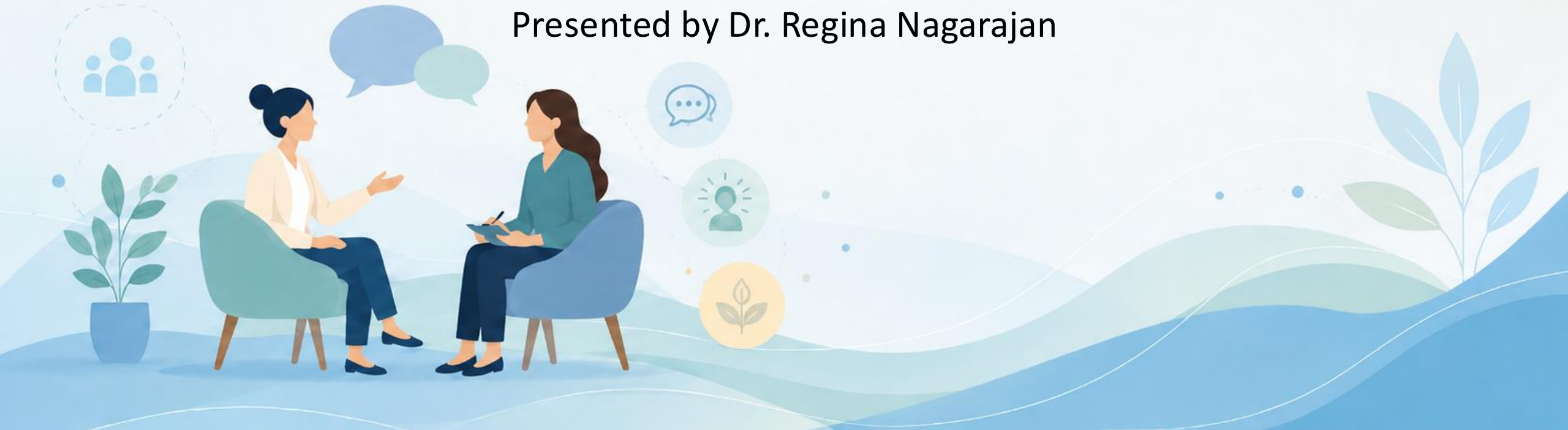
Guided Growth: Supervising APPs in Psychiatry

Friday September 25, 2026

Presented by Dr. Regina Nagarajan



Disclosures

No relevant financial relationships or conflicts of interest to disclose.

Regulatory content is educational and should be verified against current board requirements and local policy.

Why I Care About Supervision

Former teacher

Teaching changes how you think about growth, feedback, and trust.

Built APP training + oversight

Helped onboard and support supervision for ~90 APPs in a large outpatient mental-health practice.

Now in private practice

Supervise 4 PAs in a team-based psychiatric care model.

What We'll Build Today

Analyze regulatory and clinical considerations in APP supervision/collaboration.

Develop a structured supervision approach that supports safety, quality, and team-based care.

Apply feedback and oversight strategies that promote clinical growth and patient care.

*Core question: How to we move from supervision as a safety requirement to supervision as both a **relationship** and **system** for better clinical judgement, confidence and growth?*

Supervision or Collaboration is more than oversight

Safety

Catch risk earlier.
Surface uncertainty sooner.

Clinical Growth

APPs and supervisors sharpen judgment together.

Confidence + Autonomy

Build independence that is earned, supported, and appropriate.

Team Strength

Create relationships where people ask, challenge, and speak up.

**The best supervision doesn’t just prevent mistakes.
It makes the whole clinical team better.**

But supervision can feel uncomfortable at first

“What if they miss something?”

“How much am I supposed to review?”

“How available do I need to be?”

“What if I don’t know they missed it?”

“When do I step in — and when do I step back?”

Audience Poll

Which part of supervision makes you most uncomfortable?

