SPRING 2026

AHME NEWS

ASSOCIATION FOR HOSPITAL MEDICAL EDUCATION

IN THIS ISSUE

A Decade After the Single GME Accreditation System: Reflections on Unified GME....1

ACGME Milestones Update....3

Into the Unknown: Preparing for a Non-Standard Training Recognition Site Visit....3

Addressing GME Financial Challenges: Member-Driven Funding Solutions....4

The Importance of Professional Identity Formation....5

Beyond Clinical Skills: Teaching Ethics and Humanities in Medical Education....6

Flourishing and Professionalism: Growing Who We Are, Not Just What We Do....7

Using Artificial Intelligence to Create Clinical Cases in GME....8

Gamified Learning in Medical Education: Strategic Approaches from Northeast Georgia Health System's Center for Simulation and Innovation....9

Beyond the Budget Line: GME's Operational Value Hospitals....9

The Power of Mentorships: A Year of Flourishing COPAC Partnerships – Part Two....10

COPAC Council Spotlight....11

Educational Opportunities....12

2026 AHME Institute....13

A Decade After the Single GME Accreditation System: Reflections on Unified GME

Juan F. Acosta, DO, MS, FAEMS, FAOGME, FACEP, FACOEP-D
Chair AOGME

It has been ten years since United States graduate medical education (GME) underwent one of the most consequential structural changes in its history, the creation of the Single Accreditation System. When the Accreditation Council for Graduate Medical Education (ACGME) and the American Osteopathic Association (AOA) implemented the Single Accreditation System in 2015, the goal was to reduce fragmentation, remove inequities, and establish a single, transparent pathway for all residents, regardless of degree, to train, advance, and compete on equal footing. A decade later, the effects of that decision are clearly visible across hospitals, residency programs, and the communities they serve.

Before the merger, hospital-based educators navigated the inefficiencies of a dual accreditation system. Parallel standards created administrative burden and imposed structural barriers on trainees, particularly osteopathic residents seeking fellowship access, academic mobility, and national recognition. For sponsoring institutions, maintaining two accreditation models increasingly conflicted with the realities of modern healthcare delivery.

In many respects, the Single Accreditation System achieved its central objectives. Training standards became unified, program requirements were nationally consistent, and evaluation through milestones and competencies was transparent. For hospitals, this alignment simplified oversight and allowed GME to integrate more naturally with enterprise quality, patient safety, and performance initiatives. GME became less siloed and more clearly aligned with institutional mission and strategy.

For residents, the impact was substantial. Osteopathic graduates now train and advance within the same national ecosystem as their allopathic peers, with access to ACGME-accredited fellowships and leadership pathways. Structural barriers that once limited opportunities were reduced, particularly with respect to fellowship access and national portability of training. While experiences vary by specialty, region, and institutional resources, the unified system expanded pathways for many osteopathic graduates and increased their participation across the full spectrum of ACGME-accredited training environments.

At the same time, the transition revealed important trade-offs. Some community-based osteopathic programs, many of which produced highly capable clinicians and served critical local needs, were unable to meet the administrative and infrastructural demands of ACGME accreditation. Their closure represented not only lost training positions but also a narrowing of community focused physician pipelines.

One of the most consequential and underrecognized effects of the transition was the dissolution of the Osteopathic Postdoctoral Training Institution (OPTI) model within the American Osteopathic Association structure. OPTIs provided more than accreditation oversight. They offered regional governance, shared faculty development, curricular alignment, and a community-based academic home for osteopathic programs, particularly those embedded in smaller hospitals and underserved areas.

The loss of this model represented a fundamental shift away from a collectively supported, osteopathic-led infrastructure toward the sponsoring institution's responsibility. While new consortium

(continued on page 2)

arrangements emerged under the ACGME framework, they were not designed to replicate the OPTI's educational mission or its explicit commitment to osteopathic professional identity. As a result, sponsoring institutions assumed greater responsibility for sustaining educational networks, faculty development, and osteopathic integration, often without the benefit of a unifying regional structure.

An additional trade-off has been the changing relationship between osteopathic training and osteopathic board certification. As residents now complete training within a unified accreditation system, not all osteopathic physicians choose to pursue osteopathic board certification following residency. While this does not diminish clinical competence, it has implications for the long-term visibility of osteopathic certification, faculty pipelines, and leadership representation within osteopathic professional organizations.

The cultural transition was also uneven. Faculty development expectations, scholarly activity requirements, and continuous accreditation readiness required adaptation, particularly for programs that had thrived under the osteopathic model. Progress has been meaningful, but variation persists across regions and specialties.

Osteopathic identity remains an important consideration within the unified system. I was honored to serve on the first Osteopathic Recognition committee during the early implementation of the Single Accreditation System, which provided direct insight into the intent behind the designation. Osteopathic Recognition was designed as a practical framework to preserve osteopathic principles and osteopathic manipulative medicine within a unified accreditation structure. Its effectiveness has varied across institutions, reflecting differences in local priorities and educational emphasis.

My involvement in the Assembly of Osteopathic Graduate Medical Educators (AOGME) has helped me maintain a close and current understanding of the postgraduate medical education landscape during this period of change. Serving alongside colleagues from diverse institutions across the country has provided valuable perspective and the privilege of mentorship from leaders who have shaped osteopathic GME over decades. That collective experience has reinforced the importance of collaboration, institutional memory, and shared stewardship as training models continue to evolve.

For hospital executives and GME leaders, the lessons of the Single Accreditation System are clear. Accreditation provides structure and accountability, but outcomes are shaped locally. GME should be viewed not as a regulatory obligation but as a strategic asset that influences workforce readiness, institutional reputation, and community trust.

Ten years after the implementation of the Single Accreditation System, the unified accreditation framework can be judged a success in achieving unification and credibility. At the same time, it has transferred responsibility for preserving diversity in training models and professional identity to sponsoring institutions. As the next decade unfolds, the focus should remain on sustaining high quality training environments that serve both learners and the communities in which they practice.



EDITOR
Venice VanHuse, MPA
Northwell Health

ASSOCIATE EDITOR-IN-CHIEF
Marie Hugley, BA
UCLA David Geffen School of Medicine

EDITORIAL TEAM
Caroline Diez, MBA, C-TAGME
John Peter Smith Hospital Network
Lee Ann Riesenberg, PhD, MS, RN, CMQ
University of Alabama at Birmingham

EXECUTIVE COMMITTEE
President & Board Chair
Julie B. McCausland, MD, MS, FACEP
University of Pittsburgh Medical Center

President-Elect
Alyson Riddick, MHA, C-TAGME
ECU Health Medical Center

Secretary
Marie Hugley, BA
UCLA David Geffen School of Medicine

Treasurer
Tonya VanOrder, PhD, MBA
Henry Ford Genesys Hospital

Immediate Past-President
Trevor M. Burt, EdD, MS
Houston Methodist Hospital

Executive Committee Member-at-Large
Ashley Maranich, MD, FAAP, FIDSA
Uniformed Services University

Executive Director
Tia O. Drake

NATIONAL STAFF
(724) 864-7321

Director of Association & Meeting Services
Sandi Parsons

Assocation Meeting Planner
Aidan Sathoff

Member Services / Website
Karen Zagar

Accountant
Tricia Gallagher

Marketing Project Administrator
Lourdes Rodriguez

ACGME Milestones Update

Sydney McLean, MHA
Director of Milestones Development
ACGME

In 2023, the Accreditation Council for Graduate Medical Education (ACGME) completed the Milestones 2.0 project. This significant undertaking spanned nine years and encompassed more than 150 accredited specialties and subspecialties and 300 documents, and the participation of well over 1,000 volunteers. With the development phase concluding in 2023, the ACGME recognized that, despite nearly a decade of national implementation, an internal evaluation of the Milestones project had not yet been conducted. The team decided to conduct a program evaluation, which would be the first comprehensive review since the initial Milestones' rollout in 2013.

