Patient

Bill Moore, 75-year-old male

Key Highlights for Medical Decision-Making (MDM) Improvement

- Incomplete assessment of medication adherence and social factors at first visit; deeper HPI in second visit revealed non-adherence due to divorce stress. Suggest standardized adherence screens and psychosocial assessment templates.
- Documentation inconsistently captures immunization history, waist circumference, and home SMBG practices. Recommend structured fields for vaccines, diet/exercise, and self-monitoring.
- Lab interpretation is accurate (A1c 9.8%, eGFR 55) but lacks linkage to CKD staging and metformin dosing thresholds. Document CKD stage and metformin adjustments if eGFR <45 mL/min/1.73 m².
- Intensification of diabetes therapy with semaglutide is appropriate given poor control and preserved renal function. Consider upfront statin initiation for primary prevention in diabetes with LDL 137 mg/dL; document ASCVD risk calculation.
- Preventive care referrals (retinopathy screening) are ordered, but timing and tracking of results are not documented. Use a referral–results tracking tool.
- Cost-effective glycemic control alternatives (e.g., dulaglutide patient assistance programs, generic metformin titration) should be documented as part of shared decision-making.
- Contingency planning for GLP-1 agonist side effects, hypoglycemia management, and non-response is not explicitly documented. Incorporate “if–then” treatment adjustment pathways.

Chief Concern

Lab follow-up and metformin refill

Assessment

Bill Moore is a 75-year-old man with a two-year history of type 2 diabetes mellitus, poorly controlled (A1c 9.8%), stage 3a CKD (eGFR 55 mL/min/1.73 m²), obesity (BMI 36.7 kg/m²), and newly recognized hyperlipidemia (LDL 137 mg/dL). He has significant psychosocial stressors (divorce) leading to medication non-adherence and unhealthy diet/exercise behaviors. No evidence of microvascular complications on exam; scheduled ophthalmology appointment pending. Differential diagnosis: 1) uncontrolled type 2 DM due to non-adherence and suboptimal regimen, 2) secondary poor glycemic control from psychosocial stress, 3) early diabetic kidney involvement without overt albuminuria (UACR 50 mg/g).

Plan

Type 2 diabetes mellitus, uncontrolled

Status	Not at goal (A1c 9.8%); medication non-adherence
Decision Making and Diagnositic Plan	Labs on 2/8: A1c 9.8%, glucose 88 mg/dL, eGFR 55. No contraindications to GLP-1 agonist. No SMBG data—provide glucose meter and logs.
Treatment/Medication Plan	- Metformin ER 500 mg BID (continue generic; currently on max IR but was off for 6 months; titrate ER to improve tolerability) - Semaglutide 0.25 mg subcutaneously weekly ×4 weeks, then increase to 0.5 mg weekly; titrate per tolerance up to 1 mg weekly. Purpose: A1c reduction and weight loss. - Alternatives: dulaglutide weekly if semaglutide cost-prohibitive or poorly tolerated; SGLT2 inhibitor (e.g., empagliflozin) if CV/renal benefit desired.
Contingency Planning	- If GI side effects → hold semaglutide for 1 week and resume at same dose. - If A1c >8% at 3 months → increase semaglutide to 1 mg weekly or add SGLT2 inhibitor. - If eGFR falls <45 mL/min/1.73 m² → reduce metformin dose; if <30 → discontinue metformin.
Considerations for Documentation Improvement	Specify patient's home glucose monitoring plan, adherence barriers, dose-by-dose medication reconciliation, injection technique instruction.
Considerations for Cost Effective Care Improvement	Use generic metformin ER; assess insurance coverage and copay for semaglutide; consider patient assistance programs for GLP-1 agonist.

Chronic kidney disease, stage 3a

Status	Stable (eGFR 55 mL/min/1.73 m²)
Decision Making and Diagnositic Plan	Serum creatinine 1.6, BUN 14, BUN/Cr 8.75. No albuminuria requiring ACE inhibitor. Monitor renal function in 6 months.
Treatment/Medication Plan	- Avoid NSAIDs and other nephrotoxins. - Continue metformin at adjusted dose per eGFR threshold.
Contingency Planning	- If eGFR <45 → reduce or hold metformin per guidelines. - If eGFR <30 → discontinue metformin. - If UACR increases >30 mg/g → consider ACE inhibitor.

Considerations for Documentation Improvement	Document CKD stage and rationale for metformin dose adjustments.
Considerations for Cost Effective Care Improvement	Leverage generic agents; avoid expensive imaging unless clinically indicated.

