Patient

Phil Wiser, 62-year-old male

Key Highlights for Medical Decision-Making (MDM) Improvement

- Clearly document baseline and interval lab values and dates to track trends (e.g., prior A1c, lipids, renal function).
- Include patient's last eye and foot exam dates (or note "never" and reason) to justify referrals.
- Expand HPI to capture psychosocial factors in structured form (e.g., PHQ-9 for depression, stress assessment).
- Specify fasting status for lipid panel and A1c orders to avoid confusion.
- Document medication reconciliation: prior metformin regimen, adherence issues, and rationale for re-titration schedule.
- Note eGFR staging and link to metformin dosing decisions.
- Include risk stratification (ASCVD risk calculator) to guide lipid management.

Chief Concern

Prescription refill for metformin

Assessment

62-year-old man with established type 2 diabetes mellitus diagnosed 2 years ago, presenting for medication refill and diabetes management. He has been off metformin for >6 months due to personal stressors, and has not performed home glucose monitoring or attended routine diabetic screenings. Objective data show a BMI of 37.9 (obesity), HbA1c 9.8% (poor glycemic control), LDL 137 mg/dL (elevated), eGFR 55 mL/min/1.73m2 (CKD stage 3a), and microalbuminuria (ACR 50 mg/g). He denies polyuria, polydipsia, neuropathy symptoms, and has normal foot exam. He reports an unhealthy diet, sedentary lifestyle, and no immunizations on record. Differential: 1) Uncontrolled type 2 diabetes mellitus; 2) Obesity-related insulin resistance; 3) Early diabetic kidney disease.

Plan

Type 2 diabetes mellitus – uncontrolled

Status	Not at goal (HbA1c 9.8%, target <7%)
Decision Making and Diagnositic Plan	Re-established baseline labs today (CMP, CBC, A1c, lipids, urine ACR) to characterize glycemic control, renal function, dyslipidemia. Referred for annual diabetic retinopathy screening. Foot exam performed today; normal. Plan home SMBG: fasting and post-prandial checks 2x/day.

Treatment/Medication Plan	Restart metformin ER 500 mg twice daily (total 1000 mg daily), increase in 500 mg increments weekly to 2000 mg daily as tolerated. Counsel on GI side effects and advise taking with evening meal. Discussed long-term add-on therapy if A1c remains >8.0% at 3 months (e.g., GLP-1 RA or SGLT2i based on CKD).
Contingency Planning	If GI intolerance occurs → reduce to 500 mg daily for 1 week then reattempt titration. If A1c remains >8.5% at 3-month follow-up → add empagliflozin 10 mg daily (renal benefit). If eGFR falls <45 → hold metformin per guidelines and adjust regimen.
Considerations for Documentation Improvement	Include pre-visit home glucose logs and ensure explicit mention of prior regimen/dosing. Document rationale for titration schedule and metformin safety in CKD.
Considerations for Cost Effective Care Improvement	Metformin is first-line, generic, cost-effective. Delay expensive add-ons until confirming adherence and titration. Use in-house diabetes educator resources rather than outpatient nutritionist referral when possible.

Obesity (BMI 37.9)

Status	Not at goal
Decision Making and Diagnositic Plan	Recognize obesity as major contributor to insulin resistance. Screen for obstructive sleep apnea (STOP-BANG) at next visit. Assess readiness to change diet and activity.
Treatment/Medication Plan	Refer to intensive lifestyle program: 500 kcal/day deficit, dietitian consult (in-clinic group class). Encourage 150 min/week moderate exercise. Discuss potential pharmacotherapy (e.g., orlistat) if no weight loss in 3 months.
Contingency Planning	If <5% weight loss at 3 months → consider GLP-1 RA (liraglutide) for weight and glycemic control. If patient declines formal program → prescribe low-intensity walking plan and phone counseling.
Considerations for Documentation Improvement	Quantify diet recall (calories, macronutrients) and exercise history. Document patient's goals and barriers.
Considerations for Cost Effective Care Improvement	Utilize covered group visits or community resources (e.g., YMCA programs) rather than expensive one-on-one dietitian visits initially.