This marked the beginning of a large-scale, multi-phase evaluation project to better understand how the Milestones were being perceived, interpreted, and operationalized across specialties, institutions, and settings. To better support this effort, the ACGME brought together a small but diverse group (the Advisory Group) of experienced and highly engaged educators from across the graduate medical education (GME) community. In May 2023, the Advisory Group met to identify key research questions that would guide the evaluation and help to ensure the process accurately reflected how the Milestones are used nationwide.

Because the Milestones are designed to adapt and be used differently in various programs, the Milestones team worked with a researcher from the University of Illinois at Chicago to create a plan for evaluating this unique program. Using a principles-focused program evaluation approach, which is based on a core set of principles that were fundamental to the development of the original Milestones, evaluators identified a series of core and supporting principles to serve as the foundation for their project.

Milestones Core Principles

1. Enable the adoption (implementation) of competency-based medical education (CBME) (and all six Core Competencies)
2. Support the professional development (learning trajectories) of all learners
3. Support attainment of desired educational outcomes for the benefit of the public

The Milestones team has partnered with members of the GME community and has already concluded the first two phases of the principles-focused program evaluation. Phase 1 focused on structured interviews. Leaders [e.g., program directors, Clinical Competency Committee (CCC) chairs] from the 27 ACGME-accredited pipeline specialties were invited to participate in an hour-long, semi-structured interview. Participants were selected to maximize variety in program type, location, and size; 45 interviews were completed. Interviews revealed strengths, challenges, unintended effects, and specialty-specific nuances in Milestones 2.0 usage.

In Phase 2 of the program evaluation, the team expanded its research to a national level with a large-scale survey sent to all ACGME-accredited programs. Program directors, designated institutional officials (DIOs), and program and institutional coordinators were asked to distribute the survey to faculty members and learners in hopes of reaching a wide audience. Beyond the core principles, the survey also included themes that came from the Phase 1 interviews, including Milestones utility, specialty norms for CCC processes, assessment data integration, and implementation practices. Overall, the ACGME received 2,567 responses, with 1,306 completed surveys. Data were reviewed from any survey with a more than 25% completion rate. Based on these data, it was notable that over 60% of responses were from program leaders (program director: 50%; associate program director: 10%), and 74% identified as affiliated with academic medical centers. Initial findings offer a relatively positive perception of Milestones 2.0 and highlight areas for ongoing improvements.

Currently, the Milestones team, Advisory Group, and others are reviewing the collected data to identify benefits, challenges, and recommendations for improving the Milestones program in the future. The groups are focusing on content related to the three core principles, as well as other questions such as CCC use and functionality, and specialty-specific differences. The goal is to publish these findings, along with a set of recommendations for Milestones 3.0, in 2027.

Into the Unknown: Preparing for a Non-Standard Training Recognition Site Visit

Leslie Pfeiffer, MHA, C-TAGME
Accreditation Director, Henry Ford Health

Kimberly Baker-Genaw, MD
Designated Institutional Official, Henry Ford Health

Beginning in 2022, the ACGME Board of Directors approved the Non-Standard Training (NST) Recognition Requirements, which created a minimum level of standards for Sponsoring Institutions (SI) to maintain oversight of NST Programs. Foreign national physicians receive J-1 visas sponsored by the Education Commission for Foreign Medical Graduates (ECFMG) to participate in these programs. In Fall 2025, the ACGME began conducting site visits for those in Initial NST Recognition.

At Henry Ford Health, to provide oversight for our NST programs and the Institutional Recognition, we have our Institutional Coordinators and a central Training Program Liaison (TPL) that serve as leads to ensure there is a clear point of contact between the Program Directors and Program Coordinators. This has allowed us to efficiently manage onboarding and compliance, ensuring a smooth workflow, and has also enabled us to get a jump-start on site visit preparations.

Preparing for various types of site visits can be challenging, and introducing a new category of site visits often leads to apprehension related to how best to prepare. At Henry Ford Health, we have developed structured, proactive frameworks to streamline the process. A key component of this process includes setting an internal timeline well in advance of the anticipated site visit date, allowing us to build in flexibility for thorough document review in a less stressful setting.

From there, we began to review and annotate the NST Trainee contract to ensure compliance with Requirement 2.1.b. This involved a detailed approach to the contract to verify that all recognition requirements were outlined. In addition to contract review, we conducted a thorough assessment of our Graduate Medical

(continued on page 4)

Education Committee (GMEC) minutes. This allowed us to confirm that every NST program, along with its respective program director, had received the necessary GMEC approval. A summary document was prepared for the Site Visit to show the date of each program, Program Director review, and approval by GMEC.

To ensure we had a robust understanding of the Recognition Requirements we created a tracking sheet that had all NST requirements listed. We then provided a written response for each requirement explaining how it is met. This document consolidated key information and served as a centralized reference for site visit preparations. The tracking sheet was then distributed to all participants involved in the site visit, ensuring everyone had access to processes that help us meet requirements. This approach promoted transparency, facilitated collaboration, and helped guarantee readiness for the upcoming site visit.

Another useful strategy we use to prepare for site visits is organizing a mock site visit. During this exercise, our Designated Institutional Official (DIO) plays the role of the site visitor and poses various questions to participants to help them practice their responses. These mock site visits mirror the format of the actual visit—so if the real visit will be virtual, the practice session is also held online—enabling everyone involved to become familiar with the process.

Applying established procedures to the new NST site visit process enables institutions to transform a complex, unfamiliar task into an efficient and manageable workflow. Adhering to proven methods is a key factor in achieving successful outcomes.

Addressing GME Financial Challenges: Member-Driven Funding Solutions

Graduate Medical Education (GME) programs across the country are navigating mounting financial pressures, prompting institutions to rethink how they support core educational initiatives. AHME newsletter staff reached out to members to learn how they are addressing these challenges and to spotlight novel funding mechanisms that are making an impact.

Jodi Carlson, Senior Consultant at OhioHealth (Jodi.Carlson@OhioHealth.com) wrote that this problem is especially important in emerging and underserved specialties. OhioHealth's Addiction Medicine Fellowship demonstrates how external funding can serve as a strategic lever for program development, sustainability, and workforce expansion. As institutions face tightening financial environments, the Health Resources and Services Administration (HRSA) Addiction Medicine Fellowship Grant provided the catalyst needed to strengthen an emerging program while building institutional capacity in a high-need specialty.

