EHR Personas Workshop

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Delivering eHealth Ireland
Office of the Chief Information Officer

#EHRPersonas  #ehealth4all
Welcome to the workshop!

Sincere thanks to our partners for facilitating us here today
What is the National Electronic Health Record?

The National EHR is a fundamental cornerstone for the delivery of high quality, comprehensive and accurate information in a timely manner for the provision of patient centred, effective and efficient care.

The National EHR comprises:

- National Shared Record
- Integration
- Community Operational Systems
- Acute Operational Systems
- Pharmacy
- Private Hospitals
- GP Systems

What does the National EHR do?

- Transforms patient experience
- Delivers greater patient safety and more effective care
- Drives efficient delivery of health services
- Makes the wider reform programme possible:
  - Underpins integrated care
  - Provides the information for proactive health and wellbeing initiatives
  - Provides the operational systems to realise CHO’s and Hospital Groups
  - Captures accurate information on activities that show the true cost of treating a patient

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The EHR Programme

Moving from paper records locked in organisations to a digital patient record shared across care settings.

The “glue” that binds all this together and maintains integrity and security across the system.

Examples:
- Order Communications / Results Reporting
- Medicines Management
- Clinical Notes

Other healthcare providers will access and contribute to the National Shared Record through the Integration Capability.

Examples:
- Single MPI
- Scheduling
- Clinical Notes / Records
- Screening & Surveillance

The Individual Health Identifier Programme is a key enabler that allows information to be shared about a patient.
The National Electronic Health Record is not a large IT project

- The National EHR implementation is not considered an IT programme but is being approached as a broader change and transformation journey.
- It is a clinically led programme because the National EHR is a crucial element that will help deliver new models of care and greater standardisation of care processes and pathways.
The EHR Persona Development Project

Why develop Personas?

Requirements Development

The process of engaging with stakeholders to create the Personas and Scenarios helps to develop and deepen the set of National EHR requirements in a way that is meaningful for all stakeholders. The approach also takes a more holistic view of overall outcomes required.

Communications and Engagement

The Personas and Scenarios help make the National EHR real by outlining how interactions will look and feel in the future. This will be important as part of clinician, health service worker and citizen engagement and communication.

Managing Supplier Engagement

The Personas and Scenarios can be used as part of managing the engagement with potential suppliers. They provide a consistent set of cases through which suppliers can illustrate functionality and showcase how they can achieve the outcomes that will address some of our existing challenges.
Primary Care Persona Example

# hello my name is... John O’Brien

**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.

**Personality**
- **Extrovert**
- **Introvert**
- **Organised**
- **Disorganised**
- **Emotional**
- **Rational**

**Technology**
- **Broadband Access**
- **Smartphone/Tablet**
- **Tech Comfort**
- **Internet Usage**
Primary Care Scenario Example

**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.
Primary Care Scenario Example

Scenario: Patient Diagnosed with COPD

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

Background

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.

Typical interactions or activities

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.

How the EHR will be used

Unfortunately, John realises his inhaler is difficult to manage and he has trouble using it properly. He finds the inhaler difficult to manage and only uses it intermittently. John develops a worsening upper respiratory infection and his cough and breathing worsen significantly so he returns to see Dr. Mooney. 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.

Outcomes

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 summary 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 his 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.
Workshop Overview

- Instructions and examples are provided

Within your table:
- Self-select a person to act as the scribe for the table and a person to act as the table coordinator
- First develop the view of the Persona
  - The Persona should be representative of a typical person in terms of demographics and attitudes
- Create two Scenarios that are set in a future where the National EHR capabilities that are proposed have been introduced
  - focus on conditions that impact on large numbers of health service users
  - focus on a typical set of activities that the person would do during their working day
Conclusions

- Feedback and queries
  - Email to follow with short feedback survey

- Next steps
  - Outputs from today will be written up and contribute to the final Personas and Scenarios
  - Personas and Scenarios will be published online by May 2017
Conclusions

- Follow progress of EHR Personas
  - Website: www.ehealthireland.ie/personas
    - Templates are online if you wish to contribute to further Personas and Scenarios
  - Facebook: eHealth Ireland
  - Twitter: #EHRPersonas, @eHealthIreland
  - Email: Fergal.Marrinan@hse.ie
- Council of Clinical Information Officers
  - Email: ccio@ehealthireland.ie
  - Website: www.ccio.ie
Conclusions

Many thanks for your participation today