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NIH National Institute of Diabetes and Digestive and Kidney Diseases

Comorbidities

Betsy Johnson

- 60 years old
- Type 2 Diabetes and Congestive Heart Failure
- Progressive CKD eGFR<30
- Unemployed
- Lives in Springfield, IL

About Betsy

Betsy is a retired school teacher. Her husband passed away a few years ago, and she currently lives with her daughter. She also has a son who lives in a different city. Betsy has had:

- **Type 2 diabetes** for 20 years
- **Chronic kidney disease** for 10 years
- **Congestive heart failure** for 2 years

Her doctor has been encouraging her to **think about what treatment she would prefer if her kidneys fail,** but the **options are confusing** and **thinking about it is stressful** for her.

Betsy's Typical Routine & Interactions

Betsy spends her days:

- watching TV
- walking around the house
- sometimes having a meal with friends

She finds **certain activities like reading more difficult** now due to **decreased vision.**

Betsy relies on her daughter to get to her various healthcare appointments.

She is finding it **hard to schedule appointments** with her physician and specialists because of **frequent time conflicts.**

When she does see her doctors, they **all seem to have different medication and diet plans** for her.

- Currently, she follows a **carbohydrate controlled, heart healthy diet.**

Betsy's Clinical Information

Betsy Johnson
D.O.B. 10/21/1959 (60 yrs)
Phone: (111)-111-1111
Height: 5'4"
Weight: 167 lbs.

Active Medications
Lisinopril- *40 mg daily*
Insulin, *NPH/ REG 70/30 insulin 45 units 2x a day*
Simvastatin- *40 mg daily*
Furosemide- *20 mg daily*
Aspirin- *75 mg daily*

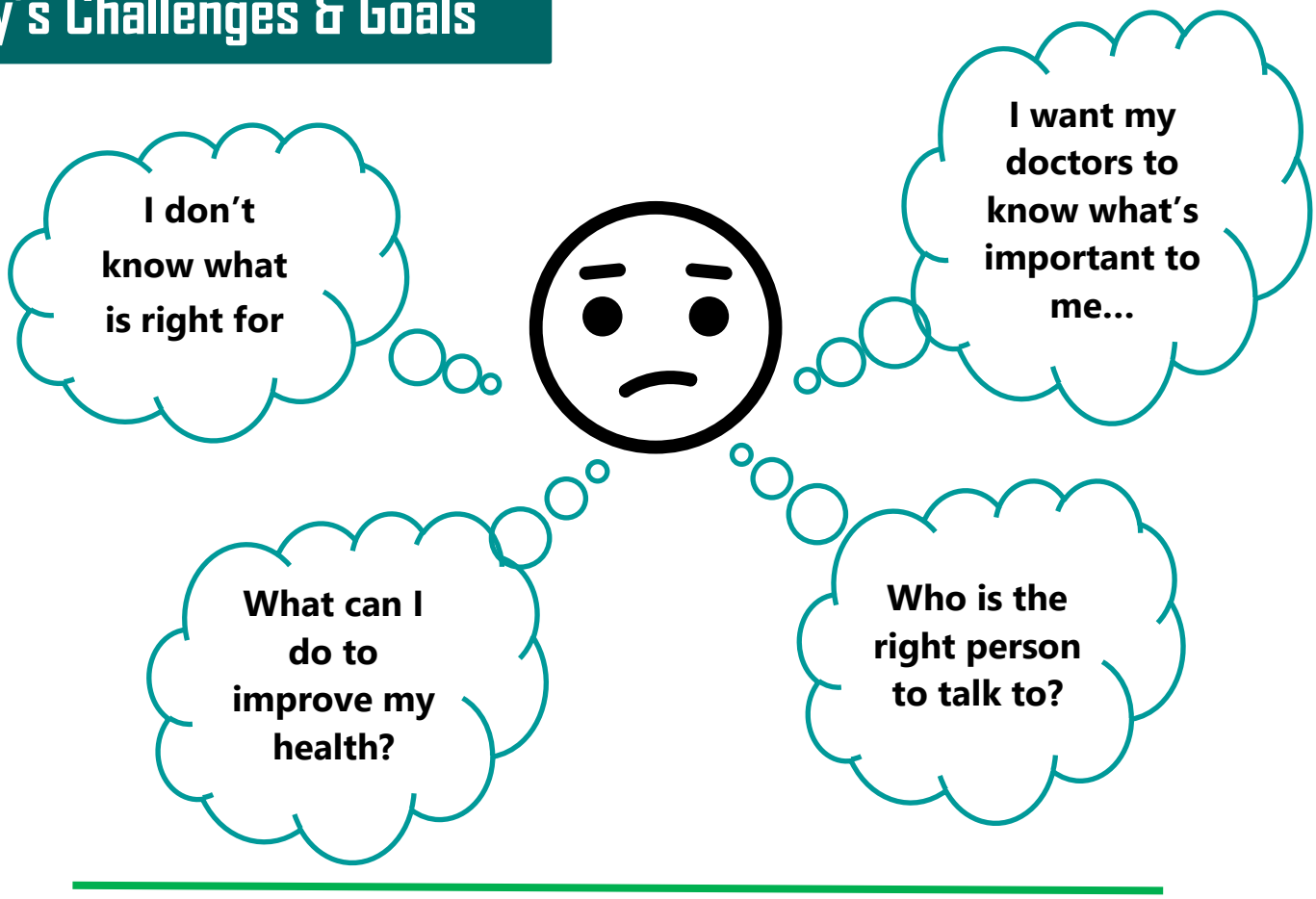
Family Hx	
Mother	Type 2 diabetes
Father	Type 2 diabetes, congestive heart failure, kidney failure

