HPEC 2016
Health Professions Education Conference 2016
Promoting Excellence in Health Professions Education

Saturday, February 27, 2016

Sponsored by Office of Medical Education
John A. Burns School of Medicine, University of Hawaii
Welcome to the 2016 Health Professions Education Conference

UH Manoa John A. Burns School of Medicine
UH Manoa School of Nursing
UH Manoa Myron B. Thompson School of Social Work
UH Manoa Office of Public Health Studies
UH Hilo Daniel K. Inouye College of Pharmacy

Aloha! It is with great pleasure that we welcome you to our first 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.

A special thanks to our HPEC 2016 Conference Planning Committee, our HPEC 2016 Program Planning Committee who determined the session topics, and to all the individuals who submitted proposals for posters. The theme of our conference is “Promoting Excellence in Health Professions Education”, and we have topics ranging from interprofessional education, professionalism, remediation and cultural competency. Our plenary speakers, Aimee Grace, MD, MPH, Health Policy Advisor for U.S. Senator Brian Schatz; Martina Kamaka, MD, Associate Professor, Department of Native Hawaiian Health; and Rachael Wong, DrPH, Director, Department of Human Services, State of Hawaii, will be sharing different issues facing the state and country in health disparities and health care needs.

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 over the past 11 months in the planning and implementation of this conference. Mahalo nui loa!

HPEC 2016 Conference Planning Committee

Ya-Wen Hsiao
Office of Medical Education
Richard Kasuya
Office of Medical Education

HPEC 2016 Program Planning Committee

Marla Berry
Department of Cell and Molecular Biology
Gretchen Gavero
Department of Psychiatry
David Horio
Department of Pathology
Kenton Kramer
Department of Tropical Medicine
Medical Microbiology and Pharmacology
Kyra Len
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Gregory Suares
Department of Surgery
Aida Wen
Department of Geriatrics
Kelley Withy
Department of Complementary and Alternative Medicine
Vanessa Wong
Department of Native Hawaiian Health
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!

Lori Chau
Noelani Ching
Kapeela Diaz
Jared Hara
Kelsey Ige
Michele Kanemori
Tammy Kasuya
Valynn Pham
Evan Sakai
Evan Taniguchi
Christina Wu
Maria Uyeunten

A very special thank you to Ya-Wen Hsiao, who designed our HPEC 2016 website and program.

And lastly, we would like to thank the Queen’s Medical Center for their sponsorship.
Mahalo for your generosity!
Abstract Reviewers

Ivy Asano, Office of Medical Education
Ann Chang, Department of Obstetrics, Gynecology and Women’s Health
Maria Chun, Department of Surgery
Sheri Fong, Office of Medical Education
Gretchen Gavero, Department of Psychiatry
Shannon Hirose-Wong, Office of Medical Education
David Horio, Department of Pathology and Office of Medical Education
Richard Kasuya, Office of Medical Education
Kenton Kramer, Department of Tropical Medicine, Medical Microbiology and Pharmacology, and Office of Medical Education
Damon Lee, Office of Medical Education
Winona Lee, Department of Native Hawaiian Health
Kyra Len, Department of Pediatrics
Karen Lubimir, Department of Geriatrics
Kamal Masaki, Department of Geriatrics
Louis Moreau, Office of Medical Education
Dan Murai, Office of Medical Education
Stephanie Nishimura, Office of Medical Education
Jill Omori, Office of Medical Education
Shilpa Patel, Department of Pediatrics
Damon Sakai, Office of Medical Education
Joseph Turban, Office of Medical Education
Jane Uyehara-Lock, Department of Pathology
Kelli-Ann Voloch, Department of Native Hawaiian Health
Vanessa Wong, Department of Native Hawaiian Health and Office of Medical Education
General Information

Contact Information
For questions related to the conference, please contact us via the web form at:
For general help on the day of the conference, please 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 credential for access. If you do not have a UH username and password, please request guest access information at the registration desk or see the information as below:

SSID: JABSOM
Username: hpec2016@yahoo.com (all lower case)
Password: Hpec2016@HI (case sensitive)

Continuing Medical Education
CME is available for the following sessions:
• Opening and Closing
• Plenary
• Concurrent presentations within Sessions I-III
• Poster Session (one hour only)

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

The Hawai‘i Consortium for Continuing Medical Education designates this live activity for a maximum of 7 AMA PRA Category 1 Credits™. Physicians should claim only the credit commensurate with the extent of their participation in the activity.
General Program Information

Driving & Parking Information for JABSOM
Due to on-going construction near the District Parking/Lot C parking lot on campus, please be advised of alternate routes. **Drivers are not allowed to turn left into District Parking/Lot C from Ilalo Street. Only vehicles traveling from the direction of Forrest Avenue will be allowed to turn into this lot.**

Those traveling **Diamond Head bound** on Ala Moana Boulevard, turn right onto Keawe Street then turn left onto Auahi Street, turn left onto Forrest Avenue, turn left on Ilalo Street (just before the Pier 1 security checkpoint), turn right into District Parking/Lot C.

For those traveling **Ewa bound** on Ala Moana Boulevard, there is no left turn onto Forrest Avenue. You will need to turn right on Keawe Street, left on Auahi Street, left again on South Street which becomes Forrest Avenue after crossing Ala Moana Boulevard.

Lot C is not a 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 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 maps, please see P68-69.

Important Addresses
JABSOM Medical Education Building: 651 Ilalo Street, Honolulu, HI 96813
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Presenter: Brenda Wong, Hawaii Consortium for Continuing Medical Education (HCCME) | P 67          |
Aimee Malia Grace is a Health Policy Advisor for Senator Brian Schatz (D-HI). She handles Senator Schatz’ health, children, families, adoption, women, and seniors portfolios. Dr. Grace was previously a Fellow in General Academic Pediatrics at Children’s National Health System in Washington, D.C., in association with the Department of General Pediatrics and Adolescent Medicine at Johns Hopkins University School of Medicine. She is also an Adjunct Assistant Professor of Pediatrics at the George Washington University. Dr. Grace graduated from Punahou School in Honolulu, HI in 2000, and then attended Stanford University as an undergraduate, where she majored in Human Biology (focus on International Health and Policy). She finished medical school at the University of Hawaii John A. Burns School of Medicine in 2009. Dr. Grace completed her residency in Pediatrics at Stanford University in 2012, and her Master of Public Health degree (Health Policy and Management) at the Harvard School of Public Health in 2013. Throughout her career, Dr. Grace has pursued global and community health work and has led multiple grassroots advocacy efforts. Her research has centered on health disparities as seen through a lens of U.S. health policy and health reform. Dr. Grace’s primary areas of interest are Medicaid and CHIP, pediatric benefits in the Affordable Care Act, Native American/Native Hawaiian health, community-based primary care, and human trafficking and health care. She is the co-founder of HEAL Trafficking (Health Professional Education, Advocacy, and Linkage), a network of health care professionals engaged against human trafficking. Dr. Grace also dedicates her time to volunteering with her social justice-oriented church, The District Church, in Capitol Hill.
Plenary Speaker

Martina Kamaka, MD

Martina Kamaka, MD is a Native Hawaiian family physician and Associate Professor in the Department of Native Hawaiian Health at the University of Hawaii at Manoa, John A. Burns School of Medicine. She received her M.D. degree from the University of Hawaii at Manoa, John A. Burns School of Medicine and finished her residency in Family Medicine in Lancaster, Pennsylvania. Her work at the University focuses on healthcare disparities and cultural competency training. She is currently the chair of the Native Hawaiian Health Care Systems Institutional Review Board and has been a member of their scientific advisory council. She is founding member and past president of both the Ahahui o na Kauka (Association of Native Hawaiian Physicians) and the Pacific Region Indigenous Doctors Congress (PRIDoC). Dr. Kamaka is one of the physicians that serves as a crew member for the Hokulea.
Rachael Wong, DrPH is the director of the State of Hawai‘i Department of Human Services (DHS), which empowers and restores people to health, safety, and well-being. Rachael and the Department’s 2,000+ team are building a healthy Hawai‘i through a multi-generational, collaborative approach that addresses the social determinants of health.

Rachael leads DHS with a goal of integrating health and human services to improve health, educational, and other outcomes. She previously served Hawai‘i through various health-focused organizations, including as vice president & COO of the Healthcare Association of Hawaii and the executive director of both Kōkua Mau (Hawai‘i Hospice & Palliative Care Organization) and the Hawai‘i Consortium for Integrative Care.

Rachael earned a bachelor’s degree in East Asian studies and certificate in women’s studies from Princeton University, a master’s degree in public health from the University of Hawai‘i at Mānoa, and a doctorate in public health from the University of North Carolina at Chapel Hill. She serves on multiple boards and commissions, as well as the National Governors Association Human Services Core Advisors Network.
Session Descriptions
Welcome and Plenary

Welcome and Opening
Plenary
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
Jerris Hedges, MD, MS, MMM
   Dean, John A. Burns School of Medicine

Plenary
Mission-Based Education and Measurement of Educational Effectiveness

Damon Sakai, MD – Moderator
   Director, Office of Medical Education, JABSOM
Aimee Grace, MD, MPH
   Health Legislative Assistant for U.S. Senator Brian Schatz
Martina Kamaka, MD
   Associate Professor, Department of Native Hawaiian Health
Rachael Wong, DrPH
   Director, Department of Human Services, State of Hawaii

Learning Objectives:

1. Participants will be able to state standard outcomes used to measure the quality of educational program.

2. Participants will be able to state how selection of more meaningful educational outcomes could reshape the curriculum of professional schools.

Brief Description of Session:
We measure many educational outcomes to determine the effectiveness of our educational programs in all professional schools. But what if we were to measure our educational success by replacing these substituted end-points by more meaningful outcomes and let those outcomes drive not only our assessment of our educational effectiveness, but our curriculum as well.

Target Audience: Health Professionals
Session I

Time: 10:30 am - 12:00 noon
MEB 301

Effective Approaches to Teaching

Forrest Batz, PharmD  
Associate Professor, Department of Pharmacy Practice, Daniel K. Inouye College of Pharmacy

Linda Connelly, PhD  
Associate Professor, Department of Pharmaceutical Sciences, Daniel K. Inouye College of Pharmacy

Trudy Hong  
Third Year Medical Student, JABSOM

Takashi Matsui, PhD  
Associate Professor, Department of Anatomy, Biochemistry and Physiology, JABSOM

Learning Objectives:
1. Describe an efficient approach to integrating anatomy and physiology in ECG training in clinical education.
2. Compare and contrast a new 3D imaging system with previous systems used in clinical education.
3. Discuss lecture capture and sharing as an adjunct teaching tool in clinical education.
4. Describe the benefits and challenges of team-based learning in clinical education.

Brief Description of Session:
This session will include discussions of:
Efficient Integration of Anatomy and Physiology in ECG Training (10:30-10:40am)
A New 3D Imaging System in Gross Anatomy (10:40-11:00am)
Lecture Capture and Sharing (11:00-11:30am)
Team-Based Learning and Clinical Thinking (11:30am-12:00pm)

Target Audience: Teachers in the Health Professions
Session I

Time: 10:30 am - 12:00 noon
MEB Auditorium

**Interprofessional Education: What’s In It for You?**

Robin Arndt, MSW
Junior Specialist, Myron B. Thompson School of Social Work

Alan Katz, MD, MPH
Professor, Office of Public Health Studies, UH Manoa

Carolyn Ma, PharmD
Interim Dean, Associate Professor and Chair, Department of Pharmacy Practice,
Daniel K. Inouye College of Pharmacy

Kelley Withy, MD, PhD
Professor, Area Health Education Center and Department of Complementary and Alternative Medicine, JABSOM

Lorrie Wong, PhD
Associate Professor and Director of Simulation Learning, UH Manoa School of Nursing

Learning Objectives:
By the end of the session the participant will be able to:
1) Define Interprofessional Education (IPE)
2) Identify the professional agencies supporting IPE
3) Describe the core domains and goals of IPE
4) Summarize ways to participate in IPE
5) Identify how IPE helps professional schools meet accreditation standards

Brief Description of Session:
Representatives from the Schools of Medicine, Nursing, Social Work, College of Pharmacy, and Office of Public Health Studies will provide an introduction to Interprofessional Education (IPE) and why it is imperative for health professionals to engage in IPE. Presenters will review the goals of IPE, describe what it is (and what it is not), and how we are working as an interdisciplinary team to develop IPE at the University of Hawaii. Participants will be asked to provide input and suggestions as to what support is needed to increase and embrace IPE activities. Additional information on how to get involved with current initiatives will be outlined.

