Patient

Samantha Baker, 54-year-old female

Key Highlights for Medical Decision-Making (MDM) Improvement

- Missing baseline vital signs (blood pressure, heart rate, weight/BMI) and no prior records—obtain and document comprehensive vitals at this visit and at follow-up.
- No medication, allergy or family history documented—perform full medication reconciliation, review allergies, and elicit a three-generation family history.
- Overdue age-appropriate cancer screenings (mammogram, Pap smear, colonoscopy)—discuss, order, and track scheduling/results in EMR.
- Undiagnosed hypertension risk—implement systematic BP measurement (office & home readings), with clear thresholds for diagnosis and treatment initiation.
- Active tobacco use (25 pack-years)—assess readiness to quit, provide cessation counseling, and offer pharmacotherapy options; document tobacco use in social history.
- Laboratory data lacking—order basic metabolic panel, lipid profile, HbA1c, CBC, TSH to establish baseline; address needle-phobia with appropriate accommodations.
- Immunization record absent—review and update according to CDC adult schedule (influenza, Tdap, COVID-19, shingles).
- Psychosocial stressors (loneliness, low motivation)—screen for depression/anxiety (PHQ-9/GAD-7), consider referral to mental health or support groups; document screening results.
- Bone health not addressed—order DEXA scan for osteoporosis risk stratification at age 54.
- EMR documentation gaps—use structured templates for HPI, ROS, social/family history to ensure completeness.

Chief Concern

“To check my health” (routine health maintenance and baseline evaluation)

Assessment

Samantha Baker is a 54-year-old woman with a remote history of being told she has “high blood pressure” (never treated), active 25 pack-year smoking history, needle-phobia leading to no prior labs or immunizations, and recent immigration with social isolation. She denies cardiopulmonary symptoms, reports occasional headaches, and has no documented chronic diagnoses. Physical exam is entirely normal. Differential: 1) essential hypertension; 2) primary tension-type headache; 3) adjustment/mood disturbance given loneliness. Workup is needed to confirm or exclude hypertension, establish baseline labs, complete preventive screening, and address psychosocial well-being.

Plan

Possible hypertension

Status	Unknown, previously told of high blood pressure but never formally diagnosed or treated
Decision Making and Diagnositic Plan	Obtain three seated office blood pressures at this visit (per ACC/AHA guidelines). Provide home BP monitor and instruct patient on twice-daily readings for one week. Correlate home readings with office values. Assess end-organ risk via labs (CMP for renal function, electrolytes) and baseline ECG if indicated.
Treatment/Medication Plan	Lifestyle: DASH diet counseling, sodium <2.3 g/day, 30 minutes moderate exercise 5 days/week, weight loss if BMI>25. If average BP ≥130/80 mmHg after home monitoring, initiate lisinopril 10 mg daily (ACE-I preferred for renal protection). Alternatives: hydrochlorothiazide 12.5 mg daily if ACE-I contraindicated or patient intolerant.
Contingency Planning	If home BP ≥140/90 mmHg after 4 weeks, increase lisinopril to 20 mg daily. If side-effects occur (e.g., cough), switch to losartan 50 mg daily. If still uncontrolled at 140/90 on two agents, add thiazide-type diuretic.
Considerations for Documentation Improvement	Document exact BP readings (office and home), devices used, and patient understanding of home monitoring protocol. Record rationale for drug choice and alternative options considered.
Considerations for Cost Effective Care Improvement	Provide a validated, low-cost home BP monitor. Start with lifestyle modification before pharmacotherapy if BP is in Stage 1 range. Use generic lisinopril. Only obtain ECG if symptomatic or abnormalities on exam.

Tobacco use (25 pack-year)

Status	Active, 1 pack/day × 25 years
Decision Making and Diagnositic Plan	Assess readiness to quit using the 5A's model. Screen for nicotine dependence using the Fagerström Test. Document tobacco use in social history section using structured fields.
Treatment/Medication Plan	Offer combination nicotine replacement therapy (NRT): patch 21 mg daily plus gum 4 mg PRN cravings. If NRT declined or ineffective, consider bupropion SR 150 mg BID, starting one week before quit date. Counsel on quit date setting and support resources (quitlines, apps).

Contingency Planning	If patch/gum fails after 8 weeks, evaluate for varenicline (start 0.5 mg daily titrating to 1 mg BID). If patient relapses, reinforce quit plan, evaluate triggers, offer additional counseling.
Considerations for Documentation Improvement	Record detailed smoking history (start/quit dates, pack-years), Fagerström score, patient's quit plan, and counseling provided.
Considerations for Cost Effective Care Improvement	Prescribe generic NRT patches and gum. Leverage state quitline services for free support. Monitor insurance coverage for pharmacotherapy.

Preventive cancer screening overdue

Status	Not at goal (no mammogram, colonoscopy, or recent Pap documented)
Decision Making and Diagnositic Plan	Schedule mammogram immediately (annual screening per USPSTF for ages 50–74). Schedule Pap smear every 3 years (last normal 4 years ago). Offer high-sensitivity HPV co-test if available. Refer for colonoscopy (age 54, average risk) or consider FIT if colonoscopy declined.
Treatment/Medication Plan	No medications. Provide patient education materials. Coordinate with radiology and OB/GYN for timely completion.
Contingency Planning	If patient declines colonoscopy, perform annual FIT for 3 consecutive years. If any screening yields abnormal result, expedite GI or gynecology referral.
Considerations for Documentation Improvement	Record patient consent/refusal, dates of scheduled studies, and results. Use preventive health templates to track due dates.
Considerations for Cost Effective Care Improvement	Use FIT as lower-cost alternative if colonoscopy access is delayed. Utilize community programs offering low-cost mammograms.

