HPEC 2018
Health Professions Education Conference 2018

Promoting Innovation, Integration and Engagement

Saturday, February 3, 2018

Sponsored by Office of Medical Education
John A. Burns School of Medicine, University of Hawaii
Welcome to the 2018 Health Professions Education Conference

Aloha! It is with great pleasure that we welcome you to our second Health Professions Education Conference. This conference focuses on faculty development and the sharing of educational scholarship, thus supporting improvements and enhancements to our educational methods and outcomes that allow us to teach and train high-quality health professionals, and to stimulate academic exchange between departments and schools.

This year marks the 25th year of the longitudinal integrated clerkship at JABSOM, and we are particularly excited and honored to welcome our plenary speaker, David Hirsh, MD, Director of the Harvard Medical School-Cambridge Integrated Clerkship, who will be discussing the decision-making process that Harvard went through when developing their longitudinal integrated clerkship and what they have learned over the years.

A special thanks to our HPEC 2018 Conference Planning Committee, our HPEC 2018 Program Planning Committee who determined the session topics, and to all the individuals who submitted proposals for posters and who served as abstract reviewers. The theme of our conference is “Promoting Innovation, Integration and Engagement”, and we have topics ranging from interprofessional education, bedside teaching, evaluating learners and effectiveness of educational programs, preventing burnout, detecting those in academic peril, professionalism, communication skills and continuing education for health care professions.

Thank you for joining us at this conference, and participating in the collaborative spirit of teaching and learning from one another.

Pupukahi i holomua
Unite to move forward; by working together, we make progress

Sincerely,
Sheri F.T. Fong, MD, PhD
Conference Chair

Kori-Jo Kochi
Conference Coordinator
# Acknowledgements

We would like to sincerely thank and gratefully acknowledge the following individuals who have guided and helped us in the planning and implementation of this conference. Mahalo nui loa!

## HPEC 2018 Conference Planning Committee

<table>
<thead>
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<th>Department</th>
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<tr>
<td>Jill Omori</td>
<td>Office of Medical Education</td>
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<tr>
<td>Damon Sakai</td>
<td>Office of Medical Education</td>
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<tr>
<td>Vanessa Wong</td>
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## HPEC 2018 Program Planning Committee

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<tr>
<td>Hyeong Jun Ahn</td>
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<td>Department of Native Hawaiian Health and</td>
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<tr>
<td>Lee Buenconsejo-Lum</td>
<td>Graduate Medical Education</td>
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<td>Gretchen Gavero</td>
<td>Department of Psychiatry</td>
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<td>Sheri Gon</td>
<td>Department of Medical Technology</td>
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<tr>
<td>William Gosnell</td>
<td>Department of Tropical Medicine, Medical</td>
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<td>David Horio</td>
<td>Department of Pathology</td>
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<td>Alan Katz</td>
<td>Office of Public Health Studies</td>
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<tr>
<td>Kenton Kramer</td>
<td>Department of Tropical Medicine, Medical</td>
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<td>Kyra Len</td>
<td>Department of Pediatrics</td>
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<tr>
<td>Amy Lower</td>
<td>Department of Communication Sciences and</td>
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<tr>
<td>Kamal Masaki</td>
<td>Pediatrics</td>
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<tr>
<td>Takashi Matsui</td>
<td>Department of Anatomy, Biochemistry and</td>
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<td>Susan Steinemann</td>
<td>Women’s Health</td>
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<tr>
<td>Cedomir Todorovic</td>
<td>Department of Cell and Molecular Biology</td>
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<tr>
<td>Lorrie Wong</td>
<td>School of Nursing</td>
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Acknowledgements

We would also like to acknowledge all of our wonderful volunteers. Thank you so very much for all your time and effort. You are amazing people!

Noelani Ching
Macayla Dietrich
Joseph Go
Adam Guzman
Gavin Ha
Gabriella Jelffs
May Maeda
Michael McNulty
Kelli Morikuni

Kayla Murata
Steven Okubo
Jasmine Padamada
Lindlelyn Tabula
Risa Tanaka
Christopher Tokeshi
Maria Uyeunten
Nichole Wamsley
Calvin Yang

And lastly, we would like to thank ~

Queen’s Health Systems for their sponsorship of the conference
Native Hawaiian Center of Excellence for donation of the name badges

Mahalo for your generosity!
Abstract Reviewers

Hyeong Jun Ahn, Department of Complementary and Integrative Medicine
Samina Ahsan, Department of Geriatric Medicine
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Hiroaki Matsumoto, Office of Medical Education
Barry Mizuo, Department of Pediatrics
Louis Moreau, Office of Medical Education
Stephanie Nishimura, Office of Medical Education
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Kristen Teranishi, Office of Student Affairs
Joseph Turban, Office of Medical Education
Aida Wen, Department of Geriatric Medicine
Lorrie Wong, School of Nursing
Vanessa Wong, Department of Native Hawaiian Health and Office of Medical Education
General Information

Contact Information
For questions related to the conference, please email us at: info@hpecjoin-l@lists.hawaii.edu. For assistance on the day of the conference, please see the volunteers at the registration table or call 808-692-0929.

Poster Session
Posters may be posted in your assigned spot starting from 8:00 am.

Wireless Internet Access
Free Wi-Fi will be available throughout the building. If you have a UH username and password, please use your UH credentials for access. If you do not have a UH username and password, please use the information below:

SSID: Events
Username: HPEC
Password: HPEC

If you have any problems, please see the registration desk.

Continuing Medical Education
CME is available for the following sessions:

- Plenary (1 hour)
- Session I (1.5 hours)
- Poster session (1.5 hours)
- Session II (1.5 hours)
- Session III (1 hour)

We will be providing CME credit through the Hawai‘i Consortium for Continuing Medical Education (HCCME). HCCME, a joint venture between the University of Hawai‘i John A. Burns School of Medicine and the Hawai‘i Medical Association, is accredited by the Accreditation Council for Continuing Medical Education for physicians.

The Hawai‘i Consortium for Continuing Medical Education designates this live activity for a maximum of 6.5 AMA PRA Category 1 Credits™. Physicians should claim only the credit commensurate with the extent of their participation in the activity.
Driving & Parking Information for JABSOM

Driving Direction from H-1 West
- Take Kinau Street Exit
- Turn Right on Ward Avenue
- Continue on through Ala Moana Boulevard onto Ilalo Street

Driving Direction from H-1 East
- Take Vineyard Exit
- Take first left onto Punchbowl Street
- Continue *makai* and take a left onto Ala Moana Boulevard
- Take second right onto Forrest Avenue

Lot C Parking Lot
Lot C is not an UH-run parking lot so you cannot use UH parking permits. The parking fee is a $5.00 flat rate. Please park in numbered stalls only and place your payment into the corresponding numbered pay box near the entrance located against the fence along Ilalo Street.

Please bring the exact amount as change is not given. DO NOT park in the Kakaako Waterfront Park lot to attend this program as those not actively using the park are subject to tow. For map, please see pages 61-62.

Important Addresses
JABSOM Medical Education Building: 651 Ilalo Street, Honolulu, HI 96813
## HPEC Program Summary

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*Campus maps are shown on pages 63-64.*
Poster Session Summary

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Health Sciences Library
MEB 1st floor

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| 9 | A Five-Part Division of Military Psychiatry Chief Resident Responsibilities 
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Plenary Speaker

David Hirsh, M.D.

David A. Hirsh graduated *summa cum laude* with a B.A. in History from Dartmouth College in 1988 and an M.D. from the University of Virginia in 1992. He is Associate Professor in Medicine at Harvard Medical School and Director and Co-Founder of the Harvard Medical School-Cambridge Integrated Clerkship. His scholarship and academic contributions span diverse areas including “educational continuity”, medical education transformation, longitudinal integrated clerkships, OSCEs, East Asian constructs of professionalism, and humanism in medicine.

He has received local, national, and international honors for his teaching, academic work, clinical practice, and public service. With colleagues, he co-founded the international Consortium of Longitudinal Integrated Clerkships. He serves as a visiting professor of education and educational consultant nationally and internationally. He served from 1995-2009, as Medical Director of the City of Cambridge Healthcare for the Homeless Program. He continues to practice primary care women’s health in Cambridge, to mentor student and faculty research, and to teach courses in all four years of the Harvard School curriculum.
Kate Regnier is Executive Vice President of the Accreditation Council for Continuing Medical Education (ACCME) and has been with the ACCME since 1995. She oversees the processes of Accreditation and Reaccreditation for national and international providers of continuing medical education (CME), the Recognition of the US-based State/Territory Medical Societies as accreditors within their states according to the Markers of Equivalency, and the Joint Accreditation of Providers of Interprofessional Continuing Medical Education with colleague accreditors, the Accreditation Council for Pharmacy Accreditation and the American Nurses Credentialing Center. Ms. Regnier is also responsible for the review of non-US accreditors for their Substantial Equivalency with the ACCME’s system. Ms. Regnier also oversees the education, communications, monitoring, and business functions of the ACCME, and serves as the primary staff liaison to the ACCME Board of Directors.

Kate received a Bachelor of Arts Degree in English from the College of the Holy Cross (1986), a Master’s Degree in English from Northwestern University (1990), and a Master’s Degree in Business Administration from Loyola University of Chicago (1995). Kate is married to John Regnier, a cartoonist/graphic artist, and they are parents of four young adults – Emma, Noah, Brennan, and Roan.
Session Descriptions
Welcome and Plenary

9:00 am - 10:15 am
MEB Auditorium

Welcome and Opening

S. Kalani Brady, MD – opening oli (chant)
   Associate Professor, Department of Native Hawaiian Health
Sheri Fong, MD, PhD
   Conference Chair, Health Professions Education Conference
Alan Otsuki, MD, MBA
   Associate Dean for Academic Affairs, John A. Burns School of Medicine

Plenary

The Educational Science and the Story of Harvard Medical School’s Longitudinal Integrated Clerkship

David Hirsh, M.D.
   Director and Co-Founder, Harvard Medical School-Cambridge Integrated Clerkship

Learning Objectives:
Learners will be able to:
1. List and interpret the “case for change” driving medical education reform;
2. Recognize and select principles derived from the sciences of learning that address the case for change and that form the basis of longitudinal integrated clerkships (LICs);
3. Investigate and interpret the data about one such LIC—Harvard’s Cambridge Integrated Clerkship;
4. Define, extrapolate, and generalize features of longitudinal integrated learning structures to your own context.

Brief Description of Session:
Harvard Medical School developed their longitudinal integrated clerkship program in 2004 as part of their curriculum reform efforts. The program is intended to emphasize whole patient care, and to promote ideals of professionalism and connection with patients. Results have shown that compared with students not in the program, these students report an increased feeling of connection with patients, greater self-awareness, and a greater responsibility for their own learning. Dr. Hirsh will review the process they went through in the decision to institute an LIC, their experience with the program, and directions for the future.

Target Audience: Health Professions Faculty and Medical Students
Session I

10:30 am – 12:00 noon
MEB 301

Learn Well: Accredited Continuing Education (CE) to the Rescue

Kate Regnier, M.A., M.B.A.
Executive Vice President, Accreditation Council for Continuing Medical Education

Learning Objectives:
At the end of this activity, participants will be able to:
1. Effectively facilitate a supportive learning environment for their clinicians
2. Be prepared to deliver efficient and effective education
3. Implement innovative approaches in their own program or organization, including spaced repetition, adaptive testing, social media, simulations, and registries to facilitate reflection and self-awareness

Brief Description of Session:
Clinicians thrive when they are intellectually stimulated and practicing at their maximal skill in a supportive learning environment. Education and educators are evolving to convene clinicians and teams to deliver efficient and effective education. Several innovative approaches have been developed, including spaced repetition, adaptive testing, virtual reality, games, social media, simulations, and registries to facilitate reflection and self-awareness. Working with teams and physician colleagues, learning and performance improvement activities can be merged. Increasingly, the regulatory systems have aligned to ensure appropriate incentives are in place to identify quality learning experiences that support the physician, the team, and ultimately the patients being served.

