Patient Barriers

NIH National Institute of Diabetes and Digestive and Kidney Diseases

Socioeconomic Status

Anthony Roberts

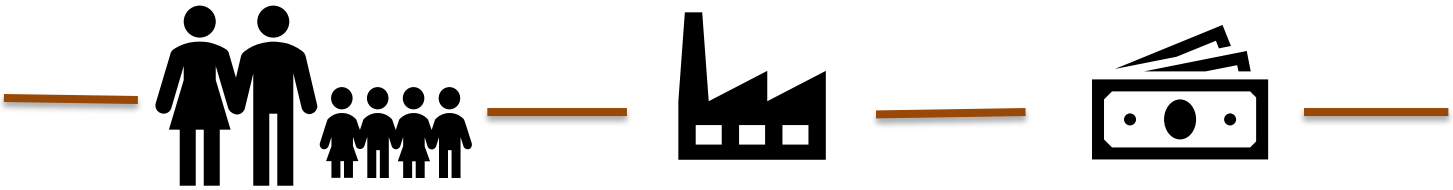
- 58 years old
- CKD eGFR<30
- Unemployed
- Philadelphia, PA

About Anthony

Anthony was diagnosed with kidney disease 8 years ago. He lives in an apartment with **his wife and 4 kids in Philadelphia.**

His job as a warehouse worker was very **labor intensive**, but **due to his severe fatigue, he was unable to perform his required duties and was laid off a year ago.**

This has put the **burden of income solely on his wife**, who is increasingly feeling pressure from balancing all the responsibilities of the home: her job, caring for the kids, and driving Anthony to appointments.



Anthony's Typical Routine & Interactions

Anthony spends most of his days **helping his wife with chores around the house that are not too fatiguing.**

He also takes **his children** to and from school.

He and his wife buy the foods they can afford and are available nearby including a lot of processed food.

Anthony knows many of these foods are not the best for him since they are high in salt and preservatives.

Healthy food like **fresh fruits and vegetables are expensive** and **not easily accessible in their neighborhood.**

Traveling farther will **take time and money they do not have.**

Anthony's Clinical Information

Anthony Roberts
D.O.B. 11/18/1961 (58 yrs)
Phone: (555)-555-5555
Height: 6'1"
Weight: 198 lbs.

Active Problems
Chronic Kidney Disease, *stage 4*
Prediabetes
Hypertension
Dyslipidemia
Anemia

Family Hx	
Mother	Congestive Heart Failure
Father	Hypertension, ESRD

Active Medications
Losartan- *50 mg daily*
Metformin- *1000 mg twice daily*
Torvastatin- *20 mg daily*

Social Hx	
Tobacco	Quit smoking 6 years ago
Alcohol	1-2 drinks/ week
Drug Abuse	n/a

Vital Signs & Labs		**Reference Range** (*Reference ranges may vary)
Blood Pressure	138/83 mmHg	< 140/90 mmHg
BMI	26.1	Underweight: < 18.5. Normal: 18.5 to 24.9. Overweight: 25 to 29.9. Obese: 30+
A1C	5.9 %	6.5% - 7.0%
LDL-C	92 mg/dL	0-100 mg/dL
HDL-C	41 mg/dL	>40 mg/dL
Triglycerides	177 mg/dL	< 150 mg/dL
Creatinine	3.2 mg/dL	0.8 – 1.3 mg/dL
eGFR	24 mL/min/1.73m^2	>60 mL/min/1.73m^2
UACR	34 mg/g	<30 mg/g

