Contents

Introduction ........................................................................................................................................ 3

The COP-2 E-Portfolio ...................................................................................................................... 5

1. Portfolio Purpose .......................................................................................................................... 5
2. Portfolio Objectives ..................................................................................................................... 5
3. Portfolio Process .......................................................................................................................... 5
4. Portfolio Learning Plans .............................................................................................................. 7
5. Time Management and Communication .................................................................................... 7
6. Portfolio Advisor Role .................................................................................................................. 7
7. Formative and Summative Assessment ....................................................................................... 8
   7.1. COP-2 Professionalism Assessment ..................................................................................... 8
   7.2. COP-2 Portfolio Entries & Assignments ............................................................................... 8
8. Summative Assessment Team (SAT) ........................................................................................... 9
9. Module Directors .......................................................................................................................... 9
10. COP e-Portfolio Coordinator ..................................................................................................... 10
11. Technical Support ....................................................................................................................... 10
12. Portfolio and COP-2 Calendar: A Year at a Glance ................................................................. 11

Portfolio Assignments .................................................................................................................... 12

1. Personal Development Plan (PDP) ............................................................................................. 13
2. History and Physical (H&P) Write-ups ....................................................................................... 14
3. Narrative Reflection .................................................................................................................... 16

Appendices ....................................................................................................................................... 17

A. Portfolio Advisor-Students Face-to-Face Group Meeting Checklist ........................................ 18
B. Personal Development Plan (PDP) Student Instructions ........................................................... 19
C. Writing Learning Goals: I-SMART Tool for Students ............................................................... 19
D. History and Physical Write-up Assessment Rubric ..................................................................... 22
E. Student Instructions on their Narrative Reflection .................................................................... 24
   Narrative Reflection ..................................................................................................................... 24
F. Assessment Rubric for Narrative Reflection ................................................................................ 25

H&P Writer's Workshop .................................................................................................................... 27
Introduction

Community of Practice: An Overview

The Community of Practice (COP) program, a key component of the Practice of Medicine module, consists of a longitudinal clinical experience that provides students with an authentic clinical context to promote deeper learning, professional identity formation, and adoption of the values of the profession. This program allows students to work one-on-one with local Central Florida practicing physicians (commonly referred to as preceptors). These early, immersive, and participatory clinical experiences help students to contextualize foundational knowledge and hone their clinical skills while working with real patients under the supervision of a practicing physician. Students also gain an understanding of the complexities of physicians’ work and the distributive nature of learning and knowledge.

During the second year of Community of Practice (COP-2), students are paired up and scheduled to rotate with preceptors along two different clinical tracks:

A) Acute/Hospital Care Track (inpatient wards, ER, urgent care)
B) Long Term/Chronic Care Track (Nursing Homes, Skilled Nursing facilities, Inpatient and Outpatient Hospice)

Students are assigned to one track for the first half of the year (Block 1) and the other track for the remainder of the year (Block 2). Each student completes a total of four (4), four-hour clinical sessions in each track for a total of 8 sessions throughout the year. Each session will have specific learning objectives and requirements for the students, including the completion of assignments through an electronic instrument known as an electronic portfolio (commonly referred to as e-portfolio).

Illustrates the track students undergo while in COP-2
Community of Practice-2 Portfolio

The COP-2 e-portfolio is a tool for 2nd-year students to chronicle their learning needs, form learning goals and plans, and record their progress towards achieving these as well as towards satisfying each COP-2 assignment. It provides a platform for students to reflect on their learning activities, key events and experiences, as well as assembling a collection of work that demonstrates their achievements of competency goals.

Building a portfolio is an interactive, longitudinal process during which students are encouraged to take ownership of their learning and be proactive in planning and pursing their educational goals while receiving guidance and feedback from a portfolio advisor.

Learning portfolios have become commonplace in both undergraduate and graduate medical education as an instrument to encourage reflection, self-assessment, and self-directed learning. Portfolios have been shown to increase students' knowledge and understanding, ability to integrate theory and practice, self-awareness and self-regulation, and ability to cope with uncertainty.

Maintaining an e-portfolio will enhance students' preparedness for their future medical training and practice during which the keeping of a portfolio and engagement in self-directed learning and reflective practice represent essential life-long learning skills for physicians.
The COP-2 E-Portfolio

1. Portfolio Purpose

The purpose of a COP-2 e-portfolio is to provide a vehicle for students to record and track their activities, achievements, and professional development longitudinally and to facilitate students’ development of essential life-long learning skills for physicians.

Specifically, it:

1.1 Shows the student’s progress through the assignments submitted, clinical experience gained, skills learned and assignments completed.
1.2 Allows the learner to establish and revise learning plans, time management schedules, and reflective learning.
1.3 Reminds the student of the learning objectives of COP-2 and the attributes of a reflective practitioner.
1.4 Promotes self-directed learning.
1.5 Chronicles evidence of the student’s ability to engage in self-assessment by identifying their best work and areas for improvement through artifacts submitted and the Personal Development Plan (PDP).
1.6 Provides evidence of self-reflection: document engagement in regular self-reflection on professionalism and humanistic qualities of being a physician, such as empathy, altruism, service and caring.

2. Portfolio Objectives

The objectives of the learning portfolio are to:

2.1 Document the student’s progress through COP-2.
2.2 Clarify areas for improvement.
2.3 Give greater responsibility to student for their learning experience.
2.4 Provide an opportunity for reflective learning.
2.5 Provide additional information to faculty regarding students’ progress and learning.
2.6 Facilitate communication between students and portfolio advisors.
2.7 Establish (and allow for revision of) learning plans and time management schedules.
2.8 Promote self-directed learning essential for continuing professional development and lifelong learning.

3. Portfolio Process

3.1 UCF College of Medicine uses LiveText® as the e-portfolio platform. LiveText® is a customizable, web-based interface that allows students to create, submit and complete assignments; and allows faculty to track and assess assignments as well as evaluate and document course objectives (www.livetext.com).
3.2 Students are introduced to the e-portfolio during the first week of the module and are instructed on how to set up a LiveText® account and personalize their profile. The e-portfolio is designed to be centered on the student who owns and fully manages its content. Thus each student is responsible for the maintenance and accuracy of their portfolio.

3.3 Students meet face-to-face with their assigned portfolio advisor at the beginning of the year to review the portfolio process, exchange contact information, and agree on best communication method(s) between them. This meeting is also dedicated to discuss the H&P write-up format, content and expectations through a portfolio advisor-lead H&P Writer’s Workshop (See materials at the end of this handbook).

3.4 Students will collect artifacts that represent their work through COP-2, including satisfaction of all assignments and achievements on competency goals.

3.5 The COP-2 learning portfolio has the following components:
   3.4.1 Assignments: These include clinical experience (clinical sessions), learning plans, self-appraisals, assessments and records of completion of each assignment.
   3.4.2 Records of professional development
   3.4.3 Reflective learning: Reflective learning uses principles similar to quality assurance employing feedback to improve learning and performance.
   3.4.4 Students are to constantly review the contents of their portfolios at regular intervals and review progress toward their learning plans and competency goals.
4. Portfolio Learning Plans

4.1 Students are required to develop and document a Personal Development Plan (PDP) at the beginning of Block 1 and update this at the beginning of Block 2.

These plans are to identify:

4.1.1 Student's personal learning needs and learning goals for COP-2.
4.1.2 Learning processes: What steps or strategies students will take to achieve their goal?
4.1.3 How will they determine that they have achieved their goals?
4.1.4 Re-evaluation of their goals and progress at (or before) the beginning of Block 2.

5. Time Management and Communication

Time management on the student's end is an essential component of maintaining a portfolio. This includes allocating appropriate time for COP-2 learning activities, reflection, documentation and maintenance of their portfolio, as well as timely submission of assignments. Students (directly or through the COP Coordinator) are required to notify their advisor via email of assignments submitted for review, specifically after each H&P.

Given the lack of an instant-messaging feature within LiveText®, students and their assigned advisor will need to agree on a communication means outside of LiveText® to exchange additional comments, questions and ideas outside of their required work.

6. Portfolio Advisor Role

The e-portfolio will function as a platform for students to chronicle their learning and reflect on their progress; as such it provides an opportunity for students to develop lifelong learning skills. Crucial to this process is the portfolio advisor, a faculty advisor who reviews students' assignments and provides formative feedback.

Portfolio advisors' role includes:

- Meet face-to-face with assigned students at the beginning of the year to review the portfolio process, exchange contact information, and agree on best communication method(s) between them. This meeting is also dedicated to discuss the H&P write-up format, content and expectations through the H&P Writer's Workshop (details in the Video-based H&P / Writer's Workshop assignment in LiveText).
- Reviewing entries sent to him/her by the student.
- Provide formative feedback on written H&Ps and help students develop documentation and clinical reasoning skills
- Provide detailed constructive feedback on each H&P within two (2) weeks of student’s submission.
- Being available to meet with students, provide support and coaching, and deal with challenging situations.
• Being a resource to students throughout the COP experience.
• Communicating to module directors any concerns regarding student entries or content not aligned with expectations or the UCF Honor Code as described in the following online document: http://med.ucf.edu/media/2012/08/UCF-COM-Honor-Code.pdf

7. Formative and Summative Assessment

The electronic portfolio will be utilized as both a learning instrument to stimulate reflection, self-regulation and professional growth, as well as an instrument for assessment. The portfolio will serve as a means to assess competencies--such as self-directed learning--as well as a vehicle for longitudinal, multi-source assessment of students’ achievements. Students will be charged with completing and submitting activities and pre-defined exercises such as H&Ps, reflective exercises, clinical checklists, logbook entries, etc. for formative feedback. For summative assessments, students will have the opportunity to use the feedback received on formative assessments (Formative H&Ps) to complete their summative assessments (Summative H&Ps) and submit this for grading (See Table 1).

