Comprehensive Care Plan

Patient Name	Ronald Green
Date of Birth	8/21/1975
Date Care Plan Initiated	4/23/2025

Care Team

- Monitoring Provider: Collins, Thomas C MD
- Case Manager: Mobley, Susanna RN

Problems

- I10 - Hypertension Summary: High blood pressure readings may lead to a diagnosis of hypertension.
  * Treatment: Medications may often prescribed to help achieve target blood pressure levels.
  * Several lifestyle modifications may help with hypertension, including maintaining a healthy weight, reducing salt intake, diets rich in vegetables and fruits, regular exercise, quitting smoking, and moderate alcohol use.
  * Using a blood pressure cuff device to monitor blood pressure at home may be recommended.
- E11.21 - Diabetes is a condition that affects how your body uses blood sugar.
  * Outcomes/Goals include follow up with your healthcare provider.
  * Focus areas include knowing signs of very high blood sugars - hyperglycemia (thirst, headache, increased urination, tired, trouble concentrating) as well as low blood sugars - hypoglycemia (sweating, hunger, shakiness, fatigue, lightheadedness).
  * Goal is to have a fasting AM blood sugar of less than 130 and a Hemoglobin A1c <7%. A major goal for people with diabetes is to maintain blood sugar levels at normal or near normal levels. .

- E11.42 - Type 2 diabetes mellitus with diabetic polyneuropathy - a known complication of diabetes is tingling and numbness sensations in hands, feet, and legs.

Goals

Blood Sugar, Fasting

Desired

Blood Sugar readings should be lesser than or equal to 120 Fasting

Patient has attended Diabetic Health Goals counseling. Goal is to reduce average fasting BG by 10 points in two months

Blood Pressure

Desired

Blood Pressure readings should be lesser than or equal to 120 / 70

Warning

Blood Pressure readings greater than or equal to 130 / 72 will trigger a warning.

Medical Alert

Blood Pressure readings greater than or equal to 140 / 80 will trigger an alert.

Patient has attending counseling on DASH diet, importance of healthy eating and regular exercise for HTN. Goal is to bring down average diastolic BP by 5 points in 3 months.

Weight, lbs

Desired

Weight, lbs readings should be lesser than or equal to 160

Patient start of CCM program BMI is 27.1 and weight of 170 (pre obesity) Goal weight reduction of 12 pounds over 2 months.

Pulse

Desired

Pulse readings should be lesser than or equal to 75

Resting pulse of 75 or less desired.

Allergies

peanut

Criticality	High
Onset Date	3/5/2024

anaylphyalxis

seasonal pollen

Criticality	Unable To Assess
Onset Date	7/1/2022

Seasonal pollen allergy noted. Patient manages with antihistamines during spring. Education on appropriate allergy medication for concurrent diagnoses given.

Medications

atenolol 50 mg

Directions	daily
Start Date	5/4/2023

baby ASA 81 mg

Directions	daily
Start Date	7/1/2022

metformin ER 500 mg

Directions two daily

Start Date 5/4/2023

ramipril 20 mg

Directions daily

Start Date 5/4/2023

Comprehensive Care Plan Assessment

Annual Wellness Visit

05/12/2023

Daily Activity Assessment

Patient is able to perform general hygiene and daily functions on own. Patient mobile and lives with wife who provides meals.

History of Surgeries

Bilateral stent placement 2001
Left side stent replacement 2015
Right Side hip replacement 2022

Vaccination History

Annual Flu Shot
Pneumonia
Shingles
COVID-19

Cancer Screening History

Colon cancer

Current employment status

Retired

Current Housing Situation

Lives in an assisted residential facility

Smoking Exposure

Non-smoker

Threats/Violence Risk

No

Patient to enroll in CCM program 08/04/2023. Consent and information of participation given.
Patient will be starting low salt and reduced calorie diet.
Blood pressure, fasting blood sugar and weight are defined goals established for patient.
Secondary goals of reduced resting HR noted.
Updated on 04/20/2025

Social Determinants of Care

Race

Asian

Employment Status

Retired

Social Integration

3-5 times a week

Stress Level - SODH

Medium-Low stress

Education Level

High school or GED

SODH questionnaire collection completed 08/15/2023

Hypertension Questionnaire

Current management of blood pressure at home:

Daily Reading Goal (current: most days except weekends)
Goal to take readings one hour after medications (currently takes at breakfast, before medications)

Self-reported knowledge of blood pressure plan:

Current plan is OK, patient aware has plan but has not focused on it.
Patient will receive DASH diet and beginning exercise pamphlets

Blood Pressure (Hypertension) Prognosis:

Favorable: Favorable prognosis given the patient's current medical support system.

Consistently with taking prescribed medications:

Patient takes all daily medications in AM with breakfast
Dosages and refill history appropriate

List any side effects or unexpected reactions from medications:

None to note

List any over-the-counter medications, supplements, or herbal remedies:

ASA 81 mg
Glucosamine
Fish Oil 1000mg daily

Details of daily water or other fluids intake:

Patient drinks less than 32 oz of clear fluids daily

Do you smoke or use tobacco products?

No, patient does not smoke or use tobacco products

List alcohol consumption:

Two to four times a month

List quantity of drinks containing alcohol consumed per event:

0, 1, or 2
3 or 4

Affecting of condition(s) on emotional or mental health:

Patient has wife living with him.
Retired and self reports no stressors
Would like DASH diet and information on Silver Sneakers programming

Signature

Sincerely,

Collins, Thomas C MD

Electronically signed by the THOMAS C COLLINS at 4/30/2025 12:20 PM