A. Missing something clinically

B. Liability

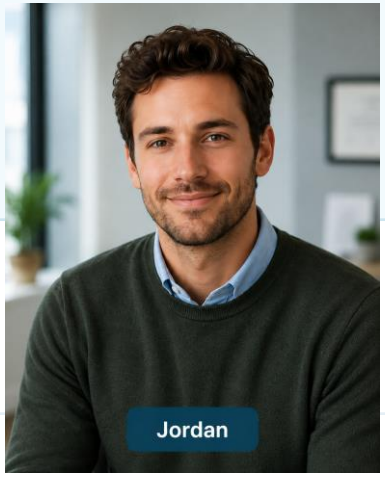
C. Giving difficult feedback

D. Knowing how much autonomy to give

Meet Jordan and Maya

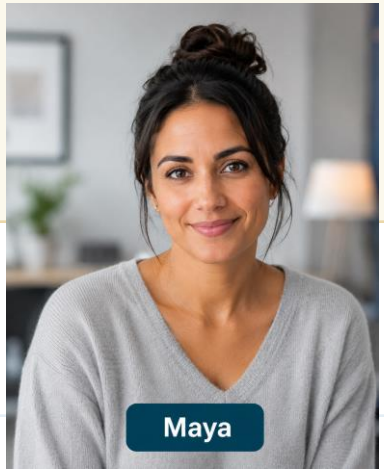
Jordan, PA-C

- Newly hired into outpatient psychiatry
- 1 year of prior clinical practice (worked in a Neurology clinic)
- Limited psychiatry-specific experience
- Bright, thoughtful, conscientious
- You agreed to be Jordan's collaborating physician



Maya, 31

- Comes for evaluation for "depression, anxiety, possible ADHD"
- Poor concentration, irritability, trouble sleeping
- Two prior antidepressant trials
- Occasional cannabis use
- No prior psychiatric hospitalizations
- No formal diagnoses in her family, but her grandmother had "mood swings"



Audience Poll

Jordan is 1 week into outpatient psychiatry.

What would you want to happen with Maya's visit?

A. Jordan manages independently and brings it up only if needed

B. Jordan evaluates independently, then discusses before changing meds

C. You directly observe part of the evaluation

D. Jordan should not yet do new evaluations independently

What information changes your answer?

- What is the regulation/requirement?
- Previous psychiatric experience?
- Training background?
- Direct observation?
- How Jordan formulates cases?
- How long you've worked together?
- Patient complexity? Setting?
- Access to backup?

Alternative answer: "I haven't given you enough information about Jordan yet."

North Carolina: Know the Floor

Regulation creates minimums

NPs/PMHNPs

- Collaborative Practice Agreement
- Primary supervising physician
- QI monthly meeting × 6 months, then every 6 months
- Review/sign annually

PAs: traditional

- Supervisory arrangement (back up physician if applicable)
- Monthly meetings × 6 months, then at least every 6 months
- Clinical issues + QI
- Document meetings (signed and dated)

PAs: team-based practice (New in NC)

- Rules effective Aug 1, 2026
- >4,000 PA clinical hours + >1,000 specialty hours
- Team-based setting + NCMB authorization
- Not a traditional supervisory arrangement

Sources: NCMB PA team-based practice guidance; NCMB PA supervision FAQ; NCBON NP FAQ / collaborative practice guidance. Verify current requirements

NCMB Requirements

- The NCPA toolkit is useful for practical supervision structures/checklists, but verify regulatory material against current Board rules
  - https://www.ncpsychiatry.org/psychiatric-supervisor

Excellent Resources:

- https://www.ncmedboard.org/resources-information/professional-resources/pa-resources
- https://www.ncmedboard.org/resources-information/faqs/professional-faqs/supervision

Sources: NCPA Psychiatrist's Toolkit; NCMB Position Statement 9.1.1.

Why Structured Transition Matters

Li et al. 2025: psychiatric APP practice is growing, but transition-to-practice support is uneven.

