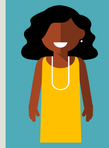
Patient personas

Angela



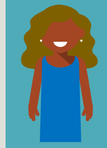
32-year-old first time mother who is three months pregnant and works full-time as a legal secretary

Wants, needs, behaviours:

- Wants to be able to understand the care she and her baby will receive
- Empathetic and personalized communication showing that her medical team truly cares
- Initially nervous about what to expect from her pregnancy and birthing journey

Private Basic Health Coverage

Vanessa



20-year-old first time mother who just found out she is 4 months pregnant. She is unemployed and wants to start college next year

Wants, needs and behaviours:

- Lacks a social support network – she lives with her parents who work full-time
- Worried about not able to afford care for herself and her baby
- Compassionate care and support to address her other needs (i.e. financial)
- Rarely visits the doctor and her medical records are limited.

No insurance

Laura

32-year-old reinsurance underwriter with who recently relocated to Bermuda from the USA

Wants, needs and behaviours:

- Has only experienced a midwife led care pathway for her first pregnancy
- Prefers an out-of-hospital birth
- Trust in the team of doctors, nurses, and staff that she is in the right care and that her choices are respected
- Would like the support of a doula

Major Health Coverage

James & Natasha

James is 34 and Natasha is 29 years old. Natasha just gave birth to baby Lucas, who was born premature at 30 weeks and flown overseas for his care

Wants, needs and behaviours:

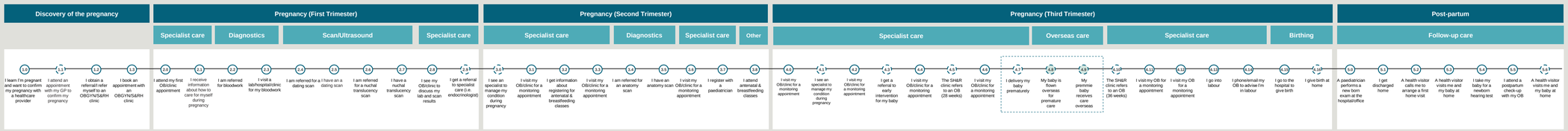
- Compassionate care as they struggle with knowing how to care for their premmie baby
- Worried about services available on island and long-waiting list to access early intervention services
- They'd like to connect with other families like them

Private Health Coverage

Journey Map (Maternal Health)

An illustrative current-state experience of the end-to-end First 1,000 Days Pathway, from the perspective of the four personas to bring it to life*

Touchpoint key
Optional touchpoint · Off-island touchpoint



GAIN POINTS

The positive experiences which enhance the journey and exceed patient and staff expectations

Self referrals to OBGYN/SH&R are made upon discovery of pregnancy.

Support for uninsured citizens: The S&RH clinic provides antenatal care to women at no cost, particularly for the uninsured.

Primary care support: GPs make referrals to specialist care and diagnostics services. They also provide information to women regarding sexual and reproductive health

Expectant mothers have access to specialist care through their OB/clinic.

Diagnostics and screening services are provided to expectant mothers in adherence to global clinical guidelines

Diagnostics and screening services for antenatal care are available on island through a network of labs, clinics and the hospital

Diagnostics imaging and scans follow global clinical guidelines.

OB/Clinic provide information to women about nutrition and how to care for their health during pregnancy.

Mother and baby's health is routinely monitored. The number of antenatal appointments a woman attends is guided by their health needs

Mother and baby's health continues to be routinely monitored with any necessary specialist referrals done when needed

Women receive information about antenatal and breastfeeding classes

An established community of doulas exist to support mothers through their pregnancy and birthing journey

The private setting provides access to antenatal/pre-natal classes

A breastfeeding class has recently been restarted by the public clinic

Women are advised to register with a pediatrician and receive some information about newborn screening

As pregnant women enter their third trimester they will visit their OB/Clinic more often, which provides a good level of reassurance of being adequately cared for.

Early intervention referrals can also be made by providers at this stage of the pathway with families needing accessing to early intervention getting education on services available.

