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Education

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April, **Chronic Low Back Pain: Appropriate Non-surgical vs Surgical Management**

May, **Weight Reduction Strategies: When to Use Medical vs Bariatric Treatments**

June, **Evaluation and Management of Sleep Apnea**

July, **Chronic Kidney Disease: Identifying Causes and Preventing Progression to End Stage Renal Disease**

Approach to Managing the Complex Patient

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March 2019

Introducing Your Faculty

Dan Sullivan, MD

Dyanne Simpson, DO

Objectives

At the end of this activity, participants should be able to:

- Create an organized and easily followed **Care Plan** usable by anyone who accesses the chart and interfaces with the patient;
- Plan and prioritize interventions using the hazard identification and risk management model;
- Discuss the importance of assessing an individual patient's specific course of deterioration or decompensation of physical or mental health conditions; and
- Understand the ethical obligation to provide care through a collaborative approach with all participants' priorities aligned including the need to determine the patients' and families' wishes and directives.

Managing the Complex Patient

Case Management Important Points:

- This information presents ideas *for consideration.*
- Some or all of the tactics and strategies **may or may not work** for you or your patients. What works in one situation may not work in another.
- A comprehensive formalized approach may not be needed in all cases.
- Whatever process you use to identify and prioritize issues and risks should be repeated periodically.
- Recommendations are not to duplicate documentation – Use the system capabilities including scoring tools and other risk assessment functionalities, use additional documentation ***when it helps YOU!***

Care Plan

- Serves as a fundamental document for identifying: Issues, goals, interventions, outcomes and can be used to identify and integrate the roles of the overall care team members, providers and practitioners.
- Can serve to prioritize: Issues, interventions and activities that are fundamental to the **Case Management** process.
- Can be (and likely is, depending on the system you are working in) the place where ideas are recorded and prioritized.
- The information presented can help to individualize the **Care Plan** and make it specific and unique to each individual.
- For the sake of this presentation a ***'Problem List'*** approach is used in lieu of developing a **Care Plan**. **The *'Problem List'* is for this presentation's purposes only.**

Don't duplicate unless it helps; work within the system you are using, use an approach that exploits system functionality and takes advantage of the available resources

Organize Your Thoughts

H.I. Health Issues
Med. Medications
L.O. Life / Lifestyle Obstacles
O.F.F. Other Facts and Figures

H.I. – Health Issues

- Diagnoses
- Physical conditions or disorders, for example:
  - Obesity
  - Wound infection
- Surgical procedures
- Behavioral health conditions or disorders, for example:
  - Mental health disorders
  - Addiction, dependence disorders (including tobacco)
  - Presence of depression / positive depression screening
- Other health needs, for example:
  - ✓ Immunizations needed
  - ✓ Preventive health evaluation and testing due or overdue
  - ✓ Therapies needed
  - ✓ Providers / Practitioners needed

Some health issues may or may not be pertinent to your management of your patient

H.I. - Behavioral Health Issues

- Patients may not reveal their mental health history and they may not fully describe past behavioral health symptoms or events
- Screen for behavioral health problems
  - History of specific psychiatric disorder or patient's report of mental health symptoms, explore and define as specifically as possible
  - When possible, obtain information on symptoms observed by other observers (your colleagues, practitioners, family members, etc.)

H.I. - Behavioral Health Issues

Be a detective

- Behavioral health conditions do not always present directly, they often **"masquerade"** as other problems or barriers to the CM's goals
- Capture and document as much specificity and details, such as:
  - Non-adherences with treatment orders or follow up appointments
  - Difficulties in engaging
    - Be as specific as possible (i.e. *"patient seems resistant to discussing," "patient seems to have lack of interest,"* etc.)
- Neuro-cognitive impairments
  - Memory problems, confusion, sedation
- Low frustration tolerance and irritability patterns

Problem List

Meet Mr. Complesso
62 year old
Heart Failure (HF)
Coronary Artery Disease (CAD)
Chronic Obstructive Pulmonary Disease (COPD)
Pulmonary nodule vs. infiltrate
Diabetes type 2
Positive depression screen
Smoker
Obesity

