#### STFM’s National Clerkship Curriculum

Curricular Focus: Acute Care

**Title of Curriculum: Teaching Motivational Interviewing Using Standardized Patients**

1. Abstract

EVMS provides an 8 week required family medicine clerkship where students practice skills in patient centered communication and motivational interviewing. They evaluate 2 or 3 standardized patients in a simulated patient-centered medical home each week. This submission includes curricular materials for a series of three acute care cases that involve a mother and step-daughter. The complete curriculum provides a menu of 18 cases covering a spectrum of acute processes, chronic disease management and preventive care. Standardized patient demographics vary across age and gender to provide a comprehensive learning experience. Each case is designed to cover aspects of the STFM core curriculum and emphasize the skills necessary to provide excellent care to patients, especially those with barriers to achieving optimal outcomes. Complementing the current curriculum, cases are designed for simulations, individual or small group discussions or role play. The curriculum in this submission includes preparatory readings for students and teaching points for educators and standardized patients. Material highlights case-specific motivational interviewing goals and effective patient-centered communication techniques to meet those goals.

First Author / Contact Information

Name: Mary Rubino, M.D.

Institution: Eastern Virginia Medical School

Email: [rubinomc@evms.edu](mailto:rubinomc@evms.edu)

Additional Authors: Bruce Britton M.D., Ann Donnelley M.D., Craig Goodmurphy, Ph.D., Mark Rehfuss, Ph.D., Amelia Wallace.

*These cases are adapted from cases used at Eastern Virginia Medical School for other programs. The original case authors for the wrist pain case are Christine Matteson and Gayle Gliva-McConvey.*

1. Has this Curriculum been published elsewhere?

✓

|  |  |
| --- | --- |
| Yes |  |
| No | X |

If so, where:

1. Curricular Focus ✓

|  |  |
| --- | --- |
| Acute | X |
| Chronic |  |
| Preventive |  |
| Other |  |

1. National Clerkship Curriculum Objectives addressed

***Biopsychosocial model***

*Patient-centered communication skills*

• Demonstrate setting a collaborative agenda with the patient for an office visit.

• Explain history, physical examination, and test results in a manner that the patient can understand.

• Use effective listening skills and empathy to improve patient adherence to medications and lifestyle changes.

• Reflect on the personal frustrations, and transform this response into a deeper understanding of the patient’s and one’s own situation, when patients do not adhere to offered recommendations or plans.

*Psychosocial awareness*

• Discuss the influence of psychosocial factors on a patient’s ability to provide a history and carry out a treatment plan.

*Patient education*

• Promote the use of support groups and other community resources in the area of mental health.

***Contextual Care***

*Person in context of family*

• Demonstrate caring and respect when interacting with patients and their families even when confronted with atypical or emotionally charged behaviors.

• Demonstrate interpersonal and communication skills that result in effective information exchange between patients of all ages and their families.

***Continuity of Care***

*Barriers to access*

• Barrier to access and utilizing health care that stem from personal barriers. Cases include:

o Lack of traditional family support

o Language and cultural barriers

***Key Characteristics of Family Physicians***

• Prior Knowledge of the patient

• Care for a heterogeneous patient population

• Multi-purpose visits

• Staged diagnostic approach

• Opportunity for follow-up care

1. Structure of clerkship in which curriculum has been used

Throughout their third year, EVMS students complete core clerkships in internal medicine, pediatrics, psychiatry and neurology, surgery, obstetrics and gynecology and family medicine-geriatrics that are each 8 weeks in length. Approximately 24 students rotate through the family medicine clerkship at a time. During the clerkship, students spend time at a family medicine practice site, community safety-net providers, a family medicine residency hospital service and two weeks at geriatric clinical sites. The final week is devoted to clerkship round-up, the final standardized patient (SP) examination and written assessments. Family medicine is the only clerkship that involves substantial time in the outpatient setting. Every Monday during their rotation, students return to campus for interactive classes that include flipped learning experiences with pre-class preparatory readings and interactive classroom experiences integrating the material learned, SP cases, procedural skills, and peer teaching. Throughout the rotation, students see 18 standardized patient cases. Students receive formative feedback following the first five sessions (total of 13 SP cases) and summative feedback based on their performance during the week 7 and 8 standardized patient sessions (total of 5 SP cases).

1. Program Content and Educational Methods

✓

|  |  |
| --- | --- |
| Experiential Learning |  |
| Small Group Sessions | X |
| Simulation/Standardized Patients | X |
| Skill Development Sessions |  |
| Case-Based Learning | X |
| Self-Study | X |
| Reflection |  |
| Products and Projects |  |

A didactic lecture on motivational interviewing and a practice session with the simulated electronic health record are provided during clerkship orientation. Students spend approximately 2 or 3 hours each week in the simulation center seeing standardized patients in a simulated patient-centered medical home. The students practice skills in motivational interviewing and patient-centered communication to assist patients in overcoming financial, psychological or health-related barriers to optimize adherence to medical plan. One week prior to the SP encounter, students are provided with material consisting of journal articles and open source internet videos which review basic science correlations to prepare for the medical management of each case.

Standardized patient sessions are structured as follows:

1. Fifteen minute orientation about logistics of the session
2. Two or 3 standardized patient encounters
   1. 25 minutes with the standardized patient in role
   2. 15 minutes to complete a patient note in simulated EHR
   3. 15 minutes for individualized feedback
   4. 10 minutes for transition to the next case
   5. Total of 1:05 for each case
3. Group wrap-up session with faculty following completion of SP cases (same day)
4. Educational prescription and example note provided to students for review 48 hours after completion of each case

This submission includes three cases. In Simulated Case 1 (Wrist Pain), students evaluate a possible scaphoid fracture in a patient context of intimate partner violence, lower English proficiency and no insurance coverage. In Simulated Case 2 (Teen Nausea), the teen step-daughter of the patient in case 1 presents with nausea and late menses. For Simulated Case 3 (Wrist Pain 2), students follow up with the same patient from case 1 to re-evaluate her wrist pain. The patient’s main concern at the follow-up visit is crampy abdominal pain from underlying irritable bowel syndrome that is exacerbated by increased stress in the family.

Pertinent support materials include the Standardized Patient case; key feedback points for motivational interviewing and patient-centered communication, a “cheat sheet” for faculty with history, physical examination and medical management teaching points and an example note in word template form.

Other potential venues for case use include small group discussions using the SP case as the starting point, small group standardized patient encounters (instead of individual), video review and discussion, or role play involving pairs or groups of students based on the SP cases.

1. Assessment Strategies to Achieve Outcomes

*Student assessment and Evaluation:*

Students are evaluated by MD faculty, behavioral faculty and standardized patients. MD and behavioral faculty provide a global evaluation on the overall effectiveness of the student’s intervention, including completeness and efficiency of medical history, physical examination and management, and provide feedback to help students refine their skills. Standardized patients score students utilizing validated scales measuring patient-centered communication, motivational interviewing, patient satisfaction and overall adherence with the student’s plan. When these scales are used together as in the EVMS Family Medicine Clerkship, they provide an array of tools for feedback, ranging from the patient’s perception of the student’s overall efficacy (most subjective) to behaviorally anchored patient-centered communication items (most objective). We have found this combination of scales to be effective for providing both a global assessment of the student’s overall efficacy and the specific feedback required for students to reproduce behaviors leading to a positive encounter and refine those that are less effective. Students who struggle with the standardized patient encounter are offered the opportunity to review their own recording and an example of a successful student encounter. Students show improvement in communication measures throughout the rotation, particularly upon follow up with “continuity” patients.

*Overall clerkship evaluation and Improvement:*

At the conclusion of the clerkship, students’ medical knowledge is measured via NBME Family Medicine Subject Examination. Student scores are generally just above the national mean as reported by the NBME. EVMS Clinical Skills evaluation scores in motivational interviewing, patient-centered communication and faculty assessment show improvement over the course of the rotation. EVMS USMLE CS scores in communications are much higher than national average.

*Faculty Development:*

When new faculty begin to review student-SP encounters, they are provided with copies of the patient satisfaction, motivational interviewing and patient-centered communication scales used by standardized patients, pre-case readings provided to students and copies of the standardized patient protocol. Their first time in the simulation center, new faculty are paired with more experienced faculty to observe several student encounters together and discuss student performance and evaluation. Planning is underway to test inter-rater reliability. At the time of the SP encounters, faculty also receive a list of teaching points (contained in appendices) to review during feedback based on student need. Feedback is structured in a way that encourages participation from faculty, standardized patients and students. Time for SPs and faculty to meet before providing feedback to students is built into the schedule. All encounters and feedback are recorded to allow refinement as needed.