There is a care pathway for premature born babies at various stages of prematurity. Usually, if born under 26 weeks, premature babies are referred overseas for further care. In addition, established relationships are in place with overseas providers such as Boston Children Hospital and the Sick Kids Hospital in Canada.

Women receive information about their birth pathway from their OBGYN in preparation for it.

All women will have access to specialist care from an OBGYN during their third trimester.

Women that receive care at the public clinic are referred to an OBGYN for a 28 and 36 weeks appointment and preparation for birth..

Women welcome the support they receive from their health visitors and home visit post-partum. During this visit, the child health record book is provided to mothers alongside general screening and health assessments

Women are able to attend a postpartum check with their OBGYN usually at 6 weeks postpartum.

EMOTIONAL JOURNEY

An illustrative scale from -3 to +3 to track the movements in the citizens' emotional journey across the touchpoints

PAIN POINTS

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

Unclear on services available: uninsured women are not always aware of services available to them through the public clinics. In some cases this leads to late presentation of pregnancies, with limited or no provision of antenatal care.

Patient confidentiality issues deters some women from accessing essential maternal services for fear of their pregnancy being disclosed to other.

Information about what to expect from pregnancy can be limited: with some women experiencing feelings of uncertainty, questions about what care they'll receive and needing guidance about how to manage existing conditions.

OB care experienced by patients vary from one provider to another: this is reflected in how people access information like results from bloodwork or scans, or in the way they communicate directly with their provider.

Anecdotally, patients take time to develop trust and relationship with their OB: this is due to appointments being perceived as too short or not empathetic.

Whilst antenatal care provided by the public clinics at no cost, medications are not covered which in some individual cases poses an additional cost burden on women.

Historically, the public clinics carry some stigma associated with the services they offered (i.e. STD testing) which may deter access to services but some segments of the population.

Emotional wellbeing support for women who miscarriage in their first trimester is limited. Currently country-led education and support initiatives about miscarriage do not exist.

As women move along the pathway, and where they continue to see an specialist for some of their care, lack of coordination of care, and medical records not shared between providers can cause unnecessary stress.

Women who are underinsured may have limited access to specialist care, which puts a strain on physical and emotional wellbeing

Conversations about mental health wellbeing can be sporadic, with women left feeling isolated during their pregnancy.

Access to paediatrician variation: some women/families will be offered an in-person visit with a pediatrician when registering whilst other won't.

Access to antenatal/prenatal classes for the uninsured provided at no cost is limited.

Patient confidentiality remains an issue: As the pregnancy progresses, women worry about their pregnancy remaining confidential outside of trusted circles.

Care transitions from the public clinics to an OBGYN at 28 and 36 weeks during their pregnancy. This is perceived as impacting continuity of care.

Patients that transfer care from the public clinics to an OBGYN worry about cost of care and not being able to pay for OBGYN appointments, which sometimes results in failure to attend the referral.

Women that give birth prematurely and whose babies are flown overseas experience emotional stress and do not feel supported by clinical teams.

Women who prefer an out-of-hospital birth (i.e. home birth) face significant challenges to opt for an 'alternative birth experience'.

Women who give birth at the hospital feel that more could be done around raising standards of care, specially post-partum.

Families and partners that accompany women during their birthing experience do not always feel sufficiently informed about clinical interventions (i.e. C sections).

Emotional wellbeing support for women who experience stillbirth is very limited with patient reporting 'out of touch' behaviors from clinical teams (i.e. sharing a room with other mothers and their babies after an stillbirth pregnancy)

Women that give birth by C-section do not always feel sufficiently informed of the risks and postpartum considerations by their clinical team

Women that do not register with a paediatrician ahead of birthing will be visited by an on-call paediatrician for their newborn screening assessment.

Women believe their postpartum follow-up care with their OBGYN is limited with not sufficient time dedicated to emotional wellbeing checks.

Mental health and wellbeing checks performed by health visitors are considered a 'checklist exercise' and not focus on understanding the needs of the patient.