Dyslipidemia – elevated LDL

Status	Not at goal

Decision Making and Diagnositic Plan	Calculate 10-year ASCVD risk using Pooled Cohort Equation. Given diabetes and LDL 137, high-intensity statin indicated.
Treatment/Medication Plan	Initiate atorvastatin 40 mg nightly. Reinforce lifestyle modifications. Recheck lipid panel in 6 weeks.
Contingency Planning	If LDL reduction <50% at 6 weeks → increase atorvastatin to 80 mg or add ezetimibe 10 mg daily.
Considerations for Documentation Improvement	Record ASCVD risk score and rationale for statin intensity. Document hepatic baseline and plan for monitoring.
Considerations for Cost Effective Care Improvement	Atorvastatin is generic, cost-effective. Delay PCSK9 inhibitors until statin ± ezetimibe trial.

Chronic kidney disease stage 3a

Status	Not at goal
Decision Making and Diagnositic Plan	eGFR 55, ACR 50 mg/g. Stage CKD 3a with microalbuminuria. Monitor renal function every 6 months.
Treatment/Medication Plan	ACE inhibitor initiation: lisinopril 5 mg daily, titrate to 20 mg daily as tolerated to reduce albuminuria. Monitor potassium and creatinine in 2 weeks.
Contingency Planning	If creatinine rises >30% or K+ >5.5 → reduce dose or discontinue. If albuminuria persists despite ACEi → consider adding SGLT2i.
Considerations for Documentation Improvement	Document precise CKD staging and albuminuria category (A2). Note indication for ACE inhibitor.
Considerations for Cost Effective Care Improvement	Generic lisinopril is low cost. Use spot urine ACR rather than 24-hour collection.

Lifestyle modification and adherence issues

Status	Not at goal
Decision Making and Diagnositic Plan	Assess psychosocial stressors contributing to non-adherence. Screen for depression/anxiety. Provide educational materials.
Treatment/Medication Plan	Refer to social work for divorce stress support. Enroll in diabetes self-management education (DSME) program. Provide pillbox and dosing calendar.

Contingency Planning	If non-adherence continues at 1 month → consider telehealth check-ins or mobile app reminders. If depression screening positive → initiate SSRI therapy or behavioral health referral.
Considerations for Documentation Improvement	Document patient's barriers, support systems, and education provided. Track adherence metrics.
Considerations for Cost Effective Care Improvement	Leverage free community resources and group DSME to minimize costs.

Preventative care gaps

Status	Not addressed
Decision Making and Diagnositic Plan	Review immunization history. Identify missing vaccines. Plan for cancer screenings per age.
Treatment/Medication Plan	Order immunizations: annual influenza, pneumococcal PCV13 then PPSV23, Tdap once, hepatitis B if risk. Schedule colonoscopy if not done.
Contingency Planning	If patient declines vaccines today → document refusal and revisit at next visit. If colonoscopy declined → offer FIT annually.
Considerations for Documentation Improvement	Include immunization table with dates or documented patient recall. Use checklist for age-appropriate screenings.
Considerations for Cost Effective Care Improvement	Use bundled vaccines through in-clinic programs covered by Medicare. Offer FIT as lower-cost colorectal screen alternative.

Anticipatory Preventative Care

Item 1	Annual diabetic retinopathy exam referral – evidence shows early detection reduces vision loss.
Item 2	Annual foot exam – structured exam to prevent ulcers and amputations.
Item 3	Immunizations: influenza yearly, pneumococcal per guidelines, Tdap once, hepatitis B – per CDC adult schedule.
Item 4	Colon cancer screening: colonoscopy at age 62 if never done, or FIT annually.
Item 5	Depression screening – PHQ-9 annually given psychosocial stressors.
Item 6	Lifestyle counseling for diet, exercise – aligns with USPSTF grade B recommendations.

Considerations for Documentation Improvement	Incorporate a standardized preventive care template in the EMR to ensure all age-appropriate items are captured.

Follow Up Care

Item 1	Recheck HbA1c in 3 months to assess metformin effectiveness and guide therapy adjustment.
Item 2	Check renal function (creatinine, eGFR, ACR) in 6 weeks after ACE inhibitor initiation, then every 6 months.
Item 3	Lipid panel in 6 weeks post-statin initiation to assess LDL reduction.
Item 4	BP and weight check at each visit to monitor obesity and hypertension risk.
Item 5	Review home glucose logs in 1 month to evaluate SMBG adherence.
Item 6	Confirm completion of retinopathy and foot exams at next annual diabetes visit.
Considerations for Documentation Improvement	Use EMR reminders and templated follow-up orders to track pending labs, referrals, and patient-reported data.

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
Restart metformin	metformin	Walmart	$9
Restart metformin	metformin	CostPlusDrugs	$5.57
atorvastatin	atorvastatin	CostPlusDrugs	$5.34