Patient personas



Tyrone

EuphemiaEuphemia was born in Bermuda but
has lived in Baltimore for the past
several years, where she worked as
cashier. She has Stage II CKD.

Wants, needs, behaviours:

- Sedentary job with little interest in activity and sport
- Very involved in her care, and frequently does her own resear and asks questions
- Lives with her daughter and has a strong desire to stay on island for treatment
- Outspoken advocate about CKD in the community
- Uses mobility aids to get around and also has diabetes

No Insurance

Tyrone is 70 years old and retired. He has Stage IV CKD, as well ad hypertension.

Wants, needs and behaviours:

- Lacks a strong support environ
- Concerns about affording treatm a retiree
- Rarely leaves the house
- Is comfortable asking questions to physician, and his medical background has given him decent understanding of his condition.

FutureCare

Orville



chef. He has a history of kidney stone diabetes, and hypertension, and has Stage V CKD.

Wants, needs and behaviours:

- Limited access to appointments a relies on his son for transportation
- Orville is uncomfortable asking questions to his physician and pre to remain stoic.
- Friends and wife are eager to sup him, but Orville is uncomfortable accepting help and feels like a but
- Long-time pastry chef who is unha to make dietary changes.
- Loves to golf and travel, which he c no longer do due to mobility restrictions.
- Concerns about affording treatmer as he only has access to basic heat coverage.

Private Basic Health Coverage



An illustrative current-state experience of the end-to-end CKD pathway, from the perspective of the three personas to bring it to life*