*Educational Research:*

The review of educational processes generates research on student acceptance of standardized patient feedback when provided with clinical faculty; research on combining feedback in simulated patient cases with MD and behavioral faculty; and finally efficiently assessing student skills in patient centered communications, motivational interviewing, patient readiness for change, and patient satisfaction.

1. Lessons Learned

The curriculum development was facilitated through a HRSA predoctoral grant. This allowed faculty to develop cases, to train standardized patients, and to refine formative and summative evaluations. Including both clinical and behavioral faculty feedback in addition to standardized patient feedback adds practical clinical communications and medical skills that students perceive as having greater value. Barriers to success of the full integrated product would be cost of standardized patient time, faculty scheduling, and the time and effort required to provide individualized feedback to students after standardized patient case experiences.

Student feedback is collected following completion of each case and used to adjust and maintain quality of case portrayal and feedback provided by SPs and faculty. Overall, students find the cases appropriately challenging for their level of training, and appreciate the individualized feedback they receive regarding their performance. Student scores in patient satisfaction, communication and motivational interviewing show improvement throughout the rotation. Maintaining the quality of case portrayal and feedback have become more challenging. The number of cases will be decreased later this academic year. In their place, students will be provided dedicated time to review their own recorded encounter and complete a self assessment. This portion of the curriculum is still in development.

1. Explanation of Appendices
2. Anchors for communication scales
   * All items are completed by the SPs for each student encounter
   * SPs receive training in the Master Interview Rating Scale and ABIM Patient Satisfaction questionnaire when they are first hired and periodic refreshers
   * Prior to participating in the Family Medicine clerkship, SPs undergo approximately 2 hours of additional training on the use of the Motivational Interviewing Treatment Integrity (MITI) global scale
3. Case 1: Joint Pain and Injury

* Fall on the outstretched hand injury with possible scaphoid fracture in patient of immigrant status, no insurance and intimate partner violence.
  + Pre-case Student Preparation Materials (provided 1 week in advance)
  + Standardized Patient Protocol for Case 1 (provided during SP training at least 1 week in advance)
  + Student Case 1 Summary (provided to students immediately prior to SP encounter)
  + Content Checklist Case 1 (completed by standardized patient immediately after encounter)
  + FM Faculty Feedback Prescription – Case 1

1. Case 2: Pregnancy (initial presentation)

* Teen step-daughter of case 1 patient who has been having nausea and vomiting with last menstrual period 8 weeks ago
* Including: Pre-case Student Preparation Materials, SP Case 2 Summary, Student Case 2 Summary, Content Checklist Case 2 Visit, FM Faculty Feedback Prescription – Case 2

1. Case 3: Abdominal Pain

* Follow up on case 1 patient who is now having crampy abdominal pain secondary to stresses in family.
* Including: Pre-case Student Preparation Materials, SP Case 3 Summary, Student Case 3 Summary, Content Checklist Case 3 Visit, FM Faculty Feedback Prescription – Case 3

1. Example note for case 1
2. List of other available cases

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Webster G. *Final Report of the Patient Satisfaction Questionnaire Project.* Philadelphia: American Board of Internal Medicine; 1989.

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**Appendix A: Anchors for Communication Scales Used by Standardized Patients**

**Patient Compliance - SP (PC)**

On a scale of 1-10 how compliant do you expect this patient to be? (ten being the most compliant)

What do you think contributed to patient compliance?

What could be adjusted to increase patient compliance?

**American Board of Internal Medicine Patient Satisfaction Questionnaire (ABIM)**

1. Would you do what this student/doctor asks you to do?
   * Definitely yes
   * Probably yes
   * Not sure
   * Probably no
   * Definitely no
2. Would you recommend this student/doctor to a friend who wanted a student/doctor with excellent communication skills?
   * Definitely yes
   * Probably yes
   * Not sure
   * Probably no
   * Definitely no
3. Would you make a special effort to see this student/doctor?
   * Definitely yes
   * Probably yes
   * Not sure
   * Probably no
   * Definitely no
4. How would you compare the personal man ner (courtesy, respectfulness, sensitivity, and friendliness) of this student/doctor to other students/doctors you have seen?
   * One of the best (10%)
   * Above average (20%)
   * About average (40%)
   * Below average (20%)
   * One of the worst (10%)

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| **Evocation** | | | | | |
| Low | | | High | | |
| 1 | 2 | 3 | | 4 | 5 |
| Clinician actively provides reasons for change, or education about change, in the absence of exploring client’s knowledge, efforts or motivation. | Clinician relies on education and information giving at the expense of exploring client’s personal motivations and ideas. | Clinician shows no particular interest in, or awareness of, client’s own reasons for change and how change should occur. May provide information or education without tailoring to client circumstances. | | Clinician is accepting of client’s own reasons for change and ideas about how change should happen when they are offered in interaction. Does not attempt to educate or direct if client resists. | Clinician works proactively to evoke client’s own reasons for change and ideas about how change should happen. |

**Motivational Interviewing Treatment Integrity Global Scales (MITI)**

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **Collaboration** | | | | | | | |
| Low | | | | High | | | |
| 1 | 2 | | 3 | | 4 | | 5 |
| Clinician actively assumes the expert role for the majority of the interaction with the client. Collaboration is absent. | Clinician responds to opportunities to collaborate superficially. | | Clinician incorporates client’s goals, ideas and values but does so in a lukewarm or erratic fashion. May not perceive or may ignore opportunities to deepen client’s contribution to the interview. | | Clinician fosters collaboration and power sharing so that client’s ideas impact the session in ways that they otherwise would not. | | Clinician actively fosters and encourages power sharing in the interaction in such a way that client’s ideas substantially influence the nature of the session |
| **Autonomy/Support** | | | | | | | |
| Low | | | | High | | | |
| 1 | | 2 | 3 | | 4 | 5 | |
| Clinician actively detracts from or denies client’s perception of choice or control. | | Clinician discourages client’s perception of choice or responds to it superficially. | Clinician is neutral relative to client autonomy and choice. | | Clinician is accepting and supportive of client autonomy. | Clinician adds significantly to the feeling and meaning of client’s expression of autonomy, in such a way as to *markedly expand client’s experience of own control and choice.* | |

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| --- | --- | --- | --- | --- | --- |
| **Direction** | | | | | |
| Low | | | High | | |
| 1 | 2 | 3 | | 4 | 5 |
| Clinician does not influence the topic or course of the session, and discussion of the target behavior is entirely in the hands of client. | Clinician exerts minimal influence on the session and misses most opportunities to direct client to the target behavior. | Clinician exerts some influence on the session, but can be easily diverted away from focus on target behavior. | | Clinician generally able to influence direction of the session toward the target behavior; however, there may be lengthy episodes of wandering when clinician does not attempt to re-direct. | Clinician exerts influence on the session and generally does not miss opportunities to direct client toward the target behavior or referral question. |

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| --- | --- | --- | --- | --- | --- |
| **Empathy** | | | | | |
| Low | | | High | | |
| 1 | 2 | 3 | | 4 | 5 |
| Clinician has no apparent interest in client’s worldview. Gives little or no attention to the client’s perspective. | Clinician makes sporadic efforts to explore the client’s perspective. Clinicians’ understanding may be inaccurate or may detract from the client’s true meaning. | Clinician is actively trying to understand the client’s perspective, with modest success. | | Clinician shows evidence of accurate understanding of client’s worldview. Makes active and repeated efforts to understand client’s point of view. Understanding mostly limited to explicit content. | Clinician shows evidence of deep understanding of client’s point of view, not just for what has been explicitly stated but what the client means but has not yet said. |

**Master Interview Rating Scale (MIRS)**

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| --- | --- | --- | --- | --- | --- |
| Spectrum of Concerns | ( ) • The Learner elicits the patient’s full spectrum of concerns within the first 3-5 minutes of the interview. | ( ) 4 | ( ) • The Learner elicits some of the patient’s concerns on his chief complaint. | ( ) 2 | ( ) • The Learner fails to elicit the patient’s concern. |