- Psychiatric APPs are an increasingly important part of the mental-health workforce
- Training pathways and psychiatry-specific exposure vary substantially
- Subspecialty exposure may be limited or absent
- Early-career APPs report uncertainty

68% reported feelings of inadequacy in one first-year survey.
63% reported anxiety/fear.
Another survey found **49%** had felt they were practicing outside their perceived competence during their first year.

- Structured transition support can help bridge the gap between graduation and independent psychiatric specialty practice

Licensure tells us what someone may do. Supervision helps us determine what this clinician should do independently today.

Source: Li L, Gates J, Westover A, et al. Curr Psychiatry Rep. 2025;27:457–463.

Transition Should Look More Like Training

- Supervising psychiatrist
- Experienced APP mentor when possible
- Direct observation with structured feedback
- Intentional didactic/self-study plan
- Exposure to experienced clinicians
- Consider 6–12 month transition/fellowship structures when feasible

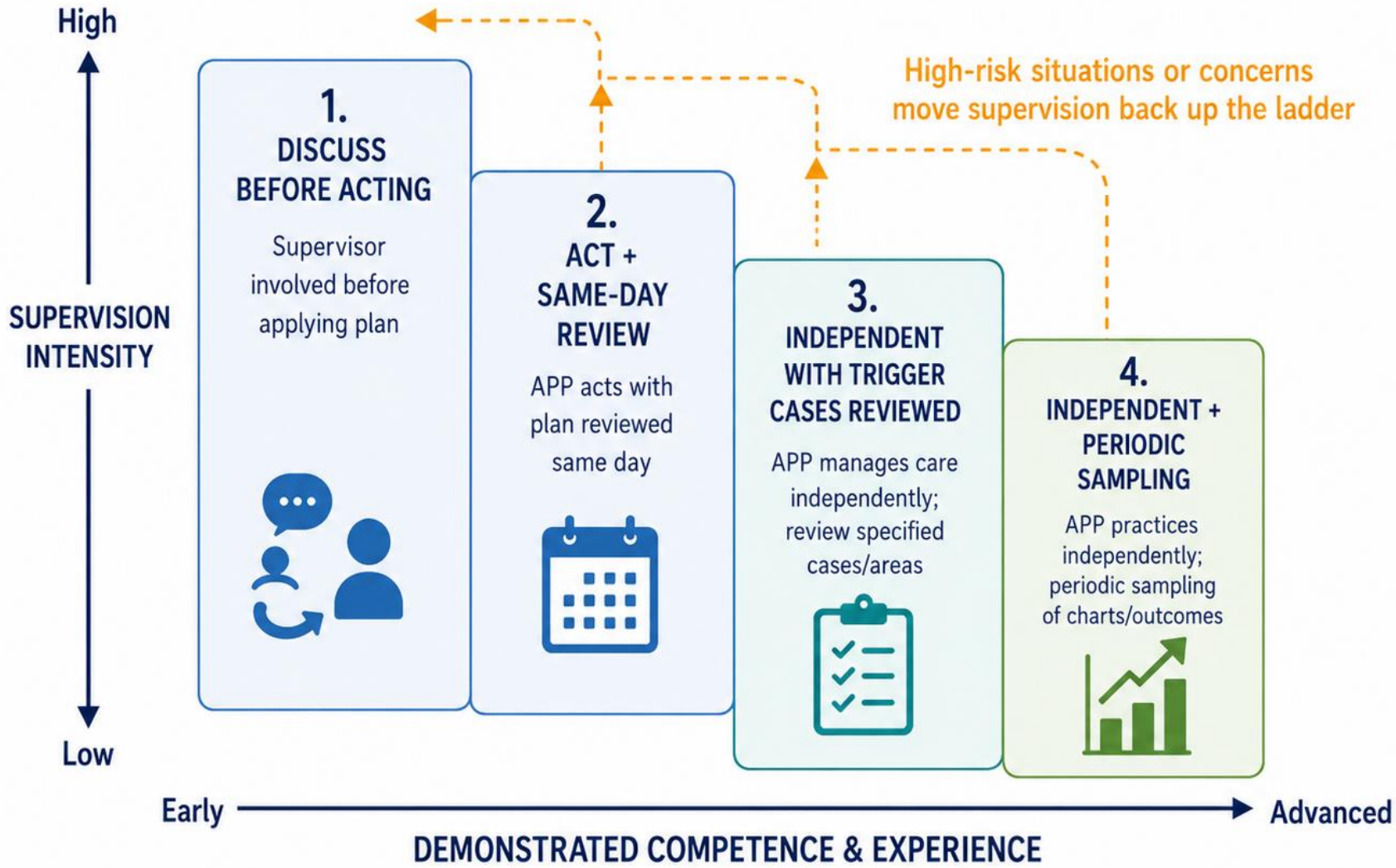
Back to Jordan: How do you know how Jordan interviews, formulates, assesses risk, or handles diagnostic uncertainty?