Target Audience: All Health Professionals
Session I

Time: 10:30 am - 12:00 noon
MEB 304

Updates on Admissions, LCME and ACGME

Patricia Blanchette, MD - Moderator
   Associate Dean of Academic Affairs, JABSOM
Naleen Andrade, MD
   Designated Institutional Official (DIO) and Director of Graduate Medical Education, JABSOM
Ivy Asano, MD, MAT
   Director of Admissions, JABSOM
Danny Takanishi, MD
   LCME Faculty Accreditation Lead, JABSOM

Learning Objectives:
At the end of this session, attendees will:
1. Know and understand the philosophy, selection criteria and admissions process that goes into creating each entering medical student class at JABSOM.
2. Be able to identify at least three (3) key diversity factors that make up JABSOM’s implementation of the Association of American Medical Colleges (AAMC) methodology for the Holistic Review initiative for Admissions.
3. Gain an understanding and working knowledge of the Liaison Committee on Medical Education (LCME), the accreditation body for all American Allopathic Medical Schools that ensures quality education and training or students studying to earn the doctor of medicine (M.D.) degree.
4. Be able to name three (3) key LCME requirements that JABSOM will need to demonstrate in its 2017 accreditation self-study site visit.
5. Gain an understanding and working knowledge of the Accreditation Council for Graduate Medical Education (ACGME), the national accrediting body for residency and fellowship programs.
6. Be able to identify two (2) new components of the ACGME accreditation system that aims to change resident/fellow performance evaluation (Milestones) and enhance the quality of the clinical learning environment (CLER).
7. Know and understand JABSOM’s comprehensive system of educating and training competent physicians from medical student to fully trained physician ready to practice in the community.

Brief Description of Session:
This session will describe JABSOM’s system of educating and training future physicians and the two U.S. accreditation bodies (LCME and ACGME) that set the standards for ensuring a quality medical education experience. The session will begin with JABSOM’s admissions process for entering medical school and the philosophy JABSOM uses for selecting its student body using the holistic review to achieve diversity. Next, a review of the updates and changes to the LCME and ACGME accreditation process will be discussed and how JABSOM is progressing toward its goal to produce qualified independent licensed physicians.

Target Audience: Faculty, Medical Students, Residents and Fellows, Healthcare Educators, Hospital Administrators, Education career counselors, and community members (e.g., secondary school students, teachers and counselors) interested in physician medical education careers.
Session II

Time: 1:30 - 3:00 pm
SimTiki Simulation Center, MEB 2nd floor

Facilitation for Simulation Instructors

Benjamin W. Berg, MD
Director of Simulation, SimTiki Simulation Center, JABSOM

Jannet Lee-Jayaram, MD
Associate Director of Simulation, SimTiki Simulation Center, JABSOM

Learning Objectives:
• List three differences between facilitation and traditional didactic teaching skills
• Demonstrate two difficult facilitation techniques for simulation scenario based training
• Describe the relationship between facilitation and debriefing

Brief Description of Session:
This is a mixed methods program incorporating a brief didactic overview of simulation facilitation principles, small group discussion, and active practice of facilitation techniques during simulation scenarios.

Target Audience: Health Professions Faculty
Teaching and Evaluating Professionalism

Maria Chun, PhD
   Associate Chair of Administration and Finance, Dept of Surgery, JABSOM

William Fong, MD
   Assistant Professor, Dept of Ob, Gyn and Women’s Health, JABSOM

Damon Sakai, MD
   Director, Office of Medical Education, JABSOM

Richard Smerz, DO
   Director, Office of Student Affairs, JABSOM

Learning Objectives:
1. Participants will be able to state topics in professionalism that could be included in a health professions curriculum.
2. Participants will be able to state teaching methods and assessment methods that could be used to evaluate students.

Brief Description of Session: Health professions educational programs are under increasing pressure from accrediting organizations to identify and teach professionalism and ethical behavior. In addition, programs are being increasingly asked to provide evidence that their students are competent in these areas. In this workshop, the faculty will describe the results of a needs assessment on professionalism, examples of teaching professionalism, and recent attempts to assess professional behavior in students.

Target Audience: Faculty who work with Health Professions Students
Session II

Time: 1:30 - 3:00 pm
MEB 314

**Writing and Utilizing Letters of Recommendation**

Ivy Asano, MD, MAT  
Director of Admissions, JABSOM

Robert Nichols, PhD  
Professor, Department of Cell and Molecular Biology, JABSOM

Shilpa Patel, MD  
Pediatric Residency Program Director, Department of Pediatrics, JABSOM

Acknowledgements: Kent DeZee, MD, MPH, Chief, Directorate of Health Education and Training, Tripler Army Medical Center

Learning Objectives:
1. The learner will describe three (3) uses of LORs in the selection process for health professionals.
2. The learner will recognize three (3) helpful attributes in a LOR.
3. The learner will recognize three (3) pitfalls in a recommendation letter.
4. The learner will utilize an outline for an effectively communicated recommendation letter.

Brief Description of Session: The Letter of Recommendation (LOR) is an essential part of a healthcare professions application. This interactive session will provide discussion with regards to how LORs are used in the selection process. Attendees will also be given an opportunity to hone their personal skills at writing LORs.

Target Audience: Faculty writers, Admissions/Selections Committee members
Session III

Time: 3:15 - 4:45 pm
MEB 301

Closing the Loop: Giving and Receiving Feedback

Gretchen Gavero, DO
Clerkship Director, Department of Psychiatry, JABSOM
Sheldon Riklon, MD
Clerkship Director, Department of Family Medicine and Community Health, JABSOM

Learning Objectives:
• Identify ways to enhance your role as a feedback “giver” and “receiver”
• Understand challenges that create difficult feedback situations
• Appreciate how effective feedback can create nurturing & empowering work/learning environments

Brief Description of Session:
Feedback: we give it, we get it, sometimes we ask for it, sometimes we avoid it. Effective feedback is a vital component in all learning and work settings. This session will explore various forms of feedback and review the key components that make this dynamic process an effective tool in improving interactions between learners and educators in clinical practice and education settings.

Target Audience: Learners and Educators
Everest vs Mauna Kea - It’s What’s Below that Counts: The Importance of Cultural Competence in Clinician-Patient Interactions

Dee-Ann Carpenter, MD  
Assistant Professor, Department of Native Hawaiian Health, JABSOM
Alaina Davis, PhD  
Assistant Professor, Department of Communication Sciences & Disorders, JABSOM
Linna Jin, MScA  
Education Coordinator, Department of Communication Sciences & Disorders, JABSOM
Martina Kamaka, MD  
Associate Professor, Department of Native Hawaiian Health, JABSOM
Vanessa Wong, MD  
Assistant Professor, Department of Native Hawaiian Health, JABSOM

Learning Objectives:
1. Participants will learn what cultural competency is and why it must be incorporated in the curriculum
2. Participants will gain awareness of their own cultural perspectives and recognize its effect during patient contact
3. Participants will explore ways of incorporating cultural competence in the classroom and clinical settings.

Brief Description of Session:
Defining which is the highest mountain in the world depends on your perspective and values. While Mount Everest has the highest altitude above sea level, our Mauna Kea has much of its height and a strong foundation hidden below the water. Similarly, the impact of culture on the clinician-patient interaction depends on the perspectives and values each individual brings to the encounter. Like the mass of Mauna Kea, cultural identity is composed of personal values and experiences that may not be visible to others but definitely influence your interactions with others and the world around you.

The session is designed as an interactive workshop that explores the definitions of culture and cultural competency. As health care professionals, and more importantly, as educators of future health care professionals, it is essential to be aware of our own cultural influences and how they can affect interpersonal interactions. Requirements for cultural competency training in professional licensing and educational curriculum will be discussed.

Target Audience: Instructors, professors, and clinical supervisors in health care
Session III

Time: 3:15 - 4:45 pm
MEB 304

Remediation of Learners and Working with Learners at Risk in a Clinical Setting

Marla Berry, PhD
Professor and Chair, Department of Cell and Molecular Biology, JABSOM

Dennis Bolger, MD
Assistant Professor, Department of Medicine, JABSOM

Lara Gomez, PharmD
Director of Clinical Education, Daniel K. Inouye College of Pharmacy

Amy Lower, MS
Clinic Manager, Communication Sciences and Disorders, JABSOM

Learning Objectives:
• Identify factors in the clinical setting that may contribute to student difficulty
• Discuss early detection strategies and interventions to help minimize the need for remediation.
• Consider secondary causes of poor (or under-) performance - the 6 D’s (distraction, depression, deprivation, disability, drugs, disordered personality)
• Examine and characterize the student problem(s) within the core competency framework
• Discuss how to utilize program supports when working with learners on remediation.

Brief Description of Session: This panel session will discuss identification, prevention and interventions for learners in need of remediation. The panel will provide insight from the perspective of various health professions programs and include discussion of program support systems and strategies.

Target Audience: Faculty who work with students
Poster Abstract Descriptions
Medication Adherence Simulation Exercise for Medical Students: The Tic Tac Project

Karen Lubimir, MD, DMD, Aida Wen, MD, Samina Ahsan, MD, Michiko Inaba, MD, Lauren Okamoto, MD, Cody Takenaka, MD, Kamal Masaki, MD
The John A. Hartford Foundation Center of Excellence in Geriatrics, Department of Geriatric Medicine, JABSOM

Background: Medication non-adherence, defined as taking less than 80% of prescribed dosage, is a multibillion dollar health care problem, leading to treatment failures with associated increases in morbidity and mortality. This crisis is most pronounced in elderly persons, who are prescribed on average 5.7 medications, with non-adherence rates estimated between 40-70%. To address this critical area in medical education, a simulation exercise was designed to focus on trainees’ personal attitudes, perception and skills regarding medication adherence and to recognize the contribution of the physician in treatment adherence.

Methods: At the University of Hawaii, all fourth year medical students and second year Internal Medicine and Family Medicine residents have a required 4-week Geriatric and Palliative Medicine clinical block rotation, during which they participated in this medication simulation exercise. Trainees were instructed to take 6 mock “prescription” medications (tic tac candies of different colors) for a one week period with 6 different dosing schedules ranging from once a week up to 4 times daily, including two with specific instructions for ingestion with or without food, one “prn” or as needed every 6 hours, and one medication with varying daily dosing schedule. At the end of the exercise, trainees returned all the bottles or blister packs, including any missed doses, and completed a retrospective pre-post survey intended to provide self-assessment, and to generate post exercise discussion. The survey included 6 questions about attitudes and perception of trainees regarding medication adherence, and 6 skills questions regarding the trainee’s ability to help patients improve medication adherence, using a 5-point Likert scale. Pill counts were conducted on each returned bottle/blister pack and recorded by the type of dosing schedule.

Results: We analyzed data from a total of 94 trainees (67 fourth year medical students and 26 IM or FM residents) from 11 consecutive clinical block rotations. Comparing pre and post data using paired t-tests, we found significant improvements in all 6 attitudes questions of 0.5 to 1.2 points, all p<0.0001. Similarly, we found significant improvements in all 6 self-rated skills questions of 0.3 to 0.9 points, all p<0.001. Post exercise pill counts were available for 60 of the 94 participants, with missed doses reported as a percentage for each prescription medication. The overall percent adherence by medication dosing schedules were: Once a day=75%; BID=67%; TID=65%; Q6H PRN=60%; QWeek=73%; Alternating daily dosing=70%.

Conclusions: This educational intervention consisting of an experiential simulation exercise in medication management provided the learners with insight to perceptions, attitudes and skills essential to understanding medication adherence. By assuming the role of “the patient” who must adhere to complex medication regimes, learners are better able to identify barriers to medication adherence.

Key Words/Phrases:
Medication Adherence
Simulation Exercise
Geriatric Medicine
Well Enough? Initiating A Wellness Program During the Pediatric Clerkship

Danielle Boyer BS; Kyra Len, MD
Department of Pediatrics

Background:
There is a high prevalence of stress and burnout in medical students. Studies have shown that over half of all medical students may be affected by burnout during their undergraduate medical education training. While preclinical or comprehensive wellness programs adopted by medical schools have shown positive impact, literature is lacking on the effect of initiating a wellness program during the clerkship years. Inspired by Dr. Slavin, the keynote speaker at the Council on Medical Student Education in Pediatrics (COMSEP) 2015 meeting, our project sought to initiate a wellness program for medical students during their pediatric clerkship. Our hypothesis was by initiating a wellness program during the pediatric clerkship we would improve our students’ wellness scores.

Methods:
Our wellness program included a short orientation, students identifying 2 wellness goals in the areas of personal well-being and physical well-being and two wellness sessions during their clerkship to openly discuss their progress of these goals. Medical students were assigned a survey code to complete their pre and post clerkship survey. The survey used was a shortened version of the American Association of Medical Colleges (AAMC) Medical Student Life Survey (MSLS) that has been validated by past research. Data were compared for the eight individuals that completed both the pre-clerkship and post-clerkship survey. The data sets were analyzed using the paired t-test.

