Patient

Phil Wiser, 62-year-old male

Key Highlights for Medical Decision-Making (MDM) Improvement

• Incomplete medication reconciliation: no documentation of over-the-counter or herbal supplements, adherence assessment, or home glucose logs.
• Lack of standardized depression screening despite self-reported stress and lifestyle barriers.
• Absence of comprehensive immunization review and health maintenance planning.
• Limited risk stratification for ASCVD and CKD progression—no formal calculation of 10-year risk or staging discussion beyond eGFR.
• Opportunity to optimize glycemic control by adding evidence-based agents (SGLT-2i/GLP-1 RA) given CKD and high A1c.
• Underaddressed lifestyle interventions: no structured referral to dietician or exercise program.
• Preventive screenings (retinopathy, foot exam, colon cancer) not documented as scheduled or completed.
• Missing follow-up intervals and contingency triggers (e.g., if A1c >8% after 3 months).
• Cost-containment: no discussion of generic statin selection, low-cost behavioral supports, or prior authorization needs for newer antidiabetic agents.

Chief Concern

Refill of metformin for type 2 diabetes mellitus management.

Assessment

62-year-old male with established type 2 diabetes mellitus diagnosed 2 years ago, presenting for refill of metformin ER 500 mg BID. Despite maximal tolerated metformin dose, A1c is 9.8% and he admits to poor adherence (out of meds 6 months), no home glucose monitoring, unbalanced diet, no exercise, and significant psychosocial stress from divorce. Vital signs notable for BMI 38 kg/m2, BP 130/79. Exam unremarkable; feet exam and monofilament testing normal. Labs: eGFR 55 mL/min (CKD 3a), urine ACR 50 mg/g (moderately increased albuminuria), LDL 137 mg/dL. Differential: 1) uncontrolled type 2 DM; 2) obesity-related insulin resistance; 3) early diabetic kidney disease with albuminuria.

Plan

Type 2 diabetes mellitus, poorly controlled

Status	Not at goal (A1c 9.8%) despite metformin ER 2000 mg daily

Decision Making and Diagnositic Plan	Reviewed A1c, eGFR, albuminuria; referred for retinopathy screening. Will obtain baseline and 3-month follow-up labs (A1c, CMP, lipids, urine ACR). Assess for hypoglycemia and GI tolerance.
Treatment/Medication Plan	• Continue metformin ER 500 mg BID (generic) • Initiate empagliflozin 10 mg daily (renal protection, cardioprotection) given eGFR 55 • Advise structured SMBG twice daily initially, then PRN. • Lifestyle: referral to dietician, prescribe 150 min/week moderate exercise.
Contingency Planning	If A1c remains >8% at 3 months, consider adding dulaglutide 0.75 mg weekly. If eGFR falls <45, discontinue empagliflozin. If GI side effects, reduce metformin to 500 mg BID and retitrate.
Considerations for Documentation Improvement	Document patient's adherence history, home glucose values, SMBG teaching and logs, tolerance of metformin, and shared decision-making regarding new agents.
Considerations for Cost Effective Care Improvement	Use generic metformin, empagliflozin available as generic soon—check formulary. Utilize manufacturer savings cards for SGLT-2i. Leverage free diabetes education programs.

Obesity (BMI 38 kg/m2)

Status	Not at goal; contributing to insulin resistance
Decision Making and Diagnositic Plan	Measured BMI and waist circumference; assessed readiness to change. Screened for secondary causes (normal TSH on last CMP panel).
Treatment/Medication Plan	• Referral to outpatient weight management program and dietician. • Prescribe home walking program, target 10 000 steps/day gradually. • Consider orlistat if <5% weight loss in 3 months and no contraindications.
Contingency Planning	If no weight loss ≥5% at 3 months, discuss pharmacotherapy (orlistat) or weight loss referral. If bariatric surgery criteria met and lifestyle fails, refer to surgery evaluation.
Considerations for Documentation Improvement	Include detailed nutritional assessment, weekly exercise logs, and weight change trajectory.
Considerations for Cost Effective Care Improvement	Promote free community exercise classes, online healthy eating resources; avoid expensive weight loss drugs unless criteria met.