Target Audience: Educators across the continuum of health professions education
Session I

10:30 am – 12:00 noon
MEB 304

Teaching on the Go: Practical Tips for Bedside Teaching

Joel Brown, M.D.
Clinical Professor, Department of Medicine, JABSOM

Gretchenjan Gavero, D.O.
Psychiatry Associate Program Director and Clerkship Director, Dept of Psychiatry, JABSOM

Christie Izutsu, M.D.
Internal Medicine Clerkship Director, Department of Medicine, JABSOM

Damon Lee, M.D.
Family Medicine Clerkship Director, Dept of Family Medicine and Community Health, JABSOM

Kyra Len, M.D.
Pediatric Clerkship Director, Department of Pediatrics, JABSOM

Michael Savala, M.D.
Ob/Gyn Clerkship Director, Dept of Obstetrics, Gynecology and Women’s Health, JABSOM

Gregory Suares, M.D.
Emergency Medicine Clerkship Director, Department of Surgery, JABSOM

Learning Objectives:
Participants will:
1. Review and practice 4 different models of bedside teaching
2. Discuss barriers and benefits to bedside teaching
3. Learn to integrate use of technology in bedside teaching

Brief Description of Session:
Bedside teaching in the busy clinical environment can be a challenge, especially with time constraints and other faculty responsibilities...among many other potential barriers. Still, even the busiest providers can be the most effective and memorable teachers. For those of us who love to teach, the excitement and energy we bring into our student encounters may not be enough to meet our teaching goals. Mindfully setting expectations, outlining the day, and facilitating active discussion are some of the important aspects of organizing our limited teaching time with our learners. In this session, Clerkship Directors across various specialties share techniques that will help preceptors maximize the learning experience of students and increase the efficacy of bedside teaching moments. Here, the participants will have an opportunity to learn and practice four practical models of bedside teaching that can be easily applied in both inpatient and outpatient settings.

Target Audience: Medical school faculty and residents who work with students and residents
Session I

10:30 am – 12:00 noon
MEB 314

Update on Interprofessional Education at the University of Hawai‘i

Robin Arndt, M.S.W., L.S.W.
  Junior Specialist, Myron B. Thompson School of Social Work
Alan Katz, M.D., M.P.H.
  Professor, Office of Public Health Studies, UH Manoa
Chad Kawakami, Pharm.D.
  Assistant Professor of Pharmacy Practice, Daniel K. Inouye College of Pharmacy
Kamal Masaki, M.D.
  Professor and Chair, Department of Geriatric Medicine, JABSOM
Lorrie Wong, Ph.D., R.N.
  Associate Professor and Director of Simulation Learning, UH Manoa School of Nursing

Learning Objectives:
1. Describe the Interprofessional Education Collaborative (IPEC);
2. Provide an update on Hawaii Interprofessional Education (HIPE) at the UH Health Professions schools;
3. Participate in a Team Simulation activity;
4. Evaluation and Future Directions

Brief Description of Session:
Faculty representing the Hawai‘i Interprofessional Education (HIPE) working group will provide an update on current and future IPE activities at the University of Hawai‘i, and will conduct a team simulation activity.

Target Audience: All health professionals and health professions students
Session II

2:00 pm – 3:30pm
MEB 301

**Best Practices to Identify and Support Academically At-Risk Learners: Developing Hawai‘i’s Healthcare Workforce**

Leona Anthony, B.A.
   Director of Student Services, Advisor and Lecturer, School of Ocean and Earth Science and Technology
Sharleen Chock, Ph.D.
   Learning Specialist, ‘Imi Ho‘ōla Post-Baccalaureate Program, Department of Native Hawaiian Health and Office of Student Affairs, JABSOM
Sheri M. Gon, M.P.H., M.L.S. (ASCP)CM
   Instructor, Department of Medical Technology, JABSOM
Mari Ono, M.S.W., L.S.W.
   Director of Student Services, Myron B. Thompson School of Social Work
Megan Terawaki, M.Ed.
   Academic Advisor, Mānoa Advising Center, Office of Undergraduate Education, UH Mānoa

**Learning Objectives:**
1. Identify common categorical areas for struggling students
2. Discuss early identification and prevention strategies
3. Examine theoretical frameworks to explain student departure
4. Discuss best practices and models to identify and support at-risk students

**Brief Description of Session:**
This diverse panel representing different programs throughout UH-Mānoa will share their best practices and models currently being used to identify and support academically at-risk students. The panel will provide insight on early intervention and prevention strategies. Discussion will also include providing perspectives as related to various health, science and social welfare programs.

**Target Audience:** Educators and advisors who work with health profession students
Session II

2:00 pm – 3:30pm
MEB 304

Teaching and Evaluating Professionalism

Lisa Taniguchi, Au.D. - moderator
   Clinical Manager/Coordinator, Department of Communication Sciences and Disorders, JABSOM
Marcel D’Eon, Ph.D.
   Professor, University of Saskatchewan
Jocelyn Lockyer, Ph.D.
   Professor, University of Calgary
Shari Goo-Yoshino, M.S.
   Instructor, Department of Communication Sciences and Disorders, JABSOM

Learning Objectives:
By the end of this session, attendees should be able to:
1. Outline how professionalism is assessed using the Multisource Feedback (MSF) questionnaire.
2. Describe how MSF developed and evolved in Canada for practicing physicians.
3. Identify strategies to develop student clinician professionalism inventory with faculty engagement.

Brief Description of Session:
This session will offer two short presentations discussing experiences in regards to assessing professionalism of health professionals. Speakers will be covering the development of the MSF for physicians, how MSF evolved in Canada, and the process of developing and implementing an inventory to assess student clinician professionalism.

Target Audience:
The content of this session is targeted towards educators from across all health professions who participate in the assessment of clinical professionalism.
Session II

2:00 pm – 3:30pm
MEB 314

Communicating with(out) Difficulty: Colleagues, Patients, Families

Lee Buenconsejo-Lum, M.D.
Designated Institutional Official (DIO) and GME Director, Office of the Dean, JABSOM
Beth Eifert, M.Ed.
Learning and Development Consultant, University Health Partners of Hawaii
Holly Olson, M.D.
Deputy DIO, Office of the Dean, JABSOM
Barbara Ward, M.S., CCC-SLP
Clinical Supervisor, Department of Communication Sciences and Disorders, JABSOM

Learning Objectives:
Upon conclusion of this session, the participant will be able to:
1. Describe critical elements and skills required to be “emotionally intelligent” in communications with colleagues, learners, patients and families
2. Identify their preferred communication style
3. Given a particular scenario, distinguish when it is appropriate or not appropriate to utilize their innate communication tendencies
4. Share approaches to a variety of real or mock communication challenges in the educational environment

Brief Description of Session:
This interactive 90-minute session will include an overview of Emotional Intelligence, a brief DISC personality assessment and some basic communication principals and strategies that can be widely applied to learning and patient care settings. Participants will leave with immediately applicable approaches to remedy or prevent communication challenges that can occur with colleagues, supervisors, patients and their families.

Target Audience:
Faculty, course or program directors who might be developing curricula to enhance interpersonal skills/communication competencies, faculty/mentors who may be counseling learners with communication challenges.
Session III

3:40-4:40 pm
MEB 301

Evaluating the Effectiveness of Educational Programs

Richard Kasuya, M.D., M.S.Ed. - moderator
Professor, Office of Medical Education, JABSOM
Michael Hosokawa, Ed.D.
Senior Associate Dean for Education and Faculty Development, University of Missouri
Amy Lower, M.S., C.C.C.-S.L.P.
Educational Coordinator, Department of Communication Sciences and Disorders, JABSOM
Susan Steinemann, M.D.
Clerkship Director, Department of Surgery, JABSOM

Learning Objectives:
By the end of this session, attendees should be able to:
1. Outline a scholarly process for evaluating educational innovations.
2. Describe a continuous quality improvement model for tracking LCME accreditation standards.
3. Discuss strategies for engaging faculty in the curriculum review process.

Brief Description of Session:
This session will offer three short presentations highlighting interesting perspectives and experiences related to evaluating educational programs. Speakers will be covering approaches to evaluating the effectiveness of new educational interventions, a model to monitor medical school accreditation standards, and a curriculum map review process using weighted student learning outcomes.

Target Audience:
Educators from across the continuum of health professions. Experiences and perspectives should be relevant to educators in all professions and who work with all levels of trainees.
Session III

3:40-4:40 pm
MEB 304

Inoculating Against Burnout by Hardwiring Resiliency

Todd B. Seto, M.D., M.P.H.
  Associate Professor, Department of Medicine, JABSOM
Shilpa J. Patel, M.D.
  Associate Professor, Department of Pediatrics, JABSOM

Learning Objectives:
1. Articulate the epidemic of healthcare provider burnout
2. Recognize signs of burnout in colleagues
3. Identify methods to build resiliency amongst healthcare providers

Brief Description of Session:
This interactive session will discuss various programs that develop the knowledge, skills, and attitudes to build resiliency within healthcare settings.

Target Audience: Open to anyone who is interested.
Session III

3:40-4:40 pm
MEB 314

High Quality Trainee Feedback: What and How?

Dennis Bolger, M.D., M.P.H., F.A.C.P., F.H.M.
   Assistant Professor and Associate Program Director, UH Internal Medicine Residency Program
   and Department of Medicine, JABSOM
   Director of Hospitalist Medicine Education, Queen’s Medical Center
Christina Chong, M.D.
   Assistant Clinical Professor, Department of Medicine, JABSOM
Jennifer Di Rocco, D.O., M.Ed.
   Assistant Professor and Associate Program Director, UH Pediatrics Residency Program and
   Department of Pediatrics, JABSOM
Sandra Loo, M.D.
   Assistant Professor, Department of Medicine, JABSOM

Learning Objectives:
By the end of this session, participants will be able to:
1. Define different types of feedback
2. Verbalize effective techniques for both immediate and global feedback
3. Define elements of high quality feedback

Brief Description of Session:
This one-hour session will be an interactive session focusing on defining and delivering high quality feedback across clinical scenarios.

Target Audience: Medical educators with emphasis on clinician-educators
Poster Abstracts
Abstract #1

Supervision via Text: Enhanced Connection or Technologic Distraction

Amanda O’Kelly, M.D.

Introduction: In today’s society, the pace of technological development promotes rapid changes in healthcare delivery and shapes the expectations and preferences of learners. Across the nation, telemedicine has been utilized to provide remote access to medical care for patients in rural or underserved areas. The University of Hawaii's School of Medicine, Department of Psychiatry has been able to involve child psychiatry fellows in providing both telepsychiatry and in-person psychiatric care to neighbor island children and their families for over a decade. Supervision and feedback methods for trainees has varied with the location of the participants and nature of patient encounters, ranging from real-time to delayed feedback, and remote to in-person supervision of sessions. Over the past 3 years, the practice has evolved to incorporate remote supervision of psychiatry trainees in real-time utilizing a combination of text messaging/phone calls and secure videoteleconferencing (VTC). As this mode of supervision is relatively new and unstudied, learners’ feedback was sought to determine the perceived effectiveness and desirability of supervision via text and VTC, as well as to further elucidate the potential benefits and drawbacks of such models of supervision.

Methods: 11 psychiatry fellows who received supervision via text, phone or VTC were queried to evaluate these new models of supervision.

Results: Overall, learner feedback has been positive, with most fellows expressing the benefits of real-time remote supervision via text/VTC outweigh any negative aspects. As fellows vary in their degree of comfort with technology and their expectations of supervision and feedback, some learners felt more comfortable and expressed stronger preference for receiving feedback via text then others, especially as it relates to integration with their patient encounters. Fellows noted benefits associated with the ability for text and VTC supervision to provide real-time feedback that informs or improves care delivery while preserving flow of the patient session and promoting fellow autonomy and clinical growth. Potential drawbacks noted include the necessity of avoiding PHI in non-secure communications and possibility of disruption to patient encounters. Implications: Our experience suggests that feedback in medical education can be successfully delivered to advanced trainees in real-time with remote supervision via text and VTC, with potential benefits for both learners and patient care delivery, leveraging technology to best utilize resources.