The HRSA funding enabled the fellowship to expand training positions, secure protected faculty time, and invest in curriculum development, areas that are typically vulnerable when budgets tighten. In addition, they were able to embed interprofessional education, diversify training sites, and establish consistent mentorship structures, thereby improving both learner experience and program quality. Recruitment improved through stipend support and lodging assistance for outside rotators, reducing barriers for applicants and broadening the candidate pool.

One of the most significant outcomes was the institution-wide effect. HRSA funding enabled the integration of standardized, Accreditation Council for Graduate Medical Education (ACGME)-required instruction on recognizing substance use disorders (SUD) into multiple residency programs.

Complementary investments, including trauma-informed care training, expanded experiential learning, and strengthened board-preparation resources, further advanced faculty development and bolstered program infrastructure.

To date, OhioHealth has graduated fifteen addiction medicine fellows, all board-certified and now practicing across clinical and academic settings. OhioHealth's experience illustrates how targeted external funding can create lasting infrastructure, expand the healthcare workforce, and equip institutions to lead in addressing pressing public-health challenges.

John Ballentine, MBA, Assistant Dean of Finance and Administration, College of Dental Medicine, Medical University of South Carolina (ballenjo@musc.edu), noted several options to address current pressure to broaden and enhance program offerings, typically without matching institutional or federal support.

Donor-driven contributions and endowed Chair programs provide flexible funding that can be directed toward educational innovation, resident development, and strategic program priorities. Creating endowed Chairs, in particular, offer long-term stability by generating annual income that can be applied to faculty leadership, curriculum enhancement, or specialized initiatives that might otherwise go unfunded.

An example of outside funding use is a foundation with funds earmarked specifically for GME. At one institution, these resources are distributed through an application-based process, proving particularly valuable for offsetting residents' travel expenses for conferences, presentations, and professional development opportunities. Such mechanisms ensure equitable access while maintaining fiduciary oversight.

Chair funds represent an additional avenue for supplementing program budgets. Depending on faculty or donor intent and institutional policy, these funds can support a wide range of activities. Examples of these include faculty development, educational technology, and resident/fellow travel, adding flexibility to meet evolving program needs in an environment of constrained resources.

While external partnerships can offer meaningful benefits, using industry funding requires careful attention. Compliance with conflict of interest policies and accreditation standards is essential to safeguard educational integrity and maintain public trust. As programs continue to navigate funding pressures, balancing innovation with ethical stewardship remains a top priority.

Angela Franco, C-TAGME, Graduate Medical Education Administrative Director at Abrazo Health (Angela.Franco@abrazohealth.com), described how their GME

team identified alternative strategies to secure additional funding.

Several years ago, the Designated Institutional Official (DIO) and I established a tax-exempt educational fund by creating a nonprofit organization dedicated to support GME. This funding helps offset unique education expenses across Abrazo Health GME programs that are not covered by institutional budgets.

To advance our educational mission, we implemented several key strategies to grow the fund. We started with outside sponsorships by applying for educational grants, and then moved towards faculty donations. Unique contributions include teaching faculty who voluntarily donate their medical student preceptor compensation to the fund. In addition, we have had success in maintaining our GME Annual Research Day by reaching out to various vendors who sponsor an Exhibitor Booth during the event.

Through these combined efforts, we have accomplished our goal of supporting unique GME funding requests. Looking ahead, our GME office is exploring the possibility of holding a GME fundraiser gala to further expand available resources.

If GME programs are going to establish something similar, they will need to identify opportunities to obtain contributions in this ever-changing GME and healthcare landscape. Feel free to contact me for additional insights.



The Importance of Professional Identity Formation

Ashley Maranich, MD, MHPE
Associate Dean for Student Affairs and Professor of Pediatrics, Uniformed Services University

Before reading this article, take 30 seconds to list 10 nouns that you would use to describe yourself. No, really, make a list!

These words, in many ways, reflect the way you see yourself as a person; they are your identity. Many of your words likely describe personal aspects of your identity, such as being a parent, a friend, a tennis player, or a music lover. However, you have probably also listed words that describe your professional identity: physician, leader, administrator, teacher. Your professional identity is not merely a job title; it is the deeply held set of values, beliefs, and behaviors that define how you see yourself as a professional and how you function within your chosen field.

Are you able to recall your own professional identity formation journey? How did you come to internalize that feeling of being a part of your chosen profession? This is a developmental process with many steps along the way; it is commonly seen as both an individual journey as well as one of being integrated into your professional community. When designing curriculum, educators should deliberately incorporate approaches that support professional identity formation across all stages of medical education.

Focusing on professional identity formation is not only important for individuals but for the medical profession as a whole. It is professional identity that gives someone an intuitive response to the call for a "doctor," the ability to find meaning in the loss of a patient, and the willingness to work toward a solution to a system error. When individuals feel connected to their professional community, they are more resilient to burnout and more likely to remain engaged, constructive members of the field of medicine.

What is your institution or program doing to support trainee professional identity formation? As with any complex concept, there is no one right way to integrate this into medical education. A 2019 article by Cruess et al[1] outlines general principles of supporting professional identity formation and is a great starting point for developing a curriculum. This development can be supported by clinical and non-clinical experiences using intentional mentorship and role modeling. Many programs with a focus on professional identity formation rely upon reflective writing as a fundamental exercise. This is a significant feature of the impactful professional identity formation curriculum for Transitional Year residents described by Dr. Diane Homeyer in the fall 2025 issue of AHME News.[2]

While professional identity formation is a critical component of medical training, it does not stop after graduation. As we continue to grow and evolve as professionals, our identity formation needs to also grow and evolve. The things we teach our trainees are lessons we can continue to learn ourselves. By engaging in reflection, seeking role models, and integrating into the professional community [through organizations like the Association for Hospital Medical Education (AHME)], we can all continue to build a resilient professional identity that not only protects us from burnout but also enables us to maximize our professional contributions no matter where we are in our journey.

References:

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

2. Homeyer D. The Hero's Journey: Writing a Better Story for Professional Identity Formation in the Transitional Year. Association for Hospital Medical Education News. Fall 2025.

The opinions and assertions expressed herein are those of the author and do not reflect the official policy or position of the Uniformed Services University of the Health Sciences or the Department of War.

Beyond Clinical Skills: Teaching Ethics and Humanities in Medical Education

Jessica Seaman, EdD, MEd
Assistant Professor for Medical Humanities and Assistant Dean for Faculty Development, Creighton University School of Medicine

It had been a long Monday. After nearly 10 hours on our health sciences campus, I was ready for my 30-minute commute home. I just finished teaching a small group of medical students. I wasn't teaching point-of-care ultrasound, ECG interpretation, or life-saving resuscitation skills.

You see, I am not a physician, nor a healthcare clinician. But I am an educator of future doctors, physician assistants, and healthcare providers. I am a teacher of medical humanities in our Social Context of Care track, and that afternoon, we discussed the possibilities of prescribing restorative recreation to patients.