Active Problems	Notes
Hypertension	
Type 2 Diabetes	Complications due to retinopathy, peripheral vascular disease, CKD (eGFR 28)
Congestive Heart Failure	
Dyslipidemia	
Anxiety	

Social Hx	
Tobacco	n/a
Alcohol	Infrequent
Drug Abuse	n/a
Cardiovascular	Retired (school teacher)

Patient Vital Signs & Labs		Reference Range (*Reference ranges may vary)
Blood Pressure	143/82 mmHg	< 140/90 mmHg
BMI	28.7	Underweight: < 18.5. Normal: 18.5 to 24.9. Overweight: 25 to 29.9. Obese: 30+
LDL-C	105 mg/dL	0-100 mg/dL
HDL-C	43 mg/dL	>40 mg/dL
Triglycerides	198 mg/dL	150-199 mg/dL
eGFR	28 mL/min/173m^2	>60 mL/min/1.73m^2
UACR	742 mg/g	<30 mg/g

Betsy's Challenges & Goals



Betsy is stressed because she does not know:

- who she should listen to
- what she should be eating
- which medications to take

She is **not sure how much phosphorous, sodium, and potassium to consume** given all her different conditions, and whether she should be focusing on them for her diet or if she should focus more on carbohydrates and fat.

Betsy wants to do what she can to **maintain her health but is confused.**

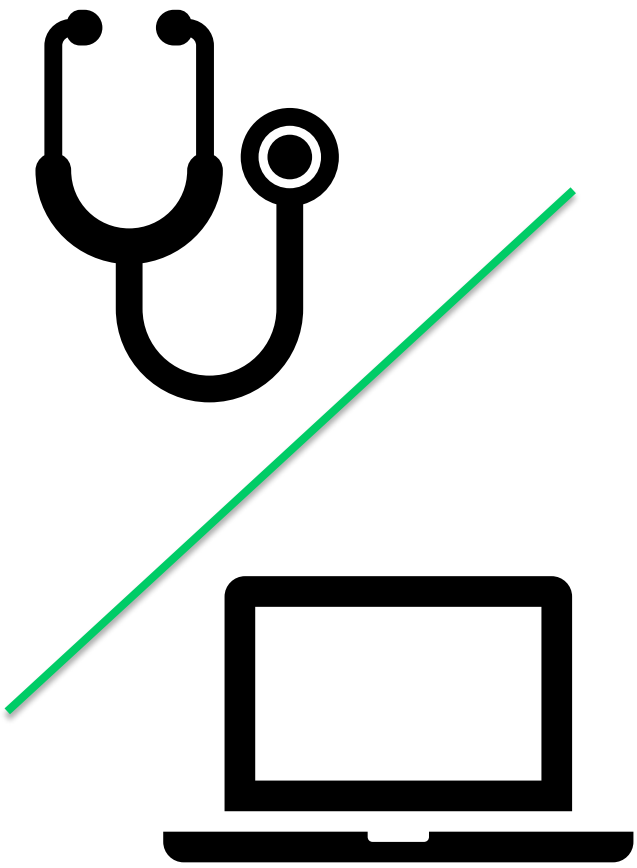
All these frustrations have caused Betsy to feel:

