

Increasing Adolescent MyHealth Enrollment: A Quality Improvement Project

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Submitted to: Dr. Sharon Norman - Chair

This paper is submitted in partial fulfillment of the requirements for
the Doctor of Nursing Practice degree.

Abstract

Patient portals are important parts of the electronic health record that can be used by adolescents to engage with the healthcare system in a variety of ways including making appointments, requesting refills, and messaging with their healthcare team. This quality improvement project aimed to increase the percentage of adolescents enrolled in the patient portal (MyHealth) from 36-50% within the span of six months. The project took place in a pediatric primary care clinic that has 1656 adolescent patients enrolled. Using two unique PDSA cycles this project combined the use of patient education, schedule scrubbing, and marketing materials to sign adolescent patients up for MyHealth. After each PDSA cycle we analyzed the number of adolescent patients enrolled in the patient portal as compared to the total number of adolescent patients. Although this project did not achieve the aim of 50% adolescent enrollment, we were able to increase the total number of adolescents enrolled as well as gain momentum for MyHealth enrollment across the clinic setting.

Introduction

Problem Description

Electronic health records have quickly replaced paper documentation, and the evolution of patient portals (secure websites or smart-phone applications) now allow patients to access their health information, participate in virtual visits, and communicate with providers and other staff from anywhere (Lee & Holland-Hall, 2021). Experts agree that there are many potential benefits to adolescents using patient portals such as increased engagement and communication (Lee & Holland-Hall, 2021; Gadowski et al, 2015). Additionally, most adolescents are already familiar with similar technology, are very receptive to using patient portals as part of their healthcare experience, and actually desire opportunities to view their health information electronically (Miklin et al, 2019). There is a large opportunity to improve communication with both adolescents and their parents and encourage them to be more engaged and interactive in their health care.

The data surrounding use of patient portals, is predominately from the adult population, and is limited regarding adolescents or children. The Office of the National Coordinator for Health Information Technology in the United States collects healthcare data and has estimated that in 2020 about 38% of individuals nationwide accessed some kind of healthcare portal either on a smartphone or computer (Johnson et al, 2021).

Recently, a study was conducted using the electronic health data from a large academic medical center in Florida with 52,713 patients. LeLaurin et al. (2021) found that 39% of all patients had activated their health portal accounts. Of the total number, this study divides the data by age groups, showing that 41% of patients aged 12–17, and 62% of patients aged 18–21

years had activated their accounts. The percentages of activation in the adolescent groups were higher than the overall population of users (LeLaurin et al, 2021).

Facilities and providers that seek reimbursement from patients covered under Medicare or Medicaid services are incentivized to demonstrate meaningful use of electronic health records as part of “Meaningful Use”, first outlined in 2011. This act encourages health systems to employ some form of patient portal system so that patients and families can interact with the system and their providers electronically, as well as view their own health information (Centers for Medicare and Medicaid Services, 2023). The adolescents in our pediatric primary clinic have low rates of activated MyHealth accounts. This led to an opportunity to increase their engagement in healthcare and communication with their providers through increased activation and engagement.

Available Knowledge

Adolescent use of healthcare portals is a nuanced issue due to privacy and security concerns from both adolescents and their parents or guardians. Several studies show that the primary access to 62-83% of adolescent patient portal accounts actually belong to parents or guardians, instead of adolescent patients themselves (Lee & Holland-Hall, 2021; Xie et al, 2021). In most states, guardianship laws allow for minors to have personal access to their own patient portal between the ages of 12 and 14, and then further transition to consenting to temporary or permanent proxy access for their parents or guardians, as desired (Lee & Holland-Hall, 2021). Additionally, many adolescent patients may be unaware of their right to seek treatment for concerns regarding mental, sexual health, and substance abuse without the consent or knowledge of their parents (Miklin et al, 2019). Overall, adolescent patients are largely unaware of their

rights and responsibilities in these regards, which likely prevents them from disclosing information and fully utilizing the electronic health system.

Adolescent use of patient portal technology has many potential benefits including increased engagement and communication, and overall patient and provider satisfaction. Not only are written instructions better comprehended, but providers have more flexibility to respond to patients at any time, and 80% of clinicians reported a decrease in telephone calls to the clinic (Bush et al., 2017). One study in adults showed that patients with access to a patient portal had increased medication and appointment adherence, with lower no-show rates (Zhong et al., 2018). Although we have limited evidence from adolescent data, the adult data provides us with clues about the potential benefits in adolescents, as well as identifies the knowledge gap which this project will fulfill in our clinic. Overall, patients and providers both report that use of a patient portal increased satisfaction and helped families feel more knowledgeable and in control of their health decisions.

