

1 Patient Information**1 PATIENT DETAILS**

Name Harold J. Whitmore	Date of Plan 05/06/2026
DOB 09/28/1959	General Practitioner / PCP Dr. Karen L. Foster, MD — Internal Medicine / Primary Care
Age / Sex 66 / Male	MRN / Patient ID GP-2026-0291
Practice / Clinic Name Midtown Primary Care Associates — Houston, TX	Care Setting Primary Care Clinic
Reason for GP Management Plan 3-month post-NSTEMI follow-up; management of multiple chronic conditions (T2DM, HTN, HF, OSA, depression); medication reconciliation post-discharge; smoking cessation; cardiac rehabilitation status review	

AM Active Medical Problems**2 CURRENT ACTIVE DIAGNOSES**

1. CORONARY ARTERY DISEASE with recent NSTEMI (02/14/2026 — 81 days ago): 3-vessel CAD confirmed on coronary angiography; underwent PCI with DES x2 (LAD mid + RCA proximal) during admission. 2. HEART FAILURE WITH REDUCED EJECTION FRACTION (HFrEF) — new diagnosis post-NSTEMI: Echo 02/18/2026: EF 35% (reduced from normal pre-NSTEMI). On guideline-directed medical therapy (GDMT). 3. TYPE 2 DIABETES MELLITUS — HbA1c 8.9% (02/2026, pre-NSTEMI). On metformin + empagliflozin + insulin. 4. HYPERTENSION — pre-existing, now managed with additional cardiac-indicated medications post-NSTEMI. 5. OBSTRUCTIVE SLEEP APNEA — diagnosed 2023; on CPAP 10 cmH2O; adherence borderline (4.2 hours/night average per CPAP download). 6. MAJOR DEPRESSIVE DISORDER — PHQ-9: 18 (severe depression) at today's visit; new or significantly worsened post-NSTEMI (adjustment disorder + MDD). Not yet on antidepressant. 7. TOBACCO USE DISORDER — 40-pack-year smoker; smoked until hospital admission 02/14. States he has not smoked since admission ('the heart attack scared me straight') — cessation counseling and pharmacotherapy needed.

HPI History of Present Illness / Current Status**3 CLINICAL SUMMARY**

Mr. Whitmore is a 66-year-old male presenting for his 3-month post-NSTEMI follow-up and comprehensive management plan review. He had a NSTEMI on 02/14/2026 (Valentine's Day — he notes this with dark humor) that presented with atypical chest pressure and diaphoresis while mowing the lawn; wife called EMS. He underwent urgent PCI with DES placement to LAD mid (3.0 x 18mm Xience) and RCA proximal (3.5 x 20mm Xience). Post-MI echo showed new EF 35% (HFrEF). Hospital course uncomplicated; discharged 02/19/2026 on extensive new medication regimen. Since discharge, he has attended 12 of 18 planned cardiac rehabilitation sessions (67% attendance — below goal). He reports: (1) Fatigue — 'I get tired going up the stairs'; (2) Bilateral ankle edema — started 2 weeks ago; (3) Shortness of breath on exertion (NYHA Class II-III); (4) Feeling 'hopeless and very down' since the heart attack; (5) No smoking since 02/14/2026 (81 days) — proud of this but craving daily (6-7/10 craving severity). PERTINENT NEGATIVES: No chest pain at rest. No chest pain during cardiac rehabilitation sessions. No syncope. No palpitations. No orthopnea. No PND. No fever.

ROS Review of Systems**4 FOCUSED ROS**

Constitutional Fatigue (significant, 6/10). No fever or chills. Appetite: reduced (6/10). Weight loss: 8 lbs since hospital (some intentional via diet, some from reduced appetite). Night sweats: denied.	Cardiovascular SOB on exertion (NYHA II-III — stairs). Bilateral ankle edema 2 weeks. No chest pain at rest or with rehabilitation sessions. No palpitations or near-syncope.
Respiratory	Gastrointestinal

SOB on exertion as above. No orthopnea. No PND. CPAP compliance: 4.2 hours/night average. Reports sleeping better when using CPAP but removes it when restless. No wheezing or productive cough.

Genitourinary

Nocturia x2 (new — may be HF-related nocturnal fluid redistribution). No dysuria.

Neurological

No new weakness or sensory changes. Headaches: mild, intermittent (new — possibly antihypertensive side effect or depression-related). No dizziness or syncope.

Nausea: mild, intermittent (attributed to medications). Appetite reduced. No vomiting. No abdominal pain. Constipation: mild (on daily stool softener). No hematemesis.