My drive home would need to wait. One student lingered after the others left. Not wanting to leave her alone, I secretly hoped we could walk out the door together while chit-chatting. I began asking her questions while I packed up my things. She sat still, tears falling on her cheeks. Not because of what I asked – they were undemanding 'how was your day' questions. Tears came because I was asking at all.

I immediately blamed myself – maybe I didn't present rejuvenation skills well, maybe I wasn't qualified to teach medical students, maybe restorative practice was out of touch. She assured me it wasn't me while I put my arms around her and gave her a huge mama hug. At that moment, the human connection mattered more than the fact that I was not her mother... she just needed a hug.

It was her turn to ask questions. Why can't doctors spend more quality time with patients? Why don't we focus more on human connection in healthcare? How can I prescribe restorative recreation to patients who are so sick? At least she and I were on the same page.

Our Social Context of Care curriculum involves teaching compassion, empathy, ethics, leadership, professionalism, service, and moral decision-making. Some may see this focus as a distraction from "real" medicine. But it hasn't stopped us. In fact, despite occasional pushback, we've expanded our curriculum to be more inclusive and interprofessional, sharing it with nursing, physical therapy, pharmacy, and occupational therapy students.

As in most medical schools, the first two years are dominated by anatomy, physiology, and pathology. Yet from day one, we want students to feel they are becoming the physicians they want to be. The doctors we hope they will become. From the beginning, they are forming habits of attention and compassion, assumptions about human connection, and patterns of responding to patients and suffering. Teaching medical ethics and humanities is not enrichment; it is formation.

Early training in ethics and humanities shapes a learners' professional identity in three significant ways, the development of humility, leadership, and well-being.

Basic science curricula unintentionally reinforce the illusion of certainty—finding clear pathways to diagnosis, choosing correct exam answers, and knowing definitive mechanisms to prevent disease. Yet real-world practice is saturated with ambiguity as patients and their families hold diverse beliefs about illness and healing. These social determinants shape outcomes in ways biochemistry alone cannot explain. Grappling with medical ethics and humanities invites students to explore health history, culture, and lived experience. Class discussions require learners to respectfully disagree and articulate their reasoning clearly, fostering intellectual and moral humility, essential traits for healthcare professionals.

As we teach ethics and humanities, we also prepare students to lead. Healthcare professionals influence policy, shape institutional culture, and advocate for patients. As students learn about medical injustices, wrestle with ethical dilemmas, and engage with diverse narratives, they become better prepared to recognize inequities and respond thoughtfully. Leadership grounded only in clinical expertise risks a narrow perspective, but when informed by moral reflection and humanistic insight, it is likely to promote healthcare, trust and justice.

Pre-clinical coursework intensity can narrow a learner's identity to grades only, making student well-being seem out of reach. Reflective writing, small-group dialogue, and engagement with difficult issues provide structured opportunities to process emotional dimensions of becoming a physician. When students reflect on their own stories or read a poem about patient grief, they learn that lived experiences are not signs of inadequacy but integral to professional life, reducing isolation and building resilience.

Ethics and humanities don't compete with scientific rigor—they strengthen it. If medicine is both a science and moral practice, then its education must intentionally nurture both from the beginning.

As my student and I walked out of the classroom, we spoke of human connection and reflected on the realities of non-clinical practice. I secretly hoped that one day she would share a huge mama hug with a patient, even though she isn't actually their mother.



Flourishing and Professionalism: Growing Who We Are, Not Just What We Do

Asia Ataide, MHA and Alice Fornari, EdD, RDN, FAMEE, HEC-C, ACC/ICF
Northwell Health

Professionalism is at the heart of healthcare. It shapes how we show up for our patients, our teams, and for ourselves. But sometimes, if we are honest, professionalism can start to feel like a checklist — a set of expectations we are trying to meet rather than something we truly live. Most of us have had moments when we are just trying to keep up, doing what is expected, staying composed, while slowly losing sight of why we started in the first place. Flourishing helps us find our way back to that "why."

Flourishing invites us to redefine professionalism from the inside out. While our understanding of professionalism has often focused on virtue, behavior, and identity, Flourishing provides a powerful framework that seamlessly integrates these perspectives. Its four guiding pillars—character, caring, practical wisdom, and purpose—effectively embody the moral center (virtue), guide daily enactment (behavior), and shape the lived identity essential for every healthcare professional. These pillars also deepen and animate the core values we already champion: integrity, accountability, respect, and excellence. By cultivating these intrinsic qualities, professionalism transcends mere standards, becoming a deeply personal reflection of who we are and what truly matters. This shift means it is no longer about simply performing professionalism; it involves the authentic embodiment of professionalism.

The Kern National Network (KNN) for Flourishing in Health describes flourishing as a dynamic and lifelong process of becoming, belonging, and contributing. Their framework emphasizes that flourishing is cultivated through the development of character, caring, practical wisdom, and purpose—pillars that directly support the formation of professional identity in medicine. This alignment between flourishing and professionalism reflects a more integrated and human approach to preparing future health professionals and shaping cultures of care.

Character keeps us grounded in our values, even when taking shortcuts might be easier. It is our continuous self-examination that changes our lens. Caring helps us spend time extending compassion to others and recognize skills that we have that can be brought to our relationships with others. Practical wisdom reminds us to self-reflect on our own lived experiences and learn from them, as context varies, and to listen deeply to one another and to gain wisdom from past experiences that we engage with personally and professionally. Purpose and mattering tie it all together; it reminds us of the why in our work and what called us in the first place, and what keeps us coming back.

Expectations keep rising for health professionals, not only in what we know, but in how we show up. It is no longer about technical skill; it is about bringing both knowledge and kindness to the work. Flourishing happens in that balance—where what we do well meets how deeply we care.

We see the connection between flourishing and professionalism in the small, everyday moments — the ones that rarely make it into reports or meetings. The environmental service worker who gets the patient a cup of water, a nurse who sits down with an anxious patient who is about to have surgery, or the colleague who takes a quiet breath before responding when tension runs high. It is these small moments that show us what professionalism really looks like, not perfect or performative, but deeply human.

As we grow, our professional identities evolve and are shaped within these communities of practice and learning environments that foster belonging, reflection, and mentorship.

Maybe it was a mentor who gave us a little faith when we did not have it ourselves. A piece of feedback that stayed with us longer than we thought it would. Or a moment when we realized we handled something with more patience and compassion than we might have before. Those moments change us. They remind us that becoming a professional is not about getting everything right — it is about becoming more grounded, more aware, and more whole.

Let's face it, things get tough in healthcare. And when they do, flourishing helps us stay steady. Healthcare moves fast, and the expectations often feel endless. It is easy to feel overwhelmed, to lose our way, and to get caught up in external expectations when it comes to professionalism. Flourishing reminds us that professionalism is not about perfection; it is about finding that crucial balance. This, in turn, truly strengthens the bond of trust between healthcare and society. When we naturally nurture character, caring, practical wisdom, and purpose into our lives, we are staying true to medicine's foundation, which is to provide care with integrity, competence, and compassion. These are the qualities that truly earn and keep society's trust. That positive energy that ripples outward, shaping how we listen, collaborate, and lead, helps us build those vibrant communities of practice where we feel a real sense of belonging, where our work feels deeply meaningful, and where integrity shines bright. At its core, flourishing does not just make us better professionals; it quite literally transforms our entire culture, creating genuinely better cultures of care for everyone.