OPTUM Stock Photo, COPD

Med. - Medications

- Regular review and reconciliation
  - Includes over-the-counter medications, herbals and other agents
- Consider listing pertinent medications on the **Care Plan** or other list
  - Include medications that may be absent when they should be used
- Look for and identify the indication for medications that does not appear to align with known diagnoses or other health issue or may not be an appropriate (or the best) medication – for example:
  - Inhaled respiratory medications without an airways disease diagnosis
  - Diabetes medication without a diabetes diagnosis
  - Anticoagulant or antiplatelet medications
  - Beers Criteria – is there a safer medication for your patient?
    (Beer Criteria: Guidelines for healthcare professionals to help improve the safety of prescribing medications for older adults)

Med. - Medications

- Identify medications not being used correctly or as prescribed
- Watch for possible duplication of agents in the same class
  - Inhaled corticosteroid + a combination metered dose inhaler (MDI) which includes a corticosteroid
- Verify that the appropriate dosage is being used for the condition which the drug is prescribed for (e.g., recommended dose of ACE-I / ARB for heart failure)
- Identify potential drug-drug interactions

Problem List

Mr. Complesso
62 year old
Heart Failure
- Valsartan160 mg/day, Metoprolol Succinate, Spironolactone

CAD
Hx: MI Oct 2017
- Rosuvastatin, Metoprolol Succinate

COPD
- Tiotropium (Spiriva HandiHaler®)
- Fluticasone-Salmeterol (Advair HFA®) – listed as PRN
- Albuterol MDI

Pulmonary nodule vs. infiltrate
Diabetes type 2
- Rosuvastatin, Valsartan

Positive depression screen
Smoker
Obesity
Warfarin (Coumadin®) Indication?

Optum Stock Photo, COPD

L.O. – Life/Lifestyle Obstacles

- Financial barriers
- Transportation needs
- Communication obstacles / requirements – caution: Mental health issues may derail any attempt at a comprehensive assessment
- Things that you may not be able to impact but should know:
  - Cultural or religious beliefs
  - Other personal beliefs (question: can you possibly impact some)
  - Family dynamics / patient's request regarding who you can and can NOT communicate with

Basically, capture anything that might interfere with your ability or influence your approach to managing your patient

Problem List

Optum Stock Photo, COPD

62 year old
Heart Failure
- Valsartan 160 mg/day, Metoprolol Succinate, Spironolactone

CAD
Hx: MI Oct 2017
- Rosuvastatin, Metoprolol Succinate

COPD
- Tiotropium (Spiriva HandiHaler®)
- Fluticasone-Salmeterol (Advair HFA®) – listed as PRN use
- Albuterol MDI

Pulmonary nodule vs. infiltrate
Diabetes type 2
- Rosuvastatin, Valsartan

Positive depression screen
Smoker
Obesity
Warfarin (Coumadin®) – What in the indication?
Financial barriers re: COPD medications
Uses public transportation for office visits clinical testing
Advance Directives documentation needed
Lives with his son – patient requested CM NOT to communicate with his son

O.F.F. – Other Facts & Figures

- Pertinent labs and other metrics planned or done
  - HbA1c, renal function labs / serum creatinine, tumor markers and receptor status, INR
  - BMI, daily weights, height/wt. percentile, BP, pulse
- Testing, procedures planned or results of studies done – cardiac function studies, pulmonary function test (PFT), colonoscopy (done, +/- results)
- Medical devices (e.g., IACD, insulin pump), self-monitoring equipment (e.g., BP monitor, INR self-testing equipment), other required equipment or assist devices in place or planned

O.F.F. – Other Facts & Figures

- Inpatient admission – Acute, rehab, SNF
- Outpatient services planned or completed – Therapies including cardiac or pulmonary rehab, preventative services, immunizations
- Clinical classification or stage – Such as: NYHA class, GOLD group for COPD, cancer staging, chronic renal disease stage
- Specialists or other pertinent providers (or the absence or need for these)

Capture facts and figures that can help YOU!

Problem List

62 year old male
Heart Failure
HFrEF – LVEF 30%
Valsartan 160 mg/day, Metoprolol Succinate, Spironolactone
IACD early 2018
Cardiologist, Electrophysiologist

CAD
Hx MI Oct 2017
Rosuvastatin, Metoprolol Succinate

COPD
Tiotropium (Spiriva HandiHaler®)
Fluticasone-Salmeterol (Advair HFA®) – listed as PRN use
Albuterol MDI
Admit 1/22 – 1/26/19 for COPD decomp.
Needs Pulmonologist

Pulmonary nodule vs. infiltrate
Seen on CXR 1/22/18 admit
Needs Pulmonologist / further work-up