Results:
Analysis of the results showed that our wellness program intervention did not change the participants’ pre and post clerkship scores, with the exception of the question regarding overall physical well-being, which declined from an average of 6.6 to 5.3 (p<0.05). Lowest wellness scores were recorded in physical well-being, level of fatigue and social activity while support from friends/family received the highest score.

Conclusion:
The wellness program we initiated did not lead to a significant change in the participants’ perceived overall wellness. The students may be more concerned with their clerkship rotation and not be prioritizing their well-being enough, which brings up the possibility that the third year is not the best time to initiate this wellness project. Another possible explanation is that our intervention method alone is not sufficient to produce significant change. We intend to conduct the wellness program another year to collect more data.

Key Words/Phrases:
Student wellness
Clerkship rotations
Meeting Milestones: Developing A School Wide Boot Camp

Kyra Len, MD, Sheldon Riklon, MD, Linda Anegawa, MD, Lawence Burgess, MD, Gretchenjan Gavero, DO, Michael Savala, MD, Gregory Suares, MD, Stephanie Nishimura, PhD
John A. Burns School of Medicine

Background:
At graduation, medical students are expected to possess a wide array of skills and attitudes when they enter residency training programs. The Accreditation Council for Graduate Medical Education (ACGME) created milestones to assess the competency of learners during residency. As postgraduate training programs are expecting incoming trainees to be ACGME Level-1 milestone ready, medical schools will need to fill the gaps between standard 3rd and 4th year curricular content to include the desired skills for incoming PG-1 trainees. The literature shows that a “boot camp” curriculum of intensive procedural and skills training is beneficial for medical students. Residency programs also adopted boot camps to teach procedural skills. To our knowledge there hasn’t been a study evaluating a multidisciplinary approach to coordinate a residency preparation boot camp and a curriculum that focuses on specialty milestones.

The primary objective was to determine if students were more confident immediately after the boot camp and 3 months into residency training.

Methods:
We created a school-wide 2-day “boot camp” for 4th year medical students. We trained students to better prepare them to be level 1 milestone ready for their matched specialty. Because of overlapping milestones, we pooled resources to create workshops for students in different specialties. For example students entering Surgery, Obstetrics and Gynecology, Emergency Medicine, and Family Medicine residencies took a suture workshop. Students were given an anonymous survey pre boot camp, immediately post-boot camp and 3 months after starting their residency. Data were analyzed using a dependent sample t-test.

Results:
Fifty five students completed the pre and immediate post surveys. We are in the process of collecting the 3 month post-surveys and analyzing that data. Student confidence level improved after the boot camp in feeling prepared to function as an intern (2.9 to 3.7; p<0.05), transferring care of patients effectively (3.8 to 4.5; p<0.05), consenting a patient (2.8 to 3.8; p<0.05) and determining decision making capacity (3.1 to 4.0; p<0.05).

Conclusion:
A milestone driven boot camp improved students’ confidence levels in certain milestones such as transition of care and specialty specific milestones in pediatrics. Coordinating a school-wide boot camp to prepare students for residency also helped to pool faculty resources.

Key Words/Phrases:
Medical student boot camp
Milestones
Preparing for residency
From Classroom To Real World - Implementing Project Based Learning To Internal Medicine Residency Education

Masayuki Nogi, MD
Department of Internal Medicine, JABSOM

Abstract Text:
Background: In our internal medicine residency training, residents receive protected time to focus on scholarly activities. Traditional model of lectures in the classroom were creating a passive learning environment and disengagement. To improve our large group teaching, we implemented the concept of project based learning to the residents who were interested in improving educational quality.

Summary of work: In March 2015, we invited a guest speaker to our program retreat (60 residents in total) to introduce the concept of project based learning, along with other methods to improve large group teaching. Starting from July 2015, we recruited six PGY-2 residents who had project ideas as a leader, and gathered residents on a volunteer basis to join each group. A 45 minute project meeting time was secured on a monthly basis, with support provided by chief residents and faculty members. Submitting meeting minutes to track progress was encouraged, but during this pilot year each team were carefully monitored so that it will not create too much of a burden. In December 2015, each group shared a mid-year progress report.

Summary of results: Survey data during pre-launching period was collected. Total of 6 project groups were created. Individual projects focused on improvement of 1) Resident wellbeing, 2) Cultural competency, 3) Outpatient clinic workflow, 4) Medical education skills, 5) Research/scholarly activity support, 6) Post-residency career planning. Mid-year progress report was performed by all groups and received immediate feedback from all residents and program faculty. Barriers and future prospectives will be discussed.

Conclusions: This is a preliminary narrative report of an innovative educational approach. Even in a busy post-graduate curriculum, internal medicine residents were able to engage in a project based learning with creations of innovative and meaningful projects that were difficult to be started by our traditional curriculum.

Take-home message:Project based learning is an innovative method to improve large group teaching by engaging residents to create meaningful products.

Key Words/Phrases:
Residency education
Project based learning
Large group teaching
The Answer Is In Da Blog: The Chief Resident’s Solution To Archive And Share Learning

Masayuki Nogi, MD and Dennis T. Bolger, Jr, MD, MPH
Department of Internal Medicine, JABSOM

Abstract Text:
Background: Keeping the residents posted with updated announcements and sharing the learning among different training sites were a challenge. Traditional approaches include E-mail updates, with risk of causing “E-mail burden” and less attention to important program matters.

Summary of work: From July 2014, our internal medicine program (60 residents in total) has launched a chief resident driven blog site for internal use, which allowed us to archive and share our learning. For categorical PGY-1 to PGY-3 internal medicine residents, a pre survey before launching the blog and post survey 6-months later were collected. Questions focused on resident’s perspective of E-mail burden and satisfaction of information access method. Web access data was retrieved by an online collector service (Statcounter®).

Summary of results: Total of 50 data were collected, which demonstrated that inattention rate of program related E-mails (defined as not reading >20%) improved from 50% to 38%. Resident satisfaction of accessing useful information improved from 18% to 86%, measured by marking a scale higher than 4 (maximum 5). Average of total monthly access was 954, with average 286 first visits per month. Most commonly accessed contents include rotation schedule, orientation slides, morning report summary and elective or fellowship information.

Conclusions: This innovative method utilizing chief resident driven blog site to archive and share learning experience improved efficiency of information delivery and resident satisfaction to access relevant information with a low running cost.

Take-home message:
Chief resident driven blog site is an innovative and effective method to archive and share learning.

Key Words/Phrases:
Residency education
Web resource
Chief resident
Creating An Individualized Senior Resident Teaching Experience

Jennifer R. Di Rocco DO, Cherise S. L. Saito MD, Shilpa J. Patel MD
Department of Pediatrics, University of Hawaii, Honolulu, HI

Body
An innovative, individualized teaching rotation was developed in the University of Hawaii Pediatric Residency Program as a means for improving senior resident leadership, teaching ability/confidence, team ownership, and professional development. The rotation was developed partially to help lessen the burden of each resident creating 6 individualized rotations in addition to ensuring a more standardized experience in these areas. Entitled Resident Resource/Resident Educator (R3E), this PGY-3 rotation incorporates facilitation, bedside and didactic teaching, mentorship, curriculum development, evaluation and reflection. Specific Rotation Elements/R3E Resident Activities Include: 1. Senior resident continuity on the wards while team leader peers are in continuity clinic, with many opportunities to practice the clinician-educator role 2. Direct, ongoing observations of 3rd and 4th year students during family centered rounds with opportunities to diagnose the learner and to provide individual direct feedback 3. Direct observations and feedback to interns and juniors performing patient handoffs 4. Facilitation of morning report 5. Creation and delivery of formal teaching sessions with topics, methods and targeted audiences of personal choice, depending on individual career path 6. Creating and utilizing an evaluation for assessing teaching activities and 7. Professional development guidance from faculty. Evaluation of R3E Resident Performance Includes: 1. Presentation and scoring of a Teaching Portfolio including curricula the resident has developed and personal reflections on teaching and mentoring experiences 2. Direct observation of the R3E resident s teaching skills using an established tool and 3. Direct observation of the R3E resident giving feedback to junior learners. Early feedback outcomes from senior residents who have completed the rotation include improved confidence in teaching skills, a better understanding of how to tailor individual and difficult feedback, and perceived positive reactions from medical students due to increased attention to their learning by a dedicated senior teaching resident.

Key Words/Phrases:
Curriculum development
Residents as teachers
Individualized education unit
Improving Communication Skills of Internal Medicine Residents Using Family Meeting Simulation Exercises in the Medical Intensive Care Unit

Travis Watai, MD, Brent Matsuda, MD, Gehan Devendra, MD, Cody Takenaka, MD, Kamal Masaki, MD, and Reid Ikeda, MD
Department of Medicine, John A. Burns School of Medicine, Honolulu, Hawaii.

BACKGROUND: Internal Medicine residents rotating through the Medical Intensive Care Unit (MICU) discuss the clinical status and prognosis of critically-ill patients during family meetings, often without formal training. The role for a curriculum focused on enhancing delivery of distressing news to families in the MICU has not been well-defined in previous studies. Our objective was to evaluate the impact of a curriculum designed to improve the communication skills and comfort level of Internal Medicine residents conducting family meetings in the MICU.

METHODS: Second and third year Internal Medicine residents rotating through the MICU (n=16) received a 30 minute didactic lecture designed to improve communication during family meetings with content specific to the SPIKES protocol (a six-step method for disclosing unfavorable medical information to patients). Pre and post-lecture Mini-Clinical Evaluation Exercise (Mini-CEX) simulations involving two different enacted scenarios were utilized to evaluate resident interpersonal and communication skills. Each Mini-CEX was graded simultaneously by two MICU attendings using a modified SPIKES evaluation tool. Residents answered a brief questionnaire to measure the educational value of the overall experience, as well as their comfort level with leading end-of-life discussions before the didactic session and after the post-lecture Mini-CEX.

RESULTS: Resident performance significantly improved after the lecture (mean pre-lecture score = 23.3 versus post-lecture score 44.9, p<0.0001). There was a high level of correlation between the Mini-CEX scores of the two MICU attendings (pre-lecture scores correlation coefficient=0.92, p<0.0001; post-lecture scores correlation coefficient=0.77, p=0.0004). We did not find significant differences in scores by gender, post-graduate level, or US graduate versus international medical graduate. The self-assessed comfort level scores of residents delivering bad news showed significant improvement (mean pre-curriculum score = 3.0 versus post-curriculum score = 3.4, p=0.004). This curriculum was very well received, with the majority of residents rating both the lecture and the Mini-CEXs as “very helpful.”

CONCLUSIONS: Establishing rapport with family members during difficult clinical situations is imperative to quality patient care. This study revealed that a focused curriculum including a brief lecture and Mini-CEXs given to Internal Medicine residents rotating in the MICU was highly effective in improving communication skills and resident comfort level during end-of-life discussions. This simple educational intervention emphasizes the value of a formal curriculum to enhance resident performance and confidence in delivering bad news.

Key Words/Phrases:
Observed simulation session
Power point didactic
SPIKES protocol
Motivational Interviewing: Improving Resident Training and Satisfaction on a Brief Treatment Unit

Ana Hilde, MD, MPH, Selena Chan, DO, Bhupi Chima MD, Trisa Danz, MD, Forrest Doan, DO, Deb Goebart, DrPH, Sarah Johnson, MD, Ruth Mondolfi, DO, Miguel Visbal, MD
Department of Psychiatry, JABSOM

Introduction: A large percentage of psychiatric emergency room visits in Hawaii are related to drug and alcohol use with co-morbid mental illness and safety concerns. These patients often require admission to a brief treatment unit (BTU) with a length of stay ranging between 24 and 72 hours. Residents train on this unit and often express frustration at the severity of substance use, the high number of readmissions, and feelings of ineffectiveness in treating these patients.

Motivational interviewing (MI) has been shown to help individuals with substance use decrease their use, consider treatment, and remain in treatment. Varying degrees of success have been demonstrated with brief interventions using MI techniques in emergency departments (ED). Of concern is the limited contact with the individual in the ED as well as intoxication limiting abilities to understand and manipulate information. Systematic adoption of motivational interviewing in the BTU could improve resident comfort and satisfaction in treating this difficult patient population as well as impact patient outcomes.

The aims of this project are to: 1) develop a curriculum to teach residents how to use motivational interviewing techniques in brief interactions, 2) measure psychiatry resident confidence in using MI and satisfaction in working with patients with severe substance use disorders and 3) measure change in patient readiness, referral to treatment and readmission rates.