- helpless
- depressed
- anxious

She **doesn't want to worry her daughter**, but she doesn't know who else she can talk with about this.

What Betsy wants from a Care Plan

- A way for all her **different providers to communicate with each other** so they are all on the same page in terms of her plan of care moving forward
- A **summary of her goals and plans reviewed by all her providers** which includes:
  - what is **most important for her to focus on** at this time
  - **medications** she should take
  - **one meal plan** that works for all of her conditions
  - ability to **contact her various providers** for clarification on questions
- Ability to **talk to a nurse about dialysis**
- **Educational materials** on living with kidney disease
- An **easier way to schedule appointments** such that there are no conflicts, and clear opportunities to reschedule should conflicts arise
- **Contact information** for a counselor



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Early CKD

David Sullivan

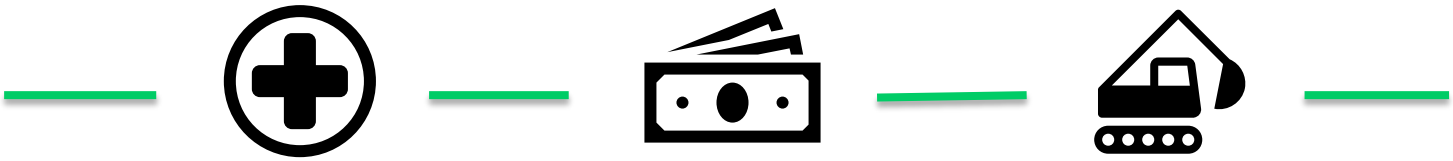
- 38 years old
- Recently diagnosed CKD eGFR <50
- Construction Worker
- San Jose, CA

About David

David has been able to lead a fulfilling life so far without any major health concerns. He has never been hospitalized, but he does have a **history of hypertension** and was **recently diagnosed with chronic kidney disease.**

He has not experienced any adverse symptoms, and thus is **not too worried at the moment.** His **main focus now is helping his parents with medical expenses** for treatment of his father's recent heart attack.

David is a **high school graduate** and has **worked in construction for many years**. He currently lives in a shared apartment with his brother.



David's Typical Routine & Interactions

Because his job is so labor-intensive, he **comes home very tired** and spends time unwinding by watching TV.

He and brother **usually order food or pick up takeout** on their way from home for dinner.

For lunch, he usually grabs something simple near his construction site such as a

- sandwich
- burrito
- soda

He knows his **habits** probably aren't the best for his health, but he's **unsure how they relate to his kidney disease.**

David's Clinical Information

David Sullivan
D.O.B. 4/11/1981 (38 yrs)
Phone: (111)-111-1111
Height: 6'2"
Weight: 203 lbs.