Each portfolio advisor is assigned a group of students and provides ongoing non-graded formative feedback to students both individually and (if desired) in group sessions throughout the year. **Summative assessments are conducted by a dedicated UCF College of Medicine assessment team.**

7.1. COP-2 Professionalism Assessment

Students’ professionalism during COP-2 is assessed by their COP preceptors at the end of each block. Students are expected to adhere to the UCF Honor Code and Guidelines of Professional Conduct as described in the following online document:


7.2. COP-2 Portfolio Entries & Assignments

Portfolio entries will be scored on timeliness, completeness, and quality based on scoring rubrics. Similarly, scoring of reflection and self-assessment assignments, including the Professional Development Plan, will be based on timely completion and submission.

<table>
<thead>
<tr>
<th>Portfolio Entries &amp; Assignments</th>
<th>Assessment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Personal Development Plan (PDP)</td>
<td>Formative</td>
</tr>
<tr>
<td>Written H&amp;Ps</td>
<td>Video-based H&amp;P (Formative)</td>
</tr>
<tr>
<td></td>
<td>Block 1 Formative H&amp;P</td>
</tr>
<tr>
<td></td>
<td>Block 2 Formative H&amp;P</td>
</tr>
<tr>
<td></td>
<td>Block 1 Summative H&amp;P</td>
</tr>
<tr>
<td></td>
<td>Block 2 Summative H&amp;P</td>
</tr>
<tr>
<td>Narrative Reflection</td>
<td>Summative</td>
</tr>
<tr>
<td>Revised Personal Development Plan</td>
<td>Formative</td>
</tr>
</tbody>
</table>

**Table 1.** List of all portfolio assignments and nature of assessment
8. Summative Assessment Team (SAT)

A dedicated summative assessment team composed of UCF College of Medicine core faculty (currently COP Module Directors) will provide rubric-based summative feedback on students’ portfolio summative assignments. Portfolio advisors are only expected to provide formative feedback.

9. Module Directors

Module Directors oversee all e-portfolios and, at this time, provide summative graded feedback on student-summative assignments. Module Directors also:

- Design the portfolio program and guidelines
- Provide faculty development for portfolio advisors
- Oversee the entire e-portfolio design and coordination process
- Serve as a resource to portfolio advisors
- Constitute the SAT Team

Anália Castiglioni, MD  
*Practice of Medicine 2, Co-Director*  
*Community of Practice 2, Director*  
**Email:** Analía.Castiglioni@ucf.edu  
**Office:** COM 317H  
**Direct:** (407) 266-1179

Caridad Hernández, MD  
*Practice of Medicine 2, Director*  
*Community of Practice 2, Co-Director*  
**Email:** Caridad.Hernandez@ucf.edu  
**Office:** COM 317G  
**Direct:** (407) 266-1151
10. COP e-Portfolio Coordinator

The COP e-Portfolio Coordinator is the primary liaison between first and second-year students and portfolio advisors. Other relevant responsibilities of this role include:

- Assist module directors in managing all aspects of the COP-2 e-portfolio experience
- Serve as liaison between students, faculty and UCF staff, as well as between community practice physicians and the COP program
- Recruit and provide orientation to community faculty directly involved with the COP and Portfolio Advisor programs
- Serve as student advisor when concerns or issues arise

Any questions or concerns regarding the COP program and e-portfolios may be forwarded to the COP e-Portfolio Coordinator directly.

Abnel Rodriguez-Castro
Community of Practice and e-Portfolio Coordinator

E-mail: Abnel@ucf.edu
Office: COM 410A
Direct: (407) 266-1160

11. Technical Support

For the resolution of technical issues related to the LiveText platform, please call 1-866-LiveText (1-866-548-3839) during the hours of operation shown below, or email them at support@livetext.com.

LiveText Hours of Operation:

- **Monday to Thursday:** 7:00am to 9:00pm (CT)
- **Friday:** 7:00am to 6:00pm (CT)
- **Saturday:** Closed
- **Sunday:** 12:00pm to 9:00pm (CT)
## 12. Portfolio and COP-2 Calendar: A Year at a Glance

<table>
<thead>
<tr>
<th>Weeks</th>
<th>Week 1</th>
<th>Week 2-5</th>
<th>Week 6-9</th>
<th>Week 10-13</th>
<th>Week 14-16</th>
<th>Week 17</th>
<th>Week 18-20</th>
<th>Week 21-23</th>
<th>Week 24-27</th>
<th>Week 28-31</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>COP-2 Session</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>SESSION ACTIVITY</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Document PDP</td>
<td>Flex</td>
<td>#1</td>
<td>#2</td>
<td>#3</td>
<td>#4</td>
<td>Flex</td>
<td>#5</td>
<td>#6</td>
<td>#7</td>
<td>#8</td>
</tr>
<tr>
<td>Face-to-face Meeting with Portfolio Advisor</td>
<td>#1 PEL</td>
<td>2 patients</td>
<td>#2 PEL</td>
<td>2 patients</td>
<td>#3 PEL</td>
<td>2 patients</td>
<td>Review PDP</td>
<td>2 patients</td>
<td>2 patients</td>
<td>2 patients</td>
</tr>
<tr>
<td>Block 1 Formative H&amp;P</td>
<td>1 PEL</td>
<td>Block 1 Summative H&amp;P</td>
<td>1 PEL</td>
<td>Block 2 Formative H&amp;P</td>
<td>1 PEL</td>
<td>1 PEL</td>
<td>1 PEL</td>
<td>1 PEL</td>
<td>1 PEL</td>
<td>1 PEL</td>
</tr>
<tr>
<td>2 patients</td>
<td>2 patients</td>
<td>2 patients</td>
<td>2 patients</td>
<td>2 patients</td>
<td>2 patients</td>
<td>2 patients</td>
<td>2 patients</td>
<td>2 patients</td>
<td>2 patients</td>
<td>2 patients</td>
</tr>
<tr>
<td>#1 PEL</td>
<td>#2 PEL</td>
<td>#3 PEL</td>
<td>#4 PEL</td>
<td>Review PDP</td>
<td>2 patients</td>
<td>2 patients</td>
<td>2 patients</td>
<td>2 patients</td>
<td>2 patients</td>
<td>2 patients</td>
</tr>
<tr>
<td><strong>PORTFOLIO ACTIVITY</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>PDP entry</td>
<td>Block 1 Formative H&amp;P entry</td>
<td>Block 1 Summative H&amp;P entry</td>
<td>Block 1 Formative H&amp;P entry</td>
<td></td>
<td></td>
<td>Block 2 Formative H&amp;P entry</td>
<td></td>
<td>Revised PDP entry</td>
<td></td>
<td>Block 2 Summative H&amp;P entry</td>
</tr>
<tr>
<td>Video-based H&amp;P entry</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**PDP**: Personal Development Plan  
**H&P**: History and Physical Write-up  
**PEL**: Patient Encounter Log (submitted by students via Qualtrics®)  
**Session Activity**: activities students complete as part of their COP-2 clinical sessions  
**Portfolio Activity**: activity students are expected to enter in the portfolio based on session activities  
**NOTE**: For specific dates on these activities, please refer to your WebCourses calendar.

*Highlighted assignments are the only ones expected to be reviewed by portfolio advisors.*
Portfolio Assignments

The following sections provide details on the different assignments and students’ expectations of the COP-2 e-portfolio for information purposes, for the sake of portfolio advisors’ understanding of student goals and program expectations, and to help facilitate a better mentoring experience. Portfolio advisors play a very important role in this educational process and are encouraged to provide spontaneous feedback on any of these e-portfolio components at any time.

Below is a list of COP-2 assignments students are expected to submit to their COP-2 e-portfolio. Portfolio advisors are expected to provide formative feedback on some of the assignments completed by students (bolded below). However, portfolio advisors may choose to review and/or provide formative feedback on any of the assignments listed below at any time. This will help gain insight into students’ learning needs, goals and progress throughout the academic year.

<table>
<thead>
<tr>
<th>e-Portfolio</th>
<th>Student Assignments</th>
<th>Due Dates for Students</th>
</tr>
</thead>
<tbody>
<tr>
<td>Personal Development Plan (PDP)</td>
<td>8/21/16</td>
<td></td>
</tr>
<tr>
<td>Video-based H&amp;P</td>
<td>10/2/16</td>
<td></td>
</tr>
<tr>
<td><strong>Block 1 Formative H&amp;P</strong></td>
<td>10/23/16</td>
<td></td>
</tr>
<tr>
<td>Block 1 Summative H&amp;P</td>
<td>12/4/16</td>
<td></td>
</tr>
<tr>
<td>Narrative Reflection</td>
<td>1/15/16</td>
<td></td>
</tr>
<tr>
<td><strong>Block 2 Formative H&amp;P</strong></td>
<td>2/12/17</td>
<td></td>
</tr>
<tr>
<td>Block 2 Summative H&amp;P</td>
<td>3/12/17</td>
<td></td>
</tr>
<tr>
<td>Revised Personal Development Plan</td>
<td>3/31/17</td>
<td></td>
</tr>
</tbody>
</table>

*Assignments reviewed by portfolio advisors*
1. **Personal Development Plan (PDP)**

An important aim of the COP-2 e-portfolio is to promote life-long learning by encouraging students to reflect on their own learning needs and to identify specific personal learning goals, i.e., their Personal Development Plan (PDP).

Students will develop and document their PDP at the beginning of COP Block 1 and update this at the beginning of COP Block 2. In the PDP students will summarize their personal learning goals during the COP-2 experience. PDP requires that the student reflect and make explicit his or her goals for learning. Students should have uploaded their PDP in the electronic portfolio prior to the first COP session. It is suggested that they review their PDP with their clinical preceptor at the beginning of that session.

**Students’ steps to writing a PDP:**

**Step 1: Identify their learning needs**
Student will consider if there are clinical skills or other competencies that they would like to enhance during their COP-2 clinical experiences. They are to write down the areas that they would like to work on.

**Step 2: Identify and document their learning goals**
Student will select 2-3 goals that they would like to work on. They can use the “I-SMART” (see Appendix) criteria to help them develop specific goals.