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| --- | --- | --- | --- | --- | --- |
| Eliciting the Narrative Thread or the "Patient's story" | ( ) • The Learner encourages and lets the patient talk about their problem.• The Learner does not stop the patient or introduce new information. | ( ) 4 | ( ) • The Learner begins to let the patient talk about their problem but either interrupts with focused questions or introduces new information into the conversation. | ( ) 2 | ( ) • The Learner fails to let the patient talk about their problem.OR • The Learner sets the pace with Q & A style, not conversation. |
| Timeline | ( ) • The Learner obtains sufficient information so that a chronology of the chief complaint and history of the present illness can be established.• The chronology of all associated symptoms is also established. | ( ) 4 | ( ) • The Learner obtains some of the information necessary to establish a chronology. • The Learner may fail to establish a chronology for all associated symptoms. | ( ) 2 | ( ) • The Learner fails to obtain information necessary to establish a chronology. |
| Lack of Jargon | ( ) • The Learner asks questions and provides information in language which is easily understood.• Content is free of difficult medical terms and jargon.• Words are immediately defined for the patient.• Language is used that is appropriate to the patient’s level of education. | ( ) 4 | ( ) • The Learner occasionally uses medical jargon during the interview failing to define the medical terms for the patient unless specifically requested to do so by the patient | ( ) 2 | ( ) • The Learner uses difficult medical terms and jargon throughout the interview. |
| Patient's Perspective | ( ) • The Learner elicits the patient’s perspective on his illness, including his beliefs about its beginning, Feelings, Ideas of cause, Function and Expectations. | ( ) 4 | ( ) • The Learner elicits some of the patient’s perspective on his illness. AND/OR • The Learner doesn’t follow through with addressing beliefs. | ( ) 2 | ( ) • The Learner fails to elicit the patient’s perspective. |

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| Impact of Illness on Patient and Patient's Self-Image | ( ) • The Learner inquires about the patient’s feelings about his illness, how it has changed his life• The Learner explores these issues.• The Learner offers counseling or resources to help. | ( ) 4 | ( ) • The Learner partially addresses the impact of the illness on the patient’s life or self-image. AND/OR.• The Learner offers no counseling or resources to help. | ( ) 2 | ( ) • The Learner fails to acknowledge any impact of the illness on the patient’s life or self-image. |
| Verbal Facilitation | ( ) • The Learner uses facilitation skills through the interview.• Use of short statements and echoing are used regularly when appropriate.• The Learner provides the patient with intermittent verbal encouragement, such as verbally praising the patient for proper health care technique. | ( ) 4 | ( ) • The Learner uses some facilitative skills but not consistently or at inappropriate times.• Verbal encouragement could be used more effectively | ( ) 2 | ( ) • The Learner fails to use facilitative skills to encourage the patient to tell his story. |
| Non-Verbal Facilitation Skills | ( ) • The Learner puts the patient at ease and facilitates communication by using:• Good eye contact.• Relaxed, open body language• Appropriate facial expression • Eliminating physical barriers• Appropriate physical contact is made with the patient. | ( ) 4 | ( ) • The Learner makes some use of facilitative techniques but could be more consistent.• One or two techniques are not used effectively OR • Some physical barrier may be present. | ( ) 2 | ( ) • The Learner makes no attempt to put the patient at ease.• Body language is negative or closed. OR • Any annoying mannerism (foot or pencil tapping) intrudes on the interview.• Eye contact is not attempted or is uncomfortable. |

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| Patient's Education and Understanding | ( ) • The Learner uses deliberate techniques to check the patient’s understanding of information given during the interview including diagnosis. • Techniques may include asking the patient to repeat information, asking if the patient has additional questions, posing hypothetical situations or asking the patient to demonstrate techniques. • When patient education is a goal, the Learner determines the patient’s level of interest and provides education appropriately | ( ) 4 | ( ) • The Learner asks the patient if he understands the information but does not use a deliberate technique to check.• Some attempt to determine the interest in patient education but could be more thorough. | ( ) 2 | ( ) • The Learner fails to assess patient’s level of understanding and does not effectively correct misunderstandings when they are evident. AND/OR • The Learner fails to address the issue of patient education. |
| Achieve a Shared Plan | ( ) • The Learner discusses the diagnosis and/or prognosis and negotiates a plan with the patient.• The Learner invites the patient to contribute his own thoughts, ideas, suggestions and preferences. | ( ) 4 | ( ) • The Learner discusses the diagnosis and/or prognosis and plan but does not allow the patient to contribute.• Lacks full quality. | ( ) 2 | ( ) • The Learner fails to discuss diagnosis and/or prognosis. |
| Investigations & Procedures | ( ) • The Learner discusses all investigations and procedures• The Learner thoroughly explains how, why and outcomes. | ( ) 4 | ( ) • The Learner discusses some of the investigations and procedures but is lacking in quality | ( ) 2 | ( ) • The Learner fails to discuss investigations or procedures. |

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| Overall Interview Techniques | ( ) • The Learner consistently uses the patient-centered technique.• The Learner mixes patient-centered and physician-centered styles that promote a collaborative partnership between patient and doctor. | ( ) 4 | ( ) • The Learner initially uses a patient-centered style but reverts to physician-centered interview at the end (rarely returning the lead to the patient). OR • The Learner uses all Pt.-centered interviewing and fails to use physician-centered style and therefore does not accomplish the negotiated agenda. | ( ) 2 | ( ) • The interview doesn’t follow the patient’s lead.• Uses only physician-centered technique halting the collaborative partnership. |
| Transitional Statements | ( ) • The Learner utilizes full transitional statements when progressing from one subsection to another. | ( ) 4 | ( ) • The Learner sometimes introduces subsections with effective transitional statements but fails to do so at other times. OR • Some of the transitional statements used are lacking in quality. | ( ) 2 | ( ) • The Learner progresses from one subsection to another in such a manner that the patient is left with a feeling of uncertainty as to the purpose of the questions. • No transitional statements are made. |
| Verification of Patient Information | ( ) The Learner always sought clarification, verification and specificity of the patient’s responses | ( ) 4 | ( ) The Learner did not always seek clarification, verification and specificity of the patient’s responses. | ( ) 2 | ( ) The Learner failed to clarify or verify the patient’s responses, accepting information at face value. |

**Appendix B.**

**CASE 1: JOINT PAIN AND INJURY, FIRST VISIT**

* Fall on the outstretched hand injury with possible scaphoid fracture in patient of immigrant status, no insurance and intimate partner violence.
* Including:
  + Pre-case Student Preparation Materials
  + SP Case 1 Summary
  + Student Case 1 Summary
  + Content Checklist Case 1 Visit
  + FM Faculty Feedback Prescription – Case 1

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Pre-case Student Preparation Materials:

2 Articles:

Forman TA, Forman SK, Rose, ER. A clinical approach to diagnosing wrist pain. *Am Fam Physician* 2005;72:1753-8. Available at: www.aafp.org/afp

Cronholm PF, Fogarty CT, Ambuel B, Harrison SL. Intimate partner violence. Am Fam Physician 2011;83:1165-72. Available at: www.aafp.org/afp

2 Video clips: Goodmurphy C. http://www.anatomyguy.com/tag/foosh/

<http://www.anatomyguy.com/family-medicine-falls-on-outstretched-hands/><http://www.anatomyguy.com/specimen-tutorial-10011-the-scapula/>

Diagnostic resource:

-Med-U CORE (Care-based Online Radiology Education). Radiology case 13 – MSK: Arthritis, osteomyelitis. Tejura, T. Case available at <http://www.med-u.org/core>

**STANDARDIZED PATIENT PROTOCOL**

**CASE 1**

Institution: Eastern Virginia Medical School, M3FM

Case Title: Intimate Partner Violence

Anticipated time needed: 25 minutes

Setting: Patient Centered Medical Home

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PATIENT DEMOGRAPHICS: to be used for recruiting the Standardized Patient

1. age range ed for 20-40
2. gender e ed f female
3. race ……………….. Asian, Filipino, Latin American, Hispanic
4. socioeconomic level in American, Hieducational background American, Hispanimotivational levelound American, Hispanicon

g. specific affect to be simulated …………….. scared

Opening Statement:

*“pening Statement:nd it hasn’t gotten better so I had to come in.*

Chief Complaint:

Hurt wrist

Spectrum of Concerns:

1. Pain in wrist
2. In a hurry (will verbalize if learner does not pick up on non-verbal cues)

History of Present Illness:

Patient states she was ess:ting toys away in the toybox and my 5 year old slammed the lid down on my wrist Schoolics ago. She has had pain since. She describes her pain as constant and severe. The pain is located in the wrist of her left hand (all SPs will state that this is the dominant hand if asked) does not radiate. It is worse with movement or lifting. There is very limited movement of the wrist and she will slightly flex her fingers if asked. (Note: It is painful to the touch.) She has tried wrapping it in an ace bandage to stop the swelling and to restrict movement. She states she is always “tripping over toys, clumsy”. She has taken some pain killers (Percocet) that she had left over from previous injuries (if asked – the Percocet came from another clinic when she went in for stomach problems.) She took 2 Percocet with minimal relief.

Pain is 4/5 of 10 at rest, 10 out of 10 on palpation or movement. The patient describes it as throbbing, stiff, sharp and possibly swelling.