Optum Stock Photo, COPD

Diabetes type 2
Rosuvastatin, Valsartan
Labs needed

Positive depression screen

Smoker

Obesity, BMI 36.8 2/07/19

Warfarin (Coumadin®) - Indications

Financial barriers re: COPD medications
Uses public transportation for office visits, clinical testing
Advance Directives documentation needed
Lives with his son – patient requested CM NOT to communicate with his son

Points on Charting

- Dates – exact dates are nice but they do not have to be precise
  - Approximate dates if that is the best you know
    Middle of the range (e.g., *"Last summer"* = July 2018; just the year if in the distant past is OK)
  - Avoid terms like *"past," "recent*" unless they can be linked to a specific date / time period
- Distances – Attempt to quantify both the distance and the conditions, for example:
  - *"SOB when walking to the mailbox"* - How far is the mailbox and under what conditions? (outside the front door vs. down and back up four flights of stairs in a NY City apartment vs. a rural home ¼ mile from the section road where the mailbox is, but only in the cold winter time)
  - *"SOB walking to the bus"* – How far? (flat vs. hills, etc.)
  - Regular exercise – Walks in the mall (how far?), walks three times around the block (How big is the block? Houston: 1/4 mile, Minneapolis 3/8th mile, Manhattan NY 2/3rds mile for one trip around)

Points on Charting

- **Sizes:** Patients may not be reliable estimators, get information from medical records, trained clinicians (e.g., HHC personnel) if an accurate assessment of size is important.
  - Side / specific location, for example:
    - Right (or left) breast, kidney, eye, etc.
    - Basal cell carcinoma of tip of the right ear
    - Right below the knee amputation (yes using BKA is OK)
- If **abbreviations** are used, use those that are accepted and recognized.
- Do not **duplicate charting**; symptoms already covered by other assessments or metrics (e.g., NYHA class, GOLD COPD group) should not be repeated or recorded elsewhere unless it helps you. However, consider using the principles as exemplified above to support your class, group or other functional / symptom.

Points on Charting

Describe the Mental Status

- Full mental status examination (MSE) isn't possible on the phone
- Categorize your thinking about mental status, so you can better document and communicate the problem:
- Think about mental status in these categories:
  - **General Observation**: Behavior – calm, agitated, belligerent, defiant cooperative, not cooperative, not forthcoming with information, resistant to answering questions, refusing to answer questions, evasive with answers, provides only minimal one- or two-word responses to questions
  - **Mood and Emotion:** As much as possible, use the patient's words – mood is subjective; Describe indicators of sarcasm or insincerity of patients' words (ie, uses sarcastic tone)

Points on Charting

- **Thoughts**:
  - Thought process – organized or disorganized, logical or not logical;
  - Thought content – suicidal or homicidal ideation, provide as much detail as possible;
  - Thought perception – auditory hallucinations, visual hallucinations, olfactory hallucinations, tactile hallucinations
- **Memory and Cognition:**
  - Orientation to person, place and time
  - Attention and focus
  - Insight and judgment

Plan and Prioritize

- P riority alignment
- R
- E
- S
- S
- U
- R
- E

and Pain

Priority Alignment

I'm pretty sure what Benjamin Franklin said was: *"In this world nothing can be said to be certain, except death and taxes …*

and competing priorities."

Many ideas and strategies have been suggested and tried. Share your ideas – Addressing everyone's priorities at least to a certain extent is an important part of successful Case Management.

A few ideas:

- Ensure that you have a clear plan and goals; communicate this to patients, all others
- Look for opportunities to leverage the patients' (or others involved) goals and priorities to achieve yours – the "win-win" concept
- If *you* can't win, consider giving the patient a "win" to foster cooperation and confidence in the case management process

Priority Alignment

- Sometimes recognizing the patient's priority / concern with redirection can help them see how there issue fits into the case management process: "I understand your frustration with [the issue] … how do you think that will affect your ability to continue your success at managing your [disease / disorder]
- In some cases a 'contract' or formalized agreement on what is to be addressed and accomplished is an effective (and sometimes necessary) approach.