**Step 3: Determine strategies and resources that will employ achievement of their goals**
Student will define time management and deadlines.

**Step 4: Share and/or discuss learning goals and PDP with their portfolio advisor**

**Step 5: Refer to their PDP throughout COP-2 to assist them in reaching goals**

*Portfolio advisors may review PDPs to gain insight into students’ learning needs and identified learning goals.*

*Although not expected, portfolio advisors may choose to provide feedback on PDPs at any time throughout the academic year.*
2. **History and Physical (H&P) Write-ups**

A major component of the Practice of Medicine-2 Module and COP-2 e-portfolios is the development of medical documentation skills. At the beginning of their 2nd year, students have had very little practice with history and physical write-ups. Students receive didactic instruction on how to write an H&P as well as several examples of 2nd- and 3rd-year-level H&Ps as resources. However, it is the portfolio process (particularly the feedback from their portfolio advisor) the primary way students learn and practice medical documentation skills. Most importantly, these documentation skills contribute to their final module grade, hence the importance of advisors’ detailed and constructive feedback to help students succeed at this level.

All students are required to write five (5) complete patient write-ups and submit them to their portfolio. Portfolio advisors provide written formative feedback on 2 of these H&Ps (Block 1 & 2 Formative H&Ps), based on a pre-defined rubric (H&P Write-up Assessment Rubric, Appendix D).

**Block 1 & 2 Summative H&P write-ups are submitted for summative assessment**, and count towards the final COP-2 and P-2 grade.

**Student H&P Assignments are as follows:**

1. **H&P Writer’s Workshop and Video-based H&P:** Prior to writing an H&P on a “real patient,” students will participate in a small group **H&P Writer’s Workshop** lead by their Portfolio Advisor. To prepare for this workshop, students create their first H&P write-up (Video-based H&P) after watching a standardized, videotaped patient encounter provided to them. In this session students and faculty use a **Guide to the Comprehensive Adult H&P Write Up** and the **H&P Write-Up Assessment Rubric** to assess and give formative feedback to each write-up, discuss the components and structure of a high-quality note as a group, and review a sample note as a reference (see H&P Writer’s Workshop packet appended to the end of this manual for faculty instructions and materials).

2. **Block 1 H&Ps:** By the end of the first COP-2 block, students are expected to complete and submit two (2) H&Ps to their portfolio. The first H&P (Block 1 Formative H&P) is reviewed by the portfolio advisor who provides formative, constructive feedback, highlighting areas to improve on future write-ups. Students should keep in mind suggestions on their first H&P when they write the second, summative one (Block 1 Summative H&P) to be graded by COP Module Directors. H&P resources and grading rubric can be found in LiveText within these respective assignments.

3. **Block 2 H&Ps:** Following a similar process as above, students submit two (2) H&Ps by the end of Block 2: Block 2 Formative H&P and Block 2 Summative H&P.
**SUGGESTIONS FOR EFFECTIVE H&P FEEDBACK**

- Provide specific feedback on each H&P (otherwise mistakes will be repeated).
- Provide feedback (+ or -) on each component of the H&P (refer to the attached rubric for module expectations).
- Encourage organization and use of conventional subheadings.
- Be specific in your comments and suggestions.
- If writing positive comments, reinforce what was done well.
- If negative comments, you may give an example of how to re-write a component of the history or physical exam.
- Consider using track changes and comments in Word; otherwise add comments to the LiveText® rubric.
- Work with students on Problem List generation and an initial assessment/plan for each problem.
- Avoid “well done” and “great job” with no additional feedback.
- Comment on and encourage correction of typos, poor grammar and misspelled words (e.g., looking up spelling of medication names).
- Encourage student to revise their H&P before submitting for a grade.
- Comment on their references and encourage use of EMB references.
- Do not be afraid to give them too many comments at once (there are only 4 H&Ps in the year, so opportunities are limited).
- Do not hesitate to make comments or suggestions; even on write-ups you believe meet expectations. You are not “marking them down”; your feedback and detailed comments will help students know what to do to get to the next level.
- It is OK to ask them to re-write the H&P if deficient in any way.
- **AVOID EXCEEDS EXPECTATIONS UNLESS TRULY OVER THE TOP**
- Remember this is the only way they learn, by practicing!

**Portfolio advisors are expected to review students’ Formative H&Ps (2 per student). Students will submit these H&Ps via LiveText® as a Word document. Portfolio advisors should expect an email notification from either the student or the COP Coordinator right after an H&P has been submitted for review.**

**Portfolio advisors will use the attached H&P Write-up Assessment Rubric to provide formative feedback to their assigned students on LiveText® as well as feedback in the way of comments or tracked changes on the Word document students attach to LiveText® (a LiveText® guide will be available as a separate document close to the first formative H&P to assess).**
3. **Narrative Reflection**

An important component of students’ COP-2 e-portfolio will be chronicling evidence of reflective capacity. Reflective capacity (i.e., the ability to engage in reflection) is at the core of life-long and self-directed learning practices, which include self-awareness, self-regulation, and self-monitoring. Reflective capacity is vital for meaning-making within the sometimes uncertain, often demanding journey of becoming a physician. Moreover, reflection is considered essential to professional development and the attainment and maintenance of clinical expertise, and physicians need to cultivate their reflective skills throughout their careers.

The COP-2 narrative assignment serves as a stimulus to help students exercise their skills in reflection and use the medium of the written word to portray impactful experiences, processes of learning, and subsequent reflections. This is important for students’ professional development and to help them recognize how they “learn from experience.”

Students will be **required to submit 1 narrative reflection as part of COP-2.**

The Narrative Reflection Writing Prompts are included in the Appendix. The *expected word count will be between 500 and 1,000 words.*

This narrative assignment will be reviewed by the Summative Assessment Team (SAT) and count towards the COP-2 final grade.

*Portfolio advisors may choose to review their assigned students’ narrative reflection. Students will submit their narrative reflection via LiveText® as a Word document.*

4. **Revised Personal Development Plan:**

You should re-assess your original PDP at the end of COP-2 Block 2, and document your progress toward achieving your initial goals. This self-assessment should help guide your goals as you plan to move into your third year. Your revised PDP should be uploaded to the portfolio prior to the end of the academic year. **Timely revision and upload of your PDP will count two (2) extra points towards the P2 final grade.**
Appendices

*The material provided in this appendix is for reference only, most of it extracted from the Student Handbook. Rubrics will be available online via LiveText.com.
A. Portfolio Advisor-Students Face-to-Face Group Meeting Checklist

Dedicate the first **10 minutes** to introductions and setting expectations:

- Share each other's backgrounds and interests (recommended ice breaker).
- Review the COP e-portfolio expectations from both sides, specifically:
  - **Student(s):**
    - Submit every H&P on time by the due date set.
    - Notify their advisor **via email** that their H&P has been submitted for review.
    - Be proactive when the need arises to communicate with their advisor.
  - **Advisor:**
    - Expect an email notification from either the student or COP Coordinator that an H&P has been submitted for review.
    - Provide detailed constructive feedback within two (2) weeks from the notification received.
    - Feel free to provide formative feedback on any other section of students' e-portfolio, if s/he sees the need.

- Discuss the type of feedback student(s) will receive and its formative nature.
- Exchange contact information.
- Decide on preferred means of communication outside of LiveText®, preferred hours, and deadlines.

The remainder **50 minutes should be dedicate to the H&P Writer's Workshop activity:**

- Review Guide to H&P and Rubric
- Peer H&P assessment
- Group discussion

- Consider the option of meeting again later in the academic year individually or as a group.
B. **Personal Development Plan (PDP) Student Instructions**

An important aim of the Community of Practice (COP) e-portfolio is to promote life-long learning by encouraging you to reflect on your own learning needs and to identify specific personal learning goals, i.e., your Personal Development Plan (PDP). Reflecting on your learning may be quite new to you but developing self-directed learning skills is an important tenet of medical professionalism and is essential to continuous professional development both during medical school and throughout your career.

The COP-2 PDP represents a way in which you can identify your own specific learning needs (i.e., what you need to learn) and strategies (i.e., how you are going to learn and how you will know that you’ve learned) while receiving guidance from your portfolio advisor. Asking you to develop a PDP puts you, the learner, at the center of the learning process as you participate in the planning and assessment of your own individual learning during the COP clinical experience.

You will develop and document your Personal Development Plan at the beginning of COP Block 1 and update this at the beginning of COP Block 2. In your PDP you will summarize your personal learning goals during the COP-2 experience.

**Step 1:** Identify learning needs
Consider if there are clinical skills or other competencies that you would like to enhance during the COP clinical experiences. Write down the areas that you would like to work on.

**Step 2:** Identify and document your learning goals
Select 2-3 goals that you would like to work on. You can use the "I-SMART™" criteria to help you develop specific goals (see next section in Appendix).

**Step 3:** Determine the strategies and resources that you will employ to achieve your goals. Define your time management and deadlines.

**Step 4:** Share and/or discuss your learning goals and PDP with your portfolio advisor.

**Step 5:** Refer to your PDP throughout COP-2 to assist you in reaching your goals.

C. **Writing Learning Goals: I-SMART Tool for Students**

**Writing an Effective Goal Statement**

Tips for writing goal statements:
1. Use clear, specific language
2. Start your goal statement with TO + a VERB
3. Write your goal statement using SMART Goal Criteria
4. Avoid using negative language. Think positive!

An example of a goal statement:

*To master performing the complete “Head-to-Toe” Physical Exam and do well on the final exam in March, I need to perform at least one complete PE during each of my COP sessions*.

Note how the above example begins with the word “To”, includes the verb “perform”, and tells what (Physical Exam), why (to do well on the final exam) and when (March).
## I-SMART Breakdown

**I - Important:** Have you identified a goal or competency that is important for you to master at this stage of your medical education? Is there an important competency that you need to master prior to progressing to the next level that you have not yet developed?

