Introduction to Primary Care Medicine

July 19-26, 2013

Overview

The Introduction to Primary Care Medicine (IPCM) block will introduce students to Primary Care Medicine, the Patient Centered Medical Home model and provide a foundational context for the curriculum including introductions to the basic science elements. Beginning the Friday of Orientation week students will be introduced to a patient with low back pain who has diabetes. This case will unfold over the next 5 days be the basis for activities that introduce and provide the context for:

- Primary Care Medicine
- The Patient Centered Medical Home model
- Clinical Decision Support
- Evidence Based Practice
- Patient Engagement and Empowerment
- Quality Improvement
- Leadership

The IPCM Schedule

Date	Time	Activity
Friday July 19th	AM	Orientation Wrap up
	PM	1. PCMH Overview – Todd Weihl 2. EBM 1 – Doug Mann
Monday July 22	AM	3. Basic Science Introduction
	PM	4. Clinical Decision Support - Jane Balbo 5. EBM 2 – Doug Mann
Tuesday July 23	AM	6. Basic Science Introduction
	PM	7. Patient Engagement and Empowerment - Todd Weihl
Wednesday July 24	AM	8. Real Patient Interviews – Mike Tomc 9. OMM Introduction and Orientation Lab – Dave Eland
		10. Quality Improvement
Thursday July 25	AM	8. Real Patient interviews – Mike Tomc
	PM	11. EBM 3 – Doug Mann
Friday July 26	AM	12. Leadership -
	PM	13. Primary Care Assessment

- During orientation students will be asked to reflect on why they chose to go to medical school and the opportunity to practice primary care medicine.

- They will be surveyed to determine their knowledge and attitudes about Primary Care and the Patient Centered Medical Home model and surveyed again longitudinally.

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Case
Chief Complaint

Maria Velasquez, a 52 year old Hispanic female presents to your office with complaint of low back pain.

History of Chief Complaint

Mrs. Velasquez is a 52 year old Hispanic female with limited English presenting with lower back pain for 3 weeks. When asked to point where her pain is, she points to her lower lumbar and sacroiliac areas bilaterally. States the pain is there all the time, worse when bending over to pick up things. Does not recall injuring herself. She is not able to rate the pain on a scale of 1 -10, stating "it just hurts". It is difficult to assess if the pain radiates due to limited English. Denies numbness, weakness, or loss of bowel or bladder. She has not tried any medications.

Past Medical History

Your chart review shows her last visit was 1 year ago for an Upper Respiratory Infection, and you recommended follow-up in 3 months for a diabetes check and routine labs.

Mrs. Velasquez has Type 2 Diabetes Mellitus

Medications: Metformin 500mg bid
Immunizations: Received a flu shot this year per chart review
Allergies: None
Injuries: None
Surgeries: Caesarian section at 26 years old
Hospitalizations: at 22 years old and 26 years old for delivery of her two children

Family Medical History

Mother is 76 years old and alive, has diabetes
Father died at 67 years old of heart attack
She has two sisters, one is 48 years old and has diabetes, and the other is 50 years old and is healthy.

Social History

Married, works in a factory where she picks up heavy boxes.

Diet: no particular diet plan
Exercise: none
Alcohol: none
Smoking: smoked as a teenager, unsure of how much. Quit several years ago.
Drugs: none

ROS

Difficult to obtain due to language barrier.

General: Patient states she is tired when coming home from work. Denies fever, chills, night sweats.
Skin: Denies rashes, itching, burns, nevi, new growth, changes in pigmentation, abnormal nails.
Head: Denies trauma, loss of consciousness, headache, seizures.
Eyes: Denies blurry vision, double vision, loss of vision, eye pain, photophobia, scleral icterus, itchy/watery eyes. She does not wear glasses.
Ears: Denies otalgia, otorrhea, bleeding, itching, tinnitus, dizziness.
Nose: Denies Epistaxis, obstruction, discharge, change in smell, stuffiness, sinus pain/pressure
Mouth/Throat: Denies difficulty swallowing, changes in taste, sore throat.
Neck: No stiffness or adeneopathy.
Breast: No masses, tenderness, discharge.
Respiratory: Denies shortness of breath, cough, wheezing.
Cardiovascular: No chest pain, palpitations, dyspnea on exertion, edema.
Gastrointestinal: No nausea, vomiting, diarrhea, constipation, abdominal pain, pyrosis, dysphagia, odynophagia, hematochezia, melena.
Genito-urinary: Denies dysuria, frequency, hesitancy, polyuria, hematuria.
Neurologic: Denies loss of consciousness, seizures, weakness numbness, tingling, paralysis.
Psychiatric: Denies depression, mania, changes in mood.
Endocrine: Does not check her blood sugar often, but when she does it is usually in the 300's. Diagnosed with Type 2 Diabetes 1½ years ago per chart review. Denies polydipsia, polyphagia, polyuria, sensitivity to heat/cold, tremor, dry skin/hair/nails, goiter.
Musculoskeletal: See HPI. Other than chief complaint, denies swelling, redness, muscle weakness, decreased/loss of function, decreased range of motion, atrophy, cramps, fracture.

Physical Findings

BP: 120/80
Pulse: 75
Respiration: 16
Temp: 98.6 F
Height: 62 in.
Weight: 182
BMI: 33.3

General : 52 year old obese Hispanic female, appears older than stated age, in no acute distress, with minimal eye contact and reluctance to answer questions.
Skin: warm and moist with good tugor. No rashes, petechiae, ecchymosis, or lesions.
HEENT: *Head* normocephalic, atraumatic, hair of average texture and distribution, scalp without lesions; *Eyes* conjunctiva pink, sclera white, pupils 3-4mm round, regular, and equal and reactive to light, EOMI, Fundascopic exam demonstrated sharp disc margins without hemorrhages, exudates, arteriolar narrowing or AV nicking; *Ears* right and left TM without good cone of light; *Nose* mucosa pink, septum midline, no sinus tenderness; *Mouth* oral mucosa pink, good dentition, no lesions or petechiae; *Throat* tonsils present, pharynx without erythema or exudates.
Neck: soft, supple, trachea midline, no lymphadenopathy or masses, thyroid mobile and without enlargement, no carotid bruits.
Breast: Deferred
Lungs: Clear to auscultation bilaterally with full breath sounds, no wheezes, rhonchi, or crackles
Heart: Regular rate and rhythm, normal S1 and S2, no S3 or S4. No murmurs, gallops or rubs. PMI midclavicular at $4^{th}/5^{th}$ intercostal space.

Abdomen: soft, non-tender, non-distended, bowel sounds present in all 4 quadrants, no hepatosplenomegaly, masses, or ecchymosis. No costovertebral angle tenderness.
GU: Deferred
Rectal: Deferred
Extremities: No edema of lower extremity, calf tenderness, varicosities, or lesions. Radial, Femoral, Popliteal, Posterior Tibial, and Dorsalis pedis pulses 2/4 bilaterally. Capillary refill <2s
Neuro: CN2-12 intact, Biceps/Triceps/Patellar/Achilles DTRs +2/4 bilaterally, Strength 5/5 in upper and lower extremities bilaterally. Sensation grossly intact in upper and lower extremity, normal monofilament test.
Psych: Affect flattened, but alert and cooperative.
Musculoskeletal/Osteopathic: Increased tissue tension of lumbar segments, right greater than left. No point tenderness, redness, swelling, or gross deformities. Decreased range of motion due to pain with flexion and extension. +seated flexion test with a Right on Right Forward Torsion, L5 R_LS_R. Negative straight leg test.