You have to see some of the work.

Source: Li et al. 2025; NCPA Toolkit examples of shadowing, observation, gradual progression and regular case discussion.

The Supervision Staircase

Supervision intensity matched to demonstrated competence, with flexibility for risk.



For educational use. Adapt to your setting, policies, and regulatory requirements.

The Supervision Operating System

A simple framework for effective supervision.

1. SET THE RAILS

- Define scope & delegated acts/tasks
- "Call me now" triggers
- Consultation expectations
- Coverage & availability
- Documentation & legal requirements
- Agree on how disagreement will be handled

Clarity up front prevents problems later.

2. SEE THE WORK

- Scheduled case supervision
- APP-selected cases
- Supervisor-selected/ random cases
- High-risk / trigger cases
- Chart review & outcomes
- Direct observation (as indicated)
- Review of prescribing patterns & adverse events

Multiple lenses give a truer picture.

3. STRENGTHEN THE CLINICIAN

- Timely, effective feedback
- Case teaching
- Reflective practice
- Competency assessment by domain
- Progressive autonomy
- Support professional growth & well-being

Grow competence, confidence, and professional identity.

For educational use. Adapt to your setting, policies, and regulatory requirements.

Specific observation beats vague praise

Less useful	More useful: observable + repeatable
“You’re really good with patients.”	“Your rapport with Maya was excellent. She shared details about her sleep that she hadn’t disclosed before. What do you think helped her open up?”
“That was a really good assessment.”	“You slowed down when Maya gave an unclear answer about sleep and asked the question three different ways. That’s what uncovered the three-hours-without-fatigue pattern.”
“Your documentation is great.”	“Your note clearly separated what Maya reported from your clinical interpretation. I could follow why bipolar disorder stayed on the differential.”

“I noticed you did ___, and it led to ___. What helped that work?”

What Should Happen Every Week?

- Li et al. 2025 propose at least 1 protected hour/week for new psychiatric APPs
- Use time for formulation, prescribing decisions, suicide/violence risk, chart review, and teaching
- Include ordinary cases, not just emergencies
- “As-needed” supervision can miss blind spots and recurring patterns

The cases someone knows to ask about are not necessarily the cases you most need to see.

Source: Li et al. 2025.

What Do I Actually Review?

A balanced portfolio of information.

1. APP-SELECTED CASES

Cases APP brings that are challenging, uncertain, or where they want feedback.

2. SUPERVISOR-SELECTED / RANDOM CASES

Cases the supervisor selects or samples randomly to avoid blind spots.

COMPLETE PICTURE INFORMS CALIBRATED TRUST

3. PREDEFINED TRIGGER CASES

High-risk situations that always require review (e.g., suicide risk, new psychosis, complex med changes, capacity questions).

4. OUTCOMES & SYSTEM DATA

Hospitalizations, ED visits, adverse events, complaints, prescribing patterns, quality measures.