OPPORTUNITY AREAS

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

*All views captured in this document are those of the colleagues and patients interviewed

Journey Map (Child Health)

An illustrative current-state experience of the end-to-end first 1,000 days pathway, from the perspective of the four personas to bring it to life*

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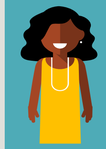

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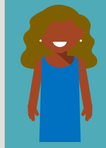

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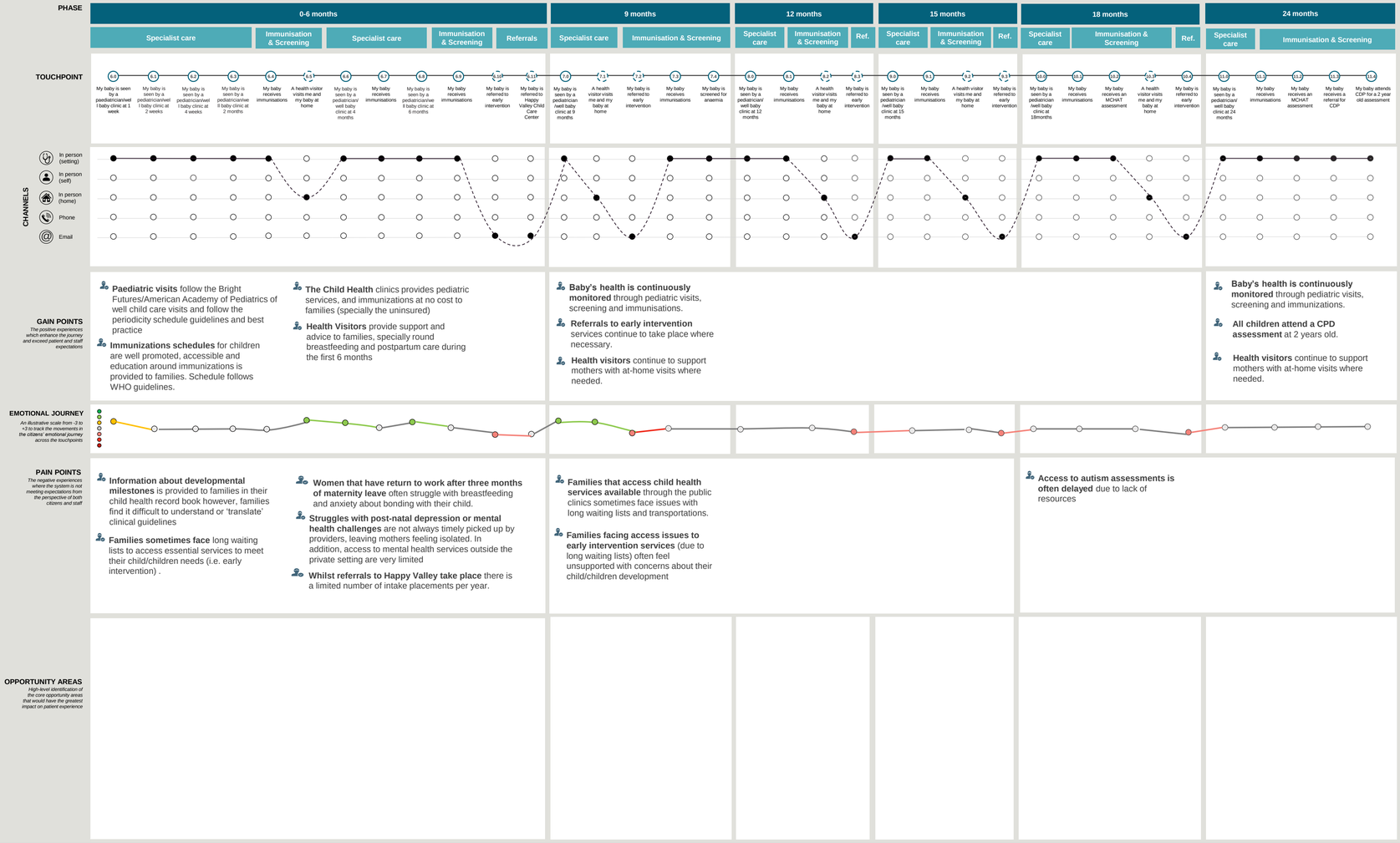

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