Keep in mind: Patients tend to place a high priority on pain and what is causing their pain even if that cause is not a case management priority

Plan and Prioritize

- Priority alignment
- Risk (likelihood) an issue leads to an adverse outcome – consider:
- E - Education deficits / needs
- S - Self-management needs
- S - Severity of illness / symptoms (including risk indicators)
- U - Untreated / undertreated / unaddressed
- R - Recency of diagnosis or disease exacerbation
- E - External factors and Effect of (or on) other disorders

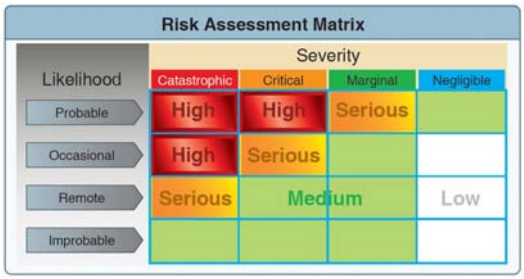
and Pain Patients tend to place a high priority on pain and what is causing their pain even if that cause is not a case management priority

This is a combination of the Risk Management principles of Hazard Identification, likelihood an adverse event will occur and factors which can be modified to reduce adverse outcomes.

Plan – the Risk Assessment Process

- Identify issues that if left unaddressed or unmodified may result in a significant adverse outcome
- Estimate the likelihood that a significant adverse outcome will occur
- Identify the severity or impact of the resulting outcome should an event related to this issue occur
- Some things to keep in mind:
  1. Serious illness or a complex condition does not necessarily make addressing issues related to that disorder a top priority. Likewise, seemingly simple problems or issues may need to be addressed promptly and this may take priority over other issues or conditions
  2. Statistics (based on large groups or populations) can be considered but generally should not be heavily weighted or used as the sole factor for determining risk or priority of intervention
  3. Risk indicators can also be a guide but like statistics should not be the sole factor when determining risk
  4. Repeat the process of risk assessment and prioritization periodically – develop your own "quick and easy to use" (but reasonably comprehensive) approach to risk assessment and prioritization of problems and issues

Risk Assessment



Courtesy of the U.S. Department of Transportation

Risk Management Handbook: www.faa.gov/regulations_policies/handbooks_manuals/aviation/media/faa-h-8083-2.pdf, Figure 6-6, pg 6-5

Problem List

62 y/o male

Heart Failure
- HFrEF – LVEF 30%
- Valsartan 160 mg/day, Metoprolol Succinate, Spironolactone
- IACD early 2018
- Cardiologist, electrophysiologist

CAD
Hx MI Oct 2017
- Rosuvastatin, Metoprolol Succinate

COPD
- Tiotropium (Spiriva HandiHaler®)
- **Fluticasone-Salmeterol (Advair HFA®) – listed as PRN use**
- Albuterol MDI
- Admit 1/22 – 1/26/19 for COPD exacerbation
- **Needs Pulmonologist**

Pulmonary nodule vs. infiltrate
- Seen on CXR 1/22/18 admit
- **Needs Pulmonologist/further work-up**

Diabetes
- Rosuvastatin, Valsartan
- Labs needed

Positive depression screen

Smoker

Obesity, BMI 36.8 2/07/19

Warfarin (Coumadin®) – Indication?

Financial barriers re: COPD medications

Uses public transportation for office visits, clinical testing

Advance Directives needed

Lives with son – patient requested CM NOT to communicate with his son

Organize – A Possible Adjunct

Separate 'To do' List + Other Information

Health Issues

Heart Failure
CAD
COPD
Pulmonary nodule vs. infiltrate
Diabetes
Smoker
Obesity

- Uses public transportation for office visits, clinical testing
- Lives with son – patient requested CM NOT to communicate with his son

(This may be part of the **Care Plan**, on a separate list or a combination of chart locations depending on your **Case Management** system)

To-do List / Other Information

the sequence can mirror your prioritization

1) Facilitate Pulmonology consult
2) Address PRN use of Fluticasone-Salmeterol (Advair HFA®) – Pharmacist referral
3) Identify indication for Warfarin (Coumadin®)
4) Address COPD med cost – MSW, Pharmacist referral, or both
5) Screen for depression
6) Provide smoking cessation resources – consider Respiratory Therapist referral
7) Obtain diabetes management labs
8) Discuss Advance Directives

Learning and Consulting

"What the mind does not know the eye cannot see"
Debesh "Zoom" Mazumdar, MD

Learn as much as you can about the patients that you manage and their diseases and disorders

- Attend additional educational sessions
- Learn from your colleagues
- Learn from your patients
- Consult with your supervisor and Medical Director as your advisors

Trends

Many common disease processes:

- Have characteristic or "classic" symptoms
- Patients tend to follow their own unique path with their own disease process

Care Plan can be a valuable tool with the:

- Identification of the patient's unique disease deterioration
- Patient's knowledge abilities to seek early interventions
- Possible prevention of inpatient admission