She has not of 10 at rest, 10 out of 10 on palpation or movement. The patient describes it as throbbing, stiff, sot that bad”, but it hadn’t gotten better. She was not able to work at her husband’s salon and he called her a baby - he feels she is over-acting injury so as not to work. She decided to come to the clinic for an urgent care visit since it is near her home while he is at work (told her husband that she will go to the bank, grocery store and then pick up the children from school/practice).

Motivation to change: Pre-contemplation, this patient wants medicine to relieve the pain. Will provide enough information and cues so that abuse is evident to most learners

Verbal/Non-verbal Cueing/Presentation:

* Keep asking for pain medication because the pain is so intense you don’t think you could stand it without drugs. i.e. *“you don’t understand my culture, the best way to help me is to get me some medicine.”*
* Non-verbally looks afraid and passive (looks down away, raised eyebrows, open mouth inspiration
* Looks anxious and in a hurry. Look at your watch/a clock frequently.
* Refuse to get a cast. You are terrified of getting a cast because then your husband would know you went to a clinic. You would rather wait till tomorrow after you ask his permission to get it looked at. Plead for something that will be removable when you get home. If learner recommends a cast, the patient will say *”If you let me go home and talk to my husband, I will come back tomorrow”*
* If learner asks/mentions getting an x-ray, state *“If it’s fast then ok”*
* If learner mentions an Orthopedist or doing an MRI, the patient will have a barrier because of finances
* If there are any questions regarding the children or having difficulty taking care of them – you will talk about how lately, your son has become *“you will talk about how lately, your son has become*  and how even without the wrist injury it has been really hard on you.
* In response to being asked abuse statements - possible statement are - *Why do you need to know that?* followed by a statement that at least somewhat answers the question.
* When describing her injury and why her husband would not let her see a doctor will make a statement that demonstrates a passive nature or low self-image
* Patient presentation is restless (anxiety level 5), checks watch frequently (husband believes she is at the bank), decreased eye contact, guarded, defensive. Increased startle response: constantly asks “why do you ask?” if interviewer addresses issues close to abuse. Concern alleviated by discussion of confidentiality and normalization of inquiry
* She is reluctant to admit to abuse, she does not want to get her husband in trouble because she is the one that will suffer.
* She refuses to have a full physical examination if this is suggested, but will allow the student to inspect the wrist, check for pulses and sensation in extremity. The patient is unable to perform full ROM due to the pain.
* She constantly minimizes: *“he doesn’t realize his own strength”*
* If asked about what her husband will do if he knows she went to the doctor will state *“I don’t know what he would do.”*

Husband:

* Seen as a the “good guy”
* Good at job, owns a nail salon since retiring from the military
* Tyrant: rigid gender role - owns her and the children
* Jealous: assumes she is having an affair with everyone therefore has her r will state wrist, check for pulses and sensation in extremity. The pa
* Checks up on her during the day if she is not working with him.
* He controls all the money, she has no savings or access to accounts
* She must keep all her receipts and show him where the money has been spent
* He has control of the medical card - therefore she is at an urgent visit today (he does not know she is here)
* Drinks regularly with the cal card - therefore s
* Drug use – uses marijuana with his friends

Relationship:

* She believes it is her job to stay out of his way and keep him happy. She believes it is her fault, that she must be doing something wrong to get him so mad that he would hit her.
* He has threatened to not let her work, take the kids, tell her parents lies about her (like sleeping around) if she even dares to think about leaving him.
* He intimidates her at every chance – and reminds her that his money and job has helped to support her family as well.
* After they have a fight he will take the kids in the car and tell her he won’t be back
* She has sexual intercourse with her husband at least every other day – even if she doesn’t want to because it is her duty to be his wife.

If a supportive rapport has been established, and the interviewer specifically asks:

* Has your husband ever done anything that frightens you – Yes, he threatens to take the children away from me and tell lies about me
* How does your husband react when he has been drinking - he gets angry easily
* Has he ever kept you from leaving the house? – no, but he needs to know where I am
* What does he do when he gets angry - he throws things and every once in a while he’ll throw me up against the wall
* When did he start hurting you? - when I was pregnant with my first child
* When was the last time he hurt you, besides this injury? – 3 months ago
* Determines severity level of physical abuse – not life threatening but has sustained injuries (bruises) – this wrist is the worst injury
* Has there been a recent change of abuse - no
* How often does he lose his temper and physically hurt you? – about 3-4 times a year, and he is always very sorry afterwards to have to punish me, he really does love me and the kids.
* Are there weapons in the house - no
* Has your husband ever threatened to hurt the children? - no
* Have you ever had any suicidal thoughts? – no
* Have you ever had thoughts about hurting him? No

Past Medical History:

Her husband rarely wants her to see the doctor but any visits would include:

1. tension headaches,
2. GI tract symptoms, wants her to see pelvic pain
3. Vague stomach pain with prior work-up that included - bloodwork, went to specialist, had flexible sigmoidoscopy If asked for symptoms type, bloating, cramps sometimes severe, sometimes constipated and sometime loose stools, with symptoms relieved by defecation at times. Some mucus in stools.

She is vague and will not answer questions directly re: her past history. She does not go to the same doctor/clinic more than once. Last GYN/Health maintenance exam 5 years ago.

Family History:

She was born in \_\_\_\_\_\_\_\_. Raised in the environment that the Father is always head of the house and the wives/girls should be docile and caregivers to the family. Husbands often punish their wives if they do something wrong. She understands that this is old-fashioned, but it is part of her heritage. Recalls needing to be “disciplined” by her parents as a child; was always getting in trouble for being outspoken. Husband was born in the US and is in the military. They met when he was overseas and married. He only speaks English, she has issues reading English.

Social History:

* 2 children (ages 17 & 5) (17-year-old is stepdaughter if SP is too young to have 17-year-old daughter)
* They married early because she was pregnant with the daughter. Second child was also unplanned.
* Her husband is retired navy and now owns his own nail salon- she works with him and takes care of the books.
* Alcohol: 3-4 drinks per week
* The patient is very proud of her heritage and spends a lot of time with the family. Her husband uses this to reinforce the male-dominance in their marriage. Both of them grew up in households where the husband rules with an iron fist and slapping and abuse are normal. The patient has gone to her sisters and mother are apathetic and tell her to behave and not upset her husband. They also remind her that she is lucky to have such a good husband and provider. Her mother and sisters now ignore any bruising or injury and consider her a “bad” wife. Divorce is not to be tolerated by the family.
* Religion – Roman Catholic – doesn’t go unless with her husband. Husband does not allow her to see the priest without him present.
* No friends

Review of Systems:

She has difficulty sleeping, she feels “wiped out” all the time

Examination Findings

\*\*The patient has point tenderness in the scaphoid or “anatomic snuffbox.” Pain exacerbated with wrist flexion, extension and radial deviation. The accident happened when the patient fell on an outstretched hand (after being pushed by her husband). Patient will have pain on palpation on the area noted in the picture below (anatomic snuff box).

\*\*Please note, the patient’s physical findings do not support her “story” of the toy box injury

Active ROM as painful as passive ROM. Light touch does not hurt



**PATIENT INFORMATION**

**CASE 1**

Ms. Renata Tebaldi has come to the Urgent Care Clinic with the complaint of wrist pain. The nurse reports patient is anxious again and seems to be in a hurry to be seen. She was last seen 3 years ago for similar problems

\*This clinic has point of care testing (x-rays, simple blood tests) and orthopedic splints, ACE wraps, and casting.\*

# Vital Signs:

T 99 F

P 88

R 16

# BP 132/86

# TASKS

1. Review patient chart information
2. Obtain a focused and relevant history and physical examination based on chart information
3. You may order testing based on your findings
4. Discuss your initial diagnostic impressions and management plans with the patient
5. Counsel the patient and provide patient education based on your history and examination
6. Complete a note in EHR that reflects patient centered care
7. Based on note, document coding rationale

**Content Checklist Case 1**

**Patient Compliance**

1. Patient Compliance SP – on a scale of 1-10 how compliant would this patient be with the learner’s OVERALL plan?
2. What effectively contributed to patient compliance? – Comment box
3. What could enhance patient compliance? – Comment box

**American Board of Internal Medicine Patient Satisfaction Questionnaire (ABIM) (comment box after each item)**

1. Would you do what this student/doctor asks you to do?
2. Would you recommend this student/doctor to a friend who wanted a student/doctor with excellent communication skills?
3. Would you make a special effort to see this student/doctor?
4. How would you compare the personal manner (courtesy, respectfulness, sensitivity, and friendliness) of this student/doctor to other students/doctors you have seen?

