills and understanding of patient experiences. Measured empathy levels did not significantly change however, likely due to the limited number of sessions. These findings highlight the potential for PCCs to meaningfully shift residents' perspectives on patient interaction beyond traditional medical education and can serve as a valuable addition to internal medicine residency curricula.

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Poster #72: **Healing Harmonies: Harnessing the Universal Language of Music for Healing and Connection**

Authors: Baffour Otchere, MD; Raheem Robertson, MD; Catherine Apaloo, MD; Patrick Berchie, MD; Tayla Greene, MBBS; Brice Njobe, MD; Samuel Dadzie, MD; Faustina Amable, MD

Team Institution: Piedmont Athens Regional Medical Center

Abstract Type: Back to Bedside

Background
Admission to the intensive care unit (ICU) is a stressful experience for patients and their relatives who often face complex decisions. Physicians, including residents, often face burnout due to demanding hours and patient mortality. Poor clinician well-being correlates with worse patient outcomes and satisfaction. Additionally, increased documentation limits patient-physician contact with resident physicians spending less than a quarter of their shift in direct patient care. Previous studies have demonstrated the benefits of music in reducing anxiety and stress in patients. This study explores the potential benefits of shared music/audio experiences between ICU patients and resident physicians.

Objectives
To evaluate whether shared music/audio experiences between ICU patients and resident physicians can strengthen relationships, enhance emotional well-being, empathy, reduce stress, and burnout for both groups.

Methods
After a pilot study, we enrolled consenting patients aged 18 or above without hearing impairment from the Med-Surg ICU of Piedmont Athens Regional Hospital from April to November 2025. All residents rotating in the ICU performed routine charting in patient rooms while listening to music using Alexa devices with Spotify subscription; genres were preselected by the patients. Residents completed questionnaires using the Mayo Well-Being Index and Stanford Professional Fulfillment Index Scores before and after their ICU rotation while patients did the Short Assessment of Patient Satisfaction at the start and end of their ICU stay. Data was collected with a pre-established questionnaire in REDCAP and compared for changes after intervention.

Results/Outcomes/improvements
A total of 51 patients completed the pre-intervention survey, and 27 completed the post-intervention survey. Participants were mostly of White or African American race. Overall, 93% reported loving the shared music experience. Music therapy was associated with improved relaxation in 89% of respondents, and decreased anxiety/stress in 80% of them. Approximately half of the participants noted some improvement in their pain levels, and almost all (93%) patients indicated they would recommend the intervention to others. Among the 14 residents who completed both pre- and post-intervention surveys, 70% noted an improvement in their overall ICU experience/well-being, but less than 50% reported any change in time spent at bedside or perceived impact on patient-physician connection.

Significance/Implications/Relevance
Our preliminary results demonstrate that shared music experiences in the ICU were highly valued by patients and associated with improved relaxation and reduced anxiety, supporting prior evidence of its benefit in critical care. Residents also reported improved overall ICU experience and well-being, suggesting music may serve as a brief restorative intervention in a high-stress environment. However, structural constraints of ICU rotation, including time

pressure, high acuity, frequent interruptions, and interactions with sedated or delirious patients, may have limited opportunities for sustained relational engagement. Connection is a complex construct that may require repeated exposure, reflection, or organizational support to meaningfully change. Overall, these findings highlight music as a feasible, low-cost intervention with meaningful patient benefits and modest but important effects on resident well-being.

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Poster #73: **Bingo for Better Health: A Gamified Approach to Enhancing Patient Adherence and Health Literacy in Diabetes, Hypertension, and Hyperlipidemia Management**

Authors: Indra Potulapati, MD; Marwa Tarbaghia, MD; Saaima Arshad, MD

Team Institution: Cleveland Clinic Fairview

Abstract Type: Back to Bedside

Background
Effective management of chronic diseases such as diabetes, hypertension, and hyperlipidemia requires active patient participation in their treatment plans. However, achieving positive health outcomes in these conditions is often challenging due to factors such as poor medication adherence, limited health literacy, and the complexity of managing multiple aspects of care. [1,2] With this quality improvement (QI) project, we aim to increase patient adherence to treatment regimens and improve understanding of chronic diseases through a gamified approach.