Anthony's Challenges & Goals

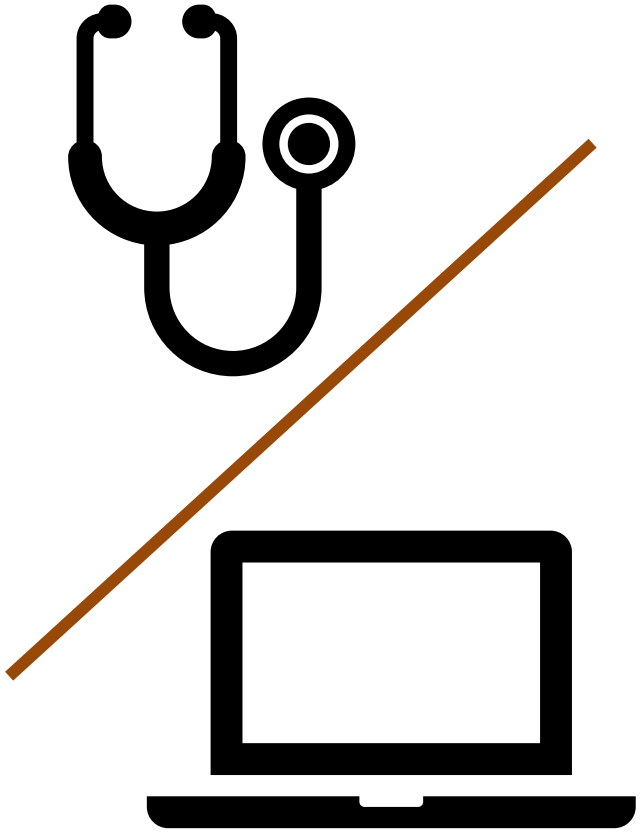
Expenses associated with his CKD are becoming more difficult to manage: medications, appointments with his providers, food, transportation, parking.

He is **frustrated with how much time and money his care is taking.**

Anthony's goal is to improve his health enough such that he can help his wife more and one day even work again.

What Anthony wants from a Care Plan

- **Resources** on how to decrease the cost of care
- **Cost comparison** of different facilities and treatment plans
- Information about whether dialysis centers and outpatient offices have **transportation options**
- **Tips** on how to follow his prescribed diet while on a budget



References

- **Greer R, Boulware LE.** Reducing CKD Risks Among Vulnerable Populations in Primary Care. Advances in Chronic Kidney Disease. 2015;22(1):74-80.
- **Johnson, D. S., Kapoian, T., Taylor, R. and Meyer, K. B.** Going Upstream: Coordination to Improve CKD Care. Semin Dial, 2016; 29: 125–134. doi:10.1111/sdi.12461
- **Lo C, Ilic D, Teede H, et al.** The Perspectives of Patients on Health-Care for Co-Morbid Diabetes and Chronic Kidney Disease: A Qualitative Study. Harris F, ed. PLoS ONE. 2016;11(1):e0146615.
- **Norton JM, Moxey-Mims MM, Eggers PW, et al.** Social Determinants of Racial Disparities in CKD. JASN; JASN 2016;27(9):2576-95.

Language

Hannah Lee

- 45 years old
- Progressive CKD eGFR<45
- Cashier
- Houston, TX

About Hannah

Hannah immigrated to the United States with her husband and daughter about 5 years ago from Beijing, China.

She lives in Houston and works as a **cashier in a large supermarket in the city's Chinatown.** Most of her coworkers and customers speak her native language, Mandarin, so **daily communication is relatively simple.**

Hannah has more difficulty with less common interactions, such as visiting the doctor, making bank transactions, or ordering food at an American restaurant.

Hannah's Typical Routine & Interactions

10 years ago, Hannah had **gestational diabetes** while pregnant with her daughter, and subsequently **developed type 2 diabetes.**

With the help of her physician in Beijing **she was able to control her blood sugars.**

She does not visit her physician in Houston very often, only every few years to check in with him.

At her last visit, her doctor mentioned something about **keeping an eye on her kidney tests.**

She wasn't exactly sure what **tests she needed to watch or what they meant.**

Hannah believed if she took all of her prescribed medications, she would be fine.

She even searched for food tips in Chinese health magazines.

Hannah's Clinical Information

Hannah Lee
D.O.B. 11/22/1974 (64 yrs)
Phone: (444)-444-4444
Height: 5'3"
Weight: 149 lbs.

