Patient

Bill Moore, 75-year-old male

Key Highlights for Medical Decision-Making (MDM) Improvement

- Inconsistent documentation across two notes on same visit date: conflicting statements regarding prior labs, eye exams, kidney disease history. Establish a single, reconciled HPI.
- Lack of documented home blood glucose monitoring data; encourage patient to record readings to guide therapy titration.
- No explicit rationale documented for choice of semaglutide over other second-line agents (e.g., SGLT2 inhibitors) given kidney disease and cost considerations.
- Preventive care gaps not addressed in early MDM: immunizations, foot and eye exam scheduling, social determinants of health impacting adherence.
- No documentation of blood pressure or microalbuminuria targets, or plan for ACE inhibitor/ARB to slow CKD progression.
- Medication reconciliation incomplete: metformin dosing history unclear, timing of last dose, reason for extended-release formulation.
- Contingency planning limited: no if-then statements for side effects, hypoglycemia, or lack of A1c response.

Chief Concern

Lab follow-up for type 2 diabetes management and refill of metformin

Assessment

Bill Moore is a 75-year-old man with type 2 diabetes mellitus diagnosed in 2023, presenting for lab review and medication refill. He reports no new symptoms but admits to six months without metformin, poor diet, no exercise, and significant psychosocial stress. Objective data: A1c 9.8%, creatinine 1.6 mg/dL (eGFR 55 mL/min/1.73 m²), microalbuminuria (50 mg/g), LDL 137 mg/dL, BMI ~36.5, BP 132/84. He has stage 3a CKD and microvascular risk. Likely diagnosis: inadequate glycemic control due to non-adherence and suboptimal regimen. Differential: 1) Persistent hyperglycemia from non-adherence vs inadequate regimen; 2) CKD progression secondary to diabetes; 3) dyslipidemia driving cardiovascular risk.

Plan

Type 2 diabetes mellitus, poor control

Status	Not at goal; A1c 9.8%; ongoing hyperglycemia

Decision Making and Diagnositic Plan	Reviewed labs showing A1c 9.8%. No home glucose data; patient to obtain glucometer and record fasting and post-prandial readings for 2 weeks. Consider CGM if adherence issues persist.
Treatment/Medication Plan	• Metformin ER 500 mg: increase from no current dose to 500 mg BID first week, then 1000 mg BID as tolerated (max 2000 mg daily). • Semaglutide subcutaneous: start 0.25 mg weekly for 4 weeks, then increase to 0.5 mg weekly; titrate to 1.0 mg based on tolerance and glycemic response. • Alternatives: empagliflozin 10 mg daily if injectable intolerance or cost barrier (renal benefit, weight loss).
Contingency Planning	• If nausea or vomiting with semaglutide: hold dose, resume at prior tolerated dose; consider switching to dulaglutide. • If A1c remains >8% at 3 months: add basal insulin (glargine) with start 10 units nightly and titrate.
Considerations for Documentation Improvement	Document baseline home glucose values and regimen adherence history; specify titration schedule and patient education on injection technique.
Considerations for Cost Effective Care Improvement	Assess patient's prescription coverage before semaglutide; consider SGLT2 inhibitor or sulfonylurea (glipizide) if cost prohibitive, with counseling on hypoglycemia risk.

Chronic kidney disease, stage 3a

Status	Not stable; eGFR 55 mL/min/1.73 m²
Decision Making and Diagnositic Plan	Monitor eGFR and albumin/creatinine ratio every 3 months. Screen for other causes of CKD if decline >5 mL/min/year.
Treatment/Medication Plan	• Initiate lisinopril 5 mg daily, titrate to 10–20 mg to target BP <130/80 mm Hg and reduce albuminuria. • Maintain metformin use until eGFR <30.
Contingency Planning	• If hyperkalemia >5.5 mmol/L: reduce or hold ACE inhibitor; consider ARB or diuretic. • If eGFR falls below 45: re-evaluate metformin safety; adjust semaglutide dosing.
Considerations for Documentation Improvement	Stage CKD explicitly in note; record rationale for ACE inhibitor initiation and target BP.
Considerations for Cost Effective Care Improvement	Use generic lisinopril; monitor potassium and creatinine per protocol to avoid costly hospitalizations.