Objectives
The objective of this QI project was to enhance resident satisfaction during patient encounters by fostering a shared, goal-oriented experience between residents and patients using a gamified approach to chronic disease management. Additionally, the project aimed to improve patient engagement and adherence to treatment regimens, with targeted clinical outcomes including a 20% reduction in hemoglobin A1c (HbA1c) levels among patients with diabetes and increased attainment of guideline-recommended blood pressure and low-density lipoprotein (LDL) cholesterol goals in patients with hypertension and hyperlipidemia.

Methods
This QI project included patients aged 40-65 years with a diagnosis of type 2 diabetes and hypertension with LDL cholesterol levels not at guideline-recommended goals. Eligible patients were introduced to a gamified intervention using a Bingo card outlining individualized chronic disease management targets, including HbA1c, blood pressure (BP), and LDL goals. At each follow-up visit, progress toward meeting Bingo card parameters was reviewed collaboratively and tracked until a “Bingo” was achieved. Baseline patient characteristics, including HbA1c, BP, and LDL values, were recorded at the initial visit, with subsequent measurements collected at follow-up visits. Clinical outcomes will be evaluated by comparing baseline and follow-up values using paired t-tests. Resident satisfaction will be assessed using pre- and post-implementation surveys.

Results/Outcomes/improvements
Preliminary results from this ongoing QI project demonstrate an overall reduction in LDL cholesterol levels and BP measurements at subsequent follow-up visits compared to baseline. HbA1c levels have remained largely unchanged to date. Data collection and patient follow-up are ongoing, and additional analyses are planned as the project continues. Resident satisfaction surveys will be distributed to assess pre- and post-intervention satisfaction and to evaluate the perceived impact of the gamified intervention on resident–patient interactions.

Significance/Implications/Relevance
This Quality Improvement project demonstrates the potential of gamification as a scalable and low-cost strategy to enhance patient engagement in chronic disease management while simultaneously improving the clinical experience for resident physicians. By fostering shared goal-setting and collaborative decision-making, this approach may address common barriers to adherence and health literacy across diverse outpatient settings. The preliminary improvements

in blood pressure and LDL cholesterol suggest that gamified interventions could support meaningful behavior change without requiring additional clinical resources. If sustained, this model may be adapted across training programs and primary care practices to promote patient-centered care, improve provider satisfaction, and enhance chronic disease outcomes on a broader scale.

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Poster #74: **Inpatient Medicine-Pediatrics Consult Service**

Authors: Kate Halper, MD; Kate Coursey, MD; Asma Bahrami, MD; Akshara Malla, MD, MPH; Esther Kang, MD; Zenith Khan, DNP; Nathan VanderVeen, MD

Team Institution: UCLA

Abstract Type: Back to Bedside

Background
Advances in medical research have extended life expectancy for individuals with childhood-onset chronic conditions, with over 90% surviving into adulthood (Reiss). Adolescents and young adults often face complex medical and social circumstances that leave them vulnerable to gaps in care during transition from pediatrics to adult medicine (White, Allen), and many health systems lack infrastructure for safe inpatient transitions of care. UCLA Med-Peds offers strong outpatient training, but inpatient experiences are limited to categorical pediatric and internal medicine hospitalist rotations, which lack opportunities to highlight inpatient transitions of care and care for special populations. To address this, we launched an inpatient Med-Peds Consult Service (MPCS) to improve care quality for vulnerable patients, advocate for transitions, and foster a sense of Med-Peds identity among trainees in an effort to reduce burnout and enhance professional identity formation among learners.

Objectives
The new inpatient MPCS aims to enhance care transitions for hospitalized adolescents and young adults with complex medical needs by leveraging the unique skills and perspectives of our med-peds trainees and attendings. The primary goal of this service is to create a unique inpatient training experience that focuses on the care of the special populations that define our specialty. We hope this will improve self-efficacy, promote professional identity formation, and, as a result, combat burnout. Using their experiences on both pediatric and internal medicine rotations, trainees will deliver age- and condition-specific medical recommendations to address the unique challenges faced by adult patients who have chronic conditions originating in childhood. Consequently, we anticipate that this structured learning opportunity will also result in improved care of some of our most vulnerable patient populations.

Methods
Individual listening sessions with residents revealed interest in dual-hospitalist careers and a lack of opportunity to explore this model at UCLA. Residents collaborated to create the MPCS to support professional identity formation by returning to the bedside of the patients central to the med-peds practice. A needs assessment among categorical pediatric and internal medicine hospitalists identified services MPCS could provide. Census analysis defined target populations and anticipated volume. A curriculum was developed using didactic, direct observation, and experiential methods to reinforce core topics from the needs assessment. Finally, a survey based on the validated “Brief Calling Scale” (Dik, et al.) and the Resident Wellness Scale from Wayne State University will track impact on professional identity formation and wellness. Baseline values were obtained pre-intervention and will be reassessed at one and six months post-intervention. Patient-centered outcomes will also be measured.

