Patient

Sol Lopez, 71-year-old female

Key Highlights for Medical Decision-Making (MDM) Improvement

- Incomplete risk stratification for atrial fibrillation: no CHADS-VASc score documented, no TSH or echocardiogram ordered to assess for reversible causes or structural heart disease.
- No formal hypertension workup: diet, exercise, end-organ assessment and repeat BP readings not documented; missing baseline labs (electrolytes, renal function).
- Medication plan absent despite clear indications for anticoagulation and antihypertensive therapy; no reconciliation of over-the-counter NSAID use and its hypertensive/bleeding implications.
- Lack of shared decision-making documentation: patient preference, cost considerations, bleeding risk versus stroke prevention not explored.
- Preventive care gaps: no cancer screening history (colon, breast), no immunization status (influenza, pneumococcal, zoster), no bone density or lipid profile.
- Follow-up plan missing: timing for lab checks, blood pressure follow-up, anticoagulation monitoring or side-effect review not specified.

Chief Concern

Newly diagnosed atrial fibrillation and desire for management recommendations.

Assessment

Sol Lopez is a 71-year-old woman with asymptomatic, irregularly irregular rhythm discovered incidentally on her Apple Watch and confirmed by exam (pulse 88 bpm, irregular) and BP 146/82 mmHg. She has untreated hypertension and no prior workup or cardiovascular risk stratification. Differential for new AF includes primary (hypertension-mediated) atrial remodeling; hyperthyroidism (TSH unknown); and occasional NSAID use potentially contributing to elevated blood pressure. Her CHADS-VASc score is at least 1 (age 65-74 = 1 point), indicating benefit from anticoagulation. No history of bleeding disorders. She is a candidate for rate control and stroke prevention.

Plan

Atrial Fibrillation

Status	Newly diagnosed, asymptomatic, rate ~88 bpm, stroke risk moderate

Decision Making and Diagnositic Plan	• Calculate CHADS-VASc and HAS-BLED scores; document shared decision-making. • Order labs: TSH (to rule out thyrotoxicosis), CBC (baseline hemoglobin/platelets), CMP (renal/hepatic function), PT/INR (if warfarin considered). • Obtain transthoracic echocardiogram to assess chamber size, LV function, valvular disease. • 12-lead ECG to confirm AF and assess conduction intervals.
Treatment/Medication Plan	• Anticoagulation: initiate apixaban 5 mg PO BID (unless CrCl <30 mL/min, then adjust to 2.5 mg BID). Alternative: warfarin with INR goal 2-3 if cost barrier. • Rate control: start metoprolol tartrate 25 mg PO BID, titrate to resting HR <80 bpm; alternative diltiazem XR 120 mg daily if beta-blockers contraindicated. • Advise against routine NSAID use; switch to acetaminophen 500 mg q6h PRN for headache.
Contingency Planning	• If HR remains >100 bpm at rest after 2 weeks, increase metoprolol to 50 mg BID or add diltiazem. • If signs of bleeding (hematuria, melena, bruising), hold anticoagulant and arrange urgent CBC/INR and clinical evaluation. • If echocardiogram reveals significant structural disease (e.g., LV dysfunction), consider referral to cardiology for rhythm control options.
Considerations for Documentation Improvement	Document CHADS-VASc/HAS-BLED scores, patient's values and preferences, shared decision-making discussion, and rationale for chosen anticoagulant.
Considerations for Cost Effective Care Improvement	Consider warfarin in patients with financial constraints; use generic metoprolol; batch lab draws to reduce phlebotomy costs.

Hypertension

Status	Elevated (146/82), previously known but untreated, not at goal (<130/80)
Decision Making and Diagnositic Plan	• Confirm diagnosis with repeat measurements on two separate days; consider home BP monitoring. • Order labs: BMP (electrolytes, creatinine), fasting glucose or A1c, lipid panel, urinalysis for end-organ damage. • Assess diet, exercise, sodium intake, alcohol history (currently none reported).
Treatment/Medication Plan	• Initiate hydrochlorothiazide 12.5 mg PO daily in the morning. • Counsel on DASH diet, sodium restriction (<2.3 g daily), weight loss (BMI ~25.0), and 150 minutes/week moderate exercise. Alternatives: lisinopril 10 mg daily if thiazide not tolerated or if diabetes/CKD develops.

Contingency Planning	• Reassess BP in 2 weeks; if BP remains >140/90, increase HCTZ to 25 mg or add ACE inhibitor/CCB. • If side effects (e.g., leg cramps, electrolyte disturbance), check BMP and consider switching to ACE inhibitor.
Considerations for Documentation Improvement	Record baseline lifestyle assessment, specific diet/exercise goals, and planned home BP log. Document the two-visit hypertension diagnostic criteria.
Considerations for Cost Effective Care Improvement	Hydrochlorothiazide is low cost and generic; coordinate lab tests with anticoagulation monitoring to minimize visits.
Item 1	Colorectal cancer screening: schedule colonoscopy (patient age 71, no prior screening) per USPSTF guidelines; if patient declines colonoscopy, offer FIT annually.
Item 2	Breast cancer screening: order annual mammogram (age 71, continue until at least 75 per guidelines).
Item 3	Osteoporosis screening: obtain DEXA scan (age ≥65 female) to assess bone density and fracture risk.
Item 4	Immunizations: administer influenza vaccine annually; pneumococcal PCV13 followed by PPSV23; recombinant zoster vaccine two doses 2–6 months apart.
Item 5	Lipid screening: fasting lipid profile every 5 years; consider statin therapy if ASCVD risk ≥7.5%.
Item 6	Diabetes screening: fasting glucose or A1c every 3 years; baseline test now given new hypertension and age.
Considerations for Documentation Improvement	Record family history of cancer and osteoporosis, prior screening history, and immunization status to support preventive recommendations.
Item 1	Recheck BP in 2 weeks with home monitoring log to assess hypertension control.
Item 2	Evaluate rate control and side effects in 2–4 weeks; review metoprolol tolerance and HR target.
Item 3	Assess anticoagulation adherence, bleeding signs, and obtain follow-up labs (CBC, renal function) at 4 weeks.
Item 4	Review TSH and echocardiogram results once available; adjust AF management accordingly.
Item 5	Confirm scheduling and results of colonoscopy, mammogram, DEXA, and vaccines at next annual visit.

Item 6	Repeat lipid panel and A1c in 3 months to guide statin initiation if indicated.
Considerations for Documentation Improvement	Include a structured follow-up timeline in the note, with assigned responsibilities (nurse calls, patient portal reminders) and clear parameters for urgent outreach (e.g., SBP >180 mmHg, HR >120).