Create a Care Plan that is specific to your patient

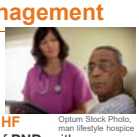
Trends

Heart failure has "classic" signs and symptoms

Lower extremity edema	Poor exercise tolerance	Orthopnea
SOB at rest	Dyspnea on exertion	Paroxysmal nocturnal dyspnea
Fatigue	Cough	Nocturia
Palpitations / tachycardia	Wheezing	Decreased appetite

Optum Stock Photo, 508485255

U.F, 58 Year Old Enrolled in Case Management



Optum Stock Photo, man lifestyle hospice

2/15/19 Enrolled in CM

Hx: IP 3x for HF over the two years prior to 2/15/19 CM enrollment

1/26/19 IP Admit, Decompensation of HF

5 days prior – noted **LE edema**; 4 days prior one episode of **PND**; with a continued increase in **LE edema;** little change in energy level, no SOB or DOE during daytime hours

3 days prior – PND x 2 during that night; still no SOB, **DOE during the day**

2 days prior – **3 pillow orthopnea** and **DOE after awakening**.

Day of admission – **Significant SOB**

2 Previous Admissions (4/20/18 and 2017)

4/20/18 admit followed similar **progression of S/S** except his orthopnea progressed to the point where he slept nearly upright in a recliner.
2017 admission was the **same progression** of 1/26/19

A.M.: 61 Year Old Enrolled in Case Management

Optum Stock Photo, woman lifestyle hospice

2/05/19 Enrolled in CM

Hx: IP 3x over two years prior to the 2/05/19 CM enrollment

1/29/19 IP Admit Decompensation of HF

3 days prior noted a **dry cough**, some **SOB** and **fatigued**. She attributed this to developing a 'cold'. Later that day she noted **increase in SOB**; that night she required **two pillows** to feel comfortable.

1-2 days prior **tired with little energy**, increases in **coughing** and noted occasional **wheezing**, no notable change in her slight **ankle puffiness.**

Day of admission – Woke-up in the early morning **significantly SOB**.

Prior 2 admissions followed similar course and she believes that her heart failure is always caused by a 'cold'.

What About Weight?

U.F. has a 14 lb. weight gain over ~ 5 days, A.M had a 4-5 lb. wt. gain over three days

Clinical Indicators:

- Provide support that there is a true change in status
- Can help trigger action plans and other interventions
- Should be used in conjunction with identified patterns of signs / symptom change, not as the sole indicator of the need for intervention
- In some cases symptom pattern may substitute for a clinical indicator – e.g., Asthma: Symptom pattern recognition can be used in lieu of peak flow to trigger the asthma action plan

Trends and Timing

- Time line for disease decompensation trend as in the previous examples – an obvious need
- Timing of symptoms / decompensation / episodes of exacerbation or instability may provide clues to the cause or to potential intervention to prevent adverse outcomes
  - Asthma – Seasonal exacerbation
  - AM fasting blood glucose – keeps going up in spite of added HS insulin – is this the Somogyi effect?
  - Chest pain when getting ready for work in the AM but no problems later in the day can indicate accelerating angina
  - Mental health disorders may also have specific trends (that may be evident only to outside observers if insight is lacking) and timing that may provide clues to how to effectively manage the patient
- In some cases your detective skills may need to be called upon (case vignette to be reviewed):
  - The case of the hyperkalemia that happened again (and again)

Unload - *"Share the fun!!"*

Take advantage of the referral and other resources available

- **Resources – for example:**
  - Pharmacist
  - Master Social Worker (MSW)
  - Behavioral Health
  - 24 Hour NurseLine
  - Patient-information materials and approved web sites
  - Health portal

Unload - *"Share the fun!!"*

- **External resources – for example:**
  - **Physician office and clinic-based:** Certified Diabetes Educator, Registered Dietitian, Genetic Counseling, Respiratory Therapist
  - **Inpatient facilities:** Pre-discharge education and discharge planning, Utilization Review personnel, the NP or PA doing rounds, PT/OT/ST personnel
  - **Community services** (some may be at no cost): Companion, transportation and some personal services offered by charitable and faith-based organizations. Government funded / subsidized transportation, education and personal services programs, Meals on Wheels, food banks, mental health resources
  - **Voluntary / not for profit organizations**: American Heart Association®, American Diabetes Association®, American Lung Association®, etc. – can provide information on partners for education and support which may be covered by the patient's health insurance carrier or available at no cost
  - **Client / Employer based programs**: Smoking cessation, health education resources

Share your "finds" with your colleagues. Build / add to a *Resource Repository.*

Manage and Mitigate

Once issues are organized, prioritized and with goals and plan in place the management course should be reasonably apparent, you have planned your work.