Key Words/Phrases:
Giving Feedback
Technology in Medical Education
Evaluating Learners
Abstract #2

ECHO Hawai‘i: Empowering Providers with Case Based Distance Learning and Support

Aida Wen, M.D., Kelley Withy, M.D., Ph.D., Pia Lorenzo, M.D., Winnie Suen, M.D., Norine Wong, M.S.W., Mary Gadam, R.N., Chad Kawakami, Pharm.D., Michiko Inaba, M.D.

Background: Hawaii has a shortage of healthcare workers specializing in behavioral health and geriatrics. These issues are felt most acutely in rural areas, where there will never be enough geriatricians or behavioral health specialists available. Therefore, we started Project ECHO (Extension for Community Healthcare Outcomes), which is a collaborative model of medical education and care management that empowers healthcare workers with distance education.

Methods: The AHEC (Area Health Education Center) established the ECHO Hawaii project in January 2016, beginning with Behavioral Health, which runs weekly on Tuesdays from noon to 1pm. Geriatrics sessions began in Aug 2016, and runs monthly, every second Wednesday from 4-5 pm. ECHO uses distance technology to provide free CME content, access to interdisciplinary resources, and the opportunity for case discussions, discussions, as well as an ongoing community of learning. Trainers include an interdisciplinary team of healthcare professionals.

Results: As of Dec 2017, ECHO Hawaii has provided a total of 63 hours of CME, and has reached 370 individuals. Physician attendance is about 20%, with the majority of the other health professionals being nurses, social workers, or mental health professionals. The average attendance per session was n=25.6 (BH) and n=12.3 (Geri). We have had participants from neighbor islands (n=40), Pacific Islands (n=40), as well as from the mainland United States (n=11). Based on Likert scale ratings with 1-poor, 5 excellent, participants rated overall satisfaction highly (BH= 3.92 average score; Geri = average score 4.42), and rated the effectiveness at helping providers give better care for patients (BH= average score 4.15; Geri= average score 4.38). Participants also describe feeling more connected to community resources and enjoyed virtual networking opportunities.

Conclusion: ECHO Hawaii is an effective and convenient way to support providers with knowledge, skills, and resources in Behavioral Health and Geriatrics. Future directions include considering other topics, and strategies to support Hawaii’s primary care providers. Ongoing evaluation of outcomes are also being developed.

Key Words/Phrases:
Distance Learning
Case Based
Behavioral Health and Geriatrics
Abstract #3

Development and Evaluation of a Quality Assurance and Process Improvement (QAPI) Curriculum Using the INTERACT Program

Aida Wen, M.D., Cody Takenaka, M.D., Said Hasib Sana, M.D., Peter Fish, M.D., James Templeman, M.D., Ishrat Jahan, M.D., Angel Kirkham, M.D., Eleanor Hastings, M.D., Seabrook Mow, M.D., Kamal Masaki, M.D.

Introduction: INTERACT (Interventions to Reduce Acute Care Transfers) is a publicly available quality improvement program that includes clinical and educational tools to manage acute changes in patients in long-term care facilities. In 2016-17, we designed a QAPI curriculum for Geriatric Medicine Fellows and Nursing Home (NH) Staff, focused on training NH staff to assess patients and communicate better with physicians.

Methods: The curriculum had 3 components: 1) A four-hour introductory QAPI seminar for NH staff and Geriatric Medicine Fellows; 2) Fellows provided monthly staff in-services on common medical conditions and using the SBAR (Situation, Background, Assessment, Recommendation) technique for communication, with the INTERACT program; and 3) Fellows monitored weekend on-call logs for quality of communication and SBAR use. All components of the curriculum were evaluated. Knowledge questionnaires and Inter-Professional Collaborative Practice Core Competencies (12 questions on attitudes and skills) were completed by fellows and NH staff before and after the introductory QAPI seminar. For the monthly in-services, pre-post questionnaires were done by NH staff about level of comfort in managing conditions using SBAR. Weekend on-call logs were monitored for quality of communication and use of SBAR. We evaluated pre-post differences in scores and percent use of SBAR before and after curriculum implementation.

Results: Seven Geriatric Medicine Fellows and five NH staff participated in the introductory QAPI seminar. Total knowledge scores (range 0-5) increased significantly after participating in the seminar (2.25 vs. 3.50, p=0.01). Similarly, mean scores on the IPEC competencies increased after participating (4.23 to 4.52, p=0.008). SBAR in-services were attended by 128 trainees, and 112 completed pre-post questionnaires which showed significant improvements in all questions. Overall mean score increased from 3.44 to 4.11 after the in-services, p<0.0001. Weekend on-call logs showed nurses’ use of SBAR increased significantly after in-services, from 26.2% in November 2016 (before in-services), to 47.5% in December 2016, 59.0% in January 2017, and 61.1% in February 2017 (p for trend <0.0001).

Conclusions: We were able to successfully implement a QAPI curriculum using the INTERACT program. Participants in the curriculum demonstrated significant increases in knowledge and use of the SBAR technique. Previous studies have found that proper use of SBAR has been associated with reductions in hospital re-admissions. We plan to review the impact of our curriculum on hospital re-admissions next year.

Key Words/Phrases:
Geriatric Education in Nursing Homes
SBAR
Interact Program
Abstract #4

Development and Evaluation of a “Geri-Lab” Experience for Medical Students at the University Of Hawaii

Samina Ahsan, M.D., James Templeman, M.D., Vanessa Wong, M.D., Aida Wen, M.D., Karen Lubimir, M.D., Kamal Masaki, M.D.

Background: The John A. Burns School of Medicine at the University of Hawaii has a problem-based learning (PBL) curriculum. Second year medical students have a “Life Cycle” unit, from pre-natal to geriatrics and end of life. The Department of Geriatric Medicine provides geriatrics PBL paper cases, a lecture series, a workshop taught by an interdisciplinary panel, and two half days of clinical skills experiences. In 2016-17, we developed, taught and evaluated a half day “Geri-Lab” experience.

Methods: The Geri-Lab experience was 3 hours, including evaluations. First, three 10-minute mini-lectures were given by Geriatric Medicine Fellows, on Functional Status, Cognition and Depression. Then students met in small groups for hands-on experiences, with 10 students and 1 Geriatric Medicine Fellow. The fellow presented a case on a geriatrics patient who fell, was hospitalized and needed rehabilitation. Tied to the case, 4 workshop topics included: Mood; Cognition; Functional Status; and Interdisciplinary Team Care. The workshops were interactive, allowing students to practice screening tools on each other. The last hour was spent debriefing with all students, with 1 student from each small group presenting 2 key learning points and what they liked best. One week following the Geri-Lab, students participated in a 3-hour clinical skills session where they utilized some of the skills taught in the Geri-Lab by interviewing an older patient in pairs, and discussing issues in small groups facilitated by Geriatric Medicine Fellows.

Results: We analyzed data from a total of 68 second year medical students. Evaluation included 7 knowledge questions before and after the Geri-Lab, and a retrospective pre-post self-assessment of attitudes and skills at the end of the clinical skills session, using a 5 point Likert scale. We found statistically significant differences in knowledge scores in 4 of the 7 questions. Total knowledge score increased from 4.51 to 6.27, p<0.0001. Self-assessed attitudes and skills significantly improved in all 7 domains, all p<0.0001. A summary skills score was 3.69 before and 4.52 after the experience, p<0.0001.

Conclusions: This hands-on educational experience was very well received by second year medical students, and significantly improved their knowledge, attitudes and skills about geriatric issues. Future plans may include converting the Geri-Lab into an interprofessional education experience and including students from the School of Nursing and other healthcare professions students.

Key Words/Phrases:
Hands-On Workshop
Geriatric Education
Pre-clerkship Medical Students
Abstract #5

UH JABSOM Medical Students Assist in TB Control in the Marshall Islands

Nash A.K. Witten, M.D.; Yusuke Kobayashi, M.D., Seiji Yamada, M.D., M.P.H.

Ebeye, an island in The Republic of the Marshall Islands (RMI), has the third highest burden of Tuberculosis (TB) in the Pacific, 299 average cases per year vs. 3 average cases per year in the United States. Between November 2016 and April 2017, a novel joint venture between the RMI Ministry of Health, CDC, WHO, and PIHOA, entitled “TB Free Ebeye” sought to lower the burden of tuberculosis (TB) by 30% and subsequently focus on TB prevention on Ebeye. During phase I of the project, Ebeye residents underwent registration and biometric data collection. In spring 2017, two fourth year medical students and one UH JABSOM professor assisted in phase II of the project, assisting with non-communicable disease and TB screening. The fourth year UH JABSOM medical students and professor participated in all aspects of phase II. Phase III of the project involved TB treatment, active case finding, program development, and non-communicable disease management. Over 5,100 people were screened during phase II of this project. Due to the success of the novel “TB Free Ebeye” project, a “TB+Leprosy-Free Majuro” project will be conducted in 2018; hopefully with UH JABSOM medical students and faculty involvement once again.

Key Words/Phrases:
Undergraduate Medical Education
Fourth Year Medical Student Elective
International Medical Student Elective
Abstract #6

Augmented Reality Presentation of Anatomical Variations

Trudy Hong, M.D., Kaori Tamura, Ph.D., A.T.C., Jesse Thompson, B.A., Beth Lozanoff, B.Sc., C.M.I, Steve Labrash, C.F.S.P., Takashi Matsui, M.D., Ph.D., Jennifer King, D.O., Scott Lozanoff, Ph.D.

Introduction: Recognition of anatomical variations is critical for proper diagnosis and management. Although the literature provides detailed descriptions and images, structures and mechanisms are still often difficult to conceptualize. Augmented reality (AR) is a novel visualization tool that could enable effective understanding of variations. Here we use AR to present aberrant right subclavian arteries (ARSA), and assess its usefulness within the context of anatomy education within the medical school curriculum.

Methods: Two ARSA’s were identified during routine dissections and quantitative characterization was performed. A plastinated heart was created and subjected to photogrammetry. Utilizing quantitative features of dissected specimens, ARSA was modeled and viewed within 3D space. An animation of its embryological mechanism was also created. The goal of this study was to assess the usefulness of this animation and AR for learning ARSA. First year medical students (N=125) participated in the online activity (including pre- and post-tests) utilizing text, images and a 3D SketchFab (www.sketchfab.com) model to learn ARSA, and either text or narrated animation for its embryological mechanism. Students then completed a quiz and perception survey based on traditional resources alone or after visualization of the ARSA hologram as well. Comparisons were analyzed using paired sample t-tests with p <.05 as the level of statistical significance.

Results: Groups performed similarly on the typical structures quiz (86.67% and 85.13%) and ARSA pre-test (51.67% and 52.92%). Post-test scores improved overall, and although the group with animation scored better, difference was not statistically significant (82.2%, compared to 76.7% (text), (NS)). Students found the SketchFab model to be helpful for learning ARSA, rating it as 4.4/5 (1: Not helpful; 5: Very helpful). For the embryological mechanism, 90% found the narrated animation more helpful than text. Regarding AR, both groups scored similarly, 76.3% (no AR) and 83.2% (with AR) (NS). Students viewed AR favorably, rating its helpfulness as 4.3/5 and ranked resources for learning ARSA from most to least helpful as follows (most common): 1) AR tool, 2) QuickTime, 3) SketchFab model, 4) Text (p<0.01).

Conclusion: Augmented reality, alongside traditional resources, is a promising tool that could facilitate better understanding and retention of anatomical variations. In the classroom, AR could also be used for teaching complex anatomy concepts. In clinical practice it may be useful for patient education and could serve as a more time-efficient and cost-effective way to plan complex surgical cases compared to current 3D-printing of models. Work is being directed at developing 3D AR models from actual medical scans (of ARSA and complex pediatric surgical cases) and at developing tools to further assess usefulness of AR.

Key Words/Phrases:
Augmented Reality
Anatomical Variants, Pediatric Surgical Conditions
Medical Education
Abstract #7

Efficiency of Task Switching and Multi-tasking: Observations of Pediatric Resident Behaviors when Managing Interruptions in Daily Workflow


Background: Residents need to demonstrate competence in prioritizing patient care through safe management of multiple competing tasks and interruptions in daily workflow. Characterizing interruptions and identifying variables that correlate with efficiency in their management may assist those who struggle with this skill set.