Results/Outcomes/improvements
MPCS is in a three-month pilot (October-December 2025); data below is preliminary.

Census analysis identified five common childhood-onset chronic conditions (sickle cell disease, cystic fibrosis, cerebral palsy, intellectual delay, eating disorders), with 424 encounters over two years (1/2023-12/2024), showing longer length of stay and higher readmission rates than average (e.g., SCD LOS +11 days, 38% readmissions vs.14% for all comers).

Preliminary consults (n=21) were requested for autism (44%), transplants (22%), genetic conditions (16%), eating disorders (11%), and gender affirming care (5%), with an even proportion of requests for medical management of complex conditions (23%) and support with transitions of care (23%), while most consults were for both (45%).

Baseline resident wellness data (n=13) show a trend toward improved self-reported wellness as residents progress through their training; follow-up at one and six months post-intervention is planned.

Significance/Implications/Relevance
The needs assessments above have identified the target populations and services where a new MPCS could positively impact the outcomes for some of our most vulnerable patient populations while meeting the needs of trainees to develop a sense of med-peds identity in the inpatient setting. Preliminary data from the pilot have provided interesting data about the types of patients and services that require additional support in our healthcare system, and the baseline wellness scores for med-peds residents in our program demonstrate a trend toward improved professional fulfillment and wellness. We are eager to evaluate the impact of the educational intervention on our learners as we begin to introduce learners into the service rotation. We hope to use this experience to create a model for the establishment of other inpatient med-peds consult services to improve patient outcomes and trainee growth around the country.

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Poster #75: Proud to Practice Inclusive Care: A Residency-Focused LGBTQ+ Health Curriculum

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Team Institution: Massachusetts General Hospital

Abstract Type: Back to Bedside

Background
The ability to cultivate trusting patient-physician relationships, provide appropriate preventive care and screening, and use inclusive language is essential to improving care for patients who identify as lesbian, gay, bisexual, transgender, or queer (LGBTQ+). Despite this need, many resident physicians report limited training and discomfort in addressing LGBTQ+-specific health concerns.

Objectives
This study aimed to equip internal medicine residents with practical skills relevant to providing comprehensive, affirming care for LGBTQ+ patients and to evaluate the impact of a structured curriculum on residents' comfort, confidence, and knowledge.

Methods
We developed a longitudinal LGBTQ+ health curriculum consisting of an interactive didactic workshop and two simulation-based sessions. All interns rotating through their ambulatory block were invited to participate. Learners completed pre-intervention surveys assessing baseline comfort, confidence, and knowledge related to LGBTQ+ patient care. Post-intervention evaluation included repeat surveys and three facilitated focus groups. The curriculum and evaluation were designed using a community-informed approach, incorporating input from LGBTQ+ community members at each stage.

Results/Outcomes/improvements
Following participation in the curriculum, residents demonstrated improved self-reported comfort and confidence in using inclusive language, inquiring about sexual orientation and gender identity, obtaining comprehensive sexual histories, and making appropriate preventive care and referral recommendations for LGBTQ+ patients. These findings support the integration of structured, community-informed LGBTQ+ health curricula into internal medicine residency training.

Significance/Implications/Relevance
These findings support the integration of structured, community-informed LGBTQ+ health curricula into internal medicine residency training.

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Poster #76: **Initiation of Medications for Alcohol Use Disorder in Hospitalized Patients: An EMR-Based Intervention**

Authors: Christopher Garcia-Wilde, MD, MPH; Margarita Vazquez Almonte, MD; Claire Garpestad, MD; Frances Lee, MD; Linda Wang, MD

Team Institution: Icahn School of Medicine at Mount Sinai Hospital

Abstract Type: Back to Bedside

Background
Hospitalizations related to alcohol use disorder (AUD) and alcohol withdrawal present a critical opportunity to initiate medications for AUD (MAUD). MAUD prescription at hospital discharge is associated with reduced 30-day readmission, yet studies show that inpatient MAUD initiation remains low. Electronic medical record (EMR) interventions may increase receipt of MAUD during hospitalization. At our 1,100-bed hospital, approximately 1,000 inpatient encounters annually involve a diagnosis of AUD. Providers routinely utilize an EMR-based CIWA order set to care for patients with alcohol withdrawal. Between October 2023 and October 2024, only 3% (20/738) of patients placed on CIWA received MAUD (oral naltrexone or acamprosate) during hospitalization, while 5% (36/738) were discharged with a prescription for MAUD after hospitalization.

