Feedback Summary

The chart review provides a thorough multi–problem plan grounded in evidence-based guidelines, with clear diagnostic and treatment strategies for hypertension, tobacco dependence, mental health, cancer screening, and immunizations. The Assessment succinctly captures the key concerns and differential diagnoses. However, the report would benefit from more complete baseline data (vital signs, labs), deeper exploration of the patient's history and readiness for interventions (including needle phobia), and tighter timelines and patient-focused details for each plan item.

Feedback Details

Assessment Section

Strengths

• Accurately summarizes patient presentation, risk factors (hypertension history, tobacco use, loneliness) and unremarkable exam.

• Clearly lists a concise differential (primary hypertension, tension headaches, adjustment disorder).

• Identifies major preventive health gaps (cancer screening, immunizations).

Areas for Improvement

• No baseline vital signs or laboratory values documented to confirm or stratify hypertension or metabolic risk—these are critical first steps.

• Sparse social, family, and prior medical history; more probing on family cardiovascular or cancer history, social support, and immunization records is needed.

• The Assessment could explicitly note the patient's needle phobia as a barrier to diagnostics and vaccines.

• Consider adding a brief summary of patient's psychosocial context to frame mental health interventions.

Problem 1

Problem Name

Suspected hypertension

Strengths

• Diagnostic plan calls for multiple BP measurements (seated/standing, home monitoring) and relevant labs (CBC, CMP, lipids, glucose).

• Lifestyle modifications are evidence-based (DASH diet, exercise) with thresholds for medication initiation.

• Contingency plan addresses therapy escalation and management of adverse effects.

Areas for Improvement

• No explicit timeline specified for obtaining today's BP readings or lab draws, especially given needle phobia—consider scheduling interventions in the same visit with comfort measures.

• Missing target BP goal (e.g., <130/80 mmHg) to guide therapy adjustments.

• Documentation considerations mention prior readings but don't provide a template for recording home logs.

• Could strengthen patient engagement by outlining how to overcome needle fear (e.g., topical anesthetic before lab draw).

Skill Assessment

Problem 2

Problem Name

Tobacco dependence

Strengths

• Plan uses the 5 A's framework and assesses dependence via Fagerström test.

• Recommends both long- and short-acting NRT, alternative pharmacotherapy, and quitline referral.

• Includes contingency for patients not ready to quit.

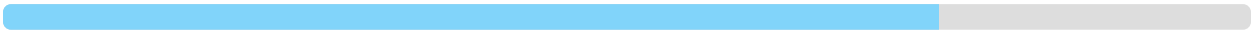
Areas for Improvement

• No documentation of patient's current readiness stage or past quit attempts.

• Lacks a specific timeline for follow-up on cessation progress (e.g., at 2 weeks post–NRT start).

• Could address coping strategies for stress-related cravings (lawyer job stress).

Skill Assessment



Problem 3

Problem Name

Adjustment disorder/depressive symptoms

Strengths

• Appropriately plans validated screening (PHQ-9, GAD-7) and referral for counseling.

• Sets SSRI initiation threshold and outlines when to adjust therapy.

Areas for Improvement

• Does not specify when screening will occur (e.g., during today's visit) or how results will be documented.

• Lacks immediate safety planning language (e.g., suicidal ideation screening questions).

• No timeline for follow-up of symptoms after therapy starts (e.g., 4 weeks specified but could be more directive).

Skill Assessment

Problem 4

Problem Name

Breast cancer screening overdue

Strengths

• Plan correctly recommends mammography with tomosynthesis and outlines management of abnormal BI-RADS results.

• Includes patient education on breast self-awareness.

Areas for Improvement

• No specific date or referral process detailed—add an order date or scheduler contact.

• Does not address patient fears or logistical barriers (transportation, language).

• Could link scheduling mammogram with addressing needle phobia by coordinating with imaging center.

Skill Assessment

Problem 5

Problem Name

Colorectal cancer screening overdue

Strengths

• Offers FIT as a patient-friendly option given needle/invasive phobia and outlines follow-up colonoscopy if positive.

• Includes reminder strategy for unreturned kits.

Areas for Improvement

• Timeline for FIT kit return (“within 4 weeks”) is stated but could tie to a specific date.

• No mention of patient education on sample collection or potential barriers.

• Could discuss alternative screening tests (e.g., stool DNA) if FIT is declined.

Skill Assessment

Problem 6

Problem Name

Immunization catch-up and needle phobia

Strengths

• Comprehensive immunization plan by vaccine type and sequence, reflecting CDC schedules.

• Proposes phobia management techniques (topical anesthetic, intranasal flu vaccine, behavioral therapy referral).

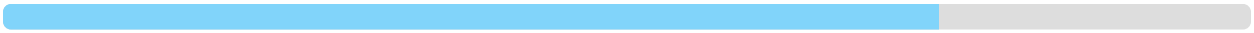
Areas for Improvement

• Lacks a clear sequence and timing (e.g., give Tdap first visit, Shingrix doses at 0 and 2 months).

• No plan to verify prior immunizations (e.g., patient recall, records from UK).

• Could consider alternative delivery settings or vaccine champions to improve uptake.

Skill Assessment



Anticipatory Preventative Care Section Feedback

Strengths

• Items align with USPSTF and CDC recommendations for cancer screening, diabetes/lipid screening, immunizations, and bone health.

• Provides evidence-based intervals and specific dosing for supplements and vaccines.

Areas for Improvement

• Falls risk assessment and osteoporosis risk tools (e.g., FRAX) could be added.

• Missing formal depression/anxiety screening under preventive care.

• Documentation suggestions mention templates but could recommend EMR health-maintenance modules.

Follow Up Care Feedback

Strengths

• Follow-up items are problem-specific with recommended intervals (4–6 weeks for BP, mental health, labs).

• Tracks completion of imaging and FIT kit return.

Areas for Improvement

• Could consolidate follow-up into a single timeline table for clarity.

• No identified responsible team member for each follow-up task (nurse, care coordinator).

• Lacks contingency if patient misses follow-up (e.g., outreach calls).

Overall Recommendations

1. Integrate baseline vital signs and lab orders into the same visit, using needle-phobia strategies to minimize barriers.
2. Add explicit timelines, responsible parties, and SMART goals to every plan item to enhance accountability.
3. Expand psychosocial documentation: quantify depression/anxiety scores, capture social/support network, and create a safety plan.
4. Leverage EMR health maintenance modules or templates for preventive care to auto-track due dates.
5. Enhance patient engagement by documenting discussions of barriers, preferences, and consent for each intervention.