Objectives: To observe and characterize interruptions in resident workflow, to measure how efficiently these interruptions are managed and to identify variables associated with efficiency.

Methods: 18 pediatric residents were individually and directly observed for a goal of 4 total hours while working in the ED or on the Wards by a trained observer using an electronic time-motion tool. All participants completed pre-and post-observation surveys, the VARK (Visual-Aural-Read/Write-Kinesthetic) Learning Style Inventory and the Multi-Tasking Assessment Test (MTAT).

Results: 68.6 observed hours (average of 3.7 hours/resident) included 374 interruptions, defined as any external event drawing the resident’s attention away from a primary task. Residents were interrupted an average of 5.7 times per hour. The average time to resume a primary task following an interruption (resumption time) was 1.8 minutes, with the primary task not resumed 11.2% of the time. Those with efficient MTAT scores (adjusted for intern status and sex) had lower resumption times following interruptions (p=0.01).

Conclusions: Workflow interruptions are common in pediatrics; learning to mitigate and manage these interruptions through effective task-switching is critical. A preceding ability to multitask (as measured by the MTAT score) improved resumption time. No significant association was found with sleep, wellness, learning style or mental strain.

Key Words/Phrases:
Efficiency and Workflow
Time Management
Clinical Skills
Abstract #8

Utilizing a Structured Morning Report Curriculum to Supplement and Optimize Resident Education in Military Psychiatry

Joseph Dragonetti, M.D. and Judy Kovell, M.D.

Introduction: Most residencies host a morning meeting that incorporates patient handoff and/or educational material. This meeting serves as a forum for dealing with administrative, clinical and educational matters. Some residencies choose to focus education sessions on case-based patient care discussions. Other residencies include didactic sessions as well, but often the didactics lack a cohesive structure that links one lecture to another. Here we describe an approach to organizing the morning report curriculum that includes multiple sub-curricula in order to add an underlying element of organization and connectedness to the lectures presented throughout the academic year(s).

Methods: The lectures and curricula are designed to build off of one another. Proper coordination then facilitates an evolving two-year cycle of lectures that allows for repetition of important subjects but guards against unnecessary redundancy. The program’s evaluation committee suggests topics based on appraisal of the residency’s overall curriculum and what areas for improvement need addressing. Sub-curricula described include neurosciences, genetics, military medicine, ethics, psychiatry cases, advances in psychiatry, residents as teachers, journal article reviews, clinical practice guidelines, wellness, addiction, current issues in social psychiatry, group theories and therapy, and in-training examination review. These sessions are designed to be taught by both residents and faculty, with residents taking responsibility for the majority of lectures.

Results: Taking into account other obligations that may take place during the morning report time slot, roughly 125 morning lectures will take place during a single academic year. Our program’s implementation of this curricular structure has been undertaken to increasing degrees over the previous two years. It has facilitated scheduling and preparing lectures far in advance, which eases the logistical burden on lecturers. Various hurdles have been encountered such as last minute scheduling changes and difficulty with incorporating new topics that may not fit into a specific sub-curriculum. On the whole, residents and faculty have engaged and responded well to this new system of education. There remains considerable room for refining the sub-curricula and the lectures therein to create an impactful and sustainable platform for educating residents.

Conclusions: Utilization of a curriculum-based organization structure for morning lectures facilitates cohesiveness among lectures and the progressive mastery in specific topics. Furthermore, resident involvement in this coordinated educational effort helps to facilitate the progression of residents along the spectrum of teaching, moving progressively through the steps of 1) assisting with lecture delivery, 2) independently teaching, 3) creating new lectures, 4) assessing the learning needs of residents, and 5) developing curricula. This progression mirrors and builds upon the development of teaching abilities as outlined in the ACGME Milestones for Psychiatry Residents.

Key Words/Phrases: Graduate Medical Education Curriculum Development Military Psychiatry
Abstract #9

A Five-Part Division of Military Psychiatry Chief Resident Responsibilities

Joseph Dragonetti, M.D., Michael Yang, D.O., Antoinette Lenton, M.D., Vanessa Ragukonis, D.O., Judy Kovell, M.D.

Introduction: The chief resident has traditionally been assigned to one individual for the duration of one whole academic year. As more requisite duties have been identified, the role of the chief resident has begun to be dispersed among multiple senior residents. However, there is little described about a team-based approach to designating responsibilities with each chief resident assigned to a specialized set of tasks.

Methods: The current chief resident roster has switched from two fourth-year psychiatry residents to five residents in the specialized roles of: executive, education, research, wellness, and technology chiefs. A weekly supervision meeting of the chief residents with the program director has been scheduled at a regular time to ensure communication and teamwork. The intention of this organization is to decrease the burden of work upon each chief resident and allow for optimal involvement of upper residents in both the function of the residency as a whole and the supervision of junior residents.

Results: To date, the five-part structure of chief resident roles has had a positive impact on the function of the residency as a whole while spreading workload between multiple residents. Two of the chief residents have taken 12-week maternity leave during this academic year, this being a unique challenge leaving the other chiefs to cover for their colleagues’ responsibilities. The education chief resident has assumed the responsibility for his stated position in addition to that of the executive chief resident. The technology chief resident has also taken on the responsibilities of the wellness chief resident. The team-based framework of the chief residents has allowed for easy coverage of responsibilities.

Conclusion: The chief residents have provided feedback, feeling that the scope of their duties and responsibilities were appropriately delineated. The compartmentalization has made their administrative workload more manageable compared to if they had undertaken more of the chief resident’s duties on their own and appears to have decreased the burden and burnout experienced by previous chief residents. Concerns about this type of leadership structure that are being monitored for include overlapping responsibilities and the lack of a single, defined leader for the residency. We also acknowledge that the size of residency classes may limit the implementation of this approach. However, such structures have already long been utilized in business and military organizations, and thus, other programs in health profession education and training may benefit from this division of leadership roles.

Key Words/Phrases:
Leadership
Military Psychiatry
Graduate Medical Education
Abstract 

Emergency Physician Workforce Assessment for the Hawaiian Islands

Gregory Suares, M.D., Justin Padron, B.S., Takashi Nakamura, M.D.

Background: The physician workforce shortage in the State of Hawaii has been well described. In the most recent report to the legislature, The Hawai‘i Medical Education Council (HMEC) identified emergency medicine as having one of the largest shortages of full time equivalents for the County of Maui. Our study provides additional details regarding the current emergency medicine workforce throughout the Hawaiian Islands.

Objectives: The primary objective was to determine the current number of full-time board certified/eligible emergency medicine physicians in the State of Hawaii. Our secondary objective was to determine if this number of full time board certified/eligible emergency physicians adequately met the current and projected patient volumes.

Methods: We created a survey to define the workforce characteristics of physician groups that staff the emergency departments in the State of Hawaii. We gathered information regarding the number of emergency departments each group covers, the number of full-time emergency physicians, the number of part-time emergency physicians, the board certified/eligible status of these physicians, the number of advanced practice providers, the number of locums physicians, and the number of clinical hours staffed. Information regarding patient volume was obtained from the Department of Health.

Results: Surveys were collected from 10 groups. No data was available from Maui County. We found that there are 196 full-time board certified/eligible physicians currently working. For the sites where patient volumes were available, it was determined that full-time board certified/eligible physicians provide 222,330 hours of clinical coverage. When adjusted for patient volume, physicians would therefore be required to see an average of 2.1 patients-per-hour.

Discussion: Our data demonstrates that the current supply/demand of full-time board certified/eligible physicians is not sustainable, even when excluding Maui County (which has already been identified as having a shortage). Using patients-per-hour as an indicator of supply/demand, the current workforce is dangerously close to exceeding commonly accepted standards regarding patient load and safety. Given the projected patient volume increase, it is clear that a more robust supply of full-time board certified/eligible physicians will be needed in the immediate future. One possible avenue would be to create and fund an emergency medicine residency program in the State of Hawaii.

Key Words/Phrases: Workforce Assessment, Emergency Medicine, Residency Training
Abstract #11

Infection Control Proximity Sensor Contact Tracing:
A Simulated Pediatric Healthcare Setting

Benjamin Berg, M.D. and Stuart T.F. Huang, M.S.E.E., J.D.

Background: Contact tracing to assess and manage infection transmission in hospitals is costly, and inefficient. We sought to evaluate accuracy of a novel contact detection method in a educational simulation facility (SimTiki) simulating a busy hospital environment. The methodology is hypothesized to accurately detect and record human-human and human-fomite contacts. Potential applications of an accurate system include prospective tracking of contacts in areas of potential contagion, and for teaching of patient and staff isolation techniques to healthcare students, using simulation.

Methods: We simulated a hospital patient care setting to assess accuracy of contact detection strategy, using proximity detection sensors (“tags”) with Wi-Fi & Bluetooth which simultaneously transmit and detect signals from tags in physical proximity. Participants in roles of healthcare workers and “visitors” wearing tags moved throughout the simulated hospital, according to movement scripts based on healthcare worker time in motion studies. Infectious patients and fomites, were represented by tags in static locations in a variety of simulated hospital locations, e.g. hospital rooms and nursing stations. Pair-wise “contact events” were recorded by sensors and evaluated for accuracy and for discrimination of “touch” and “droplet” range contact during two 30-minute scripted movement scenarios involving multiple participants and fomites. Number and type of contacts detected by tags were compared to the actual “gold standard” contacts as determined by movement scripts to determine accuracy of this novel contact detection method.

Results: We found sensitivity of 0.99, specificity of 0.90, PPV 0.94, and NPV of 0.98 for identification of scripted contacts. Cumulative exposure times were calculated for both droplet and touch range contact events.

Conclusions: Results validate the accuracy of wearable sensors to track healthcare worker contacts in a simulated contagious healthcare setting. Application of this methodology to optimize surveillance and detection of contacts during disease outbreak warrants additional research. The methodology utilized may be integrated to enhance infection control curriculum for undergraduate and post-graduate healthcare.

Key Words/Phrases:
Simulation
Infection Control
Wearable Technology
Abstract #12

Validation of CPR Ventilation Quality Measurements in SimMan3G

Jinseong Cho, M.D., Ph.D., Kristine M. Hara, B.A.S., Junseok Seo, M.D., Benjamin Berg, M.D.

Introduction: Quality of CPR (QCPR) correlates with improved cardiac arrest survival. CPR training with automated accurate assessment of CPR quality is used for both formative and summative/certification elements of the AHA ACLS program. SimMan3G (Laerdal Medical) is a commercial simulator which provides automated measurement of QCPR metrics; compression rate and depth, and ventilation rate and volume. QCPR optimal ventilation volume is 400-700cc. We sought to assess accuracy of SimMan3G QCPR measurement of tidal volume during endotracheal tube bag ventilation.

Methods: QCPR accuracy of SimMan3G ventilation rate and volume was measured by providing 10 breaths/min for 3min at volumes of 400,500,600, and 700cc, and flow rates of 20,40,60, and 80L/min for each tidal volume with a calibrated PB™ 840 ventilator. Two data collection protocols were completed for each of 2 different 3G devices. Using ANOVA we compared ventilator delivered volumes from all breaths and all flow rates with simulator sensed/recorded tidal volume.

Results: A total of 1,263 ventilator breaths were analyzed. We found no significant difference between 3G measured breath volumes delivered at widely varying ventilator tidal volumes (P=0.986). Significant differences were detected between 3G measured breath volume and delivered flow rate (<.001).

Conclusions: QCPR tidal volume measurement SimMan3G reflects inspiratory flow rate; a parameter related to the force and duration of ventilation bag compression. 3G QCPR tidal volume display does not accurately represent tidal volume across the breadth of bag compression techniques which may be used during CPR training. Our findings limit the utility of 3G tidal volume measurement for QCPR formative feedback or deliberate practice educational strategies.