Active Problems
Chronic Kidney Disease, *stage 3b*
Type 2 Diabetes
History of Gestational Diabetes
Hyperlipidemia

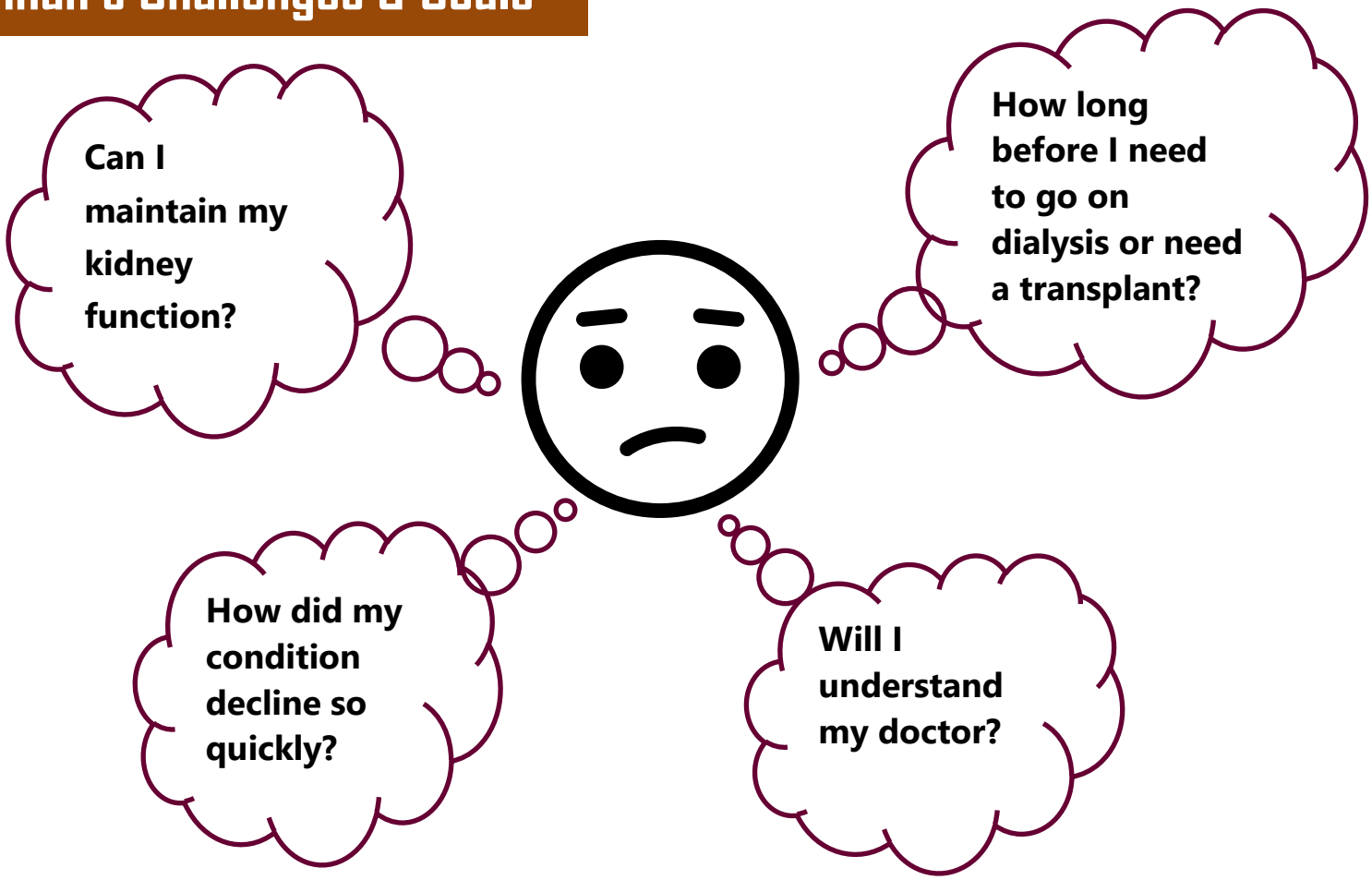
Family Hx	
Mother	diabetes
Father	unknown

Active Medications
Losartan- *50 mg daily*
Metformin- *500 mg twice daily*
Atorvastatin- *20 mg daily*