- Re-evaluate
  - Issues
  - Risks and prioritization when things change – and even if they don't periodically review your plan and adjust as needed

Manage and Mitigate

When your patient's status changes (or fails to improve)

- Identify / re-review risks and prioritization
- Mitigate the risks –
  - If applicable, review the patient's individual trends and intervene accordingly
  - Avoid "weather reporting" – take definitive action, even if that is simply actions for the patient to execute on and a *brief* follow-up call
  - If progress has not been made "up the ante" – more aggressive intervention including co-opting the help of others (temporary '*unloading*')
  - If there is imminent risk of admission, significant morbidity or other adverse outcome (vs. e.g., failure to progress on a needed service or referral that does not pose an immediate threat) –
    - Maintain close follow-up ("contract" with the patient on frequency and duration)
    - Up the ante – again (and again, if needed)
    - Consider referral to your Medical Director

Ethics

Case Management: A collaborative process of assessment, planning, facilitation, care coordination, evaluation and advocacy for options and services to meet an individual's and family's comprehensive health needs through communication and available resources to promote patient safety, quality of care, and cost effective outcomes (CMSA, 2016).

With the above in mind, we have a responsibility to ensure that the wishes of the patient and family are identified and properly documented. **Advance Directives** are the fundamental means of ensuring this occurs.

Advance Directive should be addressed and documented to ensure that anyone providing care will be aware of this information

Summary

Organize

HI, Med, LO, OFF

Plan & Prioritize

PRESSURE … *and Pain*

Trend & Timing

- Patient-specific assessment & intervention
- Helps guide management and mitigation
- May give clues to the cause of issues

Unload

- "Share the fun"
- Your friendly Pharmacist is always ready to help
- Temporary delegation in urgent/emergent situations

Manage & Mitigate

- Work your plan
- Act early, act often
- "Up the ante" as needed

Case Management: A collaborative process of assessment, planning, facilitation, care coordination, evaluation and advocacy for options and services to meet an individual's and family's comprehensive health needs through communication and available resources to promote patient safety, quality of care, and cost effective outcomes (CMSA, 2016).

Care Management

Right Provider

- Address the need for physicians, mental health specialists and other providers factors into the risk assessment process
- Identify all appropriate providers so others that access the record are aware

Right Care

- Risk management approach to prioritizing issues and care needs
- Comprehensive evaluation to include physical and mental health issues and lifestyle factors
- Incorporate other practitioners and services into the care management process

Right Medications

- Medication regimen based on recognized guidelines and standards (learned from other CES session), used as directed
- Medications without clear reason – indication should be clarified
- Address medications that may pose a risk based on age, other meds or disorders

Right Lifestyle

- Identify and address key lifestyle factors – obesity, smoking, alcohol and other substance misuse / abuse
- Identify the effect of lifestyle factors on other diseases and disorders as in the risk assessment process

Priority – High, Low, Somewhere In Between

You are covering for a colleague and have two calls for routine follow-up:

Patient #1

- 50 y/o male enrolled in case management 12/01/18
- "I have a splinter in my hand"
- CM admit for multiple fractures sustained while training for his 18th triathlon
- Splinter today – wife removed, area clean and dry
- No pain, area already appears to be healing

Patient #2

- 50 y/o male enrolled in case management 12/01/18
- "I have a splinter in my hand"
- CM admit for poorly controlled diabetes with retinopathy, COPD, heart failure
- Splinter a week or so ago – cannot see very well. Wife will not look at site – "too yucky"
- "I just need something for the pain"
- "I just need something for the pain"

Mystery of the Recurrent Hyperkalemia

J.A., a 61 y/o male enrolled in case management following his third admission for hyperkalemia. Pertinent past medical hx: J.A. was diagnosed with renal failure due to hypertension and started on dialysis in September 2014. He has been admitted three times for hyperkalemia,

1. **First in early July 2015,**
2. **Next in early July 2016 and**
3. **Most recently in early July 2018**

You have ascertained that the patient is well informed regarding self-management of his renal failure and dialysis status, including compliance with his dialysis schedule, observing for symptoms of complications including potential problems with his vascular access and his diet and fluid restrictions.

What questions would you ask regarding the timing of admissions?

Thank You.