For educational use. Adapt to your setting, policies, and regulatory requirements.

Back to Jordan, PA-C and Maya→ Chart Review Reveals

- Several periods of sleeping 4-5 hours and feeling increased anxiety
- Days when she suddenly feels productive and like "getting everything done"
- Some increased spending or impulsivity during those periods that she describes as procrastination

Audience question:
If supervision is only "What cases do you want to talk about today?" — would Maya ever come to you?

Teaching point: random review is not distrust. It is a way to find unknown unknowns.

Decide “Call Me Now” Before You Need It

- Acute suicide/homicide risk
- Initial diagnosis with meaningful uncertainty
- Safety incidents or suicide attempts
- Pregnancy or high-risk medication decisions
- Lithium, clozapine, LAIs, esketamine, Schedule II meds
- Neuromodulation: TMS / ECT
- Mandated reporting or active medical illness

Add one more:
“I am worried, but I can’t quite explain why.”

30 seconds:
Write down one situation every clinician you supervise should call about immediately.

Sources: Li et al. 2025; NCPA Toolkit for written plans / availability / emergency expectations.

Turn QI Meetings Into Useful Supervision

Instead of: “Anything to discuss?”

1. Follow up from last meeting
2. One clinical/QI topic
3. Chart review
4. One case
5. Pattern or area for improvement
6. Action / learning plan
7. Document what changed

The goal is not to document that supervision occurred.
The goal is to document that judgment, safety, or autonomy improved.

Source: NCPA Toolkit QI meeting checklist and sample QI meeting forms.

Focus on Education, Not Inspection

Case

Start with a real patient, not a generic topic.

Concept

Name the clinical principle or pattern.

Future behavior

End with what changes next time.

With Maya: "Which findings would change your confidence in bipolar vs ADHD?"

Source: Mukhalalati & Taylor. Adult Learning Theories in Context. J Med Educ Curric Dev. 2019.

Case Continued

Maya portal message:
“I’ve barely slept for three nights, but weirdly I’ve gotten a ton done and feel a lot better than I have in I don’t know how long.”

Jordan responds with sleep hygiene measures, offers addition of trazodone to help with sleep and schedules follow-up next week.

Your first instinct?

- Correct the error immediately?
- Encourage Jordan follow his own clinical intuition?
- Ask how Jordan interpreted the message?
- Create a new escalation rule?

Most of us jump straight to content. Better feedback starts with the conversation.

R2C2 Feedback Framework

A conversational model for feedback and coaching.

For educational use. Adapt to your setting, policies, and regulatory requirements.

Adapted from content in
Sargeant J, Mann K, Manos S, Epstein I, Warren A, Shearer C, Boudreau M.
R2C2 in Action: Testing an Evidence-Based Model to Facilitate Feedback and Coaching in Residency.
Journal of Graduate Medical Education.
2017;9(2):165–170.
doi: **10.4300/JGME-D-16-00398.1**

Model Uncertainty

Good supervisors make it safe to not know.

Examples

- Say “I’m not sure” out loud
- Make your reasoning visible
- Name what would change your mind
- Ask for the APP’s perspective
- Show how you seek consultation yourself
- Reward early escalation- not just correct answers

Psychological Safety Is Not Being “Nice”

