Module 8: Measuring Performance With Chart Audits

Sample Medical Record: John Donut

Use for January 2011 abstraction

WeServeEveryone Clinic

1111 First Street California
111-111-11111 Fax: 111-111-1111

Chart Summary

John Donut

Home: 000-000-0000
Male DOB: 01/01/1935 0000-11111 Ins: Commercial xxxxx

Patient Information

Name: John Donut
Address: 1111 Donut Road
Fast Food, California
Patient ID: 0000-11111
Birth Date: 01/01/1935
Gender: Male
Contact By: Phone
Soc Sec No: 111-11-1111
Resp Prov: Carl Savem
Referred by:
Email:
Home LOC: WeServeEveryone

Home Phone: 000-000-0000
Office Phone:
Fax:
Status: Active
Marital Status: Widowed
Race: Black
Language: English
MRN: MR-111-1111
Emp. Status: Part-time
Sens Chart: No
External ID: MR-111-1111

Problems

DIABETES MELLITUS (ICD-250.)
HYPERTENSION, BENIGN ESSENTIAL (ICD-401.1)
HYPERPLASIA, PROSTATE (ICD-600)
DEPRESSION (ICD-311)
RETINOPATHY, DIABETIC (ICD-362.0)
POLYNEUROPATHY IN DIABETES (ICD-357.2)

Medications

PRINIVIL TABS 20 MG (LISINOPRIL) 1 po qd
Last Refill: #30 x 2 : Carl Savem MD (05/27/2010)
HUMULIN INJ 70/30 (INSULIN REG & ISOPHANE (HUMAN)) 20 units ac breakfast
Last Refill: #600 u x 0 : Carl Savem MD (05/27/2010)

Directives

Allergies and Adverse Reactions (! = critical)

Services Due

HEMOCCULT or SIGMOID, BP DIASTOLIC, BP SYSTOLIC, FLU VAX, PNEUMOVAX, MICROALB URN

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John Donut Home: 000-000-0000
Male DOB: 01/01/1935 0000-11111 Ins: Commercial xxxxx

10/31/2010 - Office Visit: F/u Diabetes
Provider: Carl Savem MD
Location of Care: WeServeEveryone Clinic

OFFICE VISIT

History of Present Illness
Reason for visit: Routine follow up to review medications **Chief Complaint:** No complaints

History

Diabetes Management
Hyperglycemic Symptoms
Polyuria: no
Polydipsia: no
Blurred vision: no

Sympathomimetic Symptoms
Diaphoresis: no
Agitation: no
Tremor: no
Palpitations: no
Insomnia: no

Neuroglycopenic Symptoms
Confusion: no
Lethargy: no
Somnolence: no
Amnesia: no
Stupor: no
Seizures: no

Review of Systems
General: denies fatigue, malaise, fever, weight loss
Eyes: denies blurring, diplopia, irritation, discharge
Ear/Nose/Throat: denies ear pain or discharge, nasal obstruction or discharge, sore throat
Cardiovascular: denies chest pain, palpitations, paroxysmal nocturnal dyspnea, orthopnea, edema
Respiratory: denies coughing, wheezing, dyspnea, hemoptysis
Gastrointestinal: denies abdominal pain, dysphagia, nausea, vomiting, diarrhea, constipation
Genitourinary: denies hematuria, frequency, urgency, dysuria, discharge, impotence, incontinence
Musculoskeletal: denies back pain, joint swelling, joint stiffness, joint pain
Skin: denies rashes, itching, lumps, sores, lesions, color change
Neurologic: denies syncope, seizures, transient paralysis, weakness, paresthesias
Psychiatric: denies depression, anxiety, mental disturbance, difficulty sleeping, suicidal ideation, hallucinations, paranoia
Endocrine: denies polyuria, polydipsia, polyphagia, weight change, heat or cold intolerance
Heme/Lymphatic: denies easy or excessive bruising, history of blood transfusions, anemia, bleeding disorders, adenopathy, chills, sweats
Allergic/Immunologic: denies urticaria, hay fever, frequent UTIs; denies HIV high risk behaviors