Flourishing helps us cultivate this kind of professional. It imbues meaning into our journey—the long days, the mistakes, and the unexpected lessons. True growth is not a single leap; it unfolds gradually, in subtle ways—when we listen a little longer, speak a little softer, and find understanding where frustration once lived.

To learn more about establishing a *"Reimagine interprofessional development curriculum to support flourishing in healthcare,"* please contact ***Alice Fornari, EdD, RDN, FAMEE, HEC-C, ACC/ICF***- AFornari@northwell.edu.

Acknowledgement: The authors acknowledge the influence of the Kern National Network for Flourishing in Health (KNN) in advancing scholarship on flourishing, caring, character, purpose, and professional identity formation in healthcare. Additional information regarding KNN frameworks may be found here.

AI Series

Using Artificial Intelligence to Create Clinical Cases in GME

John Lowry, PhD
Director of Faculty Development, Covenant Healthcare College of Medicine at Central Michigan University. He co-directs the Webinar Series: AI Skill Building for Medical Educators from the AAMC.

After a long day at the hospital, Dr. Martinez looks at her to-do list and remembers she is scheduled to teach the residents about acid-base balance. She knows from experience that this topic is challenging, one that takes time for learners to move from memorizing facts to applying physiology in clinical care. She has slides that have been used in past years, but wonders if she needs to do something different. However, the thought of opening a blank document and doing something new is daunting.

Many faculty can relate to Dr. Martinez. Teaching medical concepts can be challenging, and creating patient cases designed to promote clinical case discussion is time-consuming. Artificial intelligence (AI) can help faculty to create effective clinical cases. Using AI with the right prompts can save time, enhance faculty effectiveness, and add new layers of creativity and engaging content.

Effective AI prompts for creating clinical cases include the following aspects:

1. **Educational context** - specify the learners you will be working with, your department, and other relevant details.
2. **Learning objectives** - identify the specific knowledge or skills you want the learners to gain.
3. **Specific clinical details** - provide history, exam findings, labs, imaging, or other clinical details.
4. **Complexity level** – specify the complexity to include, such as a basic case for junior residents, or more complex cases for senior residents or fellows.
5. **Pedagogical strategy** – describe the method you want to use to facilitate learning. You can create cases that show application of knowledge, stimulate debate about decisions, or illustrate pitfalls.

Faculty who use AI to create cases may find it helpful to use an iterative process. Before asking AI to generate a case, faculty can ask AI to provide suggestions on addressing the details above. After generating a case, faculty may use additional prompts to refine or steer the case in a specific direction.

Here are some examples of AI prompts that can be used to create clinical cases for residents and fellows.

Acid-Base Balance Question

"I'm teaching PGY-2 internal medicine residents about respiratory acid-base disorders. Create a clinical case of a patient with chronic respiratory acidosis due to Chronic Obstructive Pulmonary Disease (COPD). Include: presenting symptoms, relevant vital signs, initial ABG values, and basic metabolic panel."

Once the case is generated, you may add one or more of the following:

- Add guided questions to use in sequential slides for a resident lecture;
- Provide a step-by-step acid-base interpretation walkthrough;
- Convert this into a bedside teaching script; or
- Create a contrast case of acute-on-chronic respiratory acidosis.

Beyond the Case

In addition to creating patient cases, AI can help faculty develop important teaching tools to use with them. AI can generate multiple-choice questions, discussion items, slide content, worksheets, or an instructor's guide. In addition, AI can assist faculty in using these materials in innovative ways, such as a flipped classroom or in preparation for a simulation case.

Final Thoughts

It is always important for faculty to carefully examine each case generated by AI. The case may seem good at first glance, but AI may include some information that is not clinically accurate. Cases may lack the details or nuance of real patient presentations. Your expertise is put to good use as you critically examine the cases and add or edit the details to make them fit your teaching situations.

Even if you have not used AI to create clinical cases before, try making a simple case relevant to your context. Then critique it using your expertise to decide if it is a good case that will be useful in your teaching. Some faculty find it easier to add a few details to an AI-generated case than to start from scratch. Look ahead to your next presentation and begin preparing a few cases to have ready by then. It may be helpful to have a colleague review the cases with you and provide feedback on their utility. Share successful cases with your colleagues. By partnering with AI, your knowledge and clinical expertise can be used to move from simply presenting content to designing powerful learning experiences in GME.

For more training on using AI in medical education, check out the Webinar Series: "AI Skill Building for Medical Educators" from the AAMC. Click here for details.



Gamified Learning in Medical Education: Strategic Approaches from Northeast Georgia Health System's Center for Simulation and Innovation

Corey Hill, MSN-Ed, RN, CRRN, NPD-BC, CNEcl, CHSE;
Yesica White, BSN, RN, TCRN;
Lauren Wisnoski, MSN, RN, CEN, TCRN;
Leah Everett, MHA, BSN, RN, TCRN, CHSE

The future of medical education requires new approaches that extend beyond lectures and textbooks alone. The COVID-19 pandemic accelerated the adoption of blended learning models and exposed a critical gap: learners must not only acquire clinical knowledge but also communicate and apply it effectively under pressure. In a healthcare environment increasingly shaped by digital communication, simulation-based gamification creates opportunities for meaningful, in-persondialogue. Graduate medical education programs must support resident physicians in confidently applying clinical knowledge while preserving essential interpersonal connections.

Simulation-based gamification offers a response to these evolving educational demands. By leveraging intrinsic motivation, immediate feedback, and psychologically safe learning environments, this approach facilitates deliberate practice aligned with educational theory and training requirements. At Northeast Georgia Health System's (NGHS) Center for Simulation and Innovation (CSI), simulation-based gamification is intentionally incorporated through point systems, competition, and narrative-driven scenarios. These elements transform passive learners into active participants who collaborate, verbalize clinical assessments, and justify decisions in real time.

To translate these principles into practice, implementation should begin with a targeted needs assessment to identify competency gaps. A multidisciplinary team consisting of simulation educators, program directors, and graduate medical education faculty should then be assembled. Pilot programs allow institutions to refine educational design and logistics prior to broader implementation. Institutional support is best achieved through proposals grounded in data that demonstrate anticipated improvements in ACGME milestones and resident physician clinical preparedness.

Sustaining simulation-based gamification over time requires intentional faculty development. Simulation educators and faculty must receive training in game design principles, as well as facilitation, debriefing, and assessment strategies that address both clinical and teamwork competencies. Once this foundation is established, focus can shift toward applying these principles through structured, specialty-specific activities.

Two key examples illustrate the practical application of this strategic approach. Sim Wars exemplifies competitive simulation-based gamification in practice. Resident physicians are divided into themed teams and participate in a bracket-style tournament incorporating clinical decision-making, resuscitation skills, and communication in high-pressure scenarios. Physician faculty serve as judges and subject-matter experts, using structured scoring tools to evaluate clinical knowledge, skills, and team performance. This format redefines traditional simulation by integrating strategy, teamwork, and friendly competition to reinforce essential clinical skills.