Despite the known opportunities surrounding adolescent use of patient portals, health systems across the country continue to have low activation and utilization rates. In adult users, factors like language, age, education level, and access to a smart phone or computer influence a patient's likelihood of using a patient portal system to communicate with their providers (Bush et al., 2019). Additionally, we have some information about the patterns of use in pediatrics from a healthcare portal; specifically, that secure messaging and viewing of test results are some of the most highly utilized functions. More than half of accounts were used for less than one year, however this study represents a specialty care population, rather than primary care (Steitz et al., 2017). This data culminates in reiterating our initial claim that patient portals have the potential

to increase the health and wellness of our patients, however are being underutilized, especially in the adolescent population.

Rationale

Plan Do Study Act (PDSA) cycles were developed by the Institute for Healthcare Improvement to test specific interventions within one setting (Institute *for* Healthcare Improvement, 2023). The cycles are designed to carry out a test on a small scale, and then study and learn from the results, tweaking the intervention as needed along the way to achieve the ultimate goal. PDSA cycles have proven to be particularly valuable for quality improvement projects, and therefore our project will follow this familiar framework.

Through a review of the literature, we determined that elements of a Quality Improvement Project to increase MyChart activations among families in a Child Development Center could be replicated in our Pediatric Clinic. They were successful in meeting their aim of increasing MyChart enrollment from 1.8% to 30% within 6 months (Ratliff-Schaub & Valleru, 2017). In a series of PDSA cycles, this clinic implemented interventions including training staff and providers in using MyChart, training front office staff in MyChart registration, providing family education, and implementing marketing including brochures and signs in the clinic. As MyHealth/MyChart is currently available in our clinic, to increase enrollment, we implemented reinforced education training rather than basic education.

Specific Aims

The aim of this project is to increase MyHealth account activation in patients 14 years and older from 36% to 50% in our Pediatric Clinic by April 2023. By accomplishing this aim we will increase our adolescent communication and engagement.

Methods

Context

In our urban Pediatric Clinic, we have a total of 1656 patients aged 12-19 years of age. On a typical day we have 3-5 providers and 5-7 MAs and RNs in the back office, and 3-4 front office staff. Of the total patients in that age range, 589 patients (36%), have activated MyHealth accounts. The remaining 1067 adolescent patients have accounts that are pending activation, have been previously deactivated, or no account at all. Currently in our clinic, MyHealth accounts automatically de-active proxy access when patients turn 14. The expectation is that all patients are offered MyHealth enrollment, however staff are not comfortable utilizing the enrollment features of MyHealth and are not routinely verifying emails or offering proxy access signup.

Interventions

The interventions consisted of three elements: staff education, schedule scrubbing, and educational materials. Staff education consisted of generalized education at a staff meeting in October 2022, which included detailed instructions about how to initiate or modify MyHealth accounts, different proxy options for adolescent patients, and troubleshooting tips and tricks. The initial education was followed by individual education throughout the course of the project for new staff and refresher education for anyone with outstanding questions. Schedule scrubbing included placing reminders on the schedule for all patients that were eligible for signup. Reminders helped both front and back-office staff, as well as providers, remember to include a MyHealth discussion in their visit. Lastly, educational materials included posters advertising MyHealth that were placed in patient-facing areas including the front office and exam rooms, as

well as laminated packets of signup information and tip sheets that were placed at each nursing station for staff to use and review (see Appendix 3).

Study of the Interventions & Measures

The study of these interventions included comparing baseline data with post-intervention data regarding how many adolescent patients are actively enrolled in MyHealth. The number of adolescents enrolled was compared with the total number of adolescent patients to determine the percentage.

The outcome measure for this project was the percentage of adolescent patients 14 years of age and older who are actively enrolled in MyHealth. This number is obtained through a team-member in data informatics who provided an Electronic Health Record report. Secondly, as a qualitative measure we met monthly with stakeholders including our manager, QI project leaders, and front and back-office staff to determine barriers and implications on staffing and time management.

Analysis

Quantitative data was obtained from chart reviews and an EHR clinic report which included all adolescent patients and their MyHealth enrollment status. Pre and post intervention data was compared. The data was exported in an excel spreadsheet and rates and percentages were compared.