Active Problems
Hypertension
Chronic Kidney Disease, *stage 3a*

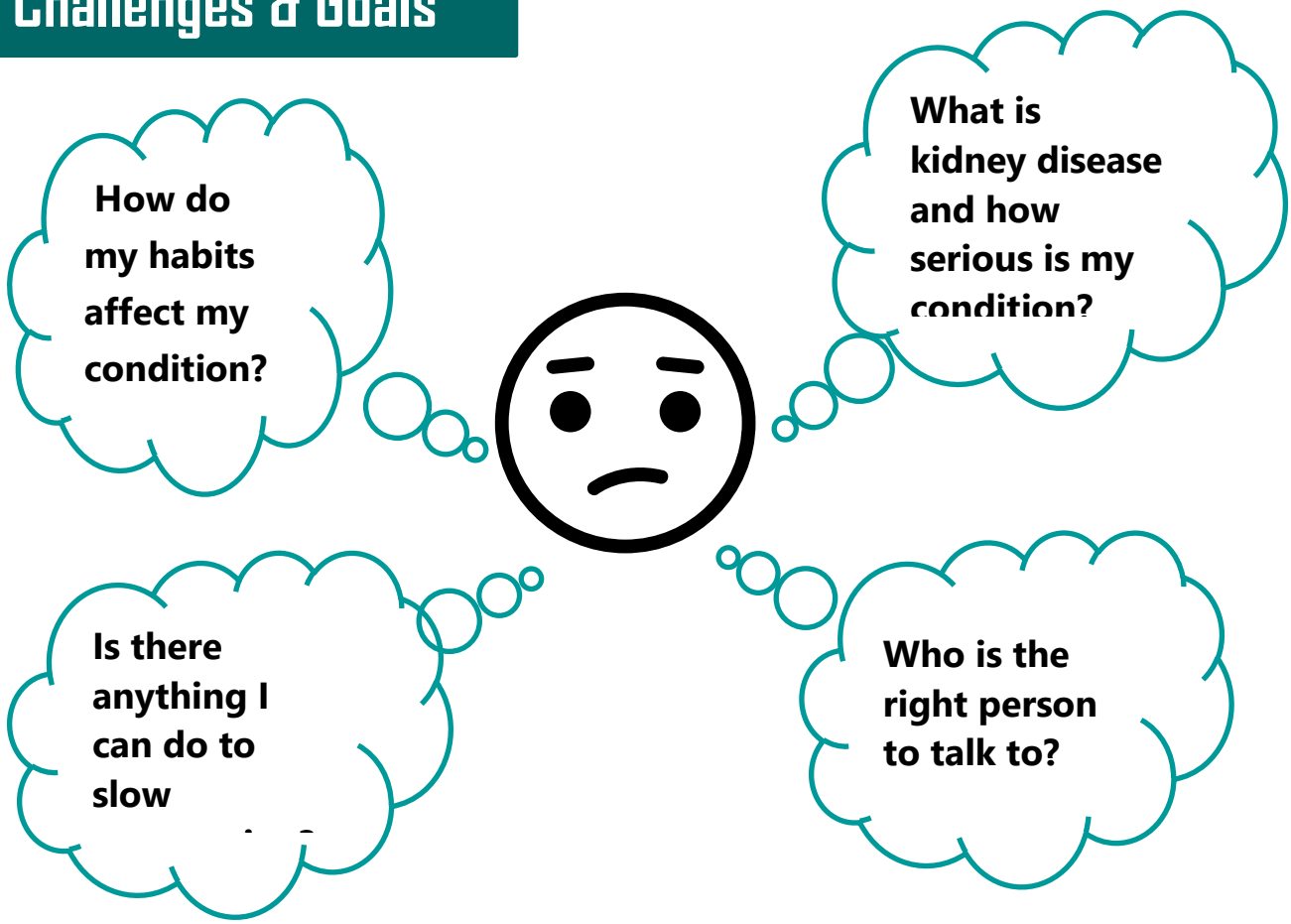
Family Hx	
Mother	Type 2 Diabetes
Father	Hypertension, Heart attack
Brother	Hypertension

Active Medications
Lisinopril- *20 mg daily*

Social Hx	
Tobacco	n/a
Alcohol	Regular consumption (5-10 drinks/wk)
Drug Abuse	n/a
Cardiovascular	Active job (construction)