**S - Specific:** Be specific with your goals. Specific goals are much more likely to be achieved than non-specific goals.
   - What do you want to accomplish during the COP-2 clinical experience?
   - Why? Specific reason, purpose, or benefits of achieving a goal.
   - What steps or strategies will you take to achieve your goals? How will you determine that you have achieved your goals?

**M - Measurable:** Measuring progress towards a goal helps you stay on track.
   - How will you measure/monitor your progress?
   - How will you keep yourself motivated to work towards your goal?

**A - Attainable:** If a goal may seem too overwhelming to tackle, try breaking it down into steps.
   - Are the goals you have outlined attainable?
   - Can your goals be broken down into steps that can make it more manageable and facilitate your success?
   - What steps and/or strategies will you take to achieve your goals?

**R - Realistic:** Personal, situational, and time factors may influence your ability to reach your goal. Consider your schedule, COP-2 dates and requirements, and other time demands and commitments when determining your goals.
   - What may have seemed realistic at the beginning of Block 1 may not seem so at the start of Block 2. At this point, “pause and think” and re-evaluate your learning goals and strategies and modify them as necessary.

**T – Time bound:** Define start and end points to your goals and maintain a commitment to these deadlines. Goals without deadlines or schedules for completion tend to be put aside for the day-to-day crises that invariably arise in a person’s life.
I-SMART Activity Worksheet for Students

Use the following I-SMART worksheet to write your learning goals and develop your PDP. Repeat this exercise as needed to write other goal statements. Once you have identified your goals, complete your PDP.

What is/are your learning goal(s)? ____________________________________________

1. Is it important?
   I  __________________________________________________________

2. Is it specific?
   S  __________________________________________________________

3. Is it measurable? How will I measure or monitor progress?
   M  __________________________________________________________

4. Is it attainable? (Can this really happen? Attainable with enough effort? What steps are involved?)
   A  __________________________________________________________

5. Is it realistic? (What knowledge, skills, and resource are necessary to reach this goal?)
   R  __________________________________________________________

6. Is it time bound? (Can I set fixed deadlines? What are the deadlines?)
   T  __________________________________________________________
## D. History and Physical Write-up Assessment Rubric

<table>
<thead>
<tr>
<th>Component of Write-up</th>
<th>Incomplete</th>
<th>Developing I</th>
<th>Developing II</th>
<th>Developing III</th>
<th>Advanced</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chief Complaint</td>
<td>None</td>
<td>Present</td>
<td>Present but lacks appropriate important information, or includes information that is not important to the differential</td>
<td>Includes patient’s main complaint, in patient’s words, and no additional information/patient information/other non-pertinent wording</td>
<td>2 points</td>
</tr>
<tr>
<td>Opening Sentence</td>
<td>None</td>
<td>None</td>
<td>None</td>
<td>includes appropriate history and not distractors</td>
<td>5 points</td>
</tr>
<tr>
<td>HPI (0-10 points, 2 for each component below)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>HPI Organization</td>
<td>Not organized</td>
<td>Partially organized</td>
<td>Well organized</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Subjective</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>HPI Thorroughness</td>
<td>Not thorough</td>
<td>Partially thorough</td>
<td>Very thorough</td>
<td></td>
<td></td>
</tr>
<tr>
<td>HPI Includes pertinent positive ROS</td>
<td>Does not include pertinent positive ROS</td>
<td>Includes some pertinent positive ROS</td>
<td>Includes most pertinent positive ROS</td>
<td></td>
<td></td>
</tr>
<tr>
<td>HPI Includes pertinent negative ROS</td>
<td>Does not include pertinent negative ROS</td>
<td>Includes some pertinent negative ROS</td>
<td>Includes most pertinent negative ROS</td>
<td></td>
<td></td>
</tr>
<tr>
<td>HPI Includes pertinent past history/family history/social history</td>
<td>Does not include pertinent past history/family history/social history</td>
<td>Includes some pertinent past history/family history/social history</td>
<td>Includes most pertinent past history/family history/social history</td>
<td>Organized, thorough, bulleted format (includes surgical history, ob/gyn history if appropriate, vaccinations &amp; developmental history if a child)</td>
<td>2 points</td>
</tr>
<tr>
<td>PMH 0-2 points</td>
<td>None</td>
<td>Disorganized, incomplete, paragraph format</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Medications 0-2 points</td>
<td>nothing written (if no medications, must state so)</td>
<td>medications listed but uses abbreviations, trade names</td>
<td>Medications listed, no abbreviations, generic names, or no meds listed as “no medications”</td>
<td>2 points</td>
<td></td>
</tr>
<tr>
<td>Allergies 0-2 points</td>
<td>Nothing listed (if no allergies, must indicate such)</td>
<td>Allergies listed but not reactions</td>
<td>Allergies and reactions listed, or no allergies listed as “no known drug allergies”</td>
<td>2 points</td>
<td></td>
</tr>
<tr>
<td>Social History 0-1 points</td>
<td>None</td>
<td>Includes some but not all of alcohol, tobacco, drug use, living situation/social support</td>
<td>Includes alcohol, tobacco, drug use and living situation/social support</td>
<td>1 points</td>
<td></td>
</tr>
<tr>
<td>Point system does NOT reflect a lack of importance to this!!!</td>
<td>0 point</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Section</td>
<td>None</td>
<td>Includes partial family history</td>
<td>Includes family history</td>
<td></td>
<td></td>
</tr>
<tr>
<td>-------------------------------</td>
<td>-------------------------------</td>
<td>--------------------------------</td>
<td>-------------------------</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Family History</td>
<td>None</td>
<td>Includes partial family history</td>
<td>Includes family history</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Point system does NOT reflect lack of importance</td>
<td>None</td>
<td>Includes partial family history</td>
<td>Includes family history</td>
<td></td>
<td></td>
</tr>
<tr>
<td>ROS</td>
<td>None</td>
<td>Lists only a few, not organized, includes PE or other findings, repeats information already described in HPI</td>
<td>Thorough, excludes information written in HPI with “as in HPI” references, does not include any PE findings in ROS [5 points]</td>
<td></td>
<td></td>
</tr>
<tr>
<td>0-5 points</td>
<td>None</td>
<td>Lists only a few, not organized, includes PE or other findings, repeats information already described in HPI</td>
<td>Thorough, excludes information written in HPI with “as in HPI” references, does not include any PE findings in ROS [5 points]</td>
<td></td>
<td></td>
</tr>
<tr>
<td>General; Skin; HEENT;</td>
<td>None</td>
<td>Lists only a few, not organized, includes PE or other findings, repeats information already described in HPI</td>
<td>Thorough, excludes information written in HPI with “as in HPI” references, does not include any PE findings in ROS [5 points]</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Respiratory; Cardiac; GI;</td>
<td>None</td>
<td>Lists only a few, not organized, includes PE or other findings, repeats information already described in HPI</td>
<td>Thorough, excludes information written in HPI with “as in HPI” references, does not include any PE findings in ROS [5 points]</td>
<td></td>
<td></td>
</tr>
<tr>
<td>GU; GYN; Musculoskeletal;</td>
<td>None</td>
<td>Lists only a few, not organized, includes PE or other findings, repeats information already described in HPI</td>
<td>Thorough, excludes information written in HPI with “as in HPI” references, does not include any PE findings in ROS [5 points]</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Vascular; Neurological;</td>
<td>None</td>
<td>Lists only a few, not organized, includes PE or other findings, repeats information already described in HPI</td>
<td>Thorough, excludes information written in HPI with “as in HPI” references, does not include any PE findings in ROS [5 points]</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Psychiatric; Endocrine;</td>
<td>None</td>
<td>Lists only a few, not organized, includes PE or other findings, repeats information already described in HPI</td>
<td>Thorough, excludes information written in HPI with “as in HPI” references, does not include any PE findings in ROS [5 points]</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hematologic.</td>
<td>None</td>
<td>Lists only a few, not organized, includes PE or other findings, repeats information already described in HPI</td>
<td>Thorough, excludes information written in HPI with “as in HPI” references, does not include any PE findings in ROS [5 points]</td>
<td></td>
<td></td>
</tr>
<tr>
<td>ROS</td>
<td>None</td>
<td>Lists only a few, not organized, includes PE or other findings, repeats information already described in HPI</td>
<td>Thorough, excludes information written in HPI with “as in HPI” references, does not include any PE findings in ROS [5 points]</td>
<td></td>
<td></td>
</tr>
<tr>
<td>0-5 points</td>
<td>None</td>
<td>Lists only a few, not organized, includes PE or other findings, repeats information already described in HPI</td>
<td>Thorough, excludes information written in HPI with “as in HPI” references, does not include any PE findings in ROS [5 points]</td>
<td></td>
<td></td>
</tr>
<tr>
<td>General; Skin; HEENT;</td>
<td>None</td>
<td>Lists only a few, not organized, includes PE or other findings, repeats information already described in HPI</td>
<td>Thorough, excludes information written in HPI with “as in HPI” references, does not include any PE findings in ROS [5 points]</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Respiratory; Cardiac; GI;</td>
<td>None</td>
<td>Lists only a few, not organized, includes PE or other findings, repeats information already described in HPI</td>
<td>Thorough, excludes information written in HPI with “as in HPI” references, does not include any PE findings in ROS [5 points]</td>
<td></td>
<td></td>
</tr>
<tr>
<td>GU; GYN; Musculoskeletal;</td>
<td>None</td>
<td>Lists only a few, not organized, includes PE or other findings, repeats information already described in HPI</td>
<td>Thorough, excludes information written in HPI with “as in HPI” references, does not include any PE findings in ROS [5 points]</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Vascular; Neurological;</td>
<td>None</td>
<td>Lists only a few, not organized, includes PE or other findings, repeats information already described in HPI</td>
<td>Thorough, excludes information written in HPI with “as in HPI” references, does not include any PE findings in ROS [5 points]</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Psychiatric; Endocrine;</td>
<td>None</td>
<td>Lists only a few, not organized, includes PE or other findings, repeats information already described in HPI</td>
<td>Thorough, excludes information written in HPI with “as in HPI” references, does not include any PE findings in ROS [5 points]</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hematologic.</td>
<td>None</td>
<td>Lists only a few, not organized, includes PE or other findings, repeats information already described in HPI</td>
<td>Thorough, excludes information written in HPI with “as in HPI” references, does not include any PE findings in ROS [5 points]</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Physical Examination</td>
<td>None</td>
<td>Present but unorganized, does not include pertinent information or includes information that is not pertinent or incorrect</td>
<td>Organized, includes pertinent HPI, PE and data leading to differential diagnosis [10 points]</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Vital Signs, General Appearance, Skin, HEENT, CV, Respiratory, GI, GU, Musculoskeletal, Neurologic, Psychiatric</td>
<td>None</td>
<td>Present but unorganized, does not include pertinent information or includes information that is not pertinent or incorrect</td>
<td>Organized, includes pertinent HPI, PE and data leading to differential diagnosis [10 points]</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Summary Statement</td>
<td>None</td>
<td>Present but unorganized, does not include pertinent information or includes information that is not pertinent or incorrect</td>
<td>Organized, includes pertinent HPI, PE and data leading to differential diagnosis [10 points]</td>
<td></td>
<td></td>
</tr>
<tr>
<td>0-10 points</td>
<td>None</td>
<td>Present but unorganized, does not include pertinent information or includes information that is not pertinent or incorrect</td>
<td>Organized, includes pertinent HPI, PE and data leading to differential diagnosis [10 points]</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Problem List</td>
<td>None listed</td>
<td>Present but incomplete</td>
<td>Organized, thorough, complete; includes chief complaint [5 points]</td>
<td></td>
<td></td>
</tr>
<tr>
<td>0-5 points</td>
<td>None listed</td>
<td>Present but incomplete</td>
<td>Organized, thorough, complete; includes chief complaint [5 points]</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Differential diagnosis</td>
<td>None</td>
<td>Less than 3 items on differential</td>
<td>At least 3 items on the differential, includes the cc as a problem for clinical reasoning [20 points]</td>
<td></td>
<td></td>
</tr>
<tr>
<td>0-20 points</td>
<td>None</td>
<td>Less than 3 items on differential</td>
<td>At least 3 items on the differential, includes the cc as a problem for clinical reasoning [20 points]</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Clinical Reasoning</td>
<td>None</td>
<td>Minimal reasoning, does not list most likely diagnosis or “must not miss” diagnosis</td>
<td>Thorough and organized, works through differential, describes why and why not diagnoses should be considered, includes most likely diagnosis (and describes this), includes “must not miss” diagnoses when appropriate; organized into “differential, work up, treatment plan” format</td>
<td></td>
<td></td>
</tr>
<tr>
<td>0-25 points</td>
<td>None</td>
<td>Minimal reasoning, does not list most likely diagnosis or “must not miss” diagnosis</td>
<td>Thorough and organized, works through differential, describes why and why not diagnoses should be considered, includes most likely diagnosis (and describes this), includes “must not miss” diagnoses when appropriate; organized into “differential, work up, treatment plan” format</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Assessment and plan</td>
<td>None</td>
<td>Minimal reasoning, does not list most likely diagnosis or “must not miss” diagnosis</td>
<td>Thorough and organized, works through differential, describes why and why not diagnoses should be considered, includes most likely diagnosis (and describes this), includes “must not miss” diagnoses when appropriate; organized into “differential, work up, treatment plan” format</td>
<td></td>
<td></td>
</tr>
<tr>
<td>TOTAL FOR ABOVE: 50 POINTS</td>
<td>None</td>
<td>Minimal reasoning, does not list most likely diagnosis or “must not miss” diagnosis</td>
<td>Thorough and organized, works through differential, describes why and why not diagnoses should be considered, includes most likely diagnosis (and describes this), includes “must not miss” diagnoses when appropriate; organized into “differential, work up, treatment plan” format</td>
<td></td>
<td></td>
</tr>
<tr>
<td>TOTAL FOR ABOVE: 50 POINTS</td>
<td>None</td>
<td>Minimal reasoning, does not list most likely diagnosis or “must not miss” diagnosis</td>
<td>Thorough and organized, works through differential, describes why and why not diagnoses should be considered, includes most likely diagnosis (and describes this), includes “must not miss” diagnoses when appropriate; organized into “differential, work up, treatment plan” format</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
E. **Student Instructions on their Narrative Reflection**