Objectives
To increase rates of MAUD initiation during hospitalization and prescribing at discharge via EMR-based interventions and provider education.

Methods
Over six months, an interdisciplinary team of trainees, an addiction medicine specialist, hepatologist, hospitalist, and medical informatics specialists developed a multi-pronged EMR strategy: (1) modification to the existing CIWA protocol order set to include MAUD; (2) EMR alert prompting providers to consider MAUD for any patient on CIWA protocol; and (3) discharge order set for outpatient MAUD prescriptions and referrals to specialty care. This intervention launched in March 2025 alongside a provider education campaign with hospital-wide emails, flyers, and educational sessions. EPIC's Reporting Workbench was used to monitor changes in MAUD initiation and discharge prescribing.

Results/Outcomes/improvements
In the six months after the CIWA protocol order set was updated, 528 patients were admitted in alcohol withdrawal requiring CIWA. Among them, 5% (27/528) were started on MAUD during hospitalization and 11% (60/528) were discharged with a MAUD prescription - increased from baseline rates of 3% and 5%, respectively, prior to EMR changes.

Significance/Implications/Relevance
Our EMR-based intervention coupled with provider education significantly improved inpatient MAUD ordering and discharge prescribing. Embedding MAUD into existing EMR workflows may improve access to MAUD during hospitalization, a critical treatment window. Limitations include concurrent EMR changes, short interval since launch, and need for ongoing provider education. Our approach offers a scalable model for other institutions aiming to improve MAUD uptake amid rising AUD-related hospitalizations.

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Poster #77: **Advancing Goal Concordant Care in Cardiology and Hepatology Teaching Services: A Pre-Implementation Survey to Assess Residents' Experiences**

Authors: Ramya Sampath, MD; Charles Marvil, MD; Alex Choi, MD; Vandana Khungar, MD, MSc; Stephen Possick, MD, FACC; Laura Morrison, MD, FAAHPM, FACP

Team Institution: Yale New Haven Hospital

Abstract Type: Back to Bedside

Background
Inpatient subspecialty medicine teaching services care for patients with high morbidity and mortality.[1,2] These rotations provide internal medicine residents with a key opportunity to engage in serious illness conversations (SIC). However, the frequency of these discussions, the extent of resident leadership, and palliative care (PC) integration remain poorly understood.[3]

Objectives
To characterize the extent of resident leadership and palliative care integration into cardiology and hepatology teaching services and support residents to develop skills in advancing goal-concordant care.

Methods
Internal medicine residents who completed inpatient hepatology and cardiology rotations at a large academic medical center between June 2023 and March 2025 were surveyed to assess their experiences delivering care for seriously ill patients on these services. The 10-question survey included questions on frequency and leadership of SIC, follow-through on PC consultations when indicated, and the perceived impact of knowing patients' baseline functional statuses. Responses were summarized descriptively.

Results/Outcomes/improvements
Fifty-three residents who rotated on the inpatient liver (27) and cardiac (26) services completed the survey. When asked to characterize the frequency of SIC on these services, 25 (47%) reported having these conversations less than once per week. When conversations were held, 39 (74%) reported never, rarely, or only sometimes leading these conversations. When a PC consult was felt to be indicated, 26 (49%) reported it was often or always placed, and 25 (47%) reported it was never, rarely, or sometimes placed. Finally, 35 (66%) respondents felt that having a better understanding of patients' baseline functional statuses would have improved care for their patients "quite a bit" or "a great deal."

Significance/Implications/Relevance
Despite frequent exposure to seriously ill patients on hepatology and cardiology services, residents reported infrequent SICs and rarely led discussions. Gaps in PC referral when indicated suggest missed opportunities for goal-concordant care, and residents' felt that understanding baseline functional status would improve decision-making. These findings highlight the need for educational and systems-level changes to support SIC for trainees on inpatient services.

To address these gaps, an intervention incorporating the Palliative Performance Scale (PPS) will be launched in January 2026 to evaluate the use of the PPS into routine admissions. The goal of this intervention will be to better support residents in incorporating prognostic data to guide clinical decision-making regarding interventions, palliative care involvement, and advancing SIC.

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