			· · ·		•			0			
	PHASE Prevention Presentation		Diagnosis		Diagnosis and discussion of treatment and support options				Treatment and ongoing care		
				Outpatient diagnostics	Inpatient diagnostics			All stages	Stage 3, 4 and 5	Stage 4 and 5	K ita atau dat
за	TOUCHPOINT	(1.0)	(2.1)(2.2)(2.3)	3.0 3.1 3.2	3.3 3.4 3.5	41 42 43 44 45	(5.0) (5.1) (5.2)	<u> </u>	<u> </u>	6.10 6.12	Kidney transplant
in		I learn about CKD and its risks through a public awareness programme, through my personal environment or through my primary care giver	I recognise early CKD symptoms areaton browing an incidental finding of CKD signs	My GP I visit my GP I get a referral arranges for to discuss the me to get outcomes of bloodwork the bloodwork	Urine and Jam admitted I am acutely transported off- are done at or Acute Care island transport difference Ward and admitted Emergency Department overseas	I meet my My I have an I discuss the I receive apphrologist appointmentat further testing and discuss arranges for me the with my about my findings from to get further initial testing testing done or other specialist	I have an I have an I manage m appointment appointment blood pressu with my GP to with my discuss nephrologist to treatment discuss options treatment options	ure modifications prescribed groups or with a dietician medications psychological	I attend regular check-ups with my Rep. incl. urine and blood testing I have an my nephrologist treatment options I take my prescribed medications with intensified medications medication	 referral for appointment appointment re dialysis and with the dialysis with the transplant nurse for an transplant of deducation education coordinator for 	I receive a appointment vith the patient work-up: testing for the transplant coordinator to discuss options transplant eligibility post-op care set transplant transplant coordinator to discuss options transplant transpla
h a ır	EUPHEMIA'S PATHWAY JOURNEY	(1)	2.1 22 2.3 The results of other requested tests/ annual check-up are showing an incidental finding of CKD signs	3.0 3.1 3.2 My GP arranges for me to get bloodwork done My GP to discuss the outcomes of the bloodwork	3.3 3.4 3.5	4.1 4.2 4.3 4.4 4.5 I meet my nephrologist and discuss arranges for me findings testing done initial testing	50 51 52 I have an I manage m appointment blood pressu with my GP to discuss treatment options		6.6 6.7 6.8 6.9 I attend regular check-ups with my GP, incl. urine and blood testing	6.19 6.19 6.19	<u>-6.13</u> <u>6.14</u> <u>6.15</u> <u>6.17</u>
in ,	EUPHEMIA'S EMOTIONAL JOURNEY An illustrative scale from -3 to +3 to track the movements in the citizens' emotional journey across the touchpoints							Na have a for a second se			
2	TYRONES PATHWAY JOURNEY	1.0	2.1 22 2.3 The results of other requested tests/ annual check-up are showing an incidental finding of CKD signs	Image: Solution of the bloodwork done I visit my GP is a referral to a solution outcomes of the bloodwork done I get a referral to a nephrologist	3.3 3.4 3.5	Imeet my nephrologist and discuss arranges for me findings from initial testing My My the discuss arranges for me to get further testing I discuss the further testing with my nephrologist I receive education about my treatment options	5.0 5.1 62 I manage m blood pressu		5.6 6.7 5.8 5.9 I have an appointment with my nephrologist to discuss treatment options I take my prescribed medications with intensified medications adherence I attend more applications in the task of task	referral for appointment dialysis and with the dialysis transplant nurse for an education education	6.136.146.156.166.17
ent nt as	TYRONES EMOTIONAL JOURNEY An Illustrative scale from -3 to +3 to track the movements in the citizens' emotional journey across the touchpoints			•				0			
his	ORVILLES PATHWAY JOURNEY	1.0	2.1 2.2 2.3 I am visiting or admitted to the hospital for experiencing symptoms	3.0 3.1 3.2	33 3.6 Urine and blood testing are done at the Emergency Department I am admitted into the ICU or Acute Care Ward	41 42 43 45 I meet my nephrologist and discuss findings from initial testing My by to get further to get further testing done I discuss the further testing with my nephrologist I receive education about my treatment options	50 60 62 I have an appointment with my nephrologist to discuss treatment options	53 54 5.5 y Lapply diet I take my modifications prescribed with a dietician medications	5.6 6.7 6.8 6.9 I have an appointment with my nephrologist to discuss treatment options treatment options	referral for appointment appointment with dialysis and with the dialysis the transplant transplant nurse for an coordinator for an education education education session	6.136.166.17
	ORVILLES EMOTIONAL JOURNEY An illustrative scale from -3 to +3 to track the movements in the citizens' emotional journey across the touchpoints		- a server at				•	•			
es, s he n. efers	CHALLENGES The negative experiences where the system is not negative expectations from the perspective of both citizens and staff	1No strategies for Prevention and Early Detection2Lacking patientPrevention and early detection of CKD are hindered by the lack of CKD-prevention strategies in Bermuda, resulting in delayed diagnoses and missed opportunities for intervention.2Lacking patient				Ants and service providersSetween healtherchough patients indicate they are provided nough information after they've been bsed, healthcare service providers feel public edge and awareness about CKD in Bermuda is his can hinder prevention and management ofBetween healthcare pathwayInadequate coordi healthcare provide physicians, specia outcomes for patie		Between healthcare s pathway	service providers in theImage: Constraint of the serviceson and communication among including primary care , and support services, e delivery and optimal with CKD in Bermuda.Image: Constraint of the services the service of the service of the service, and service, and service of the service, and service of the service of th		s hinder access to and f CKD-related healthcare ral, and informational barriers pose enges to accessing CKD-related ices. High costs associated with bined with cultural and informational a reluctance to visit healthcare dequate education about CKD, form ess CKD-related healthcare services with CKD.
rden appy can	OPPORTUNITES High-level identification of the core opportunity areas that would have the greatest impact on patient experience	IAEstablish registries for screening and data analysisIAEstablish registries for screening and dataIAIBDevelop targeted prevention programsIB		Strengthen patient education in individual 3A I and group settings		Improve information sharing among healthcare service providers		3D Promote and incentiv modalities	ise home dialysis	4C Establish uniform and equal nephrology services	
ent ealth				programs 2B Educate GP's on CKI introduce formal maguidance			Establish a non-profit support organisation for patients		4A Address barriers to care access		4D Include CKD-care in University Coverage Core Benefits Pack
		1C Pro	omote achievable lifestyle r	modifications 2C	Provide clear, repetitiv communicating to pati		Facilitate individual em patients	notional support for	4B Identify strategies for sustainability	r enhanced financial	5A Promote organ donation thro campaigns

*All views captured in this document are those of stakeholders interviewed.











Chronic Kidney Disease (CKD) Pathway – Overall current state