Dyslipidemia

Status	Not at goal; LDL 137 mg/dL (goal <100 mg/dL)
Decision Making and Diagnositic Plan	Confirmed fasting lipid panel; calculated ASCVD 10-year risk >20%. No contraindications to statin.
Treatment/Medication Plan	Initiate atorvastatin 40 mg PO nightly (high-intensity statin). Counsel on diet (reduce saturated fat).
Contingency Planning	Check LFTs at 6 weeks; if transaminases >3× ULN or myalgias, reduce to 20 mg or switch to rosuvastatin 10 mg.
Considerations for Documentation Improvement	Document discussion of ASCVD risk, statin benefits/risks, and patient preference.
Considerations for Cost Effective Care Improvement	Use generic atorvastatin; coordinate prescription with metformin refill to reduce co-pays.

Chronic kidney disease stage 3a with microalbuminuria

Status	Stage 3a (eGFR 55), ACR 50 mg/g indicates moderate albuminuria
Decision Making and Diagnositic Plan	Monitored CMP, eGFR, ACR. No referral to nephrology at this stage; will monitor progression.
Treatment/Medication Plan	Start lisinopril 10 mg PO daily to reduce albuminuria (even with BP 130/79). Monitor creatinine and K in 2 weeks.
Contingency Planning	If serum creatinine rises >30% or potassium >5.5 mmol/L, reduce or hold lisinopril. If progression (eGFR declines >5 mL/min/year), refer nephrology.
Considerations for Documentation Improvement	Record albuminuria staging, rationale for ACEi initiation despite normotension, and monitoring plan.
Considerations for Cost Effective Care Improvement	Generic lisinopril; combine refill pick-up to lower patient visits.

Psychosocial stressors and potential depression

Status	Not formally assessed; patient endorses low priority of health due to divorce
Decision Making and Diagnositic Plan	Administer PHQ-9 today; assess social supports and coping. Screen for anxiety with GAD-7 if indicated.

Treatment/Medication Plan	• If PHQ-9 ≥10, initiate sertraline 50 mg daily. • Refer to behavioral health/counseling support. • Provide stress management resources (support group).
Contingency Planning	If no improvement in mood or PHQ-9 score remains ≥10 in 4 weeks, consider therapy intensification or switch to another SSRI.
Considerations for Documentation Improvement	Document PHQ-9 score, social history details, patient resources provided, and follow-up plan.
Considerations for Cost Effective Care Improvement	Use free or sliding-scale community mental health services; generic sertraline if indicated.
Item 1	Annual diabetic eye exam referral (ophthalmology) — evidence shows early retinopathy detection reduces vision loss.
Item 2	Foot exam at every visit; patient education on daily foot self-inspection to prevent ulcers.
Item 3	Immunizations: influenza annually; pneumococcal PCV13 followed by PPSV23; zoster vaccine recombinant (Shingrix); update COVID-19 boosters per CDC.
Item 4	Colon cancer screening—colonoscopy if none in past 10 years (age 62).
Item 5	Lifestyle counseling for tobacco/alcohol (patient is a non-smoker, counsel on moderate alcohol).
Item 6	Bone health: screen for osteoporosis if additional risk factors emerge (not indicated now).
Considerations for Documentation Improvement	Create a health maintenance table in the chart with documentation of due/completed items and dates; prompt immunization history intake.
Item 1	Recheck HbA1c in 3 months to assess glycemic control and medication efficacy.
Item 2	Monitor BMP (including eGFR, electrolytes) and urine ACR in 6 months to track CKD progression.
Item 3	Lipid panel in 3 months to evaluate statin response and adjust dose.
Item 4	Blood pressure checks at home weekly; review at next visit; assess lisinopril tolerance.
Item 5	Weight and BMI at each visit; goal ≥5% weight loss by 3 months.
Item 6	PHQ-9 in 4 weeks to monitor mood and treatment response.

Considerations for Documentation Improvement	Standardize follow-up template with pending orders, target dates, and owner for each item; incorporate patient self-monitoring logs and telehealth check-ins.