Key Words/Phrases:
Simulation
CPR Feedback
Ventilation
Abstract #13

Novel use of T-NOTECHS to Assess In-Situ Pediatric Trauma Team Training

Jannet Lee-Jayaram, M.D., Susan Steinemann, M.D., Elizabeth Ferreira, MS4, Jack Branston, MS4, Eunjung Lim, Ph.D., Kristine Hara, B.A.S., Benjamin Berg, M.D.

Background: Trauma is a leading cause of death and disability for children. Preventable trauma deaths occur even in mature trauma systems, with a third of errors occurring during the initial resuscitation in the ED. Training to optimize teamwork may help prevent lapses in teamwork that are postulated to be a major source of error. Central to the training is the ability to accurately assess and provide feedback about teamwork. Trauma Team Non-technical Skills (T-NOTECHS) was designed to evaluate teamwork and provide formative feedback to adult trauma teams and has been validated in reports of adult trauma team training, but has not yet been validated for pediatric trauma team assessment.

Methods: The protocol was reviewed and approved by the Hawaii Pacific Health IRB. Emergency physicians, pediatric surgeons, critical care and emergency nurses, respiratory therapists, and clinical assistants affiliated with the trauma team at an urban, pediatric trauma center participated in the program. The curriculum consisted of a brief didactic followed by in-situ team performance during three clinical simulation scenarios using a programmable human patient simulator with video recording, and facilitator-moderated debriefings following each scenario. The scenario order of sequence was randomized. The 6 training sessions were completed and simulation videos were archived at the simulation center. We trained teamwork experts not involved in the trauma training on the use of T-NOTECHS. The raters independently viewed all the simulation videos in a randomized order and assigned T-NOTECHS scores.

Results: T-NOTECHS is composed of five behavioral domains: leadership, cooperation/resource management, communication/interaction, assessment/decision making, and situation awareness/coping with stress; each rated on a scale of 1 (no teamwork) to 5 (flawless). An analytical evaluation of the reliability of the T-NOTECHS assessment tool for pediatrics demonstrated an intraclass correlation coefficient (ICC) of 0.79 for training sessions 1, 4 and 6. Further analysis of the videos is required to evaluate reasons behind the low ICC of 0.265 when all 6 training sessions were included. Analysis of variance on T-NOTECHS scores demonstrated no improvement in teamwork performance over the 3 scenarios but instead demonstrated that a specific scenario on hemorrhagic shock tended to have the lowest scores, regardless of the order. Upon review, we surmised that this scenario had unique disrupters, including surgical decision-making and equipment that was not common to the other scenarios.

Conclusions: T-NOTECHS is applicable to use for the assessment of pediatric trauma teams as it is for adult trauma teams. Technical factors, teaching team composition, participant factors affect even expert raters ability to use T-NOTECHS. Scenario design factors should be considered carefully as they may have inadvertent effects of the level of difficulty and thus team performance.

Key Words/Phrases:
In-situ Simulation
Team-training
Assessment Tool
Abstract #14

A Makeover Story: Utilization of the Pediatric Clerkship Simulation Course to Assess Entrustable Professional Activity (EPA) 10

Barry Mizuo, M.D., Kyra Len, M.D., Jannet Lee-Jayaram, M.D., Len Tanaka, M.D., Cheryl Okado, M.D.

Introduction: The AAMC has developed 13 core entrustable professional activities (EPA) expected of all medical students prior to graduation. EPA 10 involves recognition of a patient requiring urgent or emergent care and initiation of evaluation and management. Some institutions have begun to publish how they have utilized simulation to assess EPA 10 in their students. The purpose of this project was to “makeover” the current third year pediatric simulation course and to develop a new set of simulation scenarios that could successfully assess student competency with EPA 10.

Methods: Five new pediatric case scenarios were developed as part of the makeover process. To help in the assessment of EPA 10, objectives were standardized between scenarios and aligned with EPA 10 expectations. An action checklist was also created to help facilitators keep track of whether students were fulfilling the objectives of the scenario. A maximum of 5 students were paired with one simulation facilitator with the role of team leader rotated amongst the students. A maximum of 7 minutes was allotted for each case scenario. A scenario could stop early if a critical intervention thought to be essential in the care of the patient was executed. Debriefing was then immediately conducted by the facilitator with the students after each case scenario was completed. A standard post-course survey was administered to the students after completion of the course. A 5-point Likert scale was used to answer the questions, “How satisfied were you with the training?” and, “The facilitator involved the participants during the debriefing session…”.

Results: A total of 43 third year students have participated in the new EPA simulation course so far this academic year and all were successfully surveyed. In comparison, 88 third year students participated in the prior simulation course over the past two years with only 69 students completing the post-course survey. All students who completed the new EPA simulation course felt the objectives of the course (which were aligned with EPA 10 expectations) were met. In regards to student satisfaction with the new EPA simulation course, an average score of 4.93 was calculated for student responses to the question of “How satisfied were you with the training?” this year in comparison to an average score of 4.45 last year. Average scores for student responses to the question of “The facilitator involved the participants during the debriefing…” also increased from 4.6 over the past two years to 4.95 this year. Though it was initially felt that individual assessment was possible by using a checklist to evaluate the student assigned as the team leader, it was decided early on that this was not a fair assessment.

Conclusion: Incorporation of EPA 10 into our pediatric simulation course has led to promising results so far. Student satisfaction with the new course has increased. The new course may also facilitate the debriefing process based on student feedback. However, this newly developed simulation course is not yet felt to be an appropriate assessment tool to determine whether an individual student is entrustable in regards to EPA 10.

Key Words/Phrases:
Simulation
Entrustable Professional Activities
Clinical Skills
Abstract #15

**Achieving Milestones through an Integrated BootCamp – Preliminary Results**


**Background:** A “boot camp” curriculum of intensive procedural and skills training can help teach medical students clinical skills and procedural techniques1-3. Residency programs have adopted boot camps to teach their residents procedural skills4-6. Our study evaluates a multidisciplinary approach to coordinating a boot camp and a curriculum that focuses on specialty milestones for residency preparation.

**Objectives:** The primary objective was to determine if a boot camp increased student self confidence in residency milestone-related skills. Our secondary objective was to determine if the boot camp could increase students’ knowledge and confidence when obtaining informed consent for a procedure.

**Methods:** We created a school-wide “boot camp” for 4th year medical students to help students become level 1 milestone ready for their matched specialty. All students participated in an informed consent workshop as this is a milestone common to all specialties. Pediatric topics included performing an infant lumbar puncture, writing prescriptions and communicating with families. Students were given an anonymous survey before boot camp (pre), immediately after boot camp (post) and 3 months after starting residency (final). For the third year of this boot camp, knowledge questions and a faculty observed checklist were added to evaluate the informed consent process. Data were analyzed using SAS version 9.4.

**Results:** Surveys were collected from 2015-2017; 162 students completed the pre and immediate post surveys and 48 students provided data at all three points in time (e.g., pre, post, and final). We are currently collecting 3 month post survey data from students who recently graduated. Overall, students improved their confidence level in communicating with families, obtaining consent and determining capacity. The mean level of confidence increased significantly (p at least < .05) from pre to post or pre to final. For all the pediatric specific questions, students' confidence improved from the pre to post survey.

The informed consent workshop improved students' confidence (3.1 before boot camp to 3.7 after boot camp; p<0.05) and knowledge (2.3 multiple choice score before boot camp to 2.63 after boot camp; p<0.05) in consenting patients. Students were able to achieve 92% completion of important variables on the checklist during the informed consent exercise.

**Discussion:** A milestone-driven boot camp improved the students’ confidence levels in milestone-related skills and knowledge of consenting a patient after the boot camp. These skills were retained 3 months into residency. A school wide boot camp is also helpful to improve students’ knowledge of obtaining informed consent for a procedure.

**Key Words/Phrases:**
Milestones
Boot Camp
Informed Consent
Abstract #16

From Student to Intern: Boot Camps as a Teaching Method to Support the Transition to the Psychiatry Residency

Gretchenjan C. Gavero, D.O. and Evan Taniguchi, M.D.

Background: While confidence levels vary by task, the transition from medical student to a resident physician is a significant source of anxiety in the residency transition period. The Accreditation Council for Graduate Medical Education (ACGME) Competencies and Association of American Medical Colleges (AAMC) Core Entrustable Professional Activities (EPAs) describe competency areas that can guide Clerkship and/or Residency Program Directors in designing activities like “boot camps” that can help prepare students feel more prepared, confident, and perform competently in meeting residency milestone competencies.

Objectives: The primary objective of our study was to create a boot camp course specifically for psychiatry residency and to determine if this course could increase medical student self-confidence, knowledge and skills in completing residency milestone-related tasks. This poster also describes one model for psychiatry-specialty boot camp geared for fourth-year medical students who plan to enter psychiatry residency program.

Method: University of Hawaii John A. Burns School of Medicine (UH JABSOM) Psychiatry Department’s boot camp was created in 2015 as a part of a "Senior Seminar week" (a joint project of Clerkship Directors/Clerkship Education Committee). Selected psychiatric topics allowed students to review and practice foundational clinical skills required to meet level 1 milestones in psychiatry training as outlined by the ACGME. The Clerkship Education Committee conducted a formal, IRB-approved study that tracked student feedback and evaluation of their boot camp experience. Students from 2015-2017 received a pre-survey before the first boot camp session, a post-survey at the end of the last session, and a final survey three months into their internship. The survey asked the students to rate their confidence on a Likert scale of 1-5 (1=no confidence and 5=complete confidence) in being prepared to function as an intern, communicating with patients effectively, obtaining informed consent, assessing decision-making capacity. Students who participate in the psychiatry track boot camp were asked to rate their comfort level in various areas of patient care such as: performing the mental status examination, formulating assessment in a bio-psycho-social-cultural format, and evaluating patient safety issues in a psychiatric setting. Data were then analyzed using SAS and through review of student’s comments.

Results: Surveys from a total of 13 psychiatry residency matched-students were collected from 2015-2017; surveys are still pending from students who had most recently graduated in 2017. Students improved their confidence level in all except one measured category (and all psychiatry-specific questions) with a statistically significant increase in confidence scores (p at least < .05) from pre to post-survey. Students did not report a statistically significant increase in confidence in communicating effectively with patients and their families. The largest increases in mean confidence scores were found in comfortability in evaluating safety situations in a psychiatry setting (1.38 increase in mean score, p=0.0019), formulating the psychiatric assessment in the Bio-Psycho-Social-Cultural format (1.00 increase, p=0.0008) and writing prescription orders (increase 1.23, p=0.0016). Overall confidence increased from 3.44 to 4.33 (p=0.0009).

Conclusions: The surveys from the past three years show an overall positive feedback from all students regarding the content of the boot camp curriculum. This suggests that boot camps can be a valuable tool for some students to help ease them into internship year in psychiatry. We are still awaiting results regarding students’ subjective sustained increased confidence three months into residency. Further research will need to be done regarding whether such boot camps may also increase competency ratings for interns and residents by evaluators in their respective programs.

Key Words/Phrases:
Residency Preparation
Boot Camps
ACGME and Milestone Competencies
Abstract #17

Film Clips and Teaching Moments

Gretchenjan C. Gavero, D.O.

Films are commonly used to liven up classrooms and creatively engage students in learning. Charming characters and captivating scenes from films can aid teachers in supplementing medical student and resident training curricula that can sometimes be “tedious and dry.” Psychiatric concepts, in particular, may be difficult to grasp by learners who are new to psychiatry. The use of films in teaching psychiatry is increasingly popular in academic settings. In 2014, Walt Disney Picture’s Big Hero 6 gave us the lovable Baymax, who, in this author’s opinion, may be considered as one effective teacher for medical trainees. Our aim is to illustrate how films can be used in teaching medical students (and residents) using our own experience in the psychiatry third-year clerkship. We used selected teaching moments from the film Big Hero 6 and Baymax’s character as a “personal healthcare companion” and a compassionate, high-tech superhero to supplement teaching milestone-related competencies to third-year medical students in the ambulatory setting. The film provided an effective tool in engaging students in learning about psychiatric concepts as they relate to interpersonal skills, ethics, and professionalism.

