

Patient personas

Euphemia

Euphemia was born in Bermuda but has lived in Baltimore for the past several years, where she worked as a 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 research 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

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

Wants, needs and behaviours:

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

FutureCare

Orville

Orville is a 64-year-old former pastry chef. He has a history of kidney stones, diabetes, and hypertension, and has Stage V CKD.

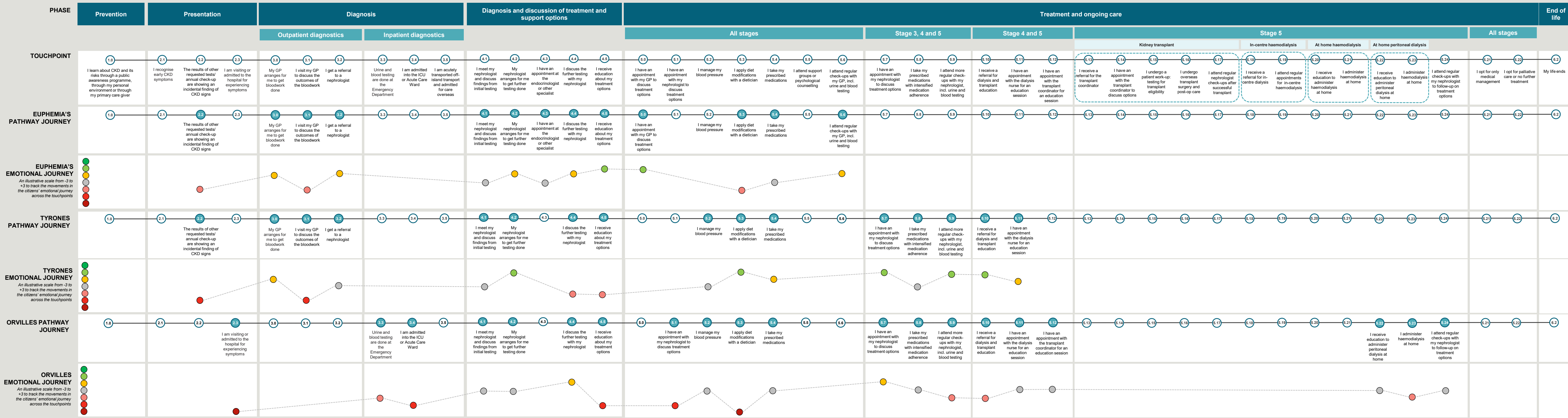
Wants, needs and behaviours:

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

Private Basic Health Coverage

Chronic Kidney Disease Pathway: Patient Journey Map

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



CHALLENGES

The negative experiences where the system is not meeting expectations from the perspective of both citizens and staff

OPPORTUNITIES

High-level identification of the core opportunity areas that would have the greatest impact on patient experience

- 1 No strategies for Prevention and Early Detection**
Prevention 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.
- 2 Lacking Education and Awareness among patients and service providers**
Even though patients indicate they are provided with enough information after they've been diagnosed, healthcare service providers feel public knowledge and awareness about CKD in Bermuda is low. This can hinder prevention and management of the disease.
- 3 Insufficient Coordination and Communication Between healthcare service providers in the pathway**
Inadequate coordination and communication among healthcare providers, including primary care physicians, specialists, and support services, hamper seamless care delivery and optimal outcomes for patients with CKD in Bermuda.
- 4 Several factors hinder access to and affordability of CKD-related healthcare services**
Financial, cultural, and informational barriers pose significant challenges to accessing CKD-related healthcare services. High costs associated with CKD-care, combined with cultural and informational factors, such as a reluctance to visit healthcare service, and inadequate education about CKD, form barriers too access CKD-related healthcare services for individuals with CKD.
- 5 No comprehensive policy around Organ Donation**
Organ Donation and Transplants - The scarcity of organ donations and the absence of comprehensive transplant facilities in Bermuda present obstacles in providing timely and accessible organ transplantation services, limiting treatment options for individuals with end-stage renal disease.

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| 1A Establish registries for screening and data analysis | 2A Strengthen patient education in individual and group settings | 3A Improve information sharing among healthcare service providers | 3D Promote and incentivise home dialysis modalities | 4C Establish uniform and equal access to nephrology services | 5B Secure robust funding for organ donation and transplants |
| 1B Develop targeted prevention programs | 2B Educate GP's on CKD-progression and introduce formal management and referral guidance | 3B Establish a non-profit support organisation for patients | 4A Address barriers to care access | 4D Include CKD-care in Universal Health Coverage Core Benefits Package | 5C Introduce standard and appropriate reimbursement or coverage for transplants |
| 1C Promote achievable lifestyle modifications | 2C Provide clear, repetitive messages when communicating to patients | 3C Facilitate individual emotional support for patients | 4B Identify strategies for enhanced financial sustainability | 5A Promote organ donation through targeted campaigns | |

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

Chronic Kidney Disease (CKD) Pathway – Overall current state