Social Hx	
Tobacco	n/a
Alcohol	n/a
Drug Abuse	n/a

Vital Signs & Labs		**Reference Range** (*Reference ranges may vary)
Blood Pressure	126/72 mmHg	<140/90
BMI	26.4	Underweight: < 18.5. Normal: 18.5 to 24.9. Overweight: 25 to 29.9. Obese: 30+
A1C	7.3%	% diabetes > 6.5%
LDL-C	69 mg/dL	0-170 mg/dL
HDL-C	37 mg/dL	>35 mg/dL
Triglycerides	138 mg/dL	30-200 mg/dL
Creatinine	1.4 mg/dL	0.6-1.0 mg/dL
eGFR	41 mL/min/1.73m^2	>60 mL/min/1.73 m^2
UACR	653 mg/g	<30 mg/g

Hannah's Challenges & Goals



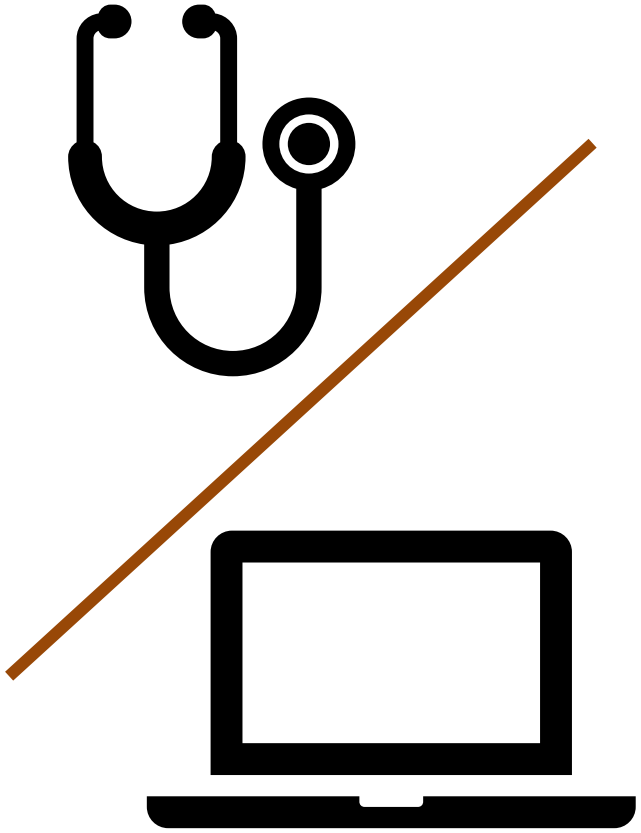
During her most recent visit, **Hannah was astonished when her doctor said her kidney function had declined rapidly.**

He also told Hannah **she was being referred to a nephrologist**, who will give specific recommendations for her condition, but **she is afraid she won't understand him/her.**

Hannah wants to maintain her current kidney function and delay renal replacement therapy for as long as possible, so she will visit the nephrologist and do whatever she can to slow progression.

What Hannah wants from a Care Plan

- An option to **review her information** in her native language
- **Educational materials** and handouts available in her native language
- Resources to access **interpreters** if needed
- Ability to **contact her providers with questions**
- **Health tips** relevant to her culture



References

- **Greer R, Boulware LE.** Reducing CKD risks among vulnerable populations in primary care. Advances in chronic kidney disease 2015;22(1):74-80.
- **Johnson, D. S., Kapoian, T., Taylor, R. and Meyer, K. B**. (2016), Going Upstream: Coordination to Improve CKD Care. Semin Dial 2016; 29: 125–134.
- **Lo C, Ilic D, Teede H, et al.** The Perspectives of Patients on Health-Care for Co-Morbid Diabetes and Chronic Kidney Disease: A Qualitative Study. BMC Nephrology; 2016;11(1): e0146615.
- **Norton JM, Moxey-Mims MM, Eggers PW, et al**. Social Determinants of Racial Disparities in CKD. Journal of the American Society of Nephrology: JASN 2016;27(9):2576-95.