Patient

Samantha Baker, 54-year-old female

Key Highlights for Medical Decision-Making (MDM) Improvement

- No baseline vitals or laboratory data documented despite reported history of hypertension; vital signs and labs are essential for risk stratification.
- Sparse past medical, surgical, family, social history; full history should be elicited and documented.
- Overdue preventive screenings: mammogram, colorectal cancer screening, Pap smear.
- No immunization record except remote tetanus; immunization status needs complete review and catch-up.
- Chronic 25 pack-year tobacco use without cessation plan documented.
- No depression/anxiety screening despite reported loneliness and low motivation after recent immigration.
- Fear of needles hindering labs and vaccines; strategies to address needle phobia should be documented.
- Referral to gastroenterology created without specifying indication or timeline; need clear rationale and patient engagement.

Chief Concern

"To check my health"

Assessment

54-year-old female immigrant from London presenting for comprehensive health evaluation with remote self-reported history of untreated hypertension and chronic 25 pack-year tobacco use. She denies cardiopulmonary symptoms but reports occasional headaches and feelings of loneliness after relocation. Physical exam is unremarkable. No vital signs or labs are available to confirm blood pressure or cardiovascular risk factors. She is overdue for age-appropriate cancer screenings (breast, colorectal, cervical) and needs immunization catch-up. Differential diagnosis: 1) Primary hypertension, 2) tension headaches, 3) adjustment disorder with depressed mood.

Plan

Suspected hypertension

Status	Not established; risk factors present

Decision Making and Diagnositic Plan	Obtain seated and standing blood pressures today and twice more on two separate occasions; consider home BP monitoring and ambulatory BP cuff if clinic readings elevated. Order basic labs (CBC, CMP), lipid panel, fasting glucose or HbA1c to assess cardiovascular risk once needle-phobia strategies in place.
Treatment/Medication Plan	Initiate lifestyle modifications: DASH diet, sodium <2.3 g/day, increase aerobic exercise (30 min most days), weight management. If average BP ≥130/80 mmHg on follow-up, start low-dose thiazide diuretic (e.g., hydrochlorothiazide 12.5 mg daily) or ACE inhibitor (e.g., lisinopril 10 mg daily) based on comorbidities.
Contingency Planning	If BP remains ≥140/90 after 3 months of lifestyle changes, intensify therapy by adding second agent (e.g., ACE inhibitor + thiazide). If adverse effects (e.g., cough with ACEi), switch to ARB. If hypertensive urgency (>180/120), urgent evaluation.
Considerations for Documentation Improvement	Record actual BP values, home readings, and method of measurement. Document prior history source, previous readings, and patient's understanding of hypertension.
Considerations for Cost Effective Care Improvement	Prioritize lifestyle modification before pharmacotherapy. Use generic antihypertensives and home BP monitoring devices rather than frequent clinic visits.

Tobacco dependence

Status	Active, 25 pack-year history
Decision Making and Diagnositic Plan	Assess readiness to quit and nicotine dependence (e.g., Fagerström test). Provide brief counseling using the 5 A's (Ask, Advise, Assess, Assist, Arrange).
Treatment/Medication Plan	Offer nicotine replacement therapy (generic nicotine patch 21 mg daily) plus short-acting NRT as needed; consider varenicline (0.5 mg daily ×3 days, then 0.5 mg BID ×4 days, then 1 mg BID) if no contraindications. Discuss behavioral support and referral to quitline (1-800-QUIT-NOW).
Contingency Planning	If patient is not ready, re-visit at next visit; offer motivational interviewing. If NRT not tolerated, switch to bupropion SR 150 mg daily ×3 days then 150 mg BID.
Considerations for Documentation Improvement	Document pack-years, willingness to quit, chosen pharmacotherapy, and referral details.
Considerations for Cost Effective Care Improvement	Prescribe generic NRT and utilize free quitline services; consider covering varenicline under patient's plan if eligible.

Adjustment disorder/depressive symptoms

Status	Suspected, not formally assessed
Decision Making and Diagnositic Plan	Administer PHQ-9 and GAD-7 screening today. Evaluate for suicidal ideation and functional impairment.
Treatment/Medication Plan	Refer to individual or group counseling (e.g., cognitive behavioral therapy). If PHQ-9 ≥10, consider starting sertraline 50 mg daily after discussing benefits and side effects.
Contingency Planning	If PHQ-9 >15 or emergent suicidal ideation, arrange urgent mental health evaluation. If no improvement in 4–6 weeks on SSRI, adjust dose or switch class.
Considerations for Documentation Improvement	Include screening results, patient's reported symptoms, and safety plan if needed.
Considerations for Cost Effective Care Improvement	Utilize sliding-scale community mental health services; generic SSRIs.