We want the COP-2 narrative reflection assignment to be a genuinely useful exercise that helps you develop real insights, not just a portfolio exercise that has to be done.

We hope that you will be reflecting everyday on your actions and inactions and those of the people around you. This is how adults learn. We would also like you to develop these skills further by undertaking activities of more critical reflection: by ‘stepping back’ from events and actions and exploring your personal role or interpretations. This increases the learning potential of these experiences and allows you to recognize events and actions from multiple perspectives.

**Narrative Reflection**

For this narrative, please reflect on your experience in COP-2 and **choose a patient, event or circumstance** that affected you strongly, whether positively or negatively. Please consider the writing prompts below as framework for your narrative. The expected word count is between 500 and 1,000 words.

1. *Describe the experience in detail (while preserving confidentiality of patients).*

2. *Write why you believe this experience affected you strongly.*

3. *What key lesson(s) you derived from this experience?*

4. *How will you use this experience to help guide your development as a physician-in-training?*
**F. Assessment Rubric for Narrative Reflection**
*(to be graded by the Summative Assessment Team)*

<table>
<thead>
<tr>
<th></th>
<th>Needs Improvement</th>
<th>Effective</th>
<th>Very Effective</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Description of Experience</strong></td>
<td>Lacking description of the experience, event or circumstance and reason for selection. Compromises patient confidentiality.</td>
<td>Satisfactory description of the experience, event or circumstance and reason for selection. Maintains patient confidentiality.</td>
<td>Thorough description of the experience, event or circumstance and reason for selection. Maintains patient confidentiality.</td>
</tr>
<tr>
<td><strong>Level of Reflection</strong></td>
<td>Superficial descriptive writing approach (fact reporting, vague impressions) without reflection or introspection. No sense of perspective, exploration of feelings and assumptions and/or personal impact.</td>
<td>Moves beyond descriptive writing approach and impressions to reflecting (i.e., attempts to understand, question, or analyze the event). Some sense of perspective, exploration of feelings and assumptions and/or personal impact.</td>
<td>Evidence of introspection, deep reflection (i.e., attempts to understand, question, or analyze the event). Includes a sense of perspective, exploration of feelings and assumptions and personal impact.</td>
</tr>
<tr>
<td><strong>Analysis and Lessons Learned</strong></td>
<td>Lack of analysis or clear description of lessons learned. No description of how reflection on experience will inform future actions.</td>
<td>Some analysis and/or description of lessons learned. Little or vague description of how reflection on experience will inform future actions.</td>
<td>Insightful analysis and clear description of lessons learned. Clear description of how reflection on experience will inform future actions.</td>
</tr>
</tbody>
</table>
H&P Writer’s Workshop
Faculty Packet
2016-2017

Adapted from Debra Bynum MD, Cristin Colford MD, David McNeely MD
University of North Carolina at Chapel Hill, North Carolina
H&P Writer’s Workshop: Teaching preclinical medical students the art of the patient “write-up”
Adapted from Debra Bynum MD, Cristin Colford MD, David McNeely MD
University of North Carolina at Chapel Hill, North Carolina

Instructor’s Guide

Objectives for this session:

1. To teach medical students how to create an organized, thorough and thoughtful patient write-up
2. To use a standardized rubric to provide specific feedback to students and more uniform assessment of student write-ups

Learning Outcomes for students:

At the end of this activity, students will be able to:

1. Demonstrate knowledge of the components and structure of a thorough, organized clinical note
2. Apply the principles of structure and components of a written note to demonstrate clinical reasoning and understanding
3. Write a comprehensive note based upon a standardized clinical encounter

Documenting the full History and Physical Examination in the format of a write-up is a core component of clinical rotations. The majority of students and faculty feel that despite the time and effort required, this exercise is essential to the clinical learning experience. The process helps the student organize thoughts and develop a differential and plan. The final product can be a useful tool in the assessment of a student’s ability to not only gather, but also to interpret and synthesize data. Finally, the ability to communicate and document a clinical encounter is not only a key skill that all medical students must have but also a Core Entrustable Professional Activity for entering residency according to a recent position statement by the Association of American Medical Colleges (AAMC).4

Most pre-clinical students struggle to write a clinical note. The complexity of the encounter is often confusing and interferes with the student’s ability to understand the basic components of a thoughtful, thorough, and organized note. Given this observation and evidence that student notes can be improved with frequent and high-quality feedback, we will use a set of educational tools that would aid in the teaching and assessment of this important skill.
This writer’s workshop utilizes a videotaped encounter with a standardized physician and standardized patient. The videotaped encounter is less than 15 minutes in length, includes enough information to create a complete note, and focuses on a single chief complaint that is straightforward, yet conducive to the development of a differential. Using a Guide and a Grading Rubric, a sample comprehensive write-up based upon this standardized encounter was created. This sample is then available as a reference for students and faculty.

Description of Activity:

Prior to the workshop, students create an H&P write-up based upon a standardized, videotaped encounter. Students bring their H&Ps for peer review in a small group session led by their portfolio advisor. Students and faculty use a guide to the write-up and a grading rubric to assess and give feedback to each write-up, discuss the components and structure of a high-quality note as a group, and review a sample note as reference. Given the fact that all of the student notes and the sample note are based upon the same standardized encounter, the focus of the session is placed on the “how to” of the write-up process.

List of resources:

1. Writer’s Workshop Instructor’s Guide (this document)
2. Guide to the Comprehensive Adult Write-up/note
3. Grading Rubric for comprehensive write-up
4. Writer's Workshop Video of standardized patient encounter
5. Sample write-up from standardized video encounter (available to students at the time of the workshop)

Activity Guide:

1. Students identify one student from the group to contact the advisor to set up a meeting date/time (portfolio advisor groups will be provided to them).
2. Individual preparation required for students to complete before class:
   a. Review the Guide to the Comprehensive Adult Write-up
   b. Review the Grading Rubric for the comprehensive adult write-up
   c. Watch the standardized clinical encounter video
   d. Create a full write-up based upon the videotaped encounter and prepare to bring this draft to the small group session.