Methods: Prior to the BTU rotation, psychiatry residents will complete five one-hour training sessions to receive instruction on MI principles, role-playing, and video demonstrations. Each patient evaluated and treated by a resident will complete screening tools to evaluate severity of substance use, readiness for change, and develop a harm reduction plan. Residents will also have direct supervision during patient encounters and will receive feedback to enhance MI skills. Residents rotating on the BTU will complete a pre- and post-test questionnaire evaluating understanding of MI, comfort with use of MI and level of satisfaction in working with patients with severe substance use disorders. Data will also be collected about patient readmission.

Results: Comparative analyses will be conducted to examine differences in resident knowledge, satisfaction, comfort, and skill with motivational interviewing. Descriptive statistics on patients as well as outcomes will be reported.

Key Words/Phrases:
Motivational Interviewing
Curriculum Development
Brief Substance Use Disorder Intervention
A Resident-Implemented Simulation-Based Curriculum to Enhance Resident Knowledge of Indwelling Port Access

Anna-Lena Lueker, MD, Lois Nosker, DO, Shilpa Patel, MD
Department of Pediatrics, JABSOM

Context
Residents at our pediatric residency program have frequent exposure to hemato-oncologic patients with indwelling ports during hematology-oncology inpatient rotations, as part of the admitting inpatient team on the wards, during initial evaluation of these patients in the emergency department, as well as during elective outpatient hematology-oncology rotations. These patients are often first evaluated by residents or physicians with limited experience in port access; therefore nurses on the in-patient hematology-oncology ward who routinely access these patients’ ports are called away from their primary work environment to access the ports. This causes disruption to nursing workflow and prolongs the time to obtain critical labs and begin IV interventions for patients with ports. We therefore initiated a resident-designed and resident-implemented curriculum to teach residents how to access indwelling ports and incorporated this new skill set into our comprehensive pediatric training. This quality improvement (QI) project was initiated in 2013 as an instructional lecture, and has since evolved into an interactive skills course with an instructional video which can be also be accessed as part of a “just in time” training, as well as an individual, hands-on, case-based manikin simulation session.

Objectives
1. To teach pediatric residents how to access ports through hands-on learning with use of pre- and post-tests to evaluate their knowledge and confidence level.
2. To train more individuals at our institution to access indwelling ports, which will be used in various settings across the hospital units, thereby improving timeliness of care for this special group of patients.
3. To include port access in the routine resident simulation training sessions during future academic years, including proficiency testing and skills renewal or “just in time” training.

Results
Prior to their educational intervention in 2013, 11% of residents (n=20) expressed confidence in accessing ports. After completion of the training, 87% of residents (n=16) expressed confidence in accessing ports (an increase of 76% from the initial survey). In 2015, 25% of residents (n=12) expressed confidence in accessing ports, compared to 58% after the training (an increase of 33%). Conclusion and Key Message: Residents can make significant contributions to graduate medical education through the development of resident-designed and resident-implemented hands-on simulation-based teaching curriculums, which utilize an educational process improvement model to adapt to changing learning environments.

Key Words/Phrases:
Simulation (active learning)
Residents Teaching Residents
Clinical Skills
Just-In-Time Training Curriculum for Intraosseous Needle Insertion and Defibrillator Use in a Pediatric Emergency Department

Taichi Itoh, MD, Jannet Lee-Jayaram, MD, Rui Fang, MS, Travis Hong, MD, Benjamin W. Berg, MD

1Department of Pediatrics, 2SimTiki Simulation Center, 3Biostatistics and Quantitative Health Sciences

Background:
In recent years, multiple factors including an increased focus on patient safety, requirement for trainee supervision by attending physicians, and work hour restrictions have resulted in decreased opportunities to experience rare events and procedures associated with critical illnesses (1). Simulation training is an established, effective method to teach psychomotor skills (2). Just-in-time training (JITT) is a method of simulation-based training where the training occurs within or in close proximity to the clinical environment in a focused concise manner. The advantages of JITT include short time for training, relevance of training to in-situ location, ability of trainee and faculty to stay in clinical area and therefore return to patient care when required. JITT has been used to improve surgical laparoscopic performance, has demonstrated effects at the learner, patient and system-wide levels and is method of learning enjoyed by trainees (3-5). JITT has the potential to address some shortfalls in current medical training by providing rare, high acuity experiences without exposing patients to harm while allowing the busy clinician to teach without leaving the clinical environment.

Research Question:
We sought to evaluate JITT curriculum for the procedures of intraosseous (IO) needle insertion and defibrillator use in the pediatric emergency department (ED) by comparing the trainees’ confidence level in performing the procedures independently (Kirkpatrick level 2a) and trainees’ knowledge of the procedures/equipment (Kirkpatrick level 2b) before and after the JITT. Our hypothesis was that the JITT in both IO needle insertion and defibrillator use would increase the trainees’ confidence level in performing those procedures independently and knowledge of the procedures/equipment thus preparing them to be contributing, competent in these roles of an acute medical response team.

Methodology:
This educational research study was approved by the University of Hawai‘i at Manoa’s Human Studies Program. This prospective study enrolled all trainees (4th year medical students, family medicine residents, and pediatric residents) who rotated through a single urban tertiary children’s hospital ED for their clinical training. Two ED attending physicians facilitated all of the JITTs by following a curriculum previously outlined to include active learning techniques. The curriculum included location of equipment in the ED, indications, contraindications, how to perform the procedure and hands-on practice. A drill-inserted IO needle trainer and actual ED defibrillator were used for the training. The trainings were conducted during clinical shifts, at different times, when allowed by low patient volume. All trainees underwent one combined course of JITT for IO needle insertion and defibrillator use during their month-long ED rotation. All JITTs took place in a trauma bay during the facilitator’s ED shift and duration varied from 10-20 minutes depending on number of trainees present. All trainees completed an anonymous online survey which was composed of 17 questions to delineate trainee’s level of medical training, prior procedure training, prior procedure experience on patients, procedures/equipment related knowledge, and confidence level in performing those procedures independently. Identical surveys were completed both before and after the JITT. The post-JITT survey was completed on the same day of training. The survey data was summarized using descriptive statistics: mean and standard deviation for continuous variables such as scores for the procedures/equipment related knowledge questions; frequency and percentage for categorical variables such as post graduate year. For the survey date comparison between pre-JITT and post-JITT, two sample t-test for continuous variables and Chi-square test or Fisher’s exact test (†) for categorical variables were used. A two-sided p-value of less than 0.05 was considered statistically significant.
Results:
71 surveys were completed in the study from August 2014 to September 2015. Three surveys were removed from the data analysis due to discrepant responses that made them unassignable to either pre-JITT survey or post-JITT survey. 68 surveys were included in the data analysis. The confidence level to perform IO needle insertion independently significantly increased from pre-JITT survey 47.1% to post-JITT survey 85.3% (p = 0.0009). The confidence level to use defibrillator independently also significantly increased from pre-JITT survey 51.4% to post-JITT survey 87.9% (p = 0.0011). The survey included three procedure/equipment related knowledge questions for IO needle insertion. The IO drill/needle storage area in the ED was correctly answered by 0% in pre-JITT survey and by 58.8% in post-JITT survey (p < 0.0001). The absolute contraindication for IO needle insertion was correctly answered by 41.2% in pre-JITT survey and by 91.2% in post-JITT survey (p < 0.0001). More than 3 correct anatomical sites for IO needle insertion out of six sites were answered by 20.6% in pre-JITT survey and by 79.4% in post-JITT survey (p < 0.0001†). Two procedure/equipment related knowledge questions were asked in the survey for defibrillator use. The two correct defibrillator placements were answered by 5.7% in pre-JITT survey and by 57.6% in post-JITT survey (p < 0.0001†). The indication for pediatric pad use was correctly answered by 8.6% in pre-JITT survey and by 72.7% in post-JITT survey (p < 0.0001). The pre-JITT and post-JITT survey data was further compared in the variables including the level of medical training, prior procedure training, and prior procedure experiences on patients. No statistically significant differences were observed in any of the variables (all p > 0.05).

Discussion/Conclusions:
JITT in our pediatric ED increased the trainees’ confidence level in performing IO needle insertion and defibrillator use independently. The procedure related knowledge also increased, presumably supporting their confidence level. The JITT in this study took place in a busy urban pediatric ED during duty hours of the attending ED physicians and the trainees in a brief period of time. The applicability of our JITT to the other institutions is conceivably high. A limitation of this study was that the impact of the JITT in actual procedures on patients was not evaluated as these procedures are a rare occurrence in pediatrics. The feasibility of teaching these procedures during an actual patient medical emergency is low, given the need for immediate delivery of life-saving interventions, often superceding the teaching of trainees. However, this training could be used to prepare trainees ahead of time to be competent, contributing members of an acute medical response team in these respective roles, increasing the likelihood of their performing these tasks correctly and independently in real patients.

Key Words/Phrases:
Just-in-time
Simulation
Emergency department
SmarTummy®: Concept Programmable Abdominal Manikin

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The SmarTummy is a manikin designed to mimic some of the common ailments of the human abdomen such as appendicitis, gallbladder disease, peritonitis, and tumors or swellings. Its use is in the training or education of medical students, interns, residents, nurses and other health care workers. The value of this simulation manikin rests upon three fundamental factors:

1. The unmet need for a simulator of abdominal illnesses. The time honored practice of utilizing sick patients for teaching is becoming more difficult as duty hours for house staff became more restricted and teaching is displaced by regulations and considerations for patient privacy. When patients were available, students were not, and when students are present, patients are not. The need for simulation is evident. Other than live patients, the only other means of teaching diagnostic techniques is by textbooks and videos.

There is a growing realization of the need for patient safety as an ethical issue with preparedness as the fundamental prerequisite for patient safety – thus training becomes foremost in importance.

The present legislative direction of health care provision for uninsured Americans gives some credence to a belief that there will be a significant expansion of the numbers of physicians, nurses and other health care workers required to care for them, thus necessitating a demand for preparedness and training with manikins.

2. The scientific soundness underpinning the design. The translation of the idea of a simulation manikin to an actual device was brought about through the collaboration of Dr. Walton Shim and two graduate engineering students, Larry Martin and John Salle, in the creation of a prototypic inflation system through a pressure manifold that allowed specific areas of the abdomen to be inflated selectively to represent lumps, tension and distension in different parts of the abdomen to represent the various disease states. The manikin is controlled through a graphical user interface (GUI).

3. The existing burgeoning simulation industry. There are existing training manikins for CPR and insertional techniques such as esophagoscopy, bronchoscopy, catheterization, but strangely, no programmable manikin to replicate abdominal pathology. SmarTummy is the first of its kind and would meld seamlessly into a field of preexisting simulation products. It is envisioned in addition to teaching institutions, the manikin can be used in certification examinations for competence.

The United States Patent Office has issued SmarTummy two patents and a third is pending. We are now poised to move forward to produce a working prototype and have had informal discussions with the simulation laboratories of JABSOM (SimTiki), Hawaii Pacific University School of Nursing, Chaminade Nursing School, KMCWC Nursing Education, and UH Manoa Nursing Simulation Laboratory relative to SmarTummy, all of whom have indicated interest and a willingness to participate in early prototype evaluation.

Key Words/Phrases:
Programmable Abdominal Manikin
Clinical Diagnostic Skills
Teaching Abdominal Diagnosis
Comparing the Utility of the Non-Mydriatic Fundus Camera to the Direct Ophthalmoscope for Medical Education

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Abstract
Visualization of the fundus is an important component of any ophthalmologic exam. Students are taught to visualize the fundus using a direct handheld ophthalmoscope. However, this device has many limitations, which may be a detriment to medical education and patient care. The invention of the non-mydriatic automatic fundus camera could significantly improve medical education. Our study examined the ability of a group of 5 medical students to visualize pathology and form a diagnosis with a traditional handheld ophthalmoscope and an automatic fundus camera. With the direct ophthalmoscope, none of the students were able to visualize the macula, a crucial aspect of the ophthalmologic exam. With the automatic fundus camera, all students were able to visualize the fundus. The latter modality also increased the proportion of students that was able to correctly diagnose the patients with diabetic retinopathy, 100% vs 40%. On average, students were also more confident in their ability to visualize basic retinal anatomy with the automatic fundus camera, 9.6/10 vs 6.4/10. Thus, incorporating the non-mydriatic automatic fundus camera into medical education, alongside the handheld ophthalmoscope, has the potential to improve both learning outcomes and patient care.

Keywords
Ophthalmoscope
Medical Education
Fundus
Physical Exam
Multivariable Analysis of Factors Associated with USMLE Scores Across U.S. Medical Schools

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PURPOSE
Medical school rankings not only provide a scale to gauge education quality, but also dictate the business of these institutions (impacting application numbers and brand recognition). Traditional methods of ranking emphasize school admissions rate, entering class MCAT and GPA, fulltime faculty-to-student ratio, and NIH funding. However, a true ranking of education quality must assess the outcome/product of the medical school. Two readily available measures of school product are the USMLE scores (Step 1 and Step 2), key factors in residency matching.