Breast cancer screening overdue

Status	Not at goal; no recent mammogram
Decision Making and Diagnositic Plan	Discuss benefits/risks of screening; refer for bilateral mammogram with tomosynthesis within the next 4–6 weeks.
Treatment/Medication Plan	No pharmacologic therapy required; provide patient education on breast self-awareness.
Contingency Planning	If abnormal finding (BI-RADS 0/4/5), expedite diagnostic imaging and surgical referral. If patient declines, document and revisit rationale.
Considerations for Documentation Improvement	Record discussion details, patient's decisions, and scheduled appointment date.
Considerations for Cost Effective Care Improvement	Order standard mammography without adjunct ultrasound unless indicated by clinical findings.

Colorectal cancer screening overdue

Status	Not at goal; no prior colonoscopy
Decision Making and Diagnositic Plan	Offer screening options: colonoscopy every 10 years vs. annual FIT. Given patient's fear of invasive tests, propose FIT.

Treatment/Medication Plan	Provide FIT kit with instructions; schedule colonoscopy only if FIT positive.
Contingency Planning	If FIT positive, refer for colonoscopy. If patient does not return FIT within 4 weeks, send reminder letter or call.
Considerations for Documentation Improvement	Document discussion of options and patient's choice; track kit distribution and return.
Considerations for Cost Effective Care Improvement	FIT is lower cost and non-invasive, improving uptake.

Immunization catch-up and needle phobia

Status	Incomplete immunizations; needle phobia present
Decision Making and Diagnositic Plan	Review immunization schedule. Address needle phobia by offering topical anesthetic and distraction techniques. Consider intranasal influenza vaccine.
Treatment/Medication Plan	Administer or schedule: influenza vaccine (inactivated), Tdap booster if >10 years since last, Shingrix two-dose series, pneumococcal PCV13 then PPSV23, COVID-19 booster per guidelines.
Contingency Planning	If severe phobia persists, refer to behavioral therapy for phobia desensitization. Offer alternative formulations (e.g., intranasal influenza).
Considerations for Documentation Improvement	Record vaccine dates, lot numbers, patient's consent/refusal, and needle-phobia interventions.
Considerations for Cost Effective Care Improvement	Bundle vaccines in one visit, use combination vaccines when available, and leverage public health vaccine programs.
Item 1	Schedule bilateral screening mammography in 4–6 weeks for early breast cancer detection (USPSTF B recommendation).
Item 2	Initiate or continue annual colorectal cancer screening with FIT, consistent with USPSTF A recommendation.
Item 3	Repeat Pap smear every 3 years until age 65 (USPSTF A recommendation), with reflex HPV co-testing if available.
Item 4	Order fasting lipid panel and HbA1c to screen for dyslipidemia and diabetes every 5 years in patients age ≥40.

Item 5	Implement bone health counseling: adequate calcium (1,200 mg daily), vitamin D (800 IU daily), weight-bearing exercise; consider DEXA scanning at age ≥65 or earlier if risk factors.
Item 6	Annual influenza vaccination and age-appropriate immunizations (Shingrix, Tdap, pneumococcal, COVID-19) per CDC schedule.
Considerations for Documentation Improvement	Use health maintenance templates to auto-populate due dates and track completed items; document patient education and decisions.

Item 1	Re-evaluate blood pressure trends and medication adherence in 4–6 weeks with home BP log.
Item 2	Assess tobacco cessation progress and tolerance of NRT/varenicline at next visit.
Item 3	Review PHQ-9/GAD-7 results and adjust mental health interventions in 4 weeks.
Item 4	Confirm completion and results of mammography; discuss findings.
Item 5	Track return of FIT kit and refer for colonoscopy if positive; follow up in 8 weeks.
Item 6	Review laboratory results (lipid panel, HbA1c) once obtained and adjust risk-reduction plan.
Considerations for Documentation Improvement	Include a structured follow-up checklist in the note to ensure each item is revisited and avoid omissions.