Ethical Considerations

This quality improvement project was vetted by the International Research Boards of both Legacy Health and Oregon Health and Sciences University and found to be quality

improvement not consistent with human research. There are no conflicts of interest to report. We would like to acknowledge the support of the entire clinic staff where this project was conducted.

Within the scope of this project, there are certainly ethical considerations including language and literacy barriers, and accessibility to smart devices and internet. We acknowledge that although the majority of our adolescent patients do have access to smart devices and internet at school and at home, there are certainly patients for whom accessing MyHealth from home would not be possible. Additionally, although the MyHealth application itself can be displayed in many different languages, medical information and messages are usually not translated, which presents a barrier for non-English readers and speakers. To mediate some of these discrepancies, we have ensured that all patients in our clinic have access to clinic staff using professional interpreters for help initiating and navigating MyHealth access.

Results

Results

Prior to starting this quality improvement project, the percentage of adolescents with activated MyHealth accounts in this pediatric clinic was 35.6%. Initially, this project was scheduled to start in August 2022, however due to extenuating circumstances in the clinic related to staff and patient safety issues this project was put on hold until the end of October 2022. In addition, the number of adolescent patients enrolled in MyHealth increased from 340 to 373 during the period between July 2022 and February 2023, with an average of 5-6 new patients enrolled each month (see Appendix 2).

PDSA Cycle 1

The first PDSA cycle included education during a staff meeting, scrubbing the schedule and adding reminders to every patient that was eligible for MyHealth signup, and placing tip sheets reminding staff of how to sign patients up for MyHealth at both of the nursing stations. After the first PDSA cycle, we observed an increase in the percentage of patients with active MyHealth accounts up to 40.4%.

PDSA Cycle 2

For the second PDSA cycle we introduced patient education materials that were placed around the clinic in strategic locations. These materials included brochures in the front office and on the nursing desks, and fliers in the hallways of the front and back clinics. Again, our interventions included scrubbing the schedule to remind staff of patients that were eligible for signup.

During the remainder of this project, we had several additional factors influencing the outcome of this project, including the high turnover of staff and changes in staffing and scheduling during an unexpected surge of children with viral illnesses. High turnover of staff in both the front and back of the clinic meant that training was constantly lacking for our new staff. While the new staff were onboarding and training at the clinic, we were unable to prioritize MyHealth training in the absence of extra training time. While we did complete training with individual staff, the interventions were limited by the lack of formal training. Additionally, we encountered an unusual surge during viral season where staffing was short and the clinic cancelled most well-child checks to accommodate visits for acutely ill children with viral illnesses, in fact the state declared a state of emergency. Since adolescent MyHealth enrollment was primarily completed well-child checks, this led to very few opportunities to sign patients up

for MyHealth during the state of emergency. At the end of PDSA Cycle 2 the percentage of activated MyHealth accounts remained largely unchanged at 40.6%.

Discussion

Summary

Although this project did result in an increased rate of adolescent MyHealth enrollment from 35.5 to 41%, we were unable to achieve our goal of 50% enrollment (see Appendix 2). However, strengths of the project included overwhelmingly positive feedback from providers, staff, and families. Additionally, we learned through two PDSA cycles the value of continuing education and commitment to this project and believe it will leave a long-term positive impact even after completion.

Interpretation

The interventions we utilized including education, schedule scrubbing, and marketing materials were successful in increasing our enrollment rate. Compared with the model study we were not able to achieve as robust of an increase. We included similar elements to the model study including training, education and marketing in PDSA cycles, however, unfortunately were not able to achieve as robust of an increase in enrollment (Ratliff-Schaub & Valleru, 2017). This is in part due to extenuating circumstances including the staffing and shortages in changes as well as the pandemic as previously discussed. This project was conducted during normal working hours and there was no increased cost to the clinic or staff, making this project sustainable to continue. Clinic staff continue to agree that this is important work for the clinic and an important way to serve our adolescent patients and families.

Limitations

Because this quality improvement project was conducted in a small pediatric clinic it may not be generalizable to larger clinics with more patients and staff. Additionally, because this project was conducted by clinic staff, there was likely implicit bias towards some staff members. As previously discussed, there were limitations related to English literacy as well as access to internet and devices.