Baseline laboratory evaluation lacking

Status	Not started
Decision Making and Diagnositic Plan	Order basic metabolic panel, lipid profile, HbA1c, CBC, TSH, liver function tests. Assess anemia, glucose intolerance, dyslipidemia, thyroid disease.
Treatment/Medication Plan	No pharmacotherapy until results reviewed. Educate on need despite needle-phobia, offer topical anesthetic (EMLA cream) and smaller gauge needles.

Contingency Planning	If patient still refuses labs, document refusal and readdress at next visit, emphasizing impact on management of BP and cardiovascular risk.
Considerations for Documentation Improvement	Document patient's needle-phobia, accommodations offered, and specific labs ordered with rationale.
Considerations for Cost Effective Care Improvement	Start with lipid panel and HbA1c if patient agrees, delaying less critical tests to reduce immediate visit burden and cost.

Adult immunizations incomplete

Status	Unknown/likely incomplete
Decision Making and Diagnositic Plan	Review patient-reported immunization history. Verify tetanus 3 years ago. Per CDC adult schedule, assess need for influenza, Tdap, COVID-19 booster, shingles vaccine.
Treatment/Medication Plan	Administer influenza vaccine (inactivated), Tdap once (if not within 10 years), COVID-19 bivalent booster if due, recombinant zoster vaccine (RZV) two-dose series.
Contingency Planning	If patient declines injection, schedule motivational interviewing in 2 weeks. Offer education on needle-free vaccines when available.
Considerations for Documentation Improvement	Use structured immunization module to track vaccines, lot numbers, dates, and patient consent.
Considerations for Cost Effective Care Improvement	Use clinic-stocked vaccines under vaccine program to reduce patient cost; immunize during same visit to minimize administration fees.

Psychosocial—loneliness and low motivation

Status	Reported social isolation since immigration
Decision Making and Diagnositic Plan	Screen for depression and anxiety with PHQ-9 and GAD-7. Assess social determinants (living situation, support network).
Treatment/Medication Plan	Provide referral to local immigrant support groups or community centers. If PHQ-9 ≥10, consider starting sertraline 50 mg daily. Provide handout on behavioral activation techniques.
Contingency Planning	If moderate–severe depression identified, expedite mental health referral; if sertraline initiated but no improvement in 6 weeks, consider dose titration to 100 mg daily or psychotherapy.

Considerations for Documentation Improvement	Record PHQ-9/GAD-7 scores in mental health section, document referrals and patient acceptance.
Considerations for Cost Effective Care Improvement	Refer to community-based counseling services or sliding-scale clinics. Consider generic SSRIs.

Bone health—osteoporosis screening

Status	Not addressed, age 54
Decision Making and Diagnositic Plan	Calculate FRAX score. Order DEXA scan for BMD assessment per USPSTF guidelines for women ≥65 or younger at increased risk.
Treatment/Medication Plan	Begin calcium 1,200 mg daily and vitamin D3 1,000 IU daily pending DEXA results.
Contingency Planning	If DEXA T-score ≤-2.5, initiate alendronate 70 mg weekly. If moderate risk (T-1.0 to -2.5), continue supplements and lifestyle (weight-bearing exercise).
Considerations for Documentation Improvement	Record FRAX inputs (family history, smoking, steroid use). Document DEXA order and results in bone health section.
Considerations for Cost Effective Care Improvement	Use generic calcium/Vitamin D. Screen selectively based on FRAX rather than universal DEXA.

Anticipatory Preventative Care

Item 1	Influenza vaccination annually—reduces risk of severe flu and complications, especially at age >50.
Item 2	Bivalent COVID-19 booster—enhances immunity against circulating variants per CDC.
Item 3	Tdap booster if >10 years since last tetanus/diphtheria—protects against pertussis and tetanus.
Item 4	Recombinant zoster vaccine (2 doses)—reduces risk of shingles and post-herpetic neuralgia in adults ≥50.
Item 5	DEXA scan and FRAX assessment—evaluates osteoporosis risk and guides prevention.
Item 6	Lipid screening every 5 years—monitors cardiovascular risk; initiate statin if indicated.
Considerations for Documentation Improvement	Use EMR preventive health dashboard to autopopulate due dates and record patient preferences or refusals.

Follow Up Care

Item 1	Re-evaluate blood pressure readings in 4 weeks; review home BP log and adjust antihypertensive therapy as needed.
Item 2	Follow up on laboratory results in 1 week—review CMP, lipid panel, HbA1c, CBC, TSH and plan management.
Item 3	Confirm completion and results of mammogram, Pap smear, and colonoscopy/FIT within 2 months.
Item 4	Check immunization record at next visit to ensure all vaccines administered and documented correctly.
Item 5	Reassess PHQ-9/GAD-7 in 6 weeks if initial screening positive; monitor response to any initiated SSRI.
Item 6	Review DEXA results and FRAX score in 6 weeks; finalize bone health treatment plan.
Considerations for Documentation Improvement	Create templated follow-up reminders in EMR with due dates and tasks assigned to care team members to ensure no gap in preventive care tracking.

Generic Drug Pricing

Mention	Generic Name	Source	30 Day Cost
lisinopril	lisinopril	Walmart	$9
lisinopril	lisinopril	CostPlusDrugs	$5.59
hydrochlorothiazide	hydrochlorothiazide	Walmart	$4
bupropion	bupropion	Walmart	$15
sertraline	sertraline	Walmart	$9
sertraline	sertraline	CostPlusDrugs	$6.04