Musculoskeletal

Fatigue-limited exercise tolerance. Right shoulder aching (pre-existing rotator cuff, not new). No joint swelling.

Psychiatric

Depression: SIGNIFICANT — PHQ-9 18 (severe). Hopelessness, anhedonia, poor sleep, poor concentration, low energy, worthlessness. No active suicidal ideation (asked directly — denied). Wife reports he has 'become a different person' since the heart attack.

V Vitals

5 VITAL SIGNS

Temperature

97.8°F

Blood Pressure

148/88 mmHg (elevated; target <130/80 per AHA/ACC post-MI)

Heart Rate

68 bpm — regular

Respiratory Rate

16 breaths/min

Oxygen Saturation

95% on room air (slightly low — HFrEF + OSA)

Height / Weight

5'10" / 221 lbs (BMI 31.7 — obese class I; down 8 lbs from 229 lbs at discharge)

BMI

31.7

Pain Score

0/10 — no current pain

PE Physical Examination

6 FOCUSED EXAM

General Appearance

Well-appearing, somewhat fatigued-looking male. Alert, oriented x4. Mild affect flattening (depression). No acute distress. Wearing cardiac rehabilitation T-shirt.

Cardiovascular

HR 68 regular. BP 148/88. S1 and S2 present. SOFT S3 GALLOP audible at apex — consistent with HFrEF/early volume overload. No murmurs or rubs. Point of maximal impulse slightly displaced laterally (dilated LV). Bilateral 1+ pitting edema at ankles extending to mid-shin.

Abdomen

Soft, non-tender. Mildly obese. No hepatomegaly. No ascites. Bowel sounds normal.

Neurological

Alert, oriented x4. CN II-XII intact. Motor 5/5 throughout. Gait: steady. No focal deficits.

HEENT

Normocephalic. JVD: borderline elevated at 45 degrees (8 cm) — consistent with mild venous hypertension from HFrEF. No lymphadenopathy.

Respiratory

Clear to auscultation bilaterally. No crackles or wheeze. RR 16, unlabored at rest. No accessory muscle use.

Musculoskeletal

No active joint disease. Right shoulder mild tenderness on abduction — chronic rotator cuff, not new.

Skin / Psychiatric

No rash. Right wrist: small healed catheterization access site (radial, well-healed). PSYCHIATRIC: Affect flat, mildly tearful when discussing recovery. PHQ-9 18 — see assessment. No acute safety concerns.

MX Medications

7 MEDICATION RECONCILIATION — POST-NSTEMI REGIMEN

COMPLETE CURRENT MEDICATION LIST (reconciled today): (1) Aspirin 81 mg PO daily — post-PCI antiplatelet, DAPT; ADHERENT (100%). (2) Ticagrelor 90 mg PO BID — DAPT post-DES (min 12 months, until 02/2027); ADHERENT (90%) — reports occasional missed PM dose. (3) Atorvastatin 80 mg PO QHS — high-intensity statin post-MI; ADHERENT (88%). (4) Metoprolol succinate 100 mg PO daily — beta-blocker for HFrEF and rate control; ADHERENT (92%). (5) Lisinopril 10 mg PO daily — ACEi for HFrEF and hypertension; ADHERENT (88%). (6) Spironolactone 25 mg PO daily — aldosterone antagonist for HFrEF (EF 35%); ADHERENT (80%) — 'I forget that one sometimes.' (7) Furosemide 20 mg PO daily — new, started 2 weeks ago by cardiology for ankle edema; ADHERENT (85%). (8) Empagliflozin 10 mg PO daily — dual indication: T2DM + HFrEF (cardioprotective); ADHERENT (90%). (9) Metformin 500 mg PO BID — T2DM; ADHERENT (82%); GI side effects mild but tolerable. (10) Insulin glargine 18 units SC QHS — T2DM; ADHERENT (88%). (11) Omeprazole 20 mg PO daily — GI protection given DAPT; ADHERENT (90%). (12) Docusate 100 mg PO daily — bowel regimen; ADHERENT (88%). MEDICATION CHANGES TODAY: (1) Increase lisinopril to 20 mg (BP 148/88 — uptitrating per GDMT and BP target). (2) Initiate bupropion SR 150 mg PO daily x7 days then 150 mg BID — smoking cessation pharmacotherapy (also some antidepressant effect; avoid

varenicline given recent ACS — no longer contraindicated per newer data but bupropion selected as initial choice). (3) Initiate sertraline 50 mg PO daily (SSRI for severe depression — SSRIs are first-line antidepressants post-MI per AHA; avoid TCAs). (4) All other medications continued unchanged.