METHODS
Ascertaining data from U.S. News and World Report in 2014, our analysis ranked institutions based on Step 1 data, and then utilized regression analysis to investigate relationships between USMLE scores and variables.

RESULTS
Results revealed a positive correlation between USMLE scores with MCAT, GPA, full-time faculty-to-student ratio, and NIH funds; MCAT and Step 1 scores displayed the most notable correlation (R2 = 0.5585). However, institution Step 1 score rankings revealed several programs that deviated greatly from the predicted trend line between Step1 scores and MCAT—despite having students with lower MCAT and college GPAs, these institutions produced fairly high Step 1 scores (comparable to institutions with higher MCAT and undergraduate GPAs).

CONCLUSION
This project presents a summary of the variables associated with USMLE scores, and a future course of action for elucidating why certain institutions produce high USMLE results despite admitting students with lower GPA and MCAT scores.

Key Words/Phrases:
USMLE Scores
University of Hawaii’s Performance on a National Scale
PBL
Stop ROP and Roll: A Case Study of Meaningful Medical Student Participation in Patient Safety and Quality Improvement

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BACKGROUND
Patient safety (PS) and quality outcomes are fundamental goals of modern healthcare. Quality Improvement (QI) is the theory and process to achieve these goals. Fundamental components of QI include understanding systems and processes, focusing on patient well being, teamwork, and the use of measures to provide better medical care. The concepts of process improvement and quality outcomes are integrated into healthcare delivery, accreditation, board certification, and reimbursement. In 2013, the American Association of Medical Colleges convened an expert panel to address the gap in training and education of health professionals in QI and PS. However, with greater demand for QI work, there is a growing disparity between practicing QI and QI medical education.

In the spring of 2015, the John A. Burns School of Medicine (JABSOM) developed the PSQI Dean’s Certificate (DC) as an innovative way for students to gain knowledge and first hand participation in QI while making a significant contribution to patient care and outcomes. Through the DC, students are guided through an in-depth study of PSQI. Students participate in activities such as IHI modules, standard of excellence meetings and are encouraged to conduct their own QI project to improve patient care. Through the guidance of the DC, we were encouraged to conduct our own QI project. The purpose of this article is a case description of a student-led QI project and its impact on student perspective and awareness around QI in healthcare.

CASE REPORT
Our project, “Stop ROP and Roll,” taught us about QI on the frontline and changed our perspectives on QI. This project focused on awareness and education of the healthcare staff to reduce the rate of Retinopathy of Prematurity (ROP) in very low birth-weight infants at Kapiolani Medical Center for Women and Children (KMCWC). From Oct 2014-Aug 2015, students conducted their project through the Plan-Do-Study-Act methodology. Data was collected prospectively from registered nurses, respiratory therapists and physicians working in the NICU at KMCWC, in real time and stored in the local database. Students composed a survey to evaluate baseline ROP awareness in the unit, conducted interviews to identify barriers in care, designed educational interventions to inform first-line providers about ROP and raised awareness by contextualizing the unit’s performance by comparison to similar institutions around the nation.

Awareness of ROP as a problem at KMCWC increased significantly among the healthcare team; the staff recognition of ROP as a significant problem increased from 43.8% in December 2014 to 59.6% in August 2015. In December 2014, 90.7% of the medical team reported to believe high levels of O2 contributed to ROP. This was unchanged in August 2015 as 90.8% of the healthcare staff believed high levels of O2 contributed to ROP. We also evaluated the perception of the dangers of hyperoxia compared to hypoxia in infants. After our educational interventions, 9.3% of nurses thought hypoxia was worse than hyperoxia, 4.7% thought hyperoxia was worse than hypoxia and 86.0% of the healthcare staff thought both were equally harmful. In terms of clinical outcome, the results of our interventions yielded a decrease in ROP from 6.7% in 2014 to 5.0% in 2015.
DISCUSSION & CONCLUSIONS

Overall, this report demonstrates the advantages of medical student participation in QI projects for both student education and healthcare outcomes. Medical students bring the advantage of a new perspective and more free time than practicing clinicians to brainstorm ideas. Although multidisciplinary input and engagement are indispensable to the success of a healthcare establishment, convening teams in a busy clinical service can be challenging. Medical students can serve as the solution to facilitate the necessary communication. In our situation, we were not able to bring everyone together for discussion so we took the project to the staff at their convenience to expedite progress. The relationships established and active teaching done by the medical students emphasized the importance of a patient-centered medical team. Meaningful roles in QI projects enhance learning by affording students autonomy and experience in important clinical work. Moreover, by actively participating in a frontline QI project, our understanding became less of an academic exercise, and more internalized as a practical part of medicine. Overall, we describe the potential for medical students to both learn from and contribute to QI projects in the community of Hawai‘i. With the growing demand for QI experience, medical schools such as JABSOM can and must facilitate student learning to prepare them for their future careers as physicians.

Key Words/Phrases:
Quality Improvement
Medical Student Education
Patient Safety
Privilege as a Social Determinant of Health in Medical Education: A Single Class Session Can Change Privilege Perspective

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Accredited medical schools are required to prepare students to recognize the social determinants of health, such as privilege, yet privilege education has been overlooked in medical school curricula. The purpose of this study is to determine whether a single class session on privilege, within a social justice elective offered to first and second year medical students, is sufficient to change the perspective of medical students concerning their own personal privilege. A pre-class survey, followed by a class session on privilege, and post-class survey were conducted. Thirteen of the 18 students enrolled in the elective completed the pre-class survey. Ten students completed the post-class survey, although only 9 completed both the pre- and post-class surveys. The demographic profile of the participants was 93% Asian and 7% White ethnicity, with 57% identifying as being culturally American. There was no significant difference between average male and female or between age groups’ self-assessed privilege amounts. For all characteristics tested, except hair color, participants had an increased self-assessed privilege perspective following the class. Three participants had an overall positive difference in privilege perspective, three participants had an overall negative difference in privilege perspective, and three participants had only a minimal change in privilege perspective. The absolute total difference in privilege perspective was 25 units of change. The single class session on privilege was sufficient to change significantly the perspective of medical students on their own personal privilege; however, future studies with larger groups of medical students are needed to elucidate other findings suggested by this study.

Key Words/Phrases:
Social Justice in Health Elective
Social Determinants of Health
Privilege
The Role of the Medical Student Mentorship Program in Recruiting Pre-medical Students and Enhancing the Medical Student Experience at the John A. Burns School of Medicine

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BACKGROUND: The Medical Student Mentorship Program (MSMP) is a medical student-run organization at the John A. Burns School of Medicine (JABSOM) that was established in 2002 to address the state’s need for pre-medical resources. MSMP welcomes all students in Hawaii (including neighbor island) who are interested in pursuing medicine and pairs them with yearlong, one-on-one medical student mentors from JABSOM. Through personalized guidance from mentors and monthly events, MSMP strives to raise pre-medical student awareness of the JABSOM curriculum, medical student life, and physician shortage in Hawaii. For medical students -- often recipients of mentorship themselves -- MSMP offers a chance to give back while strengthening interpersonal and leadership skills as well. This qualitative study examines the program’s student outcomes and impact on both pre-medical and medical students since its inception.

METHODS: Since 2003, MSMP has collected demographic data of its participants for each academic year. This data was retrospectively reviewed and analyzed with descriptive statistics. Students are also regularly invited to provide anonymous feedback after events and at the end of the academic year; comments from these surveys were summarized.

RESULTS: MSMP now pairs over 150 pre-medical student mentees with over 90 medical student mentors each academic year. Since 2003, 294 medical students have served as mentors, with 88% (259/294) participating during preclinical years (MS1 or MS2); of these students, 71% (183/259) continued as mentors during MS3 or MS4 years. Medical student mentors who responded to the last end-of-year survey (n=22) agreed or strongly agreed that MSMP enriched their medical school experience (95%) and improved their communication and leadership skills (100%). A total of 55 pre-medical student mentees who participated in MSMP have matriculated into JABSOM. Of these students, 84% (46/55) continued their participation in MSMP as medical student mentors. Pre-medical students who responded to the last end-of-year survey (n=32) agreed or strongly agreed that MSMP increased their familiarity with the medical school application process (94%), interest in attending JABSOM (94%), and understanding about student life at JABSOM (90%).

CONCLUSION: MSMP is in its 12th year since its initial inception and has seen a dramatic increase in participants, especially within the latter few years. Involvement of medical students from all four class years demonstrates the program’s ability to enrich the medical school experience regardless of student year or academic interest. Although it is difficult to quantify MSMP’s impact, student feedback suggests that the program fills a unique niche by providing a mentorship experience that both pre-medical and medical students can benefit from.

Key Words/Phrases:
Metroship
Medical student life
Student recruitment/community outreach
Increasing the Biomedical Sciences Workforce

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Despite the resilience and strength that exist amongst Native Hawaiians, devastating health disparities still remain an issue when Native Hawaiians and other Pacific Islanders are compared to other ethnic groups. As an approach to reducing health disparities, the U.S. government has called for diversifying the community of researchers by expanding research opportunities for underrepresented groups. In an effort to help eliminate the daunting disparities that exist among Native Hawaiians, a strong and committed network of highly trained indigenous researchers familiar with the needs of this community is essential. However despite both the significance of what indigenous researchers can offer to health disparities research and the priorities of federal agencies to increase research opportunities for underrepresented students, indigenous researchers continue to remain underrepresented in the scientific community. Furthermore, Native Hawaiians are among the groups underrepresented in health research in the United States.

Participation in research training programs gives students underrepresented in the sciences the opportunity to be engaged in science research and academic activities. Research engagement is an evidence-based practice that not only increases student participation in college life, but can also increase likelihood of student persistence to research careers. The Department of Native Hawaiian Health at the John A. Burns School of Medicine is aimed at growing the next generation of indigenous researchers by providing opportunities for University of Hawai‘i students to participate in pathway programs and gain health disparities research experience. Various programs are being implemented in the department to accomplish this goal, including National Institutes of Health (NIH) funded programs, the Māhina International Indigenous Health Research Training Program and the BUILD EXITO Program.

The Māhina International Indigenous Health Research Training Program was developed through the partnership of the Indigenous Wellness Research Institute (IWRI) at the University of Washington, the Department of Native Hawaiian Health at the John A. Burns School of Medicine, and Te Whare Kura and the Department for Maori Health at the University of Auckland in New Zealand. The program highlights the development and evaluation of culturally-based health promotion and disease prevention interventions that address multiple issues of concern to indigenous communities. The training curriculum is based on educating a core of indigenous students about the social, cultural, and historical determinants to indigenous well-being whilst teaching them culturally grounded conceptual models, and research ethics and protocols by which to frame their work. The program provides a unique research training opportunity with training opportunities in both traditional biomedical and behavioral research, including a 10-12 week health research training opportunity in New Zealand.

The University of Hawai‘i’s BUILD EXITO (Building Infrastructure Leading to Diversity/Enhancing Cross Disciplinary Infrastructure and Training at Oregon) initiative is a health research training pathway program focused on encouraging and supporting students from diverse backgrounds to successfully pursue careers in health-related research. Supported as part of a larger NIH-funded initiative with BUILD EXITO primary institution Portland State University, BUILD EXITO scholars have an opportunity to have far reaching impact by collaborating with institutions that span across Oregon, Washington, Alaska, and the U.S. Pacific Islands. The vision and mission of the program is rooted in the understanding that scientists from diverse backgrounds and life experiences bring different perspectives, creativity, and individual enterprise that is necessary to address today's daunting complex health issues.

Key Words/Phrases:
Research training program
Health disparities
Simulating Medical School for High School Students: Fostering Interest in the Medical Field and Recruiting Potential Matriculants

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Context
The John A. Burns School of Medicine (JABSOM) Office of Medical Education hosts two high school immersion programs each summer. The first began 10 years ago and is a three-week, half-day course for 30-36 students entering grades 11-12, from select Hawaii high schools sponsored by JABSOM faculty. Using the first course as a model, a one-week, full-day course for up to 60 students, open to any student entering 9th-12th grade, within and outside of Hawaii, was developed 3 years ago. These programs utilize the same curricular methods used by JABSOM medical students, including problem-based learning, lectures, gross anatomy laboratory, community service, clinical skills laboratories, simulation laboratories with manikins and surgical equipment, and standardized patient experiences while wearing a white coat. As part of “aftercare” of these courses, students are encouraged to contact JABSOM faculty for advice and mentorship.

