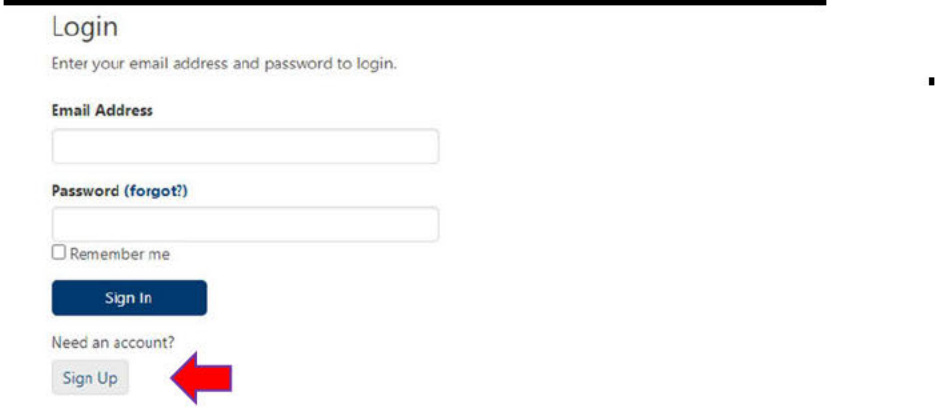
Case Review process:

1. Case writing template has been created that integrates input from DOCS and Health Equity toolkit.
    a. See Appendix A
2. We plan to review all cases that are more than 1 paragraph long (required) or any time a case writer would like feedback.
3. [redacted]



4. Initial plan is to review within 1-2 weeks of submission (depending on case load).
5. Case review committee will respond with either Accept, Minor Revisions, or Major Revisions.
    a. If revisions requested, feedback and suggestions will be provided.
    b. Revised cases will need to be re-submitted.

[redacted]

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Appendix A.

Case writing template

In an effort to improve standardization and decrease bias in our cases, all cases should be written in person-first language following the general structure below. Please note that this description is meant to be comprehensive and not all cases will require every feature, except where specified.

Sections highlighted in grey are required

Subjective:

FirstName LastName is a AGE GenderIdentity, who (insert personal factoid), and presents with Chief Concern *(should be in quotations)*.

History of present illness:

Location (include position& radiation)

Quality (i.e., character)

Severity (i.e., quantification)

Duration (i.e., chronology)

Timing (i.e., onset)

Context (include setting & temporal factors)

Modifying Factors (include aggravating/relieving/transforming factors)

Associated Symptoms (i.e., related symptoms)

Other Symptoms: Provide details/specific quotations as needed (e.g. “coffee grounds” when asked about vomit)

Context:

Identifies as: (race/ethnicity, Country of Origin)
Family structure and social supports (support system, who lives with patient, relationship dynamics, pets):
Language(s):
Cultural context: (Each case should describe the patient's perspective on each of these questions. This can either be embedded as part of the HPI or included under the Context sub-heading)

(pt's explanatory model/Kleinman's questions): "What do you think caused your problem? Why do you think it started when it did? What do you think your sickness does to you? How severe is your sickness? Do you think it will last a long time, or will it be better soon in your opinion? What are the chief problems your sickness has caused for you? What do you fear most about your sickness? What kind of treatment do you think you should receive? What are the most important results you hope to get from treatment?"

Review of Systems:
Past Medical History:
Past Surgical History:
Social History (These components of the Social History are highly recommended by our student groups. If there is a social history included, the request is to include each of these topics):

Tobacco Use
Substance Use (includes alcohol and other substances)
Diet
Exercise
Sexual history [includes sexual orientation and gender identity (SOGI)]
Spiritual History: Faith and Belief, Importance to Patient, Community, Address in care (FICA tool)
Veteran Status:
Literacy (general literacy level, education level, and health literacy)
Environment (includes living situation, neighborhood, occupation/school/what they do during the day, hobbies, socio-economic status, insurance, other resources):

Family History (if known): also include whether family history is unknown (or incompletely known) due to patient being adopted or estranged from family
Allergies: (medication, dietary, and environmental—include type of reaction)
Medications: (include prescription, over-the counter, and any vitamins/herbs/supplements)

Objective (PE template from FDC/DOCS)**:**
Vital Signs: 118/78 68 16
Gen: well nourished, alert, and in no acute distress
HENOT: head is normocephalic, face symmetric features, no lesions on lips or mucus membranes, good dental hygiene, no exudates on tonsils, uvula midline, and posterior pharynx is pink
Eyes: no edema in orbital area, sclera is white, no injection of conjunctiva, iris no irregularities, and pupils are equal, round, and reactive to light.
Neck: trachea is midline and no swelling
Thyroid: lobes are symmetric and non-tender on palpation
Lymph Nodes: one non-tender mobile lymph node in right anterior cervical chain, otherwise no other lymph nodes appreciated in submandibular, anterior cervical, or supraclavicular areas
Pulm: anterior/posterior chest is symmetric, normal percussion, clear to auscultation bilaterally, no accessory muscle use or retractions
Cardio: no lifts/heaves, PMI non-displaced, regular rate and rhythm, normal S1/S2 and no murmurs, radial, dorsalis pedis, and posterior tibial pulses equal and symmetric, no edema

Abd: no scars, non-distended, no hernias, and bowel sounds present. Non-tender to palpation and no masses appreciated. Liver edge smooth and non-tender.
MSK/Spine: no deformities of UE and LE with normal alignment and symmetry; spine is straight with normal curvatures
Neuro: oriented with clear speech and intact ability to follow directions; CN II-XII intact with no focal deficits; normal muscle tone in UE/LE; 5+ strength in bilateral UE/LE; finger-nose smooth bilaterally and accurate; normal gait; negative Romberg; 2+ bicep, patellar, and Achilles reflexes; sensation to light touch intact and symmetric in UE/LE
Skin: no scars, abnormal lesions