AL Allergies

8 KNOWN ALLERGIES

NKDA — No known drug allergies. No known food, latex, or environmental allergies. Patient confirmed allergy status at today's visit. Prior contrast allergy documented incorrectly in old record — patient was asked directly: no prior allergic reaction to IV contrast (received contrast for cardiac catheterization 02/14/2026 without reaction — confirmed).

LB Recent Lab & Diagnostic Results

9 REVIEWED DATA

LABS (from cardiology visit 04/15/2026 — most recent complete panel): CBC: WBC 7.8, Hgb 13.2 (mild anemia — post-MI, monitoring), Plt 224. BMP: Na 138, K 4.4, Cr 1.2 (eGFR 62 — mild CKD; appropriate for ACEi/ARB use), BUN 18. LFTs: WNL. Glucose (non-fasting): 148. HbA1c (02/2026, pre-MI): 8.9% — DUE FOR RECHECK today (drawn at today's visit; result pending). LDL (02/24/2026, post-MI day 10): 82 mg/dL (on atorvastatin 80 mg — at goal <70 mg/dL NOT yet achieved; need to recheck). BNP (03/10/2026, 3 weeks post-discharge): 420 pg/mL (elevated, consistent with HFrEF EF 35%). Today's BNP drawn — pending. IMAGING: Echocardiogram (02/18/2026): EF 35%, dilated LV, inferolateral wall motion abnormality (post-PCI territory). No significant valvular disease. Mild MR. Repeat echo planned at 6-month mark (08/2026). ECG (today): NSR 68 bpm. Q waves inferior leads (old — RCA territory post-MI). No new ST or T wave changes. No arrhythmia. SLEEP STUDY: Prior PSG (2023): AHI 28 (moderate OSA). On CPAP — compliance 4.2 hrs/night (below >4 hrs therapeutic target for insurance; borderline).

A Assessment

10 CLINICAL INTERPRETATION BY PROBLEM

1. POST-NSTEMI / CAD: 81 days post-PCI. No recurrent ischemic symptoms at rest or cardiac rehabilitation. However, BP remains uncontrolled (148/88 — target <130/80). LDL not yet at goal <70. DAPT compliance critical — ticagrelor adherence 90% (missed PM doses). 2. HFrEF (EF 35%): Mild decompensation — bilateral ankle edema returning, borderline elevated JVP, S3 gallop, BNP elevated (420 pg/mL post-discharge). Furosemide recently added by cardiology; weight down 8 lbs total but 2-week edema suggests need for optimization. 3. T2DM: HbA1c 8.9% pre-MI — likely poorly controlled. Today's recheck pending. Empagliflozin provides dual cardiac/renal benefit. Tight glucose control important post-MI. 4. DEPRESSION: SEVERE (PHQ-9 18) — this is the most urgent new concern today. Post-MI depression is common (up to 20-30% of post-MI patients), significantly increases mortality (3x increased risk), and impairs medication adherence and cardiac rehabilitation participation. Starting sertraline today. 5. TOBACCO CESSATION: 81 days tobacco-free — significant achievement. Cravings 6-7/10 daily — bupropion SR initiated for cessation and depression. 6. OSA: Borderline CPAP compliance (4.2 hrs/night) — inadequate; poorly controlled OSA worsens HF and hypertension. Counselor on mask comfort and consistent use.

MP Management Plan

11 PLAN BY PROBLEM / DIAGNOSIS

1. POST-MI / CAD: Continue DAPT (aspirin 81 mg + ticagrelor 90 mg BID) until 02/2027. Stress importance of NO missed ticagrelor doses — stent thrombosis risk. Uptitrate lisinopril to 20 mg (done today) for BP + HFrEF GDMT. Recheck LDL in 6 weeks — target <70 mg/dL; consider ezetimibe add-on if not achieved. Continue cardiac rehabilitation — counseled on importance of completing all 18 sessions; appointment compliance addressed with patient (he agreed to complete remaining 6 sessions). Cardiology follow-up: Dr. Kevin Lin 06/15/2026. 2. HFrEF: Continue furosemide 20 mg — weigh daily (scale given to patient), call if +3 lbs in 2 days. Continue empagliflozin, spironolactone, metoprolol, lisinopril (GDMT). BNP today pending — review and adjust if significantly elevated. Echo repeat at 6 months (08/2026). 3. T2DM: HbA1c recheck pending. Continue empagliflozin + metformin + glargine. Glucose log review at next visit. Endocrinology referral to optimize post-MI diabetes management (HbA1c goal <7.5% per ADA cardiovascular guidelines). 4. DEPRESSION: Sertraline 50 mg daily initiated — titrate to 100 mg in 2 weeks if tolerated. Bupropion SR 150 mg daily (smoking cessation + adjunct antidepressant). PHQ-9 follow-up in 4 weeks. Referral to behavioral health / cardiac psychology (specialized post-MI depression program available at Memorial). Wife educated on depression as medical illness. 5. TOBACCO CESSATION: 81 days — celebrate this success. Bupropion SR initiated. Nicotine patch 21 mg QD added as adjunct. Cessation counseling at today's visit. Next review in 4 weeks. 6. OSA: CPAP adherence coaching. Referred to sleep medicine for CPAP mask re-fitting and adherence review. Downloaded compliance data discussed with patient.