Patient Labs & Vitals		**Reference Ranges** (*Reference ranges may vary)
Blood Pressure	143/82 mmHg	< 140/90
BMI	26.1	Underweight: < 18.5. Normal: 18.5 to 24.9. Overweight: 25 to 29.9. Obese: 30+
A1C	7.4%	6.5% - 7.0%
LDL-C	113 mg/dL	0-100 mg/dL
HDL-C	38 mg/dL	>40 mg/dL
Triglycerides	144 mg/dL	< 150 mg/dL
Creatinine	1.9 mg/dL	0.8 – 1.3 mg/dL
eGFR	51 mL/min/1.73m^2	>60 mL/min/1.73m^2
UACR	26 mg/g	<30 mg/g

David's Challenges & Goals



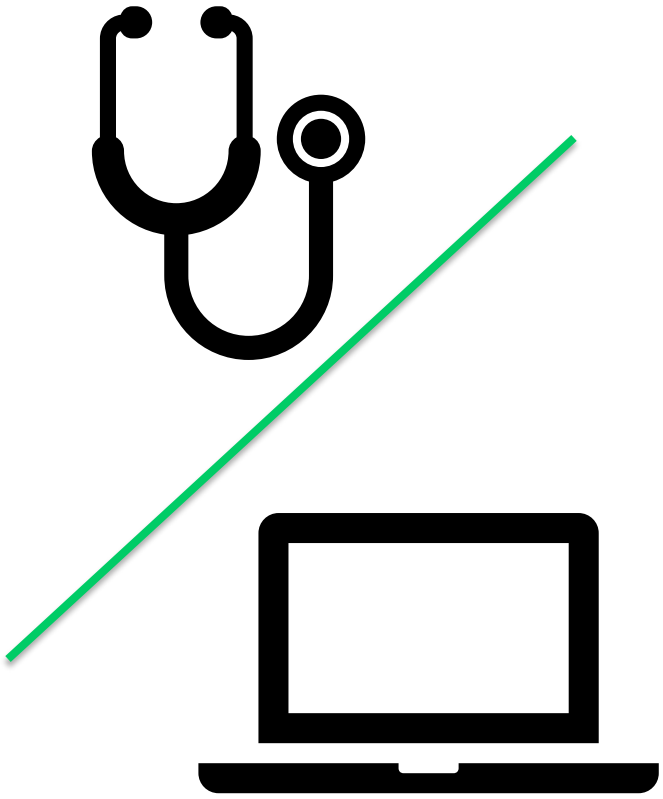
He visits his primary care provider every year but has not seen a specialist yet regarding his kidney disease**. He does not know if his condition is very serious.**

After all, his primary care provider only mentioned it briefly. David **wishes he knew exactly what kidney disease was and what he could do to slow progression.**

He wants to know if continuing his current habits are acceptable or **if he should make any changes.** His doctor mentioned **a lab value that determined he had kidney disease but he doesn't know what it means.**

What David wants from a Care Plan

- Explanation of **what chronic kidney disease is**
- **Recommendations** from his PCP to follow for **diet, exercise, and medications**
- A list of the **important lab values for CKD and what they mean**
- **Comments on his health,** if labs are normal, when he should contact his doctor or other specialist
- **Contact information for online resources** where he can ask questions and read a FAQ section about kidney disease



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Caregiver

Rose Tran

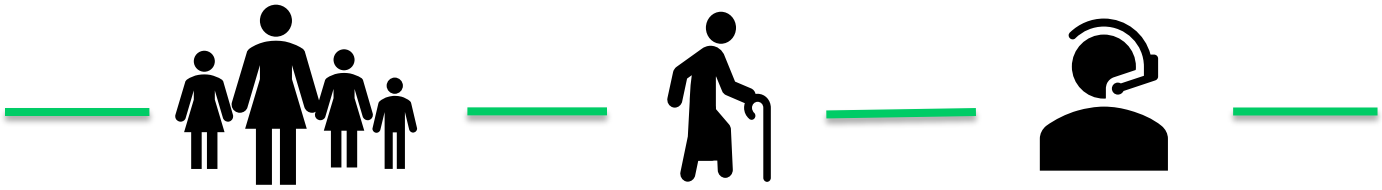
- 26 years old
- Caregiver of mother
- Receptionist
- Raleigh, NC

About Rose

Rose is a **single mother of 3 children.**

In addition, she **cares for her mother,** who has CKD and congestive heart failure.

