MyLVHN Enrollment Project

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**Introduction**

Patient portals (PPs) have shown potential to improve health outcomes and increase follow-up adherence. Also, PPs contribute towards meaningful use requirements if the patient (pt) utilizes the tool. Provider networks have found pt enrollment and utilization of PPs to be a challenge. To determine barriers to MyLVHN, the LVHN portal, this project was designed with a focus on improving transitions of care from the emergency department (ED).

**Methodology**

Primary intervention was a prospective cohort study designed to enroll ED pts into MyLVHN. Pt inclusion criteria: 1. English speaking 2. Age 19 or older 3. CC of SOB or other related CC 4. No acute distress (NAD) 5. Pt internet access 6. Pt able to consent. Cohort 1 had no intervention, Cohort 2 enrolled pts into MyLVHN, and Cohort 3 provided education only. Target enrollment was 125 pts in each cohort. A 30-day post-retrospective chart review was designed to compare cohorts. Early termination of intervention one occurred due to low enrollment, resulting in a modified methodology, which follows. Intervention two were semistructured qualitative interviews of ED pts focused on access to care, pt care interactions, barriers to care, and PPs. Themes were identified. Pt inclusion criteria: 1. English speaking 2. Age 19 or older 3. NAD 4. Pt able to consent.

**Problem Statement**

In adult patients (pts) presenting to the ED with a chief complaint (CC) of shortness of breath (SOB) who are assisted with MyLVHN enrollment prior to discharge from the ED, is pt follow-up improved at 30 days post discharge?

**Results**

913 pts reviewed, 53 pts with CC of SOB, 34 pts met inclusion criteria and 4 agreed to enroll in MyLVHN. No enrolled pts utilized their MyLVHN account at 30-days post discharge. Early termination of intervention one occurred due to low enrollment, as stated above. Intervention two was implemented to investigate low pt enrollment. 94 pts were interviewed. 89% reported good access to healthcare, 92% reported being insured, and 82% had communicated with their PCP (Primary Care Physician) before coming to the ED. Major themes of ‘good access to healthcare’ included: 1. Timely attention 2. Prescriptions easily filled 3. Access to home healthcare 4. Insurance coverage. Major themes of ‘the most difficult barrier to healthcare’ included 1. Long wait in office 2. Poor pt-doctor communication 3. Transportation 4. Difficulty scheduling. Pts reported interest in using PPs as a communication tool with their provider.

**Conclusions and Future Implications**

MyLVHN Enrollment Project was designed to understand the pt perception of PPs and potential impacts on health outcomes. Our original intervention’s inclusion criteria were too narrow, enrollment was inadequate, and intervention one was terminated. We learned that in a narrow population, approximately 1 in 9 pts approached would enroll in a PP. This information can be used in the design of interventions on small populations. Intervention two provided an understanding of pt values and also helped redefine ED pts. Pts reported wanting more direct communication with their providers. The most anticipated feature of PPs was ‘text messages’ with providers. By leveraging pt values we can better design PP intervention studies and improve utilization of PPs. Most interviewed pts were insured, had communicated with a provider before being send to the ED, were happy with their access to care, and were not in acute distress. In the future, studying the referral patterns of PCPs to the ED will help determine reasons for ED visits in the insured, non-acute population.