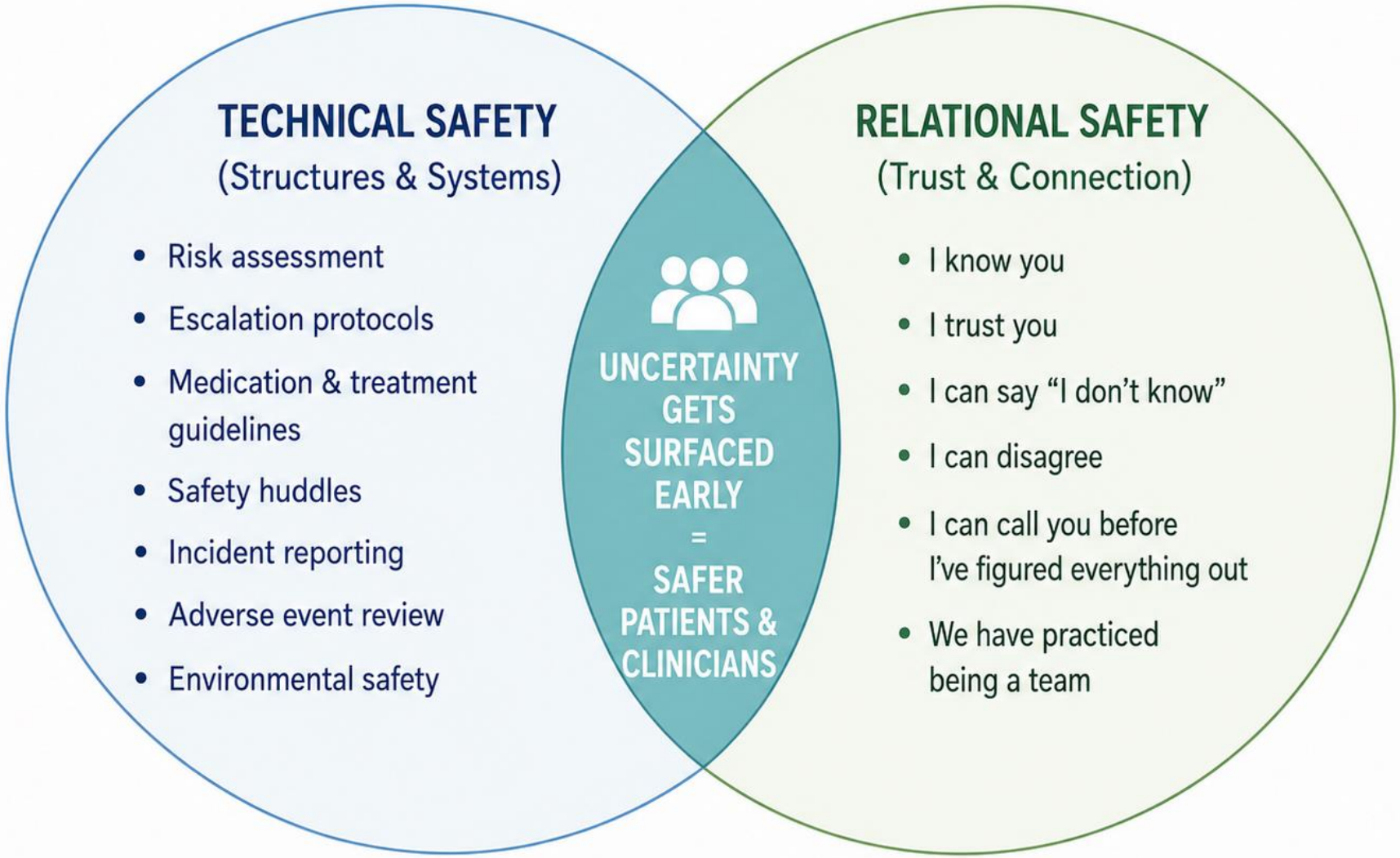
- Supervision requires clinicians to reveal uncertainty, disagreement, and mistakes
- Those behaviors carry interpersonal risk
- Your response trains the APP whether to bring you the next problem
- Psychological safety does not lower clinical standards — it makes problems visible soon enough to apply them

Every time someone brings you a mistake, you are training them whether to bring you the next one.

Source: Johnson CE, Keating JL, Molloy EK. Psychological safety in feedback. Med Educ. 2020.

Patient & Staff Safety Requires Two Systems

The strongest safety culture lives in the overlap.



For educational use. Adapt to your setting, policies, and regulatory requirements.