Objectives
1) Describe the high school outreach courses at JABSOM
2) State the outcomes of the courses
3) Discuss possible programs for future implementation

Key Message
Medical schools face a number of challenges including alleviating the physician shortage, promoting service at underserved areas, and recruiting a talented and diverse student body. The high school outreach programs at JABSOM help address some of these challenges by fostering interest in medicine as a career choice and providing valuable mentorship for students even after completion of the course, increasing recruitment of qualified applicants and matriculants. From a 2014 survey, 42 of 45 students participated because they were interested in medicine/healthcare, and 37/38 rated the course as an “appropriate level of difficulty to keep engaged and learning new things”. Student participation in the same educational methods as medical students increases their confidence that they can be successful in medical school. Of the first three cohorts, at least 58% (24/41) are in healthcare fields, with 10 attending medical school (6 at JABSOM).

Conclusion
High school teachers involved in the program state that the course has changed their student’s lives and have transformed their life dreams to something tangible and attainable. The majority of high school students who completed the original outreach course have entered healthcare fields. Of those attending medical school, the majority have matriculated at JABSOM. Current JABSOM students have stated that the program is an accurate sampling of life as a first-year medical student, and that it had an influential role in guiding them towards a medical career.

Key Words/Phrases:
High School Students
Recruitment and Mentoring
Novel Immersion Curriculum
Medical Students Participating in Elective Research Produce More Presentations and Publications of Higher Quality than Required Research Curricula

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Introduction
To better enable medical students to utilize the rich diversity of research opportunities provided by the increase in research funding over the past decade, both in Hawaii and nationally, the John A. Burns School of Medicine (JAB-SOM) restructured its curriculum in 2008. The summer between the first and second academic year was changed from a required research project at JABSOM to two 4-week “selective” blocks, during which the students select at least one of several electives offered, some of which are research opportunities at JABSOM or at other institutions.

Objectives
Our hypothesis is that under the restructured curriculum, students who are truly passionate about research have a greater likelihood of finding a mentor or principal investigator who matches their interest, and thus student research productivity would improve. The objective of this study is to determine the number of students who choose to do research in the absence of a research requirement, and evaluate the effect of this curricular change on the quantity and quality of conference presentations and publications.

Methods
We asked fourth-year medical students just prior to graduation, to provide a list of presentations and publications resulting from their research while in medical school.

Results
Data was analyzed from the graduating classes of 2008 - 2013, the last three years of required research (research cohort) and the first three years of the elective system (elective cohort). Average response rate for the research and elective cohorts were 93.8% and 92.6%, respectively. Of those who responded from the elective cohort, an average of 80.9% participated in research, mainly as MS2s (64.1%), though 23.7% participated in all four years of school. The elective cohort had more presentations per participant, and presented at more regional/national/international venues vs school-based/local venues. The elective cohort had more students who published, though a similar number of publications per participant, and a similar proportion of local vs national/ international journal publications. Preliminary analysis on a subset of students indicate the publications from the elective cohort has a higher mean impact factor and number of citations.

Discussion
Even with the change in the curriculum to have research as an elective experience, 80.9% still participated in research, and those who did participate were more productive in presentations and publications. We anticipate that the quality of the publications, as measured by journal impact factor and number of citations, will be higher in the elective cohort.

Key Words/Phrases:
Student Research
Research Productivity
Elective Research Curricula
Enhancing Nutrition Education through Diet Experiences

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Context
Diet experiences were introduced into the first year medical student curriculum in Academic Year 2012-2013. Students learned about different diets in the context of their health care problems (HCP) and had either nutrition modules or nutritionists explain the diet, then are asked to follow an assigned diet for 1 week. In the cardiovascular subunit, they followed a heart-healthy diet; in the renal subunit, they followed a pre-dialysis renal diet; and in the endocrine subunit, they followed a diabetic diet. The faculty course directors of those subunits also participated in the Diet Experience. Following each of the diets, there was an in-class discussion about the diet and the difficulties they faced, and a survey was administered at the end of the academic year.

Objectives
The objectives of the Diet Experience were for students to put into action the diets they learned about in the curriculum, and to gain insight into the difficulty patients have in following diets.

Key Message
All first year students completed the survey (N= 68). In general, students had a difficult time following the diets, citing that the diets were time-consuming and expensive. Students who attempted the diet were able to follow the cardiovascular diet for a mean of 3.08 days (N=53), the diabetic diet for 2.74 days (N=43), and the renal diet for 1.59 days (N=35). Students who followed the diet for at least one meal were more aware of the nutritional value of foods (renal and diabetic diets, p=0.001) and had more insight into the difficulty patients have in following prescribed diets (cardiovascular and diabetic diets, p=0.001). Students who attempted the diets were also significantly more likely to change the way they would approach patients about their diet (p=0.004-0.008), and more likely change their personal dietary habits (renal diet, p=0.006; diabetic diet, p=0.001).

Conclusion
Although students in general had difficulty following the diets, the Diet Experience was successful in making students more aware of the nutritional value of foods, providing insight why patients may be non-compliant with their prescribed diet and may influence how the students approach their patients’ and their own diets.

Key Words/Phrases:
Novel Diet Curriculum
Promotion of Empathy/Insight
Experiential Learning
Using a Laboratory Simulation Exercise to Teach Medical Microbiology in a PBL Curriculum

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Abstract:
JABSOM utilizes Problem Based Learning as its curricular bedrock in the preclerkship years. The basic science faculty’s dilemma is providing both longitudinal and horizontal coverage of their discipline within the framework of JABSOM’s curriculum. This is particularly challenging for a discipline like medical microbiology where the information needed to be successful in the clinical years is extensive but the time allocated to health care problems (HCP) and lectures is limited. In addition, the clinical laboratories have indicated to us that 3rd year students don’t understand the results from microbiological tests, especially when given over the phone.
To overcome these obstacles, we developed a mock laboratory exercise to reinforce organisms causing acute diarrhea in the gastroenterology sub-unit.
Within the MD4 GI sub-unit there is a HCP focusing on infectious diarrhea. Along with the HCP are 3 1-hours lectures: 1) microbiology of organisms causing acute diarrhea, 2) clinical management of infectious diarrhea, and 3) laboratory approaches to infectious diarrhea. To reinforce the concepts presented in the HCP and lectures, we have developed an additional learning opportunity, which is outlined below.
Laboratory Exercise Outline:
1. In a large group, students are given an introduction and instructions.
2. Students are broken up into groups of 8-10.
3. Each group has 4 mini-case scenarios (bacterial bloody diarrhea, bacterial non-bloody diarrhea, viral diarrhea and a parasitic infection).
4. The group works through the each case and decides which laboratory tests are needed to confirm their clinical suspicion.
5. The group fills out a laboratory request form and submits it to the laboratory (run by Tropical Medicine graduate students).
6. The laboratory reviews the requests and queries the medical students on the rationale for their request.
7. Students are given the raw laboratory results and must interpret the information; gram stain, fecal leucocytes, growth media, biochemical results, etc. The organism is not given.
8. After the group’s final discussion, the students visit a display of each mini-case, which includes explanations of the laboratory findings and the diagnosis.
These sessions increase medical student exposure to the laboratory aspects of infectious diseases while providing productive interactions between medical and biomedical graduate students.

Key Words/Phrases:
Preclerkship basic sciences
Medical microbiology
Laboratory exercise
Modified PBL Tutorial Process for Second-Year Medical Students

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Introduction
The John A. Burns School of Medicine at the University of Hawaii at Manoa has been utilizing problem-based learning (PBL) as the primary educational methodology for first- and second-year medical students since 1989. As students advance through the pre-clerkship years, they become quite skilled with the PBL process. A modification of the PBL tutorial process was recently explored with 2 cohorts of second-year medical students.

Objectives
The objectives of the project were to increase student responsibility for directing their learning and assess the effectiveness of multi-group tutoring by a single PBL tutor.

Methods
We piloted a modified PBL tutorial experience with 11 second-year medical students who were assigned to 2 small groups, with one faculty tutor responsible for both groups. Each student had several opportunities to serve as a student facilitator to lead group discussions on the learning issues and the new health care problem. The faculty tutor was present at intermittent times during each session. Exam scores and end-unit survey responses from the modified groups were compared with the traditional groups. A focus group was also conducted to gather qualitative data. This project was again conducted with a second cohort of 24 second-year medical students, divided into 4 small groups, with two faculty tutors responsible for two groups each.

Results
Mid-unit and end-unit exam scores for the initial cohort showed no significant difference when compared with the rest of the class. The modified tutorial group rated the “perceived effectiveness” of the PBL tutorial higher compared to traditional groups on the end-unit survey. Students who participated in the modified PBL tutorial enjoyed the self-directed process and felt like the group dynamics and discussion were enhanced by not having a faculty tutor present who was evaluating them. Exam scores, surveys and focus group discussions are currently being analyzed for the second cohort.

Discussion
The modified PBL tutorial experience has the potential to facilitate self-directed learning, as well as teaching and leadership skills, for students transitioning into their third-year clerkships when these skills are particularly useful.

Key Words/Phrases:
Problem-based learning
Self-directed learning
Innovations in medical education
Effect of PBL Case Nodes on Student Learning Parameters

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Introduction
The John A. Burns School of Medicine uses PBL as its main curricular platform. In processing through Health Care Problems (HCPs), essentially patients on paper, students discuss hypotheses, clinical findings and develop learning issues (LIs) to be researched for presentation. We introduced a variation in the typical HCP called a “Case Node” in which the PBL group must make a decision regarding their patient, which affects the outcome, i.e. they will receive one of two alternate end pages. There was positive feedback from both tutors and students, so we decided to rigorously test these informal observations.

Objectives
Our hypothesis is that case nodes promote duration and quality of discussion, increase HCP memorability, and improve student learning.

Methods
Two HCPs (B and G) were designed with and without nodes, but with similar content, for use in both 2011 and 2012. Both nodes were ethical: B dealt with ethics of gift-giving and G dealt with physician-assisted suicide (PAS). Approximately half the class of 66 and 67 students had B with node and G without node, while the other half had B without node and G with node. We audio-recorded the PBL discussions and analyzed using quantitative content analysis, measuring discussion time on topic and whether students expressed their opinion, justified their decision, asked others for opinion and shared personal experience. Analyses of Variance (ANOVA) and t-tests, as well as post-hoc effect sizes (Cohen’s d) were used. We conducted course evaluations of HCP memorability and case node utility, and compared examination performance. We have repeated the case nodes in 2015 and are in process of analyzing our most recent data.

Results
Three main effects were found. Groups with a node, regardless of case, spent more time in discussion and expressed their opinion more frequently on Day 1, when the ethical issue arose, than those who did not receive a node – these differences both had a large effect size. The HCP with ethics of gift giving, regardless of whether it contained a node or not, was significantly more likely to have students sharing their personal experiences than the HCP with physician-assisted suicide (PAS) – this difference also had a large effect size. Students valued the Case Node, particularly for allowing their choices to affect the HCP outcome, and promoting amount and depth of discussion. The presence of the PAS node increased case memorability. There was no significant difference in exam performance on those questions pertaining to the Case Node or case.

Discussion
The Case Node is a valuable variation in the typical linear sequential HCP used in PBL for its promotion of discussion and expression of opinion, and allowing students to make choices that affect patient outcome. The case with PAS node was more memorable.

Key Words/Phrases:
Case Node
Decision Making
Promotion of Discussion
Teaching with YouTube

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Abstract

Background: In the last decade, YouTube has become the most widely used user-generated video-sharing site in the world, with thousands of new videos being uploaded daily. The use of YouTube in health education has been slow, but is steadily increasing in popularity as the quality of educational material improves and organizations lift restrictions blocking these social media sites.

Aim: As an avid ‘YouTuber’, I have used it extensively in my personal and professional life. A few years ago I began recording videos for sharing, and more recently have tackled developing and editing videos to create engaging educational material. This presentation will discuss the lessons learned through the process in the hope that it will inspire other educators to undertake similar projects, ultimately positively impacting the quality of educational videos on YouTube.

Conclusion: Modern education needs to be innovative and creative in order to create significant learning experiences for this generation of students. YouTube offers an established, and well-recognized social media platform in which educators can share previously created videos or develop videos to meet these needs.

Key Words/Phrases:
Health education
Innovation
Teaching in technology
Healthcare Professionals’ Perceptions and Use of the Provider Orders for Life-Sustaining Treatment (POLST) Form

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Background:
The POLST form is designed to translate patient preferences for end-of-life care into actionable medical orders that are conveyed across different care settings. It has been proven effective in ensuring end-of-life preferences are honored. We explored how healthcare providers in Hawaii use and perceive the POLST.

Methods:
A cross-sectional study was conducted through a survey of attendees at the annual Hawaii Long-term Care Conference in September 2015. The survey assessed both knowledge about and attitudes towards POLST. Survey responses were de-identified and descriptive results were tabulated. For analysis, we separated respondents into two groups: providers (physicians and APRNs) and non-providers (nurses, social workers and others).

