eHealth Ireland

#hello my name is… John O'Brien

Primary Care Example Citizen Persona and Scenario

John at a glance

Age: *60*

Location: *Sligo*

Family Status: *Married with Children*

Education: *Leaving Cert*

Employment Status: *Self-employed*

Personality

Extrovert — Introvert

Organised — Disorganised

Emotional — Rational

Bio:

John is a 60 year old self-employed carpenter. He likes to spend time with his family which includes using technology to keep up with his children and grandchildren. John doesn't pay too much attention to his own health and wellbeing.

Health Status:

John smokes about 1 pack of cigarettes a week. He describes himself as being reasonably healthy but he rarely goes to see a doctor for check-ups. Sometimes he has shortness of breath. Whenever he is sick, he's not good at following treatment regimes.

Goals:

He wants to stay healthy without having to make major adjustments to his lifestyle.

Frustrations/Fears:

He doesn't like interacting with the health service and is very protective of his personal healthcare information.

Technology:

Broadband Access

Smartphone/Tablet

Internet Usage: Low — High

Tech Comfort: Low — High

Scenario: Patient Diagnosed with COPD

Actors: Citizen (John O'Brien), GPs (Dr. Mooney & Dr. Wilson), Pharmacist, Radiologist, Consultant

John O'Brien, 60, sees his family GP, Dr. Mooney, for the first time in over four years. To this point in his life, John has rarely gone to the doctor but over the last two years he has been suffering from a persistent cough with intermittent episodes of shortness of breath.

Dr. Mooney accesses his practice system and carefully reviews the history of his present illness, as well as John's past medical, family and social history. He discovers John has a 45 to 50 pack per year history of smoking. Upon completion of the examination, Dr. Mooney's presumptive diagnosis is COPD (chronic obstructive pulmonary disease). Using his practice system, (which is integrated with the EHR), Dr. Mooney creates and sends an electronic referral request for a chest x-ray and an electronic referral request for pulmonary function tests at the local hospital. Finally he prescribes a short-acting B2 agonist inhaler and counsels John to stop smoking. Dr. Mooney records all of the findings from this visit in the practice system.

Later in the day, John goes to the pharmacy and purchases his inhaler.

John also goes to the Diagnostic Imaging department of the local hospital and gets his chest x-ray done. The radiologist views the image later that day and creates a report indicating findings consistent with COPD.

Three weeks later, John attends his appointment for pulmonary function tests at the hospital outpatient department. The test is interpreted the next day by a consultant who finds evidence of obstructive airway disease and creates a report.

Unfortunately, John really enjoys smoking and is not convinced it is related to his breathing problems. As a result, he continues to smoke. He finds the inhaler difficult to manage so he rarely uses it. A few months later, John develops an upper respiratory tract infection (URTI). His cough and breathing worsen significantly so he returns to see Dr. Mooney accesses John's results for the tests he had ordered and prescribes an antibiotic and two types of inhalers. John goes to a different pharmacy than he used previously but only gets the antibiotic prescription filled.

Ten days later John is in a small town in a neighbouring county visiting family. His breathing and cough have not improved so he goes to a local GP, Dr. Wilson. The assistant in the clinic uses information provided by John to create a new profile linked to his Individual Health Identifier (IHI). Dr. Wilson tries to access John's summary health record from the national health portal but is denied access saying the patient has restricted access to his health data. John has a choice to whether to allow Dr. Wilson access to his Electronic Health Record. John grants access to Dr. Wilson via a consent tracking service. Dr. Wilson is now able to access John's Electronic Health Record and obtains a list of his five most recent encounters with the health system. Using this information along with her own examination, Dr. Wilson feels there is bacterial resistance to the antibiotic prescribed, along with non-compliance using the inhalers. She prescribes a different antibiotic and counsels John on using his inhaled medications.

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#hello my name is… Tom McCarthy

Cross Care Continuum Example Citizen Persona and Scenario

Tom at a glance

Age: *72*

Location: *Waterford*

Family Status: *Married*

Education: *College Graduate*

Employment Status: *Retired*

Personality

Extrovert — Introvert

Organised — Disorganised

Emotional — Rational

Bio:

Tom is a retired 72 year old who spends the majority of his time at home with his wife Sheila. They have a grown up family who live in other parts of the country. Tom is not a major user of technology and prefers more traditional face-to-face interaction.

Health Status:

Tom is not particularly active and while he is good at having check-ups, whenever he's prescribed medication for any condition, he's not good at remembering to take it.

Goals:

He wants clinicians to tell him straight up what the outcome is likely to be so he can plan around it.

Frustrations/Fears:

He would not like to ever become a burden on his wife or his family.

Technology:

Broadband Access

Smartphone/Tablet

Internet Usage: Low — High

Tech Comfort: Low — High

Scenario: Cerebrovascular Accident

Actors: Citizen (Tom McCarthy), Emergency Medical Technician, Registrar, Case Manager, Physiotherapist, Nurse, GP (Dr. Martin)

Tom McCarthy was diagnosed with atrial fibrillation about six months ago. He has been very non-compliant with taking his warfarin. Four hours ago he started to develop some weakness in the left side of his body and face. He chose to ignore it but it has progressed and Tom is starting to become concerned. When Tom's wife, Sheila, came home she fears he is having a stroke and calls an ambulance.