Safety Improvement: Systems + Connection Matter

Hard safety systems

DASA + interdisciplinary safety huddles
6-month implementation

↓60%
staff assaults

↓86.36%
staff injuries

+

Relationships matter too

- Familiarity
- Shared rituals
- Recognition
- Team meals / huddles
- Psychological safety

Safety culture = systems that protect + relationships that connect

Sources: Dotson et al., Archives of Psychiatric Nursing, 2026; Monroe et al., Archives of Psychiatric Nursing, 2021; Frey et al., BMC Palliative Care, 2019; Rennung & Göritz, Z Psychol, 2016.

Return to Maya: What Changed?

Set the rails

- Reduced sleep + increased energy became a “call me now” trigger
- Medication changes should be reviewed same day when bipolar disorder is in the differential

See the work

- Maya surfaced through random review

Strengthen the clinician

- Feedback became reflection + coaching
- Jordan leaves with a better bipolar-vs-ADHD interviewing strategy

The payoff: the next time Jordan is unsure, Jordan calls sooner.

Supervision Alone Is Not the Safety System

Li et al. emphasize organizational oversight in addition to individual supervision.

- Credentialing and verification of training
- Initial competency assessment and direct observation
- Routine professional-practice review
- Chart review and outcome review
- Serious-safety-event / incident review
- Peer review pathways when concerns emerge
- CME, Grand Rounds, professional development, and library resources

Source: Li et al. 2025; NCPA Toolkit quality-monitoring examples.

Clarity Beats Anxiety

Supervision feels safer when roles and responsibilities are explicit.

- Know your role: supervisor, collaborator, consultant, medical director
- Define responsibility before care begins
- Document supervisory decisions and QI discussions
- Supervise only within your own competence and scope

Lower liability by making expectations explicit, escalation easy, and supervision structured.

Sources: NCPA Toolkit liability section; NCMB Position Statement 9.1.1.

Three Things to Do Monday

1

Write your “call me now” list

Make consultation thresholds explicit.

2

Review cases the APP did not choose

Find unknown unknowns.

3

Make every supervision encounter do one thing

Safer care, better judgment, or more appropriate autonomy.

References and Resources

- **Li L, Gates J, Westover A, et al.** Supervision and Support for Advanced Practice Providers Entering Psychiatric Practice. *Curr Psychiatry Rep.* 2025;27:457–463. doi:10.1007/s11920-025-01615-7.
- **North Carolina Psychiatric Association.** *A Psychiatrist's Toolkit: Supervising NPs and PAs.* 2016. Use for supervision structure/checklists/quality-monitoring examples; verify regulatory content against current boards.
- **North Carolina Medical Board.** Position Statement 9.1.1: Physician Supervision of Other Licensed Health Care Professionals. Amended July 2025.
- **North Carolina Medical Board.** PA Team-Based Practice. Rules effective August 1, 2026.
- **North Carolina Medical Board.** Professional FAQ: Supervision of Physician Assistants.
- **North Carolina Board of Nursing.** Nurse Practitioner Scope of Practice / Collaborative Practice Agreement requirements.
- **Sargeant J, Mann K, Manos S, et al.** R2C2 in Action: Testing an Evidence-Based Model to Facilitate Feedback and Coaching in Residency. *J Grad Med Educ.* 2017;9:165–170. doi:10.4300/JGME-D-16-00398.1.
- **Johnson CE, Keating JL, Molloy EK.** Psychological safety in feedback: What does it look like and how can educators work with learners to foster it? *Med Educ.* 2020;54:559–570. doi:10.1111/medu.14154.
- **Mukhalalati BA, Taylor A.** Adult Learning Theories in Context: A Quick Guide for Healthcare Professional Educators. *J Med Educ Curric Dev.* 2019;6:2382120519840332. doi:10.1177/2382120519840332.
- **Rennung M, Göritz AS.** Prosocial Consequences of Interpersonal Synchrony: A Meta-Analysis. *Z Psychol.* 2016;224:168–189. doi:10.1027/2151-2604/a000252.