Results:
We received 113 survey responses from the 161 attendees (70.2% response rate), comprising of physicians (n=33; 29.7%), APRNs (n=7; 6.3%), nurses (n=30; 27.0%), social workers (n=23; 20.7%) and others (n=18; 16.2%). Respondents demonstrated generally good knowledge, with most correctly identifying appropriate times to both consider and review the POLST form. However, only 64.5% (providers 72.5% vs non-providers 60.0%, p=0.218) correctly answered who has to sign to make the POLST form valid. Overwhelmingly, respondents believed that the POLST improves communication about a patient’s goals of care. Time was identified as the biggest barrier to POLST completion especially among providers (59.0% of providers vs 25.35% of non-providers, p<0.0001). Nurses were significantly more concerned about liability (30.0% vs 2.56% providers and 8.7% social workers, p=0.0031). There was strong support for setting up an electronic POLST registry in Hawaii (89.5%) but there were concerns, especially among social workers, about how updates to the POLST would be done online.

Conclusions:
Overall, respondents demonstrated good knowledge and positive attitudes about POLST. However, specific knowledge gaps were identified suggesting further education about POLST is needed. Time was identified by providers as the biggest barrier to POLST completion and nurses reported concerns about liability. Most respondents were in favor of setting up a POLST registry, however, outreach to social workers should be considered to address their specific concerns.

Key Words/Phrases:
POLST
Providers
Receptions
Interprofessional Education Using Teamwork Simulation at the University of Hawaii

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Background: Interprofessional education is important to promote teamwork in caring for elders with multiple complex problems. We report on the University of Hawaii’s second year of experience in simulation based training to teach geriatric interdisciplinary teamwork before trainees enter clinical practice.

Methods: A geriatrics case with falls and polypharmacy was used to implement an interprofessional team meeting simulation exercise called HIPTCS (Hawaii InterProfessional Team Collaboration Simulation) for third year medical, nursing, pharmacy and social work students. Pharmacy students participated from another island via remote video conferencing. Prior to the exercise, students were assigned pre work: watching an interdisciplinary team rounds video, reviewing patient information and reading about geriatric assessment. The exercise began with an icebreaker team puzzle. Faculty from all four schools debriefed with the students to help them discover effective teamwork strategies to apply in the next section. The students then worked together to develop a discharge plan and participated in a simulated family meeting. Afterwards, faculty again debriefed with students to highlight principles of effective teamwork. At the end of session, students self rated interprofessional collaborative practice core competencies using a retrospective pre/post survey, with eight items rated 1 to 5 on a Likert scale (higher=better). We analyzed changes in self assessed attitudes and skills before and after the simulation exercise using Ttests.

Results: A total 104 students (30 medical, 28 nursing, 38 pharmacy and 8 social work) participated in this simulation exercise. Mean scores significantly improved for all eight self assessed skills questions including competencies of Values/Ethics (Q1 4.44 vs 4.69, p=0.0004; Q2 4.45 vs 4.62, p=0.002), Roles/Responsibilities (Q3 3.78 vs 4.33, p<0.0001; Q4 3.85 vs 4.42, p<0.0001), Communication (Q5 3.89 vs 4.37, p<0.0001; Q6 3.90 vs 4.41 p<0.0001), and Teamwork (Q7 3.96 vs 4.40, p<0.0001; Q8 4.03 vs 4.49, p<0.0001).

Conclusion: Building on previous experience, we found significant improvements in selfassessed core competencies after implementation of an interprofessional team meeting simulation exercise that brought together students from 4 disciplines and two different islands.

Key Words/Phrases:
Simulation
Interprofessional
Geriatrics
The Standardized Patient and Standardized Interdisciplinary Team Meeting (SP-SIDTM): Validation of a New Performance-Based Assessment Tool

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Background: The interdisciplinary team (IDT) approach is a key component in the care of geriatric patients, and requires new skills for trainees to master. Performance-based tools to assess these skills have not been well validated in the medical literature. We developed a novel clinical skills assessment tool consisting of two stations. In the first, trainees evaluate a standardized patient (SP) hospitalized after a fall. The second requires trainees to participate in a standardized interdisciplinary team meeting (SIDTM) with a standardized nurse (SRN) and standardized medical social worker (SMSW) for discharge planning, with the student playing the role of the physician.

Methods: The SP-SIDTM was administered to 52 fourth-year medical students (MS4) and six Geriatric Medicine fellows (GMF) in 2011-12. Trainees were surveyed on their impression of the experience. Performance of trainees was scored by the SP, SRN and SMSW on dichotomous checklists of clinical tasks and Likert scales of communications skills, and compared by level of training using t-tests. After completing the SIDT meeting, trainees formulated a care plan using The Geriatric Interdisciplinary Care Summary (GICS) sheet, graded by faculty based on predetermined criteria. Inter-rater variability (Pearson r) and reliability (Cronbach’s alpha) of checklists and rating scales were measured.

Results: Overall, trainees rated the SP-SIDTM experience as “moderately difficult,” length of time “about right,” and believability “moderate to extreme.” More than 80 percent of trainees had at least 1 similar real patient experience. Reliability was high for both cases and the GICS (Cronbach’s α=0.78-0.87). Inter-observer correlation between SRN and SMSW checklist scores (r=0.82, p<0.0001) and total scores (r=0.69, p<0.0001) were high, with weaker correlation for communication skills (r=0.45, p=0.003). The overall score on the SP-SIDTM case was significantly higher for GMF compared to MS4 (75 vs. 65, p=0.002).

Conclusion: The SP-SIDTM was positively rated by trainees and generated scores with high reliability. Observations recorded on checklists showed excellent inter-observer correlation. Geriatric Medicine fellows scored significantly higher than fourth year medical students. These observations support the validity of this novel clinical skills assessment tool.

Key Words/Phrases:
Clinical skills assessment
Interdisciplinary teams
Validation of assessment tool
Listening to our Patients: Creating a Culture of Patient-Centered Care

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An increasing number of medical schools in North America now offer “Narrative Medicine” seminars for their students. At the University of Saskatchewan, Narrative Medicine seminars were first introduced in the fall of 2010. In 2011, the name was changed to “Patient Narratives” (PN) to be inclusive of other professions and to reflect the true focus of the seminars.

The seminars were created in response to the observation that many of us, having been inundated with much factual information about health and diseases during our formative years, may, over time, lose sight of our earlier idealistic focus on patients. For example, nurses may find that the children whom they had hoped to help are (naturally) very unhappy about being in the hospital and may reject their caregivers; pharmacy students may become overwhelmed with learning a mountain of information about drugs leaving little energy for thinking about patient perspectives; and overworked physicians who take extra and unanticipated time for one patient find themselves behind in seeing other waiting patients. These situations are often frustrating and may harden health care providers to the detriment of patients.

As a result of attending PN we anticipate our students will better understand that patients experience illness both objectively and subjectively, with many often conflicting feelings about how their condition affects their own lives and the lives of their loved ones. We also hope that our students will better appreciate the importance of interprofessional communication and collaboration, will develop emotional resilience, and will strengthen their resolve to practice patient and family centered care.

Each PN seminar begins with the presentation of a selected patient story, often by invited patients/family members/caregivers, followed by a brief Q&A period where the students may interact directly with the guest patient. Then, in small interprofessional groups, students reflect on (through writing and/or small group discussion) the patient’s experience as well as their own experiences and perceptions. Seven seminars are offered per academic year on the main campus with video conferencing to two other sites. All students, staff, and faculty in the health professions are invited but typically 40 to 75 undergraduate students from medicine, pharmacy, nutrition, medical diagnostics and nursing attend as part of a course in their respective programs.

Based on evidence from student evaluation data, written reflections, and communication with faculty we find that PN seminars are both relevant and effective. More systematic research will compare first and second year student narratives and self-reports of insights into emotional resilience and patient centred care.

Key Words/Phrases:
Patient-Centred care
Patient stories
Interprofessional education
Promoting Rural Health through Pre-Clerkship Learning Experiences

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While it has been established that providing clinical training experiences in rural areas helps to increase the likelihood of future physicians choosing to eventually practice in rural areas, there is less data regarding the value of pre-clerkship rural experiences. Since 2010, the John A. Burns School of Medicine has been sending groups of first year medical students to the Island of Hawaii for one of their problem-based learning (PBL) units. The students complete their PBL tutorials, clinical skills, and community health experiences in this rural community, while joining in remotely for lectures and meetings. We will discuss the structure, pros and cons, student outcomes and feedback, and the challenges of providing this rural experience.

Key Words/Phrases:
Rural Health
Preclerkship Education
Distance Learning
The Value of Interclass Interactions Through Service Learning

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Medical students at different levels of training rarely get to interact with each other in meaningful ways in traditional medical school curricula. When interactions do occur, they usually involve more social than clinical exchanges. There is much in the way of knowledge, skills, and “navigating the system” that underclassmen can gain from their predecessors. All four levels of medical students, in addition to pre-medical students, interact on a routine basis as part of our student-run homeless clinics each week. The third and fourth years are assigned specific mentoring roles and all of the medical students provide valuable information for our pre-medical volunteers. We will discuss the structure of these interactions and feedback from students regarding the value of working together with other levels of students.

Key Words/Phrases:
Peer Mentoring
Service Learning
Community Health
Promoting Partnership and Exchange through Global Service Learning

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Global Service Learning (GSL) immerses students in service-learning experiences that are mutually beneficial to learners as well as the global populations they serve. GSL offers a model for promoting culturally compassionate learning and collaborative leadership skills while addressing global health issues. Academic institutions educating health professionals can use GSL as a framework to establish creative partnerships and provide innovative learning environments where students gain exposure and experience in global health. The purpose of this presentation is to describe a GSL partnership between the University of Hawaii at Mānoa (UHM) Nursing program and the U.S. Navy’s Pacific Partnership (PP) Mission.

The PP is an annual, United States-led humanitarian and civic assistance exercise aimed at strengthening international relationships with partner and host nations in the Asia-Pacific Region. During PP, UHM Nursing faculty and graduate students served as part of an international team comprised of civilian, military, non-governmental organization and academic personnel from multiple nations, conducting subject matter expert exchange activities centered on best practices for disaster preparedness and public health. Collaboration between UHM Nursing and PP mission provides participants with opportunities to engage in provision of health services and health promotion education activities in an international setting as part of an interdisciplinary team of providers and health educators.

The target audience for this presentation is health professional educators and students interested in global health. The presentation will describe the GSL model and its core principles. It will discuss how the GSL experience on the PP mission improves participants’ capacity to partner with people of diverse cultural backgrounds and professional training, deepens their understanding of how improvements in global health are accomplished and builds their confidence as global health leaders.

Key Words/Phrases:
Global Health
Service Learning
Interprofessional Practice
The Effect of the 2023 ECFMG Requirement on Japanese/Foreign Medical Education

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ECFMG (Educational Commission for Foreign Medical Graduates) announced in July 2010 that, effective 2023, physicians applying for ECFMG Certification would be required to graduate from a medical school appropriately accredited through a formal process. The criteria are comparable to those established for U.S. medical schools by the Liaison Committee on Medical Education (LCME), or other globally accepted criteria, such as those put forth by the World Federation for Medical Education (WFME). Currently, Japanese medical school curricula do not meet their criteria, particularly in clinical education, such as bedside teaching (clinical clerkship). Facing the wave of globalization and the impending ECFMG requirement, the Ministry of Education and Science helped establish the JACME (Japanese Accreditation Council for Medical Education) in 2015.

In the U.S., medical school is 4 years, following a 4-year undergraduate program. Bedside teaching is critical for medical-student education. LCME-accredited medical school students apply for the Match to enter residency training, which is regulated and accredited by the ACGME (Accreditation Council for Graduate Medical Education). In Japan, medical schools are 6 years following high school, and are regulated by the Ministry of Education and Science. Graduates then take the national medical licensure examination to become MDs, followed by a 2-year mandatory postgraduate training, set by the Ministry of Health and Labor, before they can seek further residency training in their desired specialty. ACGME-equivalent regulations or accreditation does not currently exist.

One of UH JABSOM’s missions is to support pan-pacific global health care and education. Over the years, JABSOM OME (the Office of Medical Education) and OGH (the Office of Global Health) have provided workshops and externship (observation) rotations to educate foreign medical students and doctors from various Asian countries.