**Motivational Interviewing Treatment Integrity (MITI) Global (comment box after each item)**

1. MITI – Evocation
2. MITI – Collaboration
3. MITI – Autonomy/support
4. MITI – Direction
5. MITI – Empathy

**Master Interview Rating Scale (MIRS) (comment box after each item)**

1. Spectrum of concerns
2. Eliciting the narrative thread
3. Timeline
4. Lack of jargon
5. Patient’s perspective
6. Impact of illness on pt/pt’s self image
7. Verbal facilitation
8. Non-verbal facilitation
9. Patient education and understanding
10. Investigations and procedures
11. Achieve a shared plan
12. Overall interview
13. Transitional Statements
14. Verification and Clarification

**Health Literacy (comment box following item)**

1. Health literacy assessment – may ask either or both to receive full credit – Yes/no
   1. Have you ever needed help filling out forms? (yes – red flag)
   2. Uses teachback to check understanding

**General Comments:**

1. In the comment box below please explain any scoring discrepancies among communication scales

**Assessment**

1. Discusses x-ray
2. Discusses alternative options for treatment
3. Discusses confidentiality issues – only has to report if children are in danger
4. Discusses abuse

**Plan**

1. Attempts to schedule follow-up
2. Immobilizes the wrist – learner receives credit for most optimal treatment option mentioned
3. Gives meds for pain control – any pain relief medication discussed receives credit
4. Attempts to educate patient regarding intimate partner violence
5. Offers assistance in the future when she is ready to leave husband
6. Discusses need for safety - safe place with support

**Physical Exam**

1. Observes alignment, contour and symmetry of bones and muscles of hand and wrist
2. Palpates wrist - *Teaching point from faculty - ask patient to ID point of maximum tenderness and examine that last. Localization of this point allows for appropriate x-ray views*
3. Checks ROM - *All four directions*
4. Checks for sensation of hand/fingers on injured hand - *This technique checks for signs of nerve damage*
5. Assesses circulation of injured hand - *radial pulse or capillary refill of any finger*

**Introduction**

1. Student introduces self by name
2. Student identifies his/her role or position
3. Student asks or uses patient's name

**Past Medical History**

1. Past illnesses: normal childhood illnesses
2. Other problems: history of tension headaches and ulcers
3. Operations, injuries, accidents - numerous "accidents"

**Family History**

1. Parents – Alive, non-supportive
2. Siblings -
3. Children – 2 1 son, 1 teen daughter
4. Family Hx of violence - yes

**Social History**

1. Occupation – housewife and worker at nail salon
2. Culture – not from this country

*Abuse*

1. Has your husband ever done anything that frightened you? – yes, threats of taking kids and lies about her
2. Does husband drink/use drugs? - yes
3. How does your husband react when he has been drinking/using? – angers easily
4. Does your husband need to know where you are during the day? - yes
5. What does he do when he gets angry? - throws, puts against wall
6. Determines severity level of physical abuse – not life-threatening but does sustain injuries, this is the worst
7. Are there weapons in the house? - no
8. Has your husband ever threatened to hurt the children? - no

**FM Faculty Feedback Prescription**

**IPV Faculty/Preceptor Key Teaching Points (Please circle areas highlighted with your learner)**

HISTORY:

* Completeness:
  + Recognized inconsistencies between mechanism of injury in patient’s story and top differential diagnosis
  + Snuff box tenderness overlying scaphoid bone – usually FOOSH
  + Elicited patient concerns re: length of visit
  + Most important severity/safety issues to assess
  + Safety of children (reportable in most states)
  + Patient concerned for her immediate safety?
  + Normalized difficult conversation
  + Cues re: intimate partner violence
    - Lack of eye contact
    - Low self-esteem of patient
    - Cultural background – wife’s duty to ensure household runs smoothly
* Efficiency:
  + Open ended elicitation
  + Use focused questions to complete/support differential diagnosis
  + History during exam – especially review of systems

EXAMINATION:

* Medically Appropriate:
  + Neurovascular
  + Range of motion
  + Identify point of maximum tenderness (anatomic snuffbox)
* Efficiency:
  + Limit exam to what is needed

MANAGEMENT:

* X-ray with scaphoid view
* Thumb spica splint/cast
* IPV support services offered
* Emergency hotline info
  + Methods to conceal
  + Attack behavior of husband, not husband as a person
* Assessment of understanding
  + Teachback
  + Written plan of care in patient-centered language
* Documentation of IPV concerns – observations
* Note E&M coding

MOTIVATION

* patient sensitive assessment of culture/context/literacy/stages of change
* efficient assessment of culture/context/literacy/stages of change

MITI domains score:

* Evocation
  + This patient desperately needs to be empowered. Verbalizing that she is in charge of how and when to talk to her husband may be extremely important.
* Collaboration
  + Ask patient how she might be able to immobilize wrist appropriately
* Autonomy/Support
  + Empowering this patient can help her consider change in the future
* Direction
  + Broaching the topic of abuse will need to be very delicate. A strong transitional statement “ I would like to ask some questions about your home life because I am getting some signals that things may be stressful” is one way to get this patient to open up.
* Empathy
* Responding to non-verbal cues with empathetic, supportive statements will help encourage this patient to talk.

**Appendix C.**

**CASE 2: PEGNANCY (INITIAL PRESENTATION)**

* Teen step-daughter of case 1 patient who has been having nausea and vomiting and last menstrual period 8 weeks ago
* Including:
  + Pre-case Student Preparation Materials
  + SP Case 2 Summary
  + Student Case 2 Summary
  + Content Checklist Case 2 Visit
  + FM Faculty Feedback Prescription – Case 2

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Pre-case Student Preparation Materials:

2 Articles:

Committee on Adolescence. Counseling the adolescent about pregnancy options,

*Pediatrics* 1998;101;938, DOI:10.1542/peds.101.5.938. Available online at: <http://pediatrics.aappublications.org/content/101/5/938.full.html>

Klein JD. Adolescent pregnancy: Current trends and issues. *Pediatrics* 2005;116;281. DOI: 10.1542/peds.2005-0999. Available online at: <http://pediatrics.aappublications.org/content/116/1/281.full.html>

**STANDARDIZED PATIENT PROTOCOL**

**CASE 2**

Institution: Eastern Virginia Medical School, M3FM

Case Author: Ann Donnelley

History based on information from Wrist Pain IPV

Case Title:  Teenage Pregnancy

Anticipated time needed: 25 minutes

Setting:  Patient Centered Medical Home

**PATIENT DEMOGRAPHICS:**to be used for recruiting the Standardized Patient

1. **age range  …………..17**
2. **gender  ……………..female**
3. **race  ………………..non-specific**
4. **socioeconomic/ educational level …………..middle class**
5. **background …………high-school**
6. **case specifics ………….**
7. **specific affect to be simulated  ……………..nervous, concerned**

**Summary of Case**

**Opening Statement:***“I’ve been feeling kind of queasy lately.”*

**Chief Complaint:** The patient is a 17-year old high school junior who has come to the office complaining of nausea, vomiting and breast tenderness. Her step-mother is a patient and encouraged her to come in and be seen.

**Full spectrum of patient concerns:**

1. Maybe ate something bad or stress from school.

2. My stepmother told me to come in. (can be added to concern one)

3. Well maybe, but not really related to this (non-verbally embarrassed)

**Patient Agenda (include any “hidden” agendas)**:

1. Confirm or rule out pregnancy
2. Anxiety about her father finding out.

**HISTORY OF PRESENT ILLNESS**

            General state of health is good. Past illnesses-usual childhood, no hospitalizations or surgeries. Not on any medications. Allergic to sulfa – patient’s grandmother told her that she gets a rash.

            Gynecologic history: Last menstrual period was 8 weeks ago, and she is always regular. She is not on birth control and has been sexually active without protection with her boyfriend who is also 17. She has had a little bit of nausea and some breast tenderness. Vomited a couple of times. Has not missed school. She has had one normal pap smear and never had any STDs.

NOTE: To elicit GYN history and pregnancy concerns, the learner must ***specifically*** ask about LMP and/or ask the patient, *“Is there any chance you could be pregnant?”*

**Review of Systems: (list abnormal only)**

            Nausea, mild and slight breast tenderness, “*like right before I get my period*.”

**Family History:**

Grandparents- alive and well. Does not have very much interaction with maternal grandparents. Lived with paternal grandparents when her dad was stationed overseas.

           Father-hypertension

           Biological Mother- Deceased.

*“She died when I was a baby. My dad doesn’t really like to talk about it.”*

Half-brother, healthy – functions as his protector when father and step-mother are fighting.

**Social History:**

The patient has done well in high school (honor roll) and plans to go to college. Is currently a senior.