Escape Box activities adapt traditional escape room challenges into portable educational tools. Using a box-within-a-box design, resident physicians progress inward, with each layer aligned to specific learning objectives. For example, a general surgery escape box for PGY1 resident physicians guides participants through a laparoscopic appendectomy from preoperative to postoperative care. Activities include multiple-choice trivia, jigsaw puzzles, sterile PPE donning, patient draping, anatomic landmark identification, and suturing task trainers. This approach grounds learning in experiential practice, using sequenced challenges to manage cognitive load, reinforce clinical reasoning through structured debriefing, and promote team-based communication within workflows that mirror operative practice.

Simulation-based gamification provides benefits beyond improved knowledge retention. By intentionally designing experiences that require communication, collaboration, and clinical reasoning under pressure, these strategies prepare resident physicians for the realities of modern patient care. Rather than replacing traditional educational methods, simulation-based gamification complements them by bridging the gap between knowledge acquisition and performance.

As graduate medical education continues to evolve, institutions that invest in thoughtfully designed gamified simulations position learners to develop not only technical competence, but also the interpersonal and decision-making skills essential for safe and effective clinical practice.

Readers interested in exploring additional simulation-based gamification activities developed at CSI can find further information and contact details, click here.

Beyond the Budget Line: GME's Operational Value to Hospitals

Kelly Conlon, MS, C-TAGME
Director, Medical Education
Northwell Health, Eastern Region

Yanick Joseph, MPA
Senior Director of Operations,
Office of Academic Affairs,
Lenox Hill Hospital

Helping hospital leaders understand the value of Graduate Medical Education (GME) is essential. GME is not education in the abstract; it is connected to what leaders manage every day: safe patient care, efficient operations, workforce stability, and a culture that retains strong clinicians. If GME is encountered only as a budget request, a space need, or an accreditation deadline, conversations become reactive. A strong training environment is a practical strategy for strengthening care today while building the physician workforce of tomorrow.

We write this as GME leaders with different vantage points. One perspective is grounded in regional oversight across multiple hospital sites. The other comes from hospital operations, working within GME to translate training standards into workflows, staffing structures, onboarding systems, and cross-department coordination. As programs grow in complexity, their operational footprint increases. It becomes important to clarify what GME is, what it is not, and how training standards influence daily hospital operations. These standards are not preferences; they shape supervision models, patient safety practices, and accountability structures across the clinical environment.

(continued on page 10)

GME is embedded in hospital operations. Residents and fellows do not move through the organization in a single lane. Their experience intersects with Human Resources (HR), Information Technology (IT), credentialing, finance, legal teams, and clinical operations. Because of this reach, GME works best when leadership recognizes training programs as a cross-functional responsibility rather than a siloed educational effort. When alignment exists, processes are coordinated, timelines are realistic, communication improves across departments, and trainees enter and progress through the clinical environment with the access, support, and structure they need.

This level of integration is the point at which Training Program Administrators (TPAs) and Managers (TPMs) become essential. They translate educational and accreditation requirements into day-to-day processes that keep programs functioning reliably in the hospital environment. Their responsibilities extend well beyond scheduling and logistics. TPAs and TPMs support credentialing workflows, ensure rotation data is accurate for Medicare reimbursement, and monitor duty hour compliance to protect both trainees and patients. They also coordinate across teams to address access, onboarding, scheduling, and evaluation needs enabling trainees to work effectively and safely within clinical operations.

Leadership alignment becomes especially visible during onboarding. Traditional onboarding models often do not account for the academic calendar, international medical graduates, varying educational pathways, licensure timelines, and complex credentialing requirements associated with residency and fellowship training. Recognizing these distinctions, and with leadership support, we developed a cross-functional working group that brings together HR, IT, credentialing, and GME operations to proactively plan for each incoming class. This structure strengthened communication, reduced last-minute escalations, and helped ensure trainees were clinically ready on day one, benefiting learners, care teams, and patients alike. Its success led leadership to use similar collaborative frameworks in other operational areas.

Financial operations provide another clear example. Medicare reimbursement linked to resident rotations depends on accurate tracking, documentation, and coordination across clinical departments. Maintaining this alignment requires structured processes and collaboration between GME and finance teams to ensure rotation data is precise and compliant with reporting requirements. When these systems function well, the hospital receives funding while maintaining regulatory compliance. Beyond financial considerations, a robust GME infrastructure supports institutional accreditation and strengthens the hospital's reputation as a teaching institution, thereby enhancing overall sustainability.

Much of GME's contribution is woven into daily operations. When systems are working well, trainees are supported, teams function smoothly, and patient care continues without interruption. Because this work often happens behind the scenes, its impact is easy to overlook. Helping leaders see how GME supports operational stability, care quality, and workforce development helps them understand its value in the same practical terms used to guide other hospital priorities.

One effective way to make GME's contributions visible is to focus on outcomes. Instead of leading with regulations, connect GME to shared goals: quality and safety, patient experience, operational efficiency, recruitment and retention, institutional reputation, and reimbursement. A practical strategy is a brief quarterly GME value snapshot, pairing a small set of indicators with one or two short examples to support leadership decision-making.

Strong GME programs do not happen by accident. They depend on leadership investment in supervision structures, faculty development, protected time where feasible, and core infrastructure, including IT access, physical space, and reliable processes for onboarding, scheduling, and evaluation. When leaders see GME as both an educational and operational partner, support becomes easier to sustain. Over time, that shared understanding leads to better decisions about infrastructure, clearer alignment on roles and responsibilities, and a learning environment that supports safe, efficient care and helps retain the physician workforce.

Coordinators' Chat

The Power of Mentorships: A Year of Flourishing COPAC Partnerships – Part Two

Elaine R. Danyew, C-TAGME Chair Elect & COPAC Connections Lead, COPAC Senior Residency Program Coordinator, Dartmouth, Addiction Psychiatry Fellowship

Barbara Gohre, BSHA, CHPM, CLSSBB (MENTOR) Manager, Accreditation for GME Program Manager, Gastroenterology & Infectious Diseases Fellowship(s), Phoenix Children's Hospital

Amy Argot, BA (MENTEE) Program Coordinator, Anesthesiology Graduate Medical Education Program,TidalHealth

In part two of "The Power of Mentorships," we feature the ongoing partnership between Barbara Gohre and Amy Argot, who were introduced to each other in September 2024 as one of the first matches through the relaunched Council of Program Administrators and Coordinators (COPAC) Connections. Over the past year, their formal mentorship has fostered significant professional growth, mutual support, and personal enrichment. Below, both share their reflections, highlighting successes, areas for improvement, and barriers encountered, demonstrating the program's impact on coordinators in the graduate medical education (GME) community.

"It's been over a year since I connected with Barbara Gohre through the COPAC Connections, and I have and continue to thoroughly enjoy this professional and personal relationship. Barbara is an encourager, and she is well grounded in her job as a GME Program Coordinator. She is supportive of me as I begin to prepare for the C-TAGME Study Group coming up in September. There is no doubt that she will assist and support me in this new endeavor. I look forward to continuing my Mentor/Mentee journey with Barbara. She inspires me to learn and to keep moving forward in my GME career as a Program Coordinator. I have a newfound appreciation for organizations like the Association for Hospital Medical Education (AHME) that promote the Mentor/Mentee professional roles."