Hyperlipidemia

Status	Not at goal (LDL 137 mg/dL)
Decision Making and Diagnositic Plan	Primary prevention in diabetic patient age 75 with LDL >70 mg/dL. Calculate 10-year ASCVD risk (likely >20%).
Treatment/Medication Plan	- Start atorvastatin 40 mg PO nightly; titrate to 80 mg if LDL remains >70 mg/dL. - Lifestyle: dietitian referral, low-saturated-fat diet.
Contingency Planning	- Recheck lipid panel in 6–12 weeks; if LDL >70 → increase to atorvastatin 80 mg. - If statin-intolerant → switch to pravastatin or add ezetimibe.
Considerations for Documentation Improvement	Include ASCVD risk score and justification for high-intensity statin.
Considerations for Cost Effective Care Improvement	Use generic atorvastatin; avoid PCSK9 inhibitors unless refractory.

Obesity

Status	Not at goal (BMI 36.7 kg/m²)
Decision Making and Diagnositic Plan	Weight trend: 200 lb at 62 in → BMI 36.7. No current exercise regimen.
Treatment/Medication Plan	- Medical nutrition therapy referral. - Prescribe 150 min/week moderate exercise gradually. - Semaglutide therapy doubles as weight-loss adjunct.
Contingency Planning	- If <5% weight loss in 3 months → consider referral to bariatric surgeon or intensive lifestyle program.
Considerations for Documentation Improvement	Record baseline BMI, waist circumference, and weight trend.

Considerations for Cost Effective Care Improvement	Use community-based exercise programs and group classes; telehealth dietitian services.

Preventive care gaps

Status	Incomplete
Decision Making and Diagnositic Plan	No immunization history, no prior eye/foot exam. Foot exam now normal.
Treatment/Medication Plan	- Ophthalmology referral for diabetic retinopathy (scheduled 2/20). - Administer: influenza vaccine (if in season), pneumococcal PCV13 → PPSV23, zoster recombinant vaccine, COVID-19 booster if indicated. - Document prior colon cancer screening; refer for colonoscopy if due.
Contingency Planning	- If patient misses referral → follow-up call in 1 week. - If vaccine refusal → document reason and revisit next visit.
Considerations for Documentation Improvement	Use structured immunization modules and preventive care checklists.
Considerations for Cost Effective Care Improvement	Bundle vaccines in one visit; use standing orders for immunizations.

Psychosocial stress

Status	Not at goal (divorce-related stress affecting self-care)
Decision Making and Diagnositic Plan	HPI reveals divorce, low priority on health. Risk of depression.
Treatment/Medication Plan	- Screen with PHQ-9 at next visit. - Refer to social work/behavioral health support and community resources (divorce support group).
Contingency Planning	- If PHQ-9 >10 → initiate counseling or consider SSRI. - If non-attendance → telehealth behavioral health consult.
Considerations for Documentation Improvement	Include psychosocial stressors and functional assessment in note.
Considerations for Cost Effective Care Improvement	Utilize free community and telephonic counseling services.

Anticipatory Preventative Care

Item 1

Annual influenza vaccination for patients ≥65 to reduce pneumonia risk.

Item 2

Pneumococcal vaccination: PCV13 followed by PPSV23 ≥1 year later per ACIP.

Item 3

Recombinant zoster vaccine (RZV) two-dose series for adults ≥50.

Item 4

COVID-19 booster per current CDC guidance.

Item 5

Colorectal cancer screening: colonoscopy q10 years if last negative; if unknown, schedule.

Item 6

DEXA scan for osteoporosis screening in men ≥70 or earlier if risk factors.

Considerations for Documentation Improvement

Implement a health maintenance flow sheet to capture vaccine dates, screening intervals, and pending referrals.

Follow Up Care

Item 1

Laboratory follow-up in 3 months: A1c, CMP, lipid panel, UACR to assess therapy response.

Item 2

Ophthalmology visit 2/20—obtain and document results of retinopathy screen.

Item 3

Primary care follow-up in 4 weeks to assess semaglutide tolerance and side effects.

Item 4

Annual foot exam at next visit; record monofilament testing results.

Item 5

Medication adherence review at each visit—bring all medications and SMBG logs.

Item 6

PHQ-9 depression screening in 1 month; document score and plan.

Considerations for Documentation Improvement

Include explicit follow-up dates, tasks, and responsibilities in plan section; use tickler systems for pending results and referrals.