3. Individual preparation required for faculty leaders to complete before small group meeting:
   a. Review this Instructor’s Guide for a better understanding of the background and process involved in this session
   b. Review the Guide to the Comprehensive Adult Write-up
   c. Review the Grading Rubric for the comprehensive adult write-up
   d. Watch the standardized clinical encounter video
4. Small group session -- Groups with 5-7 students and one faculty leader meet (1 hour)
   a. Faculty leader reviews the background and introduces the session
   b. Students trade notes and use the guide and grading rubric to provide peer feedback
to each other
   c. Faculty leader gives feedback, reviews sample write-up, addresses questions, leads
discussion
   d. Sample write-up is posted for all students to review

References:
1. McLeod PJ. Assessing the value of student case write-ups and write-up evaluations. 
   *Academic medicine : journal of the Association of American Medical Colleges.* May 
   1989;64(5):273-274.
2. Woolliscroft JO, Calhoun JG, Beauchamp C, Wolf FM, Maxim BR. Evaluating the medical 
   history: observation versus write-up review. *Journal of medical education.* Jan 
3. *Learning Objectives for Medical Student Education: Guidelines for Medical Schools.* 
   Washington, DC: Association of American Medical Colleges (AAMC);1998.
4. *CEPAER Drafting Panel Report: Core Entrustable Professional Activities for Entering 
5. Spickard A, 3rd, Gigante J, Stein G, Denny JC. Automatic capture of student notes to augment 
   mentor feedback and student performance on patient write-ups. *Journal of general internal 
   medicine.* Jul 2008;23(7):979-984.
   from medical students during web-based teaching using faculty-calibrated peer review and 
7. Kogan JR, Shea JA. Psychometric characteristics of a write-up assessment form in a medicine 
8. Park YS, Lineberry M, Hyderi A, Bordage G, Riddle J, Yudkowsky R. Validity evidence for a 
   patient note scoring rubric based on the new patient note format of the United States Medical 
   Licensing Examination. *Academic medicine : journal of the Association of American Medical Colleges.* 
Guide to the Comprehensive Adult H&P Write Up  
(Adapted from D Bynum MD, C Colford MD, D McNeely MD, University of North Carolina at Chapel Hill, North Carolina)

<table>
<thead>
<tr>
<th>Section</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Chief Complaint</strong></td>
<td>Include the primary symptom causing the patient to seek care. Ideally, this should be in the patient's words.</td>
</tr>
<tr>
<td><strong>Source &amp; Reliability</strong></td>
<td>If the patient is not the source of the information state who is and if the patient is not considered reliable explain why (e.g., “somnolent” or “intoxicated”)</td>
</tr>
</tbody>
</table>
| **History of Present Illness** | First sentence should include patient's identifying data, including age, gender, (and race if clinically relevant), and pertinent past medical history  
Describe how chief complaint developed in a chronologic and organized manner  
Address why the patient is seeking attention at this time  
Include the dimensions of the chief complaint, including location, quality or character, quantity or severity, timing (onset, duration and frequency), setting in which symptoms occur, aggravating and alleviating factors and associated symptoms  
Include the patient's thoughts and feelings about the illness  
Incorporate elements of the PMH, FH and SH relevant to the patient's story.  
Include pertinent positives and negative based on relevant portions of the ROS. If included in the HPI these elements should not be repeated in the ROS  
The HPI should present the context for the differential diagnosis in the assessment section |
| **Past Medical History** | Describe medical conditions with additional details such as date of onset, associated hospitalizations, complications and if relevant, treatments  
Surgical history with dates, indications and types of operations  
OB/Gyn history with obstetric history (G,P – number of pregnancies, number of live births, number of living children), menstrual history, birth control  
Psychiatric history with dates, diagnoses, hospitalizations and treatments  
Age-appropriate health maintenance (e.g., pap smears, mammograms, cholesterol testing, colon cancer) and immunizations  
Describe any significant childhood illnesses |
| **Medications**          | For each medication include dose, route, frequency and generic name  
Include over the counter medications and supplements; include dose, route and frequency |
<table>
<thead>
<tr>
<th><strong>Allergies</strong></th>
<th>Do not use abbreviations</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Family history</strong></td>
<td>Describe the nature of the adverse reaction</td>
</tr>
<tr>
<td>Comment on the health state or cause of death of parents, siblings, children</td>
<td></td>
</tr>
<tr>
<td>Record the presence of diseases that run in the family (e.g., HTN, CAD, CVA, DM, cancer, alcohol addiction)</td>
<td></td>
</tr>
<tr>
<td><strong>Social history</strong></td>
<td>Include occupation, highest level of education, home situation and significant others</td>
</tr>
<tr>
<td>Quantify any tobacco, alcohol or other drug use</td>
<td></td>
</tr>
<tr>
<td>Include relevant sexual history</td>
<td></td>
</tr>
<tr>
<td>Note any safety concerns by the patient (domestic violence, neglect)</td>
<td></td>
</tr>
<tr>
<td>Note presence of advance directives (e.g., living will and/or health care power of attorney)</td>
<td></td>
</tr>
<tr>
<td>Assess the patient’s functional status – ability to complete the activities of daily living</td>
<td></td>
</tr>
<tr>
<td>Consider documentation of any important life experience such as military service, religious affiliation and spiritual beliefs</td>
<td></td>
</tr>
<tr>
<td><strong>Review of Systems</strong></td>
<td>Include patient's Yes or No responses to all questions asked by system</td>
</tr>
<tr>
<td>Note “Refer to HPI” if question responses are documented in the HPI</td>
<td></td>
</tr>
</tbody>
</table>

**Review of Systems**

Include in a bulleted format the pertinent review of systems questions that you asked. Below is an example of thorough list. In a focused history and physical, this exhaustive list needn’t be included.

- **Skin**: bruising, discoloration, pruritus, birthmarks, moles, ulcers, decubiti, changes in the hair or nails, sun exposure and protection.
- **Hematopoietic**: spontaneous or excessive bleeding, fatigue, enlarged or tender lymph nodes, pallor, history of anemia.
- **Head and face**: pain, traumatic injury, ptosis.
- **Ears**: tinnitus, change in hearing, running or discharge from the ears, deafness, dizziness.
- **Eyes**: change in vision, pain, inflammation, infections, double vision, scotomata, blurring, tearing.
- **Mouth and throat**: dental problems, hoarseness, dysphagia, bleeding gums, sore throat, ulcers or sores in the mouth.
nose and sinuses discharge, epistaxis, sinus pain, obstruction.

breasts pain, change in contour or skin color, lumps, discharge from the nipple.

respiratory tract cough, sputum, change in sputum, night sweats, nocturnal dyspnea, wheezing.

cardiovascular system chest pain, dyspnea, palpitations, weakness, intolerance of exercise, varicosities, swelling of extremities, known murmur, hypertension, asystole.

gastrointestinal system nausea, vomiting, diarrhea, constipation, quality of appetite, change in appetite, dysphagia, gas, heartburn, melena, change in bowel habits, use of laxatives or other drugs to alter the function of the gastrointestinal tract.

urinary tract dysuria, change in color of urine, change in frequency of urination, pain with urgency, incontinence, edema, retention, nocturia.

genital tract (female) menstrual history, obstetric history, contraceptive use, discharge, pain or discomfort, pruritus, history of venereal disease, sexual history.

genital tract (male) penile discharge, pain or discomfort, pruritus, skin lesions, hematuria, history of venereal disease, sexual history.

skeletal system heat; redness; swelling; limitation of function; deformity; crepitation: pain in a joint or an extremity, the neck, or the back, especially with movement.

nervous system dizziness, tremor, ataxia, difficulty in speaking, change in speech, paresthesia, loss of sensation, seizures, syncope, changes in memory.

diabetes mellitus tremor, palpitations, intolerance of heat or cold, polyuria, polydipsia, polyphagia, diaphoresis, exophthalmos, goiter.

psychologic status nervousness, instability, depression, phobia, sexual disturbances, criminal behavior, insomnia, night terrors, mania, memory loss, perseveration, disorientation

Physical examination

Describe what you see, avoid vague descriptions such as “normal”: The PE that relates to the chief complaint may need to be MORE detailed than the sample below; record any “advanced” findings/lack of findings that are pertinent (for example, presence or absence of egophany, shifting dullness, HIR)

Physical Examination:

Always begin with the vital signs. These should include;

- Temperature
- Pulse
- Blood pressure
Respiratory rate

Pain (10 point scale rating)

Pulse oximetry when available: include the percentage of supplemental O2. If room air, document this.

EXAMPLE:

O2 Saturation: 88% on room air, 95% on 2 liter nasal canula.

General appearance: include information on the patient’s overall condition. It is appropriate to comment on level of comfort or distress, as well as general grooming and hygiene.

Example:

- Mr. Smith is a well appearing elderly gentleman in no acute distress.
- Mr. Smith is a frail appearing elderly gentleman in significant respiratory distress at the time of examination.

Next should follow the individual body systems in discreet subheadings.

Traditionally, systems are listed in a top down fashion when performing a full physical examination. This may vary in subspecialty examinations such as ophthalmology or orthopedics.