"It's been over a year since I connected with Amy Argot through the COPAC Connections, and it has been a tremendous professional and personal pleasure. Our meetings allowed us to establish clear professional goals, including preparation for the C-TAGME certification. I'm thrilled that she has joined study groups and is actively studying and in preparation mode. Amy has demonstrated an impressive desire and capability for growth and professional development throughout this process. I'm deeply thankful to AHME and Amy for this opportunity to continue influencing, mentoring, and shaping those who work tirelessly in our community."

This paired update illustrates the reciprocal benefits of COPAC Connections, where mentorship not only guides professional development but also builds lasting relationships and inspires ongoing commitment to excellence in GME coordination.

As we continue with new initiatives, the COPAC Connections leadership team sent a short survey to our most recent cohort of mentor-mentee partnerships to garner feedback on how the program worked for them. 100% of respondents rated the overall program good to excellent. Mentees reported that their mentor helped them feel more confident or prepared in their role, and mentors reported that the program provided enough structure and support for them to serve successfully as mentors.

As part of the mentoring program, we will continue our efforts to guide professionals through their journeys in GME, providing a robust platform for growth, collaboration, and shared success.

COPAC Council Spotlight

Kimberly Ranagan, C-TAGME
Chair, COPAC

I am honored to share an update on Council of Program Administrators and Coordinators (COPAC) as we enter an exciting new chapter of leadership, collaboration, and growth. By way of introduction, I work at Northwell Health in New York, where I serve as a Lead Medical Education Specialist and work closely with more than 80 Training Program Administrators (also known as program coordinators). Supporting, learning from and advocating for program administrators is central to my professional work, and I bring the same commitment to my role with COPAC.

Following the 2024 Institute, I assumed the role of COPAC Chair, with Melissa Molina Trinidad transitioning to Immediate Past Chair. I am grateful for Melissa's hard work over the last two years and for the strong foundation she laid during her time as Chair.

One of my first priorities was to leverage the collaborative nature of GME and grow our leadership structure by building a clearly defined, engaged, and effective team. As part of this effort, Elaine Danyew, C-TAGME, Senior Residency Program Coordinator for the Addiction Psychiatry Fellowship and Adult Psychiatry Residency Program at Dartmouth-Hitchcock Medical Center, was named Chair-Elect. Elaine works closely with me to support COPAC and its members and leads COPAC Connections, our mentorship program, which continues to grow and evolve in response to member needs.

Sadhvi Khanna, MBA, MPH, Assistant Director of Medical Education in the Department of Anesthesiology at Yale School of Medicine continues her service as a Member-at-Large and has taken on a newly defined role as COPAC's Lead for Educational Initiatives. In this capacity, Sadhvi focuses on recruiting presenters for COPAC webinars and town hall microlearning sessions, and she works closely with Elaine and me on Institute planning and educational strategy.

We were also excited to welcome two new Members at Large to the leadership team. Kelly Conlon, MS, C-TAGME, Director of Medical Education at Northwell Health, Eastern Region serves as COPAC's representative on the AHME Poster Committee, working with committee members to establish best practices and help streamline processes. Caitlin Taylor, C-TAGME, Program Manager for the Internal Medicine Residency and Hospice and Palliative Medicine Fellowship at Florida State University at Sarasota Memorial Hospital joined the team with a focus on member engagement and communications, supporting outreach efforts and helping us better connect with and inform our members.

Together, this leadership team works collaboratively with a shared goal and vision: to expand COPAC's reach while maintaining the close, open forum that allows members to share best practices, ask questions, and learn from one another. That vision is already reflected in COPAC's continued membership growth. Over the past several years, COPAC's membership has more than doubled—from 94 members in 2023, to 158 in 2024, to 189 in 2025, and reaching 207 members as of January 2026. As membership increases and we expand our reach, we will continue to support meaningful engagement, a balance that remains a key priority for me as Chair.

Several new initiatives reflect this momentum. We introduced microlearning sessions during COPAC town halls, with the first session held at the November 2025 Town Hall. That session featured Belinda Sanborn, Program Coordinator for Anesthesiology at Indiana University School of Medicine, who presented "How to Use Power Automate for Email Automation." We also introduced a new members-only quarterly briefing, with the inaugural edition released in February 2026. This briefing highlighted members' accomplishments while sharing practical tips, updates, and resources.

We continue to expand opportunities for members to get involved, including submitting abstracts for webinars and microlearning sessions, requesting specific content topics, and sharing interest in serving as a moderator for future educational offerings.

Looking ahead to 2026, a key focus for COPAC leadership is revising and refreshing the members-only resource library to ensure materials are current, relevant, and truly beneficial for members. Planned updates include a new mentorship circle with resources accessible to participants in COPAC Connections and beyond, as well as additional resources generously shared by our members.

In a short time, our leadership team has developed a strong, collaborative working relationship, and we are genuinely excited to continue building on that foundation. We look forward to connecting with many of you in person at an informal "Meet the COPAC Leaders" happy hour during the 2026 Institute in Reno. We look forward to seeing you there and to COPAC's continued growth.

EDUCATIONAL OPPORTUNITIES

AHME Academy

Mark your calendars for the next AHME Academy, scheduled for **Friday, September 18, 2026**. This dynamic, one-day virtual program is designed for the entire GME leadership team—program directors, program coordinators/administrators, faculty, and central GME staff. The event will provide timely updates and practical strategies on key topics while highlighting AHME resources and essential topics. Participants will also explore AHME resources while connecting with colleagues nationwide. Whether new to GME or experienced, the Academy provides valuable insights designed to support your success.

Details on AHME's educational sessions are posted at www.ahme.org when registrations open. Notification is made via email so be sure to keep an eye on your inbox for upcoming events.

AHME Webinars

AHME members can register for the full series of webinars at a discounted rate. Members still have the option of registering for individual webinars at the regular rate of **$75** per session!

Upcoming Webinar Schedule

Date	Sponsoring Council
June 2, 2026	CPFD (Council on Professional and Faculty Development)
August 4, 2026	COPAC (Council of Program Administrators and Coordinators)
October 6, 2026	CTYPD (Council of Transitional Year Program Directors)

Contact the AHME office at 724-864-7321 or info@ahme.org for more information.

REMEMBER AHME MEMBERS:

Information about AHME happenings is communicated to the membership via Constant Contact, an email marketing provider. When you opt out of those mailings, you no longer receive information from AHME staff or leadership – including announcements about upcoming webinars and other educational opportunities. Don't miss out! Stay connected by keeping your contact information current with AHME staff.

