Patient Name

Samantha Baker

Key Highlights for Medical Decision-Making (MDM) Improvement

- Establish comprehensive baseline: Vital signs (especially BP) and baseline labs (CBC, CMP, Lipids, A1c, TSH) were not obtained/ordered despite history of HTN, smoking, and lack of prior care. Addressing needle phobia is crucial.
- Address all identified problems: The plan only included a GI referral, neglecting critical issues like potential HTN, tobacco use, other overdue screenings (mammogram, Pap), headaches, and social isolation.
- Robust Tobacco Cessation Plan: Offer specific pharmacotherapy (NRT, bupropion, varenicline) and behavioral support, documenting the discussion and plan.
- Hypertension Management Protocol: Implement steps for diagnosis (repeat BPs, labs) and management (lifestyle counseling, medication if indicated based on thresholds), including medication reconciliation (confirming no current meds).
- Comprehensive Preventative Care: Systematically address all due items including immunizations (Tdap, Flu, Pneumococcal, Shingles), Lung Cancer Screening discussion (meets criteria), and Osteoporosis risk discussion.
- Mental Health/Social Support: Assess mood and social integration more formally and offer specific resources or referrals.
- Documentation Detail: Improve documentation by including vital signs, specific counseling points (e.g., 5 A's for smoking), medication rationale, explicit contingency plans, and tracking for all health maintenance items.

Chief Concern

to check my health

Assessment

Samantha Baker is a 54-year-old female, recent immigrant from the UK, presenting for establishment of primary care. She reports a history of untreated 'high blood pressure' several years ago and has a significant 25+ pack-year smoking history. She expresses fear of needles, declining past blood work and immunizations (except tetanus 3 years ago). Key subjective findings include occasional headaches and feelings of loneliness post-immigration. Objective findings from the documented physical exam are largely unremarkable, but vital signs are notably absent. The patient is overdue for colorectal cancer screening, mammogram, and likely requires updated immunizations. Based on her history and risk factors (age, smoking, possible HTN), she requires a comprehensive cardiovascular risk assessment, management of tobacco dependence, evaluation for hypertension, and completion of age-appropriate preventative screenings. Her needle phobia presents a significant barrier to care that must be addressed sensitively. Potential problems include: 1. Essential

Hypertension (needs confirmation), 2. Tobacco Use Disorder (active, heavy use), 3. Overdue Health Maintenance (CRC, Breast Ca screening, immunizations, Pap potentially due), 4. Needle Phobia, 5. Headaches (likely tension-type vs. migraine vs. HTN-related), 6. Possible Adjustment Disorder/Social Isolation.

Plan

Tobacco Use Disorder

Status	Active, heavy use (1 ppd x 25+ years)
Decision Making and Diagnositic Plan	High priority due to major impact on cardiovascular, pulmonary, and cancer risk. Assessed readiness to quit using the 5 A's (Ask, Advise, Assess, Assist, Arrange). Patient is a current daily smoker with long history. Discussed risks of continued smoking and benefits of quitting.
Treatment/Medication Plan	Advised cessation strongly. Offered combination therapy: Nicotine Patch (e.g., 21mg/24hr patch daily) + short-acting NRT (e.g., Nicotine gum 2mg or lozenge 2mg q1-2h PRN cravings). Alternatives discussed: Bupropion SR 150mg daily x 3 days then BID, or Varenicline starting dose titration. Provided information on state quitline (1-800-QUIT-NOW). Patient to consider options. No medications prescribed at this visit pending patient decision.
Contingency Planning	If patient chooses pharmacotherapy, provide prescription and schedule close follow-up (1-2 weeks). If not ready to quit, use motivational interviewing, reinforce benefits, and plan to reassess at every visit. If side effects occur with chosen therapy, adjust dose or switch agent/modality.
Considerations for Documentation Improvement	Document pack-year history calculation. Detail the 5 A's counseling provided. Specify pharmacotherapy options discussed, including dosages and rationale. Record patient's stage of change (e.g., contemplation) and agreed-upon next steps. Document quitline referral.
Considerations for Cost Effective Care Improvement	Discuss cost of different NRT options (patches vs. gum/lozenge) and prescription medications (generic bupropion vs. brand Varenicline). Highlight free quitline resource. Check insurance coverage for cessation aids.

Hypertension (Suspected/History of)

Status	History of 'high blood pressure', untreated. Current status unknown.

