

## Making a Bridge to Clinical Practice: Incorporation of Patient Charts into the Didactic Year

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## Goals

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- Provide a method to reinforce documentation skills in the medical record
- Create a series of case discussions designed to follow a simulated patient over time to recreate the clinical environment
- Provide opportunities to familiarize students with the components of the medical record

## Process

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- Introduce two patients each quarter to follow over 4-5 visits
- Correlate cases with Clinical Medicine course topics
- Varied gender, ages, ethnicity which allowed incorporation of different:
  - Clinical pathology
  - Psychosocial issues
  - Preventative health measures

## Our Patients

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- Meredith Kelley, WF
  - Domestic violence issues
- Beverly Garcia, HF
  - Sexual identity issues
- Manual Gonzalez, HM
  - Therapeutic lifestyle changes
- Henry Miller, AAM
  - Preventative health screening

## Chart Organization

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- Problem list/Face sheet
- Medication record
- Immunizations/Health maintenance
- Progress notes
- Laboratory
- X-rays/Diagnostics
- Hospital/Consult notes
- Discharge summary

## Documentation for Students

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- SOAP notes
  - Problem focused vs. comprehensive
  - Take home vs. in-class assignment
- Medication record/Prescriptions
- Laboratory reports
- Radiographs/x-ray reports
- Consultations
- Admission notes
- Discharge summaries

## Introducing our patient...

- Meredith Kelley
  - "Acute Knee Pain" – 16 years old
  - "Don't feel well" – 27 years old
  - "Right hand pain" – 37 years old
  - "Feeling rundown" – 52 years old
  - "Chest pain" – 62 years old



## "Right knee pain" x 2 days

- 16 years old
- Problem focused exam
- Include radiograph of right knee
- Labs - urine HCG
- Discussion pts
  - Prevention – pelvic exam/PAP
  - Patient education - safe sex
  - Marijuana use
  - Depression



## "Don't feel well"

- 27 years old
- Presents with multiple somatic complaints, including arthralgias, abdominal pain, diarrhea, anxiety
- Comprehensive exam
- Labs: CBC, CMP, thyroid panel, RA, ESR, ANA
- Discussion points:
  - Domestic violence
  - Resources available to patient

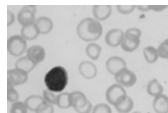
## "Right hand pain" x 3 weeks

- 37 years old
- Expanded problem-focused exam
- Include radiograph of right hand
- Labs: CBC, ESR, RF, ANA, UA, urine HCG
- Discussion points:
  - DDX includes RA, SLE
  - Address history of domestic violence and depression



## "Feeling rundown" x 3 months

- 52 years old
- Expanded problem-focused exam
- Labs: CBC, CMP, peripheral smear, iron studies, B12, folate, TSH
- Discussion points:
  - Diagnosis of anemia
  - Patient education on tobacco use
- Prevention
  - Colonoscopy, given age and FH
  - DEXA scan (chronic steroid use)
  - Eye exam (h/o Plaquenil)



## "Chest Pain" x 1 week

- 62 years old
- Comprehensive exam
- 12-lead ECG: Interpretation provided
- Labs: CBC, CMP, lipid profile
- Discussion points:
  - DDX: angina, MI, GERD, atypical chest pain
  - Ordering cardiac enzymes in outpatient setting vs. transport to ER to r/o acute MI



## Additional documentation exposure

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- Asthma
  - Spirometry, CXR
- DVT
  - Venous doppler U/S, venogram report
- Appendicitis vs. PID
  - Stat CT report, surgical consult, admit note, hospital discharge summary
- Pyelonephritis
  - Urine C&S
- Low back pain
  - MRI of lumbar spine

## What Worked Well...

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- Students became familiar with the various components of the medical record
- Students learned proper documentation pertaining to a medical record
- Students were able to address medical issues with the simulated patient over time, such as domestic violence, depression, tobacco use, chronic medication use, and preventive health measures.

## What the Challenges Were...

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- Creating a person!
- Attention to detail
  - Date of birth, progression of medical history, age of family members, smoking history, lab reports
- Chronology of patient visits
  - What to do with the gap??
  - Trying to keep it realistic

## References

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