Key Words/Phrases:
Flipped Classroom
Film, Technology in Education
Interpersonal Skills, Patient Care
Abstract #18

Patient Narratives: An Interprofessional Education Activity Designed to Help Health Professions Students Better Understand the Patient Experience

Marcel D’Eon, M.Ed, Ph.D., Ulrich Teucher, Ph.D., Doreen Walker, Jodi Thompson, Heather Thiessen

Patient stories have the potential to touch us in many ways and to teach us a great deal about health care practice. At the University of Saskatchewan for close to 10 years we have been hosting Patient Narratives, an interprofessional discussion based forum for listening to, reflecting upon, and engaging with patient stories for health professions students. We have had patient stories in text form and heard former patients and care-givers in person. We have included time for personal reflection, small interprofessional group discussion, large group Q & A and discussion, and faculty commentary. We have hosted together students from several programs: laboratory technologist, medical technologist, medicine, nursing, nutrition, and pharmacy among others from the University of Saskatchewan and Saskatchewan Polytechnic. We offer these sessions seven times a year with an average attendance of about 90. Most students attend as partial requirement for a course. While we have not conducted a formal and systematic evaluation the informal and unsolicited responses and comments from staff, students, and patients have been generally very good. In addition, student comments have demonstrated transformative learning in the areas of empathy, perspective taking, self-care, and communications.

Key Words/Phrases:
Patient Centered Care
Empathy
Perspective Taking
Abstract #19

**Differences of the Perception for the Medical Education Environment between the Medical Schools in Hawaii and Japan**

Hiroaki Matsumoto, M.D.

**Objective:** The purpose of this study is to evaluate the differences of the perception of the medical education environment and the perception of the PBL between medical schools in Hawaii and Japan.

**Methods:** In September 2017, a survey was distributed to 363 medical students via Google Forms. 302 of them were Japanese medical students from 40 medical schools in Japan who participated in the medical education program in University of Hawaii John A. Burns School (JABSOM) from 2012 to 2017. 61 of them were the students of JABSOM who participated in the medical education program in 5 medical schools in Japan from 2012 to 2017. The Dundee Ready Education Environment Measure (DREEM) inventory was used to evaluate the students’ perception of their education environment. 5 questions about their perception for PBL were added to the DREEM survey to assess their perception of PBL.

**Results:** A total of 86 students completed the questionnaire (response rate, 24%). 6 of them were the students of University of Hawaii, 80 of them were the students from 22 medical schools in Japan. The mean DREEM score was 165 (82.5%) for JABSOM students and 117 (58.5%) for Japanese students (P<.0001). The scores of JABSOM and Japanese students for the subscales are, respectively: 39.7 (82.7%) and 27.9 (58.1%) for Learning (P<.0001); 39.5 (90.0%) and 25.5 (60.0%) for Teachers (P<.0001); 25.0 (78.1%) and 19.6 (61.3%) for Academic Self Perception (P=.0039); 39.3 (81.9%) and 27.2 (56.7%) for Atmosphere (P<.001); 22.2 (78.5%) and 17.0 (60.7%) (P=0.0048). The mean score of the perception for PBL was 3.5 (70%) for JABSOM and 1.8 (36%) for Japanese students (P=0.0013). Significant positive correlations were found between DREEM score and better perception for PBL.

**Conclusion:** Students in Hawaii have better perception for their education environment and for their PBL than Japanese students. Our findings suggest that it’s time to review and reconstruct the education environment, especially in PBL, in the medical school in Japan.

**Key Words/Phrases:**
PBL
The Dundee Ready Education Environment Measure (DREEM)
Medical Education in Japan
Longitudinal integrated clerkships (LICs) have become an increasingly popular option for clinical training for medical schools in the U.S. and other countries as well. The number of medical schools utilizing LICs has more than doubled over the last 5 years. The John A. Burns School of Medicine (JABSOM) has offered an LIC during our third year of medical training as an alternative to the traditional department-specific block rotations since 1992.

The goal of the LIC is to provide an integrated learning experience that is community-based, student-directed, and patient-centered. The longitudinal nature of the program ensures that there is continuity with patients both within specialties and between them as well. The longitudinal students spend six months of their third year at a given ambulatory care site where they work in continuity clinics in each of the six clinical disciplines (family medicine, medicine, OB/GYN, pediatrics, psychiatry, and surgery). The other six months are spent completing discipline-specific mini inpatient blocks.

Though not an original goal of the LIC, the program has also expanded its focus to emphasize rural health and primary care. There are currently 11 ambulatory sites throughout the state: 4 neighbor island, 2 urban underserved, 1 rural Oahu, and 4 other sites on Oahu. The program has grown significantly over the last 25 years, starting with 6 students a year to a record-breaking 39 students for this academic year.

A total of 334 students have participated in the JABSOM LIC. Of those that have completed their training, 56% have gone into primary care, 35% are currently working in a rural or underserved community, and 26% are actively involved in academic medicine. We will present other statistics about the program over the last 25 years, comparison data between the LIC and block students, and future directions for the program.

Key Words/Phrases:
Longitudinal Integrated Clerkship
Rural Health
Continuity of Care
Learning Circle: A Teaching Modality Used by the Hawaii H.O.M.E. Project

Kayla Murata, MS2 and Christopher Tokeshi, MS2

The Hawaii H.O.M.E. (Homeless Outreach & Medical Education) Project was established in 2005 to address the health care needs of Hawaii’s homeless population. As a mobile clinic fitted into a single, expandible RV, we serve 7 locations across the island of Oahu, ranging from shelters and churches to parks and sidewalks. The H.O.M.E. Project provides University of Hawaii John A. Burns School of Medicine students and pre-medical volunteers the opportunity to learn about this vulnerable population in the context of clinical training and community health.

The teaching modality of “learning circle” was developed as a way to begin discussion on important issues raised during each clinic and to expand the amount of learning that occurs for the students and volunteers. At the end of every clinic, volunteers, students and attending physicians stand in a huddled circle. A fourth year medical student or attending physician begins by prompting the group to share learning experiences or revelations from their unique patient encounters from that day. Depending on the topic shared, an open discussion follows. An upper-level medical student or attending physician enhances the discussion by sharing clinical wisdom.

Learning circle promotes a safe atmosphere for volunteers and medical students to ask questions, resulting in shared learning which is grounded in actual patient encounters. It allows everyone who is at clinic that day to benefit from the learning that occurs for individual students. There is currently a paucity of data in the literature regarding the use and benefit of learning circles in medical education. We developed a questionnaire to look at how participants of the H.O.M.E. Project learning circles have benefited in respect to their different levels of professional experiences. We will share the results of our survey and quotes from students and volunteers that have participated in the circles.

Key Words/Phrases:
Teaching Modality
Community Health and Engagement
Homelessness
Abstract #22

The Role of Informal Social Studying Among Pre-clinical Medical Students at the John A. Burns School of Medicine

Jayden Galamgam, MS3 and Richard Kasuya, M.D., M.S.Ed.

Problem-based learning (PBL) at the John A. Burns School of Medicine (JABSOM) involves a small-group, composed of both students and a faculty member, led discussion of clinical cases. The PBL environment promotes both team-based and self-directed learning through the discussion of hypotheses, explanations for the clinical findings, and the creation of learning issues (LI) to be presented in future PBL sessions. LIs are topics that need to be further researched to better understand the clinical case. Previous studies have discussed the positive impact of this team-based and social modality through better problem-solving skills, higher USMLE Step 2 scores, and increased retention of material. This begs the question if additional social learning methods such as independent and self-organized peer study groups have added positive benefits in medical education as seen with PBL. A recent review article on informal social learning suggested benefits in student motivation and wellbeing; however, studies further exploring this role are limited.

To define the role of social studying outside of the PBL curriculum, we surveyed first-year medical students at JABSOM following the completion of two consecutive curricular units, MD2 and MD3. The students were surveyed on questions related to group studying such as subjects studied, number of individuals in a group, and duration of study time. The students were also asked to give short answers to questions including study techniques used by the group, opinion on the relative success of the group, challenges that the group faced, and if a study group was not used then why.

A total of 64 and 61 students volunteered to participate in the survey in MD2 and MD3 respectively. The results of the survey demonstrated that of these 64 students in MD2 and 61 students in MD3 surveyed, 75% in MD2 and 77% in MD3 participated in group studying outside of the curriculum. These students utilized group studying the most for covering PBL material, followed by anatomy, lecture, and then pathology. The most common studying techniques employed were quizzing and talking through topics. One commonly reported benefit to groups was “sharing ideas across PBL groups.” Other reported benefits include “combination of knowledge” and “filled knowledge deficits.” Frequently described challenges faced by various groups include staying on task and scheduling conflicts. For the non-social studying students, the reasons include thoughts of decreased efficiency and self-studying being the preferred method. The survey findings may suggest that if used, informal social studying can have a positive impact on a medical student’s education. A better understanding of informal social studying may allow medical educators to better support this learning modality and identify implications that this can have on academic success in medical school.

Key Words/Phrases:
Group Learning
Study Techniques
Problem Based Learning
Abstract #23

**Development and Assessment of an Educational Improvement Project Utilizing Spaced-Repetition Software**

Donnell Nguyen, M.S., MS1, Faith D. Hamamura, B.A., MS1, Richard Kasuya, M.D., M.S.Ed.

**Introduction:** In the pre-clinical years, medical students are expected to master a large volume of information across multiple basic science disciplines. Learning strategies from undergraduate coursework may not always be sufficient to meet the increased academic demands of medical school, and research has shown that spaced-repetition learning can improve educational outcomes. Anki, a popular spaced-repetition flashcard-learning program, is commonly utilized by medical students to maximize learning potential and efficiency; however, the relatively counterintuitive user-interface may be a barrier for some students. This project sought to understand the perceptions of Anki among first year medical students, introduce the advantages of spaced-repetition learning, and provide peer instruction on how to utilize Anki as a learning modality.

**Methods:** Two interactive workshops were given for MS1 JABSOM students in October 2017. The instructors were two MS1 peers who were experienced with using Anki as a study tool. A pre-workshop survey (n=24) and postworkshop survey (n=26) were conducted to assess participant knowledge and perceptions prior to and after attending the instructional workshop.

**Results:** Although 70.8% of respondents had attempted to use Anki before, 54.5% did not feel confident in their abilities to incorporate Anki in their learning. After the workshop, 76.9% of students reported being more likely to incorporate Anki into their study routine, and 92.3% of respondents agreed or strongly agreed they felt confident utilizing Anki to supplement their learning. Overall, 69.2% of respondents were interested in learning how to incorporate Anki into USMLE Step 1 studying.

**Conclusion:** Peer-led instructional workshops are an effective way of introducing new spaced-repetition learning strategies such as Anki to first year medical students. More research is needed to determine the role of spaced-repetition learning in both pre-clinical coursework and board exam preparation.

**Key Words/Phrases:**
Group Learning
Study Techniques
Problem Based Learning
Abstract #24

Stress Across Years of General Surgery Residency

Susan Steinemann, M.D., Gavin Ha, MS2, Joseph Go, MS2, Kenric Murayama, M.D.

Introduction: Stressors during surgical training are common and can contribute to impaired technical performance, medical errors, physical and mental health problems, physician burnout, and career turnover. There has been recent interest regarding transitions in training and practice, notably the transitions from medical school to residency and residency to practice. However, there may be transitions within residency training years that may also be stressful, as residents assume increased responsibilities. We sought to identify the prevalence and timing of perceived stressors and stress responses during general surgery residency.

Methods: Program Directors (PDs) and administrative faculty of General Surgery residency programs were contacted for their willingness to include their chief resident and graduates in the survey using the Survey Monkey platform. Programs included both university-affiliated and non-affiliated programs across the U.S. Through the PDs/staff, the survey link was forwarded to their chief residents and graduates, with the number of respondents reported. The survey comprised of 9 multiple-choice, short-answer, dropdown and array questions plus 3 demographic questions.