Best Practices from Our Members

AHME News likes to feature articles that highlight members' best practices. We invite you to submit your institution's best practices in any area of medical education to ***Venice VanHuse***, Editor, at vvanhuse@northwell.edu

2026 AHME INSTITUTE – NEVADA



2026 AHME Institute

Grand Sierra Resort

Reno, Nevada | April 29th – May 1st

The Association for Hospital Medical Education has put together an outstanding program for its 2026 AHME Institute! Sessions will include GME, CME and UME topics that are current, relevant, and important to medical education professionals. The presenters will feature some new faces as well as popular, seasoned conference speakers. All will be providing critical medical education updates.

Slated for April 29-May 1, the 2026 Institute will offer learning and networking opportunities in person with your colleagues and peers. A wide variety of educational sessions will give you information and tools you can take back to your office and use right away.

The Institute is your one-stop opportunity to hear from the most influential people in fields that span the medical education continuum. AHME members and other representatives will share their knowledge and experience to help you be better equipped to do your job. The scheduled plenary session titles are:

ACGME Update

Intealth Update: International Medical Graduates in U.S. GME

Keep in mind that there are 45 other possible sessions you can attend! You'll definitely want to register multiple people from your office to maximize the learning.

Some of the other features of the 2026 AHME Institute include:

- Hotel rooms at **super low pricing** (and a **complimentary airport shuttle!**)
- **Extensive programming** with multiple breakout sessions.
- Other **experts in the field** of medical education to provide you with the most up-to-date, nuts-and-bolts, take-and-use-today information.
- An **on-site poster session** to present what you and your peers in other institutions are doing to improve and advance their programs.
- **Exhibitors** with practical products and services
- Sessions expressly for **Program Administrator & Coordinator** learning.
- Specific programming for **Transitional Year** professionals
- Dedicated sessions focused on topics specific to **professional and faculty development.**
- Sessions geared to the work of your **Institutional Leadership.**

Reno is a new destination for the AHME Institute, and the Grand Sierra Resort is ready to welcome us in "grand" style! Learning, luxury, fun, and relaxation are all part of the Grand Sierra experience with ample meeting space, plush rooms and award-winning restaurants, multiple on-property activities, spa, and poolside oasis. Outside the doors, Reno lives up to its nickname of the "The Biggest Little City in the World" with its urban attractions and small-town charm. For the nature enthusiasts wanting to extend their stay in the area, the Sierra Nevada Mountains and Lake Tahoe beckon you to explore.

For the full 2026 AHME Institute brochure and registration information, click here. Be sure to register today and come learn with us!



Medical Education in the Teaching Hospital 6th Edition

Association for Hospital Medical Education (AHME)

Where Medical Education Meets Practice

Created for today's medical education leaders, the Guide is a trusted, practical resource designed for real-world impact. It helps readers quickly translate guidance into action across the evolving landscape of graduate medical education.

Featuring role-based content and companion online tools, it supports just-in-time learning, professional development, and accreditation-aligned practice.

Accreditation

Leadership

Evolving Practice

Scan to Purchase

amazon

ISBN-13: 979-8-218-70170-3

Supporting Educators: Recognize. Inspire. Empower.

Give a gift that develops educators, inspires learners, and shapes tomorrow's physicians.

Transform Struggle into Strength Master the Art of Coaching Medical Learners

> "Evidence-based strategies to help struggling learners cope with these negative feelings and disrupt this type of automatic reaction include..."

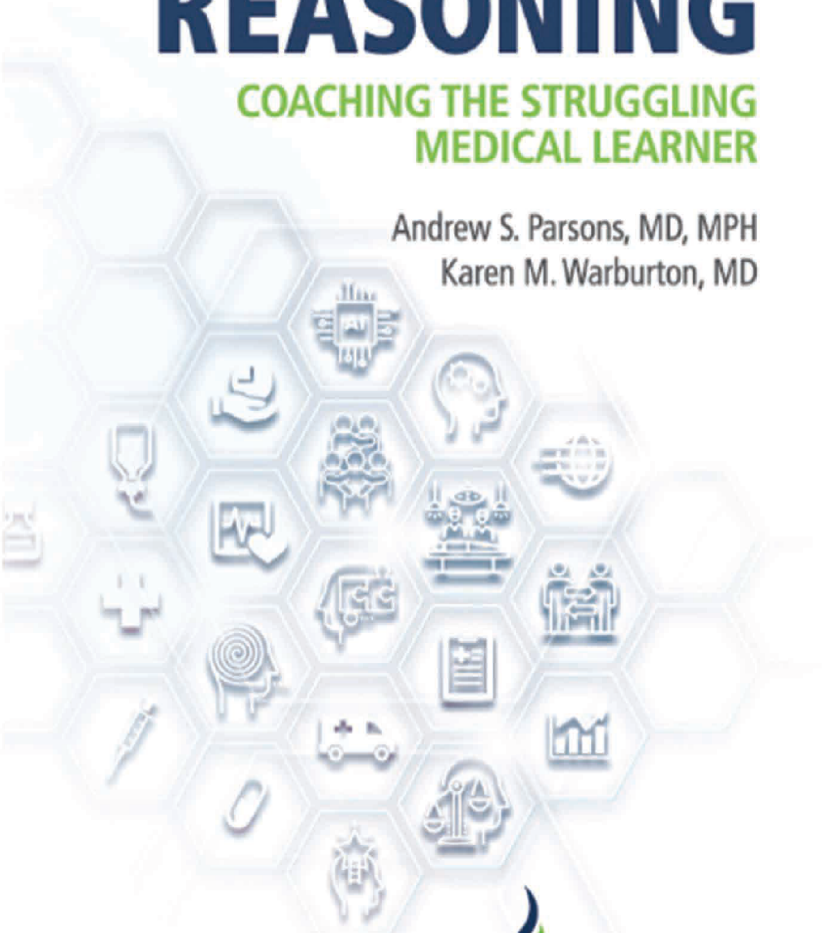
amazon

ISBN-13: 979-8218701697

CLINICAL REASONING

COACHING THE STRUGGLING MEDICAL LEARNER

Andrew S. Parsons, MD, MPH
Karen M. Warburton, MD



AHME | ASSOCIATION FOR HOSPITAL MEDICAL EDUCATION

This practical, evidence-based guide is designed to help medical educators support learners who face challenges in clinical reasoning.

Grounded in educational theory and enriched with real-world case examples, this book offers actionable coaching strategies, remediation tools, and communication techniques that promote growth, resilience, and professional identity formation.

AVAILABLE NOW

Winter 2026 • Volume 46 • Number 1 www.jcehp.org

JCEHP

The Journal of Continuing Education in the Health Professions

CONTINUING PROFESSIONAL DEVELOPMENT (CPD)

Advance lifelong learning in healthcare through research and evidence-based strategies that enhance knowledge, skills, and professional growth.

PATIENT SAFETY & QUALITY IMPROVEMENT

Explore innovations and best practices that strengthen care delivery, improve outcomes, and promote safer healthcare systems.

IMPLEMENTATION & WORKPLACE LEARNING

Discover how education translates into practice through implementation science, interprofessional collaboration, and real-world learning environments.

The Official Journal of
the Alliance for Continuing Education in the Health of Professions
the Association for Hospital Medical Education
the Society for Academic Continuing Medical Education

AHME members who join the Council on Professional and Faculty Development (CPFD) have access to JCEHP.