Decision Making and Diagnositic Plan	High priority due to cardiovascular risk, especially with smoking history. Need to confirm diagnosis. Plan: Obtain accurate BP readings today (multiple readings if elevated) and arrange for follow-up measurements (e.g., home BP monitoring log or return visit for BP check). Order baseline labs to assess for end-organ effects and guide medication choice (CMP for kidney function/electrolytes, TSH, Urinalysis) and cardiovascular risk (Lipid panel, A1c). This requires addressing needle phobia.
Treatment/Medication Plan	Emphasize lifestyle modifications immediately: smoking cessation, DASH diet, sodium restriction (<1500mg/day), regular exercise (150 min/week moderate intensity), limit alcohol. If BP confirmed >=140/90 mmHg or >=130/80 mmHg with ASCVD risk >=10%, initiate pharmacotherapy. Potential first-line agents (pending labs/patient factors): Chlorthalidone 12.5-25mg daily OR Amlodipine 5mg daily OR Lisinopril 10mg daily OR Losartan 50mg daily. No current antihypertensives documented.
Contingency Planning	If BP readings are borderline (e.g., 130-139/80-89), intensify lifestyle changes and monitor closely. If initial medication is ineffective or causes side effects, increase dose or add/switch to an agent from a different class. If office BP is high but home BP is normal, consider white coat hypertension and monitor with home BPs.
Considerations for Documentation Improvement	Record all BP readings taken during the visit. Document specific lifestyle counseling provided. If medication is initiated, include rationale for choice, drug name, dose, frequency, and target BP goal. Document plan for BP monitoring.
Considerations for Cost Effective Care Improvement	Prioritize lifestyle interventions. If medication needed, prescribe generic formulations (e.g., chlorthalidone, lisinopril, amlodipine are often Tier 1). Discuss 90-day supplies if appropriate.

Overdue Health Maintenance / Cancer Screening

Status	Colorectal cancer screening due. Mammogram date unknown, likely overdue. Pap smear performed 4 years ago, potentially due depending on prior results/testing.

Decision Making and Diagnositic Plan	Colorectal Cancer Screening: Referral to Gastroenterology placed (as noted in EMR). Need to confirm referral appointment made and screening modality chosen (likely colonoscopy recommended given age). Breast Cancer Screening: Discuss benefits/risks of screening mammogram and offer order per USPSTF guidelines (biennial for women 50-74). Cervical Cancer Screening: Clarify date/result of last Pap smear; if cytology alone 4 years ago, recommend Pap smear now. If Pap/HPV co-testing was negative 4 years ago, due in 1 year. Recommend Pap + HPV co-testing now given age >30 and uncertain history. Lung Cancer Screening: Patient meets USPSTF criteria (age 54, >20 pack-year smoking history, current smoker). Discuss benefits/risks/logistics of annual low-dose CT scan screening.
Treatment/Medication Plan	Place order for screening mammogram (bilateral). Place order for Pap smear with HPV co-testing. Initiate discussion about low-dose CT lung cancer screening. Follow up on GI referral status.
Contingency Planning	If patient declines any screening after discussion, document informed refusal and rationale, and plan to revisit discussion at future visits. If screening results are abnormal, initiate appropriate follow-up workup per standard guidelines (e.g., diagnostic mammogram, colposcopy, further GI procedures, referral for concerning lung nodule).
Considerations for Documentation Improvement	Update health maintenance section with specific dates/results when available. Document discussions about each screening modality, including risks/benefits and patient decisions. Specify type of CRC screening referred for/preferred. Document LDCT discussion and decision.
Considerations for Cost Effective Care Improvement	Ensure screenings are ordered as 'preventative' for insurance coverage. Discuss different CRC screening options (colonoscopy vs. stool-based tests like FIT/Cologuard) considering cost, insurance, and patient preference, though colonoscopy is often preferred if feasible. Utilize insurance preventative benefits fully.

Needle Phobia

Status	Active barrier to care (blood work, immunizations).
Decision Making and Diagnositic Plan	Acknowledge and validate fear. Explain necessity of blood work for HTN, lipid, diabetes evaluation and immunizations for disease prevention. Discuss management strategies: distraction techniques, deep breathing/relaxation, applying topical anesthetic (Lidocaine/prilocaine cream) 1 hour prior, using a small gauge (butterfly) needle, ensuring an experienced phlebotomist performs the draw, allowing her daughter to be present for support.

Treatment/Medication Plan	Plan for blood draw using agreed-upon strategies. Consider prescribing EMLA cream (lidocaine 2.5%/prilocaine 2.5%) with instructions for application 60 minutes before planned lab draw/ immunization visit. Avoidance of short-acting anxiolytic initially unless non-pharmacologic methods fail and patient is amenable after risk/ benefit discussion.
Contingency Planning	If strategies are insufficient and patient still refuses necessary blood work or immunizations, document the refusal and limitations to care thoroughly. Revisit the discussion periodically. Explore minimum necessary testing if absolute refusal persists.
Considerations for Documentation Improvement	Document the specific phobia, the discussion of its impact on care, the coping strategies discussed and agreed upon, and the plan implemented. If medication is used, document rationale and instructions.
Considerations for Cost Effective Care Improvement	Prioritize non-pharmacologic strategies first. Topical anesthetics are relatively low cost (generic available). Anxiolytics add cost and potential side effects.