Conclusions

This quality improvement project was successful although it did not meet the project aims. There was, however, some improvement in our adolescent MyHealth enrollment rates as well as excitement from the whole team about continuing this work outside of the scope of this project. This quality improvement project would benefit from additional PDSA cycles to further improve adolescent MyHealth enrollment and engagement.

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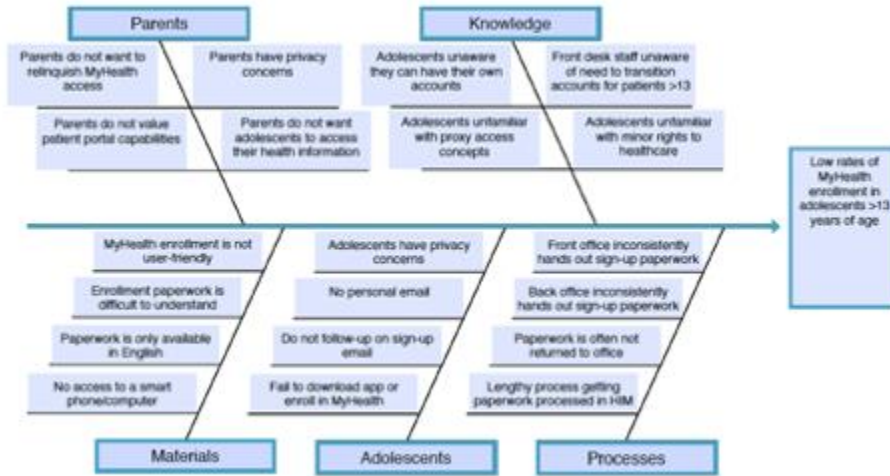
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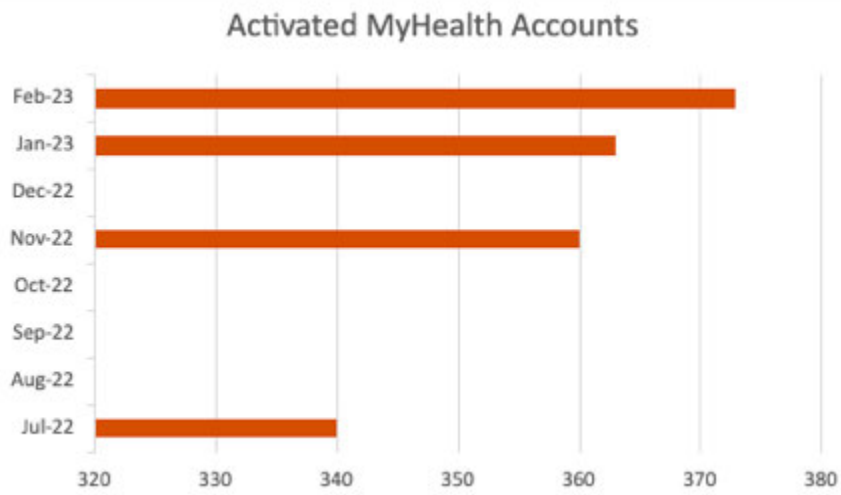
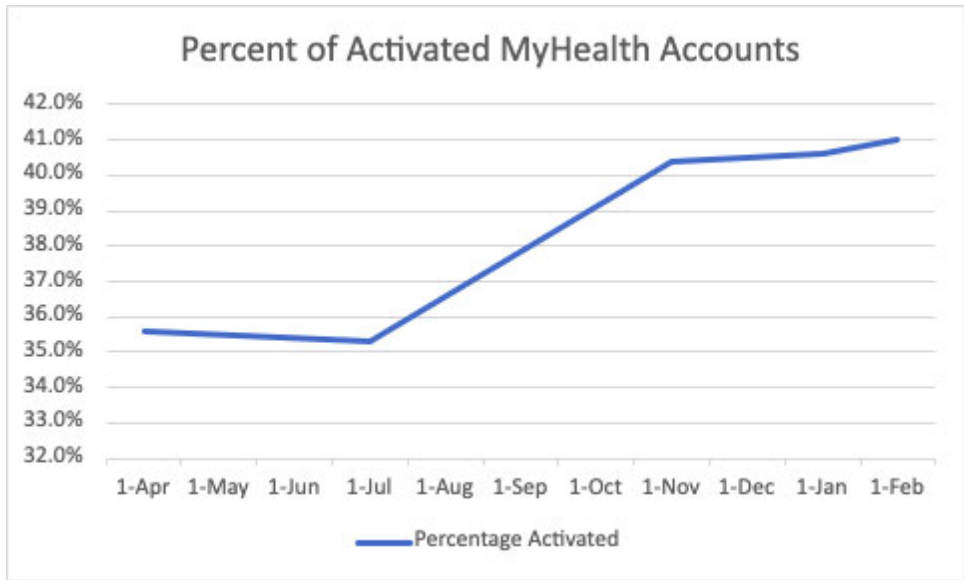
<https://doi.org/10.1186/s12911-018-0669-8>