Rose **works full-time as a receptionist** in a dental office and is finding it increasingly **difficult to balance** her job, care for her mother, and take care of her kids at the same time.



Rose's Typical Routine & Interactions

Rose starts off her day by

- **preparing breakfast** for the family
- **reminding her mother** to take her medications
- **dropping off her kids** at school
- **heading to work**

When Rose finishes work, she

- **picks up her kids** from their after-school program
- **prepares dinner**
- **takes care of her mother**

Rose's **weekends and vacation days** are spent bringing her mom to various appointments.

Rose's **feels overworked and stressed**, and combined with her **mother's feeling of helplessness,** tensions at home are sometimes high.

Gayle's Clinical Information

Gayle Tran
D.O.B. 8/22/1955 (64 yrs)
Phone: (222)-222-2222
Height: 5'2"
Weight: 115 lbs.

Active Problems
Congestive Heart Failure
Chronic Kidney Disease, *stage 4*
Congestive Heart Failure

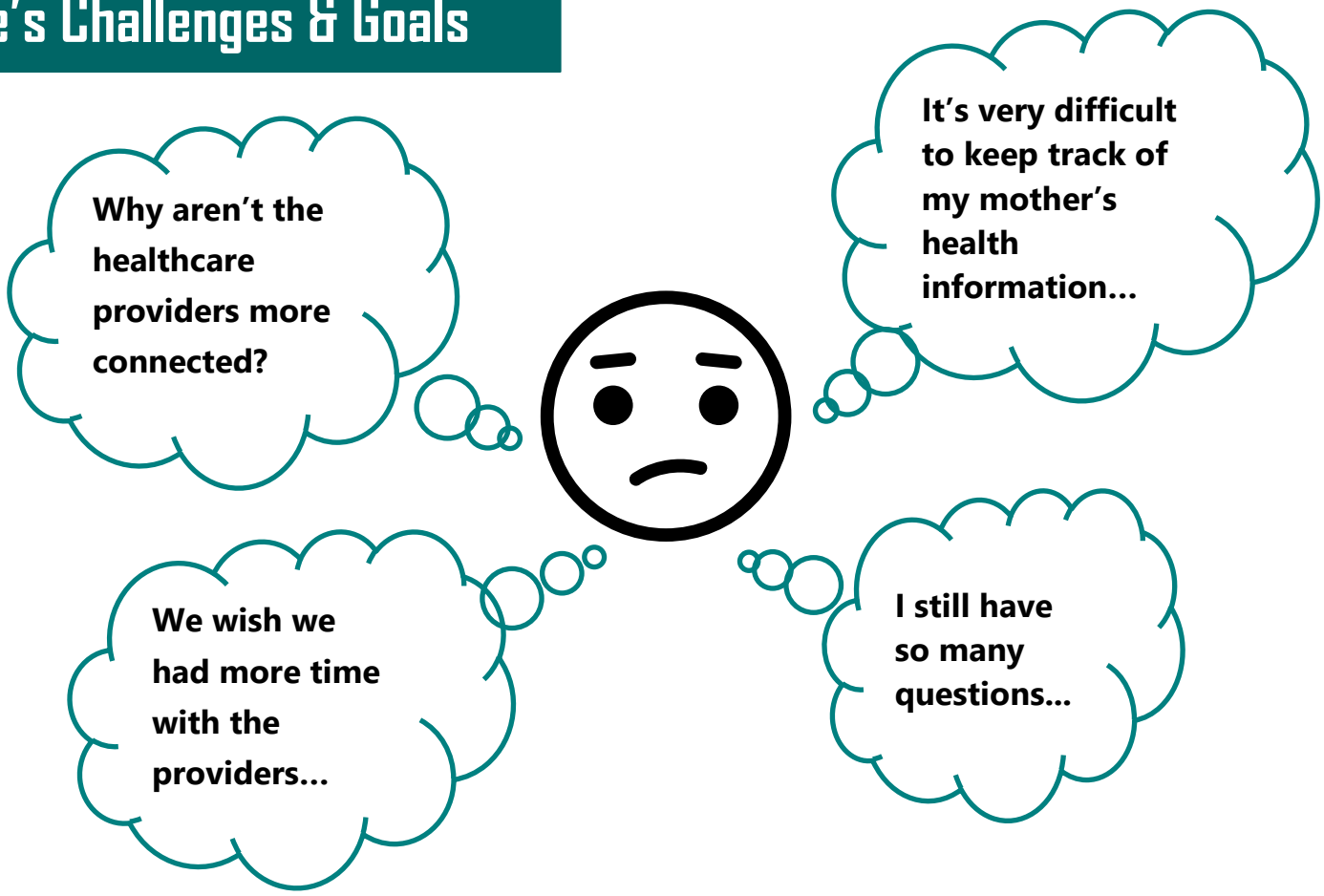
Family Hx	
Mother	Kidney failure
Father	unknown