The JABSOM Dean and the OGH will launch a new project called the HMEP (Hawaii Medical Education Program) in 2016, which will be an inaugural program that incorporates the JABSOM medical education curriculum into a partnered Japanese medical school (Tokai University) curriculum to meet the ECFMG requirement and global standards. Students enrolled in this program will experience a special program at JABSOM, called the “Transition to Clerkship,” where they will learn US-style bedside teaching with PBL (problem-based learning) and Simulation, before they start their clinical clerkship years back in Japan. We believe that this new HMEP program will be a role model to support future globalization of medical education in Japan and possibly other countries, which will also benefit JABSOM students and faculty members through reciprocal educational partnerships.

Key Words/Phrases:
ECFMG requirement
Global standard
Japanese medical education
Improvement of Patient Handoffs between Attending Hospitalists Utilizing the I-PASS Handoff Bundle and Direct Peer Observation

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Background: Transitions of care are a common juncture for communication errors. Our busy pediatric hospitalist division had no standard handoff system, despite having up to 4 handoffs per patient per day.

Objectives: Our objective was to adapt the nationally studied I-PASS handoff bundle for our pediatric hospitalist division. Our primary measurable outcomes included hospitalists’ (a.) adherence to the I-PASS mnemonic; (b.) usage of an electronic medical record (EMR) embedded handoff tool; and (c.) completion of 12 direct observations of peers.

Methods: Baseline handoff observations and pre-implementation surveys were performed. An educational retreat introduced the I-PASS bundle including (a.) team communication strategies; (b.) I-PASS mnemonic and EMR-embedded tool; and (c.) training in peer observations and feedback. The survey was repeated at 8 months and 12 months following the retreat to measure sustained self-reported use and attitudes regarding the I-PASS bundle.

Results: All 17 pediatric hospitalists completed the three surveys and the 12 direct observations. Adherence to all five elements of the I-PASS mnemonic improved (p<0.001). Twelve months post-implementation, members reported using the I-PASS mnemonic at least 75% of the time. Self-rated confidence in providing peer feedback increased significantly from 35% to 88% at 12 months (p<0.001).

Conclusions/Implications: The I-PASS handoff bundle is a successful method for improving patient handoffs at the attending level, with reported sustained use of the I-PASS system over time, including during “secret shopper” observations performed three months after the formal study concluded. Confidence in peer observation skills and effective feedback improved with practice.

Key Words/Phrases:
Transitions of care and structured communication skill improvement
Attending-level education and training
Peer observations and feedback
OHANA GROUPS: Building Engagement, Cohesion, and Quality Improvement into Residency Training

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Introduction
Advancing expectations, responsibilities, and knowledge acquisition are among the many changes that medical trainees face during residency. Studies on resident well-being and burnout reveal various factors that contribute to stress including: program-related stress, relationships, time management, financial stress, intimidation and harassment in the work place (Cohen et al 2008). A strong support system in the work place is a key factor in helping residents manage stress. One way residency programs provide support is by assigning residents a faculty or staff advisor/mentor. Other programs also implement peer mentorship systems where junior residents are paired with a senior or chief resident. This year at UH JABSOM’s Department of Psychiatry, “Ohana Groups” were implemented, where residents are placed in a team of co-residents from across all years of training. This unique peer mentorship system expands on other models of peer support that affects well-being, quality of work, and overall morale of a residency program.

Project Objectives
To develop and evaluate resident working groups and peer mentorship that promote team-building, leadership development, well-being.

Methods
At the onset of the 2015-16 academic year, all 25 of the general psychiatry residents were divided into 3 Ohana Groups which included representation from all 4 post graduate years. We hypothesize that this vertically integrated system would promote cohesion and engagement between and among classes. Ohana meetings were integrated into our weekly academic day. Each month, residents hold meetings with their respective groups, then with all residents from other groups, and finally in a combined forum with faculty.

The individual group meetings allow for open discussion on various topics. Each meeting has an assigned facilitator and note taker; roles are shared among residents in order to help develop facilitation and communication skills. Note-taking templates were provided which included check in, positive events, concerns or issues at current work site, safety events, and ideas for quality improvement. A chief resident compiles and use the notes to develop the agenda for and facilitate the all-resident meeting. The all-resident meeting serves as a way to discuss shared concerns and focus on recurring topics, pressing needs, and ideas for quality improvement. The small, intimate forum creates a space where residents feel safe to share thoughts and ideas with each other. Resident issues, needs, and ideas are shared with faculty at the resident-faculty forum facilitated by the program director and chief residents.

Results
The Ohana Groups have been in place now for six months. Feedback from the residents regarding Ohana groups highlight numerous benefits including: enhanced peer support, increased sense of connectedness, improved leadership skills, feeling safe and supported when suggesting ideas for change, and overall feeling a sense of empowerment. Teamwork and leadership among residents within each group resulted to projects such as revisions in curriculum and development of social committee. The Ohana groups also identified and addressed quality improvement issues affecting clinical practice such as those related to work space and computer access in the inpatient units and patient safety. Residents recognized improved communication among residents and faculty. With the groups they are able to share difficulties, help one another with simple but effective solutions related to feeling burnt out, be present for one another, and reach out and allow for others’ help. Overall the Ohana groups promote and nurture resident cohesion, bonding, and deeper understanding of each other.
Conclusions, Implications, & Next Steps
The Ohana groups provide a space for residents to learn about themselves and each other by working as a team. The vertical structure involving residents from various year of training enriches the mentorship experience and was helpful in identifying shared interest in various projects. Most importantly, it serves as one of many ways to promote resident well-being (and in turn patient care). We recommend that it continues to remain as a formal part of the Psychiatry residency program structure and for faculty and administration to recognize and continue to support this system. As the academic year progresses, we plan to formally assess the Ohana groups by developing a survey to obtain qualitative and quantitative data on resident feedback their experience.

Key Words/Phrases:
Resident well being
Mentorship
Quality improvement
Formalizing Quality: Curriculum Design and Implementation

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The current rising tide of quality improvement promises to make great swimmers of faculty involved in medical education and its administration. Accreditation bodies such as the Accreditation Council for Graduate Medical Education (ACGME) and The Joint Commission expect graduate medical education training programs to demonstrate learner competence in the domains of Systems-Based Practice and Practice-Based Learning and Improvement. An earlier foray into quality improvement science, which consisted of a residency program catheter-line associated bloodstream infection (CLABSI) prevention project, revealed significant deficits in both trainee knowledge and application.

We embarked on a pilot curriculum addressing quality improvement for 16 senior internal medicine residents. Herein, we describe the design and implementation of our undertaking. We applied Kern’s 6-step approach to curriculum development. The ACGME, with its creation of the CLER program requires that quality improvement rise to the forefront of training. The specific needs assessment of our learners was explored in 2013-2014 with a (CLABSI) prevention project. The project, which including a knowledge test and 6 small group sessions, revealed knowledge gaps, limited exposure to systems practice, and very low experience with systems integration. Some curricular goals were to engage in interdisciplinary committees, participate in group quality improvement initiatives, and teach some lessons learned to peers. Specific objectives were to review group practice and individual data/audits, appraise a cost-effectiveness analysis, and to complete improvement capability learning modules at the Institute for Healthcare Improvement’s (IHI) Open School (www.ihi.org). Educational strategies included synchronous weekly faculty meetings for brief lectures, journal club, and audits, as well as asynchronous and robust on-line modular resources. Two faculty members, one chief medical resident, and one administrative assistant implemented this new venture for a period of one year. Resistance to change and faculty time were the major barriers identified. Evaluation of the project consisted of standardized IHI post-modular tests, chart and data audits by faculty, appraisals of cost analyses, and guided reflections after system engagement.

Results of our mandatory pilot program were favorable. All trainees achieved 11 module test scores >=75%, appraised a cost effectiveness analysis, and delivered a quality improvement didactic to peers. Composite New Innovations evaluations score for the rotation was 4.41 on a Likert scale of 1-5, with standard deviation 0.62. The unstructured evaluation comments were mostly positive. 12 of 16 respondents would recommend the rotation to their peers. Anonymous resident feedback advised the following changes: expand faculty members to 3-4, require a practicum, reduce redundancy in readings, and allow more time for reflection.

Improvement capability remains an important and inadequately explored area of graduate medical education. The value of knowledge acquisition and skills development in this area clearly defines a commitment to life-long learning. A multidisciplinary exposure provides an understanding of different perspectives: the patient, physician, nurse, administrator, healthcare leader, epidemiologist, insurer, and accountant. Trainees need thoughtful, practical, and integrated experiences within the healthcare system. Although the move away from the bedside may intimidate medical trainees, knowledge and practice of systems function and improvement strategies remain a critical area for high stakes learning.

Key Words/Phrases:
Curriculum Development
Quality Improvement
Systems-Based Practice
The Practice Improvement in Education (PIE) Project: Patient Outcomes Related to Education on Depression in Nursing Homes

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Background: Depression is an important factor related to agitation and other behaviors in nursing home residents. As the next step in our Geriatric Education Center (GEC) Practice Improvement in Education (PIE) project on depression in nursing homes, we focused on non-pharmacologic behavioral management and psychoactive medication reduction.

Methods: This quality improvement (QI) pilot included training on effective interdisciplinary management approaches for depressive symptoms and challenging behaviors, and implementing an adapted ABC (antecedents, behaviors, consequences) log and behavioral activation. We targeted two nursing home floors and included data on residents present both before and after the QI, in June 2013 and July 2014. We examined changes in depressive symptom scores (Patient Health Questionnaire, or PHQ-9, scale 0-27, higher=worse) and antipsychotic/antidepressant medication use with paired T-tests and Fisher’s exact tests.

Results: Of the 66 nursing home residents in this QI pilot, 70% were female, 60.6% were >89 years old (range=48-108, mean=88.8), 83% were Asian and 51% had severe cognitive impairment. Mean PHQ-9 scores decreased significantly from 3.74 to 2.38 (p=0.017). Of the 13/66 (19.7%) residents on antipsychotic medications, 10/13 (76.9%) had dose reductions and 4/13 (30.8%) had medications completely discontinued (p<0.0001 for change pre/post). Of the 34 (51.5%) residents on antidepressant medication, 15/34 (42.9%) had dose reductions and 3/34 (8.8%) had medications completely discontinued (p<0.0001 for change pre/post).

Conclusion: Mean depression scores and antipsychotic and antidepressant medication use decreased significantly in this GEC PIE QI project to manage depression and behaviors non-pharmacologically in nursing home residents.

Key Words/Phrases:
Depression
Quality improvement
Nursing home
Improving Behavioral Health Care Quality through a Service-learning Scorecard Approach

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Introduction
The Affordable Care Act mandates a national health quality strategy, which includes improvements in the delivery of health care services (Kaiser Foundation, 2013). Clinical departments in medical schools can take leadership in developing quality measures, while simultaneously offering trainees an environment to learn and practice quality medicine in the Affordable Care Act era.

Methods
The Department of Psychiatry (DOP) provides behavioral health learning opportunities to medical students and residents in affiliated hospitals and clinics. Service-learning allows early, supervised training experiences for child, adolescent and adult psychiatry in acute and ambulatory settings, while introducing concepts that define quality and demonstrated results, understandable to both clinicians and affiliated hospitals.

The DOP developed quality metrics in partnership with an affiliated hospital. Measures included safe discharge protocol, treatment of medical comorbidities, suicide risk management in the medical/surgical area, and timely discharges to facilitate access to care. Each week, all medical records in the billing database were retrieved with random cases selected for review and summarization. Weekly score card meetings were held with faculty, hospital multi-professional team, residents and medical students. Performance on quality indicators and areas for improvement were key discussion points in the sessions.

Results
Algorithms were developed for each metric, ensuring quality was well defined and measurable. The discharge protocol documented safety plan, treatment options, outpatient referral and discussion with the attending psychiatrist. Medical comorbidities were identified and treated, referrals from the medical/surgical units for suicidal ideation were seen in 4 hours, and acute admissions greater than two days provided documentation on why further hospitalization was warranted.

Conclusion
Developing quality measures with hospital partners and subsequent review of key safety concepts with trainees, allowed for rich discussion on how to best match variables with outcome metrics. Variability in metric measurement reflects early stages of quality improvement, with residents actively participating with faculty to ensure the appropriate variable is matched to the metric. This service-learning process allowed trainees to see the connection of key safety concepts to practice, while improving behavioral health quality in partnership with faculty and the hospital multi-professional team.

References

Key Words/Phrases:
Quality metrics in behavioral health care
Faculty and hospital personnel involvement in service-learning quality improvement
Medical student and resident involvement in quality improvement
Continuing Education in the Health Professions

Hawaii Consortium for Continuing Medical Education (HCCME), JABSOM

This presentation will describe how continuing medical education address professional practice gaps for physicians and other health care professionals, including clinical faculty that provide medical education.

Key Words/Phrases:
- Continuing Medical Education (CME)
- Continuing Education (CE)
- Faculty Development
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This will be extremely helpful in our planning of future HPEC conferences.
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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