In general, the format should be as follows

HEENT:

Neck:

Heart:

Lungs:

Abdomen:

Exteremities:

Neurological:

MSK

Vascular:

Skin:

Example:
<table>
<thead>
<tr>
<th>HEENT:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Head: no evidence of trauma</td>
</tr>
<tr>
<td>Nares: normal pink mucosa, no discharge</td>
</tr>
<tr>
<td>Eyes: no scleral icterus, normal conjunctiva</td>
</tr>
<tr>
<td>Ears: TM’s show normal light reflex, no erythema, normal landmarks</td>
</tr>
<tr>
<td>OP: moist mucus membranes; OP with no erythema or exudate. Oral exam with no lesions.</td>
</tr>
<tr>
<td>Neck: Supple, No thyromegaly, no lymphadenopathy, normal range of motion; JVP estimated to be 7 cm.</td>
</tr>
<tr>
<td>Heart: PMI nondisplaced and normal size; No thrills or heaves; RRR, S1S2 with no s3 or s4, no murmurs, rubs or gallops</td>
</tr>
<tr>
<td>Lungs: No increase work of breathing, lungs clear to auscultation, no wheezes or crackles</td>
</tr>
<tr>
<td>Abdomen: Non distended, no scars, normoactive bowel sounds, no bruits, non-tender to palpation, no hepatosplenomegaly, no masses</td>
</tr>
<tr>
<td>Exteremities: No clubbing, cyanosis or edema;</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Vascular:</th>
</tr>
</thead>
<tbody>
<tr>
<td>pulses are 2+ bilaterally at carotid, radial, femoral, dorsalis pedis and posterior tibial; no bruits</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Neuro:</th>
</tr>
</thead>
<tbody>
<tr>
<td>alert and oriented x 3 (person, place and time), CN II-XII intact; Motor 5/5 in all extremities. Reflexes 3+ and equal throughout. Sensory testing normal to light touch, pinprick, proprioception, and vibration. Finger-nose and Heel to shin/point to point testing normal. Rapid alternating movements normal; Gait: normal get up and go, normal heel-toe and tandem gait</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>MSK:</th>
</tr>
</thead>
<tbody>
<tr>
<td>good tone throughout, no swelling/synovitis or limitation of flexion at any joint</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Skin:</th>
</tr>
</thead>
<tbody>
<tr>
<td>normal texture, normal turgor, warm, dry, no rash</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Data collection</th>
</tr>
</thead>
<tbody>
<tr>
<td>Include lab and radiological data appropriate for the HPI (include YOUR interpretation, not just copy/paste from medical record report)</td>
</tr>
<tr>
<td>Labs:</td>
</tr>
<tr>
<td>Chest xray or other xrays/scans</td>
</tr>
</tbody>
</table>
| **Problem List** | List all problems, most important first; You will use this to then begin to combine/lump problems to then create your Assessment/Plan by problem list
For example:
Problem list:
Chest pain
Fever
Shortness of breath
Hemoptysis
Elevated creatinine |
| **Summary Statement** | Label as summary (*In summary....*)
Include 1-2 sentence impression restating basic identifying information (*The patient is a 45 year old male*),
Most pertinent information related to the medical/family/social history (*with a history of tobacco use and family history of early CAD*),
Expanded chief complaint and most pertinent review of systems on presentation (*who presents with substernal chest pressure, nausea and diaphoresis*),
Most important findings on physical, labs, data (*and is found to have an S4, bilateral rales, and JVD on exam with evidence of pulmonary edema on CXR*),
Pertinent information is that which contributes directly to building the case for your differential diagnosis....

*In summary, the patient is a 45 year old male with a history of tobacco use and family history of early CAD who presents with substernal chest pressure, nausea and diaphoresis and is found to have an S4, bilateral rales, and JVD on exam with evidence of pulmonary edema on CXR*...

*Key phrases and structure for summary statement:*

*In summary, this is a ...*

*With a history of...*

*Who presents with....*

*And is found to have...*
<table>
<thead>
<tr>
<th>Assessment/Plan</th>
<th>Organize plan by problem: Label, Assessment/Plan by problem list</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Include at least 3 diagnoses for your differential potentially associated with the patient’s chief complaint</td>
</tr>
<tr>
<td></td>
<td>Include the Most Likely diagnosis/diagnoses on your differential</td>
</tr>
<tr>
<td></td>
<td>Include the DO NOT MISS diagnoses on your differential</td>
</tr>
<tr>
<td></td>
<td>Order your differential to reflect most likely diagnoses or most serious diagnoses first</td>
</tr>
<tr>
<td></td>
<td>For each diagnosis discuss physiologic disease basis relevant to the patient and elements from the patient’s history and physical that either support or refute the diagnosis. For each item on your differential, explain what makes it likely AND what makes it less likely.</td>
</tr>
<tr>
<td></td>
<td>It is OK to include less likely items on your differential – explain why it is important to consider but less likely the diagnosis (PE may be considered frequently when a patient presents with shortness of breath and should be on the differential because it is a Do Not Miss diagnosis – but if the patient has a high white count, cough with sputum and infiltrate on exam, it is LESS likely)</td>
</tr>
<tr>
<td></td>
<td>For each problem, discuss the diagnostic plan, treatment plan and patient education.</td>
</tr>
<tr>
<td></td>
<td>Outline of what this should look like...</td>
</tr>
<tr>
<td></td>
<td>Summary Statement...</td>
</tr>
<tr>
<td></td>
<td>A/P by Problem List:</td>
</tr>
<tr>
<td></td>
<td>1. Problem # 1: Differential Dx includes.... List at least 3 items for your differential, explain what is most likely and why, what is a must not miss, and what is less likely and why.... Diagnostic Plan will be... Treatment plan will include...</td>
</tr>
<tr>
<td></td>
<td>Patient education.... Instructions to patient include...</td>
</tr>
<tr>
<td></td>
<td>2. Problem # 2: Differential.... Diagnostic Plan... Treatment plan...</td>
</tr>
<tr>
<td></td>
<td>Patient education</td>
</tr>
<tr>
<td></td>
<td>3. Problem # 3: Differential... Diagnostic plan... Treatment plan... Patient education...</td>
</tr>
</tbody>
</table>
For the main problem(s) identified in your problem list, you are expected to identify a **topic or clinical question** that would help you advance your knowledge in that specific area to help you provide better care of patients presenting in a similar way in the future. The topic or clinical question can focus on an epidemiologic, diagnostic, therapeutic, pharmacologic, etc. aspect of patient care.

In order to review the topic/answer your question, you should: 1) perform a literature or textbook review to answer your clinical question, 2) incorporate your findings into the assessment and plan of your write-up in the form of 1-2 paragraphs and 3) list the resources used.

COM Library resources are strongly encouraged, for suitable resources based on topic of interest please see [P2 LibGuide](#).

**Format**

- Goal is a concise write up with your thought processes documented in logical and organized manner
- Avoid spelling or grammatical errors
- Use only commonly accepted abbreviations

**HIPAA**

- Remove patient identification from write up (e.g., name, address, medical record number)
Sample Write-Up for Writer's Workshop

Chief Complaint: “My legs are swollen and I can't breathe” chief complaint in patient’s own words, no other demographics or history

HPI: The patient is a 58 year-old female with a history of high blood pressure and high cholesterol who comes to the clinic with a 6-week history of leg swelling and difficulty breathing. opening sentence that includes most pertinent past history and presenting symptoms These symptoms have been progressing. She has noticed that she now gets short of breath when walking short distances such as getting up from a chair to the bathroom. She can no longer walk to her mailbox without becoming short of breath and stopping to rest. She has been waking up at night gasping for air, and has been sleeping propped up on 4 pillows because she gets short of breath when she lies down flat. She has a cough that is productive of clear phlegm. Story of the illness and symptoms, and pertinent positive symptoms/ROS She has not had any fevers or chills. She denies chest or leg pain. She has had no sick contacts. She has gained 15 pounds in the past two months. She has no abdominal pain but feels full after eating a small amount. Pertinent positive AND negative ROS based upon your working differential diagnosis; can also include pertinent family history (you could include the family history of heart disease) and pertinent social history (her prior smoking history)

Past Medical History:
1. Hypertension
2. High cholesterol

Allergies: NKDA

Medications:
Aspirin 81mg by mouth daily

Hydrochlorothiazide 25mg daily (note for patient--blood pressure/diuretic)

Lisinopril 20mg daily (blood pressure)

Simvastatin 40mg daily (cholesterol)

Family History: Hypertension and high cholesterol

Social History: She lives with her husband, who has had to do more of the housework including cleaning and cooking due to her shortness of breath. She did smoke1 pack of
cigarettes daily for 30 years, but quit 20 years ago. She drinks occasional alcohol, but no more than 1 glass of wine a month. No illicit drug use. She and her husband do not like to cook. They often eat out or prepare frozen meals and soups. She does not get much regular physical activity but is much more limited over the last few weeks.

**Review of Systems:**

Gen: Positive weight gain, fatigue. No fevers, night sweats

HEENT: No headaches, vision changes.

CV: As per HPI, positive for shortness of breath, orthopnea, LE edema. No chest pain or palpitations

Pulmonary: Cough productive of clear sputum. No wheezing. Positive for orthopnea, dyspnea on exertion.

GI: No abdominal pain, nausea, vomiting, diarrhea or constipation. Mild feeling of distension in stomach and feels full easily.

Psych: No depression, but feeling down that she is not able to be as active as she had been previously.

Endo: No heat or cold intolerance, no polyuria or polydipsia.

MSK: No joint pains or swelling.

Neuro: Mild dizziness when she gets winded. No weakness, numbness. No headaches.

Heme: No bruising or bleeding.

**Physical Exam:**

Vital Signs: Temp 98 F, pulse 75, Resp Rate 20, Blood Pressure 130/95

Gen: Appears tired but in no acute distress, breathing comfortably

HEENT: No trauma. TM clear. moist mucous membranes, Oropharynx with no exudates or thrush

Neck: JVP measures 12cm, no cervical lymphadenopathy, no thyromegaly

Lungs: Crackles in bottom third of lung fields bilaterally. No wheezing
CV: Displaced PMI, RRR, no murmurs. Normal S1 and S2. Positive S3 gallop.


