Module 8: Measuring Performance With Chart Audits

Sample Medical Record: Adam Pie

Use for January 2011 abstraction

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

Adam Pie
Male DOB: 08/08/1948 0000-88888 Home: 888-888-8888
Ins: Commercial xxxx

Patient Information
Name: Adam Pie
Address: 8888 Crust Dr
Filling, California
Patient ID: 0000-88888
Birth Date: 08/08/1948
Gender: Male
Contact By: Phone
Soc Sec No:888-88-8888
Resp Prov: Carl Savem
Referred by:
Email:
Home LOC: WeServeEveryone

Home Phone: 888-888-8888
Office Phone:
Fax:
Status: Active
Marital Status: Married
Race: White
Language: English
MRN: MR-111-1111
Emp. Status: Full-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
HYTRIN CAP 5MG (TERAZOSIN HCL) 1 po qd
Last Refill: #30 x 0 : Carl Savem (10/27/2010)
PRINIVIL TABS 20 MG (LISINOPRIL) 1 po qd
Last Refill: #30 x 2 : Carl Savem MD (10/27/2010)
HUMULIN INJ 70/30 (INSULIN REG & ISOPHANE (HUMAN)) 20 units
ac breakfast
Last Refill: #600 u x 0 : Carl Savem MD (10/27/2010)
PROZAC CAPS 10 MG (FLUOXETINE HCL) 1 po qd
Last Refill: #30 x 2 : Carl Savem MD (10/27/2010)

Directives
DO NOT RESUSCITATE

Allergies and Adverse Reactions (! = critical)
! CODEINE

Services Due
HEMOCCULT or SIGMOID, BP DIASTOLIC, BP SYSTOLIC, FLU VAX, PNEUMOVAX,
MICROALB URN, FLU VAX, BP DIASTOLIC, BP SYSTOLIC, FUNDUSCOPY, DIAB FOOT CK,
ALBUMIN URIN, TSH,
CHOLESTEROL, HGBA1C, CREATININE.

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12/18/2010 - 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
Social History: His wife Marzapan died 5 years ago this month and he is more introspective.

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

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Ht: **70** 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): Adam is voiding better since increasing Hytrin to 5 mg/day. 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 and symptoms of prostatism are better.

Home Glucose Monitoring:
AC breakfast 110 to 220
AC breakfast mean 142
AC dinner 100 to 250
AC dinner mean 120

Plan
Medications:
HUMULIN INJ 70/30 20 u ac breakfast
PRINIVIL TABS 20 MG 1 qd
HYTRIN CAP 5MG 1 qd
PROZAC CAPS 10 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

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12/19/2010 - 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	6.0%

(3) Lipid Profile

Cholesterol, Total	210 mg/dl
Triglycerides	236 mg/dl
HDL Cholesterol	36
LDL Cholesterol	127

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FLOWSHEET

Date	12/19/2010	12/18/2010
HEIGHT (in)		70
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)		127
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		Complete
Eye Exam		**Complete**