Appendices

Appendix 1: Cause and Effect Diagram



Appendix 2: Results



Appendix 3: Informational Posters

FULL PROXY	LIMITED PROXY
Can see past and future visits with details	Can see future visits without details
Can see all test results	Cannot see any test results
Can see and manage medications	Cannot see or manage medications
Can see all messages and starting from the time of proxy access	Can see all messages and starting from the time of proxy access (option to hide when sending)

Use MyHealth



To easily:

- *Fill prescriptions*
- *Schedule appointments*
- *Email your doctor*
- *Check health records*

...and do much more

Online, or on your phone

legacyhealth.org/myhealth

EMANUEL Medical Center GOOD SAMARITAN Medical Center MERIDIAN PARK Medical Center MOUNT HOOD Medical Center SALMON CREEK Medical Center SILVERTON Medical Center

RANDALL CHILDREN'S HOSPITAL Legacy Emanuel LEGACY MEDICAL GROUP LEGACY HEALTH PARTNERS LEGACY HOSPICE LEGACY LABORATORY LEGACY RESEARCH

Appendix 4: Project Timeline

	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar
Finalize project design and approach (703A)	X							
Complete IRB determination or approval (703A)		X	X					
PDSA Cycle 1 (703B) - Staff Meeting education - Schedule scrubbing - Tip Sheets				X	X			
PDSA Cycle 2 (703B) - Patient Education Materials - Schedule scrubbing						X		
Final data analysis (703B)							X	
Write sections 13-17 of final paper (703B)								X
Prepare for project dissemination (703B)								X



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 503.413.2491 phone
 503.413.4942 fax

LEGACY HEALTH INSTITUTIONAL REVIEW BOARD

NOTICE OF IRB ACTION

Protocol: <i>Increasing Adolescent MyHealth Enrollment: A Quality Improvement Project</i>	
Principal Investigator: Avery Kadas	Board Action: EXEMPT QI DETERMINATION
SUBMISSION TYPE/DATE: Exempt QI 7-28-22	Date of Board Action: 8-29-22
Sponsor: NA	Study Risk Level: Minimal risk
Site(s): RCH	Jurisdiction: OHRP/OCR
IRB Tracking Number: TBD	Continuing Review: NA

SUBMITTED DOCUMENTS REVIEWED

- ✓ Legacy Guidelines for Graduate RN Project Approval and Completion Form 7-22-22
- ✓ Investigator's CV
- ✓ Study Staff Training Information: CITI
- ✓ Email 7-28-22 from C. Bianchini

REVIEW

REVIEW TYPE	IRB ACTION
<ul style="list-style-type: none"> ✓ Initial Review ✓ Exemption Review ✓ QI Review 	<ul style="list-style-type: none"> ✓ Exempt from IRB Review determination

ADDITIONAL FINDINGS AND REQUIREMENTS FOR THIS STUDY

- ✓ The study is minimal risk.
- ✓ Legacy site management must be apprised of the study and the Board's action.

APPROVAL IS GRANTED SUBJECT TO THE FOLLOWING

1. Conduct the research in accordance with the protocol, applicable laws and regulations, Legacy policies, and the principles of research ethics as set forth in the Belmont Report.

2. Unless consent has been waived, conduct the informed consent process without coercion or undue influence, and provide the potential subject sufficient opportunity to consider whether or not to participate.
3. Use only the most current consent form bearing the Legacy Health IRB "APPROVED" stamp.
4. Provide non-English speaking subjects with a certified translation of the approved consent form in the subject's first language. The translation must be approved by Legacy Health IRB.
5. Obtain pre-approval from Legacy IRB for changes in research.
6. Obtain pre-approval from Legacy IRB for planned deviations and changes in research activity.
7. Report all deviations, violations, adverse events in a timely manner and submit corrective actions.
8. Report all unanticipated problems in a timely manner and submit plans to resolve such problems.
9. Provide reports to Legacy IRB concerning the progress of the research, when requested.
10. Ensure that prior to performing study-related duties, each member of the research study team has had training in the protection of human subjects e.g., CITI, appropriate to the processes required in the approved protocol.
11. Retain all IRB documentation at study site.