Tobacco use: none

Leisure activities: dancing, hanging out with friends, shopping

Exercise: PE class at school

Diet: average with junk food

Alcohol: drinks on the weekends when “partying” with friends. (2-3 drinks at a time) No to CAGE

Drugs: has tried marijuana but nothing currently

Sleep: 7-8 hours a night

**SEXUAL HISTORY:**

Has been sexually active since the age of 16 with 3 lifetime partners (two “boyfriends and one “one night stand”. Does not consider oral sex, sex. . Has used condoms off and on but not currently because her current boyfriend doesn’t “like them”. No history of sexual abuse or STDs. Currently, has sex approximately once or twice a week (last intercourse was about 1 week ago). Feels relieved when it is less.

**FEELINGS:**

She is concerned about confidentiality because her father has “a temper”. She  is embarrassed because of the pregnancy. It wasn’t supposed to happen to her. She is hoping the pregnancy test will be negative.

**IDEAS:**

She is worried that she is pregnant and know she should have been using protection but didn’t due to her boyfriend pressuring her.

If pregnancy is not discussed, the patient attributes the nausea to stress or food.

**FUNCTION:**

Not affected yet.

**EXPECTATIONS:**

Wants to confirm/rule-out pregnancy.

**VIOLENCE:**

Father is very controlling and has been emotionally abusive towards her. He has been physically violent with her step-mother, which started when she was pregnant with the patient’s younger brother. Other than expressing concern that “*something might happen when he finds out*,” the patient is reserved and vague about the violence between her father and stepmother. The learner must facilitate and acknowledge the patient’s cues twice before she will open up and admit to physical violence.

**Relationships:**

Lives at home with father, step-mother and younger half-brother (John, Renata and John Jr. ) has been dating her current boyfriend for the last 6 months. Feels like they are in love but does not think he would be supportive about having a child. Does not want to tell him until she’s sure.

Father is retired military and step-mother are first generation “xxxxx”. This culture supports more traditional family rolls with the father being the head of the household and all others subservient to him.

**Presentation:**

Slightly withdrawn, will become upset but not extremely emotional. Most concerned about her options and whether or not she has to tell her father.

**Standard Questions/Challenges to Interviewer:**

*1. Promise me you won’t tell my father.*

*2. Am I pregnant?*

*3. What am I going to tell my boyfriend?*

*4. What am I going to do now?*

*5. Are you sure that it’s not a mistake?, Could it be false?*

*6. My stepmother said you would be good to talk to.*

*7.* If asked about whether she’s going to keep the baby will say *– I just don’t know what to do about anything.*

#### PATIENT INFORMATION

**Miss Jane Tessaro, age 17, has come to the office due to missed period and stomach pain.**

**Vital Signs:**

**T 98.8**

**BP 110/60**

**P  90**

**R 18**

**TASKS**

1. Review patient chart information
2. Obtain a focused and relevant history and physical examination based on chart information
3. Discuss your initial diagnostic impressions with the patient
4. Discuss initial management plans with the patient
5. Counsel the patient
6. Provide patient education centered around changing target behavior
7. Write a note on provided template note sheet that reflects patient centered care
8. Based on note, document coding rationale

**Content Checklist Case 2**

### Stomach Complaint (Teen Pregnancy)

**Patient Compliance**

1. Patient Compliance SP – on a scale of 1-10 how compliant would this patient be with the learner’s OVERALL plan?
2. What effectively contributed to patient compliance? – Comment box
3. What could enhance patient compliance? – Comment box

**American Board of Internal Medicine Patient Satisfaction Questionnaire (ABIM)**

1. Would you do what this student/doctor asks you to do?
2. Would you recommend this student/doctor to a friend who wanted a student/doctor with excellent communication skills?
3. Would you make a special effort to see this student/doctor?
4. How would you rate this physician compared to those you have seen?

**MITI (comment box after each item)**

1. MITI – Evocation
2. MITI – Collaboration
3. MITI – Autonomy/support
4. MITI – Direction
5. MITI – Empathy

**MIRS (comment box after each item)**

1. Spectrum of concerns
2. Eliciting the narrative thread
3. Timeline
4. Lack of jargon
5. Patient’s perspective
6. Impact of illness on pt/pt’s self-image
7. Verbal facilitation
8. Non-verbal facilitation
9. Patient education and understanding
10. Verification and Clarification
11. Investigations and procedures
12. Achieve a shared plan
13. Overall interview
14. Transitional Statements
15. Verification and Clarification of Information

**Health Literacy (comment box following item)**

1. Health literacy assessment – may ask either or both to receive full credit – Yes/no
   1. Have you ever needed help filling out forms? (yes – red flag)
   2. Uses teachback to check understanding? (OK or less is red flag)

**General Comments:**

1. In the comment box below please explain any scoring discrepancies among communication scales

**Introduction:**

1. Introduces self to patient
2. Explains role and position
3. Asks patient’s name

**History of Present Illness**

1. Chronology (timing)-last period 8 weeks ago
2. Chronology (course of symptoms) has felt slightly nauseated and has had breast tenderness for the last 2 weeks.
3. Current Medications (include Rx, over-the-counter, vitamins, herbal remedies)-none
4. Risk Factors/pertinent negatives: sexually active, no birth control

*Patient’s attributions or understanding of their illness*

* 1. *(FIFE: Feelings, Ideas, Function, Expectations)*

1. F: embarrassed by pregnancy, afraid that her father will find out
2. I: worried that she is pregnant and should have been using protection
3. F: not effected yet
4. E: rule out/confirm pregnancy
5. ROS - breast tenderness
6. ROS - slight nausea
7. ROS - anxiety (over future and her father finding out)

**Past Medical History**

1. Allergies (drugs, food, environmental agents)
2. Menstrual/Obstetrical History

**Social History**

Patient Profile

1. Occupation –honor roll student

Risk Factors:*(Habits)*

Alcohol:

1. Quantity 2-3 drinks
2. Frequency  on the weekends
3. Ever had a drinking problem-no

Tobacco Use**:**

1. Type -none

Drug Use:

1. Type:  Recreational -tried marijuana but not currently

Nutritional:

1. History/current-regular diet with junk food

Sexual History

1. Age first active-16
2. Number of lifetime partners-3
3. Number of partners in last 6 months-1
4. History of molestation/abuse-father emotionally abusive
5. Contraceptive methods-none
6. Knowledge of safe sex: Use of condoms/Barrier methods
7. Ever treated for STD-never

Physical Violence; If suspect (0.5 point value)

1. How are disagreements handled at home
2. Safe in relationships, concerned for your safety
3. Guns in the home?
4. Ever been hurt or abused?

Recreational/Leisure Activities/Hobbies

1. dancing, hanging out with friends, shopping

Relationships:

1. Family
2. School friends
3. Boyfriend
4. Living Arrangements

**Physical Exam:**

1. Wash hands before examining patient
2. Heart (auscultate 4 locations)
3. Lungs (auscultate 3 pairs)
4. Abdomen Inspection (verbalization not required)
5. auscultate abdomen (four quadrants)
6. palpate abdomen 4 quadrants light/deep

**Assessment**

1. Pregnancy
2. Nausea/Vomiting secondary to pregnancy (not pathological)
3. Need for safe sex counseling (discusses)

**Plan**

1. Discusses initial diagnostic impressions
2. Discusses follow-up tests/consultations
3. Discusses initial management plans
4. Discusses time frame for tests/plans
5. Educates the patient on the use of prenatal vitamins and the avoidance of alcohol/medications that may harm the fetus
6. Discusses options for pregnancy: keeping baby, abortion, adoption
7. Assures patient confidentiality – not necessary to inform patient’s father
8. Informs patient of emancipated minor laws

**FM Faculty Feedback Prescription – Case 2 – Teen Pregnancy**

HISTORY:

* Completeness:
  + Symptoms of pregnancy
  + Menstrual history including LMP
  + recognized that the patient is concerned about pregnancy
  + Followed up on patient’s concerns about telling her father
  + asks about risk factors – contraception
* Efficiency:
  + open ended elicitation
  + history during exam

EXAMINATION:

* Medically Approp:
  + abdominal exam
  + cursory heart and lung
* Efficiency:
  + limit exam to what is needed
  + If pain/heavy bleeding or abdominal pain, pelvic indicated (this patient has neither

MANAGEMENT:

* Diagnosis of pregnancy
  + Order pregnancy test
  + Tentative dating based on LMP (Nagel’s rule)
* Counseling re: options
  + Keep the baby
  + Adoption
  + Termination
* Initial management and follow-up
  + Inform about emancipated minor laws
    - (in Virginia) *A minor may consent to the prevention, diagnosis, and treatment of (1) venereal diseases, (2) infectious or contagious diseases that the Board of Health requires to be reported, (3) pregnancy, (4) abuse of controlled substances or alcohol, or (4) mental illness or emotional disturbance.*
    - Assure patient confidentiality – not necessary to inform patient’s father (though one parent’s consent required for termination in VA)
  + Educate patient on the use of prenatal vitamins and the avoidance of alcohol/medications that may harm the fetus – keep baby/mom healthy until decision is made
* note E&M coding