Headaches

Status	Occasional, characterization needed.
Decision Making and Diagnositic Plan	Characterize headaches further: frequency, duration, location, quality, severity, triggers, associated symptoms (photophobia, phonophobia, nausea, visual changes), relieving factors. Assess relationship to stress or potential HTN. Neurological exam nonfocal.
Treatment/Medication Plan	Recommend keeping a headache diary. For presumptive tension-type headaches, recommend stress management techniques, hydration, and OTC analgesics like acetaminophen 500-1000mg or ibuprofen 400-600mg PRN, limiting use to avoid medication overuse headache. No prescription medications at this time.
Contingency Planning	If headaches worsen, increase in frequency, change character, or develop neurological symptoms, further evaluation (including potential neuroimaging) would be warranted. If features suggest migraine, consider initiating migraine-specific abortive therapy (e.g., triptan) or prophylaxis if frequent. If BP is found to be significantly elevated, reassess headaches after BP control.
Considerations for Documentation Improvement	Document detailed headache history (PQRST format). Record recommendations given (diary, OTC meds, red flags).

Considerations for Cost Effective Care Improvement	Encourage non-pharmacologic management and appropriate use of low-cost OTC analgesics initially.

Social Isolation / Adjustment Issues

Status	Patient reports feeling lonely since immigrating.
Decision Making and Diagnositic Plan	Assess impact on mood and daily function. Screen for depression (e.g., PHQ-2: 'Over the past 2 weeks, have you felt down, depressed, or hopeless?' / 'Have you felt little interest or pleasure in doing things?'). Explore coping mechanisms and available social supports (daughter).
Treatment/Medication Plan	Provide empathetic listening. Encourage connection with daughter and exploring community resources (e.g., local clubs, volunteer organizations, groups for expats/immigrants). Provide information on local community centers or resources. Consider referral to behavioral health/counseling if symptoms persist or worsen, or if screening suggests significant depression/anxiety.
Contingency Planning	If mood significantly declines or functional impairment occurs, initiate formal depression/anxiety treatment (medication and/or therapy). Reassess mood and social integration at follow-up visits.
Considerations for Documentation Improvement	Document patient's subjective report of loneliness, results of any mood screening (PHQ-2/9), discussion of social supports, and resources/referrals provided.
Considerations for Cost Effective Care Improvement	Utilize free or low-cost community resources for social integration. Behavioral health referrals should consider insurance coverage and community mental health centers.
Item 1	Immunizations: Needs Tdap (Tetanus 3 yrs ago, likely Td; needs pertussis component), Influenza (annual), Pneumococcal (PCV20 or PCV15 followed by PPSV23 due to age>50 and smoking), Shingrix (2-dose series, age >50). Requires addressing needle phobia.
Item 2	Cardiovascular Disease Prevention: Calculate 10-year ASCVD risk score once BP and lipids are known. Counsel on primary prevention. Aspirin therapy likely not indicated for primary prevention currently but reassess based on risk score and discussion of bleeding risk.
Item 3	Lifestyle Counseling: Reinforce comprehensive healthy lifestyle including DASH diet, sodium restriction, 150 mins/week moderate-intensity aerobic activity, achieving/maintaining healthy weight (assess BMI), stress reduction techniques.

Item 4	Osteoporosis Screening: Discuss risk factors (age, female, smoking). Recommend DEXA scan starting at age 65 per USPSTF, or earlier only if other significant risk factors emerge. Counsel on adequate calcium and vitamin D intake.
Item 5	Lung Cancer Screening: Discuss annual low-dose CT screening given age 54 and >20 pack-year smoking history (current smoker). Cover benefits (mortality reduction) and risks (false positives, radiation, incidental findings).
Item 6	Not applicable
Considerations for Documentation Improvement	Maintain an up-to-date health maintenance flowsheet documenting status and due dates for all relevant screenings, immunizations, and counseling topics. Document specific counseling points delivered for each item.
Item 1	Blood Pressure Monitoring: Schedule follow-up visit in 1-2 weeks for BP check and lab review, or sooner if BP severely elevated. Provide instructions for home BP monitoring if feasible.
Item 2	Smoking Cessation Status: Reassess readiness to quit and decision on pharmacotherapy at next visit (1-2 weeks). Provide support and adjust plan.
Item 3	Lab Review: Discuss results of ordered labs (CBC, CMP, Lipids, A1c, TSH, UA) and implications for HTN, diabetes, dyslipidemia risk/ management.
Item 4	Screening Status: Confirm scheduling/completion of Mammogram, Pap/HPV test, and GI consult/CRC screening. Review LDCT decision.
Item 5	Headache Pattern: Review headache diary and assess frequency/ severity.
Item 6	Mood and Social Adjustment: Briefly check in on feelings of loneliness and coping.
Considerations for Documentation Improvement	Specify timeframe for follow-up appointment (e.g., 'RTC 2 weeks'). Clearly list the specific items to be addressed at the next visit in the plan section of the note. Utilize problem-based charting to track progress on each issue over time.