Active Medications
Lisinopril- *20 mg daily*
Atoravastatin- *20 mg daily*
Furosemide- *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	137/66 mmHg	< 140/90
BMI	21.0	Underweight: < 18.5. Normal: 18.5 to 24.9. Overweight: 25 to 29.9. Obese: 30+
AIC	6.9%	6.5%-7.0%
LDL-C	122 mg/dL	0-170 mg/dL
HDL-C	34 mg/dL	35 mg/dL
Triglycerides	162 mg/dL	30-200 mg/dL
Creatinine	1.3 mg/dL	0.6-1.00 mg/dL
eGFR	43 mL/min/1.73m^2	>60 mL/min/1.73m^2
UACR	22 mg/g	<30 mg/g

Rose's Challenges & Goals



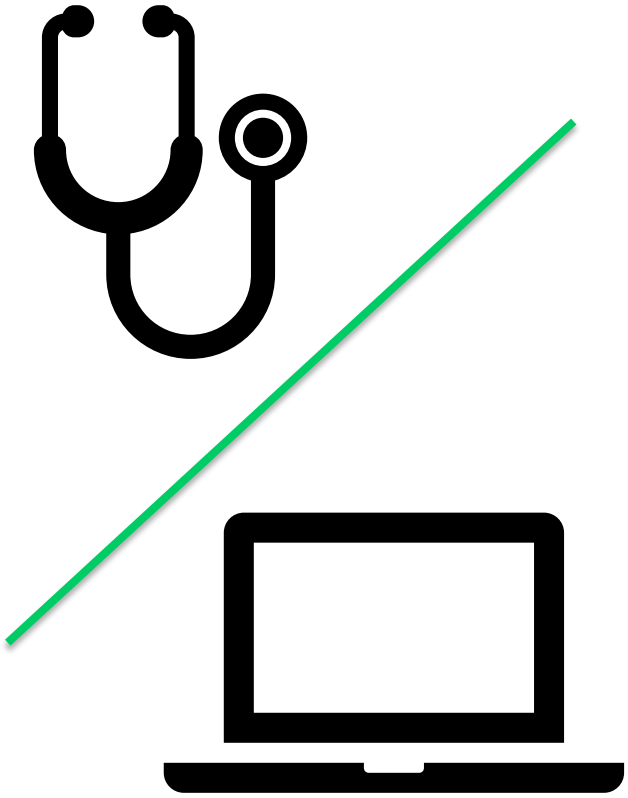
Rose's mother has **multiple specialists** who live in different parts of the city. They **do not have compatible electronic medical records,** so Rose must always ask for printouts of notes and test results and **carries a big folder of all the information** to each location.

During appointments, healthcare professionals take time **to piece together her mother's information** from the records and discussion.

There is often not enough time to address all of Rose's questions and concerns. **Discussions with professionals usually seem one-sided and do not provide as much time or information as she would like.**

What Rose wants from a Care Plan

- An **easily accessible summary** of health status and plan of care
- A **printable one-page document** which includes a list of
  - key diagnoses
  - names of medical providers
  - emergency contacts that she can refer to at home and bring to any appointments
- Ability to **contact the patient's healthcare providers**
- **Tips on caring for a CKD patient**, focused on education and empowerment



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