MOTIVATION:

* patient sensitive assessment of culture/context/literacy/stages of change
* efficient assessment of culture/context/literacy/stages of change

MITI domains score:

* Evocation
  + This patient is really worried about her father’s reaction about her pregnancy as well as her boyfriend. Finding out that she is afraid about these as well as about the responsibility she feels in the household (to stepmom) is particularly important. Getting her to talk about her fears will go a long way to establishing what she will do and how readily she will. Her ideas about how change should happen will focus around how to tell her father what is going on (or the fact that she may not have to tell him).
* Collaboration
  + Target behavior is – how to think about what to do – wants to be passive. Does not want to make a decision yet, first priority is figuring out whether she has to tell her father. The collaboration centers around helping her create a plan to prioritize her situation (talking to boyfriend, step-mom, etc.)
* Autonomy/Support
  + This patient needs this very directly. The statement you are in control is probably best supported with confidentiality statement, establishing support systems, talking about options and resources. Will shut down and become passive if expression of autonomy and support is not explicitly done.
* Direction
  + This patient will ask a couple of times if the tests are true. Will willingly talk about what to do otherwise.
* Empathy
  + Name-Understand-Respect-Support (NURS) with this patient.
  + It must be stated and reinforced non-verbally for her to listen.
  + Additionally, verbally responding to her non-verbal cues with empathy and then follow-up open-focused questions can help her articulate her feelings

**Appendix D.**

**CASE 3: WRIST PAIN (SECOND VISIT)**

* Follow up on case 1 patient who is now having crampy abdominal pain secondary to stresses in family.
* Including:
  + Pre-case Student Preparation Materials
  + SP Case 3 Summary
  + Student Case 3 Summary
  + Content Checklist Case 3 Visit
  + FM Faculty Feedback Prescription – Case 3

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Pre-case Student Preparation Materials:

1 Article:

Wilkins T, Pepitone C, Biju A, Schade RR. Diagnosis and management of IBS in adults. *Am Fam Physician*. 2012;86:419-26. Available at: www.aafp.org/afp.

**STANDARDIZED PATIENT PROTOCOL**

**Case 3 – Wrist pain/abdominal pain**

**\*\*Second visit will start from the same point for each learner**

**Opening Statement:**

*“See, I talked to my husband and he let me come in to get this (*points to splint/cast). *They told me to come back because you had to check it.”*

**Chief Complaint/Agenda:**

1. Is here for the follow-up (3 weeks later) of the wrist pain. The patient will be wearing a cast
2. Stomach Pain
3. *“kind of stressed”* Worried about daughter

**History of Present Illness:**

Since the last visit, the patient’s wrist is healing. X-ray’s revealed that there was no fracture and with a cast, the patient feels much better physically – states she discussed with her husband and came back to this clinic to get the cast (She saw someone other than the student). She has not seen an orthopedist.

* If the cast is removed and ROM checked, the patient has 80-90% movement. (patient will visibly look relieved) Pain is down to (2/10). Only really hurts if working too long. Wearing cast all the time, except removed at husband's insistence to do books/payroll at work
* Relationship with husband - was sorry to hurt her, brought her flowers, has been very attentive since her last visit.

Now complains of slight stomach pain for the past 5-6 days that she is concerned about. Patient describes the pain as intermittent butterflies in the stomach (queasy, cramps). Symptoms type, bloating, cramps sometimes severe, sometimes constipated and sometime loose stools, with symptoms relieved by defecation at times. Some mucus in stools. She is worried that something else than the “spastic colon” diagnosis that she had before. The pain is located in the LLQ and does not radiate. 3/10 on pain scale; Alleviating factors – going to the bathroom (BM); Aggravating factors – Stress; Mentions that she wants advice for her daughter.\*If younger SP, this is the husband’s daughter from an earlier marriage\* Note – this is different than her previous diagnosis of stomach pain. She does, however, recall that she has had similar symptoms before. \*\*If asked, has not used NSAIDS\*\*

Review of systems: No fever/chills, no nausea/vomiting, normal appetite, no heartburn, no weight loss, no blood in stool or melena, no dysuria or vaginal itching/discharge, increased frequency of bowel movements, but normal consistency

Motivation to change: Contemplation/preparation – The patient’s daughter has become pregnant with her boyfriend of 3 years. 5 days ago, the patient noticed her daughter in the bathroom crying. Upon questioning it was revealed that the daughter is pregnant. The patient is petrified because she does not know what her husband will do when he finds out. She also remembers that her first instance of abuse was when she was pregnant with her first child. She is also suspicious her daughter’s boyfriend because she has noticed that he is not happy that her daughter is pregnant and he also has not yet proposed.

*\*Because of these factors, the patient may be more open to leaving the situation and taking her children with her.\**

**Physical exam:**

* wrist **-** very mild tenderness over wrist (same area as initial visit), stiff on ROM, but has minimal limitation, pain at extremes only (mild)
* abdominal - no tenderness at time of visit

**PATIENT INFORMATION**

**CASE 3**

It has been three weeks since her previous visit. Ms. Renata Tebaldi has come to the office for her follow-up.

\*This clinic has point of care testing (x-rays and simple labs) and orthopedic splints, ACE wraps, casting.\*

# Vital Signs:

T 99 F

P 88

R 16

# BP 132/86

# TASKS

1. Review patient chart information
2. Obtain a focused and relevant history and physical examination based on chart information, you may order testing
3. Discuss your diagnostic impressions and management plan with the patient.
4. Provide patient education centered around changing target behavior
5. Write a note on provided template note sheet that reflects patient centered care
6. Based on note, document coding rationale

**Content Checklist Case 3**

**Patient Compliance**

1. Patient Compliance SP – on a scale of 1-10 how compliant would this patient be with the learner’s OVERALL plan?
2. What effectively contributed to patient compliance? – Comment box
3. What could enhance patient compliance? – Comment box

**ABIM (comment box after each item)**

1. Would you do what this student/doctor asks you to do?
2. Would you recommend this student/doctor to a friend who wanted a student/doctor with excellent communication skills?
3. Would you make a special effort to see this student/doctor?
4. How would you compare the personal manner of this student/doctor to other students/doctors you have seen?

**MITI (comment box after each item)**

1. MITI – Evocation
2. MITI – Collaboration
3. MITI – Autonomy/support
4. MITI – Direction
5. MITI – Empathy

**MIRS (comment box after each item)**

1. Spectrum of concerns
2. Eliciting the narrative thread
3. Timeline
4. Lack of jargon
5. Patient’s perspective
6. Impact of illness on pt/pt’s self-image
7. Verbal facilitation
8. Non-verbal facilitation
9. Patient education and understanding
10. Investigations and procedures
11. Achieve a shared plan
12. Overall interview
13. Transitional Statements
14. Verification and Clarification

**Health Literacy (comment box following item)**

1. Health literacy assessment – may ask either or both to receive full credit – Yes/no
   1. Have you ever needed help filling out forms? (yes – red flag)
   2. Uses teachback to check understanding (OK or less is red flag)

**General Comments:**

1. In the comment box below please explain any scoring discrepancies among communication scales

Introduction:

1. Student greets patient
2. Student uses patient's name
3. Student acknowledges prior visit

History of Present Illness:

1. Wrist - still hurts but much better
2. Complaint - stomach
3. Onset – 5days
4. Quality – butterflies – queasy
5. Quantity – 3/10
6. Frequency – intermittent
7. Location – epigastric, left lower quadrant (variable)
8. Alleviating – BM
9. Aggravating – stress related

Family History:

1. Daughter is pregnant

Social History:

*Stressors*

1. Worried about husband’s reaction to daughter’s pregnancy
2. Worried about daughter’s future
3. Worried about how to change her situation
4. None Discussed

*ABUSE*

Abuse Screening Questions

*Mandatory*

1. Has your husband ever done anything that frightened you? – yes, threats of taking kids and lies about her
2. Determines severity level of physical abuse – not life-threatening but does sustain injuries, this is the worst

*Important*

1. How often does he lose his temper and physically hurt you? – about 3-4 times a year, and he is always very sorry to punish me, he really does love me and the kids.
2. Are there weapons in the house?
3. Has your husband ever threatened to hurt the children?