Dyslipidemia

Status	Not at goal; LDL 137 mg/dL
Decision Making and Diagnositic Plan	Calculate ASCVD risk; guideline indication for moderate- to high-intensity statin in diabetic age >75.
Treatment/Medication Plan	• Atorvastatin 40 mg daily (generic) to target LDL <70 mg/dL. • Counsel on dietary fat reduction.
Contingency Planning	• If statin intolerance (myalgias): reduce to 20 mg or switch to pravastatin. • If LDL remains >70 mg/dL at 3 months: add ezetimibe 10 mg daily.
Considerations for Documentation Improvement	Document ASCVD risk score and rationale for statin intensity.
Considerations for Cost Effective Care Improvement	Use generic atorvastatin; defer PCSK9 inhibitors unless refractory.

Obesity and sedentary lifestyle

Status	Not at goal; BMI ~36.5, no exercise
Decision Making and Diagnositic Plan	Assess readiness for change; refer to dietitian and diabetes education.
Treatment/Medication Plan	• Provide medical nutrition therapy referral. • Encourage 150 minutes/week of moderate exercise (walking).
Contingency Planning	• If no improvement in 3 months: consider referral to structured weight-management program or behavioral health.
Considerations for Documentation Improvement	Document lifestyle counseling details and patient's stated goals.
Considerations for Cost Effective Care Improvement	Use community-based exercise programs and free online nutrition resources.

Medication non-adherence

Status	Ongoing; out of metformin >6 months
Decision Making and Diagnositic Plan	Identify barriers: psychosocial stress, divorce. Screen for depression.

Treatment/Medication Plan	• Provide pill organizer and medication calendar. • Synchronize prescriptions with one monthly fill. • Offer social work referral for coping support.
Contingency Planning	• If continued non-adherence: consider home health visits or telehealth check-ins.
Considerations for Documentation Improvement	Record patient's adherence barriers and agreed-upon support plan.
Considerations for Cost Effective Care Improvement	Use low-cost pill boxes; coordinate refills to reduce pharmacy trips.

Preventive care and screenings

Status	Not completed; multiple gaps
Decision Making and Diagnositic Plan	Review immunization records; schedule diabetic eye and foot exams.
Treatment/Medication Plan	• Refer to ophthalmology for retinopathy screening. • Schedule foot exam with primary or podiatry every visit. • Update immunizations: influenza, pneumococcal, zoster.
Contingency Planning	• If patient misses specialist appointments: arrange transportation assistance. • If immunizations refused: document counseling and plan to revisit.
Considerations for Documentation Improvement	Include a preventive care checklist in the note.
Considerations for Cost Effective Care Improvement	Use standing orders and clinic immunization stock to reduce referral costs.

Anticipatory Preventative Care

Item 1	Influenza vaccination annually to reduce respiratory infection risk in elderly and diabetic patients.
Item 2	Pneumococcal vaccines (PCV13 then PPSV23) per CDC schedule for age >65 and CKD.
Item 3	Herpes zoster recombinant vaccine (2 doses) to prevent shingles complications.
Item 4	Diabetic retinopathy screening annually via ophthalmology.
Item 5	Foot exam with monofilament testing at each diabetes visit to detect neuropathy early.

Item 6	Age-appropriate cancer screening review: consider colorectal screening status if no prior colonoscopy.
Considerations for Documentation Improvement	Implement a standardized health maintenance template capturing all immunizations and screening dates.

Follow Up Care

Item 1	Recheck A1c, CMP, albumin/creatinine ratio, lipid panel in 3 months to assess therapy efficacy.
Item 2	Measure home blood glucose logs at 2-week and 3-month visits to guide titration.
Item 3	Monitor blood pressure and renal function monthly until stable on lisinopril.
Item 4	Review semaglutide tolerability after 4 weeks; adjust dose accordingly.
Item 5	Confirm ophthalmology report from 2/20 visit and schedule next annual exam.
Item 6	Assess medication adherence and psychosocial status at next visit; screen for depression.
Considerations for Documentation Improvement	Use follow-up visit checklists with pending items and responsible party clearly noted.

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
diltiazem	diltiazem	Walmart	$9

Mention	Generic Name	Source	30 Day Cost
naproxen	naproxen	CostPlusDrugs	$6.48
chlorthalidone	chlorthalidone	Walmart	$9
chlorthalidone	chlorthalidone	CostPlusDrugs	$5.85