Ext: warm and well perfused. 2+ pitting edema to knees bilaterally

Skin: no rashes, redness, or warmth

**Labs/chest xray:** pending

**Problem List:** includes problems from history, past history, physical exam, labs

1. shortness of breath
2. orthopnea
3. PND
4. Bilateral edema
5. HTN
6. Hyperlipidemia
7. Prior tobacco use
8. Cough with clear phlegm
9. Family history of heart disease (not early onset)
10. Weight gain
11. S3 on exam
12. Bilateral crackles on exam
13. Bilateral edema on exam
14. JVD

**Summary statement:**

In summary, this is a 58 year old woman with a history of HTN and hyperlipidemia who presents with progressive SOB, orthopnea, and PND and is found to have elevated JVD, s3, basilar crackles and bilateral edema on exam. **Summary statement** - unlike opening sentence, summary statement should also include really pertinent findings from the history, PE and labs/data

**Consider this format for summary statement:**

1. **Basic demographic, advertise the summary statement** (In summary, this is a 62 year old woman...
2. **Most pertinent history related to your differential** *(with a history of HTN and hyperlipidemia...)*

3. **List most pertinent presenting chief complaint and other ROS** *(who presents with progressive SOB, orthopnea, and PND...)*

4. **List pertinent PE, lab, data findings** *(and is found to have elevated JVD, an S3, basilar crackles and bilateral lower extremity edema on exam)*

*In summary, this is a ...*

*With a history of ...*

*Who presents with...*

*And is found to have...*

**A/P by problem(s) or symptom(s):** You can “lump” problems together that have the same differential (for example, shortness of breath, PND, orthopnea and edema go together for a differential that includes heart failure); Not every item on the problem list you have created above is necessarily included as a separate problem in the assessment/plan section.

*Problem/symptom(s) # 1 should include what the patient presents with (the chief complaint) OR symptoms related to a must not miss/could be lethal diagnosis.*

---

1. **SOB/orthopnea/PND/edema** *(ok to group symptoms together if they “fit”)*: Given the constellation of symptoms and the physical exam findings of elevated JVP, bilateral crackles, S3 and bilateral edema, Congestive heart failure is the most likely on the differential diagnosis. Other less likely processes to consider would be pulmonary embolism with DVTs, pneumonia, interstitial lung disease, and pulmonary HTN. PE and DVTs could cause peripheral edema and shortness of breath, and occasionally can be associated with elevations of JVP if there is associated right heart failure, but this would not explain the s3 and crackles on exam and is much less likely with bilateral lower extremity edema. Pneumonia might explain the crackles on exam, but the time course and history do not suggest an infectious etiology and this would not explain the edema. Interstitial lung disease could explain the lung findings, and could be associated with pulmonary HTN and therefore elevation of JVP and bilateral edema due to right sided heart failure, but would not explain the PND, orthopnea and s3 which are more indicative of left sided heart failure. Anemia might explain the shortness of breath but not the other symptoms. Hyperthyroidism can also be associated with high output heart failure, but the history otherwise is not consistent. Renal and liver failure can be associated with
shortness of breath, weight gain, and edema, but again should not present with signs of left sided heart failure. **(differential diagnosis and clinical reasoning—include at least 3 items on your differential, and describe what you think is the most likely and why, and what is less likely and why; remember to clearly state any DO NOT MISS Diagnoses, and explain why they may be more or less likely...)**

Given the fact that congestive heart failure, with left ventricular involvement, is most likely on the differential diagnosis, she will need a transthoracic echocardiogram to more fully evaluate her cardiac function. Given the differential that includes anemia and renal failure, will also check basic labs including a chemistry panel and CBC as well as a TSH to rule out hyperthyroidism. Could consider checking a BNP as well. Given the crackles on exam and differential that includes ILD, will check a chest xray. PE and DVTs are less likely so will hold on checking ddimer, dopplers or CT angiogram at this point. **Work up plan**

Once basic labs are reviewed, would continue lisinopril for afterload reduction, and add a diuretic such as furosemide given evidence of volume overload on exam. Although HCTZ is a diuretic, it is not as potent as furosemide. Stop HCTZ if treating with furosemide. Will need to follow K once starting this. Further management will depend upon results from the echocardiogram, but may need further evaluation for underlying ischemic heart disease with cardiology if LV ejection fraction is depressed. Will also need BP control, especially if there is evidence for diastolic dysfunction. **Treatment plan**

In addition, the patient will need counseling and education for congestive heart failure if this is the diagnosis. Careful daily weights and monitoring, and adjusting diet to include less salt (especially with her current diet that includes processed foods) will be important. **(Patient education)**

**Keep to the outline/format - differential diagnosis with clinical reasoning, work up plan, treatment plan, patient education**

2. HTN: Given the likelihood of CHF, will need tighter blood pressure control. Will need to hold HCTZ if treating with furosemide. May need additional agent such as beta blocker or spironolactone depending upon results of cardiac echo.

3. Hyperlipidemia: continue current statin, check lipids and LFTs.
# History and Physical Write-up Assessment Rubric 2016-17

Complete this rubric by choosing the descriptor that best describes each category for the H&P reviewed.

<table>
<thead>
<tr>
<th>Component of Write-up</th>
<th>Incomplete (0)</th>
<th>Developing I (0.4)</th>
<th>Developing II (0.6)</th>
<th>Developing III (0.8)</th>
<th>Advanced (1.0)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chief Complaint</td>
<td>None</td>
<td>Present</td>
<td></td>
<td></td>
<td>Includes patient’s main complaint, in patient’s words, and no additional information/patient information/other non-pertinent wording</td>
</tr>
<tr>
<td>Opening Sentence</td>
<td>None</td>
<td>present but lacks appropriate important information, or includes information that is not important to the differential</td>
<td></td>
<td></td>
<td>includes appropriate history and not distractors</td>
</tr>
<tr>
<td>Subjective HPI</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>HPI Organization</td>
<td>Not organized</td>
<td>Partially organized</td>
<td></td>
<td>Well organized</td>
<td></td>
</tr>
<tr>
<td>HPI Thoroughness</td>
<td>Not thorough</td>
<td>Partially thorough</td>
<td></td>
<td>Very thorough</td>
<td></td>
</tr>
<tr>
<td>HPI Includes pertinent positive ROS</td>
<td>Does not include pertinent positive ROS</td>
<td>Includes some pertinent positive ROS</td>
<td></td>
<td>Includes most pertinent positive ROS</td>
<td></td>
</tr>
<tr>
<td>HPI Includes pertinent negative ROS</td>
<td>Does not include pertinent negative ROS</td>
<td>Includes some pertinent negative ROS</td>
<td></td>
<td>Includes most pertinent negative ROS</td>
<td></td>
</tr>
<tr>
<td>HPI Includes pertinent past history/family history/social history</td>
<td>Does not include pertinent past history/family history/social history</td>
<td>Includes some pertinent past history/family history/social history</td>
<td></td>
<td>Includes most pertinent past history/family history/social history</td>
<td></td>
</tr>
<tr>
<td>PMH</td>
<td>None</td>
<td>Disorganized, incomplete, paragraph format</td>
<td></td>
<td>Organized, thorough, bulleted format (includes surgical history, ob/gyn history if appropriate, vaccinations &amp; developmental history if a child)</td>
<td>[2 points]</td>
</tr>
<tr>
<td>Medications</td>
<td>nothing written (if no medications, must state so)</td>
<td>medications listed but uses abbreviations, trade names</td>
<td></td>
<td>Medications listed, no abbreviations, generic names, or no meds listed as “no medications”</td>
<td>[2 points]</td>
</tr>
<tr>
<td>Allergies</td>
<td>Nothing listed (if no allergies, must indicate such)</td>
<td>Allergies listed but not reactions</td>
<td></td>
<td>Allergies and reactions listed, or no allergies listed as “no known drug allergies”</td>
<td>[2 points]</td>
</tr>
<tr>
<td>Social History</td>
<td>None</td>
<td>Includes some but not all of alcohol, tobacco, drug use, living situation/social support</td>
<td></td>
<td>Includes alcohol, tobacco, drug use and living situation/social support</td>
<td>[1 points]</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Family History</td>
<td>None [0 point]</td>
<td>Includes partial family history</td>
<td>Includes family history [1 point]</td>
<td></td>
<td></td>
</tr>
<tr>
<td>----------------</td>
<td>----------------</td>
<td>--------------------------------</td>
<td>----------------------------------</td>
<td></td>
<td></td>
</tr>
<tr>
<td>ROS</td>
<td>None [0 point]</td>
<td>Lists only a few, not organized, includes PE or other findings, repeats information already described in HPI</td>
<td>Thorough, excludes information written in HPI with &quot;as in HPI&quot; references, does not include any PE findings in ROS [5 points]</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Physical Examination</td>
<td>None [0 points]</td>
<td>Incomplete, Unorganized</td>
<td>Includes vitals, organized in appropriate order, thorough [10 points]</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Objective</td>
<td>None [0 points]</td>
<td>Present but unorganized, does not include pertinent information or includes information that is not pertinent or incorrect</td>
<td>Organized, includes pertinent HPI, PE and data leading to differential diagnosis [10 points]</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Summary</td>
<td>None [0 points]</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Problem List</td>
<td>None listed [0 points]</td>
<td>Present but incomplete</td>
<td>Organized, thorough, complete; includes chief complaint [5 points]</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Differential diagnosis</td>
<td>None [0 points]</td>
<td>Less than 3 items on differential</td>
<td>At least 3 items on the differential, includes the cc as a problem for clinical reasoning [20 points]</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Clinical Reasoning</td>
<td>None [0 points]</td>
<td>Minimal reasoning, does not list most likely diagnosis or &quot;must not miss&quot; diagnosis</td>
<td>Thorough and organized, works through differential, describes why and why not diagnoses should be considered, includes most likely diagnosis (and describes this), includes &quot;must not miss&quot; diagnoses when appropriate; organized into &quot;differential, work up, treatment&quot; format</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>More thorough, but not organized into &quot;differential, work up, treatment&quot;</td>
<td>Differential and clinical reasoning &quot;wows&quot;; reasoning is advanced; [25 points]</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

TOTAL FOR ABOVE: 50 POINTS

TOTAL FOR ABOVE: 50 POINTS