IRB ACTION SIGNATURE

BY LEGACY IRB OFFICE – EXEMPT QI – DATE: 8-29-22

Paul Newton JD CIP – LEGACY IRB ADMINISTRATOR

8-29-22

Paul Newton JD CIP
Legacy IRB Administrator

DATE

IRB CONTACT

If you have questions or concerns or wish to ask the IRB to reconsider its action, please contact Paul Newton, JD, CIP, Research Regulatory Specialist Sr. at

IRB INFORMATION

Legacy IRB: FWA00001280
REG: #1 (Good Sam): 00000677
REG: #2 (Emanuel): 00000678
LRI IRB (LRI): 00011999

END OF IRB ACTION DOCUMENT



eIRB

Notification of Not Human Research Determination

To: Sharon Norman

Link: [STUDY00024966](#)

P.I.: [Sharon Norman](#)

Title: Adolescent MyHealth

Description: The committee reviewed this submission and assigned a determination of Not Human Research. For additional details, click on the link above to access the project workspace.

Oregon Health & Science University

Research Integrity Office

3181 SW Sam Jackson Park Road - L106RI

Portland, Oregon 97239-3098

(503)494-7887 irb@ohsu.edu

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Research and Development Service

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Appendix 6: Letter of Support

Dear Avery Kadas,

This letter confirms that I, Christian Huber, allow Avery Kadas (OHSU Doctor of Nursing Practice Student) access to complete his/her DNP Final Project at our clinical site. The project will take place from approximately August 17, 2022 to May 1, 2023.

This letter summarizes the core elements of the project proposal, already reviewed by the DNP Project Preceptor and clinical liaison (if applicable):

- **Project Site(s):** Randall Children's Clinic – 2800 N Vancouver Ave. Suite #165. Portland, OR 97227
- **Project Plan:**
 - **Identified Clinical Problem:** The adolescents receiving care at Randall Children's Clinic have low rates of MyHealth enrollment. There is an opportunity to increase engagement with the health care system and providers through increased enrollment. Previously studies have shown additional benefits such as decreased no-show rates and lower patient call volumes.
 - **Rationale:** We will be using PDSA cycles to test specific interventions, because this model has proven to be particularly valuable for quality improvement projects. The project is based somewhat on a similar QI project done in a Child Development Center, where the MyChart enrollment was increased from 1.8% to 30% within 6 months by a series of interventions including training for staff and education for patients and families.
 - **Specific Aims:** The aim of this project is to increase MyHealth account activation in patients 14 years and older from 36% to 50% by May 2023. By accomplishing this aim we will increase our adolescent communication and engagement. Our process aim is to provide education to 75% of adolescents here for 14 year-old WCC appointments.
 - **Methods/Interventions/Measures:** Primarily, we will be collecting the number of adolescent patients with active MyHealth accounts, compared to the total number of adolescents enrolled in clinic. Additionally, we will be collecting through chart review the number of patients that received MyHealth education during their 14 year-old WCC appointments. Interventions are three-fold and includes staff education during a staff meeting as well as patient education materials in the clinic waiting room, offering enrollment as well as verifying adolescent emails during the check-in process, and MA/RN education documented in the AVS using a "dot-phrase".
 - **Data Management:** Data will be collected via an Epic report about the number of adolescents enrolled every month, and entered via a run chart to track progress. All data will be de-identified and include only age and gender. The prevalence of education in the AVS material will be collected through chart review, and will also be de-identified to not include any patient information.
 - **Site(s) Support:** The study site will support the development of this project through education time in a staff meeting, as well as overall willingness of clinic staff and providers to support this project through various measures including helping provide the education to adolescents and answering questions for patients and families.

During the project implementation and evaluation, Avery Kadas will provide regular updates and communicate any necessary changes to the DNP Project Preceptor.

Our organization looks forward to working with this student to complete their DNP project. If we have any concerns related to this project, we will contact Avery Kadas and Sharon Norman (student's DNP Project Chairperson).

Regards,

DNP Project Preceptor (Name, Job Title, Email, Phone): _____

Si_____ Date Signed _____