Vital Signs

John Donut Home: 000-000-0000
Male DOB: 01/01/1935 0000-11111 Ins: Commercial xxxxx

Ht: **74** in. Wt: **190** lbs. T: **98.0** degF. T site: **oral** P: **72** Rhythm: **regular** R: **16** BP: **158/ 90**

Physical Exam

General Appearance: well developed, well nourished, no acute distress
Eyes: conjunctiva and lids normal, PERRLA, EOMI, fundi WNL
Ears, Nose, Mouth, Throat: TM clear, nares clear, oral exam WNL
Respiratory: clear to auscultation and percussion, respiratory effort normal
Cardiovascular: regular rate and rhythm, S1-S2, no murmur, rub or gallop, no bruits, peripheral pulses normal and symmetric, no cyanosis, clubbing, edema or varicosities
Skin: clear, good turgor, color WNL, no rashes, lesions, or ulcerations

Assessment

Problems (including changes): Blood pressure is lower. He is following his diet, by his account. He has not had any hypoglycemic episodes, no night sweats. Feet are inspected and there are no callouses, no compromised skin. No vision complaints.

Impression: Sub optimal sugar, control with retinopathy and neuropathy, high glucometer readings. He will work harder on diet. Will increase insulin by 2 units. BP better.

Plan

Medications:
HUMULIN INJ 70/30 20 u ac breakfast
PRINIVIL TABS 20 MG 1 qd

Treatment: Will have annual foot exam at next visit.

Orders:
Ophthalmology consult
UA
HGBA1C
Metabolic Panel
Lipid Panel
Hemoccult

Education/Counseling (time): 10 minutes

Coordination of Care (time): 10 minutes

Follow-up/Return Visit: 3 months

Disposition: return to clinic

John Donut Home: 000-000-0000
Male DOB: 01/01/1935 0000-11111 Ins: Commercial xxxxx

Ins: BHI (Futura) Grp: BHI1595

10/31/2010 - Lab Report: Metabolic Panel Provider: Carl Savem MD
Location of Care: Millennium Health System

Tests:
(1) Metabolic Panel (ML-03CHEM)

ALK PHOS	72 U/L 35-100
BG RANDOM	125 mg/dl 70-125
BUN	16 mg/dl 7-25
CALCIUM	9.6 mg/dl 8.2-10.2
CHLORIDE	101 mmol/l 96-109
CO2	27 mmol/l 23-29
CREATININE	0.7 mg/dl 0.6-1.2
PO4	2.9 mg/dl 2.5-4.5
POTASSIUM	4.5 mmol/l 3.5-5.3
SGOT (AST)	31 U/L 0-40
BILI TOTAL	0.7 mg/dl 0.0-1.3
URIC ACID	4.8 mg/dl 3.4-7.0
LDH, TOTAL	136 IU/L 0-200
SODIUM	135 mmol/l 135-145

2) HbA1c Test

HbA1c level	8.0%

(3) Lipid Profile

Cholesterol, Total	210 mg/dl
Triglycerides	236 mg/dl
HDL Cholesterol	36
LDL Cholesterol	102

John Donut

Home: 000-000-0000

Male DOB: 01/01/1935 0000-11111 Ins: Commercial xxxxx

Flowsheet

Date	10/31/2010
HEIGHT (in)	74
WEIGHT (lb)	190
TEMPERATURE (deg F)	98
TEMP SITE	oral
PULSE RATE (/min)	72
PULSE RHYTHM	
RESP RATE (/min)	16
BP SYSTOLIC (mm Hg)	158
BP DIASTOLIC (mm Hg)	90
CHOLESTEROL (mg/dL)	
HDL (mg/dL)	
LDL (mg/dL)	102
BG RANDOM (mg/dL)	125
CXR	
EKG	
PAP SMEAR	
BREAST EXAM	
MAMMOGRAM	
HEMOCCULT	neg
FLU VAX	0.5 ml g
PNEUMOVAX	0.5 ml g
TD BOOSTER	0.5 ml g
Foot Exam	
Eye Exam	