*Added Details*

1. Does husband drink/use drugs? - yes
2. How does your husband react when he has been drinking/using? – angers easily
3. Does your husband need to know where you are during the day? – yes
4. Has he ever kept you from leaving the house? – no
5. What does he do when he gets angry? - throws, puts against wall
6. When did he start hurting you? – during first pregnancy
7. When was the last time he hurt you, besides this injury? 3 months ago
8. Has there been a recent change of abuse? – no

Assessment:

1. IBS
2. Home stress
3. No fracture
4. Discusses confidentiality issues – only has to report if children are in danger

Management:

1. Attempts to schedule follow-up
2. Gives Meds
3. Educates patient regarding intimate partner violence
4. Need for safety - safe place with support
5. Provides safety resources (safe places and resources)
6. Offers assistance for her to leave now – not to go back
7. Offers assistance in the future when she is ready to leave husband

Physical Examination

1. Inspects wrist
2. Palpates wrist
3. Checks ROM
4. Checks sensation
5. Radial pulse
6. Auscultates abdomen in all four quadrants
7. Palpates abdomen in all four quadrant

**FM Faculty Feedback Prescription – Case 3 – Abdominal Pain 2nd Visit**

HISTORY:

* Completeness:
  + address IPV + IBS
  + Red flag symptoms that would prompt consideration of other diagnosis
* Efficiency:
  + efficient IBS hx
  + history during exam

EXAMINATION:

* Medically Approp:
  + same wrist examination
  + Appropriate Abd Exam (inspect, auscultate, percuss, palpate)
* Efficiency:
  + limit exam to what is needed

MANAGEMENT:

* Follow up wrist pain
  + Repeat x-ray
* IBS management
* IPV support services offered
* set for HMP/GYN follow up
* assessment of understanding
  + Teachback
  + written plan of care
* note efficient & complete
* note E&M coding

MOTIVATION:

* patient sensitive assessment of culture/context/literacy/stages of change (see checklist for details)
* efficient assessment of culture/context/literacy/stages of change

MITI domains score:

* Evocation
  + This patient is very worried about her step-daughter and how her husband might accept the news. This is the underlying cause of her abdominal symptoms. Eliciting this information from her early on, will also allow for a conversation about her relationship with her husband. She has moved from pre-contemplation to contemplation about dealing with her situation. Eliciting this early can help with other MI techniques.
* Collaboration
  + The target behavior on which to collaborate is how to help her help Jane. Getting her ideas about how to do this will work very well. Also, the learner sharing a variety of options and then having Renata pick, may be a helpful strategy.
* Autonomy/Support
  + moves specifically from collaboration “I can give ideas, but you are going to be the expert in what will work best”
* Direction
  + Talking about how the symptoms of abdominal pain are linked to stress which is caused by the household situation, will allow the learner to refocus the conversation on the underlying abuse.
* Empathy
  + Responding to non-verbal cues with empathetic, supportive statements will help encourage this patient to talk.

**Appendix E.**

Student Example Note – Case 1

|  |
| --- |
| **Chief Complaint: Injured wrist** |
| Patient: Renee Tessaro  Age:32  Sex: Female  DOB: 5/27/81  Allergies: NKDA  **Vitals**  BP: 132/86  P: 88  R: 16  T: 99 |

**History (Hx)**

|  |
| --- |
| 1. Chief complaint: (NS)   ***My wrist is better*** |
| 2. History of present illness: (NS)   ***Returned day after last visit after discussing with husband, had cast placed. Pain has largely resolved. Had use of fingers with cast on, no sensory changes.   Home situation – husband apologized for incident, has been treating her well since. No further violence in the home.  “butterflies” in stomach - epigastric, not really pain. No vomiting, normal appetite, subsides after BM. No blood in stool. Does have constipation currently, also episodically in past.*** | |
| 3. Tobacco: | (x) Never a smoker |
| ( ) Former smoker |
| ( ) Smoker, current status unknown |
| ( ) Current some day smoker |
| ( ) Current every day smoker |
| ( ) Unknown if ever smoked |
| 4. Past medical, Family and Social: (NS)   ***Colonoscopy, EGD in past with initial stomach symptoms – no pathology identified, dx ?IBS*** | |
| 5. Allergies: | [x] Allergies as documented are correct |
| 6. Additional allergies: (NS) |  |
| 7. Additional medications: (NS) | |
| **ROS:** | |
| 8. Significant findings: (NS)   ***No fever or weight loss. No dysphagia or heartburn*** | |

**Physical (PX)**

|  |
| --- |
| 9. Findings: (NS)   ***General: A&O, mildly anxious CV: RRR, no m/g/r CHEST: CTA bilaterally ABD: Soft, NT/ND, NABS, no HSM Extr: Minimal TTP over anatomic snuff box. ROM slow, but much improved from last time. Sensation intact fingertips, CR <2 sec.*** |

**Orders/Plan (OP)**

|  |  |  |
| --- | --- | --- |
| 10. Problem 1: (NS)   ***Wrist pain – question of scaphoid fracture last visit. Repeat x-ray today normal. Most likely sprain. Mobilize with PT, OTC ibuprofen for pain prn.*** | | |
| 11. Problem 2: (NS)   ***IBS – increase fiber in diet, stool softener if needed for constipation. Exacerbated by stress*** | | |
| 12. Problem 3: (NS)   ***IPV – seems to have decreased for now. Discussed cycle with pt – has noted same in past. Offered crisis hotline number to keep in shoe – pt accepted today. Discussed developing safety plan if things get out of control – has good lock on bathroom door, so can go in there if needed. Still uncertain of where she would go if she needed to leave the home, not ready to leave her husband.*** | | |
| 13. Plan: (NS)   ***initial history not consistent with examination. further history reveals FOOSH injury secondary to push from spouse. no immediate danger. wanted to cast but patient worried. agreed upon splint with work note and suggestion for casting later this week. patient understands risk of nounion if not casted and it is fractured naprosyn and hydrocodone for pain. recheck 2 weeks for repeat xray. patient contracts for safety and offered info on resources for IPV.   review health maintenance needs on follow up visits*** | | |
| 14. Follow-up | ( ) 1 week | |
| ( ) 2 weeks | |
| ( ) 3 weeks | |
| (x) 1 month | |
| ( ) 6 months | |
| ( ) 1 year | |
| 16. Please specify any of the generic labs you chose from the list above, as well as any you would like to order which are not listed: (NS) | | |
| 18. Other referrals: (NS)   ***offered ipv info*** | | |
| 20. Print Care Plan? | ( ) Yes (NS) | (x) No (NS) |

**Coding (COD)**

|  |  |
| --- | --- |
| 21. Coding: (NS)   ***Established Patient: History: 99214 -HPI 4+ -Past/fam/soc – 1 -ROS – 2 systems Exam: 12-17 - 99214 Medical Decision Making: 99214 -Risk – Moderate (chronic dz with mild exacerbation) -Data – 2 (order, review x-ray) -Diagnoses – 4 Meets 99214 (need at least 2/3 components meet/exceed level coded)*** | |
| 22. New Patient: | (x) N/A |
| ( ) 99201 |
| ( ) 99202 |
| ( ) 99203 |
| ( ) 99204 |
| ( ) 99205 |
| 23. Established Patient: | ( ) N/A |
| ( ) 99212 |
| ( ) 99213 |
| (x) 99214 |
| ( ) 99215 |

**Motivational Stage**

|  |  |
| --- | --- |
| 24. In what stage of motivation do you believe this patient to be? | ( ) Pre-contemplation |
| ( ) Contemplation |
| ( ) Preparation/Determination |
| ( ) Action |
| ( ) Maintenance |
| ( ) Relapse |
| ( ) Termination (change is no longer an issue) |
| ( ) N/A |

**Patient Compliance - Learner (PC)**

|  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| 25. On a scale of 1-10 how compliant do you expect this patient to be? (ten being the most compliant) | ( ) 1 | ( ) 2 | ( ) 3 | ( ) 4 | ( ) 5 | ( ) 6 | ( ) 7 | ( X) 8 | ( ) 9 | ( ) 10 |
| 26. Name one thing that could be adjusted to increase patient compliance. (NS)   ***decrease fear through supportive interviewing and empowering patient*** | | | | | | | | | | |
| 27. Name one thing that you thing affectingly contributed to patient compliance. (NS)   ***listening to patient and working within framework of what she was willing to do at this time*** | | | | | | | | | | |

**Appendix F.**

Additional Cases:

* Back pain – 2 visits, focus on chronic back pain, low health literacy
* Fatigue – depression, also affects chronic disease management
* Difficulty breathing – 2 visits - COPD acute presentation, smoking cessation, symptomatic vs controller meds
* Male problem – 2 visits – erectile dysfunction, metabolic syndrome, male health maintenance
* Weakness – 2 visits – acute CVA with transition call to ED, follow up with geri assessment
* Hypertension – 2 visits – new diagnosis, use of herbal meds
* Sore throat – strep vs viral
* Headache – uncontrolled hypertension, diabetes, social stressors, financial issues
* Dizziness – geri assessment, multifactorial, increased alcohol use in face of grief
* Dysuria – UTI, new sexual partner