The ambulance is en route to Tom and Sheila's home in Tramore, 13km from Waterford Regional Hospital. One of the Emergency Medical Technicians (EMT) in the ambulance has accessed the National Summary Care Record and has been able to review information about Tom. He retrieves Tom's health profile and reviews his summary medical history, current problem list, allergies and medications.

Tom is taken to Waterford Regional Hospital. After assessment in the Emergency Department there, Tom undergoes a CT scan which suggests a cerebrovascular accident (CVA, or stroke). The General Medicine Registrar on call that evening, Dr. Cheema, assesses Tom in the ED to admit him to hospital. He gets as much history as possible from Tom and Sheila, but this is limited. He examines Tom then reviews the CT images. Dr. Cheema reviews the ED notes in the hospital EHR and accesses Tom's records. He is able to view Tom's health profile and see his current and past medical problem list. He can also see the medications which have been prescribed. Dr. Cheema searches for the 15 most recent lab results to get an idea of Tom's anticoagulation status. After reviewing this information, Dr. Cheema feels Tom has had a stroke secondary to atrial fibrillation with poor anticoagulation. He creates a record of the admitting history and physical in the hospital EHR.

After several weeks in hospital, Tom has recovered to the point where he can be discharged home. On leaving the hospital, Tom is assessed for home care services. The case manager meets with Tom and reviews his recent health events with him. She accesses his records and is able to see the details of his recent hospitalisation. She reviews the medical, nursing, social worker, pharmacy, respiratory therapy, speech therapy, physiotherapy and occupational therapy notes and/or discharge summaries. The case manager does her own assessment of Tom and, together, they formulate a plan of service. She makes a record of her findings and plan in the care record and arranges for the appropriate services to be delivered at Tom's home.

The home care services arranged for Tom includes physiotherapy. The physiotherapist assigned to work with Tom accesses his records and searches for his last 5 encounters. She drills down into the recent hospitalisation encounter and reads the discharge summary and physiotherapy notes. From this she has a good impression of the history of Tom's stroke, his deficits from it, the treatment thus far and the ongoing management plan. The physiotherapist assesses Tom in his home. She performs her evaluation and commences treatment with him. At the end of the session she creates a record of the encounter in her Community EHR system.

Six months later, Tom develops a respiratory infection and is readmitted to Waterford Regional Hospital. He is not physically able to return home so is admitted to a long term care facility. He has been residing in a long term care facility for about one year following his stroke. His lung function has continued to deteriorate as a result of chronic obstructive pulmonary disease and, with it, his overall functional abilities. Tom recently developed another respiratory tract infection. He has become very weak and is having greater and greater difficulty breathing. Tom and his family had previously decided with his GP Dr. Martin, that attempts will not be made to resuscitate him should the situation arise. This wish has been recorded in Tom's Summary Care Record as a patient directive.

Late one night Tom's condition deteriorates markedly and he passes away. The nurse who was with Tom when he died makes a record of the event in the facility's electronic records and notifies Dr. Martin. Dr. Martin comes in and pronounces Tom deceased.

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#hello my name is… Jenny Moore

ED Nurse Example Health Service Worker Persona and Scenario

Bio:

Jenny Moore is a healthcare professional who prides herself on delivering care. In her personal life, she is comfortable with technology and manages to do a lot from her mobile phone.

Role:

Jenny is an ED nurse at Beaumont Hospital. She is been with the hospital and in ED for the last 5 and 3 years respectively.

Jenny at a glance

Age: *43*

Family Status: *Married with 3 Children*

Education: *Nursing Degree*

Role: *ED Nurse*

Location:

She is predominantly based in ED but within ED she has to be mobile to work around different workstations.

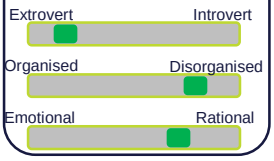
Goals:

Jenny works hard to maintain a work life balance, juggling her time with her three small children (ages 2, 5 and 7), pursuing her studies and her stressful work in ED.

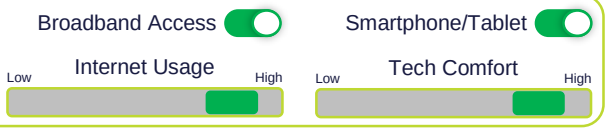
Frustrations/Fears:

She has an extensive workload and keeping informed on all cases she's involved in is frustrating.

Personality



Technology:



Scenario: Patient Diagnosed with COPD

Actors: Citizen (John O'Brien), GPs (Dr. Mooney & Dr. Wilson), Pharmacist, Radiologist, Consultant

An alert on Jenny's nurse station indicates a patient waiting to see her. Jenny takes Ken from the waiting room to an examination room.

She reviews the reason for Ken's visit which was entered in the Hospital EHR system during registration. She asks Ken about any allergies and current medications but he find it difficult to provide the information as he is feeling the effects of the recent narcotic analgesic.

Fortunately, Jenny is able to access Ken's summary health records and also his record in the community health HER. She updates his records in her system. She also obtains his blood pressure, heart rate and temperature and records all of this data in her system under Ken's health profile. She then asks Ken to wait for the doctor to see him.