Results: Twenty-three responders participated in the survey from resident programs located in the West (7), Midwest (6), South (8), and Northeast (2) and subcategorized into university medical center (56.52%) and university-affiliated medical center (43.48%). During residency, responders reported getting married (6/23) and becoming engaged (1/23), had children (8/23), had non-clinical years between PGY-2 and PGY-3 (5/23). During the non-clinical years, respondents were conducting research (3/5), research and part-time clinical opportunities (1/5), or other (1/5). Twenty ranking questions regarding suggested experiences/feelings that were felt the most strongly throughout specific years of residency were answered (i.e. “always felt this way,” “never felt this way,” PGY 1-5). Lastly, respondents provided descriptions of their most stressful work experiences, selecting the most stressful aspect of surgical training, and/or explanation of personal and residency programs/faculty actions that can reduce stress.

Conclusion: Unmanaged stress during surgical residency can lead to burnout and attrition from the program. According to this study, most residents had never thought about leaving their residency program (56%) or for another specialty (69%). Of the participants that indicated a year when they thought about leaving their program or switching to another specialty, most indicated PGY-3 as the time that they felt this the most strongly or frequently. Another alarming result was that 70% of respondents reported never feeling that they have enough sleep. Talking with friends/family (90%) was the preferred method of mitigating stress followed by watching TV or movies (62%). The common theme that these respondents agree on is that their programs can help reduce stress by giving more care to resident well-being.

Key Words/Phrases:
Stress in Surgical Residencies
General Surgery
Risk Factors for Burnout
Abstract #25

Learner Impressions About a Peer Role-Playing Activity to Improve the Adolescent Medical Interviewing Skills of First-Year Medical Students

Florence Kan, MS3 and Richard Kasuya, M.D., M.S.Ed.

The HEADSS assessment is a method used by physicians to obtain a psychosocial review of systems on adolescent patients. This acronym covers topics that should be explored with this population; namely Home, Education, Activities/employment, Drugs, Suicide, and Sex.

The HEADSS Assessment allows physicians to obtain information about their patients’ lives, formulate an assessment of the patient, and provide appropriate intervention if necessary. The assessment may also help to build increased rapport, communication, and trust between the physician and adolescent patient.

A simulated patient experience to increase medical student knowledge of the HEADSS exam and improve medical interviewing skills early in the medical school curriculum was provided to first-year medical students, and the benefit of this experience was analyzed using surveys. This project was led by a second-year medical student, under the guidance and advisement of the MD1 course directors.

This new curricular initiative was implemented during the MD1 course for the JABSOM MD classes of 2020 and 2021. The first-year students were approximately 6 weeks into medical school. Second-year medical students were recruited as volunteers and trained by the course directors to portray a patient that the first year medical students had studied in one of their first PBL cases. All first year medical students were required to meet with a simulated patient for a 10-minute interview, in which the students were instructed to conduct a HEADSS assessment.

Both first-year student participants and second-year student volunteer simulated patients were surveyed about the value of this experience. Over 90% of first-year medical students responded “Strongly Agree” to the statements, “This activity helped me to understand the appropriate method to interview adolescent patients,” “This activity increased my understanding of the components of the HEADSS assessment,” and “This activity should help to prepare me for my future experiences with actual patients.” Over 80% of second-year medical student volunteers responded “Strongly Agree” to the statements, “This was a valuable exercise to refine my own medical interviewing skills,” “This activity was a valuable exercise to refine my skills in delivering feedback,” and “This activity provided me with a new perspective on the appropriate types of questions to ask from the HEADSS assessment.” Narrative comments from both groups were uniformly positive, and included statements such as, “….It was very helpful to be exposed to this situation so early in our med school careers,” “Great experience,” and “I really appreciated the feedback that I got….”

We believe that this curricular intervention is an excellent example of a student-led curricular innovation, and represents a model for student engagement in curriculum development. The experience was perceived to be of value by the both the learners and volunteers. Methods for monitoring the longer-term impact of this educational experience are being considered.

Key Words/Phrases:
Simulated Patient Experience
Medical School Curriculum
Medical Interviewing
Abstract #26

Survey and Curriculum Development of Medical Student LGBTQ Cultural Competency

William Harris, MS1, Nicole E. Anzai, MS1, Kelly Quinn, MS1, Vanessa Wong, M.D., M.S.

Assessment and development of medical students’ understanding of lesbian, gay, bisexual, transgender, and queer (LGBTQ) issues is necessary in order to provide sensitive and comprehensive healthcare to LGBTQ patients. Despite documentation of LGBTQ-specific health disparities, the current medical school curriculum fails to address LGBTQ healthcare issues and to provide training specific to the unique needs of the LGBTQ population. LGBTQ-related content averages a total of 5 hours over 4 years in U.S. medical schools. To our knowledge, medical students at the University of Hawai‘i John A. Burns School of Medicine (JABSOM) have never been surveyed on their awareness of LGBTQ healthcare disparities, opinions regarding LGBTQ curriculum deficits, and their competency to provide care specifically tailored to the needs of LGBTQ patients. This exploratory study reports on the current curriculum and self-identified educational needs of medical students across their years of schooling. Following initial survey, an intervention consisting of a lecture and panel that addresses questions raised by students in the needs assessment will be conducted. Medical students will then be surveyed again at the beginning of each school year to reevaluate attitudes and perceptions of LGBTQ-related healthcare issues and their competency to deliver culturally sensitive care. Survey results will indicate the efficacy of current medical curriculum interventions and guide future curriculum development accordingly.

Key Words/Phrases:
Competency Assessment
Curriculum Development
LGBTQ-related Healthcare Issues
Abstract #27

Dean’s Certificate of Distinction in Medical Education:
Recognizing and Fostering Student Engagement in Medical Education

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Student engagement in curriculum management and educational quality improvement (EQI) is an increasingly important component of undergraduate medical education. We describe an innovative way to encourage and empower medical students to be actively engaged in educational innovation and EQI.

The Dean’s Certificate of Distinction (DCoD) in Medical Education at the John A. Burns School of Medicine was implemented in early 2016 to help recognize medical students who had demonstrated exceptional commitment beyond the requirements of the classroom to the field of medical education. In addition to the DCoD in Medical Education, DCoDs are available in Social Justice, Patient Safety & Quality Improvement, Native Hawaiian Health, and Rural Health.

To earn a DCoD, students must fulfill a number of criteria that generally span both curricular activities (e.g., specific electives) and co-curricular activities (e.g., completion of projects, publication, leadership roles). For the DCoD in Medical Education, students must complete a combination of curricular and co-curricular activities, actively teach and demonstrate a commitment to developing their teaching skills, participate in a curriculum development or educational research project, and demonstrate a commitment to leadership and the development of leadership skills.

Since its approval and implementation in February, 2016, the DCoD in Medical Education has been awarded to 18 graduates.

Samples of educational projects completed by these students include:

- Instructional videos on oral case presentation methods in different clinical settings, and presenting critically-appraised medical literature to other health care team members.
- An online module providing advice to future medical students interested in pursuing combined medicine-pediatrics residency training.
- Participation in a school-wide survey project on professionalism curriculum.
- Planning and implementing workshops for other medical students, premedical students or high school students.
- Enhancing clinical skills education through the use of programmable computerized stethoscopes during the processing of PBL cases.

Student participation and enthusiasm for this optional program have been very high. Currently, there are over 40 students who have declared their intention of pursuing this DCoD in Medical Education. Ways of tracking project sustainability and future engagement of those who complete the certificate with medical education beyond medical school are being considered.

Key Words/Phrases:
Student Engagement
Educational Quality Improvement
Student Recognition
Abstract #28

Master of Science in Clinical and Translational Research Graduate Program

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The Clinical and Translational Research (CTR) graduate program, housed within UH JABSOM Department of Complementary and Integrative Medicine, has recently been approved with revamping and strengthening the old Biomedical Sciences (BIOM) graduate program by recommendation of JABSOM Graduate Program Review, conducted in May 2016. Under the new leadership of department in 2017, internal Task Force Committee was organized and charged with addressing each of the critical points raised in the Report in order to restructure and improve the Master’s degree program. Enhancements include the expansion of expertise of actively involved graduate faculty, a thoroughly revised model for student participation, and a fully restructured and substantially extended curriculum, with increased didactic courses. The enhanced program will offer two parallel tracks: Clinical Research and Quantitative Health Sciences. The program will prepare graduates with skills for successful careers in clinical and translational research, and clinical and translational research support including clinical trials organization, and in areas of health care policies and implementation, health care quality and regulatory affairs, and health care data analytics. The latter being an area with specific skills needs and one that is currently lacking sufficient numbers of experts in the State. The graduate program is expecting its first class of students in the Fall 2018.

Key Words/Phrases:
Clinical Research
Quantitative Health Sciences
Clinical Translational Research
Abstract #29

The Dean’s Certificate of Distinction in Native Hawaiian Health

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Introduction: Certificates of Distinction at US medical schools are given to students who have shown additional commitment and effort in such varied areas as global health and social justice, by pursuing more in-depth study, scholarly projects, and related service activities. At the John A. Burns School of Medicine, the Certificate of Distinction in Native Hawaiian Health (COD NHH), which began in 2014, is one of four certificates currently being offered. The COD NHH is designed to offer more experience and knowledge in Native Hawaiian health as well as directly benefit Native Hawaiian communities through service and scholarly projects.

Methods: The COD NHH utilizes the Department of Native Hawaiian Health (DNHH) “na poukihi” framework represented by a hale (house). The framework represents the Native Hawaiian holistic view of health and incorporates traditional values and cultural strengths. Activities focus on four “poukihi” (pillars): 1) cultural knowledge/space (i.e. protocol), 2) community/environmental stewardship (i.e. service), 3) knowledge advancement and dissemination (i.e. research projects), and 4) social justice (i.e. advocacy). Upon completion of the requirements, the student receives a kihei (cloak) symbolizing their journey and their responsibility to the community.

Results: The first two (2) recipients of the COD NHH graduated in May 2017. There will be another (1) student graduating this year, and there are currently six (6) third year students, three (3) second year students, and eight (8) first year students actively pursuing a COD NHH. Thirteen (13) are Native Hawaiian. Challenges, such as time commitments and staying on track, were factors in nine student withdrawals.

Conclusion: This new program, though well received, has required some modification. Time commitment concerns are mitigated by including some activities that are already part of the regular curriculum. Required protocol and culturally related activities are critical to assure that students can work comfortably and effectively in our communities. Feedback from the community is ongoing.

Key Words/Phrases:
Dean’s Certificate of Distinction
Cultural Humility
Native Hawaiian Health
Abstract #30

Teaching Culture in an Ambulatory Setting to Pharmacy Students
Dee-Ann Carpenter, M.D. and Wesley Sumida, Pharm.D.

Introduction: The University Health Partners (UHP) Faculty Practice of the John A. Burns School of Medicine provides a multi-disciplinary setting that serves as an experiential ambulatory site for senior year University of Hawai‘i at Hilo Daniel K. Inouye College of Pharmacy students. The student pharmacist experience was set up to enhance students’ ability to obtain one of the CAPE outcomes (Center for the Advancement of Pharmacy Education) involving cultural sensitivity eg. respect for diverse cultures and incorporation of patients’ cultural beliefs and practices into health and wellness care plans. CAPE outcomes, similar to American Association of Medical Colleges recommendations for medical students, focus on the knowledge, skills, and attitudes pharmacy graduates should possess at the end of their doctoral program. Initially starting in the UHP Department of Native Hawaiian Health Lau Ola Clinic, utilizing culture as the crux of patient care, these pharmacy students now work with an interdisciplinary team of primary care physicians and nurses at the UHP Department of Medicine University Medicine Faculty Practice. During their rotation, the students continue to utilize the resources in the Department of Native Hawaiian Health to participate in cultural activities at various locations outside of clinic.