PG Patient Goals & Care Coordination

12 GOALS & COORDINATION

12a PATIENT-CENTERED GOALS

Patient's stated goals (with prompting — depression affecting goal articulation): (1) 'Not have another heart attack.' (2) 'Get back to walking the dog.' (3) 'Stop feeling so sad and tired.' (4) 'Stay smoke-free.' All goals aligned with medical management plan. Wife goals: 'I want the Harold I know back — he's not himself.' Shared decision-making: all medication changes, including antidepressant initiation, discussed with patient and wife. Patient agreed to try sertraline.

12b CARE COORDINATION

Specialist Communication

Cardiology (Dr. Lin): message sent re: lisinopril uptitration, depression, and CPAP update. Cardiologist to review and confirm at 06/15 visit. Sleep medicine: referral placed for CPAP adherence and re-fitting.

Pharmacy Coordination

CVS pharmacy notified of new prescriptions: bupropion SR, sertraline, lisinopril 20 mg (increased). Patient reminded to NOT stop any cardiac medications without contacting Dr. Foster first.

Referrals Placed

Cardiac psychology / behavioral health: post-MI depression program. Endocrinology: HbA1c optimization post-MI. Sleep medicine: CPAP adherence.

Social Work / Barriers

No immediate social barriers identified. Patient retired, on Medicare Part D — insurance covering all medications. Wife is supportive. No transportation issues.

SR Safety / Risk Assessment

13 RISK ASSESSMENT

Falls Risk

LOW — ambulatory, steady gait, no fall history. Furosemide and antihypertensives may cause orthostasis — counseled to rise slowly.

Mental Health / Suicide

PHQ-9 18 — assessed for SI today: DENIED active SI. Wife at home. Safety plan discussed. Return precautions given for worsening depression or passive SI.

OSA / Driving

Inadequate CPAP compliance — counseled on drowsy driving risk. Advised against prolonged highway driving until OSA better controlled.

Medication Safety

HIGH RISK: DAPT (aspirin + ticagrelor) — bleeding risk; avoid NSAIDs/ ibuprofen. Warfarin not used. Bupropion — seizure risk (low at standard doses; avoid in patients with seizure history — none here). Sertraline + ticagrelor: minor interaction — monitor for bleeding.

Cardiovascular Risk

HIGH — post-MI, EF 35%, uncontrolled BP; addressing with medication optimization and cardiac rehabilitation.

Escalation Criteria

ER immediately for: chest pain, severe SOB at rest, syncope, weight gain >3 lbs in 2 days, palpitations, suicidal ideation with intent.

FU Follow-Up

14 REASSESSMENT PLAN

Follow-Up Schedule

TELEPHONE CHECK-IN: 05/20/2026 (2 weeks) — sertraline tolerance, bupropion tolerance, BP on new lisinopril 20 mg, weight check, mood check. NEXT CLINIC VISIT: 06/10/2026 — HbA1c result review, BNP trend, LDL recheck, PHQ-9, CPAP adherence download, medication adjustments. CARDIOLOGY: 06/15/2026 (Dr. Kevin Lin). CARDIAC REHAB: complete remaining 6 sessions by 05/24/2026. ENDOCRINOLOGY: Referral placed — appointment pending. BEHAVIORAL HEALTH: Referral placed — appointment pending.

TIME DOCUMENTATION & BILLING

Total Time

48 minutes

Counseling / Coordination Time

22 minutes

Primary ICD-10 Code

Z87.891 — Personal history of NSTEMI (post-MI follow-up)

E/M / Billing Code

99215 — Established patient, high complexity

Basis for Billing

Medical Decision Making — High Complexity (multiple new medications, 6 active conditions, depression requiring management)

Secondary ICD-10 Code(s)

I50.20 — Unspecified systolic HFrEF; E11.9 — T2DM; I10 — HTN; F32.2 — MDD severe without psychosis; G47.33 — OSA; F17.210 — Nicotine dependence, cigarettes — now in remission