Methods:
Curriculum:
1. Core activities: Students learn patient-provider interaction, rapport building, history taking, medication reconciliation, and drug therapy management
2. Interprofessional collaboration: pharmacy and medical student/resident patient care interactions, pharmacy student also attend cultural competency colloquia for MS1 and MS2 at JABSOM
3. Service Learning: Health Screening in Native Hawaiian community, Papakōlea Health Fair, First Aid stations at community events, working in mala (healing garden at JABSOM)
4. Culture: Hawaiian concept of Health--holistic, Hawaiian values incorporated in teaching, concept of ‘ohana (family) i.e. Ka’ala Farms in Waianae

Survey information in the form of multiple choice and open-ended questions were gathered over the last 3.5 years and analyzed. Out of 27 student pharmacists who were assigned to our ambulatory rotation, there were 16 respondents. Questions included knowledge of Native Hawaiian health prior to and after rotation, usefulness of rotation, improvement of rapport with patients, and importance of culturally competent care. Open ended questions allow students to elaborate further regarding native Hawaiian cultural understanding, beliefs, and communication. Qualitative results were themed. Curriculum modifications were ongoing and developed from student feedback results.

Results: Students valued the multidisciplinary environment, in and outside of the clinic, which they shared with other medical professionals including medical students/residents. Quantitative themes included cultural activities, practices and beliefs, patient engagement and patient-centered care. The survey information reflects positive internalization of diversity education experience and was used to enhance the present curriculum. All respondents were in agreement that the rotation was useful, Native Hawaiian culture was learned, students felt more comfortable talking to people and that culturally competent care was important in pharmacy.

Conclusion: A multi-disciplinary setting with cultural learning opportunities is a great experiential learning environment for pharmacy students to gain knowledge, practice new skills, and foster personal growth in bridging cultural differences. Since the original ambulatory care experience which started 3 ½ years ago, our curriculum has evolved to incorporate specific cultural learning activities into the rotation. Students can utilize these opportunities to enrich their cultural awareness, become more responsive healthcare providers, teach others, and develop greater insight on how to invest in their communities.

Key Words/Phrases:
Interprofessional Teaching
Ambulatory Clinical Teaching
Cultural Resonance
Abstract #31

Native Hawaiian Culture and Interprofessional Education: Adapting a Medical Education Cultural Competency Curriculum for Clinical Researchers

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Background: Minority groups suffer from significant health disparities in the US. Clinical trials targeting minority groups can face challenges in recruitment and retention of patient subjects. Locally, Native Hawaiians suffer from large health disparities, yet Native Hawaiian patients have been reluctant to engage in clinical trials. Increasing the cultural competency of the clinical research team could help increase the communication and trust that is so critical for patients facing health crises such as cancer.

Objective: Adapting a medical school cultural competency (CC) curriculum to meet the needs of clinical researchers and their Native Hawaiian (NH) patients.

Methods: The University of Hawaii Cancer Center (UHCC) clinical trials departments’ Minority Underserved NCORP (NCI Community Oncology Research Program) grant had an objective to provide CC training to nurses, clinical research coordinators and other research staff. The UHCC approached the Department of Native Hawaiian Health (DNHH) at the John A. Burns School of Medicine (JABSOM) to assist with this CC training. The Department’s C3 (cultural competency curriculum development) team has been designing and implementing CC curricula for medical students since 2006. Planning discussions between the C3 team and the UHCC determined that an adaptation of the medical school curriculum with a focus on Native Hawaiians could be provided as a training workshop through SOCRA (Society of Clinical Research Associates), an educational membership organization that provides education and certification to those involved in clinical research activities.

The 4.5 hour workshop was divided into 4 modules. Module 1 focused on NH protocol, NH health disparities and the need for cultural competency. Module 2 featured self-awareness exercises. Module 3 covered NH history, including the impact of cultural historical trauma. Finally, Module 4 addressed the patient-researcher interaction, emphasizing establishing rapport and trust and addressing communication barriers.

Results: Twenty two participants attended; 82% worked at the UHCC and 68% were not raised in Hawaii. There was a 90% completion rate for the workshop evaluation. All participants (100%) agreed that the workshop did an excellent job of achieving its stated objective of utilizing cultural competency training to improve researcher-study participant relationships. Initial questions revealed that prior to the workshop, 50% were unsure or disagreed that they could form effective, trusting relationships with NH research participants. At the end of the workshop, all agreed or strongly agreed that they had learned skills to improve relationships with NH study participants.

Discussion: Feedback was overwhelmingly positive. Faculty found that the curriculum was easily adaptable to this set of learners. Organizers are encouraged to continue this type of workshop for other minority groups involved in clinical trials.

Key Words/Phrases:
Interprofessional Training
Cultural Competency Training
Clinical Researcher Skills
Abstract #32

The Cross-Cultural Health Care Research Collaborative (CCHCRC): A Decade of Partnership and Productivity

Maria B.J. Chun, Ph.D.

Based in the UHM Department of Surgery, The Cross-Cultural Health Care Research Collaborative (CCHCRC) was created as a forum for faculty who have an interest in cultural issues related to healthcare and healthcare delivery. It was initially referred to as the JABSOM Cultural Competency/Humility Interest Group and held its first meeting on September 24, 2008. The initial goals of the CCHCRC were to identify departmental contacts and individuals who were: 1. interested in developing cultural competency/humility initiatives; and 2. willing to share their cultural competency/humility initiatives with other departments and individuals. Over the past ten years, there have been multiple participants from UHM and other organizations – 14 faculty from UH JABSOM Departments (family medicine and community health, geriatric medicine, internal medicine, native Hawaiian health, psychiatry, surgery); UHM Office of Public Health Studies; UHM Dept of Psychology; UHM Shidler College of Business; USC School of Social Work and 4 community partners from Kokua Kalihi Valley, Queen’s Native Hawaiian Health Program, Queen Emma Clinic. A number of these faculty have served as mentors on various projects. Mentees have included 6 premedical students, 7 medical students, 1 nursing student, 2 psychology graduate students, 2 public health graduate students, and 1 geriatric medicine fellow. There have been over 10 peer-reviewed publications resulting from collaborations among group members. Two JABSOM graduates (Jacques Ambrose, M.D., Catherine Ly, M.D.) served as first authors on 2 of the articles that are directly related to cultural competency. Two (2) others (Peter Deptula, M.D., Sarah Morihara, M.D.) were first authors for papers on a related topic: professionalism. Additionally, the CCHCRC has two major ongoing projects that reflect its purpose: 1. the Biennial Cross-Cultural Health Care Conference: Collaborative and Multidisciplinary Interventions, which has held 5 conferences since 2010, with attendees from 26 U.S. Mainland states and 11 countries; and 2. the JABSOM Cultural Competency Resource Guide, which is in its 7th edition and reflects JABSOM activities and those of its collaborators. The guide is posted on the JABSOM Health Sciences Library Web site and on researchgate.net. In line with the four Interprofessional Collaborative Competencies, the CCHCRC is an excellent example of how seemingly diverse professions can share common research interests.

Key Words/Phrases:
Interprofessional Collaboration
Cultural Competency
Mentoring (Faculty and Student/Trainee)
Abstract #33

Hawai‘i Interprofessional Education and Collaborative (HIPEC) Alliance


Introduction: The University of Hawai‘i (UH) at Mānoa Hawai‘i Interprofessional Education and Collaborative (HIPEC) Alliance is an initiative that was developed to introduce an interprofessional collaborative practice (IPC) model for school-based health centers (SBHC) in Hawai‘i. The HIPEC Alliance builds on the well-established partnership between the Hawai‘i Department of Education’s and the UH Mānoa School of Nursing and Dental Hygiene’s (SONDH) “Hawai‘i Keiki-Healthy and Ready to Learn” SBHC program with the goal to keep children healthy so they can remain in school and continue to learn.

The HIPEC Alliance project is moving forward the trajectory of the UH Colleges of Health Sciences and Social Work’s (CHSSW) interprofessional education (IPE) and IPC commitment by providing opportunities for family nurse practitioner students from the UHM School of Nursing and Dental Hygiene (SONDH), senior clinical pharmacy students from the UH Hilo Daniel K. Inouye College of Pharmacy, and child/adolescent fellows from the UHM John A. Burns School of Medicine’s (JABSOM) Department of Psychiatry to practice in a unique community-based site to provide care to vulnerable groups of school-aged children. The students, fellows and faculty attend the SBHC clinic once a week and work with the SBHC NP to address the needs of the children presenting for care using an IPC practice model. They also actively engage in evidence-based reviews and share knowledge and skills unique to their respective professions throughout the clinic day. The UH CHSSW faculty and the SBHC NP supervise the students’ and fellows’ clinical experiences and facilitate their IPE and IPC practice skills.

Goals: The HIPEC Alliance project goals include:
1) Integrating IPE and IPEC competencies and experiences as essential components of the graduate curriculum and clinical practicums for UH CHSSW health professions graduate students.
2) Improving the health of school-aged children by increasing SBHC services to include targeted health promotion and illness prevention programs for the children using an IPC practice team approach.
3) Engaging community health care providers in the IPC SBHC practice initiative.

Location: The pilot site for the HIPEC Alliance IPC practice is Stanford Dole Middle School located in the Kalihi Valley on O‘ahu. The school has approximately 800 students, the majority of whom are Native Hawaiian (NH), part NH, and/or Pacific Islander with some students having recently immigrated to our State.

Outcomes: Since the HIPEC Alliance SBHC IPC practice was initiated in August 2017; therefore, data about clinical outcomes is still being collected. However, there has been an increase in referrals from the school’s counselors and teachers for assessments of children with complex problems by the IPC team. Feedback from the UH CHSSW students and faculty, as well as the SBHC NP, about this IPC practice model at Dole Middle School has been positive. As a result, plans to expand this model to other SBHC sites and other types of clinical programs are underway.

Conclusion: Integrating the HIPEC Alliance IPC practice model in SBHC provides important opportunities for UH CHSSW graduate program students and faculty to work with the SBHC NP and staff to address unique and challenging issues of a culturally diverse group of school-aged children, especially those with complex health care and socio-economic needs.

Key Words/Phrases:
Clinical Skills
Interprofessional Education and Collaboration Practice Model
School-Based Health Center
Abstract #34

Using Grit to Predict Successful Completion of Nurse Anesthesia Programs

Mikelle J. Adamczyk, DNP, CRNA MAJ/AN

Overview: Nurse Anesthesia applicants appear very similar in cognitive-based qualifications; however, once admitted, performance varies in both the academic and clinical setting which is evident by attrition rates of 9-43%. Grit, defined as passion and perseverance for long-term goals, is a non-cognitive attribute that could further discriminate applicants.

Purpose of Project: Screening for attributes that will lead to successful completion of nurse anesthesia programs is challenging due to the homogeneity of the applicant pool. In an effort to improve the applicant screening process, the level of grit must first be ascertained through a sample population of CRNAs and SRNAs. Grit, which has been demonstrated to predict success in other domains, is measured via an eight-item questionnaire, the Grit-S, which was tested in six different populations and demonstrated high internal consistency (α = .78).

Methodology: 62 (32% response rate) student registered nurse anesthetists (SRNAs) and 521 (24.5% response rate) certified registered nurse anesthetists (CRNAs) from the same Midwest state completed the Grit-S questionnaire along with a brief demographic section through an anonymous online survey. The level of grit (1=not gritty and 5=very gritty) was measured for each participant and compared between the 2 groups.

Results: High levels of grit were demonstrated (SRNA M=3.86, SD 0.59; CRNA M=3.93, SD 0.52). To identify variation in grit scores among the categories of anesthesia providers, a one-way between-groups analysis of variance was conducted. There was a statistically significant difference at the p < .05 level in grit scores for the groups: F (2) = 3.807 p = .023.

Implications for Nurse Anesthesia and Future Research: Adding the Grit-S questionnaire to the admission process has the potential to decrease attrition either form withdraw or dismissal and increase successful completion of nurse anesthesia education programs. In an effort to mitigate social desirability bias, a 360-degree approach should be considered. Currently, a longitudinal study over the course of nurse anesthesia programs at several universities is being designed in an effort to validate that the Grit-S can predict successful program completion.

Key Words/Phrases:
Graduate Nursing Education
Academic Progression
Non-Cognitive Behaviors
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JABSOM Medical Education Building – Third Floor Map
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Please complete the survey at:

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The survey will be extremely helpful in our planning of future HPEC conferences.

The end of the survey will collect information to provide a certificate to those who would like to claim Category 1 CME credits.

Thank you!
List of Disclosures

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All committee members had no relevant financial relationships with commercial interests that pertain to this CME activity.

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